

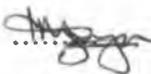
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DECLARATION

I, Dr. Ian Kanyanya, do hereby declare that this dissertation is my original work carried out in part-fulfillment of the requirements for the award of the Degree of Master of Medicine in Psychiatry (M.Med. Psych.) at the University of Nairobi, and further, that I have not presented the same for the award of any other degree or to any other university.

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SUPERVISORS' APPROVAL

This dissertation has been submitted for examination with your approval as the University supervisors.

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- Kamiti Maximum Security Prison staff, especially the Welfare Office staff, for being so helpful to me during the period of this study.
- My colleagues in the department of Psychiatry, University of Nairobi, for their critique and encouragement throughout the study.
- My wife, son and daughter for supporting me in innumerable ways when I spent endless hours working on this project.
- My God, to Whom I owe everything.

DEDICATION

TO

1. My dearest wife and friend, Millie
2. My sweet children, Joe and Grace-Joy
3. My beloved mother, Crescentia.

ABBREVIATIONS, ACRONYMS AND SOME DEFINITIONS:

- Ksh - Kenya Shillings.
- MSO - Male Sex Offender.
- IPDE - International Personality Disorder Examination.
- PM - Psychiatric Morbidity
- SCID - Structured Clinical Interview for the Diagnostic and Statistical Manual- IV.
- SDQ - Social Demographic Questionnaire.
- SQ - Sexual Questionnaire
- SPSS -Statistical Package for Social Sciences.
- WHO - World Health Organisation.
- Nrb - Nairobi (University of Nairobi).
- M.S.P. - Maximum Security Prison
- HQ - Headquarters.
- Erotica - Books, pictures et cetera intended to arouse sexual desire (Oxford Advanced Learners Dictionary).

ABSTRACT

BACKGROUND: Sexual offending is associated with enormous emotional pain and suffering to the victims and their families, as well as huge economic losses to the victims, their families and the state. Prevalence of, and factors associated with, sexual offending in Kenya should be determined with the view to reducing incidence to the minimum level possible.

OBJECTIVE: (a). To determine the prevalence and distribution of psychiatric morbidity among convicted male sex offenders (MSOs) aged 18 years and above, and (b). Establish factors associated with male sexual offending in Kenya.

DESIGN: Cross-sectional descriptive survey. **METHOD:** Those who voluntarily came forward and gave written informed consent were individually interviewed using a

socio-demographic and sexual questionnaire designed by the researcher, International Personality Disorder Examination (IPDE) and Structured Clinical Interview for the Diagnosis and Statistical Manual IV (SCID) instruments. **SETTING:** Seventy-six (76)

convicted MSOs at Kamiti M.S.P. were interviewed. Data collected was analyzed using SPSS version 11.5 computer software.

RESULTS: Of the 76 subjects, 47 (61.8%) were convicted of defilement and attempted defilement, 23 (30.3%) were convicted of rape and attempted rape, while 6 (7.9%) were convicted of various other sex offences.

Twenty-seven (27) out of 76 (35.5%) had a DSM-IV Axis I disorder while 26 (34.2%) had a DSM-IV Axis II disorder. A further breakdown of this distribution showed that 12 (15.8%) and 11 (14.5%) had Axis I and II diagnoses, respectively while 15 (19.7%) had both Axis I and II diagnoses i.e. co-morbidity. Majority of those subjects who met the criteria for DSM-IV Axis I were dependent on or abused substances (71.1% of Axis I

diagnoses). The substances most commonly misused were alcohol, cannabis and khat.

None of the subjects had psychiatric morbidity of psychotic proportions.

Of those who met criteria for Axis II diagnosis, Antisocial and Impulsive Personality Disorders were the most commonly occurring disorders (twelve out of twenty-six (46.2%)). Personality disorder unspecified also accounted for a significant number (six or 23.1%) of the twenty-six. The others (30.7%) had Histrionic, Schizoid, Paranoid and Borderline Personality Disorders.

Exposure to erotica (see Abbreviations, Acronyms and Definitions) was significantly associated with both Axes I and II ($p = 0.02$ and $p = 0.0003$ respectively) and preoccupation with thoughts about sex was associated with Axis II disorders ($p = 0.01$).

CONCLUSIONS: The following conclusions were drawn from this study:

1. More than a third (34.2%) of the subjects had personality and/or other psychiatric disorders (DSM-IV Axis II and/or I), while about a fifth (19.7%) had both (DSM-IV) Axis I and II diagnoses, 15.8% had an Axis I diagnosis alone and another 14.5% had an Axis II diagnosis alone.
2. Substance use disorders were the most commonly occurring DSM-IV Axis I disorders (71.1%).
3. Among those with Axis II disorders, those with antisocial and impulsive personality disorders accounted for nearly half of the subjects. The other half had histrionic, schizoid, obsessive-compulsive, borderline, paranoid and personality disorder unspecified.
4. There was a significant statistical association between Axes I and II disorders and exposure to sexually explicit materials but there was no such an association with

other socio-demographic factors. Further Axis II disorders were significantly associated with preoccupation with thoughts about sex too.

5. Majority (61.8%) of the offenders (defilers and potential defilers) targeted children aged less than 14 years.

Most of those with psychiatric morbidity targeted children and had antisocial or impulsive personality disorder. Awareness campaigns to enlighten the public of the fact that children are the commonest victims and research to determine the most effective ways of treating and rehabilitating sexual offenders could reduce the sexual offending in this country.

CHAPTER I: 1. INTRODUCTION

1.1 Background Sexual offending generally refers to a range of acts of sexual nature, from attempts to force a person into sexual activity to sexual intercourse. However, what constitutes a sexual offence varies between societies and within society over time. Issues relating to gender, age, relationship, aggression, the definition of consent, and location all influence whether a particular sexual act is considered to be an offence or not (1). For purposes of this study the definitions of sex offences are based on the Kenya Penal Code, whose violation was the basis of arrest and conviction of the subjects of this study.

In Kenya sexual offences are defined under Offences Against Morality (CAP XV) in the Kenya Penal Code, and include the following:

1. Rape.
2. Attempted rape.
3. Indecent assault on females.
4. Indecent assault on boys under 14 years of age.
5. Indecent practices between males.
6. Defilement of girls under 14 years.

7. Defilement of idiots and imbeciles.
8. Attempted defilement.
9. Conspiracy to defile.
10. Unnatural offences.
11. Attempt to commit unnatural offences.
12. Incest by males.
13. Incest by females.
14. Abduction of females.
15. Abduction of girls under 16 years of age

(Appendix II for definitions of these offenses).

NB. All these sex-related offenses are categorized as felonies except "Abduction of girls under 16 years." Felonies are serious offenses that draw severe sentences and those convicted of such offense are confined in maximum security prisons. Kamiti Maximum Security Prison, where this study was carried out, is the largest of the maximum security prisons in Kenya. The others are Shimo La Tewa, Naivasha, Nyeri, Kodiaga and Kibos maximum security prisons.

1.1.1 Criteria for Admission to Maximum Security Prison: Gravity of the offense and length of the sentence are the basic determinants of admission to maximum security prison. Those convicted of serious offenses (such as sex offenses) that draw sentences of at least seven years are confined in maximum security prisons. There is no rigid formula employed in choosing which of the maximum security prisons one is confined in but general considerations include;

- i). proximity of the prison: this is the main determinant of which maximum security prison one is confined in.
- ii). possession of special skills by the convict; for instance a prisoner convicted anywhere in the country may be transferred to Kamiti if he has special skills of making motor vehicle number plate (number plates are made only at Kamiti).
- iii). Personal reasons of the convict; prisoners are free to request for transfer to other maximum security prison if they deem it beneficial to them.

1.1.2 About Kamiti Prison: Kamiti Maximum Security Prison is situated on the northern outskirts of the Kenyan capital, Nairobi, about 21 kilometers from the City Centre. It is part of a bigger institution called the Kamiti Prisons Command. The other sections of this Command are the Kamiti Medium Security Prison and the Youth Corrective Training Centre (YCTC).

1.1.3 Kamiti Maximum security Prison: This prison was built in 1953 to accommodate 1800 inmates but now holds about 4100 inmates. It is the largest of the three sections of the Command. It has about 800 prison officers working under an officer of the rank of Assistant Commissioner of Prisons. This section houses inmates serving sentences ranging from 7 years to life sentence as well as those on the death row.

1.1.4 Kamiti Medium Security Prison:

Built in 1969 to accommodate 700 inmates, it now holds about 2500 inmates serving a maximum of 7 years.

1.1.5 Youth Corrective Training Centre: Built in 1975, it is home to about 400 youthful (< 18 years), petty offenders serving sentences of up to 6 months. These youths undergo

some training while serving their sentences. It is the only one of its kind in Kenya.

(Source: Welfare Office, Kamiti MSP, Nairobi).

1.1.6 The Cost of Victimization: In Australia, sexual assault has been found to exact a range of tangible and intangible costs for individuals, families and communities (2). Evidence points to the association of sexual victimization with increased short- and long-term physical and psychological morbidity, including gynecological problems, substance dependence, depression and suicidality, as well as relationship difficulties and female criminality. Tangible costs include expenditures by society and individuals on medical and psychological care, policing and incarceration and lost output for paid and unpaid work that victims are unable to carry out. Intangible costs encompass the emotional pain, suffering and losses of victims and their families, including lost quality of life, and the risk that some victims will become abusers.

A study (2) estimated medical and lost output costs and assigned a monetary value to intangible costs of various offences in Australia in 2001. While violent offences (homicide, assault and sexual assault) account for six per cent of all crime, they account for substantially more in cost terms, amounting to just over a quarter of the total. The costs of sexual assault totalled \$2,500 (Kshs 180,000) per incident, which is higher than the cost for physical assault, as sexual victimization takes a heavier emotional toll and inflates lost output and intangible costs of crime.

Given the high costs of sexual victimization, sexual offending is of great concern to communities and society as a whole. It is therefore important to formulate and implement policies aimed at appropriate management of sex offenders in order to prevent occurrence and recidivism of these offenses.

CHAPTER II

2 LITERATURE REVIEW

2.1. SEXUAL OFFENDING AND PSYCHOSIS:

Sexual offending is a form of violence and some sex offenders are motivated by a desire for dominance and control, rather than by sexual desire per se, (3), so the socio-demographic characteristics and psychiatric disorders in those exhibiting violent behavior generally are likely to apply to sex offenders specifically.

Internet and journal searches by the researcher found out that many studies have been done in the developed world to determine the social, demographic and psychiatric determinants of inappropriate sexual behaviour but no such studies were found for Kenya and Africa as a whole. Most studies show that there is a relationship between sexual offending and socio-demographic characteristics and mental disorders. For example, in a study to increase understanding of the relationship between sexual violence and mental illness, (4) researchers used Structured Clinical Interview for DSM-IV to assess for Axis I and II disorders. They assessed the legal histories, histories of sexual and physical abuse and family histories of psychiatric disorders as well as psychiatric features of males aged 25-41 years old who were convicted of sexual offenses. In their study thirty-six consecutive male sex offenders admitted from prison, jail, or probation to a residential treatment facility were interviewed. Subjects displayed high rates of lifetime DSM-IV Axis I disorders: 30 (83%) had a substance use disorder; 21 (58%), a paraphilia; 22 (61%), a mood disorder (13 [36%] with a bipolar disorder); 14 (39%), an impulse control disorder; 13 (36%), an anxiety disorder; and 6 (17%), an eating disorder. Subjects also displayed high rates of Axis II disorders, with 26 (72%) meeting

DSM-IV criteria for antisocial personality disorder. In addition, subjects reported experiencing high rates of sexual (but not physical) abuse and high rates of Axis I disorders, especially substance use and mood disorders, in their first-degree relatives. Compared with subjects without paraphilias, subjects with paraphilias displayed statistically significantly higher rates of mood, anxiety, and eating disorders, as well as significantly higher rates of childhood sexual abuse. This study was limited by the small sample size but in conclusion, the authors recommended that recognition and treatment of major psychiatric disorders among sex offenders might increase chances for successful rehabilitation, reduce recidivism and public victimization, and produce significant public health and economic benefits.

The relationship between violence and some mental disorders is well established (1). For example, personality disorders such as psychopathy are defined in part by a propensity to violence, and the ancient Greeks recognized that the abuse of substances such as alcohol was associated with violence and other offenses. Recently, there have been many developments in the understanding of the link between illnesses such as schizophrenia and violence.

In the case of the association between psychosis and violence probably the earliest best evidence came from a study by Taylor & Gunn (1) that showed that psychosis was much more common in prisoners remanded for a violent offence than it was in those remanded for non-violent offences (1). Later, large community studies showed similar results as follows;

Swanson and colleagues (1) looked at self-reported violence in a large, random community sample of 10,000 people in the USA. There was self-reported violence during

the previous 12 months in 2.1% of those with no psychiatric diagnosis, with a five-fold increase in those with a diagnosis of schizophrenia. The prevalence of violence was 12 times higher in those with a diagnosis of alcohol abuse/dependence, and 16 times higher in drug abuse/dependence, compared with those without such a diagnosis (1).

A Swedish follow up of about 650 patients with schizophrenia confirmed the association between that diagnosis and violence, and it also confirmed the importance of drug and alcohol abuse in increasing violence risk (1).

These studies showed that there was a significant association between psychotic mental illness and violence in society (1). The causal mechanisms of violence in patients with psychotic disorders are not clearly understood. Taylor reviewed research on the relationship between violence and delusions. In a follow up study, Buchanan showed that patients were more likely to act on persecutory delusions when they were emotionally aroused by the delusion, when they had looked for evidence to confirm or refute their belief, and when they were able to identify evidence in support of their delusion. It is perhaps not surprising that the combination of persecutory delusions, lack of insight and emotional distress increases the risk of violence.

Link & Stueve emphasized the importance of delusional symptoms that lead to a sense of personal threat, and of thoughts that lead to the overriding of normal mechanisms of self-control (1). They attached the label of "threat/control-override" (TCO) to these symptoms, which they saw as leading the mentally ill person to take preemptive, violent action against a perceived threat. Studies by Swanson and Link found strong associations between TCO delusions and violence in schizophrenia. Sexual violence in particular can occur for a variety of reasons:

- as a tool to overcome resistance or to ensure victim compliance,
- as an expression of anger,
- as a method of avoiding detection through intimidation or the elimination of a witness (the victim) (in homicidal cases),
- an unavoidable byproduct of certain sexual activities (such as penile penetration of small children),
- as a means of generating sexual excitement.

Another study to determine the clinical and demographic characteristics of elderly sexual offenders at a maximum-security forensic hospital in Canada, (5) found the majority of sexual offenders had mood or psychotic disorders. Almost one third had a history of violent or assaultive behavior. Fifty-seven percent (57%) had significant medical history.

Other studies aimed at determining associations between specific psychiatric disorders and sexual offences were as follows:

2.2. PERSONALITY DISORDERS AND SEXUAL OFFENDING:

Another study at Oxford University investigated the prevalence of psychiatric morbidity and personality disorders in elderly incarcerated sex offenders compared with elderly non-sex offenders(6).

One hundred and one sex offenders and 102 non-sex offenders aged over 59 years were interviewed using standardized semi-structured interviews for psychiatric illness (the Geriatric Mental State) and the personality disorder (Structured Clinical Interview for DSM-IV personality disorders). Results showed six per cent of the elderly sex offenders had a psychotic illness, 7% a DSM-IV major depressive episode and 33% a personality

disorder; and 1% had dementia. These prevalence figures were not different from the elderly non-sex offenders interviewed in this study. Differences emerged at the level of personality traits with sex offenders having more schizoid, obsessive-compulsive, and avoidant traits, and fewer antisocial traits compared with non-sex offenders, implying that sex offending in the elderly is associated more with personality factors than mental illness or organic brain disease.

2.3. PSYCHIATRIC CO-MORBIDITY AND SEXUAL OFFENDING:

In their study, Raymond and colleagues purposed to assess the rates of axis I and axis II psychiatric disorders, as defined in DSM-IV, in a group of pedophilic sex offenders (7). Forty-five male subjects with pedophilia who were participating in residential or outpatient sex offender treatment programs were recruited to participate. Subjects were interviewed by using the Structured Clinical Interview for DSM-IV.

The findings were, 93% of the subjects (N = 42) met the criteria for an axis I disorder other than pedophilia. The lifetime prevalence of mood disorder in this group was 67%. Sixty-four percent of the subjects met the criteria for an anxiety disorder, 60% for psychoactive substance use disorder, 53% for another paraphilia diagnosis, and 24% for a sexual dysfunction diagnosis. Their conclusions were, Axis I and II co-morbidity rates are high in this population.

2.4. OTHER THEORIES OF ETIOLOGY OF SEXUAL OFFENDING:

The most frequently offered explanation include reconstituted and combined versions of a) Social Learning Theory, b) Developmental Theory, c) Cognitive-Behavior Theory, d) Attachment Theory, e) Psychosis Theory, f) Addictions Theory, and g) Biological Theory (8). Three viewpoints are prevalent in the literature: deviant sexual behavior is either

learned behavior, caused by biological factors, or caused by a combination of learning and biological factors. Researchers generally agree that there are *multiple* factors (psychological, biological and sociological) that interact in complex and poorly understood ways. Studies suggest some association between sexual offending and a combination of individual characteristics, family variables, and socioeconomic factors. A history of prior physical or sexual abuse, impaired family functioning, alcohol and substance abuse, exposure to erotica (see Abbreviations, Acronyms and Definitions), neurobiological factors, and psychiatric comorbidity have been found to be associated with a higher prevalence of sexual offending.

2.4.1. Prior Abuse (physical & sexual): A history of prior abuse is a risk factor for future offending (8). A significant number of offending adolescents have a childhood history of physical abuse (25-50%) or sexual abuse (10-80%). However, the majority of those abused as children do not go on to become perpetrators. Of particular note is that children and adolescents who have been physically abused were 7.6 times more likely to rape or sodomize other children when compared to adolescents who were sexually abused or neglected. Glasser and colleagues set out to identified perpetrators of sex abuse (9) who had been victims of incest and/or paedophilia in order to:

- (i). ascertain whether subjects who had been victims become perpetrators of such abuse;
- (ii). compare characteristics of those who had and had not been victims; and review psychodynamic ideas thought to underlie the behaviour of perpetrators. Retrospective clinical case note review of 843 subjects attending a specialist forensic psychotherapy center was done. The results showed that among 747 males the risk of being a perpetrator was positively correlated with reported sexual abuse victim experiences. The

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overall rate of having been a victim was 35% for perpetrators and 11% for non-perpetrators. Of the 96 females, 43% had been victims but only one was a perpetrator. A high percentage of male subjects abused in childhood by a female relative became perpetrators. Therefore having been a victim appeared to be a strong predictor of becoming a perpetrator, as was an index of parental loss in childhood. This supports the notion of a victim-to-victimiser cycle in some male perpetrators especially in those who were sexually abused by females in childhood (8).

2.4.2. Family Dysfunction: In another study Pratt and her colleagues (8) found only half of adolescent offenders lived with both parents and one other juvenile at the time of their offending. Families of adolescent sex offenders more closely resemble those of youth with severe emotional or behavioral problems.

