PSYCHIATRIC MORBIDITY AMONG ADULT CANCER PATIENTS ADMITTED AT OCEAN ROAD CANCER INSTITUTE, DAR ES SAL AAM, TANZANIA

A DISSERTATION IN PART FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF THE DEGREE OF MASTERS OF MEDICINE IN PSYCHIATRY IN UNIVERSITY OF NAIROBI

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DECLARATION

I declare that this proposal entitled "psychiatric morbidity among adult cancer patients admitted at Ocean road cancer institute, Tanzania" is the result of my own work and that it has not been submitted either wholly or in part to, this or any other university for the award of any degree or diploma.

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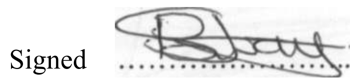
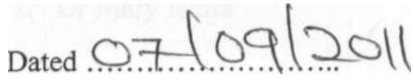
Signed 



CERTIFICATE OF APPROVAL

This is to certify that this proposal entitled "psychiatric morbidity among adult cancer patients admitted at Ocean road cancer institute, Tanzania" is the genuine research work carried out independently by Praxeda Swai, under my guidance and supervision

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DEDICATION

Special dedication to Almighty God for taking me through this course. Also special dedication to my immediate family members especially my beloved son Allen for his patience and love. Thank you all and may God bless you.

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LIST OF ABBREVIATIONS

ORCI	Ocean road cancer institute
M.I.N.I	Mini International Neuropsychiatric Interview
DSM-IV	Diagnostic Statistical Manual (4th edition)
SPSS	Statistical Package for Social Science
WHO	World Health Organization
USA	Unites States of America
MDD	Major depressive disorder
GAD	Generalized anxiety disorder
PTSD	Post traumatic stress disorder
KNH	Kenyata National Hospital
UON	University of Nairobi
ORCREC	Ocean Road Cancer Research Ethical Clearance Committee

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ABSTRACT

The number of people diagnosed with cancer is increasing each year with **10.9** million people worldwide being diagnosed with cancer annually. Among these 54% are in developing countries. Tanzania being one of the developing countries is not exceptional to the problem

Studies conducted worldwide pertaining psychiatric morbidity in cancer patients have shown significant psychiatric morbidity in these patients most of which goes undetected by the medical staff looking after these patients

Many studies have been done globally pertaining psychiatric morbidity among cancer patients yet no study of this kind has been done in Tanzania in patients with cancer and hence there was a limited information regarding the situation

Aim: To establish psychiatric morbidity among adult cancer patients admitted at ORCI, Dar es Salaam Tanzania

Study design: A cross-sectional descriptive study among adult cancer patients admitted at ORCI who fulfilled the inclusion criteria

Study area: The study was carried out at Ocean Road Cancer institute, Dar es salaam, Tanzania

Study instruments: Study participants were interviewed using Mini International Neuropsychiatric Interview (M.I.N.I) and a researcher designed social demographic and clinical questionnaire

Data analysis: Data was double entered, followed by cleaning and analysis using SPSS version 16 and inferential analysis. Results are presented in form of tables, charts, graphs and narratives.

_**RESULTS:** A total of **150** male and female patients participated in the study. Overall prevalence of psychiatric morbidity based on the MINI criteria was **50.7%** when pain disorder due to general medical condition and psychological factor was excluded as a psychiatric morbidity (i.e. pain considered as a symptom rather than a disorder) and **65.3%** when pain disorder due to general medical condition and psychological factor was included as a psychiatric morbidity. The three leading types of psychiatric morbidities were pain disorder associated with psychological factors and general medical condition **(40.7%)** when pain considered as a disorder, suicidality **(38.7%)** and major depressive episodes **(28.0%).** Others include panic disorders **(4.6** %), psychotic disorder **(4** %), antisocial personality disorder **2%,** The other less frequent psychiatric morbidities were Adjustment disorder, dysthymia, (Hypo) Manic episodes, Obsessive compulsive disorder, Alcohol abuse and dependence with each of these morbidities affecting less than 1% of the patients

None of these patients with the above psychiatric morbidities had the problem documented in the clinical file notes. Statistically significant associations were observed between types of mental disorders and marital status, level of education, occupation, type of treatment modality, and the presence of severe pain.

Conclusion: Psychiatric morbidity is high among cancer patients and often goes undetected. This calls for special attention of healthcare professionals for proper psychological assessment and management.

CHAPTER 1

1. INTRODUCTION

Cancer is a generic term for a large group of diseases that can affect any part of the body. Other terms used are malignant tumours and neoplasms. One defining feature of cancer is the rapid creation of abnormal cells that grow beyond their usual boundaries, and which can then invade adjoining parts of the body and spread to other organs. This process is referred to as metastasis. Metastases are the major cause of death from cancer (1).

Each year 10.9 million people worldwide are diagnosed with cancer. Among these more than half are in developing countries (2). Tanzania being one of the developing countries is not exceptional of the problem The disease is a leading cause of death worldwide, accounting for 7.4 million deaths (around 13% of all deaths worldwide) (1) More than 70% of all cancer deaths occurred in low- and middle-income countries and this is projected to continue rising worldwide, with an estimated 12 million deaths in 2030(1)

According to International Atomic Energy Agency Press Release 2006/3(IAEA Responds to cancer crisis in Tanzania) it was reported that each year there are over 20,000 new patients with cancer in Tanzania. Due to high population growth rate the situation may become more critical at the moment and the coming years (3)

Receiving a cancer diagnosis is a catastrophic event in an individual's life. Fears about the future, facing one's mortality, and pain and suffering are almost inevitably present. Sadness and anticipatory grief are normal reactions to the various crises faced during cancer. Patients generally react to such crises by experiencing periods of denial or despair, along with a mixture of symptoms of depressed mood, anxiety, insomnia, and irritability. For a majority of patients, these symptoms only last a few days to several weeks following diagnosis; then, resolution and adjustment should ensue. Other patients will experience these symptoms as part of a more ongoing disruptive and debilitating depressive syndrome that will affect their long-term physical and mental well-being. (42).

These patients also experience several stressors and emotional disturbances. Fear of death, interruption of life plans, changes in body image and self-esteem, changes in social role and lifestyle are all important issues to be faced (6)

Psychiatric symptoms have been shown to be common in cancer patients, being caused by both pathophysiological changes of bodily functions resulting from the cancer and the adjustment reactions to the cancer and the subsequent treatment process including chemotherapy and radiotherapy (5). These can lead to distress to the patient and care givers sometimes with unjustified guilt feeling and exaggeration of symptom impairment. In order to improve quality of life of patients and care givers, early identification and treatment of these psychiatric symptoms are important (5, 28)

Moreover, mental disorders in these patients may impact the course of the disease and compliance (5).

Studies have shown that most psychiatric symptoms in cancer patients go undetected by medical staff looking after these patients (29, 30). There is therefore a need for research priority regarding mental disorders in these patients

Studies done among cancer patients highlight the psychological and psychiatric morbidity. Among them are adjustment disorders with depressed mood, major depression, organic mental disorders, and personality disorders. (7)

According to different researchers the prevalence of psychiatric disorders following cancer diagnosis have been reported to range from 10.8% to 47% (7, 10, 11, 12, 21, 35)

1.1 BACKGROUND

According to the World Health Organization global burden of diseases, Cancer is the second most common cause of death worldwide after cardiovascular disease. Over 7 million people died of cancer in 2005, and close to 11 million new cancer cases were diagnosed, and these Cancer-related deaths are projected to increase to more than 9 million people annually by 2015 (1)

The incidence of cancer in Africa in 2002 (Ferlay et al, GLOBOCAN 2002) was 649,800 people (6% of the total world incidence) (2) Tanzania is not only experiencing different kinds of cancers as those seen in developed world but we appear to be undergoing a cancer epidemic in some kinds of cancers. Over the last two decades the number of cancer patients treated in the country has increased thirty folds (4)

Cancer has been recognized as a serious public health problem in Tanzania. For the past few decades the number of cancer patients treated at Ocean Road Cancer Institute (ORCI) has been increasing steadily. For example in 1975 were 48 new patients, 1989 were 916, 1995 were 1639 and in 2004 were 2866 (4)

More than 70 percent of cancer deaths now occur in low and middle income countries - the very countries least able to address this growing burden. Tanzania being one of these countries is not exceptional of the problem

Cancer accounts for nearly 25% of deaths in the United States, exceeded only by heart disease (43)

Life time prevalence of mental illness according to WHO update on global burden of mental disorders is estimated to range between 18.15%-36.1% (21)

Many researchers have reported that mental disorders occur more frequently in cancer patients to warrant a detailed assessment and intervention with prevalence rates ranging from 10.8% to 47% (7, 9, 11, 12, 20)

However fewer studies have been done in Africa and specifically non had been conducted in Tanzania to investigate the magnitude of mental disorders in cancer patients

1.2 PROBLEM STATEMENT

The morbidity and mortality due to cancers has been increasing worldwide, with an estimated incidence of about 60 per 100,000 population in Africa (24). In 1995 the

WHO estimated the annual cancer incidence rate of 70 per 100,000 population in **Tanzania,** that is 21,000 new cases of cancer each year (25)

Every year about 10,000 people die of cancer in Tanzania and about 32.5% of all death due to cancer are in people less than 60 yrs (4)

Cancer is well known to be a difficult disease, affecting patients and their families both physically and emotionally (9, 15, 27, 28)

Feeling restless has been highly reported by cancer patients as one of the emotional concern. Patients who are coping with advanced cancer report that their emotions and thoughts often vary from minute to minute and from day to day (26)

A diagnosis of cancer often imposes a crisis, with the person having to confront the illness and its treatment, and deal with issues concerning the meaning of life, impending death, and an uncertain future (32)

Psychosocial morbidity in cancer patients have been shown to have negative impact in their life including increased length of hospital stay, maladaptive copying and abnormal illness behavior , reduced compliance to treatment, increased risk of suicide and reduced quality of life (5, 37, 38, 39,)

1.3 JUSTIFICATION OF THE STUDY

Several studies have been done globally on cancer patients indicating high prevalence of psychiatric morbidity in these patients.

Fewer studies of this kind have been conducted locally and specifically none had been done in Tanzania, therefore this study will come up with the findings and hence fill the gap by providing the information.

Since most psychiatric symptoms in cancer patients remain unrecognized by the medical staffs it important for this study will come up with recommendations for policy guidelines regarding integrating mental health package in the management of cancer patients.

CHAPTER 2

2. LITERATURE REVIEW

Studies indicate that mental disorders occur in a significant number of cancer patients **particularly** as the disease advances and as cancer therapies become more aggressive

A study done in USA by Derogatis et al (7) aimed at establishing the prevalence of psychiatric disorders among cancer patients found that 47% of the cancer patients had sufficient distress to receive a diagnosis of a psychiatric disorder. Adjustment disorder with depressed mood and / or anxious mood was by far the most common diagnosis (68%), major depressive disorder (13%), followed by organic mental disorders (8%), personality disorders (7%) and pre-existing anxiety disorders (4%).

Grassi L and Rosti G (45) looked at psychiatric and psychosocial concomitants of abnormal illness behavior in cancer patients in **Italy** and found that out of 201 recently diagnosed cancer patients, 15% met the criteria for a Major Depressive Disorder

Another study conducted by Akhtar Iqbal (42) looked at common types of mental disorders in adult cancer patients in newly diagnosed cancer patients registered at **Shaukat Khanum Memorial Cancer Hospital and Research Centre Lahore, Pakistan** showed that Adjustment disorder was the most common type of mental disorders seen in 20.8% of all cancer patients; mood disorders especially depression was observed in 17.8% and anxiety disorders in 16.8%.

Tatsuo et al (8) in a study done at Palliative care unit of the National cancer hospital in **Chiba, Japan** to establish the psychological distress in terminally ill cancer patients associative and predictive factors found the proportion of Adjustment disorders, Major depression and PTSD at baseline to be 16.3%, 6.7%, and 0% respectively.

Study done by Steven CP et al (33) at Abramson cancer centre of the **University of Pennsylvania Philadelphia** to investigate the experience of trauma, distress and PTSD among breast cancer patients found the overall prevalence of psychiatric disorders of 17% with MDD predominating (9%) followed by GAD (6%) and PTSD

(4%). These disorders however demonstrated high comorbidity with PTSD: 20% of those with PTSD also diagnosed with GAD and 40% with MDD

According to Masako et al (6) in a study done in **Chiba, Japan** to investigate the prevalence of and factors associated with psychiatric disorders and quality of life in patients with first breast cancer recurrence found that 22% of patients met the DSM III and IV criteria for Major depression disorder, PTSD or Adjustment disorder.
Adjustment disorder was by far the most common (20%), followed by major depression disorder (2%) and PTSD (2%).

A study aimed at recognition of distress and psychiatric morbidity in cancer patients at Psychosocial care unity department of surgery, **University of Heidelberg, Germany** found the overall prevalence of psychiatric morbidity to be 28% with adjustment disorder predominating (10) The same study found the oncology doctors and nurses ability tor recognize patients' psychological morbidity compared to a diagnostic psychiatric interview to be 77% and 75% respectively. Because of low specificity, the positive predictive value was only 39% in surgeons and 40% in nurses. However, only small proportion of the distressed patients were referred for psychosociaol liason services

Another study done in **India** by Alexander et al (11) aiming at establishing psychiatric morbidity among cancer patients and its association with awareness of illness and expectation about treatment outcome found the prevalence of psychiatric disorder among cancer patients to be 40% with adjustment disorder comprising most of the psychiatric diagnosis. Major depression was seen in 13% of patients
The same study reported psychiatric morbidity to be significantly less common in patients who did not know if they had cancer

According to a study done in **USA** by Zabora J et al (12) aimed at finding the prevalence of psychosicial distress by cancer site, it was found that 35.1% of cancer patients reached a clinical diagnosis for mental illness. Distress was significantly higher in lung (43.4%) and brain cancer (42.7%), while lower levels were seen in gynecological (29.6%), prostate (30.5%) and colon (31.6%) cancers. Pancreatic cancer had the highest rates of depression (56.3%) and anxiety (56.7%).

Catherine G et al (20) looked at Onset and relapse of psychiatric disorders following early breast cancer in a case control study in **France** and found the overall prevalence of mental disorders among the patients to be 41.2% with MOD predominating 19.4%, followed by GAD 10.4%, PTSD 4.9% Panic disorder 4.2%, Dysthymic disorder 2.8% and phobia 2.8%. By using a multivariate modal it was confirmed that cancer is a strong predictor of psychiatric disorder

Study done in USA by Kadan-Lottick NS et al (19) to determine psychiatric disorders and mental health service use in patients with advanced cancer, reported 12% of the patients to meet the criteria for major psychiatric condition.
The findings in this study closely correlates with another study by Wendy G et al (21) carried out in USA to find whether rates of mental illness and existential distress among advanced cancer patients increase as death approaches and find out the overall prevalence of mental illness to be 10.8%
The same study found those patients with cancer of colon, pancrease and breast to exhibit the highest rates of mental illness overall

According to a pilot study by Holger B et al (34) to find out the long term course of psychiatric disorders in cancer patients in **Germany** it was found that 29% of the cases received at least one DSM-IV diagnosis at baseline. This frequency increased at subsequent follow up to 44%. The patterns of psychiatric disorders were as follows from baseline to subsequent follow-ups respectively; Affective disorders (13%-16%), Dysthymia (0%-13%), Anxiety disorders (8%-27%)

Tatsuo A et al (41) did a study to establish psychiatric disorders among 1721 cancer patients who were referred to two **Japanese cancer centre hospitals** for psychiatric consultation. Regarding the psychiatric diagnosis, adjustment disorders were the most common (34%), followed by delirium (17%) and major depression (14%).

People with chronic medical conditions have been reported to have high psychiatric morbidity compared to those without the disease. Wells KB et al (35) looked at psychiatric disorders in a sample of general population with and without chronic medical condition in USA and find life time prevalence of psychiatric disorders of

42.2% among people with one or more chronic medical condition compared to 17.5% for person without medical condition

Prieto JM et al (40) did a study among haematologic cancer patients receiving stem cell transplantation in **Barcelona, Spain** to find out the psychiatric morbidity among these patients and the impact on hospital stay. The overall psychiatric disorder prevalence was found to be 44.1%. Adjustment disorder was diagnosed in 22.7% of patients, mood disorder in 14.1%, and anxiety disorder in 8.2%

Researchers have found contradicting results regarding the association between psychiatric morbidity and awareness of cancer diagnosis
Other studies have found the awareness of cancer diagnosis being related to the presence of psychiatric morbidity while others reported to be no association.

Study done in **Turkey** by Atesci FC et al (9) to find out the prevalence of psychiatric morbidity among cancer patients and its association with awareness of diagnosis found that awareness of the diagnosis of cancer, history of previous psychiatric disorders, pain and stress factors were correlated with psychiatric morbidity which was significantly higher in the patients who knew that they had a cancer diagnosis
The same study established the prevalence of mental disorders among these patients to be 30% with adjustment disorders comprising the most of the psychiatric diagnosis. This study results were consistent with results from other studies done in **Tehran, Iran** which found that patients who did not know their cancer diagnosis had a better physical, social and emotional quality of life (15) and another study by Azadeh Tavoli et al (22) which showed psychological distress to be higher on those patients who knew their cancer diagnosis

According to study done by Chandra PS et al (16) aiming to establish the association between awareness of diagnosis and psychiatric morbidity among cancer patients in **South India** reported no difference between the two groups who were aware and those who were not aware of the cancer diagnosis in patterns and prevalence of psychiatric morbidity

Study done by Takashi H et al (17) among otolaryngology patients at **Tokai University Hospital Japan** to investigate the effect of true disclosure of cancer diagnosis to patients found the prevalence rate of psychiatric disorders to be 42.9% among the informed group and 48.3% among the uninformed group. These findings suggest that concealing the true diagnosis was not related to the presence of psychiatric disorders in Japanese cancer patients.

Studies have shown depression to be common among cancer patients (30%), and have a negative impact on quality of life. Those at risk have advanced stage of cancer, pains and family history of mental illness. This study was conducted among cancer patients on treatment at University college hospital **Ibadan, Nigeria** (Odejide OA et al) (13)

Another study done by Odejide et al (18) to find out psychological and physical effects of pain on cancer patients in **Ibadan Nigeria** found 37.2% of patients to have depressive symptoms, 21.4% had anxiety and 65.2% and 34.8% had suicidal ideations in those with and without pain respectful

David M Ndetei et al (46) conducted a study to establish the prevalence of mental disorders in adults in different level general medical facilities in **Kenya.** A total of 2,770 male and female inpatients and outpatients participated in the study. In all, 42% of the subjects had symptoms of mild and severe depression. Only 114 (4.1%) subjects had a file or working diagnosis of a psychiatric condition, which included bipolar mood disorder, schizophrenia, psychosis and depression.

Onyango OA (23) conducted his study in 161 patients to establish the psychological sequelae of cancer and cancer treatment **at KNH and Nairobi Hospice** (adult in and outpatients) and found 77(47.8%) out of the 161 patients being picked by the Leeds Scale for assessment of Anxiety and Depression.

CHAPTER 3

3. OBJECTIVES

3.1 Research questions

1. What is the prevalence of psychiatric disorders in cancer patients?
2. What is the pertern of psychiatric disorders in cancer patients?
3. Is there an association between awareness of diagnosis and psychiatric morbidity in cancer patients?
4. Does the psychiatric morbidity in cancer patients vary according to the cancer site and stage?
5. Are psychiatric disorders/symptoms in cancer patients recognized by the medical staff?

