PREVALENCE OF PSYCHIATRIC MORBIDITY AMONG SUDANESE REFUGEES LIVING IN NAIROBI

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

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I. DECLARATION

I declare that this dissertation entitled 'Prevalence of psychiatric morbidity among Sudan refugees living in Nairobi' is the result of my own work and that it has not been submitted eit wholly or in part to this or any other university for the award of any degree or diploma.

Department of Psychiatry.

Date 10/10/2011

Signed.....

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II. Certificate of approval

This is to certify that this dissertation entitled 'Prevalence of psychiatric morbidity amc Sudanese refugees living in Nairobi' is the bonafide research work carried out independently Dr. Wamukhoma R. Victoria under our guidance and supervision.

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IV. List of abbreviations

ASSIST	Alcohol Smoking and Substance Involvement Screening Test
DSM-IV TR	Diagnostic Statistical Manual (4th edition) Text Revised
HRW	Human Rights Watch
ICD	International Classification of Disease
MDE	Major Depressive Episodes
PTSD	Posttraumatic Stress Disorder
SCID	Structured Clinical Interview for DSM-IV
SDQ	Social Demographic Questionnaire
SPSS	Statistical Package for Social Sciences
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UON	University of Nairobi
W.H.O	World Health Organization
M.I.N.I PLUS	Mini International Neuro-psychiatric Interview PLUS

V. ABSTRACT

Introduction

One per cent of the world's populations, 50 million people, are currently uprooted. In Africa there are 6 million refugees. In the past decade the worldwide refugee population has increased tenfold and all indicators show that this number will continue to rise. Kenya hosts 374,000 refugees, mainly from Ethiopia, Somalia and Southern Sudan. Several studies of disaster victims found that PTSD, major depressive disorder, generalized anxiety disorders, and panic disorders were identified commonly by most of the studies.

Refugees could be at excess risk of psychiatric morbidity because of forced migration, traumatic events, and resettlement in unfamiliar environments. The relevant epidemiological evidence is, however, generally sparse, scattered, and apparently conflicting, and its interpretation has been complicated by the use of different sampling and assessment methods.

Objective: To establish psychiatric morbidity and substance use disorders among Sudanese refugees living in Nairobi.

Method: The study was a cross-sectional descriptive study. The Study instruments were Mini International Neuropsychiatric Interview-PLUS (M.I.N.I-PLUS), M.I.N.I screen which was used to screen clients before the M.I.N.I-PLUS was administered, a researcher designed social demographic and clinical questionnaire and alcohol, smoking and substance involvement screening test (ASSIST).

Data analysis: There was double data entry and analysis using SPSS version 16 and inferential analysis. Results are presented in form of narratives and tables.

Results: The overall prevalence of psychiatric morbidity among Sudanese refugees residing in Nairobi was 56.2% (n=135). 66.7% (n=90) out of the 135 patients diagnosed with a psychiatric morbidity had a single diagnosis. The remaining 33.3% (45) patients with psychiatric illness had comorbid psychiatric illnesses. The most commonly diagnosed psychiatric morbidities among the study participants were post-traumatic stress disorder and major depressive episodes at prevalence rates of 24.1% (n=58) and 20.4% (n=49) respectively. These two diagnoses' prevalence was significantly higher than for each of the remaining diagnosis. The other frequent psychiatric morbidities among the refugees included generalized anxiety disorder accounting for 5.8 % (n=14), dysthymia 5.4% (n=13) alcohol dependence, 3.8% (n=9) and khat dependence 3.8% (9).

Limitations: The sampling method was not random. A cultural validation study was not done.

Conclusion: This study provides important information on the prevalence of psychiatric morbidity among the urban Sudanese refugees. Consistent with other studies, it confirms that psychiatric morbidity is indeed higher in refugees than in general populations

Recommendations: More studies on the prevalence of psychiatric morbidity among refugees living in camps in Kenya are required to build evidence base in order to guide mental health policy decisions for the displaced populations. Advocacy for the mental health of refugees and displaced people should be done. All health care workers in humanitarian relief work should be well trained on identification of mental disorders in order to enhance quick diagnosis and correct management.

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1 CHAPTER 1

1.1 *INTRODUCTION*

Many wars engulf Africa, from east to west and from north to south, leaving many Africans severely traumatized[1]. The nature and type of war has been changing in recent times. War has changed from direct fighting between countries for territory or conquest of land where several countries could become involved on each side, to internal war within countries, involving ethnic and other civil groups against each other, typically "low-intensity" conflicts involving poor third world countries. There have been over 150 such wars since 1945, where 90% of all casualties were civilians. According to Bracken et al[2], what predominates is the use of terror to exert social control, if necessary by disrupting the fabric of grassroots social, economic and cultural relations. The target is often populations rather than territory and psychological warfare is the central element.

Atrocities, including civilian massacres, reprisals, bombing, shelling, mass displacements, disappearances and torture, are the norm. As can be expected, the consequences for mental health, not to mention the social, economic, cultural and other costs, can be substantial. Studies in Afghanistan, Balkans, Cambodia, Chechnya, Iraq, Israel, Lebanon, Palestine, Rwanda, Sri Lanka, Somalia, and Uganda show the devastating consequences of war on the mental health of civilians.[3]

Flight of refugees often occurs in the setting of war, famine, or human rights violations. As defined in the 1951 United Nations Convention Relating to the Status of Refugees (the Refugee Convention), a refugee is defined as: "A person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country or return there.[4]

The war between the North and South of Sudan has claimed an estimated two million lives, with many millions more homeless and displaced. The roots of this war lie in long-standing ethnic and religious hostilities between the lighter-skinned Arab-Muslim rulers of the North and the mostly Christian ethnic groups in the South, fueled by the discovery of oil in the southern provinces in the 1970s[5]. An estimated 500,000 southern Sudanese refugees have fled to nearby countries. As the war in their country drags on, making the chances of a return to their homeland unlikely at best, their only hope is to eventually join the ranks of those who have been resettled to the West, most notably the United States, Canada, or Australia.

They are unable to work legally, find affordable housing, or obtain a decent education for their children, regardless of their "official" refugee status. Consequently, thousands of individuals and families struggle to survive on little or no formal assistance, employed in the informal sector. In short, these individuals and families exist "in limbo" socially, economically, and culturally.

The social, physical, and mental challenges of adapting to forced migration have been well-documented, and include the collapse of systems of social support, socioeconomic marginalization, poor physical health, malnutrition and/or starvation, and psychological symptoms and disorders[6].

Cultural coping systems, mediated through a shared language, history, dress, and ritual practices, must either be adapted to handle the exigencies of a completely new and unknown situation, or be stripped away entirely[7]. Refugees are, as Victor Turner put it, "transitional beings," caught in between the classificatory systems that define societies and create the link between self, place, history, and future[8]. The body, as the "existential ground" of culture[9], is the terrain on which liminality is worked through and new classifications are created, as cultural practices, and even language itself, become insufficient to define self and community.

Displacement due to wars has a significant impact on survivors. Inherent to the state of displacement is the loss of social support due to the loss of community and reduced sense of control over one's life. Displacement due to losing a home can cause a profound and long-lasting psychological impact on survivors[10]. Until recently, stress was placed on emergency response to provision of food, water and shelter to displaced populations. Health and other priority needs are often delayed. Recognition of the mental health needs of refugees is emerging but remains poorly addressed as allocation of resources does not follow.

Despite scientific evidence to the fact that conflict has a devastating impact on health and on mental health, the latter is not seen as a priority by many decision-makers. Indeed, eight years after the genocide in Rwanda, a quarter of the studied population showed diagnosable PTSD[11]. This, projected to the actual numbers of Africans traumatized in Sudan, Sierra Leone, Democratic Republic of Congo, Ivory Coast, Somalia and other parts of Africa, translates to millions of people in need of help.

1.2 *BACKGROUND*

One per cent of the world's populations, 50 million people, are currently uprooted—23 million are refugees who have sought safety in another country, and 27 million are displaced within their own country[12].

In Africa there are 6 million refugees. In the past decade the worldwide refugee population has increased tenfold and all indicators show that this number will continue to rise[13]. Kenya hosts 374,000 refugees[14], mainly from Ethiopia, Somalia and Southern Sudan. Most of them are confined to designated camps despite UNHCR's appeals to allow their freedom of movement. There are three camps around the town of Dadaab, in north-eastern Kenya, and one near Kakuma, in the RiftValley. While Kenya has never officially enacted a policy stipulating it, since the early 1990s the country has in practice required refugees to reside in camps.

Together, these camps are home to 88% of Kenya's refugees. There are however a number of administrative exceptions to the 'encampment policy'. These include refugees undergoing resettlement interviews or processing, needing specialized medical or psychological care, pursuing further education or facing serious security threats in the camps[15]. In practice these exceptions are implemented arbitrarily and on an ad hoc basis, and it is difficult for refugees to leave the camps. For its part, UNHCR requires asylum-seekers and refugees to reside in the

camps unless one or more of the aforementioned administrative exceptions to the 'encampmer policy' apply.

The traditional image of life in tented, sprawling camps no longer tells the full refugee story. A the world urbanizes, refugees too are increasingly moving to built up areas – including larg towns and cities. Today, almost half of the world's 10.5 million refugees reside in urban area with only one-third in camps[16].

In 2006, the number of refugees in Nairobi and officially registered with UNHCR was 32,00 Today the number has risen to 46,316[16] refugees in Nairobi, but the real figure could be as hig as 100,000[17]. Therefore the refugee experience in Kenya is no longer solely played out in camp and that responding to the needs of urban refugees represents a growing challenge for stat authorities and development and humanitarian actors.

In Kenya, there has been significant attention on the plight of refugees living in overcrowde camps such as Dadaab in the east of the country. Yet there has been little focus on the growin number of refugees living in its urban centers. There has also been scant research into thei situation, their mental health needs, funding and resources available for assistance.

Refugees living in Nairobi are not receiving the same level of attention or assistance as thei camp counterparts. Although the phenomenon of urban displacement is starting to receiv greater attention from international humanitarian agencies and policy-makers, knowledge ga remains. The urban refugee situation in Nairobi is Pan-African and complex in nature, wit refugees from eight countries represented. Official and anecdotal information indicates that th Somali population is the largest followed by Ethiopians, Congolese, Sudanese, Ugandan an Rwandese, while smaller refugee groups residing in Nairobi include those from Eritrea an Burundi.

Urban refugees are dispersed over big cities, often highly mobile and reluctant to come forwar for support due to fears that they could be deported or sent to refugee camps. This makes them a largely 'invisible' population, despite their significant need for protection and other suppor mechanisms

Some 5 million refugees in the world constitute a group presenting chronic mental disorder (prior to the war) and of seriously traumatized, who would require specialized mental health car had it been available. Another 5 million people suffer from psychosocial dysfunction affectin their own lives and their community. The remainder majority are faced with distress an suffering. It is important to remember that refugees' reactions are normal reactions to abnorma situations.

Children, the elderly, and in many cases women, are more susceptible to the mental health consequences of war since they are already socially or economically vulnerable. The ongoin displacement, deterioration of existing social structures, limited population access to preventiv and curative health, sexual atrocities, stressors, or traumas may prolong the course o psychopathology and delay recovery. Psychological and physical pathology persist for man years after war may have ended and so does the impact of any given war.

The cognitive, emotional and socio-economic burden imposed on individual refugees, their families and the communities are enormous. Many studies report refugees to be at a higher risk of psychiatric disorders such as depression, suicide, psychosis, post-traumatic stress disorder, and substance misuse, often directly related to past physical or psychological trauma.[18,19,20,21]

The stresses can be understood as occurring at four different stages:

(1) While in their country of origin; they have often been forced to flee their homes because of exposure to war or combat and hence witnessed violence, torture, sexual atrocities, loss of property and losses of close family and friends.

(2) During the flight to safety stressors like more violence, starvation, abductions, sexual atrocities and lack of medical care for the sick.

(3) When having to settle in a country of refuge stressors like acculturation, lack of employment, pre-morbid personality and life events.

(4) The final stage of finding respite in another country can be a time of additional difficulty as many have to **prove their asylum claims and also try to integrate in a new society**. A study by Kamaldeep Bhui et al found out that Somali migrants to the UK were residentially stable after 5 years.[22]

A typical pattern of mental, emotional, and physical response is observed in the majority of people affected by a disaster[23,24]. Rubonis and Bickman[25] conducted a statistical review of studies that quantified psychopathology in the aftermath of disasters dating back to 1966 and, on the basis of this analysis, estimated that disasters are associated with a 17% increase in the best mean estimate prevalence of psychopathology in comparison to pre-disaster or control group rates. The severity of the symptoms mainly depends on individual factors, socio-cultural factors, and the severity of the disaster[26].

Individual factors include: (1) coping patterns; (2) pre-morbid personality; and (3) other individual resilience factors. Socio-cultural factors include social and family support, vulnerability of the special populations, and characteristics of the community[27] all of which are destroyed in times of war.

The fact that "someone experiences or witnesses an act of violence" does not mean that he or she "will inevitably develop psychiatric morbidity"[28]

What the currently available evidence seems to suggest is that it takes more than the agent (e.g., threat to life) to provoke psychopathology. Indeed, the role of the environment is of importance, a component of the epidemiological triangle that has been neglected by a greater focus on host-related factors (e.g., gender or age of the victim). Solomon and Laufer's study on adolescents [29] examined the effect of religiosity on youth's posttraumatic symptoms resulting from exposure to terror. Participants consisted of 1,973 Israeli high school students. Objective and subjective exposure (fear) to terror were positively associated with posttraumatic symptoms. Intrinsic religiosity was negatively associated with posttraumatic symptoms and found to decrease the effects of objective exposure. Personal extrinsic orientation and social extrinsic orientation were positively associated with posttraumatic symptoms, having no mediating effect studies by

Shalev et al[30], Kaplan et al [31] and Billig et al [32] on adults, have identified a group of fact including religious beliefs, ideological commitment and social capital, that have protec communities which were highly exposed to terrorist attacks causing loss of dear ones, physi injuries and property damage.

Very few studies have been carried out to find out the prevalence of substance use in refugees significant number of refugees use alcohol and other drugs, including tobacco, as cop mechanisms to deal with their problems, and find their own behavior troublesome. This warra further study in order to find the conditions under which substance abuse can be decreased a prevented. A study[33] of use of psychoactive substances among the Indochinese suggested t adjustment and mental health problems, with the lack of social and institutional support, may one of the major reasons refugees turn to psychoactive substances to alleviate their stresses a to forget their problems. Substance abuse among refugees creates enormous health risks fo population that is already at greater risk than the general American population. Prevent measures should be implemented at this critical moment in time so that this small problem v not grow into a larger one.

1.3 *PROBLEM STATEMENT*

Studies show that due to numerous stresses imposed on refugees they are more vulnerable mental disorders[34,35] .

Unfortunately, in circumstances of war the resources to help those affected are extremely limi or the infrastructure of the health services that may have existed is destroyed. There is am evidence of a high prevalence of psychopathology among those persons unlucky enough to h lived through war, either as combatants, or, and even more so, as civilians caught in the mid of larger conflicts[36].

The total number of urban Sudanese refugees in Nairobi is 8,240. Most of these reside Githurai, Ruiru, Zimmerman Juja and Eastleigh.[37]Having either witnessed war, lost loved or undergone atrocities we expect that psychiatric morbidity among them will be significant.

1.4 *JUSTIFICATION OF THE STUDY*

Many studies have been carried out among refugees seeking asylum in developed countr Very few studies have been carried out in our continent. Most studies have put emphasis PTSD, and fewer studies on anxiety and depression.

The urgent need to address the mental health response of these refugees cannot be undersco as their number keeps increasing especially within Kenya due to political unrest in sev countries. The trauma a refugee undergoes is carried on throughout their life and strate measures to deal with their mental health must be put in place.

Mental health intervention is as urgent for post-conflict migrant populations as physical health and other emergency interventions.

This study will outline the magnitude of psychiatric morbidity in Sudanese refugees in Nairobi, so that adequate planning and therefore evidence based mental health interventions can be extended to the populations of concern, but also to acquire this knowledge by employing studies that meet international methodological standards.

This information will ensure that adequate resources are availed to refugees with mental health problems and appropriate policies that are relevant are formulated.

2 CHAPTER 2: LITERATURE REVIEW

2.1 *INTRODUCTION TO LITERATURE REVIEW*

Very few studies have been done on Sudanese refugees. Most of these studies are done in western countries in which the refugees are seeking asylum. More-so, most studies have emphasized on researching PSTD: depression and anxiety have lesser been researched and all other psychiatric illnesses have been least researched in refugees.

Several studies of disaster victims found that PTSD, major depressive disorder, generalized anxiety disorders, and panic disorders were identified commonly by most of the studies[38]. The first 3 months after stressful life events pose the greatest risk period for onset of a major depressive disorder[39]. Thus, the extended presence of a mental health professional immediately after a disaster could aid in the detection, and possibly the mitigation, of serious depressive episodes. Studies also showed an increased risk of drug use among people traumatized by both natural and manmade disasters.[40]

Refugees could be at excess risk of psychiatric morbidity because of forced migration, traumatic events, and resettlement in unfamiliar environments[40]. The relevant epidemiological evidence is, however, generally sparse, scattered, and apparently conflicting, and its interpretation has been complicated by the use of different sampling and assessment methods[41] For example, estimates of the prevalence of post-traumatic stress disorder in adult refugees have ranged from 3%[42] to 86%[43]and those for major depression have ranged from 3%[44] to 80%[42].

There are concerns that selective citation of estimates at the lower end of this range have contributed to a neglect of refugee mental health, or conversely, that emphasis on estimates at the higher end have stigmatized refugees and given rise to inappropriate assumptions about the degree of disability associated with such psychiatric morbidity.[45, 46, 47]

2.1.1 International situation

Carlson and Rosser-Hogan have demonstrated rates of depression of 80% among a random sample of Cambodian refugees who resettled in the United States[42]. This was a majority of the refugees and if this reflects in my study then the need to address the affective disorders among refugees will be highly wanting.

A study by Kamaldeep Bhui et al[22] in the United Kingdom among 180 Somali refugees (and asylum seekers), who had been living there for an average of 8 years, reported a rate of 25% for depression and/or anxiety symptoms on the HSCL-25[19], the prevalence of PTSD was 14%. The prevalence of current episode major depressive episode was 26.6%. Despite this figure being comparatively low as compared to other studies, we must put in mind that they had been in United Kingdom for some time and they had therefore stabilised.

In a study among 54 Somalia asylum seekers (and refugees) living in reception centres in the Netherlands (65% less than 6 months), prevalence rates of 31.5% were found for PTSD, 63% for depression and 36% for anxiety symptoms, according to the HTQ and the HSCL-25. [48]

Another study[49] was carried out at The Community University Health Care Center an inner-city university outpatient clinic with medical, psychiatric, and dental services in Minnesota which serves primarily an underserved population. The aim of the study was to outline health care utilization of Somali refugees (N = 600) seen in the mental health unit of the clinic from 2001 to 2009. It was to investigate the major patterns of psychiatric disorders in this outpatient population and compare these findings with a cohort of non-Somali patients (N = 3,009) seen at the same outpatient clinic during the years 2007–2009. the study discovered unexpectedly very high rates of psychoses 46.52 % in young Somali men seen in the clinic, which has not been noted to this extent in other studies of Somali refugees, and second an expected pattern of co-morbid depressive and PTSD symptoms in the women and older men patients that are in keeping with other studies of war refugee populations and more fitting with the trauma and loss histories most of these patients experienced. Diagnosis was based on DSM-IV-R criteria.

In a study[70] comparing Somali and Rwandese war refugees in a Ugandan refugee settlement, already mentioned Onyut et al found that Somali persons had higher prevalence of PTSD than Rwandese persons (48.1 vs. 32.0%).

In a study among 51 Afghan refugees living for an average of 4 years in the Netherlands, the following prevalence rates were found based on the Composite International Diagnostic Interview: 35% with a diagnosis of PTSD, 57% with a diagnosis of depression and 12% with a diagnosis of anxiety[50].

A Cross-sectional survey study to establish the relationship between psychiatric symptoms and disability in refugee survivors of mass violence, 534 Bosnian refugee adults over 18 years interviewed in 1996 living in a camp established by the Croatian government near the city of Varaz˘din, found that 40% of respondents reported symptoms of depression and 26% reported symptoms of PTSD.[51] Culturally validated measures used for depression and PTSD included the Hopkins Symptom Checklist 25 and the Harvard Trauma Questionnaire.
In a study[52] to get factors associated with poor mental health among Guatemalan refugees living in Mexico 20 years after civil conflict, 170 respondents participated. Of the respondents (11.8%) had all symptom criteria for PTSD. Of the 160 who completed the Hopkins Symptom Checklist-25, 87 (54.4%) had anxiety symptoms and 62 (38.8%) had symptoms of depression. Despite the refugees having been in Mexico for 20 years, they exhibited poorer mental health than the natives.
Another study[53] to assess the prevalence, co morbidity, and correlates of psychiatric disorders in the US Cambodian refugee community found high rates of PTSD (62%, weighted), major depression (51%, weighted), and low rates of alcohol use disorder were found (4%, weighted).

PTSD among a sample of mass-evacuated adults from Kosovo to Sweden was studied using a prospective design with a baseline study and follow-ups at 3 and 6 months in Sweden and with an additional follow-up after 1.5 years in both Sweden and Kosovo. Trauma events and PTSD-related symptoms were measured by the Harvard Trauma Questionnaire (HTQ). At the additional follow-up after 1.5 years the same measure (HTQ) was used as well as clinical diagnostic interviews with the SCID instrument. 37% had PTSD-related symptoms at baseline. Morbidity increased at the three follow-ups. About 80% of the participants had PTSD at the

additional follow-up after 1.5 years. In a prospective study among traumatized refugees as this particular one it has been shown that symptoms of trauma both persisted and increased at least during the immediate years after exposure to trauma[54]. It seems, however, that time is a powerful healer among refugees. In earlier studies in which refugees have been followed over extensive periods of time, up to 10 years after resettlement, psychiatric symptoms due to trauma have been shown to decline over the years[55,45 ,56]. In those studies, however, the refugees were offered favorable resettlement conditions such as permanent residency, access to work and education and were thus exposed to few and often manageable post-migration stress factors in the reception programme a contrast to Kenyan Sudanese refugees.

In a survey conducted in Afghanistan among 1,011 respondents, prevalence of 20.4% was found for PTSD, 38.5% for depression and 51.8% for anxiety, according to the HTQ and HSCL-25. [57]

A survey conducted in Iran among 35,014 respondent refugees found prevalence of 21% for depression and 20.8% for anxiety symptoms using the General Health questionnaire.[58]

A population-based study[59] was conducted in the Netherlands from June 2003 to April 2004 among adult refugees and asylum seekers from Afghanistan, Iran and Somalia. Asylum seekers living in 14 randomly selected reception centers, and random samples of refugees were obtained from the population registers of three municipalities. A total of 178 refugees and 232 asylum seekers participated. Symptoms of post-traumatic stress disorder (PTSD), depression and anxiety, were measured with the Harvard Trauma Questionnaire and the Hopkins Symptoms Checklist-25. 29.3% of the refugees and 61.5% of the asylum seekers reported symptoms on the depression scale, and 27.7% and 41.2%, respectively, on the anxiety scale.
Measures included a trauma inventory, the Clinician Administered PTSD Scale (CAPS)[60] and the depression module of the Structured Clinical Interview (SCID)[61]. Results: Three diagnostic groupings emerged; normal (n = 39), pure PTSD (n = 29), and co morbid PTSD and depression (n = 58).

In a study[52] to estimate the prevalence of mental illness and factors associated with poor mental health of underserved Guatemalan refugee communities located in Chiapas, Mexico 20 years after they fled from their country, (11.8%) of the refugees who participated had all symptom criteria for PTSD, (54.4%) had anxiety symptoms and (38.8%) had symptoms of depression on the Hopkins Symptom Checklist-25.
A study[62] in north Korean refugees whose aim was to clarify the effect of migration of North Korean defectors to different host countries on the mental health and quality of life of the migrants by comparing three subject groups: North Korean defectors living in Japan, a group of Japanese workers living in Japan (for comparison), and North Korean defectors living in South Korea. The North Korean defectors living in Japan scored significantly higher on the Beck Depression Inventory, and also scored lower across all domains of the World Health Organization Quality of Life Assessment than the other two groups.

In a comparative study[63] amongst Vietnamese refugees resettled for over a decade in Australia and the host population, with an aim to assess the contributions of trauma and PTSD to overall mental disorder and related need for services, it was found that the PTSD prevalence for both groups was 3.5% and the diagnosis was present in 50% of Vietnamese and 19% of Australians

with any mental disorder(s). The study went ahead to conclude that Trauma and PTSD continue to affect the mental health of Vietnamese refugees even after a decade of resettlement in Australia a finding the researcher expects in Sudanese refugees despite their long stay in Kenya.