2.4.3. Substance Abuse Among adolescent sexual offenders, the rates of alcohol and other drug abuse range from 6 to 72% for 30 days prior to the survey (8). Because of such a wide range of prevalence rates reported in different studies it is difficult to draw definitive conclusions as to whether substance abuse is more prevalent among offenders. There is little agreement in the literature as to whether adolescent offenders were frequently intoxicated at the time of offending.

2.4.4. Exposure to Erotica Some studies suggest an association between exposure to sexually explicit materials and sexually offending behaviors while others do not find such an association(8). Causal relationships between erotic material and sexual deviance have not been clearly elucidated.

2.4.5. Biologic Factors High levels of androgens are theorized to contribute to increased libido and possibly to perpetration of sex offences (8).

CHAPTER III

3. METHODOLOGY

3.1 RESEARCH SCOPE

3.1.1 Research Question

1. What is the prevalence of psychiatric disorders among convicted male sex offenders (MSOs) at Kamiti M.S.P.?
2. What are the socio-demographic and sexual factors associated with sexual offending in males in our society?

3.1.2 Research Objectives.

- i) To establish the prevalence of psychiatric morbidity among convicted MSOs in prison.
- ii) To establish socio-demographic and sexual factors associated with sexual offending in males in Kenya.
- iii) To make appropriate recommendations towards better correctional and mental health management of MSOs in Kenya.

3.1.3 Study Design. This was a cross-sectional descriptive survey of convicted male sex offenders (MSOs) selected consecutively from a prison community.

3.1.4 Sampling & Sample Size: Eligible subjects were selected consecutively from those who volunteered to participate in the study until the desired minimum sample size of 72 was reached. This sample size was arrived at from the calculation that about 3 subjects would be interviewed per day on three days of the week for a period of about 8 weeks.

3.1.5 Study Population & Study Area. This consisted of convicted MSOs at Kamiti Maximum Security Prison, Nairobi Province, Kenya. Kamiti Maximum Security Prison

was chosen as the study area because within the Nairobi area it was the only prison where these categories of convicts (serving more than 7 years) are confined.

3.1.6 Inclusion Criteria. Convicted MSOs aged 18 years and above who voluntarily gave informed consent to participate in the study.

3.1.7 Exclusion Criteria Convicted MSOs aged 18 years and above who were unable or declined to give informed consent to participate in the study.

3.1.8 Study Instruments.

1. Socio-demographic and sexual questionnaires designed by the researcher.
2. Structured Clinical Interview for the Diagnosis and Statistical Manual IV (SCID).
3. International Personality Disorder Examination (IPDE).

3.1.9 Data Analysis and Presentations. The collected data was entered into the computer and analyzed using SPSS version 11.5 computer software. The results are presented in the form of tables and other descriptive formats.

3.1.10 Implementation

Prior to embarking on the study, the study proposal was presented for approval to the Department of Psychiatry, University of Nairobi, then to the Kenyatta National Hospital Research and Ethics Committee, the National Council for Science and Technology at the Ministry of Education, Science and Technology and Prisons authorities. Data collection took place between August and November 2005. The interviews were conducted at Kamiti Maximum Security Prison on week days between 9am and 4pm with a break between 12 and 2pm. The researcher gathered groups of 3-5 prisoners (with the help of prison authorities) at a time, gave them general information concerning the study and invited them to participate in the study individually. At that time it was emphasized to

them that their participation was entirely voluntary and that participation entailed answering questions contained in the questionnaires which the researcher had with him (socio-demographic questionnaire, SCID and IPDE). When an individual volunteered to participate in the study the exact nature and purpose of the study was further explained to him. When the individual met the inclusion criteria and on his own volition consented to participate in the study, the questionnaires were administered to him. This was done with every subject until the sample size of 76 was selected. Data collected was analyzed using the SPSS version 11.5 computer software. The results are presented in tables and other descriptive formats.

3.1.11 Standardized Instruments used in the study.

This study used the SCID and the IPDE as its standardized instruments.

The SCID is based on DSM-IV diagnostic criteria and has been used in various settings to detect psychiatric illnesses in population samples and in help-seeking individuals. It is a semi-structured diagnostic interview designed to assist clinicians, researchers and trainees in making reliable DSM-IV psychiatric diagnoses. Many studies have been carried out to assess the reliability and validity of this instrument and these can be found at the 'SCID web page': <http://cumc.columbia.edu/dept/scid/>. Reliability assessments quoted have yielded varying kappa values, ranging from -0.03 (any somatoform disorder) to 1.0 (Alcohol dependence and other substance abuse and PTSD). Most studies, however, rate it as highly reliable, with kappa values above 0.70 for most of the studied disorders. The instrument also shows high reliability with common comorbidities such as major depressive disorder, alcohol and other substance abuse as well as many anxiety disorders. Reasons for the wide variability in reliability

assessments are given as study design (joint interviews vs.. test/retest designs), interviewer training, subject population (reliability of results increases with severity of the disorder being studied) and base rates (reliability is higher in populations with higher base rates of the disorders than in those with lower base rates).

Validity assessments have been difficult due to lack of a proper 'gold standard' for diagnosis of psychiatric disorders. Certain studies have used the SCID as a standard, but the most widely accepted standard is the 'best estimate diagnosis'. The website quotes Spitzer as proposing an operationalization of this best estimate diagnosis, terming it the 'LEAD' standard, i.e. Longitudinal assessment (L)- collecting data about the subject over a period of time, expert diagnosticians (E) should be involved, and all data (AD) should be used, including family, social and occupational information. This standard is difficult to implement in the field, resulting in very few studies utilizing it. The studies that have used this standard to test various instruments demonstrate superiority of the SCID over other instruments. Ref <http://cumc.columbia.edu/dept/scid/>

3.1.12 International Personality Disorder Examination (IPDE) Instrument

IPDE is a semi structured clinical interview developed within a joint program by WHO and US National Institutes of Health (NIH) (10). It is designed to assess the personality disorders in the ICD-10 and DSM-IV classification systems. It has been in use since 1991. it has undergone some minor revisions and modifications to accommodate the transition from DSM-III-R to DSM-IV.

DSM-IV and ICD-10 are different but overlapping classification systems, the former being used more in the US while the latter is used more in other parts of the world. There are slight differences in ICD-10 and DSM-IV nomenclature: anankastic/obsessive-

compulsive, anxious/avoidant, and dissocial/antisocial. Furthermore in ICD-10 borderline and impulsive are viewed as subtypes of emotionally unstable, schizotypal is located with schizophrenia and delusional disorders, and narcissistic is not included.

3.1.12.1 Limitations of the IPDE

1. It is a self-report instrument that assumes that subjects are capable of providing valid descriptions of disturbances in their personality; but individuals may be unaware of some of their traits. They may also be resistant to acknowledge behavior if it is socially undesirable or if its disclosure is likely to adversely affect their best interests (eg release from prison). Others may exaggerate disturbances in their behavior but the IPDE discourages that by requiring documentation with convincing examples, anecdotes and descriptions.
2. Those in dysphoric states may have a selective recall or distorted perception of some of their behavior.
3. The IPDE does not include narcissistic personality disorder among its range of personality disorders.

3.1.12.2 Reliability and validity of the IPDE

The interrater agreement and temporal stability were studied at 14 clinical facilities in 11 countries in North America, Europe, Africa and Asia (10). The field trial employed 58 psychiatrists and clinical psychologists as interviewers and observers of 716 patients.

The reliability and stability of the IPDE were roughly similar to what has been reported with instruments used to diagnose the psychoses, mood, anxiety and substance use disorders. Establishing the validity of semi structured clinical interviews has proved to be a more elusive undertaking, because of the absence of an acceptable gold standard.

The use of clinical consensus as that standard is problematic without information about the reliability and validity of the clinicians themselves. The advantage of semi structured interviews like the IPDE, is that they have a certain procedural validity that makes the conclusions more readily exportable, and less susceptible to institutional and regional biases. In theory, they provide clinicians and investigators with a more uniform method of case identification, and thus facilitate the comparison and replication of research findings. It was the opinion of most of the clinicians who participated in the field trial, that the IPDE was a useful and essential valid method of assessing personality disorders for research purposes.

3.1.13 Methodological Difficulties and Limitations of the Study.

The difficulties encountered by the researcher included;

3.1.13.1 Prison procedures for gaining access to the subject:

This study was carried out in the largest maximum security prison in Kenya. Therefore strict procedure of accessing the subjects was followed on daily basis as follows; the researcher reported to the 'Welfare Office' and sought the assistance of that office to access the subjects. Then an officer from that office would personally walk to the registry which was about 150 metres away to present the request. The officers in the registry then coordinated the 'search' for a few (3-5) subjects for the interview. This process at times would half an hour or more time. This time was very valuable because the researcher could only interact with the subjects from 9am-12pm and from 2pm -4pm.

3.1.13.2. Misconceived ideas among convicts.

At the time this study was carried out, a parliamentarian had published the 'Sex Offenses Bill', a bill that proposed drastic legislative measures, including chemical

castration, to help stem the rising tide of sexual offenses in this country. Those prisoners convicted of sex-related offenses were very apprehensive of any person seeking them out for an interview as many of them interpreted any interaction with an outsider as potentially detrimental to them as he/she may castrate them. A significant number of subjects hid or otherwise declined participation in the study notwithstanding the fact that any new laws cannot be implemented retrogressively.

3.1.13.3. High incidence of denial of sexual offenses by the subjects:

60 out of 76 (78.9%) denied ever committing the offense they were convicted of. A few cases (below) illustrate some of the explanations given as circumstances surrounding their incarceration.

Case 1

Name: Phillip Mawe* (Not real name).

Age: 41 years

Religion: Catholic.

Residence before Arrest: Nairobi.

Marital Status: single.

Education: primary.

Occupation: hawker.

Alleged Offence: defilement of a six year old girl.

Circumstances Surrounding Offence Commission: Phillip vehemently denied the allegation and claimed that he was framed up by a lady neighbor whose sexual advances he had turned down. On the day of his arrested the lady had requested him to accompany her to the local police station to see a friend. On arrival at the station the

lady allegedly informed the police officers that he was the one who had defiled her daughter. Phillip was promptly arrested and later convicted of the offence. He didn't have access to a lawyer due to his poor socioeconomic state.

Case 2.

Name: John Kimbo* (Not real name).

Age: 60 years

Religion: protestant.

Residence before Arrest: Eastern.

Marital Status: widowed.

Education: primary.

Occupation: peasant farmer.

Alleged Offence: incest.

Circumstances Surrounding Offence Commission: he denied the allegation and claimed that he was implicated by a neighbor with whom he had differences. John claimed that he had lived peacefully for one year with his three children after his wife's demise. Then his neighbor accused him to the police that he was involved in an incestuous relationship with his eldest daughter who was ten years old. He was arrested and convicted of the offence. He did not have access to legal representation.

Most of those who denied the allegation volunteered these explanations in spite of the researcher not being actively involved in the pursuit of that information as determination of the authenticity of the accusation was not within the scope of this study.

These denials if true could impact negatively on the results and create a limitation given that the convictions were quite important to the study.

3.1.13.4. The Research Instruments and Education level of the subjects:

The two standardized instruments used in the study (SCID & IPDE) are both fairly lengthy instruments, particularly the IPDE instrument that would take about a half an hour to administer. The situation was further aggravated by the low educational level of majority of the subjects, who could not understand English, the language of the instruments. This in most cases necessitated the translation of questions into Swahili by the researcher in order for him to communicate with the subjects and this inevitably ate into the time of the interview.

3.1.13.5. Financial and Time Constraints:

This was a self-sponsored project. The researcher was unable to continue sampling beyond the bare minimum size of the sample notwithstanding the benefits of a larger sample size because of time and financial limitations.

CHAPTER IV:

4. RESULTS

4.1 Socio-demographic profile and sexual factors: (Table 2).

Age of subjects (yrs): The 76 convicted MSOs were aged between 18 and 73 years (Mean 33.5 Mode 23.0 Median 29.5).

Number of Children: Thirty-six (36) of the subjects had no children while 40 had 1 to 8 children (N= 40 Range 1-8 Mean 2.6 Mode 2.0 Median 2.0).

Father's age (years): Only 21 of the convicted MSOs had living fathers whose ages ranged between 45 and 80 years (N= 21 Range 45-80 Mean 61.2 Mode 45.0 Median 64.0)

Religion: Thirty-eight (38) (50%) of the study subjects were Protestants, 31 (40.8%) were Catholics and 7 (9.2%) were Muslims.

Highest Level of Education: The bulk 50 (65.8%) of the subjects had primary level of education, 20 (26.3%) were had secondary, college or university education whereas 6 (7.9%) had no formal education.

Residence Before Arrest (see Table 1):

TABLE 1: RESIDENCE BEFORE ARREST (PROVINCE)

Province	Frequency	Percentage
Central	26	34.2
Nairobi	22	28.9
Eastern	18	23.7
Rift Valley	5	6.6
North Eastern	3	3.9
Western	2	2.6

The subjects were arrested from six of Kenya's eight provinces. Most of them came from central Province (34.2%), Nairobi Province (28.9%) and Eastern Province (23.7%). The remainder (13.1%) came from the Rift Valley, North Eastern and Western Provinces.

Although Nairobi and Central Provinces were the residences of majority of the convicts, this does not necessarily mean that the two provinces produce most convicts because the main determinant of the prison one is sent to is proximity to that prison from the station of conviction. Kamiti M.S.P. is in Nairobi Province which borders Central Province.

Marital status: Thirty-two (32) (42.1%) were single, another 32 (42.1%) were married while 12 (15.8%) were widowed, separated, or divorced.

Occupation: Of the 76 subjects only 4 (5.3%) were professionals (teachers and policemen), while 21 (27.6%) were skilled workers (drivers, farmers, cooks, mechanics, farmers, barbers and businessmen); 47 (61.8%) were unskilled workers (cleaners, touts, watchmen, waiters etc) and four (5.3%) had no occupation.

Frequent physical assaults in childhood and by whom: Twenty-eight (28) (36.8%) of the 76 subjects had frequent childhood physical assaults most of whom (22) reported assaults by their parents. 6 were assaulted by other people.

History of sexual assault in childhood and by whom: Three (3) (3.9%) of the subjects were sexually assaulted in childhood. The perpetrators were a neighbor, relative and employer.

Lived with whom during adolescence: Most of the subjects (46) (60.5%) lived with both parents during adolescence 16 (21.1%) lived with their mothers alone, 1 (1.3%) lived with his father alone and the rest of them (13) (17.1%) lived with other people.

Ever suffered from mental illness: Ten (10) (13.2%) of the subjects had a positive personal history of mental illness.

Family history of mental illness: Ten (10) (13.2%) out of 76 subjects had family history of mental illness.

With whom lived before arrest: Twenty-one (21) (27.6%) lived alone, 26 (34.2%) lived with a spouse, 14 (18.4%) lived with parents and 15 (19.7%) with uncles, friends etc.

How often he thought about sex at time of arrest: Majority (40) (52.6%) hardly thought about sex, 23 (30.3%) thought about sex a few times per day while 13 (17.1%) thought about sex all the time.

Exposure to erotica: Thirty-four (34) (44.7%) of the subjects were exposed to materials with sexually explicit content.

Entitlement to sex: Ten (10) (13.2%) of the 16 who did not deny the offence felt entitled to having sex with the victim. 60 subjects denied committing any sexual offence with most of them claiming they were framed up by their employers, neighbors etc.

Use of force or threats on the victim: Three (3) (3.9%) of the 16 who did not deny the offence used force or threats on their victims.

Use of a substance at time of offence: Seven (7) (9.2%) were under the influence of a psychoactive substance at the time of offending.

Alleged offence

Most offences were related to defilement (47) (61.8%). Other offences were related to rape (23) (30.3%), sodomy (3) (3.9%), incest (2) (2.6%) and indecent assault (1) (1.3%)

(Table 2).

Table 2: Frequency of Alleged Offences N = 76

Alleged offense	Frequency	Percentage
Defilement	42	55.3
Attempted Defilement	5	6.6
Rape	19	25.0
Attempted Rape	4	5.3
Sodomy	3	3.9
Incest	2	2.6
Indecent Assault	1	1.3

SEX OFFENCES AND VARIABLES (Table 3).

1. Religion versus sexual offending: By far most of the subjects with Christian inclinations were convicted of defilement (41 of 69). Those from the Muslim community (7) were more evenly distributed between defilement, rape and other offences committed. Statistically there was no association between religion and sexual offending.
2. Marital status versus sexual offending: Defilement was the commonest offence across the various categories of the marital status but there was no statistical association between the status of marriage and sexual offending.
3. Highest level of education versus sexual offending: Defilement remained the commonest alleged offence but there was no statistical association between sexual offending and level of education attained.
4. Occupation versus sexual offending: Majority (47 out 76) fell in the category of unskilled workers and the commonest offence was defilement. There was no significant association between sexual offending and occupation, statistically.
5. Personal history of mental illness versus sexual offending:

The 10 subjects with a history of mental illness were more or less distributed evenly across the the categories of offences. There was no statistical association between sexual offending and previous personal history of mental illness.

6. Family history of mental illness versus sexual offending:

There was no significant statistical association between a positive family history of mental illness and sexual offending.

7. Childhood frequent physical assaults versus sexual offending:

Of the 28 subjects with a childhood history of frequent physical assaults 14 (50%) were convicted on defilement charges. However there was no statistically significant association between this history and sexual offending. (continued on page 28).

8. How much they thought about sex at time of alleged offence versus sexual offending:

Majority of subjects hardly thought about sex at the time of alleged offence (40 of 76) and there was no statistical association between how much they thought about sex and sexual offending.

9. Exposure to erotica versus sexual offending:

Less than a third (22 out of 76) were frequently exposed to erotic materials and there was no significant association between this exposure and sexual offending.

Table 3: Alleged Offence and Socio-demographic Variables (see over-leaf).

Variable		Alleged offence		
		Defilement	Rape	Others
Religion	Protestants	23	9	6
	Catholics	18	7	6
	Muslims	2	3	2
Marital Status	Single	21	6	5
	Married	16	10	6
	Other	6	3	3
Education level	None	3	3	0
	Primary	29	9	12
	Secondary plus	11	7	2
Occupation	Professional	4	0	0
	Skilled	8	8	5
	Unskilled	28	11	8
	None	3	0	1
At time of arrest lived with whom?	Alone	15	3	3
	Spouse	11	10	6
	Parents	13	4	3
	Other	4	2	2
Previous history of mental illness	Yes	3	4	3
	No	40	15	11
Family history of mental illness	Yes	6	2	2
	No	37	17	12
Childhood Physical Assaults	Yes	14	7	7
	No	29	12	7
Sexual assault in childhood.	Yes	0	3	0
	No	43	16	0
During adolescence lived with whom?	Both parents	28	7	11
	Father	0	1	0
	Mother	9	5	2
	Other	6	6	1
Sex Thoughts	About All Times	8	2	3
	Few times	9	10	4
	Hardly	26	7	7
Exposure to Erotica	Frequently	9	7	6
	Rarely	7	3	2
	Never	27	9	6
Taken any substance at time of offence?	Yes	2	5	0
	No	6	2	2
Specify Substance	Alcohol	2	3	0
	Alcohol and Cannabis	0	1	0
	Cannabis.	0	1	0
Knew Victim?	Yes		10	5
	No	21	8	8

10. Psychoactive substance use at the time of offending versus sexual offending

Only 7 of the subjects were under the influence of a psychoactive substance and there was no statistical association between substance use at time of offending and sexual offending.

