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Reading the Patient

A Field Guide to Dimensional Psychiatry

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Colophon

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This book is for the practising clinician and the curious reader. Nothing in it constitutes individual medical advice. Diagnostic and treatment decisions remain the responsibility of the clinician at the bedside, working with the patient, the family, and the rest of the team.

All clinical scenarios in this book are composites. No real patient is described. The patterns are real. The people are not.

A note on safety

Nothing in this book constitutes individual medical advice. Diagnostic and treatment decisions remain the responsibility of the clinician at the bedside, working with the patient, the family, and the rest of the team. Where the book offers operational guidance about starting medication or holding a referral in primary care, the guidance assumes three things: that you have run a competent suicide-risk screen and the screen is negative; that the picture you are reading is moderate, not severe; and that you have access to psychiatric escalation if the picture changes. The dimensional reading is a thinking tool. It is not a substitute for the safety practices you already know.

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The HiTOP map

A single-page reference to the dimensional model the rest of the book uses. The reader who wants the architecture in front of them while reading the chapters that follow should keep this page open. The full taxonomy with pitfalls is at Appendix A.

The general factor

p-factor is the loading of psychopathology regardless of type. High p means the patient is unwell across several spectra at once; this is one of the most prognostic findings in modern psychiatry.

The six spectra

SPECTRUM	ONE-LINE DEFINITION	SYNDROMES THAT LOAD
Internalising	Distress turned inward.	Major depression, GAD, panic, social anxiety, PTSD, OCD (partial), eating disorders.
Thought disorder	Disorganisation of perception, belief, form of thinking.	Schizophrenia, schizoaffective spectrum, psychotic mania, severe poor-insight OCD.
Disinhibited externalising	Impulse poorly held.	Substance use, ADHD, conduct disorder, impulsive antisocial.
Antagonistic externalising	Impulse held but pointed outward.	Antisocial personality, narcissistic spectrum, cluster B, organised antisocial.
Detachment	Withdrawal of affect and attachment.	Schizoid, avoidant, severe negative symptoms, autistic spectrum (partial).
Somatoform	Body as the language of distress.	Functional neurological disorder, persistent somatic symptoms, illness anxiety.

Working sentence

This patient is loaded high on [spectrum], moderate on [spectrum], with a [low / moderate / high] p-factor in the context of [biographical fact].

Opening

A young woman, four days awake

She was twenty-six and she had a baby and she had stopped sleeping. Five days, she said. Or possibly four; the husband said five and she let him, the way you let someone tell a story when the difference does not seem important to you any more. She was not crying. She was folding and unfolding a hospital wrist tag with the air of somebody politely waiting for a train.

The intern saw a sleep complaint and wrote, quite reasonably, *postpartum insomnia, advise sleep hygiene, review*. The family physician on call, who had seen one too many late-onset thyroid presentations that week, asked for a TSH. The on-call consultant from psychiatry arrived an hour later. The obstetrics ward did not always send for psychiatry early. She looked at the same patient and saw what the others had not. The husband was the one keeping his wife in the chair. Her speech had a quiet unhurried pressure underneath it. Yesterday she had spent the small hours rearranging the kitchen, because the spice tins were out of alphabetical order, and this had felt to her like an excellent and overdue use of the time.

Nobody was wrong. They were standing at different distances from the same person and they were each describing what they could see from where they were.

It is worth pausing on why those three clinicians produced three different readings of the same woman, because the answer is not that two of them were careless. The answer is that each was reaching, automatically, for a different mental model. The intern's model was symptom-as-complaint: a patient says she cannot sleep, you treat the not-sleeping. The family physician's model was the rule-out reflex of internal medicine: before you call something psychiatric, exclude the metabolic causes, because thyroid disease imitates everything. The psychiatrist's model was a pattern across time and across the body in the chair: not what the patient says about herself, but what the room is showing. None of these models is foolish. They are inherited tools, and each

clinician was using the tool they had been handed. The thing none of them had been handed, in undergraduate training, was a way of asking *along which dimension is this woman currently moving, and how far has she moved*. Frameworks are not optional intellectual luxuries. They are the difference between three readings that talk past each other and a reading that holds.

What this book is, and what it is not

You will not finish this book and become a psychiatrist. That is not what it is for. You will, if it does its job, finish it and recognise the shape of the patient in front of you a little earlier. You will know which language to use to ask the next question. You will know what your psychiatry colleague means when she says the patient is loaded internalising, or that this presentation is more antagonistic than detachment, or that the picture is consistent with high p-factor, and you will not need to nod politely while wondering what those words even refer to.

Let me say plainly who I am writing for. The MBBS intern at two in the morning, with a patient on a trolley and a senior who is in another ward and a textbook that is no help at this hour. The family physician on a Wednesday evening, with the third low-mood presentation of the day and a ten-minute slot. The emergency registrar who has been handed a man pacing the corridor and has to decide, quickly and on insufficient information, whether this is the start of something serious. The senior psychiatry resident revising before the viva, who knows the DSM cold and is quietly aware that the DSM is no longer how the field actually thinks. The MPhil clinical psychology student who has read the syndromes but has not yet seen them walk through a door. The informed lay reader is welcome. The clinician with a stethoscope is the person I am writing for first.

There is an argument inside this book that I want to make explicit, because the alternative is to bury it and let the reader pretend it is not there. Indian psychiatry, as a system, asks the family physician and the medicine registrar and the emergency officer to refer almost every psychiatric question upstream. There are reasons for this; the system also has costs. The family physician who has known a patient for fifteen years sees the depressive episode coming before any of us do. The medicine registrar at one in the

morning is the one who decides whether the agitated young man goes to a side room or to a side ward. The family physician on a Wednesday afternoon is the one who can start an antidepressant that the psychiatrist will not see for another four months. This book takes those clinicians seriously, by name. It teaches them what they need to act safely and well in their own setting. It does not pretend they will become psychiatrists. It also does not pretend that everything they meet must be passed on. That is the argument the rest of the book is going to make. Now we begin.

What you need at those moments, I am going to argue, is not another checklist. The checklists exist already, free, in many editions, and they are good at the thing they were built to do, which is to make psychiatric diagnoses reliable across clinicians on different continents. They were never built to teach you how to see. A textbook gives you the categories; a checklist gives you the inclusion criteria; this book is meant to give you the lens you put on before you reach for either. It is a teaching text, not a reference book. Every concept is going to be unpacked as if you have not met it before, because most readers have not, and the readers who have can skim. The promise is small and deliberate. Read this book and you will see a psychiatric patient through the lens that academic psychiatry actually uses now. Not the DSM-5 checklist most clinical teaching still defaults to. Not because the checklists are wrong; they have a place, and the place is later. The first thing you should be doing when you meet a psychiatric patient is not pattern-matching against a checklist. It is something older and more useful, which is *seeing*.

Eight domains. One new map (it is called HiTOP). One revolution borrowed from physics by way of vision science (it is called predictive processing). Three clinical scenes in the second half of the book, each written from a different room. Each scene is invented; the patterns inside them are not. The woman with the wrist tag is the test of whether any of this is worth your time.

Psychiatry is the medicine of inference under uncertainty

That is also a tidy description of the whole of clinical medicine, of course. But psychiatry has fewer hard tests than the rest of medicine, and more language, which means

the inference happens out loud, in real time, often in front of a frightened family, and it has to be done well or the family will leave thinking nothing happened. The work of a psychiatrist is to make a defensible probabilistic guess about a person's inner life, on the basis of how they look, what they say, what they do not say, what their family says about them, and what the body tells you when the words run out. The work is then to keep updating that guess across days and weeks as more information arrives. Inference under uncertainty. Bayesian medicine, if you like.

Let me slow down here, because the word Bayesian gets used carelessly and I do not want to lose you. The simple intuition is this. Before you meet a new patient, you already carry an expectation about what kind of trouble is likely. That expectation comes from where you are working, what you have seen lately, what the referral note said, what the ward sister mentioned in the corridor. That prior expectation is what statisticians call a *prior*. It is not a prejudice; it is a baseline probability. When you sit down with the patient, every new piece of information either nudges that prior up or nudges it down. A flat expression nudges one way. A specific delusion of being followed nudges another. A blood pressure of 180/110 nudges a third. Bayesian reasoning is just the orderly habit of letting each new piece of evidence change your prior by the right amount, no more and no less. Strong evidence should move the prior a lot. Weak evidence should move it a little. By the time you finish the interview, your guess about what is going on is the prior plus all the evidence the room gave you. Psychiatry feels uncertain not because the reasoning is loose but because the priors are wide and the evidence is mostly verbal and behavioural. The reasoning is exactly the reasoning your medicine colleagues do when they decide whether the chest pain is cardiac. They have a troponin to anchor them. We have the patient in the chair. The logic is identical; the inputs are softer.

This is the spirit of the book. We will move through eight observable domains of the mental state examination and we will, for each one, ask three questions. What does this look like in the room. Which dimension of psychopathology does it load on. What is the next sentence the clinician should say. We will then walk through three clinical scenes

that demonstrate the same eight-domain reading applied to three different bodies. We will close with a brief, honest section on when to refer, when to start, and what to actually expect from psychiatric treatment in 2026.

That is the whole project. The woman from the obstetrics ward, in the language of the chapters that follow, is loaded internalising with thought-disorder features and a rising p-factor. Let me unpack that sentence, because by the end of the book it should feel as ordinary as saying that a patient is volume-overloaded with renal involvement. *Loaded internalising* means her distress is turned inward and presents as the misery-and-fear family of symptoms; the not-sleeping, the unease, the quiet pressure. *Thought-disorder features* means there is something in the form of her thinking, not just the content, that is starting to come apart; the alphabetised spice tins at three in the morning are not a quirky habit, they are a sign that the goal-direction of thought has slipped. *Rising p-factor* means the overall load of psychopathology is climbing rather than steady; whatever the eventual label, this woman is getting worse, not better, and the trajectory matters more than the label. Three pieces of information, in three short phrases, doing more work than half a page of free text. Whether those words mean anything to you yet is the question this book is going to answer. Let us begin where everyone begins, which is with the question of why the categories you were taught do not always seem to match the patients you meet.

Part I. How psychiatry actually thinks now

1. From categories to dimensions

Most clinicians of your generation were taught psychiatry the way one is taught biochemistry. There are pathways. There are syndromes that sit at the end of those pathways. The job of the diagnostician is to recognise which pathway the patient is on and to give it the correct name. The DSM and the ICD, in their reasonable and well-intentioned way, have spent the last forty years compiling those names and tightening up the rules for using them, and the result is a working dictionary of mental disorder that almost everybody on the planet now reads in the same language. That is a real achievement. We should not be casual about it.

It helps, before going further, to be explicit about what a category is and what a dimension is, because the rest of this book leans on the difference. A category is a box with a yes-or-no membership test. Either the patient meets criteria for major depressive disorder or she does not. The decision is binary, and a clinician sitting in Bangalore is meant to make the same decision as a clinician sitting in Boston, given the same patient. This is a remarkable feat of standardisation, and it solves a real problem, which is that until the late 1970s the same patient could be called schizophrenic in New York and manic-depressive in London, and nobody quite knew what anyone meant. The DSM-III in 1980 was the great leap; it traded ambition for reliability. Boxes are not glamorous, but boxes communicate. A dimension, on the other hand, is a continuum. The patient is not in or out; she is somewhere along it. Blood pressure is a dimension. Renal function is a dimension. Mood is a dimension. The question is not *does she have it*; the question is *how much of it does she have, and is the amount rising or falling*. Medicine, almost everywhere except psychiatry, has long since accepted that most clinically important things are dimensional. We use cut-offs because we have to make decisions, but we know perfectly well that the patient with a creatinine of 1.4 is not in a different disease category from the patient with a creatinine of 1.3.

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The trouble is that the psychiatric dictionary is a snapshot of a moving thing. The categories were drawn up to be reliable, which they largely are; they were not drawn up to be true, which is a different question and one the manuals have always been honest about. When you sit with two hundred patients labelled *major depressive disorder*, you find very quickly that you are sitting with at least four different illnesses and possibly seven, and that the things they share with each other are sometimes less interesting than the things they share with patients sitting next door under a different label. Take that label apart for a moment. Patient A is the woman who has been low for three months after losing her mother, sleeps too much, has gained weight, cannot bring herself to wash her hair, and feels that the world has gone grey. Patient B is the young man whose mood has swung darkly since adolescence, who cuts himself when the loneliness gets unbearable, and who has been low for ten of the last twelve weeks. Patient C is the older gentleman who has stopped eating, lost six kilos, believes he has a tumour the scans cannot find, and lies awake from three in the morning. Patient D is the fortyish executive who is functional all day but cannot feel anything, who has not cried in nine months, and whose wife says he has gone somewhere she cannot reach. Same label. Four different illnesses. Anyone who has spent a year in a psychiatric outpatient department has met all four, and the suspicion that they cannot all be the same thing is not pedantic. It is correct.

Comorbidity, which the textbooks treat as an inconvenient complication, turns out on inspection to be the rule rather than the exception. By the time you reach a tertiary-care outpatient department, the patient with pure depression and nothing else is almost a curiosity. Most of your depressed patients are also anxious. A good number are using something. Several have personality features that complicate the picture. The textbook treats this as noise; the dimensional view treats it as signal. If most depressed patients are also anxious, perhaps depression and anxiety are not really separate boxes at all. Perhaps they are two readings on the same underlying gauge.

The patients also do not stay still. The young man you saw last year as a panic disorder is in your room this year with what looks more like an obsessive picture, and the patient

before him, who started out depressed at twenty, is forty now and presenting with what the books would call somatoform but feels in the room like the same illness wearing different clothes. Anyone who has done psychiatry for ten years has had this experience. The categories shift. The patients underneath them do not, particularly. What is changing is which face of the same underlying load happens to be presenting today. Categories cannot accommodate this. A patient cannot be in the panic-disorder box one year and the obsessive-compulsive box the next without the bookkeeping looking absurd. A dimensional view absorbs it without protest: the loading on the internalising spectrum stayed where it was, the surface symptom shifted, the underlying gauge barely moved.

There is also the boundary problem, which is the categorical view's quietest embarrassment. Categories require boundaries, and boundaries in psychiatry tend to be drawn in pencil. The line between major depression and persistent depressive disorder is a particular number of weeks. The line between bipolar I and bipolar II is whether the elevated state ever rose to a particular level of disruption. The line between social anxiety and avoidant personality is whether the avoidance is described in trait language or state language. These lines are not silly; they had to be drawn somewhere, because manuals must commit. The patients, however, do not respect the lines. They straddle them. They cross them in either direction over months. They sit on them for years. The categorical view treats the straddling patient as a diagnostic puzzle. The dimensional view treats the straddling patient as the ordinary case, because of course a continuum has more patients near the middle than near either pole. The boundary problem is not a flaw the manual writers missed; it is the natural consequence of trying to put boxes around something that is shaped like a hill.

There is one more idea you will need to hold loosely as we go on, and I will come back to it properly in the next section. Researchers who have looked at large samples of psychiatric patients keep finding that there is a single broad factor underneath all the disorders, a kind of general loading, that statisticians call the *p-factor*. Patients high on p tend to be high on lots of things at once. Patients low on p tend to have a specific

bounded illness and recover. The p-factor is roughly the psychiatric analogue of what general medicine calls *severity of illness*; the more p you have, the more your various symptoms blur into each other, and the less the specific label tells you. You will hear this idea three more times in this book, in slightly different words. That is intentional. It is the central new fact about how psychopathology is shaped, and one paragraph is not enough.

A short note on what we are not doing here. The dimensional view is not a rejection of categorical diagnosis. It is a layer above it. Insurance forms still need a code. Medication trials are still organised around diagnostic groups. The MD viva will still ask you for inclusion criteria. None of that goes away. What changes is the order of operations. You see the patient dimensionally first. You translate to a category second, when an external system requires it, and you do the translation knowing exactly how much of the patient the category leaves out. A clinician who can do both is more useful than one who can do only one, and the clinician who can do only the categorical translation is the one who tends to get stuck when the picture does not fit.

The clean way to think about all of this is that the diagnostic categories are useful at the level of the prescription pad and unhelpful at the level of the person. They tell you, roughly, which family of treatments has the best evidence base for the picture you are looking at, and that is not nothing. They do not tell you who you are looking at, or what the next ten years will hold, or what to say to the family in the corridor. For those questions, you need a different kind of map.

The different kind of map is a dimensional one. Instead of asking *which box does this patient fit into*, you ask *where does this patient sit on each of the dimensions of human psychopathology*. The patient may sit very high on one dimension and quite low on another and somewhere in the middle on a third, and the resulting profile is a far better predictor of what the next five years will look like than any single label could be. This is the central claim, and once you have it in your hand, the rest of the book is a working out of its consequences.

2. HiTOP in plain English

The most successful attempt so far to organise psychopathology dimensionally is called HiTOP. It is short for Hierarchical Taxonomy of Psychopathology, and the name is worth taking apart for a moment, because the words are doing real work. *Hierarchical* means that the model has levels. The big spectra at the top contain smaller syndromes underneath, which in turn contain individual symptoms. *Taxonomy* is just the old word for a classification system; biology has one for living things, chemistry has one for elements, psychiatry now has one for psychopathology. The two words together promise something that DSM never quite did, which is a way of describing a patient at whichever level of resolution the clinical question demands. You can say *internalising* when that is enough. You can say *internalising, distress sub-factor, depression syndrome, melancholic features* when the picture deserves the precision. You decide.

HiTOP was assembled by an international consortium of clinicians and researchers who had become quietly impatient with the limits of categorical diagnosis. The first major paper appeared in Kotter, Krueger, Watson, and colleagues in 2017. The full update from the same group followed in 2021. It is now the model that most academic psychiatry departments outside India use to organise their thinking, and it is increasingly the language Indian psychiatry training programmes are folding into their formulation pages.

The HiTOP map looks complicated when you first see it; it is, at heart, very simple. It says that human psychopathology can be described as a small number of broad spectra, each of which contains a smaller number of recognisable syndromes, each of which contains a smaller number of specific symptoms. The same symptom can sit on more than one spectrum, which is exactly what your clinical experience already tells you. Insomnia is not the property of any single disorder; it loads on internalising, it loads on thought disorder, it loads on substance use. The map does not pretend otherwise.

There are six broad spectra in the consensus version of the model. Let me walk you through each one with a single concrete vignette, the kind of one-sentence picture that would let you recognise the spectrum in a patient next Tuesday.

Internalising covers distress turned inward. It is the misery-and-fear family. Depression, generalised anxiety, panic, social anxiety, post-traumatic stress, and the larger part of obsessive-compulsive presentations all live here. The thirty-two-year-old schoolteacher who has been crying quietly for four months, whose body aches in unspecific ways, who feels she has failed her children although her children are fine; she is your high-internalising patient.

Thought disorder covers the disorganisation of perception, belief, and form of thinking that defines the schizophrenia spectrum and runs through the severe schizoaffective and psychotic-mania presentations. The twenty-year-old engineering student whose flatmate brought him in because he had spent three days drawing a diagram on the wall that proves the network is reading his mind; the diagram has internal logic, which is why his brother had not been worried until last week. He is your high thought-disorder patient. So, in a quieter way, is the woman with the wrist tag from the Opening; the alphabetised spice tins at three in the morning are not a personality detail, they are an early thought-disorder sign.

Disinhibited externalising covers impulse poorly held. Substance use disorders, attention-deficit, conduct disorder, impulsive antisocial behaviour, the patient who keeps doing the thing that has caused him trouble before because the brakes simply do not engage. The forty-one-year-old contractor who has lost two jobs to drinking, who knows perfectly well he should not have the second peg and who has it anyway, whose plans for the future are sincere on Sunday and forgotten by Wednesday; he is your high disinhibited-externalising patient.

Antagonistic externalising covers impulse held but pointed outward. Cluster-B antagonism, the narcissistic spectrum, the more organised antisocial presentations. The trick here is that antagonistic externalising is not necessarily impulsive; it can be cold, controlled, and effective. The thirty-six-year-old businessman who has been brought in by a wife who is finally leaving him, whose interpersonal style is to win every argument and remember every slight, whose charm in the consulting room is precise enough that you find yourself half-believing him by minute fifteen; he is your high antagonistic

patient. Notice that disinhibited and antagonistic are both *externalising* but they are not the same. The brakes-off patient is not the same as the brakes-on-but-aimed-at-others patient. DSM tends to mash them together. HiTOP separates them, and the separation is clinically useful.

Detachment covers the quiet ones. The withdrawal of affect and attachment, where schizoid and avoidant traits sit alongside the negative symptoms of schizophrenia and parts of the autistic spectrum. The twenty-eight-year-old IT analyst whose mother brought him in because he no longer comes out of his room, who answers your questions politely and briefly and accurately, whose face does not move much, who is not unhappy in any way he can describe and is not happy either; he is your high-detachment patient. Detachment is easy to miss because it does not complain. The patient is not in distress; the people around the patient are.

Somatoform covers the body as the language of distress. Functional neurological disorder, persistent somatic symptoms, illness anxiety. The fifty-year-old housewife who has had three CT scans of the abdomen in a year, all normal, whose pain is real to her and unhelped by the analgesics, whose family is exhausted from being told that nothing is wrong; she is your high-somatoform patient. The somatoform spectrum sits awkwardly between internal medicine and psychiatry, which is why these patients accumulate investigations and lose clinicians.

The full map sits as a fold-out at the front of the book; the reader who wants the architecture in front of them should look there now.

