CLINICAL SCIENCE · DESCRIPTIVE PSYCHOPATHOLOGY · EVIDENCE-BASED PSYCHIATRY

Major Psychiatric Disorders: Clinical Phenomenology & Treatment

A disorder-centred educational model covering aetiology, epidemiology, lived experience, explanatory hypotheses, the suicidal process as one secondary clinical node, and phase-specific treatment.

Five clinical profiles · Depressive disorders · Anxiety disorders · PTSD · Bipolar disorder · Schizophrenia-spectrum disorders

Medication guide · Starting doses · Titration · Maintenance · Monitoring · Reduction / discontinuation

HOW TO USE THIS VIEWING COPY

This PDF is a static reading version of the interactive model. The HTML version allows disorder selection, section tabs and a collapsible reference drawer; this PDF places all five profiles and all reference entries in one continuous document so it can be opened in a standard PDF reader.

Evidence distinctions: clinical description, observed signs, diagnostic criteria, epidemiological estimates, explanatory hypotheses and guideline recommendations are kept separate. A phenomenological formulation enriches—but does not replace—diagnosis, longitudinal assessment or cultural formulation.

Clinical safety: medication information is educational and is not an individual prescription. Dosing must be checked against the locally approved product information and the person’s age, pregnancy status, comorbidities, renal/hepatic function, interactions and monitoring capacity. Specialist oversight is required for higher-risk treatment such as clozapine and lithium.

CONTENTS

01 Major depressive disorder
02 Anxiety disorders
03 Post-traumatic stress disorder
04 Bipolar disorder
05 Schizophrenia-spectrum / psychotic disorders
06 Secondary clinical constructs and additional psychosocial domains
07 Reference library (62 entries)

Visual theme: deep Prussian blue and warm gold inspired by Vincent van Gogh’s The Starry Night (1889). This PDF uses a vector night-sky treatment; the painting image itself remains in the HTML interface.

DISORDER PROFILE 01

Major depressive disorder

A heterogeneous mood disorder characterised by depressed mood and/or loss of interest or pleasure, accompanied by cognitive, behavioural and somatic symptoms and clinically significant distress or impairment. Always assess a history of mood elevation to avoid misclassifying bipolar depression as unipolar MDD.

279.6 million Depressive-disorder cases globally, 2019 (GBD; includes MDD and dysthymia)	3,440 / 100,000 Age-standardised prevalence, 2019	31–42% Heritability estimate range in genetic-epidemiology literature; population estimate, not individual causation

Aetiology and risk architecture

Multifactorial liability [supported]
MDD reflects interactions among polygenic vulnerability, development, life events, chronic stress, medical illness, sleep/circadian disruption and social conditions. There is no single cause.

Genetic contribution [supported]
Family and genetic epidemiology indicate a heritable component. Common variants each contribute very small effects; genetic liability is probabilistic, not deterministic.

Environmental and developmental factors [supported]
Childhood adversity, trauma, recurrent stress, bereavement, chronic illness, pain, social isolation and socioeconomic disadvantage may contribute to onset or recurrence. Exposure does not make depression inevitable.

Biological systems [hypothesis]
Stress-response (HPA-axis), monoaminergic signalling, reward circuitry, neuroplasticity and immune/inflammatory systems are active research domains. Findings vary across subgroups.

Clinical interpretation / limitations
Avoid a “low serotonin causes depression” explanation. Monoamine systems are relevant to pharmacology, but MDD is not established as a simple serotonin-deficiency disorder.

Epidemiology and burden

Global estimate [supported]
GBD 2019 estimated 279.6 million cases of depressive disorders (95% uncertainty interval 251.6–310.3 million). The category includes major depressive disorder and dysthymia; it is not an MDD-only count.

Sex distribution [supported]
GBD 2019 estimated 170.4 million cases among females and 109.2 million among males. Differences in prevalence reflect multiple biological, social and measurement factors.

Course [supported]
Episodes may remit, recur or become persistent. Earlier onset, residual symptoms, comorbidity, chronic stress and previous episodes influence course.

Treatment gap [supported]
Global treatment coverage remains uneven; the GBD estimates should not be read as the number of people receiving adequate care.

Clinical interpretation / limitations
The epidemiology figures refer to GBD 2019 modelled prevalence. WHO’s 2026 fact sheet reports about 322 million people with depressive disorders in 2023. These estimates use different model rounds and case definitions; do not interpret the difference as a trend without harmonised data.

Phenomenology and phenomenological psychopathology

Affective experience [supported]
Depressed mood may be experienced as sadness, emptiness, emotional numbness, irritability, or a pervasive loss of emotional responsiveness. Ask about quality, persistence, reactivity to positive events, and change from the person's baseline.

Anhedonia: pleasure and motivation [supported]
Separate anticipatory pleasure (looking forward to something), consummatory pleasure (enjoying it while it happens), and motivation/effort. A person may want, anticipate and enjoy activities differently; "loss of interest" alone does not capture this profile.

Self-experience and cognition [supported]
Explore self-criticism, guilt, worthlessness, excessive responsibility, hopeless expectations, rumination, indecisiveness and impaired concentration. Establish the content, conviction, intrusiveness and cultural meaning of guilt or self-blame.

Embodiment and psychomotor change [associated]
Some people describe bodily heaviness, exhaustion, pain, slowed movement, slowed speech or thought, or inner restlessness/agitation. Observe facial expression, speech latency, movement, posture and spontaneous activity. In melancholia, psychomotor retardation and mood non-reactivity have been among the more consistent discriminating features.

Lived temporality [associated]
Time may feel slowed or stagnant; the present can seem interminable, the past can dominate experience, and the future may feel closed or devoid of possibility. This is a clinically meaningful qualitative pattern—not a formal diagnostic criterion or a universal feature.

Agency, motivation and action [associated]
Ask whether initiating ordinary actions feels effortful, whether choices feel possible, and whether the person experiences themselves as able to influence events. Distinguish lack of motivation, fear of failure, fatigue, cognitive slowing and physical incapacity.

Interpersonal world and meaning [associated]
Explore withdrawal, perceived disconnection, reduced emotional resonance with others, loss of purpose, and changes in the meaning of work, family roles or valued activities. Do not assume that social withdrawal means the person prefers isolation.

Clinical pattern and specifiers [assessment]
Assess melancholic, atypical, psychotic and seasonal patterns where relevant; ask about diurnal variation, appetite/weight, sleep, psychomotor change and mood reactivity. Psychotic guilt, nihilistic beliefs or catatonic signs require careful assessment.

Longitudinal differential [assessment]
A depressive syndrome can occur in unipolar depression, bipolar disorder, trauma-related conditions, substance/medication effects and medical illness. Establish prior mania/hypomania, episode boundaries, baseline functioning, substance exposure and physical causes.

First-person interview prompts [assessment]
"What has changed in how you feel in your body?" "Can you still look forward to or enjoy things?" "How does time pass?" "Can you imagine a future that might be different?" "Do actions feel possible?" "What has happened to your sense of connection or purpose?"

Clinical interpretation / limitations
The 2023 World Psychiatry bottom-up review co-produced with people with lived experience describes altered emotion, body, self, agency, social world and time. These accounts deepen clinical understanding but do not define a required symptom profile. Phenomenological concepts must not be mistaken for diagnostic criteria or proof of a causal mechanism.

Explanatory hypotheses and mechanisms

Cognitive model [hypothesis]
Negative schemas, biased information processing, rumination and hopelessness may maintain depressive affect and behaviour. These processes are clinically useful treatment targets, but not universal causes.

Behavioural model [hypothesis]
Reduced access to rewarding activity, withdrawal and reduced positive reinforcement can maintain low mood; behavioural activation targets these loops.

Stress-diathesis / HPA axis [hypothesis]
Genetic and developmental vulnerability may interact with stress exposure and altered stress-response regulation. HPA findings are heterogeneous and not diagnostic biomarkers.

Neuroplasticity / immune pathways [hypothesis]
Neurotrophic, synaptic-plasticity, inflammatory and metabolic findings are under investigation. They likely describe subgroups and interacting systems rather than one pathway for all patients.

Reward and circadian systems [hypothesis]
Altered reward processing, motivation and sleep/circadian regulation may contribute to anhedonia, fatigue and episode persistence.

Clinical interpretation / limitations
These are explanatory models with differing levels of evidence. A mechanism associated with MDD is not necessarily a mediator of suicidal behaviour.

Suicidal process: one secondary clinical node

Most defensible clinical link [supported]
Depressive disorders are associated with suicidal ideation and attempts. Severity, persistence, previous suicidal behaviour, comorbidity and acute clinical change are important assessment domains.

Small construct nodes to retain [associated]
Hopelessness, psychological pain, defeat/entrapment and interpersonal disconnection may co-occur in some patients. They should be measured as distinct constructs, not assumed from the diagnosis.

Transition is separate [assessment]
MDD diagnosis or depressive severity alone does not explain who transitions from ideation to attempt. Assess prior attempts, current intent, planning, acute intoxication, access to lethal means and support/safety context directly.

Psychotic / agitated / mixed features [assessment]
Psychotic depression, severe agitation, profound insomnia, catatonia, abrupt deterioration or inability to maintain safety require urgent specialist assessment.

Clinical interpretation / limitations
The suicide-specific constructs are mapped from IPTS, 3ST and IMV as complementary frameworks. No single model is validated as a complete causal pathway for MDD.

Evidence-based treatment — stepped and phase-specific

A. Non-pharmacological interventions

Structured psychotherapy [Strong guideline support]
Offer CBT, behavioural activation, interpersonal psychotherapy (IPT), problem-solving therapy or brief psychodynamic therapy according to severity, formulation, patient preference and availability. WHO mhGAP gives structured psychological treatment a strong recommendation (moderate certainty) for moderate-to-severe depression.

Behavioural activation and daily structure [Evidence-based intervention]
Map avoidance and loss of reinforcement; collaboratively schedule achievable, valued activities; restore daily rhythm, social contact and self-care. Monitor activity and mood rather than relying on motivation alone.

Exercise and lifestyle support [Adjunct / selected option]
Offer a tailored group exercise programme as an adjunct or selected treatment option; address sleep regularity, physical illness, pain, alcohol/substance use, nutrition and social stressors. Do not imply lifestyle change is a substitute for indicated treatment in severe depression.

Relapse prevention and collaborative care [Continuity of care]
Use measurement-based follow-up (e.g., PHQ-9 alongside clinical interview), identify early warning signs, agree a relapse plan, involve family/supports with consent and coordinate primary and specialist care. Consider

maintenance-focused CBT or mindfulness-based cognitive therapy in recurrent depression.

B. Pharmacological interventions

Sertraline (SSRI) — A common first-line adult option for MDD; also useful when anxiety symptoms co-occur. Consider interactions, sexual adverse effects, GI effects, hyponatraemia risk and bleeding risk.

