PSYCHIATRIC MORBIDITY AMONG YOUTH PATIENTS AT NAKURU LEVEL 6 HOSPITAL

BY

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H56/37728/2020

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UNIVERSITY OF NAIROBI

A RESEARCH SUBMITTED IN PARTIAL FULFILLMENT FOR THE AWARD OF DEGREE OF MASTER OF SCIENCE IN CLINICAL PSYCHOLOGY

2023

DECLARATION

The undersigned, declare that this research thesis titled:

"PSYCHIATRIC MORBIDITY AMONG YOUTH PATIENTS AT NAKURU LEVEL 6 HOSPITAL"

Is the result of my own work and that it has not been submitted for any other degree or professional qualification.

Mercy Cheptoo Kipkemboi

Signed  Date: 24/10/23

STATEMENT OF APPROVAL

This work has been brought together and reviewed under our supervision in University of Nairobi, Department of Psychiatry lecturers.

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ACKNOWLEDGEMENT

I would like to thank my supervisors Dr. Teresia Mutavi and Dr. John Mburu for the guidance they offered during the analysis of this research.

I would also like to recognize Dr. Mutavi's efforts and advice during concept development and proposal development as she helped me move forward to proposal defending up to data collection and analysis. Thank you.

I wish to express my sincere gratitude to Nakuru level 6 hospital for the permit to conduct my study at their facility and the support they gave me.

DEDICATION

I dedicate this research to my parents (Dr. Rose Ramkat and Prof. Julius Kipkemboi) for the support they have offered me throughout my study period. Our nanny Agnes and my sisters Faith and Joy for the prayers and motivation they gave me.

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OPERATIONAL DEFINITIONS

Youth: this is a young individual who is considered to be full of energy.

Psychiatric morbidity: Psychiatry is a field that involves assessment, diagnosis or treatment of psychiatric disorders. Morbidity is referred to as the commonness of psychiatric illnesses in a region. Therefore, psychiatric morbidity is taking into account a person's mental capacity in a population in regards to symptoms and factors surrounding the diagnosis.

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ABSTRACT

Introduction: Among the most rampant leading causes of global burden of disease is psychiatric disorders which are very common, with the approximation of roughly 12% of a globally disease burden. There is a decreased life span of 10-15 years in persons with psychiatric illnesses in contrast with the public population; hence interventions on first onset may improve some end results. In Kenya, there is limited data on psychiatric morbidity among youths, however, youths have been noted to present with different psychiatric illnesses from depression, anxiety disorders, to PTSD/post-traumatic stress disorder, hence the importance of this study.

Aim: The purpose of this study was to determine the psychiatric morbidity among youth patients at the Nakuru Level 6 Hospital and examine the associated socio-demographic variables.

Methods: This study implemented a descriptive cross sectional method, whereby 385 outpatient youths seen at Nakuru level 6 hospital of age bracket 18-35 years were targeted for the study. Informed consent and confidentiality was sought at the beginning of the study. Simple random sampling technique was applied in attaining the 385 sample size. The version seven of MINI Instrument Neuropsychiatric was incorporated in the collection of data. Data was analyzed using version 23 of the SPSS.

Setting: The study took place at Nakuru level 6 hospital. Youth patients of age bracket 18-35 who were seen at the hospital during the study period were targeted in data collection.

Data analysis: Assembled Data was analyzed using version 23 of SPSS software and findings were presented in descriptive narrative, charts, graphs and tables.

Results: Marital status and employment status were noted to have a statistically inferable association with psychiatric morbidity. The singles (P=0.024) had an Odds Ratio/OR (4.771)

higher chance of having a psychiatric morbidity as compared the married. On the other hand, those who were widow/widower (P=0.016) had an OR (5.650) times of developing a psychiatric illness in contrast with the married.

Conclusion: In Nakuru level 6 hospital, the prevalence of psychiatric morbidity among youth outpatients of the age bracket 18-35 years stands at 46.5%. 26.8% of this met the criteria for only one psychiatric disorder. Marital status and employment status were noted to have a statistically inferable link with psychiatric morbidity.

1.0 CHAPTER ONE

1.1 INTRODUCTION

1.1.1 Background of the study

Among the most rampant leading causes of global burden of disease is psychiatric disorders which are very common (Meyer & Ndetei, 2016), with the approximation of roughly 12% of a globally disease burden (Aillon et al., 2013). There is a decreased life span of 10-15 years in persons with psychiatric illnesses in contrast with the public population; hence interventions on first onset may improve some end results (Solmi, Olivola et al., 2022). Above 70% of individuals globally, are not treated for psychiatric disorders by health practitioners due to lack of information on symptoms of mental disorders, unfamiliarity with treatment access, harsh judgement with regard to persons having a mental illness and belief of stigmatization towards those with a psychiatric illness (Henderson, Evans-Lacko & Thornicroft, 2013).

Mental disorder also known as psychiatric illness is defined as a pattern in psychological and behavioral manifestations which leads challenges and deteriorations in daily life functioning (Ogboghodo et al., 2018). Whereas according to the version seven of Mini International Neuropsychiatric Interview (MINI), of the Diagnostic and Statistical Manual of Mental Disorders (DSM 5), fitting into one of its category of disorders is described as psychiatric morbidity (Kwobah, Epstein & Mwangi et al., 2017).

Kenya is now considered a middle- income country, after 7 years (Jonah, Sambu & May, 2018) ,however, poverty has been linked to the rising burden of psychiatric disorders with factors

involving financial constraints, education and housing showing a positive relation, in a world where over 85% of its inhabitants reside in 153 low and middle income nations (Lake & Turner, 2017). In a discussion on mental health investment, held by the Ministry of Health which engaged more than 100 skilled personnel's, it was noted that in every 1 in 4 persons who seek mental health services in Kenya, has a psychiatric condition with depression being the most common while substance and alcohol use disorder being on the rise (WHO, 2021).

The 2010 constitution of Kenya states that a youth is a person who falls in the age category of 18-35 years old (Hope Sr., 2012) and according to the Kenya-office of the high commissioner for human rights, the age bracket of 18-35 constitutes roughly 75% of Kenya's inhabitants, making it a much more youthful Country. However, in Sub-Saharan Africa, research indicates that psychiatric disorders are a burden with children and youths suffering the most from it (Meyer & Ndetei, 2016). Whereby, the low and middle income states have a notable mental well being treatment gap of nearly 85% (Marangu, Mansouri & Sands et al. 2021), accounting for those not getting help for mental illnesses in contrast with adults aged 26-49 (25.0%). Moreover, National institute of mental health (NIHM, 2019) indicates that American youth aged 18-25 years accounts for the greatest percentage of any mental illness. More crucial studies on youths have suggested that at any point in time, 1 in 5 young individuals will have, not less than one psychiatric, behavioral and emotional challenges whereby 50% will have a diagnosis by 14 years while 75% by 24 years (Ahmed & de Jesus Mari, 2014).

In a study conducted during this period of Corona virus disease of 2019 (COVID-19), the age group of 21-40 years which contains most of this study's youth age bracket, suggests that they experience notable levels of stress, anxiety and depression, mostly due to future concerns and economic burden (Salari, Hosseinian-Far, Jalali et al., 2020). Nevertheless, depression is

prevalent among youths who are unemployed with approximately 13-14% (Mokona, Yohannes & Ayano, 2020). Therefore, this study will aim to determine the psychiatric morbidity among youth patients attending Nakuru level 6 Hospital.

1.2 Problem Statement

The youth's capability to achieve age-relevant key developmental milestones may be hindered by psychiatric illnesses which has its commencement early in life, leading to an international disease hardship (Gustavon, 2018). Kenya is considered a youthful Country since most of its inhabitants constitutes of age bracket 18-34 years (Chumo, 2018), however the frequency of common psychiatric disorders accounts for 10.3% with lifespan prevalence of suicidal thoughts at 7.9% and 1.9% lifespan frequency of suicidal attempts (Ministry of Health, 2018).

In addition, according to 2015-2030 of the Kenya Mental Health Policy, there is insufficient statistics and information regarding the frequency of neurological, mental wellbeing and substance use in Kenya. It is also noted that the general practitioners in hospitals may lack the expertise necessary to perform psychiatric assessments hence rarely provide them (Zhang et al., 2019), this in turn points out that some patients seeking general treatment in hospitals may have undiagnosed psychiatric illness which may endanger their lives.

Therefore, conducting a study on the psychiatric morbidity among youth patients in Nakuru level 6 Hospital will be a great step towards filling this gap for those in need of knowing their mental health status and even facilitation of necessary data on the morbidity of psychiatric disorders.

2.0 CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This section looks into the global, regional and local reviews of related topics of this research proposal. It relates with the information in chapter one and further explains the importance of this research proposal.

2.2 Global studies

In Great Britain, research was done on the mental distress among the youths of 16-34 years, investigating the lengthy shifts and timely changes in COVID-19 epidemic. Using the general health questionnaire +4 tool (GHQ+4), increased levels of distress was significant in April 2020 compared to 2018-2019 in both men and women of 25-34 years, with a (PRs) of 1.55 (95% (CI) 1.25-1.92) in the male gender to 1.80 (95% CI 1.56-2.08) in the female gender (Gagne, Schoon & McMunn et al., 2021). Furthermore, in July-September 2020, the mental distress risk decreased in both groups by 21% to 46%; whereby men experienced less decrease with (PR = 0. 79, 95% CI 0.65-0.79) of ages 25-34 while women of age bracket 16-24 years had (PR =0.54, 95% 0.45-0.65) and those of 25-34 years had (PR = 0.57, 95% CI 0.48-0.67).

In Canada, psychiatric illnesses affect about one in four youths, with the age range of 12 to 24 recording a weighty number of mental illnesses in contrast to any other age category whereby this age bracket is considered the climax period for psychiatric illnesses to start with 75% beginning before 25 years of age (Barbic, Leon & Manion et al., 2019). In addition, another

Canadian study which examined the trends in the mental well-being of youths from 2011 to 2018, indicated that the rate of suicidality increased from 2011 to 2016 (3.0% to 5.8%); identified disorders of the mood, surging to 7.8% from 4.3%; detected anxiety disorder increased to 12.9% from 6.0% (Wiens et al., 2020). Moreover, the rate of cannabis use disorder was constant with the commonness of 21.4% while binge drinking dropped from 25.5% to 17.6%.

A yearly cross sectional study in the United States of America, of years 2005 to 2015 suggests that there is an increase in depression in ages 12 to 17 years, 18-25 years and 50 years or older whereby ages 12 to 17 years old has 95% CI (1.04, 1.05), 18 to 25 years 95% CI (1.01, 1.03), 26 to 34 years 95% CI (0.99, 1.01), 35 to 49 years 95% CI (0.99. 1.01) and 50 or older 95% CI (1.00, 1.03) (Weinberger et. al, 2018). The estimate rise in depression indicates a drastic increase among youth comparable to all older age brackets (Weinberger et. al, 2018). An increase in the number of grown-ups in the united states of America identified with major depressive disorder was noted by 12.9% from previously 15.5 to 17.5 million in the years 2010-2018, with the age bracket of 18-34 years experiencing the increment in Major Depressive disorder (Greenberg, Fournier & Sisitsky et al. 2021). In addition, this led to an increase in economic burden in grown-ups with MDD with roughly 37.9% heightening to $US326.2 billion from $US236.6 billion (Greenberg, Fournier & Sisitsky et al. 2021). A peer reviewed study conducted from 1986 to 2019 through numerous electronic data bases in the Arab world indicates that the prevalence of individuals vulnerable to eating disorders, to range from 2 to 54.8% (Melisse, 2020). In addition some participants exhibited eating disorders somatically instead of psychiatrically.

Norwegian twins longitudinal study targeting the commonness and steadiness of psychiatric disorders among young adults in two waves (1994- 2004 and 2010-2011) established that, in wave one; psychiatric illnesses for those in age twenties were (19.8%) men and (32.4%) women;

anxiety disorders (9.6%) in men, (26.7%) in women; major depressive disorder (4,4%) in men, (7.2%) in the female gender; alcohol use disorder (8.7%) in the male gender and (4.4%) in women (Gustavson et al. 2018). It was also identified that the presence of anxiety and major depressive disorders in those in age twenties predicted their presence in about ten years later, whilst the interconnections were controlled in the twenties (Gustavon et al. 2018).

2.3 Regional studies

A Malian descriptive study about Schizophrenia cases, suggests that among its 164 participants with Schizophrenia, those of 25-34 years were more by 44.5% unlike the rest of the age groups (Coulibaly, Ba, Mounkoro et al., 2021). In Morocco hospital with a sample population of a median age of 33, indicates that schizophrenia is the most common with 69.9% then 8.4% bipolar disorder, manic episodes with 8.3%, 5.8% major depressive disorder, epilepsy at 3.7% and drug addiction at 1.5% (Ouanouche, Lamine, Tliji et al., 2021).

A study conducted on the regional distribution of anxiety disorders suggests that young adults of 10-19 years has an increasing prevalence of anxiety disorders as it peaks at ages 20-34 youthful years, followed by a constant/steady decrease afterwards and a prevalence point in both genders being estimated as 2.4% in (0-19 years) and 5.0% in (20-64 years) old adults, who work and 3.7% in those above 65 years (Baxter et al., 2014).

In Rwanda, a cross sectional research on behaviors of suicide and clinical associations in young adults using the Mini international neurpsychiatric interview tool, postulates that, 16.0% of its sample experienced suicidal tendencies whereas 84.0% had no suicidal behaviors (Muwonge et al., 2019).

A Benin study on the disorder of depression and ideations of suicide among the youths of age bracket 10-25 years, implies that majority of its respondents were of age group 20-24 years (64.5%) and that 44.2% of the participants had depression while 14.9% had suicidal ideations; whereas, among those with depression, 69.1% presented with mild depression; 25.1% with moderate depression and 4.5% had severe depression (Ogboghodo, Osadiaye & Omosun-Fadai, 2018).

2.4 Local Studies

Within Kenya, most studies on Psychiatric disorders in youths are mainly focusing on the adolescent age group of 10-18 years or just a broad group of 18- 65 years and onwards, whereby some has no specified details on specific age bracket and its morbidity on mental disorders hence limiting data.

One study that examined the commonness of depressive disorder on youths being seen at the public health centers and those in college preparatory schools was noted to have increased, with the commonness of anxiety on youths receiving treatment at the general health centers being 41.3% (OR = 2.41, 95% CI 1.04 to 8.26, $p = 0.012$), and behavior of suicide (OR = 5.27, 95% CI 1.94 to 11.66, $p < 0.001$) (Khasakhala et al., 2013). In addition, the findings implies that most of the youths in the age bracket of 16-18 years presented with the disorder of major depression compared to those below 16 or even above 18 years with (OR= 2.66, 95% CI 1.40 - 5.05, $p = 0.003$).

Moreover, a study conducted in Maseno, in the countryside region of Kenya suggests that, the commonness of frequent psychiatric illnesses were 10.8%; with 6.1% mixed anxiety depression, 6.1% panic disorder, and 1.6% generalized anxiety disorder, 0.7% depressive episodes with the

age category of 16-29 having a prevalence of any common mental disorder at 5.8%, while those in 30-64 years having 14.7% (Jenkins et al., 2012).

A descriptive cross sectional study aimed at identifying the rate of prevalent psychiatric disorders in 10 facilities among those of 18 years and above, indicated that all participants had 42% of mild and severe depression (Ndetei, 2009). Moreover, the clinician's assessment rate of psychiatric disorders was 4.1%, that is, only 114 participants had a diagnosis.

In a medical care space in Kenya, a study used a cross sectional descriptive design with the purpose of approximating the commonness, types and co-occurrences of disorders of the mental well-being and risk of suicide in those 18 years and older was conducted with the use of the plus 5.0.0 Mini international neuropsychiatric interview to identify mental illnesses and risk of suicide (Allion et. al, 2013). The results indicated a 12.7% of suicide risk among participants, 56.3% of the total 300 respondents presented with at least one mental illness, with the exceedingly most common being (39.0%) Affective, (13.0%) Somatoform, (31.3%) Anxiety, whereas individual disorders: bulimia nervosa (1%), bipolar disorder (9%), generalized anxiety disorder (9.3%), Pain disorder (12.5%), Agoraphobia (16.7%) and depressive disorder (26.3%) (Allion et al., 2013).

In the Western Kenya, a research identifying the commonness of psychiatric morbidity in a community representative of those 18 years and older indicates that, 15.7% of participants had anxiety disorder, major depressive disorder (12.3%), alcohol and substance use disorder (11.7%), psychotic episode (7.6%), lifetime suicidal attempt (16.4%), whereas only 1.7% had psychiatric disorders that were identified (Kwobah et al., 2017).

2.5 Psychiatric disorders in the research tool (version 7.0.0 of M.I.N.I)

2.5.1 Major Depressive Episode/disorder (MDD)

Major depressive episode/disorder is considered one of the exceedingly prevailing psychiatric disorders globally; in addition, it is frequently persistent leading to a significant deterioration (Chun-Te, Yi-Cheng & Jing-Yang, et al. 2016). According to the worldwide established population surveys and the United States, the disorder of major depression affects roughly 10%-15% of individuals within their duration of life (McHugh & Weiss, 2019). Moreover, major depressive disorder is made distinctive through the existence of at least 5 or more features which have to persist at the minimum of two weeks (McHugh & Weiss, 2019). It includes a lasting feeling of being hopeless or loss of motivation in extrinsic push that is followed by lack of enjoyment, less self-confidence and enthusiasm within everyday activities in-which adversely affects an individual's family, energy and private life (Islam & Adnan, 2017). The commonness of Depression has been often associated with various demography and social class including, age, gender identity and social disadvantage (Arias-de la Torre et al. 2021; Maske, Beesdo-Baum, Riedel-Heller et al., 2016). However, they differ extensively within and beyond countries hence adding to worldwide differences in the commonness of depression disorder (Arias-de la Torre et al. 2021).

Greenberg, Fournier & Sisitsky et al. 2021, suggested in a study conducted in United states of America in the period of 2010-2018 that grown-ups within the bracket of age 18-34 had the most high the rate of Major depressive disorder cases which made it an unproportioned distribution by age, whereby there was a 53.7% rate heightening it to 8.3 million people from 5.4 million. In contrast, the adults aged ≥35 years with major depressive disorder decreased in that period by 9.8% from 10.2 million people to 9.2 million (Greenberg, Fournier & Sisitsky et al. 2021).

Solmi, Radua, Olivola, et al., (2022) on the other end suggested that the average age onset of depressive disorder is 30-35 years. Villarroel and Terlizzi (2020) suggested that age bracket 0f 18-29 (21.0%) years had the highest symptoms of depression and that the last group with least symptoms was 30-44 years (16.8%).

Those with lower extent of educational background were found to have more prevalence of major depressive disorder (Shi, Zhang, Liu et al., 2014; Chun-Te, Yi-Cheng & Jing-Yang, et al., 2016). Moreover, in 2021, Arias-de la Torre et al., indicated that age brackets of 15-29 has a prevalent rate of MDD by 5.26% (4.93-5.59) & 30-44 having a 4.86% (4.59-5.12); and that the education level also impacts the outcome of MDD by; primary or lower level having 11.48% (10.93-12.02); Secondary level 6.52% (6.34-6.70) and tertiary 4.13% (3.90-4.37). Islam & Adnan, 2017, on the other hand indicated that (56%) of married individuals showed a likelihood of having depression in contrast to (36%) of not married persons. Gutierrez-Rojas et al. (2020) indicated that the major socio demographic correlations with major depressive disorder were being divorced/separated or having a female sex. Additionally, Bulloch et al (2009) findings concluded that individuals who are divorced or separated have higher risk of developing major depressive disorder Another cross sectional study suggested associations between low income and major depressive disorder (Economou, Madianos, & Peppou et al. 2013). Unemployment is persistently linked with increased rates of depression in young adults (Paul & Mauser, 2009; McGee & Thompson, 2015. Findings of McGee & Thompson, (2015), indicated that depression is higher in young adults who are unemployed. In depression, antidepressant medicines are commonly considered the first line of management when it is moderate to severe (Krupnick et al., 2018; Luo et al., 2020). However, emerging studies shows that all-inclusive management comprises of psychotherapy combined with medications (Cuijpers et al., 2014; Wiles et al.,

2016; Luo et al., 2020). Many of the convenient antidepressant medicines work through balancing the monoamine neurochemical in the brain. The main process of the medications is heightening the general synaptic centralization of monoamines (dopamine, serotonin, and norepinephrine). This is obtained through obstructing their reabsorption to the presynaptic neuron attaching to a specific neurochemical carrier or even via hindrance of monoamine degenerating chemical MAO resolvable or irresolvable (Holtzheimer & Nemerroff, 2008; Fekadu, Sjibeshi & Engidawork, 2016). An extensively used management for depression is cognitive behavioral therapy (Luo et al., 2020). Moreover, it aids persons to recognize unhelpful and incorrect cognitive thoughts (Mor & Haran, 2009; Luo et al., 2020). Patients acquire knowledge on skillfulness to help them get through incorrect thinking and ideologies in particular changed thoughts and behavior (Luo et al., 2020). Whiston, Bockting, & Semkovska (2019) noted in their findings that cognitive behavior therapy on its own is effective more than interpersonal therapy (IPT) on its own or when done as merged management, however, IPT on its own is non-inferior to merged management. Luo et al. (2020) systematic review gives average proof that electronic cognitive behavior therapy is way effectual as compared to the one on one CBT when it comes to minimizing the graveness of manifestations in patients. As a result of its linked probability of biasness, increased diverseness and absence of between-group distinctions in the universal practicality their summary were not conclusive.

2.5.2 Suicide

Suicide is considered a universal health challenge in the public a (WHO, 2020; Ferguson 2022). Globally, among the most noted reasons for death or impairment is suicide (Pandaye, Bisat & Dhungana et al. 2019). It is also considered the second main source of death in those of age bracket 15-29 (WHO, 2018). Moreover, it majorly impacts the nations with low or middle capital

which explain nearly 78% worldwide deaths by suicide (WHO, 2018). Females have a higher percentage of suicide attempts as compared to males (WHO, 2014; Hegerl, 2022). Nonetheless, in terms of mortality in suicidal behaviors, males have a higher percentage of suicide accomplishment in contrasts to females (WHO, 2014; Hegerl, 2022).

Some of the vulnerabilities for suicide is being female, low levels of education, joblessness, previous history of mood disorder, earlier suicide attempt and being hopeless while shielding factors includes having a religious aspect and morals, good support system and personal perception of support from loved ones and outsiders (Vidya et al. 2021). Allan, Volarov, and Koscinski et al. (2021), noted that being lonely has also been linked with heightened suicidal thoughts. On the other hand, findings of Oien-Odegaard, Hauge & Reneflot, (2021) indicated high chances of suicide being twice or thrice more linked to being divorced or a widow/widower as opposed to being married. Moreover, Naes, Mehlum & Qin, (2021) findings reported a distressing heightening rate of suicide in males (13.6%) and females (21.8%) who are experiencing marital separation or having a title of being separated of divorced. Patients with depressive disorders have prevalent suicidal behaviors; moreover, up to 50% of individuals with depressive disorder will try a suicidal attempt not less than once in their life (Isometsa, 2014; Parameswari, Raju & Vidya et al. 2021). Findings of a study showed that adult patients above 19 years, who were not married or widowed had a heightening in suicide rate especially after the corona pandemic in contrast to earlier on (Kim, Paek, & Kwon et al. 2022). Crump et al., (2014); Crump et al., (2021) stated that drug use disorders (DUD) has been noted to be one of the common factors leading to suicide behavior whereby women and men having been stated to indicate a minimum of about 4 and 7 chances of having suicide deaths correspondingly in comparison to the public population following an adjustment in the socio demographic

indifferences as well as other somatic and psychiatric challenges. Very many efficacious methods of management exist (Zalsman et al., 2016; Ferguson et al., 2022), however, a small number of them are adaptable as much as necessary to be applicable beyond the scope of suicide related occurrences or in all measures of international elimination, in particular and desiganted (Ferguson et al., 2022). Cognitive behavior therapy and dialectical behavior therapy were noted to produce a substantial outcome in minimizing suicidal ideations in comparison to treatment as usual or a control group in wait list (D'Anci et al., 2019). Moreover, Cognitive behavior therapy also minimized the attempts in suicide in contrast to treatment as usual whereas Ketamine and lithium minimized the amount of suicide done as compared to the placebo although there was insufficient data on related harm (D'Anci et al., 2019). Ferguson et al., 2022 concluded in his findings that, the safety planning intervention was noted to be an essential management indicator for the adults and veteran public inhabitants encountering suicide linked suffering, essentially in one on one health surrounding.

2.5.3 Manic and hypomanic episodes

Bipolar mood disorder is considered a persistent and more technical mental illness which is linked with decreased life standard, functionality, cognitive challenges or even untimely death. Its complexity is further worsened by the existence of numerous ailments (such as hypertension, diabetes and obesity or mental illnesses (such as substance use disorders, anxiety) coexistence in majority of patients (Donna, Jessica & Charles, 2020). Bipolar disorder has been long known to be genetically induced however, some social and environmental elements can impact its onset, course and end result (Johnson & Weinberg, 2022). Those with high vulnerability of developing Bipolar Disorder include those with a first line family member with Bipolar Disorder and schizophrenia, psychotic symptoms history and sub-clinical mood or attaining the bracket of age

(i.e adolescence) that is highly linked with its onset (Rios, Noto & Rizzo et al. 2015). However, Solmi, Radua, Olivola, et al., (2022) noted that the average global age onset of bipolar disorder to be 30-35 years.

When diagnosing bipolar I disorder, there should be an occurrence of not less than one episode of mania whether having or not having a past history of previous disorder of major depression, however when diagnosing bipolar II disorder there should be a minimum of a single hypomanic and a single major depressive (APA 2013; Datto, Pottorf & Feeley et al. 2016). Moreover, patients regularly present to medical practitioners with depressive features since depressive incidents normally surpasses manic/hypomanic episodes in bipolar I and II subsets (Datto, Pottorf & Feeley et al. 2016). Donna, Jessica & Charles, (2020) further suggested that not less than 50% of the patients who have bipolar mood illness also have an incident of depression and about 40% of the patients who have bipolar mood illness undergo medication primarily in a health care set-up. Bipolar I mood illness has also been attested to be far much less chronic and mildly impairing as compared to bipolar II (Datto, Pottorf & Feeley et al. 2016). Misdiagnosis of unipolar depression may lead to unsuitable treatment plan for the depression in bipolar leading to administration of antidepressants that aggravates the illness, post pones the introduction of the suitable medication and subsequently may cause disastrous outcomes such as antidepressant-arising mania and suicidality (Fornaro et al., 2018: Donna, Jessica & Charles, 2020). In a study conducted to identify different manifestations of bipolar I and II in a group of 8766 individuals, Karanti et al., (2020) found that persons with Bipolar II disorder had more percentages of episodes of depression as well as a commonly repeated attempts of suicide as compared to the bipolar I disorder. Moreover, the bipolar II disorder sample had their first symptoms of psychiatric illness when younger and also indicated increased commonness of psychiatric

coexistence however, they were more probable to have finished their higher level of education and be more self reliant in contrast to bipolar I disorder category (Karanti et al., 2020). More than 15 accepted treatment methods are available for different episodes of bipolar mood disorder however; the end results are mostly suboptimal due to lack of effectiveness, following complications and even minimal level of availability (Goes, 2023). One of the most continuous efficacious drug is lithium which was the first ever accepted treatment method for bipolar mood disorder even though full remission is mostly seen in particular subset of patients (Goes, 2023). Moreover, for most bipolar mood disorder, a blend of psychotherapy and medication could be important so as to treat other symptoms occurring in different episodes of the illness (Goes, 2023).

2.5.4 Panic disorder

Panic attack can be interpreted as "the immediate rise of extreme discomfort or even fearfulness which heightens to its highest in few minutes," represented by rapid mobilization of stress-connected physiology and fear-connected perception (DSM 2021; McGinnis, O'Leary, Gurchiek et al. 2022). It is considered to be among the most prevalent anxiety disorders having a lifetime commonness rate within the public population being reported between 2.1-2.7% (Carta et al. 2015; Kim, 2019) and it affects approximately about 12.8% of the global population and being classified by a repeated and unpredicted panic attacks (de Jonge et al., 2016: Zhang et al., 2022). It also has a persistent course, a compelling burden of psychiatric and medical co-occurring conditions and may have notable negative consequences on everyday life operations and quality of living (Brettschneider, Bleibler, Hiller TSS, et al. 2019; Caldirola, Alciati, Cuniberti et al. 2021). Panic disorder can be a one-off incident however, most individuals experience recurrent incidences in a prolonged lifespan (Bonevski & Naumovska, 2019). Few individuals who

experience panic attacks develop panic disorder since majority of them get well without treatment (Bonevski & Naumovska, 2019). Individuals who experience panic attacks manifests deterioration in emotional and physical health in addition to financial and occupational functioning's (McGinnis, O'Leary, Gurchiek et al. 2022). Furthermore, individuals experiencing bereavement frequently exhibit enduring psychological manifestations including panic attacks (Shin, Park, & Ryu et al. 2020).

Zhang et al., concluded in a study he conducted on suicidality in patients with a primary diagnosis of panic disorder; that in the event panic disorder was noted to have a coexistence with another psychiatric disorder, the life span attempt of suicide rate consequently heightened too by approximately 50%. Kalin (2020) stated that the life span coexistence in major depressive disorder is approximated at around 50% in patients who have panic disorder.

Implementation of neurobiological, physiological, behavioral and hereditary information is important for the conceptualization of a bio-psycho-social-behavioral model of panic disorder (Kim, 2019). The first line of non-pharmacological intervention is Cognitive behavioral therapy (CBT) (Bandalew, Michaelis & Wedekind 2017; Caldirola, Alciati, Cuniberti et al. 2021). Even though the effectiveness of approved medications and CBT is greatly developed, a lot of patients roughly 20-40% could not attain full remission whereas the amount of recurrence or persistence of sub-threshold characteristics following termination of pharmacotherapy was considerably about 50% of patients (Perna, Caldirola 2017; Caldirola, Alciati, Cuniberti et al. 2021).

2.5.5 Agoraphobia

Agoraphobia is a type of anxiety that happens when an individual is in a public or congested area, whereby chances of escaping is narrow, or assistance may be unavailable (Roest AM et al.

2019; Balaram & Marwaha, 2022). In addition, its characteristic is noted by the exhibition of fearfulness that the panic-like or panic attack manifestations could happen in such circumstances therefore, people with agoraphobia would attempt to evade such situations or settings (Roest AM et al. 2019; Balaram & Marwaha, 2022). A hereditary vulnerability is enhanced by family aggregation however; unspecified surrounding occurrences may also subsidize its commonness (Barzegar, Farahbakhsh, Azizi et al. 2021). Preti et al referenced that were no specified root cause of agoraphobia that had been established for its onset although there are some vulnerabilities that were more common in the history of those with an established diagnosis of agoraphobia: other than genetic vulnerability, detrimental traumatic life experiences during childhood development, occurrences of loss of a loved one in early life and over protectiveness form a parent were the most commonly noted. Moreover, a history of fears in childhood development or even night terrors is noted to be a common predecessor of agoraphobia in young adults and adults (Catarozoli, Mishan & Schild et al., 2019; Preti et al., 2020). The National Institute of Mental Health approximates the lifespan commonness of agoraphobia standing at 1.3% and having a 0.9% incidence estimate; moreover, an annual commonness estimate of agoraphobia is comparative in both females by 0.9% and males by 0.8% (Balaram & Marwaha, 2022). From accessible findings, the designated age onset of the commonness of agoraphobia within panic attack, panic disorder, and agoraphobia categories was roughly 21-13 years old and the commonness of agoraphobia was detailed to be 25-29 years old (Barzegar, Farahbakhsh, Azizi et al. 2021).

Shin, Park, & Ryu et al. (2020) stated that the association between agoraphobia and panic disorder continues to be not clearly demonstrated. Lastly, reports from Grant et al. indicated that panic disorder comorbid with agoraphobia was thought to be a serious difficulty of agoraphobia

and panic disorder which was previously contemplated to be an outcome from frequent panic attacks. Preti et al., (2021) noted in his study that out of 2338 respondents only 26 cases of participants with agoraphobia had a coexistence of panic disorder while 9 participants had no coexistence making it a total of 35 participants. Moreover he concluded that 1 in every 70 people may have agoraphobia in their life span.

A number of pharmacological and psychological approaches are effectual in the treatment of panic disorder and/or agoraphobia (Imai et al., 2016, Pompoli et al., 2016, Domhardt et al., 2020) with psychological approaches being suggested as the first line of treatment in more or less treatment directions such as the NICE, 2019. Specifically Cognitive behavior therapy (CBT) in various Meta analytic reviews up to date has shown beyond doubt in its efficacy in panic disorder and agoraphobia (Cuijpersetal et al., 2016, Domhardt et al., 2020). In a study conducted to understand the effectiveness of internet and mobile interventions in adult with diagnosed panic disorder and or agoraphobia it was found that, internet and mobile based approaches were more effectual in lessening manifestations of agoraphobia and panic disorder as compared to already diagnosed panic disorder and agoraphobia in a wait list control group (Domhardt et al., 2020). On the other hand, (Carpenter et al., 2018; Preti et al., 2021) stated that for milder cases of agoraphobia, cognitive behavior therapy (CBT) is considered to be efficient in terms of relieving manifestations and advancing the quality of living. However, in more variants that are severe, anti-depressants were regarded to be the first line of treatment (Plag et al., 2018; Preti et al., 2021).

