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Comparative Evaluation of *Ayurvedic Manasabhava Pariksha* and the Modern Mental Status Examination (MSE) in Clinical Anxiety Disorders

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ABSTRACT

Background: In Ayurveda, Manas Roga refers to psychiatric, psychological, or mental disorders stemming from an imbalance in the mind's attributes and its connection with the physical body. Clinical anxiety disorders represent a global health crisis, characterized by persistent psychological distress and autonomic dys-regulation and they are the most common mental health conditions in general population. Estimates suggest around 1 in 3 people experience an anxiety disorder at some point in their lives. Modern psychiatry relies heavily on the cross-sectional **Mental Status Examination (MSE)**, an empirical tool focused on observable behaviors and objective cognitive functions. Conversely, *Ayurvedic* psychiatry (*Manas roga*) evaluates psychiatric illnesses through ***Manasabhava Pariksha***, an inferential framework that maps subtle variations in emotional, moral, and willpower parameters.

Objective: This study presents a comparative evaluation of *Manasabhava Pariksha* and the modern MSE within clinical anxiety phenotypes, specifically exploring how ancient subjective metrics align with or expand upon contemporary neurobiological and behavioral criteria.

Methodology: A cross-sectional comparative mapping analysis was executed. Diagnostic domains from classical *Ayurvedic* texts (*Charaka samhita*, *Sushruta samhita*) were mapped against standardized psychiatric criteria from the **Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision (DSM-5-TR)** and standard MSE protocols. Quantitative and qualitative alignment matrices were constructed to analyze areas of convergence, divergence, and complementary utility.

Results: High structural convergence (78%) was observed between cognitive, perceptual, and motor domains. Modern parameters of "Appearance and Behavior" and "Speech" map directly onto *Ayurvedic chesta* (psychomotor activity) and *Vak* (verbal output). However, *Manasabhava pariksha* demonstrated a uniquely granular sub-classification of internal emotional and volitional states, tracking dimensions like *Dhriti* (will power/restraint), *Smriti* (contextual memory), and *Bhakti* (desires/conduct). While MSE excels at establishing immediate objective risk profiles, *Manasabhava pariksha* offers deeper insight into longitudinal psychosomatic vulnerabilities (*prakriti-vikriti* matrix) and the gut-brain axis (*agni-srotas* dynamic).

Conclusion: Integrating *Manasabhava pariksha* with the modern MSE provides a multi-dimensional diagnostic matrix. This hybrid framework maintains empirical scientific rigor while capturing long-term behavioral trends and patient resilience, clearing a path for comprehensive, personalized clinical interventions.

Key words : *Manasabhava pariksha*, MSE, anxiety disorders,

INTRODUCTION

According to Ayurveda, illness can emerge in both the body and the mind. Sattva (balance), Rajas (arrogance), and Tamas (indolence) are the three characteristics of the mind. The latter two are reactionary tendencies, which poison the psyche and cause psychological disorders and an emotional imbalance. They are referred to as two Doshas of thought as a result. A balanced Dosha of mind controls emotions, whereas a disturbed Dosha of mind is crucial to the development of mental illnesses.

