“PSYCHIATRIC COMORBIDITIES IN PATIENTS WHO ARE AVAILING CONSULTATION LIAISON SERVICES OF A PSYCHIATRY OPD IN A TERTIARY CARE HOSPITAL – A CROSS-SECTIONAL STUDY”

By

DR. MANO RANJITHA, MBBS

Dissertation submitted tothe

SRI DEVARAJ URS ACADEMY OF HIGHER EDUCATION AND RESEARCH CENTRE, KOLAR

In partial fulfillment of the requirements for the degree of

DOCTOR OF MEDICINE (M.D.)

IN**PSYCHIATRY Under** the

guidance of

DR. MOHAN REDDY M., MBBS,MD

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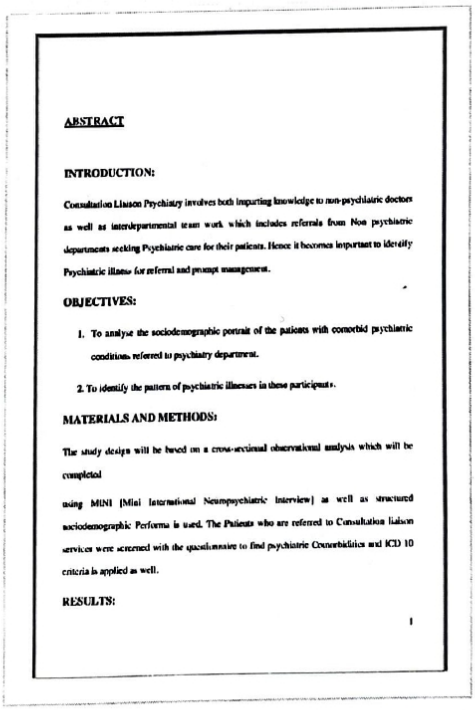

ABSTRACT

INTRODUCTION:

Consultation Liaison Psychiatry involves both imparting knowledge to non-psychiatric doctors as well as interdepartmental team work which includes referrals from Non psychiatric departments seeking Psychiatric care for their patients. Hence it becomes important to identify Psychiatric illness for referral and prompt management.

OBJECTIVES:

1. To analyse the sociodemographic portrait of the patients with comorbid psychiatric conditions referred to psychiatry department.
2. To identify the pattern of psychiatric illnesses in these participants.

MATERIALS AND METHODS:

The study design will be based on a cross-sectional observational analysis which will be completed

using MINI [Mini International Neuropsychiatric Interview] as well as structured sociodemographic Performa is used. The Patients who are referred to Consultation liaison services were screened with the questionnaire to find psychiatric Comorbidities and ICD 10 criteria is applied as well.

RESULTS:

1

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ABBREVIATIONS

CLP	Consultation Liaison Psychiatry
DSH	Deliberate Self Harm
ADS	Alcohol Dependence Syndrome
SUI	Suicidality
ASPD	Antisocial Personality Disorder
MDD	Major Depressive Disorder
RDD	Recurrent Depressive Disorder
PTSD	Post Traumatic Stress Disorder
SSRI	Selective Serotonin Reuptake Inhibitors
SNRI	Selective Norepinephrine Reuptake Inhibitors
GAD	Generalized Anxiety Disorder
MHCA	Mental Health care Act
IPC	Indian Penal Code
NSSI	Non suicidal Self Injury
DBT	Dialectical Behavioral Therapy
SB	Suicidal Behavior
AUD	Alcohol use Disorder

ADH	Alcohol Dehydrogenase
ALDH	Aldehyde Dehydrogenase
MEOS	Microsomal Oxidation System
MZ	Monozygotic Twins
DZ	Dizygotic Twins
NRT	Nicotine Replacement Therapy
THC	Tetrahydrocannabinol
CBD	Cannabidiol
AEA	Anandamide
2- AG	2-arachidonoylglycerol
CB 1,2	Cannabinoid receptors
ADHD	Attention Deficit Hyperactivity Disorder
HPA	Hypo thalamo Pituitary Axis
CRH	Corticotropin releasing Hormone
MAOI	Mono Amine Oxidase Inhibitors
PSD	Post stroke Depression
SES	Socio Economic Status
OXTR	Oxytocin Receptor gene
AVPR1A	Arginine Vasopressin Receptor 1 A
FDA	Food and Drug Administration

ICD	International Classification of Diseases
DSM	Diagnostic and Statistical Manual of Mental Disorders
CBT	Cognitive Behavioral Therapy
SAD	Social Anxiety Disorder
ECT	Electro Convulsive Therapy
CNMP	Chronic NonMalignant Pain
MEOS	Microsomal Oxidation System
BAC	Blood Alcohol Concentration

ABSTRACT

INTRODUCTION:

Consultation Liaison Psychiatry involves both imparting knowledge to non psychiatric doctors as well as interdepartmental teamwork which includes referrals from Non psychiatric departments seeking Psychiatric care for their patients. Hence it becomes important to identify Psychiatric illness for referral and prompt management.

OBJECTIVES:

1. To study the sociodemographic profile of the patients with comorbid psychiatric conditions referred to psychiatry department.
2. To identify the pattern of psychiatric illnesses in these patients.

MATERIALS AND METHODS:

It is a cross-sectional observational study done using MINI [Mini International Neuropsychiatric Interview] as well as structured sociodemographic Performa is used. The Patients who are referred to Consultation liaison services were screened with the questionnaire to find psychiatric Comorbidities and ICD 10 criteria is applied as well.

RESULTS:

Most of the patients referred to the department are males at 62.5% and females are about 37.5%. It was found people who belonged to the geriatric population have had less referrals compared with other population. Most

of the patients referred to consultation liaison services had Psychiatric Comorbidities 79.9% and about 20.1% had nil Psychiatric Comorbidities. Patients who are referred from Medicine Department are the Overwhelming majority at 74.4%.

The majority of Patients diagnosed to have Alcohol Dependence syndrome 21.5% followed by Major Depressive Disorder 9.2%.Patients who had higher suicidality with comorbid Major depressive disorder amounting to 1.4%

CONCLUSION:

The majority of patients diagnosed to have Alcohol Dependence syndrome 21.5% followed by Major

Depressive Disorder 9.2%. Depressive disorder and Suicidality are closely linked. Hence training of non-psychiatric doctors, Junior residents, Interns about Psychiatric illnesses is integral for prompt identification, referral of such

identified cases to Psychiatry and commence the treatment.

KEYWORDS: Consultation, Liaison, Services

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INTRODUCTION

INTRODUCTION:

It is very pertinent to identify and treat the underlying psychiatric illness to hasten the recovery of the detected/existing medical illness. Since psychiatric illnesses are highly stigmatized in society, the number of patients voluntarily coming to the psychiatric outpatient department is usually less compared to other departments. More knowledge and awareness regarding mental health conditions should be emphasized in the community. Discrimination against mentally ill patients, as well as the treating psychiatrist, is not uncommon in Indian society. There are many patients who are referred from other departments, both medical and surgical specialties.

According to Mental Health Survey in India done for common Mental disorders, it was found that the older population had a higher prevalence of Depressive disorders, both Lifetime and current, at 6.93% and 3.53% when compared with younger Adults at 4.96% and 2.54% respectively.[1] In rural areas, the awareness and knowledge about mental illnesses are almost close to none. In contrast to urban settings, people are much more aware of their conditions like anxiety and depression, etc., and the technology to get any amount of knowledge in the snap of their fingers. So, in urban settings, people are much more likely to come forward to seek psychiatric help when needed. Since people have little to no knowledge about their psychiatric conditions, a lot of false information, fear-mongering, and stigmatization towards mental illnesses in rural India affect the quality of mental health in the Indian population. Hence it has been decided to take up patients who are referred from other departments to evaluate them and to know the pattern of psychiatric illnesses prevalent among these patients. Hence it is important to psycho-educate them about their illnesses as well regarding their socioeconomic, interpersonal issues, etc., if any. Hence therapy forms an

inherent part of psychiatry itself.

Psychological stressors like interpersonal relationship problems, sociocultural issues, and financial issues play a huge role in contributing to psychiatric morbidity in these patients. Diagnosing and treating the underlying psychiatric comorbidities helps in the speedy recovery of their physical illnesses as well. It is important for the clinician to identify common psychiatric conditions like depression and anxiety so that they can be referred to psychiatry OPD as and when required.

AIMS AND OBJECTIVES

AIMS & OBJECTIVES

Aim

The aim of this study is to investigate the prevalence and types of psychiatric comorbidities present in patients who are availing consultation liaison services of a psychiatry outpatient department in a tertiary care hospital using a cross-sectional design.

Objectives

1. To examine the sociodemographic portrait of the participants with comorbid psychiatric conditions referred to the psychiatry department.

2. To identify the pattern of psychiatric illnesses in these patients.

REVIEW

OF

LITERATURE

HISTORY OF CONSULTATION PSYCHIATRY:

The terminology of "liaison psychiatry" was primarily utilized in 1939 by Billings. After that, it has only been used in recent times. The main consideration was observed for a comprehensive diagnostic assessment of the patient on the basis of advice provided by a non-psychiatric physician. Consultation Liaison Psychiatrists in the 1950s and 1960s proposed several consultations: Patient-centric, crisis-centric, consultee-centric, situation-centric, and extended Psychiatric consultation.

(b) the crisis-centric approach in which the consultant can do a quick examination of a patient's illness and conjugant psychotherapy is required. (c) consultee-centric consultation, in which the consultant's observation of the Patient's Problem is addressed. (d) a situation-centric consultation is mainly based on the close communication of the clinical team members and the patients, and (e) an expanded psychiatric consultation can be deemed as the inclusion of both Patient's Family and clinical healthcare team members.

Liaison research can be of two types: evaluative studies and clinical research at the intersectional connection aligning the field of medicine and clinical psychiatry. Evaluative studies involve research about Psychiatric morbidity in the clinical population of those who seek consultation from non-psychiatric physicians.

And (ii) research at the interface between medicine involves aetiology, therapeutic response outcome, and Psychiatric complications due to physical illness. [2]

Lipowski discusses that the secondary and primary function of C-L psychiatry is teaching. CL psychiatrists should impart education to various students pursuing clinical courses and the residents. Psychiatric residents. It is essential and should be

done during CL rotations.

C-L psychiatry involves dealing with the Patient's reaction to the illness, mechanisms for coping, caregiver burden, psychiatric complications on the physically ill patients, consumption of psychotropic drugs, and the implementation of various behavioural therapeutic interventions and which are also related to the medical/surgical problems in patients.

EPIDEMIOLOGY

DELIRIUM:

The condition of Delirium or also known as the acute state of mind being confused is a medical emergency in which there is a clouding of consciousness accompanied by auditory or visual hallucinations, Delusions, impaired recent memory, and disoriented to name, place, and person. Patients with Delirium can have either increased or decreased [hypoactive Delirium] Psychomotor activity. They have sleep disturbances, confusion, irritability, etc. Delirium patients typically have worsening symptoms at night, becoming more agitated or restless, commonly called sundown phenomena.

Usually, Delirium is quite common in intensive care settings. Causes for Delirium include Electrolyte disturbances, infections, drug interactions, post-operative period, arrhythmia, reduced sensory input, old Age, dementia, stroke, fractures, neurological diseases, Alcohol withdrawal, and severe medical conditions. Delirium can be superimposed on dementia as well. Complete Hemogram, Random blood glucose, ECG, and Arterial blood gas analyses can be sent. If there are abnormalities, they should be corrected and managed accordingly.