2.5.6 Social Anxiety disorder

Social anxiety disorder (SAD) is categorized by continuous or identified fear/anxiety concerning a minimum of one social interactions or performance set of circumstances in social surroundings

(American Psychiatric association 2013, Koyuncu et al., 2019). Social Anxiety Disorder happens in public areas and an individual perceives that others are observing and judging them (Harrison, Cowen & Burbs et al. 2017; Al-Johan, Alshamlan, & AlAmer et al. 2022). In addition, fear of making speech was considered the most prevalent presentation of Social anxiety disorder (Harrison, Cowen & Burbs et al. 2017; Al-Johan, Alshamlan, & AlAmer et al. 2022). Due to fears of humiliation and embarrassment brought about by managing oneself or being the center of attention in public (Ambusaidi, Al-Huseini & Alshaqsi et al. 2022), different people experience variety of cognitive and somatic anxiety manifestations distinguished by automatic stimulation including tremors, increased sweating, blushing and tachycardia (DSM, 2013; Al-Johan, Alshamlan, & AlAmer et al. 2022). A prevalence of 2%-3% was found in regulated diagnostic approaches in the general public, moreover, with regards to gender; different studies summarized that social anxiety disorder seems to be more prevalent in women (5.67%) in contrast to men (4.20%) (Ambusaidi, Al-Huseini & Alshaqsi et al. 2022). Each person undergoes some form of unpleasant interaction occurrences in their life span. However, there could be a possibility that persons who develop social anxiety disorder have a psychological predisposition to the circumstances which may not be ordinarily viewed as traumatic (Rodebaugh et al., 2017; Bjornsson et al., 2020). Social anxiety disorder is also contemplated of being a notable vulnerability component for promoting the disorder of major depression and alcohol abuse challenges (Al-Johan, Alshamlan, & AlAmer et al. 2022). The coexistence of social anxiety disorder and major depressive disorder has been continuously noted in clinical research with coexistence figures varying in between 35 to 70% (Koyuncu et al., 2019) while Kalin (2020) stated a coexistence with depression at around 20 – 70%. Moreover, this coexistence causes an increment in the seriousness of more chances of relapse, social anxiety disorder and poor life

functioning (Koyuncu, Ertekin, Binbay et al., 2014; Koyuncu et al., 2019**)**. In a study conducted to assess, describe and evaluate the impact of social trauma, the findings concluded that one third of persons who have social anxiety disorder could develop post traumatic stress disorder due to responding to a social trauma and furthermore, this category of individuals reported higher levels of depressive as well as anxiety manifestations (Bjornsson et al., 2020). Jefferies & Ungar (2020) stated that their findings to be indicating remarkably greater figures of Social anxiety disorder than expected, especially for the persons in the age bracket of 18-24 years. Pelissolo, Abou Kassm & Delhay (2019) focused attention on psychotherapy and drug treatment which are the main and similar plan of action in the handling of patients with social anxiety disorder. In addition to that, Cognitive behavioral therapy (CBT), administered in one person or group environment is considered the best verified psycho-social application which consists of many methodologies in particular psycho education, cognitive psychotherapy and behavior exposure. Nevertheless, modern advances of cognitive behavior therapy in regards to the implementation of social anxiety disorder control involve the third-wave methods (such as acceptance and commitment therapy as well as mindfulness based approach), attention bias modification, internet-based therapy and virtual reality exposure (Pelissolo, Abou Kassm & Delhay, 2019). Surveys conducted propose that selective serotonin reuptake inhibitors (SSRIs) are effectual in the treatment of social anxiety disorders (Mayo-Wilson et al., 2014; Cipriani et al., 2018; Hjorth, Frick, Gingnell et al., 2021).

2.5.7 Generalized anxiety disorder

GAD or fully known as Generalized anxiety disorder is frequently stated as a psychiatric illness that is distinguished by too much worry, in addition, patients identified with GAD always live in anticipation of a horrible thing occurring to them concerning their health, money, work or even

any social judgement (Zhu, Sun & Wang et al 2020; Aljurbua, Selaihem & Alomari et al 2021). Nevertheless, GAD presents distinctly in different situations and is mostly manifested through physical symptoms like faintness, fast heartbeat, sweating or wavering (Zhu, Sun & Wang et al 2020; Aljurbua, Selaihem & Alomari et al 2021). The root cause of generalized anxiety disorder is not clearly comprehended; however, there are various theories all consisting of different levels of empirical reinforcement. Despite that, the key matter in those various models is about the abnormal regulation of worry. The rising information indicates that patients who have generalized anxiety disorder can undergo continuous stimulation of section of the brain region linked to psychological activities as well as self-analysis kind of thoughts due to the worry activated stimuli (Paulesu, Sambugaro, Torti et al. 2010; Locke, Krist & Shultz, 2015). In addition, twin studies propose that the surrounding and even the inheritable components are in all probability connected (Mackintosh et al. 2006; Locke, Krist & Shultz, 2015). Generalized anxiety disorder commonly starts at adolescent stage although it has a prevalence rate of around 2% among the adult citizens; its lifetime prevalence stands at about 4.7% (Madonna, Delvecchio & Soares et al. 2019). However, Solmi, Radua, Olivola, et al., (2022), suggests its age onset to be at 30-35 years. In lieu, Gambin et al. (2021) findings indicated that younger brackets of age 18-29 years and 30-44 years shown to have larger percentage of generalized anxiety and depressive features in comparison to adults in the older age groups. Although, Aljurbua, Selaihem & Alomari et al (2021) noted that the commonness of anxiety symptoms was most in the age group of 18-24 as compared to the older age groups and that females (15.6%) had the more severe anxiety features in contrast to men (9.8%). More females are affected by it than men (Melo-Carrillo, Rodriguez & Ashina et al. 2023). Moreover, some of the common risk factors for Generalized anxiety disorder include subjection to childhood hardships, low socio-economic

background and female gender (Fonzo, Ramsawh & Flagan et al. 2016; Madonna, Delvecchio & Soares et al. 2019).Using GAD-7, Aljurbua, Selaihem & Alomari et al (2021) noted that GAD was more in females (15.6%) and (9.8%) in males although no significant distinctions were present between the two genders. Nonetheless, it was noted that the fraction of those 18 years and above who had mild, moderate or severe manifestations of anxiety specifically generalized anxiety disorder in the formerly two weeks reduced with age and more proportion was in women in contrast to men (Terlizzi & Villarroel, 2020). Kalin (2020) referenced coexistence between generalized anxiety disorder and depression at about 43% in patients. One of the best methods suggested and practiced in the treatment of GAD is psychotherapy (Bandelow, Michaelis & Wedekind 2017; Melo-Carrillo, Rodriguez & Ashina et al. 2023). Tricyclic antidepressants are noted to be effectual in managing panic disorder as well as generalized anxiety disorder; however, it is more researched on panic disorder. Venlafaxine is effectual as well as tolerable for GAD and panic disorder due to its prolonged release, contrary, duloxetine (Cymbalta) is noted to have been studied sufficiently but only in GAD (Locke, Krist & Shultz, 2015). In a study where a random control experiment was conducted on, rational emotive behavior cognitive behavioral therapy, and acceptance and commitment; the findings were that all the management tested were linked to a great pre-post intervention decline on generalized anxiety disorder manifestations and problematic instant thoughts, therefore, all of them seem to be effectual (Stefan et al. 2018).

2.5.8 Obsessive compulsive disorder

OCD also called Obsessive-compulsive disorder is a psychiatric illness that impacts just about 2% of the public in their lifetime (Pedley, Wearden & Berry, 2019**).** Most of the people with OCD experience obsessions and compulsions at the same time (Castle, Beilharz, & Phillips et al. 2021). The commonness of obsessive compulsive disorder among the adult inhabitants ranges

between 1& and 3% (Geller, Homayoun & Johnson, 2021). Moreover, in various countries and continents, the commonness of this disorder in adults has been observed to be incredibly steady (Geller, Homayoun & Johnson, 2021). Furthermore, compulsions are more often than not followed by obsessions and even personalized episodes of not being complete or 'feelings of not being right' or the better known sensory phenomena (perceptual occurrences which follow or go along with compulsions). 'Phase-specific' Coexisting conditions are mostly present with Obsessive compulsive disorder (Castle, Beilharz, & Phillips et al. 2021). The United Kingdom backed The National Institute for Health and Care Excellence (NICE) in ratifying cognitive behavior therapy commonly called CBT as well as EPR or exposure and response prevention as the first-line treatment for OCD (Pedley, Wearden & Berry, 2019). Obsessive compulsive disorder figures were detailed to be around 2 to 19% in patients with social anxiety disorder whereas its commonness in outpatients with obsessive compulsive disorder was noted to be around 8 to 42% (Koyuncu et al., 2019). There are few verified main management methods of obsessive-compulsive disorder in particular, Cognitive behavioral therapy and Exposure-response prevention (EPR) (Koran, Hanna, Hollander et al., 2007; Goodman, Storch & Sheth, 2021), and SSRIs (Bloch, 2014; Goodman, Storch & Sheth, 2021). It is estimated that around 25% to 40% of patients do not get better with the latter two approaches (LG, Havnen, Hansen et al., 2015; Goodman, Storch & Sheth, 2021) and less patients achieve full symptom resolution (Simpson, Huppert, Petkova et al., 2006; Goodman, Storch & Sheth, 2021). The expansion of other more efficacious management methods in particular to those patients who do not respond to approved methods would be further comprehension of the neurobiology of Obsessive Compulsive Disorder (Goodman, Storch & Sheth, 2021). Neuromodulation managements using methods that are non-invasive such as transcranial magnetic stimulation and even invasive

methods including deep brain stimulation) gives more assistance to the Cortico-striato-thalamo-cortical pathway (CSTC) model of Obsessive compulsive disorder (Goodman, Storch & Sheth, 2021). However, deep brain stimulation for OCD is not yet fully regarded as confirmed therapy (Wu et al., 2021; Baldermann et al., 2021) this is because of the unpredictability of the exact network of the brain that should be modulated for a successful management.

2.5.9 Post-traumatic stress disorder

PTSD or Post traumatic stress disorder is known as a psychiatric illness which can occur after being exposed to extremely terrifying situations and it can present following one episode of traumatic experience or even a prolonged subjection to trauma (Qian, Wang & Sun et al. 2021). Persons with PTSD often suffer from extreme mental manifestations that may affect one's living through panic attacks especially when faced with memories of the traumatic event (DSM-5, 2013; Spottswood, Davydow, & Huang, 2017). Nonetheless, instead of focusing attention on the different varieties of incidences which are considered as traumatic, an additional practical viewpoint would put into consideration the various perceived threats which are associated to the generative successful outcome towards the changing history of our breed that are related to reproductive success in the evolutionary history of our species (Stein & Nesse 2011; Bjornsson et al 2020). Larsen and Berenbaum (2017); Bjornsson et al., (2020) looked into numerous indicators of post traumatic stress disorder signs and only identified one accordant factor: a person's evaluation of threat to life. In addition to that, life threat is among many other kinds of threat which could lead to a response that is considered traumatic. Moreover, it is significant to take a look at the extensiveness of which contrasting kinds of threats enacts towards the growth and continuation of more psychiatric disorders for instance social anxiety disorder (Pinto et al.,

2015; Bjornsson et al., 2020). Lifetime prevalence ranges of PTSD in empirical studies have been indicated to be 13.0%-20.4% in females and 6.2%-8.2% in males (Bryant, 2019). Similarly, da silva et al. (2019) findings indicated that women patients 33(80.5%) had more PTSD as compared to men 8 (19.5%). Furthermore, Qian, Wang & Sun et al. (2021) stated that at any time, it has been noted that adults (3.0%) would present with a positive for PTSD. In addition, a lifetime prevalence of post traumatic stress disorder stands at 8.3% (Kilpatrick, Rensnick, & Milanak et al., 2013; Qian, Wang & Sun et al. 2021. Coexisting mental illnesses equally anxiety disorders, substance use disorders and depression have been shown to be common among most individuals in empirical studies (Bryant, 2019). Da Silva, Furtado da Rosa & Berger et al. (2019), noted that post traumatic stress disorder still remains hugely not diagnosed and inadequately treated in the mental health outpatients with a diagnosis estimate of the lowest level being 4% even in teaching hospital settings.

A study suggested that females in the age bracket of 25-35 may experience the most level of Post-traumatic stress symptoms, although other studies indicated that chances are high for persons of the age group 18-24 years to experience PTSD symptoms (Liu, Liu & Huang et al., 2020). Another study by McGinty, Fox, & Ben-Ezra et al., (2021), suggested that persons of the age category 25-35 were found to be 4.19 times most likely than those of the age bracket 65 or above to attain the full diagnosis criteria for post traumatic stress disorder. Solmi, Radua, Olivola, et al., (2022), on the other hand suggested that the average global onset of post traumatic stress disorder to be 30-35 years. In addition to that, it was concluded that it can be stated without any reasonable doubt that females have a risk higher for developing PTSD in contrast to males regardless of age and that the amount of PSTD is in general greater in younger age bracket regardless of sex (McGinty, Fox, & Ben-Ezra et al., 2021). This could be due to the distinctions

of sex and behavior in the brain and behavior leading to PTSD being more common in females as compared to males (Olff, 2017). The amount of post traumatic stress disorder is noted to be around 3.2 to 16 % in patients with social anxiety disorder (Koyuncu et al., 2019). Kalin (2020) referenced coexistence between post traumatic stress disorder and depression at about 48% in patients. There have always been intense conversations on the most methods of controlling and managing post traumatic stress disorder (Bisson & Olff, 2020). In a study conducted in 6560 participants, Mavranezouli et al., (2020) concluded that Eye movement desensitization and reprocessing and trauma focused cognitive behavioral therapy were noted to be more effectual in minimizing manifestations and enhancing rates of remission in adults with post traumatic stress disorder. Moreover, they were found to be also effectual in maintaining manifestation advancements past the management end point (Mavranezouli et al., 2020). Post traumatic stress disorder medical management in adults have shown very weak outcome in various medical methods (Hoskins et al., 2020; Bisson & Olff, 2021). Nevertheless, Sertaline, Fluoxetine, paroxine and venlafaxine have all been proven to have great outcome with PTSD manifestations minimization in adults, however, the amount of improvement stated seems to be small as compared to verification gotten from management using evidence based psychological methods (Hoskins et al., 2020; Bisson & Olff, 2021).

2.5.10 Alcohol use disorder

Globally, AUD or Alcohol use disorder is considered to be the substance use disorder with the most commonality (Degenhardt, Charlson, Ferrari et al., 2018; Kuhns, Kroon, Lesscher, et al. 2022). Alcohol use disorder is one of the most leads of morbidity and death implications intercontinentally (Catillo-Carniglia et al., 2019). Other than their high rate of commonness, alcohol use disorders remain poorly managed to a certain degree due to the heightening rate of

stigmatization relating to it, however, due to low effective structured check-ups in primary Medicare care, even though efficacious and affordable managements in the medicinal and psychosocial categories are present (Carvalho et al., 2019). A study indicated that adults in the age bracket of 18-34 averagely use not less than 2 drinks per drinking instances in contrast to the older adults who drink not more than 1 drink (Delker, Brown & Hasin, 2016). In addition, the commonness of any kind of alcohol use heightens in young adults hence 73.1% of the participants of age category 18-29 stated to have been drinking in the previous year (Delker, Brown & Hasin, 2016). Slade, Mewton & O'dean et al. (2021) discussed that the age group 18-24 experienced a high weekly consumption of alcohol. WHO, (2022); Handren et al, (2016); (Wysokinska & Kolota, (2022) noted that age group 20-24 had the most heavy consumption times whereas WHO, (2022); Public opinion research center, (2022); Wysokinska & Kolota, (2022) noted those of age group 25-45 years indicated a peak in alcohol usage. However, Solmi, Radua, Olivola, et al., (2022) discussed that median onset of alcohol used disorder was noted to be 25-27 years. Some sex differentiation on the incidences, resource usage or medication of alcohol use disorder and dysfunctional alcohol drinking habits have been noted; this is because males and females are attributed with contrasting societal morals and norms (Agabio et al. 2017; Castillo-Carniglia et al., 2019; Gilbert et al., 2019; White, 2020; Greaves et al., 2022; Maxwell et al., 2022; Goh, Asharani & Abdin et al. 2022). Moreover, sociocultural viewpoints, customary masculine norms particularly, can be part of the reason and is largely connected to alcohol consumption in males and has ascribed to a lot of usage of alcohol hence forecasting alcohol-rated challenges (Maxwell et al. 2022; Goh, Asharani & Abdin et al. 2022).

Some studies conducted in public general hospital environment indicated various results on alcohol use disorders from the different countries; such as Nigeria 9.7-41.4% (Abiodum et al.,

2013; Obadeji et al., 2015; Demilew, Boru, Tesfaw et al., 2021), Uganda 4.1-17.4% (Nalwadda et al. 2018; Demilew, Boru, Tesfaw et al., 2021), Ethiopia 3.0-32.6% (Soboka et al., 2014; Teferra et al., 2016; Zewdu, Fekadu, Medhin et al., 2019; Demilew, Boru, Tesfaw et al., 2021) and south Africa 18.9% (Peltzer, Pengpid, 2012; Demilew, Boru, Tesfaw et al. 2021). Less educational level was correlated with more risk of having a drinking challenge even after balancing marital status, age, job status and income and personal-rated health and mental stress (Murkakami & Hashimoto, 2019). Similarly, Norstrom, & Landberg (2020) findings indicated a relationship between per shot intake and alcohol-linked hazard which was more the lesser the level of education category. Having a lesser level of education predisposes one to be a binge drinker due to occasional predisposition to social distress and poor health enlightenment about dangers of alcohol consumption (Cerda, Johnson-Lawrence & Gales, 2011; Murkakami & Hashimoto, 2019). Alcohol use disorder was significantly linked with self-employment (Kiarie, 2021). Hunt, Malhi & Lai et al (2020) found that alcohol use disorder in males with major depressive disorder was indicated to be at 36% while 19% in females with MDD. Research in the public population indicated that persons with depressive illnesses have a 2-3 times chance of having AUDs and in regards to a yearly co-existence in participants who have assessed and identified Alcohol dependency, of the participants 29% had a minimum of one mood illness and the most prevalent was the disorder of major depression with 28% (Yang, Tao, & He et al. 2018). McHugh and Weiss, (2019) highlighted a number of possible pathways of development which have been suggested so as to give an explanation of the great percentage of coexisting Alcohol use disorder and depressive disorders. This included that; the probability of alcohol use disorder were high due to depressive disorders; alcohol use disorders led to an increment likelihood of depressive disorders and; depressive disorders and alcohol use disorder have a

similar pathophysiology as well as similar vulnerabilities (McHugh and Weiss, 2019). Statistical health analysis noted high figures in the association between social anxiety disorder and alcohol use disorder (Koyuncu et al., 2019). Furthermore, the amount of alcohol use disorder could reach to about 50% in patients with social anxiety disorder (Koyuncu et al., 2019). Managements done clinically for alcohol use disorder ought to be set in a supporting setting, and this can be made stronger through the coming up with alcohol control proposed actions targeting the minimization of the general amount of intake (Carvalho et al., 2019). Majority of the people who develop alcohol use disorder or develop unapparent related alcohol challenges are bound to minimize and even tackle their challenges by themselves or using the help of a professional addiction management and similar help groups (Bergman, Hoeppner et al., 2017; Fan, Chou, Zhang et al., 2019; Kelly, Tucker, Chandler & Witkiewitz 2020). Without the presence of formal management, altering the narrative to focus on the probability of recovering would aid more persons in taking part in the personal related alcohol assistance which in turn would aid individuals to minimize on their alcohol intake (Tucker, Chandler & Witkiewitz 2020). Motivational interviewing (MI) conducted in groups was noted to cause a remarkable reduction in the use of alcohol, depressive and anxiety manifestations in the study respondents (Csillik et al. 2021). Moreover, it appeared that individuals scored higher in subjective level of happiness after undergoing MI in groups (Csillik et al. 2021). In a study conducted by Kang & Kim (2021), Motivation interviewing in combination with cognitive behavioral therapy resulted in desirable outcomes in motivation and self reliance in heavy alcohol consumers. Automatically, levels of advancements in self driven and self reliance using MI and CBT were anticipated so as to change the problematic behavioral drinking. Nevertheless, more monitoring of the self and acquired

problem solving ways activities were essential interventions in heightening self reliance (Kang & Kim 2021).

2.5.11 Substance use disorder

Cannabis, Tobacco

Drug use disorder has an extreme risk of untimely death and it is considered responsible for an approximation of about 41.7% of all the years an individual loses and attributed to a part of psychiatric or substance use disorder (Ferrari et al., 2014; Crump et al., 2021).

In a study, age was greatly linked with previous 30 day cannabis-only use, in persons of age bracket 18 to 25 years (2.0%) and 26 to 49 years (0.7%) indicating greater chances of cannabis only usage in comparison to much elder adults (Carlini & Schauer, 2022). Moreover, 18-25 years (20.2%) and 26-49 years (11.5%) stated to be using cannabis in combination with other substances in the previous 30 days (Carlini & Schauer, 2022). This corresponded with Mauro, Carliner & Brown et al. (2018) findings which indicated that daily cannabis use was significant in age group of 18-25 and 26-34 years olds transversely all years. Moreover, Solmi, Radua, Olivola et al. (2022) indicated that the age onset of cannabis use disorder to be 17-22 years old. UNODC, 2019; Kroon, Mansueto & Kuhns et al., 2022, showed that men in contrast to women have almost double the rate of cannabis use (Cuttler, Mischley and Sexton, (2016) findings showed that males use cannabis regularly and in larger amounts, in addition to that, men also reported using more hits in smoking sessions as compared to women. In a study conducted, results indicated that the evidence mostly invariably shows that the beginning of bipolar disorder mostly lead to cannabis use. However, some individuals may start off cannabis use with the aim of self medicating their features. Moreover, coexistence of cannabis use or cannabis use disorder

is mostly linked to a severe prognosis in the depressive episodes and bipolar disorder as well as manifestations of more suicidal (Kunhns et al., 2022).

In a research done by Ngaruiya, Abubakar, Kiptui et al. (2018), men were found to be the highest in using tobacco actively (n=468/605, 83.8%) and that the median age of beginning tobacco use was 21 years. In addition to that, older men who were of less education level, married and who have alcohol use history had higher chances of using tobacco actively as compared to the opposites. Similarly Amrita, Debjit, Arvind (2019) found that respondents with low-educational status were the most in tobacco use. Those in age bracket 50-59 are twice probable to participate in use of tobacco in contrast to those in age category of 18-29 years, indicating an increase in tobacco use with age increase (Ngaruiya, Abubakar, and Kiptui et al. 2018). On the other hand, Amrita, Debjit, Arvind (2019) suggested that the basic prevalence of the now users of tobacco is shown to be largest in age 25 to 34 years by 20% sequentially age 35 to 44 years by 17% whereas current tobacco consumers were highest in age 45-54, 35-44 then 55-64 respectively. Women had less chances of using tobacco since the male gender had roughly seven more times of being users of tobacco (Ngaruiya, Abubakar, Kiptui et al., 2018). The commonness in current usage of tobacco ranked between 3.8-19% (Gathecha, 2014).

Melchior, Chollet, Elidemir et al. (2015) findings concluded that unemployment can affect population rates of substance use, especially in youths with low level of education. This was similar to Lee, Hill, Hartigan et al. (2015) findings which indicated that the commonness in substance abuse is greater in unemployed in contrast to those employed. In a study done by Crump et al., (2021) adults who had drug use disorder or who's death was caused by suicide

were more apparently of age below 45 years; were mostly male; highly unmarried; had lower level of education; had alcohol use disorder or another mental illness and possible had multiple hospitalizations times or encounters in specialized clinics.

2.5.12 Psychotic disorders and mood disorders with psychotic features

A combination of psychological manifestations which lead to a loss of touch in reality is considered to be a psychosis (Van Os et al 2001; Calabrese & Al Khalili, 2019). The present knowledge is that even though about 1.5 – 3.5% of individuals will attain the criteria for the diagnosis of a psychotic disorder, a notable big fluctuating number at some point in their life will undergo not less than one psychotic signs (Van Os et al 2001; Calabrese & Al Khalili, 2019). Disorders of psychosis have about 3% lifetime prevalence (Perala, Suvisaari, Saarni et al, 2007; Sullivan, Kounali, Cannon et al. 2020). Average age onset for Schizophrenia was suggested to be 25-27 years globally while temporary psychotic disorders to be 30-35 years (Solmi, Radua, Olivola, et al., 2022). Barajas, Ochoa, Obiols et al. (2015) indicated that there were no gender distinctions in the commonness of schizophrenia in recent studies. However, Li, Ma, Wang et al. (2016) further stated that whereas females and males have the same prevalence of schizophrenia, many studies show that women's age of onset is roughly 3 to 5 years late than men. In addition to that, the male gender have a heightening start age of 21-25 years whereas the female gender have two heightening ages of onset at age 25 to 30 and just after age 45 (Li, Ma, Wang et al. 2016). The common occurrence of major depressive disorder and psychotic characteristics in the public population is approximated to be about 0.4% in contrast to schizophrenia which is about 0.46% (Heslin & Young, 2018). 18.5% of patients in a research done in European had attained the classification for major depressive disorder also met diagnosis criteria for major depression with psychotic features (Rothschild, 2013). In addition to that, a study carried out in the United

States indicated that patients who attained diagnosis classification for major depressive disorder represented by 14.7% also had a previous psychotic symptoms history (Rothschild, 2013). In a random sample research including 1342 patients of bipolar I disorder, a duration of life history of psychotic manifestations were found to be existing in about 73.8% which consisted of 68.9% of those with delusions while 42.6% of those with hallucinations (Van Bergen et al., 2019). Nevertheless, respondents who had hallucinations were noted to have had remarkable heightening rate of mistreatment in their childhood. Moreover, participants with psychotic signs in bipolar I disorder had a link with a previous onset of disease and more repeated inpatient care especially in those with manic incidences (Van Bergen et al., 2019). Whereas in another study, results indicated that mood congruent manifestations of psychosis in Bipolar disorder were linked with a more critical, for the most part manic illness development (Chaudhary, Parikh & Sharma, 2021). While considering the root cause of a psychosis, its treatment to a patient will majorly be different. Furthermore, a psychiatrist will need to assess any patient presenting with symptoms of psychosis. The golden rule management of psychotic incidences and disorders is the use of antipsychotic medications; however, the possible course of action in medication often mostly varies with the kind of presenting situation (Calabrese & Al Khalili, 2019).

2.5.13 Anorexia nervosa, binge eating disorder, bulimia nervosa

Eating disorders are known to be comparatively scarce in the community and getting help is commonly evaded or slowed up for instance in the case of denial experienced by those with anorexia nervosa or shame and stigma experienced by those with bulimia nervosa. Therefore the general inhabitant researches on eating disorders become expensive and unproductive due to the mentioned components (Smink, Van Hoeken & Hoek 2012; Hoek, 2016; Van Eeden, Van Hoeken & Hoek, 2021). The key psychopathological specifiers of binge eating disorder are in

particular, incidences whereby persons take in relatively a huge quantity of food in a joined span of time for example in under two hour span, at the same time undergoing inability to take charge of their ingestion tendency (DSM V, 2013; Giel et al., 2023). Whereas, bulimia nervosa is considered a critical mental illness which is distinguished by a person consuming food in a joined span of time and the food is considered to be too much as opposed to what the majority of people can eat under the same event; the individual also loses a sense of control while eating during that period. These binge eating incidences are commonly accompanied by a sense of guilt and shame, which mostly precipitates compensatory habits so as not to gain weight; for example self-inflicted throwing up, usage of laxatives or diuretics, exercising and even fasting (DSM V, 2013; Frank, 2020). The average onset age of anorexia nervosa, binge eating disorder and bulimia nervosa was stated to be 17-22 years (Solmi, Radua, Olivola, et al., 2022). However, Volpe, Tortorella & Manchia et al. (2016) indicated that anorexia nervosa was found to have an early onset of averagely 16.2 years whereas its late onset was at 23.6 years and having a cutoff point of age 22. A variety of psychological risky conditions were recognized in anorexia nervosa for instance, early years anxiety disorders, traumatic experiences (for example neglect, being assaulted sexually, physical abuse) childhood feeding challenges, temperamental characteristics for instance self control, overly perfect and harm prevention (Herpertz-Dahlmann, Seitz & Konrad, 2011; Frostad & Bentz, 2022). Other than that, staying in a culture whereby being thin is considered of high value for instance professions which need lean body types and being overly perfect such as sports and modelling appear to be linked with heightening chances of developing anorexia nervosa (Mitchell & Peterson, 2020; Trottier & MacDonald, 2017; Cost, Krantz & Mehler, 2020; Frostad & Bentz, 2022). Bulimia Nervosa on the other end was indicated to have an averagely early age onset of 16.3 years, but a mean age at onset to be 18.2 years and a cutoff

point of 24 years (Volpe, Tortorella & Manchia et al. 2016). This was almost similar to Ward, Rodriguez & Wright et al (2019) who indicated that first time cases of eating disorders occur by latest age 25 years although the disorder prolongs into later ages in life. Other than electrolyte distortions occurring from purging other health challenges are different depending with the style of purging. Nevertheless, bulimia nervosa has been noted to heighten the danger of developing a cardiorespiratory illness, in particular ischemic heart condition and mortality in the female gender (Tith, Paradis, Potter et al., 2020; Nitsch et al., 2021). Patients who suffer from binge eating disorder are inclined to be obese since they do not undergo purging after having a binge incident. As a consequence, most of the health conditions arising from binge eating disorder for instance high blood pressure, type 2 diabetes, non alcoholic fatty liver disease and metabolic syndrome are linked to obesity (Wassenaar, Friedman & Mehler, 2019; Nitsch et al., 2021). The persons who are obese and who look for habitual or invasive methods of losing weight management composed of about 30% do have co-existing binge eating disorder (Agh et al., 2015; Dawes et al., 2016; Giel et al., 2023). Contrary to this, most patients who have bulimia nervosa do have an ordinary body mass index. Hence, it can be challenging to conclude that the health challenges arising in binge eating disorder could be similar to those which happen in binge eating specific to bulimia nervosa (Bern, Woods & Rodriguez, 2016; Nitsch et al., 2021). In another study referenced that among the female gender, at about the age of 15 years is when the commonness of anorexia nervosa at great height (Smink, Van Hoeken, Donker et al., 2016; Petkova, Simic, Nicholas et al., 2019; Silen, Sipila, Raevuori et al., 2020; Van Eeden, Van Hoeken & Hoek, 2021).

Anorexia is reported to be about 0.35% of all females and about 0.1% of all males; Bulimia is about 1.5% in the female gender and 0.5% in the male gender while Binge eating is about 3.5%

in the female gender and about 2% in the male gender (Statistics & Research on Eating Disorders, 2019; Fang 2020). Similarly, the commonness of bulimia nervosa in a duration of life is estimated to be at 1.0% whereas its co-existing disorders in particular, anxiety disorders are at 80% as the highest, followed by 70% in mood disorders, then 60% in impulse control disorder and lastly a 40% co-occurring with substance use disorder (Husdon, Hiripi, & Pope et al., 2007; Frank, 2020). However, Van Eeden, Van Hoeken & Hoek, 2021 concluded that anorexia nervosa and bulimia nervosa happen in both genders internationally, despite the age category and is commonly linked to a heightening death probability. Riquin, Raynal, & Mattar et al. (2021) linked Anorexia nervosa with some mental illnesses coexistence including the disorder of major depression in about 64% of the participants while having not more than one disorder of anxiety in about 72% of the participants and an obsessive-compulsive illness in about 62% of the respondents. Moreover its prevalence ranges at intervals of 1-10% subject to one's culture (Calvo-Rivera, Navarrete-Paez, & Bodoano et al. 2022). Immediate starting of professional management is important since early involvement enhances the end result (McClelland et al., 2018; Frostad & Bentz, 2022). One of the central components for anorexia nervosa management is outpatient psychotherapy services since it is more affordable and less troublesome as compared to other more exhaustive degree of care (Dalle et al., 2021; Frostad & Bentz, 2022). Empirical based managements for binge eating disorder, encouraged by the worldwide instructions comprises psychological psychotherapy; specifically cognitive behavior therapy as well as medicinal treatment using the second generation antidepressants, anti convulsants in particular zonisamide and topiramate and zonisamide), Central nervous system catalyst such as lisdexamfetamine and anti-obesity medicines (orlistat) (NICE, 2017; Hay et al. 2014; Hilbert, Hoek & Schmidt, 2017; Giel et al. 2023). For bulimia nervosa, some of the management of

choice includes selective serotonin reuptake inhibitor (SSRI), cognitive behavioral therapy, interpersonal therapy, and fluoxetine however, it is estimated that around 50% do have a constantly recurring course or are only halfway recovered. Therefore, the management outcome is moderate since there is also a lack of medicinal strategies which aims at bulimia nervosa as a single management or in combining with behavioral strategies (Frank, 2020).

2.5.14 Antisocial personality disorder

ASPD commonly known as antisocial personality disorder is explained by a sequence of socially unacceptable, exploiting and unremorseful conduct (Black, 2015). Even though the accurate root cause is not known, genetic make-up and surrounding components are considered part of what leads to the occurrence of antisocial personality disorder. Nevertheless, a variety of research conducted in former times indicated contrary approximations of inheritability from roughly 38-69%. In addition, harsh early years occurrences in particular; sexual and physical abuse and also abandonment, inclusive of early years psychiatric illness such as conduct disorder and attention deficit hyperactivity disorder (DeLisi, Drury & Elbert, 2019; Fisher & Hany, 2023). A probable lifetime incidence of antisocial personality disorder in the public population is estimated to be about 1-4% and with an annual incident rate of about 2-3.3% (APA, 2013; Werner, Few & Bucholz, 2015). It is commonly diagnosed in the age range of 18-32 years. In reference to an epidemiologic catchment region analysis, 2% to 4% of males and 0.5% to 1% of the female gender achieved DSM-III-R diagnosis classification of ASPD (Chang, Li, 2021). This was similar to Lenzenweger, Lane, Loranger et al 2007; Fisher, Hany, 2023) who pointed out the probability of lifetime incident of ASPD in the public population to be 1-4%. Gender was noted to be biased against men whereby men had about 3-5 chances of having ASPD unlike women

with 6% rate in males and 2% rate in females in the public population (Compton, Conway, Stinson et al. 2005; Fisher, Hany, 2023). Moreover, antisocial personality disorder diagnosis indicated a notable connection with substance abuse (Fisher, Hany, 2023). Literary information leads to the belief that early management startegies of conduct disorder in childhood as the most affordable and more efficacious method when managing antisocial personality disorder (Frick, 2016; Fisher & Hany, 2023). However, there's little verification in existence to back up the use of a specific psychological management of ASPD in adults (Gibbon et al., 2010; Gibbon et al., 2020; Fisher & Hany, 2023). Gibbon et al., (2020) concluded that only three management strategies in particular; contingency management, social management and dialectical behavioral therapy indicated proof that management could be more efficacious as compared to the control condition. However, there was no specific management which detailed compulsive confirmation of modification in antisocial behavior. In addition to that, there is no medicinal management that has indicated to nurse ASPD, however; pharmacological methods are particularly commended for the management of co-existing conditions.