Starting dose	50 mg orally once daily. In sensitive patients or prominent anxiety, a clinician may start at 25 mg/day for several days to 1 week, then increase to 50 mg/day.
Titration method	If response is incomplete and tolerability is acceptable, increase by 25–50 mg/day no more frequently than weekly. Maximum usual labelled adult dose: 200 mg/day.
Usual maintenance	Usual effective range 50–200 mg once daily. There is no single fixed maintenance dose: continue the dose that achieved remission, unless adverse effects or another clinical reason justify a change.
Monitoring	Review within 2 weeks (within 1 week for age 18–25 or specific suicide concern); assess response, activation, agitation, sleep, adherence, adverse effects, interactions and suicidal thoughts. Consider sodium in older adults or those at risk of hyponatraemia.
When and how to reduce / stop	After remission, usually continue at least 6 months; consider longer (often 2 years or more) with recurrent episodes, residual symptoms, severe past episodes or persistent risk factors. Do not stop abruptly. Reduce in stages, commonly using proportional reductions (e.g., about 50% of the previous dose, then smaller 25% steps at lower doses); hold each step until withdrawal symptoms are absent or tolerable. This may take weeks to months. If severe withdrawal occurs, consider returning to the last tolerated dose and tapering more slowly with the prescriber.

Escitalopram (SSRI) — Adult MDD option; may suit some patients who prefer a relatively simple once-daily regimen. Review QT-prolongation risk, interactions, age and hepatic status.

Starting dose	10 mg orally once daily in most adults. A lower initial dose may be appropriate in selected sensitive, older or medically complex patients according to local product information.
Titration method	If needed and tolerated, increase to 20 mg once daily after at least 1 week. Do not exceed the maximum dose in the relevant national product label; lower limits may apply in older age or hepatic impairment.
Usual maintenance	Usual range 10–20 mg once daily; continue the effective remission-producing dose. Maintenance is not automatically 20 mg.
Monitoring	Early clinical review; monitor mood, activation, suicidality, sexual function, GI effects, sodium in at-risk patients, QT risk and concomitant QT-prolonging medicines.
When and how to reduce / stop	Apply the same indication- and relapse-risk-based continuation principle as for other antidepressants. Taper gradually over weeks or months using smaller proportional reductions as the dose falls; monitor for both withdrawal and recurrence. Avoid alternate-day dosing for short-half-life SSRIs.

Prescribing principles

Check for previous mania/hypomania before prescribing an antidepressant. Antidepressant monotherapy is inappropriate when bipolar I disorder is present. Avoid tricyclic antidepressants where overdose toxicity is a major concern. Consider pregnancy, age, renal/hepatic function, drug interactions and local registration. If there is no meaningful response, reassess diagnosis, adherence, dose, duration, comorbidity and psychosocial adversity before simply escalating. Consider tapering after sustained full remission and a shared relapse-risk review—not simply because early improvement has occurred. Persistent adverse effects or patient preference may justify a dose change sooner, but balance this against recurrence risk and monitor closely.

Guideline recommendations and clinical considerations

Mild / less severe depression [WHO / NICE]

Active monitoring when appropriate; guided self-help; behavioural activation; CBT-based or problem-solving approaches; address sleep, physical activity, stressors and social needs. Shared decision-making and follow-up are essential.

Moderate-to-severe depression: psychological treatment [WHO mhGAP 2023]
WHO mhGAP 2023 gives a STRONG recommendation (MODERATE certainty) for structured psychological treatments: behavioural activation, CBT, IPT, problem-solving therapy, brief psychodynamic and third-wave therapies. These can be task-shared by trained providers with supervision.

Medication and combined care [WHO mhGAP 2023; Cipriani et al. 2018]
SSRIs are commonly used first-line pharmacotherapy; choice depends on previous response, adverse-effect profile, comorbidity, interactions, overdose toxicity and preference. Combined psychotherapy plus antidepressant treatment is appropriate for many moderate/severe, chronic or recurrent presentations. WHO says antidepressant monotherapy for moderate-to-severe depression should generally be considered when psychological treatment is unavailable (conditional; LOW certainty).

Review and continuation [NICE NG222]
Review early after treatment initiation (NICE recommends review between 2–4 weeks), monitoring adherence, response, adverse effects and suicidal ideation. Continue effective treatment through remission and individualise maintenance/gradual tapering according to recurrence risk and prior course.

Severe / psychotic / urgent presentations [NICE NG222; specialist guidance]
Urgent specialist assessment. Consider antidepressant plus antipsychotic treatment for psychotic depression; ECT may be appropriate for life-threatening, severe psychotic/catatonic depression or when rapid response is required. rTMS and specialist augmentation strategies may be options for treatment-resistant depression.

Before and during treatment [NICE NG222]
Screen for past mania/hypomania and bipolar spectrum; review substance use, medical comorbidity, pregnancy/reproductive considerations and interactions. Monitor activation, agitation, suicidality and treatment-emergent adverse effects.

Clinical interpretation / limitations
Guidelines differ in how they position antidepressant monotherapy versus psychotherapy in moderate-to-severe depression. WHO mhGAP is particularly relevant to LMIC/non-specialist settings; NICE and CANMAT provide additional specialist options. The choice must be individualised.

DISORDER PROFILE 02

Anxiety disorders

A heterogeneous group including generalised anxiety disorder (GAD), panic disorder, social anxiety disorder, specific phobias and agoraphobia. They share excessive fear/anxiety and avoidance, but the feared stimuli, symptom patterns and optimal exposure strategies differ by diagnosis.

301.4 million Anxiety-disorder cases globally, 2019 (GBD)	3,779.5 / 100,000 Age-standardised prevalence, 2019	30–40% Heritability estimates in twin/family literature; not an individual genetic forecast

Aetiology and risk architecture

Genetic and temperamental liability [supported]
Twin/family studies suggest moderate heritability, with shared genetic liability across anxiety and depression. Behavioural inhibition, negative affectivity and threat sensitivity may contribute.

Learning and environment [supported]
Conditioning, observational learning, developmental adversity, chronic stress and unpredictable threat can shape fear and avoidance.

Cognitive processes [supported]
Threat overestimation, attentional bias, intolerance of uncertainty, catastrophic misinterpretation of bodily sensations and safety behaviours may maintain specific disorders.

Biological systems [hypothesis]
Fear/threat circuitry, autonomic arousal, noradrenergic, GABAergic and serotonergic systems are implicated. Findings are heterogeneous and not diagnostic biomarkers.

Clinical interpretation / limitations
Anxiety disorders are not one disease with one mechanism. GAD, panic, social anxiety and phobias require disorder-specific formulation.

Epidemiology and burden

Global estimate [supported]
GBD 2019 estimated 301.4 million cases of anxiety disorders worldwide (95% UI 252.6–356.0 million).

Age-standardised rate [supported]
GBD 2019 estimated 3,779.5 cases per 100,000 people, with differences by age, sex, region and socioeconomic context.

Comorbidity [supported]
Anxiety disorders frequently co-occur with depressive disorders, substance-use disorders, insomnia and physical-health problems.

Treatment gap [supported]
The WHO review notes that many people with anxiety disorders receive no care; barriers include recognition, availability, affordability and acceptability.

Clinical interpretation / limitations
GBD 2019 figures cover a modelled group of anxiety disorders; they are not a single-diagnosis prevalence estimate. WHO’s 2026 fact sheet reports about 470 million people with anxiety disorders in 2023; this is a different model round and should not be read as a directly comparable trend.

Phenomenology and phenomenological psychopathology

Generalised anxiety: anticipatory worry [supported]
Worry is commonly repetitive, difficult to control and oriented toward possible future threats across several domains. Characterise its verbal/imaginal form, controllability, perceived usefulness, uncertainty, duration and impact; distinguish it from depressive rumination focused on past events or self-evaluation.

Panic: sudden threat and bodily alarm [supported]
Panic attacks involve abrupt surges of intense fear or discomfort with autonomic and cognitive symptoms. Ask what the person notices first, how bodily sensations are interpreted, whether there is fear of dying/losing control, and whether attacks lead to persistent concern or avoidance.

Interoceptive experience [associated]
Palpitations, breathlessness, dizziness, trembling, sweating, gastrointestinal sensations and muscle tension can become central to the person's threat experience. Explore attention to bodily sensations and their meaning; do not presume that every physical symptom is anxiety.

Social anxiety: the gaze of others [supported]
The feared situation centres on scrutiny, embarrassment, rejection or negative evaluation. Explore anticipatory anxiety, self-focused attention, shame, safety behaviours, avoidance and post-event review of perceived mistakes.

Specific phobia and agoraphobia [supported]
Fear may be tightly linked to a cue or situation; in agoraphobia, concern often relates to escape difficulty or unavailable help if panic-like or incapacitating symptoms occur. Clarify trigger, expected catastrophe and avoidance pattern.

Lived time and future horizon [associated]
Phenomenological literature describes anxiety as narrowing attention toward an anticipated threat and making the future feel accelerated, urgent or constricted. This is a conceptual description of experience, not a diagnostic criterion and not equally applicable to every anxiety disorder.

Lived space and social world [associated]
Avoidance can progressively narrow where a person feels able to go; some describe ordinary places or interpersonal encounters as unsafe, intrusive or dominated by anticipated judgement. Establish what is feared in the specific context rather than assuming one general mechanism.

Attention, uncertainty and control [hypothesis]
Assess hypervigilance, threat monitoring, intolerance of uncertainty, reassurance seeking, checking and attempts to control internal sensations. These processes may maintain symptoms, but their salience varies across GAD, panic, social anxiety and phobic disorders.

Functional phenomenology [associated]
Map how worry, panic or avoidance affects work, study, travel, sleep, relationships and daily routines. Short-term relief after avoidance may reinforce avoidance over time; assess the actual sequence with the person.

Differential and physical assessment [assessment]
Consider depression, PTSD, OCD, psychosis, substance/stimulant use or withdrawal, medication effects, thyroid and cardiopulmonary conditions, and other medical explanations. Panic-like symptoms should not be attributed to anxiety without appropriate clinical assessment.

First-person interview prompts [assessment]
"What do you fear may happen?" "What do you notice first in your body?" "What do you do to prevent the feared outcome?" "What situations have become smaller or harder to enter?" "What do you believe uncertainty would mean?"

Clinical interpretation / limitations
The 2026 scoping review mapped 36 publications and describes temporal, spatial and intersubjective dimensions of anxiety. This is a growing conceptual literature, not evidence that all anxiety disorders share one validated phenomenological signature. Interoceptive findings are heterogeneous and should be interpreted by disorder and task.

Explanatory hypotheses and mechanisms

Fear-conditioning / extinction [hypothesis]
Learning models propose that threat associations are acquired and maintained, while exposure therapy supports new learning and reduced avoidance.

Intolerance of uncertainty [hypothesis]
In GAD, uncertainty may be experienced as threatening, promoting repetitive worry and reassurance seeking.

Interoceptive misinterpretation [hypothesis]
In panic disorder, benign bodily sensations may be catastrophically interpreted, increasing autonomic arousal and fear of sensations.

Social-evaluative threat [hypothesis]
Social anxiety models emphasise self-focused attention, negative predictions about evaluation and safety behaviours.

Avoidance and negative reinforcement [hypothesis]
Avoidance reduces distress short term, which can reinforce avoidance and maintain impairment over time.

Clinical interpretation / limitations
The models are complementary and disorder-specific. They are not established biological causes or mandatory mediators of suicidal ideation.

Suicidal process: one secondary clinical node

Clinical association [associated]
Anxiety disorders are associated with suicidal outcomes, but the strength differs by diagnosis, comorbidity and study population.