3.2 AIM

To establish psychiatric morbidity among adult cancer patients admitted at ORCI, Dar es salaam Tanzania

3.3 SPECIFIC OBJECTIVES

To determine the prevalence of psychiatric morbidity among cancer patients admitted at ORCI, Dar es salaam Tanzania

To determine the pattern of psychiatric morbidity among cancer patients admitted at ORCI, Dar es salaam Tanzania

To determine the association between psychiatric morbidity and awareness of cancer diagnosis among cancer patients admitted at ORCI Dar es salaam Tanzania

To determine the sociodemographic profile of cancer patients with and without psychiatric morbidity among cancer patients admitted at ORCI Dar es salaam Tanzania

To determine the association between psychiatric morbidity and the site of cancer among cancer patients admitted at ORCI Dar es salaam Tanzania

To determine the association between psychiatric morbidity and the stage of cancer among cancer patients admitted at ORCI Dar es salaam Tanzania

3.4 NULL HYPOTHESIS

There is no psychiatric morbidity in cancer patients admitted at ORCI, Dar es salaam Tanzania

3.5 ALTENATIVE HYPOTHESIS

There is psychiatric morbidity in cancer patients admitted at ORCI, Dar es salaam Tanzania

CHAPTER 4

4. METHODOLOGY

4.1 Study design: The study was cross-sectional descriptive study

4.2 Study area: The study was conducted at Ocean road cancer institute (ORCI), Dar es salaam Tanzania. Ocean Road Cancer Institute (ORCI) is located along the Indian Ocean about 200 meters from the beach between the junction of Ocean and Luthuli roads. This health facility is one of the oldest health institutions in Tanzania having been founded in 1895 by the German colonial government and established by the government in 1996. This is Tanzania's only cancer treatment center. It has a capacity of 130 beds, admitting both males and females including children, however the number of inpatients ranges from 175-200 at a time. Among these the number of adults ranges from 150-180, the rest are children. The total number of outpatients per day is about 100, including new cases of about 40 patients and follow ups of about 60 patients

The institute receives patients mainly from the three municipal hospitals (within Dar es
Salaam Region and from the whole country as referral suspected or confirmed cancer cases to undergo radiotherapy, and/or chemotherapy procedures.

OCRI evolved from the radiotherapy department of the university teaching hospital known as Muhimbili.

The services offered here include palliative care, radiotherapy, chemotherapy and cancer screening services. Surgical services are offered at Muhimbili National Hospital

4.3 Study population

The study population consisted of inpatients at ORCI who met the inclusion criteria

4.4 Inclusion criteria

Those above 18yrs of age

Those who gave informed consent to participate in the study

Those with histological/ hematological confirmation of cancer

4.5 Exclusion criteria

Those below 18 yrs of age

Those with severe physical or mental debilitation

Those who declined to give consent

4.6 SAMPLE SIZE

The sample size was calculated using the formula: Naing L et al (45)

$$N=\frac{Z^2pq}{d^2}$$

Where n is the sample size

Z is the standard normal deviation usually set at 1.96 which corresponds to 95% confidence interval,

p is the hypothesized prevalence level from other prevalence studies -10.8% according to Wendy G et al (18) in USA

Q is 1-p

D is the degree of precision set at 0.05(5%)

Therefore substituting the values as follows;

$$N=\frac{1.96x1.96x0.11x0.89}{(0.05)^2}$$

$$=150$$

4.7 SAMPLING METHOD

Participants for the study were obtained from the study population who met the inclusion criteria. Since the total number of adult cancer patients in the study area was estimated to range from 150-180 during the study period, all adult patients were enrolled to the study except those who didn't meet the inclusion criteria

4.8 STUDY INSTRUMENTS

1. Social demographic data and clinical questionnaire

   This is a researcher designed questionnaire that captures identification data and relevant demographic variables like sex, religion, marital status occupation level of education, previous history of mental illness, awareness of the patient to his/her illness

2. The M.I.N.I, was designed as a brief structured interview for the major Axis I psychiatric disorders in DSM-IV and ICD-10. Validation and reliability studies have been done comparing the M.I.N.I. to the SCID-P and the CIDI. The results of these studies show that the M.I.N.I. has acceptably high validation and reliability scores, but can be administered in a much shorter period of time (mean 18.7 ± 11.6 min., median 15 min.) than the above referenced instruments. It can be used by clinicians, after a brief training session. Lay interviewers require more extensive training.

   The researcher have been trained on how to use the tool

   Permission to use the MINI TOOL was obtained from the developers of the tool in Paris

   Swahili version of the MINI TOOL was used after all the protocols for the translation being followed

4.9 DATA ANALYSIS AND PROCESSING

The study data obtained was double entered followed by cleaning and analysis using SPSS (statistical package for social scientists) version 16 and inferential analysis. Results are presented in form of tables, charts, graphs and narratives.

4.10 STUDY IMPLEMENTATION

The researcher interviewed the participants five days in a week (Monday to Friday) over a period of 6 weeks. About 8-10 patients were interviewed per day, but somedays the number could go as lower as 4-6 patients per day due to slow turnover number of the patients in the wards. About 30- 45 minutes was spent in each interview. Total number of participants in the study was 150 which is the total number of the estimated sample size.

Permission to conduct the study was obtained from Ocean Road Cancer Research Ethical Clearance Committee (ORCREC) and Kenyata National Hospital /University of Nairobi ethics research committee. Those who met the inclusion criteria to participate in the study were explained about the study, and an informed consent form was signed. Study instruments were administered and serial numbers were assigned instead of names.

At the end of the interview the patient was thanked and the interview was terminated

4.11 Time schedule for the study

Proposal development .... Sept 2009-Febr 2010

Approval by the department .... Febr 2010

Ethical committee clearance .... March-July 2010

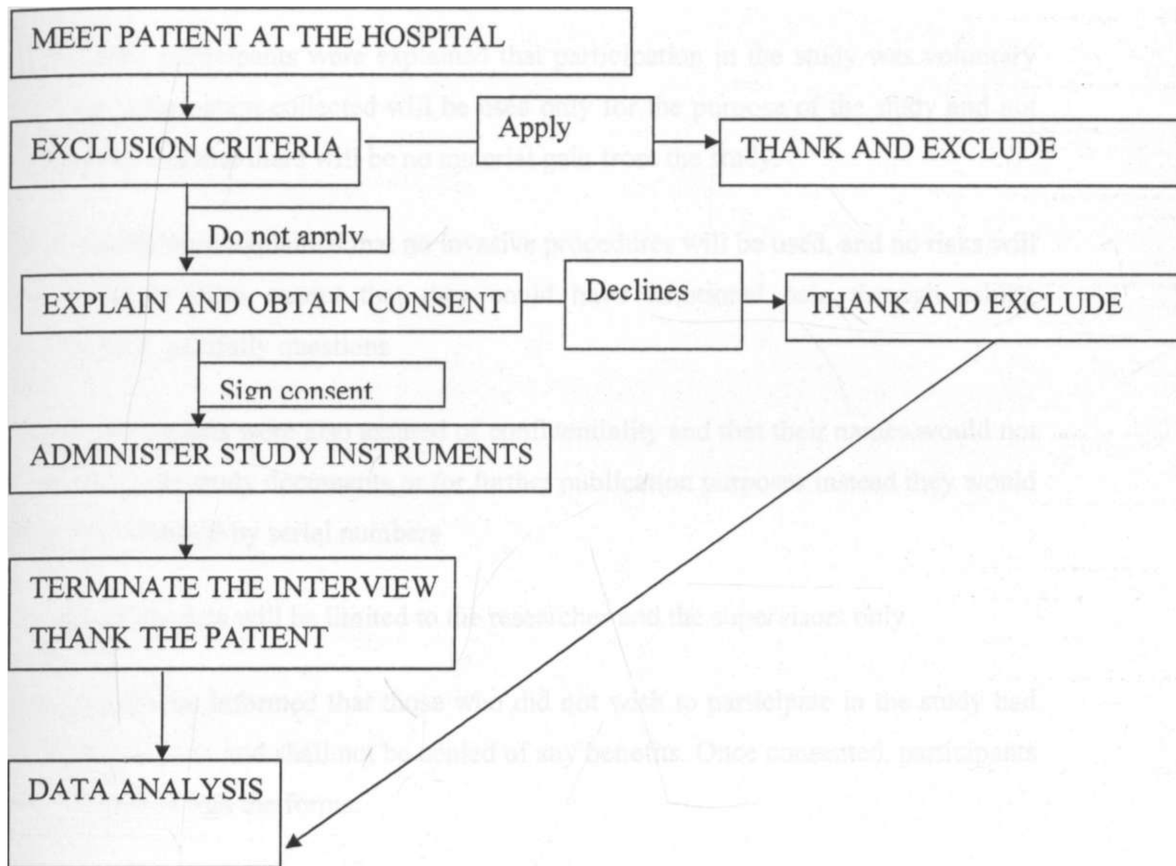
Data collection .... August-Sept 2010

Data analysis .... October-Nov 2010

Report writing .... Dec-Jan 2010

Presentation of results .... Feb 2011

4.12 FLOW CHART ILLUSTRATING METHODOLOGY



5. ETHICAL CONSIDERATION

Authority to carry out the study

Approval to carry out the study was obtained from the department of psychiatry University of Nairobi and clearance was obtained from Ethics and research committee at KNH and from Ocean Road Cancer Research Ethical Clearance Committee (ORCREC).

Consent

A written informed consent was sought from the participants after full detailed explanation of the study in a language conversant to them

There after participants were explained that participation in the study was voluntary and that information collected will be used only for the purpose of the study and not otherwise, and that there will be no material gain from the study.

Participants were explained that no invasive procedures will be used, and no risks will be posed to them except that they could have emotional pain through asking emotionally painfully questions

Study participants were also assured of confidentiality and that their names would not be used on the study documents or for further publication purposes instead they would only be identified by serial numbers

Access to the data will be limited to the researcher and the supervisors only

They were also informed that those who did not wish to participate in the study had the right to do so and shall not be denied of any benefits. Once consented, participants were asked to sign the forms.

6. FINANCIAL BUDGET (KENYA SHILINGS)

Stationary	10000/=
Computer/Printer/Photocopy services	25000/=
Communication and local transport	10000/=
Data analysis	10,000
Dissertation typing /Binding	5000/=
Contingencies	10000/=
Total	**80,000/=**

Total amount in Tanzania shillings..................1,440,000/=

The research funds was provided by ministry of Health and Social welfare of Tanzania

CHAPTER 5: RESULTS

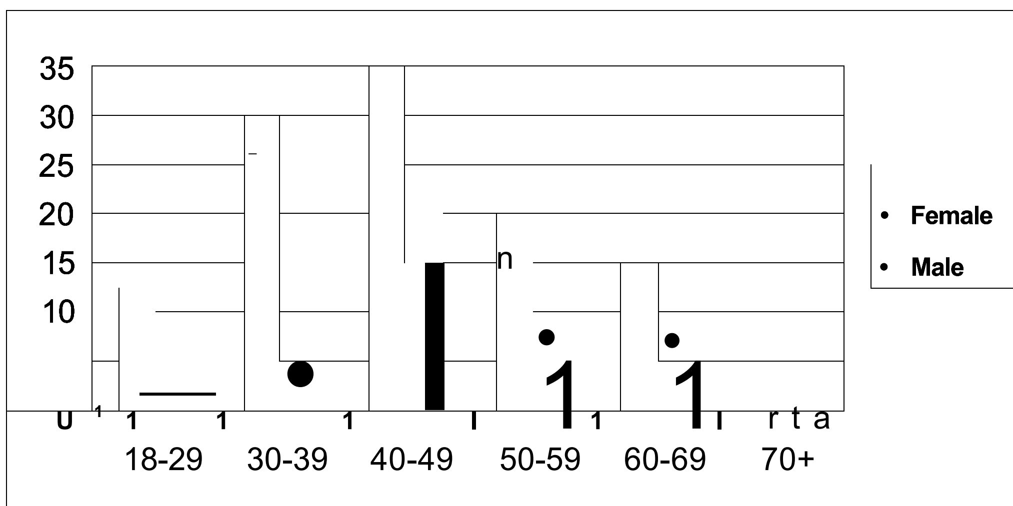
In this study conducted during 6-weeks period from August to September 2010, a total of 150 patients with cancer were recruited from among the adults admitted at the Ocean Road Cancer Institute, in Dar es Salaam. A total number of 19 patients were excluded from the study due to different reasons including severe physical illness and unwillingness to participate in the study.

5.1 Patients' social and demographic characteristics

The study participants came from all the 27 regions in the country. The regions that had significant numbers among the participants were: Morogoro (14.7%); Shinyanga (11.3%); Mtwara (7.3%); and Tanga (6.7%). Of all 150 patients the mean age was 45.1 years, and the range of study participants' age was 18 years to 80 years. In general, most patients were comparatively young with a majority being below 50 years as presented in Figure 1.

There were 101 (67.3%) females resulting in a female to male ratio of 2:1. Figure 1 below shows patient distribution by their age and gender. Female patients formed the majority in all the patient age groups except two groups: those aged 18 to 29 years and above 70 years where the number of male patients was slightly higher than that of females.

Figure 1: Patient distribution by age and gender



Findings of the descriptive analysis of the basic social and demographic characteristics of all the study participants are presented in Table 1 and reported below.

As shown in Table 1 below, the most frequent occupations (n=150) recorded were peasant or subsistence farmers (68.7%), self employment (14%), and formal employment (5.3%). Approximately 9% of the patients reported that they were unemployed.

Fifty-eight per cent of the patients interviewed stated that they were married or living with a spouse. A further 16% were single having never been married while the remaining patients were divorced, separated or widowed. The majority of patients were either Christians (58.7%) or Muslims (38.0%). Lastly, most (70.0%) of the patients had some primary level education while 8.7% reported that they had secondary level education. With the exception of a single patient who had attained college education the remaining (20.7%) patients reported not having attended formal education.

Table 1: Basic demographic characteristics of study participants

	Frequency (N)	Percent (%)
Gender		
Female	101	67.3
Male	49	32.7
Total	150	100.0
Occupation		
Peasant farming	103	68.7
Self employed	21	14.0
Unemployed	13	8.7
Formal employment	8	5.3
Students	5	3.3
Total	150	100.0
Marital status		
Married/ cohabiting	87	58.0
Single	24	16.0
Divorced or separated	20	13.3
Widowed	19	12.7
Total	150	100.0
Religion		
Christian	88	58.7
Muslim	57	38.0
Others	5	3.3
Total	150	100.0
Education		
No formal education	31	20.7
Primary	105	70.0
Secondary	13	8.7
College	1	0.7
Total	150	100.0

5.2 Clinical charecteristics of study participants

Table 2 below summarizes information regarding duration since cancer diagnosis, cancer site and stage, and treatment modality among study participants. In general, most cancers were newly diagnosed. Up to 68% of cancers had been diagnosed over the one year period preceding the study. There were few cases (1.3%) of cancer, however, that had been diagnosed more than 5 years earlier.

Most patients (22%) had stage III cancer.

Radiotherapy was the most common management for cancer, followed by chemotherapy administered in combination with radiotherapy, and these treatments had been used in 49.3% and 18% of patients, respectively. Fourteen percent of the patients were on palliative care only.

The combination treatment including radiotherapy, chemotherapy and surgery had been used in the treatment of 6.7% of patients while chemotherapy alone was used in 8% of cases.

Table 2: The clinical charecteristicsof cancer among study participants

	Frequency (N)	Percent (%)
Duration since diagnosis with cancer		
Less than a year	102	68.0
1 to 5 years	37	24.7
Over 5 years	2	1.33
Not stated	9	6.0
Total	150	100.0
Treatment modality*		
Radiotherapy alone	74	49.3
Radiotherapy plus chemotherapy	27	18.0
Palliative care	21	14.0
Chemotherapy alone	12	8.0
Radiotherapy, chemotherapy plus surgery	10	6.7
Chemotherapy+surgery	6	4.0
Cancer stage		
I	2	1.3
II	33	22.0
III	39	26.0
IV	22	14.7
Not staged	54	36.0
Total	150	100.0

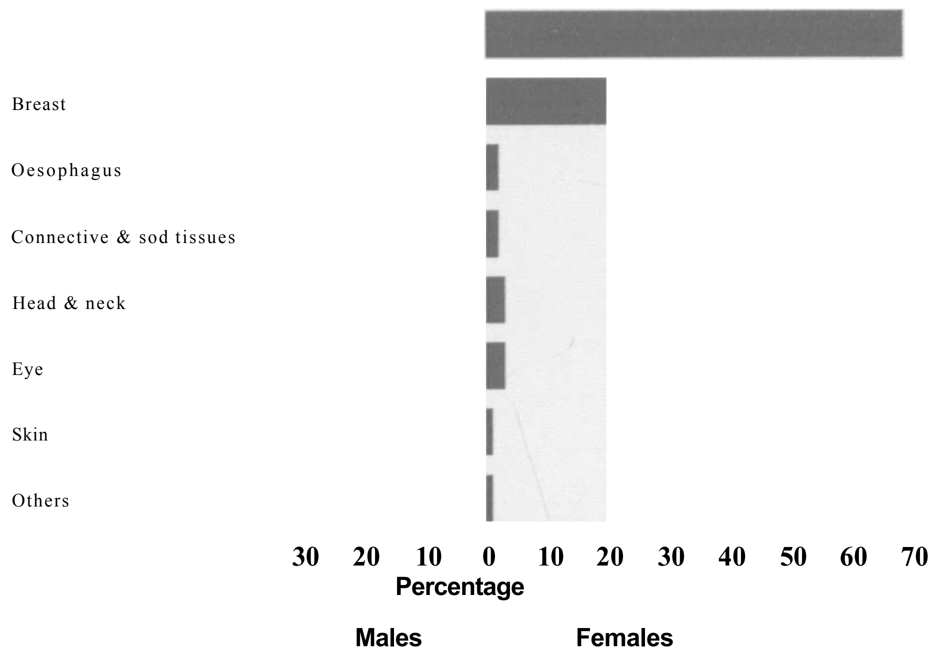
Cancer of the cervix and breast comprised a large proportion (cervix = 46%; breast= 13%) of all the cancers reported in this study.

As shown in Figure 2 these 2 cancers were the most common cancer among the 101 women studied with reported prevalence of cancers of the cervix and breast at 68.3% and 19.8%, respectively. Among the 49 men in the study cancer of the head and neck (28.6%) predominated followed by oesophagus (24.5%).

The group of cancers categorized as affecting the head and neck included cancer of the jaw, maxilla, tongue and pharynx. The group of cancers affecting the connective and soft tissue, eye and skin, among both sexes were seen less frequently.

Other cancers as shown in figure 2 below were cancer of the abdomen, bloo(}, bones, intestines ,lymphnodes, multiple myeloma and disseminated cancer each affecting one patient except the disseminated cancer which had affected 2 patients of the study population

Figure 2: Prevalence of cancer by site and gender



5.3 Prevalance and pattern of psychiatric morbidities among cancer patients

Out of the 150 cancer patient screened using the MINI International Neuropsychiatric Interview (MINI), 76 **(50**.7%) were found to have a psychiatric morbidity when pain disorder due to general medical condition and psychological factor was excluded as a psychiatric morbidity. However when pain disorder due to general medical condition and psychological factor was included as a psychiatric morbidity the overall prevalence of psychiatric morbidity based on the MINI criteria was found to be **98(65.3%)** in this sample of adult patients diagnosed with cancer at ORCI.

The three leading types of psychiatric morbidities were pain disorder associated with psychological factors and general medical condition (40.7%). suicidality (38.7%) and major depressive episodes (28.0%). Chronic pain, low risk suicidality and major

depressive episode with melancholic features were more prevalent than acute pain; high risk suicidality and current major depressive episodes without maelancholic features respectively. Others include psychotic disorder (4 %) and panic disorders including panic with agoraphobia (3.3 %), panic without agoraphobia (1.3 %), and agoraphobia (0.7 %) were reported. The other less frequent psychiatric morbidities were Adjustment disorder, dysthymia, (Hypo) Manic episodes, Obsessive compulsive disorder, Alcohol abuse and dependence and with each of these morbidities affecting less than 1% of the patients.

Table 3: Prevalence of psychiatric morbidity among study participants with cancer

	Frequency* (n)	Percent
Pain disorder Associated with psychological factors and general medical condition		
Chronic pain	43	28.7
Acute pain	18	12.0
	61	40.7
Suicidality (current)		
Low risk	53	35.3
High risk	5	3.3
	58	38.7
Major depressive episode^current)		
With melancholic features	24	16.0
Without melancholic features	18	12.0
	42	28.0
Panic disorders		
With agoraphobia	5	3.3
Without agoraphobia	2	1.3
	7	4.6
Other psychiatric morbidities		
Psychotic syndrome- lifetime	6	4.0
Antisocial personality disorder	3	2.0
Agoraphobia without history of panic disorder-current	1	0.7
Obsessive compulsive disorder	1	0.7
Adjustment disorder	1	0.7
Dysthymia	1	0.7
(Hypo) Manic episode	1	0.7
Alcohol abuse and dependence	1	0.7
"The sum of all psychiatric morbidity episodes is greater than 76 because some patients had more than one morbidity		

5.3.1 Characteristic of cancer patients with pain symptoms

Pain as a symptom was a common complaint among these cancer patients and was reported by 61 (40.7%) patients who were more likely to report chronic (n=43) rather than acute pain (n=18).