11. Did you know the victim vs. sexual offending versus sexual offending

Thirty-five (46.1%) of the subjects knew the alleged victims.

However there was no statistical association between knowledge of the victim and sexual offending.

Other variables with no significant statistical association with sexual offending include with whom the offender lived at the time of arrest, with whom he lived during adolescence and history of childhood sexual assault in childhood.

DSM-IV AXIS I

Majority of those subjects who met the criteria for DSM-IV Axis I had life-time dependence or abuse of substances (71.1% of Axis I diagnoses). Some had been dependent on more than one substance. Alcohol and cannabis use disorders were the most common. Other Axis I diagnoses anxiety-related (15.8% of all axis I diagnoses) and mood disorders, all of which were depression- related (13.1% of Axis I diagnoses). The substances most commonly misused were alcohol, cannabis and khat. None of the subjects had psychiatric morbidity of psychotic proportions (Table 4).

Table 4: DSM-IV Axis I Disorders N= 27

CODE (DSM-IV-TR)	VARIABLE	FREQUENCY
303.90	Alcohol Dependence	8
305.00	Alcohol abuse	3
305.1	Nicotine Dependence	2
304.30	Cannabis Dependence	7
305.20	Cannabis Abuse	1
304.90	Khat Dependence	5
305.90	Khat Abuse	1
309.81	Post traumatic stress disorder	1
296.6	Past major depressive episode	2
296.23	Current major depressive episode	1
300.4	Dysthymic disorder	2
300.29	Lifetime specific phobia	4
300.81	Somatisation disorder	1

DSM-IV AXIS I DISORDERS AND SOCIO-DEMOGRAPHIC/SEXUAL VARIABLES:**(Table 5)**

This study found significant statistical association between Axis I disorders and exposure to erotic materials ($p= 0.02$).

It did not find any significant association between psychiatric morbidity and the following variables; religion, marital status, occupation, with whom offender lived with at time of arrest, previous history of mental illness in the offender, family history of mental illness, frequent childhood physical assaults, history of childhood sexual assault.

Others were with whom the offender lived during adolescence, parents of offender being alive, how much the offender thought about sex, the offence allegedly committed and the offender knowing the victim.

Table 5: DSM-IV Axis I Disorders and Socio-Demographic/Sexual variables

VARIABLE		DSM-IV Axis I Disorders		P-Value
		Yes	No	
Religion	Protestants	14	24	0.46
	Catholics	12	19	
	Muslims	1	6	
Marital Status	Single	7	25	0.06
	Married	13	19	
	Other	7	5	
Occupation	Professional	3	1	0.34
	Skilled	6	15	
	Unskilled	17	30	
	None	1	3	
With whom did you live at time of arrest?	Spouse	11	16	0.56
	Alone	9	12	
	Parents	3	4	
	Mother	2	9	
	father	0	2	
	Other	2	6	
Previous history of mental illness	Yes	5	5	0.30
	No	22	44	
Family history of mental illness	Yes	3	7	0.70
	No	24	42	
Childhood Physical Assaults	Yes	10	18	0.70
	No	17	31	
Childhood history of sexual assault	Yes	3	0	
	No	27	49	
During adolescence lived with whom?	Both Parents	16	30	0.72
	Father	0	1	
	Mother	5	11	
	Other	6	7	

Parents Alive?	Yes	19	37	0.63
	No	8	12	
Sex Thoughts	About all the times.	6	7	0.67
	Few times	8	15	
	Hardly	13	27	
Exposure to Erotica	Frequently	12	10	0.02*
	Rarely	1	11	
	Never	14	28	
Alleged Offence	Defilement	15	28	0.99
	Rape	7	12	
	Others	5	9	
Knew Victim?	Yes	14	21	0.36
	No	11	26	

Chi-square statistical test used. *.Means statistical significant.

Table 6: DSM-IV Axis II Disorders N = 26

Code	DSM-IV Axis II Disorders	Frequency
301.7	Antisocial personality disorder	7
	Impulsive personality disorder	5
301.50	Histrionic personality disorder	3
301.20	Schizoid personality disorder	2
301.4	Obsessive-Compulsive personality disorder	1
301.83	Borderline personality disorder	1
301.0	Paranoid personality disorder	1
301.9	Personality disorder NOS	6

DSM-IV AXIS II DISORDERS: (Table 6)

Antisocial (26.9%) and Impulsive (19.2%) personality Disorders were the most commonly occurring personality disorders among those who met the criteria for personality disorders (twelve out of twenty-six (46.2%)). Personality disorder unspecified also accounted for a significant number (six or 23.1%) of the twenty-six. The others (30.7%) had Histrionic, Schizoid, Paranoid and Borderline Personality Disorders.

DSM-IV AXIS II DISORDERS AND SOCIO-DEMOGRAPHIC/SEXUAL

VARIABLES: (Table 7)

There was significant statistical association between Axis II disorders and

- i). How much the offender thought about sex at the time of offending ($p= 0.01$), and;
- ii). Exposure to erotica ($p= 0.0003$).

But there was no significant statistical association between Axis II disorders and the following socio-demographic variables; religion, marital status, occupation, with whom the offender lived with at the time of sexual offending, previous history of mental illness in the offender, family history of mental illness, history of frequent childhood physical assaults, with whom the offender lived during adolescence, history of childhood sexual abuse in the offender, parents of the offender being alive, the sexual offence, and whether the offender knew the victim.

Table 7: DSM-IV Axis II Disorders and Socio-Demographic/Sexual Variables

Variable	Personality Disorder		P-Values	
	Yes	No		
Religion	Protestants	12	26	0.83
	Catholics	11	20	
	Muslims	3	4	
Marital Status	Single	9	23	0.32
	Married	14	18	
	Other	3	9	
Occupation	Professional	1	3	0.81
	Skilled	6	15	
	Unskilled	17	30	
	None	2	2	
With whom did you live before arrest?	Spouse	11	16	0.79
	Alone	6	15	
	Parents	3	4	
	Mother	4	7	
	father	0	2	
	Other	2	6	
Previous history of mental illness.	Yes	6	4	0.07
	No	20	46	
Family history of mental illness.	Yes	4	6	0.68
	No	22	44	
Childhood Physical Assaults	Yes	13	15	0.09
	No	13	35	
During adolescence- lived with whom?	Both Parents	14	32	0.63
	Father	0	1	
	Mother	6	10	
	Other	6	7	
History of childhood sexual assault	Yes	3	0	0.13
	No	23	58	
Parents Alive?	Yes	17	39	0.23
	No	9	11	
Sex Thoughts	About All Times	9	4	0.01*
	Few times	7	16	
	Hardly	10	30	
Exposure to Erotica	Frequently	16	6	0.0003*
	Rarely	3	9	
	Never	7	35	
Alleged Offence	Defilement	11	32	0.12
	Rape	10	9	
	Others	5	9	
Knew Victim?	Yes	15	20	0.16
	No	10	27	

DSM-IV AXIS I AND II DISORDERS: (Table 8)

Of the seventy-six subjects, fifteen (19.7%) met criteria for a personality disorder and other psychiatric morbidity. Eleven (14.5%) met the criteria for a personality disorder alone, twelve (15.8%) had psychiatric disorders other than personality disorder while fifty (65.8%) had no psychiatric morbidity.

Table 8: DSM-IV Axis I and Axis II Disorders

		Axis II Disorders		
		Yes	No	Total
Axis I Disorders	Yes	15 (19.7%)	12 (15.8%)	27 (35.5%)
	No	11(14.5%)	38 (50.0%)	49 (64.5%)
	Total	26 (34.2%)	50 (65.8%)	76 (100%)

CHAPTER 5

5. DISCUSSION:

5.1 Socio-Demographic and Sexual Factors

This study showed that sexual offending was not limited to any particular age group of perpetrators as the ages of the convicts ranged from 18 to 73 years, notwithstanding the fact that there appeared to be more young people convicted for sexual offending (mean 33.5, mode 23.0) than older people.

Majority of the Kenyan population are affiliated to the Christian religion. Although the exact Christian: Muslim ratio in the catchment areas (residences before arrest) of this study is unknown, the Christian: Muslim ratio of the subjects of the study of 69: 7 or 90.8%: 9.2% respectively may roughly reflect the ratio on the ground in the catchment areas. Religion did not appear to play a role in sexual offending as, for example, those convicted of defilement and rape (57 out of 69) (82.6%) from the Christian group were comparable to those convicted of the same offences who came from the Muslim population (5 of 7) (71.4%).

The subjects were arrested from six of Kenya's eight provinces. Central Province produced the highest number (26) (34.2%), followed by Nairobi Province (22) (28.9%) and Eastern Province (18) (23.7%). The remainder (10) (13.1%) came from the Rift Valley, North Eastern and Western Provinces. Coast Province and Nyanza Provinces, some of the most far-flung provinces from the centrally located Kamiti M.S.P., did not produce any subjects for this study. These findings do not necessarily imply that the two provinces, Nairobi and Central, produce most convicts because; i). Proximity to a maximum security prison is one of the most basic consideration in determining to which

prison one is sent (Kamiti M.S.P. is in Nairobi Province which borders Central Province) and these two provinces have maximum security prisons either within their boundaries or in neighboring provinces. Furthermore, information from the prison authorities indicate that rape and related convictions account for roughly 20% of maximum security prison populations across all the maximum security prisons in the country (Source: **Research & Statistics Office, Prisons HQ**).

Occupation- the vast majority (72 of 76) (94.7%) of the subjects of this study were skilled workers, unskilled workers or unemployed altogether. In Kenya these categories of workers are in the lower socio-economic class. Being people of low socio-economic status may contribute to convictions, perhaps wrongfully sometimes, because most of these people could not afford the services of lawyers. Intertwined with this is the lack of, or low level of education that nearly three quarters (73.7%) of the subjects. However, occupation and level of education did not appear to be associated with sexual offending ($p > 0.05$).

Thirty-two (32) (42.1%) of the subjects were married while 44 (57.9%) were divorced, separated or otherwise single. The marital status of the offender was not statistically associated with sexual offending.

Childhood history physical & sexual abuse and by whom:

Some studies have found an association between childhood physical and sexual abuse and sexual offending later in life (8).

And a high percentage of male subjects abused in childhood by a female relative became perpetrators (9). In this study 28 (36.8%) had history of frequent childhood physical assaults, most of whom (22) (78.6%) were assaulted by their own parents and

only 6 (21.4%) were assaulted by other people. Three (3) (3.9%) had childhood sexual assault history. Neither childhood sexual or physical abuse was statistically associated with sexual offending in this study.

And in the case of childhood sexual abuse where only 3 of the 76 subjects gave a positive history, it is possible that this was under-reported.

According to some research findings the adolescents who lived with their parents are less likely to sexually offend than those who did not live with their parents (11), (12) and Parental loss is also linked to being a sex offender later in life (9).

In this study majority (46) (60.5%) of the subjects lived with both parents, 17 (22.4%) lived with one parent while 13 (17.1%) lived with other people during adolescence and there was no significant statistical association between sexual offending and with whom these subjects lived during adolescence.

Only 10 (13.2%) had previous history of mental illness and this was not statistically associated with sexual offending.

An absence of empathy with victims is a fundamental deficit in sexual offenders (13). In this study most subjects claimed they were wrongfully convicted and denied they committed the offenses but a significant 62.5% (10 of 16) of those who did not deny it felt entitled to having sex with the victim, indicating lack of empathy with the victim.

Exposure to Erotica:

Some studies suggest an association between exposure to sexually explicit materials and sexually offending behaviors while others do not find such an association. (8).

In this study 34 (44.7%) were exposed to sexually explicit materials before offending.

However, there was no significant statistical association between exposure to erotica and sexual offending.

Pre-occupation with thoughts about sex- 13 (17.1%) of the subjects thought about sex almost all the time before the offense was committed. This was significantly associated with DSM-IV Axis II (personality) disorders ($p= 0.01$) but not with sexual offending.

5.2 OFFENSES

This study found that majority (47) (61.8%) of offenders (defilement and attempted defilement) targeted minors (children aged less than 14 years). There are various possible reasons for this pattern, including:

- i). Children could be easy prey as they can be overwhelmed by the offender more easily than in the case of an adult and / or,
 - ii). conversely, since the issue of defilement of children has been carried very prominently and sensationally by the mass media in this country in the last few years and given that majority of the study subjects denied the accusation and blamed their predicament on factors such as lack of proper legal representation, there exists a possibility that some of these people were convicted wrongly, giving the impression that more people offending children than is the case.
 - iii). Under-reporting of other crimes could be another reason for projecting defilement and attempted defilement as the most common sexual offense in the Kenyan set up.
- Those convicted of rape and attempted rape represented a significant (30.3%) of all convicts.

5.3 DSM-IV AXIS I

Twenty-six (26) (34.2%) had DSM-IV Axis I disorders majority of whom met the criteria for DSM-IV Axis I were dependent on or abused substances (life-time) (71.1% of the Axis I diagnoses). Some were dependent on more than one substance. The substances most commonly misused were alcohol, cannabis and khat. Other Axis I diagnoses anxiety-related (15.8% of all axis I diagnoses) and mood disorders, all of which were depression-related (13.1% of Axis I diagnoses). None of the subjects had psychiatric morbidity of psychotic proportions. These findings somewhat differ from those found in studies carried out among a similar population in the developed world, for example McElroy showed higher percentages of lifetime DSM-IV Axis I disorders (83%) and a significant (36%) mood disorders and these two studies both had high rates of substance use disorders (58% and 71%) (4).

5.4 DSM-IV AXIS I DISORDERS AND VARIABLES

This study found significant statistical association between psychiatric morbidity (by SCID) and exposure to erotic materials ($p= 0.02$).

It did not find any significant association between psychiatric morbidity and the following variables; religion, marital status, occupation, with whom offender lived with at time of arrest, previous history of mental illness in the offender, family history of mental illness, frequent childhood physical assaults, history of childhood sexual assault. Others were with whom the offender lived during adolescence, parents of offender being alive, how much the offender thought about sex, the offence allegedly committed and the offender knowing the victim.

5.5 AXIS II DISORDERS:

Antisocial (27%) and Impulsive personality Disorders (19.2%) were the most commonly occurring personality disorders among those who met the criteria for personality disorders (46.2%). Personality disorder unspecified also accounted for a significant number (six or 23.1%) of the twenty-six. The others (30.7%) had Histrionic, Schizoid, Paranoid and Borderline Personality Disorders. These findings showed lower rates of Axis II disorders, specifically antisocial personality disorder, than in comparable studies done in other parts of the world. For example, a study done at Oxford University to determine prevalence of psychiatric morbidity and personality disorders among elderly incarcerated sex offenders showed low rates of psychotic disorders (6%), major depression (7%) and personality disorders (33%) which did not differ from elderly non-sex offenders interviewed in the study. However, there were differences in personality traits with sex offenders having more schizoid, obsessive-compulsive, and avoidant traits. And fewer antisocial traits compared with non-sex offenders.

5.6 AXIS II DISORDERS AND VARIABLES

There was no significant statistical association between personality disorders and the following socio-demographic variables; religion, marital status, occupation, with whom the offender lived with at the time of sexual offending, previous history of mental illness in the offender, family history of mental illness, history of frequent childhood physical assaults, with whom the offender lived during adolescence, history of childhood sexual abuse in the offender, parents of the offender being alive, the sexual offence, and whether the offender knew the victim. However, there was significant statistical association between personality disorders and;

- i). How much the offender thought about sex at the time of offending ($p= 0.01$), and;
- ii). Exposure to erotica ($p= 0.0003$).

5.7 COMORBIDITY:

Of the 76 subjects, 15 (19.7%) met criteria for both Axis I and II (DSM-IV) disorders. 12 (15.8%) had an Axis I disorder alone, 11 (14.5%) met the criteria for Axis II disorder alone, while 50 (65.8%) had no psychiatric morbidity. These rates are lower than what has been found in some of the studies done in the western world where rates of Axis I disorders was as high as 93% (7)

6. CONCLUSIONS

The following conclusions were drawn from this study:

1. More than a third (34.2%) of the subjects had a personality or other psychiatric disorders (DSM-IV Axis I & II), while about a fifth (19.7%) had both (DSM-IV) Axis I and II diagnoses, 15.8% had an Axis I diagnosis alone and another 14.5% had an Axis II diagnosis alone.
2. Among those with an Axis I diagnosis, substance use-related disorders accounted for the majority (69.4%) of the conditions picked by the instruments.
3. Among those with an Axis II disorders, two disorders (antisocial and impulsive personality disorders) took the largest share (46.2%) while the other six personality disorders (histrionic, schizoid, obsessive-compulsive, borderline, paranoid and personality disorder unspecified) took the rest (53.8%).
4. There was a significant statistical association between Axes I and II disorders and exposure to sexually explicit materials but there was no such an association with

other socio-demographic factors. Further Axis II disorders were significantly associated with preoccupation with thoughts about sex too.

5. The offences were committed by persons in a wide range of age bracket (18-73years). This implies that sexual offending may be committed by all age groups.
6. Majority (61.8%) of the offenders (defilers and potential defilers) targeted children aged less than 14 years.
7. There was no significant statistical association between sexual offending and the socio-demographic factors of the convict.

7. RECOMMENDATIONS:

1. **Prevention of sexual offending:** This study has demonstrated that young children (victims of defilers) are by far the commonest target of perpetrators of sexual offenses in the Kenyan society. Equipping society with this knowledge can help prevent or minimize sexual offenses. This can be done by increasing vigilance on the part of parents (and guardians) as well as the hapless potential victims.
2. **Swahili research instruments:** most of the subjects in the study could not understand and communicate effectively in the English language. It would be advantageous to such subjects to have a Swahili version of the SCID and IPDE instruments.
3. **Funding:** in future anybody venturing into a project such as this study will do well to be sufficiently funded before starting on the project. This study was limited to a sample size of 76 subjects basically due to financial constraints.

4. Both (DSM-IV) Axes I and II disorders in this study were significantly associated with exposure to sexually explicit material while Axis II disorders were associated with preoccupation with thoughts about sex. Some studies have shown that exposure to sexually explicit materials and preoccupation with sexual fantasies contributed to increased incidents sexual offending. Treatment of these disorders may help prevent these offenses.
5. More research to determine the prevalence of psychiatric morbidity in the Kenyan general population and prison populations is recommended. This would make it possible to compare with the morbidity prevalence of those convicted of sexual offenses.

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APPENDIX I INFORMED CONSENT EXPLANATION

To be read and questions answered in a language in which the subject is fluent.

Introduction : I am Dr. Ian Kanyanya from the University of Nairobi, Faculty of Medicine, Dept. of Psychiatry. I would like to tell you about a medical study which I am carrying out in prisons around Nairobi. I am working under the supervision of:

1. Prof. David Ndeti, Professor of Psychiatry, Dept. of Psychiatry, University of Nairobi
2. Dr. Caleb Othieno, Senior Lecturer, Dept. of Psychiatry, University of Nairobi

In this study I seek to interview people who have been sentenced for sex-related offences so as to be able to detect any psychological problems the subject might have. At the end of the study recommendations will be made that will hopefully positively influence policy concerning mental healthcare and correctional care in those sentenced for sex-related offences in this country. I would like to invite you to participate in this study.