Above these six, the model places a single broad factor, which it calls the p-factor, and which represents the general loading of mental disorder regardless of type. The p-factor was first formally described by Caspi and colleagues in 2014, working with the Dunedin birth cohort, when they noticed that statistical models of psychopathology kept finding a single broad factor underneath all the specific ones, much the way intelligence research had long ago found a g-factor underneath specific cognitive abilities. Patients high on p tend to be high on several spectra at once. They tend to have started young,

they tend to do less well over time, and they tend to need more sustained care. P-factor is measured, in research settings, by combining the patient's loadings across all the spectra and pulling out the variance that is shared between them. In the clinic you do not measure it; you sense it. It is the impression a senior psychiatrist gives when she comes out of a long interview and says *this one is going to be a difficult patient for a long time*. She is not being defeatist. She is reading the p-factor off the room. The p-factor is one of the model's most clinically useful features, because it captures something every senior psychiatrist already knows in their bones, which is that some patients are simply more unwell across the board than others, and that this fact is more prognostic than any single diagnostic label.

If you are not sure about the p-factor yet, do not worry; it returns several times in Part II, where it begins to do real work.

Underneath the six spectra, the model places clusters of disorders, and underneath those, the actual symptoms. Hierarchy. Not menu. The point is not to make you choose; the point is to let you describe the patient at whichever level of detail the clinical question requires. This is also why HiTOP handles two of the things DSM struggles with, comorbidity and heterogeneity, more naturally. Comorbidity, in DSM, is when a patient meets criteria for more than one disorder, and it is treated as a complication. In HiTOP, comorbidity is mostly an artefact of having drawn the boxes too small in the first place. A patient who meets criteria for major depression and generalised anxiety is not a patient with two disorders; she is a patient with high internalising who has been described, by the manual, twice. Heterogeneity, the fact that two patients with the same label can be very different people, is a sign that the label is too coarse; HiTOP solves it by letting you describe the same internalising loading with sub-factors and specific syndromes underneath, until the description is fine-grained enough to capture the difference between the bereaved schoolteacher and the executive who cannot feel.

It is worth being explicit about what hierarchy actually buys you, because the word can sound technical without seeming useful. A hierarchical description lets you change the resolution of your reading depending on the question. When you are calling the night

duty doctor at home, you say *high internalising, rising p, sleep collapsing*; that is enough for the next two hours. When you are writing the discharge summary, you go down a level: *internalising spectrum, distress sub-factor, depressive syndrome with melancholic features and prominent insomnia*. When you are sitting with the patient herself and her husband, you go up a level: *the picture is a depression, and underneath the depression is a wider load on the system; we are going to treat the depression and we are also going to think about why the load is high*. Same patient, three resolutions, three different conversations. Categories cannot do this; a category is at one resolution by design.

A short example will fix this. A 32-year-old woman is referred with depression that has not responded to two SSRIs. The DSM label is *major depressive disorder, recurrent, severe, without psychotic features*. The HiTOP description is *high internalising, moderate detachment, low p-factor when first seen but rising over six months, somatoform features in the form of persistent gastrointestinal symptoms*. Same patient, two ways of describing her. The first description tells you which class of medicine to try next. The second description tells you why two SSRIs were not enough, where she is heading, and what to say to her general physician about the abdominal pain. Both are useful; they are useful for different things.

A second example, a different kind of patient. A 19-year-old boy is brought to the emergency room by his uncle after a fight at home. The DSM label is, plausibly, *intermittent explosive disorder, rule out emerging bipolar, rule out substance use*. Three rule-outs and one diagnosis, none of which tells you very much. The HiTOP description is *moderate antagonistic externalising, moderate disinhibited externalising, low internalising, low thought disorder, p-factor low to moderate, no detachment features*. Now look at what the second description does that the first cannot. It tells you the brakes are loose and there is an outward edge to the impulse, but the patient is not unwell across the board; the load is concentrated. It tells you where to focus, what to expect over the next year, and which family conversations are likely to help. The first description tells you, essentially, that the boy hits people sometimes. The second description tells you what kind of trouble he is in.

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A practical word about how HiTOP is best used in the room. You do not need to memorise the full map. You need to know which spectrum each presenting symptom loads on, and you need to know that any patient is allowed to sit on more than one spectrum at once. That is most of the work. The detailed taxonomy is a reference document that you keep on your phone, the way a clinical pharmacologist keeps the BNF. You consult it when the picture is unusual; the rest of the time, you operate from a working internal version of the six spectra and the p-factor, and you find very quickly that the patients become easier to talk about and the registrar discussions become more honest.

3. Computational psychiatry, briefly

If HiTOP is the new descriptive map, computational psychiatry is the new explanatory frame. The two are independent and can be used separately; they fit together quite naturally, and the fit is part of what makes the current moment in psychiatry interesting.

The frame, in one sentence, is that the brain is a prediction machine, and many psychiatric symptoms are what happens when the predictions go wrong in particular ways. That sentence is doing a lot of work, so let me unpack it slowly.

Start with the word prediction. We tend to use the word in its conscious sense; you predict that it will rain on Sunday, you predict your team will lose the match. The brain's predicting is not like that. It is constant, automatic, and largely below awareness. Every fraction of a second, your brain is generating an expectation of what the next moment will look, sound, and feel like. When you reach for a cup, your brain has already predicted the weight of the cup before your fingers close around it; this is why a cup that turns out to be empty when you expected it to be full produces that small jolt of confusion. When you walk into a room, your brain has already predicted the layout, and if a chair has been moved, your visual system flags it before you consciously notice. Perception, on this view, is not a passive intake of sensory data. It is your brain's running prediction, gently corrected by the senses where the prediction was wrong.

Now the second key word: prediction error. A prediction error is the gap between what the brain expected and what arrived. Every time the world fails to match the prediction, the system generates an error signal, and that error signal is what nudges the brain to update its model. Most prediction errors are tiny and unconscious. The cup was slightly heavier than expected; you adjust grip, end of story. Some prediction errors are large and dramatic; you walk into your living room and there is a stranger sitting on your sofa. Prediction errors are the currency of learning. Without them, the brain's model of the world would never update.

The third key word, and this is where it gets interesting, is precision. Precision is the brain's confidence weighting. For every prediction the brain makes, and for every signal coming in from the senses, the brain assigns a precision: how much should I trust this. A high-precision prior means the brain is very confident in its expectation. A high-precision sensory signal means the brain is very confident in what the senses are reporting. Mental life, in this frame, is largely a running balance between these two, and the precision the brain assigns to each shifts the balance. If priors are weighted very high and sensory signals very low, your perception will be dominated by what the brain expected; if sensory signals are weighted very high and priors very low, your perception will be dominated by what just arrived.

Karl Friston, working at the Wellcome Trust Centre in London, formalised this as the free-energy principle in a series of papers from the late 2000s onward, with the canonical paper appearing in 2010. The framework is now the dominant computational story being told about why mental disorders look the way they do.

This sounds abstract until you see it applied. Take hallucinations first, because the sensory case is the cleanest. A patient with psychosis, in this frame, is someone whose brain has assigned too much precision to certain priors and too little to certain prediction errors. The expectation that a voice will be heard is weighted so heavily that the absence of a real auditory signal is no longer enough to overrule it. The patient is, in a literal sense, perceiving what their brain predicted rather than what arrived. Adams, Stephan, Brown, Frith and Friston laid this out for psychosis in a much-cited 2013 paper,

and the model has held up reasonably well; it explains why delusions are stable (the prior is too strong to be moved by ordinary evidence), why hallucinations have the compelling quality of perception rather than imagination (because perception itself is built largely from priors), and why insight comes back slowly (because what is recovering is the precision balance, not a single belief).

Now mood. A patient with depression, in the same frame, is someone whose model of the future has collapsed onto a narrow band of bleak predictions, and whose precision weights make positive prediction errors hard to register. The good thing that happens is real, but the patient cannot use it; the brain's running model is so heavily weighted toward the bleak prediction that the disconfirming evidence does not make it through. This is why genuine reassurance often does not help in the room; the prior is doing the work, and the prior is not what your sentence is touching. The clinical correlate is the experience that depressed patients themselves report, that good news arrives muted, as if behind glass.

Now anxiety. A patient with anxiety is over-predicting threat. The prior on something-bad-about-to-happen has been weighted so heavily that ordinary safety signals fail to update it. This is why anxious patients can know, in the rational part of their mind, that they are not in danger and still feel the danger fully; the rational knowledge is at one level of the system, and the precision-weighted threat prior is at another, and the lower level is louder. It also explains why anxiety is sticky. The threat prior is not built from a single thought; it is built from years of weighting, and weighting is not what a single conversation can shift.

A fourth case is worth flagging because it changes how you read autistic patients. Pellicano and Burr, in 2012, suggested that autism could be understood as the opposite imbalance: the priors are weak and the prediction errors are very strong. The world arrives raw, without the smoothing that priors normally provide. This explains the sensory overload, the difficulty with novelty, the preference for exact repetition, in a way that the older deficit-of-theory-of-mind story never quite did.

Take one of those cases and walk it through the frame, just to see the apparatus working in the room. A forty-six-year-old businessman comes in convinced his junior partner is poisoning the office water cooler. The belief is six months old, has survived two changes of office, has cost him one friendship, and is now costing him sleep. Categorically, this is a delusional disorder, persecutory subtype. Computationally, the question is which prior has become over-weighted, and which prediction errors are being shut out. The prior, in his case, is the prior on betrayal; he has been betrayed before, by a previous partner, in a way the system never updated from properly. Sensory and social signals that would normally update that prior, such as the partner's ordinary friendliness in the corridor, the absence of any physical evidence, his wife's gentle reassurance, are being arriving with too little precision; the prior is too strong to be moved. Notice what the frame predicts. It predicts that direct argument will not work, because direct argument is just another low-precision signal trying to push against a high-precision prior. It predicts that the symptom will be unusually stable, because the system has stopped being open to disconfirming evidence. It predicts that medication, by adjusting the precision balance broadly across the system, may help even though no medication will address the specific belief. All three predictions tend to be borne out, which is part of why clinicians have found the frame useful even when they cannot follow the underlying mathematics.

The frame also makes sense of one of the most baffling things about psychiatric recovery, which is that insight comes back slowly, and in steps that do not feel proportional to the patient's effort. If insight were a single belief, you would expect it to flip; the patient one day realises the partner is not poisoning the water and the picture resolves. Insight is not a single belief. It is the precision balance returning to something nearer normal. The first thing that comes back is the willingness to entertain the possibility that the belief is not certain. The second thing that comes back is the ability to register a single piece of disconfirming evidence without dismissing it. The third thing that comes back is the patient's own surprise at how strongly they had held the belief. Each of those is the precision weighting moving by a small amount. None of them is a flip. This is why a senior psychiatrist will say, of a recovering patient, *insight is partial*, and mean

something specific by it; partial insight is what the precision balance looks like halfway home.

You do not need the mathematics to use the frame. The clinical move is simply to ask, of any psychiatric symptom you do not understand, *what is this patient predicting and what evidence are they failing to update on*. It turns out to be a remarkably useful question. It cuts through a great deal of older language and points you straight at the level of intervention; if the prior is too strong, you are looking at therapy that helps with belief flexibility, and if the prediction errors are too noisy, you are looking at containment, structure, and quite often medication.

The reason this matters for non-psychiatrists is small but real. When your psychiatry colleague says *I think she is over-weighting threat priors* or *the precision balance is off*, they are not being theatrical. They are using shorthand from a real model. You can read it as *anxiety is high, reassurance is not landing, expect this picture to be sticky*, and you will not be wrong. You will, in fact, be quite close.

4. Network thinking

A third strand has been quietly reshaping how clinicians describe individual patients, and it now deserves its own section. The strand is called network thinking, and it was sharpened into psychiatric form by Denny Borsboom and colleagues at the University of Amsterdam in the 2010s, with Borsboom's 2017 paper offering the cleanest statement of the position.

The starting move is to take seriously the idea that symptoms cause each other. The categorical view treats symptoms as outputs of a hidden disorder, the way a fever and a cough are outputs of an underlying pneumonia. The network view says that in psychiatry there often is no underlying entity in that sense; the symptoms themselves are doing the causing, and the disorder is the pattern they make together. Insomnia causes fatigue. Fatigue causes loss of concentration. Loss of concentration causes loss of confidence at work. Loss of confidence at work causes low mood. Low mood causes insomnia. The disorder, on this picture, is not an underlying entity that produces the symp-

toms; the disorder *is* the network, and the work of treatment is to weaken the connections in it until the system stops resonating.

The network metaphor is worth sitting with for a moment, because it is a precise picture, not a vague one. Imagine the patient's symptoms as nodes, drawn as small circles. Now imagine a line, called an edge, drawn between any two symptoms that influence each other. A thicker line means a stronger influence. The whole pattern of nodes and edges, taken together, is the patient's network. Different patients have different networks, even when they carry the same diagnostic label. Two patients with major depression can have networks that look very different; the edges are arranged differently, the central nodes are different ones, and what holds the picture together in one patient is not what holds it together in the other.

The most useful idea that comes out of network thinking is the *keystone symptom*. In any given patient's network, one or two nodes turn out to be doing a disproportionate amount of the holding-together work. Cut the edges connected to that node and the rest of the network loosens; leave it intact and your interventions on the other nodes will keep being undone. The keystone is patient-specific. Insomnia is the keystone in a great many depressions, which is why treating sleep alone is sometimes enough to release the rest of the picture. Avoidance is the keystone in many anxiety disorders, which is why exposure work is more powerful than reassurance. In the patient whose two evening pegs are the load-bearing wall, alcohol is the keystone; the depression and the marital trouble and the morning tremor are all downstream of those two pegs, and the categorical framing that says he has *both* a depressive disorder and an alcohol use disorder misses the architecture entirely. He has one network. The keystone happens to be alcohol.

For the working clinician, the practical contribution of the network frame is that it gives you a language for the *one symptom* that, in a particular patient, seems to be holding everything else in place. The patient who cannot let go of the fight with her mother in 2019. The patient whose insomnia, once treated, releases everything else. The patient whose two pegs in the evening, on examination, turn out to be the load-bearing wall of

their depressive picture. The categorical and the dimensional descriptions both miss this patient-specific architecture; the network description sees it directly.

Network analysis as a research method has its critics, and rightly so. The psychometrics are still being worked out. Bringmann and colleagues have been the most honest critics, pointing out that the early network estimates were unstable across samples, that small datasets gave dramatically different networks for the same disorder, and that the field had an over-confident first decade. Those criticisms are correct and they have reshaped how the research is now done. The clinical use of network thinking, however, is largely independent of the research-methods debate. As a way of *talking to a patient* about their own picture, the network metaphor has quietly become indispensable. You will hear it in any modern formulation meeting: *what is the maintaining factor, what is the keystone, where do we cut first*.

5. Illuminative psychiatry

Three frames have arrived in the last two decades, then, and the working clinician needs all three. HiTOP gives you a way of describing the patient. Computational psychiatry gives you a way of explaining why the picture takes the shape it does. Network thinking gives you a way of choosing where to cut first. Categorical diagnosis sits underneath all of this, doing the prescription-pad work it has always done. None of these frames replaces clinical judgment, and none of them is meant to. They are tools that help you think in front of a patient.

The reason to hold all three at once, rather than picking the one you find most convincing, is that they answer different questions. HiTOP answers *what is the shape of this patient's psychopathology*. Computational psychiatry answers *why is this symptom standing up, mechanically*. Network thinking answers *which symptom is holding the rest in place*. A clinician using only the first will describe the patient accurately but not know where to push. A clinician using only the second will have a story about the brain but no map of the patient's life. A clinician using only the third will cut in the right place without quite knowing what is being cut. Used together, they let you stand in front of a patient and say something like: *high internalising with rising p-factor, the precision*

balance has tilted toward narrowed forward prediction, and the keystone is the not-sleeping. Each phrase comes from a different frame. The sentence as a whole is more useful than any of them alone.

Working psychiatry, when it is done well, weaves these together into something that is older than any of them and that does not have a fashionable name. The aim of clinical psychiatry, in the end, is not to label a person; it is to *see* them, in the older sense of that word, the sense the word carries in a psychiatric history when a clinician says of a difficult case *I think I see what is going on now*. Throughout this book we will use the word *illuminative* for that act, because it captures the small, careful brightness that good clinical work brings to a person who has felt unseen. To illuminate a patient is to bring just enough light to the picture that the next move becomes obvious; it is not to floodlight them, and it is not to leave them in the dark while you reach for a manual. Illumination is what the patient is paying us for, whether the bill comes from a private clinic or the state hospital. Everything else, prescriptions and admissions and referrals included, is downstream of seeing clearly.

Return for a moment to the woman with the wrist tag. She is a high-internalising picture with thought-disorder features just beginning to emerge, on a rising p-factor trajectory; the computational reading is that her precision balance has tilted, with priors becoming over-weighted in a way that is starting to corrupt the form of her thinking; the network reading is that the not-sleeping is the keystone, because four nights of no sleep in the postpartum period will pull the rest of the system apart on its own. None of those frames was available to the intern or the family physician. Each, on its own, would have got them part of the way. All three, together, would have given them what the consultant arrived with: the ability to see, at the level of the room, what was actually moving, and to know which sentence to say next. That is the whole skill. The rest of this book is a working out of how to acquire it.

A practical word about how the three frames are best held in working memory, because nobody has time, in the consulting room, to consciously consult each. With practice, the frames collapse into a single habit of attention. You enter the room and you are already,

automatically, doing three things. You are placing the patient on the spectra, roughly, by what they look like and what they say. You are asking yourself which priors and prediction errors are doing the work in this person's symptoms. You are looking for the keystone, the one node that, if loosened, would slacken the rest of the system. None of this is conscious any more, by about the third year of doing it. It feels, from the inside, like simply seeing the patient. From the outside, to the trainee watching, it looks like a kind of slow magic, and the trainee says afterwards, *how did you know to ask about her sleep first*. The honest answer is that you did not know; the three frames pointed there together and you went where they pointed.

This is the working stance that the rest of the book trains. It is not a technique you can write on a card and check off. It is a way of standing in front of a person that integrates description, mechanism, and architecture into a single unhurried reading. We have called this *illuminative* because the verb captures the temperature; the room is brighter without becoming clinical, the patient feels seen without feeling examined, and the next clinical move presents itself rather than having to be hunted for. Illuminative psychiatry is the standard the second half of this book is going to teach you to meet.

The rest of the book is about how to see clearly, and how to read what you see. We turn next to the eight domains where the seeing happens, and to the dimensional map onto which the reading is written. Part II takes the eight domains of the mental state examination, one at a time, and asks of each: what does this look like in the room, which spectrum does it load on, what is the next sentence the clinician should say. Part III walks the same eight-domain reading through three clinical scenes, written from three different rooms, so that the apparatus is shown working under conditions that resemble real clinical hours. Part IV closes with the honest section on referral, treatment, and what to expect from psychiatric care in 2026. By the time you finish, the woman with the wrist tag will read very differently to you than she did at the start. The aim is not that you will know what to do with her. The aim is that you will know what you are looking at.

Part II. The dimensional mental state examination

The mental state examination is, in everyday practice, the single most important investigation a psychiatrist performs. It is also the one most often misunderstood by colleagues from other specialities, who tend to read it as a kind of structured interview when it is in fact something stranger and older. The MSE is not a list of questions. It is a description of a person at a moment in time, written in such a way that another competent clinician could read it and form roughly the same picture you formed in the room. The list of headings is a scaffold for the description, not the description itself.

We will move through eight observable domains. For each one, the same four pieces. What to look for in the room. Which HiTOP spectrum the finding loads on, when it loads on anything. The next sentence the clinician should say. The common pitfall, the one that earns the eye-roll in case-discussion. Each domain closes with a quick-reference table of observation, spectrum, what to think about, and what not to miss.

A working note before we start. The MSE captures the patient at the moment of the interview, anchored to the previous seven days. Document the date, the time, the language of the conversation, and whether a translator was used. An undated MSE is not interpretable. The discipline of the timestamp is the cheapest thing on this list and the easiest one to forget.

1. Stance

DOMAIN 1 · STANCE

What is this person showing me about how they are in the world?

LOADS ON
FIRST 60 SECONDS

Most MSE proformas you will find, including the one your psychiatry rotation handed you, do not have a heading called *stance*. They should. Stance is how the patient is

holding themselves toward the encounter. Not their gait, not their hygiene, not their cooperation rated on a four-point scale; the texture of the way they have agreed, or partly agreed, or not agreed, to be in the room with you. It is the first thing you read, often before the patient has spoken, and it is one of the most prognostic signals in the entire examination.

The standard proformas fold stance into general appearance and rapport, but the act of agreeing to be examined is not a neutral act, and the way it is done carries information the appearance heading cannot hold. The older textbooks called it *attitude towards the examiner* and graded it on a four-point scale; the texture deserves more.

A patient may sit forward and meet your eye and laugh too easily; that is a stance, and it is informative. A patient may sit back and answer minimally and offer nothing; that is also a stance, and it is informative in a different direction. A patient may seem to be performing the role of a patient, complete with the right amount of gratitude and the right amount of distress, and that is a third stance, with its own diagnostic implications. The stance is not, in itself, the diagnosis; it is the coloured glass through which the rest of the examination must be read.