Since Delirium can be due to multifactorial causes, it can be resolved by treating the cause. Sometimes untreated Delirium is indeed fatal. Hypoactive Delirium is often overlooked since the Patient looks as if sleeping and also has slow speech and apathetic mood but is delirious. Hence it is quite vital to check orientation in Intensive care units regularly. Treatment includes reorientation to the surroundings. Low-dose Antipsychotics are beneficial for patients with perceptual abnormalities, Agitation, and reversal of the sleep-wake cycle.[3]

In a study by Samer El Hayek on liaisons offering psychiatry consultation mainly during COVID-19 times, Delirium is the most common referral. The Hypothesis is likely that the state of confused mind or Delirium usually developed at enhanced rates during COVID-19. [4]

According to Wang C, patients with a positive COVID-19 and a diagnosis of delirium are at greater risk for a more serious infection, longer hospital stays, admission to the intensive care unit, and death. Therefore, the primary objective should be early recognition and treatment of delirium.[5]

Key findings from a systematic review and meta-analysis study were focused upon, y included the fact that despite the use of antipsychotics, which might have adverse consequences, including cardiac issues, delirium does not go away.[6] In [a] study by E. Delgado-Parada, it was found that during the COVID pandemic, the referral

to consultation liaison psychiatry services among Delirium 9.4% are more predominant, followed by adjustment disorders 7.8%. Many patients admitted were old. [7]

SUICIDALITY:

Many suicides are either due to depression or impulse attempts. Risk factors include loneliness, Bereavement, financial loss, severe and chronic medical conditions,

Physical/verbal abuse, etc. Suicide is a Psychiatric emergency. If warning signs are not noticed, it will be at the cost of losing a life. The most vulnerable

populations are marginalized groups, adolescents, the geriatric population, and physically challenged people.

Although previously, as per the Indian Penal Code [IPC] 309, suicide was a crime, the Mental Healthcare Act [MHCA] in 2017 was passed by the Indian Government. Among the many provisions of the act, Section 115 legalised medical assistance in dying by suicide. As a result, the victim of the crime will experience less trauma as a result of this. For accurate diagnosis and early treatment, specialists in the field of mental health should regularly update their knowledge.

A patient's suicidal attempt should be assessed thoroughly by the Psychiatrist through careful History taking and examination.Past history of previous suicidal attempts is a risk factor for another attempt. After examination, whether the attempt is alethal attempt to die, nonsuicidal self-injury, or an accident should be determined for further course of action.

When a patient is admitted to the hospital

After the patient has been stabilisedmedically, after a suicide attempt, they may be sent to a mental health facility if there is a significant risk that the patient would attempt suicide again while in the hospital. Repeated acts of self-harm need to be stopped before they start.[8] According to research by Kumar *et al.,* poisoning (50%) and drug overdose (35%), voluntary hanging (10%), Using sharp instruments, drowning, and falling from a height (5%) are among the most common means of attempting suicide. In addition, 48 percent of the people who participated in the study were found to have a mental health condition.

NONSUICIDAL SELF-INJURY:

The term "nonsuicidal self-injury" (NSSI) is used to describe when someone intentionally causes harm to themselves without suicidal intent. Some of the most commonly observedbehavioural presentation features of this type of injury can be noted as cutting, burning, scratching, and banging or hitting. Another common presentation is self-harm and harm to individuals who are within the close vicinity of the vulnerable individual.[10]

NSSI is correlated with emotional and psychiatric distress,[11] it can increase the chance of suicide[12] Adolescents are the most involved in NSSI. [13]

NSSI participants should not, ideally, make the initial choice to end their lives. One does not have the option of ending their own life in this way. This is mostly a defence mechanism to temporarily relieve an individual's stress and suicidal ideation.[14] Dialectical behavioural therapy targets Patients who have made a Suicidal attempt and NSSI by reducing emotional pain through DBT-based coping skills.[15]

In a study done by Anju Poudel, it was found that the presence of both NSSI and suicidal behaviour [S.B.] is usually on the higher side amongst adolescents. Depression was significantly correlated with NSSI and S.B.

This behaviour was noted to be significant amongst males compared to their female counterparts. Patients with a prior NSSI diagnosis were more likely to develop SB.[16]

ALCOHOL USE DISORDER

HISTORY OF ALCOHOL:

Drinking has been present for the past 12,000 years, starting from ancient civilizations like the Greeks, Who specifically lived where they could cultivate the ingredients for Alcohol. Romans began to use Alcohol as well. Alcohol continued to grow leaps and bounds in the Middle Ages and flourished in the Renaissance around the 15th to 16th centuries. Alcohol was prescribed as a medication by Physicians. Throughout the years, lots many products have been promoted without knowing their significant side effects in the long term, and Alcohol is one of them. In the 17th Century, Wine was created by English people by fermenting yeast. It grew till the 20th century. After research advances, many countries started to prohibit Alcohol. [17]

In recent times, it has become that Alcohol is enjoyed socially hence the risk of people underestimating their issues with Alcohol and consequently decrease in treatment-seeking as well only if Patients have problems like Gastritis, Seizures, confusion, disorientation, Psychosis which people come to the hospital to seek treatment.

Alcohol is a psychoactive substance that can be very addictive. Alcohol use disorders (AUDs) can cause a financial burden and interpersonal relationship issues and decrease productivity. It has a greater impact on the personal areas of an individual's life. According to research by Bridget F. Grant *et al.,* People with alcohol use disorder for 12 months are at increased risk for developing mood and anxiety disorders, including Major Depressive Disorder, Panic Disorder, Antisocial and borderline Personality Disorders, Bipolar Affective Disorder Type I, and Generalized Anxiety Disorder. Mental and social functioning were also much lower. Multiple substance

disorders were linked to AUD. [17]

According to CDC data, drunkenness can increase the risk of car accidents, unintentional falls, drownings, domestic violence, and intimate partner violence. Since alcohol is a depressant of the central nervous system, it increases the likelihood that sexually risky behaviour would occur, which could lead to unprotected sexual encounters. As was previously mentioned, these are only temporary results of alcohol consumption. Alcohol usage during pregnancy increases the risk of complications like miscarriage, stillbirth, and foetal alcohol syndrome. Blood alcohol content increases are associated with ataxia, slowed judgement, and slowed reaction times. If the blood alcohol concentration (BAC) is above 300–400 mg/dL, it can significantly increase sedation, impede respiratory drive, and even cause coma or death in a normal human being.

Alcohol poisoning can also be deemed as a medical emergency which usually results due to increased levels of blood glucose levels. Long Term Health Risks include Hypertension, cardiovascular disorders, Liver disorders, Pancreatitis, and Cancer of the breast, mouth, throat, oesophagus, Larynx, liver, colon, and rectum. Alcohol can decrease immunity increasing the chance of developing diseases such as tuberculosis. [18]

In alcohol metabolism, ethanol is metabolized to acetic acid from three different enzymatic systems in the liver cells: 1. Alcohol dehydrogenase (ADH) metabolizing alcohol to acetaldehyde.

PSYCHIATRIC COMORBIDITIES:

Heavy alcohol consumption can cause psychiatric problems like depression, anxiety, and psychoses, typically called alcohol-induced disorders. People with substance use disorders are a risk of Psychiatric comorbidities and vice versa. Alcohol withdrawal

can be simple or complicated withdrawal. It is secondary to either decreasing the quantity of Alcohol taken or stopping the Alcohol suddenly. While simple withdrawal may not be as severe as complicated, both need prompt and adequate treatment. [20]

NEUROLOGICAL AND MEDICAL COMPLICATIONS OF ALCOHOL:

Alcohol can cause pellagra, fetal alcohol syndrome myopathy, alcoholic dementia, alcoholic cerebral atrophy, cardiomyopathy, anemia thrombocytopenia, leukopenia, meningitis hypothermia hyperthermia hypotension, respiratory depression, Toxic Encephalopathy, electrolyte imbalances including Hypoglycaemia, Hyperglycaemia, hyponatremia, hypercalcemia, hypomagnesemia hypophosphatemia, increased incidence of trauma like hematoma, spinal cord injury, liver disease, gastrointestinal diseases, malabsorption syndrome, pancreatic encephalopathy, compressive neuropathies.[21]

CATEGORIZATION OF ALCOHOL USE DISORDER:

According to ICD 10 criteria, Alcohol is characterized by some diagnostic guidelines, which include,

1. Strong craving or urge to consume the substance.
2. Difficulty managing the use of the substance in terms of when and how much is consumed.
3. Use of the substance to alleviate or prevent withdrawal symptoms when use is reduced or stopped.
4. Need for higher doses of the substance to achieve the same effects as before.

5. Decrease in participation in other enjoyable activities or interests because of substance use, as well as
6. more time and effort dedicated to obtaining and consuming the substance.

Clinically and diagnostically, Alcohol harmful use is less severe than alcohol dependence syndrome. [22] At lower amounts, alcohol can have an anxiolytic effect, causing one to feel relaxed and less inhibited in social situations. Sedation, decreased respiratory drive, unconsciousness, and even death can occur at blood concentration levels above 300–400 mg/dL. It is important to note that both pharmaceutical and nonpharmaceutical approaches are used to treat alcohol use disorder. Drug treatments can be used in conjunction with other therapies, including rehabilitation and detoxification.

Nonpharmacological interventions aim to reduce alcohol consumption to increase the period of abstinence. The Patient is encouraged to be compliant with the medications, and the Family should be given Psychoeducation regarding the same. Family plays a huge role in the Patient maintaining abstinence in terms of reducing
criticality and being supportive of the Patient. [23]

Benzodiazepines like Lorazepam, Chlordiazepoxide, and Diazepam remain the first line of treatment intervention for enabling effective withdrawal of Alcohol for patients being managed within in-patient and outpatient clinical settings. They have the potential to be habit-forming; hence it is to be given in the short term only. They will be tapered according to the symptoms or front loading in high-risk patients. Vitamins like Thiamine must be given to replenish storage and to prevent Wernicke Korsakoff's Syndrome. Anti-craving Medications need to be started, which include Baclofen, and Naltrexone needs to be started to reduce the desire to take Alcohol. It should be continued after discharge to decrease the chances of relapse. Aversive agent

Disulfiram should be only started if necessary. Patients are motivated to abstain, and patients should be warned before starting the drug. [21] Understanding one's addiction, increasing one's drive to change harmful behaviours, instructing one in healthy coping mechanisms, and optimising one's recovery are all goals of behavioural therapy for addiction. [22]

TWIN STUDIES:

Research on twins has shed light on the significant role that hereditary factors play in addiction. When comparing monozygotic and dizygotic twins' groups, it was found that monozygotic twins had greater concordance for addiction. [19] According to the review by Javier Romeo, Alcohol Consumption in Moderation can have a protective effect on immunity. The types of Alcohol mentioned are wine and beer, and it is for adults to consume, not for children, adolescents, and the elderly.[24]

ADOPTION STUDIES:

Children of parents who had alcohol disorders were adopted, and no contact with their biological parents was studied. It can probably answer the question of whether the disorders develop due to biological abnormalities [Nature] or Environmental causes like peer pressure, psychological stressors, etc. [Nurture]. [19]

NICOTINE USE DISORDER:

Tobacco is used by Native Americans and Europeans. In the 1950s, It was assumed that tobacco smoke was deemed addictive. And it has the potential for increased risk of lung cancer. By 1971, New evidence brought to was light which found that Nicotine present in tobacco is responsible for addiction. If Nicotine is stopped, Withdrawal symptoms occur, and it was studied. The Fagerstrom Test of Nicotine Tolerance and Dependence was established as the gold standard for measuring nicotine addiction. Researchers were able to analyse Nicotine addiction treatment

options because of this study. [25]

According to the Food and Drug Administration [FDA], tobacco plants contain extremely addictive nicotine. Cigarettes, cigarillos, smokeless tobacco, electronic cigarettes, hookah tobacco, chewing tobacco, and most e-cigarettes contain nicotine. Smoking can cause nicotine addiction.[26]

EPIDEMIOLOGY:

Tobacco usage is the primary avoidable factor in cancer development. Clinical studies from the World Health Organization confirm the widespread use of tobacco, estimating that 1.27 billion people smoke cigarettes every day. Nearly 5.4 million fatalities annually can be attributed to tobacco use alone, and if global tobacco consumption continues at its current rate, one billion lives could be lost by the end of the millennium.