There are, however, a few things I would like you to understand before you decide whether you will participate in this study or not:

- i). Participation in this study is entirely voluntary.
- ii). Participation involves answering questions that I have put in a questionnaire format and this will be conducted in the form of an interview.
- iii). You may withdraw from this study at any time, if you choose to, without any penalty or loss of benefits that you are otherwise entitled to.
- iv). Your name shall not be used anywhere in this study and all information gathered from you shall be treated as confidential and shall be used for no other purposes other than this study. Be assured that information given by you shall not be given to the authorities and shall not be used against you in any way.
- v). You shall not be subjected to any physically painful procedures such as injections or blood withdrawal during this study.
- vi). If any psychological problems are found in you, you will be assisted as necessary, i.e. by being given medical advice, being issued with a prescription or being referred to hospitals such as KNH. For purposes of facilitation, Prisons authorities shall be informed appropriately about such problems.
- vii). You are welcome to ask questions both now and anytime hereafter, concerning this study and your participation in it.

If you agree to participate in this study I will request you to sign under the “**Subject’s Statement**” here below after reading through it.

Subject's Statement

This study has been explained to me in a language that I understand and I have understood it. I have had opportunity to ask questions and I am informed that the researcher, Dr. Kanyanya, would answer future questions that I may have about the study. I voluntarily consent to participate in it.

Signature of subject: _____

Signature of researcher: _____

APPENDIX II

DEFINITIONS OF SEX OFFENCES : NB: The Oxford Advanced Learners Dictionary definitions:

.Offense- breaking of a rule or law: illegal act; crime.

.Felony- a serious crime, eg murder, armed robbery or arson.

.Misdemeanour- minor wrong doing, misdeed; punishable offense less serious than a felony.

Sex offence

For purposes of this study the definitions of sex offences are based on the Kenya Penal Code, whose violation was the basis of arrest and conviction of the subjects of this study.

In the Kenya Penal Code, sexual offences are defined under Chapter XV-Offences Against Morality- and include the following:

1. Rape Any person who has unlawful carnal knowledge of a woman or a girl, without her consent, or with her consent if the consent is obtained by force or by means of threats or intimidation of any kind, or by fear of bodily harm, or by means of false representations as to the nature of the act, or in the case of a married woman, by personating her husband, is guilty of the felony termed rape.

2. Attempted rape Any person who attempts to commit rape is guilty of a felony...

3. Abduction. Any person who, with intent to marry or carnally know a woman of any age, or to cause her to be married or carnally known by any other person, takes her away, or detains her, against her will, is guilty of a felony...

4. Abduction of girls under sixteen years. Any person who unlawfully takes an unmarried girl under the age of sixteen years out of the custody or protection of her

father or mother, or other person having lawful care or charge of her, and against the will of father or mother or other person, is guilty of a misdemeanour.

5. Indecent assault on females.

a). Any person who unlawfully and indecently assaults any woman or girl is guilty of a felony...

b). It shall be no defence to charge for an indecent assault on a girl under the age of fourteen years to prove that she consented to the act of indecency;

Provided that it shall be a sufficient defence to any charge under this subsection if it is made to appear to the court before whom the charge is brought that the person so charged had reasonable cause to believe and did in fact believe that the girl was of or above the age of fourteen years or was his wife.

c). Whoever, intending to insult the modesty of any woman or girl, utters any word, makes any sound or gesture, or exhibits any object, intending that the word or sound shall be heard, or that the gesture or object shall be seen, by the woman or girl, or intrudes upon the privacy of the woman or girl, is guilty of a misdemeanour...

6. Defilement of girls under fourteen years of age.

a). Any person who unlawfully and carnally knows any girl under the age of fourteen years is guilty of a felony...

b). Any person who attempts to have unlawful carnal knowledge of a girl under the age of fourteen years is guilty of a felony ...

Provided that it shall be sufficient defense to any charge under this section if it is made to appear to the court before whom the charge is brought that the person so charged had

reasonable cause to believe and did in fact believe that the girl was of or above the age fourteen years or was his wife.

7. Defilement of idiots or imbeciles Any person who, knowing a woman or a girl to be an idiot or imbecile, has or attempts to have unlawful carnal knowledge of her under circumstances not amounting to rape, but which prove that the offender knew at the time of the commission of the offence that the woman or girl was an idiot or an imbecile, is guilty of a felony ...

8. Conspiracy to defile: Any person who conspires with another to induce any woman or girl, by means of any false pretence or other fraudulent means, to permit any man to have unlawful carnal knowledge of her is guilty of a felony ...

9. Unnatural offences Any person who-

- a). has carnal knowledge of any person against the nature of nature; or
- b). has carnal knowledge of an animal; or
- c). permits a male person to have carnal knowledge of him or her against the

order of nature, is guilty of a felony ...

10. Attempt to commit unnatural offences any person who attempts to commit any of the offences specified in #9 above is guilty of a felony...

11. Indecent assault on boys under fourteen years of age. Any person who unlawfully and indecently assaults a boy under the age of fourteen years is guilty of a felony...

12. Indecent practices between males any male person who, whether in public or private, commits any act of gross indecency with another male person, or procures another male person to commit any act of gross indecency with him, or attempts to

procure the commission of any such act by any male person with himself or with another male person, whether in public or private, is guilty of a felony...

13. Incest by males Any male person who has carnal knowledge of a female person who is to his knowledge his granddaughter, daughter, sister or mother is guilty of a felony ... Provided that, if it is alleged in the information or charge and proved that the female person is under the age of thirteen years, the offender shall be liable to imprisonment for life. (i). It is immaterial that the carnal knowledge was had with the consent of the female person.

- (ii) If any male person attempts to commit any such offence as aforesaid he is guilty of a misdemeanour.
- (iii) On the conviction before any court of any male person of an offence under this section, or of an attempt to commit the same, against any female under the age of twenty-one years, it shall be in the power of the court to divest the offender of all authority over such a female, and, if the offender is the guardian of such a female, to remove the offender from such guardianship, and is in such case to appoint any person or persons to be the guardian or guardians of such females during her minority or less period; Provided that the High Court may at any time vary or rescind the order by the appointment of any other person as such guardian, or in any other respect.

14. Incest by females Any female person of or above the age of sixteen years who with her consent permits her grandfather, father, brother or son to have carnal knowledge of her (knowing him to be her grandfather, father, brother or son, as the case may be), is guilty of a felony ...

APPENDIX III: SOCIO-DEMOGRAPHIC AND SEXUAL QUESTIONNAIRES

SOCIO-DEMOGRAPHIC QUESTIONNAIRE

- 1. Study No. _____
- 2. Date of birth (D/M/Y) ___/___/___
- 3. Residence (District) _____
- 4. Religion (Tick the most appropriate choice): Catholic
 Protestant
 Muslim
 Other (specify) _____

- 5. Highest level of education and year of completion:
 None
 Primary (____)
 Secondary (____)
 Tertiary college (____)
 University (____)
 Other (specify) _____ (____)

6. Household size ____

- 7. Marital status at time of index crime (Tick appropriate choice):
 Single
 Married
 Separated
 Divorced
 Widowed
 Co-habiting
 Other (specify)

8. How many children do you have?

- 9. Are your parents living?
 (a) If yes: how old are they?
 (b) If no: when did they die?

10. (a). Do you have brothers or sisters?

(b). If yes: how old are they?

11. With whom do you live?

12. During adolescence (13-17years) lived with:

-both parents

-father

-mother

-other (specify) _____

13. Occupation:

Student

Unskilled

Skilled

Professional

Other (specify) _____

14. Previous personal mental illness: Yes/No

If yes specify; when (yr)? ____

Admitted? Yes/No

15. Family history of mental illness? Yes/No

If yes, specify relationship _____

16. History of frequent childhood physical assault? Yes/no

If yes, by whom (state relationship) _____

SEXUAL QUESTIONNAIRE

1. In your estimation, how often do you think about sex in a day? (Tick appropriately)

-about all the time

-a few times

-hardly

-other (specify) _____

2. For index crime, did you feel you were entitled to having sex with the victim?
Yes/no
3. Did anybody else participate in the sexual encounter with the victim? Yes/no
4. Did you use any of the following;
 - force or threats
 - weapon (specify type of weapon) _____
 - did you cause any physical injury?
5. Had you taken alcohol or any other substance(s)? Yes /no.
6. If yes, specify what you had taken _____
7. Did you know her/him? Yes/no
8. Were you related? Yes/no. If yes, how? _____
9. In your childhood, were you ever sexually assaulted? Yes/no. If yes, by whom
(state relationship) _____
10. How often were you viewing materials with explicit sex content e.g. certain TV
programs, magazines, or websites on the internet?
 - daily
 - weekly
 - monthly
 - never
 - other (specify) _____

APPENDIX IV: Structured Clinical Interview for the Diagnosis and Statistical

Manual IV (SCID)

Now I want to ask you some more specific questions about problems you may have had. We will go into more details later.

1 = NO (N) 2 = SUBTHRESHOLD (S) 3 = YES (Y)

Responses 2 or 3 score means more probing needed. Go to the pages indicated in the brackets. The following sections are mandatory: 1, 2, 3, 8, 9, 20, and 21. All the same, try all sections.

- S1 Have there been any times in your life when you have had 5 or more drinks of alcohol N
- S2 Have you ever used drugs of addiction? (6) 1
- S3 Have you ever gotten hooked on any prescribed medication or taken more of it than you were supposed to? (Insert/give details at the back of the code sheet) 1 2 3
- S4 Have you ever had a panic attack; when you suddenly felt frightened or anxious or suddenly developed a lot of physical symptoms? (12) 1
- S5 Were you ever afraid of going out of the house alone, being in crowds, standing in the line, traveling in taxis or buses? (13) 1
- S6 Is there anything that you have been afraid to do or felt uncomfortable doing in front of other people, like speaking, eating or writing?(14) 1
- S7 Are there any other things that you have been especially afraid of like flying, seeing blood, heights, closed places or certain kinds of animals/insects? (15) 1
- S8 Have you ever been bothered by thoughts that did not make any sense and kept coming to you even when you tried not to have them? (16) 1
- S9 Was there ever anything that you had to do over and over again, that you could not resist doing, like washing your hands again and again, counting up a certain number, or checking something several times to make sure you had it right? (16) 1
- S10 Sometimes things happen to people that are extremely upsetting, like being in life

threatening a situation like a major disaster, accidents or fire; being physically assaulted or raped; seeing another person killed or dead or badly hurt; or hearing about something horrible happening to someone close to you. At any time during your life, have any of these things happened to you? (17) 1 2

S11 In the last six months, have you been particularly nervous or anxious? (18,19) 1 2

S12 Have you been sick a lot over the years? (20) 1 2

S13 Have you ever had a time when you weighed much less than other people thought you ought to weigh? (1, 2, 3, 8, 9, 21) 1 2

S14 Have you often had times when your eating was out of control? (as S13 above) 1 2

S15 Has there ever been a time when your mood was excessively high for several days or more? If yes, anyone of the following present? (10) 1 2

(a) Were your thoughts racing? 1 2

(b) Were you bursting with energy? 1 2

(c) Did you think you had "special" power or abilities? 1 2

S16 Have you ever had unusual experiences, for example, interference of your thoughts, that your thoughts could be read; that messages could be put in your mind; that the radio, TV or newspaper were talking about you; that you were being spied on; or that you could hear voices that other people could not? (11) 1 2

NB: IF ANY OF THE ABOVE IS SCORED "2" OR "3", GO TO THE APPROPRIATE MODULE.

SCID MODULES

1. DEPRESSIVE EPISODES

A1	Depressed mood for 2 or more weeks	1	2
A2	Loss of interest in daily activities	1	2
A3	Weight loss or gain	1	2
A4	Weight loss or decreased appetite	1	2
A5	Weight loss or increased appetite	1	2
A6	Insomnia	1	2
A7	Hypersomnia	1	2
A8	Psychomotor agitation	1	2

A9 Psychomotor retardation	1	2
A10 Fatigue or loss of energy	1	2
A11 Feelings of worthlessness	1	2
A12 Feelings of inappropriate guilt	1	2
A13 Diminished ability to concentrate or think	1	2
A14 Indecisiveness	1	2
A15 Recurrent thoughts of own death	1	2
A16 Suicidal ideation	1	2
A17 Specific plan for suicide	1	2
A18 Suicide attempt	1	2
A19 At least 5 of the primary symptoms above are coded "3" and at least one of these is item A1 or A2 (Official only)	1	
A20 Symptoms cause significant distress or impairment	1	2
A21 Not due to direct effect of substance or medical condition	1	2
A22 Not better accounted for by bereavement	1	2
A23 Major depressive episode (Official only)	1	
2. DYSTHYMIC DISORDER		
A83 Depressed mood for the past 2 years	1	2
A84 Poor appetite or over-eating	1	2
A85 Insomnia or hypersomnia	1	2
A86 Low energy or fatigue	1	2
A87 Low self-esteem	1	2
A88 Poor concentration or difficulty in making decisions	1	2
A89 Hopelessness	1	2
A90 At least 2 symptoms above (A84-A89) are coded "3" (Official only)	1	
A91 Symptoms have not been absent for more than 2 months	1	2
A92 No major depressive episode during first 2 years of disturbance	1	2
A93 Age of onset of current dysthymic disorder (Insert actual age in score sheet)		
A94 Has never had a manic or hypomanic episode	1	2
A95 Does not occur during course of chronic psychotic disorder	1	2

A96 Not due to direct effects of a substance or medical condition	1	2
A97 Symptoms cause significant distress or impairment	1	2
A98 Dysthymic disorder (Official only) [A83, A90, A91, A95, A96, and A97 are all code "3"]	1	

3. DEPRESSIVE DISORDER NOT OTHERWISE SPECIFIED(NOS)

D7 Depressive symptoms that do not meet criteria for manic-depressive episode, dysthymia, adjustment disorder, or not accounted for by bereavement	1	2
D8 Not due to direct effect of a substance or medical condition	1	2
D9 Depressive disorder not otherwise specified(NOS): - (Official) Rate 1, 2, 3,4 or 5		
1- Post-psychotic depressive disorder of schizophrenia		
2- Major depressive disorder superimposed on delusional disorder, psychotic disorder not otherw specified, or active schizophrenia		
3- Minor depressive disorder		
4- Recurrent brief disorder		
5- Other		
D10 Depressive disorder not otherwise specified present in the last month	1= Yes	
No		

4. SUBSTANCE USE DISORDERS:

ALCOHOL DEPENDENCE

A1 Alcohol taken in large amounts or for long periods	1	2
A2 Persistent desire or unsuccessful efforts to cut down drinking	1	2
A3 Large amounts of time spent in activities obtaining alcohol	1	2
A4 Important activities given up or reduced	1	2
A5 Use continued despite physical or physiological problems	1	2
A6 Increased tolerance	1	2
A7 Withdrawal: at least two of		
(a) Sweating or	1	2
(b) Racing heart,	1	2
(c) Hand shakes,	1	2
(d) Trouble sleeping,	1	2

- | | | |
|---|---|---|
| (e) Feeling nauseated, | 1 | 2 |
| (f) Feeling agitated, | 1 | 2 |
| (g) Feeling anxious, | 1 | 2 |
| (h) Having a seizure, | 1 | 2 |
| (i) Seeing or, | 1 | 2 |
| (j) Hearing things that are not really there. | 1 | 2 |
| (k) If no withdrawal, then alcohol to relieve withdrawal. | 1 | 2 |

A8 Onset and course:

- (a) When did your drinking problems first start? (Insert date in the scores)
- (b) How long did they go on for?(Insert in the score sheet)

A9 Treatment:

- | | | |
|--|---|---|
| (c) Did you see a doctor about your drinking problems? | 1 | 2 |
| (d) Did you receive any treatment? | 1 | 2 |
| (e) What treatment? (Insert in the score sheet) | | |
| (f) Did you seek any other professional help? | 1 | 2 |
| (g) What help?(Insert in the score sheet) | | |

5. ALCOHOL ABUSE: At least one of the items A10-A13 coded "3" if present in the
last 12 months period.

- | | | |
|-----------------------------|---|---|
| A10 Failure to fulfill role | 1 | 2 |
| A11 Physically hazardous | 1 | 2 |
| A12 Legal problems | 1 | 2 |
| A13 Social problems | 1 | 2 |

6. DRUG DEPENDENCE

Now I am going to ask you some specific questions about your use of.....(drugs)

Have you ever taken any of these to get high, to sleep better, to lose weight, or to change your mood?

Sedatives/hypnotics/anxiolytics: Valium, Librium, barbituarates, Milltown, Ativan, Restoril, Seconal.

Cannabis: marijuana, hashish, bhang, tetrahydrocannabinol.

Stimulants: amphetamine /"speed", Crystal meth, Dexadrine, Ritalin/methylphenidate/'ice'.

Opioids: heroin, morphine, opium, Methadone, Darvon, Demerol, Dilaudid, Pethidine,

Codeine, Pentazocine, methaqualone, Madrax.

Cocaine: intranasal, intravenous, 'freebase', 'crack', and 'speedball'.

Hallucinogens: PCD, LSD, Mescaline, Peyote, PCP ('angle dust'), Ecstasy, MDMN, others.

Other drugs e.g. Khat, nicotine, glue, paint, inhalants, nitrous oxide ('laughing gas').

B1 Large amounts / longer periods	1	2
B2 Persistent desire / unsuccessful efforts to control/cut down	1	2
B3 Great deal of time spent obtaining/recovering	1	2
B4 Social, occupations, recreations given up or reduced	1	2
B5 Use despite physiological/physical problems	1	2
B6 Tolerance (either markedly increased amounts for desired effects, or markedly diminished effects)	1	2
B7 Withdrawal		
(a) Ever had withdrawal symptoms when cut down or stopped drug?	1	2
(b) Ever taken more of drug to get rid of withdrawal symptoms?	1	2

LIST OF WITHDRAWAL SYMPTOMS

(a) Sedatives/hypnotics/anxiolytics: two or more of the following developing within several hours a few days after cessation (or reduction) after heavy or prolonged use

1. Autonomic hyperactivity	1	2
2. Increased hand tremor	1	2
3. Insomnia	1	2
4. Nausea and vomiting	1	2
5. Transient visual, tactile or auditory hallucinations or illusions	1	2
6. Psychomotor agitation	1	2
7. Anxiety	1	2
8. Grand mal seizures	1	2

(b) Stimulants:

(i) Cocaine:- dysphoric mood and two or more of the following physiological changes

1. Fatigue	1	2
2. Vivid unpleasant dreams	1	2
3. Insomnia or hypersomnia	1	2
4. Increased appetite	1	2

5. Psychomotor retardation or agitation 1 2

(ii) Opioids:- three or more of the following

1. Dysphoric mood 1 2

2. Nausea and vomiting 1 2

3. Lacrimation or rhinorrhoea 1 2

4. Muscle aches 1 2

5. Sweating, piloerection 1 2

6. Diarrhea 1 2

7. Yawning 1 2

8. Fever 1 2

9. Insomnia 1 2

7. DRUG ABUSE

B8 Recurrent use/failure to fulfill major roles / obligations 1 2

B9 Recurrent use in hazardous situations 1 2

B10 Recurrent use related to social problems 1 2

B11 Recurrent use related to social problems 1 2

B12 Onset and course

(a) When did the drug problems first start? (Insert on the score sheet)

(b) When did they finally stop? (Insert on the score sheet)

B13 Treatment

(a) Did you see a doctor about the drug problems? 1 2

(b) Did you receive any treatment? 1 2

(c) What treatment? (Insert on the score sheet)

(d) Did you seek any other professional help? 1 2

(e) What help? (Insert on the score sheet)

(f) How old were you when you first started taking drugs? (Insert on the score sheet)

8. RECENT MAJOR DEPRESSIVE EPISODE: AT LEAST FIVE ITEMS C1-C9 CODED

"3", ONE OF THEM C1 OR C2, IN SAME 2-WEEK PERIOD.