Walk through four readings. The withdrawn stance. A young man on the post-natal ward with a head injury two months ago is brought to outpatients by his sister, who has been on leave from her bank job for a fortnight. He sits in the chair the nurse points him to. His shoulders are turned slightly away from you. He answers when spoken to, in the shortest possible phrase, and his eyes return each time to a point on the floor about two feet in front of him. The nursing handover noted that he ate breakfast in his room, which the staff thought was politeness; the sister, in the corridor before the appointment, told you that he had not initiated a conversation with her in a week. The right first move, with this stance, is not to push for content. It is to slow your own tempo to match his, to ask short, concrete questions, and to run the catatonia screen briefly before you conclude that the picture is simply depression.

The suspicious stance. A woman in her early thirties is brought to the OPD by her husband and her father-in-law. She positions her chair so that she can see the door of your consulting room. She watches the husband when he speaks; she watches you when you write. Her answers are brief and accurate. She does not lie; she does not embroider; she gives you precisely what you ask for and nothing more. When you ask her, gently, why she has come, she says her husband says she should. The right first move here is not to ask about beliefs. It is to ask about the journey to the clinic, the events of the last week, the small textures of the day. The guarded patient often arrives with a story that explains the guardedness; the story is rarely the full account, but it is the door.

The over-familiar stance. A man in his late forties walks in ahead of his wife and sits in your chair instead of the patient chair, then notices and laughs and changes seats. He calls you by your first name within thirty seconds. He compliments the painting in your office. He produces a list of medications on a folded sheet of paper and reads it out, with editorial commentary on each one. The wife is silent. The over-familiar stance can be mania, can be a frontal-lobe presentation, can be a characterological pattern, and the right first move is to leave the diagnostic question open and run the cognitive examination earlier than usual. The over-familiar patient often gets misclassified as cluster B because the cognitive screen was skipped.

The performative stance. A young woman in the emergency department after a self-harm episode tells a tidy story with gratitude inserted at the right places; she has read about her presumed diagnosis and uses the right vocabulary. Rehearsal is sometimes a way of holding oneself together in front of a stranger, not a sign of deceit. Hold the impression lightly and read the affect across longer windows.

The HiTOP loadings on stance are diffuse but worth knowing. A withdrawn, low-engagement stance tends to load on detachment and on the more severe end of internalising; the underlying phenomenon is a flattening of the relational drive, which co-occurs with anhedonia, with negative-symptom presentations of schizophrenia, and with the early stages of severe depression. A hostile or suspicious stance tends to load on antagonistic

externalising and on the persecutory end of thought disorder; the underlying phenomenon is a high prior on threat, which co-occurs with first-episode psychosis, with paranoid personality structures, and with stimulant intoxication. An over-familiar, intrusive, theatrical stance tends to load on disinhibited externalising or on cluster B antagonism, depending on what is underneath it; the underlying phenomenon is a failure of social braking, which co-occurs with mania, with frontal-lobe pathology, and with the more dramatic personality patterns. A markedly atypical stance, the sort that draws comment from the nursing staff before the doctor arrives, is one of the strongest single indicators of high p-factor.

The clinician's working sentence is the one you say to yourself, silently, when the patient sits down.

WORKING SENTENCE

What is this person showing me about how they are in the world?

Run the question slowly. Do not move on until you have an answer that is more specific than *cooperative* or *anxious*. The answer can be a phrase: *holding herself together with effort*, *politely refusing the encounter*, *eager to be approved of*, *reading me as a threat*. The phrase becomes the line that opens the stance entry in the case sheet, and the rest of the MSE is written underneath it. If you cannot answer the question by the end of the first minute, you are not yet looking. Slow down.

PITFALL

The pitfall is to write *cooperative* and move on. *Cooperative* is not a description; it is a placeholder for a description that has not been done. The reason this is the most common error in the MSE is structural. The proformas reward speed; the morning ward round rewards completion; the resident has been taught that *cooperative* is the safe default. The cost of the safe default is that the next reader, the consultant on the round or the registrar at the case discussion, has nothing to read. Replace it with three words that capture how this particular patient is being cooperative. Reluctantly, with effort. Brightly, but only on safe topics. Genuinely, with relief at being asked. The three words tell the next reader something. *Cooperative* tells them nothing. The self-correction, when you find yourself reaching for the word, is to stop, ask the working sentence again, and write the answer.

WHAT THIS TEACHES YOU

Stance is the first dimensional signal you collect, before any content has been spoken.

The reading is provisional, and the rest of the examination will refine it; the point of taking it seriously is that it shapes the questions you ask next, and the questions you ask next shape what the patient gives you.

OBSERVATION	SPECTRUM	THINK ABOUT	DON'T MISS
Withdrawn, minimal engagement, eyes down	Detachment, severe internalising	Catatonia screen, severe depression, profound negative symptoms	The mute patient is not necessarily uncooperative. Run Kirby's observational protocol.

OBSERVATION	SPECTRUM	THINK ABOUT	DON'T MISS
Suspicious, guarded, watchful of door	Thought disorder (paranoid pole), antagonistic externalising	First-episode psychosis, paranoid personality, methamphetamine use	Ask about the journey to clinic. The guarded patient often arrives with a story.
Over-familiar, intrusive, theatrical	Disinhibited externalising, antagonistic externalising	Mania, cluster B presentation, frontal pathology	Frontal lobe disinhibition can mimic mania. Examine cognition.
Performative, rehearsed, polished	High p-factor, antagonistic externalising	Factitious presentation, secondary gain, characterological structure	Rehearsed does not mean dishonest. Hold it lightly.

2. Appearance and behaviour

Once stance has been read, the appearance reads itself, mostly. Build, grooming, clothing, facial expression, eye contact, posture, gait, the abnormal motor phenomena that come and go through the consultation; you have done this examination on every medical patient you have ever seen. The psychiatric difference is the level of detail and the willingness to interpret what you find. A consultant of mine used to say that you should be able to write a paragraph on the patient's appearance before you have asked them anything, and that the paragraph, if it is honest, will already contain half the diagnosis.

The teaching frame for this domain is older than DSM and it is worth restoring. George Kirby, working at the Manhattan State Hospital in the early decades of the twentieth century, was the first English-language psychiatrist to write up a protocol for examining the patient who could not, or would not, speak. His question was simple. *What would I have written about this patient if I had been unable to speak to them at all*. The Kirby protocol is the disciplined form of that question; it forces you to extract every available signal from observation alone, to record it, and to interpret it. The protocol was designed for the mute and the stuporose, but the discipline is worth applying in every encounter. The articulate patient distracts you with content; the silent observation

grounds the content in body, in clothing, in motor texture, in the small involuntary signals that the patient cannot edit.

Walk through the components. Build. Athletic, lean, asthenic, or obese, with a rough estimate of body mass index when the picture is clinically relevant. The thinned frame, with hollowing at the temples and the visible carriage of the wrist, points at the eating-disorder cluster of internalising or at the cachectic end of severe depression; the chronically obese frame, in a patient on long-term antipsychotic medication, points you back at the prescription. Grooming. Hair, nails, skin, the state of the teeth, the cleanliness of the clothes. Self-neglect that has accumulated over days, in the form of unwashed hair and unbrushed teeth, is a strong internalising signal in the depressive direction; self-neglect that is patchy, with one part of the body well-attended to and another part frankly disordered, loads on thought disorder. Clothing. Appropriate to the season, to the social setting, to the patient's pre-morbid taste. The mismatched layering, the ceremonial garment in an unceremonial setting, the cluster of bright colours stacked together with a faint air of campaign-launch, all carry information that the next reader can use.

Facial expression. Fixed, changing, appropriate, inappropriate; the masked face of parkinsonian states; the slight rigidity of expression in the patient on a high antipsychotic dose; the flat face of the schizophrenia spectrum; the over-mobile face of the manic patient. Eye contact. Established and maintained, intermittent, averted, glazed, watchful. The cultural caveat applies here. Direct sustained eye contact is not the universal social default; in much of South Asia, sustained eye contact between an unfamiliar man and an unfamiliar woman is impolite, and the absence of it should not be over-read as detachment in the woman who is, in her own social context, behaving correctly.

Posture. Relaxed, anxious, guarded, slumped, the suggestive posturing of a catatonic state. Gait. Normal, slowed, shuffling, ataxic, circumductive, festinant. The gait test is cheap; ask the patient to walk to the window and back. The shuffling gait of a parkinsonian state, the slowed depressive gait, the wide-based ataxia of a cerebellar lesion,

the festinant gait of advanced Parkinson disease are all readable in fifteen seconds and all of them change the formulation. Behaviour-in-interview. Psychomotor activity increased or decreased relative to the patient's premorbid state; restlessness, fidgeting, the picking and plucking of carphologia, stereotypies, mannerisms.

The catatonia screen deserves its own paragraph because the diagnostic yield is high and the cost is two minutes. The Bush-Francis screening tool was developed at Stony Brook in the 1990s and has been the standard ever since. It identifies twelve signs: excitement, immobility or stupor, mutism, staring, posturing, grimacing, echopraxia or echolalia, stereotypy, mannerisms, verbigeration, rigidity, negativism. Three or more of these in a single examination is the threshold for considering catatonia and for trialling a small dose of lorazepam as a confirmatory step. The screen is run quickly. Watch for excitement and stuporous reduction. Note any mutism. Note staring. Test posturing by asking the patient to hold an arm out, then leaving it alone for thirty seconds. Test rigidity and waxy flexibility by passively flexing and extending the upper limb, slowly, looking for the gentle plastic resistance that holds the limb in the position you leave it. Two minutes of upper-limb tone examination, in any patient who looks even slightly under-engaged, is one of the highest-yield interventions in inpatient psychiatry. The catatonic patient on the medical ward, missed on admission, deteriorates in the absence of treatment that is cheap and effective; the cost of the missed diagnosis falls on the patient.

The appearance loads heavily on the dimensional map. Self-neglect in the form of unwashed hair, soiled clothes and reduced grooming over days is a strong internalising signal in the depressive direction. Self-neglect in the form of bizarre attire, mismatched layering, or grooming that has clearly been attempted and abandoned in odd places loads on thought disorder. Over-grooming, conspicuous jewellery, bright colours stacked together and a faint air of campaign-launch, loads on the manic pole of internalising and on disinhibited externalising. Worn clothes hanging off a markedly thinned frame, possibly with the hands kept hidden, loads on the eating-disorder cluster of internalising. Carphologia, plucking at the bedsheet, fluctuating attention with a clean

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sensorium between fluctuations, loads heavily on neurocognitive disorder of the delirium type and is one of the few MSE findings that should send you to the bedside before the rest of the examination is complete.

The clinician's working sentence here is *what would I have written if I had been unable to speak to this patient at all*. This is the Kirby protocol question, and it is worth running silently in every encounter, not just in the mute or stuporose patient. A small variant of the question, worth running in parallel, is *if the photograph of this patient at this moment were the only data I had, what would I write*. The two questions, asked together, are the discipline of the appearance heading.

The pitfall is the inverse of the stance pitfall: writing too much without interpretation. Three pages on what the patient was wearing tell the next reader nothing if the writer has not asked themselves what the wearing of those clothes meant. The reader does not need a wardrobe inventory; the reader needs the inventory plus the interpretation. The most common form of this error is the resident who has been told to write detailed appearances and writes long itemised lists with no inference at the end. Description plus interpretation, in that order, every time. The interpretation can be brief: *self-neglect of recent onset, in the depressive direction*; *bizarre layered dress, in the thought-disorder direction*; *over-groomed, with conspicuous jewellery, in the manic direction*. One short interpretive line at the end of the descriptive paragraph rescues the entire entry.

What this teaches you about the patient. Appearance is the second dimensional signal, and it is the one most easily checked against the history. The depressive picture is congruent across appearance, behaviour, gait, and stance; the manic picture is congruent across grooming, clothing, posture, and motor activity; the thought-disorder picture often shows incongruence within the appearance itself, which is in fact the diagnostic finding. When the appearance does not hang together with itself, the patient is telling you something the language has not yet found.

OBSERVATION	SPECTRUM	THINK ABOUT	DON'T MISS
Self-neglect, drooping posture, slowed gait	Internalising (depressive pole)	Severe depression, hypothyroid, malnutrition	Severe depression and severe physical illness look identical at the door. Examine the body.
Bizarre, mismatched, layered or patchwork dress	Thought disorder	Schizophrenia spectrum, mania with psychosis, prodromal states	The mismatch is the message. Read it as form, not content.
Bright colours, over-grooming, intrusive postures	Internalising (manic pole), disinhibited externalising	Mania, hypomania, frontal disinhibition	Stimulant intoxication mimics mania. Pupils, blood pressure, the story.
Carphologia, plucking, shifting attention	Thought disorder, neurocognitive	Delirium, especially in the ill or the elderly	Delirium fluctuates; the calm interview hour is not reassurance.

3. Speech

Speech is what comes out of the mouth as physical output, before you have begun to interpret what is being said. Coherence, relevance, spontaneity, volume, tone, tempo, reaction time, prosody. The discipline is to describe the *speech* under this heading and the *thoughts* under the next one, and to keep them apart until both have been recorded.

The separation matters more than it sounds. Speech is the physical act of talking; thought is the content of what is talked about. A patient may have entirely intact speech, in the physical sense, while saying things that are entirely disorganised; a patient may have entirely organised thoughts while saying them in a way that is dysarthric or aprosodic. Collapsing the two together is one of the most common ways the MSE goes wrong, because the reader who comes to it later cannot tell whether the abnormality was in the act of speaking or in the substance of what was said. The exam vivas test this distinction precisely because residents fail it precisely. The disciplined

writer keeps the two headings separate even when the picture is overwhelming, and writes the speech entry before the thought entry, in that order, every time.

Walk through the parameters with concrete examples. Coherence. The patient's words are intelligible and follow grammatically; the audio of the consultation, played back, would be transcribable by a stenographer. Relevance. The answers connect to the questions; the deviation, when it occurs, is an interpretable kind of deviation. Spontaneity. The patient initiates speech, offers information, answers in sentences rather than monosyllables; the patient who only ever responds, never spontaneously offers, is giving you a finding. Volume. Conversational volume in the room you are in, accounting for the patient's age, the room's acoustics, and the ambient noise of the OPD corridor; the soft voice of the depressed patient, the loud voice of the manic patient, the whispered voice of the woman with depression and shame. Tone. High, normal, low pitched; the post-pubertal woman with a high-pitched childlike voice, in the absence of an organic cause, gives you a finding worth following up. Tempo. Slow, normal, fast, pressured; pressured speech is the speech that you cannot interrupt without raising your voice. Reaction time. Increased in depression, in parkinsonian states, in patients on heavy antipsychotic loads; decreased in mania, in anxiety, in stimulant intoxication. Prosody. The melody and stress of speech, preserved or flat; the aprosodic patient sounds like a screen-reader.

A slow, low-volume, monotonous speech with a long reaction time is the classic depressive picture and loads firmly on internalising. The reaction time is sometimes the most informative single parameter; the depressed patient takes four or five seconds to begin answering a simple question, and the silence carries information. A pressured, accelerated, high-volume speech that you find yourself struggling to interrupt loads on the manic pole of internalising and, when the connections begin to come apart, on thought disorder. The phenomenon underneath pressured speech is increased drive coupled with decreased latency to action; the manic patient is generating thought faster than the speech apparatus can deliver, and the result is a speech that overruns its own punctuation. A coherent but oddly inflected speech, with prosody that does not quite match

the content, loads on thought disorder of the schizophrenia type, particularly when it co-occurs with the negative-symptom appearance described above. A very scant speech in a patient who is otherwise alert and engaged loads on detachment, on autistic spectrum, and on the negative symptoms of schizophrenia.

The major formal disorders of speech, in working order, are dysarthria, aphasia, poverty of speech, pressure of speech, and mutism. Each of these is a distinct entity and conflating them is a common viva error. Dysarthria is a peripheral articulation defect; the words are correctly chosen and grammatically arranged, but the muscular execution is impaired. The slurred speech of intoxication, the scanning speech of cerebellar disease, the bulbar dysarthria of motor neuron disease all fall here, and the finding sends you to the neurologist or to the toxicology screen. Aphasia is a central language disorder; the words themselves are wrong, missing, or unreachable. Broca aphasia is non-fluent and the patient knows their speech is wrong; Wernicke aphasia is fluent, often copious, and the patient does not know their speech is wrong; conduction aphasia spares fluency and comprehension but breaks repetition; global aphasia loses both. The aphasic patient is not psychiatric; the aphasic patient has had a stroke. Poverty of speech is a negative-symptom finding in which the patient produces very little speech, but what is produced is grammatical and articulated normally; the words are simply few. Pressure of speech is the manic finding in which the patient produces an excess of speech that is hard to interrupt. Mutism is the absence of speech, and it has three principal causes in the psychiatric ward: catatonia, severe depression, and conversion. Each of these has a different management; the work of the MSE is to record the mutism precisely enough for the management to be chosen later.

The clinician's working sentence on speech is *if I closed my eyes and only heard this patient, what diagnosis would I be considering*. The answer is often surprisingly specific. Depression sounds different from schizophrenia, which sounds different from mania, which sounds different from a patient with a frontal lesion who is technically articulate but disinhibited in the texture of the speech. Train your ear. The information is free. A small additional discipline, when in doubt, is to record thirty seconds of the patient's

speech (with consent, on a non-personal device, deleted after the case is written up) and listen to it later without the visual; the speech alone, played back, is often more diagnostic than the speech in the room.

The pitfall is the lazy *normal* on every parameter. Speech is rarely entirely normal in a psychiatric patient who has come to your service. If it really is normal, write *speech was unremarkable on all parameters*; that is a description and the next reader can use it. *Normal* without elaboration is, again, a placeholder for a description that has not been done. The reason this error is common is fatigue; the resident on the seventh patient of the morning runs out of vocabulary, and *normal* is the word that requires the least effort. The self-correction is to write the parameter-by-parameter line whenever the patient is in any way clinically interesting, and to reserve *unremarkable* for the patient in whom the parameters genuinely do not deviate from the conversational baseline.

What this teaches you about the patient. Speech is the bridge between the bodily domains (stance, appearance) and the cognitive domains (thought, perception). It tells you, at a single hearing, whether the substrate of language is intact. Most psychiatric findings ride on the language substrate; a finding in the speech itself, before you have heard a single word of content, often determines whether the rest of the examination is interpretable.

OBSERVATION	SPECTRUM	THINK ABOUT	DON'T MISS
Slow, soft, monotonous, long reaction time	Internalising (depressive pole)	Severe depression, hypothyroid slowing, parkinsonian states	Hypothyroidism and depression coexist; check the TSH.
Pressured, loud, fast, hard to interrupt	Internalising (manic pole)	Mania, hypomania, stimulant intoxication, agitated psychosis	The amphetamine-using young adult sounds manic. Take a substance history.
Coherent but oddly inflected, prosody flat	Thought disorder, detachment	Schizophrenia spectrum, autism, frontal pathology	Prosody is a soft sign; do not over-call it on a single sample.

OBSERVATION	SPECTRUM	THINK ABOUT	DON'T MISS
Markedly scant or absent	Detachment, severe internalising, thought disorder	Catatonia, severe depression, mutism of conversion	Run the Kirby protocol; do not write *MSE could not be assessed*.

4. Mood and affect

Mood is the patient's pervasive emotional climate over the past seven days, as reported by them. Affect is the cross-sectional weather of the consultation room as observed by you. Beginners run them together, often using the patient's word for both; a useful discipline is to write the patient's own word for mood in quotation marks, in their own language, and then to write your own description of affect underneath, in your own language. The two will not always match. The mismatch is itself diagnostic.

The climate-versus-weather distinction is the easiest way to teach the separation, and it carries more clinical weight than it sounds. Climate is the average, the prevailing conditions, the seven-day window. Weather is the right-now, the cross-section, the consultation hour. A patient may report a low mood over the past week and present in your room with a brief, transient brightening of affect, perhaps because a relative has come with them and there is something genuinely warming about the relative; the climate is depressed, the weather is briefly clearer, and both readings are correct. A patient may report a stable euthymic mood and present with an irritable, restless, narrow affect, perhaps because something happened on the way to the clinic; the climate is, by report, fine, and the weather contradicts it. The contradiction is data. The disciplined writer records both, in their own languages, and lets the next reader hold the contradiction.

The reported-versus-observed distinction is the second axis. Mood is reported, in language the patient owns. Affect is observed, in language the clinician owns. The patient's word for mood, recorded verbatim in the patient's language, is the gold standard for the mood entry. *Theek nahi lag raha*. *Man kahin nahi lagta*. *Ek khaalipan*. *Bohot heavy lag raha hai dil*. The translation, in plain English, sits underneath. The affect line below records what you saw: *depressed, restricted, low intensity, congruent with*

reported mood. The two lines, side by side, are the mood-and-affect entry; one without the other is half a finding.

Mood loads predominantly on internalising; affect carries information across more spectra. A pervasively low mood, reported by the patient as *empty* or *flat* or in the local idiom (*man kahin nahi lagta*, *mind doesn't settle anywhere*), with a depressed, restricted affect of low intensity, is the classical depressive picture and loads on internalising. An elevated, expansive mood with a wide-ranging high-intensity affect, congruent with grandiose content, is the manic picture and also loads on internalising, simply at the other pole. A flat or blunted affect, with a reported mood that does not match the affect, loads on thought disorder. An anxious, mobile, reactive affect with reported mood of constant edge loads on internalising of the anxiety subtype. A labile affect that swings to the opposite emotion within minutes loads on the cluster B end of antagonistic externalising and, in the older patient, on neurocognitive pathology of the frontal type.

The vocabulary matters here, more than in most domains. Use the right word; the next reader is using your word to make a clinical decision. Walk the words.