E-Cigarette [Electronic Cigarette] seems to be the trend and is on the rise in many countries. Nicotine can cause many adverse effects, which include Lung cancer, and it affects the Cardiovascular system, Reproductive system, and Kidney.

Nicotine can be absorbed by the oral mucosa, lungs, skin, or gastrointestinal tract. Desensitization of inhibitory GABAergic neurons can be induced by persistent activation. As a result, dopamine's inhibitory impact may be diminished. Resulting in nicotine cravings are possible. The CYP2A6 gene has been associated leading to heritable dependence on Nicotine.[27]

Nancy A Rigotti discusses that Nicotine dependence should be treated with both pharmacological and nonpharmacological methods. The first step is asking the Patient about Nicotine use, initiation, Age of onset, withdrawal symptoms, Cravings, attempts to quit using Nicotine, Frequency, and Types of Nicotine used; hence many users consume more than one type of Nicotine. Second-hand cigarette smoking should be

asked about as well. Giving Psychoeducation about the Harmful effects of Nicotine by Physicians to the Patient has a possibility of reducing the use of Nicotine or Abstinence. After assessing the patient's motivation to stop nicotine and their willingness to begin treatment, it is important to brief them on Nicotine replacement therapy.

Pharmacological treatment includes using Nicotine Patches, Chewing gums, and lozenges. The use of Drugs like Bupropion or Varenicline is beneficial. The use of Pharmacotherapy in Nicotine Replacement therapy is recommended for at least a minimum of three months. It can be extended up to a year if there is the possibility of relapse. If comorbid depression is present, thenthe Continuation of therapy is recommended. Others include E-cigarettes, Nortriptyline, Clonidine,Selective serotonin reuptake inhibitors, and Nicotine Vaccine.

E-cigarettes are another effective option for managing smoking addiction and extensive use of different types of smoking methods by the subject. However, the long-term safety of the drug is uncertain. The role of e-cigarettes in Nicotine replacement therapy [NRT]is still unclear. A meta-analysis of previous studies supports their claims. Although this may not work as a treatment, it can help avoid future complications and improve clinical results. Multiple study participants were found to have maintained their e-cigarette use following the intervention, according to a second meta-analysis. Since the long-term effect of E-cigarettes is unknown, this could be risky.[28]

CANNABIS USE DISORDER:

Cannabis use dates to 12,000 years in Central Asia, and studies suggest that it was cultivated by farmers as a part of fooding options. Ancestors carefully cultivated in a way that a more psychoactive THC female counterpart was chosen rather than the

Male cannabis plant, which is less psychoactive. It is possible that the fact that the euphoric effects of heated cannabis are discovered in the resin generated by female plants is just a coincidence. Lord Shiva of Indian mythology is claimed to have had a taste for marijuana. For thousands of years, people have relied on the healing benefits of cannabis in Ayurveda to alleviate symptoms, including nausea, vomiting, anxiety, poor appetite, insomnia, muscle tension, and pain. Ancient references to cannabis use can be discovered in multiple historical records from China, Rome, Saudi Arabia, Japan, Austria, and England. British physician J. Russel Reynolds recently wrote an article for the Lancet Journal in which he discussed his decades of experience with cannabis. He found that the major disadvantage was that Cannabis only could be used with THC, the agent which causes psychoactive properties which affected the dosing at the time. Separation of the psychoactive compound was found many years later, in 1964. He had found cannabis to be useful in facial neuralgia, migraine, dysmenorrhea, numbness, and other paraesthesia.

TREATMENT OF CANNABIS USE DISORDER:

Pouliquen reviewed that Interventions for the treatment of cannabis use disorder include Cognitive Behavioural Therapy, Motivational Interviewing, Therapy based on social support, and Psychoeducation. [30] The term Medical Marijuana refers to the use of oral cannabinoids, which are non-intoxicating products used to alleviate symptoms. Epidiolex is the only FDA-approved CBD medicine, and it's a pure version of CBD used to treat Lennox-Gastaut syndrome and Dravet syndrome.

Literature states that cannabis can have anxiolytic, antipsychotic, antidepressant, and anti-craving qualities. It is also used for sleep disorders, PTSD, ADHD, and skincare.

Common ways to use Cannabis are through sublingual, oral, edible products, smoking, Topical lotions, ointments, and capsules. Adverse effects of using CBD can

include sedation, diarrhoea, sleep disturbances, weight loss, and the chance of psychoactive effects if used with THC.

Concerns for using CBD in pregnancy include affecting the foetal brain. CBD at moderate doses does not have addiction potential, but at high doses, it can have some subjective effects. Vapourised CBD can evoke a feeling of 'high.' Patients with underlying liver disease should be cautious in using CBD. [31]

A case report by NantananJengsuebsant observed a man who had two years of cannabis use had an increased amount of smoking cannabis one day, following which he felt an erection followed by a sharp pain in his penis.He severed his penis using scissors, eliminating the pain. His psychosis was determined to be cannabis-related. An immunoassay for THC in the patient's urine was positive.[32]

Among the 45,570 Swedish conscripts Sven Andréasson and his colleagues followed for 15 years, 21 cases of schizophrenia were found among the 752 who had used cannabis more than 50 times. This finding is proportional to a risk that is six times the group mean. Even though they had a greater than three-to-one risk of developing another psychiatric disorder, none of these 21 participants had been diagnosed with schizophrenia when they were first screened at age 18. The authors interpreted the results as causative, suggesting that cannabinoids play a role in the development of schizophrenia (Hypothesis 1). However, they also admitted the Second Hypothesis, which states that individuals with certain personality or other traits prior to the start of schizophrenia are more likely to experiment with cannabis. [33]

Patients with first-episode psychosis who do not respond to therapy with antipsychotic medicines, as well as those who are hesitant to use antipsychotics due to worries about side effects and stigmatization, may benefit from CBD, as discussed in a review by Edward Chesney.[34]

OPIOID USE DISORDER:

HISTORY:

In the 1990s, Opioid pain medications were used to reduce cancer and acute pain. Increased opioid use started, Oxycontin was approved, and In 1998 Fentanyl was approved for treating cancer pain. Fentanyl was approved in 1998. It carried a risk of potential abuse. It was later included in the category of Transmucosal immediate release Fentanyl Products. But in ethe early 2000s, overdose-related deaths became more especially related to OxyContin. Additional warnings to Label Oxycontin as a potential abuse drug were given by FDA. [35]

In 2017, opioid-related mortality reached an all-time high, and the U.S. government declared a public health emergency. In 2016, 64,000 people died from fentanyl overdoses, accounting for 20,000 drug overdose deaths and 42,000 opioid-related deaths. Opioids were considered safe and used to treat chronic pain a decade ago. However, opioid use is rampant and should be controlled by strict policies. Utmost importance should be given to controlling illicit drug use. Multidisciplinary teams, the general public, legislators, pharmaceutical companies, and educators must ensure the epidemic does not continue. [36]

Several case studies have demonstrated that opioid painkillers are among the most effective treatments available, although the consequences of long-term use remain debatable. There is a concern for overtreatment or undertreatment of the condition. The treating physician, especially those involved in pain management, should follow guidelines. Other novel medications should be brought to market that is more effective and has lesser side effects.[38]

MAJOR DEPRESSIVE DISORDER:

HISTORY:

Kenneth S Kendler discusses Three phases of the Evolution of Melancholia categorized according to years. All of the important authors of the first historical epoch, which lasted from 1780 to 1830, stressed the mental disorder nature of melancholy, saying that it was often accompanied by a lack of interest in life.

William Cullen's (1710–1790) in his medical nosology, Melancholy, was categorized under the order and the class of neuroses nervous diseases. "A disturbance of the operations of the judging faculty of the mind, without fever or tiredness" is how it is described.[41]

Melancholy was defined as "partial madness without dyspepsia," the omission of which distinguished it from hypochondriasis. According to Cullen, someone with partial insanity has delusions about only one specific topic while their other cognitive abilities remain unaffected.

Hypomania is a form of depression first identified and named by Jean Esquirol (1772-1840).[43] Melancholy, also known as hypomania, is a mental disorder that we might describe as partial, chronic delirium in the absence of fever and the maintenance of a sorrowful, debilitating, or oppressive passion.[44]

Phase 2 saw a challenge to the prevalent notion that melancholia is a main intellectual illness. Depression, as it is currently understood, was first conceptualized by Joseph Guislain (1789-1860). He went on to describe the new category of non-delusional melancholy as a pathological emotion that is characterized solely by an exaggeration of affective sensations such as sadness, grief, anxiety, dread, and panic. Mental capacity is not much diminished in this condition.[45]

In Phase 3, Richard vonKrafft-Ebing (1840–1902), one of the neuropsychiatrists of the late 19th century, said, "The essential Psychic pain in its most basic form, or

mental depression, is a common symptom in melancholy insanity. Melancholia, which might be compared to peripheral neuralgia, turns ordinary psychological sensations into agony and misery. The experiences of those who are affected are repeatedly "painfully distorted," and "all his relations to the external world are different...he is unfeeling, homeless...with unbearable despair." [46]

Major depression is a common, severe, and recurring illness that has been linked to lower quality of life,impaired role functioning, increased medical morbidity, and death. [47] WHO reports that depression is the fourth leading cause of disability worldwide. By 2020 Global[48] predicts it will have surpassed polio as the second largest cause of disability worldwide.

AGE OF ONSET:

Most cases of anxiety and depression, disrupting behavioural problems, and Severe Depressive Episodes [MDE] occur in late adolescence, early middle age, and late adulthood, while the majority of cases of substance use disorders occur during these same time periods.[51]

Community epidemiological research consistently finds a link between depression andage, gender, and marital status. About twice as many women as men suffer from major depression; the risk is higher among the divorced and separated than among the married, and the occurrence of major depression tends to decrease with age. However, the majority of this data comes from research done in Western nations. The prevalence of depression gets lesser as people get older.

EDUCATION:

Numerous research demonstrates a link between early mental illness start and dropping out of school. In this research, the strongest connections between disruptive behaviour disorders and bipolar disorder and MDD (and in some studies, MDE) also

considerably increases the probability of not finishing secondary school by about 60% compared to otherwise comparable kids in high-income nations. However, these negative impacts are less pronounced in low-income countries.

MARITAL STATUS:

Numerous research has looked at links between mental health issues before marriage and later marriage. Early-onset mental problems indicate a low likelihood of ever being married, although they are either unrelated to or positively correlated with early marriage (before 18), which is associated with a number of poor consequences, and negatively linked with on-time and late marriage, which is associated with a number of positive consequences (e.g., social support, financial security). MDD is the most serious premarital mental illness. Divorce is substantially correlated with premarital mental illness.

EMPLOYMENT:

Although there is consensus that melancholy and joblessness go hand in hand, most studies have looked at how the former can lead to the latter rather than the other way around.[52]

ENVIRONMENTAL FACTORS:

The majority of life's traumatic events, such as losing a job, having trouble making ends meet, dealing with a chronic or life-threatening illness, witnessing or experiencing violence, getting divorced, or losing a loved one, happen to adults. Stressful life experiences that occurred around the time of development of MDD [Major Depressive Disorder], often during the preceding year, were the primary focus of the earliest epidemiological research.