Transdiagnostic constructs [hypothesis]
Psychological pain, hopelessness, defeat/entrapment and social disconnection may co-occur, especially with depression or trauma. These are proposed/associated constructs, not anxiety-specific causal mediators.

Risk distinction [assessment]
Anxiety diagnosis alone does not reliably distinguish ideation from attempts. Assess comorbid depression, PTSD, SUD, prior behaviour, current intent and acute change.

Panic and acute distress [assessment]
Panic attacks may cause severe distress and avoidance; ask directly about suicidal thoughts rather than inferring them from symptom intensity.

Clinical interpretation / limitations
The WHO 2024 recommendations specifically address GAD and panic disorder in general health-care settings. They should not be generalised uncritically to every anxiety diagnosis.

Evidence-based treatment — diagnosis-specific

A. Non-pharmacological interventions

CBT for GAD [Strong guideline support]
Use a structured CBT protocol targeting excessive worry, intolerance of uncertainty, threat appraisal, problem-solving and behavioural experiments. WHO mhGAP gives brief structured CBT-based interventions a strong recommendation (moderate certainty) for adults with GAD and/or panic disorder.

CBT for panic disorder [Evidence-based intervention]
Use psychoeducation, cognitive restructuring, interoceptive exposure to feared bodily sensations, and graduated in-vivo exposure to avoided situations. Explain the panic cycle without reinforcing reassurance-seeking or avoidance.

Social anxiety and specific phobia [Diagnosis-specific CBT]
For social anxiety, use disorder-specific CBT (e.g., attention retraining, behavioural experiments and exposure) addressing fear of negative evaluation and safety behaviours. For specific phobia, graduated exposure is central; generic relaxation alone is insufficient.

Relapse prevention and self-management [Adjunct / continuity]
Teach a plan for early symptom recognition, graded approach rather than avoidance, sleep and caffeine review, physical activity and supported practice between sessions. Include trauma, substance, thyroid/cardiac and medication differential assessment where clinically indicated.

B. Pharmacological interventions

Escitalopram (SSRI) — GAD — An adult pharmacological option for GAD where medication is indicated or preferred; check national indication/registration and local guidance.

Starting dose	10 mg orally once daily in most adults. For marked sensitivity, some clinicians begin at 5 mg/day briefly before moving to 10 mg/day.
Titration method	If response is insufficient and tolerability is acceptable, increase to 20 mg/day after at least 1 week; in practice, allow several weeks to assess response at a therapeutic dose.
Usual maintenance	Usual range 10–20 mg/day. Use the lowest dose that produces sustained functional improvement.
Monitoring	At initiation and after dose changes, check for early activation, increased anxiety, sleep disturbance, GI effects, sexual adverse effects, adherence, suicidality, QT risk and interactions.
When and how to reduce / stop	If responding, NICE advises continuing for at least 6 months after the optimal dose is reached, then review. Taper gradually with proportionate reductions; use smaller steps at low doses and pause if withdrawal symptoms are problematic. Monitor for recurrence of anxiety as well as withdrawal.

Sertraline (SSRI) — panic disorder — A guideline- and label-supported option for adult panic disorder. Starting below the MDD dose can reduce early activation.

Starting dose	25 mg orally once daily for 1 week, then 50 mg/day.
Titration method	If required, increase by 25–50 mg/day at intervals of at least 1 week according to response and tolerability; maximum 200 mg/day.
Usual maintenance	Usual effective range 50–200 mg/day. Keep at the effective dose after remission for at least 6 months after the optimal dose, then reassess relapse risk.
Monitoring	Review early activation, panic frequency, avoidance, functioning, adherence, sleep and adverse effects. Screen for bipolar history and substance/caffeine contributors.
When and how to reduce / stop	Do not stop suddenly. Taper in stepwise, proportionate reductions over weeks or months; use smaller decrements at lower doses. If marked withdrawal appears, return to the last tolerated dose where clinically appropriate and taper more slowly.

Prescribing principles
WHO mhGAP advises against routine benzodiazepines for GAD/panic (strong recommendation against; low certainty). For emergency management of acute, severe anxiety, WHO allows only a very short course, maximum 3–7 days. Do not use benzodiazepines as routine long-term treatment: dependence, tolerance, cognitive impairment, falls, driving risk and withdrawal may outweigh benefit. Exposure-based psychological treatment is core care, not an optional add-on. Consider a planned taper after sustained symptomatic and functional recovery and at least 6 months after reaching the optimal dose; extend treatment for recurrent/chronic illness or residual symptoms. Dose reduction can also be considered for persistent adverse effects after reassessing relapse risk.

Guideline recommendations and clinical considerations

GAD and panic: brief psychological treatment [WHO mhGAP 2023]
WHO mhGAP 2023 gives a STRONG recommendation (MODERATE certainty) for brief, structured psychological interventions based on CBT principles for adults with GAD and/or panic disorder. Use worry-focused CBT for GAD and panic-focused CBT (including interoceptive exposure) for panic disorder.

Social anxiety and specific phobia [RANZCP 2018; broader CBT evidence]
Offer disorder-specific CBT with graduated exposure and behavioural experiments; for social anxiety, target feared evaluation, self-focused attention and safety behaviours. For specific phobia, exposure-based treatment is central.

Medication [WHO mhGAP 2023; RANZCP 2018]
WHO mhGAP 2023 says SSRIs should be considered for adults with GAD or panic disorder (CONDITIONAL; LOW certainty). RANZCP guidance also includes SSRIs/SNRIs as pharmacological options. Select based on diagnosis, prior response, comorbidity, interactions and preference.

Adjunctive strategies [WHO mhGAP 2023]
Relaxation or mindfulness-based stress management may be considered (WHO: CONDITIONAL; LOW certainty). Physical activity and collaborative care may support treatment, but do not replace diagnosis-specific therapy.

Benzodiazepine caution [WHO mhGAP 2023]
WHO does NOT recommend benzodiazepines for routine GAD/panic treatment (STRONG against; LOW certainty). For emergency management of acute, severe anxiety, WHO says they may be considered only as a short-term measure, maximum 3–7 days. Consider dependence, withdrawal, sedation and interaction risks.

Follow-up [Guideline-informed care]
Measure symptom change, avoidance, functioning, treatment engagement and adverse effects. Reassess diagnosis and medical/substance contributors if response is poor. Continue effective medication long enough to reduce relapse risk, then taper gradually with monitoring.

Clinical interpretation / limitations
WHO’s 2023 anxiety recommendations are specifically for adults with GAD and/or panic disorder. For social anxiety and specific phobia, use condition-specific guideline pathways.

DISORDER PROFILE 03

Post-traumatic stress disorder

A trauma-related disorder that may develop after exposure to a potentially traumatic event. Trauma exposure is not equivalent to PTSD: most exposed people do not develop the disorder. Symptoms must persist and cause meaningful distress or functional impairment.

3.9% Estimated global lifetime prevalence (WHO 2026)	~70% Estimated global lifetime exposure to a potentially traumatic event	5.6% Proportion of trauma-exposed people estimated to develop PTSD

Aetiology and risk architecture

Necessary exposure, not sufficient cause [supported]
PTSD follows exposure to a qualifying traumatic event, but most people exposed do not develop PTSD. Event type, threat, repetition, chronicity and aftermath matter.

Pre-existing vulnerability [supported]
Prior trauma, previous mental disorder, family history, low social support, socioeconomic disadvantage and cumulative adversity may increase vulnerability.

Peri-traumatic and post-trauma factors [associated]
Peri-traumatic fear/dissociation, ongoing threat, displacement, stigma, injury, loss and inadequate support may influence onset or persistence.

Biopsychosocial interaction [hypothesis]
Genetic and developmental vulnerability interacts with trauma exposure, memory, appraisal, stress regulation and post-event social context. No single PTSD biomarker is clinically diagnostic.

Clinical interpretation / limitations
Do not infer PTSD from trauma history alone. Diagnosis requires the characteristic symptom pattern, duration and impairment.

Epidemiology and burden

Lifetime prevalence [supported]
WHO’s 11 September 2026 fact sheet estimates that 3.9% of the global population has experienced PTSD at some point in life.

Trauma exposure [supported]
WHO estimates that around 70% of people globally experience a potentially traumatic event during their lifetime.

Conditional risk [supported]
WHO estimates that about 5.6% of trauma-exposed people develop PTSD; estimates differ markedly by trauma type and population.

High-risk contexts [supported]
WHO reports higher PTSD prevalence among people exposed to violent conflict/war (15.3% in the cited evidence) and following sexual violence.

Clinical interpretation / limitations
Population prevalence is strongly dependent on trauma exposure, population, survey method, diagnostic definition and time period.

Phenomenology and phenomenological psychopathology

Intrusive memories versus flashbacks [supported]
Distinguish unwanted recollections or images experienced as memories of the past from flashbacks with a vivid “here-and-now” quality. Flashbacks may involve sensory fragments, emotion and bodily sensations, with reduced temporal distance and a sense of reliving.

Nightmares and cue reactivity [supported]
Ask about trauma-related dreams, physiological reactions to reminders, sudden sensory fragments and the specific cues that precipitate distress. Clarify whether the person remains oriented to the present during the experience.

Avoidance and narrowing of life [supported]
Avoidance may concern memories, feelings, conversations, people, places or activities. Map the protective purpose the person attributes to avoidance and how it affects mobility, relationships and daily roles.

Altered meanings of self and world [supported]
Explore persistent beliefs such as “I am unsafe,” “I am to blame,” “I cannot trust anyone,” or “the world is dangerous,” and emotions such as guilt, shame, anger, fear or emotional numbing. Distinguish realistic appraisal of ongoing danger from generalised post-traumatic threat.

Threat monitoring and arousal [supported]
Hypervigilance, exaggerated startle, irritability, concentration difficulty, sleep disturbance and persistent scanning for danger may keep the person oriented toward threat. Describe triggers, intensity and recovery time.

Dissociative phenomena [supported]
Ask separately about depersonalisation (feeling detached from oneself or one’s body), derealisation (the surroundings feel unreal), gaps in awareness or memory, emotional numbing and compartmentalised experience. The dissociative subtype is not present in all PTSD.

Lived time, body and emotion [associated]
Trauma-related experiences may alter the felt boundary between past and present, bodily ownership or connectedness, and access to emotion. The 4-D framework organises these phenomena across time, thought, body and emotion; it is a conceptual model, not a separate diagnostic test.

Relational and intersubjective experience [associated]
Explore trust, safety with others, shame, intimacy, perceived threat, social withdrawal and the effects of ongoing violence or unsafe living conditions. Do not treat a continuing threat as merely a trauma reminder.

Diagnostic timing and differential [assessment]
Establish the nature and timing of trauma exposure, symptom clusters, duration, impairment and course. Differentiate acute stress reactions, PTSD, complex PTSD where ICD-11 is used, dissociative disorders, depression, psychosis, TBI, substance effects and ongoing threat.

First-person interview prompts [assessment]
“When the memory comes, does it feel like something remembered or something happening now?” “What changes in your body?” “Do you feel present in the room?” “What reminders do you avoid?” “What has changed in your trust, safety or view of yourself?”

Clinical interpretation / limitations
The 2024–2025 PTSD reviews describe flashbacks as distinct from ordinary autobiographical recall because of their sensory vividness and altered here-and-now quality. Dissociation should be assessed specifically; it is neither universal in PTSD nor synonymous with psychosis. Use trauma-informed, non-coercive interviewing and avoid requiring detailed trauma narration when it is not clinically necessary.