C1 Depressed mood 1 2

C2 Diminished interest/pleasure	1	2
C3 Weight/appetite gain or loss	1	2
C4 Sleep disturbance: insomnia or hypersomnia or early waking	1	2
C5 Psychomotor agitation or retardation	1	2 3
C6 Fatigue or loss of energy	1	2
C7 Feeling of worthlessness or inappropriate guilt	1	2
C8 Diminished ability to concentrate or indecisiveness	1	2
C9 Recurrent thoughts of death, suicidal ideation	1	2
C10 Episode not due to medical condition/medication/substance	1	2
C11 Episode not following bereavement	1	2
C12 Treatment (Insert on the score sheet)		
C13 When did your depression start? (Insert on the score sheet)		
C14 How long did it go on? (Insert on the score sheet)		

9. PAST MAJOR DEPRESSIVE EPISODE

I would like to ask you about other times in your life when you have felt very low.

C15 Depressed mood	1	2
C16 Diminished interest/pleasure	1	2
C17 Weight/appetite gain or loss	1	2
C18 Sleep disturbance: insomnia or hypersomnia or early waking	1	2
C19 Psychomotor agitation or retardation	1	2
C20 Fatigue or loss of energy	1	2
C21 Feeling of worthlessness or inappropriate guilt	1	2
C22 Diminished ability to concentrate or indecisiveness	1	2
C23 Recurrent thoughts of death, suicidal ideation, specific suicide plan, or suicide attempt(s)	1	2
C24 Episode not due to medical condition/medication/substance	1	2
C25 Episode not following bereavement	1	2
C26 Treatment (Insert on the score sheet)		
C27 When did your depression start? (Insert on the score sheet)		
C28 How long did it go on? (Insert on the score sheet)		

**10. MANIA: CURRENT MANIC EPISODE. AT LEAST D1 PLUS ANY THREE D2-D7
(OR FOUR IF MOOD IS IRRITABLE) IN A WEEKS TIME (OR LESS IF
ADMISSION NEEDED)**

D1	Persistently elevated expansive or irritable mood	1	2
D2	Inflated self-esteem or grandiosity	1	2
D3	Decreased need for sleep	1	2
D4	Flight of ideas/subjective experiences of racing thoughts	1	2
D5	Distractibility (attention too easily drawn to unimportant or irrelevant stimuli)	1	2
D6	Increase in goal directed activity (socially, at work, school or sexually) or psychomotor agitation	1	2
D7(a)	Excessive involvement in pleasurable activities that have high potential for painful experience	1	2
D7(b)	3 Three or more of above (D1-D7): MANIC EPISODE (Official)	1	
D8	Not due to a mixed episode	1	2
D9	Significant impairment in function	1	2
D10	Not due to medication, drug of abuse or medical condition	1	2
D11	(a) Past episodes of mania	1	2
	(b) How many? (Insert on the score sheet)		
D12	Treatment (Insert on the core sheet)		

11. SCHIZOPHRENIA:

E1 Delusions

1.	Delusions of reference	1	2
2.	Persecutory delusions	1	2
3.	Grandiose delusions	1	2
4.	Somatic delusions	1	2
5.	Delusions of control	1	2
6.	Bizarre delusions	1	2
7.	Thought insertion	1	2
8.	Thought broadcasting	1	2
9.	Thought insertion	1	2

10. Other delusions (**Insert on the score sheet**)**E2 Hallucinations**

1. Running commentary hallucinations	1	2
2. Third party hallucinations	1	2
3. Visual hallucinations	1	2
4. Tactile hallucinations	1	2
5. Commanding hallucinations that are obeyed	1	2
6. Other hallucinations (Insert on the score sheet)		

E3 Disorganized speech

1 2

E4 Behavior

1. Catatonic (motor immobility)	1	2
2. Excessive motoric activity	1	2
3. Extreme negativism	1	2
4. Posturing or stereotyped movements	1	2
5. Grossly disorganized speech	1	2
6. Grossly inappropriate effect	1	2

E5 Negative symptoms

1. Affective flattening	1	2
2. Alogia	1	2
3. Avolition	1	2

E6 Social/ occupation dysfunction

1 2

E7 Not schizoaffective or mood disorder

1 2

E8 Previous treatment (Insert in the score sheet)**E9 If any two of E1-E5 are "3": SCHIZOPHRENIA**

1

12. LIFE HISTORY OF PANIC DISORDER

Panic attack

F1 Suddenly felt frightened, or anxious or developed physical symptoms	1	2
F2 Attacks came out of the blue	1	2
F3 How many attacks? (Insert in the score sheet)		

IF NONE STOP, HERE; IF PRESENT:

F4 Worry about implications?	1	2
F5 Concern about additional attacks?	1	2
F6 Significant changes in behavior	1	2
F7 Criterion panic attack	1	2
F8 Abrupt/peak in 10 minutes	1	2
F9 Autonomic symptoms:		
(i) Heart race, pound or skip beat	1	2
(ii) Tremble /shake	1	2
(iii) Short of breath	1	2
(iv) Feel choking	1	2
(v) Have nausea, stomach upset or diarrhoea	1	2
(vi) Feel dizzy, unsteady or faint	1	2
(vii) Feel unreal	1	2
(viii) Fear of going crazy or dying	1	2
(ix) Tingling/numbness in parts of the body	1	2
(x) Flushes or chills	1	2
F10 Not due to substance medical condition	1	2
F11 Life time panic disorder: Recurrent unexpected panics (at least two) with four or more autonomic symptoms	1	

13. PANIC DISORDER WITH AGORAPHOBIA

F12 Situations

(i) Away from home	1	2
(ii) Crowded places	1	2
(iii) Standing in a queue	1	2
(iv) Being on a bridge	1	2
(v) Using public transport	1	2
F13 Endured with marked distress	1	2
LIFE TIME AGORAPHOBIA (NO HISTORY OF PANIC ATTACK)		
F14 Agoraphobic symptom (being alone, in a crowd, in a queue public transport or other)	1	2

IF "NO", STOP HERE.

F15 Endured with marked distress	1	2
F16 Avoidance	1	2
F17 Not due to substance or medical condition	1	2

14. LIFETIME SOCIAL PHOBIA

F18 Marked and persistent fear in social situations	1	2
---	---	---

IF "NO", STOP HERE

F19 Exposure to feared social situation almost invariably provokes anxiety	1	2
F20 Fear is excessive	1	2
F21 Avoidance	1	2
F22 Endured with marked distress	1	2
F23 Interfered with normal routine	1	2
F24 Not due to substance or medical condition	1	2

15. LIFETIME SPECIFIC PHOBIA

F25 Marked and persistent fear of flying, seeing blood, heights, closed places, certain kind of animals or insects	1	2
--	---	---

IF "NO", STOP HERE

F26 Exposure to feared phobic stimulus almost invariably provokes anxiety	1	2
F27 Fear excessive	1	2
F28 Avoidance	1	2
F29 Endured with marked distress	1	2
F30 Interference with normal routine	1	2
F31 Not due to substance or medical condition	1	2

16. LIFE TIME OBSESSIVE COMPULSIVE DISORDER (OCD)

F32 Obsessions: recurrent and persistent thoughts/impulses/images	1	2
---	---	---

IF "NO", STOP HERE.

F33 Attempts to ignore or suppress such thoughts	1	2
--	---	---

F34 Thoughts/images/impulses recognized as coming from own mind	1	2
F35 Compulsions: Repetitive behaviour e.g. washing, counting, checking	1	2
F36 Behaviour aimed at preventing or reducing mental distress or preventing some dreaded event/situation	1	2
IF "NO" TO OBSESSIONS OR COMPULSIONS, STOP HERE.		
F37 Excessive thoughts	1	2
F38 Marked distress/time consuming	1	2
F39 Not due to substance medical condition	1	2

17. LIFE TIME POST TRAUMATIC STRESS DISORDER (PTSD)

F106 Traumatic Event List: (Score for each one of them 0=not present; or 1=present)

(i) Been involved in a road or motor accident?	0	1
(ii) Been attacked with a gun?	0	1
(iii) Been attacked with a knife or a similar weapon?	0	1
(iv) Any member of your family been attacked with a gun?	0	1
(v) Any member of your family been attacked with a knife or a similar weapon?	0	1
(vi) Ever been physically assaulted, causing you bodily harm?	0	1
(vii) Been sexually assaulted/raped?	0	1
(viii) Your house been burned by fire?	0	1
(ix) Been caught up in a riot?	0	1
(x) Been robbed in armed robbery or mugged?	0	1
(xi) Your house/home been broken into by armed robbers?	0	1
(xii) Been involved in a car- or matatu-jacking?	0	1
(xiii) Been involved in a life-threatening flood?	0	1
(xiv) Been involved in tribal clashes?	0	1
(xv) Witnessed violence in the street, neighbourhood, or school?	0	1
(xvi) Been robbed?	0	1
(xvii) Seen family members injured, beaten, hurt or killed?	0	1
(xviii) Been beaten or physically hurt, beaten or hurt?	0	1
(xix) Been physically hurt or attacked by a non-family member?	0	1

(xx) Others (specify/insert in the score sheet)	0	1
F107 (a) Experienced, witnessed, or was confronted with an event involving actual or threatened death, serious injury, or the physical integrity of self or others, e.g. a very serious accident or fire; being physically assaulted or raped; seeing another person killed, dead or badly injured	1	2
(b) Hearing about something horrible that has happened to some one close to you	1	2
IF "NO", STOP HERE.		
F108 Response: involved intense fear, helplessness or horror	1	2
F109 Recurrent, intrusive and distressing recollections (including images, thoughts, perceptions)	1	2
F110 Recurrent distressing dreams	1	2
F111 Re-living the experience	1	2
F112 Autonomic symptoms	1	2
F113 Intense psychological distress to cues	1	2
F114 At least one of the above (F109-F113) coded "3" (Official)	1	
IF NO SYMPTOM PRESENT, STOP HERE.		
F115 Efforts to avoid thoughts, feelings, conversation about event	1	2
F116 Efforts to activities, places or conversation about event	1	2
F117 Inability to recall an important aspect	1	2
F118 Diminished interest or participation in activities	1	2
F119 Detachment or estrangement from others	1	2
F120 Restricted range of affect	1	2
F121 Sense of foreshortened future	1	2
F122 At least three of the above (F115-F121) coded "3" (Official)	1	
F123 Difficulty falling or staying asleep	1	2
F124 Irritability or outbursts of anger	1	2
F125 Difficulty in concentrating	1	2
F126 Hypervigilance	1	2
F127 Exaggerated startle response	1	2
F128 At least two of the above (F123-F127) coded "3" (Official)	1	

F129 Duration at least one month	1	2
F130 Causes marked distress or significantly interferes	1	2
F131 Post -Traumatic Stress Disorder F107, F108, F114, F122, F122, F128, F130 all coded "3" (Official)	1	
F132 Current PTSD (symptoms of PTSD in past month) (Official)	1	

18. GENERALISED ANXIETY DISORDER (GAD)

F138 Excessive anxiety and worry	1	2
F139 Difficult to control	1	2
F140 Not during mood disorder or psychotic disorder	1	2
F141 Restless, keyed up or on edge	1	2
F142 Easily fatigued	1	2
F143 Difficulty in concentrating	1	2
F144 Irritability	1	2
F145 Muscle tension	1	2
F146 Sleep disturbance	1	2
F147 At least three of the above (F141-F146) coded "3" (Official)	1	
F148 Focus not confined to another axis I disorder	1	2
F149 Distress or impairment	1	2
F150 Not due to direct effects of a substance or medical condition	1	2
F151 Generalized anxiety disorder (F138, F140, F150 ALL CODED "3") (Official)	1	

19. ACUTE STRESS DISORDER

J9 Numbing, detachment or absence of emotional response	1	2
J10 Reduction in awareness of surroundings	1	2
J11 Derealization	1	2
J12 Depersonalization	1	2
J13 Dissociative amnesia	1	2
J14 At least three of the above (J9-J13) coded "3" (Official)	1	
J15 Causes marked distress or significantly interferes	1	2

J16 Duration at least 2 days and less than 4 weeks; and occurs within 4 weeks of traumatic event	1	2
J17 Not due to direct effects of a substance or medical condition	1	2
J18 ACUTE STRESS DISORDER		
(J6-J9 all code "3" and F107, F114, F122, F128 all code "3") (Official)	1	
J19 ACUTE CURRENT STRESS DISORDER		
(Symptoms of Acute Stress Disorder in past month) (Official)	1	
20. SOMATIZATION DISORDER		
G1 Screen 12-Somatization Disorder (Official)	1	
G2 History of many physical complaints before age 30 (Official)	1	
G3 Age at onset (Insert on the score sheet)		
G4 Impaired co-ordination or balance	1	2
G5 Paralysis or localized numbness	1	2
G6 Difficulty swallowing or lump throat	1	2
G7 Aphonia	1	2
G8 Urinary retention	1	2
G9 Loss of touch or pain sensation	1	2
G10 Double vision	1	2
G11 Blindness	1	2
G12 Deafness	1	2
G13 Seizures	1	2
G14 Amnesia	1	2
G15 Loss of consciousness	1	2
G16 One symptom above (G4-G15) code "3" (Official)	1	
G17 Head pain	1	2
G18 Stomach pain	1	2
G19 Back pain	1	2
G20 Joint pain	1	2
G21 Pain in the extremities	1	2
G22 Chest pain	1	2

G23 For women, pain during menstruation	1	2
G24 Pain during intercourse	1	2
G25 Pain during urination	1	2
G26 Pain anywhere else	1	2
G27 Four symptoms above (G17-G26) coded "3" (Official)	1	
G28 Nausea	1	2
G29 Bloating	1	2
G30 Vomiting other than during pregnancy	1	2
G31 Diarrhoea	1	2
G32 Intolerance of several foods	1	2
G33 Sexual indifference	1	2
G34 Two symptoms above (G28-G33) coded "3" (Official)	1	
G35 Irregular menses	1	2
G36 Excessive menstrual	1	2
G37 Vomiting through out pregnancy	1	2
G38 One symptom above coded "3"	1	
G39 Somatization Disorder (G2, G16, G27, F34, G38) all coded "3" (Official)	1	

21. ADJUSTMENT DISORDER

H1 Emotional or behavioural symptoms in response to an identifiable stressor occurring within 3 months of stressor e.g. divorce, diagnosis of a terminal illness	1	2
H2 The symptoms cause marked distress in excess of what would be expected	1	2
H3 The symptoms cause significant impairment in social or occupational functioning	1	2
H4 The symptoms do not represent, bereavement	1	2
H5 Once the stressor has terminated, the symptoms do not persist for more than an additional 6 months	1	2
H6 Predominant symptoms may be of depressed mood, anxiety, mixed or disturbance of conduct	1	2

22. DELIRIUM

K1 Disturbance of consciousness with reduced ability to focus, sustain or shift attention	1	2
---	---	---

K2 Change in cognition not due to established or evolving dementia	1	2
K3 Disturbance develops over a short period of time (hours to days) and tends to fluctuate during the of the day	1	2
K4 Disturbance is not caused by direct physiological consequences of a general medical condition	1	2
23. DEMENTIA		
L1 Impaired ability to learn new information or to recall previously learned information	1	2
L2 One or more of:		
(i) Aphasia	1	2
(ii) Apraxia	1	2
(iii) Agnosia	1	2
(iv) Disturbance in executive functioning i.e. planning, organizing	1	2
L3 Cognitive deficits in L1 and L2 cause significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning	1	2
L4 Course is characterized by gradual onset and continuing decline	1	2
L5 Deficits do not occur exclusively during the course of a delirium		
	1	2
	3	

SCID SCORE SHEET
SCREENING PAGE

S1---S2---S3---S4---S5---S6---S7---S8---S9---S10---S11---S12---S13---S14---S15--- S15(a)----S15(b).

S15(c) -----S16-----

1. DEPRESSIVE EPISODES

A1---A2---A3---A4---A5---A6---A7---A8---A9---A10---A11---A12---A13---A14---15---A16---A17-
A18---
A19*---A20---A21---A22---A23*---

2. DYSTHYMIC DISORDERS

A83-----A84-----A85-----A86-----A87-----A88-----A89-----A90*-----A91-----A92-----A93-----
A94---
A95-----A96-----A97-----A98*-----

3. DEPRESSION DISORDER NOT OTHERWISE SPECIFIED

D7-----D8-----D9-----D10*-----

4. SUBSTANCE USE DISORDERS:

ALCOHOL DEPENDENCE

A1-----A2-----A3-----A4-----A5-----A6-----A7(a)-----A7(b)-----A7(c)-----A7(d)-----A7(e)-----7(f)-----A7

 A7(h)-----A7(i)-----A7(j)-----A7(k)-----A8(a)-----A8(b)-----A9(c)-----A9(d)-----
 A9(e)-----A9(f)-----
 A9(g)-----

5. ALCOHOL ABUSE

A10-----A11-----A12-----A13-----

6. DRUG DEPENDENCE

B1-----B2-----B3-----B4-----B5-----B6-----B7(a)-----B7(b)-----

a) Sedatives: a)1-----a)2-----a)3-----a)4-----a)5-----a)6-----a)7-----a)8-----

b) Stimulants:

(i) Cocaine: b)(i)1-----b)(i)2-----b)(i)3-----b)(i)4-----b)(i)5-----

(ii) Opioids: b)(ii)1-----b)(ii)2-----b)(ii)3-----b)(ii)4-----b)(ii)5-----b)(ii)6-----b)(ii)7-----b)(ii)8-----b)(ii)9-----

7. DRUG ABUSE

B8-----B9-----B10-----B11-----B12(a)-----B12(b)-----B13(a)-----B13(b)-----

B13(c)-----

B13(d)-----B13(e)-----B13(f)-----

8. RECENT MAJOR DEPRESSIVE EPISODE

C1-----C2-----C3-----C4-----C5-----C6-----C7-----C8-----C9-----C10-----C11-----

C12-----C13-----C14-----

9. PAST MAJOR DEPRESSIVE EPISODE

C15-----C16-----C17-----C18-----C19-----C20-----C21-----C22-----C23-----C24-----C25-----

C26-----C27-----C28-----

10. CURRENT MANIC EPISODE

D1-----D2-----D3-----D4-----D5-----D6-----D7-----D8-----D9-----D10-----D11(a)-----D11(b)-----

D12-----

APPENDIX V: IPDE INTERVIEW SCHEDULE

The questions I am going to ask concern what you are like most of time. I'm interested in what has been typical of you throughout your life and not just recently. If you have changed and your answers might have been different at some time in the past, be sure to let me know.

I. WORK

(If the subject has rarely or never worked, and is not a housewife/homemaker, student, or recent graduate, circle NA for 1 and go to 2)

1. I'd like to begin by discussing your life at work (school). How well do you usually function in your work (at school)?