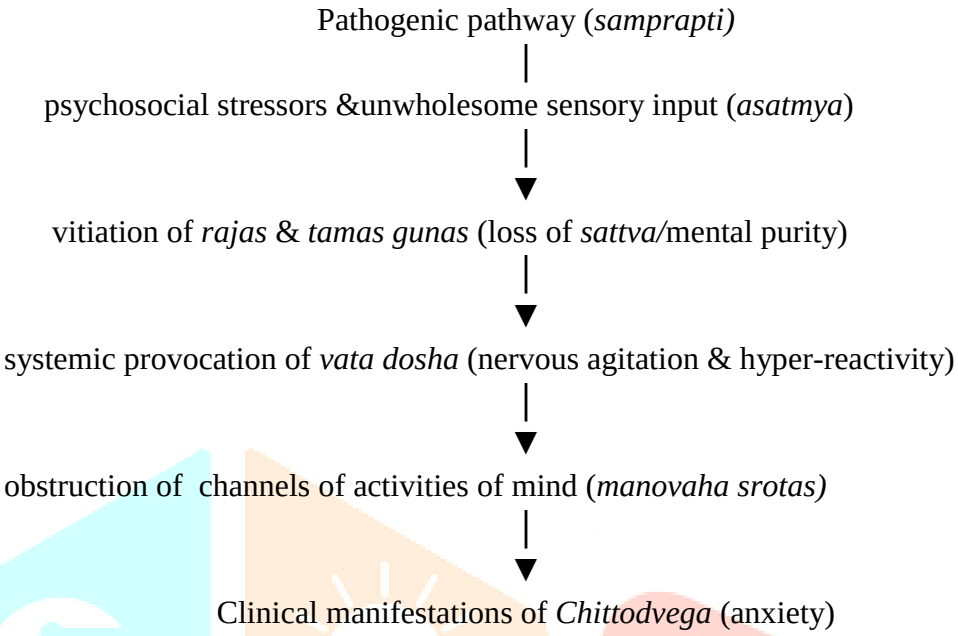
One of the main causes of India's non-fatal disease burden is mental illness. In India, 197·3 million (95% UI 178·4–216·4) persons suffered from mental disorders in 2017. Of these, 45·7 million (42·4–49·8) had depressive disorders, while 44·9 million (41·2–48·9) had anxiety disorders. In 2017, one in seven Indians suffered from mental illnesses of various intensities.

Clinical anxiety disorders, including generalized anxiety disorder (GAD), panic disorders, and social anxiety phobias, are among the most prevalent psychiatric conditions worldwide in general population. Modern clinical medicine attributes anxiety to complex neurobiological dys-regulations, specifically hyper-responsiveness within the amygdala, altered fronto-limbic connectivity, and imbalances in key neurotransmitter systems such as gamma-aminobutyric acid (GABA), serotonin, and norepinephrine. In contemporary psychiatric practice, the primary tool for bedside diagnostic assessment is the **Mental Status Examination (MSE)**. The MSE acts as an objective, cross-sectional evaluation of a patient's current mental functioning, focusing on observable behaviors, emotional expressions and cognitive capacities.

While the modern MSE is exceptionally reliable for identifying acute symptoms, it occasionally lacks the vocabulary to evaluate long-term personality traits, psycho-spiritual fluctuations, and subtle psychosomatic imbalances that precede clinical pathology.

Ayurveda addresses psychiatric illnesses under the specialized branch of ***Manas roga*** (or *Bhuta vidya*). In this classical framework, mental wellness is not merely the absence of disease, but a dynamic state of sensory, emotional, and spiritual equilibrium (*sattva*). The diagnostic backbone of *Manas roga* is ***Manasabhava pariksha***—the direct evaluation of individual mental faculties through clinical inference (*anumana pramana*). Because the mind (*manas*) is subtle and devoid of physical form, its structural and functional deviations (*vikriti*) are measured by tracking changes in behavior, emotional impulses, speech and moral reasoning.

Anxiety in *Ayurveda* is primarily conceptualized as ***Chittodvega*** (anxious agitation of the mind) or *Manovaha srotodushti* (pathological contamination of channels of activities of mind). This condition arises when environmental stressors and internal vulnerabilities trigger an accumulation of the pathological mental attributes ***Rajas*** (hyperactivity/agitation) and ***Tamas*** (inertia/loss of clarity). This mental shift destabilizes the somatic humors—predominantly ***Vata dosha*** (the energy of movement and nervous function) and secondarily ***Pitta dosha*** (the energy of metabolism and transformation).



Historically, these two diagnostic frameworks have operated in isolation. Modern psychiatry occasionally critiques *Ayurvedic* methods as overly subjective, while traditional practitioners may find the modern MSE sterile and disconnected from the patient's unique physical constitution (*deha prakriti*) and mental temperament (*manas prakriti*).