A number of studies involving multiple older adult immigrant groups (ranging from Korean, Chinese, Mexican, and Russian/Eastern European) point to high risks for depressive symptoms and disorders, somatization, and a variety of traditional culture-bound syndromes[64]

2.1.2 Review of studies in Africa

A cross-sectional, random cluster survey[65] with a sample of 1242 adults (aged over 18 years) was conducted in November 2007 in the town of Juba, the capital of Southern Sudan. The objective of this study was to measure PTSD and depression in the population in the town of Juba in Southern Sudan; and to investigate the association of demographic, displacement, and past and recent trauma exposure variables, on the outcomes of PTSD and depression. Levels of exposure to traumatic events and PTSD were measured using the Harvard Trauma Questionnaire (original version), and levels of depression measured using the Hopkins Symptom Checklist-25. 36.2% of respondents met symptom criteria for PTSD and half of respondents met symptom criteria for depression. The PTSD rates were 42.5% amongst women and 29.7% amongst men. 49.9% of respondents met symptoms for depression. The depression rates were 58.7% amongst women and 40.9% amongst men.

Musisi [66] in his chapter in the recently published volume "Essentials of clinical psychiatry for sub- Saharan Africa", reports significant physical and psychological war-related trauma inflicted to the Ugandans in their homes, at military checkpoints and in detention. The most commonly encountered mental disorders were found to be post-traumatic stress disorder (PTSD) at 39.9%, depression at 52%, anxiety at 60% and somatization disorder at 72.2%. The prevalence of suicidal behaviour was recorded as 22.7% and that of alcohol abuse as 18.2%. These incredibly high figures for mental disorders in war-affected Ugandans are reflected by another recent study among internally displaced Kenyans following ethnic clashes in parts of the country.

Njau [67] found, in this highly traumatized population in a comparative study in the Rift Valley, a prevalence rate of 80.2% of PTSD amongst the heads of households.

Neuner et al [68] studied a random sample of 3,339 refugees in the west Nile region, including Ugandans and Sudanese, and found that 31.6% of the male and 40.1% of the female respondents fulfilled the criteria for a DSM-IV PTSD diagnosis.

In a recent study, Pham et al[69] found that, among the 2091 participants who survived the 1994 genocide in Rwanda, 24.8% met the symptom criteria for PTSD.

In a study done by Lamaro P. Onyut et al among Somali and Rwandese refugees living in Nakivale refugee settlement in Uganda[70] they found the prevalence of PTSD in the whole sample to be 37.8% (n = 538).

In a comparative study[71] to compare the incidence of traumatic events and its association symptoms of post-traumatic stress disorder in three population groups in northern Uganda southern Sudan nationals and refugees, the population prevalence of PTSD was estimated t 48% for Sudanese stayees, 46% for Sudanese refugees and 18% for Ugandan nationals.

Research into post conflict psychiatric sequelae in low-income countries by De Jong e assessed 3048 respondents from post conflict communities in Algeria, Cambodia, Ethiopia, Palestine with the aim of establishing the prevalence of mood disorder, somatoform disor post-traumatic stress disorder (PTSD), and other anxiety disorders. The study cited 37.4% PT prevalence in Algeria and 15.8% in Ethiopia[72].

3 CHAPTER 3: RESEARCH SCOPE

3.1 *OBJECTIVES OF THE STUDY*

3.1.1 Main objective

To determine the prevalence of psychiatric morbidity among Sudanese refugees living in Nairobi.

3.1.2 Specific objectives

1. To determine the socio demographic profiles of Sudanese refugees residing in Nairobi.
2. To determine the prevalence of psychiatric morbidity among Sudanese refugees residing in Nairobi.
3. To determine the relationship between social demographic characteristics (age, gender, sex, level of education, employment, marital status) and psychiatric disorders.

3.2 *NULL HYPOTHESIS*

There is no psychiatric morbidity among Sudanese refugees living in Nairobi.

3.3 *ALTERNATIVE HYPOTHESIS*

There is psychiatric morbidity among Sudanese refugees living in Nairobi.

4 CHAPTER 4: METHODOLOGY

4.1 *STUDY DESIGN AND AREA*

4.1.1 Study design

The study was a cross-sectional descriptive study. The researcher was present at all the time of data collection. Data was captured and recorded at the time of interview.

4.1.2 The study area

The study areas were Githurai, Ruiru, Zimmerman and Juja. The areas were found to have a high number of Sudanese refugees.[37]

4.2 *STUDY POPULATION AND SAMPLING*

The study population was the Sudanese refugees living in Githurai, Ruiru, Zimmerman and Juja. The researcher used snowballing as a sampling method.

4.2.1 Inclusion criteria

1. Those $\geq$ 18 years of age
2. Sudanese refugees.
3. Those who gave informed consent to participate in the study.
4. Those who understood English.

4.2.2 Exclusion Criteria

1. Those < 18 years of age.
2. Those with overt psychosis and interviews were impossible to take place.
3. Those who were not Sudanese.
4. Those who did not understand English.
5. Those who declined to give consent.

4.3 *SAMPLE SIZE*

A total of 240 refugees were interviewed. The sample size was calculated using the formula (Naing et al 2006)

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

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 80% from other prevalence[42] studies

Q is 1-p

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

Therefore substituting the values as follows;

$$N=\frac{1.96^2 \times .80 \times .20}{0.05^2}$$

$$= 245$$

4.4 *DATA COLLECTION METHODS AND INSTRUMENTS*

4.4.1 Study instruments

M.I.N.I PLUS and ASSIST were used to pick psychiatric disorders and substance abuse disorders respectively. The M.I.N.I. screen was used to screen clients before the M.I.N.I PLUS was administered.

4.4.2 Socio-Demographic Data Questionnaire

This is a researcher designed questionnaire that captures identification data and relevant demographic variables like age, Sex, Religion, Marital status, Occupation, level of education, employment, duration of stay in Kenya and history of stay in a refugee camp.

4.4.3 The Mini-International Neuropsychiatric Interview-PLUS (M.I.N.I.-PLUS)

Mini-International Neuropsychiatric Interview (M.I.N.I.-PLUS) is a structured diagnostic interview, developed jointly by psychiatrists and clinicians in the United States and Europe, for DSM-IV and ICD-10 psychiatric disorders. The main uses of the M.I.N.I.PLUS are for diagnostic, Evaluation, research, and the training of mental-health professionals. The M.I.N.I. Plus is a psychiatric structured interview that takes approximately 30-45 minutes to administer. It uses decision tree logic to assess the major adult Axis I disorders in DSM-IV and ICD-10. It elicits all the symptoms listed in the symptom criteria for DSM-IV and ICD-10 for 24 major Axis 1 diagnostic categories, one Axis II disorder and for suicidality. Its diagnostic algorithms are consistent with DSM-IV and ICD-10 diagnostic algorithms.

Validation and reliability studies have been done comparing the M.I.N.I. to the SCID-P for DSM-III-R and the CIDI (a structured interview developed by the World Health Organization for lay interviewers for ICD-10). 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 tir (mean 18.7 ± 11.6 minutes, median 15 minutes) than the above referenced instruments. It can b used by clinicians, after a brief training session. Lay interviewers require more extensiv training.

The M.I.N.I. Plus is a more detailed edition of the M.I.N.I. Symptoms better accounted for by a organic cause or by the use of alcohol or drugs should not be coded positive in the M.I.N.I. Th M.I.N.I. Plus has questions that investigate these issues. Two joint papers present the inter-rat and test-retest reliability of the Mini-PLUS the validity versus the Composite Internation Diagnostic Interview (CIDI)[73] and the Structured Clinical Interview for DSM-IH-R patien (SCID) (joint paper). Three-hundred and forty-six patients (296 psychiatric and 50 no psychiatric) were administered the MINI-PLUS and the CIDI 'gold standard'. Forty two we interviewed by two investigators and 42 interviewed subsequently within two days. Interviewe were trained to use both instruments. The mean duration of the interview was 21 min with th MINI-PLUS and 92 for corresponding sections of the CIDI. Kappa coefficient, sensitivity an specificity were good or very good for all diagnoses with the exception of generalized anxie disorder (GAD) (kappa = 0.36), agoraphobia (sensitivity = 0.59) and bulimia (kappa = 0.53 Inter-rater and test-retest reliability were good. The main reasons for discrepancies we identified. The MINI-PLUS provided reliable DSM-HI-R diagnoses within a short time frame.

Validity assessment has been difficult due to a lack of proper gold standard for diagnosis c psychiatric disorders.

Permission to use the MINI-PLUS tool was obtained from Professor D.M Ndetei.

4.4.4 Alcohol Smoking and Substance Involvement Screening Te (ASSIST)

This is a tool developed by the WHO in 1997 to detect and manage substance use and relate problems in primary and general medical care settings. The ASSIST provides information on th substances which subjects have ever used in their lifetime, the substances they have used in th past 3 months, problems related to substance use, risk of current or future harm, and injectin drug use.

4.5 *DATA ANALYSIS METHODS*

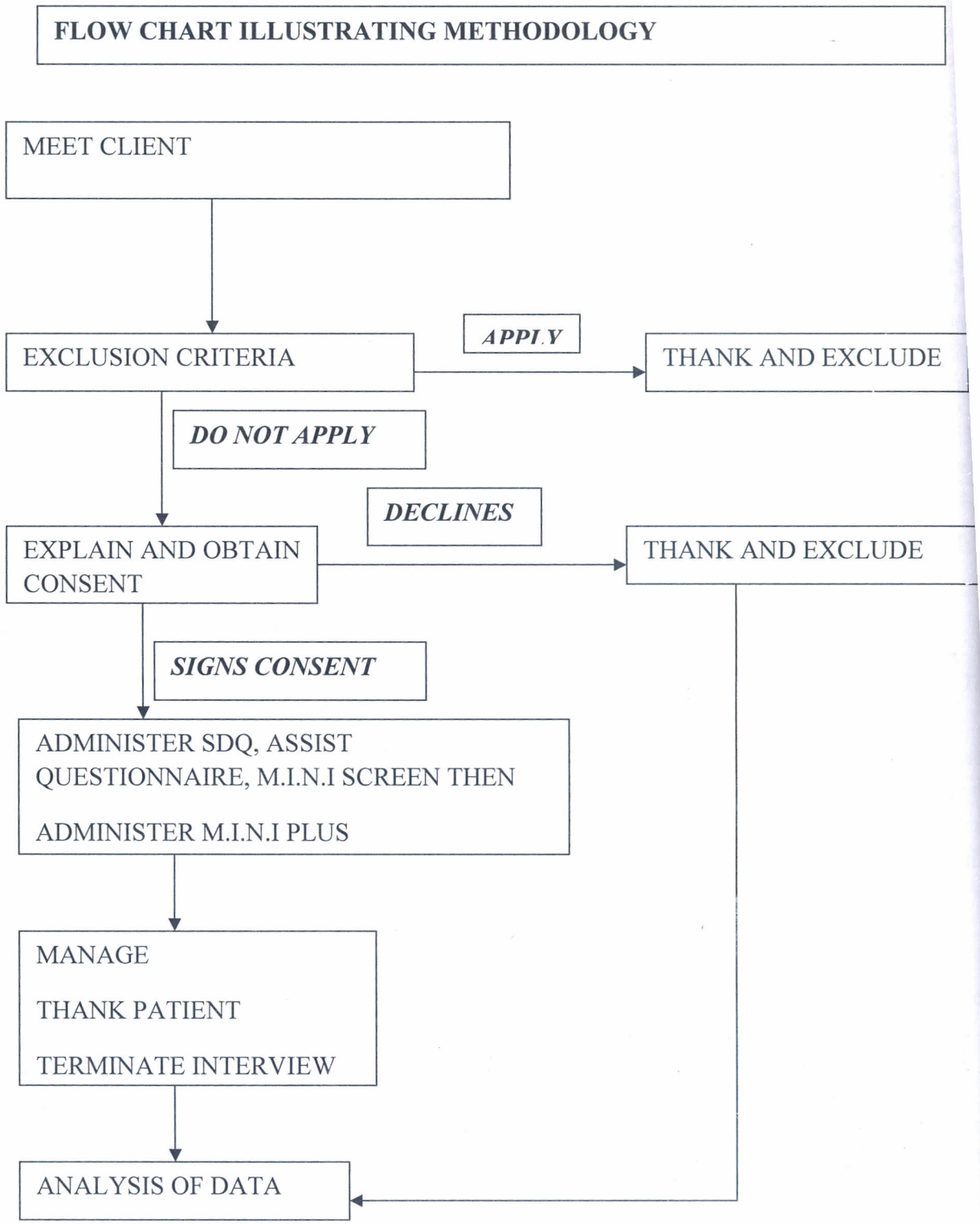
Descriptive and inferential analysis was done using the statistical package for social science (SPSS) version 16. The results are presented in narratives and tables.

4.6 *STUDY IMPLEMENTATION*

Immediately after the approval of the protocol by the ethics committee, the researcher contacte local institutions, NGO officials and refugee community leaders, in person and explained th research purpose to seek their support. It took one week to contact the local institutions, NG officials and refugee community leaders. The researcher also requested refugee communit leaders and the NGO officials on the ground to identify potential interviewees, on the initial da of the interview, who then initiated the snow balling technique.

Once potential interviewees were identified and interviewed they were requested to direct us t other members. The assessment of patients for inclusion criteria was done. Those who did no fulfill the inclusion criteria were thanked and excluded from the study. The study was explaine to those who fulfilled the inclusion criteria. An informed consent was sought and signed. A seria number was assigned as no names were used. The researcher proceeded to administer the socio demographic questionnaire, ASSIST, and the M.I.N.I. PLUS. The interviewee was thanked onc the interview was complete. Interviews were done from Monday to Friday over a period of 1 weeks. The aim was to conduct 5 interviews per day to allow for total of projected 24 interviews during the stated period. Despite interviews being projected to take 40 minutes, th researcher also needed ample time to move from home to home. On average interviews wer estimated to take about 40 minutes. Due to the nature of the study the researcher also need t factor in adequate time to debrief clients who are re-traumatized by narrating their events. Th goal of the debriefing was to reduce the likelihood of post traumatic disorder or othe psychological problems. Those found to have mental disorders were referred to the mai psychiatric referral hospital for management.

4.7 *FLOW CHART ILLUSTRATING METHODOLOGY*



4.8 *ETHICAL CONSIDERATIONS*

Approval to carry out the research was obtained from the department of psychiatry of the University of Nairobi. Clearance was sought from the Ethics and Research committee of Kenyatta National Hospital.

It was made clear to the clients that participation in the study was voluntary and information obtained was for research purposes only and there was no material gain from the study. Refusal to participate did not result in loss of any benefits. However, those found to suffer from any mental disorder were referred to the main psychiatric referral hospital for management and those re-traumatized by recounting of events were debriefed.

4.8.1 Debriefing

A debriefing or psychological debriefing is a one-time, semi-structured conversation with an individual who has just experienced a stressful or traumatic event. In most cases, the purpose of debriefing is to reduce any possibility of psychological harm by informing people about their experience or allowing them to talk about it.

As the researcher I anticipated that some of the interviewees would become re-traumatized by narration of some traumatic events they may have undergone. I took my time to counsel or debrief these clients. The goal of the debriefing was to reduce the likelihood of post traumatic disorder or other psychological problems.

4.8.2 Confidentiality

Study subjects were assured of confidentiality and anonymity. Their names did not appear on the study documents and they were to be identified by a serial number. Access to the data was limited to the researcher and data will be destroyed after completion of the study.

4.8.3 Informed consent explanation

The informed consent was read in English to the interviewees who had fulfilled the inclusion criteria and given consent.

4.9 *STUDY PERIOD*

Proposal Development	April– October	2010
Approval by department	November	2010
Ethical committee clearance	December-February	2011
Data collection	February -May	2011
Data analysis	May	2011
Report Writing	June	2011
Presentation	June	2011

4.10 *BUDGET (Kenya shillings)*

Stationary, printing and Photocopy services	25,000
Internet access/ computer services	15,000
Transport	20,000
Telephone services	10,000
Data analysis	15,000
Miscellaneous	10,000
Total	**95,000**

Funding was sourced from personal savings.

There was time spent by the researcher on the study which was unquantifiable.

5 CHAPTER 5: RESULTS

5.1 *INTRODUCTION*

This chapter presents the study findings and is divided into three sections following the study objectives. The first section presents the results of the descriptive analysis covering social demographic characteristics of Sudanese refugees residing in Nairobi. The second section shows findings on prevalence and types of psychiatric morbidities diagnosed among study participants based on screening conducted using the M.I.N.I screen, ASSIST and M.I.N.I Plus tools. The final part of the chapter presents the relationships between social demographic characteristics and psychiatric disorders.

5.2 *SOCIAL DEMOGRAPHIC PROFILES OF SUDANESE REFUGEES IN NAIROBI.*

During the study period extending from February 2011 to May 2011, a total of 240 interviews were conducted with Sudanese refugees residing in Nairobi. For all the 240 refugees recruited in the study, data were complete for social and demographic factors, substance abuse (ASSIST) and neuropsychiatric interview (MINI Plus). The social and demographic characteristics of the participants are summarized in Table 1 and presented in the following section.

Table 1: Social and demographic features of 240 respondents participating in the study

Social demographic characteristic	Frequency n (%)
Age groups	
18-24 years	95 (39.6)
25-34 years	84 (35.0)
35-44 years	37 (15.4)
45-54 years	11 (4.6)
55-64 years	8 (3.3)

65-75 years	5 (2.1)
Sex	
Male	113 (47.1)
Female	127 (52.9)
Marital status	
Married	119 (49.6)
Single	99 (41.3)
Widowed	20 (8.3)
Separated/ Divorced	2 (0.8)
Formal education	
None	50 (20.8)
Primary	108 (45)
Secondary	58 (24.2)
Tertiary	24 (10)
Occupation	
Unemployed	157 (65.7)
Student	49 (20.5)
Informal employment	18 (7.5)
Formal employment	13 (5.4)
Business	2 (0.8)
Religion	
Protestant	152 (63.3)
Catholic	87 (36.3)
Other religion	1 (0.4)
Previous stay in refugee camp	
Yes	181 (75.4)
No	59 (24.6)

5.2.1 Age

The mean age of the participants was 30 years (SD = 11.2). The participants' ages ranged fr 18 years to 80 years. Table 1 shows that most participants were young. 39.6% (95) were in t age groups 18-24 years, 35% (84) were 25 to 34 years. Compared to the other age groups the a groups over 55 years had relatively few participants with 3.3% and 2.1% of participants bei found in the age groups 55-64 years and 65-75 years, respectively. These two age groups we combined into a single age group (55 years and above) for all further analysis on age.

5.2.2 Sex

The study sample consisted of 47.1% (113) males and 52.9% (127) females (Table 1). There was a statistically significant association between sex and age of study participants with most males being younger ($p < 0.001$). Figure 1 show that only 1.8% (2) male participants were aged 45 years and above compared to 17.3% (22) female participants found in the same age group (45 years and above).

Table 2: Sex distribution of study participants in the different age groups

Characteristic	Gender		Fisher's exact p value
	Male, n (%)	Female, n (%)	
Age groups			
18-24 years	60 (63)	35 (37)	< 0.001
25-34 years	36 (43)	48 (57)	
35-44 years	15 (41)	22 (59)	
45 years and above	2 (8)	22 (92)	
Total	113 (47.1)	127 (52.9)	

5.2.3 Marital status

Table 1 shows that the most commonly reported marital status was married with 49.6% (119) participants indicating that they were married. Single and never married participants constituted a further 41.3% (99) of all study participants. There were 8.3% (20) widowed participants and only 0.8% (2) had separated or divorced their spouses.

5.2.4 Education

Table 3: Level of formal education among study participants and its association with sex and marital status

	Level of formal education				Fisher's exact P value
	None	Primary	Secondary	Tertiary	
Sex	n (%)	n (%)	n (%)	n (%)	

Male	5 (4)	33 (29)	53 (47)	22 (19)	< 0.001
Female	45 (35)	75 (59)	5 (4)	2 (2)	
Marital status					
Single	3 (3)	32 (32)	47 (47)	17 (17)	< 0.001
Married	36 (30)	65 (55)	11 (9)	7 (6)	
Widowed or separated/ divorced	11 (50)	11 (50)	0	0	

45% (108) participants had primary level education and 20.8% (50) did not have any formal education (Table 1). Education was significantly associated with both sex and marital status (Table 2). 90% of participants with no formal education were female and over 90% of those with secondary or tertiary education were male (fisher's exact $p < 0.001$). For marital status most of the patients with secondary (81%) and tertiary (71%) education were also single (fisher's exact $p < 0.001$).

5.2.5 Occupation

The types of occupations that the refugees in this study reported to engage in are presented in Table 1. 65.7% (157) reported that they were unemployed and the next most commonly reported occupation was student, which accounted for 20.5 % (49) of the responses. The remaining 7.5% (18) participants were engaged in the informal sector, 5.4% (13) formal employment or 0.8% (2) business.

5.2.6 Education and employment

	Formal Employment n (%)	Informal employment/ business n (%)	unemployed n (%)	Total n (%)	Fisher's exact p
No formal education	1 (2)	3 (6)	46 (92)	50 (100)	0.211
Primary	6 (7)	11 (12)	47 (81)	91 (100)	
Secondary and above	6 (12)	6 (12)	37 (76)	49 (100)	

The relationship between formal employment and level of education was not significant after excluding 49 students since the question on employment was invalid for this group. (Fisher's exact p = 0.211). 92% (46) of refugees with no formal education were unemployed, 81% of those with primary education were unemployed and 76% of patients with secondary education and above were unemployed.

5.2.7 Religion

The participants in this study reported belonging to two main Christian groups as shown in Table 1. Most 63.3% (152) respondent reported that they were Protestants and 36.3% (87) reported that they were Catholics. Only 0.4% (1) of the participants did not practice any religion.

5.2.8 Previous stay in refugee camp

Table 1 shows that 75% (181) of the interviewed refugees reported that they had ever stayed at a refugee camp while the remaining 25% (59) had never stayed at a refugee camp. Of the 181 refugees who had ever stayed at a camp 43.6% (79) indicated that their stay at the camp lasted for a duration less than 5 years, 27.1% (49) stayed for 5 to 10 years and 29.3% (53) stayed in a camp for at least 10 years.

5.2.9 Psychiatric and substance abuse history

Table 4: Previous psychiatric history of Sudanese refugees residing in Nairobi and participating in study

Psychiatric history	**Frequency n (%)**
Previous admission to psychiatric hospital	
Yes	7 (2.9)
No	233 (97.1)
Family history of mental illness	
Yes	72 (30.1)
No	166 (69.5)
Don't know	1 (0.4)
Family history of substance abuse	

Yes	107 (44.6)
No	131 (54.6)
Don't know	2 (0.8)

The previous psychiatric history of refugees participating in this study is presented in Table 4. Only 2.9% (7) of the refugees had ever been admitted to a psychiatric hospital. 30.1% (71) of the participants reported that they had positive family history of mental illness and 44.6% (107) of all the participants reported a family history of substance abuse.

5.3 *PREVALENCE OF PSYCHIATRIC MORBIDITY.*

The overall prevalence of any psychiatric morbidity among Sudanese refugees residing in Nairobi is 56.2% (135). 66.7% (90) out of the 135 patients diagnosed with a psychiatric morbidity had a single diagnosis. The remaining 33.3% (45) patients with psychiatric illness had comorbid psychiatric illnesses. At least two psychiatric diagnoses were made for each of 41 patients with psychiatric illnesses, and three diagnoses were made for each of the remaining four patients. Thus, a total of 184 psychiatric diagnoses were made among 135 patients with psychiatric illness in this study.

Development of a psychiatric illness was not significantly associated with previous stay in a refugee camp ($\chi^2(1) = 1.6$, $p = 0.21$). However psychiatric illness prevalence was slightly higher among participants who had previously stayed in a refugee camp compared to those who had not stayed in camps. 58.6% (106)) refugees who had stayed in camps had a psychiatric illness compared to 49.1% (29) of refugees who had never stayed in a camp. Patients who were currently seeking asylum were more likely to be diagnosed with a mental illness compared to those not seeking asylum (65.8% versus 51.6%, Fishers' exact p =0.039). Formal education level also showed a significant association with development of mental illness (Fishers' exact p = 0.003). Prevalence of psychiatric illness decreased gradually with increasing level of education

no formal education (68%, Risk ratio [RR] = 1.00), primary (63%, RR = 0.9, 95% CI 0.7-1.2), secondary (43%, RR = 0.6, 95% CI 0.4-0.9) and tertiary (33%, RR =0.5, 95% CI 0.3-0.9).

5.3.1 Types of psychiatric morbidity

Table 5: Current episodes of psychiatric morbidities diagnosed among Sudanese refugees residing in Nairobi

Psychiatric morbidity	Frequency n	Percent (95% CI)
Post-traumatic stress disorder	58	24.1(18.7-29.6)
Major Depressive episode	49	20.4 (15.3-25.6)
Generalized anxiety disorder	14	5.8 (2.8-8.8)
Dysthymia	13	5.4 (2.5-10.1)
Panic disorder	11	4.6 (1.9-7.2)
khat dependence	9	3.8 (1.7-7.0)
Alcohol dependence	9	3.8 (1.7-7.0)
Manic episode	8	3.3 (1.0-5.6)
Somatization disorder	4	1.7 (0.4-4.2)
Hypochondriasis	4	1.7 (0.4-4.2)
Hypomanic episode	3	1.25 (0.3-3.6)
Schizophrenia	2	0.8 (0.1-3.0)
Obsessive compulsive disorder	1	0.4 (0.01-2.2)
Pain disorder	1	0.4 (0.01-2.2)

Table 5 above shows a list of the specific DSM-IV diagnoses of psychiatric morbidity and their prevalence among Sudanese refugees in Nairobi. All the diagnoses in this study reflected current episodes of psychiatric morbidity.