Pain symptoms were significantly associated with both depression (chi=l0.9(2), p=0.001) and suicidality (chi=6.4(2), p=0.01). As shown by the findings of the chi square test presented in Table 5, patients with pain symptoms were more likely to have depression compared to those without pain (61.9% versus 38.1%, respectively) and 53.4% of the patients presenting with pain also had suicidality compared to 46.6% of patients without pain who also had suicidality.

Table 4: Association between pain symptom with depression and suicidality among cancer patients at ORCI

		Pain symptoms		Total	Chi(df)	P value
		Absent	Present			
Depression	Absent	73(67.6%)	35(32.4%)	108(100.0)	10.9(2)	0.001
	Present	16(38.1%)	26(61.9%)	42(100.0%)		
		89(74%)	61(26%)	150(100.0)		
Suicidality	Absent	62(67.4%)	30(32.6%)	92(100.0%)	6.5(2)	0.01
	Present	27(46.6%)	31(53.4%)	58(100.0%)		
Total		89(74%)	61(26%)	150(100.0)		

5.3.2 Characteristics of suicidal cancer patients

There was no significant association between suicidality and sex (p=0.985), suicidality and religion (p=0.57), suicidality and marital status (p=0.77) and suicadality and occupation(p=0.65) but there was significant association between level of education and suicide(p=0.013) with those with low level of education at a higher risk of committing suicide than those with post secondary level of education (table 5)

Table 5: Association between suicidality and socio-demographic characteristics

		suicide		Total	Chi Square (df)	P value
		no risk	At risk			
Sex	Male	30(61.2%)	19(38.8)	49(100.0%)	0.004(1)	0.985
	Female	62(61.3%)	39(38.6)	101(100.0%)		
	Total	92(61.3%)	53(38.6)	150(100.0%)		
Religion	Christian	49(55%)	39(39.8)	88(100.0%)	1.01(2)	0.57
	Islam	40(70%)	17(28.1)	57(100.0%)		
	Others	3(60%)	2(40.0%)	5(100.0%)		
	Total	92(61%)	53(35.3)	150(100.0%)		
Marital	Single	16(66.6%)	8(33.3 %)	24(100.0%)		
	Married/Cohabiting	51(58.6%)	36(41.3)	87(100.0%)		
	Divorced/Widowed	25(64.1 %)	14(35.9 %)	39(100.0%)	0.68 (2)	0.77
	Total	92(61%)	53(35.3)	150(100.0%)		
Education	No Education	23(74%)	8(25.8%)	31(100.0%)		
	Primary	63(60%)	42(38.1)	105(100.0%)	6.25(2)	0.013*
	Secondary/ College	6(46.2%)	8(30.8%)	13(100.0%)		
	Total	92(61%)	53(35.3)	150(100.0%)		
Occupation	Employed	4(50%)	4(37.5%)	8(100.0%)		
	Self employed	15(71%)	6(23.8%)	21(100.0%)	1.59(3)	0.65
	Peasant	63(61%)	40(36.9%	103(100.0%)		
	Unemployed	10(53.8%)	8(46.2%)	13(100.0%)		
	Total	92(61%)	53(35.3%	150(100.0%)		

5.3.3 Characteristics of cancer patients diagnosed with major depressive episode

Major depressive episode was the third most frequently diagnosed psychiatric morbidity (Table 6). All the cases were current as opposed to past depressive episodes and more patients (n=24) presented with major depressive episode with melancholic features compared to major depressive episode without melancholic features - (n=18). Marital status and occupation were significantly associated with a diagnosis of major depressive episode with (p=0**.04)** and (p=0.043) respectively. The prevalence of major depression episode ranged from 19.5% among those who were married/cohabiting to 45.9% and 35.9% for those who were single and widowed/separated respectively. The prevalence of major depression episode ranged from 22.4% among peasants to 37.5% for employed/self employed patients

Table 6: Association between occurrence of major depressive episodes and socio-demographic characteristics

		Major depression episode			Total	Chi Square (df)	P value
		No episode	Current	Melancholic			
Sex	Male	35(71.4%)	6(12.2%)	8(16.3%)	49(100%)	0.01(2)	0.94
	Female	73(72.3%)	12(11.9%)	16(15.8%)	101(100%)		
Total		108(72.0%)	18(12.0%)	24(16.0%)	150(100%)		
Religion	Christian	64(72.7%)	10(11.4%)	14(15.9%)	88(100%)	0.45(4)	0.87
	Islam	41(71.9%)	7(12.3%)	9(15.8%)	57(100%)		
	Others	3(60.0%)	1(20.0%)	1(20.0%)	5(100%)		
	Total	108(72.0%)	18(12.0%)	24(16.0%)	150(100%)		
Marital	Single	13(54.2%)	4(16.7%)	7(29.2%)	24(100%)	9.97(4)	0.04*
	Married/Cohabiting	70(80.5%)	9(10.3%)	8(9.2%)	87(100%)		
	Divorced/widowed	25(64.1 %)	5(12.8%)	9(23.1 %)	39(100%)		
	Total	108(72.0%)	18(12.0%)	24(16.0%)	150(100%)		
Education	No Education	24(77.4)	2(6.5%)	5(16.1%)	31(100%)	5.97(3)	0.19
	Primary	77(73.3%)	14(13.3%)	14(13.3%)	105(100%)		
	Secondary/ College	7(53.8%)	2(15.4%)	5(30.8%)	13(100%)		
	Total	108(72.0%)	18(12.0%)	24(16.0%)	150(100%)		
Occupation	Employed/Self employed	17(62.5%)	5(12.5%)	7(25.0%)	29(100%)	9.17(4)	0.043*
	Peasant	80(77.7%)	12(11.7%)	11(10.7%)	103(100%)		
	Unemployed	11(69.2%)	1(0%)	6(30.8%)	18(100%)		
	Total	108(72.0%)	18(12.0%)	24(16.0%)	150(100%)		

5.3.4 Characteristics of cancer patients diagnosed with pain disorder associated with general medical condition and psychological factors

As shown in Table 7 below the age of patients with pain disorder (mean = 42.91) was lower than that of patients without pain symptoms (mean = 46.62). This difference in ages was, however, not significant based on the findings of the t-test comparing average age in the two groups (p=0.085).

The level of formal education showed a significant association with pain disorder. Compared to a prevalence of 40.67% among all participants, the prevalence of pain disorder ranged from 29.03% among patients with no formal education to 44.76% in patients with primary education. The single patient with college education was also diagnosed with pain disorder. (p=0.038)

There were no significant associations between pain disorder and gender (p=0.37), religion (p=0.68), marital status (p=0.59) or occupation (p=0.97).

Table 7: Association between occurrence of pain disorder due to general medical condition and psychological factors and demographic characteristics

		Pain disorder		Total	Chi(df)	P value
		No	Yes	0		
Sex	Male	32(65.3%)	17(34.7%)	49(100.0%)	1.07(1)	0.37
	Female	57(56.4%)	44(43.6%)	101(100.0)		
	Total	89(59.3%)	61(40.7%)	150(100.0)		
Religion	Christian	52(59.1%)	36(40.9%)	88(100.0%)	0.87(2)	0.68
	Islam	35(61.4%)	22(38.6%)	57(100.0%)		
	Others	2(40.0%)	3(60.0%)	5(100.0%)		
	Total	89(59.3%)	61(40.7%)	150(100.0)		
Marital	Single	16(66.7%)	8(33.3%)	24(100.0%)	1.90(3)	0.59
	Married/Cohabitig	53(60.9%)	34(39.1%)	87(100.0%)		
	Divorced/separatd	11(55.0%)	9(45.0%)	20(100.0%)		
	Widow/widower	9(47.4%)	10(52.6%)	19(100.0%)		
	Total	89(59.3%)	61(40.7%)	150(100.0%		
Education	No education	22(71.0%)	9(29.0%)	31(100.0%)	4.45(3)	0.038*
	Primary	58(55.2%)	47(44.8%)	105(100.0%		
	Secondary	9(69.2%)	4(30.8%)	13(100.0%)		
	College	0(0%)	1(100.0%)	1(100.0%)		
	Total	89(59.3%)	61(40.7%)	150(100.0%		
Occupation	Employed	5(62.5%)	3(37.5%)	8(100.0%)	0.65(4)	0.97
	Self employed	12(57.1%)	9(42.9%)	21(100.0%)		
	Peasant	60(58.3%)	43(41.7%)	103(100.0%		
	Unemployed	9(69.2%)	4(30.8%)	13(100.0%)		
	Others	3(60.0%)	2(40.0%)	5(100.0%)		
	Total	89(59.3%)	61(40.7%)	150(100.0%		

5.4 Clinical characteristics versus psychiatric morbidity

Information on the duration since cancer diagnosis was made, clinical staging of cancer, histology findings, and treatment modality previously presented in Table 2 were compared with the prevalence of psychiatric morbidity. The clinical staging was done for 98.53% (n=67) and 94.44% (n=17) of cervical and breast cancer cases, respectively. All cancers of the gastrointestinal tract and skin were not given a clinical stage. As a result the association between psychiatric morbidity and stage of cancer was explored only for cervical and breast cancer which had adequate information to allow for these analyses. The findings of chi square tests of association between psychiatric morbidity and the stage of cancer among cancer patients indicated that the overall prevalence of psychiatric morbidity is not significantly associated with stage of disease (chi square=2.24; d.f=4 ; p=0.69). There was a significant association between the stage of cancer and suicidality among breast and cervical cancer patients (chi square=13.7; p=0.043).

Awareness of the type of diagnosis for which patients were being treated for was high among the patients. A total of 140 (93%) patients knew that they were suffering from cancer and 9 (6%) patients were unaware about their diagnosis.

Among patients with the three most common cancers the prevalence of psychiatric morbidity was 49.3% for cervical cancer, 52.9% for head and neck cancers and 60% for breast cancer. As shown in Table 8 within-diagnosis comparison showed that the site of the cancer did significantly influence the overall prevalence of psychiatric morbidity (Chi square = 2.23; p= 0.79).

The prevalence of psychiatric morbidity ranged for 48.6% to 52.9% among the patients who had been aware about the cancer diagnosis for one to five years and for less than a year, respectively (Table 8)

Table 8: Association between psychiatric morbidity and clinical characteristics among cancer patients

	Psychiatric morbidity		Total	Chi Square (df)	P value
	No	Yes			
Knowledge of diagnosis					
Yes	73(52.1%)	67(47.9%)	140(100.0%)	2.23 (1)	0.33
No	4(40%)	6(60%)	10(100.0%)		
Duration of illness					
Less than 1 year	48(47.1%)	54(52.9%)	102(100.0%)	1.35 (3)	0.76
1 to 5 years	19(51.4%)	18(48.6%)	37(100.0%)		
Over 5 years	1(50.0%)	1(50.0%)	2(100.0%)		
Not stated	6(66.7%)	3(33.3%)	9(100.0%)		
Type of cancer					
Cervix	35(50.7%)	34(49.3%)	69(100.0%)		
Breast	8(40.0%)	12(60.0%)	20(100.0%)	4.8(8)	0.79
Head and Neck	8(47.1%)	9(52.9%)	17(100.0%)		
Oesophagus	7(58.3%)	5(41.7%)	12(100.0%)		
Connective and soft tissue	8(72.2%)	3(27.3%)	11(100.0%)		
Eye	2(33.3%)	4(66.7%)	6(100.0%)		
Skin	2(40.0%)	3(60.0%)	5(100.0%)		
Rectal	1(33.3%)	2(66.7%)	3(100.0%)		
Others	3(42.9%)	4(57.1%)	7(100.0%)		
Stage of cancer					
I	1(50.0%)	1(50.0%)	2(100.0%)	2.24(4)	0.69
II	19(49.4%)	14(50.7%)	33(100.0%)		
III	16(30.0%)	23(70.0%)	39(100.0%)		
IV	10(42.9%)	12(57.1%)	22(100.0%)		
Not stated	28(51.9%)	26(48.1%)	54(100.0%)		

Mode of treatment: The mode of treatment was significantly associated with suicidality (chi=15.0; d.f=10; p=0.008) only. Other psychiatric morbidities did not show statistically significant associations with mode of treatment.

Table 9: Association between treatment modalities and psychiatric morbidity

	Psychiatric morbidity		Total	Chi Square (df)	P value
	No	Yes			
Radiotherapy	45(60.8%)	29(39.2%)	74(100.0%)	15.0(5)	0.008*
Radiotherapy+chemotherapy	6(22.2%)	21(77.8%)	27(100.0%)		
Palliative care	9(45.0%)	11(55.0%)	20(100.0%)		
Chemotherapy	8(66.7%)	4(33.3%)	12(100.0%)		
Radiotherapy+chemotherapy+ surgery	3(30.0%)	7(70.0%)	10(100.0%)		
Chemotherapy +surgery	3(42.9%)	4(57.1%)	7(100.0%)		
Total	74(49.4%)	76(50.7%)	150(100.%)		

Multivariate analysis

Results of the multivariable logistic regression analysis are presented in Table 10. The independent variables regressed on prevalence of psychiatric morbidity in the multivariate regression model included age, sex, religion, marital status, education and occupation. After adjusting for the effects of these predictors, age of the patient showed the strongest significant association with prevalence of psychiatric morbidity in cancer (p = 0.023). The prevalence of psychiatric morbidity reduced with increasing age and the risk of psychiatric morbidity reduced by at least 65% in the age groups above 30 years compared to the prevalence among patients aged between 18 and 29 years. The odds of psychiatric morbidity were 28% higher in males compared to females but this association was not statistically significant.

Religion did not show an overall association with psychiatric morbidity but patient in other religions was six times more likely to have psychiatric morbidity compared to Christians while Muslims had a slightly lower risk (0.86) of morbidity compared to Chistians. Similarly, marital status (p= 0.296), education level (p= 0.238) and occupation (0.94) did not show statistically significant associations with the prevalence of psychiatric morbidity among cancer patients.

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Table 10: Logistic regression analysis of independent predictors of the prevalence of psychiatric morbidity among adult patients with cancer

	Psychiatric morbidity (76) n(%)	No psychiatric morbidity (74) n(%)	Adjusted Odds Ratio (95% CI)	P value
Sex				
Female	52 (51.5)	49 (48.5)	1.0	0.56
Male	24 (49)	25 (51)	1.28 (0.56-2.94)	
Age group				
18-29 years	13 (72.2)	5 (27.8)	1.0	0.025
30-39 years	19(59.4)	13 (40.6)	0.35 (0.07-1.75)	
40-49 years	25 (53.2)	22 (46.8)	0.26 (0.06-1.15)	
50-59 years	13(48.2)	14(51.8)	0.19(0.04-0.95)	
60-69 years	5 (23.8)	16 (76.2)	0.07 (0.01-0.41)	
70 years and above	1(20)	4(80)	0.02 (0.001-0.63)	
Religion				
Christian	47 (53.4)	41 (46.6)	1.0	0.25
Muslim	26 (45.6)	31 (54.4)	0.86 (0.4-1.88)	
Others	3(60)	2(40)	6.35 (0.51-79.13)	
Marital status				
Single	12(50)	12 (50)	1.0	0.296
Married/ cohabiting	43 (50.6)	44 (49.4)	2.13 (0.63-7.21)	
Divorced/ separated	12(60)	8(40)	3.76 (0.82-17.24)	
Widowed	9 (47.4)	10 (52.6)	4.0 (0.79-20.2)	
Others				
Education				
None	10(32.3)	21 (67.7)	1.0	0.238
Primary	56 (53.3)	49 (46.7)	1.78 (0.65-4.9)	
Secondary/ college	10(66.7)	4 (33.3)	4.19(0.73-24.0)	
Occupation				
Employed	4(50)	4(50)	1.0	0.94
Self employed	11 (52.4)	10 (47.2)	0.94 (0.13-6.8)	
Peasant farmer	51 (49.5)	52 (50.6)	1.05 (0.09-5.54)	
Unemployed	6 (46.2)	7 (53.8)	0.71 (0.09-5.55)	
Other	4(80)	1(20)	2.35 (0.1-53.2)	

CHAPTER 6

6. DISCUSSION

The main objective of this study was to determine the psychiatric morbidity among adult cancer patients admitted at Ocean road cancer institute, Dar es salaam, Tanzania. This is the first study of its kind to be conducted in the country and the instrument used in this study (MINI Swahili version 5) was used for the first time in the country and hence this is a pilot study for this particular instrument. It will also be used as a baseline for future studies.

6.1 SOCIAL DEMOGRAPHIC CHARACTERISTICS

The male to female to ratio was 1:2 reflecting that the gynecological cancers namely cancer of the cervix and breast were the leading cancers reported in this study. These two cancers were the most common cancer among the 101 women studied with reported prevalence of cancers of the cervix and breast at 68.3% and 19.8%, respectively. This is consistent with other previous studies done in cancer patient. Odejide, Nuhu et al (13, 18) in two different studies in which cancer of the cervix and breast were reported in high proportion compared to the rest of the cancers.

Marital status, occupation and level of education were significantly associated with psychiatry morbidity specifically suicide and depression. Those who were living with a spouse were less prone to depression (19.5%) compared to those who were single (45.9%) and those who were widows/separated (35.9%). This could be due to the fact that being single, separated; widow is among the risk factor for depression for those vulnerable

Those with no formal education were less prone to suicide (25.8%) compared to the rest in the other levels of education (31%-38%). This could be due the fact that lack of formal education is linked to low knowledge about cancer and it implications in life as well as the prognosis. Also this is the group which had low risk of depression compared to others and hence less suicidal.

The significant association between occupation and major depressive episode in which those who were employed/self employed were found to have the highest prevalence of depression (37.5%) compared to the rest could be because those who were self employed could be the sole bread winners of their families and the chronic

debilitating illness and their hospitalization could be negatively affecting their families financially and hence more depression.

6.2 CLINICAL CHARACTERISTICS

Treatment modality with the finding that those on palliative care and combination therapies were being more suicidal compared to those on monotherapies is consistent with other previous studies. Fatma, Mohamoud et al (48) found that Triple treatment modality in cancer patients adversely affected global quality of life compared to radiotherapy or chemotherapy alone. This is supported by their findings in their study that more than half of the patients who were treated with triple modality suffered severely from the side-effects of treatment (physical toxicity) including easy fatigue and vomiting as well as headache, dizziness, anorexia and diarrhea compared to those on monotherapy

Presece of pain symptoms: Previously done studies have shown the presence of pain in cancer patients to be highly associated with psychiatric morbidity especially depression and suicidality. Ojedije et al (18) in their study to determine the psychological and physical effect of pain among cancer patients in Nigeria found the presence of pain in cancer patients to be significantly associated with both depression and suicidality. . More specifically they found that among the patients with pain 41.3% were found to have depression compared to 25.5% of those without pain and 65.2% of those with pain had suicidal ideation as compared to 34.8% of those without pain. These findings are consistent with the current study in which patients with pain symptoms were more likely to have depression compared to those without pain (61.9% versus 38.1%, respectively) and 53.4% of the patients presenting with pain also had suicidality compared to 46.6% of patients without pain who also had suicidality . However in both the Nigerian study and this study it was difficult to determine whether the pain symptoms were due to direct effect of the cancer or due to the cormobid disorders like depression

Awareness of cancer diagnosis: Different researchers have found contradicting results regarding the association between psychiatric morbidity and awareness of cancer diagnosis. Atesci FC et al (9) in Turkey, Alexander et al (11) in India and by

Azadeh Tavoli et al (22) in Tehran Iran found significant association between awareness of cancer diagnosis and psychiatric morbidity in which psychiatric morbidity was reported to be significantly less common in patients who did not know if they had cancer

The present study found the psychiatry morbidity to have no association with the awareness of cancer diagnosis which contradicts the above findings, however supports previous findings by Chandra et al (16) and Takashi et all (17) which showed no difference in terms of patterns and prevalence of psychiatric morbidity between those who were aware and those who were not aware of the cancer diagnosis. Other researchers concluded that the cultural issues and the way information regarding cancer is provided to cancer patients have an important role in their improved or decreased psychological status (22).

Clinical stage and site of the cancer: Psychiatric morbidity in the present study was found to have no correlation with the stage or the site of cancer and this is consistent with some other studies (49, 50, 51) which concluded that meaning and interpretation of having cancer may be more important in developing psychological symptoms (52). However other studies have reported statistically high prevalence of psychiatric morbidities in patients with cancer of the pancrease, brain and colon (12, 21) cancers which were not diagnosed in this Tanzanian study.