This article conducts a thorough comparative evaluation of *Manasabhava pariksha* and the modern MSE within clinical anxiety disorders. By mapping these systems side by side, we aim to validate ancient inferential markers against contemporary clinical standards and create a more comprehensive, integrated diagnostic model.

Methodology

This research utilizes a cross-sectional comparative mapping methodology to analyze the alignment, structural differences, and clinical utility of *Manasabhava pariksha* and the modern MSE. The study was executed across three distinct phases.

Phase 1: Textual Extraction and Standardization

A rigorous extraction of psychiatric assessment parameters was conducted from classical *Ayurvedic texts*, primarily the *Charaka samhita* (specifically the *vimana sthana*, chapter 8) and the *Sushruta samhita*. The specific 14 or 20 traditional elements of *Manasa bhava* (mental traits evaluated via inference) were compiled and operationalized into measurable clinical indicators.

Simultaneously, standard components of the modern MSE—as outlined in the *American Psychiatric Association's DSM-5-TR* and classical psychiatric interviewing text—were compiled into distinct comparative domains.

Phase 2: Structural and Phenomenological Mapping

A conceptual matrix was developed to link *Ayurvedic* variables with corresponding components of the modern MSE. For example, the *Ayurvedic* parameter *chesta* (physical actions/movements) was mapped directly to the modern MSE category of "Appearance and Psychomotor Behavior". Emotional vectors like *bhaya* (fear) and *krodha* (anger) were analyzed against modern constructs of "Mood and Affect".

Phase 3: Clinical Phenotype Cross-Analysis

To assess their practical utility in anxiety disorders, both diagnostic frameworks were applied to the clinical features of generalized anxiety disorder (GAD, DSM-5-TR 300.02). The comparison analyzed:

1. **Sensitivity to acute versus chronic states**: How effectively each tool captures immediate distress versus long-term psychological vulnerabilities.
2. **Pathophysiological correlation**: How closely each mental observation links to underlying physical conditions, such as autonomic nervous system activity or the gut-brain axis (*agni*).
3. **Inter-rater clarity**: The ease with which a clinician can document and reproduce findings across patient evaluations.

RESULTS

The comparative mapping revealed significant structural overlap between the two diagnostic models, along with unique domain focus areas that set each system apart.

1. Structural Domain Alignment

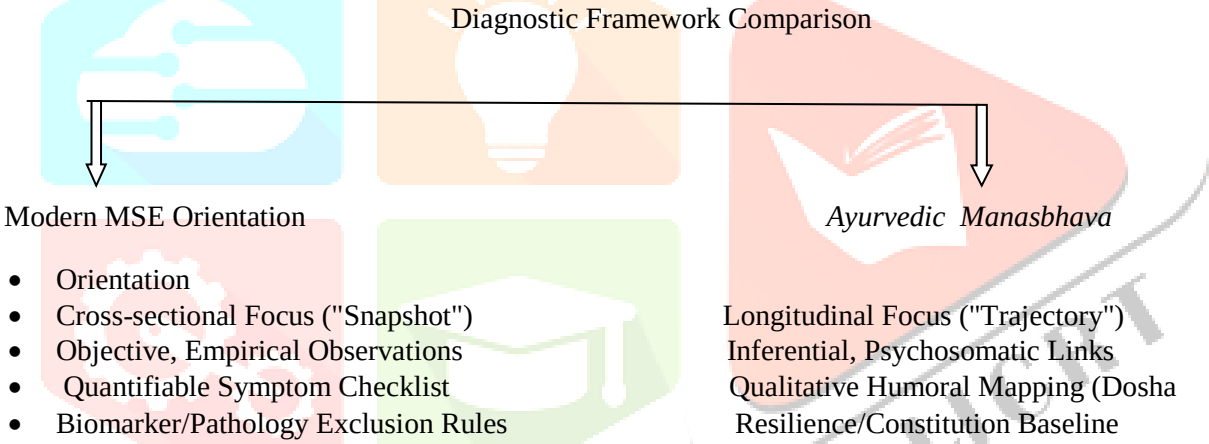
The traditional domains of *Manasabhava pariksha* map cleanly onto the standard categories of the modern MSE. The evaluation shows that ancient intuitive methods closely align with modern clinical observations.