2.6 Theoretical model

2.6.1 Biopsychosocial model

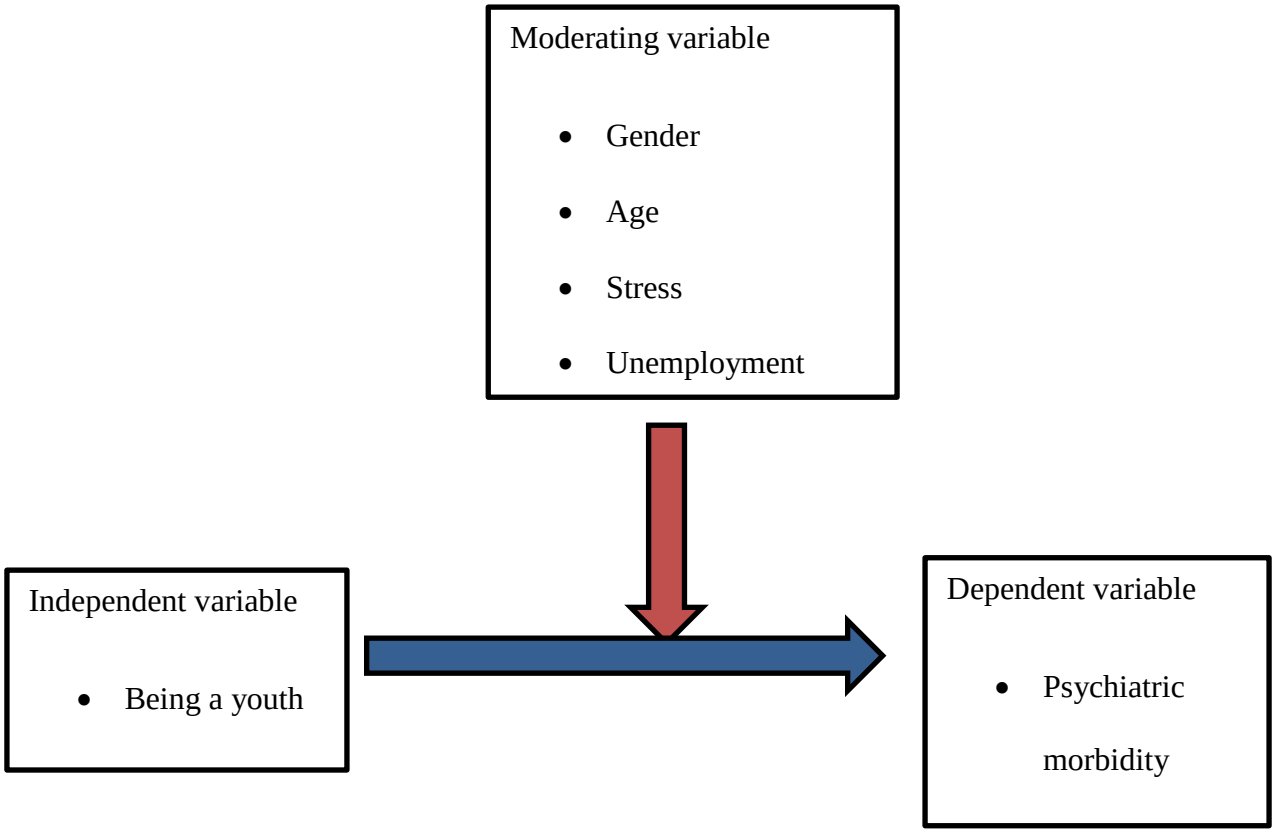
A scientific journal publish was done by the American pathologist and psychiatrist known as Geroge Engel in the 1977 on: "The need for a new medical model: A challenge for biomedicine", therefore, establishing the word Biopsychosocial model (Papadimitriou, 2017). The model is a multidisciplinary and all round theory which propounds the correlation in the biological, psychological and social surrounding impact on the well being and ill health (Frazier, 2020). It is considered in all likelihood to be the main extensively noted and practiced model in studies, in recovery as well as dysfunction in particular chronic pain, mental illness and most

likely functional illnesses (Alvarez, Pagani & Meucci, 2012; Wade & Halligan 2017) hence why it was chosen as a theoretical model for this study. A patient's susceptibility and ill health development and graveness can be jointly ascertained by psychosocial factors. Nevertheless, the biopsychosocial puts into consideration the link with inherent predisposition, temperament, stressful situations and overall with the patient's interactional circumstances. Components in one's setting heightens the chances of the objective appearance of a psychiatric illness, taking part in the starting time of the ill health signs, and they may even hinder a susceptible individual from developing an illness (Papadimitriou, 2017). The findings of a study conducted by Tong, Sung & Sanchez (2019) indicated that the outcome encourages the usage biopsychosocial model in comprehending the sense of community in individuals who have serious psychiatric disorder (Tong, Sung & Sanchez, 2019). Monteiro (2015) suggested the extension of this theory of clinical and study implementation in psychiatry so as to center on the socio cultural and spiritual aspects which are considered the foundation of most traditional descriptive models of psychiatric disorders in Africa as well as key considerations of disease, health and holistic. Even though it is not so global, the usage of this theory in classifying methodologies and instructions, encourages its validity as an administration equipment and its heightening application in research pertaining complicated well being interventions encourages its rationality as a scientific and descriptive (Alvarez, Pagani & Meucci, 2012; Wade & Halligan 2017).

2.7 Conceptual framework

In this study youths are the Independent variable whereas psychiatric morbidity is the dependent variable as presented on figure 2.1

Figure 1: Conceptual framework



My conceptualization is that: the independent variable; youths being seen at Nakuru Level 6 hospital may cause the dependent variable which is psychiatric morbidity such as depression, anxiety and so on. However, factors such as gender, age, stress and unemployment may enhance both the independent and dependent variable.

2.8 Justification of the study

The main goal of this research is to indicate the psychiatric morbidity among youth outpatients at Nakuru level 6 Hospital. Many people are suffering from undiagnosed mental illnesses, screening them for various mental disorders is a step towards gathering necessary data, and for

better approaches in mental health to be enforced by the government as its obligation, this type of research has to be conducted so that a scheme can be outlined from the study's results.

There is some disproportion in the research of mental well-being in accordance to the burden of psychiatric illnesses however, this is even worse in the low and middle revenue nations (Ahmed & de Jesus Mari, 2014). Hence, this research will help in having well-documented and updated information about the alarming rate of mental illnesses among the youths at the site of study which will be additional to existing literature and filling the knowledge gaps. Therefore, this study will solely focus on the youths of age bracket 18-35, so as to be able to understand how psychiatric illnesses are a burden to them and what the morbidity at the Nakuru Level 6 Hospital stands at.

2.9 Significance of the study

In overall, the results of this study will inform policy makers in enhancing policies that will strengthen the psychological mental health of youths (18-35 years) in response to psychiatric morbidity rate in Nakuru level 6 hospital and other similar hospitals. It will also give insight to youths who are not aware of their mental health status; to take caution and seek the necessary help for those in need.

2.10 Overall Research Question

What is the psychiatric morbidity among youth patients at Nakuru Level 6 Hospital?

2.11 Specific Research Questions

1. What are the socio-demographic profiles of youth patients at Nakuru level 6 Hospital?
2. What is the prevalence of psychiatric morbidity among the youth patients at Nakuru Level 6 Hospital?

3. What is the association between socio-demographic features and psychiatric disorders among the youth patients at Nakuru Level 6 Hospital?

2.12 Main Objective

To determine the psychiatric morbidity among psychiatric youth patients at the Nakuru Level 6 Hospital

2.13 Specific Objectives

1. To determine the socio-demographic profiles of youth patients at Nakuru Level 6 Hospital
2. To describe the prevalence of psychiatric disorders among youth patients at Nakuru Level 6 Hospital
3. To determine the association between the socio-demographic characteristics and psychiatric disorders of youth patients at Nakuru Level 6 Hospital

3.0 CHAPTER THREE

METHODOLOGY

3.1 Study design

In this study, a cross sectional descriptive method was used. This design helps in testing the relationship between a risk factor and a disease (Omair, 2015). This study centered on determining psychiatric morbidity among youth patients in Nakuru Level 6 hospital. However, the limitation with this design is that, it's impossible to conclude causation since it's carried out in one point in time and gives no suggestion of the series of events (Levin, 2006). That is; if the vulnerability transpired before, after or during the beginning of the disease outcome.

3.2 Study area

This research was done in Nakuru level 6 hospital located in Nakuru City. Nakuru level 6 hospital was initially a military hospital which was founded in 1906; in 1956, it became gazetted as a general public hospital. In addition, the hospital adjusted from being a level 5 hospital to a level 6 hospital in 2019, making it a national referral hospital. It is situated along Nakuru-Sigor London area. Nakuru level 6 hospital is considered a facility of greatness in providence of quality medical care, teaching practices and even research areas in the fields of health. It has different sections providing different services such as the psychiatric unit, Comprehensive care clinic, general medical wards, radiology unit, maternity unit, pediatric unit, Oncology unit, Renal unit and the casualty for general medical conditions. It facilitates great clinical exposure to students doing Medicine from Egerton University as well as other Universities, psychologists,

occupational therapists and student nurses. It is considered the largest hospital in Nakuru and it attends to over 300, 000 outpatients annually.

3.3 Study population

The target population for this study was youth aged 18-35 years being seen at the outpatient Nakuru Level 6 hospital.

3.3.1 Inclusion criteria

The criteria used for inclusion involved all patients in the age bracket of 18-35 years who were at the causality area of Nakuru Level 6 hospital and who were not too sick to understand, to consent or to take part in the research.

3.3.2 Exclusion criteria

The method used for exclusion included all youths below 18 years or those above 35 years, patients who were too sick to participate in the process and those who did not consent to it.

3.4 Variables

Dependent variable: Includes psychiatric morbidity e.g. Depression, Bipolar mood disorder

Moderating variable: Gender, age, stress, unemployment

Independent variable: Being a youth

3.5 Sample size and sampling procedure

A simple random sampling technique was used so as to randomly select respondents, hence providing an equal chance for participation to the target population.

The sample size was found using Cochran's formula (1977)

$$n = \frac{z^2 * \hat{p}(1-\hat{p})}{\varepsilon^2}$$

Whereby:

- n indicates the size of sample
- z represents the z-score
- $\hat{p}$ indicates the population proportion
- ε represents the confidence interval or margin of error

$$n = \frac{1.96^2 * 0.50(1-0.50)}{0.05^2}$$

$$\boldsymbol{n = 385}$$

- z equals 1.96 using a margin error of 5%
- $\hat{p}$ = 50% or 0.50
- ε = 5% or 0.05

3.6 Recruitment procedure

On approval of the proposal by the University of Nairobi-Kenyatta National Hospital ethics and Research Committee (KNH-UON ERC), the researcher sought to obtain an introduction letter from the department of Psychiatry. The researcher applied for permit from NACOSTI which was then presented to the Nakuru level 6 hospital upon approval. The Nakuru level 6 hospital management team was informed about the researcher's goals within their institution and the importance of the study hence aiming at obtaining a permit to conduct the research.

The study respondents were recruited from the outpatients being seen at Nakuru Level 6 hospital. After the researcher obtains a permit to conduct the study at the hospital, she informed the nurse in charge so that he/she would be able to assist the researcher with daily patient's registration details so as to have a specific target. Using simple random sampling technique the researcher sought to acquire a complete list of all registered outpatients at the hospital. With the help of Excel, the researcher randomly generated numbers for each element then used a lottery method to randomly pick participants until required sample size was achieved. The sample size was proportionately divided according to the ratio of the population hence everyone had a uniform likelihood of getting chosen. This included a ratio in terms of gender in the population of study.

Participants were explained to about the study and its significance. Matters on confidentiality, anonymity and freedom of refusing to participate were stated. Respondents were issued a consent form to go through voluntarily and on agreeing to participate they signed it. Those who did not consent were thanked and next participant was sought for. Those who were not yet seen by the doctor and were on que, those who were already checked by the doctor and those who were waiting for their lab results were targeted for the recruitment. All participants eligible for the study, both new and those for follow-up were recruited. For inclusion and exclusion criteria,

screening was done based on age category of 18-35 years. The M.I.N.I tool was administered together with a socio-demographic data collection sheet which took approximately 20 minutes. All Covid-19 protocols were observed for the safety of the participants.

3.7 Data Collection Procedures

This research was done using primary data by using the English version seven of MINI International Neuropsychiatric Interview, for Diagnostic and Statistical Manual of mental disorders-five (DSM-5) assessment tool. The research instrument was first tested in the field before being used in the actual data collection. It was delivered according to the research objectives where by study data was acquired by administering the assessment tool to the youths of age bracket 18-35 years, at the Nakuru level 6 hospital casualty areas. The MINI assessment tool took approximately 20 minutes to administer. It contained 17 different categories of mental disorders with specific questions tailored for the participant to answer so as to know whether he/she met the criteria or not. Respondents were answering either a yes or no as per the tool's questions. Depending on the given answer to the first question of the assessed psychiatric disorder, the participant either continued with the assessment by proceeding to the next questions or ended that assessment and proceeded to the following psychiatric disorder assessment questions. This method helped participants remain with the categories met for their specific mental disorders. All 17 categories of the assessment tool were covered to ensure full completion of the data collection. Each respondent had their own sheets of the assessment questions from MINI International Neuropsychiatric Interview; hence collected data provided clarity during data analysis avoiding errors. While finishing the procedure, respondents were thanked for their cooperation and feedback. Data collected data were safely put in a lock and key drawer until the research process ended.

3.8 Pilot Study

The pilot study for this research was carried out to examine the study instrument and procedures to be used. This was carried out on a number of youths, from a hospital in Nakuru. It was important to do this so as to test the reliability and validity of the research instruments as well as feasibility of the study.

3.9 The Instrument

The version seven of MINI Instrument Neuropsychiatric Interview is a short organized diagnosis assessment tool whose author is Dr. Sheehan D.V (2015) and it contains 17 disorders recognized as modules that are presented with alphabetic letters on each diagnostic criterion. Fitting into one of its category of disorders is described as psychiatric morbidity (Kwobah, Epstein & Mwangi et al., 2017), which is what was used to measure psychiatric morbidity in this study. The researcher keyed in the patient's personal information on its section before starting the interview which took about 15 minutes to administer. An instruction provided on how to use it was followed as well as utilization of the screening questions provided at the beginning of each disorder. Using the provided box after each module, it was indicated whether a disorder's criteria have been met or not. All provided questions were rated as either yes or no by circling it, and coding the responses as per the clinical judgement. Whenever a patient answered yes, a point was scored. Moreover, respect towards diversified cultural beliefs of different patients was enhanced during interviewing and rating of responses as well as the use of examples and questions from patients for further clarifications. In addition to that, time, regularity, severity and alternatives were also keenly considered.

3.10 Reliability and Validity of the research instrument

A study which aimed in identifying the reliability and validity of the MINI instrument in association with the structured Clinical interview for DSM-III-R patients (SCID-P) indicated that the results supported the validity and reliability of the MINI; and the research results also supported the test-retest and inter-rater reliability of the MINI (Sheehan et al., 2020). It has also been embraced in the clinical setting (Aboraya 2009; Aboraya 2016). The DSM-5 version seven of MINI instrument was used by Kwobah, Steve and Mwangi et al., in 2017 whereby it was administered to 420 adults who consented in being tested for the commonness of mental morbidity in a district representative in the Western side of Kenya. It was also used by Wafula et al., (2020) in Moi referral and teaching hospital, in researching on the vulnerability components of mental morbidity and demography attributes in patients having facial bruises. In 2020, the instrument was also used in Southern Ethiopia as a gold standard reference in identifying psychological measurements of alcohol use disorder classification screening test instrument in health care outpatients in the University of Dilla referral hospital (Habtamu & Madoro, 2022).

These references indicated that the research instrument has contents that can address the study objectives since it has stability and consistency. The researcher also sought help and guidance from the university supervisor.

3.11 Study duration

This study took a period of three months from when it was approved by the Ethics committee.

3.12 Quality assurance procedure

The research proposal was reviewed by the University of Nairobi; Psychiatry department and Kenyatta National Hospital, the University of Nairobi Ethics and Research Committee (KNH-

UON ERC). The ethics and research committee ensured that the proposal passed the quality threshold and the researcher fully understood their area of study, including potential risks and benefits.

The researcher is a postgraduate student at the University of Nairobi and underwent training on the research methods, data collection tools needed for the study and the researcher worked working under the supervision of University of Nairobi Supervisors.

The researcher also ensured that collected data as well as research materials were stored in a lock and key cabinet and only accessible to the researcher as hardcopies. Soft copies were stored in a password protected Microsoft database to maintain the confidentiality and anonymity of respondents in the research study.

Double entry and checking procedures was done to reduce errors. The results of the research were presented to the University of Nairobi; Psychiatry department and Kenyatta National Hospital, the University of Nairobi Ethics and Research Committee (KNH-UON ERC) for peer review.

3.13 Ethical Considerations

The researcher sought a go ahead from KNH-UON ERC; Kenyatta National Hospital (KNH), the University of Nairobi Ethics and Research Committee. Participation in the research was optional and respondents were well informed that they could stop participation if they wished to. This was communicated to them before the commencement of the study. All measures were taken to ensure that the participant's information remains confidential. Names were coded instead of using real names and assembled data was filed in a lock and key drawer whereby the only authorized individual to access was the researcher. Any information keyed in from participants,

in computer devices was protected by use of passwords only known by the researcher. A portion of some participant could have felt sections of asked question to be discomforting and therefore cause them psychological stress. The questions asked were sensitive to the respondent's feelings. In the event that they were uncomfortable with a question, they were put under no obligation to respond if they so wish. The researcher provided brief counselling or referred participants for further psychosocial support if need be. Moreover, no physical harm was inflicted to any respondent during the study. Covid-19 guidelines were adhered to, for the safety of the study population.

3.14 Data Management and Analysis Procedure

Researcher checked for completeness while still in the field. Any missing information was filled in before leaving the site. Data collected was entered into MS-Excel where numeric identification code was used to identify respondents. All filled in questionnaires was stored in lockable cabinets which was only accessible to the researcher. The database was set up and also evaluated through version 23 of SPSS. Findings were presented in descriptive narrative, charts, graphs and tables. A bivariate and multivariate analysis was done for inferential statistics.

3.15 Study limitations

This study applied a cross sectional methods hence it's impossible to conclude causation since the research was done at a specific date time and gives no suggestion of the series of events that transpired before, after or during the beginning of the disease. Therefore, a longitudinal is important in the hereafter to comprehend the certain cause and effect link. The study population included youths of age bracket 18-35 years seen at Nakuru level 6 hospital hence data obtained cannot be generalized to the rest of population out of the mentioned age bracket. More studies may be needed on the age brackets out of the study population to solve this limitation. Some

participants who felt uncomfortable answering some questions which appeared to be sensitive to them hence answering in a socially acceptable manner hence giving a false response; were assured on confidentiality and anonymity of their provided information to ease on the tension brought about by this limitation.

3.16 The Study Flow chart

Figure 2: **Study flow chart**

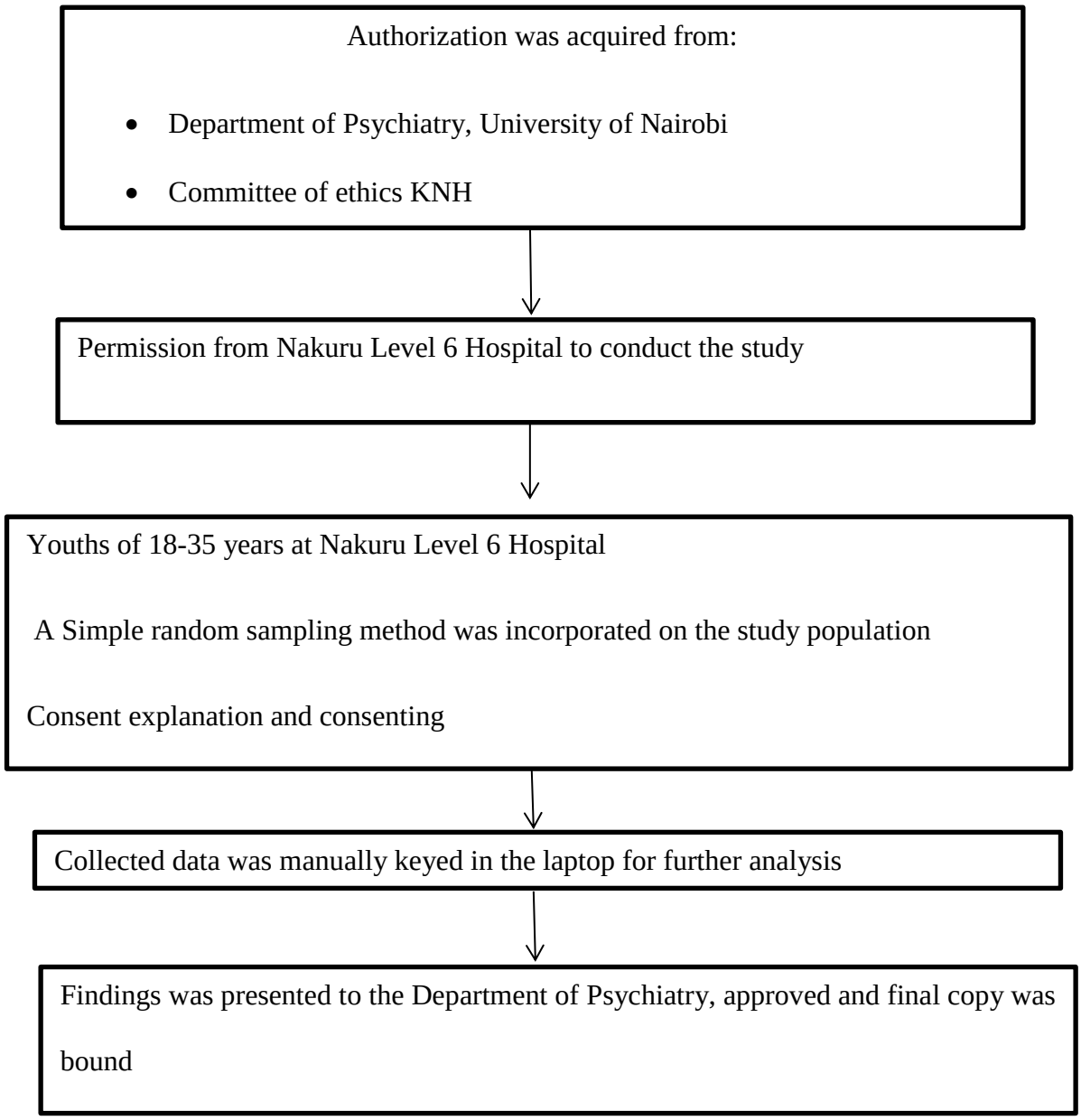


Table 1: Dummy data collection sheet

CATEGORY	CHARACTERISTICS	NUMBER	
INTERVIEWER I.D		**1-385**	
LOCATION	Sub location, Ward, village		
AGE GROUP	18-23 24-29 30-35		
GENDER	MALE FEMALE		
MARITAL STATUS	SINGLE MARRIED WIDOW/WIDOWER DIVORCED/SEPARATED		
EDUCATION LEVEL	NONE LEVEL PRIMARY NOT COMPLETED PRIMARY COMPLETED LEVEL SECONDARY NOT COMPLETED SECONDARY COMPLETED TERTIARY COMPLETED LEVEL TERTIARY AND ABOVE		
EMPLOYMENT STATUS	EMPLOYED UNEMPLOYED		

	SELF-EMPLOYED		
RELIGION	CHRISTIAN MUSLIM ATHEIST		
	OTHERS		
TOTAL			

3.18 Psychiatric morbidity in association with socio-demographic characteristics dummy

Table 2: Dummy table on psychiatric morbidity in association with socio-demographic characteristics

Variable	MDD	BMD	Schizophrenia	Anxiety	Others
Age group					
Gender					
Marital status					
Education level					
Employment status					
Religion					

3.19 Common psychiatric morbidity dummy

Table 3: Dummy table for common psychiatric morbidity

Common psychiatric morbidity	MDD	BMD	Anxiety	Schizophrenia	Others

3.20 Study Timelines

Table 4: study timelines

OCCURRENCES	TIMING
Research proposal development and departmental defense	May-August 2022
Proposal presentation, authorization by ethics and clearance	September-November 2022
Pilot study	December 2022
Data assembling	January-March 2023
Data cleaning, entry and analysis	March 2023
Defense of results and thesis preparation for submission	March-May 2023

3.21 Study Budget

Table 5: Budget

OBJECT	NUMBER	PRICING	AMOUNT
Arranging of data collection instruments	Printing data collection sheet 1 page Photocopying data collection sheet 9,316	@10 @5	10 46,580
Public transport trips to Nakuru Level 6 Hospital	50 trips	@200	10,000
Statistician	1 person	@28,000	28,000
Printing of thesis	80 pages	@10	800
Photocopying of thesis	240 pages	@5	1,200
Binding of thesis	3	@700	2,800
Sub total			89,390
Contingencies	11% of budget		8,939
TOTAL			98,329

4.0 CHAPTER FOUR

RESULTS

A sum of 385 participants was engaged for the study. The resulting findings to this research were outlined in accordance to the objectives of the study as follows:

1. Socio-demographic profiles of youth patients at Nakuru level 6 Hospital
2. The prevalence of psychiatric disorders among youth patients at Nakuru Level 6 Hospital
3. The association between the socio-demographic characteristics and psychiatric disorders of youth patients at Nakuru Level 6 Hospital

4.1 Socio demographic profiles of study participants

Table 6: Socio demographic characteristics of study respondents

Socio-demographic profiles	**Categories**	**Frequency**	**Percentage (%)**
Gender	**Female**	213	55.3
	Male	172	44.7
	Total	385	100
Age group	**18-23**	122	31.7
	24-29	151	39.2
	30-35	112	29.1
	Total	385	100

Marital status	**Single**	206	53.5
	Married	160	41.6
	Widow/widower	5	1.3
	Divorced/separated	14	3.6
	Total	385	100
Education level	**None**	3	0.8
	Primary not completed	10	2.6
	Primary completed	30	7.8
	Secondary not completed	44	11.4
	Secondary completed	149	38.7
	Tertiary not completed	86	22.3
	Tertiary completed	63	16.4
	Total	385	100
Employment status	**Employed**	72	18.7
	Self-employed	138	35.8
	Unemployed	175	45.5
	Total	385	100
Religion	**Christian**	354	91.9
	Muslim	20	5.2
	Atheist	5	1.3
	Others	6	1.6
	Total	385	100

There was a high number of female (55.3%) compared to male (44.7%) participants. The greater sums of the respondents were of age category 24-29 years (39.2%) followed by age group 18-23 (31.7%) and age group 30-35 years (29.1%). Furthermore, most were single (53.5%), married (41.6%), widow/widower (1.3%), divorced/separated (3.6%). Most participants (38.7%) had completed secondary level of education, 22.3% tertiary not completed, 16.4% tertiary completed, 11.4% secondary not completed, 7.8% primary completed, 2.6% primary not completed and 0.8% no level of education. Almost half (45.5%) were unemployed, self-employed comprised (35.8%) while less than a quarter of the participants (18.7%) were employed. Majority of (91.9%) were Christians, 5.2% of Muslims, 1.6% belonged to other faiths and 1.3% of Atheists.

4.2 Prevalence of psychiatric disorders among youth patients at Nakuru Level 6 Hospital

Table 7: Prevalence of psychiatric morbidity among youth patients

Variable	Frequency	Percentage (%)
Major Depressive Disorder	84	21.8
Suicidality	34	8.8
Alcohol use disorder	33	8.6
Suicidal behavior disorder	32	8.3
Post-traumatic stress disorder	24	6.2
Generalized anxiety disorder	20	5.2
Social anxiety disorder	19	4.9
Panic disorder	12	3.1

Manic and hypomanic episodes	9	2.3
Agoraphobia	9	2.3
Obsessive compulsive disorder	9	2.3
Substance use disorder (non-alcohol)	8	2.1
Psychotic disorders lifetime	7	1.8
Antisocial personality disorder	4	1
Mood disorder with psychotic features lifetime	3	0.8
Binge eating	3	0.8
Psychotic disorders Current	2	0.5
Mood disorders with psychotic features current	2	0.5
Anorexia nervosa	2	0.5
Bulimia nervosa	1	0.3

The prevalence of psychiatric morbidity

The psychiatric illness with the highest prevalence was major depressive episode (21.8%) and systematically followed by; suicidality (8.8%), alcohol use disorder (8.6%), Suicidal behavior disorder (8.3%), Post-traumatic stress disorder (6.2%), GAD/Generalized anxiety disorder (5.2%), SAD/Social anxiety disorder (4.9%), panic disorder (2.9%), Manic and hypomanic episodes (2.3%), Agoraphobia (2.3%), OCD/Obsessive compulsive disorder (2.3%), SUD/Substance use disorder (non-alcohol)(2.1%), Psychotic disorder lifetime (1.8%), antisocial personality disorder (1%), mood disorders with psychotic features lifetime (0.8%), Binge eating disorder (0.8%), psychotic disorders current (0.5%), Anorexia nervosa (0.5%) , mood disorders with psychotic features current (0.5%) and Bulimia nervosa (0.3%).

4.3 Ruling out category for organic, medical, and drug causes on all disorders

Table 8: Ruling out category for psychiatric morbidity

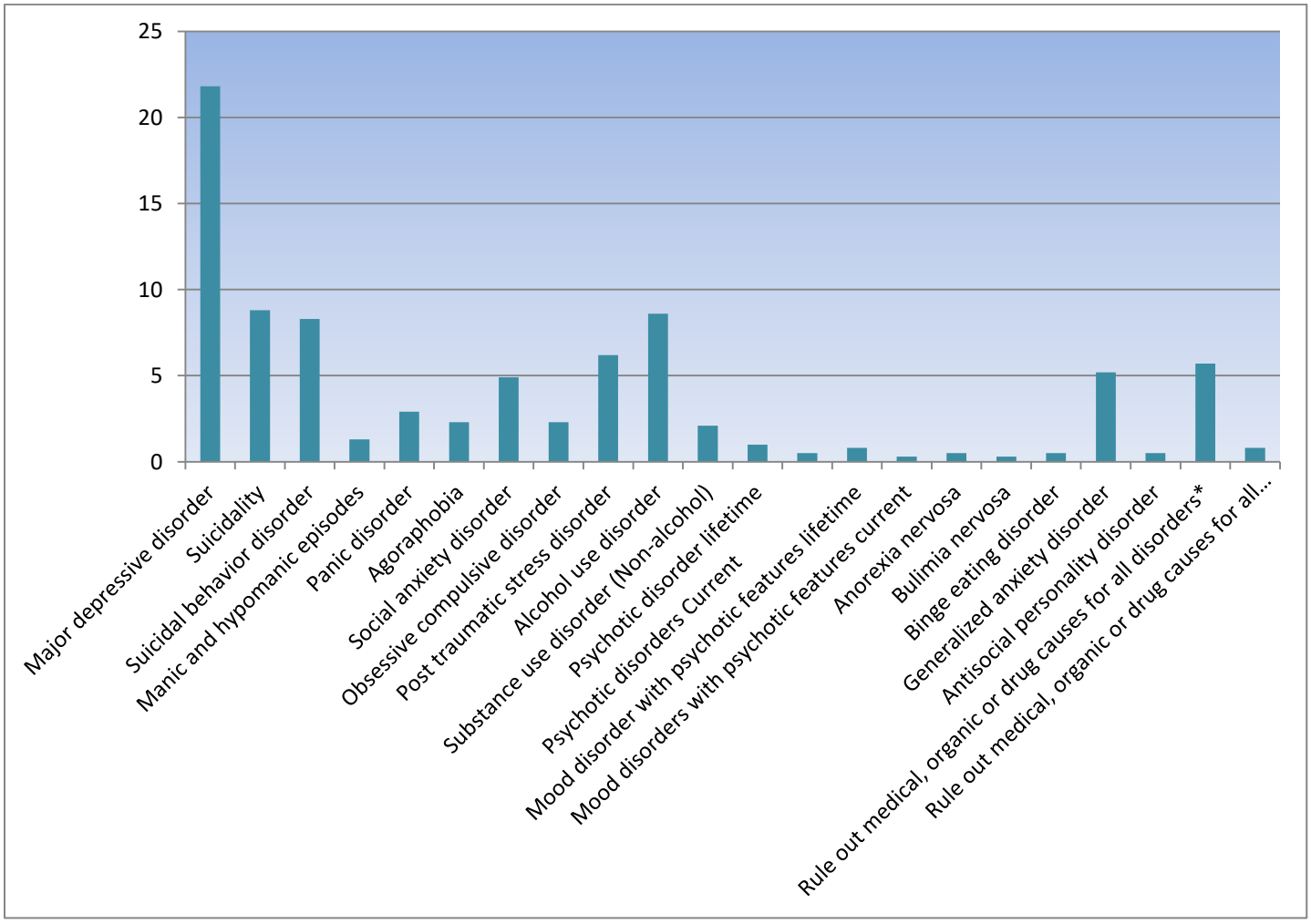
Ruling out category	**Frequency**	**Percentage**
Ruling out organic, medical, and drug causes for all disorders*No	22	5.7
Ruling out organic, medical, and drug causes for all disorders*uncertain	3	0.3
Ruling out organic, medical, organic and drug causes for all disorders*Yes	360	93.5
Total	**385**	**100**

22 (5.7%) of participants rated a no for ruling out organic, medical, and drug causes on all disorders hence their psychiatric diagnosis being possibly caused by their ailing symptoms.

3(0.8%) of respondents rated uncertain for ruling out organic, medical, and drug causes on all disorders hence their psychiatric diagnosis being uncertain whether it's events in their life causing it or the presenting medical conditions.