Explanatory hypotheses and mechanisms

Fear conditioning / generalisation [hypothesis]
Trauma-related cues may become associated with threat; generalisation can trigger fear in safe contexts.

Contextual memory and extinction [hypothesis]
Altered contextual processing and difficulty updating safety learning are proposed mechanisms for persistent re-experiencing and hyperarousal.

Cognitive appraisal [hypothesis]
Perceived ongoing threat, shame, guilt, self-blame and negative beliefs about self/world may maintain distress.

Stress-regulation systems [hypothesis]
HPA-axis, noradrenergic and amygdala–hippocampal–prefrontal circuitry are research domains. Findings vary and are not diagnostic tests.

Social context [associated]
Ongoing threat, low support, discrimination and barriers to safety or recovery can sustain symptoms.

Clinical interpretation / limitations
These mechanisms are plausible and empirically studied but are not all established causal mediators. Trauma-informed formulation should include current safety and social context.

Suicidal process: one secondary clinical node

Association [associated]
PTSD is associated with suicidal ideation, attempts and suicide death in systematic reviews and meta-analyses.

Potential psychological correlates [hypothesis]
Defeat, entrapment, shame, guilt, anger and negative cognitions have been linked with PTSD/suicide outcomes in recent synthesis. They are correlates, not proven mediators.

Comorbidity and context [assessment]
Comorbid depression, SUD, chronic pain, insomnia, previous suicidal behaviour and ongoing victimisation require assessment.

Transition [assessment]
PTSD diagnosis or trauma exposure alone does not identify who will attempt. Assess current intent, planning, prior behaviour, acute state and safety directly.

Clinical interpretation / limitations
PTSD-specific suicide associations should not be collapsed into the general IPTS/3ST/IMV nodes as if all trauma survivors share the same mechanism.

Evidence-based treatment — trauma-focused care

A. Non-pharmacological interventions

Individual trauma-focused CBT [Strong guideline support]
Offer a validated manualised trauma-focused CBT approach, including Cognitive Processing Therapy, cognitive therapy for PTSD, Narrative Exposure Therapy or Prolonged Exposure. NICE describes a typical course of 8–12 sessions, with more sessions when clinically indicated; delivery requires training and ongoing supervision.

EMDR [Strong guideline support]
Offer EMDR using a validated protocol and trained practitioner. Treatment should include psychoeducation, distress-management skills, target-memory processing and support for functioning; NICE typically describes 8–12 sessions, adjusted to clinical need.

Stabilisation, safety and engagement [Trauma-informed delivery]
Assess current safety, housing, ongoing violence, substance use, dissociation, self-harm, sleep and practical barriers. Build trust, explain trauma reactions, use grounding and arousal-management strategies, and avoid coercive or premature trauma disclosure. Stabilisation supports engagement but should not become an indefinite barrier to effective trauma-focused care.

Recovery and comorbidity care [Integrated care]
Address depression, anxiety, chronic pain, sleep disorders, substance-use disorders and social needs. Include family/supports with consent, functional rehabilitation and planned follow-up; task-shared care requires competency-based training and supervision.

B. Pharmacological interventions

Sertraline (SSRI) — One of the medicines with strongest guideline support for adult PTSD when medication is preferred, trauma-focused psychotherapy is unavailable/not accepted, or residual symptoms warrant pharmacotherapy. Medication is not the preferred first-line option over trauma-focused psychotherapy in VA/DoD guidance.

Starting dose	25 mg orally once daily for PTSD/panic-sensitive patients; after about 1 week increase to 50 mg/day if tolerated.
Titration method	If response remains incomplete, increase by 25–50 mg/day no more often than weekly; maximum 200 mg/day.
Usual maintenance	Usual guideline-supported range 50–200 mg/day. Assess adequate dose and duration before judging non-response; individualise to response and tolerability.
Monitoring	Monitor activation, sleep, GI and sexual adverse effects, sodium risk, bleeding risk, suicidal thoughts, comorbid bipolarity and overall PTSD symptoms/function. Review nightmares and dissociation separately rather than assuming global response.
When and how to reduce / stop	Reassess ongoing benefit and adverse effects regularly. When discontinuing, taper gradually over weeks or months; sertraline can cause withdrawal, especially after long treatment or rapid reductions. Monitor for both withdrawal and return of PTSD symptoms.

Venlafaxine XR (SNRI) — A guideline-supported adult PTSD medication option; particularly consider blood pressure, withdrawal liability and prior response. Product indication differs by country.

Starting dose	37.5 mg orally once daily (extended-release); increase to 75 mg/day after approximately 4–7 days if tolerated.
Titration method	Increase by 37.5–75 mg/day at intervals of 1–2 weeks depending on response and tolerability. VA/DoD dosing table lists 75–300 mg/day for XR; local product label may set a lower maximum.
Usual maintenance	Common effective range 75–225 mg/day; some guideline dosing tables extend to 300 mg/day. The appropriate maintenance dose is the lowest effective dose within the locally approved range.
Monitoring	Check blood pressure before and during treatment, pulse, activation, sleep, GI and sexual effects, hyponatraemia risk, interactions and adherence. Venlafaxine has a relatively high risk of discontinuation symptoms.
When and how to reduce / stop	Avoid abrupt cessation. Taper particularly slowly and proportionately, with small reductions near the end; weeks to months may be required. If severe withdrawal develops, contact the prescriber promptly; a return to the last tolerated dose followed by a slower taper may be considered.

Prazosin — trauma-related nightmares only — Off-label, symptom-targeted option sometimes considered for PTSD-associated nightmares. Evidence and recommendations are mixed; it is not a general treatment for core PTSD or daytime PTSD symptoms.

Starting dose	1 mg orally at bedtime to reduce first-dose orthostatic hypotension/syncope risk.
Titration method	Increase gradually according to nightmare response and standing/supine blood pressure; often by 1 mg increments every few nights to weekly. Do not use a fixed escalation schedule without checking blood pressure and tolerability.
Usual maintenance	VA/DoD dosing table lists approximately 3–20 mg at bedtime; many patients require less. Use only if clear benefit outweighs dizziness, hypotension and syncope risk.
Monitoring	Check sitting/standing blood pressure, dizziness, falls, syncope and concomitant antihypertensives/PDE-5 inhibitors. Warn about first-dose syncope and rising slowly from bed.
When and how to reduce / stop	If ineffective or poorly tolerated, reduce/stop under prescriber guidance and reassess blood pressure and nightmare recurrence. There is no single evidence-based PTSD-specific taper schedule; avoid unsupervised changes.

Prescribing principles
Do not prescribe benzodiazepines to treat PTSD routinely; VA/DoD recommends against them. Prazosin recommendations vary and should be restricted to a nightmare-targeted trial after shared decision-making. Treat comorbid bipolar disorder before using antidepressant monotherapy where mood switching is a concern. There is no single universally established medication duration for PTSD. Consider tapering after sustained improvement/recovery when the patient prefers it and risk-benefit review supports it; monitor both PTSD symptoms and withdrawal. Serious adverse reactions require prompt prescriber-led action rather than a routine taper.

Guideline recommendations and clinical considerations

Preferred first-line psychotherapy [VA/DoD 2023]
The 2023 VA/DoD guideline recommends individual manualised trauma-focused psychotherapies over medication (STRONG FOR): Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), and Prolonged Exposure (PE).

Other structured therapies [VA/DoD 2023]
The VA/DoD guideline suggests Ehlers Cognitive Therapy, Present-Centered Therapy and Written Exposure Therapy (WEAK FOR). Availability, training, patient preference and trauma context matter.

Medication options [VA/DoD 2023]
When psychotherapy is unavailable, not preferred or insufficient, the 2023 VA/DoD guideline recommends sertraline, paroxetine or venlafaxine. Medication choice should account for comorbidity, adverse effects and prior response.

Avoid routine benzodiazepines [VA/DoD 2023]
VA/DoD recommends against benzodiazepines for PTSD. They do not treat core PTSD mechanisms and may complicate recovery or substance-related risk.

Nightmares and sleep [Guideline-dependent]
Assess trauma-related nightmares, insomnia, sleep apnoea and substance use. Prazosin evidence is mixed and recommendations differ by symptom target; do not treat it as a general PTSD medication.

LMIC / task-sharing [WHO mhGAP 2023]
Where specialist capacity is limited, use mhGAP-compatible trauma-informed care and structured psychological interventions delivered by trained, supervised providers; refer severe, complex, dissociative or high-risk cases.

Clinical interpretation / limitations
The VA/DoD recommendations are based largely on its care-system context; local availability, clinician training, patient preferences and WHO mhGAP guidance should shape implementation in Cambodia.

DISORDER PROFILE 04

Bipolar disorder

An episodic mood disorder involving mania or hypomania and commonly depressive episodes. Diagnostic formulation requires a lifetime history of mood elevation, duration, functional change and exclusion of substance/medical causes.

>2% Population affected across bipolar-spectrum estimates cited by CANMAT/ISBD	Episodic Mania/hypomania and depression	State-sensitive Sleep, circadian and mixed features

Aetiology and risk architecture

Polygenic vulnerability [supported]
Bipolar disorder has substantial genetic liability, with complex polygenic architecture and family aggregation. No single gene determines the illness.

Development and environment [associated]
Stressful life events, childhood adversity, substance use, sleep disruption and social rhythm changes may influence onset, relapse or episode timing.

Sleep and circadian systems [associated]
Sleep/wake and circadian rhythm disruption are common across mood states and may be linked to episode instability; causal direction is still being studied.

Neurobiology [hypothesis]
Reward/activation systems, monoaminergic and glutamatergic signalling, neuroplasticity and immune-metabolic processes are research domains rather than clinical diagnostic tests.

Clinical interpretation / limitations
The 2024 review describes sleep/circadian disturbance as clinically salient, but it is not a sufficient explanation of bipolar disorder.

Epidemiology and burden

Spectrum prevalence [supported]
CANMAT/ISBD 2023 summary describes bipolar disorder as affecting more than 2% of the population; prevalence varies depending on whether bipolar I, II and subthreshold spectrum are included.

Course [supported]
The illness is commonly recurrent, with substantial between-person variation in episode polarity, frequency, duration, inter-episode symptoms and functional recovery.

Onset and recognition [associated]
Onset often occurs in adolescence/early adulthood, but diagnosis may be delayed when early episodes are depressive or hypomania is not recognised.

Comorbidity [supported]
Anxiety, substance-use disorders, ADHD, sleep disorders and physical-health conditions may complicate course and treatment.

Clinical interpretation / limitations
Do not treat the >2% spectrum estimate as the prevalence of bipolar I disorder alone. WHO’s 2026 fact sheet reports about 36 million people with bipolar disorder in 2023; definitions and model rounds differ.

Phenomenology and phenomenological psychopathology

Mood quality and activation [supported]
Mania/hypomania involves a distinct episode of elevated, expansive or irritable mood together with increased energy or activity. The quality may be euphoric, dysphoric, irritable or labile; mood alone is insufficient without assessing activation and change from baseline.