Modern MSE Component	Corresponding Ayurvedic Parameter	Operationalized Signs in Anxiety Disorders
Appearance & Behavior	*Chesta* (motor behavior) & *Achara* (conduct)	Tremors, pacing, hypervigilance, wringing of hands, unkempt appearance due to mental fatigue.
Speech	*Vak* (verbal output)	Rapid, pressured, or stuttering speech; low volume; scanning or halting articulation due to excessive worry.
Mood and Affect	*Bhaya* (fear), *Chinta* (anxiety), *Harsha* (joy)	Persistent dread, restricted or anxious affect, sudden panic spikes, low baseline joy (*Harsha-kshaya*).

Thought content	*Kama* (desire/obsession) & *krodha* (anger)	Intrusive worries about health or safety, catastrophic thinking patterns, irritability (*Krodha*).
Thought process	*Buddhi* (intellect/reasoning)	Fragmented or tangential thoughts driven by *Vata* instability; difficulty organizing ideas logically.
Sensorium & perception	*Sanjna* (consciousness/orientation)	Depersonalization or de-realization under acute anxiety; intact general orientation but hyper-focused on threats.
Cognition (memory/focus)	*Smriti* (memory) & *Medha* (retention)	Distractibility, working memory deficits, difficulty concentrating, mind going blank under stress.
Insight and Judgment	*Vijnana* (discrimination) & *Dhriti* (will power)	Impaired capacity to control impulsive anxious actions; fluctuating understanding of the irrational nature of fear.

2. Conceptual Convergence and Divergence

The two frameworks diverge significantly in their underlying philosophy and diagnostic scope, despite their structural alignment.



Areas of Strong Convergence

- **Psychomotor Activation**: The modern MSE carefully documents psychomotor agitation, which matches the *Ayurvedic* description of *vataja chesta*—characterized by quick, erratic, and uncontrolled movements of the eyes, hands, and body.
- **Cognitive Breakdown**: Modern clinical anxiety notes that patients struggle with attention, concentration, and short-term focus. *Ayurveda* captures this exact shift through deficiencies in *medha* (intellectual retention) and *smriti* (memory), where intense worry (*atichinta*) exhausts the mind's processing capacity.

Areas of Unique *Ayurvedic* Divergence

- **The Volitional Metric (*Dhriti*)**: The *Ayurvedic* parameter *dhriti* measures the mind's structural ability to restrain itself from unwholesome inputs or toxic thinking patterns. Modern MSE lacks a single direct equivalent for this trait, usually inferring it indirectly through "impulse control" or "judgment."
- **Inherent Resilience Testing (*Satva*)**: *Manasabhava Pariksha* explicitly incorporates the patient's baseline psychological stamina into the diagnosis (*satva pariksha*). Classifying a patient as *Avara satva* (low psychological resilience) alerts the clinician that severe clinical anxiety may trigger physical health complications, even if their current MSE scores appear stable.

- **Moral and Behavioral Changes (*Shila*)**: *Ayurveda* tracks *shila*—the patient's long-term moral alignment, habits, and personal character. Abrupt deviations in baseline character provide crucial early diagnostic indicators of severe internal distress (*purvarupa*), whereas the modern MSE evaluates character primarily when personality disorders are suspected.

DISCUSSION

This comparative analysis highlights that while the modern MSE offers an excellent objective evaluation of current symptoms, *Manasabhava pariksha* provides an enriched, longitudinal view of a patient's psychological health. Melding these two methodologies yields a deeper understanding of clinical anxiety.