Recent studies have linked adverse childhood experiences to major depressive disorder in adulthood. There is undeniable evidence that the frequency and intensity

of unpleasant life events increase the likelihood, severity, and chronicity of MDD.[54] Neglect, physical or sexual abuse, witnessing marital violence, or losing a parent at a young age are all examples of traumatic experiences.

The integrated neurobiological paradigm that seeks to explain the long-term effects of early trauma focuses on the hypothalamic-pituitary-adrenal (HPA) axis. Multiple animal investigations have revealed that early-life stress leads to persistent increases in the activity of brain circuits containing corticotropin-releasing hormone (CRH). [55]When exposed to standardised psychosocial stressors or following endocrine tests intended to reduce HPA axis activity, those who were physically or emotionally abused as youngsters have considerably higher HPA axis activity, according to clinical investigations. [56]

TYPES OF MAJOR DEPRESSIVE DISORDER:

There are three distinct forms of depression recognised by the ICD 10 criteria. Major criteria include depressed mood, lack of interest and enjoyment, increased fatigability, and other symptoms in mild, moderate, and severe cases.

a) Reduced ability to focus and concentrate
b) a loss of pride in oneself, and confidence
c) beliefs about one's own shame and unworthiness (even in a mild type of episode).
d) A negative outlook on life in general.
e) Suicidal notions or attempts, or thoughts of doing so.
f) Disturbed sleep
g) loss of appetite

The diagnostic threshold for major depression across all three severity levels is two weeks. If the signs and symptoms are severe, a quicker time frame for diagnosis is

appropriate. Anhedonia, a lack of emotional responsiveness, waking up two hours or more early than normal, exacerbation of depressive symptoms in the morning, psychomotor slowness or agitation, marked loss of appetite, weight loss (typically defined as 5% or more of body weight in the last month), and marked loss of libido are all examples of somatic symptoms associated with major depressive disorder. Only after four or five of these symptoms have been met for doctors consider this Somaticcondition to be present.

MILD DEPRESSION:

Two of the Major criteria and at least two of the minor criteria are needed to clinically diagnose a Mild depressive Episode. The specifiers are With and without the somatic syndrome.

MODERATE DEPRESSION:

Two of the Major criteria and at least Three of four of the minor criteria should be present to diagnose a Moderate depressive episode. The moderate episode can be with or without the somatic syndrome.

SEVERE DEPRESSION WITHOUT PSYCHOTIC SYMPTOMS:

Suicide is a real risk in extreme situations because of the accompanying loss of self-esteem, feelings of uselessness, rage, remorse, and hopelessness. There will be symptoms of the somatic syndrome. Those affected personally and professionally would suffer greatly. The patient would have Biological function disturbances as well.

SEVERE DEPRESSION WITH PSYCHOTIC SYMPTOMS:

Delusions and hallucinations are hallmarks of a manic or manic-depressive episode. The patient may internalise false beliefs about sin, material deprivation, and personal accountability as a result of these delusions. Most voices heard in a hallucination are malicious or accusing. Stupor can result from severe psychomotor impairment.[57]

OTHER DEPRESSIVE EPISODES:

ATYPICAL DEPRESSION:

Atypical depression is characterized by increased sleep, appetite, Significant weight gain, and Leaden paralysisIn which increased weight is experienced in the legs and arms. Increased rejection sensitivity, perplexity, Agitation, paranoid features, respond well to electroconvulsive therapy (ECT). It is commonly experienced in Adolescents. It responds well to MAOI inhibitors compared to Tricyclic Depressants. Atypical depression has been found to affect women at a rate almost four times higher than that of men.[58]

POST-STROKE DEPRESSION:

Depression was noticeably more prevalent in stroke victims than in people with similar physical limitations. According to the first comprehensive longitudinal research of PSD, the severity of Substantial impairment in everyday living tasks, social interaction, and cognitive performance were all linked to the

presence of PSD [59.]

In a review article by Robert G Robinson, he discusses that treatment for post-stroke depression is by treatment of SSRI. But some risks such as Electrolyte imbalances, Falls, risk of stroke, and Myocardial infarction can be likely. Hence preventive measures are needed. [60]

POSTPARTUM DEPRESSION:

Postpartum depression onset occurs within the first four to eight weeks after delivery. It could be triggered by a postpartum decline in reproductive hormones. Patients who are at risk for developing postpartum depression are strong family history or previous

history of depression for the Patient.[61]

MAJOR DEPRESSIVE DISORDER MANAGEMENT:

Depressive disorder is categorized into mild, moderate, and severe. While Moderate to Severe depression can be treated with Pharmacotherapy, it would be best to treat Mild depression with Psychotherapy alone. [62] Drugs like SSRIs and SNRIs block the reabsorption of serotonin and noradrenaline, respectively (SNRIs). There are a variety of approaches to psychotherapy, including interpersonal therapy, CBT, problem-solving therapy, MT, ACT, and psychodynamic therapy.

COGNITIVE BEHAVIOURAL THERAPY:

Cognitive-behavioral therapy can be useful in identifying the negative, distorted patterns of thought that cause depression and teaching the coping skills necessary to test and question these thoughts and substitute them with more realistic positive ones.

BEHAVIOURAL ACTION TREATMENT:

The goal of behavioural activation treatment is to increase the Patient's enjoyment or sense of mastery of their positive behaviours. The focus of this therapy is typically on recognizing and challenging avoidance mechanisms.

PSYCHODYNAMIC THERAPY:

In order to better understand how emotions, thoughts, and past experiences have contributed to current issues, The Patient in psychodynamic therapy is assisted in exploring and gaining insight into these patterns. A person can cope with and change these tendencies by being aware of them.

PROBLEM-SOLVING THERAPY:

Patients who receive problem-solving therapy learn an organized set of abilities to come up with original solutions to problems. Difficulties in recognizing and going

around potential roadblocks to achieving objectives and making wise decisions.

INTERPERSONAL THERAPY:

The goal of interpersonal therapy is to assist clients in recognizing and resolving issues that arise in interpersonal interactions, changes in social roles, and decreased or impoverished relationships.

COGNITIVE BEHAVIORAL (Mindfulness)THERAPY:

Mindfulness, which originates primarily in Buddhism and other contemplative faiths, is a meditation technique in which one learns to observe one's inner experience without judgment or attachment to any particular outcome.[63] The best treatment for major depressive disorder would combine pharmaceuticals with talk therapy.

RECURRENT DEPRESSIVE DISORDER:

Repeated periods of depression without a history of independent episodes of mania or hypomania describe the illness known as Recurrent depressive disorder, which is classified in ICD 10 as mild, moderate, or severe depressive episodes. Onset typically occurs in one's 50s. Less frequent episodes last anywhere from three months to a year. Patients typically make good recoveries between episodes; however, some, especially as they get older, may have greater risk of recurrence of depression. Stressful personal conditions often come just before an individual's first episode, regardless of its severity. Manic episodes should lead to a diagnosis of bipolar affective disorder. Mild, medium, extreme, and remission are the categories used to classify recurring depression episodes.[64]

There is conflicting evidence on the relationship between experiencing a traumatic incident and having a higher risk of experiencing a recurrence in the absence of social support. Decreased functioning in areas such as work, relationships, and leisure time

after full remission increases the risk of a recurrence of major depressive disorder. There is some evidence that a personality disorder can foretell future disorders. A higher rate of recurrence was associated with cluster B and C personality types in a trial of 50 patients that lasted 33 to 84 months. Conflicting Evidence in other studies has been found as well. Additionally, the age of the index episode does not appear to be a factor in recurrence.[65]

BIPOLAR AFFECTIVE DISORDER:

Bipolar disorder is characterised by episodes of extreme depression (accompanied or unaccompanied by anxiety) and exhilaration. When people's moods shift as a result of stress, they also tend to become less active overall. Most of these conditions repeat, with stress often precipitating a new episode. Single-episode illnesses have been differentiated from multi-episode disorders like bipolar disorder because a large proportion of individuals have only a single episode of illness, and severity is prioritized.

MANIC EPISODE:

Improved disposition and a corresponding surge in both output and velocity of physical and mental activity. All the subcategories in this group should be reserved for a single manic episode. Bipolar affective disorder describes someone who has had more than one episode.

MANIA WITHOUT PSYCHOTIC SYMPTOMS:

Exuberance, ranging from carefree abandonment to nearly unbridled enthusiasm, characterises the patient's state of mind. Excessive activity, rushed speech, and a reduced need for sleep are all side effects of elation and a surge in energy. Disruption of normal social inhibitions, inability to maintain concentration, impulsivity, increased self-esteem, Abnormalities of perception such as experiencing colors as

unusually brilliant, excessive spending, or behaviour that is rude, sexually aggressive, or otherwise out of place. The mood during certain manic episodes is irritable and suspicious rather than elated. In most cases, the initial episode happens between the ages of 15 and 30, though it can happen at any point from late childhood through the seventh or eighth decade. To qualify as an episode**,** it must last for at least a week and be severe enough to significantly impair daily life.

MANIA WITH PSYCHOTIC SYMPTOMS:

Grandiose beliefs and exaggerated self-worth can turn into delusions, and hostility and suspicion can turn into persecution fantasies. In extreme situations, grandiose or religious illusions of identity or role may be prevalent, and the person may become incoherent due to a flight of thoughts and pressure on their speech. Neglecting to

Eat, drink, or practice good hygiene can result in dangerous states of mind, while intense and prolonged physical activity and excitement can cause hostility or violence. Associated with decreased Self-care and dehydration.[64]

Initial symptoms of bipolar disorder typically appear in one's early twenties. Community studies typically show much younger ages of onset and highlight the prevalence of manic and hypomanic episodes, even in teenagers and young adults. First onset of mania and hypomania in 3021 people participating in prospective, long-term community research (EDSP, Early Developmental Stages of Psychopathology Study). 2.3% of people in this age range reported having hypomanic episodes at least once, but only one point five percent reported experiencing full-blown manic episodes. There was a mean age of 14.9 years for the beginning of hypomania

and 14.5 years for mania in these individuals. There were 11.4% new instances of unipolar major depression in 2015 (mean age of onset of 17.2 yr). Both hypomania and mania were predicted to have a 4.7% and 2.6% cumulative lifetime occurrence

throughout two 5-year follow-up periods.[66]

TREATMENT OF BIPOLAR DISORDERS:

Treatment included the use of lithium as well as second-generation antipsychotics such as carbamazepine, valproate, and chlorpromazine. Overall, 68 randomized controlled trials examining 13 medications were evaluated in a meta-analysis of combination therapies (16, 073 participants). This research found clinically significant variations amongst the drugs studied, both in terms of their effectiveness and their safety profile. Manic episodes don't seem to respond as well to lithium or anticonvulsants as they do to antipsychotics. The medications olanzapine, risperidone, and haloperidol are also beneficial in treating schizophrenia. As a result, antipsychotic drugs are often the most effective short-term therapeutic treatment, while lithium may be preferable when continued pharmacological therapy is desired due to better long-term evidence of effectiveness.

Lithium is used as a maintenance treatment for bipolar illness. A meta-analysis of five placebo-controlled lithium-maintained trials (n=770) found that lithium reduced the risk of manic relapse by 38% and the risk of depressive relapse by 28%. In randomized controlled trials, lithium was the only anti-suicide medicine to reduce suicide risk by more than half. Lithium has a few drawbacks, such as a low therapeutic index and adverse effects on renal function. Although the likelihood is smaller, using lithium during pregnancy can result in congenital abnormalities in the foetus. Before stopping lithium, the risk-benefit ratio should be taken into account. Before and during treatment, calcium concentrations should be evaluated, as well as thyroid function tests and parathyroid hormone blood tests.