2. What annoyances or problems keep occurring in your work (at school)?

Q1. Undue preoccupation with [productivity to the exclusion of pleasure and interpersonal relationships.

Anankastic 5

3.a. Do you spend so much time working that you don't have time left for anything else?

b. If yes: tell me about it.

4.a. Do you spend so much time working that you (also) neglect other people?

b. If yes: tell me about it.

The examiner should be alert to the use of rationalizations to defend the behavior. The fact that work itself may be pleasurable to the subject should not influence the scoring. There is no requirement that the subject actually enjoy the work, although that is often the case.

Personal ambition, high economic aspirations, or inefficient use of time, are also unacceptable excuses. Exoneration due to economic necessity should be extended only when supported by convincing explanations. Allowance should be made for short term, unusual circumstances, e.g., physicians in training who have little or no control over their work schedule. Avoidance of interpersonal relationships or leisure activities for reasons other than devotion to work is not within the scope of this criterion.

0, 1, 2,?, NA.

2. Undue preoccupation with work that usually prevents any significant pursuit of both leisure activities and interpersonal relationships.

1. Undue preoccupation with work that occasionally prevents any significant pursuit of both leisure activities and interpersonal relationships.

Undue preoccupation with work that usually prevents any significant pursuit of both leisure activities or interpersonal relationships but not both.

0. Denied or rarely or never leads to exclusion of leisure activities or interpersonal relationships.

0, 1, 2,?.

Q2. Perfectionism that interferes with task completion

Anankastic: 3

5. a. Are you more of a perfectionist than almost anyone you know?

b. If yes; does it slow you down a lot or prevent you from getting things done on time?

c. If yes; tell me about it.

Many subjects view themselves as perfectionistic, but do not have the trait to a pronounced degree or to the extent that it significantly interferes with their functioning.

It is particularly important to verify that there is effect on task completion or productivity.

0, 1, 2,?.

2. Perfectionism frequently prevents completion of work, or interferes with productivity.

1. Perfectionism frequently prevents completion of work, or interferes with productivity.

0. Denied, rarely or never prevents completion of work, or interferes with productivity.

Q3. Preoccupation with details, rules, lists, order, organization or schedule

6.a. Are you fussy about little details?

b. If yes: do you spend much more time on them than you really have to?

c. If yes: does that prevent you from getting as much work done as you're expected to do?
d. If yes: tell me about it.

7.a. Do you spend so much time scheduling or organizing things that you don't time left to do the job you are really supposed to do?

b. If yes: tell me about it.

The subject is so concerned with the details or method of accomplishing a task or objective, that they almost become an end in themselves, consuming much more time and effort than necessary, and thereby preventing the task from being accomplished, or markedly prolonging the time required to achieve the objective.

The subject need not display all of the features enumerated in the criterion.

0, 1, 2, ?.

2. Convincing evidence supported by examples that the behavior frequently interferes with reasonable expectations of productivity.

1. Convincing evidence supported by examples that the behavior occasionally interferes with reasonable expectations of productivity.

0. Denied, rare, or consequences are insignificant.

Q4. Avoidance of occupational activities that involve significant interpersonal contact, because of fear of criticism, disapproval, or rejection

Avoidant (Anxious): 6 (partial)

8.a. Do you usually try to avoid jobs or things you have to do at work (school), that bring you into contact with other people?

b. If yes: give some examples.

c. Why do you think you do that?

0, 1, 2,?, NA.

The criterion is not so readily applicable to housewives/ homemakers and ordinarily should be scored NA with them. They have an opportunity to qualify on the other half of the criterion (21, Avoidance of social activities). 'significant interpersonal contact' in this context means that the subject would like be engaged in conversation with others. It does not refer to the mere physical presence of others in the building or work area. The reason for the avoidance must be fear of criticism, disapproval or rejection.

2. Almost always avoids jobs or work (school) assignments that involve significant interpersonal contact. Subject provides one or more of these as the primary reason: fear of criticism, disapproval or rejection.

1. Often avoids jobs or work (school) assignments that involve significant interpersonal contact. Subject provides one or more of these as the primary reason: fear of criticism, disapproval or rejection.

Almost always avoids jobs or work (school) assignments that involve significant interpersonal contact. Subject acknowledges one or more of the three reasons but insists that they are not the primary reason.

0. denied, infrequent, not supported by convincing examples, or avoidance is due to other reasons.

II SELF

. Now let me ask some questions about the kind of person you are.

9.a. How would you describe your personality?

b. Have you always been like that?

c. If no: when did you change?

d. What were you like before?

Q5. Disturbance in and uncertainty about self-image

Emotionally unstable; borderline type: 1 (partial)

10.a. Do you think one of your problems is that you are not sure what kind of a person you are? b. If yes: how does that affect your life?

11.a. Do you behave as though you don't know what to expect of yourself?

b. If yes: are you so different with different people or in different situations that you don't behave like the same person?

c. If yes: give me some examples.

d. If no: have others told you that you're like that?

e. If yes: why do you think they have said that?

0, 1, 2,?

In this context 'uncertainty about self-image' may manifest itself in different ways, any one of which, if obviously present, is sufficient for a positive score. Subjects may be

uncertain about what kind of person they are, because their behavior is so different at various times or with different people, that they do not know what to expect of themselves. Their behavior may be inconsistent, erratic, or contradictory. Or they may be chameleon-like and take on the identity or personality of the particular person they are with at the moment. It is not necessary that subjects acknowledge or be aware that this is the source of distress or problems. Strikingly different behavior or views of oneself confined to discrete episodes of illness are not within the scope of the criterion. However, changes in self-image or erratic behavior indicative of an inconsistent sense of self, may be counted when they occur in conjunction with chronic anxiety or chronic depression.

2. Obvious and well documented persistent uncertainty about self-image, as described above.

1. Probable but less well documented persistent uncertainty about self-image, as described above.

Q6. Disturbances in and uncertainty about aims.

12. What would you like to accomplish during your life?

13.a. Do your ideas about this change often?

b. If yes: tell me about it.

(Not asked of housewives/homemakers, adolescents, students, and those who have never or almost never worked)

14.a. Do you often wonder whether you have made the right choice of job or career?

b. If yes: how does that affect you?

(Asked only of housewives/homemakers)

15.a. Do you often wonder whether you have made the right choice in becoming a housewife/homemaker?

b. If yes: how does that affect you?

(Adolescents, students and those who have never or almost never worked.)

16.a. Have you made up your mind about what kind of a job or career you would like to have?

b. If no: how does that affect you?

The requirements for this criterion may be fulfilled in any one of several different ways. Subjects may report that they cannot decide about their long-term goals or career choice, and that this has an obvious effect on the way they lead their life. They may deny that they are uncertain about them, but it may be obvious from their behavior, which is characterized by persistent erratic or fluctuating consideration or selection of strikingly different careers or long-term goals. Persons 30 years or older who have not embarked on a career path (when one is available to them), or insist that they have no idea at all about what their long-term goals are, should receive a score of 2. The criterion should be scored conservatively with adolescents and not usually given to them.

0, 1, 2,?

2. Obvious and well documented persistent uncertainty about long-term goals or career choice.

1. Probable but less well documented persistent uncertainty about long-term goals or career choice.

0. Absent, doubtful, or not supported by convincing examples.

Q7. Disturbances in and uncertainty about internal preferences.

17.a. Do you have trouble deciding what's important in life?

b. If yes: how does that affect you or the way you live your life?

18.a. Do you have trouble deciding what is morally right and wrong?

b. If yes: how does that affect you or the way you live your life?

In this context "internal preferences" refers both to issues of ethics and morality ("right and wrong") and to values (what is important in life). For a positive score both are not required. Subjects may qualify for either in two ways. They may report that they are so uncertain about internal preferences, that it causes subjective distress or problems in social or occupational functioning. Or they may, with or without acknowledgement or awareness of any uncertainty, demonstrate the phenomenon by extremely erratic or inconsistent behavior indicative of uncertain values.

2. Obvious and well documented persistent uncertainty about internal preferences as described above.

1. Probable but less well documented or persistent about internal preferences as described above.

0. Absent, doubtful, or not supported by convincing examples.

Q8. Limited capacity to make everyday decisions without an excessive amount of advice and reassurance from others.

19.a. Are you usually able to make ordinary, everyday decisions without asking others for advice or reassurance?

b. If no: give me some examples

Indecisiveness not associated with the need for advice or reassurance is not within the scope of the criterion, which concerns ordinary, every day, types of decisions, and is not meant to include unusual, special, or major decisions. The essence of the criterion is the inability to make these ordinary decisions without seeking advice or confirmation from others. Both elements, advice and reassurance, are not required.

0, 1, 2,?.

2. Frequently depends on others for an excessive amount of advice or reassurance before making decisions about ordinary matters, so that the decisions are not otherwise made.

1. Occasionally depends on others for an excessive amount of advice or reassurance before making decisions about ordinary matters, so that the decisions are not otherwise made.

0. Absent, doubtful, or not supported by convincing examples.

Q9. Feelings of excessive doubt and caution.

20.a. Do you have a lot of doubts about things? If yes: does that upset you or cause any problems for you?

b. If yes tell me about it.

21.a. Are you very cautious and afraid of making a mistake?

b. If yes: does that bother you or cause any problems for you?

c. If yes: give me some examples of what you mean.

If the preceding item (8) was scored 1 or 2, the subject should be questioned carefully to establish that the reason for the excessive doubt is not solely the dependent's need for advice and reassurance from others. Caution is reflected by exceptional concern about

making a mistake. Caution limited to concerns about physical security is not within the scope of the criterion. For a 2 score there must be evidence of both doubts and caution, and indications that they are sometimes a source of distress or problems.

0, 1, 2,?

2. Frequently shows excessive doubt and caution, and this sometimes causes distress or problems in social or occupational functioning.
 1. Frequently shows excessive doubt or caution, but not both, and this sometimes causes distress or problems in social or occupational functioning.
 2. Occasionally shows excessive and caution and this sometimes causes distress or problems in social or occupational functioning.
0. Absent, doubtful, or not supported by convincing examples.

Q10. Encouraging or allowing others to make most of one's important life decisions

22.a. Do you let other people take charge of your life?

b. If yes: tell me about it.

23.a. Do you let them make your important decisions for you?

b. If yes: what decisions have they made for you?

The essence of the criterion is that one encourages or allows others to assume responsibility for most major areas of one's life, such as decisions about the selection of schools, occupation, place of employment spouse, friends, place of residence, etc. merely seeking advice or reassurance is not within the scope of the criterion. The subject must abdicate responsibility for the decisions and leave them for others to make. The criterion should be applied conservatively to those under 25 years of age. Allowance should also be made for obvious ethnic and cultural factors.

0, 1, 2,?

2. Has allowed others to make several important decisions in at least 2 different areas of life.
 1. Has allowed others to make at least two major decisions in one or more areas of life.
0. Denied or examples unconvincing.

Q11. Difficulty in maintaining any course of action that offers no immediate reward.

24.a. Do you have trouble sticking with a plan or course of action, if you don't get something out of it right away?

b. If yes: does that ever cause problems for you or get you into trouble/

c. If yes: give me some examples.

This refers to impatience and lack of perseverance when there is no immediate reward.

To be scored positively there must be evidence from convincing examples that this results in subjective distress or problems in social or occupational functioning.

Impatience associated with the pursuit of minor, everyday matters is not within the scope of the criterion.

0, 1, 2,?.

2. Frequently has difficulty maintaining any course of action that offers no immediate reward. This sometimes causes subjective distress or problems in social or occupational functioning.

1. Occasionally has difficulty maintaining any course of action that offers no immediate reward. This sometimes causes subjective distress or problems in social or occupational functioning.

0. Denied, rare, or examples unconvincing.

Q12.Suggestibility (the individual is easily influenced by others or by circumstances)

25.a. Are you easily influenced by other people's suggestions?

b. If yes: do you ever go along with suggestions that get you into trouble?

c. If yes: give me some examples.

26.a. Are you easily influenced by what is going on around you?

b. If yes: does that ever get you into trouble?

c. If yes: give me some examples.

The essence of the criterion is the ease and frequency with which one's behavior is influenced by the conditions around one, or by the ideas and opinions of others rather than one's own. It is scored positively only if there are convincing examples that this suggestibility sometimes causes social or occupational problems.

0, 1, 2,?.

2. is frequently suggestible. This sometimes causes social or occupational problems.

1. is occasionally suggestible. This sometimes causes social or occupational problems.

0. Denied, rare, or examples unconvincing.

Q13. Belief that one is socially inept, personally unappealing, or inferior to others.

27.a. Do you feel awkward or out of place in social situations?

b. If yes: give me some examples of what you mean.

28.a. Do you believe that people find you uninteresting or unappealing?

b. If yes: tell me about it.

29.a. Do you feel inferior to most people?

b. If yes: why do you believe that?

Whether or not one is really socially inept, personally unappealing, or inferior to others is irrelevant. What counts is one's beliefs. All three aspects of the criterion are not required. It is particularly important to determine whether the beliefs are confined to isolated episodes of mental illness, in which case they are not scored as present.

0, 1, 2, ?.

2. Almost always feels socially inept, unappealing, or inferior to others.

1. Often feels socially inept, unappealing, or inferior to others.

0. Denied, rare, confined to isolated episodes of mental illness, or not supported by convincing examples.

Q14. Excessive conscientiousness and scrupulousness

30.a. Are morals and ethics much more important to you than they are to most people?

b. If yes: including people from your own background or religion?

c. If yes: give me some examples of what you mean.

31.a. Are you (also) very concerned about rules and regulations?

b. If yes: give me some examples.

32.a. Are you so strict or conscientious that you spend a lot of time worrying whether you have broken any rules or done something wrong?

b. If yes: give me some examples.

33.a. If no: have people accused you of being too strict or rigid about what's right or wrong? b. If yes: why do you think they've said that?

It is not uncommon for people to view themselves as conscientious or subscribing to higher morality than others. This is insufficient grounds for a positive rating. There must be evidence of an excessive concern about rules, ethics, morality, or matters of right or wrong. This may express itself in extreme rigidity and in inflexibility about such matters, undue concern or preoccupation with doing what is right, or excessive worrying about having broken rules or done something immoral or unethical. It is not necessary that subjects impose their scrupulosity or rigidity on others. It is particularly to view the subjects' behavior within the context of their cultural background and religious beliefs or allegiances. Individuals should be judged in relation to others of the same sect, and scored positively only if members of the same religion will also view them as scrupulous or inflexible. The criterion should not be scored positively if their behavior is present only during isolated episodes of depression or obsessive-compulsive disorder.

0, 1, 2, ?.

2. Usually is over conscientious, scrupulous, and inflexible about matters of morality, ethics, or values.

1. Occasionally is over conscientious, scrupulous, and inflexible about matters of morality, ethics, or values.

0. Denied, rare, confined to isolated episodes of depression or obsessive-compulsive disorder, or not supported by convincing examples.

Q15. Very low tolerance to frustration.

34.a. Do you ever feel very frustrated or angry when you don't get what you want right away?

b. If yes:

when that happens does it ever cause problems for you or get you into trouble?

c. If yes: give me some examples.

Subjects must indicate that they experience annoyance or anger when they cannot get what they want right away or have to wait too long for it. In order for the criterion to be scored positively the feeling of frustration must lead to behavior that causes problems or

gets the subject into trouble. The mere experience of anger or frustration is insufficient for a positive score.

0, 1, 2, ?.

2. Actions frequently directed toward obtaining immediate satisfaction, and feels frustrated when not immediately gratified. This sometimes leads to behavior that causes social or occupational problems.

1. Actions occasionally directed toward obtaining immediate satisfaction, and feels frustrated when not immediately gratified. This sometimes leads to behavior that causes social or occupational problems.

0. Denied, rare, does not cause social or occupational problems, or examples unconvincing.

Q16. Continual seeking for activities in which the individual is the center of attention.

35.a. Do you ever have a strong need to be the center of attention?

b. If yes: tell me about it.

36. How do you feel when you're not the center of attention?

37.a. If no: have people ever said you need to be the center of attention?

b. If yes: why do you think they have said that?

It is normal to desire a certain amount of attention. The criterion refers only to those who have an almost insatiable need for it. This is manifest by the frequency with which they pursue behaviours that are intended to ensure that they are the centre of attention, and the discomfort of one form or another that they experience when too much time elapses without their receiving the attention they crave. The criterion is not scored 2 unless the subject acknowledges discomfort or distress, when the attention is not received.

0, 1, 2, ?.

2. Frequently has a very strong need to be centre of attention. When the need is not gratified, there is sometimes an experience of considerable discomfort or distress.

1. Frequently has a very strong need to be the centre of attention. When the need is not gratified, there is rarely or never an experience of considerable discomfort or distress.

Occasionally has a very strong need to be the centre of attention. When the need is not gratified, there is sometimes an experience of considerable discomfort or distress.

0. Denied, the need for attention is reasonable, or the examples are unconvincing.

Q17. Over-concern with physical attractiveness.

38. How important to you is your physical appearance?

39. Do you like to dress so that you can stand out in a crowd?

40.a. Do you ever try to use your physical appearance to attract attention?

b. If yes tell me more about it.

(In rating this criterion also consider subject's appearance during interview)

The essence of the criterion is the use of one's physical appearance as a means of drawing attention to oneself. Denial of the behaviour and obvious manifestation of it in the interview may be used as the basis for a positive rating, including a score of 2 if it is very striking and not due to hypomania

0, 1, 2, ?.

2. Frequently uses physical appearance to draw attention to self.

Denied but very striking in interview.

1. Occasionally uses physical appearance to draw attention to self.

Denied but somewhat present in interview

0. Rarely or never uses physical appearance to draw attention to self.

Q18. Excessive preoccupation with fantasy and introspection.

41.a. Do you get much more enjoyment from daydreaming than you do from real life?

b. If yes: tell me about it.

42.a. Do you (also) prefer to be alone with your own thoughts, rather than involved with other people or with what's going on around you?

b. If yes tell me about it.

This concerns a detachment from the outer world in favor of one's own inner mental life.

In order to be scored 2 subjects should make it very clear that they overwhelmingly prefer or enjoy being alone with their own thoughts and imagination, rather than involved with other people and with what is going on in the world around them.

0, 1, 2, ?.

2. Overwhelmingly prefers to spend time with own thoughts or imagination, rather than with other people and with what is going on in environment.

1. Prefers, but not overwhelming so, to spend time with own thoughts or imagination rather than with other people and with what is going on in environment.

0. Denied, acknowledged but not supported by subject's description, or fantasy life and introspective reverse are not prominent.

III. INTERPERSONAL RELATIONSHIPS

Now I'd like to talk to you about the people in your life. Remember I'm interested in what has been typical of you throughout your life and not just recently, but if you have changed and are different from the way you used to be, be sure to let me know.

43.a. Who are the most important people in your life?

b. In what way are they important?

44. During your life what kind of problems or difficulties have you had getting along with other people?

Q19. No desire for, or possession of, any close friends or confiding relationships (or only one).

45.a. Do you have any close friends or close people you confide in?

b. If yes: tell me about them.

c. If no: Would you like to?

d. If yes: tell me about it.

e. If no: is there anyone you have ever been close to or confided in?

f. If yes; tell me about it.

The criterion also requires no desire for close friendships or confiding relationships, and not merely their absence from one's life.

0, 1, 2, ?.