Recognition of psychiatric morbidity by staff: In the present study none of the study participant had a documentation of psychiatric morbidity in the file case notes despite the high prevalance of psychiatric morbidity detected. This means the cases remain undiagnosed and thus, unmanaged. This results support other findings from previously done studies. According to Ndetei DM et al (46) in a study to establish the prevalence of mental disorders in adults in different level general medical facilities in Kenya found clinicians detection rate of mental disorders to be 4.1%. In contrast Keller, L et al (52) (2004) aiming at recognition of distress and psychiatric morbidity in cancer patients at Psychosocial care unity department of surgery, University of Heidelberg, Germany found the oncology doctors and nurses ability tor recognize patients' psychological morbidity compared to a diagnostic psychiatric interview findings to be 77% and 75% respectively. Because of low specificity, the positive Predictive value was only 39% in surgeons and 40% in nurses. However, only small

proportions of the distressed patients were referred for psychosociaol liason services. The authors suggested systematic screening of patients upon admission to allow timely support to those who are most in need (52). Others conluded that the low clinician detection rate for mental disorders means that most psychiatric disorders in general medical facilities remain undetected and unmanaged and this calls for improved diagnostic practices in general medical facilities (46).

6.3 PREVALANCE AND PATTERN OF PSYCHIATRIC MORBIDITY

The overall prevalence of psychiatric morbidity in this study was (50.7%) when pain disorder due to general medical condition and psychological factor was excluded as a psychiatric morbidity. However when pain disorder due to general medical condition and psychological factor was included as a psychiatric morbidity the overall prevalence of psychiatric morbidity based on the MINI criteria was found to be 98(65.3%). These findings are similar to other studies (7, 20, 23, 40) which have reported overall prevalence of psychiatric disorder in cancer patients to range from 42% to 47.8 %. Some studies hawever reported much lower prevalaces (6, 10, 12, 19). The three leading types of psychiatric morbidities in the present study based on the MINI criteria were pain disorder associated with psychological factors and general medical condition (40.7%). suicidality (38.7%) and major depressive episodes (28.0%). Anxiety disorder specifically panic disorder was 4.6%. The rest of psychiatric morbidities were reported in lower prevalances.

These findings contradict other reported findings in which adjustment disorder was the leading psychiatric morbidity followed by Major depression and anxiety disorder (7, 8, 10, 11, 18, 40, 42). The contradiction could be due to the fact that in most of the above mentioned studies SCID-1 was used as the screening instrument. This instrument does not limit the diagnosis of adjustment disorder even if other axis I psychiatric disorders are present in the same patient, also it lacks a separate module for suicidality and pain disorder due to general medical condition and psychological factors. This present study used MINI which limits the diagnosis of adjustment disorder in the presence of any other axis I psychiatric disorder, and also it includes a separate modules for the suicidality and and pain disorder due to general medical condition and psychological factors.

6.4 LIMITATIONS

Despite assurance of confidentiality to the study participants it was difficult to interview all the participants in privacy due to lack of side rooms in some of the wards where interviews could be conducted and also some patients due to severe pain could not move from their beds to be interviews privately, this necessitated the interview to be done by the bed side.

A total number of 54 (36%) of study participants had no documentation of the clinical stage of their cancer in their file case notes. This could have biases the outcome of the findings

This study used the Swahili version of MINI version 5, this is because it is the version which had the Swahili version available in the country where the study was done. However this version had some drawbacks as follows:

1. Provided that this study was dealing with cancer patients of whom most had pain and physical impairment, the module for depression which assess symptoms like trouble with sleep, lethargy/tiredness, problems with appetite, all this could have resulted from the complications of the cancer itself including the severe pain or in combination with the complications of the different treatment modalities which the patients were receiving and this could have biases the results. Also this module does not include a criterion to state whether the symptoms are due to general medical condition or not.
2. The module for screening depression with melancholic features included a question which asks the patient whether they have lost the ability to respond to things that they used to enjoy previously, and most patients could not respond to this question since this were inpatients and hence lack entertairnments or other activities which could chear them up, and hence could have biased the results as well
3. The module for screening anorexia nervosa included the question which ask the patient about their height and weight which most did not know and there was neither weighing machine nor height measures in the wards and therefore the conclusion was mostly relied on the response of whether the patient had feared gaining weight despite the subjective feelings of weight loss
4. The module for screening pain disorder diagnosed majority of patients with pain disorder due to general medical conditions and psychological factors but it is not

clearly known to what extent had the psychological factors had contributed to the patients pain symptoms

5. Finally the module for adjustment disorder limits the screening for this disorder in the present of any other axis 1 psychiatric disorder in the same patient and this lead to fewer cases to be diagnosed with the adjustment disorder despite the fact that the emotional and behavioral symptoms of most patients were the result of the life stress (being diagnosed with cancer)

6.5 CONCLUSION

Psychiatric morbidity is high among cancer patients. There was a significant association between the presence of pain and psychiatric morbidity specifically suicidality and depression and hence adequate management of pain in cancer patients is important. Combined treatment modalitity especially triple therapy and palliative care in cancer patients have been shown to increase the chances for developing psychiatric morbidity, therefore psychosocial support and assessment for psychological distress should be prioritized in this group.

Psychiatric morbidity among cancer patients goes undetected and hence unmanaged. This calls for the need for routine screening and consultation liason psychiatric services for those in need

6.6 RECOMMENDATIONS

Future studies to focus on the psychological effects of anti cancer drugs, as well as the other risk factors for psychiatric morbidity among cancer patients.

Future studies to be done among outpatient cancer patients for comparison purposes as this study was done among inpatients only almost all of whom were coming from other regions apart from Dar es Salaam and they probably had very little family support

Policy and Practical Implications

These findings support routine psychological assessment as part and parcel of the management of cancer patients. This can also be archieved by training the physicians and nurses taking care of the cancer patients as well as strengthening the consultation liason psychiatric services in the hospital for appropriate care of these patients

Adequate control of pain among cancer patients to reduce the psychiatric distress resulting from pain

APPENDICES

APPENDIX 1: INFORMED CONSENT EXPLANATION

To be read and questions answered in a language in which the study subject is conversant (English or Kiswahili)

My name is Dr Praxeda James Swai; I am a pursuing masters in Psychiatiy at University of Nairobi. I am doing a study entitled psychiatric morbidity among adult cancer patients admitted at Ocean road cancer institute Dar es salaam, Tanzania as part of my degree award fulfillment. My supervisors are Prof. D.M.Ndetei, Dr. Mary Kuria and Dr Owiti who are all Lecturers in the Department of Psychiatry, University of Nairobi

The aim of this study is to find out the magnitude of psychological problems among people diagnosed to have cancer

This study will be conducted by me under supervision of my supervisors

This is a medical research and you are required to understand the following which apply to all in medical research

Your participation is completely voluntary and you may withdraw consent at any time in the course of the interview

Refusal to participate will not in any way affect your health services/benefits which you are entitled

After reading the explanation, don't hesitate to ask any questions in case you need clarifications

I will assess your psychological profile by using an instrument which will take about 30minutes of your time. This instrument will assist me to pick any mental health problems that you may have and it will contain questions concerning your feelings, thoughts and behavior

No invasive procedures such as drawing blood will be involved and no risks will be posed to you except that you may experience an emotional pain through asking you emotionally painfully questions

All information obtained from this study will remain confidential and your privacy will be upheld. Serial numbers instead of your name will be used in this study for identification, however your name will only appear on the consent form which will be signed and kept separately from the study documents for legal purposes and for

identification in case you will be found with psychological problems that need follow up

There will be no material gain from this study. However the overall study will be of benefit to cancer patients and the hospital in general in terms of implementation and better intervention and comprehensive care of cancer patients in the aspect of mental health

I can also be of help to you if you feel you need such help

If you have any questions related to this study, or your health you can call me on my telephone numbers **+254735341511 or +255754660214** or my lead supervisors at the department of psychiatry, University of Nairobi Or KNH/ UON Ethics and Research Committee at Kenyatta Hospital on telephone number **7263009** or P.O BOX **20723,** Nairobi.

INFORMED CONSENT EXPLANATION (SWAHILI TRASLATION)

Fomu ya maelezo ya maridhiano

To be read and questions answered in a language in which the study subject is conversant (English or Kiswahili)

Mimi ni daktari na jina langu Praxeda James Swai, nasoma shahada udhamini ya magojwa ya akili chuo kikuu cha Nairobi. Nafanya utafiti unaojulikana kama 'matatizo ya kisaikolojia miongoni mwa wagojwa wa kansa waliolazwa hospitali ya Ocean Road' Dar es salaam' ikiwa ni sehemu ya mahitaji ya digrii yangu. Wasimamizi wangu ni Profesa D.M. Ndetei, Dr Mary Kuria na Dr Owiti ambao wote ni wahadhiri katika kitengo cha magojwa ya akili Chuo kikuu cha Nairobi.

Dhumuni la utafiti huu ni kujua ukubwa wa matatizo ya kisaikolojia miongoni wa wagonjwa waliogundulika kuwa na kansa, na huu utafiti utafanywa na mimi menyewe chini ya usimamizi wa wasimamizi wangu niliowataja hapo juu.

Huu ni utafiti wa kitabibu na unahitaji kuelewa mambo yafuatayo ambayo hutumika katika tafiti zote za namna hii

Kushiriki kwako ni kwa hiari na unaweza kusitisha ridhaa yako ya kushiriki wakati wowote

Kukataa kwako kushiriki haitaathiri kwa namna yoyote ile huduma zako za kiafya unazotakiwa kupewa

Baada ya kusoma maelezo usisite kuuliza maswali endapo utahitaji ufafanuzi.

Nitapima matatizo yako kwa kutumia kifaa ambacho kitachukua kama dakika 30 ya muda wako. Hiki kifaa kitanisaidia hupata matatizo yoyote ya kisaikolojia ambayo unaweza kuwa nayo, pia ina maswali yanayohusu vile unajisikia, mafikira na pia tabia yako

Hakutakuwa na utolewaji damu katika utafiti huu

Hakutakuwa na athari zozote kwako isipokuwa labda maumivu ya kihisia kufuatia maswali yanayoumiza kihisia nitakayokuuliza

Habari zitakazopatikana katika utafiti huu zitabakia kuwa siri, na itatumika namba badala ya jina lako katika kukutambua ,ila itakubidi kuandika jina lako katika fomu ya maridhiano ambayo itahifadhiwa tofauti na nyaraka nyingine za utafiti. Hii ni kwa madhumuni ya kukutafuta na kukufuatilia afya yako baadae endapo utapatikana na matatizo ya kisaikolojia, na pia itakuwa kwa ajili ya mambo ya kisheria

Hakutakuwa na kupewa hela ama zawadi zozote zile katika utafiti huu ila matokeo yake yatawasaidia wagojwa wote wa kansa na hospitali kwa ujumla katika kuhakikisha huduma bora za afya ya akili zinatolewa kwa wagojwa wa kansa

Nitaweza pia kukusaidia endapo utahitaji msaada ambao upo ndani ya uwezo wangu

Endapo utakuwa na maswali yoyote kuhusiana na utafiti huu au afya yako tafadhali nipigie katika namba zangu za simu ambazo ni **+254735341511 au +255754660214** au unaweza kuwauliza wasimamizi wangu katika kitengo cha afya na magonjwa ya akili chuo kikuu cha Nairobi Au unaweza kuwasiliana na KNH/ UON Ethics and Research Committee at Kenyatta Hospital kwenye namba **726300-9** au S.L.**P 20723,** Nairobi.

CONSENT FORM

I, the undersigned do hereby volunteer to participate in this study. The nature and purpose have been fully explained to me by Dr Praxeda Swai

I understand that all information obtained will be used for this study only and that I can withdraw my consent at any time without loosing any benefits which iam entitled

Name.............................serial no........signature/thumbprint...............date
(patients name)

Witnessed (Dr Praxeda swai) signature...........................date

FOMU YA MARIDHIANO

Mimi ninayesaini najitolea kwa hiari yangu kushiriki katika utafiti huu ambao asili na lengo lake nimeelezwa kwa kina na dokta Praxeda Swai

Naelewa kwamba habari itakaypoatikana itatumika tu kwa ajili ya huu utafiti na si vinginevyo na kwamba naweza kusitisha ridhaa yangu ya kushiriki katika utafiti huu wakati wowote na hii haitaathiri kwa namna yoyote ile huduma zangu za kiafya ninazotakiwa kupewa.

Jina.................................Namba......................Saini/dole gumba..................Tarehe
(Jina la mgonjwa)

Mbele ya shahidi (Dr Praxed Swai) Saini.....................................Tarehe

APPENDIX II: QUESTIONNAIRE

Socio-demographic and clinical questionnaire

SERIAL NUMBER

1. Age
2. Sex

   (i) Male

   (ii) Female

3. Residence
4. Religion

   (i) Christian

   (ii) Islam

   (iii) Others (specify)

5. Marital status

   (i) Single

   (ii) Married

   (iii) Divorced

   (iv) Separated

   (v) Cohabiting

   (vi) Others (specify)

6. Education level

   (i) No formal education

   (ii) Primary

   (iii) Secondary

   (iv) College

   (v) University

   (vi) Others (specify)

7. Occupation

(i) Employed (specify)

(ii) Self employed

(iii) Unemployed

(iv) Others (specify)

8. Social economic status

Amount of income per month

Possesions (specify)

9. Do you know what kind of an illness/disease you are suffering from?

(i) Yes

(ii) No(skip questions (10, 11, 12)

10. What is it? Specify...(if the answer is not cancer skip questions 11, 12)

11. When did you know that you have cancer?...........(month/year)

12. Before knowing that you have cancer were you having any psychological problem?

(i)Yes (specify)

(i)No

13. Main system/organ involved by the cancer (extract from patient's file notes)

14. The type of cancer from histology confirmation (extract from patient's file notes)

15. The stage of the cancer (extract from patient's file notes)

16. Current treatment(extract from patient's file notes)

(i) Chemotherapy

(ii) Radiotherapy

(iii) Combined treatment (specify)

17. psychological problem (if documented in patients file)

    (i) Yes

    (ii) No (skip questions 18, 19, 20)

18. What kind of psychological problem? (extract from patient's file notes)

19. Was the case treated/referred? (extract from patient's file notes)

    (i) Yes

    (ii) No

20. Has any one discussed the psychological problems with you?

    (i) Yes

    (ii) No

21. Has any one discussed with you the psychological consequence of your cancer?

    (i) Yes

    (ii) No

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M.I.N.I.

Mini International Neuropsychiatry Interview

English Version 5.0.0

DSM-IV

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powers for her advice on the modules on Anorexia nervosa and Bulimia. Printed, 29

PATIENT'S NAME:	***PROTOCOL NUMBER :***
JINA LA MGONJWA:	***NAMBA YA PROTOKALI:***
DATE OF BIRTH:	***Time Interview Began:***
TAREHE YA KUZALIWA:	***Muda wa Kuanza Usaili:***
INTER VIE WER 'S NAME :	***Time Interview Ended:***
JINA LA MSAILI :	***Muda wa Kumaliza Usaili:***
DA TE OF INTER VIEW :	***TOTAL TIME :***
TAREHE YA USAILI :	***MUDA ULIOTUMIKA :***

S S . X . N ' . Z . S . O . O / English version / DSM-IV / current

MODULES VIHLNZI HURU	TIME FRAME MUDA	
A. MAJOR DEPRESSIVE EPISODE A. TUKIO LA SONONA	Current (past 2 weeks) + Lifetime Kwa sasa(wiki 2) +siku za nyuma	
A'. MDE with melancholic features TUKIO LA SONONA lenye uzito wa moyo(hiari)	Current (past 2 weeks)	Optional
B. DYSTHYMIA B. DISTHIMIA	Current (past 2 years)	
C. SUICIDALITY C. HALI YA KUTAKA KUJIUA	Current (past month)	
D. (HYPO) MANIC EPISODE D. TUKIO LA MANIA (MANIA NDOGO)	Current + Lifetime	
E. PANIC DISORDER E. UGONJWA WA HOFU KUBWA	Lifetime + current (past month)	
F. AGORAPHOBIA F. WOGA WA NAFASI ZA WAZI	Current	
G. SOCIAL PHOBIA G. WOGA WA MKUSANYIKO WA WATU	Current (past month)	
H. OBSESSIVE-COMPULSIVE DISORDER H. UGONJWA WA SHAUKU LAZIMISHO	Current (past month)	
I. POSTTRAUMATIC STRESS DISORDER I. UGONJWA WA MSONGO BAADA YA MATUKIO MABAYA	Current (past month)	Optional
J. ALCOHOL DEPENDENCE / ABUSE	Current (past 12 months)	

J. KUTAWALIWA NA POMBE / MATUMIZI MABAYA YA POMBE		
K. DRUG DEPENDENCE / ABUSE (Non-alcohol) K. KUTAWALIWA / MATUMIZI MABAYA YA MADAWA YA KULEVYA (isiyo pombe)	Current (past 12 months)	
L. PSYCHOTIC DISODERS L. MAGONJWA YA SAIKOSIS	Lifetime + Current	
M. ANOREXIA NERVOSA M. UGONJWA WA TAFSIRI YA MAUMBILE BINAFSI UNAOHUSIANA NA KUTOKULA	Current (past 3 months)	
N. BULIMIA NERVOSA N. UGONJWA WA TAFSIRI YA MAUMBILE BINAFSI UNAOHUSIANA NA KULA MNO	Current (past 3 months)	
O. GENERALIZED ANXIETY DISORDER O. UGONJWA WA WASIWASI MKUBWA	Current (past 3 months)	
P. ANTISOCIAL PERSONALITY DISORDER P. UGONJWA WA MAKUZI YA HULKA NA TABIA ZINAZOPINGANA NA JAMII	Lifetime	Optional

GENERAL INSTRUCTIONS

The M.I.N.I. was designed as a brief structured interview for the major Axis I psychiatric disorders in DSM-IV and ICD-10. Validation and reliability studies have been done comparing the M.I.N.I. to the SCID-P and the CIDI. The results of these studies show that the M.I.N.I. has acceptably high validation and reliability scores, but can be administered in a much shorter period of time (mean 18.7 ± 11.6 min., median 15 min.) than the above referenced instruments. It can be used by <u>clinicians, after a brief training session</u>. Lay interviewers require more extensive training.

- **Interview:**

In order to keep the interview as brief as possible, inform the patient that you will conduct a clinical interview that is more structured than usual, with very precise questions about psychological problems which requires a yes or no answer.

- **General format:**

  The M.I.N.I. is divided into **modules** identified by letters, each corresponding to a diagnostic category.

  - At the beginning of each module (except for psychotic disorders module), **screening question(s)** corresponding to the main criteria of the disorder are presented in a **gray box.**
  - **At** the end of each module, **diagnostic box(es)** permit(s) the clinician to indicate whether the diagnostic criteria are met.

- **Conventions :**

  Sentences written in « normal font » should be read exactly as written to the patient in order to standardize the assessment of diagnostic criteria.

  Sentences written in « CAPITALS » should not to be read to the patient. They are instructions for the interviewer to assist in the scoring of the diagnostic algorithms.

  Sentences written in « **bold** » indicate the time frame being investigated. The interviewer should read them as often as necessary. Only symptoms occurring during the time frame indicated should be considered in scoring the responses.

  Sentences (in parentheses) are clinical examples of the symptom .These may be read to the patient to clarify the question.

  Answers with an arrow above them (4) indicate that one of the criteria necessary for the diagnosis (es) is not met. In this case, the interviewer should go to the end of the module, to circle « NO » in all the diagnostic boxes and move to the next module.

  When terms are separated by a ***slash (/),*** the interviewer should read only those symptoms known to be present in the patient (for example, question A3).

- **Rating instructions:**

  All questions read must be rated. The rating is done at the right of each question by circling either YES or NO.

  The clinician should be sure that <u>each dimension</u> of the question is taken into account by the patient (i.e.: time frame, frequency, severity, «and/or» alternatives).

Symptoms better accounted for by an organic cause or by the use of alcohol or drugs should not be coded positive in the M.I.N.I.. The M.I.N.I. Plus has questions that investigate these issues.