Valproate's role in long-term prevention is still poorly supported by placebo-controlled research. According to the BALANCE experiment, lithium prevents mood

episodes more effectively than valproate. Lithium plus valproate therapy is superior to valproate monotherapy as a form of treatment. Antipsychotics are the most effective therapies for acute mania; for this reason, they are continued even after remission. Despite the lack of long-term studies, lithium is a more effective antipsychotic than other drugs. Hence the role of antipsychotics in long-term therapy is questionable or unclear.

PSYCHOTHERAPY FOR BIPOLAR DISORDER:

Family-focused therapy is based on the observation that carer anger and criticism increase mood disorder and schizophrenia relapse risk. Family-focused treatment includes psychoeducation, communication, and problem-solving for patients and carers. Family-focused therapy and pharmaceutical medication reduced relapse, rehospitalization, and severe symptoms in the 1-2 years after a manic, mixed, or depressed episode by 30-35% compared to case management28 or equally intensive solo treatment. Two randomized controlled trials with symptomatic bipolar I and II patients yielded these outcomes.

There is strong evidence linking alterations in circadian rhythms to mood instability in bipolar disorder. The connection between emotion and sleep. It appears that disturbances are reciprocal. Bipolar disorder recurrences and diurnal mood fluctuations are linked to polymorphisms in the CLOCK gene. In one animal model, mice with CLOCK gene mutations exhibited behaviourssimilar to manic episodes in humans (e.g., increased activity and decreased sleep), which were reverted by lithium administration.[67]

GENERALIZED ANXIETY DISORDER:

Persistent and continual anxiety are hallmarks of generalised anxiety disorder. These include anxiety that is all over the place (about money, family, health, the future), is

out of proportion, and is hard to regulate. The prevalence of GAD is high in primary care settings. which 7-8% of patients are affected. Patients rarely express concern about the disease. Physical symptoms are the most prevalent presenting condition in primary care (such as headaches or gastrointestinal problems). When children suffer from GAD, they may experience physical symptoms like stomach ache or other issues that could lead them to skip school. Thirty-five percent of people with generalised anxiety disorder also self-medicate with alcohol or other drugs. This pattern of use is associated with an increased risk of alcohol and drug dependence. Adverse childhood experiences, such as intimate partner violence, alcoholism, drug use,sexual or physical abuse, and neglect, are risk factors for generalised anxiety disorders, as are low socioeconomic position and a lack of educational opportunities.

Although Low mood might be hard to distinguish from nervousness due to various nonspecific symptoms, it is common for major depression to coexist with GAD.Fatigue and sleep disturbances can be associated as well. Generalized anxiety disorder is not characterised by persistent feelings of apathy. In contrast to the hopelessness that may be experienced by those suffering from clinical depression, patients frequently describe feeling helpless. Deliberate self-harm, including suicide attempts, is more common among people who suffer from generalised anxiety disorder. Differential Hypochondriasis, OCD, Social Phobia, and PTSD are all examples of diagnostic labels associated with GAD. Patients with GAD have increased amygdala activity in response to emotional faces, as detected by functional magnetic resonance imaging.

TREATMENT OF GENERALIZED ANXIETY DISORDER:

The Generalized Anxiety Disorder 7 (GAD-7) scale is a helpful, fast screening measure. The purpose of this assessment is to measure the intensity of the symptoms

and the success of the treatment.[65] Generalized anxiety disorder has a variety of potential treatments, but the first-line treatments are cognitive behavioural therapy and medication with an SSRI or SNRI. Both buspirone and pregabalin can be used as a supplementary or secondary therapy.[68]A high economic burden was related to GAD due to decreased work productivity and a noticeable impairment in role functioning and social life. GAD causes substantial social impairment on par with that caused by chronic somatic disorders.[69]

PANIC DISORDER:

HISTORY:

The concept of irritable heart syndrome may be the basis for panic disorder, which Jacob Mendes DaCosta (1833–1900), a doctor, observed in soldiers in the Civil War in America. Many psychological and somatic symptoms were present in DaCosta's syndromeSigns that are now part of the diagnostic criteria for panic disorder. Sigmund Freud first proposed the idea of anxiety neurosis in 1895, in which bodily and psychological problems are both severe and persistent.[70]

A panic attack is a sudden, sharp wave of extreme fear or discomfort that begin in a calm or apprehensive state. Usually, the symptoms peak within minutes and disappear within an hour. During the episode, a person exhibits at least four symptoms out of the thirteen symptoms listed below. Palpitations, Sweating, Tremors, shortness of breath, choking sensation, Chest discomfort or pain, nausea or discomfort in the abdomen, feeling dizzy, Feelings of heat or cold, Paraesthesia, Depersonalization or derealization, Fear of "becoming insane" or losing control, and Fear of death. One episode of a panic attack is not sufficient to make a diagnosis of the panic disorder. Patients report having frequent, unprovoked panic attacks, as well as anxiety about future attacks or unfavorable changes in behaviour connected to the attacks, for at

least one month.

EPIDEMIOLOGY:

An extensive review of 13 European research found a prevalence rate of panic disorder among the general population of 1.8% over a 12-month period. Panic disorder occurs among primary care patients atthe double the rate of the general population (4-8% vs. 2%-4%). The average first symptom appearance is between the ages of 24 and 25. Reduced incidence is seen in those over the age of 60. About 2% of males and 5% of females will get the condition in their lifetime. Agoraphobia is a complication of panic disorder that manifests as a person's avoidance of places where it would be difficult to exit in the event that they experience panic or other embarrassing symptoms. About a third of the population will have a panic episode at some point in their lives, making them more common than the panic disorder itself.

Instead of seeing a mental health professional, people with panic disorder frequently go to general physicians. People with persistent or unexplained symptoms of panic disorder frequently seek medical attention. Numerous emergency room visits and medical evaluations, the use of several drugs, and frequent tests to rule out medical illness. Electrocardiograms, Endoscopy, and cardiac tests are frequently taken.

Panic disorder and its differential diagnosis and panic attack causation sometimes coexist and are difficult to disentangle. Medical comorbidities include illnesses like asthma, COPD, arrhythmias, vestibular dysfunction, and gastrointestinal disorders like irritable bowel syndrome. Psychiatric comorbidities include mood disorders, anxiety disorders, PTSD, and substance use disorders. In an effort to cope, some people with panic disorder turn to substances like alcohol or sedatives. Substance usage may temporarily alleviate anxiety and panic symptoms, but this relief is often followed by a worsening of these conditions as blood levels of the substance are

reduced. Before deciding that someone has panic disorder, it's important to rule out other possible diagnoses. [70]

Pharmacotherapy includes treatment with SSRI, while other medications, including SNRI, tricyclic antidepressants, monoamine oxidase inhibitors, and benzodiazepines, have shown effectiveness in treating panic disorder. It is for people who have had a poor response to SSRIs. SSRIs are preferred over other antidepressants because of their comparatively low risk of side effects and safety during an overdose. SSRIs have undergone the most clinical testing of any medicine for panic disorder and have been found to be effective when compared to a placebo.

Headaches, agitation, Gastrointestinal distress, sleeplessness, and sexual dysfunction are typical SSRI adverse effects. All patients prescribed SSRIs under the age of 25 experience an elevated risk of suicidality; this risk is expected to be similar in those with panic disorder and depression.[71] panic disorder with agoraphobia is linked to high levels ofdistress, functional impairment, and social expenses. Cognitive Behavior Therapy (CBT) is used as a treatment and has been demonstrated in numerous research. The CBT regimens, however, that have been shown to be the most successful require regular exposure to the specific surroundings that the agoraphobic patient fears. Research is being conducted on repeated exposure through VR rather than in vivo. There has already been some encouraging research on the use of virtual reality and exposure treatment for anxiety problems. [72]

SOCIAL PHOBIA:

A prevalent disease known as social anxiety disorder (SAD), commonly referred to as social phobia, is marked by extreme worries of scrutiny, shame, and embarrassment in social or performance contexts, which can cause serious distress or functional impairment. Usually starting in childhood or adolescence, SAD can lead to significant

depression, substance misuse, and other mental health issues. If left untreated, the condition can be linked to. Significant functional impairment and a lower quality of life. People with social anxiety disorder frequently feel humiliated, criticized, and feel negatively evaluated by others. They often struggle with anticipation anxiety.

They exhibit social phobias covering most interpersonal and performance settings, which might sometimes result in withdrawal from social activities. They could engage in subtle avoidance tactics like avoiding eye contact or starting up topics. After leaving a social setting, people with SAD frequently dwell on their perceived flaws, criticize themselves, and experience low moods. Social phobia can be manifested physically in the form of a panic attack in social or performing situations, characterized by flushing, perspiration, trembling, and palpitations. May experience embarrassment while eating or drinking in public. Present with social phobias that are restricted to public settings. Individuals with SAD experience low levels of positive emotions. This interferes with social connectedness. SAD can be associated with significant disability, with impairments in school and work functioning.

Individuals with SAD are more likely to act timid during a diagnostic interview, making little to no eye contact and providing short, brief replies. However, some people with social anxiety may be hesitant to talk to a doctor about their symptoms out of shame, fear of being labelled as unreasonable, or a lack of confidence in the clinician's ability to help them. SAD sufferers may benefit from using the Mini-Social Phobia Inventory. Since avoidance is frequently the most disabling part of SAD, studying its prevalence and severity is essential.

Keeping tabs on the treatment's efficacy as time goes on is also crucial.

Several additional mental health issues, such as avoidant personality disorder, significant depression, alcoholism, schizoaffective disorder, eating disorders, and

anxiety disorders, often occur together with SAD. According to studies, seasonal affective disorder (SAD) may have both genetic and environmental roots. Studies have not consistently identified specific genes. Psychosocial aspects include early adversity, parental and peer influences, and social context. [73]

SPECIFIC PHOBIA:

A clinically significant dread of a specific object, situation, or person is the hallmark of specific phobia, which typically manifests as avoidance behaviour. Some common phobias are those of animals, insects, heights, water, enclosed spaces, driving, flying, seeing blood, injections, choking, and vomiting. Exposure to the stimulus, exposure to the trigger, or even hearing the name of the stimulus stated aloud may all provoke the phobicanxiety. Anxiety about experiencing physical symptoms, the possibility of physical injury, or the feeling of revulsion may all play a role in the development of a phobia. [74]

POSTTRAUMATIC STRESS DISORDER:

EPIDEMIOLOGY:

Roughly between 10-14% of women and 5-6% of men in the United States have PTSD, making it the 4th most common psychiatric ailment. People who have directly experienced or witnessed severe injury or death or have

A loved one involved in such an event is more likely to develop PTSD compared to just learning about a traumatic event happening to a loved one. Traumatic events have a strong emotional response that can lead to multiple mental and physical health issues. Those who have gone through trauma are more likely to have PTSD, depression, anxiety, substance abuse, and physical issues like hypertension, asthma, and chronic pain.

For a person to be diagnosed with post-traumatic stress disorder (PTSD), they must have experienced a traumatic event to which they reacted with extreme anxiety, helplessness, or terror. They need to be excessively attentive, constantly reliving the experience, and avoiding reminders for at least a month. Reliving the event is used to describe unwelcome flashbacks, nightmares, or other memories of the experience. Avoidance symptoms include avoiding anything that might serve as a reminder of the incident, including people, places, or even ideas connected to it. Hyperarousal symptoms include physical manifestations like sleeplessness, irritability, poor focus, hypervigilance, and heightened startle responses.