2. Neither desires nor has any close friends or confidants (or only one).

1. Probably neither desires nor has any close friends or confidants (or only one), but there is some doubt about this based on the subject's uncertainly or description of the nature of the friendships.

0. Denied or description unconvincing.

Q20. Incapacity to maintain enduring relationships, though with no difficulty in establishing them. (If 19-above- was scored 2 circle NA and go to 21).

46. How long have these relationships lasted?

To be scored positively there should be convincing evidence from examples that subject has an inability to sustain friendship and relationships with others, excluding family member. Not scored positively are those who claim never to establish friendship and relationships in the first place (NA), and those who through misfortune or events beyond their control (death, illness, moving, etc.) report their interruption of many relationships. Five years is considered evidence of an enduring relationship.

0, 1, 2, ?.

2. The subject has never maintained an enduring or longstanding relationship with anyone (excluding family members) since the completion of childhood.

1. The subject has maintained an enduring or longstanding relationship with only one person (excluding family members) since the completion of childhood.

Examples suggest the likelihood that the subject has never maintained an enduring or longstanding relationship (excluding family members) since the completion of childhood, but they are less than totally convincing.

0. Denied, not supported by examples, or due to circumstances beyond the subject's control.

Q21. Avoidance of social activities that involve significant interpersonal contact, because of fear of criticism, disapproval, or rejection.

47.a. Some people almost always keep to themselves and rarely socialize. Are you like that? b. If yes: tell me more about it.

c. Why do you behave like that?

For a positive score there must be evidence of an obvious avoidance of joint leisure activities, social visits, parties, or participation in community, civic, or other organizations. Social contacts at work or with one's family do not exempt one from meeting the criterion. The reason for the avoidance must be fear of criticism, disapproval or rejection.

0, 1, 2, ?.

2. Almost always avoid social activities (outside of family or work) that involve significant interpersonal contact. Subject provides one or more of these as the primary reason: fear of criticism, disapproval or rejection.

1. Often avoids social activities (outside of family or work) that involve significant interpersonal contact. Subject provides one or more of these as the primary reason: fear of criticism, disapproval or rejection.

Almost avoids social activities (outside of family or work) that involve significant interpersonal contact. Subject acknowledges one or more of the three reasons, but insists that they are not the primary reasons.

0. Denied, infrequent, not supported by convincing examples, or avoidance is due to other reasons.

Q22. Consistent choice of solitary activities.

48.a. Do you almost always choose the kind of activities that you can do all by yourself rather than with other people?

b. If yes: give me some examples.

For a score of 2 there must be compelling evidence from examples that subjects almost always select activities (occupational and leisure) that they can do alone. The mere preference for such activities is insufficient. It must be acted on. Those who almost always choose solitary leisure activities but claim that their job occasionally prevents them from choosing solitary occupational activities should receive a score of 2.

0, 1, 2, ?.

2. Almost always chooses solitary occupational and leisure activities.

Almost always chooses solitary occupational and leisure activities, except occasionally when the nature of the job prevents it.

1. Often chooses solitary occupational and leisure activities.

0. Denied or examples unconvincing.

Q23. Unwillingness to become involved with people unless certain of being liked.

49.a. Are you willing to get involved with people when you are not sure they really like you?

b. If no: does that affect you or the way you live your life?

c. If yes: tell me about it.

Many people acknowledge this tendency, but that is insufficient for a positive score. For a score of 2 the subject's description must make it clear that it has a significant impact, e.g., missing out on opportunities for potential friendships and relationships.

0, 1, 2, ?.

2. Usually unwilling to become involved with people unless certain of being liked, and this has an obvious effect on friendships and relationships.

Occasionally unwilling to become involved with people unless certain of being liked, and this has an some effect on friendships and relationships.

0. Denied, rare, or not supported by description.

Q 24. Excessive preoccupation with being criticized or rejected in social situations.

50.a. Do you spend a lot of time worrying about whether people like you?

b. If yes: are you afraid they will criticize or reject you when you are around them?

c. If yes: how much does this bother you?

There is an inclination for subject to confuse an ordinary, understandable concern about criticism or rejection in social situations with an excessive preoccupation. It is particularly important that acknowledge of the behaviour be supported by convincing examples indicating that concern is well beyond that experienced by most people in similar circumstances.

0, 1, 2, ?.

2. Frequently is concerned about being criticized or rejected in social situations.

1. Occasionally is concerned about being criticized or rejected in social situations.

0. Denied, rare, or not supported by convincing examples.

Q25. Disturbances in and uncertainty about internal preferences.

51.a. Do you have a lot of trouble deciding what type of friends you should have? b. If yes; does that have an effect on your life or cause any problem for you?

c. If yes: give me some examples.

52.a. Does the kind of people you have as friends keep changing?

b. If yes: tell me about it.

The aspects of the criterion is met when subjects report that they are so uncertain about what type of friends they desire, that this cause significant distress or problems in their

relations with others. A positive score is also given when subjects describes frequent or erratic changes in the type of friends they have, even if they don't acknowledge uncertainty about type of friends to have. Doubt about whether to have a particular person as a friend is not within the scope of the criterion, unless it is a particular instance of the more general uncertainty about the type of friends to have.

0, 1, 2, ?.

2. Obvious and well documented persistent uncertainty about type of friends to have, as described above.

1. Probable but less well documented persistent uncertainty about type of friends to have, as described above.

0. Absent, doubtful, or not well documented examples.

Q26. Liability to become involved in intense and unstable relationships often leading to emotional crises.

53.a. Do you get into intense and stormy relationships with other people with lots of ups and downs? I mean where your feelings about them run "hot" and "cold" or change from one extreme to the other.

b. If yes: in those relationships do you often find yourself alternating between admiring and despising the same person?

c. If yes: give me some examples.

d. In how many different relationships has this happened?

For a positive score three features must be present: instability, strong feeling, and alternation between overidealization and devaluation. The latter does not require continuous switching from overidealization to devaluation. If the other requirements are met, it does not matter whether the behaviour is confined to specific types of relationships, e.g., those with parents, members of the opposite sex, etc.

0, 1, 2, ?.

2. Example illustrating a pattern of unstable and intense relationships (more than one or two) characterized by alternating between the extremes of overidealization and devaluation.

1. Example illustrating that one or two relationships were unstable, intense and characterized by alternating between the extremes of overidealization and devaluation.

0. Denied or not supported by convincing examples.

Q27. Unreasonable insistence by the individual that others submit to exactly his or her way of doing things, or unreasonable reluctance to allow others to do things.

54.a. Do you often insist that people do things exactly your way?

b. If yes: does that cause any problems for you or for others?

c. If yes: tell me about it.

55.a. Are you reluctant to let people do things, because you're convinced that they won't do them your way? If yes: does that cause any problems for you or for them?

b. If yes tell me about it.

For a positive score the behaviour must cause subjective distress or problems.

0, 1, 2, ?.

2. Frequent insistence that others submit to exactly his or her way of doing things. This sometimes causes subjective distress or problems.

Frequent unreasonable reluctance to allow others to do things because of the conviction that they will not do them correctly. This sometimes causes subjective distress or problems.

1. Occasional unreasonable reluctant to allow others to do things because of the conviction that they will not do them correctly. This sometimes causes subjective distress or problems.

0. Denied, does not cause distress or problems, or not supported by convincing examples.

Q28. Rigidity and stubbornness

56.a. Are you very stubborn and set in your ways?

b. If yes: give me some examples of what you mean.

c. Does this upset you or cause any problems?

d. If no: have people ever accused you of being that way?

e. If yes: why do you think they have?

Resistance to the suggestion and views of others, and a reluctant to change one's way under reasonable pressure from others to do so, should be taken as evidence of rigidity and stubbornness. For a positive score there should be indications that this sometimes leads to subjective distress or social or occupational problems.

0, 1, 2, ?.

2. Frequent rigidity and stubbornness that sometimes leads to subjective distress or social occupational problems.

1. Occasionally rigidity and stubbornness that sometimes leads to subjective distress or social occupational problems.

0. Denied, not associated with subjective distress or social or occupational problems.

Q29. Callous unconcern for the feelings of others.

57.a. Some people are not too concerned about other people's feelings. Are you like that?

b. If yes: tell me more about it.

c. If no: has anyone ever told you that you're not concerned about other people's feelings?

d. If yes: why do you think they've said that?

Many callous people may be unaware of it or fail to acknowledge it. Therefore, it is particularly important to adequately pursue the reasons for any accusations by others.

0, 1, 2, ?.

2. Usually is not concerned about the feelings of others.

1. Often is not concerned about the feelings of others.

0. Denied, infrequent, or not supported by examples.

Q30. Marked tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or criticized

58.a. Do you have a habit of getting into arguments and disagreements?

b. If yes: when are you likely to behave like that?

c. Give me some examples.

d. If no: have people told you that you argue or disagree too much?

e. If yes: why do you think they have?

To receive a positive score there must be evidence from examples that the quarrelsome behaviour and conflict occur especially when the subject's impulsive acts are prevented, condemned, or criticized.

0, 1, 2, ?.

2. Frequently engages in quarrelsome behaviour and conflict with others, especially when impulsive acts are prevented, condemned, or criticized.

1. Occasionally engages in quarrelsome behaviour and conflict with others, especially when impulsive acts are prevented, condemned, or criticized.

Frequently engages in quarrelsome behaviour and conflict with others, but not especially in relation to impulsive acts.

0. Denied, rare, not in relation to impulsive acts, or not supported by convincing examples.

Q31. A combative and tenacious sense of personal rights out of keeping with the actual situation

58.a. Do you insist on standing up for your rights?

b. If yes: do you do this even when it means getting into a confrontation and arguing about something that many people would ignore?

c. If yes: give me some examples

d. If no: have people accused you of being like that?

e. If yes: why do you think they have?

Argumentative or disagreeable behaviour is not within the scope of the criterion, unless it occurs within the context of subject's defending in an exaggerated or inappropriate fashion what they perceive to be their rights.

0, 1, 2, ?.

2. Frequently displays a combative and tenacious sense of personal rights out of keeping with the actual situation.

1. Occasionally displays a combative and tenacious sense of personal rights out of keeping with the actual situation.

0. Denied, rare, or not supported by convincing examples.

Q32. Unwillingness to make even reasonable demands on the people one depends on

59.a. Do you depend a lot on some people?

If no: score 32 & 33 NA and go to 34.

b. If yes: do you ask them to help you or do things for you? Tell me about it.

This refers specifically to reasonable demands on the people the subject depends on, e.g., spouse, parents, adult offspring, lover, friends, etc. It does not include such behaviour when it occurs with an employer, or outside the context of dependent relationships.

0, 1, 2, ?, NA.

2. Usually unwilling to make even reasonable demands on the people the subject depends on.

1. Occasionally unwilling to make even reasonable demands on the people the subject depends on.

0. Denied, rare, or not supported by convincing examples.

Q33. Subordination of one's own needs to those of others on whom one is dependent, and undue compliance with their wishes.

60.a. When you depend a lot on another person, do you give in too easily to what that person wants?

b. If yes: give me examples of what you mean.

61.a. Do you almost always put that person's needs ahead of your own?

b. If yes: tell me about it.

As with the preceding item (32) this applies only to behaviour that occurs with those on whom the subject is dependent, e.g., spouse, parents, adult offspring, lover, friends, etc. It does not include such behaviour when it occurs with an employer, or outside the context of dependent relationships.

0, 1, 2, ?, NA.

2. Frequently subordinates own needs to those on whom subject is dependent, or unduly complies with their wishes.

1. Occasionally subordinates own needs to those on whom subject is dependent, or unduly complies with their wishes.

0. Denied, rare, or not supported by convincing examples.

Q34. Tendency to bear grudges persistently, e.g., refusal to forgive insults, injuries, or slights.

62.a. Have you ever held a grudge or taken a long time to forgive someone?

- b. If yes: tell me about it.
- c. Did you try to avoid or talk to the person?
- d. How long did you continue to act that way?
- e. Has this ever happened with anyone else?
- f. If yes: with how many people?

As evidence of a grudge the subject should either try to avoid or refuse to speak to the person for more than a year. For a score of 2 there should be evidence of grudges against more than one or two people. The examples should establish that the reaction is obviously disproportionate. For example, a grudge against a parent responsible for child abuse or incest would not warrant a positive score.

0, 1, 2, ?.

2. Has born persistent grudges, i.e., has been unforgiving of insults, injuries, or slights against several people.

1. Has born persistent grudges, i.e., has been unforgiving of insults, injuries, or slights against several people.

0. Denied not supported by example

Q35. Suspiciousness and a pervasive tendency to distort experience by misconstruing the neutral or friendly actions of others as hostile or contemptuous

63.a. Has it been your experience that people often try to use you or take advantage of you?

b. If yes: give me some examples.

64.a. Has anyone ever deliberately tried to harm you, ruin your reputation, or make life difficult for you?

b. If yes: give me some examples.

Affirmation replies to the question that assess this criterion require considerable probing and judgment on the part of the examiner, because there must be an assessment of the possible reality basis of the subject's reported experiences. Too much emphasis should

not be given to accounts of isolated incidents. The focus should be on identifying a characteristic attitude on the part of the subject, suggestion an orientation or set toward the expectation of exploitation or harm. The subject's approach to the interview itself may be taken into consideration in the scoring, but should never be the sole basis for a score of 2.

0, 1, 2, ?.

2. Frequently expects, without sufficient basis, to be exploited or harmed by others.

1. Occasionally expects, without sufficient basis, to be exploited or harmed by others.

Denied, but evident in interview.

0. Denied, rare, or not supported by convincing examples.

Q36. Persistent self-referential attitude, associated particularly with excessive self-importance.

65.a. When you enter a room full of people do you often wonder whether they might be talking about you, or even making unflattering remarks about you?

b. If yes: give me some examples.

66.a. When you're in a public place or walking down the street, do you often wonder whether people might be looking at you, talking about you, or even making fun of you?

b. If yes: give me some examples

It not uncommon for people to experience fleeting self-referential ideas when they first enter a large social gathering, particularly one involving unfamiliar people. Such behaviour should not be considered within the scope of the criterion. There should be indications that the ideas are more than momentary. If it appears that they may be of delusional proportions, the subject should be questioned carefully, since delusions of reference are excluded.

0, 1, 2, ?.

2. Frequently experience ideas of reference.

1. Occasionally experience ideas of reference.

0. Denied, rare, or not supported by convincing examples, or delusional in nature

IV. AFFECTS

Now I am going to ask some questions about your feelings. Again I am interested in the way you have been most of your life and not just recently. If you've changed and are different from the way you used to be, be sure to let me know.

67. How do you usually feel?

68. How do you usually feel deep down inside?

69. What problems do you have with your feelings?

Q37. An appearance of indifference to either praise or criticism.

70.a. When you're praised, do you show any reaction so that the people around you know how you feel?

b. If yes: tell me about it.

71.a. What about when you are criticized?

b. If yes: tell me about it.

For a positive score subjects must report the absence of any overt reaction, so that observers might conclude that they are indifferent to the praise or criticism. Apparent indifference to both praise and criticism is not required.

0, 1, 2, ?.

2. Almost always gives the appearance of being indifferent to praise or criticism.

1. Often gives the appearance of being indifferent to praise or criticism.

0. Denied, does not occur often, or not supported by subject's account.

Q38. Excessive sensitivity to setbacks and rebuffs.

72.a. Are you easily slighted or offended?

b. If yes: tell me about it

73.a. When you are slighted or offended, do you sometimes have too strong a reaction?

b. If yes: give me some examples.

74. How do you react when things don't go your way?

For a positive score the subject's example should establish the presence of a characteristic inclination toward being slighted in situations where most people would not especially feel that way; or of reacting excessively to actual slights. This may occur as a consequence of what others say or fail to say, or what they do or fail to do. For a 2

score there must also be evidence of similar behaviour in response to setback, i.e., things not going one's way.

0, 1, 2, ?.

2. Frequently is easily slighted, or reacts excessively to actual slights. Also displays similar behaviour in response to setbacks.

1. Occasionally is easily slighted, or reacts excessively to actual slights. Also displays similar behaviour in response to setbacks.

Frequently is easily slighted, or reacts excessively to actual slights. But not to setbacks.

0. Denied, rare, or not supported by convincing examples.

Q39. Limited capacity to express warm, tender feelings towards others.

75.a. Some people rarely show affection or talk about it. Are you like that?

b. If yes: tell me about it.

c. If no: have people told you that you're not affectionate?

d. If yes: why do you think they've said that?

Warmth, tenderness, or affection are the only emotions within the scope of the criterion, which concerns their display or expression, not the subjective experience of them.

0, 1, 2, ?.

2. Claims to rarely or never express affection.

1. Claims to occasionally express affection.

0. Frequently express affection.

Q40. Self-dramatization, theatricality, or exaggerated expression of emotions

76.a. Do you almost always show your feelings in a very obvious way for others to see?

b. If yes: do you ever get carried away and exaggerate the way you feel?

c. If yes: give me some examples.

77.a. Have people told you that you're dramatic?

b. If yes: why do you think they've said that?

(In rating this criterion also consider subject's behavior during interview)

Subject should be questioned very closely if they acknowledge self-dramatization, but shown no signs of it during the interview. Strikingly obvious theatricality or frequent exaggerated expression of emotions during the interview may justify a positive rating,

including a score of 2, even if the subject denies the behaviour, provided there is no reason to suspect hypomania.

0, 1, 2, ?.

2. Acknowledges with supporting examples frequent self-dramatization and exaggerated expression of emotion, or display it during the interview in an obvious and striking way.

1. Acknowledges with supporting examples occasionally self-dramatization and exaggerated expression of emotion, or display it to a limited degree during the interview.

0. Denied, rare, or not supported by convincing examples or behavior during the interview.

Q41. Continual seeking for excitement

77.a. Do you need a lot of excitement in your life?

b. If yes: tell me more about it.

78.a. Does needing excitement ever cause problems for you?

b. If yes: give me some examples.

Proneness to boredom without obvious seeking of excitement is not within the scope of the criterion. For a positive score there should be evidence that the search for exciting forms of behaviour sometimes causes problems for the subject.

0, 1, 2, ?.

2. Frequently seeks excitement. This leads to the pursuit of exciting forms of behaviour that sometimes cause problems for the subject.

1. Occasionally seeks excitement. This leads to the pursuit of exciting forms of behaviour that sometimes cause problems for the subject.

0. Denied, not supported by subject's description, or rarely or never leads to exciting forms of behaviour that cause problems for the subject.

Q42. Few, if any, activities provide pleasure.

79.a. Are there any activities that you enjoy?

b. If yes: tell me about them.

c. If no: tell me more about it.

It is particularly important to establish that the anhedonia is not limited to the episodes of depression. Positive ratings should also not be given to those with dysthymia or persistent depression.

0, 1, 2, ?.

2. Claims to rarely, if ever, experience pleasure or joy.

1. Claims not to experience pleasure or joy most of the time.

0. Denied, infrequent, due to depression, or not supported by the subject's description.

Q43. Liability to outbursts of anger or violence, with inability to control the resulting behavioral explosions.

80.a. Do you sometimes get angrier than you should, or feel very angry without a good reason?

b. If yes: give me some examples.

c. If no; have people ever told you that you're a very angry person?

d. If yes: why do you think they've said that?

81.a. Do you ever lose your temper and have tantrums or angry outbursts?

b. If yes: do you yell and scream in an uncontrolled way?

c. If yes: give me some examples.