The most commonly diagnosed psychiatric morbidities among the study participants were post-traumatic stress disorder and major depressive episodes. 24.1% (58) of all participants in this sample suffered from post-traumatic stress disorder and 20.4% (49) of the participants had major depressive episodes. The prevalence of these two diagnoses was significantly higher than for each of the remaining conditions diagnosed during the study.

The prevalence of these two conditions was not significantly different from each other as evidenced by the overlapping 95% confidence intervals.

The other frequent psychiatric morbidities diagnosed among these refugees included generalized anxiety disorder among 5.8 % (14) of refugees, Dysthymia in 5.4% (13) of participants, 3.8% (9) had Alcohol dependence and another 3.8% (9) had khat dependence. All the 18 reported episodes of substance abuse or dependence in Table 4 occurred in 12 patients only and with two substances of abuse namely alcohol or khat. Of interviewees with substance abuse 25% (3) patients abused alcohol only, another 25% (3) abused khat only and the remaining 50% (6) interviewees reported abuse of both substances.

Lastly the group of psychiatric morbidities that were infrequently diagnosed among study participants with prevalence of less than 3.5% each include: Mania, hypomanic episodes, panic disorder, somatization disorder, hypochondriasis, schizophrenia, obsessive compulsive disorder, and pain disorder (Table 5).

5.3.2 Psychiatric comorbidity

52.6% (135) participants were diagnosed with a psychiatric illness. Of these 66.7% (90) participants had a single psychiatric condition while 33.3% (45) participants had at least two comorbid psychiatric illnesses. The common types of psychiatric comorbidities among these 45 patients with comorbid psychiatric diagnoses are shown in Table 5 below. The leading comorbidity was PTSD and MDE diagnosed in ten patients followed by PTSD and dysthymia in six patients. Three patients had a substance abuse problem along with a diagnosis of manic depressive episodes. Four patients had at least three psychiatric diagnoses and the remaining 16 patients had other types of psychiatric comorbidities.

Table 6: Psychiatric comorbidities among patients with more than one psychiatric diagnosis

Main comorbidities	Frequency n (%)
PTSD and MDE	10
PTSD and dysthymia	6
MDE and alcohol dependence/ abuse	3
MDE and panic disorder	2
PTSD and mania	2
MDE and generalized anxiety disorder	2
At least three illnesses	4
Other comorbidities	16
Total with comorbidities	45

5.4 *RELATIONSHIP BETWEEN PSYCHIATRIC MORBIDITY AND SOCIAL DEMOGRAPHIC CHARACTERISTICS*

The associations between the main psychiatric morbidities and patient factors were explored and are presented in the following sections.

5.4.1 Post-traumatic stress disorder

Table 7 shows the findings of Fisher's exact tests comparing prevalence of PTSD and the different patient characteristics. The relation between PTSD and level of education was significant (Fisher's exact p = 0.036). 38% (19)) refugees with no formal education had PTSD. The prevalence of PTSD was significantly lower among refugees with tertiary or secondary education compared to those with primary education. 22% (24) of refugees with primary level education (RR = 0.6, 95% CI, 0.4-0.96) and 18% (15) of those with secondary education and above (RR = 0.5, 95% CI 0.3-0.9) had PTSD.

The relation between PTSD and the remaining patient characteristics examined was not statistically significant (Table 7).

Table 7: PTSD prevalence and risk ratios (95% CI) by patient characteristics

Characteristic	Post-traumatic stress disorder		Risk ratio (95% CI)	Fisher's exact p value
	Yes, n (%)	No, n (%)		
Age groups				0.368
18-24 years	18 (19)	77 (81)	1.00	
25-34 years	23 (27)	61 (73)	1.4 (0.8-2.5)	
35-44 years	9 (24)	28 (76)	1.3 (0.6-2.6)	
45 years and above	8 (33)	16 (67)	1.8 (0.9-3.6)	
Sex				
Male	24 (21)	89 (79)	1.00	0.366
Female	34 (27)	93 (73)	1.3 (0.8-2.0)	
Marital status				
Married	30 (25)	89 (75)	1.00	0.54
Single	21 (21)	78 (79)	0.84 (0.5-1.4)	
Widowed or Separated/ Divorced	7 (32)	15 (68)	1.3 (0.6-2.5)	
Formal education				
None	19 (38)	31 (62)	1.00	0.036*
Primary	24 (22)	84 (78)	0.6 (0.4-0.96)	
Secondary and above	15 (18)	67 (82)	0.5 (0.3-0.9)	
Occupation				
Unemployed	40 (25)	117 (76)	1.00	0.582
Student	12 (24)	37 (76)	0.96 (0.5-1.7)	
Informal employment/ business	4 (20)	16 (80)	0.79 (0.3-2.0)	
Formal employment	1 (8)	12 (92)	0.3 (0.05-2.0)	
Religion				
Protestant	40 (26)	112 (74)	1.00	0.351
Catholic	18 (21)	69 (79)	0.78 (0.5-1.3)	
Previous stay in refugee camp				
Yes	46 (25)	135 (75)	1.00	0.487
No	12 (20)	47 (80)	0.8 (0.8-1.5)	
Family history of mental illness				
Yes	13 (18)	59 (82)	1.00	0.244
No	43 (26)	123 (74)	1.4 (0.8-2.5)	
Previous admission to psychiatric hospital				
Yes	2 (29)	5 (71)	1.00	0.68
No	56 (24)	177 (76)	0.8 (03-2.8)	

* Statistically significant at 0.05 cut off

5.4.1.1 Multivariable analysis of PTSD prevalence

Table 8 presents logistic regression results examining association between PTSD and patient characteristics.

Table 8: Multivariable regression of patient characteristics on the prevalence of PTSD

	Risk Ratio (95% CI)	Standard error	P value
Formal education			
None	1.00	-	-
Primary	0.62 (0.37-1.02)	0.16	0.060
Secondary and above	0.36 (0.16-0.81)	0.15	0.014
Age			
18-24 years	1.00	-	-
25-34 years	1.54 (0.81-2.94)	0.51	0.186
35-44 years	1.51 (0.67-3.42)	0.63	0.325
45-54 years	1.59 (0.57-4.45)	0.83	0.375
55 years and above	5.52 (2.78-10.97)	1.93	<0.001
Sex			
Male	1.00	-	-
Female	0.82 (0.34-1.95)	0.36	0.651
Occupation			
Unemployed	1.00	-	-
Student	0.27 (0.04-2.02)	0.28	0.201
Informal employment/ business	0.55 (0.16-1.80)	0.33	0.320
Formal employment	0.81 (0.38-1.71)	0.31	0.577
Marital status			
Married	1.00	-	-
Single	0.89 (0.34-2.35)	0.44	0.816
Widowed or separated/ divorced	0.72 (0.24-2.14)	0.40	0.551
Religion			
Protestant	1.00	-	-
Catholic	0.99 (0.57-1.72)	0.28	0.978
Previous stay in refugee camp			
Yes	1.00	-	-
No	0.80 (0.44-1.45)	0.24	0.463
Previous admission to psychiatric hospital			
Yes	1.00	-	-
No	1.17 (0.22-6.28)	1.00	0.858
Family history of mental illness			
Yes	1.00	-	-
No	1.33 (0.77-2.29)	0.37	0.309

The refugees' level of education was independently associated with PTSD after adjusting for the effect of patient characteristics including age, sex, and family history of mental illness, previous stay in refugee camp or admission to a psychiatric hospital. The risk of PTSD was 64% lower among refugees with secondary level education and above compared to those with no formal education (RR= 0.36, 95% CI 0.16-0.81, p = 0.014). Refugees with primary level education also had a lower risk of PTSD compared to those with no education (RR= 0.62, 95% CI 0.37-1.02, p = 0.06). As shown in Table 7, the remaining patient characteristics were not significantly associated with a diagnosis of PTSD.

5.4.2 Major depressive episode

Table 9 shows association between prevalence of MDE and individual patient factors examined using Fisher's exact test with risk ratios. The relation between MDE and previous stay in a refugee camp showed a significant statistical association (Fisher's exact $p < 0.001$). 44% (40) refugees who had previously stayed at a refugee camp had MDE compared to only 6% (9) out of the 150 refugees who had not stayed in a refugee camp and also had MDE (RR = 0.14, 95% CI 0.07-0.3). Refugees with no family history of mental illness has a lower risk of MDE but this association was not statistically significant (RR = 0.9, 95% CI 0.5-1.5). 19% (32) of patients with no family history of mental illness had MDE compared to 21% (16) of refugees with family history of mental illness who also had MDE (Fisher's exact p = 0.602).

Similarly, MDE did not show significant association with age, sex, education level, religion, and occupation. (Fisher's exact p values > 0.05).

Table 9: Prevalence of major depressive episode and risk ratios (95% CI) by patient characteristics

Characteristic	Major depressive episode		Risk ratio (95% CI)	Fisher' exact p value
	Yes, n (%)	No, n (%)		
Age groups				
18-24 years	19 (20)	76 (80)	1.00	0.779
25-34 years	19 (23)	65 (77)	1.13 (0.6-2.0)	
35-44 years	8 (22)	29 (78)	1.1 (0.5-2.3)	
45 years and above	3 (13)	21 (87)	0.6 (0.2-1.9)	
Sex				
Male	22 (19)	91 (81)	1.00	0.751
Female	27 (21)	100 (79)	1.1 (0.7-1.8)	
Marital status				
Married	27 (23)	92 (77)	1.00	0.704
Single	18 (18)	81 (82)	0.8 (0.5-1.4)	
Widowed or separated/ divorced	4 (18)	18 (82)	0.8 (0.3-2.1)	
Formal education				
None	11 (22)	39 (78)	1.00	0.956
Primary	22 (20)	86 (80)	0.9 (0.5-1.8)	
Secondary and above	16 (20)	66 (30)	0.9 (0.4-1.8)	
Occupation				
Unemployed	29 (18)	128 (82)	1.00	0.544
Student	12 (24)	37 (76)	1.3 (0.7-2.4)	
Informal employment/ business	4 (20)	16 (80)	1.1 (0.4-2.8)	
Formal employment	4 (31)	9 (69)	1.7 (0.7-4.0)	
Religion				
Protestant	32 (21)	120 (79)	1.00	0.868
Catholic	17 (20)	70 (80)	0.9 (0.5-1.6)	
Previous stay in refugee camp				
Yes	40 (44)	50 (56)	1.00	< 0.001*
No	9 (6)	141 (94)	0.14 (0.07-0.3)	
Family history of mental illness				
Yes	16 (22)	56 (78)	1.00	0.602
No	32 (19)	134 (81)	0.9 (0.5-1.5)	

* Statistically significant at 0.05 cut off

5.4.2.1 Multivariable regression of MDE prevalence

Table 10 shows results of the logistic regression of patient factors on major depression episodes. There was no statistically significant association between MDE and the patient characteristics examined.

Table 10: Multivariable regression of patient characteristics on the prevalence of major depression

	Risk Ratio (95% CI)	Standard error	P value
Formal education			
None	1.00	-	-
Primary	0.85 (0.41-1.75)	0.31	0.652
Secondary and above	0.81 (0.30-2.19)	0.41	0.675
Age			
18-24 years	1.00	-	-
25-34 years	0.93 (0.48-1.80)	0.31	0.834
35-44 years	0.88 (0.36-2.14)	0.40	0.775
55 years and above	0.52 (0.11-2.41)	0.41	0.404
Sex			
Male	1.00	-	-
Female	0.95 (0.40-2.31)	0.43	0.918
Marital status			
Married	1.00	-	-
Single	1.52 (0.62-3.78)	0.71	0.362
Widowed or separated/ divorced	1.58 (0.35-7.13)	1.22	0.55
Religion			
Protestant	1.00	-	-
Catholic	1.06 (0.59-1.89)	0.31	0.85
Previous stay in refugee camp			
Yes	1.00	-	-
No	0.67 (0.32-1.40)	0.25	0.288
Family history of mental illness			
Yes	1.00	-	-
No	0.83 (0.47-1.45)	0.24	0.512

5.4.3 Dysthymia

Dysthymia showed significant statistical association with several patient factors including sex, marital status, age, and education level. All the 13 patients with dysthymia were female (fisher's exact p= 0.0001) and 10 were married (fisher's exact p= 0.0001). The diagnosis of dysthymia showed a significant association with refugees' age (Fisher's exact p = 0.012). 21% (5) of the patients aged 45 years and above had dysthymia compared to 2% (2) of patient aged 18-24 years

(RR = 9.9, 95% CI 2.0-47.9). 5% (2) of patients aged 35-44 years had dysthymia (RR = 2.6, 95%CI 0.4-17.6) and 5% (4) of patients 25-34 years also had dysthymia (RR = 2.3, 95% CI 0.4-12.0). None of the refugees with secondary education and above had dysthymia. 8% (4) of the refugees with no formal education and 8.3% (9) of refugee with primary education had dysthymia (Fisher's exact p = 0.99).

Table 10: Prevalence of dysthymia according to age group among Sudanese refugees

Characteristic	Dysthymia		Risk ratio (95% CI)	Fisher's exact p value
	Yes, n (%)	No, n (%)		
Age groups				0.012
18-24 years	2 (2)	93 (98)	1.00	
25-34 years	4 (5)	80 (95)	2.3 (0.4-12.0)	
35-44 years	2 (5)	35 (95)	2.6 (0.4-17.6)	
45 years and above	5 (21)	19 (79)	9.9 (2.0-47.9)	

5.4.4 Alcohol abuse/ dependence

Alcohol abuse/ dependence showed significant association with sex. All the nine patients with this diagnosis were male (p = 0.001). The association between alcohol abuse or dependence and occupation was significant (p = 0.004). Although the unemployed participants formed 65.7% of the total sample they only accounted for 22.2% of patients with alcohol abuse/ dependence diagnosis. Conversely, formally employed participant formed 5.4% of the total study sample but accounted for 33.3% of alcohol abusers.

Alcohol abuse/ dependence were not significantly associated with the remaining patient factors including age (0.47), religion (p =0.49), and education (p = 0.14).

5.4.5 Khat dependence

Non-alcohol substance dependence (khat) was similarly associated with sex (p < 0.001) and occupation (p =0.009). All the 9 patients with this diagnosis were males. 33.3% (3) substance

abusers were formally employed implying that patients in formal employment were significan more likely to abuse non-alcohol substances compared to participants in the other occupations.

This diagnosis did not show a statistically significant association with the remaining pati factors including family history of psychiatric illness ($p=0.52$), previous psychiatric admission = 0.99), or age ($p = 0.41$).

6 CHAPTER 6: DISCUSSION

This is the first mental health study to be conducted on Sudanese refugees in Nairobi. Its main objective was to determine the prevalence of psychiatric disorders among Sudanese refugees living in Nairobi. Unlike most studies that look for PTSD or depression alone among refugees or displaced populations, this study looked for the prevalence of almost all psychiatric morbidities. The study will contribute evidence for the status of mental health of urban Sudanese refugees.

6.1 *SOCIAL DEMOGRAPHIC CHARACTERISTICS*

The study found no significant relationship between PTSD, MDE and gender. Some studies[74] have showed that women are more vulnerable to developing PTSD. However, my study findings were similar to other studies which found no difference in gender rates in PTSD and depression[75,76,77].

The study did not also show any significant association between getting PTSD and MDE and marital status as has been found in other studies. Earlier studies showed that married women were more vulnerable to getting mental illnesses (in particular depression) than married men. This was postulated to be secondary to limited access to other roles, social isolation in the home and economic dependence on a male partner[78]. However other studies have reported that the mental health benefits of being married extend equally to men and women[79,80,81].

Overall development of a psychiatric illness was not significantly associated with previous stay in a refugee camp (χ^2 (1) = 1.6, p = 0.21). However, the prevalence of psychiatric illness was slightly higher among participants who had previously stayed in a refugee camp compared to those who had not. The relation between MDE and previous stay in a refugee camp showed a significant statistical association (Fisher's exact $p < 0.001$). This finding can be compared to

studies done among refugees in detention camps[82] where the prevalence of mental illnesses was higher due to lack of free movement rights, inability to get employment, and sometimes overcrowding in the camps. This finding was especially true for those who developed a major depressive episode in my study which showed a significant statistical association of (Fisher's exact $p < 0.001$).

The study also showed that patients who were seeking asylum were more likely to be diagnosed with a mental illness than those not seeking asylum (65.8% versus 51.6%, $p = 0.039$). This compares to other studies[82] done among asylum seekers in Australia. The study found that the administrative and legal appeals were often too protracted further compounding the trauma, and that there was a diminished sense of self future and purpose, leading to high levels of distress among the refugees seeking asylum.

The education level was significantly associated with development of mental illness ($p = 0.003$). The prevalence of psychiatric illness decreased gradually with increasing level of education: 68% of those with no formal education, 63% of those with primary education, 43% of those with secondary education and 33% of those with tertiary education. However, the relationship between formal employment and level of education was not significant in my study at Fisher's exact $p = 0.211$.

This finding was very consistent with the findings found in development of PTSD and educational level in other studies, wherein those with no formal education at all were at much higher risk than those educated to develop PTSD. This is consistent with other studies[83,84], which possibly indicates that when displaced, educated people could find ways to support themselves in a new place as it is easier for them to find jobs. Education plays a critical role in the path to wellbeing because it is a resource and a human capital in itself.

Education develops competence on many levels, giving people the ability and motivation to shape and control their lives[85]. High levels of education increase the sense of personal control. In contrast, the poorly educated may not possess the resources necessary to achieve their goals, which produces a sense of powerlessness, fatalism, and helplessness[86]. Education increases learned effectiveness; its absence breeds learned helplessness.

6.2 *PSYCHIATRIC MORBIDITY*

The overall prevalence of any psychiatric morbidity among Sudanese refugees residing in Nairobi is 56.2% (135). The leading conditions in prevalence in the sample studied were post-traumatic stress disorder and major depressive episodes with 24.1% (58) and 20.4% (49) respectively. The prevalence of generalized anxiety disorder was 5.8% (14), panic disorder 4.6% (11).

6.2.1 Post-traumatic stress disorder

24.1% (58) of my study subjects had PTSD, which compares to a Cross-sectional survey[51] which studied the relationship between psychiatric symptoms and disability in 534 Bosnian refugee survivors of mass violence of whom 26% reported symptoms of PTSD. Some previous studies [22,52.] found much lower rates for PTSD while other studies[48,50,53,54,57,63,65,66,69,70,71,72.] found much higher rates. The study[65] among southern Sudanese in Juba in 2007, found that 36.2% of the respondents had PTSD with rates of 42.5% among women and 29.7% among men. My study did not find any statistical significance in gender and PTSD though some studies have shown higher vulnerability in women developing PTSD.

In a comparative study[71] of the incidence of traumatic events and its association with symptoms of post-traumatic stress disorder in three population groups in northern Uganda and southern

Sudan nationals and refugees, the population prevalence of PTSD was estimated to be 48%

Sudanese non-refugees , 46% for Sudanese refugees and 18% for Ugandan nationals.

PTSD is a recognized response to violence and trauma[87] and since its inclusion in the DSM in 1980 it has been used to explain reactions to trauma in different situations such as v civilian and military casualties of war. It is also the most intensely and widely stud psychiatric outcome in individuals who have undergone trauma.

6.2.2 Major depressive episodes

The findings on MDE in this study compare to other studies[22, 58]. A study[22] done by Kalmade Bhui et al in the United Kingdom among 180 Somali refugees and asylum seekers reported a r of 26.6% for current major depression on the HSCL-25, while a survey[58] conducted in Ir among 35,014 respondent refugees found prevalence of 21% for depression using the Gener Health questionnaire. Other studies[48,50,51,52,53,57,59,65,66.] found much higher rates of maj depressive episodes among the study subjects.

A study[65] on the prevalence of mental disorders in Sudanese refugees in Juba found that 49.9 had current major depression (using the 15 depression items from the HSCL-25 which a consistent with depression items in the DSM-IV[88]). Previously most studies put emphasis finding the prevalence of PTSD among refugees and victims of trauma but later studies[22] sho that the prevalence of depression and other disorders are equally important and of much publ health value on the mental health of refugees.

6.2.3 Comorbidity between PTSD and MDE

The leading comorbidity was PTSD and MDE diagnosed in 4.2% of the patients, which w much lower than what has been found in other studies[89,90]. Comorbidity has been documented a diversity of trauma-affected populations[91,92,93] with the extent of the diagnostic overlap varyi

from 21% in Bosnian refugees[94] to 45% in survivors of civilian violence[95]. In adults with posttraumatic stress disorder (PTSD) comorbid depression is a common feature, occurring in nearly 50% of individuals with chronic PTSD[76].

It has been proposed that when PTSD and depression co-occur in the aftermath of trauma, they might represent a single traumatic stress construct with a shared vulnerability and similar predictor variables[89]. This is particularly true in more chronic forms of the condition; O'Donnell et al[89] found that the two disorders were distinct at 3 months but merged to form a general traumatic distress factor by 12 months following the trauma. While this comorbidity may be explained in part by a high number of overlapping symptoms across the two diagnoses, it is also consistent with recent theoretical models that propose the existence of underlying dimensions of psychopathology[96]. These underlying dimensions, or latent factors, may influence the expression of psychopathology and explain the high level of comorbidity.

Comorbidity in refugees appears to be clinically important in relation to the intensity of PTSD symptoms, according to author[97] Karam in his book 'Post traumatic Disorder: acute and long term responses to traumas and disaster'. He reports a three- to five-fold greater severity of overall symptoms in comorbidity compared to those with PTSD alone, findings that have been mirrored in other studies amongst refugees[98] as well as amongst combatants[92].

Evidence is emerging from both the general trauma literature[99] and the field of refugee mental health that those suffering from comorbid PTSD and depression may stand out as a group with substantial levels of psychosocial impairment and occupational impairment, at least in the short-term. Refugees and war survivors are exposed to multiple sequential events like traumatic loss and life threats, and the simultaneous occurrence of all these events could lead to a person developing depression comorbid with PTSD.

6.2.4 *Dysthymia*

The prevalence of dysthymia was 5.4% (13), with significant statistical association with sex, marital status, and age. Out of the 13 patients with a diagnosis of dysthymia ten were married ($p < 0.001$), an expected finding since marriage is known to be associated with the diagnosis. It was also significantly more likely to occur in older patients with 26.7% (4) of all cases occurring in participants above the age of 45 years. An epidemiologic and clinical study of dysthymic disorder [100] was performed in a Finnish population aged 60 years or over. The prevalence of dysthymia was lower in men (17.2%) than in women (22.9%). The age at onset was in late life (60 years) with average illness duration of 9 years. The occurrence of the disorder was related to poor health and poor functional status, and also to recent social and health stressors.

6.2.5 *Alcohol and substance use disorders*

A study to assess the psychiatric morbidity in Cambodian refugees living in USA found 4% rates of alcohol use disorder, which is comparable to this study's finding of 3.8%. Another study[66] however, showed high rates of 18.2% among war affected Ugandans.

Alcohol dependence showed significant association with sex ($p = 0.001$) with all affected being male (9). Traditionally, epidemiological studies have shown a greater prevalence of substance use disorders among men, but more recent surveys show an increase in prevalence rates of substance use disorders among women, particularly in younger age groups[101]. This phenomenon appears related to the fact that, in recent years, availability and opportunities for access to drugs and alcohol have increased among women. This compared to other studies in which substance use is usually more prevalent in males than females. The association between alcohol dependence and occupation was significant ($p = 0.004$). This could have been due to availability of money within this group, making alcohol accessible.

The finding was also very similar to that found among non-alcohol substance dependence. Khat dependence was associated with sex ($p < 0.001$) and occupation ($p = 0.009$). All the 9 patients with this diagnosis were males. The reasons could again be very similar to those for alcohol dependence[102]. Illicit drug use among U.S. employed adults has been well-documented[103,104] and the significant association between employment and drug use found. The National Household Survey on Drug Abuse (NHSDA) has found a substantial number of full-time adult workers engaging in past month (i.e. current) illicit drug and heavy alcohol use. Almost 6 million of an estimated 8.6 million current illicit drug users in the 1994 NHSDA, and about 6.6 million of an estimated 8.5 million heavy alcohol users, were employed full time.

However there was no statistical significance between any of the substance dependence and education.

6.2.6 Anxiety Disorders

The study found a prevalence of 5.8% for GAD, 4.6% for panic disorder and 0.4% for OCD. In his study[22] among Somali refugees Kalmadeep found a prevalence of 0.7% for GAD 7.6% for panic disorder and 1.4% for OCD. Other studies[52,57,58,66,] referred to in my literature however, showed very high prevalence of anxiety disorders. In these studies all anxiety disorders were grouped together and hence it is difficult to make a fair comparison between these and my findings.