Studies on the cause of PTSD have revealed changes in the brain's amygdala and hippocampus, areas linked to memory and fear, as well as changes in the hormones, chemicals, and physiological systems that control the body's stress response. An important aspect of treating PTSD is creating a safe and supportive environment for dealing with traumatic experiences and their effects, educating the patient on the disorder's causes, and reducing the distress caused by memories and reminders of the traumatic event. PTSD can be treated effectively with a variety of approaches, such as medication, cognitive therapy, and exposure therapy.

TREATMENT OF POSTTRAUMATIC STRESS DISORDER:

A primary care doctor can recommend medications that can help traumatized patients. Drugs such as tricyclic antidepressants, monoamine oxidase inhibitors, and selective serotonin reuptake inhibitors have been shown to alleviate PTSD symptoms and promote improved general functioning in clinical trials. SSRIs are the go-to for treating mental health issues since they are less likely to cause negative side effects and are more effective overall. The FDA has given the drugs sertraline, and paroxetine approved for Nefazodone can be provided if

there is no improvement after eight weeks. A mood stabilizer such as Divalproex is added if there is only a partial response. In patients with PTSD, benzodiazepines should be avoided or administered exceptionally sparingly. Benzodiazepines such as alprazolam and Clonazepam, if used after a traumatic event, do not seem to be showing any response.

Psychoeducation to Patients and explaining that biological stress response is the reason for the illness and that the disease itself does not mean a sign of weakness. Giving victims of trauma information, a sense of security, and support is crucial to treating them. People who have experienced trauma are notoriously reluctant to seek treatment for their symptoms, especially from mental health professionals.

Reducing the level of distress brought on by recollections of the event and calming the ensuing physiological reactions are part of the treatment. Research has shown the value of approaches like exposure therapy, cognitive therapy, anxiety management, and interpersonal therapies in helping patients process their thoughts and feelings and confront unpleasant memories and emotions (assisting patients to understand how the traumatic event continues to affect relationships and other aspects of their lives). Additionally, group therapy might help to lessen stigma and loneliness.[75]

PSYCHOSIS:

Psychosis is a contributor to impaired functioning and inhibits involvement and production in all of these disorders. As a result, neurologists and psychiatrists devote a lot of time and energy to figuring out what's wrong with their patients who present with psychosis and then treatingthem. Delusions are symptoms of defective reality testing because they are held steadfastly despite overwhelming evidence to the contrary, and the present classification system for psychosis defines the impairment of reality testing by defining the symptoms that serve as evidence of such impairment.

When a person is having hallucinations, they may not be able to tell the difference between their hallucinations and real life. Hallucinations are perceptions that occur without accompanying external or bodily cues.

DELUSIONAL MISIDENTIFICATION SYNDROMES:

Capgras and Fregoli syndrome come under delusional misidentification syndromes. Although they are frequently seen in people with mental diseases, particularly primary psychotic disorders, 20% to 40% of these cases involve problems of the right hemisphere's nervous system. Therefore, the existence of these delusions should trigger an examination for any neurologic diseases that may be possibly curable.

Certain types of bizarre delusions, as described by Schneider, are "first-rank" indicators of schizophrenia. This includes but is not limited to, beliefs that one can manipulate one's own thoughts through methods like thought withdrawal and thought insertion. Schizophrenia can be diagnosed based on bizarre delusions alone, without the presence of additional symptoms (such as negative thoughts, speech, and behavioural abnormalities). Psychotic symptoms and other characteristics can vary widely in severity, frequency, and persistence across the range of schizophrenia disorders.

Schizotypal disorder or schizotypal personality disorder can severely impair social functioning and lead to intense discomfort in interpersonal settings. Illusions and cognitive biases are two symptoms that typically occur together with these deficits. Similar to, but less extreme than, the delusional certainty experienced by people with schizophrenia, these individuals may experience ideas of reference, suspicion or paranoia, unusual beliefs, or magical thinking.

DELUSIONAL DISORDER:

One month without hallucinations and at least one delusion characterizes the diagnostic criteria for delusional disorder. There must be a correlation between hallucinations and the delusional theme if they are present (e.g., a patient's delusions of parasitosis included skin-crawling insect hallucinations).

SCHIZOPHRENIFORM DISORDER:

Schizophreniform disorder exists in a range between a brief psychotic episode and full-blown schizophrenia. Delusions, hallucinations, disorganized speech indicative of formal thought disorder, abnormal psychomotor behaviour, such as excessively disorganised or catatonic behaviour, and negative symptoms are all indicative of this illness. There must have been at least one month and no more than six months of these symptoms.

TREATMENT OF PSYCHOSIS:

Pharmacological treatments should be carefully chosen with the goal of providing the greatest benefit while causing the least amount of harm. This will entail using atypical or second-generation antipsychotics at their lowest potential effective dose wherever possible.

It is important to reduce the risk of extrapyramidal symptoms in patients taking antipsychotic medication in order to increase their likelihood of taking their medication as prescribed in the future. Although conventional antipsychotics may be equally effective as atypical antipsychotics in reducing positive psychotic symptoms, they are typically less well tolerated, even at low doses. As a first line of defence, atypical antipsychotics should be given at a low dose and gradually increased over a period of weeks. Initial target doses that are appropriate for the vast majority of people include 2 milligrams per day of risperidone or 7.5-10.0 milligrams per day of olanzapine. First-target dosages have not yet been determined for other medications

such as amisulpride, ziprasidone, and quetiapine. After the first dose, between 50 and 70 percent of patients will have a reduction in their positive psychotic symptoms within three weeks.

If the patient's reaction to the antipsychotic is insufficient, the dosage can be increased, but only gradually and under close observation for sedation and the development of extrapyramidal side effects (after the initial titration, which usually lasts 14-21 days). Frequent assessments of response and danger are necessary. It is recommended to try a different atypical antipsychotic if the response at therapeutic dosages is still unsatisfactory after 6-8 weeks. When traditional antipsychotics are necessary, they should be given in extremely low doses (1-2 mg of haloperidol or an equivalent) and titrated very carefully, keeping extrapyramidal side effects in mind.

Clozapine and cognitive behavioural therapy are clearly the best solutions for dealing with persistent problems. Psychological education on illnesses, treatments, and outcomes for families is important. Relapses or a delayed rate of recovery may necessitate a more intensive and prolonged psychoeducational and supportive intervention for families. Risk factors for relapse should be discussed with the patient and their loved ones.

It is possible that a patient who refuses treatment will require depot medication if they demonstrate a pattern of high-risk, suicidal, or aggressive behaviour; have chronic symptoms; relapse often; or experience multiple relapses. Knowing that this unfavourable outcome has a limited duration can motivate people to take

preventative measures or encourage them to stick with treatment plans. All forms ofRestraints need to be assessed frequently and stopped when needed. All symptoms of depression, suicidal ideation, substance misuse, and social anxiety should be looked for and treated.

Antipsychotic prescription side effects, such as weight gain, erectile dysfunction, and sleepiness, can impede recovery and should be frequently evaluated. Slow reduction of antipsychotic dosage should be undertaken once Psychosis has been successfully treated.It is unknown how long maintenance antipsychotic therapy should last in order to reduce the chance of relapsing into the initial psychotic episode. Current clinical practice ranges from suggesting antipsychotic maintenance therapy for one year to an unlimited amount of time after treatment begins.

People who choose to stop taking their medications, whether intentionally or unintentionally, should still be closely watched and given continuous care. In every situation, careful psychoeducation regarding the likelihood of relapse and its symptoms should be given, together with regular review and support and unrestricted access to early psychiatric care in the case of relapse. Determine the lowest effective dose. In the critical phase, psychological and psychosocial treatments should be essential components and should be employed to help control secondary comorbidity, resolve persistent positive and negative symptoms, and encourage recovery and good mental health. Work on recovery should place a strong emphasis on the need to understand the psychotic experience and gain power over it.[77]

ANTISOCIAL PERSONALITY DISORDER:

ASPD is a pervasive and maladaptive cognitive process that prioritizes antisocial, delinquent, and criminal behaviour without remorse on the part of the affected individual. Similar to narcissistic, borderline, and histrionic disorders, ASPD is classified as a member of clusterB in the DSM V.

ETIOLOGY:

Multiple theories have been proposed to explain the origin of ASPD, including genetic and environmental factors. In the past, researchers have estimated heritability at anything from 38% to 69%. Environmental factors linked to the emergence of antisocial personality disorder include exposure to physical and sexual abuse, neglect, and behavioural issues in childhood. Peer groups and family dynamics are just two examples of influential environmental factors. The 2p12 region of chromosome 2, AVPR1A variation, and oxytocin receptor gene variation are all thought to contribute to the wide range of behaviours seen in people with antisocial personality disorder (OXTR).

EPIDEMIOLOGY

Lifetime prevalence estimates place ASPD anywhere from 1-4% of the population. Six percent of men and two percent of women in the general population have been identified as having ASPD, demonstrating a gender distribution that favors men. While there is evidence of a negative correlation between education and intelligence, with a higher prevalence of ASPD among those with lower IQs and reading levels, drug abuse has been found to have a strong correlation with the diagnosis of ASPD. Changes in personality traits with age and higher death rates associated with antisocial personality disorder behaviour have been proposed to explain this age-dependent variation.

TREATMENT OF ANTISOCIAL PERSONALITY DISORDER:

A psychiatric hospital's atmosphere is disrupted by the presence of people with ASPD, which has an adverse effect on the treatment of other patients who require therapeutic care. Hospitalization is only appropriate for concurrent substance use disorder and withdrawal or recent suicidal behaviour. There is insufficient data to

support psychological treatment for adults with ASPD.

No pharmacological treatment for ASPD has been demonstrated, but medications for comorbid conditions like aggression are required.Quetiapine (100–300 mg/day) and risperidone (2–4 mg/day) are two examples of second-generation antipsychotics used in the initial stages of treatment. Mood stabilizers like lithium and carbamazepine and SSRIs like sertraline (100–200 mg/day) or fluoxetine (20 mg/day) are second and third-line therapies for aggression, respectively. Carbamazepine and oxcarbazepine are two anticonvulsants that have been shown to reduce impulsivity. Bupropion and atomoxetine are common medications used to treat ADHD.[78]

ANTISOCIAL PERSONALITY DISORDER AND ITS ASSOCIATION WITH PSYCHOPATHY:

The most common overlap between the psychopathy concept and antisocial personality disorder may exist. Despite not being included in the DSM 5 diagnostic criteria, psychopathy is a term used to characterize people who exhibit many of the same traits as ASPD, as well as a unique set of interpersonal and affective traits, such As callousness, shallow effect, and superficial charm. While some people with ASPD may exhibit psychopathic symptoms, others might not. Some contend that while ASPD and psychopathy share many characteristics, the underlying psychobiological mechanisms may be different.[79]

CONSULTATION LIAISON PSYCHIATRY:

The American Board of Psychiatry and Neurology recently suggested that consultation-liaison psychiatry be given subspecialty designation and the name "psychosomatic medicine." Patients' psychiatric requirements will always persist, insightful clinical observations must be made and investigated, and fresh, successful Interventions must be implemented. The necessity to aid in our co-workers' education

is more important than ever in this technology age. As a result, consultation-liaison psychiatry, or as it has been suggested psychosomatic medicine, should endure and grow because its widespread practice results in better medical care thanks to its practitioners' direct clinical work as well as their teaching and research.[80]

In India, the CLP specialty has rapidly expanded over the past few decades. However, there is still much work to be done. In addition to addressing mental diseases, psychiatrists must be made aware of and educated about their medical role. Providing holistic and individualized care should be the main focus of psychiatry training rather than the major psychiatric illnesses. Psychiatrists should be aware that they can contribute significantly to the evaluation of organ transplant candidates and recipients, pain management, the prevention, diagnosis, and treatment of delirium in intensive care units, gender reassignment surgeries, Cosmetic surgeries, addressing the needs of cancer patients, palliative care, etc. Primary care physicians and other specialists must also be a priority for centers with telepsychiatry facilities in addition to providing services to their fellow psychiatrists. If telepsychiatry services are not offered, then CLP services can be made available to all professionals with the least amount of financial outlay, thanks to the widespread availability of high-speed internet, video calling capabilities, and smartphones.