82.a. Do you ever throw, break, or smash things?

b. If yes: give me some examples.

83.a. Do you ever hit or assault people?

b. If yes: give me some examples.

The subjective of intense anger or psychodynamically inferred anger are not within the scope of the criterion. The anger must be either inappropriate, or intense and uncontrolled. Overt verbal or physical displays of anger are required.

0, 1, 2, ?.

2. Frequently verbally displays inappropriate or intense, uncontrolled anger.

Occasionally indulges in extreme physical displays of inappropriate or intense, uncontrolled anger.

1. Occasionally verbally displays inappropriate or intense, uncontrolled anger.

On one or two occasions indulges in extreme physical displays of inappropriate or intense, uncontrolled anger.

0. Denied.

Q44. Limited capacity to express anger towards others.

(If 43 is scored 1 or 2, score 44 0 and go to 45)

84. When you're angry with someone, do you show it so that the person is aware of it?

Tell me about it.

The concerns the expression or display and not the experience of anger toward others.

0, 1, 2, ?.

2. Claims to almost never express anger towards others, so that they are aware of it.

1. Claims to almost never express anger towards others, so that they are aware of it.

0. Express anger towards others or claim not supported by subject's accounts.

Q45. Chronic feelings of emptiness

85.a. Do you often feel empty inside?

b. If yes: does that upset you or cause any problems for you?

c. If yes: tell me about it.

For a positive score there must be evidence that the emptiness is obviously distressing to the subject or leads to maladaptive behaviour, e.g. substance abuse, self-mutilation, suicidal gestures, impulsive sexual activity, etc.

0, 1, 2, ?.

2. Frequent feelings of emptiness that are obviously distressing or sometimes led to maladaptive behaviour.

1. Occasional feelings of emptiness that are obviously distressing or sometimes lead to maladaptive behaviour.

0. Denied, rare or not associated with obvious distress or maladaptive behaviour.

Q46. Feeling uncomfortable or helpless when alone, because of exaggerated fears of inability to care for oneself

86. How do you usually feel when you're alone?

(If he reports uncomfortable or helpless feelings:)

87.a. How much of a problem is that? How much does it actually bother you?

b. Why do you think you feel that way?

For a positive score subjects must experience significant and obvious discomfort or helplessness when alone, or provide convincing examples that they do to great lengths to avoid being alone. The reason for this must be fear of being unable to care for oneself. A feeling of loneliness as such does not receive a positive score..

0, 1, 2, ?.

2. Frequently feels very uncomfortable or helpless when alone, because of exaggerated fear of inability to care for oneself.

1 Occasionally feels very uncomfortable or helpless when alone, because of exaggerated fear of inability to care for oneself.

0 Denied, rare, feelings insignificant, nor supported by subject's description, or solely for other reasons e.g. loneliness.

Q47. Preoccupation with fears of being left alone to care for oneself

88.a. Do you spend a lot of time worrying about the possibility that you may be left alone and have to care for yourself?

b. If yes: tell me about it.

The criterion refers to a fear and not the actual event. An occasional or transient is not within the scope of the criterion. There must be long-standing preoccupation, not limited to an episode of illness. Positive scores should not be given if the preoccupation is due to special circumstances, such as those created by the serious or impending death of another, or the absence of other support system, such as might occur in an elderly person with no surviving friends or family members.

0, 1, 2, ?.

2. Frequent unrealistic preoccupation with fears of being left to care for oneself.

1. Occasional unrealistic pre-occupation with fears of being left to care for oneself.
- 0 Denied, rare, not supported by subject's description, or the fears have a definite basis in reality.

Y48. Excessive efforts to avoid abandonment

89.a. Do you ever find yourself frantically trying to stop someone close to you from leaving you?

b. If yes: give me some examples.

Unlike the previous dependent item (47), which concerns preoccupation with fears of being left alone to care for oneself, this has to do with efforts on the part of the subject to avoid or imagined abandonment. The efforts should be associated with obvious feelings of anxiety or agitation. 0, 1, 2, ?.

2. Frequent frantic efforts to avoid real or imagined abandonment.
1. Occasional frantic efforts to avoid real or imagined abandonment
0. Denied, rare, occurs only in association with suicidal or self-mutilating behaviour, or not supported by examples.

Q49. Shallow and labile affectivity

90.a. Do your feelings often change very suddenly and unexpectedly, sometimes for no obvious reason?

b. If yes: give me some examples.

91.a. Has anyone ever accused you of being a shallow person?

b. If yes: why do you think they have?

(In rating this criterion also consider subject's behaviour during interview)

Unlike the next item (50), the emotion as involved are not necessarily negative ones, such as anxiety, depression, and irritability, but may include enthusiasm, warmth, joy, etc. Display of the behaviour or display of it in the interview is insufficient for a score of 2. Do not give a positive rating when the behaviour is due to a bipolar disorder

0, 1, 2, ?.

2. Frequent displays rapidly shifting and shallow expression of emotions

1. Occasionally displays rapidly shifting and shallow expression of emotions.

0. Denied, but definitely displayed during interview

Q50. Unstable and capricious mood

92.a. Do you often change from your usual mood to feeling very irritable, very depressed, or very nervous? b. If yes: when that happens how long do you usually stay that way? c. Give me some examples of what it's like when you're feeling that way.

The subject need not report instability of all these moods, depression, irritability, and anxiety. For a positive score the description and examples should establish that the mood changes are not only frequent and short lived (a few hours or days), but also of some intensity

0, 1, 2, ?.

2. Frequently experienced effective instability

1. Occasionally experiences effective instability

0. Denied, rate, or note supported by examples.

Q51. Restrictions in lifestyle because of need for physical security

93.a. Some people have a very strong need to feel safe from physical harm. That may affect the way they live their lives or prevent them from doing a lot of things. Are you like that?

b. If yes: give me some examples.

The restrictions on the way subjects live their life because of the need for physical security may involve a variety of areas: Social, leisure, and occupational. A positive score requires documentation with obvious examples. Vague generalities are insufficient.

0, 1, 2, ?.

2. The need for physical security has an obvious effect on the subject's lifestyle as reflected by convincing examples from different areas of life.

1. The need for physical security has a definite but less extensive effect on the subject's lifestyle.

0. Denied, insignificant

Q52. Persistent and pervasive feelings of tension and apprehension

94.a. Do you almost always feel tense or nervous?

b. If yes: how much of an effect does it have on you?

Give me some examples.

95.a. Are you the kind of person who is always worrying that something bad or unpleasant is going to happen?

b. If yes: is it very hard for you to get those thoughts out of your mind?

c. If yes: how much of an effect does being a worrier have on your life?

A positive rating should not be given if the tension and apprehension are limited to isolated episode of depressive, anxiety, phobic, panic or obsessiveness compulsive disorders. However, those with chronic anxiety disorders fall within the scope of the criterion. There must be convincing evidence that both tension and apprehension have an obvious effect on the subject's life.

0, 1, 2, ?.

2. Frequent experience of persistent and pervasive feelings of both tension and apprehension with an obvious effect on the subject's life.

1. Frequent experience of persistent and pervasive feelings of both tension and apprehension (but not both) with an obvious effect on the subject's life.

Occasional experience of persistent and pervasive feelings of both tension and apprehension with an obvious effect on the subject's life.

0. Denied, rate, confined to episodic anxiety or depressive disorders, does not have an obvious effect on the subject's life, or not supported by subject's description.

Q53. Little interest in having sexual experiences with another person (taking into account age)

(The examiner should exercise discretion about inquiring about sexual behaviour in certain cultures. Where this might be inappropriate, the item should be scored?

96.a. Now a few questions about your sexual behaviour. There are some people who have little or no desire to have sexual experiences with another person. Are you like that?

b. If yes: tell me about it.

The lack of sexual interest or desire should be longstanding and not due to old age or to physical or mental illness, including depression. Allowance should also be made for the possible effect of certain medications.

0, 1, 2, ?.

2. Almost never has any desire to have sexual experienced within another person.

1. Much of the time has not desire to have sexual experiences with another person.

0. Denied, does not occur much of the time, explicable by age, physical or mental illness, medications, or not supported by subject's description.

Q54. Inappropriate seductiveness in appearance or behaviour

(The examiner should exercise discretion about inquiring about sexual behaviour in certain cultures. Where this might be inappropriate, the item should be scored?

97.a. Do you ever find yourself dressing or behaving in a sexually seductive way?

b. If yes: what kind of things do you do?

98.a. Have you ever been told that what you do is inappropriate?

b. If yes: tell me about it.

c. If no: have you ever been told that you do?

d. If yes: why do you think people have said that?

(In rating this consider subject's appearance or behaviour during interview)

For a score of 2 the subject must provide examples of obviously inappropriate seductiveness. The subject's appearance or behaviour during the interview may influence the rating and may be sufficient for a score of 2, if it is not due to hypomania..

0, 1, 2, ?.

2. Frequently inappropriately sexually seductive in appearance or behaviour

Obviously inappropriately seductive in appearance or behaviour during the interview.

1. Occasionally inappropriately sexually seductive in appearance or behaviour, but rarely inappropriately so.

Somewhat inappropriately seductive in appearance or behaviour during the interview.

0. Denied, insignificant, or not supported by subject's description

Q55. Recurrent suspicions, without justification, regarding sexual fidelity of spouse or sexual partner.

(The examiner should exercise discretion about inquiring about sexual behaviour in certain cultures. Where this might be inappropriate, the item should be scored?

(Asked only of those who have never been married).

99.a. Have you ever had sexual relations with anyone?

b. If no: circle NA and go to 56.

100.a. Have you ever been concerned about whether a sexual partner was unfaithful to you? b. If yes: tell me about it.

For a score of 2 there should be admission of more than brief, transient concerns about the sexual fidelity of one's spouse or partner. Subjects who admit to frequent suspicions, but who insist that it is justified, should be questioned very carefully. When in doubt about the possible reality basis of their account, the

criterion should not be scored positively, unless there is evidence from other sources that the suspicious are pathological.

0, 1, 2, ?.

2. On a number of different occasions or with a number of different partners was obviously very concerned about fidelity, with no apparent justification.

1. On one or two occasions was obviously very concerned about fidelity, with no apparent justification.

0. Denied, rare, insignificant or not supported by subject's account

Q56. Disturbances in and uncertainty about internal preferences (including sexual).

(The examiner should exercise discretion about inquiring about sexual behaviour in certain cultures. Where this might be inappropriate, the item should be scored?)

101.a. Have you ever been uncertain whether you prefer a sexual relationship with a man or a woman? b. If yes: tell me about it.

c. Does this ever upset you or cause any problems for you?

d. If yes: tell me about it.

Homosexuality or bisexuality as such are not within the scope of the criterion unless they are associated with significant doubt or uncertainty about one's sexual orientation. This doubt or uncertainty causes subjective distress or problems with others.

0, 1, 2, ?.

2. Has considerable doubt or uncertainty about sexual orientation. This frequently causes subjective distress.

1. Has considerable doubt or uncertainty about sexual orientation. This sometimes causes subjective distress.

0. Denied, rare, does not cause subjective distress, or not supported by subject's account.

V. REALITY TESTING

Now a question about some of your beliefs.

Q57. Preoccupation with unsubstantiated "conspiratorial" explanations of events either immediate to the patient or in the world at large?

102.a. Do you spend time thinking about the possibility that there may be some kind of conspiracy going on around you or in the world at large?

b. If yes: does this bother you or have any effect on your life?

c. If yes: tell me about it.

This should be scored conservatively. Passing suspicions or abstract ideas with little or no impact on the subject's behaviour are not within the scope of the criterion. For a positive score there should be a definite preoccupation that either produces emotional distress or has an obvious influence on the subject's behaviour. If people rather than events are the focus of the "conspiracy" then more than one person must be involved, and there must be communication between or among them.

0, 1, 2, ?.

1 Occasionally preoccupied with unsubstantiated conspiratorial explanations.

This sometimes produces emotional distress or has an obvious influence on the subject's behaviour.

0. Denied, rare, does not cause distress or influence behaviour, or not supported by subject's description.

VI. IMPULSE CONTROL

103.a. I'm going to conclude the interview with some questions about impulsive and irresponsible behaviour. Have there been times when your behaviour hasn't conformed to what you believe or have been taught is right?

b. If yes: tell me about it.

Q 58. Marked tendency to act unexpectedly and without consideration of the consequences.

104.a. Some people have a habit of doing things suddenly or unexpectedly without giving any thought to what might happen. Are you like that?

b. If yes: what kind of things have you done?

This refers to the consequences of acting suddenly and unexpectedly on impulse.

It is scored positively only if the subject can produce convincing examples of problems that have arisen or could have arisen as a result of this tendency.

0, 1, 2, ?.

2. Frequently acts suddenly and unexpectedly on impulse. This sometimes causes problems or could cause problems.

1. Occasionally act suddenly and unexpectedly on impulse. This sometimes causes problems or could cause problems.

0. Denied, rate, or supported by convincing examples

Q59. Recurrent threats or acts of self-harm

105.a. Have you ever threatened to commit suicide?

b. If yes: how many times? Tell me about it.

106.a. Have you ever actually made a suicide attempt or gesture?

b. If yes: how many times? Tell me about it.

107.a. Have you ever deliberately cut yourself, smashed your fist through a window, burnt yourself, or hurt yourself in some other way (not counting suicide attempts or gestures)? b. If yes: tell me about it.

The mere sharing of one's suicidal thoughts with another person does not ordinarily constitute a threat. There must be communication of an intent to commit suicide. The motive for making the threat is irrelevant. Suicidal gestures

0, 1, 2, ?.

2. On several occasion engaged suicidal thteats, gestures, or acts of self-harm.,

1. Once or twice engaged in suicidal threats, gestures, or acts of self-harm.,

0. Denied

Q60. A low threshold for discharge of aggression, including violence.

108.a. Have you ever hit or physically abused anyone in your family?

If yes: how many times? Tell me about it.

109.a. Have you ever hit anyone (else) or been in any (other) fights?

b. If yes: how many times? Tell me about it.

Do not count aggression or violence associated with legitimate efforts at defending oneself or others. Alcohol and drugs are not exonerating factors
0, 1, 2, ?.

2. Several times has been involved in physical fights, assaults or physical abuse of others.

1. Once or twice has been involved in physical fights, assaults, or physical abuse of others.

0. Denied, or required by job or to defend someone or oneself

Q61. Gross and persistent attitude of irresponsibility and disregard for social norms, rules, and obligations.

110.a. Have you ever been unemployed?

b. If yes: for how long? Why?

111.a. Have you ever traveled from place to place without a job or definite purpose or clear idea of when the travel will end?

b. If yes: tell me about it.

112.a. Have you ever defaulted on debts or failed to honour financial obligations?

b. If yes: tell me about it.

113.a. Have you ever failed to provide financial support for other members of your family, when you were expected to do so?

b. If yes: tell me about it.

(Asked only of those with children)

114.a. Have you ever failed to take adequate care of your children, or neglected their safety or physical well-being?

b. If yes: tell me about it.

c. If no: has anyone ever accused you of any of those things?

d. If yes: why do you think they have?

(Asked only of males who have been separated or divorced)

115.a. Have you ever failed to provide alimony (financial maintenance) or child support payments when you were expected to?

b. If yes: tell me about it.

116.a. Are you inclined to lie if it serves your purpose?

b. If yes: give me some examples.

c. If no: have people accused you of lying or not telling the truth?

d. If yes: why do you think they have?

117.a. Have you ever used an alias?

b. If yes: why?

118.a. Have you ever "conned" anyone?

b. If yes: tell me about it.

119.a. Do you ever take unnecessary chances and risk harm or injury to yourself or others?

b. If yes: tell me about it.

120.a. Have you ever driven a car while you were intoxicated with alcohol or drugs?

b. If yes: how many times? Tell me about it.

121.a. Have you ever been arrested?

b. If yes: for what?

122.a. Have you ever done anything (else) that you could have been arrested for, if you had been caught?

b. If yes: what?

This criterion is rated based on the application of clinical judgement to the replies to the questions.

0, 1, 2, ?.

2. Convincing evidence of gross and persistent behaviour indicative of irresponsibility and disregard for social norms, rules and obligations.

1. Suggestive but less than convincing evidence of gross and persistent behaviour indicative of irresponsibility and disregard for social norms, rules and obligations.

0. No evidence or insufficient evidence for a positive rating.

Q62. Incapacity to experience guilt

(If 60 & 61 are both scored 0, score 62-64 NA and go to 65)

123. How do you feel about (cite behaviour acknowledged in 60 & 61)?

124. Do you think you were justified in behaving that way?

This criterion is rated based on consideration of the history of dissocial behaviour viewed in conjunction with replies to questions regarding remorse or guilt. The examiner should cross-examine the subject closely to verify the authenticity of any alleged remorse or guilt. Regret because of the consequences of oneself, e.g. imprisonment, is not remorse. The rating should ultimately be based on the application of clinical judgement to all of this information.

0, 1, 2, ?.

2. Convincing evidence that the subject lacks remorse or the capacity to experience guilt

1. Probable but less than convincing evidence that the subject lacks remorse or the capacity to experience guilt.

0. Appears to experience appropriate remorse or demonstrates the capacity to experience guilt.

Q63. Marked proness to blame others, or to offer plausible rationalization for the behaviour that has brought the individual into conflict with society

125. Why do you think you behaved that way?

(Be sure to confront the subject with all areas and examples of dissocial behaviour)

The criterion is rated based on a consideration of the history of dissocial behaviour viewed in conjunction with the explanations of the behaviour offered

viewed in conjunction with the explanations of the behaviour offered by the subject. The examiner should cross examine and confront the subject when necessary, to determine the validity of any attempts to blame others, or the plausibility of explanations for the behaviour. The rating is ultimately based on the application of clinical judgement to all of this information

0, 1, 2, ?.

2. Convincing evidence that the subject is prone to blame others or to offer rationalizations for the dissocial behavior.

1. Probable but less than convincing evidence that the subject is prone to blame others or to offer rationalizations for the dissocial behaviour.

0. Appears to profit from experience, particularly punishment.

126.Q64. Incapacity to profit from adverse experience, particularly punishment

The criterion is rated based on the application of clinical judgment on all of the information obtained in the interview that is relevant to the subject's history of dissocial behavior.

2. Convincing evidence that the subject is unable to profit from experience, particularly punishment.

1. probable but less convincing evidence that the subject is unable to profit from experience, particularly punishment.

0. Appears to profit from experience, particularly punishment.

127. Q65. Excessive pedantry and adherence to social conventions

Anankastic: 6

Rate ostentatious displays of learning and excessive formality in relating to the interviewer.

128. Q66. Marked insensitivity to prevailing social norms and conventions; disregard for such norms and conventions is intentional.

Rate such phenomena as unkempt appearance, bizarre dress, unusual mannerisms, and talking to oneself. When in doubt about the possible role of depression or intentionally rebellious or nonconformist behavior, do not score 2.

129. Q67. Display of emotional coldness, detachment, or flattened affectivity.

Tate unchanged facial expression, monotonous or unvarying vocal inflection, lack of expressive gestures, maintenance of a rigid, unchanging posture, poor eye contact, lack of apparent interest in the examiner, failure to smile when almost everyone would. When in doubt about the presence or significance of these phenomena, including the possible role of psychotropic medications or depression, do not score 2.

IPDE ANSWER SHEET

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