Flat is the near-absolute absence of any signs of affective expression. The face does not move, the voice does not modulate, the limbs do not gesture; a videotape of the patient at one minute would be indistinguishable from a videotape of the same patient at twenty minutes. Flat affect is the most severe end of the reduction spectrum and most often loads on thought disorder, particularly the negative-symptom presentations of chronic schizophrenia. A small worked example. A man in his forties, brought to the OPD by his elder brother, who has been in his care for fifteen years. The patient sits where placed. The face is unchanging across the entire forty-five-minute consultation. He answers when addressed, in a voice without inflection, and there is no flicker of expression when the brother begins to weep beside him.

Blunted is significant reduction, less severe than flat. There is some affective expression, but it is muted; the smile when his daughter is mentioned is small and brief, and the

rest of the face stays still. *Constricted* is less severe than blunt; the range is narrow, the intensity is reduced, but the affect is observably present and observably reactive. *Restricted* is mild, at the edge of the normal range; the affect is on the low end of normal without being clearly abnormal. The four words sit on a single dimension of intensity, and the gradation matters because the reader uses the word to triangulate severity.

Inappropriate describes a discordance between affect and situation. The patient laughs while describing the death of a parent; the patient cries while describing breakfast. The classic textbook example, in the schizophrenia spectrum, is the patient who giggles softly during the disclosure of a paranoid persecutory belief that, on its content, should be terrifying. *Incongruent* describes a related but distinct finding: the discordance is between the affect and the content of the patient's own thought, not between the affect and the external situation. The depressed patient who describes severe self-blame with a flat, neutral affect is incongruent in this technical sense; the affect does not match the content the patient is herself producing. The two words are sometimes used interchangeably; the disciplined writer keeps them apart.

Labile describes shifts to the opposite affect, not just within the same affect. The patient laughs and then cries within two minutes; the patient is irritable and then tender within five. Lability is most often a finding of the cluster B presentations and of pseudobulbar affect in the post-stroke patient. *Volatile* describes a different kind of shift, within the same affective state: the irritable patient who escalates to anger and back, the anxious patient who escalates to panic and back. Lability and volatility are different and the next reader needs to know which one you saw.

Communicable asks whether the affect transmits. The depressed patient with a heavy, communicable affect leaves the consulting room weighing on you; the schizophrenic patient with a flat affect leaves you with nothing transmitted. *Appropriate* is a coarse word that covers situational match. *Congruous* is the older word for what congruent now describes; both are used. The disciplined writer sticks to one usage and avoids switching mid-paragraph.

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Mood states in mania form a teaching ladder that is worth holding in mind. *Euthymia* is the normal state, neither depressed nor elevated. *Elated* mood is more cheerful than usual without yet being pathological; the patient is having a good week. *Euphoric* mood is a feeling of well-being inappropriate to real events; the patient is having a much better week than the events justify. *Expansive* mood adds the element of unrestrained expression, with overestimation of the significance of one's own state. *Elation* in the technical sense couples euphoria with triumph and increased psychomotor activity. *Exaltation* is intense elation with grandiose delusions. *Ecstasy* is an intense rapture, occasionally seen in the manic patient and occasionally in the temporal-lobe-epilepsy patient. The ladder is useful because the words map onto severity, and the disciplined writer who reaches for *exaltation* is signalling something more severe than the writer who reaches for *elated*. Match the word to the patient; the next reader is relying on you.

The clinician's working sentence on mood is *what is this person's emotional climate, in their own language, over the past week*. The clinician's working sentence on affect is *what am I receiving from them, right now, as I sit here*. The two sentences require different attention. Mood requires the patient to talk; affect requires you to watch. A useful discipline, in the noisy OPD, is to ask the mood question and then to spend the next thirty seconds watching the affect rather than writing; the answer to one question is in the patient's words, the answer to the other is in their face, and the eye and the pen cannot do both at once.

The pitfall is to write *euthymic* on a patient who is plainly not euthymic. Euthymia is a real category and it does occur; it does not occur very often in the psychiatric outpatient department. The reason this error is common is the proforma default. The form lists *euthymic* as the first option; the busy resident ticks it because it is least disruptive to the rest of the entry. The cost is that the entry no longer matches the patient. If you find yourself writing *euthymic* twice in a clinic session, look again at the affect, and check whether you are actually seeing euthymia or whether you are reading the affect through the resistance of a long morning. The self-correction is to require yourself to use a more specific word whenever there is any deviation from the conversational base-

line; *mildly restricted with reactivity preserved* is more honest than *euthymic* on the patient who has come in with a complaint.

What this teaches you about the patient. Mood and affect, taken together, are the affective signature of the dimensional formulation. Internalising lives here, in both poles. Thought disorder lives here, in the form of incongruence and flatness. Antagonistic externalising lives here, in the form of lability and irritability. The neurocognitive disorders show up here, in the form of pseudobulbar affect and frontal-lobe disinhibition. When the mood and the affect disagree with each other, the patient is telling you that the climate and the weather have come apart, and the formulation should record the gap.

OBSERVATION	SPECTRUM	THINK ABOUT	DON'T MISS
Low mood, depressed restricted affect, congruent	Internalising (depressive pole)	Major depression, dysthymia, depressive episode of bipolar	Anhedonia is the more specific symptom; ask.
Elevated mood, wide-range elated affect, congruent	Internalising (manic pole)	Mania, hypomania, mixed states, schizoaffective	Mixed states are missed. Look for irritability inside the elation.
Flat or blunted affect with mood-affect mismatch	Thought disorder, detachment	Schizophrenia spectrum, severe negative symptoms, autistic spectrum	The flatness can mask depression. Ask about anhedonia explicitly.
Anxious mobile reactive affect	Internalising (anxiety pole)	Generalised anxiety, panic, social anxiety, OCD	Akathisia from medication looks like agitation; check the prescription.
Labile, opposite-pole shifts within minutes	Antagonistic externalising, neurocognitive	Borderline pattern, frontal lobe pathology, pseudobulbar affect	The post-stroke patient with crying spells is not depressed; it is pseudobulbar.

5. Thought, form and content

Thought is the largest domain in the examination, and it is the one that gets handled badly more often than any other. There are reasons for this. The vocabulary is older and more specialised than the vocabulary of mood or speech. The signs are subtle and the patient does not always volunteer them. The classical sub-divisions sound as if they belong in a viva and not at the bedside. Most clinicians, including most psychiatry residents in their first year of training, end up writing the thought paragraph as a hurried sentence with a few abbreviations and the patient's most striking belief copied out without context. The MSE entry that reads *thoughts: AH+ VH+ delusions of persecution+* is, with apologies, not an MSE entry at all. It is a placeholder for one.

The reason the thought domain is divided into four sub-headings is not bureaucratic. It is cognitive. The four sub-headings are *form*, *stream*, *possession*, and *content*, and each one answers a genuinely different question. Form asks whether the architecture of the patient's thinking is intact, the way you would ask whether a building's walls are still vertical. Stream asks about the flow of thinking, the tempo and the continuity, the way you would ask whether the river is moving at the right speed. Possession asks who owns the thoughts, whether they feel like the patient's own or like something inserted from outside. Content asks what the thoughts are actually about. A clinician who asks all four questions will produce a description that another clinician can act on; a clinician who asks only the fourth produces a description that says, in effect, *the patient said something strange*. That is not enough.

Let me slow down here, because the difference between form and content is the single most-often-blurred distinction in the MSE. *Form* is the structure of the thinking, regardless of what the thinking is about. *Content* is the topic of the thinking, regardless of how it is structured. A patient may have intact form and abnormal content; that is the patient with a fixed persecutory belief, expressed in clear well-organised sentences, who is delusional but not formally thought-disordered. A patient may have abnormal form and unremarkable content; that is the patient who is talking about her grocery list and somehow cannot keep the sentences connected to each other. Most patients on the

schizophrenia spectrum show both, but the two findings are independent and they should be recorded independently.

Form

The major formal disorders, in something like the order you will meet them in clinic, are derailment, tangentiality, substitution, drivelling, fusion, and word salad. Each one names a slightly different way that the architecture of thinking has come apart, and each one is worth a worked example.

Derailment is the slipping of the train of thought from one track onto another, where the second track is not connected to the first by any reasonable bridge. Ask a patient how she came to clinic and she answers, *the bus was crowded, my mother always preferred my brother, electricity bills are terrible these days*. Three statements, each grammatical, none of them connected to any of the others. The patient is not being evasive; the link between thoughts has loosened. Derailment is one of the most specific signs of formal thought disorder of the schizophrenia type. Sample carefully, though. A single sentence of derailment can be ordinary distractibility. You want to hear it across at least two or three minutes of free speech before you commit to the finding.

Tangentiality is different and milder. The patient does answer the question, more or less, but the answer goes off at an angle and never comes back. You ask, *what brought you to hospital*. She replies, *well it started years ago when my husband was posted to Pune, and I have always found Pune a difficult city, because of the traffic and the language, and the traffic is really getting worse everywhere these days*. The reply has a relationship to the question, but a thinning one, and the relationship dissolves before the question is answered. Tangentiality loads on thought disorder when severe, and on anxiety or distractibility when mild.

Substitution is the sudden replacement of one idea with another, without acknowledgement. The patient is in the middle of describing her son's school and abruptly the sentence is about her father's diabetes, with no transition and no awareness that a transition has been skipped. *Drivelling* is the breakdown of the internal structure of the

sentence itself, so that the words within a single sentence stop making coherent sense together; the word order is preserved, but the meaning is not. *Fusion* is the welding of two unrelated ideas into a single statement, as if the patient's thought had collapsed two streams into one channel. *Word salad* is the most severe form, in which neither the structure between sentences nor the structure within sentences holds, and the listener can no longer make any continuous sense of the speech at all.

A practical word on sampling. Form is a finding that requires a *sample* of speech. You cannot read formal thought disorder off a yes-or-no question, and the structured psychiatric interview, with its tight questions and short answers, actively suppresses the finding. Make space for at least two or three minutes of free speech. Ask the patient to tell you about her week, or her childhood, or the events of the day she came to hospital. Listen across the whole sample. The form will declare itself.

Stream

Stream asks about tempo, continuity, and goal-direction. The findings here are less specific than the formal disorders but often more clinically useful, because they map cleanly onto syndromal pictures.

Pressure of speech is the increased rate and volume of speech that you find yourself unable to interrupt without effort. The patient finishes one sentence and is into the next before you can speak; if you do speak, she talks over you, not rudely but as if your interruption had not registered. Pressure loads on the manic pole of internalising. *Flight of ideas* is the manic version of derailment, with one important difference. The connections between thoughts in flight of ideas are *understandable*; they are merely rapid and superficial. The patient says *Pune, June, June bug, jitterbug, jittery, tea*, and you can, with effort, follow the chain of associations. In derailment of the schizophrenic type, the chain itself is broken; in flight of ideas, the chain is intact and racing. This distinction matters at the bedside, because the two findings load on different spectra and point to different treatments.

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Poverty of thought is the opposite finding. The speech is sparse, the sentences are short, the answers do not develop. The patient is not being evasive and she is not silent; she simply has, by report and by appearance, very little to say. Poverty of thought loads on the depressive pole of internalising and on the negative symptoms of the schizophrenia spectrum. *Circumstantiality* is the long-way-round answer, where the patient does eventually reach the goal of the sentence, but only after a great deal of unnecessary detail. Ask whether she has been sleeping, and she begins with the layout of the bedroom, the position of the window, the temperature in March, the changes in her husband's snoring pattern, and only then arrives at the actual sleep complaint. Mild circumstantiality is normal for some cultures and some personalities. Severe circumstantiality loads on the obsessional end of internalising, on certain epileptic syndromes, and on early dementia.

Perseveration is the repetition of the same response across different questions, after the response has stopped being correct. You ask the patient her age; she says sixty-four. You ask the year; she says sixty-four. You ask the prime minister; she says sixty-four. Perseveration is a classic finding of frontal-lobe pathology and it should send you to look for a neurological cause. *Thought blocking* is the sudden arrest of the train of thought in the middle of a sentence, with no obvious reason, often followed after a pause by a fresh thought that bears no relation to the one that was abandoned. The patient stops, looks slightly puzzled, and then begins on something else. Patients sometimes describe the experience subjectively as their mind going blank or being taken away. Thought blocking loads on the schizophrenia spectrum.

Possession

Possession asks who the thoughts belong to. The question sounds metaphysical until you meet a patient who genuinely does not feel that her thoughts are her own, at which point it becomes clinical and pressing.

Obsessions are recurrent, intrusive thoughts that the patient recognises as her own and as excessive or irrational. The recognition matters; the obsessional patient is, by definition, fighting the thought. The most common categories are contamination, doubt,

symmetry, aggression, and forbidden sexual or religious content. *Compulsions* are the motor or mental acts performed to neutralise the obsessions, and the relationship between the two is the diagnostic dyad of OCD. The patient who washes thirty times a day because she is afraid of contamination has the contamination obsession and the washing compulsion, and the two together load on the OCD subtype of internalising.

The dimension of insight matters here. Most OCD patients have full insight; they know the thoughts are excessive even as they cannot stop having them. A minority have partial insight, where the thoughts feel half-true and the patient is uncertain whether to fight them or believe them. A small subset have absent insight, where the obsessional content has crystallised into something that looks like a delusion. The Brown Assessment of Beliefs Scale is the standard instrument; the clinical short cut is to ask, *do you think this thought is reasonable, or do you know it is unreasonable but cannot stop it*. The patient who answers the first way has poor-insight OCD and her presentation loads partly on thought disorder; the patient who answers the second way has classical OCD and her presentation loads on internalising.

Thought alienation is the experience that the patient's thoughts are not, in the most basic sense, her own. The classical triad is insertion, withdrawal, and broadcasting. *Thought insertion* is the experience of alien thoughts being placed into the patient's mind from outside; she is thinking, but the thoughts are not hers. *Thought withdrawal* is the experience of one's own thoughts being removed by an external agency; the patient is thinking, and then the thought is gone, taken. *Thought broadcasting* is the experience that one's thoughts are escaping the head and becoming available to others; the patient cannot privately think, because thinking is now public. The triad loads heavily on the thought-disorder spectrum and was historically a Schneiderian first-rank symptom. Schneider's first-rank symptoms are no longer regarded as pathognomonic of schizophrenia in the way they were once taught; they appear in mania and in dissociative states and in delirium. They retain their value as a checklist of phenomenologically interesting experiences, and the resident who can elicit and describe them is the resident the consultant trusts at handover.

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Content

Content asks what the thoughts are about, and the most important content question, in every adult psychiatric examination, is whether the patient holds any *delusional beliefs*. The Fish definition, which still rewards careful reading, runs along these lines. A delusion is a belief that is *false*, *held with absolute conviction*, *not amenable to reason or contrary evidence*, and *out of keeping with the patient's social, cultural, religious, and educational background*. Each clause is doing work. False, because a true belief is not a delusion regardless of how strange it sounds. Held with conviction, because the patient who entertains the idea but is uncertain about it has an overvalued idea, not a delusion. Unshakeable by argument, because the patient who can be talked out of the belief in clinic does not have a delusion in the technical sense. And, most importantly for Indian psychiatry, *out of keeping with the patient's cultural background*.

Let me slow down on the cultural test, because this is the place where colleagues from other specialities, and many MBBS interns rotating through psychiatry, make their most consequential mistake. A grandfather in rural Karnataka who tells you he saw the goddess walking through the courtyard at dawn, and who reports the experience without distress, who finds his neighbours and his priest treating it as a meaningful experience rather than as evidence of illness, who has continued his usual functioning, is not necessarily delusional. He may be reporting a religious experience that his community recognises and shares. The cultural test, applied honestly, points the diagnosis away from delusion in this case. To call it a delusion is to mistake an unfamiliar cultural form for psychopathology, and the psychiatry literature is full of harm caused by exactly this mistake.

The opposite mistake is also possible, and almost as common. A patient from the same village who tells you that he is married to the goddess specifically, that she communicates with him through the cooking vessels, that she has commanded him to refuse food, and whose family is alarmed because none of this fits the religious frame they recognise, is reporting something that is *not* in keeping with his cultural background, even though the surface vocabulary is religious. The content uses the available cultural symbols, but the experience has crossed into private territory that the community does

not endorse. The cultural test, applied honestly, points to delusion in this case. The presence of the words *goddess* and *temple* does not protect the belief from being delusional, any more than their presence makes it delusional in the first patient.

Three working questions help. Does the patient's family or community share the belief, or do they recognise it as outside the norm. Does the patient's religious or cultural authority recognise the experience as legitimate within the tradition, or do they themselves treat it as illness. Does the belief have the shape of communal knowledge (other people hold it, they hold it in the same form, the tradition has language for it) or the shape of private revelation (only this patient holds it, in a form specific to him). Communal religious experience is not delusion; private revelation extending beyond what the tradition endorses often is. The same three questions sort the visions of the saint from the visions of the patient with paranoid schizophrenia, and they should be asked of every belief that is offered as religious.

Delusions are then sorted, classically, into *primary* and *secondary*. A primary delusion arises out of nothing, with no antecedent mood or perceptual change; the experience is one of sudden uninvited certainty, often with the quality of revelation. The classical primary delusional experiences are autochthonous delusion (the idea simply appears, complete), delusional perception (a real perception is invested with private meaning, such as the patient seeing a traffic light turn red and knowing immediately that he is being summoned by God), delusional mood (the patient feels that something portentous is about to be revealed, before any specific belief has formed), and delusional memory (the patient remembers an event in delusional terms, which may never have occurred). Primary delusions load heavily on schizophrenia. *Secondary* delusions arise out of a preceding mood or experience that makes them comprehensible; the depressed patient who comes to believe she has ruined her family financially is showing a secondary delusion of guilt, secondary to a depressive mood, and the belief is therefore a feature of the affective illness rather than of an independent thought-disorder process.

The common delusion types form a small vocabulary that every clinician should own. *Persecution* is the belief that one is being targeted, harmed, or conspired against. *Reference* is the belief that ordinary events carry private personal meaning, that the news is speaking to the patient, that strangers in the street are commenting on her. *Grandeur* is the inflation of the self into someone of special importance, ability, or identity. *Infidelity* is the fixed belief that a partner is unfaithful, often in the absence of evidence and often with persistent searching for proof; this delusion is over-represented in late-life and in heavy alcohol use, and it has a higher rate of associated violence than most clinicians appreciate. *Erotomania* is the fixed belief that another person, often someone of higher status, is in love with the patient. *Nihilism* is the belief that the self, or part of the self, or the world, has ceased to exist; the elderly patient with severe depression who reports that her bowels have rotted away, or that she is already dead, is showing a nihilistic delusion (Cotard's syndrome in its full form). *Guilt* is the unshakeable belief in one's own moral or financial ruin. *Ill-health* is the belief in a serious illness in the absence of evidence, distinguished from hypochondriasis by the fixity of the belief. *Delusions of control*, sometimes called passivity phenomena, are the belief that one's actions, feelings, or impulses are being driven by an external agency.

Beyond the delusions, the content paragraph holds *suicidal ideation*, and this is the part of the MSE that most often costs lives when it is done badly. Suicidal ideation should never be screened with a single yes-or-no. The structured move runs through frequency (how often does the thought come), intent (does the patient intend to act on it), plan (is there a specific method in mind), and lethality (is the chosen method one that could in fact kill her, with access to the means). Each step refines the risk. The patient who reports passing thoughts of death without intent and without a plan is in a different clinical position from the patient who has a specific method, has access to the means, and has set a date. Both patients are reporting suicidal ideation, and both should be documented; the difference between them is the difference between out-patient follow-up and admission. The MSE that says *SI+* is, again, not adequate. Document the four parameters in order. *Homicidal ideation* follows the same structure and is rarer; when

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present, it is medico-legally consequential and the threshold for documentation is the same.

The content paragraph also holds the depressive triad of *worthlessness*, *helplessness*, and *hopelessness*; *anhedonia*, which is more specific to depression than low mood itself and which patients sometimes describe more readily as *I cannot enjoy things any more* than as low mood; and, in the substance-using patient, *craving* and the patient's stage in the Prochaska model of behavioural change. Each item is worth a sentence. None is worth a one-letter abbreviation.

The clinician's working sentence on thought is in fact two sentences, asked together, one for form and one for content. *Is the thinking organised, and is the content of the thinking congruent with the patient's situation*. The two questions, asked in that order, sort almost every presenting picture into the right family.

The pitfall is single and famous. Writing *delusions present, hallucinations present* without the patient's verbatim phrase, without the modality, without the frequency, without the cultural context. The MSE that says *AH+ VH+ delusions+* is not an MSE; it is a notational shrug. Quote the patient. Translate underneath if the language was not English. Mark the translation as yours.

OBSERVATION	SPECTRUM	THINK ABOUT	DON'T MISS
Derailment, drivelling, word salad	Thought disorder	Schizophrenia spectrum, severe schizoaffective, psychotic mania	Sample enough speech; do not call form on a thirty-second exchange.
Pressured speech with flight of ideas	Internalising (manic pole)	Mania, schizoaffective, stimulant intoxication	Flight of ideas has understandable connections; derailment does not.
Thought insertion, withdrawal, broadcasting	Thought disorder	First-rank-positive schizophrenia spectrum	Religious traditions sometimes describe similar experiences; apply the cultural test.