Subjective acceleration [supported]
People may describe racing thoughts, rapid shifts of ideas, pressure to speak, increased associations, distractibility or difficulty slowing mental activity. Observe speech rate, interruptibility, coherence and goal direction.

Reduced need for sleep [supported]
Clarify reduced need for sleep (sleeping less without feeling tired) versus insomnia or externally imposed sleep loss. Record duration, change from baseline and consequences; sleep/circadian disruption may also precede relapse.

Self-appraisal, agency and goal pursuit [supported]
Explore unusually increased confidence, grandiosity, perceived capacity, ambitious plans, increased goal-directed activity and altered judgement. Ask how realistic plans feel to the person and how family or colleagues observe the change.

Behavioural and interpersonal change [supported]
Increased sociability, talkativeness, sexual or financial risk, overcommitment, irritability, argumentativeness or psychomotor agitation may occur. Establish consequences, boundaries, vulnerability and safety in context.

Bipolar depressive experience [supported]
The depressive pole may phenomenologically resemble unipolar depression, including anhedonia, low energy, guilt, hopelessness, cognitive slowing and psychomotor change. The distinction depends heavily on lifetime episodicity and prior mania/hypomania, not the depressive symptom pattern alone.

Mixed features [supported]
Assess simultaneous or closely co-occurring depressive symptoms with activation, increased energy, racing thoughts, irritability, agitation or reduced sleep. Mixed presentations may be dysphoric and distressing rather than euphoric; do not confuse them with rapid cycling.

Course, inter-episode state and prodromes [assessment]
Construct a longitudinal life chart: onset, episode duration, polarity, frequency, inter-episode recovery, residual symptoms, seasonality, sleep pattern, substance exposure and treatment-emergent activation. Collateral history can help identify episodes the person experienced as normal or productive.

Hypomania versus mania [assessment]
Determine duration, observable change, functional impact, need for hospitalisation and presence of psychosis. Hypomania does not involve the marked impairment, hospitalisation or psychosis that define mania; a hypomanic episode is not simply a “good mood.”

First-person interview prompts [assessment]
“How much sleep did you need, and how did you feel the next day?” “Did thoughts feel faster?” “Did others notice a change?” “Did plans or confidence become unusually intense?” “Were low mood and increased energy present together?”

Clinical interpretation / limitations
The World Psychiatry clinical-characterisation review emphasises the heterogeneity of bipolar disorder and the importance of episode polarity, energy/activity and course. It also cautions that finer distinctions among euphoric, expansive, dysphoric and irritable mood states have limited demonstrated treatment-outcome value apart from identifying mixed features. Use observable change and longitudinal history rather than relying on a single cross-sectional mood description.

Explanatory hypotheses and mechanisms

Circadian / social-rhythm dysregulation [hypothesis]
Irregular sleep, light exposure and social rhythms may interact with vulnerability and contribute to episode destabilisation. Causal evidence is still incomplete.

Reward and activation regulation [hypothesis]
Altered reward sensitivity, motivation and activation may contribute to manic/depressive polarity changes.

Stress sensitisation [hypothesis]
Repeated episodes and stress exposure may interact with biological vulnerability, but no simple progressive mechanism applies to all.

Genetic and neural network models [hypothesis]
Polygenic risk and distributed neural systems are studied; no biomarker currently replaces longitudinal clinical diagnosis.

Clinical interpretation / limitations
Do not assume that sleep loss is the sole cause of mania, or that circadian disruption is an individually predictive biomarker.

Suicidal process: one secondary clinical node

Mood-state risk [associated]
Depressive and mixed states, episode severity, agitation, anxiety and comorbid substance use are clinically important contexts for suicide assessment.

Sleep / circadian change [associated]
Marked reduction in sleep or rhythm disruption may indicate a changing episode and deserves clinical review; it is not a stand-alone suicide marker.

History and transition [assessment]
Past attempts, current intent, acute intoxication, psychosis and rapid change in state are direct assessment domains.

Do not use unipolar assumptions [assessment]
Do not infer the same mechanism or treatment pathway as unipolar MDD. Antidepressant monotherapy can destabilise some bipolar presentations.

Clinical interpretation / limitations
Separate suicidal ideation, attempts and suicide death; the correlates and interventions differ.

Evidence-based treatment — phase-specific

A. Non-pharmacological interventions

Psychoeducation and relapse signatures [Core adjunctive care]
Provide structured education on illness course, medication adherence, early warning signs, sleep disruption, substance triggers and a written relapse/action plan. Involve family or supporters with consent.

Family-focused therapy [Evidence-based adjunct]
Work on communication, problem-solving, expressed emotion and collaborative relapse prevention. Family intervention complements rather than replaces pharmacotherapy in bipolar I disorder.

CBT and interpersonal/social rhythm therapy [Evidence-based adjunct]
CBT can address residual depressive symptoms, routines and unhelpful appraisals. Interpersonal and Social Rhythm Therapy targets regularity of sleep/wake and social rhythms and management of interpersonal triggers.

Sleep, substance and physical-health interventions [Relapse prevention]
Protect regular sleep and wake times, reduce alcohol/other substances, support physical activity and cardiometabolic health, and provide coordinated care for comorbidities. Avoid sleep deprivation and stimulant exposure where possible.

B. Pharmacological interventions

Lithium — Core option for acute mania and long-term maintenance; choice requires renal/thyroid assessment, interaction review and capacity for serum monitoring.

Starting dose	A common adult initiation is 300 mg twice daily or 300 mg three times daily, depending on formulation and clinical context. Dose must be individualised; do not use a fixed mg target without serum levels.
Titration method	Adjust in small increments (often 300 mg/day) according to response, tolerability and a 12-hour post-dose trough level. Check level about 5–7 days (or 1 week) after starting and each dose change; repeat until stable.
Usual maintenance	CANMAT/ISBD: acute mania target about 0.8–1.2 mmol/L (lower in older adults); maintenance commonly 0.6–1.0 mmol/L. The corresponding daily dose varies widely with renal function, age, hydration, interacting drugs and formulation.
Monitoring	Before and during treatment: eGFR/creatinine, urea/electrolytes, thyroid function, calcium, weight, pregnancy considerations, ECG when indicated, serum levels and toxicity symptoms. Maintain consistent fluid/salt intake; review NSAIDs, ACE inhibitors/ARBs and diuretics. Vomiting, diarrhoea, dehydration, coarse tremor, ataxia or confusion require urgent assessment.
When and how to reduce / stop	Never stop routinely or rapidly. For planned discontinuation, reduce gradually over at least 4 weeks and preferably up to 3 months, even when another antimanic drug is started. Monitor closely for mania/depression during taper and for at least 3 months afterwards; NICE recommends continued symptom monitoring for 2 years after stopping long-term bipolar medication.

Divalproex / valproate — Effective option for acute mania and selected maintenance plans; not a first-line treatment for bipolar depression. Use is tightly restricted by reproductive and hepatic safety considerations.

Starting dose	For acute mania, product labelling commonly starts at 750 mg/day in divided doses. Some specialist protocols start at 250 mg twice or three times daily and titrate according to tolerability and urgency.
Titration method	Increase every few days as clinically needed to achieve response and a trough level; label trials used 50–125 micrograms/mL for acute mania. Avoid automatic escalation: use the lowest effective dose.
Usual maintenance	Dose is individualised by response and adverse effects. CANMAT/ISBD cites a commonly used divalproex trough range of about 50–100 micrograms/mL; acute mania labels report 50–125 micrograms/mL. Routine level checks depend on response, adherence, toxicity and local guidance.
Monitoring	Before/during: pregnancy and reproductive-risk review, CBC/platelets, liver function, weight/BMI and metabolic risk; assess for abdominal pain/pancreatitis, bruising/bleeding, sedation and hepatic toxicity. Check interactions, especially with lamotrigine.
When and how to reduce / stop	If switching/stopping, reduce gradually over at least 4 weeks to reduce relapse risk, with a replacement plan where needed. Do not stop unsupervised. If pregnancy occurs or is planned, urgent specialist review is required; do not abruptly discontinue without a risk-managed alternative plan.

Lamotrigine — Useful for bipolar depression prevention and maintenance, particularly depressive-polarity relapse. It is not an acute antimanic medicine and requires slow titration because of serious rash risk.

Starting dose	If NOT taking valproate or enzyme-inducing antiseizure medicines: 25 mg once daily for weeks 1–2.
Titration method	Standard schedule without valproate/enzyme inducers: weeks 3–4, 50 mg/day; week 5, 100 mg/day; week 6 onward, 200 mg/day. With valproate, the schedule is slower (25 mg every other day for 2 weeks, then 25 mg/day for 2 weeks, then 50 mg/day, then gradual increases); follow the product-specific interaction table.
Usual maintenance	Usual target 200 mg/day without interacting medicines; lower target (often 100 mg/day) with valproate and higher targets may be required with enzyme inducers. Dosing must follow the interaction-specific product schedule.
Monitoring	Ask about new rash, mucosal lesions, fever, facial swelling or systemic symptoms, particularly during titration. Any new rash requires prompt clinical assessment; suspected serious rash requires stopping and urgent evaluation. Review adherence and interactions.
When and how to reduce / stop	For planned withdrawal, taper over at least 2 weeks (often slower if clinically appropriate). If interrupted for more than about 5 half-lives, do not simply resume the previous full dose: re-start titration according to product information. A serious rash is an exception requiring urgent discontinuation/assessment.

Quetiapine — Evidence-supported for acute mania, bipolar depression and adjunctive maintenance. Dose schedule depends on the phase being treated; do not conflate bipolar depression and mania schedules.

Starting dose	Bipolar depression: 50 mg at bedtime on day 1. Mania: total 100 mg/day in divided doses on day 1.
Titration method	Bipolar depression: 50, 100, 200, then 300 mg nightly on days 1–4. Mania: total daily dose 100, 200, 300, 400 mg on days 1–4; if needed, increase toward 400–800 mg/day by day 6 in steps no greater than 200 mg/day.
Usual maintenance	Bipolar depression: 300 mg nightly. Mania/maintenance: commonly 400–800 mg/day according to indication and prior stabilisation; use the lowest effective tolerated dose.
Monitoring	Monitor sedation, orthostatic hypotension, falls, weight, waist, blood pressure, glucose/HbA1c, lipids, movement symptoms, QT risk and functional impact. Consider slower titration for older or medically vulnerable patients.
When and how to reduce / stop	Avoid abrupt cessation after regular use because insomnia, nausea, headache, irritability and symptom recurrence can occur. Reduce gradually over at least 1–2 weeks as a minimum product-label precaution; slower tapers may be appropriate after long-term treatment. Monitor relapse and withdrawal.

Prescribing principles
Avoid antidepressant monotherapy in bipolar I disorder. In bipolar depression, use a phase-appropriate treatment; lamotrigine is slow to titrate and is not suitable for acute mania. Valproate carries major fetal malformation/neurodevelopmental risks and is contraindicated or tightly restricted in pregnancy and in people with pregnancy potential under many national rules; review local regulations. Lithium has a narrow therapeutic index and requires reliable laboratory follow-up. Do not discontinue a mood stabiliser simply because the person is currently euthymic: maintenance is intended to prevent recurrence. Consider a planned reduction only after longitudinal review of episode history, duration of stability, adverse effects, patient preference and a written relapse plan; taper drug-specifically and monitor.