An additional study must be conducted. The goal of the study should be to improve patients' overall outcomes by creating native instruments, practice models, and interventions. From single-center studies with a small sample size to multicentric studies, the research should proceed.[8]

MATERIALS

AND

METHODS

MATERIALS AND METHODS:

STUDY TOOLS:

1. SEMI-STRUCTURED SOCIODEMOGRAPHIC PROFORMA SHEET

2. MINI [MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW]6.0

STUDY SETTING

It is a hospital-based, cross-sectional, observational study conducted among all the patients referred from other departments to the psychiatry department.

STUDY POPULATION

All patients were referred to the psychiatry department in R.L Jalappa hospital from other departments, including the emergency department in the hospital.

INCLUSION CRITERIA:

1. Patients who are referred from other departments to psychiatry OPD for consultation-liaison services.
2. Patients who agree to participate in the study with written informed consent.
3. Patients who belong to the age group 18-65 years old

EXCLUSION CRITERIA

1. patients who have known cases of psychiatric illnesses and are currently on treatment.
2. patients who belong to the pediatric age group below 18 years old.
3. Patients who have delirium and complex withdrawal seizures.
4. Patients who are not willing to participate in the study.
5. Patients who have speech or hearing impairment.
6. Patients who belong to the geriatric age group above 65 years.

SOURCE OF DATA

At RL. Jalapa Hospital and Research Centre from 2021 – 2022 will be included in this study. The investigator sees the referral patients and conducts an interview after their written informed consent. Patients are screened

for diseases like panic disorders, eating disorders, neurotic disorders and psychotic disorders, suicidality, etc. A detailed history from a reliable informant and a detailed MSE will be made.

STUDY COURSE- January 2021 to March 2022

DURATION OF STUDY – 1 year and two months.

STUDY DESIGN– Cross-sectional observational study.

METHOD OF COLLECTION: Sample data will be collected from January 2021 to March 2022.

METHODOLOGY:the scale of measurement in our study will be MINI [Mini international neuropsychiatric interview]

All patients who are referred to consultation liaison psychiatry services from other departments are taken as part of the study subjects. Patients who give consent to participate in the study are included. Patients who fit the exclusion criteria are excluded from the study. Patients have explained the aim of the study by the investigator. Reasons for referral and the location where they are referred will be noted. Patients will be diagnosed using a structural and validated scale using MINI.

The sociodemographic details of the patient are recorded. By applying the MINI scale, the underlying psychiatric disorders which were not previously thought of can also be brought to light so that the patient receives appropriate treatment.

STATISTICAL ANALYSIS:

Data were entered into a data sheet created in Microsoft Excel, and the SPSS 22 version software was used to perform the analysis. Frequencies and percentages were used to depict the categorical data.

For qualitative data, a test of significance was performed using either **the Chi-square test or Fischer's exact test**(only for use with 2x2 tables). The continuous data was shown as a mean and standard deviation.

A statistical test for significance was performed using an **Independent t-test** to determine the average difference between two numerical variables.

Statistics data representation in graph form: Microsoft Excel and Microsoft Word were used in order to create a variety of graphs.

P value With the standard assumptions made for statistical tests, a (Probability that the result is true) of 0.05 was deemed statistically significant.

Statistical software: MS Excel**,** SPSS version 22 **(**IBM SPSS Statistics, Somers, NY, USA) was used to analyze data.

METHOD OF COLLECTION OF DATA, INCLUDING SAMPLING PROCEDURE:

Previous research by Mudgal V, Rastogi P, Niranjan V, et al. found that anomalous behaviour was the most common reason for referral (n=45, 26.2%), followed by a history of suicidal ideation or self-harm (n=42, 24.4%), anxiety (n=18, 10.5%), substance abuse (n=17, 10%), and confusion (n=13, 7.6%).

Sample Size: 293

Calculation**:** $Z_{\alpha}^{2}(p)\ (1-p)\ x\ DE\ d^{2}$

ABSOLUTE ERROR; 5%

RESULTS

RESULTS

Table 1:- Distribution of subjects according to age group

Age group	Frequency	Percent
18-20yrs	19	6.5
21-30yrs	90	30.7
31-40yrs	77	26.3
41-50yrs	52	17.7
51-60yrs	34	11.6
61-65yrs	21	7.2
Total	293	100.0

Most of the Patients who were referred for consultation belonged between 21 to 30 years old at 30.7%, which was followed by 31 to 40 years old at 26.3%. It was found subjects who belonged to the geriatric population had fewer referrals compared with other populations.

Figure 1:-Graph showing the Distribution of subjects according to age group.

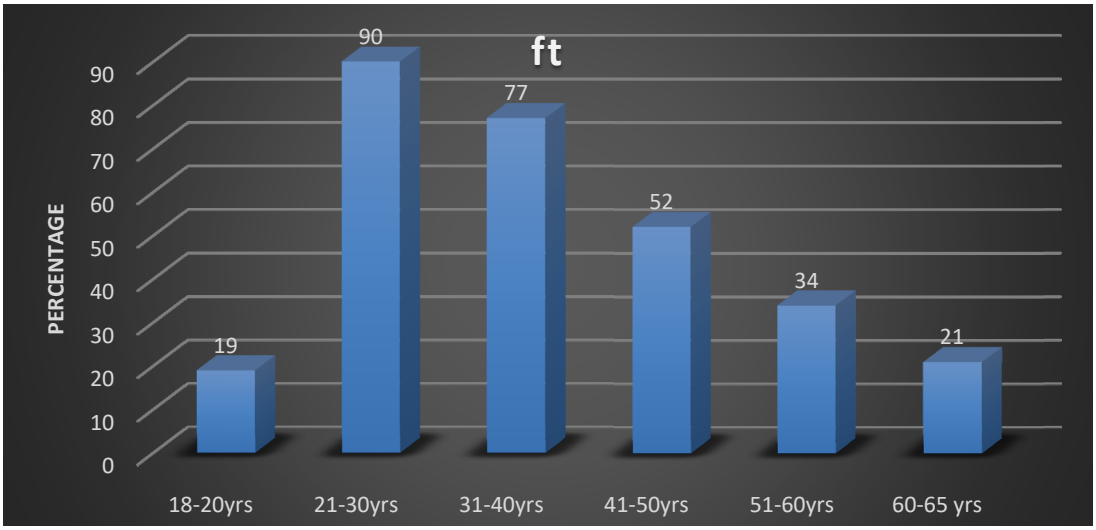


Table 2:- Distribution of subjects according to sex

	Frequency	Percent
Female	110	37.5
Male	183	62.5
Total	293	100.0

Most of the patients referred to the department are males at 62.5% [183], and females are about 37.5%[110]

Figure 2:- Graph showing the Distribution of subjects according to sex

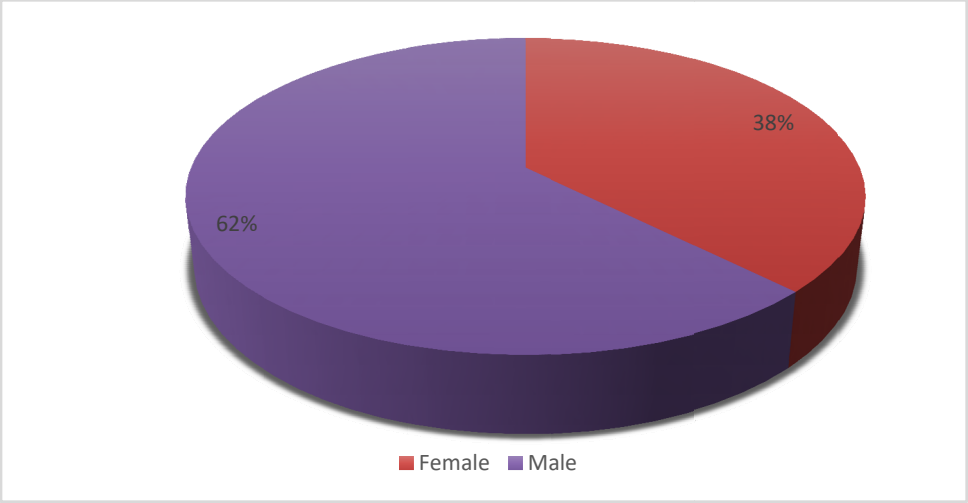


Table 3:- Distribution of subjects according to Education

Education	Frequency	Percent
Illiterate	34	11.6
Primary	62	21.2
10^{TH}	73	24.9
12^{TH}	81	27.6
Graduate	40	13.7
Post Graduate	3	1.0
Total	293	100.0

Most of the patients have completed Higher secondary schooling at 27.6% [81], followed by secondary schooling at 24.9%[73]. Very few have completed their Post-Graduation at 1.0%[3] People who are illiterate are at 11.6%[34]

Figure 3:-Graph showing the Distribution of subjects according to Education.

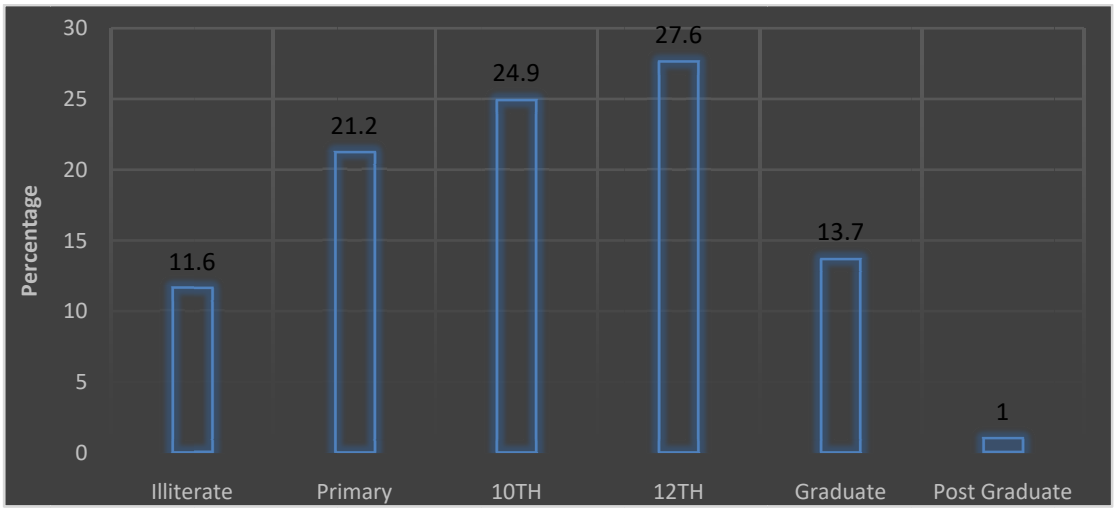


Table 4:- Distribution of subjects according to occupation

	Frequency	Percent
Unemployed	111	37.9
Homemaker	7	2.4
Professional	1	.3
Semi Professional	4	1.4
Skilled Worker	16	5.5
Unskilled Worker	154	52.6
Total	293	100.0

Many of the Patients are unskilled workers at 52.6%[154] followed by Unemployed at 37.9%[111]. Only very few patients are Professionals and Semi Professionals at 0.3%[1] and 1.4%[4]

Figure 4:-Graph showing Distribution of subjects according to occupation.