6.3 LIMITATIONS

No initial cultural validity studies of the instruments were carried out as this was expensive for the researcher. The study excluded all those who could not speak English. Even those picked by the demographic questionnaire as not having formal education were actually in informal schools

where English alone was taught. This could have resulted in a bias of the respondents as they had some form of education, and that left out all those who were not educated.

This study was limited to only one nationality despite several other urban refugee nationalities. A comparative study of all different nationalities of refugees in the city would give conclusive data on who is most affected.

Due to strong cultural taboos against suicide, there was stigma which prevented reporting of suicidal ideation, thoughts or reports. Some of the interviewees even stopped the researcher from asking this question. Therefore, the lack of a single case with suicidal ideation or attempt reported could be due to under-reporting.

Despite the results falling within the range of results found elsewhere, the method of sampling was not random.

Refugees with no family history of mental illness have a lower risk of MDE but this association was not statistically significant (RR = 0.9, 95% CI 0.5-1.5). In my study19% (32) of interviewees with no family history of mental illness had MDE compared to 21% (16) of refugees with family history of mental illness (Fisher's exact p = 0.602). Studies[105,106,107] have confirmed that those who develop MDE have a higher likelihood of having relatives with mental disorders. It may also be a limitation that my study failed to show this association.

6.4 *RECOMMENDATIONS*

Future studies should be carried out among refugees in camps in Kenya to ascertain the extent of mental illness among them and also for comparison with urban refugees.

Investigation on the prevalence of mental disorders should be carried out among all refugees newly arriving in camps, and the findings can be compared with those of studies on refugees who have been in camps or in urban areas for a much longer period of time.

Humanitarian agencies should incorporate mental health services among the emergency services offered to refugees and displaced people, as several studies now support early psychological interventions to prevent protracted disability secondary to psychological distress and mental illness. This would require more advocacy, more funds and better policies laid down for adequate mental health interventions for refugees and displaced populations.

All health care workers in humanitarian relief work who routinely come into contact with refugees should be well trained on identification of mental disorders, in order to enhance quick diagnosis and correct management.

There is evidence to suggest that studies[94] done on refugees way after they were exposed to traumatic events yielded the same results as when they were initially exposed. This means that there is need for mental health services to be supplied way after war since refugee trauma persists over extended periods of time. This explains the importance of post-disaster mental health screening in the emergency department.

Refugee screening will also benefit by focusing on the mental health issues when selecting high risk refugees for psychosocial intervention programs aimed at reducing risk of long term morbidity and psychosocial dysfunction. Professional health care workers and auxiliary health care workers involved in humanitarian relief work should bear in mind that a substantial proportion of patients presenting to them with medical complaints may actually be experiencing mental health consequences.

Provision of education to refugees and displaced people should also be prioritized as education empowers people and results in development of competence on many levels. It is a resource that gives people the ability and motivation to shape and control their lives, and also enables them to get employment in their new settlements.

6.5 *CONCLUSION*

This study provides important information on the prevalence of psychiatric morbidity among the Sudanese refugees and confirms that psychiatric morbidity is indeed higher in refugees than in general populations.

7 APPENDICES

7.1 *INFORMED CONSENT EXPLANATION*

I, Dr Wamukhoma Victoria, wish to do a study entitled "Prevalence of psychiatric morbidity in Sudanese refugees living in Nairobi."

The purpose of the study is to establish the magnitude of Psychiatric illness among this group of people. The research will be carried out by me under the supervision of Professor David M. Ndetei and Dr Muthoni Mathai who are all Lecturers in the Department of Psychiatry, University of Nairobi.

This is a Medical research study and you are required to understand the following general principles, which apply to all in medical research.

Your participation is entirely voluntary.

You may withdraw from the study at any time.

Refusal to participate will not lead to any penalty or benefit to which you are otherwise entitled.

After you read the explanation, please feel free to ask any questions that will allow you to understand clearly the nature of the study.

The procedure will involve me asking you questions concerning your feelings, thoughts and behavior. I will also ask you questions concerning your history of use of substances such as alcohol, tobacco, cannabis, khat and others and whether their use has led to any health, social, legal or financial problems. These will be in form of Questionnaires. No invasive procedure such as drawing of blood will be involved.

All information obtained from this study will remain confidential and your privacy will be upheld. Identification will be by number only; no names will be used in this study or in its future publications.

I hope that information generated by this study will be of benefit, leading to the implementation of better interventions and comprehensive care of refugees with mental disorders and substance use disorders.

If you have any questions you can contact me on telephone number 0722956732 or my lead supervisor Dr. Muthoni Mathai at the Department of Psychiatry, University of Nairobi. You can also forward any concerns to the KNH/ UON Ethics and Research Committee at Kenyatta Hospital on telephone number 726300-9 or P.O BOX 20723, Nairobi.

7.2 *CONSENT FORM*

I, the undersigned do hereby Volunteer to participate in this study. The nature and purpose have been fully explained by Dr. Wamukhoma Victoria.

I understand that all information gathered will be used for the purposes of this study only.

Signature _____ Date _____

Serial number _____

Signature _____ Date_____

(Dr. Wamukhoma Victoria)

7.3 *QUESTIONNARES*

7.3.1 Socio-demographic questionnaire

Date_____

Serial number_____

1. Age in years_____

2. Sex Male ☐ Female ☐ (tick where appropriate)

3. Marital status.

I. Single ☐

II. Married ☐

III. Separated ☐

IV. Divorced ☐

V. Widowed ☐

VI. Cohabiting ☐

4. Highest level of education.

I. No formal education ☐

II. Primary ☐

III. Secondary ☐

IV. Tertiary (College/University ☐

5. Occupation

I. Student ☐

II. Formal employment ☐

III. Informal employment ☐

IV. Business person ☐

V. Unemployed ☐

VI. More than 1category ☐

specify_____

Others specify_____

7. Religion

I. Catholic ☐

II. Protestant ☐

III. Muslim ☐

IV. Others specify _____

8. Previous stay in a refugee camp (Yes) ☐ (No) ☐

If Yes,

Duration of stay in the camp

1. 0-5 years ☐
2. 5-10 years ☐
3. >10 years ☐

Currently seeking asylum? (Yes) ☐ (No) ☐

9. Previous admission to a psychiatric hospital (Yes) ☐ (No) ☐

If yes,

Number of previous admissions in psychiatric hospital

1 ☐

2 ☐

>2 ☐

10. Family history of mental illness (Yes) ☐ (No) ☐

11. Family history of substance abuse (Yes) ☐ (No) ☐

12. Age of onset of substance abuse

<10yrs

10-18yrs

>18yrs

7.3.2 Assist questionnaire

THE ALCOHOL, SMOKING AND SUBSTANCE INVOLVEMENT SCREENING TEST (ASSIST)

1. **In your life, which of the following substance have you Ever used**?	0= No	1= Yes
a) Tobacco products (cigarettes, chewing tobacco, cigars etc)		
b) Alcoholic beverages (beer, wine, spirits changaa, (kumi kumi)		
c) Caffeine		
d) Cannabis (marijuana, pot, grass, hash, bhang)		
e) Cocaine (coke, crack, etc)		
f) Amphetamine type stimulants (speed, diet pills, ecstasy, khat/ Miraa)		
g) Inhalants (nitrous, glue, petrol, paint thinner, etc)		
h) Sedatives or sleeping pills (valium, Serepax, Rohypnol)		
i) Hallucinogens (LSD, acid, mushrooms, PCP, Special K)		
j) Opioids (heroin, morphine, codeine, Brown sugar)		
k) Other-specify		

Q2 – Q5 tick: 0= Never, 1= once or twice, 2= Monthly, 3=Weekly, 4=Daily or Almost daily	**0**	**1**	**2**	**3**	**4**
2. In the past 3months, how often have you used the substance you mentioned?					
a) Tobacco products (cigarettes, chewing tobacco, cigars etc)					
b) Alcoholic beverages (beer, wine, spirits changaa, (kumi kumi)					
c) Caffeine					
d) Cannabis (marijuana, pot, grass, hash, bhang)					
e) Cocaine (coke, crack, etc)					
f) Amphetamine type stimulants (speed, diet pills, ecstasy, khat/ Miraa)					
g) Inhalants (nitrous, glue, petrol, paint thinner, etc)					
h) Sedatives or sleeping pills (valium, Serepax, Rohypnol)					
i) Hallucinogens (LSD, acid, mushrooms, PCP, Special K)					
j) Opioids (heroin, morphine, codeine, Brown sugar)					
k) Other-specify					

3. During the past 3 months, substance you have mentioned in 4. Q1 how often have you had a strong desire					
a) Tobacco products (cigarettes, chewing tobacco, cigars etc)					
b) Alcoholic beverages (beer, wine, spirits changaa, (kumi kumi)					
c) Caffeine					
d) Cannabis (marijuana, pot, grass, hash, bhang)					
e) Cocaine (coke, crack, etc)					
f) Amphetamine type stimulants (speed, diet pills, ecstasy, khat/ Miraa)					
g) Inhalants (nitrous, glue, petrol, paint thinner, etc)					
h) Sedatives or sleeping pills (valium, Serepax, Rohypnol)					
i) Hallucinogens (LSD, acid, mushrooms, PCP, Special K)					
j) Opioids (heroin, morphine, codeine, Brown sugar)					
k) Other-specify					
5. During the past 3 months, how often has your use of drugs mentioned in question 1 led to health, and social, legal, or financial problems? (**Specify the four leading drugs)**					
Health problems (specify the four leading drugs					
Drug i)					
Drug ii)					
Drug iii)					
Drug iv)					
Social problems (specify the four leading drugs					

Drug i)					
Drug ii)					
Drug iii)					
Drug iv)					
Legal problems (specify the four leading drugs					
Drug i)					
Drug ii)					
Drug iii)					
Drug iv)					

6. During the past 3 months, how often have you failed to do what was normally expected of your Because of your use of: (**Specify the four leading drugs)**				
Drug i)				
Drug ii)				
Drug iii)				
Drug iv)				
Q6 – Q8 0=No, Never, 1= Yes, but in the past 3 months , or 2= yes in the past 3 months				
7. Has a friend or relative or anyone else never expressed concern about your use of drug **(if yes Specify the four leading drugs)**	**0**	**1**	**2**	
Drug i)				
Drug ii)				
Drug iii)				
Drug iv)				
8. Have you ever tried to control, cut down or stop using drug **(if yes Specify the four leading drugs)**				
Drug i)				
Drug ii)				
Drug iii)				
Drug iv)				
9. Have you ever used any drug by injection (non-medical use only(**if yes Specify the four leading drugs)**				
Drug i)				
Drug ii)				
Drug iii)				
Drug iv)				

8 WORK PLAN SHOWING ACTIVITY TIME FRAME

	SEPT					OCT				NOV				DEC					JAN				FEB				MAR					APR				MAY				JUNE			
WEEK	1	2	3	4	5	1	2	3	4	1	2	3	4	1	2	3	4	5	1	2	3	4	1	2	3	4	1	2	3	4	5	1	2	3	4	1	2	3	4	1	2	3	4
FINAL OF PROPOSAL																																										
REVIEW BY ETHICS COMMITTEE																																										
CORRECTIONS FROM ETHICS																																										
REVIEW BY ETHICS COMMITTEE																																										
MEET NGO OFFICIALS																																										
MEET COMMUNITY / INSTITUTIONAL LEADERS																																										
DATA COLLECTION																																										
DATA ENTRY																																										
DATA ANALYSIS																																										
REPORT WRITING																																										
PRESENTATION TODEPARTMENT																																										

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MINI SCREEN

PATIENT NAME : _____ *DATE OF BIRTH:* _____

DATE OF INTERVIEW: _____ *If YES, go to the corresponding M.I.N.I. module*

➢ Have you been **consistently** depressed or down, **most of the day, nearly every day,** for the past two weeks ?	NO	YES	→ **A**
➢ In the past two weeks, have you been much less interested in most things or much less able to enjoy the things you used to enjoy **most of the time** ?	NO	YES	→ **A**
➢ Have you felt sad, low or depressed **most of the time** for the last two years ?	NO	YES	→ **B**
➢ In the past month did you think that you would be better off dead or wish you were dead ?	NO	YES	→ **C**
➢ Have you **ever** had a period of time when you were feeling 'up' or 'high' or 'hyper' 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.)	NO	YES	→ **D**
➢ 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 ?	NO	YES	→ **D**
➢ 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 surge to a peak, within 10 minutes of starting ? CODE YES ONLY IF THE SPELLS PEAK WITHIN 10 MINUTES.	NO	YES	→ **E**
➢ Do you feel anxious or uneasy in places or situations where you might have a panic attack or panic-like symptoms, or where help might not be available or escape might be difficult : like being in a crowd, standing in a line (queue), when you are away from home or alone at home, or when crossing a bridge, traveling in a bus, train or car ?	NO	YES	→ **F**
➢ In the past **month** were you fearful or embarrassed being watched, being the focus of attention, or fearful of being humiliated ? This includes things like speaking in public, eating in public or with others, writing while someone watches, or being in social situations.	NO	YES	→ **G**
➢ 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	→ **H**

Turn Page

- 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, or arranging things, or other superstitious rituals ? NO YES

- 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
  EXAMPLES OF TRAUMATIC EVENTS INCLUDE SERIOUS ACCIDENTS, SEXUAL OR PHYSICAL ASSAULT, A TERRORIST ATTACK, BEING HELD HOSTAGE, KIDNAPPING, FIRE, DISCOVERING A BODY, SUDDEN DEATH OF SOMEONE CLOSE TO YOU, WAR, OR NATURAL DISASTER.
- Did you respond to the trauma with intense fear, helplessness, or horror ? NO YES
- During the past month, have you re-experienced the event in a distressing way (such as, dreams, intense recollections, flashbacks or physical reactions) ? NO YES

- 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

- Now I am going to show you / **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 ? NO YES

amphetamines	speed	crystal meth	Dexedrine	Ritalin, diet pills, rush
cocaine	crack	freebase	speedball	
heroin	morphine, methadone	opium	Demerol	codeine, Percodan, OxyContin
LSD	mescaline	PCP, angel dust	MDA, MDMA	ecstasy, ketamine
inhalants	glue	ether	GHB	steroids
THC, marijuana	cannabis, hashish	grass	weed, reefer	barbiturates, Valium, Xanax, Ativan

- How tall are you ? |__|__|__| inches

- What was your lowest weight in the past 3 months ? |__|__|__| lbs

IS PATIENT'S WEIGHT LOWER THAN THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT ? NO YES
SEE TABLE BELOW

Height (ft in)	4'9	4'10	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7
Weight (lbs)	81	84	87	89	92	96	99	102	105	108	112
Height (ft in)	5'8	5'9	5'10	5'11	6'0	6'1	6'2	6'3			
Weight (lbs)	115	118	122	125	129	132	136	140			

- 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

- In the last **3 months**, did you have eating binges as often as twice a week ? NO YES

- Have you worried **excessively** or been anxious about several things over the past 6 months ? NO YES

M.I.N.I. PLUS

MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW

English Version 5.0.0

USA: D. Sheehan, J. Janavs, R. Baker, K.Harnett-Sheehan, E. Knapp, M. Sheehan
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I.N.I. Plus 5.0.0 (January 1, 2005)

Patient Name:		***Patient Number:***	
Date of Birth:		***Time Interview Began:***	
Interviewer's Name:		***Time Interview Ended:***	
Date of Interview:		***Total Time:***	

	MODULES	TIME FRAME	MEETS CRITERIA	DSM-IV	ICD-10
A	MAJOR DEPRESSIVE EPISODE	Current (2 weeks)	☐	296.20-296.26 Single	F32.x
		Recurrent	☐	296.30-296.36 Recurrent	F33.x
	MOOD DISORDER DUE TO A GENERAL MEDICAL CONDITION	Current	☐	293.83	F06.xx
		Past	☐	293.83	F06.xx
	SUBSTANCE INDUCED MOOD DISORDER	Current	☐	29x.xx	none
		Past	☐	29x.xx	none
	MDE WITH MELANCHOLIC FEATURES	Current (2 weeks)	☐	296.20-296.26 Single 296.30-296.36 Recurrent	F32.x F33.x
B	DYSTHYMIA	Current (Past 2 years)	☐	300.4	F34.1
		Past	☐	300.4	F34.1
C	SUICIDALITY	Current (Past Month) Risk: ☐ Low ☐ Medium ☐ High	☐	none	none
D	MANIC EPISODE	Current	☐	296.00-296.06	F30.x-F31.9
		Past	☐	296.00-296.06	F30.x-F31.9
	HYPOMANIC EPISODE	Current	☐	296.80-296.89	F31.8-F31.9/F34.0
		Past	☐	296.80-296.89	F31.8-F31.9/F34.0
	BIPOLAR I DISORDER	Current	☐	296.0x-296.6x	F30.x-F31.9
		Past	☐	296.0x-296.6x	F30.x-F31.9
	BIPOLAR II DISORDER	Current	☐	296.89	F31.8
		Past	☐	296.89	F31.8
	MANIC EPISODE DUE TO A GENERAL MEDICAL CONDITION	Current	☐	293.83	F06.30
		Past	☐	293.83	F06.30
	HYPOMANIC EPISODE DUE TO A GENERAL MEDICAL CONDITION	Current	☐	293.83	none
		Past	☐	293.83	none
	SUBSTANCE INDUCED MANIC EPISODE	Current	☐	291.8-292.84	none
		Past	☐	291.8-292.84	none
	SUBSTANCE INDUCED HYPOMANIC EPISODE	Current	☐	291.8-292.84	none
		Past	☐	291.8-292.84	none
E	PANIC DISORDER	Current (Past Month)	☐	300.01/300.21	F40.01-F41.0
		Lifetime	☐	300.01/300.21	F40.01-F41.0
	ANXIETY DISORDER WITH PANIC ATTACKS DUE TO A GENERAL MEDICAL CONDITION	Current	☐	293.89	F06.4
	SUBSTANCE INDUCED ANXIETY DISORDER WITH PANIC ATTACKS	Current	☐	291.8-292.89	none
F	AGORAPHOBIA	Current	☐	300.22	F40.00
G	SOCIAL PHOBIA (Social Anxiety Disorder)	Current (Past Month)	☐	300.23	F40.1
H	SPECIFIC PHOBIA	Current	☐	300.29	F40.2
I	OBSESSIVE-COMPULSIVE DISORDER	Current (Past Month)	☐	300.3	F42.8
	OCD DUE TO A GENERAL MEDICAL CONDITION	Current	☐	293.89	F06.4
	SUBSTANCE INDUCED OCD	Current	☐	291.8-292.89	none
J	POSTTRAUMATIC STRESS DISORDER	Current (Past Month)	☐	309.81	F43.1
K	ALCOHOL DEPENDENCE	Past 12 Months	☐	303.9	F10.2x
	ALCOHOL DEPENDENCE	Lifetime	☐	303.9	F10.2x
	ALCOHOL ABUSE	Past 12 Months	☐	305.00	F10.1
	ALCOHOL ABUSE	Lifetime	☐	305.00	F10.1
L	SUBSTANCE DEPENDENCE (Non-alcohol)	Past 12 Months	☐	304.00-.90/305.20-.90	F11.0-F19.1
	SUBSTANCE DEPENDENCE (Non-alcohol)	Lifetime	☐	304.00-.90/305.20-.90	F11.0-F19.1
	SUBSTANCE ABUSE (Non-alcohol)	Past 12 Months	☐	304.00-.90/305.20-.90	F11.0-F19.1
M	PSYCHOTIC DISORDERS	Lifetime	☐	295.10-295.90/297.1/	F20.xx-F29
		Current	☐	297.3/293.81/293.82/ 293.89/298.8/298.9	
	MOOD DISORDER WITH PSYCHOTIC FEATURES	Current	☐	296.24	F32.3/F33.3
	SCHIZOPHRENIA	Current	☐	295.10-295.60	F20.xx

	Lifetime	☐	295.10-295.60	F20.xx
SCHIZOAFFECTIVE DISORDER	Current	☐	295.70	F25.x
	Lifetime	☐	295.70	F25.x
SCHIZOPHRENIFORM DISORDER	Current	☐	295.40	F20.8
	Lifetime	☐	295.40	F20.8
BRIEF PSYCHOTIC DISORDER	Current	☐	298.8	F23.80-F23.81
	Lifetime	☐	298.8	F23.80-F23.81
DELUSIONAL DISORDER	Current	☐	297.1	F22.0
	Lifetime	☐	297.1	F22.0
PSYCHOTIC DISORDER DUE TO A GENERAL MEDICAL CONDITION	Current	☐	293.xx	F06.0-F06.2
	Lifetime	☐	293.xx	F06.0-F06.2
SUBSTANCE INDUCED PSYCHOTIC DISORDER	Current	☐	291.5-292.12	none
	Lifetime	☐	291.5-292.12	none
PSYCHOTIC DISORDER NOS	Current	☐	298.9	F29
	Lifetime	☐	298.9 296.24	F29
MOOD DISORDER WITH PSYCHOTIC FEATURES	Lifetime	☐		F31.3/F31.2/F31.5
MOOD DISORDER NOS	Lifetime	☐	296.90	F39
MAJOR DEPRESSIVE DISORDER WITH PSYCHOTIC FEATURES	Current	☐	296.24	F33.X3
	Past	☐	296.24	F33.X3
BIPOLAR I DISORDER WITH PSYCHOTIC FEATURES	Current	☐	296.04-296.64	F31.X2/F31.X5
	Past	☐	296.04-296.64	F31.X2/F31.X5
ANOREXIA NERVOSA	Current (Past 3 Months)	☐	307.1	F50.0
BULIMIA NERVOSA	Current (Past 3 Months)	☐	307.51	F50.2
BULIMIA NERVOSA PURGING TYPE	Current	☐	307.51	F50.2
BULIMIA NERVOSA NONPURGING TYPE	Current	☐	307.51	F50.2
ANOREXIA NERVOSA, BINGE EATING/PURGING TYPE	Current	☐	307. 1	F50.0
ANOREXIA NERVOSA, RESTRICTING TYPE	Current	☐	307. 1	F50.0
GENERALIZED ANXIETY DISORDER	Current (Past 6 Months)	☐	300.02	F41.1
GENERALIZED ANXIETY DISORDER DUE TO A GENERAL MEDICAL CONDITION	Current	☐	293.89	F06.4
SUBSTANCE INDUCED GAD	Current	☐	291.8-292.89	none
ANTISOCIAL PERSONALITY DISORDER	Lifetime	☐	301.7	F60.2
SOMATIZATION DISORDER	Lifetime	☐	330.81	F45.0
	Current	☐		
HYPOCHONDRIASIS	Current	☐	300.7	F45.2
BODY DYSMORPHIC DISORDER	Current	☐	300.7	F45.2
PAIN DISORDER	Current	☐	300.89/307.8	F45.4
CONDUCT DISORDER	Past 12 Months	☐	312.8	F91.8
ATTENTION DEFICIT/HYPERACTIVITY DISORDER (Children/Adolescents)	Past 6 Months	☐	314.00/314.01	F90.0/F90.9/ F98.8
ATTENTION DEFICIT/HYPERACTIVITY DISORDER (Adults)	Lifetime	☐	314.00/314.01	F90.0/F98.8
	Current	☐		
ADJUSTMENT DISORDERS	Current	☐	309.xx	F43.xx
PREMENSTRUAL DYSPHORIC DISORDER	Current	☐		
MIXED ANXIETY-DEPRESSIVE DISORDER	Current	☐		

WARNING

EVEN IF A PATIENT HAS A CLEAR LIFE STRESS AGGRAVATING THEIR SYMPTOMS FIRST EXPLORE THE OTHER DIAGNOSES ABOVE. NEVER USE AN ADJUSTMENT DISORDER DIAGNOSIS IF THE DISTURBANCE MEETS CRITERIA FOR ANY OF THE ABOVE DISORDERS.

DISCLAIMER

Our aim is to assist in the assessment and tracking of patients with greater efficiency and accuracy. Before action is taken on any data collected and processed by this program, it should be reviewed and interpreted by a licensed clinician.

This program is not designed or intended to be used in the place of a full medical and psychiatric evaluation by a qualified licensed physician – psychiatrist. It is intended only as a tool to facilitate accurate data collection and processing of symptoms elicited by trained personnel.

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 IC Validation and reliability studies have been done comparing the M.I.N.I. to the SCID-P for DSM-III-R and the CI structured interview developed by the World Health Organization for lay interviewers for ICD-10). The results of studies show that the M.I.N.I. has acceptably high validation and reliability scores, but can be administered in a much sl period of time (mean 18.7 ± 11.6 minutes, median 15 minutes) than the above referenced instruments. It can be us clinicians, after a brief training session. Lay interviewers require more extensive training. The M.I.N.I. Plus is a detailed edition of the M.I.N.I. Symptoms better accounted for by an organic cause or by the use of alcohol or drugs sh not be coded positive in the M.I.N.I. The M.I.N.I. Plus has questions that investigate these issues.

TERVIEW:

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

NERAL FORMAT:

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

•At the beginning of each diagnostic module (except for psychotic disorders module), screening question(s) corresponding the main criteria of the disorder are presented in a **gray box**.

•At the end of each module, diagnostic box(es) permit the clinician to indicate whether diagnostic criteria are met.