OBSERVATION	SPECTRUM	THINK ABOUT	DON'T MISS
Obsessions recognised as own and excessive	Internalising (OCD pole)	OCD, obsessive-compulsive personality, prodromal states	OCD with poor insight loads on thought disorder; check the BABS.
Persecutory delusions, fixed and systematised	Thought disorder, antagonistic externalising	Schizophrenia, delusional disorder, severe paranoid personality	A culturally-sanctioned belief is not a delusion. The cultural test, every time.

6. Perception

Perception is the part of the examination that most non-psychiatrists find hardest, partly because the vocabulary is large and partly because the underlying philosophy is unfamiliar. Let me start a step further back than most textbooks do, because the step is worth taking. *Perception is not reception*. The brain is not a passive instrument that receives sensory data and presents it, as it is, to consciousness. The brain is an active inference machine that builds the percept out of two ingredients: the incoming sensory data, and the prior expectations the brain already holds about what is likely to be out there. Most of what you experience as perception is, technically, prediction. The eye and the ear deliver fragments; the brain assembles those fragments into a stable scene by combining them with what it already expects. This is the predictive-processing account introduced in Part I, and it explains why perceptual disorders are not, as the older textbooks framed them, failures of the senses. They are failures of the inference. The senses bring noisy data; the brain, in psychiatric illness, weighs that data against priors that are too strong, or too weak, or distorted by mood. The result is a perception that does not match the world, but it is still a perception, built by the same machinery that builds your perception now.

This view changes how you read the perceptual findings. There are two broad categories. *Distortions* are alterations in real perceptions; the stimulus is there, the brain receives it, the construction is altered. *Deceptions* are perceptions that arise without an adequate stimulus; the brain has built a percept from priors and noise, with no

anchoring sensory event. Within the deceptions, the further split is between *illusions*, where a real but misperceived stimulus is the seed, and *hallucinations*, where there is no seed at all.

True hallucinations and how to know one

The classical six criteria for a *true* hallucination are worth memorising, because they are how you separate a hallucination from the things that resemble one. A true hallucination is *substantial* (it has the quality and weight of real perception, not the lighter quality of imagination); located in *objective space* (it is out there in the world, not inside the head); *delineated* in detail (the patient can describe its features as one would describe a real object or sound); *constant* on inspection (it does not dissolve when the patient pays close attention to it); *independent of the will* (the patient cannot turn it on or off); and made of *fresh sensory elements* (the experience is not a memory or a recombined imagery but a new sensory event). When all six features are present, you are looking at a true hallucination. When some are present and some are not, you are looking at one of the related phenomena, usually a pseudo-hallucination or a vivid imagery.

The hallucination loads most heavily on thought disorder when it is auditory, third person, derogatory, persistent, and accompanied by disorganisation of form and content. The same finding loads less heavily, and on a different part of the map, when it is fleeting, mood-congruent, occurring during a depressive episode, and accompanied by full insight; mood-congruent hallucinations of severe depression load on the severe end of internalising and not on thought disorder per se. Visual hallucinations of small animals, in the elderly post-operative patient, load on neurocognitive disorder of the delirium type and should send you to the bedside, not to the psychiatrist. Tactile hallucinations of insects under the skin, in the patient with chronic alcohol use, load on the substance-use end of disinhibited externalising. Olfactory and gustatory hallucinations, in the absence of other psychiatric features, load on temporal-lobe pathology and should send you to the neurologist.

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Documenting a hallucination

For each hallucination, the documentation is fixed, and the discipline of the long description pays for itself within the same admission, when the registrar discussion comes back to the question of whether the patient really has command hallucinations and you find that the answer is in your own MSE. The fixed parameters are these. *Modality*, first; auditory, visual, tactile, olfactory, gustatory, or somatic. For auditory hallucinations specifically, then: *verbal or non-verbal* (voices saying words, or sounds that are not words); *continuous or intermittent* (occurring throughout the day or in episodes); *single or multiple* (one voice or several); *familiar or unfamiliar* (a known voice or a stranger's); *first, second, or third person* (the voice as the patient's own, or talking to the patient, or about the patient); the *content in verbatim* (what the voice says, in the patient's own words, in the patient's own language); pleasantness or unpleasantness; *command character* (does the voice instruct, and does the patient feel pulled to obey); *mood-congruence* (does the content match the patient's prevailing mood); and the *patient's response* (does she argue with the voice, ignore it, comply, become frightened). Ten parameters. Each is worth recording. The MSE that captures all ten makes the next clinical decision almost trivial; the MSE that captures none of them forces the next clinician to start from scratch.

The vocabulary of special hallucinations

Beyond the standard auditory and visual phenomena, a small vocabulary of named hallucinations appears in the MSE often enough that the reader should own the words rather than reaching for the textbook each time. *Hypnagogic* hallucinations occur in the drowsy state as one is falling asleep. *Hypnopompic* hallucinations occur on waking. Both are common in healthy people, more common in those with disrupted sleep, and a strong indicator of narcolepsy when persistent and accompanied by sleep paralysis. *Imperative* hallucinations are command hallucinations of the strongest kind, where the patient feels that the voice must be obeyed. *Thought echo* is the hallucinatory experience of one's own thoughts being spoken aloud, sometimes a fraction of a second after the thought; this loads on the schizophrenia spectrum. *Functional* hallucinations are hallucinations that occur only in the presence of another stimulus in the same modality (the patient hears a voice only when the tap is running). *Reflex* hallucinations are hallu-

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cinations in one modality triggered by a stimulus in another (the patient sees flashes of light when a door slams). *Extracampine* hallucinations are perceived as occurring outside the normal range of the senses (a voice heard in Mumbai by a patient sitting in Hubli). *Autoscopy* is the visual hallucination of seeing oneself; in its rarer forms, the patient sees a double or feels a presence. *Formication* is the tactile hallucination of insects crawling on or under the skin, classical of cocaine and methamphetamine intoxication and of severe alcohol withdrawal. *Fantastic hallucinations* are vivid scenic experiences, often involving complex and bizarre imagery. *Kinaesthetic* hallucinations are perceptions of movement of one's own body parts when no movement is occurring. *Haptic* hallucinations are tactile perceptions of being touched.

You do not need to be able to recite all of these from memory. You do need to recognise them when a colleague uses the word, and you need to know the most clinically loaded ones (formication, command, thought echo, extracampine) by name. The vocabulary is part of the discipline; learning it costs you nothing once and saves you the search every time afterwards.

Pseudo-hallucinations and imagery

A pseudo-hallucination is a mental image that is clear and vivid but lacks substantiality, is recognised by the patient as not real, and is located in subjective space, often *inside the head*. Read against the six criteria above: it fails at substantiality, fails at objective space, fails (often) at independence of will. The patient with a pseudo-hallucination knows that it is not really out there. She may describe it as *like a voice but not really a voice*, or as *a picture in my mind, very strong, but I know it is in my mind*. Pseudo-hallucinations are not, in themselves, a sign of psychosis; they are a perceptual finding of internalising in the dissociative or grief-related direction, and they appear commonly in normal bereavement, in dissociative disorders, in PTSD, and in severe trauma reactions. The bereaved widow who hears her husband's voice for a few weeks after his death is not psychotic; she is grieving in a culturally common form, and the experience is a pseudo-hallucination.

Distortions and the common error

Depersonalisation and *derealisation* are not hallucinations. Let me say that twice, because the error is so common. They are not hallucinations. They are *distortions*: alterations in the way real perceptions are experienced. Depersonalisation is the experience of feeling unreal, detached from oneself, as if one were watching oneself from outside, as if the self were not solidly there. Derealisation is the experience of the world feeling unreal, dreamlike, distant, as if seen through glass. Both involve real perceptual input that is being processed in an altered way; nothing is being added that is not there. They load on internalising of the dissociative subtype, and they appear commonly in severe anxiety, in panic, in PTSD, in dissociative disorders, and in the fringes of normal experience under conditions of fatigue or stress. Writing *VH+* on the chart of a patient with derealisation is one of the more consequential errors a non-psychiatrist can make; it points the next clinician at thought disorder when the patient is suffering from internalising, and the resulting management plan is wrong.

The clinician's working sentence on perception is *what is this patient experiencing that I am not, and where is it located in their world*. The location matters. Voices outside the head, coming through the wall, with the texture of real perception, sit in different diagnostic territory from voices inside the head, recognised as one's own thinking made loud.

The pitfall is two-fold. Calling depersonalisation a hallucination. Calling a pseudo-hallucination a true hallucination. Both errors point the next reader towards thought disorder when the patient is in fact suffering from internalising of the dissociative or depressive subtype, and both errors are common.

OBSERVATION	SPECTRUM	THINK ABOUT	DON'T MISS
Third-person derogatory AH, persistent	Thought disorder	Schizophrenia spectrum, schizoaffective, psychotic depression	Mood-congruent AH in severe depression looks similar; the mood is the deciding signal.

OBSERVATION	SPECTRUM	THINK ABOUT	DON'T MISS
VH of small animals, fluctuating sensorium	Neurocognitive (delirium), substance withdrawal	Delirium, alcohol withdrawal, anticholinergic toxicity	The delirium is reversible and is the priority; psychiatry is downstream.
Tactile hallucination of insects	Disinhibited externalising (substance), neurocognitive	Chronic alcohol use, methamphetamine use, delirium	Formication is a substance signal until proven otherwise.
Depersonalisation, derealisation	Internalising (dissociative subtype)	Severe anxiety, dissociative states, panic	Not a hallucination. Do not write VH+.
Pseudo-hallucination, recognised as own	Internalising (dissociative subtype)	Bereavement, dissociation, grief	Not a hallucination. Do not write AH+.

7. Cognition

Cognition is the substrate domain. The findings here do not load on a single HiTOP spectrum; they load on the p-factor when impaired across the board, and they load on neurocognitive disorder when impaired in characteristic patterns. The reason cognition is called the substrate domain is that the rest of the MSE rests on it. If the patient is not conscious enough to attend, you cannot test memory; if the patient cannot attend, you cannot test thought form; if the patient is disoriented to time, the rest of her account of her last week is provisional. The cognitive findings come first not because they are the most important diagnostically, but because they tell you whether the rest of the examination is safe to interpret at all. The discipline is to test rather than infer. *Cognition appears intact* is not a finding; it is a claim that has not been examined.

Consciousness

The first question is whether the patient is fully conscious. The four levels worth knowing are clear, drowsy, stuporose, and comatose. *Clear* consciousness is the ordinary state in which the patient is awake, aware, and oriented to the encounter. *Drowsy* consciousness is the state in which the patient is awake but with reduced alertness, takes longer to register the question, and may drift between attention and inattention.

Stupor is the state in which the patient is unresponsive to most stimuli but can be roused, briefly, by vigorous stimulation. *Coma* is the state of full unresponsiveness, even to noxious stimulation. The Glasgow Coma Scale is the standard quantitative tool for the lower levels and the patient with stupor or coma belongs in the medical or neurological setting first; psychiatry is consulted afterwards.

The single most important fact about consciousness is that *impaired consciousness invalidates everything that follows*. A drowsy patient cannot give you a reliable account of her week, cannot perform memory testing in any interpretable way, and cannot be held responsible for the form or content of her speech. The drowsy patient may also be a delirious patient, and delirium is a medical emergency that is reversible if the cause is found and irreversible if it is not. If the patient appears drowsy, the next move is not to press on with the MSE. The next move is to find the cause.

Orientation

Orientation is tested in three domains, in a fixed order: time, place, and person. *Time* covers the date, the day of the week, the month, the year, and the approximate time of day. *Place* covers the location, the city, the floor of the building, the type of facility. *Person* covers the patient's awareness of who she herself is and who you are. The order of testing is the order of loss in organic disease. Time goes first, place next, person last; recovery happens in the reverse order. A patient who is disoriented to person but oriented to time is unlikely to have an organic cause for the disorientation, and the picture is more likely to be dissociative or factitious. A patient who is disoriented to time and place but not to person has the classical signature of organic disease. The order itself is diagnostic.

Attention and concentration

Attention is the ability to focus on a single stimulus and hold the focus. Concentration is the ability to sustain that attention across time and to manipulate information mentally. The two are related but separable. The standard tests are the digit span (forward span tests attention; the reverse span tests concentration and working memory), serial subtraction (commonly serial sevens from one hundred, or serial threes from

twenty for less educated patients), and the months-of-the-year backward test, which is the most useful single screener because it is robust across educational levels and culturally fair across most settings. Normal forward digit span is around seven plus or minus two; reverse span is normally around five. The patient who can manage seven forward and four or five back has normal attention and concentration. The patient who cannot manage four forward, or who fails on serial subtraction within thirty seconds, has impaired attention until proven otherwise.

Inattention is the cardinal feature of delirium and the single most useful sign for distinguishing delirium from dementia at the bedside. The dementing patient with intact attention will perform poorly on memory but well on the digit span; the delirious patient will fail the digit span and may not even sustain attention long enough for the memory test to be interpretable.

Memory

Memory is tested in three time-bands, and each band requires its own technique. *Immediate* memory, sometimes called registration, is tested by giving the patient three to five unrelated objects to remember and asking for them after a delay of three to five minutes during which active distraction is provided (counting backward, reciting the months, naming the prime ministers). The active distraction is essential; without it, the patient is rehearsing the words and the test becomes a test of attention rather than of memory. Normal performance is recall of all three to five items. *Recent* memory is tested by asking about events of the last day or two, the contents of breakfast, the route to the hospital, the events that brought the patient in. The address test (giving the patient a fictitious address to remember and asking for it ten minutes later) is the standard formal probe. *Remote* memory is tested by asking about autobiographical landmarks the family can verify: the year of marriage, the name of the school attended, the names and ages of children, the year of moving house. Verification with the family is part of the test; without verification, you are testing the patient's confabulation rather than her memory.

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The patterns matter. Recent-memory deficit with relatively preserved remote memory is the classical signature of Alzheimer disease. Patchy memory loss with islands of preservation is more typical of vascular dementia. Memory failure that improves with effort and motivation is suggestive of pseudodementia, of which more in a moment. Confabulation, where the patient fills memory gaps with confident fabrication, is classical of Korsakoff syndrome and is over-represented in chronic alcohol use.

Intelligence

Intelligence in the MSE is a *clinical estimate*, not an IQ measurement. The clinical question is whether the patient's general cognitive ability appears commensurate with her educational and cultural background, or whether there is a marked discrepancy in either direction. The probes are simple. Comprehension items (what would you do if you found a stamped addressed envelope in the street). Abstraction items (what is the difference between a child and a dwarf; what does the proverb *a stitch in time saves nine* mean). General-information items (the name of the prime minister, the capital of the country, recent significant events). Calibrate to the patient. A patient with two years of formal schooling is not expected to abstract a complex proverb the way a postgraduate is. The question is fit between performance and background, not absolute level.

Pseudodementia

The single most-missed cognitive pattern in psychiatric practice is the pseudodementia of severe depression. The depressed patient often appears cognitively impaired: she answers slowly, she says *I don't know* to questions she clearly should be able to answer, her memory testing is poor, her processing is sluggish, her global cognitive impression is one of dementia. The crucial clinical move is to ask the patient to *try* harder, to give the answer even if she is unsure, to commit to a guess. The patient with pseudodementia, when pressed, often produces the right answer. The patient with true dementia produces a confabulation, a perseveration, or a frank failure. Pseudodementia is reversible with treatment of the depression; missing it leads to wrongful institutionalisation and a wrongful prognosis. It loads, of course, on internalising, not on neurocognitive disorder; the cognition itself is intact, and the failure is one of motivation and of the depressive collapse of effort.

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The clinician's working sentence on cognition is *can this person hold the thread of the present moment*. The question is not yet about the diagnosis; it is about whether the substrate is intact for the rest of the examination to be interpreted. If the answer is no, the rest of the MSE is provisional and the priority shifts to the cause of the cognitive impairment.

The pitfall is to skip cognitive testing because the patient is articulate. Articulacy and cognition are not the same thing. The grandfather brought to the OPD by his daughter, who answers your social questions with practised charm, may fail the address test at five minutes. The articulate patient may be a confabulating patient. Test the cognition; do not infer it. The rule for the non-psychiatrist is even firmer than for the psychiatrist, because the non-psychiatrist sees these patients in settings (the medical ward, the family clinic, the emergency department) where impaired cognition is common and routinely missed.

OBSERVATION	SPECTRUM	THINK ABOUT	DON'T MISS
Fluctuating consciousness, inattention, disorientation to time	Neurocognitive (delirium)	Sepsis, metabolic, drug toxicity, withdrawal	The cause of delirium is medical; psychiatry is consultative.
Clean consciousness, recent-memory deficit, preserved remote memory	Neurocognitive (Alzheimer pattern)	Mild cognitive impairment, early Alzheimer, B12 deficiency	Reversible causes of dementia, every time, before the label is given.
Inattention, working-memory weakness, slowed processing	Thought disorder, p-factor	Chronic schizophrenia, severe affective illness, antipsychotic load	The cognitive picture is core, not side-effect; do not blame the medicine without checking.
Apparent global impairment improving with motivation	Internalising (depressive pole)	Pseudodementia of depression	Treat the depression and re-examine; the cognition often returns.

8. Insight and judgement

Insight, in the older psychiatric usage, is the patient's awareness of being unwell, her attribution of the unwellness to mental illness, and her acceptance of the need for help. The classical six-grade scale, still used in most Indian training programmes and worth knowing in detail, runs from no insight at one end to full emotional insight at the other. *Grade 1* is complete denial of illness; the patient does not believe anything is wrong and resists any suggestion that something is. *Grade 2* is slight awareness of being ill but with simultaneous denial; the patient acknowledges, when pressed, that something might be off, but reverts to denial when not pressed. *Grade 3* is awareness of being ill, but the patient attributes it to external or physical causes (the neighbours, the food, the weather) rather than to a mental illness. *Grade 4* is awareness of being ill and of having a mental cause for the illness, but with limited engagement; the patient knows she is mentally ill but does not yet feel motivated to do the work of recovery. *Grade 5* is intellectual insight; the patient can articulate the illness, the precipitating factors, and the necessary treatment, but the understanding has not yet translated into emotional and behavioural change. *Grade 6* is true emotional insight; the patient understands her illness at the level of motivation and applies that understanding to her behaviour and her relationships.

The grades sound clean on paper and are messier at the bedside. A useful disaggregation is into three components: *awareness* (does the patient recognise that something is wrong), *attribution* (does she ascribe the wrongness to a mental cause), and *acceptance* (does she accept the help that is offered). A patient may be aware but not attribute (Grade 3). A patient may attribute but not accept (Grade 4). A patient may accept intellectually but not emotionally (Grade 5). The three-part division is more useful clinically than the six-grade ladder, because it tells you *where* to work; awareness is built through observation and gentle reflection, attribution through psychoeducation, acceptance through the slow building of therapeutic alliance.

Insight loads on the spectra in characteristic ways. Acute psychosis tends to present with low insight (Grade 1 or 2), which improves over weeks as the episode settles.

Severe depression often presents with intact insight and self-blaming attribution that overshoots into pathology; the depressed patient frequently has Grade 5 or 6 insight into her depression, and the over-attribution is itself part of the illness. Manic episodes tend to present with poor insight on the way up and improving insight as the episode resolves; the manic patient who thinks she is fine at the height of the episode often has good insight, retrospectively, two months later. Personality-pattern presentations sit on the *I see the pattern but cannot change it* end of the scale, which is its own kind of insight and is not adequately captured by the six-grade tool.

Judgement, in three parts

Judgement, in the same older tradition, has three subdomains, and each is independently informative. *Personal judgement* is the question of whether the patient's behaviour is disrupting her own life; whether her decisions, taken across the last weeks, are recognisably the decisions of someone caring for her own interests. *Social judgement* is the question of whether her behaviour is disrupting her social functioning; her relationships, her work, her family role. *Test judgement* is the question of whether she can solve the standard hypothetical problem in a way that suggests intact reasoning; the lost stamped envelope in the street, the building on fire, the wallet found on a bench. The three are independently informative, and the contrasts between them are often the most diagnostic part of the finding. A patient may show preserved test judgement on the standard items and grossly impaired personal judgement on the question of whether to continue using methamphetamine; the contrast itself is the finding.

Insight is not capacity

The single most important medico-legal point in this domain is that *insight is not capacity*. They are different examinations, they ask different questions, and they yield different answers. Insight is a global descriptive judgement about the patient's understanding of her illness. Capacity is a *decision-specific* assessment of whether the patient can make a particular decision at a particular time. The classical four-part capacity test asks whether the patient can *understand* the information relevant to the decision, *retain* it long enough to use it, *weigh* it in arriving at a choice, and *communicate* the choice. A patient may have poor insight (Grade 1 or 2 on the global scale) and still have

the capacity to refuse a specific intervention, if she can demonstrate the four components for that decision. A patient may have good insight (Grade 5) and lack capacity for a particular decision, if her understanding does not extend to the specifics of the decision in question. Capacity is always *capacity for what*. The question must specify the decision: capacity to consent to ECT, capacity to refuse antibiotics, capacity to manage her own finances. Each is assessed separately. The doctor on the ward who confuses insight with capacity is the doctor who finds himself in difficulty at the medico-legal review, and the error costs both patients and clinicians.