Guideline recommendations and clinical considerations

Acute mania [WHO mhGAP 2023]
WHO mhGAP 2023 recommends an oral antipsychotic (aripiprazole, haloperidol, olanzapine, paliperidone or quetiapine) or mood stabiliser (carbamazepine, lithium or valproate), balancing efficacy, harms and preference. Lithium requires close clinical/laboratory monitoring.

Bipolar depression [CANMAT/ISBD 2023; WHO 2023]
CANMAT/ISBD 2023 lists quetiapine, lurasidone plus lithium/divalproex, lithium, lamotrigine and cariprazine among

first-line options for bipolar I depression. WHO mhGAP 2023 lists selected options and advises that fluoxetine/venlafaxine be used with a mood stabiliser.

Antidepressant caution [CANMAT/ISBD 2023; WHO 2023]
Avoid antidepressant monotherapy in bipolar I depression; if an antidepressant is used in selected cases, combine with mood-stabilising treatment and monitor for activation, mixed symptoms or switching.

Maintenance [WHO mhGAP 2023]
Lithium, valproate/carbamazepine or selected antipsychotics may be used for maintenance according to prior response, polarity and tolerability. WHO gives a conditional recommendation for maintenance mood stabilisers/selected antipsychotics.

Psychosocial interventions [CANMAT/ISBD 2018/2023]
Psychoeducation, family-focused interventions, CBT, interpersonal/social rhythm approaches, relapse signatures, sleep regularity and substance-use treatment complement medication.

Reproductive / monitoring safety [WHO mhGAP 2023]
Avoid valproate in women and girls of childbearing potential where possible due to fetal malformation and neurodevelopmental risks. Lithium requires renal, thyroid, calcium and serum-level monitoring; valproate requires metabolic/hepatic/haematologic and reproductive-safety monitoring.

Clinical interpretation / limitations
Medication selection and monitoring require specialist input. WHO mhGAP emphasises feasibility in non-specialist settings; CANMAT/ISBD provides detailed specialist treatment sequencing.

DISORDER PROFILE 05

Schizophrenia-spectrum / psychotic disorders

A heterogeneous group characterised by disturbances in perception, belief, thought organisation, motivation, affect and cognition. Psychosis is a syndrome that also occurs in mood disorders, substance/medication conditions and medical/neurological disorders.

27 million People living with schizophrenia worldwide (WHO 2026 fact sheet)	~1 in 300 Global WHO estimate	Multi-domain Positive, negative, cognitive and affective symptoms

Aetiology and risk architecture

Polygenic susceptibility [supported]
Large numbers of common and rare variants contribute to liability; family history increases risk but does not determine outcome.

Neurodevelopmental interaction [hypothesis]
Prenatal/perinatal events, early neurodevelopment, childhood adversity and later environmental exposures may interact with genetic vulnerability.

Social and environmental exposures [associated]
Urbanicity, migration-related adversity, discrimination, childhood trauma, cannabis exposure (especially high-potency / early use) and socioeconomic stress are investigated risk domains.

Biological systems [hypothesis]
Dopamine dysregulation is an influential model for positive symptoms; glutamatergic, GABAergic, synaptic and neurodevelopmental hypotheses extend beyond dopamine. None is a complete explanation.

Clinical interpretation / limitations
Do not describe schizophrenia as “caused by excess dopamine.” Dopamine is relevant to some symptom dimensions and treatment targets, not a full aetiological account.

Epidemiology and burden

Global burden [supported]
WHO’s 11 September 2026 fact sheet estimates about 27 million people globally live with schizophrenia, approximately 1 in 300 people.

Onset and course [supported]
Onset often occurs from late adolescence to early adulthood; the course ranges from episodic to persistent, with considerable variation in remission and functioning.

Mortality and disability [supported]
Schizophrenia is associated with substantial disability, physical-health inequalities and premature mortality; integrated physical and mental healthcare is important.

Treatment gap [supported]
Access to continuous medication, psychosocial treatment, community follow-up and physical-health monitoring remains uneven, particularly in LMICs.

Clinical interpretation / limitations
The 27 million / 1-in-300 figures are WHO global estimates for 2023, published in the September 2026 fact sheet. They are population estimates, not an individual forecast.

Phenomenology and phenomenological psychopathology

Hallucinatory experiences [supported]
Describe modality, sensory vividness, location (inside/outside the head), perceived source, agency, controllability, frequency, emotional tone, meaning and distress. For voices, ask what is said, whether commands occur, and how the person understands the experience; do not assume every voice is experienced as external.

Delusional experience and salience [supported]
Explore the belief's content, degree of conviction, preoccupation, personal significance, evidence considered, response to alternative explanations and cultural context. Ask how ordinary events acquire special meaning or seem directed toward the person.

Thought and communication disturbance [supported]
Assess derailment, tangentiality, loosening of associations, thought blocking, incoherence and difficulty organising or communicating ideas. Distinguish subjective thought interference from observable disorganisation.

Selfhood and minimal self-experience [associated]
Some people describe weakened self-presence, thoughts or actions that feel unfamiliar or not fully their own, heightened self-observation (hyperreflexivity), altered bodily self-experience or less stable boundaries between self and world. These anomalous self-experiences are an active research domain, not a universal symptom.

Negative symptom dimensions [supported]
Assess avolition, anhedonia, asociality, blunted affect and alogia separately. Distinguish primary negative symptoms from secondary effects of depression, anxiety, active psychosis, medication adverse effects, substance use, social deprivation or medical illness.

Cognitive functioning [supported]
Evaluate attention, processing speed, working memory, executive function and social cognition, including their impact on daily function. Cognitive difficulties may be experienced as mental effort, distractibility or loss of fluency rather than as a named deficit.

Affective and trauma-related dimensions [supported]
Depression, anxiety, shame, fear, irritability, trauma symptoms and emotional distress can be prominent. Ask what the experiences mean to the person and whether distress arises from symptoms, stigma, social adversity, coercion or unmet needs.

Lived world, space and intersubjectivity [associated]
Explore whether familiar places feel strange, ordinary events seem unusually significant, time or continuity feels altered, or interactions with other people feel effortful, threatening or lacking reciprocity. These are phenomenological descriptions and are not diagnostic criteria in themselves.

Insight and reality testing are dimensional [assessment]
Assess awareness of change, explanations, conviction, openness to alternatives and impact on decisions. Avoid treating insight as simply present/absent; a person may function in everyday shared reality while holding unusual experiences or beliefs in another domain.

Longitudinal and differential assessment [assessment]
Establish onset, progression, functional change, mood episodes, substance/medication exposure, sleep deprivation, trauma, neurological symptoms and medical causes. Distinguish schizophrenia from affective psychosis, brief psychosis, delirium and substance/medical-induced psychosis.

Phenomenological tools and interview prompts [assessment]
Ask "What is it like when this happens?" "Does the thought feel like yours?" "Has the world or your body felt unfamiliar?" "How do you know whether an event is meant for you?" EASE is a specialist semi-structured instrument for anomalous self-experience; it is not a brief screening test or a stand-alone diagnostic instrument.

Clinical interpretation / limitations
Contemporary phenomenological work proposes selfhood, embodiment, temporality and intersubjectivity as useful dimensions for understanding some schizophrenia-spectrum experiences. The evidence is clinically and theoretically informative but does not establish a single phenomenological profile, biomarker or diagnostic substitute. Distinguish the person's report, the clinician's observation and explanatory interpretation.

Explanatory hypotheses and mechanisms

Dopamine / aberrant salience [hypothesis]
Dopaminergic dysregulation in striatal pathways is linked to positive symptoms and aberrant salience. This is an influential symptom-level model, not a complete cause.

Glutamate / NMDA models [hypothesis]
Glutamatergic and NMDA-receptor hypotheses may help explain cognitive, negative and positive symptom dimensions and interactions with dopamine.

Neurodevelopmental model [hypothesis]
Early brain-development processes may interact with polygenic vulnerability and later environmental exposures to alter neural networks.

Network / cognitive models [hypothesis]
Disrupted integration of perception, prediction, memory and belief updating may contribute to psychotic experiences. These remain active research frameworks.

Clinical interpretation / limitations
Mechanisms are research hypotheses. No blood test, genetic test or brain scan establishes schizophrenia in routine clinical practice.

Suicidal process: one secondary clinical node

Clinical correlates [associated]
Depressive symptoms, previous suicidal behaviour, substance use and recent illness-related distress are important correlates.

Do not over-attribute [assessment]
Hallucinations or delusions alone do not explain all suicidal behaviour. Assess content, command phenomena, affective state, insight, distress and context.

Transition factors [assessment]
Prior attempts, current intent, agitation, substance use, treatment discontinuity and access to means require direct assessment.

Service transition [assessment]
First episode, relapse, discharge and discontinuity of care are periods requiring planned follow-up and shared safety planning.

Clinical interpretation / limitations
The pathway should distinguish suicide risk in psychosis from self-harm without suicidal intent and from risk arising in co-occurring mood or substance-use disorders.

Evidence-based treatment — integrated and phase-specific

A. Non-pharmacological interventions

Coordinated specialty care / early intervention [Guideline-supported]
For first-episode psychosis, coordinate antipsychotic treatment with case management, family education, supported education/employment, recovery planning and substance-use treatment. Maintain continuity across acute care, discharge and community follow-up.

CBT for psychosis [Guideline-supported]
Offer CBTp as an adjunct to medication, focusing on distress, coping, appraisals, functioning and personally meaningful goals. Do not frame therapy as an argument intended to force the person to abandon a belief.

Family intervention [Guideline-supported]
Offer family intervention where the person is in close contact with family, using education, communication/problem-solving and relapse planning. Obtain the person's consent and attend to caregiver burden.

Psychosocial rehabilitation [Recovery-oriented care]
Provide supported employment/education, social skills and cognitive remediation where indicated, occupational rehabilitation, peer support and community-based care. Address physical-health inequities and substance use.

B. Pharmacological interventions

Aripiprazole — Adult antipsychotic option with relatively lower metabolic/prolactin burden than some alternatives; akathisia and activation can limit tolerability.

Starting dose	10–15 mg orally once daily is the labelled adult starting/target dose. Consider a more cautious start in selected patients based on prior exposure, interactions and tolerability.
Titration method	Do not routinely increase before 2 weeks (time to steady state). Evaluated range 10–30 mg/day; doses above 10–15 mg often do not add average efficacy and may increase adverse effects.
Usual maintenance	Usually 10–15 mg/day; use the lowest effective dose within the licensed range.
Monitoring	Monitor akathisia/restlessness, insomnia, activation, impulse-control problems, nausea, movement symptoms, weight/metabolic measures and CYP2D6/3A4 interactions.
When and how to reduce / stop	If stopping, do not stop abruptly without a clinical plan. Reduce gradually—at least 4 weeks per NICE antipsychotic guidance, and often more slowly after long treatment or prior relapse. Monitor early warning signs during and after withdrawal.

Risperidone — Common oral option; monitor dose-related extrapyramidal symptoms, prolactin effects, sedation and weight/metabolic changes.