NVENTIONS:

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

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

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

Answers with an arrow above them (\ ) indicate that one of the criteria necessary for the diagnosis(es) is not met. In this cas the interviewer should go to the end of the module and 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 patie (for example, questions M20-M23).

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

ATING INSTRUCTIONS:

All questions must be rated. The rating is done at the right of each question by circling either Yes or No. Clinical judgmen by the rater should be used in coding the responses. The rater should ask for examples when necessary, to ensure accurat coding. The patient should be encouraged to ask for clarification on any question that is not absolutely clear.

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

<u>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.</u> The M.I.N.I. Plus has questions that investigate these issues.

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

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A. MAJOR DEPRESSIVE EPISODE

(\ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE **NO** IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

FOR PATIENTS WHO APPEAR PSYCHOTIC BEFORE STARTING THE INTERVIEW, OR WHO ARE SUSPECTED TO HAVE SCHIZOPHRENIA, PLEASE ADOPT THE FOLLOWING ORDER OF ADMINISTRATION OF MODULES:

1) PART 1 OF MODULE M (PSYCHOTIC DISORDERS M1-M18).
2) SECTIONS A-D (DEPRESSION TO (HYPO)MANIC EPISODE).
3) PART 2 OF MODULE M (PSYCHOTIC DISORDERS M19-M23).
4) OTHER MODULES IN THEIR USUAL SEQUENCE.

IF MODULE M HAS ALREADY BEEN EXPLORED AND PSYCHOTIC SYMPTOMS HAVE BEEN IDENTIFIED (M1 TO M10b), EXAMINE FOR EACH POSITIVE RESPONSE TO THE FOLLOWING QUESTIONS IF THE DEPRESSIVE SYMPTOMS ARE NOT BETTER EXPLAINED BY THE PRESENCE OF A PSYCHOTIC DISORDER AND CODE ACCORDINGLY.

A1 a Have you **ever** been consistently depressed or down, most of the day, nearly every day, for at least two weeks?

b Have you been consistently depressed or down, most of the day, nearly every day, for the past 2 weeks?

A2 a Have you **ever** been much less interested in most things or much less able to enjoy the things you used to enjoy most of the time over at least 2 weeks?

b In the past 2 weeks, have you been much less interested in most things or much less able to enjoy the things you used to enjoy most of the time.

IS **A1a** OR **A2a** CODED **YES?** \ NO YES

IF CURRENTLY DEPRESSED (**A1b** OR **A2b** = **YES**): EXPLORE ONLY CURRENT EPISODE.
IF **NO**: EXPLORE THE MOST SYMPTOMATIC PAST EPISODE.

A3 **Over the two week period when you felt depressed or uninterested,**

		Current Episode		Past Episode	
a	Was your appetite decreased or increased nearly every day? Did your weight decrease or increase without trying intentio (I.E., BY ±5% OF BODY WEIGHT OR ±8 LBS. OR ±3.5 KGS. FOR A 160 LB./70 KGS. PERSON IN A MONTH)? IF **YES** TO EITHER, CODE **YES**.	NO	YES	NO	YES
b	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)?	NO	YES	NO	YES
c	Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still almost every day?	NO	YES	NO	YES
d	Did you feel tired or without energy almost every day?	NO	YES	NO	YES
e	Did you feel worthless or guilty almost every day?	NO	YES	NO	YES

IF **A3e** = **YES**: ASK FOR AN EXAMPLE.
THE EXAMPLE IS CONSISTENT WITH A DELUSIONAL IDEA. ☐ NO ☐ YES

f Did you have difficulty concentrating or making decisions almost every day? NO YES | NO YES

g Did you repeatedly consider hurting yourself, feel suicidal, or wish that you were dead? NO YES | NO YES

ARE **3** OR MORE **A3** ANSWERS CODED **YES** (OR **4 A3** ANSWERS, IF **A1a** OR **A2a** ARE CODED **NO** FOR PAST EPISODE OR IF **A1b** OR **A2b** ARE CODED **NO** FOR CURRENT EPISODE)? NO YES | NO YES

VERIFY IF THE POSITIVE SYMPTOMS OCCURRED DURING THE SAME 2 WEEK TIME FRAME.

IF **A4** IS CODED **NO** FOR CURRENT EPISODE THEN EXPLORE **A3a - A3g** FOR MOST SYMPTOMATIC PAST EPISODE.

Did the symptoms of depression cause you significant distress or impair your ability to function at work, socially, or in some other important way? NO YES

Are the symptoms due entirely to the loss of a loved one (bereavement) and are they similar in severity, level of impairment, and duration to what most others would suffer under similar circumstances? If so, this is uncomplicated bereavement.

HAS UNCOMPLICATED BEREAVEMENT BEEN RULED OUT? NO YES

a Were you taking any drugs or medicines just before these symptoms began?
☐ No ☐ Yes

b Did you have any medical illness just before these symptoms began?
☐ No ☐ Yes

IN THE CLINICIAN'S JUDGMENT: ARE EITHER OF THESE LIKELY TO BE DIRECT CAUSES OF THE PATIENT'S DEPRESSION? IF NECESSARY ASK ADDITIONAL OPEN-ENDED QUESTIONS.

A7 (SUMMARY): HAS AN ORGANIC CAUSE BEEN RULED OUT? NO YES UNCERTAIN

CODE **YES** IF **A7(SUMMARY)** = **YES** OR **UNCERTAIN**.

SPECIFY IF THE EPISODE IS CURRENT AND/ OR PAST OR BOTH (RECURRENT).

NO	YES
Major Depressive Episod	
Current	☐
Past	☐

CODE **YES** IF **A7b** = **YES** AND **A7 (SUMMARY)** = **NO**.

SPECIFY IF THE EPISODE IS CURRENT AND/ OR PAST OR BOTH (RECURRENT).

NO	YES
Mood Disorder Due to a General Medical Condition	
Current	☐
Past	☐

CODE **YES** IF **A7a** = **YES** AND **A7 (SUMMARY)** = **NO**.

SPECIFY IF THE EPISODE IS CURRENT AND/ OR PAST OR BOTH (RECURRENT).

NO	YES
Substance Induced Mood Disorder	
Current	☐
Past	☐

CHRONOLOGY

A11 How old were you when you first began having symptoms of depression? ☐ age

A12 During your lifetime, how many distinct times did you have these symptoms of depression (daily for at least 2 weeks)? ☐

MAJOR DEPRESSIVE EPISODE WITH MELANCHOLIC FEATURES (optiona

(\ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE **NO**, AND MOVE TO THE NEXT MODULE)

IF THE PATIENT CODES POSITIVE FOR A CURRENT MAJOR DEPRESSIVE EPISODE (**A8 = YES, CURRENT**), EXPLORE THE FOLLOWING:

A13	a	During the most severe period of the current depressive episode, did you lose almost completely your ability to enjoy nearly everything ?	NO YES
	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? **IF NO,** DOUBLE CHECK ANSWER BY ASKING: When something good happens, does it fail to make you feel better, even temporarily?	NO YES
		IS EITHER **A13a** OR **A13b** CODED **YES**?	\ NO YES

A14 **Over the past two week period, when you felt depressed and uninterested:**

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
b	Did you feel regularly worse in the morning, almost every day?	NO YES
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
d	IS **A3c** CODED **YES** (PSYCHOMOTOR RETARDATION OR AGITATION)?	NO YES
e	IS **A3a** CODED **YES** FOR ANOREXIA OR WEIGHT LOSS?	NO YES
f	Did you feel excessive guilt or guilt out of proportion to the reality of the situation?	NO YES

ARE **3** OR MORE **A14** ANSWERS CODED **YES**?

NO	YES
Major Depressive Episode **with** ***Melancholic Features, Current***	

BTYPES OF MAJOR DEPRESSIVE EPISODE

	Mark all that apply.
Mild	☐ 296.21/296.31
Moderate	☐ 296.22/296.32
Severe without psychotic features	☐ 296.23
Severe with psychotic features	☐ 296.24
In partial remission	☐ 296.25
In full remission	☐ 296.26
Chronic	☐
With catatonic features	☐
With melancholic features	☐
With atypical features	☐
With postpartum onset	☐
With seasonal pattern	☐
With full interepisode recovery	☐
Without full interepisode recovery	☐

A8 OR **A9** OR **A10** = **YES**, SKIP TO SUICIDALITY (

B. DYSTHYMIA

(MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE **NO**, AND MOVE TO THE NEXT MODULE)

patient's symptoms currently meet criteria for major depressive episode, do NOT explore current dysthymia, but do explore AST dysthymia. Make sure that the past dysthymia explored is not one of the past major depressive episodes, and that it was parated from any prior major depressive episode by at least 2 months of full remission. [APPLY THIS RULE ONLY IF YOU RE INTERESTED IN EXPLORING DOUBLE DEPRESSION.]

SPECIFY WHICH TIME FRAME IS EXPLORED BELOW: ☐ Current ☐ Past

Have you felt sad, low or depressed most of the time for the last two years? (OR IF EXPLORING PAST DYSTHYMIA: "In the past, did you ever feel sad, low or depressed for 2 years continuously?")	NO	YES
Was this period interrupted by your feeling OK for two months or more?	NO	YES

During this period of feeling depressed most of the time:

a	Did your appetite change significantly?	NO	YES
b	Did you have trouble sleeping or sleep excessively?	NO	YES
c	Did you feel tired or without energy?	NO	YES
d	Did you lose your self-confidence?	NO	YES
e	Did you have trouble concentrating or making decisions?	NO	YES
f	Did you feel hopeless?	NO	YES
	ARE **2** OR MORE **B3** ANSWERS CODED **YES**?	NO	YES
	Did the symptoms of depression cause you significant distress or impair your ability to function at work, socially, or in some other important way?	NO	YES

B5 Were you taking any drugs or medicines just before these symptoms began?
Did you have any medical illness just before these symptoms began?
IN THE CLINICIAN'S JUDGMENT: ARE EITHER OF THESE LIKELY TO BE DIRECT CAUSES OF THE PATIENT'S DEPRESSION?

HAS AN ORGANIC CAUSE BEEN RULED OUT? NO YES

IS **B5** CODED **YES**?

NO	YES
DYSTHYMIA	
Current	☐
Past	☐

CHRONOLOGY

B6 How old were you when you first began having symptoms of 2 years of continuous depression? ☐ age

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C. SUICIDALITY

In the past month did you:

				Points
C1	Think you would be better off dead or wish you were dead?	NO	YES	1
C2	Want to harm yourself?	NO	YES	2
C3	Think about suicide?	NO	YES	6
C4	Have a suicide plan?	NO	YES	10
C5	Attempt suicide?	NO	YES	10
	In your lifetime:			
C6	Did you ever make a suicide attempt?	NO	YES	4

IS AT LEAST **1** OF THE ABOVE CODED **YES**?

IF **YES,** ADD THE TOTAL NUMBER OF POINTS FOR THE ANSWERS (C1-C6) CHECKED 'YES' AND SPECIFY THE LEVEL OF SUICIDE RISK AS FOLLOWS:

NO	YES
SUICIDE RISK CURRENT	
1-5 points	Low ☐
6-9 points	Moderate ☐
≥ 10 points	High ☐

D. (HYPO) MANIC EPISODE

(\ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

PATIENTS WHO APPEAR PSYCHOTIC BEFORE STARTING THE INTERVIEW OR WHO ARE SUSPECTED TO HAVE SCHIZOPHRENIA, PLEASE ADOPT THE LOWING ORDER OF ADMINISTRATION OF MODULES:

PART 1 OF MODULE M (PSYCHOTIC DISORDERS M1-M18).
SECTIONS A-D (DEPRESSION TO (HYPO)MANIC EPISODE).
PART 2 OF MODULE M (PSYCHOTIC DISORDERS M19-M23).
OTHER MODULES IN THEIR USUAL SEQUENCE.

IF MODULE M HAS ALREADY BEEN EXPLORED AND PSYCHOTIC SYMPTOMS HAVE BEEN IDENTIFIED (**M1** TO **M10b**), EXAMINE FOR EACH POSITIVE RESPONSE TO THE FOLLOWING QUESTIONS IF THE (HYPO)MANIC SYMPTOMS ARE NOT BETTER EXPLAINED BY THE PRESENCE OF A PSYCHOTIC DISORDER AND CODE ACCORDINGLY.

a Have you **ever** had a period of time when you were feeling 'up' or 'high' or 'hyper' 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.) — NO YES

IF NO, CODE NO TO **D1b**: IF **YES** ASK:

b Are you **currently** feeling 'up' or 'high' or 'hyper' or full of energy? — NO YES

IF PATIENT IS PUZZLED OR UNCLEAR ABOUT WHAT YOU MEAN BY 'UP' OR 'HIGH', CLARIFY AS FOLLOWS: BY 'UP' OR 'HIGH' OR 'HYPER' I MEAN: HAVING ELATED MOOD; INCREASED ENERGY; NEEDING LESS SLEEP; HAVING RAPID THOUGHTS; BEING FULL OF IDEAS; HAVING AN INCREASE IN PRODUCTIVITY, MOTIVATION , CREATIVITY, OR IMPULSIVE BEHAVIOR.

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? — NO YES

IF NO, CODE NO TO **D2b**: IF **YES** ASK:

b Are you **currently** feeling persistently irritable? — NO YES

IS **D1a** OR **D2a** CODED **YES**? — NO YES

IF **D1b** OR **D2b** = **YES**: EXPLORE ONLY **CURRENT** EPISODE, OTHERWISE
IF **D1b** AND **D2b** = **NO**: EXPLORE THE MOST SYMPTOMATIC **PAST** EPISODE

During the times when you felt high, full of energy, or irritable did you:

	Current Episode		Past Episode	
a Feel *that you could do things others couldn't do, or that you were an* especially important person? IF YES, ASK FOR EXAMPLES. THE EXAMPLES ARE CONSISTENT WITH A DELUSIONAL IDEA. ☐ No ☐ Yes	*NO*	YES	NO	YES
b Need less sleep (for example, feel rested after only a few hours sleep)?	NO	YES	NO	YES
c Talk too much without stopping, or so fast that people had difficulty understanding?	NO	YES	NO	YES
d Have racing thoughts?	NO	YES	NO	YES

e Become easily distracted so that any little interruption could distract you? NO YES | NO YES

f Become so active or physically restless that others were worried about you? NO YES | NO YES

g Want so much to engage in pleasurable activities that you ignored the risks or consequences (for example, spending sprees, reckless driving, or sexual indiscretions)? NO YES | NO YES

D3(SUMMARY): ARE **3** OR MORE **D3** ANSWERS CODED **YES** (OR **4** OR MORE IF **D1a** IS **NO** (IN RATING PAST EPISODE) OR **D1b** IS **NO** (IN RATING CURRENT EPISODE)? RULE: ELATION/EXPANSIVENESS REQUIRES ONLY THREE D3 SYMPTOMS WHILE IRRITABLE MOOD ALONE REQUIRES **4** OF THE **D3** SYMPTOMS. NO YES | NO YES

VERIFY IF THE SYMPTOMS OCCURRED DURING THE SAME TIME PERIOD.

D4 a Were you taking any drugs or medicines just before these symptoms began?
☐ No ☐ Yes

b Did you have any medical illness just before these symptoms began?
☐ No ☐ Yes

IN THE CLINICIAN'S JUDGMENT: ARE EITHER OF THESE LIKELY TO BE DIRECT CAUSES OF THE PATIENT'S (HYPO)MANIA? IF NECESSARY, ASK ADDITIONAL OPEN ENDED QUESTIONS.

D4 (SUMMARY): HAS AN ORGANIC CAUSE BEEN RULED OUT? NO YES | UNCERTAIN

D5 Did these symptoms last at least a week and cause problems beyond your control at home, work, school, or were you hospitalized for these problems? NO YES | NO YES

IF **D5** IS CODED **NO** FOR CURRENT EPISODE, THEN EXPLORE **D3, D4** AND **D5** FOR THE MOST SYMPTOMATIC PAST EPISODE.

D6

IF **D3** (SUMMARY) = **YES** AND **D4 (SUMMARY)** = **YES** OR **UNCERTAIN** AND **D5** = **NO**, AND NO DELUSIONAL IDEA WAS DESCRIBED IN **D3a**, CODE **YES** FOR HYPOMANIAC EPISODE.

SPECIFY IF THE EPISODE IDENTIFIED IS CURRENT OR PAST.

NO	YES
HYPOMANIC EPISODE	
Current	☐
Past	☐

D7 IF **D3 (SUMMARY)** = **YES** AND **D4 (SUMMARY)** = **YES** OR **UNCERTAIN** AND EITHER **D5** = **YES** OR A DELUSIONAL IDEA WAS DESCRIBED IN **D3a**, CODE **YES** FOR MANIC EPISODE.

SPECIFY IF THE EPISODE IDENTIFIED IS CURRENT OR PAST.

NO	YES
MANIC EPISODE	
Current	☐
Past	☐

D8 IF **D3 (SUMMARY)** AND **D4b** AND **D5** = **YES** AND **D4 (SUMMARY)** = **NO**, CODE **YES**?

SPECIFY IF THE EPISODE IDENTIFIED IS CURRENT OR PAST.

NO	YES
(Hypo) Manic Episode Due to a General Medical Condition	
Current	☐
Past	☐

IF **D3 (SUMMARY)** AND **D4a** AND **D5** = **YES** AND **D4 (SUMMARY)** = **NO**, CODE **YES**?

SPECIFY IF THE EPISODE IDENTIFIED IS CURRENT OR PAST.

NO	YE
Substance Induced (Hypo) Manic Episode	
Current	☐
Past	☐

IF **D8** OR **D9** = **YES,** GO TO NEXT MODULE.

TYPES

Rapid Cycling

Have you had four or more episodes of mood disturbance in 12 months?

NO	YES
Rapid Cycling	

Mixed Episode

PATIENT MEETS CRITERIA FOR BOTH MANIC EPISODE AND MAJOR DEPRESSIVE EPISODE NEARLY EVERY DAY DURING AT LEAST A ONE WEEK PERIOD.

NO	YES
Mixed Episode	

Seasonal Pattern

THE ONSET AND REMISSIONS OR SWITCHES FROM DEPRESSION TO MANIA OR HYPOMANIA CONSISTENTLY OCCUR AT A PARTICULAR TIME OF YEAR.

NO	YES
Seasonal Pattern	

With Full Inter-episode Recovery

Between the two most recent mood episodes did you fully recover?

NO	YES
With Full Interepisode Recovery	

CIRCLE ONE

MOST RECENT EPISODE WAS A **MANIC / HYPOMANIC / MIXED / DEPRESSED** EPISODE

SEVERITY

X1	Mild	☐
X2	Moderate	☐
X3	Severe without psychotic features	☐
X4	Severe with psychotic features	☐
X5	In partial remission	☐
X6	In full remission	☐

CHRONOLOGY

How old were you when you first began having symptoms of manic/hypomanic episodes? ☐ age

Since the first onset how many distinct times did you have significant symptoms of mania/ hypomania? ☐

E. PANIC DISORDER

(\ MEANS: GO TO **E6** AND **E7** AND **E8** AND **E9** AND **E10**, CIRCLE **NO** TO ALL AND MOVE TO NEXT MODULE – MODULE **F**)

E1	a	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?	NO	YES
	b	Did the spells surge to a peak within 10 minutes of starting?	NO	YES
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
E3		Have you ever had one such attack followed by a month or more of persistent concern about having another attack, or worries about the consequences of the attack?	NO	YES
E4		During the worst spell that you can remember:		
	a	Did you have skipping, racing or pounding of your heart?	NO	YES
	b	Did you have sweating or clammy hands?	NO	YES
	c	Were you trembling or shaking?	NO	YES
	d	Did you have shortness of breath or difficulty breathing?	NO	YES
	e	Did you have a choking sensation or a lump in your throat?	NO	YES
	f	Did you have chest pain, pressure or discomfort?	NO	YES
	g	Did you have nausea, stomach problems or sudden diarrhea?	NO	YES
	h	Did you feel dizzy, unsteady, lightheaded or faint?	NO	YES
	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
	j	Did you fear that you were losing control or going crazy?	NO	YES
	k	Did you fear that you were dying?	NO	YES
	l	Did you have tingling or numbness in parts of your body?	NO	YES
	m	Did you have hot flushes or chills?	NO	YES
		E4 (SUMMARY): ARE **4** OR MORE **E4** ANSWERS CODED **YES**?	NO	YES
E5	a	Were you taking any drugs or medicines just before these symptoms began? ☐ No ☐ Yes		
	b	Did you have any medical illness just before these symptoms began? ☐ No ☐ Yes		
		IN THE CLINICIAN'S JUDGMENT: ARE EITHER OF THESE LIKELY TO BE DIRECT CAUSES OF THE PATIENT'S PANIC DISORDER?		
		E5 (SUMMARY): HAS AN ORGANIC CAUSE BEEN RULED OUT? IF **E5 (SUMMARY)** IS CODED **NO**, SKIP TO **E9**.	NO	YES

DOES **E3** AND **E4 (SUMMARY)** AND **E5 (SUMMARY)** = **YES**?

NO YES
PANIC DISORDE
LIFET

IF **E6** = **YES**, SKIP TO E8.

IF **E6** = **NO**, ARE ANY E4 ANSWERS CODED **YES**?

NO YES
LIMITED SYMPT
ATTACKS
LIFETIM

THEN SKIP TO **F1**.

In the past month, did you have such attacks repeatedly (2 or more), followed by persistent concern about having another attack?

NO YES
PANIC DISORDE
CURRE

(IF THIS IS DENIED BY THE PATIENT—CHALLENGE BY REVIEWING THE SYMPTOMS ENDORSED IN **E4).**

ARE **E3** AND **E4 (SUMMARY)** AND **E5b** ALL CODED **YES** AND **E5 (SUMMARY)** CODED **NO**?

NO **YES**

Anxiety Disorder with Pan
Attacks Due to a
General Medical Conditio
CURRENT

ARE **E3** AND **E4 (SUMMARY)** AND **E5a** ALL CODED **YES** AND **E5 (SUMMARY)** CODED **NO**?

NO **YES**

Substance Induced
Anxiety Disorder with Pani
Attacks
CURRENT

CHRONOLOGY

How old were you when you first began having symptoms of panic attacks? ☐ age

During the past year, for how many months did you have significant symptoms of panic attacks or worries about having an attack? ☐

F. AGORAPHOBIA

F1 Have you ever felt anxious or uneasy in places or situations where you might have a panic attack or the panic-like symptoms we just spoke about , or where help might not be available or escape might be difficult: 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? NO YES

IF **F1** = **NO**, CIRCLE **NO** IN **F2** AND IN **F3**.

F2 Have you ever feared these situations so much that you avoided them, or suffered through them, or needed a companion to face them? **NO** **YES**

AGORAPHOBIA **LIFETIME**

F3 Do you **NOW** fear or avoid these places or situations? **NO** **YES**

AGORAPHOBIA **CURRENT**

CHECK ONLY IF **YES**

IS AGORAPHOBIA CODED **YES**? **F2** ☐ lifetime **F3** ☐ current
IS PANIC DISORDER CODED **YES**? **E6** ☐ lifetime **E8** ☐ current

F4 a IS PANIC DISORDER, CURRENT (**E8**), CODED **YES**, AND IS AGORAPHOBIA, CURRENT (**F3**), CODED **NO?** **NO** **YES**

Panic Disorder, Current *without* *AGORAPHOBIA*

b IS PANIC DISORDER, CURRENT (**E8**), CODED **YES**, AND IS AGORAPHOBIA, CURRENT (**F3**), CODED **YES?** **NO** **YES**

Panic Disorder, Current *with* *AGORAPHOBIA*

c IS PANIC DISORDER, LIFETIME (**E6**), CODED **NO**, AND IS AGORAPHOBIA, CURRENT (**F3**), CODED **YES?** **NO** **YES**

AGORAPHOBIA, CURRENT without history of Panic Disorder

d IS AGORAPHOBIA, CURRENT (**F3**) CODED **YES**, AND IS PANIC DISORDER CURRENT (**E8**) CODED **NO**, AND IS PANIC DISORDER, LIFETIME (**E6**) CODED **YES**? **NO** **YES**

AGORAPHOBIA, CURRENT **without current Panic Disorder but with a past history of Panic Disorder**

e IS AGORAPHOBIA, CURRENT (**F3**) CODED **YES**, AND LIMITED SYMPTOM ATTACKS (**E7**) CODED **NO**?