360(93.5%) of respondents rated a yes for ruling out organic, medical, and drug causes on all disorders hence their diagnosis was not caused by any medical, organic or drug causes.

Figure 3: Prevalence of psychiatric morbidity among youth patients



4.4 Psychiatric morbidity

Table 9: Psychiatric morbidity among youth patients at Nakuru level 6 hospital in age 18-35 years

Psychiatric morbidity	**Frequency**	**Percent**
Psychiatric morbidity absent	206	53.5
Psychiatric morbidity present	179	46.5
Total	**385**	**100**

As indicated above, the prevalence of psychiatric morbidity among youth outpatients at Nakuru level 6 hospital was 46.5 %. 179/385 youth patients met criteria for psychiatric morbidity.

4.5 Psychiatric comorbidity

Table 10: Psychiatric comorbidities among youth patients

Number of comorbidity	**Frequency**	**Percent**
0	206	53.5
1	103	26.8
2	38	9.9
3	26	6.8
4	12	3.1
Total	**385**	**100**

Most of the participants had met a single diagnosis criterion by 26.8% (103), 9.9% (38) had 2 comorbidities, 6.8% (26) had 3 comorbidities while 3.1% (12) had 4 comorbidities.

4.6 The association between the socio demographic characteristics and psychiatric disorders

A. Major depressive episode

Table 11: Major depressive episode versus socio-demographic characteristics bivariate analysis

Socio-demographic profiles		No major depressive episode	Yes major depressive episode	P-value
Gender	Female	166(77.9%)	47(22.1%)	0.896
	Male	135(78.5%)	37(21.5%)	
Age	18-23	103(84.4%)	19(15.6%)	
	24-29	127(84.1%)	24(15.9%)	0.000
	30-35	71(63.4%)	41(36.6%)	
Marital status	Single	171(83.0%)	35(17.0%)	
	Married	121(75.6%)	39(24.4%)	0.000
	Widow/widower	4(80.0%)	1(20.0%)	
	Divorced/separated	5(35.7%)	9(64.3%)	
Education level	None	1(33.3%)	2(66.7%)	
	Primary not completed	4(40.0%)	6(60.0%)	
	Primary completed	22(73.3%)	8(26.7%)	
	Secondary not completed	32(72.7%)	12(27.3%)	0.010

	Secondary completed	116(77.9%)	33(22.1%)	
	Tertiary not completed	73(81.4%)	13(18.6%)	
	Tertiary completed	53(84.1%)	10(15.9%)	
Employment status	Employed	55(76.4%)	17(23.6%)	0.296
	Self-employed	103(74.6%)	35(25.4%)	
	Unemployed	143(81.7%)	32(18.3%)	

Age with a (P=0.000), marital status with a (P=0.000) and education level with (P=0.010) were significantly related to major depressive episode. Majority 41 (36.6%) of the participants aged 30-35 years had major depressive episode. Respondents who were divorced/separated 9 (64.3%) had a high number of major depressive episodes as opposed to other marital statuses. A greater sum of the respondents with a secondary level of education and below recorded the highest number of major depressive episode as compared to those of tertiary level and above. Employment status and gender were not found to be statistically related to major depressive episode.

B. Suicidality

Table 12: Suicidality versus socio-demographic characteristics bivariate analysis

Socio-demographic profiles		**No suicidality**	**Yes suicidality**	**P-value**
Gender	Female	197(92.5%)	16(7.5%)	0.310
	Male	154(89.5%)	18(10.5%)	
Age	18-23	113(92.6%)	9(7.4%)	0.663
	24-29	138(95.4%)	13(4.6%)	
	30-35	100(89.3%)	12(10.7%)	

Marital status	Single	192(93.2%)	14(6.8%)	
	Married	145(90.6%)	15(9.4%)	0.003
	Widow/widower	5(100.0%)	0(0.0%)	
	Divorced/separated	9(64.3%)	5(35.7%)	
Education level	None	3(100.0%)	0(0.0%)	
	Primary not completed	8(80.0%)	2(20.0%)	
	Primary completed	29(96.7)	1(3.3%)	
	Secondary not completed	37(84.1%)	7(15.9%)	0.348
	Secondary completed	136(91.3%)	13(8.7%)	
	Tertiary not completed	81(94.2%)	5(5.8%)	
	Tertiary completed	57(90.5%)	6(9.5%)	
Employment status	Employed	66(91.7%)	6(8.3%)	
	Self-employed	126(91.3%)	12(8.7%)	0.977
	Unemployed	159(90.9%)	16(9.1%)	

Marital status showed a statistically inferable link with suicidality (p=0.003). In those who were divorced/separated 5(35.7%), exhibited high rate of suicidality followed by those who were married 15(9.4%).

C. Post-traumatic stress disorder

Table 13: Post-traumatic disorder versus socio-demographic characteristics bivariate analysis

Socio-demographic profiles		No PTSD	Yes PTSD	P-value
Gender	Female	195(91.5%)	18(8.5%)	0.045
	Male	166(96.5%)	6(3.5%)	
Age	18-23	115(94.3%)	7(5.7%)	
	24-29	142(94.0%)	9(6.0%)	0.892
	30-35	104(92.9%)	8(7.1%)	
Marital status	Single	198(96.1%)	8(3.9%)	
	Married	147(91.9%)	13(8.1%)	0.005
	Widow/widower	3(60.0%)	2(40.0%)	
	Divorced/separated	13(92.9%)	1(7.3%)	
Education level	None	3(100.0%)	0(0.0%)	
	Primary not completed	9(90.0%)	1(10.0%)	
	Primary completed	27(90.0%)	3(10.0%)	
	Secondary not completed	40(90.9%)	4(9.1%)	0.781
	Secondary completed	139(93.3%)	10(6.7%)	
	Tertiary not completed	82(95.3%)	4(4.7%)	
	Tertiary completed	61(96.8%)	2(3.2%)	
Employment status	Employed	71(98.6%)	1(1.4%)	
	Self-employed	123(89.1%)	15(10.9%)	0.012
	Unemployed	167(95.4%)	8(4.6%)	

Gender with a (P=0.045), Marital status (P=0.005) and employment status having (P=0.012) were significantly associated with PTSD. A higher percentage (8.5%) of female participant, 2 (40.0%) of widowed/widowers and 15 (10.9%) self-employed participants had PTSD.

D. Alcohol use disorder

Table 14: Alcohol use disorder versus socio-demographic characteristics bivariate analysis

Socio-demographic profiles		**No AUD**	**Yes AUD**	**P-value**
Gender	Female	204(95.8%)	9(4.2%)	0.001
	Male	148(86.0%)	24(14.0%)	
Age	18-23	116(95.1%)	6(4.9%)	
	24-29	137(90.7%)	14(0.3%)	0.175
	30-35	99(88.4%)	13(11.6%)	
Marital status	Single	196(95.1)	10(4.9%)	
	Married	151(94.4%)	9(5.6%)	0.252
	Widow/widower	4(80.0%)	1(20.0%)	
	Divorced/separated	12(85.7%)	2(14.3%)	
Education level	None	1(33.3%)	2(66.7%)	
	Primary not completed	9(90.0%)	1(10.0%)	
	Primary completed	27(90.0%)	3(10.0%)	
	Secondary not completed	39(88.5%)	5(11.4%)	0.009
	Secondary completed	139(93.3%)	10(6.7%)	
	Tertiary not completed	82(95.3%)	4(4.7%)	
	Tertiary completed	55(87.3%)	8(12.7%)	

Employment status	Employed	64(88.9)	8(11.1%)	0.000
	Self-employed	117(84.8%)	21(15.2%)	
	Unemployed	171(97.7%)	4(2.4%)	

Gender (P=0.001), education level (0.009) and employment status (0.000) showed to be statistically significant in alcohol use disorder. Majority of the male participants 24(14.0%) had AUD. Participants with at least a completion in the secondary level of education or below rated more in AUD. Self-employed respondents 21(15.2%) had the highest rate of AUD.

E. Social anxiety disorder

Table 15: Social anxiety disorder versus socio-demographic characteristics bivariate analysis

Socio-demographic profiles		**No SAD**	**Yes SAD**	**P-value**
Gender	Female	203(95.3%)	10(4.7%)	0.809
	Male	163(94.8%)	9(5.2%)	
Age	18-23	114(94.7%)	8(6.6%)	0.379
	24-29	143.94.7%)	8(5.3%)	
	30-35	109(97.3%)	3(2.7%)	
Marital status	Single	195(94.7%)	11(5.3%)	0.787
	Married	152(95.5%)	8(5.0%)	
	Widow/widower	5(100.0%)	0(0.0%)	
	Divorced/separated	14(100.0%)	0(0.0%)	
Education level	None	3(100.0%)	0(0.0%)	
	Primary not completed	10(100.0%)	0(0.0%)	

	Primary completed	29(96.7%)	1(3.3%)	0.961
	Secondary not completed	41(93.2%)	3(6.8%)	
	Secondary completed	142(95.3%)	7(6.8%)	
	Tertiary not completed	82(95.3%)	4(4.3%)	
	Tertiary completed	59(93.7%)	4(6.3%)	
Employment status	Employed	67(93.1%)	5(6.9%)	0.356
	Self-employed	134(97.1%)	4(2.9%)	
	Unemployed	165(94.3%)	10(4.9%)	

As illustrated above, no statistical inferable link between all the socio demographic characteristics of the study participants with Social anxiety was present.

F. Generalized anxiety disorder

Table 16: Generalized anxiety disorder versus socio-demographic characteristics bivariate analysis

Socio-demographic profiles		No GAD	Yes GAD	P-value
Gender	Female	198(93.0%)	15(7.0%)	0.068
	Male	167(97.1%)	5(2.9%)	
Age	18-23	113(92.6%)	9(7.4%)	
	24-29	144(95.4%)	7(4.6%)	
	30-35	108(96.4%)	4(3.6%)	0.392
Marital status	Single	197(95.6%)	9(4.4%)	
	Married	150(93.8%)	10(6.3%)	0.794
	Widow/widower	5(100.0%)	0(0.0%)	
	Divorced/separated	13(92.9%)	1(7.1%)	
Education level	None	3(100.0%)	0(0.0%)	
	Primary not completed	8(80.0%)	2(20.0%)	
	Primary completed	28(93.3%)	2(6.7%)	
	Secondary not completed	42(95.5%)	2(4.5%)	0.503
	Secondary completed	141(94.6%)	8(5.4%)	
	Tertiary not completed	83(96.5%)	3(3.5%)	
	Tertiary completed	60(95.2%)	3(4.8%	
Employment status	Employed	68(94.4%)	4(5.6%)	
	Self-employed	133(96.4%)	5(3.6%)	0.567
	Unemployed	164(93.7%)	11(6.3%)	

No association was found between socio-demographic characteristics and generalized anxiety disorder (AS ABOVE).

G. Substance use (Non-alcohol)

Table 17: Substance use (Non-alcohol) (SUD-NA) versus socio demographic profiles bivariate analysis

Socio demographic profiles		**No SUD-NA**	**Yes SUD-NA**	**P-value**
Gender	Female	211(99.1%)	2(0.9%)	0.081
	Male	166(96.5%)	6(3.5%)	
Age	18-23	121(99.2%)	1(0.8%)	
	24-29	146(96.7%)	5(3.3%)	0.346
	30-35	110(98.2%)	2(1.8%)	
Marital status	Single	202(98.1%)	4(1.9%)	
	Married	157(98.1%)	3(1.9%)	0.589
	Widow/widower	5(100.0%)	0(0.0%)	
	Divorced/separated	13(92.9%)	1(7.1%)	
Education level	None	3(100.0%)	0(0.0%)	
	Primary not completed	10(100.0%)	0(0.0%)	
	Primary completed	29(96.7%)	1(3.3%)	
	Secondary not completed	44(100.0%)	0(0.0%)	0.875
	Secondary completed	61(97.3%)	2(2.7%)	
	Tertiary not completed	85(98.8%)	1(1.2%)	
	Tertiary completed	61(96.8%)	2(3.2%)	

Employment status	Employed	72(100.0%)	0(0.0%)	0.008
	Self-employed	131(94.9%)	7(5.1%)	
	Unemployed	174(99.4%)	1(0.6%)	

Employment status (P=0.008) was statistically associated with SUD-NA. Self-employed participants had a high percent 7 (5.1%) of SUD-NA.

Table 18: Multiple logistic regression analysis of the link between psychiatric morbidity and socio demographic profiles

Socio-demographic profiles	P-value	Odds Ratio(OR)	Confidence Interval (95%)	
			Lower	Upper
Age Bracket				
18-23	.529	Ref		
24-29	.735	1.140	.534	2.432
30-35	.294	1.371	.760	2.471
Gender				
Male	.910	1.026	.661	1.592
Marital status				
Married	.121	Ref		
Single status	.024	4.771	1.227	18.543
Widow/widower	.016	5.650	1.382	23.096
Divorced/separated status	.999	.000	0.000	
Education level				
None	.722	Ref		
Primary not completed	.825	1.118	. 416	3.007
Primary completed	.999	.000	0.000	2.976
Secondary not completed	.443	.791	.434	1.440
Secondary completed	.598	.669	.151	2.976

Tertiary not completed	.293	.653	. 295	1.445
Tertiary completed	.119	.540	.249	1.173
Employment status				
Unemployed	.018	Ref		
Employed	.087	1.638	.931	2.880
Self employed	.007	2.440	1.270	4.690

A logistic regression analysis was done for odds ratio/OR with a confidence interval of 95% between social demographic characteristics and the absence or presence of at least one or more psychiatric morbidity. The results are summarized in table 22 above. P value of not more than 0.05 was considered to be statistically inferable.

Marital status and employment status were noted to have a statistical inferable link with psychiatric morbidity. The singles (P=0.024) had an Odds Ratio/OR (4.771) higher chance of having a psychiatric morbidity as compared the married. Those who were widow/widower (P=0.016) had an OR (5.650) times of developing a mental illness compared to the married while those who were divorced/separated had a low odds ratio (0.000) of having a psychiatric morbidity compared to those who were married.

Participants who were self-employed (P=0.007, OR 2.440, CI 1.270- 4.690) indicated a strong odds of developing a psychiatric morbidity as compared to those who were unemployed (P=0.018).

Table 19: A multiple logistic regression analysis of the link between Major depressive episode and significant socio-demographic characteristics

Socio-demographic profiles	P Value	OR/Odds ratio	95% C.I.	
			Lower	Upper
Age Bracket				
18-23	.010	Ref		
24-29	.009	.323	.138	.757
30-35	.005	.370	.184	.746
Marital status				
Married	.061	Ref		
Single	.009	.198	.059	.663
widow/widower	.024	.227	.062	.825
divorce/separated	.083	.111	.009	1.337
Education level				
None	.271	Ref		
Primary not completed	.905	.932	.295	2.948
Primary completed	.221	4.899	.386	62.245
Secondary not completed	.475	1.315	.621	2.785
Secondary completed	.111	3.482	.752	16.128
Tertiary not completed	.441	.677	.251	1.824
Tertiary completed	.343	1.575	.616	4.024

Age and marital status were noted to have an inferable statistic link with major depressive episode. Although age was found to be significant to major depressive episode the OR of those in the age group of 24-29 (P=0.009) (OR: 0.323; CI (0.138-0.757)) and 30-35 (P=0.024) (OR: 0.370; CI (0.184-0.746)) were low hence chances of developing major depressive episode are consequentially low as compared to those in age group 18-23 years.

In marital status those who were single and widow/widower had a significant association with major depressive episode. However, the OR of both (single: OR: 0.198; CI (0.059-0.663); widow/widower: OR: 0.227; CI (0.062-0.825)) were also weaker hence indicating less probability of developing major depressive episode as compared to those married.

Table 20: Multiple logistic regression analysis of the link between Suicidality and significant Socio demographic profiles

Socio-demographic profiles	**P-Value**	**OR**	**95% C.I.**	
			Lower	**Upper**
Married	.014	Ref		
Single	.007	.186	.055	.628
widow/widower	.001	.131	.039	.445
divorced/separated	.999	.000	0.000	

Marital status (those married with a P=0.014, single P=0.007 and widow/widower P=0.001) showed a significant relation with suicidality. In contrast the OR was found to be weak. The

single had an OR (0.186, CI 0.055-0.628) while the widow/widower had OR (0.131, CI 0.039-0.445), the two indicated very weak odds of suicidality as compared to the married respectively.

Table 21: Multiple logistic regression analysis of the link between AUD/Alcohol use disorder and significant socio-demographic characteristics

Socio-demographic profiles	P Value	OR	95% Confidence interval	
			Lower	Upper
Employment status				
Unemployed	.003	Ref		
Employed	.001	7.646	2.359	24.782
self employed	.373	1.528	.601	3.885
Education level				
No level	.361	Ref		
Primary not completed	.546	.596	.111	3.203
Primary completed	.048	.033	.001	.971
Secondary not completed	.748	1.233	.344	4.426
Secondary completed	.913	1.142	.105	12.451
Tertiary not completed	.687	.754	.191	2.973
Tertiary completed level	.363	.510	.120	2.173
Gender				
Male	.003	3.534	1.532	8.152

Employment status; those unemployed with P=0.003 and those employed having P=0.001). In education level; (primary completed (P=0.048)) and gender were found to have an association with alcohol use disorder. Those who were employed had an OR (7.646, CI 2.359-24.782) which indicated a very high probability of those employed having an alcohol use disorder by 7.646 times higher as compared to those unemployed. Those who had attained primary completion level of education had an OR of (0.033, CI 0.001-0.971) this indicated a weak probability of this level of education developing AUD as compared to those of no level of education. The male gender with OR (3.534, CI 1.532-8.152) indicated a very strong probability of developing AUD by 3.534 as compared to the female gender.

Table 22: Multiple logistic regression analysis of the association between Post traumatic stress disorder and significant socio-demographic characteristics

Socio-demographic profiles	**P-Value**	**OR**	**95% C.I.**	
			Lower	**Upper**
Marital status				
Married	.049	Ref		
Single	.967	.956	.112	8.140
Widow/widower	.597	1.812	.200	16.425
Divorced/separated	.116	.105	.006	1.740
Employment status				
Unemployed	.064	Ref		
Employed	.166	2.001	.750	5.338
self employed	.037	8.961	1.136	70.685

Those who were self-employed (P=0.037, OR 8.961 CI 1.136-70.685) showed high odds of developing post-traumatic stress disorder as compared to those who were unemployed.

Table 23: Multiple logistic regression analysis of the link between SUD-NA/Substance use disorder (Non-Alcohol) and significant socio-demographic characteristics

Socio-demographic profile	**P-Value**	**OR**	**95% C.I.**	
			Lower	**Upper**
Unemployed	.116	Ref		
Employed	.038	.108	.013	.885
Self employed	.997	.000	0.000	

Those who were employed (P=0.038, OR 0.108, CI 0.013-0.885) indicated a very weak odds ratio of developing SUD-NA as compared to those unemployed.

5.0 CHAPTER FIVE

DISCUSSION

5.1 Socio-demographic characteristics

In Gender, females 213 (55.3%) were the majority compared to males 172(44.7%) whereas in age, those of 24-29 years 151 (39.2%) followed by 18-23 years 122(31.7%) were the most compared to 30-35 years 112 (29.1%). This could be because health care-seeking tendencies are determined by various personal traits such as age and gender, whereby men are inadequately represented in medical care and it is hard to comprehend why because it's a continuing matter (Thompson, Anisimowicz, Miedema et al. 2016). Moreover, more youthful patients both men and women are ready to get health care assistance as opposed to older patients (Thompson, Anisimowicz, Miedema et al. 2016). Lastly, males were noted to inadequately utilize the medical services specifically health screening and primary care (Baker, 2016; Mursa, Patterson, Halcomb, 2022) and to also use medical services minimally as compared to females (Australian institute of Health welfare, 2019; Mursa, Patterson, Halcomb, 2022).

5.2 The Prevalence of psychiatric disorders and its association with socio demographic characteristics

Psychiatric disorders which had correlations with socio-demographic characteristics involved Major depressive disorder, Suicidality, post-traumatic stress disorder/PTSD, AUD/alcohol use disorder and SUD/substance use disorder.

5.2.1 Major depressive episode

This study shows that the most prevalent mental illness in youth patients of age bracket 18-35 years was major depressive episode (21.8%) this was less in contrast to a research done by Greenberg, Fournier & Sisitsky et al. (2021) that showed major depressive disorder to be at 53.7%% among those in age bracket of 18-34. However, age category 30-35 years had the highest level of major depressive episode suggesting that there is an increase of major depressive episode with increase in age. Similarly Solmi, Radua, Olivola, et al., (2022) noted that average age onset of depressive disorder was 30-35 years. This was in contrast with Villarroel and Terlizzi (2020) who noted that those who were of age bracket of 18-29 years (21.0%) had the majority incidences of symptoms of depression while those in age group 30-44 years (16.8%) had the least symptoms.

Level of education indicated a correlation to major depressive episode, it was noted that those who were of secondary level and below had higher prevalence of major depressive episode compared to those of tertiary level and above. This was in alignment with the findings of Shi, Zhang, Liu et al., (2014); Chun-Te, Yi-Cheng & Jing-Yang, et al. (2016). In addition to that, Arias-de la Torre et al., (2021) also noted in her study that education level impacts outcome of MDD.

In this study divorced/separated respondents (64.3%) showed a high level of major depressive episode this was in alignment with Gutierrez-Rojas et al. (2020) whose results indicated a strong correlation between major depressive disorder and being divorced/separated. Additionally, Bulloch et al (2009) findings concluded that individuals who are divorced or separated have

higher risk of developing major depressive disorder. Married participants (24.4%) followed in second position. This was in contrast to Islam & Adnan (2017) findings which indicated that married individuals 56% had a tendency to develop depression the highest.

Those who were unemployed (82.4%) had a slightly higher of percentage of major depressive episode as opposed to those who were employed (81.0%) and self-employed (81.4%). This could be because unemployment is persistently linked with increased rates of depression in young adults (Paul & Mauser, 2009; McGee & Thompson, 2015. This finding is also consistent with findings on depression and unemployment in young adults by McGee & Thompson, 2015).

5.2.2 Alcohol use disorder

This was systematically followed by; alcohol use disorder which had a prevalence rate of 8.6% and indicating a correlation with gender, education level and employment status. Males (14.0%) used more alcohol as compared to females (4.2%), this could be because males and females are attributed with contrasting societal morals and norms (Agabio et al., 2017; Castillo-Carniglia et al., 2019; Gilbert et al., 2019; White, 2020; Greaves et al., 2022; Maxwell et al., 2022; Goh, Asharani & Abdin et al. 2022). Similarly, Maxwell et al. (2022); Goh, Asharani & Abdin et al. (2022) supported that sociocultural viewpoints, customary masculine norms particularly could be the reason for men's high levels of alcohol consumption with possibility of having more alcohol related challenges. Those who were of secondary level of education and below indicated a higher intake of alcohol use as compared to those of tertiary level and above, this corresponded with Murkami & Hashimoto (2019) findings which indicated that less educational level was correlated with more risk of having a drinking challenge. Similarly, Norstorm, & Landberg (2020) findings also supported this. Moreover, lesser educational level predisposes one to being

a binge drinker due to occasional predisposition to social distress and poor health enlightenment about dangers of alcohol consumption (Cerda, Johnson-Lawrence & Gales, 2011; Murkakami & Hashimoto, 2019).

Employment status was also linked to alcohol use disorder whereby the self-employed had a 15.2% AUD while, those employed had 11.1% and those unemployed had a 2.4% this was similar to Kiarie, (2021) who found a link between self-employment and alcohol use (p-0.045). However, this contrasted with Compton & colleagues, (2014); Collins, (2016) who indicated that unemployment was what was found to be greatly linked with heavy alcohol consumption and alcohol use disorder. Although age was not statistically significant to AUD the age group of 30-35 rated higher percent (11.6%) of AUD in contrast to other age groups which was consistent with WHO, (2022); Public opinion research center, (2022); Wysokinska & Kolota, (2022) who noted those of age group 25-45 years had a peak in alcohol usage. This differentiated with Delker, Brown & Hasin, (2016) findings which indicated a heightening of alcohol use in age group 18-29 years.

5.2.3 PTSD/Post-traumatic stress disorder

PTSD/Post traumatic stress disorder indicated a link between gender and employment status. Females had a greater percentage (8.52%) of PTSD as compared to males (3.5%). This was complementary with McGinty, Fox, & Ben-Ezra et al., 2021 findings which concluded that females had a higher chance of developing PTSD in contrast to the males regardless of the age. Similarly, da silva et al. (2019) findings indicated that women patients 33(80.5%) had more PTSD as compared to men 8 (19.5%). This can further be explained by Olff, (2017) study which summarized that the distinctions of gender and sex in brain and behavior can describe why PTSD is more common in females than males. Those who were self-employed (10.9%) had the highest

PTSD as compared to unemployed (4.6%) and employed (1.4%). Limited research on self-employment is present however most studies correlate specific types of employments with PTSD hence having a gap in this particular area. No link was found between PTSD and age in this study, however other studies suggested that persons of age 18-24 years had the highest chances of experiencing PTSD symptoms (Liu, Liu & Huang et al., 2020), contradicting McGinty, Fox, & Ben-Ezra et al., (2021) who implied that persons of the age category 25-35 had more likelihood of attaining the classification for PTSD. Interestingly, Solmi, Radua, Olivola, et al., (2022), in lieu indicated that the average global onset of PTSD to be 30-35 years.

5.2.4 Social anxiety disorder

Even though no statistical significance was noted between socio-demographic characteristic and SAD, the age group of 18-23 indicated a greater sum of percent (6.6%) of SAD as opposed to the other group categories; this corresponded with Jefferies & Ungar (2020) findings which noted greater figures of Social anxiety disorder in persons in the age bracket of 18-24 years.

5.2.5 Generalized anxiety disorder

GAD was noted to be higher in women (7.0%) than men (2.9%) although no statistical significance was found between the genders. This was similar to Aljurbua, Selaihem & Alomari et al (2021) who used GAD-7, and noted that anxiety was more in females (15.6%) and (9.8%) in males even though no significant distinctions were present between the two genders. The female gender was also noted to be one of the risk factors for GAD (Fonzo, Ramsawh & Flagan et al. 2016; Madonna, Delvecchio & Soares et al. 2019). With no significance the age group 18-23 years (7.4%) indicated a higher GAD percentage as compared to 24-29 (4.6%) and 30-35 (3.6%). This aligned with Gambin et al. (2021) who found that younger age brackets of 18-29 years have larger percentage of generalized anxiety. On the other end, Solmi, Radua, Olivola, et al., (2022),

suggests GAD age onset to be noted at 30-35 years. Similarly, Aljurbua, Selaihem & Alomari et al (2021) noted that the commonness of anxiety symptoms was most in the age group of 18-24.

5.2.6 Suicidality and suicidal behavior disorder

Those who were divorced/separated were found to have high rates of suicidality 5(35.0%) and suicidal behavior disorder 5(35.7%). This corresponded with Oien-Odegaard, Hauge & Reneflot, (2021) findings that indicated that high chances of suicide is twice or thrice more linked to being divorced or a widow/widower as opposed to being married. Similary, Naes, Mehlum & Qin, (2021) findings reported a distressing heightening rate of suicide in males (13.6%) and females (21.8%) who are experiencing marital separation or having a title of being separated of divorced.

Men 18(10.5%) were found to be have more suicidality as compared to females 16(7.5%) although no statistical significance was present. This was different from WHO (2014); Hegerl, (2022) who indicated that females have a higher percentage of suicide attempts as compared to males. On the other end men rated an 18(10.5%) in suicidal behavior disorder whereas women rated 14(6.6%) this was in agreement that in terms of mortality of suicidal behaviors, males have a higher percentage of suicide accomplishment in contrasts to females (WHO, 2014; Hegerl, 2022).

5.2.7 Substance use disorder (Non-Alcohol)

Those who were self-employed (5.1%) rated high in SUD-NA as compared to those unemployed (0.6%). This differentiated from Melchior, Chollet, Elidemir et al. (2015) findings which concluded that unemployment can affect population rates of substance use, especially in youths with low level of education. This was similar to Lee, Hill, Hartigan et al. (2015) findings which

indicated that the commonness in substance abuse is greater in unemployed in contrast to those employed.

5.2.8 Multivariate logistic regression

A logistic regression analysis was done for odds ratio with a 95% confidence interval between social-demographic characteristics and the absence or presence of at least one or more psychiatric morbidity. The results are summarized in table 22. P value of not more than 0.05 was regarded as being statistically significant.

Marital status and employment status were noted to have statistically inferable link with psychiatric morbidity. This was in contrast with Kwobah, Epstein, Mwangi et al. (2017) who noted that there was no link found between marital status and employment status having an association with psychiatric morbidity. On the other hand Bulloch, Williams, Lavorato et al. (2009) indicated an association of marital status and psychiatric illness while Eid, Heim, Doucette et al. (2013) indicated an association between employment status and psychiatric illness.

6.0 CHAPTER SIX

CONCLUSION

6.1 Conclusion

The prevalence of psychiatric morbidity among youth patients at Nakuru level 6 hospital in youth patients of the age bracket 18-35 years stands at 46.5%. 26.8% of this attained a classification for not more than one psychiatric illness.

The most prevalent psychiatric illness was found to be major depressive episode (21.8%), it indicated that as one advances in age chances are high of getting depression since major depressive episodes were found to be increasing with age. This was followed by: suicidality (8.8%), alcohol use disorder (8.6%), suicidal behavior disorder (8.6%), and post-traumatic stress disorder (6.2%), psychiatric illness due organic, medical and drug causes (5.7%), generalized anxiety disorder/GAD (5.2%) and social anxiety (4.9%).

Marital status and employment status were noted to have a statistically inferable link with psychiatric morbidity.

6.2 Recommendations

1. Due to the high percentage of psychiatric morbidity noted, regular psychological assessments should be conducted as part of treatment evaluations so that patients can be able to get more interventions necessary for them hence bettering their health outcome broadly.

2. By virtue of high prevalence of psychiatric morbidity among youth patients as indicated in this study, the Ministry of Health is warranted for more guidelines and policies to be set in place, in handling of youth patients who seek treatment at the hospital.

3. Psychoeducation to patients should be done about the hospital's youth center which provides free counselling services so that patients may be more aware about it and be able to seek psychological interventions when facing challenges.

6.3 Suggestions for further research

1. This research was a cross-sectional study whose duration was 3 months hence a longitudinal study may be of importance so as to further evaluate the temporality of the results and predictors of psychiatric morbidity among youth patients (18-35 years) at the site of study.
2. This study found that self-employment was consistently related to psychiatric morbidity hence future studies should look into the specific factors related to self-employment that increases the vulnerability of psychiatric morbidity in the age bracket (18-35 years).

6.4 Limitations

1. The main limitation noted was that some youth patients would get tired while answering questions due to long questionnaire which had long different questions for different 16 mental disorders hence future studies would benefit from using brief tool with just as good validity as Mini International Neuropsychiatric interview version 7.0.0. To tackle this limitation, the participants who did not wish to continue with the interview were allowed to leave since participation was voluntary.

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Name: Mercy Chepton Kipkemboi Registration n.o: H56/37728/2020 Sign:

1st Research Supervisor: Dr. Teresia Mutavi Sign:

ORIGINALITY REPORT

6%	5%	3%	%
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PRIMARY SOURCES

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Prof. Anne Obondo
Chair. Dept. of Psychiatry

24/10/2023

UNIVERSITY OF NAIROBI
DEPARTMENT OF PSYCHIATRY
P. O. BOX [illegible] - [illegible], KNH
TEL: [illegible] EXT: [illegible]

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APPENDIX 1: PARTICIPANT INFORMATION AND CONSENT FORM

(ADULT CONSENT FOR ENROLLMENT IN THE STUDY)

Title of Study: Psychiatric morbidity among youth patients at Nakuru level 6 hospital

Principal Investigator\and institutional affiliation: Mercy Cheptoo Kipkemboi, University of Nairobi

Introduction:

I would like to tell you about a study being conducted by the above-named researcher. The purpose of this consent form is to give you the information you will need to help you decide whether or not to be a participant in the study. Feel free to ask any questions about the purpose of the research, what happens if you participate in the study, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When I have answered all your questions to your satisfaction, you may decide to be in the study or not. This process is called 'informed consent'. Once you understand and agree to be in the study, I will request you to sign your name on this form. You should understand the general principles which apply to all participants in a medical research: i) Your decision to participate is entirely voluntary ii) You may withdraw from the study at any time without necessarily giving a reason for your withdrawal iii) Refusal to participate in the research will not affect the services you are entitled to in this facility or other facilities. We will give you a copy of this form for your records.

May I continue? [YES] / [NO]

This study has approval by The Kenyatta National Hospital-University of Nairobi Ethics and

Research Committee protocol No. _____

WHAT IS THIS STUDY ABOUT?

The researcher named above is interviewing youth patients being seen at the outpatient Nakuru level 6 hospital.

The purpose of the interview is to determine the psychiatric morbidity among youth patients at Nakuru level 6 hospital.

Participants in this research study will be asked questions about their current situation.

Participants will also have the choice to undergo assessment using The MINI International Neuropsychiatric Interview version 7.0.0 which contains 17 sections that has different questions aiming to detect presence of a mental illness.

There will be approximately 385 participants in this study randomly chosen. We are asking for your consent to consider participating in this study.

WHAT WILL HAPPEN IF YOU DECIDE TO BE IN THIS RESEARCH STUDY?

If you agree to participate in this study, the following things will happen:

• You will be interviewed by the researcher in a private area where you feel comfortable answering questions. The interview will last approximately 20 minutes. The interview will include answering questions with either "yes or no" from 17 different modules.

ARE THERE ANY RISKS, HARMS DISCOMFORTS ASSOCIATED WITH THIS STUDY?

This research has neither social nor economic risks identified associated with your participation to the study however; some of you may find some of the questions that will be asked uncomfortable and hence you will be allowed not to respond.

ARE THERE ANY BENEFITS BEING IN THIS STUDY?