For any questions, suggestions, need for a training session, or information about updates of the M.I.N.I., please contact:

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MEANS : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

A. MAJOR DEPRESSIVE EPISODE
TUKIO LA SONONA

A1	Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks ? Je, ulishawahi kukosa raha muda mwingi wa siku, karibu kila siku, kwa muda wa wiki mbili zilizopita?	HAPANA	YES NDIYO	1 1
A2	In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time ? Katika wiki mbili zilizopita, je, umekosa hamu/ari katika vitu vingi au kukosa raha kwa muda mwingi katika vitu vilivyokuwa vikikufurahisha ?	NO HAPANA	YES NDIYO	2 2
	IS **Al** OR **A2** CODED YES ? JE, KIPENGELE **Al** AU **A2** KIMEJIBIWA NDIYO?	NO HAPANA	YES NDIYO	
A3	**Over the past two weeks, when you felt depressed and/or uninterested :** **Katika kipindi cha wiki mbili zilizopita, ulipojisikia kukosa raha na / au kutokuwa na ari:**			
a	Was your appetite decreased or increased nearly every day or did your weight decrease or increase without trying intentionally ? (**i.e.,** ± 5 % of body weight or ± 3,5 kg or ± 8 lbs., for a 70 kg / 120 lbs. person in a month) Je, hamu yako ya kula ilipungua au kuongezeka, karibu kila siku? Uzito wako ulipungua au uliongezeka bila wewe kukusudia? (yaani ± 5 % ya uzito wako au kg. 3.5 katika mwezi) **IF YES** TO EITHER, CODE **YES** IWAPO JIBU NI NDIYO KWA LOLOTE, JAZA NDIYO	NO HAPANA	YES NDIYO	
	Did you have trouble sleeping nearly every night (difficulty falling asleep, waking up in the middle of the night, early morning wakening, or sleeping excessively) ? Je, ulipata shida ya usingizi karibu kila siku? (tabu ya kupata usingizi, kukatika usingizi katikati ya usiku, kuamka mapema sana, au kulala mno)	NO HAPANA	YES NDIYO	
c	Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still, almost every day? Je, ulikuwa ukiongea au kutembea taratibu zaidi kuliko kawaida yako, au ulikuwa na hali ya kuhangaika, kutotulia, au kuwa na tatizo la kukaa kwa utulivu karibu kila siku?	NO HAPANA	YES NDIYO	
		NO	YES	6

	Question			
d	Did you feel tired or without energy, almost every day? Je, ulijisikia mchovu au kutokuwa na nguvu karibu kila siku?	**HAPANA**	**NDIYO**	**6**
e	Did you feel worthless or guilty, almost every day? Je, ulijisikia huna thamani au kuwa na hali ya kujilaumu karibu kila siku?	**NO** **HAPANA**	**YES** **NDIYO**	
f	Did you have difficulty concentrating or making decisions, almost every day? Je, ulikuwa na matatizo ya kuwa makini au kufanya maamuzi karibu kila siku?	**NO** **HAPANA**	**YES** **NDIYO**	
	Did you repeatedly consider hurting yourself, feel suicidal, or wish that you were dead? Je, mara kwa mara ulifikiria kuhusu kujiumiza, au kutaka kujiua, au bora ufe?	**NO** **HAPANA**	**YES** **NDIYO**	
A4	ARE **3** OR MORE **A3** ANSWERS CODED **YES ?** (OR **4** **A3** ANSWERS IF **A1** OR **A2** ARE CODED **NO)** JE, VIPENGELE **3** AU ZAIDIVYA **A3** VIMEJIBIWA **NDIYO?** (AU MAJIBU **4 YA A3** IKIWA **AI** AU **A2** VIMEJIBIWA **HAPANA)**	**NO** **HAPANA**	**YES** **NDIYO**	
		MAJOR DEPRESSIVE EPISODE CURRENT ***TUKIO LA SONONA KWA SASA***		
A5	**IF PATIENT MEETS CRITERIA FOR MAJOR DEPRESSIVE EPISODE CURRENT:** IKIWA MGONJWA ATAFIKIA VIGEZO VYA TUKIO LA SONONA KWA SASA:	**NO**	**YES**	10
a	During your lifetime, did you have other periods of two weeks or more when you felt depressed or uninterested in most things, and had most of the problems we just talked about ? Katika maisha yako, uliwahi kuwa na kipindi kingine cha wiki mbili au zaidi ambapo ulikosa raha au kukosa ari katika mambo mengi na kwamba umekuwa na shida kama zile tulizokwishazizungumza?	**HAPANA**	**NDIYO**	10
		NO	**YES**	11
		HAPANA	**HAPANA**	11
b	Was there an interval of at least 2 months without depression and/or lost of interest between your current episode and your last episode of depression ? Je, kulikuwa na kipindi cha angalau miezi 2 bila hali ya kukosa raha na /au kupoteza ari kati ya wakati huu na ulipokuwa na hali hii siku za nyuma?			
	IS A5b CODED YES ? JE, KIPENGELE A5b KIMEJIBIWA **NDIYO?**	**NO** **HAPANA**	**YES** **NDIYO**	
		MAJOR DEPRESSIVE EPISODE PAST		

MEANS : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

TUKIO LA SONONA WAK.4TI ULIOPITA

A. MAJOR DEPRESSIVE EPISODE WITH MELANCHOLIC FEATURES (optional)
A. TUKIO LA SONONA LILILOAMBATANA NA UZITO WA MOYO (HIARI)

IF THE PATIENT CODES POSITIVE FOR A MAJOR DEPRESSIVE EPISODE (A4 = YES), EXPLORE THE FOLLOWING :
KAMA MGONJWA ATADHIHIRISHA KUWA NA SONONA KWA SASA (A4 = NDIYO), CHUNGUZA YAFUATAYO:

A6 a IS **A2** CODED YES ? — **NO** / **YES** **12**
JE KIPENGELE **A2** KIMEJIBIWA NDIYO? — **HAPANA** / **NDIYO** **12**

B During the most severe period of the current depressive episode, did you lose your ability to respond to things that previously gave you pleasure, or cheered you up? — **NO** / **YES** **13**
Wakati wa hali mbaya zaidi ya sonona ya sasa, uliwahi kupoteza uwezo wa kufanya vitu ambavyo mwanzoni vilikuwa vikikupa furaha au kukuchangamsha? — **HAPANA** / **NDIYO** **13**
IF NO : When something good happens does it fail to make you feel better, even temporarily ?
KAMA JIBU NI HAPANA: Wakati jambo zuri linatokea, je, jambo

IS EITHER **A6a** OR **A6b** CODED YES ? — **NO** / **YES**

JE, KIPENGELE **A6a** AU **A6b** KIMEJIBIWA NDIYO? — **HAPANA** / **NDIYO**

Over the past two weeks period, when you felt depressed and uninterested :
Katika kipindi cha wild mbili zilizopita, ulipojisikia kukosa raha au kukosa ari:

A7 a Did you feel depressed in a way that is different from the kind of feeling you experience when someone close to you dies ? — **NO** / **YES** **14**
Je, ulikosa raha tofauti na vile unavyojisikia wakati unapofiwa na mtu wako wa karibu? — **HAPANA** / **NDIYO** **14**

b Did you feel regularly worse in the morning, almost every day ? — **NO** / **YES** **15**
Je, ulijisikia kuwa na hali mbaya zaidi kwa kila asubuhi karibu kila siku? — **HAPANA** / **NDIYO** **15**

c Did you wake up at least 2 hours before the usual time of awakening and have difficulty getting back to sleep, almost every day ? — **NO** / **YES** 16
Je, ulikuwa ukiamka angalau masaa mawili kabla ya muda wako wa kawaida wa kuamka na kupata tabu ya kulala tena karibu kila siku? — **HAPANA** / **NDIYO** **16**

e IS A3c CODED **YES ?** — **NO** / **YES** **17**
JE, KIPENGELE A3c KIMEJIBIWA NDIYO? — **HAPANA** / **NDIYO** **17**

d IS A3a CODED **YES** (**ANOREXIA OR WEIGHT LOSS ONLY**)? — **NO** / **YES**
HAPAN / **NDIYO** **18**

MEANS : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

JE, KIPENGELE **A3a** KIMEJIBIWA NDIYO (KUKOSA HAMU YA CHAKULA AU KUPUNGUA MWILI)?	**A**		18
Did you feel excessive guilt or out of proportion to the reality of the situation ?	**NO**	**YES**	**19**
JE, A3e IMEJIBIWA NDIYO (KUJILAUMU KUPITA KIASI, AU KUJILAUMU KUSIVYOSTAHILI)?	**HAPAN** A	**NDIYO**	**19**

ARE **3** OR MORE **A7** ANSWERS CODED **YES ?**
JE, VIPENGELE **VITATU** AU ZAIDI VYA **A7** VIMEJIBIWA **NDIYO?**

NO
YES
HAPANA
NDIYO

MAJOR DEPRESSIVE EPISODE
With Melancholic Features
CURRENT

TUKIOLA SONONA lililoambatana na uzito wa moyo KWA SASA

B. DYSTHYMIA
DISTHIMIA

IF PATIENT'S SYMPTOMS CURRENTLY MEET CRITERIA FOR MAJOR DEPRESSIVE EPISODE, DO NOT EXPLORE THIS MODULE
KAMA DALILI ZA MGONJWA KWA SASA ZINAFIKIA KIGEZO CHA TUKIO LA SONONA, USICHUNGUZE KIHUNZIHURU HIKI

B1	Have you felt sad, low or depressed most of the time for the last two years? Je, ulijisikia huzuni, mnyonge au kukosa raha muda mwingi kwa kipindi cha miaka miwili iliyopita?	N0 * I HAPANA	YES **NDIYO**	20
B2	Was this period interrupted by your feeling **OK** for two months or more? Je, kipindi hiki kilikatizwa na hali ya kujisikia safi kwa muda wa miezi miwili au zaidi?	N0 **HAPANA**	**NDIYO**	21 21
B3	**During this period of feeling depressed most of the time :** **Wakati wa kipindi hiki cha kujisikia kukosa raha muda mwingi:**			
A	Did your appetite change significantly ? Je, hamu yako ya kula ilibadilika kwa kiasi kikubwa?	**NO** **HAPANA**	**YES** **NDIYO**	**22** **22**
B	Did you have trouble sleeping or sleep excessively ? Je, ulipata tabu ya kupata usingizi au kulala mno?	**NO** **HAPANA**	**YES** **NDIYO**	**23** **23**
C	Did you feel tired or without energy ? Je, ulijisikia kuchoka au kukosa nguvu?	**NO** **HAPANA**	**YES** **NDIYO**	**24** **24**
D	Did you lose your self-confidence ? Je, ulipoteza uwezo wa kujiamini?	**NO** **HAPANA**	**YES** **NDIYO**	**25** **25**
E	Did you have trouble concentrating or making decisions ? Je, ulikuwa na tabu ya kuwa makini au ya kutoa maamuzi?	**NO** **HAPANA**	**YES** **NDIYO**	**26** **26**
F	Did you feel hopeless ? Je, ulijisikia kukosa matumaini?	**NO** **HAPANA** *	**YES** **NDIYO**	**27** **27**
	ARE **2** OR MORE **B3** ANSWERS CODED **YES ?** JE, VIPENGELE **2** AU ZAIDI VYA **B3** VIMEJIBIWA NDIYO?	**NO** **HAPANA**	**YES** **NDIYO**	

MEANS : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

B4 Did the symptoms of depression cause you significant distress or impair your ability to function at work, socially, or in some other important way ?

NQ y£S 2g

4

HAPANA NDIYO 28

Je, dalili za kukosa raha zilikupa shida nyingi au kudhoofisha ufanisi wako kazini, kijamii, au katika njia nyingine muhimu?

IS **B4** CODED YES ?
JE KIPENGELE **B4** KIMEJIBIWA **NDIYO?**

NO YES
HAPANA NDIYO

DYSTHYMIACURRENT
DISTHIMIA KWA SASA

C. SUICIDALITY
HALI YA KUTAKA KUJIUA

In the past month did you :
Katika mwezi uliopita, je:

CI	Think that you would be better off dead or wish you were dead? Ulifikiria kwamba ni bora ungekufa?	NO HAPANA	YES NDIYO
C2	Want to harm yourself? Ulitaka kujidhuru?	NO HAPANA	YES NDIYO
C3	Think about suicide ? Ulifikiria juu ya kutaka kujiua?	NO HAPANA	YES NDIYO
C4	Have a suicide plan ? Ulikuwa na mipango ya kujiua?	NO HAPANA	YES NDIYO
C5	Attempt suicide ? Ulijaribu kujiua?	NO HAPANA	YES NDIYO

In your lifetime
Katika maisha yako

C6	Did you ever make a suicide attempt ? Ulishawahi, wakati wowote, kujaribu kujiua?	NO HAPANA	YES NDIYO	6 6

IS AT LEAST 1 OF THE ABOVE CODED YES ?
JE, ANGALAU KIPENGELE KIMOJA KATI YA VYA HAPO JUU, KIMEJIBIWA NDIYO?

NO HAPANA — YES NDIYO

SUICIDE RISK
CURRENT
HATARI YA KUJIUA
KWA SASA

IF YES, SPECIFY THE LEVEL OF SUICIDE RISK AS FOLLOWS

KAMA NDIYO, ELEZA KIWANGO CHA HATARI YA KUJIUA KAMA IFUATAVYO:

CI or C2 or C6 = YES : LOW CI au C2 au C3 = NDIYO : HATARI NDOGO	Low HATARI NDOGO	• •
C3 or (C2 +C6) = YES : MODERATE C3 au (C2 +C6) = NDIYO : HATARI YA KATI	MODERATE HATARI YA KATI	• •

MEANS : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

C4 or C5 or (C3 + C6) = YES : HIGH

C4 au C5 au (C3 + C6) = NDIYO : HATARI KUBWA

HIGH	•
HATARI KUBWA	•

/

D. (HYPO) MANIC EPISODE
TUKIO LA MANIA (MANIA NDOGO)

D1 a	Have you ever had a period of time when you were feeling "up" or "high" or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol) **IF PATIENT IS PUZZLED OR UNCLEAR ABOUT WHAT YOU MEAN BY "UP" OR "HIGH", CLARIFY AS FOLLOW** : By "up" or "high" I mean : having elated mood, increased energy, needing less sleep, having rapid thoughts, being full of ideas, having an increase in productivity, creativity, motivation or impulsive behavior.	**NO**	**YES**	
	Je, ulishawahi kwa kipindi Fulani kujisikia una hali ya juu, au umejawa na nguvu au umesongwa kiasi cha kupatashida, au kwamba watu kukudhania kuwa sio mtu wa kawaida? (usichukulie muda ambao ulikuwa umedhurika kwa madawa au pombe) KAMA MGONJWA ANAONEKANA KUTOELEWA MAANA YA "HALI YA JUU", FAFANUA KAMA IFUATAVYO : Hali ya juu ina maana ya kuwa na hali ya furaha; kuhitaji usingizi mchache;kuwa na fikra za haraka; kusongwa na mawazo; kuongezeka katika tija, ubunifii, motisha au tabia ya kuamua ghafla	**HAPA NA**	**NDIYO**	**1**
	IF YES: KAMA JIBUNI NDIYO:			
B	Are you currently feeling "up" or "high" or full of energy?	**NO**	**YES**	**2**
	Je, sasa hivi unajisikia kuwa na hali ya juu au kujawa na nguvu?	**HAPA NA**	**NDIYO**	**2**
D2 a	Have you ever been persistently irritable, for several days, so that you had arguments or verbal or physical fights, or shouted at people outside your family ? Have you or others noticed that you have been more irritable or over reacted, compared to other people, even in situations that you felt were justified ? (Do not consider times when you were intoxicated on drugs or alcohol)	**NO**	**YES**	
	Je, umeshawahi kuwa mwenye kuudhika upesi kwa muda mrefu, kwa siku nyingi, kiasi kwamba ukawa na mabishano, au mapigano kwa maneno au vitendo, au kuwapigia kelele watu wasiokuwa wa familia yako?			
	IF YES: **KAMA JIBUNI NDIYO:**			
B	Are you currently feeling persistently irritable ?	**NO**	**YES**	**4**
	Je, kwa sasa unajisikia kuwa mwepesi wa kuudhika kwa muda mrefu?	**HAPA NA**	**NDIYO**	**4**
	ARE D1a OR D2a CODED YES ?	**NO** *	**YES**	
	JE, KIPENGELE D1a AU D2a KIMEJIBIWA NDIYO?	**HAPA NA**	**NDIYO**	

D3 **IF** D1 b **OR** D2 b = YES: **EXPLORE ONLY CURRENT EPISODE**

MEANS : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

IF D1 b **AND** D2 b = NO : **EXPLORE THE MOST SYMPTOMATIC PAST EPISODE**

KAMA DIB AU D2B = NDIYO: CHUNGUZA TUKIO **LA SASA** TU
KAMAD1B NA D2B = HAPANA: CHUNGUZA TUKIO LILILOPITA AMBALO LILIKUWA NA **DALILINYINGIZAIDI**

During the time(s) when you felt "high", full of energy and/or irritable did you:
Kwa muda ambao ulijisikia hali ya juu, kujawa na nguvu, au mwenyekuudhika upesi, je :

A	Feel that you could do things others couldn't do, or that you were an especially important person ? Ulijisikiakuweza kufanya vitu ambavyo wengine hawawezi au kujiona kuwa mtu pekee muhimu	NO HAPANA	YES NDIYO	
B	Need less sleep (e.g., feel rested after only a few hours sleep) ? Ulihitaji usingizi mchache (kwa mfano, kujisikisa mapumziko baada ya muda mdogo tu wa kulala) ?	NO HAPANA	YES NDIYO	6 **6**
C	Talk too much without stopping, or so fast that people had difficulty understanding ? Uliongea sana bila kunyamaza, au kwa haraka zaidi kiasi kwamba watu wakapata tabu ya kukuelewa?	NO HAPANA	YES NDIYO	
D	Have thoughts racing? Umekuwa na mawazo ya harakaharaka	NO HAPANA	YES NDIYO	
E	Become easily distracted so that any little interruption could distract you ? Ulikuwa mwepesi wa kuvurugwa kiasi kwamba hata kukatizwa kidogo kunakuvuruga?	NO HAPANA	YES NDIYO	9 9
F	Become so active or physically restless that others were worried about you ? Ulikuwa mashuhuri au kutotulia kiasi kwamba watu wengine wakapata wasiwasi juu yako?	NO HAPANA	YES NDIYO	10 10
8	Want so much to engage in pleasurable activities that you ignored the risks or consequences (e.g., spending sprees, reckless driving, or sexual indiscretions)? Ulitaka sana kujiingiza katika shughuli za starehe na kutojali hatari	N0	YES	11

zake au matokeo yake(mfano, kufanya shamrashamra , udereva wa kizembe, au ngono bila kujihadhari)?

HAPANA NDIYO 11

ARE **3** OR MORE **D3** ANSWERS CODED **YES**
OR 4 IF D1a = NO (PAST EPISODE) OR D1b = NO (CURRENT EPISODE) ?
JE, VIPENGELE **3** AU ZAIDI VYA **D3** VIMEJIBIWA **NDIYO**
AU VIPENGELE **4,** IKIWA **D1a = HAPANA** (TUKIO LILILOPITA)
AU **D1b = HAPANA** (TUKIO LA SASA)

NO YES

HAPANA NDIYO

Did these symptoms last at least a week **and** cause significant problems at home, at work, or at school,
or were you hospitalized for these problems?
Je, dalili hizi zilidumu kwa muda wa angalau wiki moja na kusababisha matatizo makubwa nyumbani, kazini, kijamii, au shuleni, au alilazwa hospitalini kwa ajili ya matatizo haya?