The mixed-insight patient

The pitfall that catches almost everyone is the mixed-insight patient, and it is worth slowing down on. A patient may have Grade 4 insight regarding her depression, in the sense that she knows she is depressed and knows it has a mental cause and is willing to take treatment; and the same patient may have Grade 1 insight regarding her drinking, in the sense that she does not recognise the alcohol use as a problem, does not attribute her difficulties to it, and has no intention of changing it. This patient is not a Grade 2.5 patient. She is two patients in one body, with different insight in different domains, and the MSE should describe each separately. *Grade 4 insight regarding depressive illness, Grade 1 insight regarding alcohol use, willing to engage on the first and resistant on the second.* That sentence is doing the work of accurate description; an averaged grade is doing the work of false economy. Where the picture is mixed, write it as mixed. The averaging hides the very contrast that determines what to do next.

Closing the formulation

A short word on how this domain integrates with the other seven. Insight and judgement are the last MSE domain because they synthesise the rest. The patient's stance, appearance, speech, mood, thought, perception, and cognition all feed into what she knows about her own state and what she can do about it. The internalising-loaded patient with severe depression and Grade 5 insight is in a different clinical position from the thought-disorder-loaded patient with persecutory delusions and Grade 1 insight; the next move with each is different, and the difference is captured in the insight finding. The eight domains are independent enough to be testable separately and inte-

grated enough that the eighth domain commonly gathers up the previous seven into a single working sentence. *This patient presents with internalising loading on depressive symptoms, intact insight, preserved test judgement, and impaired personal judgement around medication adherence.* That sentence, written at the end of an MSE, is the formulation. Everything that follows in the management plan is downstream of it.

The clinician's working sentence on insight and judgement is *does this patient know what is happening to her, and can she make a defensible decision about what to do about it*. The two halves of the question are different. Insight is descriptive; judgement is forward-looking. Insight does not, on its own, determine capacity; capacity is its own examination, and the doctor on the ward who confuses insight with capacity is the doctor who finds themselves in difficulty at the medico-legal review.

The pitfall is to grade insight without specifying which domain you are grading on. The patient who has Grade 4 insight regarding her depression and Grade 1 insight regarding her drinking is not a Grade 2.5 patient; she is two patients in one body, and the MSE should describe each separately. Where the picture is mixed, write it as mixed.

OBSERVATION	SPECTRUM	THINK ABOUT	DON'T MISS
Denial of illness, attribution to external causes	Thought disorder, severe internalising	Acute psychosis, severe mania, delusional disorder	Insight is not capacity. Examine capacity separately when needed.
Intact insight, self-blaming attribution	Internalising (depressive pole)	Severe depression, depressive episode of bipolar	Severe self-blame can carry suicidal intent; ask explicitly.
Insight present, judgement disrupted on a single domain	Disinhibited externalising	Substance use, ADHD with impulse problems, mania resolving	The single-domain disruption is often the entry point for treatment.
Sees the pattern, reports inability to change	High p-factor, antagonistic externalising	Personality-pattern presentations, chronic eating disorders	Recognising a pattern is not the same as changing it; do not over-credit it.

A short closing thought before we move to the worked examples. The eight-domain examination is not a checklist that you complete and put aside. It is a way of seeing the patient, and once it has become a habit, you find yourself running it silently in the lift on the way down from the ward. The HiTOP loadings are not labels you stick on the patient; they are the dimensional vocabulary that lets you talk about the patient with another clinician without the categorical fight that often follows from the DSM language. The patient is not a schizophrenia or a depression; the patient is an internal-ising-thought-disorder profile with somatoform features, in their forty-first year, with a particular history and a particular family. That description is what good psychiatry produces. The next three chapters apply it to three different rooms, in three different hospitals, to three patients you will recognise.

A working dimensional formulation

A one-page worksheet to take to the bedside or the morning ward round. Eight rows, six spectrum loadings, one keystone, one sentence stem. The reader should photocopy this page; the formulation lives on paper, not in memory.

DOMAIN	OBSERVATION	LOADING
1. Stance		INT · TD · DE · AE · DET · SOM
2. Appearance and behaviour		INT · TD · DE · AE · DET · SOM
3. Speech		INT · TD · DE · AE · DET · SOM
4. Mood and affect		INT · TD · DE · AE · DET · SOM
5. Thought		INT · TD · DE · AE · DET · SOM
6. Perception		INT · TD · DE · AE · DET · SOM
7. Cognition		INT · TD · DE · AE · DET · SOM
8. Insight and judgement		INT · TD · DE · AE · DET · SOM

p-factor low / moderate / high

Network keystone, the one symptom holding the rest in place: ___

Formulation sentence-stem, *this patient presents with ___ loading on ___, with ___ as the keystone symptom, in the context of ___, suggesting ___ as the next step.*

Spectrum codes: INT = internalising · TD = thought disorder · DE = disinhibited externalising · AE = antagonistic externalising · DET = detachment · SOM = somatoform.

Part III. Three rooms, three patients

The dimensional reading is portable. You can apply it in casualty, in a family physician's clinic, on a surgical ward, in a paediatric outpatient department. The shape changes, the questions stay the same. Three cases follow. They are composites; the people are not real, the patterns are. The cases are written from three different rooms, each with a different non-psychiatrist holding the front line, each with the same eight-domain examination producing different answers. Read each one with the formulation worksheet from the end of Part II in front of you, because the point of the chapter is to watch the worksheet being filled in.

Case 1. The casualty at two in the morning

PT-A12 is a twenty-three-year-old man brought in by two friends who have been holding him by the shoulders for the past forty minutes and who release him only when the security guard signals that they should sit down. The triage nurse has written *agitated young male, query intoxication*. He is wearing a shirt that has lost a button and a face that is not quite resolved into one expression. He is shouting at the registrar but the shouting has the look of a man trying out the experience of shouting rather than the look of a man who has decided to shout. The casualty itself is the casualty of any tertiary hospital after midnight; one trauma in the resuscitation bay, two chest pains in the side cubicles, a road traffic accident on its way in, a single intern moving between them at the speed the night will allow. The medicine intern, in his second month of internship, has the patient because the senior is busy with the trauma and because the friends are insistent that *something is wrong, doctor*.

The intern's job, before psychiatry arrives, is to do three things. Make sure the patient is not dying. Make sure the patient is not actively dangerous to himself or others. Form a working hypothesis specific enough that the psychiatrist can move on it. The casualty is loud, the lighting is the wrong kind of bright, and the patient is the only thing in the room that is moving. The intern stands with his back to the corridor, which is a small

piece of teaching that nobody had taught him explicitly; he has the door behind him without making a show of it.

Vital signs. Pulse one-twenty, blood pressure one-fifty over ninety, respiratory rate twenty, temperature normal, oxygen saturation ninety-eight per cent on air. Pupils mid-dilated, reactive. The intern smells alcohol but not strongly. Capillary glucose is normal. There are no marks on the skin and no obvious head injury. The patient resists the otoscope but can be persuaded; the tympanic membranes are clear. He has not vomited.

The intern's eight-domain reading runs in parallel with the physical examination, because that is what a competent intern in casualty is doing whether they know it or not. *Stance*: hostile, restless, unable to settle in the chair, eye contact intermittent and intense rather than absent. The stance loads on antagonistic externalising and on the persecutory pole of thought disorder; it does not, on its own, distinguish between substance use and primary psychosis, but it tells the intern that the room is not yet safe and that the rest of the examination must be done with the door behind him. *Appearance and behaviour*: dishevelled, sweating, psychomotor activity markedly increased, no overt catatonic signs, no tremor that the intern can isolate from the agitation. The sweating, the tachycardia and the mid-dilated pupils together form a sympathomimetic profile, which loads on disinhibited externalising of the substance subtype; the intern files the autonomic finding on the substance side of the ledger. *Speech*: pressured, loud, fast, the volume difficult to bring down, the content interruptible only with effort. Pressured speech loads on the manic pole of internalising and, when the connections are starting to come apart, on thought disorder; combined with the autonomic features, the speech finding fits a stimulant or an entactogen better than it fits a primary mania. *Mood and affect*: reported by the patient as *fine, just leave me alone*, observed as anxious-irritable with rapid shifts between fear and anger. Labile affect with anxious-irritable colouring loads on internalising of the anxiety subtype and on disinhibited externalising acutely; the rapidity of the shifts is the substance signature. *Thought*: form preserved on the brief sample, content dominated by the conviction that

the friends have brought him to the casualty to have him admitted against his will; an idea of reference that the registrar is in on it; an oblique suggestion that the patient knows what is really going on and is protecting himself by not saying. Persecutory content loads on thought disorder; the preservation of form, against the persecutory content, is the finding that makes the intern hold the diagnosis loosely. *Perception*: the intern asks, gently, whether anyone is speaking to him whom others cannot hear; the patient says no, after a pause that is not the right length. The pause is itself a finding. *Cognition*: oriented to person and place, uncertain about the time, can subtract serial sevens with effort. The mild attentional slip, in a previously well young man, loads on the p-factor acutely and is consistent with substance loading rather than with primary thought disorder, which classically preserves cognition early. *Insight*: absent.

The intern, before psychiatry arrives, has a working dimensional read. Acute thought-disorder presentation with disinhibited-externalising loading, acute onset, in a previously well young man, with autonomic features that point as strongly at substance use as at primary psychosis. The intern's job now is to keep the patient safe and to gather the small set of facts that will let psychiatry move quickly when they arrive. The teaching heuristic, internal to him by the end of his casualty rotation if it has been a good rotation, is that the agitated young patient in casualty is a substance presentation until proven otherwise. The base rate matters; in a city of a million on a Saturday night, the agitated young man in casualty is overwhelmingly more likely to be carrying a substance picture than a first-episode primary psychosis, and the working hypothesis should reflect the base rate rather than the most dramatic option on the differential.

The friends are interviewed in the corridor, because they will not stay if they are kept in the cubicle. The patient was at a party four hours ago. He took a tablet that someone said was *MD*. He has been drinking. He started saying odd things in the rickshaw on the way over. He has no psychiatric history. His maternal uncle was *not well in the head*, the friends are not sure with what; he was on tablets for years.

This single piece of history reframes the whole picture. The dimensional reading is the same; the cause is now substance-induced rather than primary, the trajectory is there-

fore likely to be hours to days rather than weeks, and the immediate priority is containment with safety rather than antipsychotic loading. The intern phones psychiatry, requests a review, secures the patient with one nurse close by, and writes a single intramuscular dose of lorazepam two milligrams on the prescription, which the registrar signs after a brief examination at the bedside. The patient is in a side room, observed, by the time the psychiatry resident arrives, and the conversation that follows is short because the work has already been done.

The counterfactual is worth walking through, because it is the move a less experienced clinician would have made and because it would have gone wrong. A different intern, on a different night, takes the agitation at face value, does not ask the friends about the party in the corridor, and reads the persecutory content as the leading edge of a first-episode psychosis. He writes haloperidol ten milligrams intramuscularly, which is the dose the textbook taught him for *acute behavioural disturbance*. The patient, who is loaded on an entactogen with sympathomimetic features, receives a dose of haloperidol that drops his seizure threshold, prolongs his QT, and converts a self-limiting four-hour picture into a forty-eight-hour casualty stay with a cardiac monitor and a worried family. The MDMA history was always there in the corridor; the failure was the failure to ask. This is the cost of treating the symptom rather than reading the dimension.

PT-A12 is loaded disinhibited-externalising (acute substance) with thought-disorder features (transient), low detachment, high p-factor, in the context of a 23-year-old previously-well man with family history of *nerve tablets*. The provisional diagnostic shape is substance-induced psychosis, expected to settle over twenty-four to seventy-two hours; the keystone symptom is the agitation, which is what the intervention targets first. The dimensional reading does not eliminate the possibility of a primary psychosis declaring itself later; the family history of an uncle on tablets for years is a piece of information that the team should hold in mind and ask about again at follow-up in two weeks, when the substance loading has cleared and the underlying signal, if there is one, will be visible.

What the non-psychiatrist needed to know, in this case, was not how to differentiate primary psychosis from substance-induced psychosis with confidence. That was always going to be the psychiatrist's job, with time and the trajectory to help. What the non-psychiatrist needed to know was that the eight-domain reading and a clean substance history are enough to keep the patient safe and to point the next clinician at the right tree. The next steps the intern owes the system are small and concrete. Hand over the substance history in writing, not just verbally, because the night ends and people forget. Document the autonomic findings at presentation, because the team in the morning will need to know what the patient looked like when the picture was hot. Ask the friends, before they leave the corridor, for one of their phone numbers; the patient may not remember much of the night by the time he is asked, and the friends are the historians of record. Tell the patient, when he is settled enough to hear it, that he is safe and that he will feel different in the morning. The diagnostic category will sort itself out by morning.

IF YOU ONLY REMEMBER ONE THING.

The young agitated patient in casualty is, until proven otherwise, a substance presentation. Take the history from whoever brought them in, before they leave; the friends do not always wait. A clean substance history with a clean physical examination reframes the dimensional reading from primary thought-disorder, which needs antipsychotics and admission, to substance-induced thought-disorder, which needs containment, observation, and time. Reach for the benzodiazepine before the antipsychotic; the picture will declare itself by morning.

Case 2. The Wednesday-morning clinic

PT-A09 is a forty-one-year-old woman, second child of two, married, working in a private bank in a town outside Hubli, attending the family physician with a chief complaint of *I'm tired all the time*. She has come twice in the last six months. The first visit, four months ago, generated a thyroid panel that came back at the upper end of normal and a haemoglobin of eleven point two; she was started on iron and told to come back in three months. She has come back. She is not better. The family physician is reading the file with a small frown, because the patient is the kind of patient he would

normally have placed by now. The Wednesday clinic is the slow clinic; the rush is on a Monday and a Saturday, and the Wednesday list has the patients who need ten minutes rather than four. This is not, in his clinic, a small distinction. He has time, and he uses it.

The room is quiet. The fan is off because she is wearing a cardigan despite the warmth of the morning, and that is itself a small finding. The two photographs on his desk are of his children; her eyes go to them and stay a beat longer than the social glance, which he files silently. He has known her for six years, in the way a family physician knows a patient, which is partly through her own visits and partly through the husband's and the children's. The eight-domain reading takes the family physician about ninety seconds, woven into the consultation, requiring no extra time.

She sits cooperatively, slightly apologetic, her bag in her lap as if she might leave at any moment, well groomed and visibly thinner than the photograph in the file. The stance is internalising in colour; the apology is the giveaway, the bag in the lap is the giveaway, and the visible weight loss against the file photograph is the kind of finding the patient will not volunteer because she has not noticed it herself. *Appearance and behaviour*: psychomotor activity normal; no abnormal motor phenomena; the cardigan in warm weather is a small thermoregulatory or self-soothing finding that loads on internalising softly and that should not be overcalled. *Speech*: spontaneous and slightly slow, prosody preserved, the reaction time mildly increased; the slowing loads on internalising of the depressive pole, the preservation of prosody is the finding that distinguishes depressive slowing from a developing parkinsonian picture or from a thyroid picture. *Mood*: she tells him she is fine, just tired; *affect*: he sees a mildly depressed affect, restricted in range, congruent with what little content is on offer. The mood-affect mismatch is small, in the direction of the patient under-reporting, which is itself an internalising signal in this culture and in this age band. *Thought*: form intact; content is guilt: about not being a better mother to her two children, about mistakes she has been making at work, about an oblique comment that her family would manage if anything happened to her, which the family physician notes silently and returns to later. Guilt with a narrow circle of self-blame loads on internalising of the depressive pole; the

oblique comment is the suicide screen earning its place in the consultation. *Perception*: there are no abnormal perceptual phenomena. *Cognition*: she reports being subjectively forgetful (*I forget things, doctor*) but tests intact on the small screen he runs; the dissociation between the subjective complaint and the objective finding loads on internalising in the depressive direction and is the classical pseudodementia profile in miniature. *Insight*: present, framed as physical (*I think it is the iron, doctor*) rather than psychological, which is a finding in its own right. The somatic framing of psychological distress is the form most common in middle-aged Indian women in primary care, and it loads on internalising with a somatoform colour that should not be missed.

The family physician's working differential, fed by the eight-domain reading, is now wide and useful. The dimensional read is internalising of the depressive pole, with a mild somatoform component, of moderate severity, in a woman of perimenopausal age with a slightly low haemoglobin and a borderline thyroid. The candidate diagnoses are not in competition; they are layered. This is the central teaching point of the case, and it is worth slowing down over. Categorical psychiatry, asked to make a diagnosis here, becomes paralysed; the DSM logic forces the clinician to choose, and the choice is always wrong, because the patient is in fact carrying more than one process at once. Major depressive disorder, recurrent or first episode. Hypothyroidism, given the upper-limit TSH on the previous panel and the symptom overlap. Perimenopausal mood and energy change, which on the modern reading is itself a hormonal contributor to the depressive picture rather than a separate entity. Iron-deficiency contribution, which the four months of iron has only partly addressed. Marital and work stress, in the form she is willing to talk about. The family physician's job is not to choose one diagnosis; it is to investigate the layers in the right order and to start what can be safely started today.

The practical sequence runs as follows. Repeat the thyroid panel with a free T4. Repeat the haemoglobin and a ferritin, since the iron may not have replenished the stores even if the haemoglobin has corrected. Take a brief sleep history (she is sleeping but not refreshed; the early morning waking, when asked, is present). Take a brief sexual and reproductive history (her cycles have been irregular for six months and she had not

mentioned it). Ask the suicide question explicitly, in the form the consultation has already half-taught her to expect (*sometimes when people feel this stretched, the thought arrives that life is not worth living; has that thought come to you*); she says no, then says she sometimes thinks her family would be better off, then walks back to the first answer. The family physician notes both. Start a serotonergic antidepressant at a starter dose with a one-week review; explain that the medicine does not work in twenty-four hours and that she is expected to feel slightly worse before she feels better; secure her phone number for an interim message; refer to psychiatry routinely with a one-page summary, in writing, that the patient takes with her.

The counterfactual is the move a less experienced family physician would make, which is to refer to psychiatry and do nothing. It looks like the safe move. It is in fact the dangerous move. The psychiatry waiting list in the district is four months. In four months, an untreated moderate depressive episode in a woman who is already making oblique comments about her family being better off has a real chance of becoming a severe one, with the trajectory into suicidal ideation that the suicide screen has already gestured at. The risk of starting a starter-dose SSRI in primary care, with a one-week review and a phone number, is small. The risk of leaving her unmedicated for sixteen weeks while a referral letter sits in a queue is not small. The teaching move, here, is to act under uncertainty and to share the uncertainty with the next clinician, not to defer until certainty arrives. Certainty does not arrive. Patients deteriorate while we wait for it.

PT-A09 is loaded moderate-internalising (depressive pole) with mild-somatoform features, low-to-moderate p-factor, in the context of a 41-year-old working woman with perimenopausal cycle change, borderline thyroid, low-normal haemoglobin, and home stressors inferred but not articulated. Keystone: anhedonia and the sleep complaint; formulation sentence: depression is the primary process; thyroid and iron are correcting; refer to psychiatry while starting the SSRI today. The keystone matters, because the network frame from Part I tells us where to cut first. If the sleep is the load-bearing wall, the SSRI plus a brief hygiene conversation will start to release the rest of the network

within two to three weeks; if the keystone is the work stress, the medicine will help less and the conversation will help more, and the family physician will know which it is by the time of the four-week review.

The dimensional reading has done two things in this consultation. It has prevented the family physician from sticking a single label on the patient and missing the layer beneath. It has, equally, prevented the family physician from referring to psychiatry without starting anything, on the assumption that depression is the psychiatrist's problem; at one episode of major depression in a town with a four-month psychiatry waiting list, starting safely and reviewing actively is the right move, not the heroic move. The patient is followed up at one week and four weeks; the second thyroid panel is mildly hypothyroid this time and is treated; the antidepressant is up-titrated; the psychiatry appointment, when it comes, finds a patient who is already partway better and who can use the time for work that the family physician was never going to be able to do.

IF YOU ONLY REMEMBER ONE THING.

The tired middle-aged woman in your clinic with a borderline thyroid and a low-normal haemoglobin is not a thyroid problem. She is, until proven otherwise, depression layered on perimenopause layered on iron deficiency layered on whatever has been heavy at home. Treat the layers in parallel. **Two preconditions before you start an antidepressant in primary care: the suicide screen is fully negative, and the picture is moderate, not severe.** *With both met, do not wait for the psychiatry referral to start the SSRI. Without both met, refer first and start later. The dimensional reading lets you act in clinic, while still referring on.*

Case 3. The surgical ward, post-operative day three

PT-A24 is a seventy-eight-year-old retired schoolteacher, admitted four days ago for a hemiarthroplasty after a fall at home in which he fractured the right neck of femur. The surgery was uncomplicated. The post-operative course was unremarkable until last night, when the night nurse noticed him trying to climb over the cot side at three in the morning, talking to someone who was not there. The morning surgical round notes him as *cooperative, oriented, no acute distress*. The afternoon registrar, doing a routine review, finds him drowsy and inattentive; he has not eaten his lunch. The team requests

a psychiatric opinion for *behavioural disturbance, possible depression, possible dementia*. The ward is the orthopaedic ward of a general hospital; six beds in a row, the curtain drawn for privacy that is mostly an idea, the patient's daughter on a plastic stool by the bed reading a newspaper. The afternoon light is the wrong angle and the television in the next bay is loud.

The first move of the on-call psychiatry resident, before any further interview, is to read the chart. This is the move the team did not do, and the move that decides the case. The patient is on tramadol, at a dose appropriate for his weight; he is on hyoscine, prescribed two days ago for post-operative nausea and continued; he is on a low-molecular-weight heparin; he is on no regular psychotropic medication. His pre-operative assessment recorded a Mini-Mental State Examination score of twenty-eight out of thirty, which is in the normal range for his age and education, and a brief functional history that suggested intact independent living before the fall.