You may benefit from knowing about various mental disorders as well their signs and symptoms. We will refer you for further treatment if you're found to be suffering from any of the assessed conditions. In the long term presentation of the Study findings will inform policy makers in enhancing policies that will strengthen the psychological mental health of Youths in response to psychiatric morbidity rate and will also help in having well-documented and updated information about the rate of mental illnesses among the youths at the site of study.

WILL BEING IN THIS STUDY COST YOU ANYTHING?

No. Participation in this study is free of charge.

WHAT IF YOU HAVE QUESTIONS IN FUTURE?

If you have further questions or concerns about participating in this study, please call or send a text message to the researcher at the number provided at the bottom of this page. For more information about your rights as a research participant you may contact the Secretary/Chairperson, Kenyatta National Hospital-University of Nairobi Ethics and Research Committee Telephone No. 2726300 Ext. 44102 email uonknh_erc@uonbi.ac.ke.

The researcher will pay you back for your charges to these numbers if the call is for study-related communication.

WHAT ARE YOUR OTHER CHOICES?

Your decision to participate in research is voluntary. You are free to decline participation in the study and you can withdraw from the study at any time without injustice or loss of any benefits.

CONSENT FORM (STATEMENT OF CONSENT)

Participant's Statement

I have read this consent form or had the information read to me. I have had the chance to ask questions and discuss this research study with the researcher. I have had my questions answered in a language that I understand. The risks and benefits have been explained to me. I understand that my participation in this study is voluntary and that I may choose to withdraw any time. I freely agree to participate in this research study. I understand that all efforts will be made to keep information regarding my personal identity confidential.

By signing this consent form, I have not given up any of the legal rights that I have as a participant in a research study.

I agree to participate in this research study: [Yes] [No]

I agree to allow the researcher to contact me through the institution for follow-up: [Yes] [No]

Participant's printed name: _____

Participant's signature/Thumb stamp: _____ Date: _____

NEXT OF KIN CONSENT (Where Applicable)

I being the next of kin to _____ hereby give consent to allow the researcher to include him/her in the study as a participant. I understand that only consented forms are considered, and participation is voluntary.

NoK's Name: _____ Relationship to participant: _____

NoK's Signature: _____ Date: _____

RESEARCHER'S STATEMENT

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has willingly and freely given his/her consent.

Researcher's Name: _____ Date: _____

Signature: _____

For more information contact Mercy Cheptoo at 0705742892 from Monday to Friday during working hours.

Witness Printed Name (If witness is necessary, A witness is a person mutually acceptable to both the researcher and participant)

Name: _____ Contact information: _____

Signature /Thumb stamp: _____ Date: _____

(Translated - Swahili)

FOMU YA TAARIFA NA IDHINI YA MSHIRIKI
(IDHINI YA MTU MZIMA KWA KUJIANDIKISHA KATIKA UTAFITI)

Kichwa cha Utafiti: Saikolojia Unyevu kati ya wagonjwa vijana katika hospitali ya Nakuru kiwango cha 6.
Mpelelezi Mkuu\na uhusiano wa kitaasisi: Mercy Cheptoo Kipkemboi, Chuo Kikuu cha Nairobi Utangulizi:
Ningependa kukuambia kuhusu utafiti unaofanywa na mtafiti aliyetajwa hapo juu. Madhumuni ya fomu hii ya idhini ni kukupa taarifa utakayohitaji ili kukusaidia kuamua kama kuwa mshiriki au la katika utafiti. Jisikie huru kuuliza maswali yoyote kuhusu madhumuni ya utafiti, nini kitatokea ukishiriki katika utafiti, hatari na manufaa yanayoweza kutokea, haki zako kama mtu wa kujitolea, na jambo lingine lolote kuhusu utafiti au fomu hii ambalo haliko wazi. Wakati nimejibu maswali yako yote kwa kuridhika kwako, unaweza kuamua kuwa katika utafiti au la. Utaratibu huu unaitwa 'kibali cha taarifa'. Ukishaelewa na kukubali kuwa katika utafiti, nitakuomba utie sahihi jina lako kwenye fomu hii. Unapaswa kuelewa kanuni za jumla zinazotumika kwa washiriki wote katika utafiti wa kimatibabu: i) Uamuzi wako wa kushiriki ni wa hiari kabisa ii) Unaweza kujiondoa kwenye utafiti wakati wowote bila ya kueleza sababu ya kujiondoa iii) Kukataa kushiriki katika utafiti huu. utafiti hautaathiri huduma unazostahiki katika kituo hiki au vifaa vingine. Tutakupa nakala ya fomu hii kwa rekodi zako
Naweza kuendelea? [NDIO] / [LA]
Utafiti huu umeidhinishwa na Kenyatta National Hospital-University of Nairobi Ethics and Research Committee protocol No. _____

UTAFITI HUU UNAHUSU NINI?
Mtafiti aliyetajwa hapo juu anahoji vijana wagonjwa ambao wanaonekana kaitka hospitali ya Nakuru Kiwango cha 6.
Madhumuni ya mahojiano ni saikolojia Unyevu kati ya wagonjwa vijana katika hospitali ya Nakuru kiwango cha 6.
Washiriki wa utafiti huu wataulizwa maswali kuhusu hali yao ya sasa.
Washiriki pia watakua na chaguo la kufanya tathmini kwa kutumia MINI International Neuropsychiatric Interview version 7.0.0 ambayo inayo sehemu 17 ya mawali tofauti kulenga kugundua uwepo wa ugonjwa wa akili.
Kutakua na takriban washiriki 385 kwa utafiti huu ambao watachaguliwa bila mpango.

NINI KITAENDELEA UKIAMUA KUWA KATIKA UTAFITI HUU?

Ukikubali kushiriki katika utafiti huu, mambo yafuatayo yatafanyika: • Utahojiwa na mtafiti katika mazingira unayohisi vizuri kujibu maswali. Mahojiano yatadumu takriban dakika 20. Mahojiano itajumuisha lujibu maswali na ama “ndio au la” kutoka kwa moduli 17 tofauti.

JE, KUNA HATARI, MADHARA YOYOTE YANAYOHUSISHWA NA UTAFITI HUU?
Utafiti huu haina hatari za kijamii au kiuchumi zilizotambuliwa kuhusisshwa na ushiriki wako kwenye utafiti. Walakini wengine wenu wanaeweza kupata maswali kadhaa ambayo yataulizwa kuwa haifuraihishi kwa hivyo utaruhusiwa kutojibu.

JE, KUNA FAIDA YOYOTE KUWA KATIKA UTAFITI HUU?
Unaweza kufaidika kwa kujua aina tofauti wa ugonjwa wa kiakili pamajoa na ishara na dalili zao. Tutakuelekeza Kwa matibabu zaidi ikiwa utapatikana unateseka na hali yoyote ilipimwa. Katika uwasilishaji wa muda mrefu wa utafiti huu, matokeo yatawajulisha watunga sera katika kuongeza sera ambazo zitaimarisha afya ya akili ya kisaikolojia ya vijana kujibu kiwango cha hali ya hewa ya akili na pia itasaidia kuwa na kumbukumbu nzuri na habari iliyosasishwa juu ya kiwango cha mangonjwa ya akili kati ya vijana kwenye tovuti ya masomo.

JE, KUWA KATIKA SOMO HILI ITAKUGHARIMU LOLOTE?
Hapana. Kushiriki katika utafiti huu ni bila malipo.

JE IKIWA UNA MASWALI BAADAYE?
Ikiwa una maswali zaidi au wasiwasi kuhusu kushiriki katika utafiti huu, tafadhali piga simu au tuma ujumbe mfupi wa maandishi kwa mtafiti kupitia nambari iliyotolewa chini ya ukurasa huu.
Kwa maelezo zaidi kuhusu haki zako kama mshiriki wa utafiti unaweza kuwasiliana na Katibu/Mwenyekiti, Hospitali Kuu ya Kenyatta-Kamati ya Maadili na Utafiti ya Chuo Kikuu cha Nairobi Nambari 2726300 Ext. 44102 barua pepe uonknh_erc@uonbi.ac.ke
Mtafiti atakurudishia malipo ya mawasiliano kwa nambari hizi ikiwa simu ni ya mawasiliano yanayohusiana na utafiti.

MENGINE NI GANI?
Uamuzi wako wa kushiriki katika utafiti ni wa hiari. Uko huru kukataa kushiriki katika utafiti na unaweza kujiondoa kwenye utafiti wakati wowote bila dhuluma au hasara ya manufaa yoyote.

FOMU YA IDHINI (TAARIFA YA IDHINI)

Kauli ya Mshiriki

Nimesoma fomu hii ya idhini au nimesomewa maelezo. Nimepata nafasi ya kuuliza maswali na kujadili utafiti huu na mtafiti. Nimejibiwa maswali yangu kwa lugha ninayoielewa. Hatari na faida zimeelezewa kwangu. Ninaelewa kuwa ushiriki wangu katika utafiti huu ni wa hiari na kwamba ninaweza kuchagua kujiondoa wakati wowote. Ninakubali kwa uhuru kushiriki katika utafiti huu.

Ninaelewa kuwa juhudi zote zitafanywa ili kuweka taarifa kuhusu utambulisho wangu wa kibinafsi kuwa siri.

Kwa kutia saini fomu hii ya idhini, sijaacha haki zozote za kisheria nilizo nazo kama mshiriki katika utafiti.

Ninakubali kushiriki katika utafiti huu: [Ndiyo] [Hapana]

Ninakubali kumruhusu mtafiti awasiliane nami kupitia taasisi kwa ufuatiliaji: [Ndiyo] [Hapana]

Jina lililochapishwa la mshiriki: _____

Sahihi ya mshiriki/muhuri wa kidole gumba: _____ Tarehe: _____

IDHINI YA JAMAA WA KARIBU (Ambapo husika)

Mimi nikiwa jamaa wa karibu wa _____ natoa ridhaa ya kumruhusu mtafiti kumhusisha katika utafiti huu kama mshiriki. Naelewa kuwa fomu zilizoidhinishwa pekee ndizo zinazozingatiwa, na ushiriki ni wa hiari.

Jina la jamaa wa karibu: _____

Uhusiano na mshiriki: _____

Sahihi ya jamaa wa karibu: _____ Tarehe: _____

KAULI YA MTAFITI

Mimi, niliyetia sahihi chini, nimeeleza kikamilifu maelezo muhimu ya utafiti huu kwa mshiriki aliyetajwa hapo juu na ninaamini kuwa mshiriki ameelewa na ametoa ridhaa yake kwa hiari na kwa uhuru.

Jina la Mtafiti: _____ Tarehe: _____

Sahihi: _____

Kwa maelezo zaidi wasiliana na Mercy Cheptoo kwa 0705742892 kuanzia Jumatatu hadi Ijumaa saa za kazi

Jina Lililochapishwa la Shahidi (Ikiwa shahidi ni muhimu, Shahidi ni mtu anayekubalika kwa pande zote mbili kwa mtafiti

na mshiriki)

Jina: _____ Maelezo ya mawasiliano: _____

Sahihi /muhuri wa kidole gumba: _____ Tarehe: _____

Appendix 2: Researcher Designed Data Collection Sheet

DATA COLLECTION SHEET

Serial Number……...

7.1 Age in years……...

7.2 Gender……

7.3 Marital status……..

7.4 Education level……...

7.5 Employment status…….

7.6 Religion…….....

7.7 DSM V Psychiatric diagnosis made……..

M.I.N.I.

MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW

English Version

7.0.0FOR

DSM-5

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. It is not a diagnostic test.

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-5	ICD-10	PRIMARY DIAGNOSIS
A	MAJOR DEPRESSIVE EPISODE	Current (2 weeks)	❒			
		Past	❒			
		Recurrent	❒			
	MAJOR DEPRESSIVE DISORDER	Current (2 weeks)	❒	296.20-296.26 Single	F32.x	❒
		Past	❒	296.20-296.26 Single	F32.x	❒
		Recurrent	❒	296.30-296.36 Recurrent	F33.x	❒
B	SUICIDALITY	Current (Past Month)	❒			❒
		Lifetime attempt	❒	❒ Low ❒ Moderate ❒ High		❒
	SUICIDE BEHAVIOR DISORDER	Current	❒	(In Past Year)		❒
		In early remission	❒	(1--2 Years Ago)		❒
C	MANIC EPISODE	Current	❒			
		Past	❒			
	HYPOMANIC EPISODE	Current	❒			
		Past	❒	❒ Not Explored		
	BIPOLAR I DISORDER	Current	❒	296.41-296.56	F31.0--F31.76	❒
		Past	❒	296.41-296.56	F31.0- F31.76	❒
	BIPOLAR II DISORDER	Current	❒	296.89	F31.81	❒
		Past	❒	296.89	F31.81	❒
	BIPOLAR DISORDER UNSPECIFIED	Current	❒	296.40/296.50	F31.9	❒
		Past	❒	296.40/296.50	F31.9	❒
	BIPOLAR I DISORDER WITH PSYCHOTIC FEATURES	Current	❒	296.44/296.54	F31.2/31.5	❒
		Past	❒	296.44/296.54	F31.2/31.5	❒
D	PANIC DISORDER	Current (Past Month)	❒	300.01	F41.0	❒
		Lifetime	❒	300.01	F40.0	❒
E	AGORAPHOBIA	Current	❒	300.22	F40.00	❒
F	SOCIAL ANXIETY DISORDER (Social Phobia)	Current (Past Month)	❒	300.23	F40.10	❒
G	OBSESSIVE-COMPULSIVE DISORDER	Current (Past Month)	❒	300.3	F42	❒
H	POSTTRAUMATIC STRESS DISORDER	Current (Past Month)	❒	309.81	F43.10	❒
I	ALCOHOL USE DISORDER	Past 12 Months	❒	303.9	F10.10-20	❒
J	SUBSTANCE USE DISORDER (Non-alcohol)	Past 12 Months	❒	304.00-.90/305.20-.90	F11.1x-F19.288	❒
K	PSYCHOTIC DISORDERS	Lifetime	❒	297.3/297.9/ 293.81/298.83/298.89	F20.81-F29	❒
		Current	❒	297.3/297.9/ 293.81/298.83/298.89	F20.81-F29	❒
	MOOD DISORDER WITH PSYCHOTIC FEATURES	Lifetime	❒	296.24/296.34-296.44 296.54	F31.2/F32.2/F33.3	❒
		Current	❒	296.24/296.34/296.44/296.54	F31.2/F32.2/F33. 3	❒
L	ANOREXIA NERVOSA	Current (Past 3 Months)	❒	307.1	F50.01-02	❒
M	BULIMIA NERVOSA	Current (Past 3 Months)	❒	307.51	F50.2	❒
MB	BINGE-EATING DISORDER	Current (Past 3 Months)	❒	307.51	F50.8	❒
N	GENERALIZED ANXIETY DISORDER	Current (Past 6 Months)	❒	300.02	F41.1	❒
O	MEDICAL, ORGANIC, DRUG CAUSE RULED OUT		❒ No	❒ Yes	❒ Uncertain	
P	ANTISOCIAL PERSONALITY DISORDER	Lifetime	❒	301.7	F60.2	❒

IDENTIFY THE PRIMARY DIAGNOSIS BY CHECKING THE APPROPRIATE CHECK BOX.
(Which problem troubles you the most or dominates the others or came first in the natural history?) _____

GENERAL INSTRUCTIONS

The M.I.N.I. was designed as a brief structured interview for the major Axis I psychiatric disorders in DSM-5 and ICD-10. 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). The results of these studies show that the M.I.N.I. has similar reliability and validity properties, but can be administered in a much shorter period of time (mean 18.7 ± 11.6 minutes, median 15 minutes) than the above referenced instruments. Clinicians can use it, after a brief training session. Lay interviewers require more extensive training.

INTERVIEW:

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

GENERAL FORMAT:

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

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

CONVENTIONS:

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

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

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

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

When terms are separated by a *slash (/)* the interviewer should read only those symptoms known to be present in the patient (for example, questions J2b or K6b).

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

RATING INSTRUCTIONS:

All questions must be rated. The rating is done at the right of each question by circling either Yes or No. Clinical judgment by the rater should be used in coding the responses. Interviewers need to be sensitive to the diversity of cultural beliefs in their administration of questions and rating of responses. The rater should ask for examples when necessary, to ensure accurate coding. The patient should be encouraged to ask for clarification on any question that is not absolutely clear.
The clinician should be sure that each dimension of the question is taken into account by the patient (for example, time frame, frequency, severity, and/or alternatives).
Symptoms better accounted for by an organic cause or by the use of alcohol or drugs should not be coded positive in the M.I.N.I. The M.I.N.I. has questions that investigate these issues.

For any questions, suggestions, need for a training session or information about updates of the M.I.N.I., please contact: David V Sheehan, M.D., M.B.A.

University of South Florida College of Medicine
tel: +1 813-956-8437

e-mail : dsheehan@health.usf.edu

A. MAJOR DEPRESSIVE EPISODE

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

A1	a	Were you ever depressed or down, or felt sad, empty or hopeless most of the day, nearly every day, for two weeks?	NO	YES
		IF NO, CODE NO TO **A1b**: IF **YES** ASK:		
	b	For the past two weeks, were you depressed or down, or felt sad, empty or hopeless most of the day, nearly every day?	NO	YES
		Were you ever much less interested in most things or much less able to enjoy the things you used to enjoy most of the time?	NO	YES
		IF NO, CODE NO TO **A2b**: IF **YES** ASK:		
	b	In the past two weeks, were you much less interested in most things or much less able to enjoy the things you used to enjoy, most of the time?	NO	YES
		IS **A1a** OR **A2a** CODED **YES**?	➡	YES

A3 IF **A1b** OR **A2b** = **YES**: EXPLORE THE **CURRENT** AND THE MOST SYMPTOMATIC **PAST** EPISODE, OTHERWISE
IF **A1b** AND **A2b** = **NO**: EXPLORE ONLY THE MOST SYMPTOMATIC **PAST** EPISODE

Over that two week period, when you felt depressed or uninterested:

		Past 2 Weeks		Past Episode	
		NO	YES	NO	YES
	a	Was your appetite decreased or increased nearly every day? Did your weight decrease or increase without trying intentionally (i.e., by ±5% of body weight or ±8 lb or ± 3.5 kg, for a 160 lb/70 kg person in a month)? IF **YES** TO EITHER, CODE **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? Did anyone notice this?	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 **YES**, ASK FOR EXAMPLES. LOOK FOR DELUSIONS OF FAILURE, OF INADEQUACY, OF RUIN OR OF GUILT, OR OF NEEDING PUNISHMENT OR DELUSIONS OF DISEASE OR DEATH OR NIHILISTIC OR SOMATIC DELUSIONS. THE EXAMPLES ARE CONSISTENT WITH A DELUSIONAL IDEA. Current Episode ☐ No ☐ Yes Past Episode ☐ No ☐ Yes				
	f	Did you have difficulty concentrating, thinking or making decisions almost every day?	NO	YES	NO	YES
		Did you repeatedly think about death **(FEAR OF DYING DOES NOT COUNT HERE)**, or have any thoughts of killing yourself, or have any intent or plan to kill yourself? Did you attempt suicide? IF **YES TO EITHER, CODE YES.**	NO	YES	NO	YES

g

A5 In between 2 episodes of depression, did you ever have an interval of at least 2?

A5 In between 2 episodes of depression, did you ever have an interval of at least 2? months, without any significant depression or any significant loss of interest? N/A NO YES

ARE **5** OR MORE ANSWERS (**A1**-**A3**) CODED **YES** AND IS **A4** CODED YES FOR THAT TIME FRAME?

AND

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

IF **A5** IS CODED **YES,** CODE **YES** FOR RECURRENT.

NO	**YES**
MAJOR DEPRESSIVE EPISODE	
CURRENT	☐
PAST	☐
RECURRENT	☐

A6 a H o w many episodes of depression did you have in your lifetime? _____

Between each episode there must be at least 2 months without any significant depression.

B. SUICIDALITY

In the past month did you:

				Points
B1	Have any accident? This includes taking too much of your medication accidentally. IF NO TO B1, SKIP TO B2; IF YES, ASK B1a:	NO	YES	0
B1a	Plan or intend to hurt yourself in any accident, either by not avoiding a risk or by causing the accident on purpose?	NO	YES	0
	IF NO TO B1a, SKIP TO B2: IF YES, ASK B1b:			
B1b	Intend to die as a result of any accident?	NO	YES	0
B2	Think (even momentarily) that you would be better off dead or wish you were dead or needed to be dead?	NO	YES	1
B3	Think (even momentarily) about harming or of hurting or of injuring yourself -- with at least some intent or awareness that you might die as a result -- or think about suicide (i.e. about killing yourself)?	NO	YES	6

IF NO TO B2 + B3, SKIP TO B4. OTHERWISE ASK:

Frequency		Intensity	
Occasionally	☐	Mild	☐
Often	☐	Moderate	☐
Very often	☐	Severe	☐

B4	Hear a voice or voices telling you to kill yourself or have dreams with any suicidal content? If YES, was it either or both: ☐ was it a voice or voices? ☐ was it a dream?	NO	YES	4
B5	Have a suicide method in mind (i.e. how)?	NO	YES	8
B6	Have a suicide means in mind (i.e. with what)?	NO	YES	8
B7	Have any place in mind to attempt suicide (i.e. where)?	NO	YES	8
B8	Have any date/timeframe in mind to attempt suicide (i.e. when)?	NO	YES	8
B9	Think about any task you would like to complete before trying to kill yourself? (e.g. writing a suicide note)	NO	YES	8
B10	Intend to act on thoughts of killing yourself? If YES, mark either or both: ☐ did you intend to act at the time? ☐ did you intend to act at some time in the future?	NO	YES	8
B11	Intend to die as a result of a suicidal act? If YES, mark either or both: ☐ did you intend to die by suicide at the time? ☐ did you intend to die by suicide at some time in the future?	NO	YES	8
B12	Feel the need or impulse to kill yourself or to plan to kill yourself sooner rather than later? If YES, mark either or both: ☐ was this to kill you? ☐ was this to plan to kill yourself? If YES, mark either or both: ☐ was this largely unprovoked? ☐ was this provoked?	NO	YES	8

IN ASSESSING WHETHER THIS WAS LARGELY UNPROVOKED ASK: "5 minutes before this Impulse, could you have predicted it would occur at that time?"

B13	Have difficulty resisting these impulses?	NO	YES	8
B14	Take any active steps to prepare for a suicide attempt in which you expected or intended to die (include anything done or purposely not done that put you closer to making a suicide attempt)? This includes times when you were going to kill yourself, but were interrupted or stopped yourself, before harming yourself. IF NO TO B14, SKIP TO B15.	NO	YES	
B14a	Take active steps to prepare to kill yourself, but you **did not start** the suicide attempt?	NO	YES	9
B14b	Take active steps to prepare to kill yourself, but then **you stopped yourself just before** harming yourself ("aborted").	NO	YES	10
B14c	Take active steps to prepare to kill yourself, but then **someone or something stopped you just before** harming yourself ("interrupted")?	NO	YES	11
B15	Injure yourself on purpose without intending to kill yourself?	NO	YES	0
B16	Attempt suicide (to kill yourself)? IF NO TO B16, SKIP TO B17.	NO	YES	
B16a	Start a suicide attempt (to kill yourself), but then **you decided to stop** and did not finish the attempt?	NO	YES	12
B16b	Start a suicide attempt (to kill yourself), but then **you were interrupted** and did not finish the attempt?	NO	YES	13
B16c	Went through with a suicide attempt (to kill yourself), **completely** as you meant to? A suicide attempt means you did something where you could possibly be injured, with at least a slight intent to die. IF NO, SKIP TO B17:	NO	YES	14

Hope to be rescued / survive ☐

Expected / intended to die ☐

B17 **TIME SPENT PER DAY WITH ANY SUICIDAL IMPULSES, THOUGHTS OR ACTIONS:**
Usual time spent per day: hour's___ minutes. Least amount of time spent per day: ___ hour's ____ minutes. Most amount of time spent per day: hour's minutes.

In your lifetime:

B18	Did you ever make a suicide attempt (try to kill yourself)? If YES, how many times? _____ If YES, when was the last suicide attempt?	NO	YES	4

Current: within the past 12 months ☐

In early remission: between 12 and 24 months ago ☐

In remission: more than 24 months ago ☐

"A suicide attempt is any self-injurious behavior, with at least some intent (> 0) to die as a result of the act. Evidence that the individual intended to kill him-or herself, at least to some degree, can be explicit or inferred from the behavior or circumstance. For example, it is defined as a suicide attempt if it is clearly not an accident or if the individual thinks the act could be lethal, even though denying intent." (FDA Guidance for Industry Suicidal Ideation and Behavior Document 2012 and C-CASA definition). Posner K et al. Am J Psychiatry 2007; 164 (7): 1035-1043 & http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm/

B19 How likely are you to try to kill yourself within the next 3 months on a scale of 0-100% _____%

ANY LIKELIHOOD > 0% ON B19 SHOULD BE CODED YES	NO	YES	13

IS AT LEAST **1** OF THE ABOVE (EXCEPT B1) CODED **YES**?

IF YES, ADD THE TOTAL POINTS FOR THE ANSWERS (B1-B19) CHECKED 'YES' AND SPECIFY THE SUICIDALITY SCORE CATEGORY AS INDICATED IN THE DIAGNOSTIC BOX:

INDICATE WHETHER THE SUICIDALITY IS CURRENT (PAST MONTH) OR A LIFETIME SUICIDE ATTEMPT OR BOTH BY MARKING THE APPROPRIATE BOXES OR BY LEAVING EITHER OR BOTH OF THEM UNMARKED. CURRENT = ANY POSITIVE RESPONSE IN B1a THROUGH B16C OR ANY TIME SPENT IN B17. LIFETIME ATTEMPT = B18 CODED YES.

LIKELY IN THE NEAR FUTURE = B19 CODED YES.

MAKE ANY ADDITIONAL COMMENTS ABOUT YOUR ASSESSMENT OF THIS PATIENT'S CURRENT AND NEAR FUTURE SUICIDALITY IN THE SPACE BELOW:

NO	YES

SUICIDALITY

1-8 points Low ☐

CURRENT ☐

LIFETIME ATTEMPT ☐

IS **B18** CODED YES?

AND A YES RESPONSE TO

Was the suicidal act started when the subject not in a state of confusion or delirium?

AND A YES RESPONSE TO

Was the suicidal act done without a political or religious purpose?

IF YES, SPECIFY WHETHER THE DISORDER IS CURRENT, IN EARLY REMISSION OR IN REMISSION.

NO	YES

SUICIDAL BEHAVIOR DISORDER

CURRENT

Current ☐

In early remission ☐

C. MANIC AND HYPOMANIC EPISODES

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

Do you have any family history of manic-depressive illness or bipolar disorder, or any family member who had mood swings treated with a medication like lithium, sodium valproate (Depakote) or lamotrigine (Lamictal)? NO YES

THIS QUESTION IS NOT A CRITERION FOR BIPOLAR DISORDER, BUT IS ASKED TO INCREASE THE CLINICIAN'S VIGILANCE ABOUT THE RISK FOR BIPOLAR DISORDER.

IF YES, PLEASE SPECIFY WHO:_____

C1	a	Have you **ever** had a period of time when you were feeling 'up' or 'high' or 'hyper' and so active or full of energy or full of yourself that you got into trouble, -- or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.) IF PATIENT IS PUZZLED OR UNCLEAR ABOUT WHAT YOU MEAN BY 'UP' OR 'HIGH' OR 'HYPER', CLARIFY AS FOLLOWS: By 'up' or 'high' or 'hyper' I mean: having elated mood; increased energy or increased activity; needing less sleep; having rapid thoughts; being full of ideas; having an increase in productivity, motivation, creativity, or impulsive behavior; phoning or working excessively or spending more money. IF NO, CODE NO TO **C1b**: IF **YES** ASK:	NO	YES
	b	Are you currently feeling 'up' or 'high' or 'hyper' or full of energy?	NO	YES
C2	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? IF NO, CODE NO TO **C2b**: IF **YES** ASK:	NO	YES
	b	Are you currently feeling persistently irritable?	NO	YES
			➡	
		IS **C1a** OR **C2a** CODED **YES**?	NO	YES

C3 IF **C1b** OR **C2b** = **YES**: EXPLORE THE **CURRENT** EPISODE FIRST AND THEN THE MOST SYMPTOMATIC **PAST** EPISODE, OTHERWISE
IF **C1b** AND **C2b** = **NO**: EXPLORE ONLY THE MOST SYMPTOMATIC **PAST** EPISODE

WHEN EXPLORING THE CURRENT EPISODE, PREFACE EACH QUESTION AS FOLLOWS:

Over the past few days including today, when you felt high and full of energy or irritable, did you:

WHEN EXPLORING THE PAST EPISODE, PREFACE EACH QUESTION AS FOLLOWS:

Over a period of a few days in the past, when you felt most high and most full of energy or most 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**.**

NO YES NO YES

THE EXAMPLES ARE CONSISTENT WITH A DELUSIONAL IDEA. Current Episode ☐ No ☐ Yes

Past Episode ☐ No ☐ Yes

NO YES

b Need less sleep (for example, feel rested after only a few hours' sleep)? NO YES

		Current Episode		Past Episode	
c	Talk too much without stopping, or felt a pressure to keep talking?	NO	YES	NO	YES
d	Notice your thoughts going very fast or running together or racing or moving very quickly from one subject to another?	NO	YES	NO	YES
e	Become easily distracted so that any little interruption could distract you?	NO	YES	NO	YES
f	Have a significant increase in your activity or drive, at work, at school, socially or sexually or did you become physically or mentally restless? This increase in activity may be with or without a purpose.	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

C3 SUMMARY: WHEN RATING CURRENT EPISODE: NO YES NO YES

IF C1b IS NO, ARE 4 OR MORE C3 ANSWERS INCLUDING C3f CODED YES?
IF C1b IS YES, ARE 3 OR MORE C3 ANSWERS INCLUDING C3f CODED YES?

WHEN RATING PAST EPISODE:
IF C1a IS NO, ARE 4 OR MORE C3 ANSWERS INCLUDING C3f CODED YES?
IF C1a IS YES, ARE 3 OR MORE C3 ANSWERS INCLUDING C3f CODED YES?

CODE YES ONLY IF THE ABOVE 3 OR 4 SYMPTOMS OCCURRED DURING THE SAME TIME PERIOD.

RULE: ELATION/EXPANSIVENESS REQUIRES ONLY THREE C3 SYMPTOMS, WHILE IRRITABLE MOOD ALONE REQUIRES 4 OF THE C3 SYMPTOMS.

C4 What is the longest time these symptoms lasted (most of the day nearly every day)? ASSESS THIS DURATION FROM THE VERY START TO THE VERY END OF SYMPTOMS, NOT JUST THE PEAK.

	Current Episode	Past Episode
a) 3 days or less	☐	☐
b) 4 days or more	☐	☐
c) 7 days or more	☐	☐

C5	Were you hospitalized for these problems?	NO	YES	NO	YES
C6	Did these symptoms cause significant problems at home, at work, socially, in your relationships, at school or in some other important way?	NO	YES	NO	YES
C7	Were these symptoms associated with a clear change in the way that you previously functioned and that was different from the way that you usually are ?	NO	YES	NO	YES

IF YES, CIRCLE YES IN MANIC EPISODE FOR THAT TIME FRAME AND GO TO C7.

ARE **C3** SUMMARY AND **C7** AND (**C4c** OR **C5** OR **C6** OR ANY PSYCHOTIC FEATURE IN **K1** THROUGH **K8**) CODED **YES**

AND

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

NO	**YES**
CURRENT	☐
PAST	☐

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

IS **C3** SUMMARY CODED **YES** AND ARE **C5** AND **C6** CODED **NO** AND **C7** CODED **YES**,

AND IS EITHER **C4b** OR **C4c** CODED **YES?**

AND

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

AND

ARE ALL PSYCHOTIC FEATURES IN K1 THROUGH K8 CODED **NO**?

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

IF **YES** TO CURRENT MANIC EPISODE, THEN CODE CURRENT HYPOMANIC EPISODE AS **NO.**

IF **YES** TO PAST MANIC EPISODE, THEN CODE PAST HYPOMANIC EPISODE AS **NOT EXPLORED.**

HYPOMANIC EPISODE

CURRENT ☐ **NO**

☐ **YES**

PAST ☐ **NO**

☐ **YES**

☐ **NOT EXPLORED**

ARE **C3** SUMMARY AND **C4a** CODED **YES** AND IS **C5** CODED **NO**?

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

IF **YES** TO CURRENT MANIC EPISODE OR HYPOMANIC EPISODE,
THEN CODE CURRENT HYPOMANIC SYMPTOMS AS **NO.**

IF **YES** TO PAST MANIC EPISODE OR YES TO PAST HYPOMANIC EPISODE,
THEN CODE PAST HYPOMANIC SYMPTOMS AS **NOT EXPLORED.**

HYPOMANIC SYMPTOMS

CURRENT ☐ **NO**

☐ **YES**

PAST ☐ **NO**

☐ **YES**

☐ **NOT EXPLORED**

C8 a) IF MANIC EPISODE IS POSITIVE FOR EITHER CURRENT OR PAST ASK:
Did you have 2 or more of these (manic) episodes lasting 7 days or more (**C4c**) in your lifetime (including the current episode if present)? NO YES

b) IF MANIC OR HYPOMANIC EPISODE IS POSITIVE FOR EITHER CURRENT OR PAST ASK:
Did you have 2 or more of these (hypomanic) episodes lasting 4 days or more (**C4b**) in your lifetime (including the current episode)? NO YES

c) IF THE PAST "HYPOMANIC SYMPTOMS" CATEGORY IS CODED POSITIVE ASK:
Did you have these hypomanic symptoms lasting only 1 to 3 days (**C4a**) 2 or more times?

in your lifetime, (including the current episode if present)? NO YES

D. PANIC DISORDER

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

D1	a	Have you, on more than one occasion, had spells or attacks when you **suddenly** felt anxious, very 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
D2		At any time in the past, did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?	➡ NO	YES
D3		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 -- or did you make any significant change in your behavior because of the attacks (e.g., avoiding unfamiliar situations, or avoiding leaving your house or shopping alone, or doing things to avoid having a panic attack or visiting your doctor or the emergency room more frequently)?	NO	YES
D4		**During the worst attack 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 or a smothering sensation?	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, and lightheaded or feel faint?	NO	YES
	i	Did you have hot flushes or chills?	NO	YES
	j	Did you have tingling or numbness in parts of your body?	NO	YES
	k	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
	l	Did you fear that you were losing control or going crazy?	NO	YES
	m	Did you fear that you were dying?	NO	YES
D5		ARE BOTH **D3,** AND **4** OR MORE **D4** ANSWERS, CODED **YES**?	➡ NO	YES ***PANIC DISORDER LIFETIME***

D6	In the past month did you have persistent concern about having another attack, or worry about the consequences of the attacks, or did you change your behavior in any way because of the attacks?	NO	YES ***PANIC DISORDER CURRENT***

IS EITHER **D5** OR **D6** CODED **YES**,

AND

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

SPECIFY IF THE EPISODE IS CURRENT AND / OR LIFETIME.