NO **YES**

AGORAPHOBIA, CURRENT
without history of Limited Symptom Attacks

CHRONOLOGY

How old were you when you first began to fear or avoid these situations (agoraphobia)? ☐ age

During the past year, for how many months did you have significant fear or avoidance of these situations (agoraphobia)? ☐

G. SOCIAL PHOBIA (Social Anxiety Disorder)

(MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE **NO**, AND MOVE TO THE NEXT MODULE)

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. (NO YES

Is this fear excessive or unreasonable? (NO YES

Do you fear these situations so much that you avoid them or suffer through them? (NO YES

Does this fear disrupt your normal work or social functioning or cause you significant distress? **NO** **YES**

SOCIAL PHOBIA
(Social Anxiety Disorder)
CURRENT

SUBTYPES

Do you fear and avoid 4 or more social situations? NO YES
If YES ⌧ generalized social phobia (social anxiety disorder)
If NO ⌧ social phobia (social anxiety disorder), not generalized

CHRONOLOGY

How old were you when you first began to fear social situations? ☐ age

During the past year, for how many months did have you have significant fear of social situations? ☐

H. SPECIFIC PHOBIA

(\ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

H1	In the past month, have you been excessively afraid of things like: flying, driving, heights, storms, animals, insects, or seeing blood or needles?	NO	YES
H2	Is this fear excessive or unreasonable?	NO	YES
H3	Do you fear these situations so much that you avoid them or suffer through them?	NO	YES
H4	Does this fear disrupt your normal work or social functioning or cause you significant distress?	NO	YES

SPECIFIC PHOBIA
CURRENT

CHRONOLOGY

H5	How old were you when you first began to fear or avoid this situation?	☐ age
H6	During the past year, how many times have you had significant fear of this situation?	☐

I. OBSESSIVE-COMPULSIVE DISORDER

(\ ABOVE A NO MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

I1	In the past month, have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive, or distressing? (For example, 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.) (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.)	NO \ to I4	YES
I2	Did they keep coming back into your mind even when you tried to ignore or get rid of them?	NO \ to I4	YES
I3	Do you think that these obsessions are the product of your own mind and that they are not imposed from the outside?	NO	YES

obsessions

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 Y com

IS **I3** OR **I4** CODED **YES**? NO Y

Did you recognize that either these obsessional thoughts or compulsive behaviors were excessive or unreasonable? NO Y

Did these obsessions or compulsions significantly interfere with your normal routine, occupational functioning, usual social activities, or relationships, or did they take more than one hour a day? NO Y

a Were you taking any drugs or medicines just before these symptoms began?
☐ No ☐ Yes

b Did you have any medical illness just before these symptoms began?
☐ No ☐ Yes

IN THE CLINICIAN'S JUDGMENT: ARE EITHER OF THESE LIKELY TO BE DIRECT CAUSES OF THE PATIENT'S OBSESSIVE COMPULSIVE DISORDER*?*

I7 (SUMMARY): HAS AN ORGANIC CAUSE BEEN RULED OUT? NO YE

ARE **I6** AND **I7 (SUMMARY)** CODED **YES?** **NO** Y

O.C.D.
CURRENT

ARE **I6** AND **I7b** CODED **YES** **NO** Y

AND **I7 (SUMMARY)** CODED **NO**?

O.C.D.
CURRENT
Due to a General Medical Condition

ARE **I6** AND **I7a** CODED **YES** **NO** YE

AND **I7 (SUMMARY)** CODED **NO**?

Current Substance Induced
O.C.D.

CHRONOLOGY

How old were you when you first began having symptoms of OCD? ☐ age

During the past year, for how many months did you have significant symptoms of OCD? ☐

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 **compulsions**

IS **I3** OR **I4** CODED **YES**? NO YES

Did you recognize that either these obsessional thoughts or compulsive behaviors were excessive or unreasonable? NO YES

Did these obsessions or compulsions 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

a Were you taking any drugs or medicines just before these symptoms began?
☐ No ☐ Yes

b Did you have any medical illness just before these symptoms began?
☐ No ☐ Yes

IN THE CLINICIAN'S JUDGMENT: ARE EITHER OF THESE LIKELY TO BE DIRECT CAUSES OF THE PATIENT'S OBSESSIVE COMPULSIVE DISORDER?

I7 (SUMMARY): HAS AN ORGANIC CAUSE BEEN RULED OUT? NO YES

ARE **I6** AND **I7 (SUMMARY)** CODED **YES?**

NO **YES**

O.C.D.
CURRENT

ARE **I6** AND **I7b** CODED **YES**

AND **I7 (SUMMARY)** CODED **NO**?

NO **YES**

O.C.D.
CURRENT
Due to a General Medical Condition

ARE **I6** AND **I7a** CODED **YES**

AND **I7 (SUMMARY)** CODED **NO**?

NO **YES**

Current Substance Induced
O.C.D.

CHRONOLOGY

How old were you when you first began having symptoms of OCD? ☐ age

During the past year, for how many months did you have significant symptoms of OCD? ☐

J. POSTTRAUMATIC STRESS DISORDER (optional)

(\ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE **NO**, AND MOVE TO THE NEXT MODULE)

J1	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? EXAMPLES OF TRAUMATIC EVENTS INCLUDE: SERIOUS ACCIDENTS, SEXUAL OR PHYSICAL ASSAULT, A TERROIST ATTACK, BEING HELD HOSTAGE, KIDNAPPING, FIRE, DISCOVERING A BODY, SUDDEN DEATH OF SOMEONE CLOSE TO YOU, WAR, OR NATURAL DISASTER.	\ NO	YES
J2	Did you respond with intense fear, helplessness or horror?	\ NO	YES
J3	During the past month, have you re-experienced the event in a distressing way (such as, dreams, intense recollections, flashbacks or physical reactions)?	\ NO	YES

J4	**In the past month:**			
	a	Have you avoided thinking about or talking about the event ?	NO	YES
	b	Have you avoided activities, places or people that remind you of the event?	NO	YES
	c	Have you had trouble recalling some important part of what happened?	NO	YES
	d	Have you become much less interested in hobbies or social activities?	NO	YES
	e	Have you felt detached or estranged from others?	NO	YES
	f	Have you noticed that your feelings are numbed?	NO	YES
	g	Have you felt that your life will be shortened or that you will die sooner than other people?	NO	YES
		J4 (SUMMARY): ARE **3** OR MORE **J4** ANSWERS CODED **YES**?	\ NO	YES
J5	**In the past month:**			
	a	Have you had difficulty sleeping?	NO	YES
	b	Were you especially irritable or did you have outbursts of anger?	NO	YES
	c	Have you had difficulty concentrating?	NO	YES
	d	Were you nervous or constantly on your guard?	NO	YES
	e	Were you easily startled?	NO	YES
		J5 (SUMMARY): ARE **2** OR MORE **J5** ANSWERS CODED **YES**?	\ NO	YES
J6	During the past month, have these problems significantly interfered with your work or social activities, or caused significant distress?		NO	YES

IS **J6** CODED **YES**?

NO	YE
Posttraumatic Stress Dis **CURRENT**	

CHRONOLOGY

How old were you when you first began having symptoms of PTSD? ☐ age

Since the first onset how many illness periods of PTSD did you have? ☐

During the past year, for how many months did you have significant symptoms of PTSD? ☐

K. ALCOHOL ABUSE AND DEPENDENCE

(\ MEANS: GO TO THE DIAGNOSTIC BOXES, CIRCLE **NO** IN BOTH AND MOVE TO THE NEXT OPTIONAL **K.** MODULE)

K1	**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
K2	**In the past 12 months**:		
a	Did you need to drink more in order to get the same effect that you got when you first started drinking?	NO	YES
b	When you cut down on drinking, did your hands shake, did you sweat or feel agitated? Did you drink to avoid these symptoms or to avoid being hungover, for example, "the shakes", sweating or agitation? If **YES** to either question, code **YES**.	NO	YES
c	During the times when you drank alcohol, did you end up drinking more than you planned when you started?	NO	YES
d	Have you tried to reduce or stop drinking alcohol but failed?	NO	YES
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
f	Did you spend less time working, enjoying hobbies, or being with others because of your drinking?	NO	YES
g	Have you continued to drink even though you knew that the drinking caused you health or mental problems?	NO	YES

ARE **3** OR MORE **K2** ANSWERS CODED **YES**?

* IF YES, SKIP K3 QUESTIONS, CIRCLE N/A IN THE ABUSE BOX AND MOVE TO THE NEXT DISORDER. DEPENDENCE PREEMPTS ABUSE.

NO	YES*
ALCOHOL DEPENDENCE **CURRENT**	

K3	**In the past 12 months:**		
a	Have you been intoxicated, high, or hungover more than once when you had other responsibilities at school, at work, or at home? Did this cause any problems? (CODE **YES** ONLY IF THIS CAUSED PROBLEMS.)	NO	YES
b	Were you intoxicated more than once in any situation where you were physically at risk, for example, driving a car, riding a motorbike, using machinery, boating, etc.?	NO	YES
c	Did you have legal problems more than once because of your drinking, for example, an arrest or disorderly conduct?	NO	YES
d	Did you continue to drink even though your drinking caused problems with your family or other people?	NO	YES

ARE **1** OR MORE **K3** ANSWERS CODED **YES?**

NO	N/A	YES
ALCOHOL ABUSE **CURRENT**		

(Optional) K. LIFETIME ALCOHOL ABUSE AND DEPENDENCE

(\ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE **NO** IN BOTH, AND MOVE TO THE NEXT MODULE)

	\ NO	YES
Did you ever have 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions?		

In your lifetime:

a	Did you need to drink more in order to get the same effect that you did when you first started drinking?	NO	YES
b	When you cut down on drinking did your hands shake, did you sweat or feel agitated? Did you drink to avoid these symptoms or to avoid being hungover, for example, "the shakes", sweating or agitation? IF **YES** TO EITHER QUESTION, CODE **YES**.	NO	YES
c	During the times when you drank alcohol, did you end up drinking more than you planned when you started?	NO	YES
d	Have you tried to reduce or stop drinking alcohol but failed?	NO	YES
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
f	Did you spend less time working, enjoying hobbies, or being with others because of your drinking?	NO	YES
g	Have you continued to drink even though you knew that the drinking caused you health or mental problems?	NO	YES

ARE **3** OR MORE **K5** ANSWERS CODED **YES?**

* IF YES, SKIP K6 QUESTIONS, CIRCLE N/A IN THE ABUSE BOX AND MOVE TO THE NEXT DISORDER. DEPENDENCE PREEMPTS ABUSE.

NO	YES*
ALCOHOL DEPENDENCE **LIFETIME**	

In your lifetime:

a	Have you been intoxicated, high, or hungover more than once when you had other responsibilities at school, at work, or at home? Did this cause any problems? (CODE **YES** ONLY IF THIS CAUSED PROBLEMS.)	NO	YES
b	Were you intoxicated in any situation where you were physically at risk, for example, driving a car, riding a motorbike, using machinery, boating, etc.?	NO	YES
c	Have you had any legal problems because of your drinking, for example, an arrest or disorderly conduct?	NO	YES
d	Have you continued to drink even though your drinking caused problems with your family or other people?	NO	YES

ARE **1** OR MORE **K6** ANSWERS CODED **YES?**

NO	N/A	YES
	ALCOHOL ABUSE LIFETIME	

L. NON-ALCOHOL PSYCHOACTIVE SUBSTANCE USE DISORDERS

(\ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE **NO** IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

Now I am going to show you/read to you a list of street drugs or medicines.

L1 a **Have you ever taken** any of these drugs more than once to get high, to feel better, or to change your mood? NO YES

CIRCLE EACH DRUG TAKEN:

Stimulants: amphetamines, "speed", crystal meth, "crank","rush", Dexedrine, Ritalin, diet pills.

Cocaine: snorting, IV, freebase, crack, "speedball".

Narcotics: heroin, morphine, Dilaudid, opium, Demerol, methadone, codeine, Percodan, Darvon, OxyContin.

Hallucinogens: LSD ("acid"), mescaline, peyote, PCP ("Angel Dust", "peace pill"), psilocybin, STP, "mushrooms", ecstasy, MDA, MDMA or ketamine ("special K").

Inhalants: "glue", ethyl chloride, "rush", nitrous oxide ("laughing gas"), amyl or butyl nitrate ("poppers").

Marijuana: hashish ("hash"), THC, "pot", "grass", "weed", "reefer".

Tranquilizers: Quaalude, Seconal ("reds"), Valium, Xanax, Librium, Ativan, Dalmane, Halcion, barbiturates, Miltown, GHB, Roofinol, "Roofies".

Miscellaneous: steroids, nonprescription sleep or diet pills. Any others?

Specify MOST USED Drug(s): _____

CHECK ONE BOX

ONLY ONE DRUG / DRUG CLASS HAS BEEN USED ☐

ONLY THE MOST USED DRUG CLASS IS INVESTIGATED. ☐

EACH DRUG CLASS USED IS EXAMINED SEPARATELY (PHOTOCOPY L2 AND L3 AS NEEDED) ☐

b SPECIFY WHICH DRUG/DRUG CLASS WILL BE EXPLORED IN THE INTERVIEW BELOW IF THERE IS CONCURRENT OR SEQUENTIAL POLYSUBSTANCE USE: _____

L2 **Considering the (name of drug / drug class selected), in your lifetime:**

a Have you found that you needed to use more (name of drug / drug class selected) to get the same effect that you did when you first started taking it? NO YES

b When you reduced or stopped using (name of drug / drug class selected), did you have withdrawal symptoms (aches, shaking, fever, weakness, diarrhea, nausea, sweating, heart pounding, difficulty sleeping, or feeling agitated, anxious, irritable, or depressed)? Did you use any drug(s) to keep yourself from getting sick (withdrawal symptoms) or so that you would feel better? NO YES

IF **YES** TO EITHER QUESTION, CODE **YES**.

c Have you often found that when you used (name of drug / drug class selected), NO YES

you ended up taking more than you thought you would?

d Have you tried to reduce or stop taking (name of drug / drug class selected), but failed? NO YES

e On the days that you used (name of drug / drug class selected), did you spend substantial time (> 2 hours) in obtaining, using or in recovering from drug(s), or thinking about drug(s)? NO YES

f Did you spend less time working, enjoying hobbies, or being with family or friends because of your drug use? NO YES

g Have you continued to use (name of drug / drug class selected) even though it caused you health or mental problems? NO YES

ARE **3** OR MORE **L2** ANSWERS CODED **YES**?

SPECIFY DRUG(S): _____

NO **YES**

SUBSTANCE DEPENDENCE

LIFETIME

a Have you used (most used drug, any drug) in the past 12 months? NO YES

b ARE **3** OR MORE **L2** ANSWERS CODED **YES** WITHIN THE PAST 12 MONTHS? NO YES

ARE **L3a** AND **b** CODED **YES**?

SPECIFY DRUG(S): _____

NO **YES***

SUBSTANCE DEPENDENCE
CURRENT

* IF YES, SKIP L4 QUESTIONS, CIRCLE N/A IN THE ABUSE BOX FOR THIS SUBSTANCE AND MOVE TO THE NEXT DISORDER. DEPENDENCE PREEMPTS ABUSE.

Considering your use of (name the drug / drug class selected), in the past 12 months:

a Have you been intoxicated, high, or hungover from (name of drug / drug class selected) 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

b Have you been high or intoxicated from (name of drug / drug class selected) more than once, in any situation where you were physically at risk, (for example, driving a car, riding a motorbike, using machinery, boating, etc.)? NO YES

c Did you have legal problems more than once, because of your drug use, for example,an arrest or disorderly conduct? NO YES

d Did you continue to use (name of drug / drug class selected) even though it caused problems with your family or other people? NO YES

ARE **1** OR MORE **L4** ANSWERS CODED **YES**?

SPECIFY DRUG(S): _____

NO **N/A** **YES**

SUBSTANCE ABUSE
CURRENT

CHRONOLOGY

L5 How old were you when you first began having problems with drug abuse? ☐ age

M. PSYCHOTIC DISORDERS - Part 1

R AN EXAMPLE OF EACH QUESTION ANSWERED POSITIVELY. CODE YES ONLY IF THE EXAMPLES CLEARLY SHOW A DISTORTION OF THOUGHT OR OF PTION OR IF THEY ARE NOT CULTURALLY APPROPRIATE. BEFORE CODING, INVESTIGATE WHETHER DELUSIONS QUALIFY AS "BIZARRE".

IONS ARE "BIZARRE" IF: CLEARLY IMPLAUSIBLE, ABSURD, NOT UNDERSTANDABLE, AND CANNOT DERIVE FROM ORDINARY LIFE EXPERIENCE.

CINATIONS ARE SCORED "BIZARRE" IF: A VOICE COMMENTS ON THE PERSON'S THOUGHTS OR BEHAVIOR, OR WHEN TWO OR MORE VOICES ARE ERSING WITH EACH OTHER.

F THE PATIENT'S RESPONSES TO THE QUESTIONS SHOULD BE CODED IN COLUMN A. USE THE CLINICIAN JUDGMENT COLUMN (COLUMN B) ONLY IF THE IAN KNOWS FROM OTHER OUTSIDE EVIDENCE (FOR EXAMPLE, FAMILY INPUT) THAT THE SYMPTOM IS PRESENT BUT IS BEING DENIED BY THE PATIENT

Now I am going to ask you about unusual experiences that some people have.

		COLUMN A Patient Response			COLUMN B Clinician Judgment (if necessary)	
				BIZARRE		BIZARRE
a	Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you?	NO	YES	YES	YES	YES
b	IF **YES**: Do you currently believe these things? **NOTE**: ASK FOR EXAMPLES, TO RULE OUT ACTUAL STALKING.	NO	YES	YES ↑**M6**	YES	YES ↑**M6**
a	Have you ever believed that someone was reading your mind or could hear your thoughts or that you could actually read someone's mind or hear what another person was thinking?	NO		YES		YES
b	IF **YES**: Do you currently believe these things?	NO		YES ↑**M6**		YES ↑**M6**
a	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? CLINICIAN: ASK FOR EXAMPLES AND DISCOUNT ANY THAT ARE NOT PSYCHOTIC.	NO		YES		YES
b	IF **YES**: Do you currently believe these things?	NO		YES ↑**M6**		YES ↑**M6**
a	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?	NO	YES	YES	YES	YES
b	IF **YES**: Do you currently believe these things?	NO	YES	YES ↑**M6**	YES	YES ↑**M6**
a	Have your relatives or friends ever considered any of your beliefs strange or unusual? **INTERVIEWER:** ASK FOR EXAMPLES. CODE **YES** ONLY IF THE EXAMPLES ARE **CLEARLY** DELUSIONAL IDEAS (FOR EXAMPLE, SOMATIC OR RELIGIOUS DELUSIONS OR DELUSIONS OF GRANDIOSITY, JEALOUSY, GUILT, RUIN OR DESTITUTION OR OTHERS NOT EXPLORED IN **M1** TO **M4**).	NO	YES	YES	YES	YES
b	IF **YES**: Do they currently consider your beliefs strange?	NO	YES	YES	YES	YES

					BIZARRE		BIZARRE
M6	a	Have you ever heard things other people couldn't hear, such as voices? HALLUCINATIONS ARE SCORED "BIZARRE" ONLY IF PATIENT ANSWERS YES TO THE FOLLOWING:	NO	YES		YES	YES
		IF **YES:** Did you hear a voice commenting on your thoughts or behavior,or did you hear two or more voices talking to each other?	NO		YES	NO	YES
	b	IF **YES**: Have you heard these things in the past month? SCORE AS "YES BIZARRE" IF PATIENT HEARD A VOICE COMMENTING ON THEIR THOUGHTS OR BEHAVIOR OR HEARD TWO OR MORE VOICES TALKING TO EACH OTHER.	NO	YES	YES ↑**M8**	YES	YES ↑**M8**
M7	a	Have you ever had visions when you were awake or have you ever seen things other people couldn't see? CLINICIAN: CHECK TO SEE IF THESE ARE CULTURALLY INAPPROPRIATE.	NO	YES		YES	
	b	IF **YES**: Have you seen these things in the past month?	NO	YES		YES	

CLINICIAN'S JUDGMENT

M8	b	Is the patient currently exhibiting incoherence, disorganized speech, or marked loosening of associations?	NO	YES
M9	b	Is the patient currently exhibiting disorganized or catatonic behavior?	NO	YES
M10	b	Are negative symptoms of schizophrenia, for example, significant affective flattening, poverty of speech (alogia) or an inability to initiate or persist in goal-directed activities (avolition) prominent during the interview?	NO	YES
M11	a	IS THERE AT LEAST ONE "**YES**" FROM **M1** TO **M10b**?	NO	YES

M11 b

ARE THE ONLY SYMPTOMS PRESENT THOSE IDENTIFIED BY THE CLINICIAN FROM **M1** TO **M7** (COLUMN B) AND FROM **M8b** OR **M9b** OR **M10b**?

IF **YES**, SPECIFY IF THE LAST EPISODE IS CURRENT (AT LEAST ONE "b" QUESTION IS CODED "**YES**" FROM **M1** TO **M10b**) AND/OR LIFETIME (ANY QUESTION CODED **YES** FROM **M1** TO **M10b**) AND PASS TO THE NEXT DIAGNOSTIC SECTION.

IF **NO**, CONTINUE.

NO **YES**

PSYCHOTIC DISORDER NOT OTHERWISE SPECIFIED*

Current ☐
Lifetime ☐

***Provisional diagnosis due to insufficient information available at this time.**

WARNING: IF AT LEAST ONE "b" QUESTION IS CODED **YES**, CODE **M11c** AND **M11d**.
IF ALL "b" QUESTIONS ARE CODED NO, CODE ONLY **M11d**.

M11c

FROM **M1** TO **M10b**: ARE ONE OR MORE "b" ITEMS CODED "**YES BIZARRE**"?

OR

ARE TWO OR MORE "b" ITEMS CODED "**YES**" BUT NOT "**YES BIZARRE**"?

NO
Then Criterion "A" of Schizophrenia is not currently met

YE
Then Criterion "A" of
Schizophrenia
is currently met

d FROM **M1** TO **M10b**: ARE ONE OR MORE "a" ITEMS CODED "**YES BIZARRE**"

NO
Then Criterion "A" of
Schizophrenia
is not met Lifetime

ARE TWO OR MORE "a" ITEMS CODED "**YES**" BUT NOT "**YES BIZARRE**"?
(CHECK THAT AT LEAST 2 ITEMS OCCURRED DURING THE SAME TIME PERIOD.)

IS **M11c** CODED **"YES"**

YES
Then Criterion "A" of
Schizophrenia
is met Lifetime

2a Were you taking any drugs or medicines just before these symptoms began?
☐ No ☐ Yes

b Did you have any medical illness just before these symptoms began?
☐ No ☐ Yes

c IN THE CLINICIAN'S JUDGMENT, ARE EITHER OF THESE LIKELY TO BE DIRECT CAUSES OF THE PATIENT'S PSYCHOSIS?
(IF NECESSARY, ASK OTHER OPEN-ENDED QUESTIONS.)
☐ No ☐ Yes

d HAS AN ORGANIC CAUSE BEEN RULED OUT? NO YES UNCERTAIN

IF **M12d** = **NO**: SCORE **M13 (a, b)** AND GO TO THE NEXT DISORDER
IF **M12d** = **YES**: CODE **NO** IN **M13 (a, b)** AND GO TO **M14**
IF **M12d** = **UNCERTAIN**: CODE **UNCERTAIN** IN **M13 (a, b)** AND GO TO **M14**

3a IS **M12d** CODED **NO** BECAUSE OF A GENERAL MEDICAL CONDITION?

NO YES

IF **YES**, SPECIFY IF THE LAST EPISODE IS

CURRENT (AT LEAST ONE "b" QUESTION IS CODED **YES** FROM **M1** TO **M10b**) AND/OR LIFETIME ("a" OR "b") QUESTION IS CODED **YES** FROM **M1** TO **M10b**.

PSYCHOTIC DISORDER
Due to a General Medical Condition
Current ☐
Lifetime ☐
Uncertain, code later ☐

3 b IS **M12d** CODED **NO** BECAUSE OF A DRUG?

NO YES

IF **YES**, SPECIFY IF THE LAST EPISODE IS

CURRENT (AT LEAST ONE QUESTION "b" IS CODED **YES** FROM **M1** TO **M10b**) AND/OR LIFETIME (ANY "a" OR "b" QUESTION CODED **YES** FROM **M1** TO **M10b**).

Substance Induced
PSYCHOTIC DISORDER
Current ☐
Lifetime ☐
Uncertain, code later ☐

How long was the longest period during which you had those beliefs or experiences? _____ _____
IF <1 DAY, GO TO THE NEXT SECTION.

M15 a During or after a period when you had these beliefs or experiences, did you have difficulty working, or difficulty in your relationships with others, or in taking care of yourself? NO YES

b IF **YES**, how long did these difficulties last? _____
IF ≥6 MONTHS, GO TO **M16.**

c Have you been treated with medications or were you hospitalized because of these beliefs or experiences, or the difficulties caused by these problems? NO YES

d IF **YES**, what was the longest time you were treated with medication or were hospitalized for these problems? _____

M16 a THE PATIENT REPORTED DISABILITY (**M15a CODED YES**) OR WAS TREATED OR HOSPITALIZED FOR PSYCHOSIS (**M15c = YES**). NO YES

b CLINICIAN'S JUDGMENT: CONSIDERING YOUR EXPERIENCE, RATE THE PATIENT'S **LIFETIME** DISABILITY CAUSED BY THE PSYCHOSIS.

absent	☐	1
mild	☐	2
moderate	☐	3
severe	☐	4

M17 WHAT WAS THE TOTAL DURATION OF THE PSYCHOSIS, TAKING INTO ACCOUNT THE ACTIVE PHASE (**M14**) AND THE ASSOCIATED DIFFICULTIES (**M15b**) AND PSYCHIATRIC TREATMENT (**M15d**).

