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Reading the Patient

A Field Guide to Dimensional Psychiatry

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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.

Contents

Opening

Part I. How psychiatry actually thinks now

Part II. The dimensional mental state examination

Part III. Three rooms, three patients

Part IV. When to refer, when to start

Closing

Appendix

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.

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