NO **YES**

PANIC DISORDER

CURRENT ☐

E. AGORAPHOBIA

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

E1	Do you feel anxious or uneasy in places or situations where help might not be available or escape might be difficult if you had a panic attack or panic-like or embarrassing symptoms, like: being in a crowd, or standing in a line (queue), being in an open space or when crossing a bridge, being in an enclosed space, when you are alone away from home, or alone at home, or traveling in a bus, train or car or using public transportation?	➡ NO	YES
	ARE 2 OR MORE **E1** SITUATIONS CODED YES?	➡ NO	YES
E2	Do these situations almost always bring on fear or anxiety?	➡ NO	YES
E3	Do you fear these situations so much that you avoid them, or suffer through them, or need a companion to face them?	➡ NO	YES
E4	Is this fear or anxiety excessive or out of proportion to the real danger in the situation?	➡ NO	YES
E5	Did this avoidance, fear or anxiety persist for at least 6 months?	➡ NO	YES
E6	Did these symptoms cause significant distress or problems at home, at work, socially, at school or in some other important way?	➡ NO	YES

IS **E6** CODED **YES?**

NO **YES**

AGORAPHOBIA
CURRENT

F. SOCIAL ANXIETY DISORDER (Social Phobia)

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

F1	In the past month, did you have persistent fear and significant anxiety at being watched, being the focus of attention, or of being humiliated or embarrassed or rejected? This includes things like speaking in public, eating in public or with others, writing while	➡	YES

EXAMPLES OF SUCH SOCIAL SITUATIONS TYPICALLY INCLUDE

- INITIATING OR MAINTAINING A CONVERSATION,
- PARTICIPATING IN SMALL GROUPS,
- DATING,
- SPEAKING TO AUTHORITY FIGURES,
- ATTENDING PARTIES,
- PUBLIC SPEAKING,
- EATING IN FRONT OF OTHERS,
- PERFORMING IN FRONT OF OTHERS,
- URINATING IN A PUBLIC WASHROOM, ETC.

F2	Do these social situations almost always bring on fear or anxiety?	➡ NO	YES
F3	Do you fear these social situations so much that you avoid them, or suffer through them, or need a companion to face them?	➡ NO	YES
F4	Is this social fear or anxiety excessive or unreasonable in these social situations?	➡ NO	YES
F5	Did this social avoidance, fear or anxiety persist for at least 6 months?	➡ NO	YES
F6	Did these social fears cause significant distress or interfere with your ability to function at work, at school or socially or in your relationships or in some other important way?	➡ NO	YES

IS **F6** CODED **YES**

and

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

NOTE TO INTERVIEWER: PLEASE SPECIFY IF THE SUBJECT'S FEARS ARE RESTRICTED TO SPEAKING OR PERFORMING IN PUBLIC.

NO	**YES**

SOCIAL ANXIETY DISORDER

RESTRICTED TO PERFORMANCE SAD ONLY ☐

G. OBSESSIVE-COMPULSIVE DISORDER

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

G1a	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 it disturbs or distresses you, or fear you would act on some impulse, **or** fear or superstitions that you would	NO ↓	YES
G1b	In the past month, did you try to suppress these thoughts, impulses, or images or to neutralize or to reduce them with some other thought or action? (DO NOT INCLUDE SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PROBLEMS. DO NOT INCLUDE OBSESSIONS DIRECTLY RELATED TO HOARDING, HAIR PULLING, SKIN PICKING, BODY DYSMORPHIC DISORDER, 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 ↓	YES
G2	Did they keep coming back into your mind even when you tried to ignore or get rid of them?	NO	YES **obsessions**
G3a	In the past month, did you feel driven to do something repeatedly in response to an obsession or in response to a rigid rule, like washing or cleaning excessively, counting or checking things over and over, or repeating or arranging things,	NO	YES
G3b	Are these rituals done to prevent or reduce anxiety or distress or to prevent something bad from happening and are they excessive or unreasonable?	NO	YES **compulsions**
	ARE (**G1**a AND **G1**b AND G2) OR (**G3**a AND **G3**b) CODED **YES**?	➡ NO	YES

G4 In the past month, did these obsessive thoughts and/or compulsive behaviors cause significant distress, or interfere with your ability to function at home, at work, at school or socially or in your relationships or in some other important way or did they take more than one hour a day?

and

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

(CHECK FOR ANY OC SYMPTOMS STARTING WITHIN 3 WEEKS OF AN INFECTION)

SPECIFY THE LEVEL OF INSIGHT AND IF THE EPISODE IS TIC-RELATED.

NO **YES**

O.C.D.

CURRENT

INSIGHT:

GOOD OR FAIR ☐

POOR ☐

TIC-RELATED ☐

H. POSTTRAUMATIC STRESS DISORDER

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

H1	Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury or sexual violence to you or someone else? EXAMPLES OF TRAUMATIC EVENTS INCLUDE: SERIOUS ACCIDENTS, SEXUAL OR PHYSICAL ASSAULT, A TERRORIST ATTACK, BEING HELD HOSTAGE, KIDNAPPING, FIRE, DISCOVERING A BODY, WAR, OR NATURAL DISASTER, WITNESSING THE VIOLENT OR SUDDEN DEATH OF SOMEONE CLOSE TO YOU, OR A LIFE THREATENING ILLNESS.	➡ NO	YES
H2	Starting after the traumatic event, did you repeatedly re-experience the event in an unwanted mentally distressing way, (such as in recurrent dreams related to the event, intense recollections or memories, or flashbacks or as if the event was recurring) or did you have intense physical or psychological reactions when you were reminded about the event or exposed to a similar event?	➡ NO	YES

H3	**In the past month:**			
	a	Did you persistently try to avoid thinking about or remembering distressing details or feelings related to the event?	NO	YES
	b	Did you persistently try to avoid people, conversations, places, situations, activities or things that bring back distressing recollections of the event?	NO	YES
		ARE **1** OR MORE **H3** ANSWERS CODED **YES**?	➡ NO	YES
H4	**In the past month:**			
	a	Did you have trouble recalling some important part of the trauma? (but not because of or related to head trauma, alcohol or drugs).	NO	YES
	b	Were you constantly and unreasonably negative about yourself or others or the world?	NO	YES
	c	Did you constantly blame yourself or others in unreasonable ways for the trauma?	NO	YES
	d	Were your feelings always negative (such as fear, horror, anger, guilt or shame)?	NO	YES
	e	Have you become much less interested in participating in activities that were meaningful to you before?	NO	YES
	f	Did you feel detached or estranged from others?	NO	YES
	g	Were you unable to experience any good feelings (such as happiness, satisfaction or loving feelings)?	NO	YES
		ARE **2** OR MORE **H4** ANSWERS CODED **YES**?	➡ NO	YES
H5	**In the past month:**			
	a	Were you especially irritable or did you have outbursts of anger with little or no provocation?	NO	YES
	b	Were you more reckless or more self-destructive?	NO	YES
	c	Were you more nervous or constantly on your guard?	NO	YES

d Were you more easily startled? NO YES

e Did you have more difficulty concentrating? NO YES

f Did you have more difficulty sleeping? NO YES

➡

ARE **2** OR MORE **H5** ANSWERS CODED **YES**? NO YES

➡

H6 Did all these problems start after the traumatic event and last for more than one month? NO YES

H7 During the past month, did these problems cause significant distress, or interfere with your ability to function at home, at work, at school or socially or in your relationships or in some other important way?

and

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

SPECIFY IF THE CONDITION IS ASSOCIATED WITH DEPERSONALIZATION, DEREALIZATION OR WITH DELAYED EXPRESSION.

NO **YES**

POSTTRAUMATIC STRESS DISORDER CURRENT

WITH

DEPERSONALIZATION ☐

DEREALIZATION ☐

DELAYED EXPRESSION ☐

I. ALCOHOL USE DISORDER

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

		➡	
I1	**In the past 12 months**, have you had 3 or more alcoholic drinks, -- within a 3 hour period, -- on 3 or more occasions?		YES

I2 **In the past 12 months**:

a.	During the times when you drank alcohol, did you end up drinking more than you planned when you started?	NO	YES
b.	Did you repeatedly want to reduce or control your alcohol use? Did you try to cut down or control your alcohol use, but failed? IF **YES** TO EITHER, CODE **YES**.	NO	YES
c.	On the days that you drank, did you spend substantial time obtaining alcohol, drinking, or recovering from the effects of alcohol?	NO	YES
d.	Did you crave or have a strong desire or urge to use alcohol?	NO	YES
e.	Did you spend less time meeting your responsibilities at work, at school, or at home, because of your repeated drinking?	NO	YES
f.	If your drinking caused problems with your family or other people, did you still keep on drinking?	NO	YES
g.	Were you intoxicated more than once in any situation where you or others were physically at risk, for example, driving a car, riding a motorbike, using machinery, boating, etc.?	NO	YES
h.	Did you continue to use alcohol, even though it was clear that the alcohol had caused or worsened psychological or physical problems?	NO	YES
i.	Did you reduce or give up important work, social or recreational activities because of your drinking?	NO	YES
j.	Did you need to drink a lot more in order to get the same effect that you got when you first started drinking or did you get much less effect with continued use of the same amount?	NO	YES
k1.	When you cut down on heavy or prolonged drinking did you have any of the following:	NO	YES

1. increased sweating or increased heart rate, ☐
2. hand tremor or "the shakes" ☐
3. trouble sleeping ☐
4. nausea or vomiting ☐
5. hearing or seeing things other people could not see or hear or having sensations in your skin for no apparent reason ☐
6. agitation ☐
7. anxiety ☐
8. seizures ☐

IF **YES** TO 2 OR MORE OF THE ABOVE 8, CODE k1 AS **YES**.

k2. Did you drink alcohol to reduce or avoid withdrawal symptoms or to avoid being hung-over? NO YES

K SUMMARY: IF **YES** TO k1 OR k2, CODE **YES** NO YES

ARE **2** OR MORE **I2** ANSWERS FROM **I2a** THROUGH **12J** AND 12**K SUSUMMARY** CODED **YES**?

NO **YES**

ALCOHOL USE DISORDER

SPECIFIERS FOR ALCOHOL USE DISORDER:

MILD = 2-3 OF THE I2 SYMPTOMS
MODERATE = 4-5 OF THE I2 SYMPTOMS
SEVERE = 6 OR MORE OF THE I2 SYMPTOMS

IN EARLY REMISSION = CRITERIA NOT MET FOR BETWEEN 3 & 12 MONTHS
IN SUSTAINED REMISSION = CRITERIA NOT MET FOR 12 MONTHS OR MORE
(BOTH WITH THE EXCEPTION OF CRITERION d. – (CRAVING) ABOVE).

IN A CONTROLLED ENVIRONMENT = WHERE ALCOHOL ACCESS IS RESTRICTED

SPECIFY IF:

MILD ☐
MODERATE ☐
SEVERE ☐

IN EARLY REMISSION ☐
IN SUSTAINED REMISSION ☐

IN A CONTROLLED ENVIRONMENT ☐

J. SUBSTANCE USE DISORDER (NON-ALCOHOL)

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

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

J1 a **In the past 12 months**, did you take any of these drugs more than once,to get high, to feel elated, to get "a buzz" or to change your mood? ➡ YES

CIRCLE EACH DRUG TAKEN:

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

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

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

Hallucinogens: LSD ("acid"), mescaline, peyote, psilocybin, STP, "mushrooms", "ecstasy", MDA, MDMA. **Dissociative Drugs**: PCP (Phencyclidine, "Angel Dust", "Peace Pill", "Hog"), or ketamine ("Special K").

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

Cannabis: 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. Cough Medicine? Any others?

SPECIFY THE MOST USED DRUG(S): _____

WHICH DRUG(S) CAUSES THE BIGGEST PROBLEMS? _____

FIRST EXPLORE THE CRITERIA BELOW FOR THE DRUG CLASS CAUSING THE BIGGEST PROBLEMS AND THE ONE MOST LIKELY TO MEET CRITERIA

FOR SUBSTANCE USE DISORDER. IF SEVERAL DRUG CLASSES HAVE BEEN MISUSED, EXPLORE AS MANY OR AS FEW AS REQUIRED BY THE PROTOCOL.

J2 **Considering your use of (NAME OF DRUG / DRUG CLASS SELECTED), in the past 12 months:**

a. During the times when you used the drug, did you end up using more (NAME OF DRUG / DRUG CLASS SELECTED) than you planned when you started? NO YES

b. Did you repeatedly want to reduce or control your (NAME OF DRUG / DRUG CLASS SELECTED) use? Did you try to cut down or control your (NAME OF DRUG / DRUG CLASS SELECTED) use, but failed? IF **YES** TO EITHER, CODE **YES**. NO YES

c. On the days that you used more (NAME OF DRUG / DRUG CLASS SELECTED), did you spend substantial time obtaining (NAME OF DRUG / DRUG CLASS SELECTED), using it, or recovering from the its effects? NO YES

d. Did you crave or have a strong desire or urge to use (NAME OF DRUG / DRUG CLASS SELECTED)? NO YES

e. Did you spend less time meeting your responsibilities at work, at school, or at home, because of your repeated (NAME OF DRUG / DRUG CLASS SELECTED) use? NO YES

f. If your (NAME OF DRUG / DRUG CLASS SELECTED) use caused problems with your family or other people, did you still keep on using it? NO YES

g. Did you use the drug more than once in any situation where you or others were physically at risk, for example, driving a car, riding a motorbike, using machinery, boating, etc.? NO YES

h. Did you continue to use (NAME OF DRUG / DRUG CLASS SELECTED), even though it was clear that the (NAME OF DRUG / DRUG CLASS SELECTED) had caused or worsened psychological or physical problems? NO YES

i. Did you reduce or give up important work, social or recreational activities because of your (NAME OF DRUG / DRUG CLASS SELECTED) use? NO YES

j. Did you need to use (NAME OF DRUG / DRUG CLASS SELECTED) a lot more in order to get the same effect that you got when you first started using it or did you get much less effect with continued use of the same amount? NO YES
THIS CRITERION IS CODED NO IF THE MEDICATION IS PRESCRIBED AND USED UNDER MEDICAL SUPERVISION.

k1. When you cut down on heavy or prolonged use of the drug did you have any of the following withdrawal symptoms? NO YES
IF **YES** TO THE REQUIRED NUMBER OF WITHDRAWAL SYMPTOMS FOR EACH CLASS, CODE J2k1 AS **YES**.

THIS CRITERION IS CODED NO IF THE MEDICATION IS PRESCRIBED AND USED UNDER MEDICAL SUPERVISION.

Sedative, Hypnotic or Anxiolytic (2 or more)

1. increased sweating or increased heart rate ☐
2. hand tremor or "the shakes" ☐
3. trouble sleeping ☐
4. nausea or vomiting ☐
5. hearing or seeing things other people could not see or hear or having sensations in your skin for no apparent reason ☐
6. agitation ☐
7. anxiety ☐
8. seizures ☐

Opiates (3 or more)

1. feeling depressed ☐
2. nausea or vomiting ☐
3. muscle aches ☐
4. runny nose or teary eyes ☐
5. dilated pupils, goose bumps or hair standing on end or sweating ☐
6. diarrhea ☐
7. yawning ☐
8. hot flashes ☐
9. trouble sleeping ☐

Stimulants (2 or more)

1. fatigue ☐
2. vivid or unpleasant dreams ☐
3. difficulty sleeping or sleeping too much ☐
4. increased appetite ☐
5. feeling or looking physically or mentally slowed down ☐

Cannabis (3 or more)

1. irritability, anger or aggression ☐
2. nervousness or anxiety ☐

3. trouble sleeping ☐
4. appetite or weight loss ☐
5. restlessness ☐
6. feeling depressed ☐
7. significant discomfort from one of the following:
   "stomach pain", tremors or "shakes", sweating, hot flashes,
   chills, headaches. ☐

k2. Did you use (NAME OF DRUG / DRUG CLASS SELECTED) to reduce or avoid withdrawal symptoms? NO YES

J2k **SUMMARY**: IF **YES** TO J2k1 OR J2k2, CODE **YES** NO YES

ARE **2** OR MORE **J2** ANSWERS FROM **J2a** THROUGH **J2k SUMMARY** CODED **YES**?
(**J2**k1 AND **J2**k2 TOGETHER COUNT AS ONE AMONG THESE CHOICES)

NO **YES**

SUBSTANCE

(Drug or Drug Class Name)
USE DISORDER

SPECIFIERS FOR SUBSTANCE USE DISORDER:

MILD = 2-3 OF THE J2 SYMPTOMS
MODERATE = 4-5 OF THE J2 SYMPTOMS
SEVERE = 6 OR MORE OF THE J2 SYMPTOMS

IN EARLY REMISSION = CRITERIA NOT MET FOR BETWEEN 3 & 12 MONTHS
IN SUSTAINED REMISSION = CRITERIA NOT MET FOR 12 MONTHS OR MORE
(BOTH WITH THE EXCEPTION OF CRITERION d. – (CRAVING) ABOVE).

IN A CONTROLLED ENVIRONMENT = WHERE SUBSTANCE / DRUG ACCESS IS RESTRICTED

SPECIFY IF:

MILD ☐
MODERATE ☐
SEVERE ☐

IN EARLY REMISSION ☐
IN SUSTAINED REMISSION ☐

IN A CONTROLLED ENVIRONMENT ☐

K. PSYCHOTIC DISORDERS AND MOOD DISORDER WITH PSYCHOTIC FEATURES

ASK FOR AN EXAMPLE OF EACH QUESTION ANSWERED POSITIVELY. CODE **YES** ONLY IF THE EXAMPLES CLEARLY SHOW A DISTORTION OF THOUGHT OR OF PERCEPTION OR IF THEY ARE NOT CULTURALLY APPROPRIATE. THE PURPOSE OF THIS MODULE IS TO EXCLUDE PATIENTS WITH PSYCHOTIC DISORDERS. THIS MODULE NEEDS EXPERIENCE.

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

K1	a	Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you? **NOTE**: ASK FOR EXAMPLES TO RULE OUT ACTUAL STALKING.	NO	YES
	b	**IF YES:** do you currently believe these things?	NO	YES
K2	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
	b	**IF YES:** do you currently believe these things?	NO	YES
K3	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
	b	**IF YES:** do you currently believe these things?	NO	YES
K4	a	Have you ever believed that you were being sent special messages through the TV, radio, internet, newspapers, books, or magazines or that a person you did not personally know was particularly interested in you?	NO	YES
	b	**IF YES:** do you currently believe these things?	NO	YES
K5	a	Have your relatives or friends ever considered any of your beliefs odd or unusual? INTERVIEWER: ASK FOR EXAMPLES. ONLY CODE YES IF THE EXAMPLES ARE CLEARLY DELUSIONAL IDEAS NOT EXPLORED IN QUESTIONS K1 TO K4, FOR EXAMPLE, RELIGIOUS, DEATH, DISEASE OR SOMATIC DELUSIONS, DELUSIONS OF GRANDIOSITY, JEALOUSY OR GUILT, OR OF FAILURE, INADEQUACY, RUIN, OR DESTITUTION, OR NIHILISTIC DELUSIONS.	NO	YES
	b	**IF YES:** do they currently consider your beliefs strange or unusual?	NO	YES
K6	a	Have you ever heard things other people couldn't hear, such as voices?	NO	YES
		IF YES TO VOICE HALLUCINATION: Was the voice commenting on your thoughts or behavior or did you hear two or more voices talking to each other?	NO	YES
	b	**IF YES TO K6a:** have you heard sounds / voices in the past month?	NO	YES
		IF YES TO VOICE HALLUCINATION: Was the voice commenting on your thoughts or behavior or did you hear two or more voices talking to each other?	NO	YES

K7 a Have you ever had visions when you were awake or have you ever seen things other people couldn't see? NO YES

CLINICIAN: CHECK TO SEE IF THESE ARE CULTURALLY INAPPROPRIATE.

b **IF YES:** have you seen these things in the past month? NO YES

CLINICIAN'S JUDGMENT

K8 a DID THE PATIENT EVER IN THE PAST EXHIBIT DISORGANIZED, INCOHERENT OR DERAILED SPEECH, OR MARKED LOOSENING OF ASSOCIATIONS? NO YES

K8 b IS THE PATIENT CURRENTLY EXHIBITING INCOHERENCE, DISORGANIZED OR DERAILED SPEECH, OR MARKED LOOSENING OF ASSOCIATIONS? NO YES

K9 a DID THE PATIENT EVER IN THE PAST EXHIBIT DISORGANIZED OR CATATONIC BEHAVIOR? NO YES

K9 b IS THE PATIENT CURRENTLY EXHIBITING DISORGANIZED OR CATATONIC BEHAVIOR? NO YES

K10 a DID THE PATIENT EVER IN THE PAST HAVE NEGATIVE SYMPTOMS, E.G. SIGNIFICANT REDUCTION OF EMOTIONAL EXPRESSION OR AFFECTIVE FLATTENING, POVERTY OF SPEECH (ALOGIA) OR AN INABILITY TO INITIATE OR PERSIST IN GOAL-DIRECTED ACTIVITIES (AVOLITION)? NO YES

K10 b ARE NEGATIVE SYMPTOMS OF SCHIZOPHRENIA, E.G. SIGNIFICANT REDUCTION OF EMOTIONAL EXPRESSION OR AFFECTIVE FLATTENING, POVERTY OF SPEECH (ALOGIA) OR AN INABILITY TO INITIATE OR PERSIST IN GOAL-DIRECTED ACTIVITIES (AVOLITION), PROMINENT DURING THE INTERVIEW? NO YES

K11 a IS 1 OR MORE « a » QUESTIONS FROM K1a TO K7a, CODED **YES**?

ARE AND IS EITHER:

MAJOR DEPRESSIVE EPISODE, (CURRENT, RECURRENT OR PAST)
OR
MANIC OR HYPOMANIC EPISODE, (CURRENT OR PAST) CODED **YES**? NO YES
↳ **K13**

HOW LONG HAS THE MOOD EPISODE LASTED? _____
HOW LONG HAS THE PSYCHOTIC EPISODE LASTED? _____
IF SUCH A MOOD EPISODE IS PRESENT, IT MUST BE PRESENT FOR THE MAJORITY OF THE TOTAL DURATION OF THE ACTIVE AND RESIDUAL PERIODS OF THE PSYCHOTIC SYMPTOMS. OTHERWISE CODE NO TO K11a.

IF NO TO K11a, CIRCLE NO IN BOTH 'MOOD DISORDER WITH PSYCHOTIC FEATURES' DIAGNOSTIC BOXES AND MOVE TO K13.

b You told me earlier that you had period(s) when you felt (depressed/high/persistently irritable).

Were the beliefs and experiences you just described (SYMPTOMS CODED **YES** FROM **K1**a TO **K7**a) restricted exclusively to times when you were feeling depressed/high/irritable?

IF THE PATIENT EVER HAD A PERIOD OF AT LEAST 2 WEEKS OF HAVING THESE BELIEFS OR EXPERIENCES

(PSYCHOTIC SYMPTOMS) WHEN THEY WERE NOT DEPRESSED/HIGH/IRRITABLE, CODE NO TO THIS DISORDER.

IF THE ANSWER IS NO TO THIS DISORDER GROUPING, ALSO CIRCLE NO TO K12 AND MOVE TO K13

NO **YES**

MOOD DISORDER WITH

PSYCHOTIC FEATURES

K12 a ARE 1 OR MORE « b » QUESTIONS FROM K1b TO K7b CODED **YES** AND IS EITHER:

MAJOR DEPRESSIVE EPISODE (CURRENT)

OR

MANIC OR HYPOMANIC EPISODE (CURRENT) CODED **YES**?

IF THE ANSWER IS YES TO THIS DISORDER (LIFETIME OR CURRENT), CIRCLE NO TO K13 AND K14 AND MOVE TO THE NEXT MODULE.

NO **YES**

MOOD DISORDER WITH

PSYCHOTIC FEATURES

K13 ARE 1 OR MORE « b » QUESTIONS FROM K1b TO K8b, CODED **YES**?

AND

ARE 2 OR MORE « b » QUESTIONS FROM K1b TO K10b, CODED **YES**?

AND DID AT LEAST TWO OF THE PSYCHOTIC SYMPTOMS OCCUR DURING THE SAME 1-MONTH PERIOD?

AND

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

NO **YES**

PSYCHOTIC DISORDER

CURRENT

K14 IS **K13** CODED **YES**

OR

(ARE 1 OR MORE « a » QUESTIONS FROM K1a TO K8a, CODED **YES**?

AND

ARE 2 OR MORE « a » QUESTIONS FROM K1a TO K10a, CODED **YES?**

AND DID AT LEAST TWO OF THE PSYCHOTIC SYMPTOMS OCCUR DURING THE SAME 1-MONTH PERIOD?)

AND

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

NO	YES

PSYCHOTIC DISORDER

LIFETIME

L. ANOREXIA NERVOSA

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

L1	a	How tall are you?	☐ft ☐☐in. ☐ ☐☐cm	
	b.	What was your lowest weight in the past 3 months?	☐☐☐lb ☐ ☐☐kg	
	c	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:

L2		In spite of this low weight, have you tried not to gain weight or to restrict your food intake? Have	➡ NO	YES
L3		you intensely feared gaining weight or becoming fat, even though you were underweight?	➡ NO	YES
L4	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
L5		ARE 1 OR MORE ITEMS FROM **L4** CODED **YES**?	➡ NO	YES

IS **L5** CODED **YES**?

NO	YES

HEIGHT / WEIGHT TABLE CORRESPONDING TO A BMI THRESHOLD OF 17.0 KG/M^2

Height/Weight														
ft/in	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	5'10
lb	79	82	84	87	90	93	96	99	102	106	109	112	115	119
cm	145	147	150	152	155	158	160	163	165	168	170	173	175	178
kg	36	37	38.5	39.5	41	42.5	43.5	45.5	46.5	48	49	51	52	54

Height/Weight					
ft/in	5'11	6'0	6'1	6'2	6'3
lb	122	125	129	133	136
cm	180	183	185	188	191
kg	55	57	58.5	60	62

The weight thresholds above are calculated using a body mass index (BMI) equal to or below 17.0 kg/m^2 for the patient's height using the Center of Disease Control & Prevention BMI Calculator. This is the threshold guideline below which a person is deemed underweight by the DSM-5 for Anorexia Nervosa.

M. BULIMIA NERVOSA

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

M1	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 ↳ **M3**
M2	During these binges, did you feel that your eating was out of control?	NO YES

		➡
M3	Did you do anything to compensate for, or to prevent a weight gain, like vomiting, fasting, exercising or taking laxatives, enemas, diuretics (fluid pills), or other medications? Did you do this as often as once a week? CODE YES TO M3 ONLY IF THE ANSWER TO BOTH THESE M3 QUESTIONS IS YES.	NO YES
M3a	Number of Episodes of Inappropriate Compensatory Behaviors per Week? _____ Number of Days of Inappropriate Compensatory Behaviors per Week? _____	
		➡
M4	In the last 3 months, did you have eating binges as often as once a week?	NO YES
		➡
M5	Does your body weight or shape greatly influence how you feel about yourself?	NO YES
M6	DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?	NO YES ↓ Skip to M8
M7	Do these binges occur only when you are under (_____lb/kg)? INTERVIEWER: WRITE IN THE ABOVE PARENTHESIS THE THRESHOLD WEIGHT FOR THIS PATIENT'S HEIGHT FROM THE HEIGHT / WEIGHT TABLE IN THE ANOREXIA NERVOSA MODULE.	NO YES

M8 IS **M5** CODED **YES** AND IS EITHER **M6** OR **M7** CODED **NO**?

NO **YES**

BULIMIA NERVOSA

CURRENT

IS **M7** CODED **YES**?

NO **YES**

ANOREXIA NERVOSA

Binge Eating/Purging Type

DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?

AND

ARE M2 AND M3 CODED NO?

NO **YES**

ANOREXIA NERVOSA

Restricting Type

SPECIFIERS OF EATING DISORDER:

MILD = 1-3 EPISODES OF INAPPROPRIATE COMPENSATORY BEHAVIORS
MODERATE = 4-7 EPISODES OF INAPPROPRIATE COMPENSATORY BEHAVIORS
SEVERE = 8-13 EPISODES OF INAPPROPRIATE COMPENSATORY BEHAVIORS
EXTREME = 14 OR MORE EPISODES OF INAPPROPRIATE COMPENSATORY BEHAVIORS

SPECIFY IF:

MILD ☐
MODERATE ☐
SEVERE ☐
EXTREME ☐

MB. BINGE EATING DISORDER

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

MB1	DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?	NO	➡ YES
MB2	DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR BULIMIA NERVOSA?	NO	➡ YES
MB3	M2 IS CODED YES	➡ NO	YES
MB4	M3 IS CODED YES	NO	➡ YES
MB5	M4 IS CODED YES	➡ NO	YES
	In the last 3 months during the binging did you:		
MB6a	Eat more rapidly than normal?	NO	YES
MB6b	Eat until you felt uncomfortably full?	NO	YES
MB6c	Eat large amounts of food when you were not hungry?	NO	YES
MB6d	Eat alone because you felt embarrassed about how much you were eating?	NO	YES
MB6e	Feel guilty, depressed or disgusted with yourself after binging?	NO	YES

ARE 3 OR MORE **MB6** QUESTIONS CODED YES?

➡
NO YES

MB7 Does your binging distress you a lot? ➡ NO YES

MB8 Number of Binge Eating Episodes per Week? _____

Number of Binge Eating Days per Week? _____

IS MB7 CODED YES?

NO **YES**

BINGE-EATING DISORDER

SPECIFIERS OF EATING DISORDER:

MILD = 1-3 EPISODES OF BINGE EATING PER WEEK
MODERATE = 4-7 EPISODES OF BINGE EATING PER WEEK
SEVERE = 8-13 EPISODES OF BINGE EATING PER WEEK
EXTREME = 14 OR MORE EPISODES OF BINGE EATING PER WEEK

SPECIFY IF:

MILD ☐
MODERATE ☐
SEVERE ☐
EXTREME ☐

N. GENERALIZED ANXIETY DISORDER

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

N1	a	Were you excessively anxious or worried about several routine things, over the past 6 months? IN ENGLISH, IF THE PATIENT IS UNCLEAR ABOUT WHAT YOU MEAN, PROBE BY ASKING (Do others think that you are a worrier or a "worry wart"?) AND GET EXAMPLES.	➡ NO	YES
	b	Are these anxieties and worries present most days?	➡ NO	YES
		ARE THE PATIENT'S ANXIETY AND WORRIES RESTRICTED EXCLUSIVELY TO, OR BETTER EXPLAINED BY, ANY DISORDER PRIOR TO THIS POINT?	NO	➡ YES
N2		Do you find it difficult to control the worries?	➡ NO	YES
N3		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, did you, most of the time:		
	a	Feel restless, keyed up or on edge?	NO	YES
	b	Have muscle tension?	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
		ARE **3** OR MORE **N3** ANSWERS CODED **YES?**	➡ NO	YES
N4		Do these anxieties and worries significantly disrupt your ability to work, to function socially or in your relationships or in other important areas of your life or cause you significant distress? AND IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?	**NO**	**YES**

GENERALIZED ANXIETY DISORDER
CURRENT

O. RULE OUT MEDICAL, ORGANIC OR DRUG CAUSES FOR ALL DISORDERS

IF THE PATIENT CODES POSITIVE FOR ANY CURRENT DISORDER ASK:

Just before these symptoms began:

O1a	Were you taking any drugs or medicines or in withdrawal from any of these?	❒ No	❒ Yes	❒ Uncertain
O1b	Did you have any medical illness?	❒ No	❒ Yes	❒ Uncertain
O2	IF O1a OR O1b IS CODED YES, IN THE CLINICIAN'S JUDGMENT IS EITHER LIKELY TO BE A DIRECT CAUSE OF THE PATIENT'S DISORDER? IF NECESSARY, ASK ADDITIONAL OPEN-ENDED QUESTIONS.	❒ No	❒ Yes	❒ Uncertain

O2 SUMMARY: AN "ORGANIC" / MEDICAL / DRUG RELATED CAUSE BEEN RULED OUT ❒ No ❒ Yes ❒ Uncertain

IF **O2** IS YES, THEN **O2** SUMMARY IS NO. IF **O2** IS NO, THEN **O2** SUMMARY IS YES. OHTERWISE IT IS UNCERTAIN.

P. ANTISOCIAL PERSONALITY DISORDER

(➡ MEANS: GO TO THE DIAGNOSTIC BOX AND CIRCLE NO)

P1 **Before you were 15 years old, did you:**

a	repeatedly skip school or run away from home overnight or stayed out at night against your parent's rules?	NO	YES
b	repeatedly lie, cheat, "con" others, or steal or break into someone's house or car?	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 into sexual activity?	NO	YES
		➡	
	ARE **2** OR MORE **P1** ANSWERS CODED **YES**?	NO	YES

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

P2 **Since you were 15 years old, have you:**

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

ARE **3** OR MORE **P2** QUESTIONS CODED **YES**?

NO	YES
	ANTISOCIAL PERSONALITY DISORDER **LIFETIME**

THIS CONCLUDES THE INTERVIEW

MINI INTERNATIONALNEUROPSYCHIATRICINTERVIEW

M

Mfumo wa

Kiswahili 7.0.0

I

ya

DSM-5

ONYO

Nia yetu ni kuwasaidia kwa kuchunguza na kufuatilia wagonjwa kwa urahisi na umantiki. Kabla ya hatua yoyote kuchukuliwa kuhusiana na data iliyokusanywa kwa kupitia programu hii, lazima ipitiwe na na itafsiriwe na daktari aliyeidhinishwa.