Starting dose	Labelled adult schizophrenia starting dose: 2 mg/day orally, once daily or divided. Consider a lower start in older, sensitive or renal/hepatic-impaired patients.
Titration method	Increase by 1–2 mg/day at intervals of at least 24 hours according to tolerability; slower titration is often appropriate in routine practice.
Usual maintenance	Common target 4–6 mg/day; labelled recommended target range 4–8 mg/day. Doses above 6 mg/day, especially twice-daily regimens, often add EPS and other adverse effects without clear additional benefit.
Monitoring	Monitor akathisia/EPS, prolactin-related symptoms, weight, waist, BP, glucose/HbA1c, lipids, sedation, orthostasis and adherence. Consider ECG when cardiac risk or local label indicates.
When and how to reduce / stop	Planned withdrawal should be gradual over at least 4 weeks; slower may be needed after long-term treatment. Monitor relapse and withdrawal-related agitation, insomnia or dyskinesia; do not use intermittent dose reduction as routine maintenance.

Olanzapine — Effective antipsychotic option but with substantial weight-gain and metabolic liability; balance prior response against cardiometabolic risk.

Starting dose	5–10 mg orally once daily; use 5 mg in older, frail or more sensitive patients where appropriate.
Titration method	Target 10 mg/day within several days in typical adults. If further adjustment is needed, change by 5 mg no more frequently than weekly; usual labelled range 5–20 mg/day.
Usual maintenance	Often 10 mg/day; individualise within 5–20 mg/day based on sustained response and adverse effects.
Monitoring	Monitor weight (weekly for first 6 weeks, then at 12 weeks, 1 year and annually), waist, BP, fasting glucose/HbA1c, lipids, sedation, anticholinergic effects and movement symptoms.
When and how to reduce / stop	If withdrawal is chosen, reduce gradually over at least 4 weeks; consider a longer taper after prolonged use or prior relapse. Monitor for recurrence, insomnia, nausea, agitation and cholinergic rebound; plan an alternative where indicated.

Clozapine — specialist-only — For treatment-resistant schizophrenia after adequate antipsychotic trials, or persistent substantial suicide risk in schizophrenia/schizoaffective disorder according to APA guidance. Not a routine first-line antipsychotic.

Starting dose	12.5 mg orally once or twice on day 1. Initiation must be specialist-led with baseline ANC and physical-health assessment.
Titration method	If tolerated, increase total daily dose by 25–50 mg/day. Many patients require slower titration than the fastest label schedule. Labelled target is 300–450 mg/day by the end of 2 weeks, but adjust for orthostasis, inflammation, age, smoking status, interacting drugs and tolerability.
Usual maintenance	Common target 300–450 mg/day in divided doses; effective dose and plasma concentration vary substantially. Use the lowest effective dose with therapeutic drug monitoring when indicated.
Monitoring	ANC monitoring according to current local product label/regulatory scheme; monitor myocarditis (especially early treatment), severe constipation/ileus, seizures, orthostatic hypotension, tachycardia, weight/metabolic risk, infection and smoking/caffeine changes. Establish a bowel monitoring/prevention plan.
When and how to reduce / stop	Do not stop abruptly unless a serious adverse reaction requires urgent cessation. Planned discontinuation should be specialist-directed and gradual, with close monitoring for rebound psychosis and cholinergic rebound. If 48 hours or more are missed, do not restart the previous dose: re-initiate at 12.5 mg once or twice daily and re-titrate under specialist supervision.

Prescribing principles
Treat medication as an explicit therapeutic trial: document target symptoms, expected benefit, side effects the person is willing to tolerate, baseline measures and review date. NICE recommends lower-end starting doses, slow titration and an adequate 4–6-week optimum-dose trial. Before antipsychotics, record weight, waist, pulse/BP, HbA1c or fasting glucose, lipids, prolactin, movement status and ECG when indicated. After response, maintenance is usually important; after a first episode, NICE warns relapse risk is high if medication is stopped in the next 1–2 years. If withdrawn, monitor for relapse for at least 2 years. Do not stop solely because acute symptoms have improved. After a first episode, discuss that relapse risk is high if medication is stopped in the first 1–2 years. Consider withdrawal only after an individualised specialist review of sustained stability, adverse effects and preference; taper gradually and maintain relapse monitoring for at least 2 years after withdrawal.

Guideline recommendations and clinical considerations

Antipsychotic treatment [APA Practice Guideline 2020]
APA 2020 recommends antipsychotic medication for schizophrenia, monitoring effectiveness and adverse effects, and continuation after response. Select through shared decision-making, considering prior response, adverse effects, comorbidity and preference.

Treatment-resistant illness / substantial suicide risk [APA Practice Guideline 2020]
Clozapine is recommended for treatment-resistant schizophrenia and when risk for suicide attempts or suicide remains substantial despite other treatment. Requires structured blood monitoring and specialist management.

Long-acting injectable options [APA Practice Guideline 2020]
Offer an LAI when the person prefers it or has a history of poor/uncertain adherence, after discussing benefits, adverse effects and practicalities.

Psychological and family treatment [APA Practice Guideline 2020]
APA recommends CBT for psychosis and coordinated specialty care for first-episode psychosis; family interventions and psychosocial rehabilitation support recovery and relapse prevention.

Physical health / adverse-effect monitoring [APA guideline / standard monitoring]
Track weight, waist, blood pressure, glucose/HbA1c, lipids, movement disorders, prolactin-related effects, sedation, cardiovascular risk and agent-specific safety (including clozapine blood monitoring).

Early intervention and continuity [WHO mhGAP / APA]
Coordinate medication, psychological intervention, family support, education/employment goals, substance-use care and follow-up after acute episodes. Avoid routine antipsychotic polypharmacy unless a justified specialist plan exists.

Clinical interpretation / limitations
The APA guideline applies specifically to schizophrenia. For other psychotic syndromes, establish the underlying diagnosis and cause before adopting a schizophrenia treatment plan.

SUPPLEMENTARY CLINICAL DOMAINS

Secondary constructs and psychosocial context

The psychiatric disorder remains the primary organising structure. These nodes represent additional experiences, assessment domains or theoretical constructs that may be relevant in selected clinical presentations. They are not universal symptoms, causal steps or individual risk scores.

Suicidal process

Framework: One secondary clinical node
A dynamic and heterogeneous clinical process, not the organising structure of this model and not an inevitable sequence. Assess suicidal thoughts, intent, planning, behaviour and outcomes as distinct phenomena; distinguish ideation, suicide attempt and suicide death. The presence of a psychiatric diagnosis or a proposed construct does not establish an individual trajectory.

Hopelessness

Framework: 3ST · IPTS-related
Negative expectations that suffering or circumstances will not improve. A well-studied correlate of suicidal ideation, but neither sufficient nor deterministic.

Psychological pain

Framework: 3ST
Intense psychological suffering. In the Three-Step Theory, pain combined with hopelessness contributes to suicidal ideation. The interaction is a theoretical proposition, not a diagnosis-specific causal rule.

Defeat / humiliation

Framework: IMV
A perceived experience of loss, defeat or humiliation that may precede entrapment in the IMV motivational phase.

Entrapment

Framework: IMV
The subjective perception that an intolerable situation cannot be escaped. Associated with suicidal ideation across several clinical contexts; its temporal and causal role varies.

Perceived burdensomeness

Framework: IPTS
The subjective belief that one is a burden to others. It is not equivalent to objectively needing care. Meta-analytic associations with ideation are stronger than evidence for the proposed interaction with belongingness.

Thwarted belongingness

Framework: IPTS · 3ST
A subjective sense of unmet belonging and interpersonal disconnection. It is not simply living alone or having few social contacts.

Capability / volitional moderators

Framework: IPTS · 3ST · IMV
Factors proposed to distinguish ideation from action. Prior suicidal behaviour, exposure to suicidal behaviour, acute intoxication, planning, intent and means access require separate assessment; no single factor is a universal gate.

Suicidal ideation

Framework: Outcome / clinical assessment
Thoughts about suicide, which vary in presence, frequency, persistence, intensity and intent. Ideation does not inevitably progress to an attempt.

Suicide attempt

Framework: Ideation-to-action outcome
A non-fatal self-injurious act accompanied by at least some intent to die. Distinguish from non-suicidal self-injury.

Suicide death

Framework: Fatal outcome
A separate fatal outcome, not merely a more severe ideation state. Method lethality, rescue and access to timely care influence fatal outcome.

Additional clinical and psychosocial domains

Substance-use disorders

Chronic substance use and acute intoxication are distinct clinical states. Chronic SUD is associated with ideation and attempts; acute alcohol exposure has separate evidence as a proximal attempt risk. Assess withdrawal, intoxication, co-occurring disorders and prior behaviour.

Eating disorders

Clinical cohorts show substantial prevalence of ideation and attempts. Co-occurring depression, anxiety, NSSI, medical burden and previous attempts deserve direct assessment. Prevalence estimates are heterogeneous and do not establish a single mediated pathway.

Borderline personality disorder

High lifetime prevalence of suicidal ideation and attempts in clinical samples. Do not infer imminent risk from diagnosis alone, and do not dismiss acute escalation as “chronic.” Assess current intent, recent behaviour, function, comorbidity and changes in state.

Insomnia / sleep disturbance

Longitudinal studies associate sleep disturbance with later suicidality; within-person findings suggest small short-term associations with ideation. Sleep is a dynamic clinical domain, not a stand-alone risk score.

Chronic physical pain

Physical pain and chronic pain are associated with suicidal ideation and attempts. Depression, disability, sleep disturbance and social effects may contribute, but no single mediation pathway is established.

Childhood adversity / interpersonal violence

An upstream life-course exposure, not a diagnosis. Effects vary with timing, severity, chronicity, protection and social context. Potential sequelae include trauma symptoms, depression, anxiety and interpersonal difficulties.

Bullying / victimisation / violence

An interpersonal exposure, not a psychiatric disorder. May involve humiliation, fear, exclusion and trauma-related symptoms. Do not infer one universal bullying → entrapment → suicide chain.

Loneliness / social disconnection

Distinguish objective isolation from subjective thwarted belongingness. Connection can be protective, but it is not a guarantee of safety and does not replace clinical assessment.

EVIDENCE LIBRARY

References and source notes

Reference titles and source notes are reproduced from the interactive model. Selectable URLs are included where they were present in the source file.

01. GBD 2019 Mental Disorders Collaborators (2022)
Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990–2019: systematic analysis for GBD 2019. The Lancet Psychiatry.
Epidemiology; depressive and anxiety disorder burden.

02. GBD Anxiety Collaborators (2021)
Global, regional and national burden of anxiety disorders from 1990 to 2019: results from GBD 2019. Epidemiology and Psychiatric Sciences.
Anxiety epidemiology.

03. WHO (2026)
Mental disorders fact sheet (11 September 2026): WHO global estimates for 2023.
Current global epidemiology: depressive, anxiety and bipolar disorders; estimates use a different model round from GBD 2019.

04. WHO (2026)
Schizophrenia fact sheet (11 September 2026).
Current global estimate: approximately 27 million people in 2023.

05. Lee et al. (2021)
The Molecular Basis of Depression: Implications of Sex-Related Differences in Epigenetic Regulation. Frontiers in Molecular Neuroscience.
Genetic and environmental contributions; molecular and epigenetic hypotheses.

06. Middeldorp et al. (2005)
The co-morbidity of anxiety and depression in the perspective of genetic epidemiology: a review of twin and family studies. Psychological Medicine.
Foundational twin/family evidence; interpret heritability as population-level liability, not individual causation.