1 ☐ ≥1 day to <1 month
2 ☐ ≥1 month to <6 months
3 ☐ ≥>6 months

CHRONOLOGY

M18 a How old were you when you first began having these unusual beliefs or experiences? ☐ age

b Since the first onset how many distinct times did you have significant episodes of these unusual beliefs or experiences? ☐

PSYCHOTIC DISORDERS - PART 2

DIFFERENTIAL DIAGNOSIS BETWEEN PSYCHOTIC AND MOOD DISORDERS

CODE THE QUESTIONS **M19** TO **M23** ONLY IF THE PATIENT DESCRIBED AT LEAST 1 PSYCHOTIC SYMPTOM (**M11a = YES** AND **M11b = NO**), NOT EXPLAINED BY AN ORGANIC CAUSE (**M12d = YES** OR **UNCERTAIN**).

M19 a DOES THE PATIENT CODE POSITIVE FOR CURRENT AND/OR PAST MAJOR DEPRESSIVE EPISODE (QUESTION **A8** CODED **YES**)? NO YES

b IF **YES**: IS **A1** (DEPRESSED MOOD) CODED **YES**? NO YES

c DOES THE PATIENT CODE POSITIVE FOR CURRENT AND/OR PAST MANIC EPISODE (QUESTION **D7** IS CODED **YES**)? NO YES

d IS **M19a** OR **M19c** CODED **YES**? NO YES
↓
STOP. Skip to M24

NOTE: VERIFY THAT THE RESPONSES TO THE QUESTIONS **M20** TO **M23** REFER TO THE PSYCHOTIC, DEPRESSIVE (**A8**) AND MANIC EPISODES (**D7**), ALREADY IDENTIFIED IN **M11c** AND **M11d, A8 AND D7**. IN CASE OF DISCREPANCIES, REEXPLORE THE SEQUENCE OF DISORDERS, TAKING INTO ACCOUNT IMPORTANT LIFE ANCHOR POINTS/MILESTONES AND CODE **M20** TO **M23** ACCORDINGLY.

When you were having the beliefs and experiences you just described (GIVE EXAMPLES TO PATIENT), were you also feeling depressed/high/irritable at the same time?

NO YES
↓
STOP. Skip to M24

Were the beliefs or experiences you just described (GIVE EXAMPLES TO PATIENT) restricted exclusively to times you were feeling depressed/high/irritable?

NO YES
↓
STOP. Skip to M24

Have you ever had a period of two weeks or more of having these beliefs or experiences when you were not feeling depressed/high/irritable?

NO YES
↓
STOP. Skip to M24

Which lasted longer: these beliefs or experiences or the periods of feeling depressed/high/irritable?

1 ☐ mood
2 ☐ beliefs, experiences
3 ☐ same

AT THE END OF THE INTERVIEW, GO TO THE DIAGNOSTIC ALGORITHMS FOR PSYCHOTIC DISORDERS.

CONSULT ITEMS **M11a** AND **M11b**:

IF THE CRITERION "A" OF SCHIZOPHRENIA IS MET (**M11c** AND/OR **M11d** = **YES**) GO TO DIAGNOSTIC ALGORITHMS I

IF THE CRITERION "A" OF SCHIZOPHRENIA IS NOT MET (**M11c** AND/OR **M11d** = **NO**) GO TO DIAGNOSTIC ALGORITHMS II

FOR MOOD DISORDERS GO TO DIAGNOSTIC ALGORITHM III.

N. ANOREXIA NERVOSA

(\ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

N1 a How tall are you? ☐ft ☐☐in. / ☐☐☐cm

b What was your lowest weight in the past 3 months? ☐☐☐lbs. / ☐☐☐kgs

IS PATIENT'S WEIGHT EQUAL TO OR BELOW THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT? (SEE TABLE BELOW) — \ NO YES

In the past 3 months:

N2 In spite of this low weight, have you tried not to gain weight? — \ NO YES

N3 Have intensely you feared gaining weight or becoming fat, even though you were underweight? — \ NO YES

N4 a Have you considered yourself too big / fat or that part of your body was too big / fat? NO YES

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

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

N5 ARE 1 OR MORE ITEMS FROM **N4** CODED **YES**? — \ NO YES

N6 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)? — \ NO YES

FOR WOMEN: ARE **N5** AND **N6** CODED **YES**?
FOR MEN: IS **N5** CODED **YES**?

\ **NO** **YES**

***ANOREXIA NERVOSA* CURRENT**

CHRONOLOGY

N7 How old were you when you first began having symptoms of anorexia? ☐ age

N8 Since the first onset how many distinct illness periods of anorexia did you have? ☐

N9 During the past year, for how many months did you have significant symptoms of anorexia? ☐

LE HEIGHT / WEIGHT TABLE CORRESPONDING TO A BMI THRESHOLD OF 17.5 KG/M^2

ht/Weight													
4'9	4'10	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'
81	84	87	89	92	96	99	102	105	108	112	115	118	12
145	147	150	152	155	158	160	163	165	168	170	173	175	17
37	38	39	41	42	43	45	46	48	49	51	52	54	55

ht/Weight				
5'11	6'0	6'1	6'2	6'3
125	129	132	136	140
180	183	185	188	191
57	59	60	62	64

weight thresholds above are calculated using a body mass index (BMI) equal to or below 17.5 kg/m^2 for the patient's heigh threshold guideline below which a person is deemed underweight by the DSM-IV and the ICD-10 Diagnostic Criteria for arch for Anorexia Nervosa.

O. BULIMIA NERVOSA

(\ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE **NO** IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

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

In the last 3 months, did you have eating binges as often as twice a week? NO YES

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

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

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

DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA? NO YES

↓ Skip to O8

Do these binges occur only when you are under (_____lbs./kgs.)? NO YES

INTERVIEWER: WRITE IN THE ABOVE PARENTHESIS THE THRESHHOLD WEIGHT FOR THIS PATIENT'S HEIGHT FROM THE HEIGHT/WEIGHT TABLE IN THE ANOREXIA NERVOSA MODULE.

IS **O5** CODED **YES** AND IS EITHER **O6** OR **O7** CODED **NO**?

NO **YE**

BULIMIA NERVOSA
CURRENT

CHRONOLOGY

How old were you when you first began having symptoms of bulimia? ☐☐ age

Since the first onset how many illness periods of bulimia did you have? ☐☐

During the past year, for how many months did you have significant symptoms of bulimia? ☐☐

SUBTYPES OF BULIMIA NERVOSA

Do you regularly engage in self induced vomiting, misuse of laxatives, diuretics or enemas?

[IN THE NON-PURGING TYPE THE PATIENT HAS USED OTHER COMPENSATORY BEHAVIORS SUCH AS FASTING OR EXCESSIVE EXERCISE, BUT NOT PURGING.]

NO	YES
Non-Purging Type	Purging Type

BULIMIA NERVOSA

SUBTYPES OF ANOREXIA NERVOSA

Binge-Eating/Purging Type

IS **O7** CODED **YES**?

NO	YES

ANOREXIA NERVOSA
Binge Eating/Purging Type
CURRENT

Restricting Type

Do you lose weight without purging?

NO	YES

ANOREXIA NERVOSA
Restricting Type
CURRENT

P. GENERALIZED ANXIETY DISORDER

(MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE **NO** IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

Have you worried excessively or been anxious about several things over the past 6 months? NO YES

Are these worries present most days? NO YES

IS THE PATIENT'S ANXIETY RESTRICTED EXCLUSIVELY TO, OR BETTER EXPLAINED BY, ANY DISORDER PRIOR TO THIS POINT? NO YES

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

FOR THE FOLLOWING, CODE **NO**, IF THE SYMPTOMS ARE CONFINED TO FEATURES OF ANY DISORDER EXPLORED PRIOR TO THIS POINT.

When you were anxious over the past 6 months, most of the time did you:

a Feel restless, keyed up or on edge? NO YES

b Feel tense? NO YES

c Feel tired, weak or exhausted easily? NO YES

d Have difficulty concentrating or find your mind going blank? NO YES

e Feel irritable? NO YES

f Have difficulty sleeping (difficulty falling asleep, waking up in the middle of the night, early morning wakening, or sleeping excessively)? NO YES

SUMMARY OF P3: ARE **3** OR MORE **P3** ANSWERS CODED **YES**? NO YES

Did these symptoms of anxiety cause you significant distress or impair your ability to function at work, socially, or in some other important way? NO YES

Were you taking any drugs or medicines just before these symptoms began?
☐ No ☐ Yes

Did you have any medical illness just before these symptoms began?
☐ No ☐ Yes

IN THE CLINICIAN'S JUDGMENT: ARE EITHER OF THESE LIKELY TO BE DIRECT CAUSES OF THE PATIENT'S GENERALIZED ANXIETY DISORDER?

P5 (SUMMARY): HAS AN ORGANIC CAUSE BEEN RULED OUT? NO YES

IS **P5 (SUMMARY)** CODED **YES**?

NO **YES**

Generalized Anxiety Disorder
CURRENT

P6 IS **P5 (SUMMARY)** CODED **NO** AND **P5b** CODED **YES**?

NO **YES**

Current
Generalized Anxiety Disorder
Due to a General Medical Condition

P7 IS **P5 (SUMMARY)** CODED **NO** AND **P5a** CODED **YES**?

NO **YES**

Current
Substance Induced
Generalized Anxiety Disorder

CHRONOLOGY

P8 How old were you when you first began having symptoms of generalized anxiety? ☐ age

P9 During the past year, for how many months did you have significant symptoms of generalized anxiety? ☐

Q. ANTISOCIAL PERSONALITY DISORDER (optional)

(\ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

Before you were 15 years old, did you:

a	repeatedly skip school or run away from home overnight?	NO	YES
b	repeatedly lie, cheat, "con" others, or steal?	NO	YES
c	start fights or bully, threaten, or intimidate others?	NO	YES
d	deliberately destroy things or start fires?	NO	YES
e	deliberately hurt animals or people?	NO	YES
f	force someone to have sex with you?	NO	YES
		\	
	ARE **2** OR MORE **Q1** ANSWERS CODED **YES?**	NO	YES

DO NOT CODE **YES** TO THE BEHAVIORS BELOW IF THEY ARE EXCLUSIVELY POLITICALLY OR RELIGIOUSLY MOTIVATED.

Since you were 15 years old, have you:

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
b	done things that are illegal even if you didn't get caught (for example, destroying property, shoplifting, stealing, selling drugs, or committing a felony)?	NO	YES
c	been in physical fights repeatedly (including physical fights with your spouse or children)?	NO	YES
d	often lied or "conned" other people to get money or pleasure, or lied just for fun?	NO	YES
e	exposed others to danger without caring?	NO	YES
f	felt no guilt after hurting, mistreating, lying to, or stealing from others, or after damaging property?	NO	YES

ARE **3** OR MORE **Q2** QUESTIONS CODED **YES**?

NO	YES
	ANTISOCIAL PERSONALI
	DISORDER
	LIFETIME

R. SOMATIZATION DISORDER (optional)

(MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

R1 a Have you had **many** physical complaints not clearly related to a specific disease beginning before age 30? NO YES

b Did these physical complaints occur over several years? NO YES

c Did these complaints lead you to seek treatment? NO YES

d Did these complaints cause significant problems at school, at work, socially, or in other important areas? NO YES

R2 Did you have pain in your:

(a) Did you have pain in your: head
(b) Did you have pain in your: abdomen
(c) Did you have pain in your: back
(d) Did you have pain in your: joints, extremities, chest,
(e) Did you have pain in your: during menstruation
(f) Did you have pain in your: sexual intercourse
(g) Did you have pain in your: urination

ARE **2** OR MORE **R2** ANSWERS CODED **YES?** NO YES

R3 Did you have any of the following abdominal symptoms:

Did you have any of the following abdominal symptoms:nausea NO YES
Did you have any of the following abdominal symptoms:bloating NO YES
Did you have any of the following abdominal symptoms:vomiting NO YES
Did you have any of the following abdominal symptoms:diarrhea NO YES
Did you have any of the following abdominal symptoms:intolerance of several different foods NO YES

ARE **2** OR MORE **R3** ANSWERS CODED **YES?** NO YES

R4 Did you have any of the following sexual symptoms:

(a) loss of sexual interest NO YES
(b) erection or ejaculation problems NO YES
(c) irregular menstrual periods NO YES
(d) excessive menstrual bleeding NO YES
(e) vomiting throughout pregnancy NO YES

ARE **2** OR MORE **R4** ANSWERS CODED **YES?** NO YES

R5 Did you have any of the following symptoms:

a. paralysis or weakness in parts of your body NO YES
b. impaired coordination or imbalance NO YES
c. difficulty swallowing or lump in throat NO YES
d. difficulty speaking NO YES
e. difficulty emptying your bladder NO YES
f. loss of touch or pain sensation NO YES
g. double vision or blindness NO YES
h. deafness, seizures, loss of consciousness NO YES
i. significant episodes of forgetfulness NO YES

j. unexplained sensations in your body NO YES
(CLINICIAN: PLEASE EVALUATE IF THESE ARE SOMATIC HALLUCINATIONS)

ARE **2** OR MORE **R5** ANSWERS CODED **YES?** NO YES

Were the symptoms investigated by your physician? NO YES

Was any medical illness found, or were you using any drug or medication that could explain these symptoms?
☐ No ☐ Yes

R6 AND R7 (SUMMARY): CLINICIAN: HAS AN ORGANIC CAUSE BEEN RULED OUT? NO YES

Were the complaints or disability out of proportion to the patient's physical illness? NO YES

IS **R7 (SUMMARY)** OR **R8** CODED **YES**? NO YES

Were the symptoms a pretense or intentionally produced (as in factitious disorder)? NO YES

IS **R9** CODED **NO?**

NO	YES
SOMATIZATION DISORDER **LIFETIME**	

Are you currently suffering from these symptoms?

NO	YES
SOMATIZATION DISORDER **CURRENT**	

S. HYPOCHONDRIASIS

(\ **MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)**

In the past six months, have you worried a lot about having a serious physical illness? NO YES
DO NOT CODE **YES** IF ANY PHYSICAL DISORDER CAN ACCOUNT FOR THE PHYSICAL SENSATIONS OR SIGNS THE PATIENT DESCRIBES.

Have you had this worry for 6 months or more? NO YES

Have you ever been examined by a doctor for these symptoms? NO YES

Have your illness fears persisted in spite of the doctor's reassurance? NO YES

Does this worry cause you significant distress, or does it interfere with your ability to function at work, socially, or in other important ways? NO YES

S6 IS **S5** CODED **YES?**

NO	YES
	HYPOCHONDRIASIS **CURRENT**

T. BODY DYSMORPHIC DISORDER

(\ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE **NO**, AND MOVE TO THE NEXT MODULE)

Are you preoccupied with a defect in your appearance?	\ NO	YES
Has this preoccupation persisted in spite of others (including a physician) genuinely feeling that your worry was excessive?	\ NO	YES
Does this preoccupation cause you significant distress, or does it interfere significantly with your ability to function at work, socially, or in some other important way?	NO	YES

IS **T3** CODED **YES?**

NO **YES**

BODY DYSMORPHIC DISORDER
CURRENT

U. PAIN DISORDER

(\ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE **NO** IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

Currently, is pain your main problem?	\ NO	YES
Currently, is the pain severe enough to need medical attention?	\ NO	YES
Currently is the pain causing you significant distress, or interfering significantly with your ability to function at work, socially, or in some other important way?	\ NO	YES
Did psychological factors or stress have an important role in the onset of the pain, or did they make it worse, or keep it going?	\ NO	YES
Is the pain a pretense or intentionally produced or feigned? (As in factitious disorder?)	NO	\ YES
Did a medical condition have an important role in the onset of the pain, or did the medical condition make it worse, or keep it going?	NO	YES
Has the pain been present for more than 6 months?	NO ↓ Acute	YES ↓ Chronic

IS **U6** CODED **NO?**

NO **YES**

PAIN DISORDER
associated with psychological factors
CURRENT

U9 IS **U6** CODED **YES?**

NO Y

IF **U8** OR **U9** ARE CODED YES
AND **U7** = **NO**, ADD: ACUTE TO DIAGNOSIS TITLE
AND **U7** = **YES**, ADD: CHRONIC TO DIAGNOSIS TITLE

PAIN DISORDER
associated with
psychological factor
and general medical con
CURRENT

V. CONDUCT DISORDER Age 17 or Younger

(\ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE **NO**, AND MOVE TO THE NEXT MODULE)

Please involve the family or significant caregiver in eliciting this information.

V1 **In the past 12 months** have you:

a	bullied, threatened or intimidated others	NO	YES
b	started fights	NO	YES
c	used a weapon that could harm someone (for example, knife, gun, bat, broken bottle)	NO	YES
d	deliberately hurt people	NO	YES
e	deliberately hurt animals	NO	YES
f	stolen things using force (for example, armed robbery, mugging, purse snatching, extortion)	NO	YES
g	forced anyone to have sex with you	NO	YES
h	deliberately started fires to damage property	NO	YES
i	deliberately destroyed things belonging to others	NO	YES
j	broken into someone's house or car	NO	YES
k	lied repeatedly to get things or "conned" (tricked) other people	NO	YES
l	stolen things	NO	YES
m	stayed out late at night in spite of your parents forbidding you, starting before age 13 years	NO	YES
n	run away from home at least twice	NO	YES
o	often skipped school, starting before age 13 years	NO	YES

ARE **3** OR MORE **V1** ANSWERS CODED **YES** WITH AT LEAST ONE CODED **YES** IN THE PAST 6 MONTHS? \ NO YES

V2 Did these behaviors cause significant problems at school, at work, or with friends and family? NO YES

IS **V2** CODED **YES?**

NO YES

CONDUCT DISORDE
CURRENT

Subtypes	**Mark all that appl**
With ADHD	☐
With history of physical or sexual abuse	☐
With history of traumatic divorce	☐
With history of adoption	☐
With other stresses	☐

W. ATTENTION DEFICIT/HYPERACTIVITY DISORDER
(Children/Adolescents)

(\ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE **NO**, AND MOVE TO THE NEXT MODULE)

Please involve the family or significant caregiver in eliciting this information.

In the past 6 months have you often:

a	Failed to pay attention to details or made careless mistakes in school, work or other activities?	NO	YES
b	Had difficulty paying attention when playing or doing some work?	NO	YES
c	Seemed not to listen when spoken to directly?	NO	YES
d	Not followed instructions, or failed to finish schoolwork or chores (even though you understood the instructions and weren't trying to be difficult)?	NO	YES
e	Had difficulty getting organized?	NO	YES
f	Avoided or disliked things that require a lot of thinking (like schoolwork or homework)?	NO	YES
g	Lost things you needed?	NO	YES
h	Become easily distracted by little things?	NO	YES
i	Become forgetful in your day to day activities?	NO	YES
	W1 (SUMMARY): ARE **6** OR MORE **W1** ANSWERS CODED **YES**?	NO	YES
	In the past 6 months have you often:		
a	Squirmed in your seat or fidgeted with your hands or feet	NO	YES
b	Left your seat in class when you were not supposed to?	NO	YES
c	Run around and climbed a lot when you shouldn't or others didn't want you to?	NO	YES
d	Had difficulty playing quietly?	NO	YES
e	Felt like you were "driven by a motor" or were always "on the go"?	NO	YES
f	Talked too much?	NO	YES
g	Blurted out an answer before the question was completed?	NO	YES
h	Had difficulty waiting your turn?	NO	YES
i	Interrupted or intruded on others?	NO	YES
	W2 (SUMMARY): ARE **6** OR MORE **W2** ANSWERS CODED **YES**?	NO	YES
	Did you have some of these hyperactive-impulsive or inattentive symptoms before you were 7 years old?	NO	YES
	Have some of these symptoms caused significant problems in two or more of the following situations: at school, at work, at home, or with family or friends?	NO	YES

IS **W4** CODED **YES?**

NO	YES
Attention Deficit/Hyperactivity Disorder CURRENT	

ATTENTION DEFICIT/HYPERACTIVITY DISORDER
(Adult)

(MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE **NO**, AND MOVE TO THE NEXT MODULE)

As a child:

W5	a	Were you active, fidgety, restless, always on the go?	NO	YES
	b	Were you inattentive and easily distractible?	NO	YES
	c	Were you unable to concentrate at school or while doing your homework?	NO	YES
	d	Did you fail to finish things, such as school work, projects, etc.?	NO	YES
	e	Were you short tempered, irritable, or did you have a "short fuse", or tend to explode.	NO	YES
	f	Did things have to be repeated to you many times before you did them?	NO	YES
	g	Did you tend to be impulsive without thinking of the consequences?	NO	YES
	h	Did you have difficulty waiting for your turn, frequently needing to be first?	NO	YES
	i	Did you get into fights and/or bother other children?	NO	YES
	j	Did your school complain about your behavior?	NO (	YES
		W5 (SUMMARY): ARE **6** OR MORE **W5** ANSWERS CODED **YES**?	NO (	YES
W6		Did you have some of these hyperactive-impulsive or inattentive symptoms before you were 7 years old?	NO	YES

As an adult:

W7	a	Are you still distractible?	NO	YES
	b	Are you intrusive, or do you butt in, or say things that you later regret either to friends, at work, or home?	NO	YES
	c	Are you impulsive, even if you have better control than when you were a child?	NO	YES
	d	Are you still fidgety, restless, always on the go, even if you have better control than when you were a child?	NO	YES
	e	Are you still irritable and get angrier than you need to?	NO	YES
	f	Are you still impulsive? For example, do you tend to spend more money than you really should?	NO	YES
	g	Do you have difficulty getting work organized?	NO	YES
	h	Do you have difficulty getting organized even outside of work?	NO	YES
	i	Are you under-employed or do you work below your capacity?	NO	YES

Are you not achieving according to people's expectations of your ability?	NO	YES
k Have you changed jobs or have been asked to leave jobs more frequently than other people?	NO	YES
l Does your spouse complain about your inattentiveness or lack of interest in him/her and/or the family?	NO	YES
m Have you gone through two or more divorces, or changed partners more than others?	NO	YES
n Do you sometimes feel like you are in a fog, like a snowy television or out of focus?	NO	YES
W7 (SUMMARY): ARE **9** OR MORE **W7** ANSWERS CODED **YES**?	NO	YES
Have some of these symptoms caused significant problems in two or more of the following situations: at school, at work, at home, or with family or friends?	NO	YES

IS **W8** CODED **YES?**

NO	YES
	Adult Attention Deficit/Hyperactivity Disorder

X. ADJUSTMENT DISORDERS

(MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

EVEN IF A LIFE STRESS IS PRESENT OR A STRESS PRECIPITATED THE PATIENT'S DISORDER, DO NOT USE AN ADJUSTMENT DISORDER DIAGNOSIS IF ANY OTHER PSYCHIATRIC DISORDER IS PRESENT. SKIP THE ADJUSTMENT DISORDER SECTION IF THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOTHER SPECIFIC AXIS I DISORDER OR ARE MERELY AN EXACERBATION OF A PREEXISTING AXIS I OR II DISORDER.

ONLY ASK THESE QUESTIONS IF PATIENT CODES NO TO ALL OTHER DISORDERS.

Are you having emotional or behavioral symptoms as a result of a life of stress? [Examples include anxiety/depression/misbehavior/physical complaints (examples of misbehavior include fighting, driving recklessly, skipping school, vandalism, violating the rights of others, or doing illegal things)].	NO	YES
Did these emotional/behavioral symptoms start within 3 months of the onset of the stressor?	NO	YES
Are these emotional/behavioral symptoms causing marked distress beyond what would be expected?	NO	YES
Are these emotional/behavioral symptoms causing significant impairment in your ability to function socially, at work, or at school?	NO	YES
Are these emotional/behavioral symptoms due entirely to the loss of a loved one (bereavement) and are they similar in severity, level of impairment and duration to what most others would suffer under similar circumstances? (If so this is uncomplicated bereavement.)		
HAS UNCOMPLICATED BEREAVEMENT BEEN RULED OUT?	NO	YES
Have these emotional/behavioral symptoms continued for more than 6 months after the stress stopped?	NO	YES

WHICH OF THESE EMOTIONAL / BEHAVIORAL SUBTYPES ARE PRESENT? MARK ALL THAT APP

A Depression, tearfulness or hopelessness. ☐

B Anxiety, nervousness, jitteriness, worry. ☐

C Misbehavior (for example, fighting, driving recklessly, skipping school, vandalism, violating other's rights, doing illegal things). ☐

D Work problems, school problems, physical complaints or social withdrawal. ☐

IF MARKED:

- A only, then code as Adjustment disorder **with depressed mood**. 309.0
- B only, then code as Adjustment disorder **with anxious mood**. 309.24
- C only, then code as Adjustment disorder **of conduct**. 309.3
- A and B only, then code as Adjustment disorder **with mixed anxiety and depressed mood**. 309.28
- C and (A or B), then code as Adjustment disorder **of emotions and conduct**. 309.4
- D only, then code as Adjustment Disorder **unspecified**. 309.9

IF **X5** IS CODED **NO,** THEN CODE DISORDER **YES** WITH SUBTYPE.