NO YES 12

HAPANA NDIYO 12

IF YES **TO EITHER, CODE** YES
KAMA JIBU NI NDIYO KWA LOLOTE, JAZA NDIYO

IS **D4** CODED **NO ?**
JE, KIPENGELE **D4** KIMEJIBIWA **HAPANA?**

NO
YES
HAPANA
NDIYO

IF YES, SPECIFY IF THE EPISODE EXPLORED IS CURRENT OR PAST
KAMA NDIYO, ELEZA NI TUKIO LA SASA AU LILILOPITA

HYPOMANIC EPISODE
TUKIO LA MANIA NDOGO

CURRENT •
KWA SASA •

PAST •
LILILOPITA •

IS **D4** CODED YES ?
JE, KIPENGELE **D4** KIMEJIBIWA **NDIYO?**

NO
YES
HAPANA
NDIYO

YES, SPECIFY IF THE EPISODE EXPLORED IS CURRENT OR PAST
KAMA NDIYO, ELEZA NI TUKIO LA SASA AU LILILOPITA

MANIC EPISODE
TUKIO LA MANIA

MEANS : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

CURRENT	•
KWA SASA	•
PAST	•
LILILOP1TA	•

E. PANIC DISORDER
UGONJWA WA HOFU KUBWA

	Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way ? Did the spells peak within 10 minutes ?	NO	YES	
	Je, kwa mara zaidi ya moja, umekuwa na vipindi vya kujisikia au kupatwa na wasiwasi wa ghafla, hofu, kutotulia au mashaka, hata katika mazingira ambayo watu wengi hawajisikii hivyo? Je, mshituko huo uliisha ndani ya dakika kumi?	HAPANA	NDIYO	1

CODE YES ONLY IF THE SPELLS PEAK WITHIN 10 MINUTES
JAZA NDIYO IKIWA TU MSHITUKO HUO ULIISHA NDANI YA DAKIKA KUMI

IF EL = NO, CIRCLE NO IN E5 AND SKIP TO F1

KAMA EL = HAPANA, JAZA HAPANA KATIKA E5 NA NENDA KIPENGELE F1

E2	**At any time in the past, did any of those spells or attacks come on unexpectedly or spontaneously, or occur in an unpredictable or unprovoked manner ?**	NO	YES	2
	Katika wakati wowote uliopita, je, vipindi hivi au mishituko hiyo ilikuja bila kutegemea au kutokea katika namna isiyobashirika au kuchochewa?	HAPANA	NDIYO	2

IF E2 = NO, CIRCLE NO IN E5 AND SKIP TO F1
KAMA E2 = HAPANA, JAZA HAPANA KATIKA E5 NA NENDA KIPENGELE F1

E3	**Have you ever had one such attack followed by a month or more of persistent fear of having another attack, or worries about the consequences of the attack ?**	NO	YES	3
	Je, ulishawahi kupata tukio moja kama hilo lililofuatiwa na kipindi cha mwezi mmoja au zaidi cha kujisikia hofu ya tukio jingine au woga wa madhara ya tukio hilo?	HAPANA	NDIYO	3

IF E3 = NO, CIRCLE NO IN E5 AND SKIP TO F1
KAMA E3 = HAPANA, ZUNGUSHIA HAPANA NA NENDA KIPENGELE F1

E4	**During the worst spell that you can remember :**			
	Katika kipindi kibaya zaidi ambacho unakumbuka :			
A	**Did you have skipping, racing or pounding of your heart ?**	NO	YES	4
	Je, moyo wako ulidundadunda, kwenda mbio, au kupiga kwa kasi?	HAPANA	NDIYO	4
B	**Did you have sweating or clammy hands ?**	NO	YES	5
	Je, ulitokwa na majasho au mikono kuwa ya baridi?	HAPANA	NDIYO	5
C	**Were you trembling or shaking ?**	NO	YES	6
	Je, ulitetemeka au kutikisika?	HAPANA	NDIYO	6
D	Did you have shortness of breath or difficulty breathing ?	NO	YES	7
	Je, ulipata kutapia hewa au tabu ya kupumua?	HAPANA	NDIYO	7

MEANS : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

E	Did you have a choking sensation or a lump in your throat ?	**NO**	**YES**	**8**
	Je, ulihisi kupaliwa au donge kifuani kwako?	**HAPANA**	**NDIYO**	**8**
F	Did you have chest pain, pressure or discomfort ?	**NO**	**YES**	**9**
	Je, ulipata maumivu ya kifua, shinikizo au usumbufu?	**HAPANA**	**NDIYO**	**9**
G	Did you have nausea, stomach problems or sudden diarrhea ?	**NO**	**YES**	**10**
	Je, ulipata kichefuchefu, matatizo ya tumbo au kuharisha kwa ghafla ?	**HAPANA**	**NDIYO**	**10**
H	Did you feel dizzy, unsteady, lightheaded or faint ?	**NO**	**YES**	**11**
	Je, ulijisikia kizunguzungu, kutetereka, kichwa chepesi, au kuzirai ?	**HAPANA**	**NDIYO**	**11**
I	Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from part or all of your body ?	**NO**	**YES**	**12**
	Je, vitu vilivyokuzunguka uliviona ni vya ajabu, sio halisi, upweke au vya kigeni, au je, ulijisikia upo kando ya, au kujitenga kutoka katika sehemu au mwili wako wote ?	**HAPANA**	**NDIYO**	**12**
J	Did you fear that you were losing control or going crazy ?	**NO**	**YES**	**13**
	Je, ulihofia kwamba umeshindwa kujizuia au umepata wazimu ?	**HAPANA**	**NDIYO**	**13**
K	Did you fear that you were dying ?	**NO**	**YES**	**14**
	Je, ulihofia kwamba unakufa ?	**HAPANA**	**NDIYO**	**14**
L	Did you have tingling or numbness in parts of your body ?	**NO**	**YES**	**15**
	Je, ulipatwa na msisimko au ganzi katika sehemu za mwili wako ?	**HAPANA**	**NDIYO**	**15**
M	Did you have hot flashes or chills ?	**NO**	**YES**	**16**
	Je, ulipatwa na wekundu usoni(kuiva uso) u mzizimo wa baridi ?	**HAPANA**	**NDIYO**	**16**

E5 ARE **4** OR MORE **E4** ANSWERS CODED **YES ?**
JE, VIPENGELE **4** AU ZAIDI VYA **E4** VIMEJIBIWA **NDIYO ?**

NO **YES**
HAPANA **NDIYO**

Panic Disorder Life time
Hofu kubwa Maisha yote

IF E5 = NO, SKIP TO **E7**

KAMA **E5 = HAPANA**, NENDA KIPENGELE **E7**

E6 In the past month, did you have such attacks repeatedly (2 or more) followed by persistant fear of having another attack ? — **NO** **YES** **17**

Katika mwezi mmoja uliopita, ulipatwa na matukio hayo kwa kujirudiarudia (mara 2 au zaidi) kufuatiwa na hofu ya kupata tukio jingine ? — **HAPANA** **NDIYO** **17**

Panic Disorder Current
Hofu kubwa kwa sasa

IF E6 = YES, SKIP TO **F1**

KAMA E6 = NDIYO, NENDA **F1**

E7 ARE **1, 2** OR **3 E4** ANSWERS CODED **YES ?** — NO YES 18

Limited Symptom Attacks Lifetime

F. AGORAPHOBIA
WOGA WA NAFASI ZA WAZI

F1	Do you feel anxious or particularly uneasy in places or situations from which escape might be difficult, and where help might not be available in case of panic attack, like being in a crowd, standing in a line (queue), when you are alone away from home or alone at home, or when crossing a bridge, traveling in a bus, train or car ? Je, unajisikia wasiwasi au mashaka katika sehemu au mazingira ambapo unaweza kupata mshituko wa hofia kubwa au dalili zinazofanana na hofu kubwa tulizozizungumza hivi punde, na ambapo msaada unaweza usiwepo, au ambapo kukwepa kunaweza kuwa kugumu: kama kuwa kwenye kundi la watu wengi, kusimama kwenye foleni, ukiwa peke yako mbali na nyumbani, au upo nyumbani peke yako, au ukiwa unavuka daraja, kusafiri ndani ya basi, treni, au gari ?	HAPANA	NDIYO	19

IF **F1 = NO,** CIRCLE **NO** IN **F2**
KAMA **F1 = HAPANA,** ZUNGUSHIA **HAPANA** KATIKA **F2**

F2	Do you fear these situations so much that you avoid them, or suffer through them, or need a companion to face them ? Je, unahofia sana mazingira haya kiasi cha kujitenga nayo, au kuteseka kwa ajili ya mazingira hayo auunahitaji mwenzi kukabiliana nayo ?	**NO** **HAPANA**	**YES** **NDIYO** *Agoraphobia Current* *Woga wa nafasi za wazl kwa sasa*

IS F2 (CURRENT AGORAPHOBIA) CODED NO
and
IS E6 (CURRENT PANIC DISORDER) CODED YES ?
JE F2 (WOGA WA NAFASI ZA WAZI KWA SASA)

NO
YES

PANIC DISORDER without Agoraphobia CURRENT

IS F2 (CURRENT AGORAPHOBIA) CODED YES
and
IS E6 (CURRENT PANIC DISORDER) CODED YES ?

NO
YES

PANIC DISORDER withAsoraphobia

MEANS : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

	CURRENT

IS F2 (CURRENT AGORAPHOBIA) CODED YES and **IS E5 (PANIC DISORDER LIFETIME) CODED NO ?**	**NO** **YES** ***AGORAPHOBIA without history of Panic Disorder*** ***CURRENT***

G. SOCIAL PHOBIA
G. WOGA WA MKUSANYIKO WA WATU

G1 G1	In the past month, were you fearful or embarrassed being watched, being the focus of attention, or fearful of being humiliated ? This includes situations like speaking in public, eating in public or with others, writing while someone watches, or being in social situations. Katika mwezi uliopita, je ulipata hofu au shida ukiwa uanaangaliwa, ukiwa mlengwa, au hofu ya kufedheheshwa? Hii ni pamoja na mambo kama kuongea hadharani; kula hadharani au kula na watu, kuandika wakati mtu anakuangalia au kuwa katika mikusanyiko ya watu.	NO	YES	1
G2 G2	Is this fear excessive or unreasonable ? Je hofu hii ni kubwa mno au yenye kuzidi?	4 NO	YES	
G3 G3	Do you fear these situations so much that you avoid them or suffer through them ? Je unahofia sana mazingira haya kiasi cha kujitenga nayo au kuteseka kwa ajili ya mazingira hayo.	4 NO	YES	
G4 G4	Does this fear disrupt your normal work or social functioning or cause you significant distress ? Je hofu hizi zinavuruga shughuli zako za kawaida au shughuli za kijamii au zinakusababishia shida kubwa.	NO	YES	

IS G4 CODED YES ?
Je kipengele G4 kimejibiwa ndiyo?

NO **YES**

SOCIAL PHOBIA
CURRENT

means : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

H. OBSESSIVE-COMPULSIVE DISORDER
H. SHAUKU LAZIMISHO

HI In the past month, have you been bothered by recurrent thoughts, impulses or images that were unwanted, distasteful, inappropriate, intrusive or distressing ? (e.g., the idea that you were dirty, contaminated or had germs, **or** fear of contaminating others, **or** fear of harming someone even though you didn't want to, **or** fearing you would act on some impulse, **or** fear or superstitions that you would be responsible for things going wrong, **or** obsessions with sexual thoughts, images or impulses, **or** hoarding, collecting, **or** religious obsessions.) NO YES 1

Do NOT INCLUDE SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PROBLEMS.
DO NOT INCLUDE OBSESSIONS DIRECTLY RELATED TO EATING DISORDERS, SEXUAL DEVIATIONS, PATHOLOGICAL GAMBLING, OR ALCOHOL OR DRUG ABUSE BECAUSE THE PATIENT MAY DERIVE PLEASURE FROM THE ACTIVITY AND MAY WANT TO RESIST IT ONLY BECAUSE OF ITS NEGATIVE CONSEQUENCES.

HI

Katika mwezi ulioputa, je ulishawahi kukerwa na mawazo yenye kujirudiarudia, misukumo, au fikra ambazo hazihitajiki, za maudhi, zisizostahili, zenye kuingilia, au zenye kuleta shida? (mf: mawazo ya kwamba umchafu, umechafuliwa na vijidudu, au hofu ya kuwachafua wengine, au hofu ya kumdhuru mtu hata kama hukutaka kufanya hivyo, au kuhofia kutenda kwa msukumo, au hofu au imani za kichawi kwamba ungewajibika kwa mambo mabaya, au shauku yenye mawazo ya ngono, fikra au misukumo,au shauku ya kuhodhi, kukusanya au ya kidini).

(Usichanganye na wasiwasi juu ya matatizo halisi ya maisha, usichanganye na shauku zinazoendana moja kwa moja na magonjwa ya kula chakula, tabia za uasherati, kamari, au pombe au madawa ya kulevya kwa sababu, mgonjwa anaweza kupata starehe kutokana na tendo hilo na kutaka kujizuia kwa sababu tu ya matokeo hasi ya jambo hilo.

IF HI = NO, SKIP TO H4

H2 Did they keep coming back into your mind even when you tried to ignore or get rid of them ? NO YES
if **H2 = NO, skip TO H4**

H2 JE» yanaendelea kukurudia ndani ya mawazo yako hata wakati unapojaribu kuyadharau au kujaondoa?

H3 Do you think that these obsessions are the product of your own mind and that they are not imposed from the outside ? NO YES

H3 Je, unadhani kwamba shauku hizi zinatokana na mawazo yako mwenyewe na kwamba hazijalazimishwa kutoka nje?

H4 In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, arranging

things, or other superstitious rituals ? NO YES 4

H4 Katika mwezi uliopita, je ulifanya kitu kwa kurudiarudia bila kuwa na uwezo wa kujizuia kufanya hivyo, kama vile kuosha au kusafisha sana, kuhesabu, kukagua vitu mara kwa mara, au kurudia, kukusanya, kupanga vitu, au matambiko mangine ya kishirikina.

ARE **H3** OR **H4** CODED YES ? NO YES
re KIPENDELE **H3** AU **H4** KIMEJIBIWA NDIYO?

H5 Did you recognize that either these obsessive thoughts and / or these compulsive behaviors you can not resist doing them, were excessive or unreasonable ? + NO YES

H5 Je ulitambua kwamba kujiwa na mawazo haya au hizi tabia zisizodhibitika zimekuwa ni nyingi mno au zimezidi?

H6 Did these obsessive thoughts and / or compulsive behaviors significantly interfere with your normal routine, occupational functioning, usual social activities, or relationships, or did they take more than one hour a day ? NO YES

H6 Je kujawa na mawazo haya na/au tabia zisizodhibitika kwa kiasi kikubwa kunaingilia zako za kawaida, shughuli za kikazi, kazi za kawaida za kijamii, au mahusiano, au yamechukua zaidi ya saa nzima kwa siku?

IS **H6** CODED YES ? **NO** YES

OBSESSIVE-COMPULSIVE DISORDER
CURRENT

means : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

I. POSTTRAUMATIC STRESS DISORDER (optional)
I. UGONGWA WA MSONGO BAADA YA MATUKIO MABAYA (Hiari)

I1	Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else?	NO	YES	1
I1	Je, umewahi kupata au kushuhudia au kushughulika na matukio mabaya ikiwepo kifo au tishio la kifo au ajali mbaya kwako au mtu mwingine?			
	Ex OF TRAUMATIC EVENTS: SERIOUS ACCIDENT, SEXUAL OR PHYSICAL ASSAULT, A TERRORIST ATTACK, BEING HELD HOSTAGE, KIDNAPPING, HOLD-UP, FIRE, DISCOVERNG A BODY, UNEXPECTED DEATH, WAR, NATURAL DISASTER...			
I2	During the past month, have you re-experienced the event in a distressing way (i.e., dreams, intense recollections, flashbacks or physical reactions)?	NO	YES	2
I?	Kwa mwezi uliopita je umewahi kupata tena tukio hilo katika namna ya mashaka (Kama vile, ndoto, mkusanyiko mkali, kumbukumbu za ghafla, au kujibu kwa matendo)?			
I3	**In the past month :**			
I3	**Katika mwezi uliopita:**			
a	Have you avoided thinking about the event, or have you avoided things that remind you of the event?	NO	YES	3
a	Je, umewahi kujizuia kufikiria juu ya tukio hilo, au kujiepusha na vitu vinavyokukumbusha tukio hilo?			
b	Have you had trouble recalling some important part of what happened?	NO	YES	4
b	Je, umepata tabu ya kukumbuka baadhi ya sehemu muhimu juu ya kilichotokea?			
c	Have you become less interested in hobbies or social activities?	NO	YES	5
c	Je umekuwa na mvuto hafifu kwa mambo uyapendayo au kazi za kijamii?			
d	Have you felt detached or estranged from others?	NO	YES	6
d	Je, ulijisikia umejitenga au kutenganisha na wengine?			
e	Have you noticed that your feelings are numbed?	NO	YES	7
e	Je, ulitambua kwamba mawazo yako ni mazito?			
f	Have you felt that your life would be shortened because of this trauma?	NO	YES	8
f	Je, ulijisikia kwamba maisha yako yangekuwa mafupi kutokana na tukio hili?			

ARE **3** OR MORE **13** ANSWERS CODED YES? JE, VIPENGELE **VITATU** AU ZAIDI VYA **13** VIMEJIBIWA NDIYO?	NO	YES	
In the past month :			
Katika mwezi uliopita:			
Have you had difficulty sleeping? Je ulipata tabu ya usingizi?	NO	YES	9
Were you especially irritable or did you have outbursts of anger? Je ulikuwa mwenye kuudhika upesi, au ulipatwa na milipuko ya hasira?	NO	YES	10
Have you had difficulty concentrating? Je, umepata tabu ya kuwa makini?	NO	YES	11
Were you nervous or constantly on your guard? Je, ulikuwa na wahaka/wasiwasi au muda wote kujilinda?	NO	YES	12
Were you easily startled? Je, ulikuwa mwepesi wa kushtushwa?	NO	YES	13
	*		
ARE 2 OR MORE **14** ANSWERS CODED YES? JE VIPENGELE **2** AU ZAIDI YA **14** VIMEJIBIWA **NDIYO?**	NO	YES	
During the past month, have these problems significantly interfered with your work or social activities, or caused significant distress? Katika mwezi uliopita, je matatizo haya kwa kiasi kikubwa yalivuruga utendaji wa kazi yako au shughuli za kijamii au kusababisha mashaka makubwa?	NO	YES	14
IS **15** CODED **YES?**	**NO**	**YES**	
JE 15 IMEJIBIWA NDIYO?	***POSTTRAUMATIC STRESS DISORDER***	***CURRENT***	

MEANS : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

J. ALCOHOL ABUSE AND DEPENDENCE
J. MATUMIZI MABAYA NA KUTAWALIWA NA POMBE

J1 In the past 12 months, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions? NO YES

J1 Katika miezi 12 iliyopita, ulishawahi kuwa na vinywaji vitatu au zaidi vya pombe ndani ya kipindi cha masaa matatu katika matukio m atatu au zaidi/

J2 **In the past** 12 **months :**

Did you need to drink more in order to get the same effect that you did when you first started drinking? NO YES

J2 **Katika miezi** 12 **iliyopita:**

a Je, ulihitaji kunywa zaidi ili upate matokeo sawa nay ale uliyokunywa mara ya kwanza?

b When you cut down on drinking did your hands shake, did you sweat, or feel agitated ?
Or, did you drink to avoid these symptoms or to avoid being hangover, e.g., "the shakes", sweating or agitation ? NO YES

b Je, wakati ulipoacha kunywa mikono yako ilitetemeka ulitokwa na majasho, au kujisikia wasiwasi?
Je, ulikunywa ili kuondoa dalili hizi au kuepuka kuwa mchovu, mfano mtetemeko, kutokwa majasho au wasiwasi?

IF YES **TO EITHER, CODE** YES
KAMA NI NDIYO KWA CHOCHOTE, JIBU NDIYO

c During the times when you drank alcohol, did you end up drinking more than you planned when you started ? NO YES

c Wakati ambapo umelewa pombe, je uliishia kunywa zaidi kuliko ulivyopanga mwanzoni?

d Have you tried to reduce or stop drinking alcohol but failed ? NO YES

d Je ulijaribu kupunguza au kuacha ulevi ikashindikana?

e On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovering from the effects of alcohol ? NO YES

e Katika siku ambazo umelewa, je ulipoteza muda mwingi kupata pombe, kunywa au kupata nafuu kutoka katika athari za pombe?

f Did you spend less time working, enjoying hobbies, or being with others because of your drinking ? NO YES 7

f Je ulitumia muda mchache kufanya kazi kufurahia uvipendavyo au kuwa na wenzako kwa sababu ya ulevi wako?

g Have you continued to drink even though you knew that the drinking caused you health or mental problems ? NO YES 8

g Je uliendelea kulewa japo kuwa ulifahamu kuwa ulevi ulikusababishia matatizo ya kiafya na kiakili?