Programu hii haijaundwa ama nia yake ni kutumika kwa niaba ya matibabu kamilifu ya daktari aliyehitimu na kuidhinishwa, bali nia yake ni kutumika kama chombo cha kuhakikisha usahihi wa data iliyokusanywa ili kuonyesha dalili zinazoibuka kama anavyoona daktari aliyehitimu.

Jina la mgonjwa: MADAWA YA ***Nambari ya mgonjwa:***

Tarehe ya kuzaliwa: ***Wakati mahojiano yalianza:***

Jina la mhoji: KULEVYA (Isiyo pombe) miezi 12 iliyopita ❒ 304.00-.90/305.20-.90 F11.1x-F19.288 ❒ ***Wakati wa kukamilika kwa mahojiano:***

Tarehe ya mahojiano: ***Jumla ya muda uliyotumika:***

	VIHUNZI HURU	MUDA	K MAGONJWA YA SAIKOSIS	CRITERIA	DSM-5	maisha	ICD-10	Matabaka ya kimsingi
			yote ❒	297.3/297.9/			F20.81-F29 ❒	
A	TUKIO KUU LA SONONA		Kwa sasa (wiki 2) ❒					
			Siku za nyuma ❒					
	UGONJWA WA KUSONONA KUU		Kwa sasa (wiki 2) ❒		296.20-296.26	Single	F32.x	
			Siku za nyuma ❒		296.20-296.26	Single	F32.x	
			Kujirudia rudia ❒		296.30-296.36	Recurrent	F33.x	
			Majaribio ya maisha nzima ❒		❒ chini ❒ kati ❒ juu			❒
	HULKA YA KUTAKA KUJIUA		kwa sasa ❒		(kwa mwaka mmoja)			
			Majibu ya hapo awali ❒		(kati ya mwaka 1-2)			
C	TUKIO LA MANIA		Kwa sasa ❒					
			Siku zilizopita ❒					
	TUKIO LA MANIA NDOGO		Kwa sasa ❒					
			Siku zilizopita ❒		❒ Bado			
	UGONJWA WA BIPOLA		Kwa sasa ❒		296.41-296.56		F31.0--F31.76	
			Siku zilizopita ❒		296.41-296.56		F31.0- F31.76	
	UGONJWA WA BIPOLA		Kwa sasa ❒		296.89		F31.81	
			Sik zilizopita ❒		296.89		F31.81	
	UGONJWA WA BIPOLA USODHIHIRIKA		Kwa sasa ❒		296.40/296.50		F31.9	
			Siku zilizopita ❒		296.40/296.50	Kwa	F31.9	
			Kwa sasa ❒		296.44/296.54	sasa	F31.2/31.5	❒ 297.
			Siku zilizopita ❒		296.44/296.54	3/297.9/	F31.2/31.5	F20.81-
						F29		❒
D	UGONJWA WA HOFU KUBWA		Kwa sasa (mwezi uliopita) ❒		300.01		F41.0 F	
E	WOGA WA NAFASI ZA WAZI	293.81/298.83/298.89	Kwa sasa ❒		300.22		F40.00	
F	WOGA WA MKUSANYIKO WA WATU		Kwa sasa (mwezi ❒		300.23		F40.10	
			UGONJWA WA HALI YA MTU NA TUKIO LA SAIKOSIS				maisha yote	
			❒		296.24/296.34-296.44 ❒		F31.2/F32.2/F33.3	❒
G	UGONJWA WA SHAUKU LAZIMISHO		Kwa sasa (mwezi ❒		300.3		F42	
H	UGONJWA WA MSONGO BAADA YA MATUKIO		296.54 Kwa sasa (mwezi ❒		309.81		F43.10	
J						Kwa sasa		❒
			296.24/296.34/296.44/296.54F31.2/F32.2/F33. 3 ❒					
M A T U M I Z I			L UGONJWA WA TAFSIRI YA MAUMBILE					❒ 307
			M UGONJWA WA TAFSIRI YA MAUMBILE			Kwa sasa (miezi 3		❒ 307
			MB UGONJWA WA TAFSIRI YA MAUMBILE PINAFSI UNAOHUSIANA KULA MARA			Kwa sasa (miezi 3 iliyopita)		❒ 307
			N UGONJWA WA WASIWASI MKUBWA			kwa sasa (miezi 6		
			iliyopita) ❒		300.02		F41.1	❒
M A B A Y A			O UTIBABU WA KIOGANIKI					❒LA ❒ND
			P UGONJWA WA MAKUZI YA HULKA NA TABIA			Maisha yote		❒ 301

ANGALIA MATIBABU KWA KUANGZIA MWANYA MWAFAKA.

Y A (Shida gani inakusumbua ama inajitokeza zaidi ama huja ya kwanza kwa historia yako?)

M AAGIZO YA JUMLA

M.I.N.I. iliundwa kama mahojiano kwa ufupi, kushughulikia Magonjwa makuu ya akili (Axis I psychiatric disorders) kulingana na DSM5 na ICD10. utafiti kuthibitisha mefanywa kulinganishwa na M.I.N.I. kwa SCID-P ya DSM-III-R ya (Mahojiano mafupi imetengenezwa na shirika la afya ulimwenguni).Matokeo ya uchunguzi huu inaonyesha kuwa M.I.N.I.ina usawa katika kukubalika kwake. Lakini inaweza kutumika kwa wakati mfupi, (mean 18.7 ± 11.6 minutes, median 15 minutes) kushinda yale yaliyoorodheshwa hapo juu. Kwa hivyo madaktari wanaweza kuitumia baads ya mafunzo kwa ufupi.Wahoji wa Lay watahitaji mafunzo kwa Upana.

MAHOJIANO

:

Ili kuifanya mahojiano iwe mafupi iwezekanavyo, muelezee mgonjwa kuwa utakuwa ukifanya mahojiano ya matibabu ambayo ni hojaji funge, na maswali yatakuwa mahususi, kuhusiana na hali yake ya kiakili na itahitaji majibu ya ndio au la.

MFUMO WA JUMLA:

M.I.N.I. imegawanywa katika vikundi ambavyo vimeonyeshwa kwa kutumia herufi ambayo inaonyesha kikundi husika.

- Kila mwanzo wa matibabu hizi tofauti (isipokuwa psychotic disorders module), screening question(s) corresponding to the main criteria of the disorder are presented in a **gray box**.
- Kila mwisho wa mada, vijisanduku vimewewa ili daktari aweze kuonyesha maafikio kama yalifikiwa.

MAAGIZO:

Sentensi ambazo zimeandikwa katika herufi za kawaida zisomwe kama vile zimeandikiwa mgonjwa, ili kuifanya iuwiane na matokeo yanayotarajiwa.

Sentensi zilizoandikwa kwa herufi kubwa, magonjwa asisomewe. Ni maagizo kwa anayehoji ili kumwezesha kupeana alama za matokeo yatakayopatikana.

Sentensi zilizokolezwa inaonyesha wakati wa kufanya utafiti. Mhoji anafaa kuisoma mara nyingi iwezekanavyo. Dalili zinazojitokeza pekee kwa wakati uliopewa ndio itakayotumika kupatiana alama ya responses.

Jawabu zilizo na mishale hapo juu (➨) zimetumika kuonyesha kuwa nfumo uliotumika katika matibabu haija afikiwa. Kwa hivyo mhoji ataenda hadi mwisho ili aweze kuviringa **LA** kwa matibabu kwa pengo zote zilizoachwa na na kuenda kwa kipande kinachofuata.

Kama maneno yamebainishwa na mshazari *(/) m*hoji anafaa kusoma tu zile dalili ambazo zajulikana kuwepo kwa wakakti huo kwa magonjwa. (mfano, swaliJ2bor K6b).

Maneno kwenye parandesi ni mifano ya kimatibabu ya dalili za ugonjwa. Haya yanaweza kusomewa mgonjwa ili aweze kuelewa maswali.

MAAGIZO YA MAKADIRIO:

Maswali yote lazima yakadiriwe. Makadirio yanafanywa kwa upande wa kulia wa kila swali kwa kuviringa 'ndio' au 'la'.Maamuzi ya kimatibabu kwa anayekadiria itatumika kuzingatia tabia. Wahoji wanafaa kukuwa makini kwa kuzingatia utofauti wa mila na tamaduni wakati wa kuuliza maswalina kukadiria tabia. Anayekadiria anafaa kuulizia mifano kama ni lazima ndio apate jawabu mwafaka. Mgonjwa anahimizwa kuuliza ahakikishiwe maswali yoyote aliyo nayo.

Daktari anafaa kuhakikisha kuwa kila kipande cha maswali yameshughulikiwa ili kumsaidia mgonjwa (kwa mfano, wakati uliopewa).

Dalili ambazo zimeonyeshwa kwa kutumia vitu kama vile vileo haifai kuonyeshwa kama chanya (+) kwa M.I.N.I. M.I.N.I.ina maswali inayochunguza maswala haya.

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

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e-mail : dsheehan@health.usf.edu

A.TUKIO KUU LA SONONA

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

A1	a	Umewahi kusononeka, kuwa chini, mwenye huzuni, utupu wa moyo ama mwenye kukosa matumaini, muda mwingi wa Siku, karibu kila siku, kwa muda wa wiki mbili?	LA	NDIO
		Je jawabu ni La ama NDIYO, Kama NDIYO uliza;:		
	b	Kwa wiki mbili zilizopita, ulisononeka, kuwa chini, mwenye huzuni , utupu wa moyo ama kukosa matumaini, muda mwingi wa Siku, karibu kila siku?	LA	NDIO
A2	a	Uliwahi kosa hamu,ya vitu vingi, au kukosa kufurahia vitu vingi vilivyo kufurahisha hapo awali kwa muda wa wiki mbili?	LA	NDIO
		Kama LA, jaza LA kwa A2b: **Kama NDIO Uliza:**		
	b	Wiki mbili zilizopita, Uliwahi kukosa hamu ya vitu vingi au kukosa kufurahia vitu vingi vilivyo kufurahisha hapo awali ?	LA	NDIO
			LA	NDIO

Kama **A1b** na **A2b** = **LA**: Chunguza tukio la Zamani lenye dalili nyingi.

Kwa muda wa wiki mbili uliposononeka ama kukosa hamu:

		Wiki 2 zilizopita		Tuki	
a	Hamu yako ya chakula ilipungua ama kuongezeka karibu kila siku? Kilo au Uzito wako uliongezeka au kupungua bila kukusudia (mfano, kwa ±5% ya ±8lb ama±3.5kg,kwa mtu wa 160lb/70kgkwa mwezi?) kama NDIO, onyesha Ndio.	LA	NDIO	LA	NDIO
b	Ulikuwa na ugumu wa kulala karibu kila usiku, (yaani ugumu wa Kupata usingizi), kuamka katikati ya usiku ama kuamka mapema au kulala zaidi.	LA	NDIO	LA	NDIO
c.	Uliongea au kutembea polepole kulioko kawaida au kuhangaika au kutotulia, kushidwa kukaa mahali pamoja, karibu kila siku. Watu wengine waliona haya?	LA	NDIYO	LA	NDIYO
d.	Ulihisi kuchoka au kukosa nguvu karibu kila siku	LA	NDIYO	LA	NDIYO
e.	Ulihi kuwa huna maana/thamana, au mweneye hatia karibu kila siku	LA	NDYO	LA	NDIYO

(Kama ndiyo*, uliza mifano. Tafuta fikira danganyifu (delusions of failure, of inadequacy, of ruin or of guilt,*

Or of needing punishment or delusions of Disease or death or nihilistic or somatic delusions)

Mifano hii inaambatana na fikira danganyifu (delusional idea). Tukio la sasa ☐ LA ☐ NDiyo

Tukio la ZAmani ☐ LA ☐ Ndiyo

A5 Katikati ya matukio mawili ya sonona ulikua na angalau miezi miwili bila dalili muhimu za kusononeka au kukosa hamu

SI HUSIKA LA NDIO

Kuna jawabu 5 au zaidi (**A1**-**A3**) ambazo ni NDIO na **A4** imeandikwa NDIO

Kwa muda iliyoonyeshwa?

NO/LA YES/NDIYO

NA

MAJOR DEPRESSIVE

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

EPISODE/ TUKIO LA SONONA

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

IF **A5** IS CODED **YES,** CODE **YES** FOR RECURRENT.

A6 a Umekuwa na matukio mangapi ya sonona katika maisha yako? ----------

Katikati ya matukio mawili lazima kuwe na miezi miwili bila dalili muhimu ya sonona.

B.SUICIDALITY/HALI YA KUTAKA KUJIUA

				Points
	Kwa mwezi mmoja uliopita;			
B1	Ulikuwa na ajali yoyote? Hii ni pamoja na kutumia zaidi madawa uliyopewa kimakosa? KAMA NI LA B1, RUKA HADI B2; KAMANI NDIO,ULIZA B1a:	LA	NDIO	0
B1a	Ulipanga ama kukusudia kujiumiza katika ajali, kwa kutoepuka hatari ama kwa kusababisha ajali makusudi	LA	NDIO	0
	KAMA NI LA KWA B1a, RUKA HADI B2: KAMA NI NDIO, ULIZA B1b:			
B1b	Una nia ya kufa kutokana na ajali yoyote?	LA	NDIO	0
B2	Ulifikiria (Hata kwa dakika) kuwa ingekuwa afadhali kama umeaga, ama ulitamani kufa au Ulihitajika kufa	LA	NDIO	1
B3	Ulifikiria (Hata kwa dakika) Kujidhuru, kujiumiza au kujijeruhi? --ukiwa na kusudi au unajua kwamba kutokana na hayo unaweza ukaaga dunia? --ama umefikiria kuhusu kujiua (kujitia kitanzi)?	LA	NDIO	6
	KAMA NI LA KWA B2+B3, RUKA HADI B4. LA SIVYO ULIZA:			
	Frequency/ Wingi Intensity/ Kiwango Mara kwa mara ☐ ☐ Mara nyingi ☐ Kadiri ☐ Mara nyingi sana ☐ Kubwa/kali ☐			
B4	Ulisikia sauti ndani yako ikikuambia ujiuwe, ama ukawa na ndoto zenye mambo ya kujiua? Kama ndiyo, ilikuwa mojawapo au zote mbili: ☐ilikuwa sauti moja au nyingi? ☐ ilikuwa ndoto?	LA	NDIO	4
B5	Una njia ya kujitia kitanzi akilini (vipi) kipi?	LA	NDIO	8
B6	Una mbinu ya kujitia kitanzi? (kwa kutumia kifaa kipi)	LA	NDIO	8
B7	Una mahali pa kutendea kitendo hicho?	LA	NDIO	8
B8	Una tarehe ama muda fulani akilini wa kufanya hivyo?	LA	NDIO	8
B9	Umefikiria kama kuna kazi yoyote ambayo ungependa kukamilisha kabla kujitia kitenzi?) (barua ya kujiua_ suicidal note)	LA	NDIO	8
B10	Una nia ya kutenda kulingana na fikira za kutaka kujiua?	LA	NDIO	8

Kama ni ndio, weka alama kwa moja, ama zote: Ulikuwa na nia ya ya kuchukua hatua wakati huo?

Ulikuwa na nia ya kuchukua hatua wakati ujao?

B11 Ulikuwa na nia ya kufa kutokana na jaribio la kifo? LA NDIO 8

Kama ni ndio, weka alama kwa moja au zote: ulitaka kufa wakati huo?

B14 Ilichukua hatua madhubuti kutayarisha jaribio la kifo, huku ukitarajia au kuwa na nia ya kufa LA NDIYO 8

Tia ndani jambo ulilofanya, au, au kutofanya makusudi, lililokuleta karibu na jaribio la kifo. Hii ni pamoja na wakati ulikuwa ujiue lakini ukaingiliwa, au, au ukajisimamisha mwenyewe, kabla

Kama ni LA kwa B14, Ruka hadi B15

B14a Chukua hatua muhimu za kujitayarisha kujiua, lakini hukuanza jaribio la kifo? LA NDIO 9

B14b Chukua hatua muhimu kujitayarisha kujiua, lakini ukaajisimamisha mwenyewe kabla ya LA NDIO 10

B14c Chukua hatua muhimu ya kuanza kujiua lakini mtu au kitu kikakuzuia kabla ya kujijeruhi? LA NDIYO 11

Ulitaka kufa wakati ujao?

B12 Unahisi haja au msukumo wa kutaka kujiua, ama una panga kujiua mapema kuliko baadaye? NDIO 8
kama ndio weka alama kwa moja am azote mbili: ilikuwa kujiua? ilikuwa ni njama ya kutaka kujiua?
Kama ndio, weka alama kwa moja am azote mbili: Ulikuwa bila kuchochewa? Hii ilichochewa?

Kwa kutathmini kama ilikuwa kwa kuchochewa uliza swali, “dakika tano kabla ya msukumo, ugetabiri kwamba msukumo huu ungetokea kwa wakati huo?)

B15 Ukajiumiza makusudi bila nia ya kutaka kujiua? LA NDIO 0

B16 Ulijaribu kujitia kitanzi LA NDIYO

KamaLA kwa B16, RUKA HADI B17.

B16a Kuanza jaribio la kifo, lakini mwenyewe ukaamua kuikatiza na hukumaliza? LA NDIO 12

B16b Kuanza jaribio la kifo, ukakatizwa, kwa hivyo hukumaliza? LA NDIO 13

B16c Ulifanikiwa kumaliza jaribio la kifo kama ulivyokuwa umepanga? LA NDIYO 14

(jaribio la kifo lina maananisha ulifanya jambo ambalo lingefanya ujeruhiwe, huku ukiwa na nia hata kidogo ya kufa?)

Kama la ruka hadi b17

Ulikuwa na matumaini ya kuokolewa au kuishi? ☐

Ulitarajia au kuwa na nia ya kufa? ☐

B17 **WAKATI UNOTUMIKA KWA SIKU UKIWA NA FIKIRA ZA KUJITIA KITANZI:**

Muda wa kawaida unaotumika kwa siku: ---------- saa---------- dakika.

Muda mfupi unaotumika kwa siku: ----------saa---------- dakika.

Muda mrefu unaotumika kwa siku: ----------▒-------dakika.

Kwa maisha yako yote:

B18 Umewahi jaribu kujitia kitanzi? LA NDIO 4

Kama ni ndio, mara ngapi?----------

Kama ni ndio, mara ya mwisho ilikuwa ni lini?

Tukio la sasa: katika miezi 12 iliyopita ☐

Tukio lililopungua hivi karibuni: kati ya miezi 12 na 24 iliyopita ☐

Tukio lililopungua zamani, zaidi ya miezi 24iliyopita ☐

B19 Kuna uwezekano gani wa wewe kujiua kwa miezi mitatu itakayofuata, kati ya asilimia 0-100% …….. %

Kama kuna uwezekano>0% kwa B19iandikwe NDIO LA NDIO 13

Je angalau moja ya haya (isipokua B1) imwekwa alama ya ndiyo?

NO/LA	YES/NDIYO

SUICIDALITY/ HALI YA KUTAKA KJIUA

1--8 points Low/Chini ☐

9--1 points Moderate/Wastani ☐

Kama ni NDIO ongeza alama zote za majibu ya (B1-B19)iliyoandikwa NDIO, kisha uzingatie anajipata katika kikundi kipi kama ilivyoonyeshwa kwenye KIsanduku.

Onyesha kama naonyesha tabia za kujitia kitenzi kwa sasa ama ni kitendo cha maisha yakeama yote mawili kwa kuonyesha kwenye kijisanduku ama kuiacha bila kuonyesha ama kuviacha vyote kama havijaonyeshwa

Tukio la sasa- jibu lolote lenye NDIO kutoka **B1a**-B**16c**, au muda wowote **B17**

Tukio la maisha- **B18** imewekwa **NDIYO**

Tukio linawezekana wakati ujao- **B19** imewekwa **NDIYO**.

Ongeza hoja nyingine kuhusiana na utahini wa magonjwa kuhusiana na tabia yake ya sasa na hapo mbeleni kwa nafasi iliyowachwa hapo chini:

NO/NDIYO	YES/LA
SUICIDAL BEHAVIOR DISORDER	
Current/ Sasa	

Je B18 Imeandikkwa NDIYO?

Na jibu NDIYO kwa swali hili:

Je jaribio la kifolilianza wakati mgonjwa hakuwa katika hali ya kuchanganyikiwa au kutojielewa?

Na jibu NDIYO kwa swali hili:

Je, jaribio la kifo bila Sababu ya kisiasa ama ya kidini?

Taja kama Tukio ni la sasa, lililopungua hivi karibuni, au lilipungua zamani,

C.TUKIO LA MANIA NDOGO NA MANIA

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

Kuna mtu yeyote kwa historia ya jamii yako ambaye amekuwana na ugonjwa wa mania na sonona ama ugonjwa wa bipolar, au mtu ambaye amekuwa na hisiana kutibiwa na dawa hizi: Lithium, sodium valproate(Depakote)orlamotrigine(Lamictal)?
SWALI HILI SI YA KUFUATILIA UGONJWA WA BIPOLA, LAKINI NI YA KUONGEZA UCHUNGUZI WA DAKTARI KUHUSU UGONJWA HUO WA BIPOLA.
KAMA NI NDIO, ONYESHA KWA UMAHUSUSI NI NANI:----------

C1	a	Umewahi kuwa na wakati ulikuwa na hali ya juu, mchangamfu zaidi, mwenye nguvu nyingi Mwenye kukamilika, Ukajipata taabani?-ama watu wengine wakafikiria sio wewe wa kawaida? (Usizingatie wakati ulikuwa umelewa kwa dawa za kulevya ama pombe.)	LA	NDIO
		Kama haelewi- eleze kuwa hali ya juu ina maana ya kufurahia zaidi, nguvu nyingi, kufanya kazi zaidi, kuhitaji usingizi kidogo, mawazo ya haraka, mawazo mengi, kuongezeka kwa uzalishaji, KAMA NI LA, ANDIKA LA KWA **C1b**: KAMA NI NDIO ULIZA:		
	b	Kwa sasa unahisi ukiwa na hali ya juu, mchangamfu zaidi, mwenye nguvu nyingi?	LA	NDIO
C2	a	Umewahi kuwa na hasira inayoendelea, kwa siku kadhaa kiasi kwamba ukawa na mabishano, au mapigano kwa maneno au vitendo, au kuwapigia kelele watu wasiokuwa wa familia yako? Wewe au wengine wamegundua kuwa umekuwa mwenye hasira au kuudhika upesi ukilinganisha na wengine, hata katika hali ulizohisi zinafaa?	LA	NDIO
		KAMA NI LA,ANDIKA LA KWA **C2b**: KAMA NI NDIO ULIZA:		
	b	Unahisi mwenye hasira inayoendelea?	LA ➨	NDIO
		C1a ama **C2a** imeandikwa NDIO?	LA	NDIO

C3 K**ama C1b** ama **C2b** = **NDIO**: chunguza tukio la sasa,na tukio la zamani
Kama **C1b** na **C2b** = **LA**: Chunguza tukio la zamani lenye dalili nyingi.

Ukichunguza tukio la sasa, uliza swali hivi:

Je, kwa siku chache zilizopita, ulipohisi ukiwa hali ya juu, mwenye nguvu au mwenye hasira, ulifanywa yafuatayo:

Ukichunguza tukio la zamani la, uliza swali hivi:

Kwa siku chache hapo zamani, wakati ulihisi mchangamfu, mwenye nguvu au kukasirika haraka, ulifanywa yafuatayo:

		Tukio la sasa		tukio la kale	
a	Ulihisi una uwezo wa kufanya vile wengine hawawezi,	LA	NDIO	LA	NDIO

ama kuhisi mtu muhimu? uliza mifano.

Mifano iko samabamba na fikira danganyifu/ delusional idea: Tukio la sasa ☐ LA ☐ NDiyo

Tukio la ZAmani ☐ LA ☐ Ndiyo

		Tuki la sasa		tukio za awali	
b.	Hitaji usingizi wa kiwango cha chini(hisi umepumzika baada ya kulala kidogo)	LA	NDIYO	LA	NDIYO
c	Ongea sana bila kunyamaza, ama ni kama unalazimika kuongea?	LA	NDIO	LA	NDIO
d	Umegundua mawazo yako yakienda mbio, kama kwenye mashindano, Na kutoka haraka kwenye mado moja hadi nyingine?	LA	NDIO	LA	NDIO
e	Unaondolewa kwa shughuli zako haraka, hata kwa kusumbuliwa kidogo?	LA	NDIO	LA	NDIO
f	Kuongezeka kwa shughulizako au kwa motisha, kazini, shuleni, kijamii au hata Katika ngono, na ulikuwa na hali ya kutotulia kimwili na kiakili.	LA	NDIO	LA	NDIO
g	Hali ya kuongezeka inaweza kuwa na lengo au bila lengo Kujihusisha na mambo ya kujifurahisha hadi ukakosa kufikiria hatari au matokea (mfano, kuendesha gari haraka, kutumia fedha bila mpango,au Kushiriki ngono kiholela)?	LA	NDIO	LA	NDIO

C3 kwa ufupi: WAKATI WA KUKADIRIA MATUKIO YA SASA: LA NDIO LA NDIO

KAMA C1b NI LA**, je majibu 4 au zaidi ya** C3, PAMOJA NA C3f ni NDIyO?

Kama C1b ni Ndiyo, je majibu 3 au zaidi ya C3 pamoja na Cf ni Ndiyo?

UKichunguza tukio la zamani:

Kama C1a ni la, je majibu4 au zaidi ya C3 pamaja na Cf3 ni Ndiyo?

Kama C1a ni ndiyo, je majibu 3 au zai ya diC3 pamoja naCf3 ni ndiyo.

Weka ndiyo kama dalili tatu au nne zilitokea pamoja kipindi kimoja.

Kanuni: WIngi wa furaha unahitaji dalili 3pekee kwa C3 ilhali hasira ya kuendelea inahitaji dalili 4 kwa C3.

C4 Kwa upi muda mrefu zaidi dalili hizi zilidumu (muda mwingi wa siku, karibu kila siku?

Tathmini muda kutoka mwanzo hadi mwisho wa dalili hizo, sio kwa kilele chake tu.

a) siku 3 au chini yake ☐ ☐

b) siku 4 au zaidi ☐ ☐

c) siku 7 au zaidi ☐ ☐

C5 Ulilazwa hospitalini kwa sababu ya matatizo haya? LA NDIYO LA NDIYO

C6 Dalili hizi zilileta matatizo nyumbani, kazini na katika jamii, kwenye uhusiano
au LA NDIYO LA NDIYO

Shuleni au kwa njia yote ingine muhimu?

C7 Dalili hizi zinahusiana kwa njia yoyote na mabadiliko ya vile ulikuwa ukifanya vitu? LA NDIYO LA NDIYO

NO /LA YES/NDIYO
MANIC EPISODE
TUKIO LA MANIA

Je ufupi wa C3 (summary), na C7 na (C4c au C5 au C6 dalili ya kichaa (Psychosis) K1 hadi K8

Ina alama ya **ndiyo**?

Na

Je “ondoa yenye chanzo kwa Viungo, Ufupi 02’’ ina alama ya **Ndiyo.**

Taja kama tukio ni la sasa au la ZAmani.

HYPOMANIC EPISODE

TUKIO LA MANIA NDOGO

CURRENT/SASA

☐NO /LA

☐ YES/NDIYO

JE C3 ni ndiyo, na C5 na C6 ni LA, na C7 ni ndiyo,

Na C4b au C4c ni ndiyo,

NA

Je, “Ondoa yenye chanzo kwa viuongo ufupi 02” ni Ndiyo,

NA

DAlili zote za kichaa (psychosis) K1 hadi K8 ni LA?

TAja kama tukio ni la sasa au la zamani

Kama tukio la mania ni la sasa, basi taja tukio la mania ndogo kama la

Kama tukio la mania ni la zamani, taja tukio la mania ndogo kama halikuchunguzwa

HYPOMANIC SYMPTOMS

DALILI ZA MANIA NDOGO

CURRENT/SASA

☐NO /LA

☐ YES/NDIYO

JE ufupi wa C3 na C4a ni ndiyo, na C5 ni LA,

TAja kama tukio ni la sasa au la zamani

Kama tukio la mania au mania ndogo ni la sasa, basi taja dalili za mania ndogo kama la.

Kama tukio la mania au mania ndogo ni la zamani, taja dalili za mania ndogo kama halikuchunguzwa

C8 a) Kama kuna tukio la mania la sasa au la zamani, uliza:

Je Ulikuwa Na matukio Mawili au zaidi yaliyodumu siku 7 ama zaidi (**C4c**) maishani mwako? LA NDIYO (Likiwemo tukio la sasa kama liko)

b) Kama KunaTUKIO LA MANIA AMA MANIA NDOGO la sasa ama la zamani uliza:

Ulikuwa na matukio mawiili au zaidi ya mania ndogo yaliyodumu siku 4 au zaidi (**C4b**)

maishani mwako? (Likiwemo tukio la sasa kama lipo) LA NDIO

c) KAMA TUKIO LA 'DALILI ZA MANIA NDOGO" lina alama ndiyo uliza:

Ulikuwa na dalili hizi za MANIA NDOGO iliyokaa Kati ya siku 1 hadi 3 maishani Mwako? LA NDIO

D.PANIC DISORDE/ UGONJWA WA HOFU KUBWA

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

➡

D1 a Uliwahi kuwa na muda zaidi ya mmoja, ambapo ulikuwa na shambulio la ghafla ukawa na wasiwasi, uoga, msumbuko au mashaka, hata kwa mazingira ambayo watu wengi hawangesikia hivyo? LA NDIYO

➡

b Hali hiyo ilifika kilele katika muda wa dakika 10 kutoka mwanzo? LA NDIYO

➡

Halingetabiriwa, na bila kuchochewa?

Tukio kama hilo, au hofu ya matokeo ya shambulizi hili, au je, ulibadilisha mienendo yako kufuatia tukio hilo (kuepuka hali isiyojulikana, kuepuka kutoka kwa nyumba au kufanya manunuzi peke yako, Kufanya juhudi kuzuia shambulizi la hofu, kutembelea daktari au kituo cha dharura mara

D4 **Wakati wa shambulio mbaya zaidi, unakumbuka:**

a Moyo wako ulikuwa ukiruka, kupiga kwa nguvu ama kwenda kwa kasi? LA NDIO

b Mikono yenye jasho au yenye mnato? LA NDIO

c Ulikuwa ukitetemeka au kutingika? LA NDIO

d Ulikuwa naupungufu wa kupumua, ugumu wa kupumua, au hisia za kulainika? LA NDIO

e Ulikuwa na hisia za kukabwa roho, au donge kooni? LA NDIO

f Ulihsi uchungu, msukumo au msumbuko kwenye kifua? LA NDIO

g Ulikuwa na kichefuchefu (kujiskia kama kutapika), shida tumboni, ama kuendesha kwa ghafla? LA NDIO

h Ulihisi kizunguzungu, asiye imara, au mdhaifu? LA NDIO

i Ulihisi mvuto wa joto au baridi? LA NDIO

j Ulihisi kuwakwa au kufa ganzi? LA NDIO

k Je uliona Vitu karibu nawe vikiwa ajabu, visivyo halisi, vilivyotengwa au visivyo vya kawaida au kuhisi ukiwa nje ya mwili wako, au kama umetenganishwa na sehemu ya mwili wako au mwili wote. LA NDIO

l Uliogopa kwamba ulikuwa unapoteza udhibiti ama kuwa unapatwa na wazimu? LA NDIO

m Uliogopa kuwa unafariki? LA NDIO

D5 Je **D3** na dalili 4 ama Zaidi ya **D4** ni **Ndiyo** LA NDIO

UGONJWA WA HOFU KUBWA

MAISHANI

D6 Kwa mwezi moja uliopita umekuwa na wasiwasi ulioendelea, ya kuwa na shambulio lingine? LA NDIYO

au wasiwasi wa matokeo ya sambulio, au kubadilisha mienedo yako kwa sababu ya shambulio la hofu **UGONJWA WA HOFU KUBWA KWA SASA**
A

Je D5 na D6 ni ndiyo

NA*"ondoa enye chanzo kwenye viuongo*
Summary 02 =Ndiyo

Taja kama ni tukio la sasa au la maisha

NO/LA	**YES/NDIYO**
PANIC DISORDER	
Ugonjwa wa hofu kubwa	

E.AG ORAPHOBIA

WOGA WA NAFASI ZA WAZI

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

E1 Wewe huhisi mwenye wasiwasi au mashaka, ukiwa kwenye hali au pahali ambapo huwezi kupata usaidizi,

Ama ni vigumu kukimbia ukipatwa na shambulio la hofu kubwa, au dalili kama za hofu kubwa au dalili zinazoleta aibu.

kama:

Kuwa kwenye umati wa watu, ama kusimama kwenyefoleni/ laini

Kuwa nafasi iliyo wazi au kuvuka daraja

Kuwa kwenye nafasi iliyofungwa kila upande

Kuwapeke yako mbali na nyumbani, ama peke yako nyumbani ➨

Kusafiri kwa kutumia basi, treni, gari ama kutumia usafiri wa umma? LA NDIO

Je dalili 2 AMA ZAIDI kwenye E1 ni Ndiyo? LA NDIO

➨

E2 Je hali hizi karibu kila mara hukuletea uoga ama wasiwasi? LA NDIO

E3 Waogopa hali hizi sana hivyo basi unaziepuka, ama kuteseka ukiwa ndani ya hali hizi, ama unahitaji rafiki ilikukabiriana nazo? LA NDIO

E4 Je, uoga na wasiwasi unaopata, ni mwingi kupita kiasi cha hatari inayotokana LA NDIYO

na hali hii?

➨

E5 Je, huu uepukaji, uoga na wasiwasi uliendelea kwa angalaui ya miezi 6? LA NDIYO

➨

E6 Je, dalili hizi zilisababisha, dhiki au matatizo nyumbani, kazini, kwenye jamii, shuleni ama hata kwa njia yeyote ingine muhimu?