07. Shen et al. (2024)
Sleep and circadian disruption in bipolar disorders: From psychopathology to digital phenotyping in clinical practice. Psychiatry and Clinical Neurosciences.
Bipolar phenomenology and circadian / sleep hypotheses.

08. Nature Reviews Disease Primers (2025)
Schizophrenia. Nature Reviews Disease Primers.
Contemporary review of schizophrenia epidemiology, multifactorial aetiology, phenomenology and treatment.

09. Cipriani et al. (2018)
Comparative efficacy and acceptability of 21 antidepressant drugs for acute treatment of adults with MDD: systematic review and network meta-analysis. The Lancet.
Antidepressant efficacy.

10. CANMAT (2016)
Clinical Guidelines for the Management of Adults with Major Depressive Disorder. Canadian Journal of Psychiatry.
MDD specialist treatment guideline.

11. WHO (2023)
mhGAP guideline for mental, neurological and substance use disorders, third edition.
LMIC / non-specialist guidance across depression, anxiety, PTSD, psychosis and bipolar disorders.

12. WHO (2023)
Brief, structured psychological treatment for moderate-to-severe depression: 2023 recommendation.
Strong recommendation; moderate certainty.

13. WHO (2023)
Antidepressant medication compared with psychological treatment for moderate-to-severe depression: 2023 recommendation.
Conditional recommendation; low certainty.

14. WHO (2024)
Management of GAD and panic disorder in general health-care settings: new WHO recommendations. World Psychiatry.
WHO mhGAP recommendation synthesis.

15. WHO (2023)
Brief structured psychological interventions for GAD and/or panic disorder.
Strong recommendation; moderate certainty.

16. WHO (2023)
Benzodiazepines in treatment of adults with GAD and/or panic disorder.
Strong recommendation against routine use; emergency use maximum 3–7 days only.

17. RANZCP (2018)
Clinical practice guidelines for treatment of panic disorder, social anxiety disorder and GAD. Australian & New Zealand Journal of Psychiatry.
Anxiety diagnosis-specific treatment.

18. WHO (2026)
Post-traumatic stress disorder fact sheet, 11 September 2026.
Global PTSD lifetime epidemiology.

19. VA/DoD (2023; synopsis 2024)
Management of PTSD and acute stress disorder: 2023 VA/DoD Clinical Practice Guideline synopsis. Annals of Internal Medicine.
CPT, EMDR, PE and medication recommendations.

20. Kirshenbaum et al. (2024)
Why do adolescents attempt suicide? Insights from leading ideation-to-action theories: systematic review. Translational Psychiatry.
PTSD/anxiety and disorder-related suicide pathway interpretation.

21. Ma et al. (2016)
Systematic review of predictions of the Interpersonal–Psychological Theory of Suicidal Behavior. Clinical Psychology Review.
IPTS constructs; limits of interaction evidence.

22. May & Klonsky (2016)
What distinguishes suicide attempters from suicide ideators? A meta-analysis. Clinical Psychology: Science and Practice.
Ideation-to-action distinction.

23. O'Connor & Kirtley (2018)
The Integrated Motivational–Volitional Model of suicidal behaviour. Philosophical Transactions of the Royal Society B.
IMV framework.

24. Klonsky & May (2015)
The Three-Step Theory (3ST): A new theory of suicide rooted in the ideation-to-action framework. International Journal of Cognitive Therapy.
3ST framework.

25. Keramatian et al. (2023)
CANMAT and ISBD Guidelines for the Treatment of Bipolar Disorder: Summary and a 2023 Update of Evidence. Focus.
Specialist bipolar treatment update.

26. Yatham et al. (2018)
CANMAT and ISBD 2018 guidelines for management of bipolar disorder. Bipolar Disorders.
Bipolar treatment guideline.

27. WHO (2023)
WHO mhGAP: antipsychotics and mood stabilisers in bipolar mania.
Bipolar mania in non-specialist settings.

28. WHO (2023)
WHO mhGAP: maintenance treatment of bipolar disorder.
Maintenance recommendations and reproductive-safety warning.

29. WHO (2023)
WHO mhGAP: antidepressant medicines in depressive episode in bipolar disorder.
Antidepressant combination and switch monitoring.

30. American Psychiatric Association (2020)
Practice Guideline for the Treatment of Patients With Schizophrenia. American Journal of Psychiatry.
Antipsychotics, clozapine, LAI, CBTp and coordinated specialty care.

31. Dutheil et al. (2022)
PTSD and risk of suicidal behavior: systematic review and meta-analysis. Suicide and Life-Threatening Behavior.
PTSD and suicidal outcomes.

32. Brown et al. (2026)
Explaining the link between PTSD and suicide: a meta-analysis to introduce the CEASE framework.
Recent PTSD-associated cognitive/emotional correlates; associations, not proven mediation.

33. Fusar-Poli et al. (2023)
The lived experience of depression: a bottom-up review co-written by experts by experience and academics. World Psychiatry.
Co-produced synthesis of first-person accounts: altered emotion, body, self, agency, social world and time.

34. Doerr-Zegers et al. (2017)
Disturbances of Embodiment as Core Phenomena of Depression in Clinical Practice. Psychopathology.
Phenomenological account of embodied self, intentionality and lived time; conceptual clinical contribution.

35. Martino et al. (2019)
Melancholia: An Attempt at Definition Based on a Review of Empirical Data. Journal of Nervous and Mental Disease.
Review of latent-factor studies; psychomotor retardation and mood non-reactivity were the more consistent discriminating features.

36. Stanghellini et al. (2017)
Abnormal Time Experiences in Major Depression: An Empirical Qualitative Study. Psychopathology.
Qualitative study of altered time experience in depression; experiential description, not diagnostic criteria.

37. Silva et al. (2026)
A phenomenological approach to the phenomena of anxiety: a scoping review. Frontiers in Psychology.
36-paper scoping review; conceptual dimensions include temporality, spatiality and intersubjectivity. Cultural/contextual limitations noted.

38. McIntyre et al. (2022)
The clinical characterization of the adult patient with bipolar disorder aimed at personalization of management. World Psychiatry.
Detailed clinical phenomenology, polarity, energy/activity, mixed features, course and assessment.

39. Lanius (2015)
Trauma-related dissociation and altered states of consciousness: a call for clinical, treatment, and neuroscience research. European Journal of Psychotraumatology.
Conceptual 4-D framework for trauma-related experience: time, thought, body and emotion.

40. Ehlers et al. (2004)
Intrusive re-experiencing in post-traumatic stress disorder: phenomenology, theory, and therapy. Memory.
Trauma-memory phenomenology; contrasts intrusive re-experiencing with ordinary autobiographical recall. Scite flags one later contrasting citation, so use as one source among the broader PTSD literature.

41. Brewin et al. (2025)
Post-traumatic stress disorder: evolving conceptualization and evidence, and future research directions. World Psychiatry.
Contemporary review of PTSD symptom structure and the sensory, emotional, bodily and temporal features of flashbacks.

42. Parnas & Sandsten (2024)
The phenomenological nature of schizophrenia and disorder of selfhood. Schizophrenia Research.
Review of selfhood, basic complaints, hallucinations, delusions and phenomenological structure in schizophrenia.

43. Mosca et al. (2025)
Anomalous self-experience in schizophrenia spectrum disorders: Phenomenological and psychopathological correlates. Schizophrenia Research: Cognition.
Empirical correlates of anomalous self-experience; findings support further study, not universal diagnostic status.

45. NICE (2022)
Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management (NG215).
Proportionate stepwise reductions, smaller decrements at lower doses and individualised tapering.

46. DailyMed / US NIH (2026)
Sertraline hydrochloride — current adult dosage and administration information.
Adult starting doses and weekly 25–50 mg increments up to 200 mg/day.

47. US FDA (2025)
Escitalopram prescribing information.
Adult MDD/GAD start 10 mg/day; increase to 20 mg/day no sooner than 1 week.

48. NICE (2020; current online)
Generalised anxiety disorder and panic disorder in adults (CG113).
Start antidepressants at low dose, increase slowly and continue at least 6 months after optimal dose if responding.

49. WHO (2023)
Benzodiazepines for adults with GAD and/or panic disorder: mhGAP recommendation.
Strong recommendation against routine use; emergency use maximum 3–7 days.

50. VA/DoD (2023)
Clinical Practice Guideline for Management of PTSD and Acute Stress Disorder — pharmacotherapy dosing table.
Sertraline, paroxetine, venlafaxine and prazosin dosing ranges; prazosin specifically for nightmares.

51. VA National Center for PTSD (2026 online)
Clinician’s Guide to Medications for PTSD.
Medication evidence and dosage ranges; notes on comorbidity and adverse effects.

52. NICE (2018; current online)
Post-traumatic stress disorder (NG116) — adult psychological and pharmacological treatment.
Trauma-focused CBT and EMDR recommendations; medication if preferred; no benzodiazepines for PTSD prevention.

53. CANMAT/ISBD (2023)
Bipolar disorder treatment guideline summary and 2023 evidence update.
Lithium acute and maintenance serum targets; divalproex monitoring and phase-specific treatment.

54. NICE (2014; current online)
Bipolar disorder: assessment and management (CG185).
Lithium monitoring and tapering; valproate, lamotrigine and antipsychotic discontinuation recommendations.

55. DailyMed / US NIH (2025)
Lithium carbonate prescribing information.
Lithium dose examples, trough serum monitoring and interaction/toxicity warnings.

56. DailyMed / US NIH (2026)
Divalproex sodium delayed-release prescribing information.
Adult mania starting dose 750 mg/day divided; acute trough range and safety information.

57. DailyMed / US NIH (2026)
Lamotrigine prescribing information — adult bipolar titration schedules.
Interaction-specific slow titration schedules; rash and interruption precautions.

58. DailyMed / US NIH (2026)
Quetiapine fumarate prescribing information.
Phase-specific titration for bipolar depression, mania and maintenance.

59. NICE (2014; amended 2021)
Psychosis and schizophrenia in adults: prevention and management (CG178).
Individual antipsychotic trials, baseline metabolic/physical monitoring and gradual withdrawal.

60. DailyMed / US NIH (2026)
Aripiprazole prescribing information.
Adult schizophrenia starting/target dose, dose range and titration interval.

61. DailyMed / US NIH (2026)
Risperidone prescribing information.
Adult schizophrenia starting dose, increments and recommended target range.

62. DailyMed / US NIH (2026)
Olanzapine prescribing information.
Adult schizophrenia starting and target dose, dose increments and metabolic monitoring.

63. DailyMed / US NIH (2025)
Clozapine prescribing information.
Specialist initiation, 12.5 mg starting dose, gradual titration and ANC monitoring.

IMPORTANT EDUCATIONAL AND CLINICAL LIMITATIONS

This material is a teaching and clinical reference aid, not a diagnostic instrument, suicide-risk prediction tool or substitute for local clinical protocols. Prevalence figures are modelled population estimates and not individual probabilities. Phenomenological concepts enrich clinical formulation but do not replace recognised diagnostic criteria. Treatment recommendations vary by patient group, jurisdiction, treatment availability and guideline version. Medication selection, initiation, dose changes and discontinuation require a qualified prescriber, appropriate monitoring and patient-specific review.