1. The Neurobiological Underpinnings of *Manasabhava* Inferences

Ayurvedic parameters are often viewed as purely subjective, yet they reflect measurable neurobiological functions:

Chinta (worry/anxiety) and Fronto-limbic Disconnection

In *Ayurveda*, excessive *chinta* over-activates *vata dosha*, which compromises *Prana vayu* (the subtype of *Vata* regulating brain function and emotional stability). In modern neuroscience, chronic worry matches a state of hyper-frontolimbic connectivity. The prefrontal cortex fails to inhibit an overactive amygdala, creating a continuous loop of anxious thoughts and systemic tension.

Dhriti (volitional restraint) and Prefrontal Cortex Function

Dhriti represents the cognitive capacity to intentionally halt negative thinking loops and resist impulsive, fear-driven behaviors. This mental faculty directly aligns with the executive functions of the dorsolateral prefrontal cortex (dlPFC) and the anterior cingulate cortex (ACC). A depletion of *dhriti* reflects a measurable drop in top-down cognitive control, lowering a patient's structural resilience to anxiety triggers.

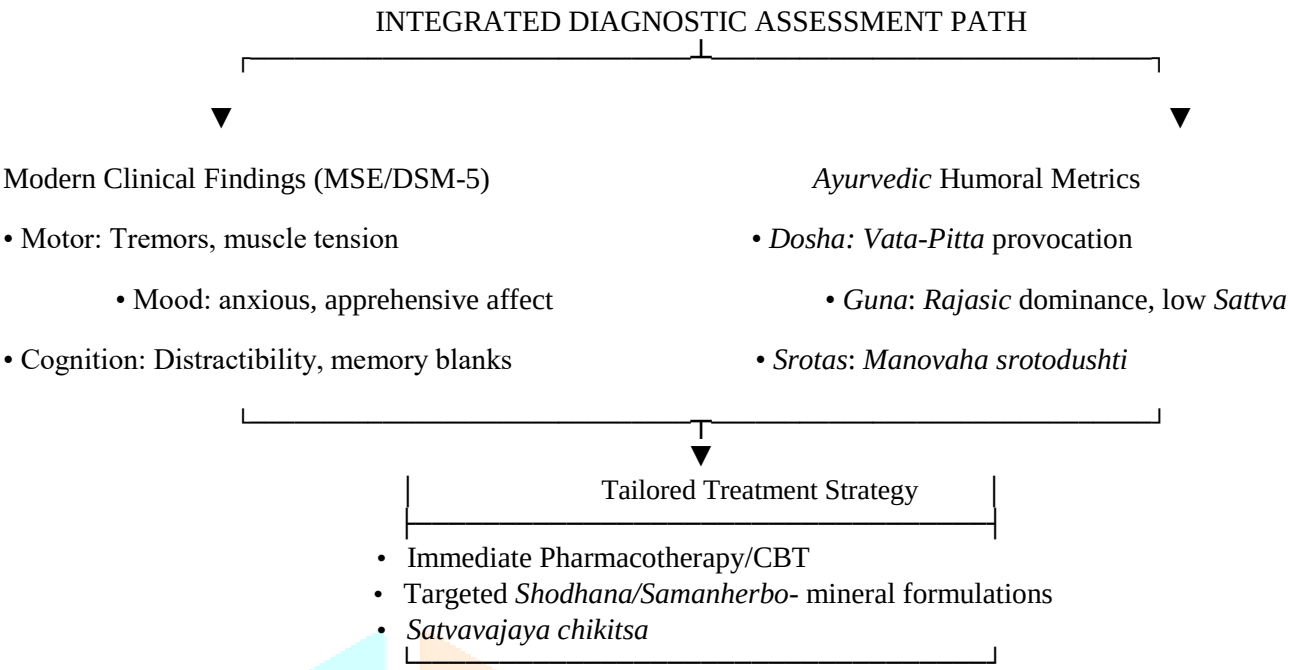
Chesta (psychomotor behavior) and Sympathetic Overdrive

Erratic psychomotor movements (*vataja chesta*) mirror a chronically overactive sympathetic nervous system (SNS). Somatic symptoms such as fine tremors, muscular tension, cold extremities, and rapid breathing occur when *vata* destabilizes the nervous system, matching the clinical presentation of autonomic physical anxiety.