ARE **3** OR MORE **J2** ANSWERS CODED YES ?
JE VIPENGELE **VITATU** AU ZAIDI VYA **J2** VIMEJIBIWA NDIYO?

NO YES

ALCOHOL DEPENDENCE
CURRENT

DOES THE PATIENT CODES POSITIVES FOR ALCOHOL DEPENDENCE ? NO YES

In the past 12 months :
Katika miezi 12 iliyopita:

a Have you been intoxicated, high, or hangover more than once when you had other responsibilities at school, at work, or at home ? Did this cause any problems ? NO YES 9

a Je, umewahi kurukwa akili, kuwa na hali ya juu, au kuwa na uchovu wa pombe zaidi ya mara moja wakati ambapo ulikuwa na majukumu mengine shuleni, kazini au nyumbani? Je hili litaleta matatizo yeyote?

CODE YES **ONLY IF THIS CAUSED PROBLEMS**
(JIBU NDIYO IKIWA TU HILI LILILETA MATATIZO)

b Were you intoxicated in any situation where you were physically at risk, e.g., driving a car, riding a motor bike, using machinery, boating, etc.? NO YES 10

b Je, ulirukwa akili katika mazingira yeyote ambapo ulikuwa hatarini mf. Kuendesha gari, kuendesha pikipiki, kutumia mashine, kusafiri kwa mashua, etc.

MEANS : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

c	Did you have any legal problems because of your drinking, e.g., an arrest or disorderly conduct ?	NO	YES	11
c	Je ulipata matatizo yeyote ya kisheria kwa sababu ya ulevi wakomfa. Kutiwa mbaroni au kufanya vurugu?			
d	Did you continue to drink even though your drinking caused problems with your family or other people ?	NO	YES	12
d	Je, uliendelea kulewa japokuwa ulevi wako ulisababisha matatizo kwa familia yako au watu wengine?			

ARE **1** OR MORE **J3** ANSWERS CODED YES ? **NO** **YES**

JE KIPENGELE **KIMOJA** AU ZAIDI CHA **J3** KIMEJIBIWA NDIYO?

ALCOHOL ABUSE
CURRENT

MEANS : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

CARD OF SUBSTANCES

AMPHETAMINE	**GASOLINE**	**MORPHINE**
CANNABIS	**GLUE**	**OPIUM**
COCAINE	**GRASS**	**PALFIUM**
CODEINE	**HASHISH**	**PCP**
CRACK	**HEROIN**	**RITALIN**
DICONAL	**LSD**	**TEMGESIC**
ECSTASY	**MARIJUANA**	**THC**
ETHER	**MESCALINE**	**TOLUENE** t
FREEBASE	**METHADONE**	**TRICHLORETHYLENE**

K. NON-ALCOHOL PSYCHOACTIVE SUBSTANCE USE DISORDERS
UGONJWA WA MATUMIZI YA MADAWA YA KULEVYA AMBAYO SI POMBE

K1 a Now, I am going to show you (**SHOW THE CARD OF SUBSTANCES**) / to read to you, a list (**READ THE LIST BELOW**) of street drugs or medicines. In the past 12 months, did you take any of these drugs, more than once, to get high, to feel better or to change your mood? — 4 NO YES

Sasa ninakuonyesha (ONYESHA KADI YA MADAWA) / ninakusomea orodha ya madawa ya mitaani. Katika miezi 12 iliyopita, je ulitumia dawa yeyote katika hizi zaidi ya mara moja, ili uwe na hali <u>ya juu, kujisikia mbora zaidi, au kubadilisha hali yako?</u>

CIRCLE EACH DRUG TAKEN :

<u>Stimulants</u>: amphetamines, « speed », crystal meth, « rush », Dexedrine, Ritalin, diet pills.
<u>Cocaine</u>: snorting, IV, freebase, crack, « speedball ».
<u>Narcotics</u>: heroin, morphine, dilaudid, opium, demerol, methadone, codeine, percodan, darvon.
<u>Hallucinogens</u>: LSD (« acid »), mescaline, peyote, PCP (« angel dust », « peace pill »), psilocybin, STP, « mushrooms », ecstasy, MDA, or MDMA.
<u>Inhalants</u>: « glue », ethyl chloride, nitrous oxide, (« laughing gas »), amyl or butyl nitrate (« poppers »).
<u>Marijuana</u>: hashish (« hash »), THC, « pot », « grass », « weed », « reefer ».
<u>Tranquilizers</u>: quaalude, Seconal (« reds »), Valium, Xanax, Librium, Ativan, Dalmane, Halcion, barbiturates, Miltown.
<u>Miscellaneous</u>: steroids, nonprescription sleep or diet pills. Any others ?

SPECIFY <u>MOST</u> USED DRUG(S) :

I

ZUNGUSHIA KILA DAWA ULIYOTUMIA:
Vichangamsho:Amphetamini
Cokein:
Nakotiks:
Hallucinogens:
Inhalants:
Marijuana:
Tranquilizers:
Nyinginezo:

ELEZA DAWA / MADAWA UTUMIAYO ZAIDI:

b **SPECIFY WHICH WILL BE EXPLORED IN CRITERIA BELOW :**

- **IF CONCURRENT OR SEQUENTIAL POLYSUBSTANCE USE :**
  - **EACH DRUG (OR DRUG CLASS) USED INDIVIDUALLY**
  - Most **USED DRUG (OR DRUG CLASS) ONLY** •
- **IF ONE DRUG (OR DRUG CLASS) USED :** •
  - **SINGLE DRUG (OR DRUG CLASS) ONLY**

b. ELEZA NI DAWA IPI IPO NDANI YA VIGEZO HAPA CHINI:
KAMA NI MATUMIZI YA PAMOJA AU YENYE KUFUATANA YA DAWA ZAIDI YA MOJA:

- KILA KUNDI LA DAWA KUTUMIKA PEKE YAKE U •
- KUNDI LA DAWA LINALOTUMIKA ZAIDI TU Q
- NI DAWA MOJA TU / KUNDI LA DAWA IMETUMIKA

K2 **Considering your use of [NAME THE SELECTED DRUG / DRUG CLASS] in the past 12 months :**
Fikiria matumizi yako ya madawa (TAJA JINA LA DAWA / KUNDI LA DAWA LILILOCHAGULIWA), katika miezi 12 iliyopita:

a Have you found that you needed to use more of [**NAME OF SELECTED DRUG/ DRUG CLASS**] to get the same effect that you did when you first started taking it ? NO YES 1
Je, uliona kwamba unahitaji kutumia zaidi (Jina la dawa au kundi la dawa lililochaguliwa) ili kupata athari sawa na ile ulipotumia mara ya kwanza?

B When you reduced or stopped using [**NAME OF SELECTED DRUG / DRUG**

CLASS] did you have withdrawal symptoms (aches, shaking, fever, weakness, diarrhea, nausea, sweating, heart pounding, difficulty sleeping, or feeling agitated, anxious, irritable or depressed) ?
Or did you use any drug(s) to keep yourself from getting sick (WITHDRAWAL SYMPTOMS) or so that you would feel better ?
IF YES TO EITHER, CODE YES — NO YES 2

Wakati ulipopunguza au kutotumia (JINA LA DAWA / KUNDI LA DAWA LILILOCHAGULIWA) Je, ulipatwa na dalili zinazotokana na kuacha madawa? (Maumivu, kutetemeka, homa, udhaifu, kuharisha, kichefuchefu, kutokwa jacho, moyo kudunda, tabu ya usingizi, kujisikia wasiwasi, dukuduku, mwenye kuudhika upesi, au mwenye huzuni). Je ulitumia dawa/madawa yeyote ili kukufanya usiumwe (dalili za kuacha dawa) au kukufanya ujisikie vizuri zaidi?
IKIWA JIBU NI NDIYO KWA SWALI LOLOTE, JAZA NDIYO

Have you often found that when you used [NAME OF SELECTED DRUG / DRUG CLASS], you ended up taking more than you thought you would? — NO YES
Je, mara kwa mara ulijiona kwamba wakati unatumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), uliishia kutumia nyingi zaidi kuliko uwezo wako?

Have you tried to reduce or stop taking [NAME OF SELECTED DRUG / DRUG CLASS] but failed? — NO YES
Je, ulijaribu kupunguza/kuacha kutumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA) lakini ukashindwa?

On the days that you used [NAME OF SELECTED DRUG / DRUG CLASS], did you spend substantial time (>2 hours), obtaining, using or recovering from the effects, or thinking about it ? NO YES
Katika siku ambazo ulitumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA)Je, ulipoteza muda mwingi (> masaa 2) kupata, kutumia au kupata nafuu kutoka katika madawa au kufikiria juu ya madawa?

Did you spend less time working, enjoying hobbies, or being with family or friends, because of your drug use ? NO YES
Je, ulitumia muda mchache kufanya kazi, kufiirahia uvipendavyo, au kuwa na familia yako au marafiki kwa sababu ya kutumia kwako madawa?

Have you continued to use [NAME OF SELECTED DRUG / DRUG CLASS] even though it caused you health or mental problems? NO YES
Je, uliendelea kutumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), japokuwa ilikusababishia matatizo ya kiafya na kiakili?

ARE **3** OR MORE **K2** ANSWERS CODED **YES ?** **NO** **YES**

SPECIFY DRUG(S) :.

JE VIPENGELE 3 AU ZAIDI VYA K2 VIMEJIBIWA NDIYO?

TAJA DAWA/MADAWA:

DRUG(S) DEPENDENCE
CURRENT

DOES PATIENT CODES POSITIVE FOR DRUG DEPENDENCE? NO YES

K3 **In the past 12 months :**
Fikiria matumizi yako ya madawa (Jina la kundi la dawa lililochaguliwa)
Katika kipindi cha miezi 12 iliyopita:

a Have you been intoxicated, high, or hangover from [NAME OF SELECTED DRUG / DRUG CLASS], more than once when you had other responsibilities at school, at work, or at home? Did this cause any problem? (CODE YES ONLY IF THIS CAUSED PROBLEMS) NO YES
Je, umewahi kurukwa akili, kuwa na hali ya juu, au kuwa na uchovu wa dawa (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), zaidi ya mara moja, wakati ambapo ulikuwa na majukumu mengine shuleni, kazini au nyumbani? Je hili lilileta matatizo yeyote?
(JAZA NDIYO IKIWA TU HILI LILILETA MATATIZO)

b Have you been high or intoxicated from [NAME OF SELECTED DRUG /

DRUG CLASS] in any situation where you were physically at risk (e.g., driving a car, or a motorbike, using machinery, boating, etc.)? Je, umewahi kujisikia na hali ya juu au kurukwa akili kutokana na (UNA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA) katika mazingira yeyote ambapo ulikuwa hatarini (mfano, kuendesha gari, kuendesha pikipiki, kutumia machine, kusafiri kwa mashua, nk).	NO	YES	
Did you have any legal problems because of your **[NAME OF SELECTED DRUG / DRUG CLASS]** use, e.g., an arrest or disorderly conduct ? Je, ulipata matatizo yeyote ya kisheria kwa sababu ya matumizi ya madawa mf. Kutiwa mbaroni au kufanya vurugu.	NO	YES	10
Did you continue to use **[NAME OF SELECTED DRUG / DRUG CLASS]** even though it caused problems with your family or other people ? Je uliendelea kutumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), japokuwa ilisababisha matatizo kwa familia yako au watu wengine	NO	YES	11

ARE **1** OR MORE **K3** ANSWERS CODED **YES ?** **NO** **YES**

SPECIFY DRUG(S) :

DRUG(S) ABUSE CURRENT

JE, KIPENGELE KIMOJA AU ZAIDI CHA K3 KIMEJIBIWA NDIYO?

TAJA DAWA/MADAWA:

NDIYO
HAPANA

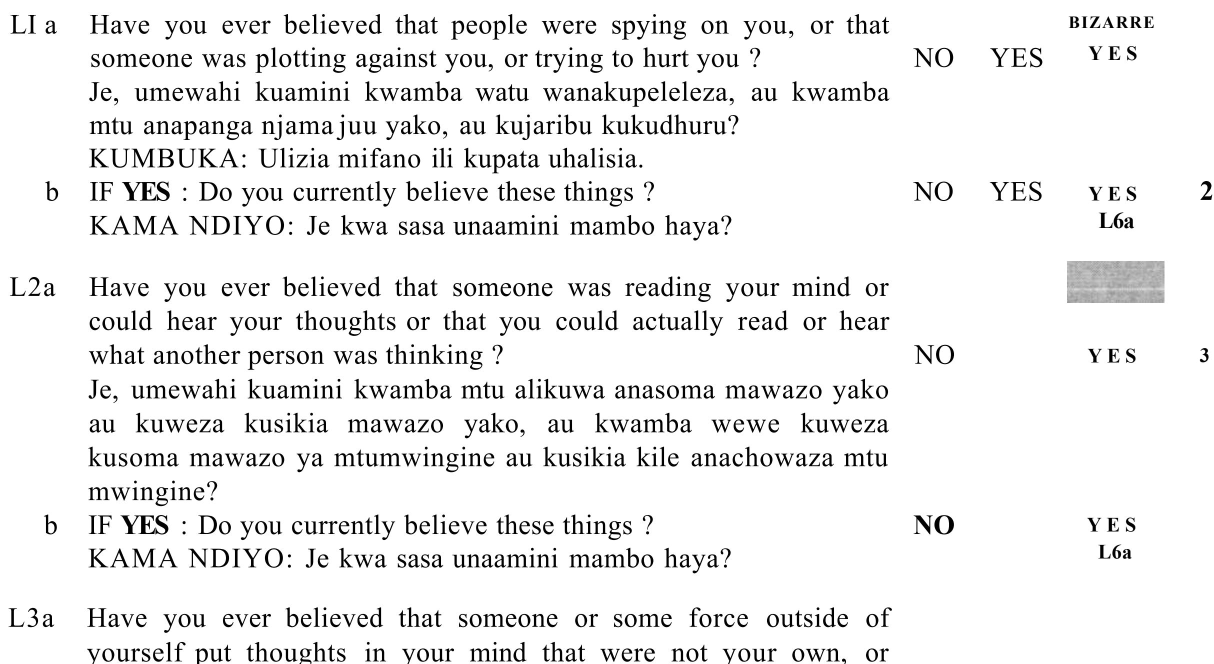
MATUMIZI YA MADAWA KWA SASA

L. PSYCHOTIC DISORDERS
L. MAGONJWA YA SAIKOSIS

ASK FOR AN EXAMPLE OF EACH QUESTION ANSWERED POSITIVELY. CODE YES ONLY IF THE EXAMPLES CLEARLY SHOW A DISTORTION OF THOUGHT OR OF PERCEPTION OR IF THEY ARE NOT CULTURALLY APPROPRIATE.
BEFORE CODING, INVESTIGATE WHETHER DELUSIONS QUALIFY AS « BIZARRE ».
DELUSIONS ARE BIZARRE IF : CLEARLY IMPLAUSIBLE, ABSURD, NOT UNDERSTANDABLE, AND CANNOT DERIVE FROM ORDINARY LIFE EXPERIENCE.
HALLUCINATIONS ARE RATED BIZARRE IF : A VOICE COMMENTS ON the PERSON'S THOUGHTS OR BEHAVIOR, OR WHEN TWO OR MORE VOICES ARE CONVERSING WITH EACH OTHER.

OMBA MFANO KWA KILA SWALI LINAJIBIWA NDIYO. JAZA NDIO IWAPO TU MIFANO INAONYESHA WAZI MABADILIKO YA MAWAZO AU UTAMBUZI AU KAMA HAIHUSIANI NA MILA NA DESTURI KABLA YA KUJAZA CHUNGUZA IWAPO IMANI ZA UWONGO ZINA SIFA ZA KUWA SI ZA KAWAIDA.
IMANI POTOFU AMBAZO "SI ZA KAWAIDA" KAMA: ISIYOWEZEKANA KUWA KWELI, UPUUZI, ISIYOELEWEKA, NA ISIYOTOKANA NA MAISHA YA KAWAIDA.
HISIA POTOFU AMBAZO "SI ZA KAWAIDA" NI KAMA: SAUTI KUELEZEA JUU YA MAWAZO YA MTU AU TABIA, AU WAKATI SAUTI 2 AU ZAIDI ZINAZUNGUMZA ZENYEWE.

Now I'm going to ask you about unusual experiences that some individuals may experience.
Sasa ninakuuliza kuhusu matukio yasiyo ya kawaida ambayo watu wanapata.



				BIZARRE	
LI a	Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you ? Je, umewahi kuamini kwamba watu wanakupeleleza, au kwamba mtu anapanga njama juu yako, au kujaribu kukudhuru? KUMBUKA: Ulizia mifano ili kupata uhalisia.	NO	YES	YES	
b	IF **YES** : Do you currently believe these things ? KAMA NDIYO: Je kwa sasa unaamini mambo haya?	NO	YES	YES **L6a**	**2**
L2a	Have you ever believed that someone was reading your mind or could hear your thoughts or that you could actually read or hear what another person was thinking ? Je, umewahi kuamini kwamba mtu alikuwa anasoma mawazo yako au kuweza kusikia mawazo yako, au kwamba wewe kuweza kusoma mawazo ya mtumwingine au kusikia kile anachowaza mtu mwingine?	NO		YES	3
b	IF **YES** : Do you currently believe these things ? KAMA NDIYO: Je kwa sasa unaamini mambo haya?	**NO**		YES **L6a**	

L3a Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or

	made you act in a way that was not your usual self ? Have you ever felt that you were possessed? Je , umewahi kuamini kwamba mtu au nguvu Fulani kutoka nje zimeweka mawazo ndani yako na kwamba umekuwa siyo wewe mwenyewe, au imekufanya utende matendo ambapo haikuwa kawaida yako? Je, umewahi kujisikia kama kwamba umemilikiwa? ***TABIBU***: ULIZIA MIFANO NA UONDOE YEYOTE ISIYOHUSIANA NA KURUKWA AKILI	NO		YES	5
b	IF YES : Do you currently believe these things ? KAMA NDIYO: Je, kwa sasa unaamini mambo haya?	NO		YES L6a	6
L4a	**Have you ever believed that you were being sent special messages through the TV, radio or newspaper, or that a person you did not personally know was particularly interested in you ?** **Je, umewahi kuamini kwamba umekuwa ukipokea ujumbe maalum kupitia TV, redio, au magazeti, au kwamba mtu usiyemjua akawa amevutiwa na wewe?**	NO	YES	YES	7
b	**IF YES** : Do you currently believe these things ? **KAMA** NDIYO: Je, kwa sasa unaamini mambo haya?	NO	YES	YES * L6a	8
L5a	Have your relatives or friends ever considered any of your beliefs strange or out of reality? **ANY DELUSIONAL IDEAS NOT EXPLORED IN QUESTIONS LI TO L4, E.G., OF GRANDIOSITY, RUIN, GUILT, HYPOCONDRIASIS,...** Je, ndugu zako au marafiki walishawahi kuona kwamba imani zako ni za ajabu au si za kawaida? Tafadhali, naomba mifano. ***MSAILI:*** Jaza ndiyo ikiwa tu mifano inaonyesha wazi kuwa ni imani za uwongo ambazo hazikuelezwa katika maswali LI mpaka L4, mfano, za kujifaharisha, za unyong'onyevu, za maangamizi, kuwa na hatia, n.k.	NO	YES	YES	9
b	**IF YES** : Do they currently consider your beliefs strange ? **KAMA NDIYO:** Je, kwa sasa wanaona imani zako ni za ajabu?	NO	YES	YES |	10
L6a	Have you ever heard things other people couldn't hear, such as voices ? **HALLUCINATIONS ARE CODED « BIZARRE » ONLY IF PATIENT ANSWERS YES TO THE FOLLOWING :** Did you hear a voice commenting on your thoughts or behavior, or did you hear two or more voices talking to each other ? Je umewahi kusikia mambo ambayo wengine hawasikii, kama vile sauti? HISIA POTOFU ZINAKUWA "SI ZA KAWAIDA" IKIWA TU MGONJWA ANAJIBU NDIYO KATIKA SWALI LIFUATALO: Je ulisikia sauti ikielezea mawazo yako au tabia au kusikia sauti mbili au zaidi zikizungumza zenyewe?	NO	YES	YES	11
b	**IF YES** : Have you heard these things in the past month ? **KAMA NDIYO:** Je, umesikia vitu hivi ndani ya mwezi 1 uliopita?	NO	YES	YES *	12

L7a	Have you ever had visions when you were awake or have you ever seen things other people couldn't see ? **CODE YES ONLY IF THE VISIONS ARE CULTURALLY INAPPROPRIATE.** Je, umewahi kuwa na ndoto wakati yu macho au kuona vitu ambapo watu wengine hawavioni? TABIBU: chunguza iii kujua kama havihusiani na mambo ya kimila na desturi?	**NO**	**YES**	**13**
B	**IF YES** : Have you seen these things in the past month? : **INTERVIEWER'S JUDGMENT:** KAMA NDIYO: Je umeviona vitu hivi katika mwezi mmoja uliopita? UAMUZI WA TABIBU	NO	YES	14
L8 b L8b	IS THE PATIENT CURRENTLY EXHIBITING INCOHERENCE, DISORGANIZED SPEECH, OR MARKED LOOSENING OF ASSOCIATIONS ? JE MGONJWA KWA SASA ANAONYESHA MAMBO YASIYOELEWEKA, MANENO YASIYO NA MPANGILIO, AU MAMBO YASIYOUNGANIKA.	NO	YES	15
L9 b L9 b	IS THE PATIENT CURRENTLY EXHIBITING DISORGANIZED OR CATATONIC BEHAVIOR ? JE KWA SASA MGONJWA ANAONYESHA TABIA ISIYOELEWEKA AU KUZUBAA?	NO	YES	16
L10 b L10 b	ARE NEGATIVE SYMPTOMS OF SCHIZOPHRENIA, E.G. SIGNIFICANT AFFECTIVE FLATTENING, POVERTY OF SPEECH (ALOGIA) OR AN INABILITY TO INITIATE OR PERSIST IN GOAL DIRECTED ACTIVITIES (AVOLITION), PROMINENT DURING THE INTERVIEW ? JE, DALILI HASI ZA SKIZOFRENIA, MFANO KUTODHIHIRISHA HISIA, UPUNGUFU WA MANENO YA KUSEMA (KUTOSEMA) AU KUTOWEZA KUANZISHA AU KUDUMU KATIKA SHUGHULI MAALUM, ZINAONEKANA WAKATI WA USAILI?	NO	YES	17

L11 FROM LI TO L10 :

- ARE 1 OR MORE « b » QUESTIONS CODED YES BIZARRE?