NO **YE**
Adjustment Disorde
with _____
(see above for subtype

Y. PREMENSTRUAL DYSPHORIC DISORDER

(MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

Y1	During the past year, were most of your menstrual periods preceded by a period lasting about one week when your mood changed significantly?	(NO	YES
Y2	During these periods, do you have difficulty in your usual activities or relationships with others, are you less efficient at work, or do you avoid other people?	(NO	YES
Y3	During these premenstrual episodes (but not at in the week after your period ends) do you have the following problems most of the time:		
a	Do you feel sad, low, depressed, hopeless, or self-critical?	NO	YES
b	Do you feel particularly anxious, tense, keyed up or on edge?	NO	YES
c	Do you often feel suddenly sad or tearful, or are you particularly sensitive to others' comments?	NO	YES
d	Do you feel irritable, angry or argumentative?	NO	YES
	ARE 1 OR MORE Y3 ANSWERS CODED YES?	(NO	YES
e	Are you less interested in your usual activities, such as work, hobbies or meeting with friends?	NO	YES
f	Do you have difficulty concentrating?	NO	YES
g	Do you feel exhausted, tire easily, or lack energy?	NO	YES
h	Does your appetite change, or do you overeat or have specific food cravings?	NO	YES

i Do you have difficulty sleeping or do you sleep excessively? NO YES

j Do you feel you are overwhelmed or out of control? NO YES

k Do you have physical symptoms such as breast tenderness or swelling, headaches, joint or muscle pain, a sensation of bloating, or weight gain? NO YES

ARE **5** OR MORE **Y3** ANSWERS CODED **YES**?

IF **YES,** DIAGNOSIS MUST BE CONFIRMED BY PROSPECTIVE DAILY RATINGS DURING AT LEAST 2 CONSECUTIVE CYCLES.

NO **YES**
Premenstrual Dysphoric Disorder Probable
CURRENT

Z. MIXED ANXIETY-DEPRESSIVE DISORDER

DO NOT USE THIS MODULE ALONE WITHOUT FIRST COMPLETING ALL THE ANXIETY AND MOOD DISORDERS.

(\ **MEANS : GO TO THE DIAGNOSTIC BOX AND CIRCLE NO.**

[SKIP THIS DISORDER IF PATIENT 'S SYMPTOMS HAVE ALREADY MET CRITERIA FOR ANY OTHER DISORDER AND CODE **NO** IN THE DIAGNOSTIC BOX.]

Have you been depressed or down consistently for at least a **month**? NO YES

When you felt depressed did you have any of the following symptoms for at least **one month**:

a. Did you have difficulty concentrating or find your mind going blank? NO YES

b. Did you have trouble sleeping (difficulty falling asleep, waking up in the middle of the night, early morning wakening, or sleeping excessively)? NO YES

c. Did you feel tired or low in energy? NO YES

d. Did you feel irritable? NO YES

e. Did you worry too persistently for at least a month? NO YES

f. Did you cry easily? NO YES

g. Were you always on the lookout for possible dangers? NO YES

h. Did you fear the worst? NO YES

i. Did you feel hopeless about the future? NO YES

j. Was your self-confidence low, or did you feel worthless? NO YES

Summary of Z2: ARE **4** OR MORE **Z2** ANSWERS CODED **YES**? NO YES

Do these symptoms cause you significant distress or impair your ability to function at work, socially, or in some other important way? NO YES

Z4 a Were you taking any drugs or medicines just before these symptoms began?

b Did you have any medical illness just before these symptoms began?

IN THE CLINICIAN'S JUDGMENT are either of these likely to be direct causes of the patient's symptoms?

	HAS AN ORGANIC CAUSE BEEN RULED OUT?		NO	YES UNCERTAIN
Z5 a.	The patient's symptoms meet criteria for:	Major Depression **LIFETIME**	NO	YES
		Dysthymia **LIFETIME**	NO	YES
		Panic Disorder **LIFETIME**	NO	YES
		Generalized Anxiety Disorder **LIFETIME**	NO	YES
b.	The patient's symptoms **CURRENTLY** meet criteria for:	any other anxiety disorder	NO	YES
		any other mood disorder	NO	YES
c.	The patient's symptoms are better accounted for by another psychiatric disorder.		NO	YES

Z6 IS **Z5c** CODED **YES?**

NO **YES**

MIXED ANXIETY - DEPRESSIVE DISORDER **CURRENT**

THIS CONCLUDES THE INTERVIEW

DSM-IV/ICD-10 DIAGNOSTIC/BILLING CODES FOR M.I.N.I. DIAGNOSES

Depressive Disorder
ngle Episode/F32.x
96.20/F32.9 Unspecified
96.21/F32.0 Mild
96.22/F32.1 Moderate
96.23/F32.2 Severe Without Psychotic Features
96.24/F32.3 Severe With Psychotic Features
96.25/F32.4 In Partial Remission
96.26/F32.4 In Full Remission
ecurrent/F33.x
96.30/F33.9 Unspecified
96.31/F33.0 Mild
96.32/F33.1 Moderate
96.33/F33.2 Severe Without Psychotic Features
96.34/F33.3 Severe With Psychotic Features
96.35/F33.4 In Partial Remission
96.36/F33.4 In Full Remission
ymia
00.4/F34.1
a
Bipolar I, Single Manic Episode/F30.x
296.00 Unspecified
296.01/F30.1 Mild
296.02/F30.1 Moderate
296.03/F30.1 Severe Without Psychotic Features
296.04/F30.2 Severe With Psychotic Features
296.05/F30.8 In Partial Remission
296.06/F30.8 In Full Remission
Bipolar I, Most Recent Episode: Manic/F31.x
296.40/F31.0 Hypomanic
296.40 Unspecified
296.41/F31.1 Mild
296.42/F31.1 Moderate
296.43/F31.1 Severe Without Psychotic Features
296.44/F31.2 Severe With Psychotic Features
296.45/F31.7 In Partial Remission
296.46/F31.7 In Full Remission
Bipolar I, Most Recent Episode: Depression/F31.x
296.50 Unspecified
296.51/F31.3 Mild
296.52/F31.3 Moderate
296.53/F31.4 Severe Without Psychotic Features
296.54/F31.5 Severe With Psychotic Features
296.55/F31.7 In Partial Remission
296.56/F31.7 In Full Remission
Bipolar I, Most Recent Episode: Mixed/F31.6
296.60 Unspecified
296.61/F31.3 Mild
296.62/F31.3 Moderate
296.63/F31.4 Severe Without Psychotic Features
296.64/F31.5 Severe With Psychotic Features
296.65/F31.7 In Partial Remission
296.66/F31.7 In Full Remission
296.70/F31.9 Bipolar I Disorder, Most Recent Episode: Unspecified
296.80/F31.9 Bipolar I Disorder, NOS
296.89/F31.8 Bipolar II Disorder

ic Disorder/F40.01
300.01/F41.0 Without Agoraphobia
300.21/F40.01 With Agoraphobia
oraphobia
300.22/F40.00 Without History of Panic Disorder

Social Phobia (Social Anxiety Disorder)
300.23/F40.1
Specific Phobia
300.29/F40.2
Obsessive-Compulsive Disorder
300.30/F42.8
Generalized Anxiety Disorder
300.02/F41.1
Substance Dependence/Abuse
303.90/F10.2x Alcohol Dependence
305.00/F10.1 Alcohol Abuse
305.20/F12.1 Cannabis Abuse
305.30/F16.1 Hallucinogen Abuse
305.40/F13.1 Sedative, Hypnotic, or Anxiolytic Abuse
305.50/F11.1 Opioid Abuse
305.60/F14.1 Cocaine Abuse
305.70/F15.1 Amphetamine Abuse
305.90/F15.00 Caffeine Intoxication
305.90/F18.1 Inhalant Abuse
305.90/ F19.00-F19.1 Other (or Unknown) Substar Abuse
305.90/F19.1 Phencyclidine Abuse
Psychotic Disorders
295.10/F20.1x Schizophrenia, Disorganize Type
295.20/F20.2x Schizophrenia, Catatonic Type
295.30/F20.0x Schizophrenia, Paranoid Ty
295.40/F20.8 Schizophreniform Disorder
295.60/F20.5x Schizophrenia, Residual Ty
295.70/F25.x Schizoaffective Disorder
295.90/F20.3x Schizophrenia, Undifferent Type
297.10/F22.0 Delusional Disorder
297.30/F24 Shared Psychotic Disorder
293.81/F06.2 Psychotic Disorder Due to. (Indicate the General Med Condition) With Delusion
293.82/F06.0 Psychotic Disorder Due to (Indicate the General Med Condition) With Hallucin
293.89/F06.4 Anxiety Disorder Due to.... (Indicate the General Me Condition)
293.89/F06.x Catatonic Disorder Due to.. (Indicate the General Me Condition)
298.80/F23.xx Brief Psychotic Disorder
298.90/F29 Psychotic Disorder NOS
Anorexia Nervosa
307.10/F50.0
Bulimia Nervosa
307.51/F50.2
Posttraumatic Stress Disorder
309.81/F43.1
Suicidality
no code assigned
Antisocial Disorder
301.70/F60.2
Somatoform Disorders
300.81/F45.0 Somatization Disorder
300.70/F45.2 Hypochondriasis
300.70/F45.2 Body Dysmorphic Disorde

Pain Disorders

307.80/F45.4 Pain Disorder Associated with Psychological Factors

307.89/F45.4 Pain Disorder Associated with Both Psychological Factors and a General Medical Condition

Conduct Disorder

312.80/F91.8

Attention Deficit Disorder

314.01/F90.0 Attention Deficit/Hyperactivity Disorder, Combined Type

314.00/F98.8 Attention Deficit/Hyperactivity Disorder, Predominately Inattentive Type

314.01/F90.0 Attention Deficit/Hyperactivity Disorder, Predominately Hyperactive-Impulsive Type

Adjustment Disorders

309.00/F43.20 Adjustment Disorder with Depressed Mood

309.24/F43.28 Adjustment Disorder with Anxiety

309.28/F43.22 Adjustment Disorder with Mixed Anxiety & Depressed Mood

309.30/F43.24 Adjustment Disorder with Disturbance of Conduct

309.40/F43.25 Adjustment Disorder with Mixed Disturbance of Emotions & Conduct

309.90/F43.9 Adjustment Disorder, Unspecified

Premenstrual Dysphoric Disorder

no code assigned

CRITERION FOR RULING OUT OTHER AXIS I DISORDERS

event of comorbidity, the following algorithm (or hierarchy of disorders based on DSM-IV) can be used to reduce th
orbid disorders down to those likely to be clinically meaningful.]

ion Ye

e symptoms of X restricted exclusively to or better explained by Y, Z? ☐

nosis X is made, call up question, insert diagnosis X in column 1, and the corresponding Y, Z diagnosis in Column 2.

y mix where:

Diagnosis X			Diagnosis Y, Z, etc.
Major Depressive Disorder (MDE)	is present, leave it unless disorder is restricted exclusively		Manic, Hypomanic, or Mixed Episodes, Schizoaffective Disorder, Schizophreniform Disorder, Delusional Disorder or Psychotic Disor
Dysthymia	to, or better explained by, diagnosis Y, Z:		MDE or Mania
Suicidality			Can coexist with any other Axis I disorder
(Hypo)Manic Episode	"	"	MDE concurrently during the same week = mixed episode
Panic Disorder (PD)	"	"	Social Phobia, Specific Phobia, OCD, PTSD
Agoraphobia (AG)	"	"	Social Phobia, Specific Phobia, OCD or PTSD
Social Phobia (Soc Ph) (Social Anxiety Disorder)	"	"	PD or Agoraphobia
Specific Phobia (Sp Ph)	"	"	PD or AG or OCD or PTSD
Obsessive-Compulsive Disorder	"	"	Any Axis I Disorder
Posttraumatic Stress Disorder	"	"	Agoraphobia
Alcohol Dependence/Abuse	"	"	Can coexist with any other Axis I disorder
Drug Dependence/Abuse (Non-alcohol)	"	"	Can coexist with any other Axis I disorder
Psychotic Disorders (Psy)	"	"	Can coexist with any other Axis I disorder
Anorexia Nervosa (AN)	"	"	Can coexist with any other Axis I disorder
Bulimia Nervosa (BN)	"	"	Can coexist with any other Axis I disorder
Generalized Anxiety Disorder	"	"	MDE, Dys, Mania, PD, Psy, Soc Ph, Sp Ph, OCD, PTSD, Anxiety Disor
Antisocial Personality Disorder	"	"	Mania or Psychotic
Somatization Disorder	"	"	Can coexist with any other Axis I disorder
Hypochondriasis	"	"	GAD, OCD, PD, MDE, Separation Anxiety Disorder, another Somatoform disorder, Delusional disorder, Body Dysmorphic Disorder
Body Dysmorphic Disorder	"	"	MDE, PD, AN, Soc Ph, Sp Ph, OCD, PTSD, Psychotic
Pain Disorder	"	"	MDE, Mania, PD, GAD, OCD, PTSD, Soc Ph, Sp Ph, Psy, Dyspareunia
Conduct Disorder	"	"	Can coexist with any other Axis I disorder, ADHD
Attention Deficit Hyperactivity Disorder (ADHD)	"	"	Psychotic, Mania, Anxiety Disorder, MDE, Conduct Disorder
Adjustment Disorders	"	"	Any Axis I Disorder
Premenstrual Dysphoric Dis.	"	"	PD, MDE, Dysthymic Disorder or a Personality Disorder
Mixed Anxiety-Depressive Dis.	"	"	Any other psychiatric disorder.

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Translations	M.I.N.I. 4.4 or earlier versions	M.I.N.I. 4.6/5.0, M.I.N.I. Plus 4.6/5.0 and M.I.N.I. Screen 5.0:
Afrikaans	R. Emsley	W. Maartens
Arabic		O. Osman, E. Al-Radi
Bengali		H. Banerjee, A. Banerjee
Brazilian Portuguese	P. Amorim	P. Amorim
Bulgarian	L.G.. Hranov	
Chinese		L. Carroll, Y-J. Lee, Y-S. Chen, C-C. Chen, C-Y. Liu, C-K. Wu, H-S. Tang, K-D. Juang, Yan-Ping Zheng. In preparation
Croatian		
Czech		P. Zvlosky
Danish	P. Bech	P. Bech, T. Schütze
Dutch/Flemish	E. Griez, K. Shruers, T. Overbeek, K. Demyttenaere	I. Van Vliet, H. Leroy, H. van Megen
English	D. Sheehan, J. Janavs, R. Baker, K. Harnett-Sheehan, E. Knapp, M. Sheehan	D. Sheehan, R. Baker, J. Janavs, K. Harnett-Sheehan, M. Sheehan
Estonian		J. Shlik, A.Aluoja, E. Khil
Farsi/Persian		K. Khooshabi, A. Zomorodi
Finnish	M. Heikkinen, M. Lijeström, O. Tuominen	M. Heikkinen, M. Lijeström, O. Tuominen
French	Y. Lecrubier, E. Weiller, LI. Bonora, P. Amorim, J.P. Lepine	Y. Lecrubier, E. Weiller, P. Amorim, T. Hergueta
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Greek	S. Beratis	T. Calligas, S. Beratis
Gujarati		M. Patel, B. Patel
Hebrew	J. Zohar, Y. Sasson	R. Barda, I. Levinson, A. Aviv
Hindi		C. Mittal, K. Batra, S. Gambhir
Hungarian	I. Bitter, J. Balazs	I. Bitter, J. Balazs
Icelandic		J.G. Stefansson
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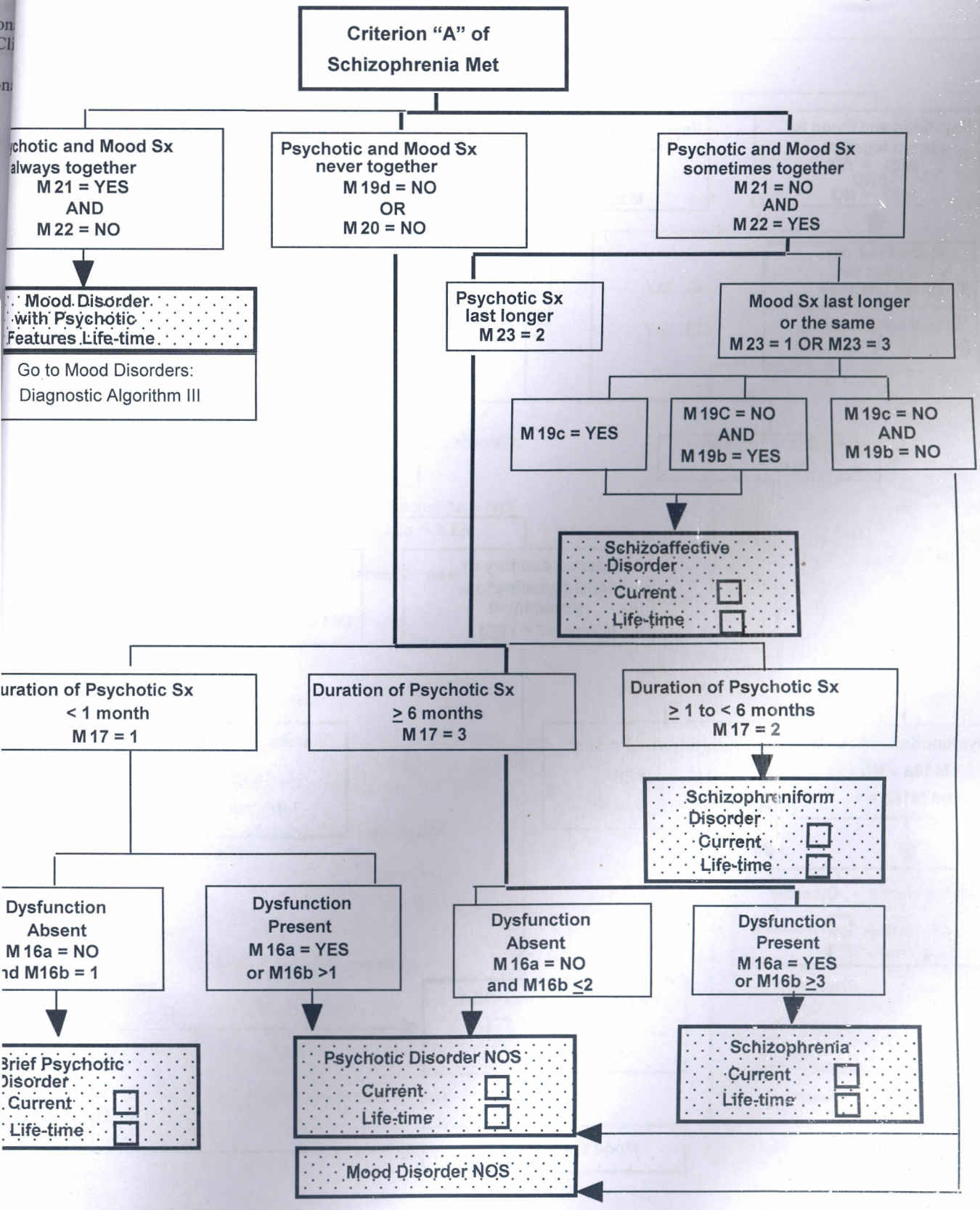
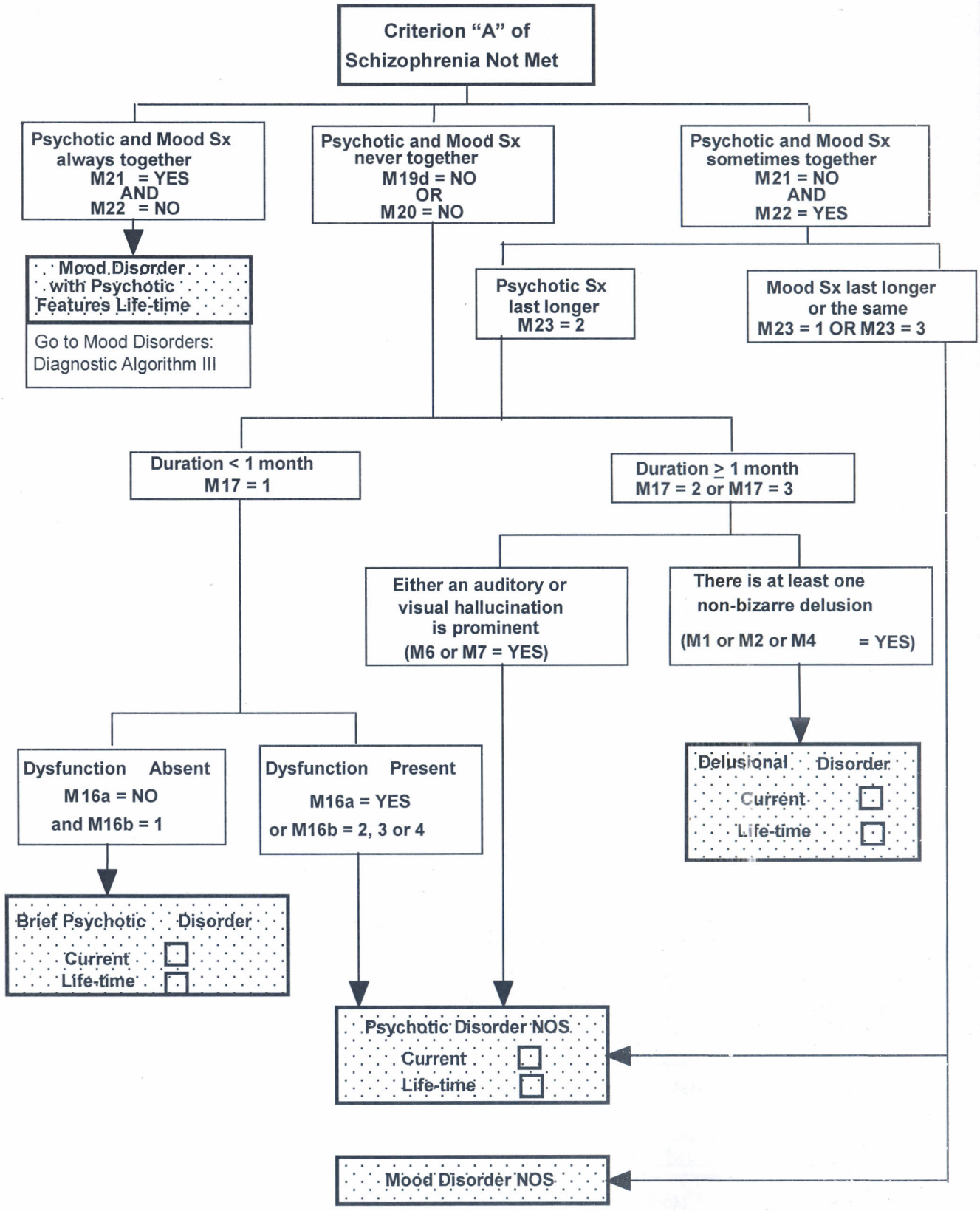
PSYCHOTIC DISORDERS: DIAGNOSTIC ALGORITHMS I

Circle the appropriated diagnostic box both for current and life-time diagnosis. One positive diagnosis excludes the others. If criterion A of schizophrenia is not currently met, but is present in life-time, current and life-time diagnosis may be different.



PSYCHOTIC DISORDERS: DIAGNOSTIC ALGORITHMS II

Circle the appropriated diagnostic box both for current and life-time diagnosis. One diagnosis excludes the others. If criterion A of schizophrenia is not currently met, but present in life-time, current and life-time diagnosis may be



MOOD DISORDERS: DIAGNOSTIC ALGORITHM III

Modules: A [Major Depressive Episode]
D [(Hypo)manic Episode]
M [Psychotic Disorders]

JLE M:

1 a IS **M20** CODED **NO**? NO YES → GO TO **2c**

b IS **M21** CODED **NO** AND **M22** CODED **YES**? NO YES → CODE **NO** IN **2d** AND **2e**

c IS **M21** CODED **YES** OR **M22** CODED **NO**? NO YES

ULES A and D:

ı IS A DELUSIONAL IDEA IDENTIFIED IN **A3e**? No ☐ Yes ☐

ɔ IS A DELUSIONAL IDEA IDENTIFIED IN **D3a**? No ☐ Yes ☐

c Is **A8 = YES** (Major Depressive Episode present)
and
D6 and D7 = NO (Hypomanic and Manic Episodes absent)?

Specify:
WITHOUT Psychotic Features: IF **1a = YES** and **2a = NO**
WITH Psychotic Features: IF **1a = NO** and **2a = YES**

Specify if last depressive episode is current or past (Question A8)

NO **YES**

MAJOR DEPRESSIVE DISORDER

without PF ☐
with PF ☐
current ☐
past ☐

d Is **D7 = YES** (Manic Episode present)?

Specify:
WITHOUT Psychotic Features: IF **1a = YES** and **2a = NO** and **2b = NO**
WITH Psychotic Features: IF **1a = NO** and **2a = YES** and **2b = YES**

Specify if the last mood episode is current or past (Question A8 or D6 or D7)

NO **YES**

BIPOLAR I DISORDER

without PF ☐
with PF ☐
current ☐
past ☐

e Is **A8 = YES** (Major Depressive Episode present)
and
D6 = YES (Hypomanic Episode present)
and
D7 = NO (Manic Episode absent)?

Specify if the last mood episode is current or past (Question A8 or D6)

NO **YES**

BIPOLAR II DISORDER

current ☐
past ☐