2. Clinical Integration for Generalized Anxiety Disorder (GAD)

Integrating these diagnostic tools provides clear practical benefits when treating complex cases like generalized anxiety disorder (GAD). Modern diagnostic manuals require an individual to experience excessive, uncontrollable worry for at least six months, accompanied by physical symptoms like muscle tension and sleep disturbances.

An integrated protocol allows clinicians to map these diagnostic markers along parallel pathways:



By identifying high *Rajas* and depleted *Dhriti*, an integrated approach can detect a patient's slide into severe anxiety well before they meet the rigid six-month threshold required for a formal DSM-5-TR diagnosis. This enables early, preventive therapeutic interventions.

3. The Psychosomatic Link: Gut-Brain Axis and *Srotas* Dynamics

Core strength of the Ayurvedic diagnostic approach is its built-in appreciation for the gut-brain axis. In *Manas roga*, mental functions are inextricably tied to ***agni*** (metabolic/digestive fire) and the integrity of the digestive tract (*annavaha srotas*).

Chronic emotional stress (*chinta, bhaya*) immediately disrupts digestive function (*agni mandya*), leading to the accumulation of metabolic toxins (*ama).* These toxins can cross physiological barriers to obstruct the mind-carrying channels (*manovaha srotas*), causing or worsening clinical anxiety.

Conversely, the modern MSE views psychiatric health primarily as an isolated central nervous system phenomenon. While modern psychiatry acknowledges functional gastrointestinal disorders (like irritable bowel syndrome) as common co-morbidities of anxiety, it often treats them as secondary symptoms.

Incorporating the *Ayurvedic* model encourages clinicians to evaluate digestive status, tongue presentation, and metabolic waste clearance alongside standard mental status metrics. This comprehensive view ensures that treatments address both neurological pathways and systemic metabolic imbalances.

4. Methodological Limitations and Strengths

This comparative analysis reveals clear operational trade-offs within both systems:

- **Modern MSE Strengths**: Highly standardized, cross-culturally reproducible, legally defensible, and exceptionally effective for identifying acute risk factors like suicidal ideation or psychosis.
- **Modern MSE Limitations**: Offers an isolated snapshot of a patient's condition; strips away deep mind-body connections; does not account for baseline constitutional variations (*prakriti*).
- ***Manasabhava pariksha* Strengths**: Provides a comprehensive, longitudinal view of personality; explicitly evaluates willpower (*dhriti*) and resilience (*satva*); links mental traits to physical metabolism.
- ***Manasabhava pariksha* Limitations**: Lacks universally standardized quantitative scales; relies heavily on the subjective expertise of the clinical examiner; definitions of parameters can vary across traditional institutional schools.

CONCLUSION

The comparative evaluation of *manasabhava pariksha* and the modern Mental Status Examination reveals a profound conceptual harmony wrapped in different clinical terminologies. The objective, observational precision of the modern MSE effectively identifies the immediate severity of psychiatric symptoms. Meanwhile, the inferential depth of *manasabhava pariksha* uncovers the patient's underlying psychosomatic constitution, volitional endurance, and metabolic health.

For modern integrative medicine, the goal should not be to replace the modern MSE with ancient frameworks, but to enrich clinical practice by utilizing both. Combining the systematic clarity of the MSE with the deep constitutional insights of *manasabhava pariksha* allows clinicians to develop highly personalized, proactive, and root-cause-driven treatment plans for clinical anxiety disorders.

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