The hyoscine is the finding. Hyoscine is butylscopolamine in many Indian formularies and it is an antimuscarinic; it crosses the blood-brain barrier in a fraction of patients, particularly the elderly, and it is one of the cleaner ways in routine ward practice to precipitate an anticholinergic delirium. The seventy-eight-year-old brain has, on average, a thinner cholinergic reserve than the brain of a forty-year-old; the same dose that produces dry mouth and quiet relief in a young patient produces, in the elderly, the visual hallucinations of small figures, the inattention, the fluctuating consciousness, the fragmentary memory, the picture the night nurse saw at three in the morning. The tramadol, on top of the hyoscine, contributes its own central effects through serotonergic and anticholinergic pathways. The picture is iatrogenic, partly, and the iatrogenic component is the part that is most rapidly reversible. This is the central teaching point of the case, and it is worth holding it explicitly: delirium is a medical emergency, not a psychiatric one, and the first move is to read the prescription chart with the eyes of a physician rather than the eyes of a behavioural consultant.

The eight-domain reading is now done at the bedside, and it is done not as a checklist but as a sequence of small targeted observations. *Stance*: variable, drowsy at the start

of the interview and more alert by the end. The fluctuation across a fifteen-minute interview is the finding; it is the single most discriminating sign for delirium against dementia, in which the stance is steady across a comparable window. *Appearance and behaviour*: lying in bed, plucking at the bed-sheet (carphologia), occasionally reaching for something at the edge of the bed that is not there, drowsy but rousable. Carphologia loads heavily on neurocognitive disorder of the delirium type. *Speech*: when present, scant, slow, slightly slurred. Slurring in the absence of dysarthric structural pathology, in a fluctuating sensorium, loads on the delirium picture. *Mood and affect*: reported as *all right*, observed as labile and reactive, briefly tearful when the daughter is mentioned and then settling. Lability in the elderly post-operative patient, in the context of fluctuating attention, loads on neurocognitive of the delirium type, not on a primary affective process. *Thought*: form mildly disorganised, with some loosening on the longer responses, content dominated by the worry that the nursing staff are *not letting him go home* and by a transient, half-stated, idea that the meal trolley contained something he should not eat. Disorganised form on long answers that resolves on shorter answers is the cognitive-load signature of delirium; the persecutory content is mild and not systematised, which is also the delirium signature. *Perception*: he does not endorse hearing voices but says, in the patient way of saying these things, that *the children come and sit at the foot of the bed*; on examination, there are no children, and he is mildly puzzled when this is gently pointed out. The puzzlement is itself the finding; in primary thought disorder, the patient is rarely puzzled by their own perceptions. *Cognition*: this is the central finding, examined in detail because it is the deciding domain. He is oriented to person, partially to place (he names the hospital but not the floor), and disoriented to time (he gives the year as two thousand and eighteen); his attention fails on serial subtraction at the second step; his digit span forward is three; he cannot recall the address test at five minutes; his recent memory for the operation is fragmentary. Attention fails first; orientation to time fails second; person fails last; this is the textbook organic pattern, and it loads unambiguously on neurocognitive disorder of the delirium type with a high acute p-factor across the rest of the spectra. *Insight and judgement*: he says he is well enough to go home today.

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The dimensional read is unambiguous. This is delirium. The cognitive impairment with fluctuating consciousness, inattention, disorientation to time, visual hallucination of a benign perceptual type (the children), and the abrupt onset over the previous twenty-four hours, are the textbook picture. The team's working differential of *behavioural disturbance / depression / dementia* dissolves in front of the eight-domain reading; this is not a psychiatric problem in the primary sense, it is a medical problem with psychiatric clothing.

The next step, accordingly, is medical. The psychiatry resident writes a short note that says so, and includes the operational priorities. Stop the hyoscine. Step the tramadol down to a non-opiate alternative if pain control allows. Send a sodium, a calcium, a magnesium, a CRP, a urine culture, and a chest film. Examine the cannula site and the wound. Withhold the night sedative the team have just prescribed, which would have made the picture worse rather than better. Re-orient the patient with familiar objects from home; the daughter is asked to bring his reading glasses, his hearing aid, and a single photograph. Family at the bedside in the evenings. A single low-dose antipsychotic is held in reserve, not started; the evidence for prophylactic antipsychotic in delirium is poor and it tends to extend the picture rather than shorten it. The note ends with the sentence *delirium of multifactorial origin in a previously cognitively intact gentleman; treat the cause; review in twenty-four hours*.

The counterfactual, here, is the reflex prescription. A different team, on a different evening, calls the on-call medical officer for the agitation at three in the morning, and the medical officer writes haloperidol two and a half milligrams intramuscularly because that is what the ward doctor reaches for when *the patient is climbing over the cot side*. The antipsychotic sedates the patient for the rest of the night. The next morning, the hyoscine is still running, the tramadol is still running, the urinary tract infection is still untreated, and the patient is now also drug-loaded with an antipsychotic that he metabolises slowly because he is seventy-eight. The picture extends. Day five becomes day seven becomes day ten. The discharge that should have happened on day six does not happen until day fourteen. The family begins to ask whether their father has *gone*,

in the way Indian families ask that question, and the team has no good answer because they have not addressed any of the causes. This is the cost of behavioural control as a substitute for medical reasoning.

The ideal next forty-eight hours, by contrast, look like this. Six in the evening on day three; the hyoscine is stopped, the tramadol is replaced with paracetamol with rescue tramadol only if pain breaks through, and the urine specimen is sent. Eight in the evening; the daughter arrives with the reading glasses, the hearing aid and a single framed photograph from the patient's bedside table at home, and the photograph goes on the windowsill where he can see it. Ten in the evening; the patient is settled, oriented to the hospital and to the daughter, has eaten a small amount of dinner, and goes to sleep without sedation. Three in the morning on day four; the patient wakes briefly, sees the photograph, hears the daughter on the stool beside him, and goes back to sleep. Ten in the morning on day four; the urine culture comes back positive, the antibiotic is started, the patient asks for the newspaper. Six in the evening on day five; the patient is sitting up reading the headlines aloud to his daughter, who corrects his pronunciation. The single low-dose antipsychotic that was held in reserve is never given. The picture is over.

PT-A24 presents with neurocognitive-type delirium on a background of previously intact cognition, loaded across all HiTOP spectra acutely (high acute p-factor) because delirium is by definition a global failure, in the context of a 78-year-old post-operative day 3 with anticholinergic exposure and probable urinary source. Keystone: the inattention and fluctuation; treatment target: the anticholinergic, the infection, and the sensory environment. Psychiatry is consultative; medicine owns the case.

The surgical team are not always grateful for this kind of note in the moment, since it returns the problem to them rather than transferring it away. Forty-eight hours later, when the urine culture comes back positive, when the hyoscine has been off for two days, when the patient is sitting up reading a newspaper and asking after his grandson, the team are usually grateful then. The teaching, if any of it lands, is that the request for a psychiatric opinion in the post-operative elderly patient is, more often than not, a

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request that the medical team do their own work; the psychiatrist's contribution is to read the chart, name the picture, return the case, and review tomorrow.

IF YOU ONLY REMEMBER ONE THING.

The post-operative elderly patient who is not quite himself is, until proven otherwise, delirious. The dimensional reading distinguishes delirium from depression and from dementia in under three minutes at the bedside. The treatment of delirium is the treatment of its cause, which is medical, and the reflex prescription of an antipsychotic for behavioural control tends to lengthen the episode rather than shorten it. Refer to psychiatry by all means; treat the cause yourself, while you wait.

Part IV. When to refer, when to start

The dimensional reading does not, on its own, tell you what to do next. It tells you what kind of patient you are sitting with. The decision about who needs psychiatric input today, who needs it next week, who can be safely begun in your own clinic, and who needs to be sent to a hospital, is a separate decision and a perfectly answerable one. This last short part of the book sets out the working frame.

The frame has four moves. First, you check for the five red flags that override every other consideration. Second, if no red flag is present, you ask what the good-enough first step is in your own clinic for the dimensional pattern in front of you. Third, you decide whether the pattern needs talk, medicine, or both, and you adjust that decision for what is actually available in your district. Fourth, you handle the three Indian particulars that the international literature underweights, which are family, stigma, and cost. The four moves are sequential and each is teachable; the rest of this part teaches them in order.

The red flags that move the decision today

There are five clinical pictures in which a non-psychiatrist's job, on the day, is not to refine the differential. It is to act. The five are worth memorising. They are the only situations in which the dimensional reading takes a back seat to a simpler question, which is *can this patient leave my clinic safely tonight*.

The first is *active suicidal intent with means and a plan*. The assessment move is not a single question; it is a short sequence, and you should run the whole sequence rather than stop at the first reassuring answer. Begin with frequency, asking how often the thoughts come and whether they have changed in the last fortnight. Move to intent, asking whether the patient has thought about acting on the thoughts and how seriously. Move to plan, asking whether a method has been considered, where, when, and how recently the plan was rehearsed in the patient's mind. Move to lethality, asking what the patient thinks would happen if they did what they have been thinking. Move

to means, asking whether the method is accessible at home, in the workplace, or in the immediate environment, and whether the access can be removed today. End with protective factors, asking what has stopped the patient until now and whether those factors still hold.

The credible reason concept matters here, and is taught poorly. A credible reason is a present, specific, emotionally live tie to staying alive that the patient can articulate without prompting and that survives gentle probing. *I will not do anything because of my children* is a credible reason in many patients and not a credible reason in patients whose depression has reached the conviction that the children would be better off without them. *My mother needs me; she has nobody else* is credible if the patient also describes the daily acts of caring for her; not credible if the patient describes her as a burden in the next sentence. *It is wrong, religiously* is credible in a patient whose practice is intact and whose community is in contact; less credible if the patient has stopped going to the temple, the church, or the mosque in the last month. The cardinal sign of a non-credible reason is the patient who lists reasons quickly and without affect, in the manner of a checklist. Document the answers verbatim. The medical record is part of the safety plan.

The second is *acute psychosis*, particularly first-episode, particularly with command hallucinations or with passivity phenomena, particularly in a patient whose family cannot supervise at home. The first episode is one of the few moments in psychiatric care where speed of access to treatment changes the long arc of the illness. The duration of untreated psychosis literature is consistent enough across cohorts that the working clinician should treat the first-episode patient the way a colleague treats a stroke. Each additional week between symptom onset and effective treatment is associated with poorer functional recovery, longer time to remission, and higher rates of subsequent relapse; the effect is not enormous in any single week, but it accumulates, and the early intervention services that have driven outcomes upward in the last twenty years work, by and large, by compressing duration of untreated psychosis. The work-up is in the hospital, not the outpatient department.

The third is *capacity loss*, in the technical rather than the colloquial sense. The four-component test is the working tool, and is decision-specific. The patient must be able to *understand* the relevant information, including the nature of the proposed intervention, its purpose, and the alternatives. The patient must be able to *retain* the information long enough to use it; thirty seconds is sometimes enough, an hour is sometimes required. The patient must be able to *weigh* the information, which means hold the considerations against each other and form a view. The patient must be able to *communicate* the decision, by speech, gesture, or any reliable means. Failure on any one component means failure on the whole. The same patient may have capacity to refuse a particular medication and lack capacity to consent to surgery on the same day; the test is run separately for each decision. The Indian Mental Healthcare Act 2017 is the relevant frame, and the medico-legal trail is non-optional. If you suspect lost capacity, examine for it, document the examination component by component, and involve psychiatry today.

The fourth is *the organic mimic*. The post-operative patient with new disorientation, the woman with new psychosis at thirty-five who has never been unwell before, the elderly patient with new mood symptoms and a history of falls, the young man whose new manic picture comes with a fever and a stiff neck. These are not psychiatric problems in the primary sense; they are medical problems wearing psychiatric clothing. Three rules are worth memorising. First, *new psychiatric symptoms in a patient over fifty without a psychiatric history* is an organic work-up first. Second, *new psychiatric symptoms with any neurological sign* is an organic work-up first; the neurological sign can be minor, a brisk reflex on one side, a subtle gait change, a small visual field defect found on bedside testing. Third, *new psychiatric symptoms with any abnormal vital* is an organic work-up first; the abnormal vital can be a low-grade fever, a tachycardia that does not settle, a saturation slightly below the patient's baseline. The patients who are missed in this category are the ones who do badly, and the costs of a miss are large; a delirium that is treated as schizophrenia goes on to a longer hospital stay and a worse cognitive outcome, an autoimmune encephalitis treated as a first-episode psychosis goes on to

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permanent neurological damage, a hypoglycaemia treated as panic goes on to seizure. The cost of an unnecessary work-up is small. Run the work-up.

The fifth is *acute substance withdrawal in a patient who has been drinking heavily*. Alcohol withdrawal kills, and it kills more often than it should because it is mistaken for primary anxiety or primary psychosis. The seventy-two-hour window is the dangerous one; the most severe withdrawal phenomena, including delirium tremens and withdrawal seizures, cluster between forty-eight and ninety-six hours after the last drink. The Clinical Institute Withdrawal Assessment for Alcohol, revised, gives you a structured ten-item read of the patient: nausea, tremor, sweating, anxiety, agitation, tactile disturbance, auditory disturbance, visual disturbance, headache, and orientation. A CIWA-Ar score under eight, with a quiet pulse, a normal blood pressure, no tremor, no sweating, and intact orientation, is reassuring; anything else, in a patient who has stopped drinking in the last three days, is a hospital problem. The patient who tells you they drink a quarter of a bottle every evening and has not had a drink since yesterday morning is a patient at risk; treat them accordingly.

The good-enough first step

For the patient who is not flagged by any of the above, the family physician's question is not *who has the right to manage this patient*; it is *what is the good-enough first step today*. The good-enough frame is worth teaching as a pedagogical position, because it inverts a habit that medical training installs early. The training teaches the junior doctor that the right move, when in doubt, is to refer to the specialist. In psychiatry, in India, with the population we serve and the workforce we have, that habit produces worse outcomes than its opposite. Not all patients need the specialist; many need the informed generalist who is willing to begin treatment, hold the case, and refer when the picture either fails to settle or shifts in a way that demands specialist input. The dimensional reading helps you decide which patients are which.

For an *internalising picture of moderate severity*, meaning mild to moderate depression, generalised anxiety, the panic disorder that has not yet driven the patient out of work, there is good evidence that an SSRI started by a competent non-specialist, at the right

dose, with a proper safety conversation about the first two weeks, is non-inferior to a specialist start, provided the follow-up is real. The follow-up is the part that gets dropped. A one-week telephone review and a four-week clinic review, with a clear plan for what to do if the patient feels worse, is the price of admission. The safety conversation should explicitly cover the early increase in anxiety that some patients experience in the first week, the rare emergence of suicidal ideation in younger patients in the first fortnight, the typical four-to-six-week timeline for therapeutic effect, and the plan for telephoning the clinic if either the suicidal ideation or the early anxiety becomes intolerable. If you cannot deliver the follow-up, refer.

For a *thought-disorder picture*, the good-enough first step is not to start an antipsychotic in your clinic. It is to keep the patient safe overnight and arrange a psychiatric review in the next twenty-four to forty-eight hours. The non-psychiatrist should not begin antipsychotic medication except in two narrow situations: a patient with an established diagnosis whose own psychiatrist has communicated a clear restart plan, and a patient in acute agitation where a single dose is being given as a safety measure pending psychiatric handover. The threshold for admission is a function of supervision at home, the presence of any of the red flags above, and the family's capacity to bring the patient back if the picture worsens. A first-episode patient with a stable family, no suicidality, no command hallucinations, and a psychiatric appointment confirmed for the next morning, can sometimes be held overnight at home; otherwise, admit.

For a *disinhibited-externalising picture in the substance-use direction*, the good-enough first step is brief intervention plus a referral. The brief intervention is the part that the family physician undervalues. Five minutes of motivational interviewing, delivered well, with an honest statement of the medical findings, a short reflection on the patient's stated reasons for coming in, and a single open question about what the patient wants their drinking or their use to look like in six months, has a measurable effect at population level. It is a treatment in itself. The referral is to a deaddiction service or to a psychiatrist with addictions experience; the family physician who does not know where to refer should build that contact before the next such patient arrives.

For a *somatoform picture*, the good-enough first step is to *not* refer, in many cases. The somatoform patient who has been to four specialists and ends up in psychiatry as the fifth tends to do badly; the patient whose family physician holds the case, names the dimensional reading carefully, and uses scheduled rather than as-needed contact, does better. The non-psychiatrist who can hold a somatoform case has three skills to practise: the ability to validate the symptom without endorsing every test the patient asks for, the ability to schedule the next contact at the time of the current one rather than leaving it open, and the ability to introduce the dimensional reading in plain language at a calm moment. Refer when the picture is severe, when there is co-morbid internalising of depressive type, when the family is exhausted, or when the patient asks. Otherwise, hold.

For a *neurocognitive picture*, the good-enough first step is the medical work-up. Reversible causes of cognitive impairment first, and that list is longer than it is given credit for: thyroid disease, B12 deficiency, normal-pressure hydrocephalus, depression, polypharmacy, alcohol, sleep apnoea. If those are negative, then a memory clinic review, then psychiatry if the behavioural component is the dominant issue. The non-psychiatrist who begins an acetylcholinesterase inhibitor in an undifferentiated cognitive impairment is making a mistake; the work-up comes first.

Talk, medicine, or both

The honest answer about what works in psychiatric treatment, for the kinds of patients you will see, is uncomfortable for everyone and worth saying clearly. For *mild and moderate internalising pictures*, talking therapy and medication are roughly equivalent in average effect; the choice is partly a matter of patient preference, partly of what is actually available, and partly of speed, since medication acts somewhat faster and talking therapy holds gains somewhat longer. For *severe internalising*, including most major depression that has reached your clinic, the combination is consistently better than either alone; the effect sizes for combined treatment are not small. For *thought-disorder pictures*, medication is not optional and talking therapy is an adjunct, with cognitive remediation, family-oriented work, and cognitive therapy for psychosis

having modest but real effects on top of pharmacotherapy. For *disinhibited-externalising pictures in the substance direction*, the talking therapy is the load-bearing intervention and the medications are adjuncts; naltrexone, acamprosate, baclofen and disulfiram each have their place, but the recovery is built in the room, not in the prescription. For *somatoform pictures*, the talking therapy is the only intervention with durable effect; the prescriptions you write for these patients are mostly to manage co-morbid mood and sleep.

The Indian context modifies these averages in a single direction, which is access. Talking therapy is in short supply outside the metros, and the supply that exists is unevenly trained. The honest counsel to a non-psychiatrist colleague is to know your local providers. Build a working list of three to five clinical psychologists, counsellors, or therapists in your district whom you have either met, supervised informally, or had patients return from with audible improvement. Update the list every six months. Do not refer to therapists you have not vetted, and do not refer because a name appeared on a Google search. A bad therapy referral is worse than no therapy referral; the patient who has had a poor first experience of therapy will tell you, accurately, that talking did not help, and that statement will close a door for years. The same caution applies to choosing between therapy modalities; if your district has one well-trained CBT practitioner and no schema therapists, refer to the CBT practitioner even when the formulation suggests schema work, and explain to the patient that the modality is a starting point. The good first therapist is more important than the perfect modality.

A closing note on agency

This last part of the book has been about agency. About the four moves a competent non-psychiatrist can run safely on a patient who, in the way the system is currently structured, would otherwise wait. About knowing your red flags so that you also know what is not a red flag. About the good-enough first step. About the honest conversation about what works. About working with family rather than around family. None of this is a substitute for psychiatry as a specialty. All of it is the argument this book has been

making since the Opening, and is the argument it ends on: that the work is shared, and that the share you are holding has been understated for too long.

The Indian context, briefly and honestly

Three things shape psychiatric practice in India in ways that the international literature does not always capture, and the working clinician should not pretend otherwise.

The first is *family*. Psychiatric care in India is rarely a contract between the patient and the doctor; it is a contract among the patient, the family, and the doctor. The family will be in the room, the family will be paying, the family will be administering the medication, and the family will be making the decisions in the moments when the patient cannot. This is neither a problem nor a virtue; it is the fact, and the competent psychiatrist works with it rather than around it. Working with the family, in practice, means three things. It means giving the family a seat at the formulation, in the sense of explaining the dimensional reading in language the family can use at home. It means giving the family a small set of explicit jobs, since families who feel useful are families who keep the patient in treatment; the jobs are usually some combination of medication supervision, sleep regularity, alcohol abstention, and the early-warning watch that catches relapse two weeks before the patient mentions it. It means respecting the family's authority while protecting the patient's confidence, which is the harder balance, and is achieved by setting the rules of the conversation explicitly at the first visit. Tell the patient and the family, at the same time, what you will share with the family, what you will not, and what circumstances will change the rule.

The second is *stigma*. The patient who is willing to come to a family physician for a tired-mother presentation may not be willing to come to the psychiatry outpatient department for the same picture, and the framing of the referral is, accordingly, part of the treatment. The phrasing is worth teaching as a clinical move, not a euphemism. *I would like a psychiatry colleague to see you, in the same way I would ask a cardiology colleague to see you*. The work the sentence does is several layered. It places psychiatry on the same medical footing as cardiology, which is where it belongs and where the patient's stigma had moved it from. It uses the word *colleague*, which signals that you

trust the person on the other end and are not handing the patient over. It gives the patient permission to say yes without admitting weakness, since the admission is now to a normal medical referral rather than a confession of mental illness. It is an act of medical solidarity, performed in plain language, and patients can hear the difference between a clinician who means it and a clinician who has read it in a guideline.