LA NDIYO

NO YES

AGORAPHOBIA

E6 inaonyesha NDIYO?

F.WOGA WA MKUSANYIKO WA WATU/SOCIAL PHOBIA

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

➨

F1 Kwa mwezi moja uliopita, umekuwa na uoga ulioendelea, na wasiwasi muhimu, wa kuangaliwa, Kutazamwa kwa makini, kufedheheshwa, kuaibishwa au kukanwa? LA NDIO

Hii ni pamoja na kuongea kwenye umma, kula hadharani au na watu wengine, kuandika ukitazamwa, Kuigiza hadharani, ama kuwa katika maeneo ya jamii.

Mifano ya maeneo ya jamii:

- kuanzisha na kuendeleza mazungumzo,
- kujihusisha katika vikundi vidogo,
- Kujihusisha kimapenzi,

Hudhuria sherehe

Kuigiza mbele ya watu

- Kuongea na watu walio na cheo,
- Kuongea kwenye umma,
- kula mbele ya watu,
- Kujisaidia kwenye choo za umma

➨

F2 Je hizi hali za jamii karibu kilawakatu huleta uoga ama wasiwasi? LA NDIO

➨

F3 Je, unaogopa hali hizi kiasi kwambaunaziepuka, unateseka ukiwa pale, au kuhitaji rafiki iliuweze kukabiliana nazo? LA NDIYO

➨

F4 Je uoga huu, au wasiwasi unazidi au kuosa sababu muhimu, ukilinganisha na hali yenyewe? LA NDIYO

➨

F5 Je uepukaji jamii, uoga na wasiwasi, uliendelea angalau kwa miezi 6? LA NDIYO

F6 Uoga huu wa jamii, ulikuletea matatizo, au kuingilia utendaji wako kazini, shuleni au kwenye Jamii, au kwa uhusiano wako na watu, au kwa njia yeyote ingine muhimu?

LA NDIO

NO/LA YES/NDIYO

SOCIAL ANXIETY DISORDER

(Social Phobia)

WOGA WA MKUSANYIKO WA WATU

Je F6 = Ndiyo?

Na

"ondoa yenye chanzo kwa viungo, Summary 2= Ndiyo

Kwa mwenye kuhoji: Tafadhali bainisha kama uoga uko kwenye kuongea au kuigiza hadharani.

G.UGONJWA WA SHAUKU LAZIMISHO

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

G1a	Kwa mwezi uliopita, umesumbuliwa na mawazo ya kujirudia rudia	LA	NDIO
		RUKA HADI **G3**a	
G1b	Kwa mwezi uliopita, umejaribu kuifutilia mbali picha hizi ama kuzipunguza kwa kufikiria maneno Mengine tofauti?-	LA ↓	NDIO
G2	Mawazo haya hurudi kila mara akilini hata kama umejaribu kuzifutilia mbali?	LA	NDIO
		obsessions	
G3a	Kwa mwezi uliopita unajihisi wataka kufanya jambo fulani kwa kujirudia ili kukwepa sheria fulani	LA	NDIO
G3b	Vitu hivi vinafanywa kupunguza Taharuki ama kukwepa kitu kibaya kufanyika na ni kwa zaidi?	LA	NDIO
		compulsions	
		➨	

(**G1**a NA **G1**b NA G2) AMA (**G3**a NA **G3**b) ONYESHA NDIO? LA NDIO

G4 Kwa mwezi uliopita, fikra hizi zimesababisha wewe kutofanya kazi yako kama ulivyotakiwa nyumbani, kazini au hata shuleni?

LA NDIO

UGONJWA WA SHAUKU LAZIMISHO

KWA SASA

KWA UNDANI:

VIZURI AMA KADIRI☐

VIBAYA ☐

KOTOKUWEPO☐

DELUSIONAL☐

TIC-RELATED☐

H.UGONJWA WA MSONGO BAADA YA MATUKIO MABAYA

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

	Kukuletea majeraha ama kutishia kijinsia kwako au kwa mtu mwengine?	➨	
H2	Kuanzia kwa kisa hicho,umekuwa ukikumbana na kisa hicho	LA	NDIO
	a Umejaribu kila mara kuzuia kufikiria kuhusiana na hisia zako kutokana na tukio hilo?	LA	NDIO
	b Umejaribu kufutilia mbali watu, mazungumzo,au pahali ambazo zinarejesha mawazo ya matukio Yaliyotendeka?	LA	NDIO
	1 AMA ZAIDI YA JAWABU **H3 JAWABU ZIONYESHE NDIO**?	LA	NDIO
H4	**Kwa mwezi uliopita:**		
	a Ulikuwa na shida kukumbuka mambo muhimu kuhusiana na janga hilo?	LA	NDIO
	b Umekuwa na mafikira hasi kujihusu mwenyewe, wengine ama ulimwengu kwa ujumla?	LA	NDIO
	c Umekuwa ukijilaumu mwenyewe ama wengine kwa janga liloyotukia?	LA	NDIO
	d Umekuwa na hisia ambazo ni hasi?	LA	NDIO
	e Umekosa hamu ya kutaka kujiunga na mambo ambayo ni muhimu kwako hapo mbeleni?	LA	NDIO
	f Ulijihisi ni kama umetengwa na wengine ama ni mgeni kwa wengine?	LA	NDIO
	g Umekuwa na uwezo wa kuweza kupata hisia nzuri kama furaha na kutosheka?	LA	NDIO
	2 AMA ZAIDI YA JAWABU **H4 ZIONYESHWE NDIO**?	➨ LA	NDIO
H5	**Kwa mwezi uliopita:**		
	a Umekuwa wa kukasirika kwa haraka bila kukasirishwa au kukasirishwa kidogo?	LA	NDIO

b Umekuwa wa kutozingatia ama wa kuharibu vitu? LA NDIO

c Umekuwa na uoga ama mwenye kukua macho? LA NDIO

d Umekuwa wa kustaajabika kwa urahisi? LA NDIO

e Umekuwa na ugumu wa kutulia? LA NDIO

f Umekuwa na ugumu wa kulala? LA NDIO

2 ZAIDI YA JAWABU ⇧ **ZIANDIKWE NDDIO**? LA NDIO

H6 Shida hizi zilianza baada ya kutukia kwa janga hilo na kukaa kwa zaidi ya mwezi mmoja? LA NDIO

NLA NDIO ;

H7 Katika mwezi ambao umepita, shida hizi zimeweza kutokea na kisha kuleta mtafaruku, ama kupunguza uwezo wako wa kufanya kazi, nyumbani, kazini, na hata shuleni?

I.MATUMIZI MABAYA YA POMBE

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

			➨	
I1	**Katika miezi 12 iliyopita**, Umekunywa zaidi ya chupa 3 kwa muda wa chini ya masaa 3 mara 3?		LA	NDIO
I2	**Kwa miezi 12 iliyopita**:			
	a. Wakati wote ambao ulikuwa umepanga kunywa vileo, uliishia kunywa zaidi ya vile ulikuwa umepan umepangakalcohol,didyouendup drinkingmorethan Ulikuwa umepanga ulipoanza?		LA	NDIO
	b. Kila mara ulikuwa wataka kupunguza ama kudhibiti unywaji wako wa hivi vileo? Ulijaribu kupunguza lakini ukilemewa? IF YE**S** TO EITHER, CODE **YES**.		LA	NDIO
	c. Kwa zile siku ambazo ulikunywa pombe, ulipoteza muda mwingi kuitafuta pombe, kunywa ama		LA	NDIO
	d. Ulitamani kutumia vileo?		LA	NDIO
	e. DUmepata muda kidogo wa kufanya majukumu yako kwa sababu ya kurudia kutumia vileo? huo?		LA	NDIO
	g. Ulikuwa mlevi mara zaidi ya moja wakati kulikuwa na kitu kibaya kingeweza kutendeka Mfano kuendesha gari?		LA	NDIO
	h. Bado uliendelea na ulevi huo hata kama ulikuwa ilikuwa wazi kwamba ilisababisha matatizo ya kiakili na kimwili?		LA	NDIO
	i. Ulipunguza au kutofanya kazi muhimu ama maswala ya kufurahisha kwa sababu ya ulevi?		LA	NDIO
	j. Ulikunywa kwa wingi zaidi ili uweze ukajihisi kama ulivyojihisi mara yako ya kwanza?		LA	NDIO
	k1. Ulipopunguza unywaji wa pombe, ulikuwa na yafuatayo: 1. kuongezeka kwa kutokwa jasho na mpigo wa moyo☐ 2. mikono kutetemeka ☐		LA	NDIO

3. shida wakati wa kulala ☐
4. kujihisi kama wa kutapika ☐
5. kuskia ama kuona yale ambayo wengine hawaoni
   Ama kukua na mwisho kwenye ngozi ☐
6. kukasirika kwa haraka ☐
7 mwenye taharuki ☐
8. visunzi ☐

IF **YES** TO 2 OR MORE OF THE ABOVE 8, CODE k1 AS **YES.**

k2.Je, ulikunywa pombe ili kupunguza ama kujiepusha na dalili za unywaji wa pombe? LA NDIO

K**SUMMARY**: IF **YES** TO k1 OR k2, CODE **YES**

LA NDIO

LA NDIO

MATUMIZI MABAYA YA POMBE

MIEZI 12 ILIYOPITA

SPECIFIERS FORALCOHOLUSE DISORDER:

ONYESHA UTOFAUTI KAMA:

MILD = 2-
3 OF THE I2 SYMPTOMS MODERATE = 4-
5 OF THE I2 SYMPTOMS SEVERE = 6 OR MOR
E OF THE I2 SYMPTOMS

MILD ☐

MODERATE ☐

SEVERE ☐

IN EARLY REMISSION = CRITERIA NOT MET FOR BETWEEN 3 & 12 MONTHS IN SUSTAINED REMISSION = CRITERIA NOT MET FOR 12 MONTHS OR MORE (B OTH WITH THE EXCEPTION OF CRITERION d.–(CRAVING) ABOVE).

IN EARLY REMISSION ☐

IN SUSTAINED REMISSION ☐

IN ACONTROLLED ENVIRONMENT -WHERE ALCOHOL ACCESS ISRESTRICTED

IN ACONTROLLED ENVIRONMENT ☐

J.MATUMIZI MABAYA YA MADAWA YA KULEVYA (ISIYO POMBE)

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

Sasa nitakuonyesha/kukusomea Orodha ya dawa za kulevya.

➨

J1 a **Katika miezi 12 iliyopita, umetumia yoyote ya dawa hizi za kulevya zaidi ya mara moja** LA NDIO

Ili kujihisi vizuri ama kuwa mwenye fahamu nzuri?

VIRINGA KILA DAWA ILIYOTUMIKA:

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

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

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

Hallucinogens: LSD ("acid"), mescaline, peyote, psilocybin, STP, "mushrooms", "ecstasy", MDA, MDMA.

Dissociative Drugs: PCP (Phencyclidine, "Angel Dust", "Peace Pill", "Hog"), or ketamine ("Special K").

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

Cannabis: 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. Cough Medicine? Any others?

ONYESHA DAWA YA KULEVYA INAYOTUMIKA SANA:

DAWA ZA KULEVYA ZIPI HUWA NA MADHARA NYINGI?

J2 **Kwa kuzingatia dawa ambayo imechaguliwa hapo juu kwa miezi 12:**

a. Wakati wa kutumia dawa unayotumia, ulijipata unatumia zaidi ya vile ulikuwa umepanga LA NDIO

b. Kila mara ulikuwa unataka kupunguza ama kudhibiti utumiaji wa dawa hiyo lakini ukanishindwa LA NDIO

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

c. Kwa siku ambazo ulitumia zaidi ya kawaida, ulitumia wakati mwingi kuzipata, kuzitumia ama kupona LA NDIO
Kutoka kwa madhara yake?

d. Ulikuwa na tamaa ya kutumia dawa yenyewe? LA NDIO

e. Ulitumia muda kidogo kutimiza kazi zako kazini, shuleniau hata nyumbani kaw kurudia kuitumia? LA NDIO

f. Kama dawa unayoitumia imesababisha matatizo nyumbani au hata na watu wengine, bado unaotumia?LA NDIO

g. Ulitumia dawa hizo zaidi ya mara moja na ukajipata ukihatarisha maisha yako ama ya wengine LA NDIO
Mfano. Ukaendesha gari?

h. Uliendelea kutumia dawa hiyo hata kama ilikuwa inajitokeza kuwa dawa hizo zilisababisha kudidimia LA NDIO
Kwa afya yako kiakili na pia kimwili

i. Ulipunguza ama kuacha kazi muhimu, ama matendo ya furaha kwa sababu ya utumiaji wa dawa hizi? NO YES

j. Ulihitaji kutumia nyingi zaidi ili uweze kukua na ile hisia uliyokuwa nayo mara ya kwanza Ulianza kutumia ama ulipata hisia ya chini kidogo ukiendelea kutumia kiwango wastani NO YES

THIS CRITERION IS CODED NO IF THE MEDICATION IS PRESCRIBED AND USED UNDER MEDICAL SUPERVISION.

k1. Ulipopunguza matumizi ya dawa hizi ambazo umetumia kwa muda mrefu, ulikuwa na madhara yafuatayo: NO YES

THIS CRITERION IS CODED NO IF THE MEDICATION IS PRESCRIBED AND USED UNDER MEDICAL SUPERVISION.

Sedative, Hypnotic orAnxiolytic(2ormore)

1. Kuongezeka kwa kutokwa jasho ama mdundo wa moyo ☐
2. Mikono yako kutetemeka ☐
3. Kukua na shida wakati wa kulala ☐
4. Kutapika ☐
5. Kuskia na kuona vitu ambavyo wengine hawaoni ama Ama kuwa na mwashowasho kwenye ngozi ☐
6. Kukasirika ☐

Opiates (3ormore)

2. Kutapika ☐
3. Kuumwa kwa mwili ☐
4. Kutokwa na kamasi au kutokwa na machozi ☐
6. Kuendesha ☐
7. Kupiga miayo ☐
8. hotflashes ☐
9. Una shida wakati wa kulala ☐

Stimulants (2ormore)

1. Kuchoka ☐
2. [illegible] ☐

Cannabis (3ormore)

2. taharuki ☐
3. ugumu wa kulala ☐
5. kutokuwa mtulivu ☐
6. kuhisi mshuko wa moyo ☐

"maumivu ya tumbo, kutetemeka, kutokwa kwa jasho, na kichwa kuuma. ☐

k2. Ulitumia kupunguza madhara yake? LA NDIO

J2k **SUMMARY**: IF **YES** TO J2k1 OR J2k2, CODE **YES** LA NDIO

ARE **2** OR MORE **J2** ANSWERS FROM **J2a** THROUGH **J2k SUMMARY** CODED **YES**? **LA** **NDIO**

(**J2**k1 **AND J2**k2 TOGETHER COUNT AS ONE AMONG THESE CHOICES)

SUBSTANCE

(Matumizi mabaya ya dawa za kulevya)

MIEZI 12 ILIYOPITA

SPECIFIERS FOR SUBSTANCE USE DISORDER:

ONYESHA KAMA:

MILD = 2-
3 OF THE J2 SYMPTOMS MODERATE = 4-
5 OF THE J2 SYMPTOMS SEVERE = 6 OR MOR
E OF THE J2 SYMPTOMS

KWA UCHACHE ☐

KATI ☐

UMEATHIRIKA KABISA ☐

IN EARLY REMISSION = CRITERIA NOT MET FOR BETWEEN 3 & 12 MONTHS IN SUSTAINED REMISSION = CRITERIA NOT MET FOR 12 MONTHS OR MORE (B OTH WITH THE EXCEPTION OF CRITERION d.–(CRAVING) ABOVE).

IN EARLY REMISSION ☐

IN SUSTAINED REMISSION ☐

IN A CONTROLLED ENVIRONMENT =WHERE SUBSTANCE /DRUG ACCESS IS RESTR ICTED

IN A CONTROLLED ENVIRONMENT ☐

K.MAGONJWA YA SAIKOSIS NA HALI YA MTU MWENYE DALILI ZA SAIKOSIS

FANO INAJITOKEZA NA KUONYESHA KUCHANGANYIKIWA KIAKILI, VILE MTU ANAWAZA AMA INAKUBALIKA KITAMADUNI. LENGO KUU YA KITENGO HIKI NI KuWATOA WAGONJWA KWA UGONJWA WA SAIKOSIS. KITENGO HIKI KINAHITAJI TAJRIBA.

ULIZIA MIFANO YA MASWALI YA LIYOJIBIWA VIZURI. ONYESHA NDIO KAMA MI

Nitauliza maswali ambayo yamekuwa si kawaida ambayo umekuwa nazo.

K1 a Umewahi amini kwamba kuna watu wanakufuata kisirisiri ama kuna mtu ana njama Ya kutaka kukuumiza? LA NDIO

b **IF YES:** kwa sasa unaamini mabo hayo? LA NDIO

K2 a Umewahi amini mtu anasoma mawazo yako ama una uwezo wa kusoma Mawazo ya mtu mwengine ama kuskia kile ambacho mtu mwengine anawaza? LA NDIO

b **IF YES:** kwa sasa unaamini maneno hayo? LA NDIO

Kukufanya ufanye vitendo visivyo ya kawaida yako? Umewahi jihisi umepagawa?

CLINICIAN: ASK FOR EXAMPLES AND DISCOUNT ANY THAT ARE NOT PSYCHOTIC.

b **IF YES:** Unaamini mambo hava kwa sasa? LA NDIO

NDIO

Mtandao, gazeti, vitabu ama mtu ambaye hukuwa ukimjua kibinafsi ameanza Kuhusika na maslahi yako?

b **IF YES:** kwa sasa hado unaamini vitu hivi? LA NDIO

NDIO

K5 a Jamaa na marafiki wako wameona imani yako kuwa kinyume na matarajio? LA

b **IF YES:** kwa sasa bado wanaona imani yako kuwa geni na kinyume na matarajio? LA NDIO

K6 a Umewahi sikia vitu ambavyo watu wengine hawasikii, kama vile sauti? LA NDIO

or behaviorordid you heartwo ormorevoicestalkingto each other?

b **IF YES TO K6a:** umewahi sikia sauti hizi kwa mwezi uliopita LA NDIO
NATION: sauti yenyewe ilikuwa ikizungumza na wewe ama ni zaidi NO YES

ya sauti moja wakiongea?

H AL LU CI p

K8 a DID THE PATIENT EVER IN THE PAST EXHIBIT DISORGANIZED, INCOHERENT OR DERAILED SPEECH OR MARKED LOOSENING OF ASSOCIATIONS? LA NDIO

SPEECH OR MARKED LOOSENING OF ASSOCIATIONS?

K9 a DID THE PATIENT EVER IN THE PAST EXHIBIT DISORGANIZED OR CATATONIC BEHAVIOR? LA NDIO

K9 b IS THE PATIENT CURRENTLY EXHIBITING DISORGANIZED OR CATATONIC BEHAVIOR? LA NDIO

EMOTIONAL EXPRESSION OR AFFECTIVE FLATTENING, POVERTY OF SPEECH (ALOGIA) OR AN INABILITY TO INITIATE OR PERSIST IN GOAL-DIRECTED ACTIVITIES (AVOLITION)?

K10 b ARE NEGATIVE SYMPTOMS OF SCHIZOPHRENIA, E.G. SIGNIFICANT REDUCTION OF EMOTIONAL EXPRESSION OR AFFECTIVE FLATTENING, POVERTY OF SPEECH (ALOGIA) OR AN INABILITY TO INITIATE OR PERSIST IN GOAL-DIRECTED ACTIVITIES (AVOLITION), PROMINENT DURING THE INTERVIEW? LA NDIO

K11 and ARE 1 OR MORE « a » QUESTIONS FROM K1a TO K7a, CODED **YES**?

ARE AND IS EITHER:

MAJOR DEPRESSIVE EPISODE, (CURRENT, RECURRENT OR PAST)

OR

MANIC OR HYPOMANIC EPISODE, (CURRENT OR PAST) CODED **YES**? NO

K13 YES

HOW LONG HAS THE MOOD EPISODE LASTED?

HOW LONG HAS THE PSYCHOTIC EPISODE LASTED? _____

IF SUCH A MOOD EPISODE IS PRESENT, IT MUST BE PRESENT FOR THE MAJORITY OF THE TOTAL DURATION OF THE ACTIVE AND RESIDUAL PERIODS OF THE PSYCHOTIC SYMPTOMS. OTHERWISE CODE NO TO K11a.

IF NO TO K11a, CIRCLE NO IN BOTH (MOOD DISORDER WITH PSYCHOTIC

LA NDIO

b Umeniambia hapo awali kwamba kipindi au vipindi ambapo umejihisi(huzuni/juu/hasira inayo endelea).

Je umekuwa na imani na uzoefu kama ulivyoelezea

Abao ni wakipeke mara wakati ulikuwa na hisia ya kukata tamaa / juu / hasira?

UGONJWA WA HALI YA MTU NA DALILI YA SAIKOSIS

MAISHA NI

(SYMPTOMS CODED **YES** FROM **K1**a TO **K7**a)

IF THE PATIENT EVER HAD A PERIOD OF AT LEAST 2 WEEKS OF HAVING THESE BELIEFS OR EXPERIENCES

(PSYCHOTIC SYMPTOMS) WHEN THEY WERE NOT DEPRESSED/HIGH/IRRITABLE, CODE NO TO THIS DISORDER.

IF THE ANSWER ISNO TO THIS DISORDER GROUPING, ALSO CIRCLE NO TO K12 AND MOVE TO K13

K12 a ARE 1 OR MORE « b » QUESTIONS FROM K1b TO K7b CODED **YES** AND IS EITHER: **LA** NDIO

UGONJWA WA HALI YA MTU NA DALILI YA SAKOSIS

MAJOR DEPRESSIVE EPISODE (CURRENT)
OR

MANIC OR HYPOMANIC EPISODE (CURRENT) CODED **YES**?

KWA SASA

IF THE ANSWER ISYES TO THIS DISORDER (LIFETIME OR CURRENT), CIRCLE NO TO K13 AND K14 AND MOVE TO THE NEXT MODULE.

K13 ARE 1 OR MORE « b » QUESTIONSFROM K1b TO K8b, CODED **YES**? **LA** NDIO

AND

UGONJWA WA SAIKOSIS

ARE 2 OR MORE « b » QUESTIONSFROM K1b TO K10b, CODED **YES**?

AND DID AT LEAS
T TWO OF THE PSY

CHOTIC SYMPTOMS OCCUR DURING THE SAME 1-MONTH PERIOD?

KWA
SASA

AND

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

LA NDICS

K14 IS **K13** CODED **YES**

OR

(ARE 1 OR MORE « a » QUESTIONS FROM K1a TO K8a, CODED **YES**?

UGONJWA WA SAIKOSIS

MAISHAN I

AND

ARE 2 OR MORE « a » QUESTIONS FROM K1a TO K10a, CODED **YES?**

AND DID AT LEAST TWO OF THE PSYCHOTIC SYMPTOMS OCCUR DURING THE SAME 1-MONTH PERIOD?)

AND

IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

L.UGONJWA WA
TAFSIRI YA MAUMBILE
BINAFSI UNAOHUSIANA
NA KUTOKULA

(➨MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE✖, AND MOVE TO THE NEXT MODULE)

L1 a Urefu wako wa kimo ni? ☐ ft ☐ ☐ in.

☐ ☐ ☐ cm

☐ ☐ ☐ lb

b. Uzani wako wa chini kabisa kwa miezi 3 iliyopita ni? ☐ ☐ ☐ kg

➨
LA NDIO

(ANGALIA JEDWALI HAPO CHINI)

➨
L2 Umejaribu kutoongeza uzani wako ama umejinyima chakula? LA NDIO

L3 Umekuwa ukiogopa kuwa utakuwa mnene, hata kama kwa sasa uko chini ki uzani? LA NDIO

b Umbo au uzani wako umechangia kwa vyovyote vile ambavyo unajiona? LA NDIO

c Umefikiria kwamba uzani wako wa sasa ni kawaida ama umezidi? LA NDIO

L5 ARE 1 OR MORE ITEMS FROM **L4** CODED **YES**? LA NDIO

IS **L5** CODED **YES**? **LA** NDIO

UGONJWA WA MAUMBILE UNAOHUSIANA NA KUTOKULA

KWA SASA

HEIGHT /WEIGHT TABLE CORRESPONDING TO A BMI THRESHOLD OF 17.0 KG/M^2

Height/Weight

ft/in	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	5'10
lb	79	82	84	87	90	93	96	99	102	106	109	112	115	119
cm	145	147	150	152	155	158	160	163	165	168	170	173	175	178
kg	36	37	38.5	39.5	41	42.5	43.5	45.5	46.5	48	49	51	52	54

Height/Weight

The weight thresholds above are calculated using a body mass index (BMI) equal to or below 17.0 kg/m^2 for the patient's height using the Center of Disease Control & Prevention BMI Calculator. This is the threshold guideline below which a person is deemed underweight by the DSM-5 for Anorexia Nervosa.

M. UGONJWA WA
TAFSIRI YA MAUMBILE
BINAFSI UNAOHUSIANA
NA KULA MNO

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

M1 Katika miezi mitatu iliyopita, kumekuwa na wakati ambapo umezidisha kipimo chako cha chakula LA NDIO

➨ **M3**

M2 Wakati wa kula hivi ulijihisi kula kwako huwezi kulidhibiti? LA NDIO

Kutapika, kufunga, kufanya mazoezi, enemas, diuretics (fluid pills), or other medications? Ulifanywa hivi kama mara ngapi kwa wiki?

➨

M3a Idadi ya matukio ya Mwataka Tabia zisizotaa za ulipizaji kwa Wiki?

Number of Days of Inappropriate Compensatory Behaviors per Week?

➨

➨

M5 Uzani ama umbo lako linachangia vile ambavyo unahisi kujihusu? LA NDIO

↓
Ruka hadi M8

M7 Je, vipindi vifupi unavyojitoa kwa kujihusisha katika _____ shughuli zinazopita kiasi, hutokea tu wakati wewe ni chini ya (lb/kg)? LA NDIO

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

M8 IS **M5** CODED **YES** AND IS EITHER **M6** OR **M7** CODED **NO**?

LA NDIO

IS **M7** CODED **YES**?

UGONJWA WA KULA MNO

KWA SASA

LA NDIO

ANOREXIA NERVOSA *Binge Eating/Purging Type* **CURRENT**

DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?

LA NDIO

AND

ARE M2 AND M3 CODED NO?

ANOREXIA NERVOSA
Restricting Type **CURRENT**

SPECIFY IF:

SPECIFIERS OF EATING DISORDER:

MILD ☐

MODERATE ☐

SEVERE ☐

EXTREME ☐

MILD = 1-3 EPISODES OF INAPPROPRIATE COMPENSATORY BEHAVIORS
MODERATE = 4-7 EPISODES OF INAPPROPRIATE COMPENSATORY BEHAVIORS
SEVERE = 8-13 EPISODES OF INAPPROPRIATE COMPENSATORY BEHAVIORS
EXTREME = 14 OR MORE EPISODES OF INAPPROPRIATE COMPENSATORY BEHAVIORS

MB. BINGE EATING DISORDER

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

➨

MB1 DALILI ZA MGONJWA ZAONYESHA MTINDO WA UGONJWA WA KUTOKULA? LA NDIO

➨

MB2 DALILI ZZA MGONJWA ZAONYESHA MTINDO WA KUKULA MNO? LA NDIO

MB3 M2 ISCODEDYES LA NDIO

MB4 M3 ISCODEDYES LA NDIO

MB5 M4 ISCODEDYES LA NDIO

Katika miezi mitatu iliyopita wakati wa kutoweza kudhibiti ulaji wako ulifanya:

MB6a Ulikula haraka na kwa fujo kushinda kawaida? LA NDIO

MB6b Ulikula hadi ukaijaza tumbo yako kabisa? LA NDIO

MB6c Ulikula viwango vikubwa vya chakula na hukuwa mwenye njaa? LA NDIO

MB6d Ulikula peke yako kwani uliona haya kwa kiwango cha chakula ulichokila? LA NDIO

ARE 3 OR MORE **MB6** QUESTIONS CODED YES? LA NDIO

MB7 Kutodhibiti kula kwako hukupa mfadhaiko? NDIO

MB8 Mara ngapi umekosa kudhibiti kula kwako kwa wiki?

Siku ngapi kwa wiki hukosa kudhibiti?

NO YES

IS MB7 CODED YES?

BINGE-EATING DISORDER

CURRENT

SPECIFIERS OF EATING DISORDER:

SPECIFY IF:

MILD ☐

MODERATE ☐

SEVERE ☐

EXTREME ☐

MILD = 1-
3 EPISODES OF BINGE EATING PER WEEK MODERATE = 4-
7 EPISODES OF BINGE EATING PER WEEK SEVERE = 8-
13 EPISODES OF BINGE EATING PER WEEK

EXTREME = 14 OR MORE EPISODES OF BINGE EATING PER WEEK

N. UGONJWA WA WASIWASI MKUBWA

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

N1	a	Umekuwa na woga ama wasiwasi mwingi kuhusiana na vitu vya kawaida, Kwa miezi sita iliyopita? KAMA MGONJWA HAELEWI KWA KISWAHILI, ULIZA (Watu wengine hukuona kama mtu mwenye wasiwasi mwingi"?)NA UPEWE MIFANO	➨ LA	NDIO
	b	Hii woga na wasiwasi zipo kwa siku nyingi?	➨ LA	NDIO
		ARE THE PATIENT'S ANXIETY AND WORRIES RESTRICTED EXCLUSIVELY TO, OR BETTER EXPLAINED BY, ANY DISORDER PRIOR TO THIS POINT?	➨ LA	NDIO
N2		ULIKUWA NA UGUMU WA KUDHIBITI WASWASI UIOKUWA NAO?	➨ LA	NDIO
N3		FOR THE FOLLOWING, CODE **NO** IF THE SYMPTOMS ARE CONFINED TO FEATURES OF ANY DISORDER EXPLORED PRIOR TO THIS POINT**.**		
		Wakati ulikuwa na Taharuki miezi 6 iliyopita mara nyingi:		
	a	Ulikuwa hujatulia?	LA	NDIO
	b	Ulijihisi kukakamaa?	LA	NDIO
	c	Ulijihisi mwenye kuchoka na kukosa nguvu?	LA	NDIO
	d	Ulikuwa na ugumu wa kutulia kiakili?	LA	YNDIO
	e	Ulikuwa unakasirishwa kwa haraka?	LA	NDIO
	f	Ulikuwa ma ugumu wa kulala, yaani kuamka katikati ya usikunama kulala kwa sana?	LA	NDIO
		ARE **3** OR MORE **N3** ANSWERS CODED **YES?**	➨ LA	NDIO

N4 Hizi Taharuki huwa inabatilisha jinsi ambavyo unafanya kazi, uhusiano zako ama pahali popote penye umuhimu maishani mwako?

AND IS "RULE OUT ORGANIC CAUSE (**O2** SUMMARY)" CODED **YES**?

LA NDIO

GENERALIZED ANXIETY DISORDER

CURRENT

O. RULE OUT MEDICAL, ORGANIC OR DRUG CAUSES FOR ALL DISORDERS

IF THE PATIENT CODES POSITIVE FOR ANY CURRENT DISORDER ASK:

Kabla ya hizi dalili kutokea:

O1a Ulikuwa unameza dawa zozote, kwa hivyo ni madhara yake? ❒la❒ndio ❒sina uhakika

O1b Ulikuwa na ugonjwa wowote? ❒la❒ndio ❒sina uhakika

O2 IF O1a OR O1b IS CODED YES, IN THE CLINICIAN'S JUDGMENT IS EITHER LIKELY TO BE A DIRECT CAUSE OF THE PATIENT'S DISORDER? IF NECESSARY, ASK ADDITIONAL OPEN-ENDED QUESTIONS. ❒la❒ndio ❒sina uhakika

O2 SUMMARY: AN "ORGANIC" / MEDICAL / DRUG RELATED CAUSE BEEN RULED OUT❒la❒ndio❒sina uhakika

IF **O2** IS YES, THEN **O2** SUMMARY IS NO. IF **O2** IS NO, THEN **O2** SUMMARY IS YES. OHTERWISE IT IS UNCERTAIN.

P. UGONJWA WA MAKUZI YA HULKA NA TABIA ZINAZOPINGANA NA JAMII

(➨ MEANS: GO TO THE DIAGNOSTIC BOX AND CIRCLE NO)

P1 **Kabla ya miaka 15 ulifanya:**

a kukosa kwenda shuleni ama kutoroka nyumbani usiku, ama kukaa nje usiku bila ruhusa kutokaLA NDIO

kwa wazazi?

b mara kwa mara kudanganya au kuwahadaa wengine, au kuiba? LA NDIO

c kuanzisha vita au kuwatishia wengine? LA NDIO

d kimakusudi kuharibu vitu au kuanzisha moto? LA NDIO

e kimakusudi kuwaumiza wanyama au hata watu? LA NDIO

f kumlazimisha mtu kujamiiana? LA NDIO

➨

ARE **2** OR MORE **P1** ANSWERS CODED **YES**? LA NDIO

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

P2 **Tangu uwe miaka 15 umewahi:**

a fanya vitu ambavyo ni kinyume na sheria, hata kama hukushikwa LA NDIO

kama kuharibu mali, wizi ama kuuza dawa za kulevya?

b mara nyingi kuwadanganya aama kuwahadaa watu wengineili ukaweze kupata pesa amaLA NDIO

tu kujifurahisha?

c hupangi mambo yako ya hapo mbeleni? LA NDIO

d umepigana ama umewaumiza watu wengine kama vile mchumba ama watoto wako? LA NDIO

e umejiweka ama umewaeka wengine kwenye hatari bila ya kujali? LA NDIO

f mara kwa mara umeonyesha tabia isiyokuwa ya ki utu kama kutolipa deni, ama kukata kufanya kaziLA NDIO

ili kujimudu?

g hukuwa na aibu hata baada ya kuwaumiza wengine, kuwadanganya, kuwaibia ama hata kuharibuLA NDIO

mali yao?

ARE **3** OR MORE **P2** QUESTIONS CODED **YES**?

HII INAKAMILISHA MAHOJIANO

KWA SASA