OR

- ARE 2 OR MORE « b » QUESTIONS CODED YES (RATHER THAN YES BIZARRE) ?

L11

- JE KIPENDELE KIMOJA AU ZAIDI VYA MASWALI (b) KIMEJIBIWA NDIYO SI YA KAWAIDA?

AU

- JE, VIPENGELE 2 AU ZAIDI VYA MASWALI (b) VIMEJIBIWA NDIYO (BADALA YA NDIYO SI YA KAWAIDA).

NO
YES

PSYCHOTIC SYNDROME
CURRENT

L12 FROM LI TO L7:

- ARE 1 OR MORE « a » QUESTIONS CODED YES BIZARRE?

NO
YES

-*	MEANS : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

OR

- ARE **2** OR MORE « a » QUESTIONS CODED **YES** (RATHER THAN YES BIZARRE) ?

(CHECK THAT THE 2 SYMPTOMS OCCURRED DURING THE SAME TIME PERIOD)

OR

- IS **L11** CODED **YES?**

L12

- JE, KIPENGELE 1 AU ZAIDI YA MASWALI (a) VIMEPITIWA **NDIYO SI YA KAWAIDA?**

AU

- JE, VIPENGELE **2** AU ZAIDI VYA MASWALI (a) VIMEJIBIWA **NDIYO** (BADALA YA NDIYO SI YA KAWAIDA)

UAMUZI WA TABIBU

CHUNGUZA KAMA DALILI 2 ZILITOKEA WA KATI MMOJA

AU

- JE, KIPENGELE **Ll 1** KIMEJIBIWA **NDIYO?**

PSYCHOTIC SYNDROME
LIFETIME

LI3a IF L12 IS CODED YES OR AT LEAST ONE YES FROM LI TO L7 :

DOES THE PATIENT CODE POSITIVE FOR EITHER
MAJOR DEPRESSIVE EPISODE (CURRENT OR PAST)
or MANIC EPISODE (CURRENT OR PAST) ?

* NO YES

LI3a KAMA L12 IMEJIBIWA NDIYO NA ANGALAU NDIYO MOJA KUTOKA LI MPAKA L7:

JE DALILI HIZO ZIMEJIBIWA NDIYO KWA AIDHA
TUKIO LA SONONA, (KWA SASA)
AU TUKIO LA MANIA, (KWA SASA AU MUDA ULIOPITA)?

b

You told me earlier that you had period(s) when you felt depressed/ high/ persistently irritable.
Were the beliefs and experiences you just described (SYMPTOMS CODED YES FROM LL TO L7) restricted exclusively to times when you were feeling depressed / high / irritable ?

NO YES 18

b

Kama L13 imejibiwa ndiyo:
Uliniambia mwanzoni kwamba kulikuwa na vipindi ambavyo ulijisikia (huzuni/hali ya juu/mwepesi wa kuudhika mara zote).
Je, imani na matukio uliyoyaeleza hivi punde (dalili zimejibiwa ndiyo kutoka Ll mpaka L7).vimekuwepo pale tu ulipojisikia huzuni/hali ya juu/mwenyekuudhika?.

IS **L13b** CODED **YES ?** — **NO**
JE, **L13b** IMEJIBIWA **NDIYO?** — **YES**

MOOD DISORDER WITH PSYCHOTIC FEATURES
CURRENT

M. ANOREXIA NERVOSA
M. UGONJWA WA TAFSIRI YA MAUMBILE BINAFSI UNAOHUSIANA NA KUTOKULA

M1 a How tall are you ? |__|__|__| Ft jj,s Cm

Una urefu kiasi gani?

b What was your lowest weight in the past 3 months ? |__|__|_| Kg Jl

b Ni uzito upi mdogo kuliko wote katika miezi mitatu iliyopita.

c IS PATIENT'S WEIGHT LOWER THAN THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT ? SEE TABLE BELOW — NQ YES 1

c JE, UZITO WA MGONJWA NI MDOGO KULIKO KIWANGO KINACHOLINGANA NA UREFU WAKE? (ANGALIA JEDWALI CHINI)

In the past 3 **months :**
Katika miezi 3 **iliyopita:**

M2 In spite of this low weight, have you tried not to gain weight ? — NO YES 2
M2 Pamoja na uzito huu mdogo, je ulijaribu kutoongeza uzito?

M3 Have you feared gaining weight or becoming fat, even though you were underweight ? — NO YES 3
M3 Je, ulihofia kuongezeka uzito au kuwa mnene hata kama ulikuwa na uzito mdogo?

M4a Have you considered yourself fat or that part of your body was too fat ? — NO YES 4

a Je ulijiona wewe mwenyewe mnene, au sehemu ya mwili wako nene sana?

b Has your body weight or shape greatly influenced how you felt about yourself? — NO YES 5

* means : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

b Je, uzito wa mwili wako au umbile umeathiri kwa kiasi kikubwa jinsi unavyojiona?

c Have you thought that your current low body weight was normal or excessive ? NO YES

c Je, ulifikiria kwamba uzito wako mdogo wa sasa ni kawaida au umezidi?

M5 ARE **1** OR MORE **M4** ANSWERS CODED YES ? NO YES

M5 JE, KIPENGELE **KIMOJA** AU ZAIDI VYA **M4** VIMEJIBIWA **NDIYO?**

M6 FOR WOMEN ONLY : During the last 3 months, did you miss all your menstrual periods when they were expected to occur (when you were not pregnant) ? 4 NO YES 7

M6 Kwa wanawake tu: Katika miezi mitatu iliyopita, Je ulikosa siku zako zote za hedhi pale ambapo ulizitarajia kutokea (wakati hukuwa mjamzito)?

FOR WOMEN : ARE **M5** AND **M6** CODED YES ?
FOR MEN : IS **M5** CODED YES ?
KWA WANAWAKE: JE, **M5** NA **M6** VIMEJIBIWA **NDIYO?**
KWA WANAUME: JE, **M5** IMEJIBIWA **NDIYO?**

NO **YES**

ANOREXIA NERVOSA
CURRENT

TABLE HEIGHT / WEIGHT THRESHOLD (HEIGHT-WITHOUT SHOES ; WEIGHT-WITHOUT CLOTHING)

HEIGHT(cm) UREFU (sm)	140	145	150	155	160	165	170	175	180	185.
WEIGHT (kg) UZITO (kilo) Females Wanawake	37	38	39	41	43	45	47	50	52	54
Males Wanaume	41	43	45	47	49	51	52	54	56	58

IS

THE WEIGHT THRESHOLDS ABOVE ARE CALCULATED AS A 15% REDUCTION BELOW THE NORMAL RANGE FOR THE PATIENT'S HEIGHT AND GENDER AS REQUIRED BY DSM-IV.

N. BULIMIA NERVOSA
N. UGONJWA WA TAFSIRI YA MAUMBILE BINAFSI UNAOHUSIANA NA KULAMNO

N1 In the past three months;* did you have eating binges or times when you ate a very large amount of food within a 2-hour period ? NO YES 4

? §§ L - , ^SSP....;;

N1.. je uliwahi. kula-kupita. kiasi.au wakatL ambapo umekula chakula kingi sana ndani ya masaa mawili?

N2 In the last three months, did you have eating binges as often as twice a week? NO YES 9

N2 Katika miezi 3 iliyopita, je umewahi kula kupita kiasi kila mara, mara 2 kwa wiki?

N3 During these binges, did you feel that your eating was out of control ? NO YES 10

N3 Katika milo hii, ulijisikia kwamba kula kwako ni kwa kushindwa kujitawala?

N4 Did you do anything to compensate for, or to prevent a weight gain from these binges, like vomiting, fasting, exercising or taking laxatives, enemas, diuretics (fluid pills), or other medications ? NO YES 11

N4 Je ulifanya kitu chochote kufidia, au kuzuia kuongezeka uzito kutokana na milo hii, kama vile kutapika, kushinda na njaa, kufanya mazoezi, kumeza dawa za kuharisha, enema, kuongeza mkojo au dawa nyinginezo?

N5 Does your body weight or shape greatly influence how you feel about yourself? NO YES 12

N5 Je uzito wako au umbile lako linaathiri kwa kiasi kikubwa jinsi unavyojiona?

* **MEANS** : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

N6 DOES THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA ? NO YES 13

IF **N6 = NO**, SKIP TO **N8**

N7 Do these binges occur only when you are under_______kg/lbs.*? NO YES 14

- **TAKE THE THRESHOLD WEIGHT FOR THIS PATIENT'S HEIGHT FROM THE HEIGHT / WEIGHT TABLE IN THE ANOREXIA NERVOSA MODULE**

Je, milo hii ya kupita kiasi hutokea pale tu una uzito chini ya kilo ?

- **ANDIKA KIWANGO CHA UZITO KINACHOLINGANA NA UREFU WA MGONJWA KUTOKA KATIKA JEDWALILILILOPO KWENYE KIHUNZI CHA UGONJWA WA KUTOKULA**

N8 IS N5 CODED YES AND N7 CODED NO (OR SKIPPED) ? NO YES
JE, N5 IMEJIBIWA NDIYO N7 IMEJIBIWA HAPANA (AU IMERUKWA KWA SABABU DALILI ZA MGONJWA HAZIFIKII VIGEZO VYA UGONJWA WA KUTOKULA)?

BULIMIA NERVOSA
CURRENT

IS N7 CODED YES ? NO YES
JE, N7 IMEJIBIWA NDIYO?

ANOREXIA NERVOSA
Binge-Eating/Purging Type
CURRENT

O. GENERALIZED ANXIETY DISORDER
O. UGONJWA WA WASIWASI MKUBWA

O1 a	Have you worried excessively or been anxious about several things of day to day life, at work, at home, in your close circle over the past 6 months ?	NO	YES	1
	DO NOT CODE YES IF THE FOCUS OF THE ANXIETY IS CONFINED TO ANOTHER DISORDER EXPLORED PRIOR TO THIS POINT SUCH AS HAVING A PANIC ATTACK (PANIC DISORDER), BEING EMBARRASSED IN PUBLIC (SOCIAL PHOBIA), BEING CONTAMINATED (OCD), GAINING WEIGHT (ANOREXIA NERVOSA)...			
	Are these worries present most days ?	NO	YES	2
01 a	Je, ulikuwa na woga sana au kupata wasiwasi juu ya mambo mawili au zaidi(mf. Pesa, afya ya watoto, msiba) kwa kipindi cha miezi 6 iliyopita? Zaidi ya watu wengi webgine wanavyokuwa?			
	Je, woga huu unakuwepo karibu siku zote?			

02	Do you find it difficult to control the worries or do they interfere with your ability to focus on what you are doing ?	NO	YES	3
02	Je unapata tabu kujizuia na woga, au je inavuruga uwezo wako wa kuwa makini kwa unachokifanya?			
	FROM 03a **TO** 03f, **CODE NO THE SYMPTOMS CONFINED TO FEATURES OF ANY DISORDER EXPLORED PRIOR TO THIS POINT**			
03	**When you were anxious over the past** 6 **months, did you, almost every day :**			
03	**Waakati ulipokuwa na wasiwasi katika miezi** 6 **iliyopita, je, muda mwingi:**			
a	Feel restless, keyed up or on edge ?	NO	YES	4
a	Ulijisikia kutotulia, kuamshwa, au mwenye kiherehere?			
b	Feel tense ?	NO	YES	5
b	Ulijisikia kukakamaa?			
c	Feel tired, weak or exhausted easily ?	NO	YES	6
c	Ulijisikia kuchoka, mdhaifu, au kuchoka mapema?			
d	Have difficulty concentrating or find your mind going blank ?	NO	YES	7

MEANS : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

d Ulipata tabu ya kuwa makini, au kuona unapoteza kumbukumbu?

e	Feel irritable ?	NO	YES	8
e	Ulijisikia mwenye kuudhika upesi?			
f	Have difficulty sleeping (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively) ?	NO	YES	9
f	Ulipata tabu ya usingizi (tabu ya kupata usingizi, kuamka katikati ya usiku, kuamka mapema asubuhi, au kulala mno)?			

ARE **3** OR MORE **O3** ANSWERS CODED **YES ?**

JE VIPENGELE **3** AU ZAIDI VYA **O3** VIMEJIBIWA **NDIYO?**

NO YES

GENERALIZED ANXIETY DISORDER

CURRENT

P. ANTISOCIAL PERSONALITY DISORDER (optional)
P. UGONJWA WA MAKUZI YA HULKA NA TABIA ZEVAZOPINGANA NA JAMn (hiari)

PI **Before you were 15 years old, did you :**
Kabla hujawa na umri wa miaka 15, je:

a Repeatedly skip school or run away from home overnight ? NO YES
Ulikuwa ukitoroka shule mara kwa mara au kuondoka nyumbani usiku?

b Repeatedly lie, cheat, « con » others, or steal? NO YES
Ulikuwa ukidanganya mara kwa mara, ukilaghai, kutapeli wengine, au kuiba?

c Start fights or bully, threaten, or intimidate others? NO YES
Ulianzisha ugomvi au kudhulumu, kutishia au kutisha wengine?

d Deliberately destroy things or start fires? NO YES
Kwa makusudi uliharibu vitu au kuwasha moto?

e Deliberately hurt animals or people? NO YES
Kwa makusudi kuwadhuru wanyama au watu?

f Force someone to have sex with you? NO YES
Kumlazimisha mtu kufanya mapenzi na wewe?

ARE 2 OR MORE **PI** ANSWERS CODED **YES?** NO YES
JE, VIPENGELE 2 AU ZAIDI VYA **PI** VIMEJIBIWA **NDIYO?**

P2 **DO NOT CODE** YES **THE BEHAVIORS BELOW IF THEY ARE EXCLUSIVELY POLITICALLY OR RELIGIOUSLY MOTIVATED**
USIJIBU NDIYO KWA TABIA ZILIZO HAPA CHINIIKIWA ZIMESABABISHWA NA MAMBO YA KISIASA AU KIDINI

**Since you were 15 years old, have you: **
Tangu umri wa miaka 15, je:

a Repeatedly behaved in a way that others would consider irresponsible, like failing to pay for things you owed, deliberately being impulsive or deliberately not working to support yourself? NO YES 7
Mara kwa mara ulikuwa na tabia ambayo watu wengine wangeona kama ni kutowajibika, kama vile kushindwa kulipa madeni, kwa makusudi kuwa jazba au kwa makusudi kutofanya kazi ili kujitegemea?

b Done things that are illegal even if you didn't get caught (i.e., destroying property, shoplifting, stealing, selling drugs, or committing NO YES 8

a felony) ?
Hufanya mambo kinyume cha sheria hata kama hukutiwa mbaroni (kama vile, kuharibu mali, kuiba vitu dukani, wizi, kuuza madawa ya kulevya, au kufanya kosa la jinai)?

c	Been in physical fights repeatedly (including physical fights with your spouse or children) ? Ulikuwa ukipigana mara kwa mara (ikiwemo kupigana na mke / mume wako au watoto)	NO	YES	9
d	Often lied or « conned » other people to get money or pleasure, or lied just for fun? Mara kwa mara kudanganya au "kutapeli" watu wengine ili kupata pesa au starehe, au kudanganya kwa kuchekesha watu tu?	NO	YES	10
e	Exposed others to danger without caring? Kuwaweka wengine katika hatari bila ya kujali?	NO	YES	11
f	Felt no guilt after hurting, mistreating, lying to, or stealing from others, or after damaging property? Kujiona huna hatia baada ya kuleta madhara, kufanya maovu, kudanganya, au kuwaibia watu, au baada ya kuharibu mali?	NO	YES	12

ARE **3** OR MORE ITEMS FROM **P2** CODED YES ?
JE, VIPENGELE **3** AU ZAIDI VYA **P2** VIMEJIBIWA **NDIYO?**

ANTISOCIAL PERSONALITY DISORDER
LIFETIME

* means : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

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The M.I.N.I. was developed simultaneously into French and English. The French and English original versions of the M.I.N.I. for DSM-IV were translated and can be asked to the authors (see page 3). An ICD-10 version is also available into French, English, Danish and Indonesian.

Languages	M.I.N.I. 4.4 and previous versions	M.I.N.I. 5.0.0 +
Afrikaans		R. Emsley, N. Keyter
Arabic		0. Osman, E. Al-Radi
Basque		In preparation
Bengali		H. Banerjee, A. Banerjee
Brazilian	P. Amorim	P. Amorim
Bulgarian		L.G. Hranov
Catalan		In preparation
Czech	P. Zvolsky	P. Zvolsky
Croatian		In preparation
Danish	P. Bech	P. Bech, G. Bech-Andersen, T. Schotze
Dutch/Flemish	E. Griez, K. Schruers, T. Overbeek, K. Demyttenaere	1, van Vliet, H. Leroy, H. van Megen
Egyptian (Arabic)		R Haddad. W Naja, C. Baddoura, A. Okasha
Estonian		J. Shlik, A. Aluoja, E. Kihl
Farsi/Persian		K. Khooshabi, A. Zomorodi
Finnish	M. Heikkinen, M. LijestrOm, O. Tuominen	M. Heikkinen
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Icelandic		J. Stefanson
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Japanese		T. Otsobo, H. Watanabe, H. Miyaoka, K. Kamijima, J. Shinoda, K. Tanaka, Y. Okajima
Korean		H. Y. Jung et al.
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Lebanese (Arabic)		R. Haddad, W. Naja, C Baddoura
Lithuanian		V. Danilevicute
Malay		Adapted from A. Maramis
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Polish	M. Masiak, E. Jasiak	M. Masiak, J. Przychoda
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Punjabi		A. Gahunia, S. Gambhir
Romanian	0. Driga	M.D. Gheorghe
Russian		A. Bystitsky, E. Selivra, M. Bystitsky
Serbian	1. Timotijevic	I. Timotijevic
Setswana		K. Ketlogetswe
Slovak		L VavruSovS, J. PefeftSk, I!. ForgSfovS
Slovenian	M. Kocmur	M. Kocmur
Spanish	L. Ferrando, J. Bobes-Garcia, J. Gibert-Rahola	L. Ferrando, L. Franco-Alfonso, M. Soto, J. Bobes, 0. Soto, L. Franco, J. Gibert. Adaptation for Central and South America: G. Heinze
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