The third is *cost*. Psychiatric medication, when bought generically, is among the cheaper categories of treatment in Indian medicine. A standard SSRI, prescribed generically, runs to a few rupees a tablet; a standard antipsychotic, generically, the same; lithium, generically, less. Psychiatric talking therapy is among the more expensive medical interventions in the country, when bought privately at metro rates; a single session can cost what a month of antidepressant medication costs. The economics drive the access pattern more than anything else, and the working clinician should know the local rate card and should have the cost conversation explicitly at the time of referral. Tell the family what the medication will cost per month for six months and what the therapy will cost per session for the expected number of sessions. Tell the family what the cheaper alternatives are when they exist, including hospital outpatient psychotherapy, sliding-scale clinics, and supervised therapy by trainees. A single honest sentence about money at the time of referral prevents a great deal of disengagement two months later, when the family quietly stops the medication or stops the appointments because nobody has asked them whether they can afford the plan.

Closing

What to watch in the next two years

Three currents in psychiatry are moving fast enough that they are worth naming, briefly, even though the working clinician of 2026 does not yet need to act on any of them in clinic. The teaching question is not what these currents are; the journals will tell you that. The teaching question is what the working clinician should actually do when one of them shows up in the consulting room.

The first is the slow re-entry of *psychedelic-assisted psychotherapy* into mainstream practice. Ketamine in its various forms has been in clinical use for treatment-resistant depression for several years now and is beginning to settle into protocols, with intravenous racemic ketamine and intranasal esketamine the two main routes; the Indian regulatory position permits off-label intravenous use in supervised settings, with intranasal esketamine not yet routinely available. Psilocybin and MDMA are further behind, with regulatory pathways uneven across countries; the Indian position remains conservative and is likely to stay so for some years. The clinical question for the working psychiatrist is not whether these treatments will arrive; the question is what kind of psychotherapy will be developed around them, since the molecule in isolation is not the treatment. When a patient asks you whether they should fly to Bengaluru or Mumbai for a ketamine clinic, your answer should hold three points: the evidence is strongest for treatment-resistant depression after two failed antidepressant trials, not for general anxiety or stress; the protocol matters more than the molecule, and a clinic that offers a clear preparation phase and integration sessions is preferable to one that does not; the gains are real but maintenance is required, since unsupported single-dose treatments often fade. Watch the protocols, not the headlines.

The second is *digital phenotyping*. The smartphone collects, passively, a continuous stream of behavioural data: sleep timing, movement, social activity, voice features, message length, the small thousand things that change before a person notices that they are changing. The early work, mostly in bipolar disorder and in psychosis, suggests

that the day-to-day fluctuations in some of these signals are tightly coupled to mood and to relapse risk. The clinical implementations are still rough, the privacy questions are real, and the working psychiatrist has nothing to do here yet. When a Fitbit, an Oura ring, or a Whoop band shows up on a generalist's desk with a worried patient who has been tracking their sleep stages and heart-rate variability for three months, the right move is not to dismiss the data and not to treat it as diagnostic. The right move is to ask the patient what changed in their behaviour the week the numbers shifted, since the behavioural reading is what makes the device data useful, and is the part the patient can already give you. The next decade is likely to bring tools that supplement, rather than replace, the eight-domain examination, in ways that change what an outpatient appointment can be; until then, treat the data as a conversation starter, not a result.

The third is *computational diagnostics*. Machine-learning approaches to brain imaging, electrophysiology, and language analysis are producing classifiers that perform credibly on group-level discrimination tasks; the question of whether they can be made to work for the individual patient in the consultation room is still open and will be open for some time. When a predictive classifier is mentioned at a conference, the working clinician's stance is interested but unhurried. Three sceptical questions are worth asking the speaker. Did the model train and validate on populations resembling the patient in front of you, including age range, ethnicity, and clinical setting. Does the reported accuracy hold at the base rate of the disorder you actually see, or only at the inflated base rate of the research sample. Is the marginal information the model adds worth the time, the cost, and the false-positive rate, in a setting where a careful clinical interview already produces a usable answer. Read the papers; do not buy the hardware.

What to read next

The list is short and is meant to be read, not skimmed. Each entry is followed by two sentences: what the book teaches, who it is for, and one honest note on its limits.

1. Sims A. *Symptoms in the Mind*, sixth edition (2024). Still the canonical text on descriptive psychopathology in English; the source for almost every definition you will need at the bedside. The book teaches the discipline of careful

phenomenology to any clinician willing to read slowly; its limit is that it predates the dimensional turn and treats the categorical diagnoses as more settled than the field now does.

2. Andreasen NC. *The Broken Brain* and *Brave New Brain*. Older, but unmatched for the prose voice that translates clinical neuroscience into a plain language that patients understand, and a model for how to write to a non-specialist reader without dumbing down. The neuroscience is thirty years old in the first volume and a decade old in the second; read for the voice and the shape of the argument, not the citations.
3. Kotov R, Krueger RF, Watson D, et al. (2017). *The Hierarchical Taxonomy of Psychopathology (HiTOP)*. The foundational paper, suitable for clinicians who want to see how the model was built from factor-analytic data across decades of psychometric research. Read the introduction and the discussion; the methods are for specialists and the paper rewards a second read after the working clinician has tried the model in clinic.
4. Kotov R, Krueger RF, Watson D, et al. (2021). *The Hierarchical Taxonomy of Psychopathology (HiTOP): a quantitative nosology based on consensus of evidence*. The consortium update; the cleaner statement of the model, written four years after the original and with the conceptual seams better stitched. The limit is that it remains a research document; the clinical translations are still being written, and this book is one attempt at one of them.
5. Friston K. (2010). *The free-energy principle: a unified brain theory?* Nature Reviews Neuroscience 11(2): 127-138. The single best entry point to predictive processing for a clinician with limited time, written by the field's most influential theorist. Skim the equations; the prose carries the argument, and the equations will be there when you come back.
6. Borsboom D. (2017). *A network theory of mental disorders*. World Psychiatry 16(1): 5-13. The clearest statement of the network frame, by its sharpest exponent, and a useful counterweight to the latent-variable frame that HiTOP rests on. The limit is the limit of the network frame itself, which has not yet produced the clinical tools that the dimensional model has.

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7. Sharma E, Murthy P (eds). *Practical Psychiatry: A Clinical Companion for Indian Practice* (forthcoming). The Indian-context volume that the field has been waiting for; check the publisher's catalogue when it arrives. Until it does, the most useful Indian-context work is in the journal *Indian Journal of Psychological Medicine*, which the working generalist should keep an eye on.
8. Saraceno B. *The Time Has Come* (2023). A short, plain book on global mental health policy by the former director of WHO Mental Health, and useful for context that the clinical literature does not give. The limit is that policy is upstream of the consulting room; the book changes how you see the system you work in, not what you do with the patient at four in the afternoon.

About the author

Dr Wilfred D'souza is a psychiatry resident at Karnataka Medical College Research Institute, Hubli, completing residency in October 2026 and entering independent practice in Mumbai thereafter. He works on integrative psychotherapy, on a computational model of psychosis and affect with collaborators at NIMHANS, and on a co-authored monograph with Dr Avinash Desouza on archetype-informed parenting for Indian families. He teaches the history-taking and phenomenology rotations for junior residents at KMCRI and runs the Gatekeeper suicide-prevention training programme for medical students there. He writes at weave.clinic, the homepage for Weave, the small clinical practice that hosts this book and its companion volumes. *Reading the Patient* is the first volume from Weave Press; the second volume, on the integrative formulation in Indian outpatient practice, is in preparation for late 2027.

Appendix

A. The HiTOP cheat sheet

A single full-page reference to the dimensional model used throughout the book. The headings repeat the definitions from Part I in compressed form, suitable for the back of a clipboard. Read across the row, not down the column.

SPECTRUM	ONE-LINE DEFINITION	LOADS HEAVILY ON	LOADS PARTIALLY ON	COMMON PITFALLS
p-factor	The general loading of mental disorder regardless of type. High p-factor patients tend to be high on several spectra at once.	Severe presentations across categories, co-morbid presentations, chronic illness, high genetic loading	Treatment-resistant pictures, picture-shifting illness, recurrent admissions	Mistaking high p for *malingering* or *attention seeking* in cluster B presentations.
Internalising	Distress turned inward, in the direction of misery, fear, or the body.	Major depression, generalised anxiety, panic disorder, social anxiety, PTSD, OCD (partial), eating disorders	Adjustment, dysthymia, prolonged grief	Calling depressive psychomotor retardation *cognitive impairment*. Calling severe anhedonia *autistic withdrawal*.
Thought disorder	Disorganisation of perception, belief or form of thinking.	Schizophrenia spectrum, schizoaffective, mania with psychosis, severe OCD with poor insight	Some BPD presentations under stress, transient psychotic phenomena in PTSD	Calling religious or culturally sanctioned beliefs delusional. Failing to apply the cultural test.
Disinhibited externalising	Impulse poorly held.	Substance use disorders, ADHD, conduct disorder, antisocial behaviour driven by impulse	Bipolar in the up-phase, frontal pathology, delirium	Mistaking ADHD-driven impulsivity for character pathology.

SPECTRUM	ONE-LINE DEFINITION	LOADS HEAVILY ON	LOADS PARTIALLY ON	COMMON PITFALLS
Antagonistic externalising	Impulse held but pointed outward.	Antisocial personality, narcissistic spectrum, borderline (partial), cluster B traits	Paranoid presentations in psychosis, irritable mania	Confusing *antagonistic* with *aggressive*. The two are not the same.
Detachment	Withdrawal of affect and attachment.	Schizoid traits, avoidant personality, severe negative symptoms, autistic spectrum (partial)	Severe depression, post-traumatic numbing	Reading detachment as *uncooperative* or *resistant to therapy*.
Somatoform	The body as the language of distress.	Functional neurological disorder, persistent somatic symptoms, illness anxiety	Severe internalising with prominent somatic features	Iterative referral to medical specialists; the right move is often to *hold* the case.

B. Symptom to spectrum, a quick-reference card

A working table for the consultation room. The mapping is one-to-many; treat the table as a starting point, not an answer.

SYMPTOM IN THE ROOM	FIRST SPECTRUM TO THINK ABOUT	SECOND SPECTRUM TO THINK ABOUT
Sustained low mood	Internalising	Thought disorder (mood-congruent)
Sustained elevated mood	Internalising (manic pole)	Thought disorder (psychotic mania)
Pressured speech	Internalising (manic pole)	Disinhibited externalising
Slowed speech, long reaction time	Internalising (depressive pole)	Neurocognitive

SYMPTOM IN THE ROOM	FIRST SPECTRUM TO THINK ABOUT	SECOND SPECTRUM TO THINK ABOUT
Persistent auditory hallucinations	Thought disorder	Internalising (severe mood-congruent)
Visual hallucinations of small animals	Neurocognitive (delirium)	Disinhibited externalising (substance)
Persecutory beliefs, fixed	Thought disorder	Antagonistic externalising
Obsessions recognised as own	Internalising (OCD pole)	Thought disorder (poor-insight OCD)
Disorientation to time	Neurocognitive	Severe psychiatric illness with high p
Self-neglect	Internalising (depressive pole)	Thought disorder, neurocognitive
Social withdrawal	Detachment	Internalising
Persistent functional somatic symptoms	Somatoform	Internalising
Impulsive substance use	Disinhibited externalising	Antagonistic externalising
Recurrent self-harm	Antagonistic externalising (BPD pattern)	Internalising (severe)
Paroxysmal anxiety	Internalising (panic)	Somatoform
Anhedonia	Internalising (depressive pole)	Detachment
Catatonic signs	Thought disorder	Internalising (severe), neurocognitive
Mood incongruent affect	Thought disorder	Detachment
Labile affect, opposite-pole shifts	Antagonistic externalising	Neurocognitive (frontal)

C. Twenty self-test questions

Twenty short clinical vignettes, each followed by a single best answer. The answers are at the end of the section. Cover them with your hand on the first pass.

1. A 24-year-old man brought to casualty after a party, agitated, mid-dilated pupils, pulse 120, persecutory ideas of two hours duration. The most useful first question to the friends is about *substance history / family psychiatric history / academic performance / past medical history*.
2. A 41-year-old woman attending the family physician for tiredness, with low-normal haemoglobin and upper-limit TSH. Her affect is mildly depressed and she has passing thoughts that her family would manage without her. The right next step is to *refer to psychiatry and wait / repeat the thyroid panel and start an SSRI today / give iron and review in three months / refer to gynaecology for menopause work-up*.
3. A 78-year-old man, post-operative day three, plucking at the bedsheet, drowsy, oriented to person but not to time, says children are at the foot of the bed. Most likely diagnosis: *depression / dementia / delirium / functional neurological disorder*.
4. The HiTOP spectrum on which OCD primarily loads is *thought disorder / internalising / disinhibited externalising / somatoform*.
5. Pseudo-hallucinations are *hallucinations that occur during sleep / mental images recognised as one's own, in subjective space / hallucinations on a single modality only / hallucinations associated with malingering*.
6. Flight of ideas is distinguished from derailment by *the speed of speech / the patient's awareness of the disturbance / the presence of understandable connections between thoughts / the duration of the episode*.
7. The cultural test in the assessment of delusions means that beliefs *held by more than ten per cent of the population are not delusional / shared with the patient's social and cultural background are not labelled as delusions / supported by religious texts are not delusions / are excluded from the MSE entirely*.
8. The single most prognostic feature in the MSE of a 19-year-old at first presentation with psychosis is *the type of hallucination / the duration of untreated psychosis / the presence of a family history / the patient's intelligence quotient*.
9. In delirium, orientation is lost in the order *person, place, time / time, place, person / place, person, time / time, person, place*.

10. Catatonic signs in a depressed patient should prompt a trial of *electroconvulsive therapy as first line / lorazepam as a diagnostic and therapeutic challenge / olanzapine at high dose / lithium*.
11. A patient with severe depression and cognitive impairment that improves with motivation and effort most likely has *Alzheimer dementia / pseudodementia of depression / delirium / mild cognitive impairment*.
12. The free-energy principle, applied to psychiatry, proposes that the brain *minimises prediction errors by updating beliefs or by acting on the world / generates random outputs which are then filtered by environment / functions purely on classical conditioning / has no relevance to clinical work*.
13. A 32-year-old woman with two prior depressive episodes, currently on her third, shows mood incongruent persecutory ideas. The dimensional read is *internalising only / internalising plus thought disorder / antagonistic externalising plus detachment / somatoform*.
14. The good-enough first step for moderate internalising in a family physician's clinic, in the absence of red flags, is *immediate psychiatry referral / SSRI started with proper safety conversation and one-week review / counsel and review in three months / no intervention required*.
15. The red flag that takes immediate priority over diagnostic refinement is *active suicidal intent with means and a plan / family history of bipolar / recent unemployment / mild thyroid dysfunction*.
16. Capacity, in the technical sense, is *a fixed property of the patient / decision-specific and assessable / determined by the diagnosis / equivalent to insight*.
17. The first move in the post-operative patient with new behavioural disturbance is to *prescribe an antipsychotic / start an SSRI / examine for delirium and review the medication chart / refer to psychiatry without further work*.
18. The Indian Mental Healthcare Act of 2017 is the relevant frame for *prescription writing / capacity and admission / outpatient billing / continuing medical education*.
19. A patient with chronic schizophrenia on stable antipsychotic medication shows attentional impairment and slow processing. The cognitive picture is *medication*

side-effect, change the antipsychotic / core feature of the illness / always indicates a co-morbid neurocognitive disorder / clinically irrelevant.

20. The best framing of psychiatry, for a non-psychiatrist colleague who has read this book, is *the medicine of inference under uncertainty / the medicine of symptoms not yet explained by biology / the medicine of the worried well / a sub-branch of neurology*.

Answer key. 1 substance history. 2 repeat the thyroid panel and start an SSRI today. 3 delirium. 4 internalising. 5 mental images recognised as one's own, in subjective space. 6 the presence of understandable connections between thoughts. 7 shared with the patient's social and cultural background are not labelled as delusions. 8 the duration of untreated psychosis. 9 time, place, person. 10 lorazepam as a diagnostic and therapeutic challenge. 11 pseudodementia of depression. 12 minimises prediction errors by updating beliefs or by acting on the world. 13 internalising plus thought disorder. 14 SSRI started with proper safety conversation and one-week review. 15 active suicidal intent with means and a plan. 16 decision-specific and assessable. 17 examine for delirium and review the medication chart. 18 capacity and admission. 19 core feature of the illness. 20 the medicine of inference under uncertainty.

D. Glossary

A working glossary, weighted toward the terms a non-psychiatrist will meet at the bedside or in a discharge summary. One line per term, in the spirit of Sims.

TERM	ONE-LINE MEANING
HiTOP	Hierarchical Taxonomy of Psychopathology; the dimensional model used throughout this book, organised across six broad spectra plus the general p-factor.
p-factor	The general loading of mental disorder, regardless of type; the dimension on which a patient is severely unwell across categories.

TERM	ONE-LINE MEANING
Six spectra	The mid-level dimensions of HiTOP: internalising, thought disorder, disinhibited externalising, antagonistic externalising, detachment, and somatoform.
Internalising	The HiTOP spectrum covering distress turned inward, including depression, anxiety, panic, OCD (partial), and eating-disordered presentations.
Thought disorder	The HiTOP spectrum covering disorganisation of perception, belief or form of thinking; the home of the schizophrenia-spectrum and psychotic-mood pictures.
Predictive processing	The neuroscience frame in which the brain is described as an active inference machine, generating predictions and updating them via prediction errors.
Prediction error	The mismatch between what the brain expected and what the senses delivered; the signal that drives belief updating or further action.
Network thinking	The frame in which a mental disorder is described as a network of mutually reinforcing symptoms, rather than as a hidden underlying entity.
MSE	Mental state examination; the structured description of the patient at a point in time, across the eight domains taught in Part II.
Catatonia	A clinical syndrome of motor and behavioural disturbance, recognised by the Bush-Francis screen and treated with lorazepam.
Delirium	An acute disturbance of consciousness, attention, and cognition, with fluctuating course and a medical cause; the prototype of the organic mimic.
Pseudodementia	A reversible cognitive impairment in the context of severe depression, recovering with treatment of the depression.

TERM	ONE-LINE MEANING
Capacity	The decision-specific ability to understand, retain, weigh, and communicate a clinical decision; assessed component by component, decision by decision.
MHCA	The Indian Mental Healthcare Act 2017, the legal frame for capacity, admission, and the rights of the person with mental illness in India.
DUP	Duration of untreated psychosis; the interval between symptom onset and effective treatment, and one of the few prognostic factors that is shortenable.
CIWA-Ar	Clinical Institute Withdrawal Assessment for Alcohol, revised; a ten-item structured score for alcohol withdrawal severity.
Dysarthria	A disturbance of the motor production of speech, with intact language; speech is slurred, indistinct, or weak, but words are correctly chosen.
Aphasia	A disturbance of language itself, in production, comprehension, or both; speech may be fluent but empty, or non-fluent and effortful.
Poverty of speech	A reduction in the quantity of speech produced; the patient says little and adds little when asked open questions.
Pressure of speech	An increase in the rate, volume, and amount of speech, often difficult to interrupt; characteristic of mania.
Mutism	The complete or near-complete absence of spoken output; seen in catatonia, severe depression, and selected neurological conditions.
Derailment	A formal thought disorder in which speech moves from one idea to another along weak or absent connections; the listener loses the thread.

TERM	ONE-LINE MEANING
Tangentiality	A formal thought disorder in which the patient answers off the point and does not return; the answer drifts away from the question.
Circumstantiality	A formal thought disorder in which the patient takes a long, detailed, and digressive route to the point but eventually arrives.
Flight of ideas	A formal thought disorder in which thoughts move quickly along understandable connections, often with rhyme, pun, or distraction; characteristic of mania.
Thought blocking	A sudden, complete interruption of the train of thought, with the patient unable to recover the lost idea; characteristic of psychosis.
Obsession	An intrusive, recurrent, ego-dystonic thought, image, or urge, recognised by the patient as their own and resisted.
Compulsion	A repetitive behaviour or mental act performed in response to an obsession or according to rigid rules, aimed at reducing distress.
Thought alienation	The experience that one's thoughts are no longer one's own; includes thought insertion (placed in by others), withdrawal (taken out by others), and broadcasting (audible to others).
Depersonalisation	The experience of being detached from one's self, as if observing one's own actions or feelings from outside.
Derealisation	The experience of the external world as unreal, distant, or dreamlike, while the self is felt as intact.
Hallucination	A perception in the absence of an external stimulus, experienced as occurring in objective space and indistinguishable from real perception.
Pseudo-hallucination	A vivid mental image recognised as one's own and located in subjective space; not a true hallucination, and not a sign of psychosis.

TERM	ONE-LINE MEANING
Illusion	A misperception of an actual external stimulus, often in conditions of poor light, fatigue, or affective arousal.
First-rank symptoms	Schneider's set of symptoms once thought specific to schizophrenia, including thought alienation, passivity phenomena, and certain auditory hallucinations; less specific than originally believed but still clinically useful.
Delusion (primary)	A delusion arising suddenly and without psychological antecedents, often emerging from an autochthonous mood or atmosphere; classically associated with schizophrenia.
Delusion (secondary)	A delusion that arises from, or is understandable in the light of, another psychological process such as low mood, elevated mood, or another delusion.