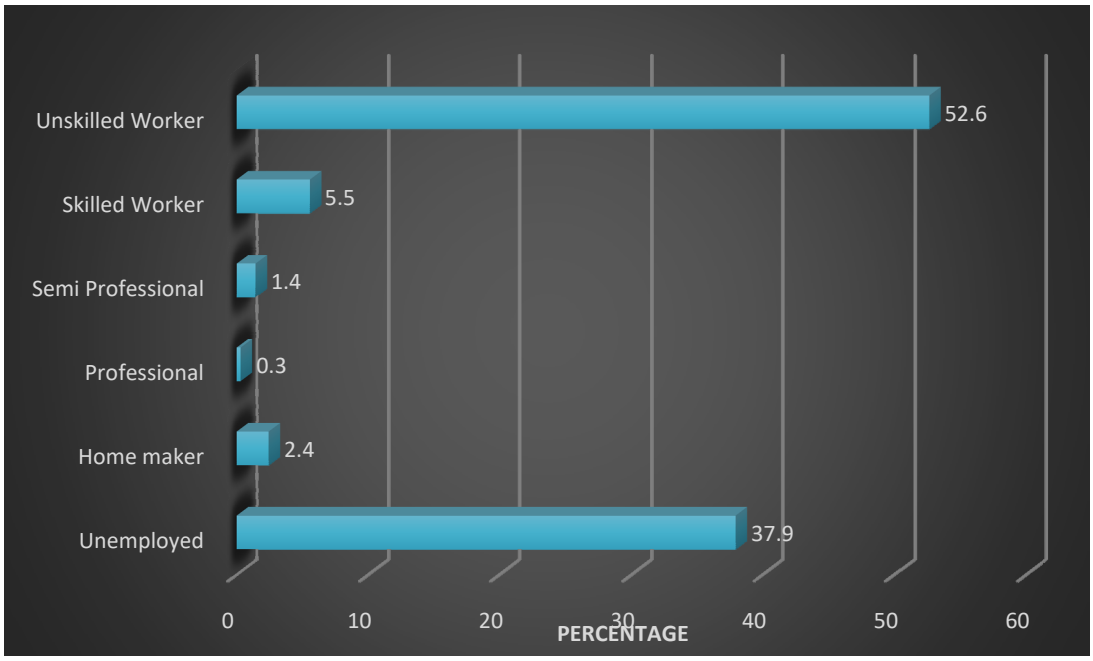


Table 5:- Distribution of subjects according to marital status.

	Frequency	Percent
Married	218	74.4
Single	75	25.6
Total	293	100.0

Figure 5:- Graph showing the Distribution of subjects according tomarital status.

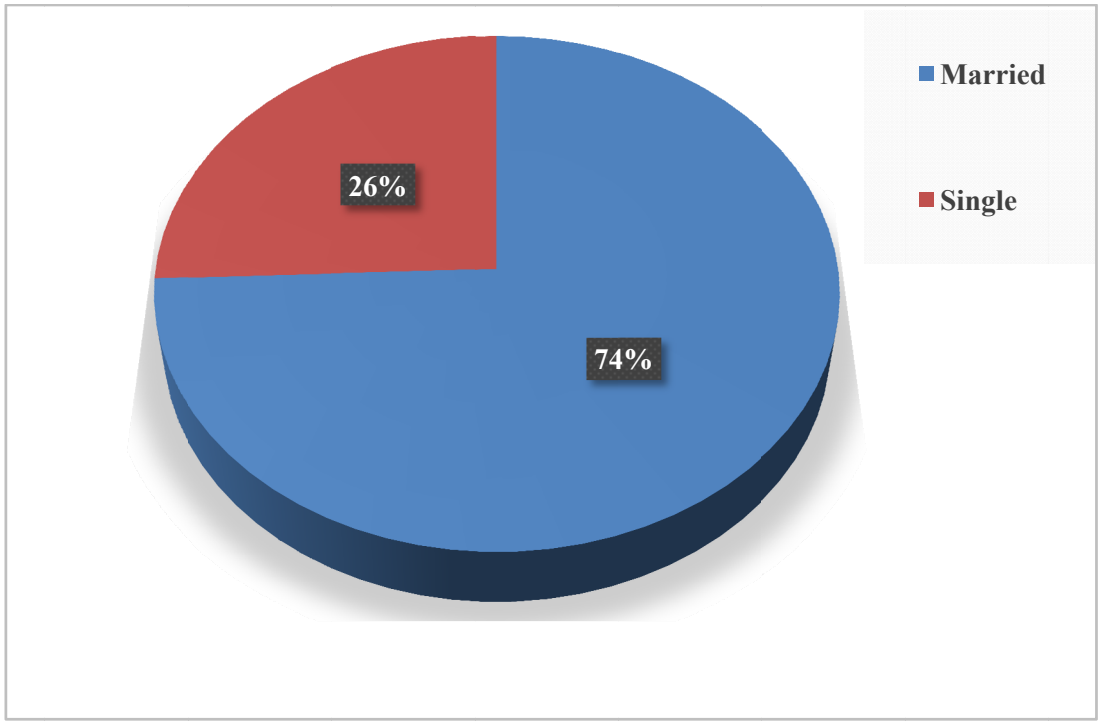


Table 6:- Distribution of subjects according to locality.

	Frequency	Percent
Rural	281	95.9
Urban	12	4.1
Total	293	100.0

The majority of the Study sample belonged to Rural areas. 95.9% [281] Urban population comprises a small percentage. 4.1% [12]

Figure 6:- Graph showing the Distribution of subjects according to locality.

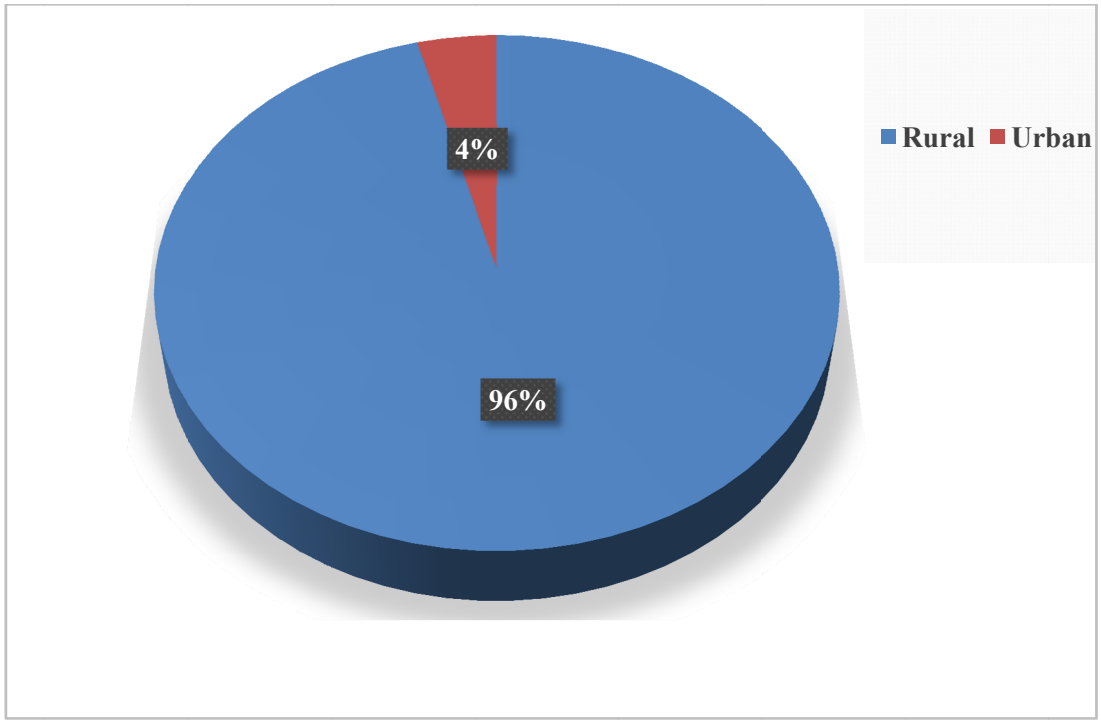


Table 7:- Distribution of subjects according to religion.

	Frequency	Percent
Christian	3	1
Hindu	273	93.2
Muslim	17	5.8
Total	293	100.0

Most of the population is Hindu by religion 93.2%[273], followed by Muslim 5.8[17%], and the Christian population is the least among the referrals.

Figure 7:- Graph showing the Distribution of subjects according to religion.

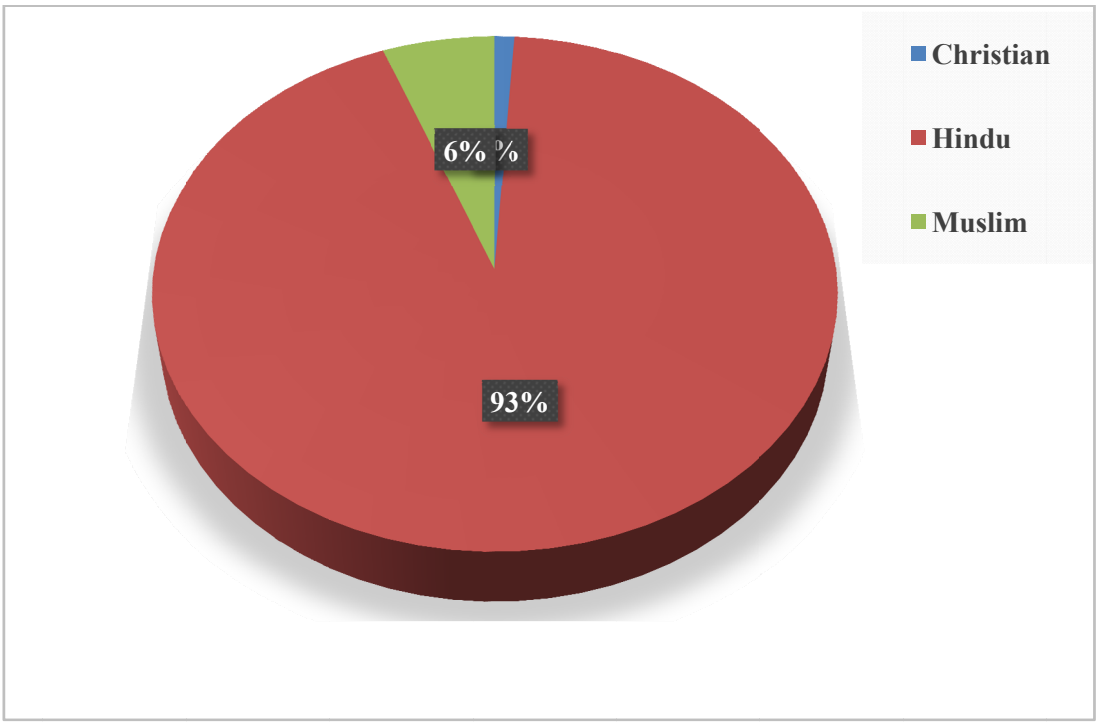


Table 8:- Distribution of subjects according to income

	Frequency	Percent
APL	188	64.2
BPL	105	35.8
Total	293	100.0

People who belong Above the poverty line are 64.2%, and People who belong Below the Poverty line are lesser compared to APL at 35.8%

Figure 8:- Graph showing the Distribution of subjects according to income.

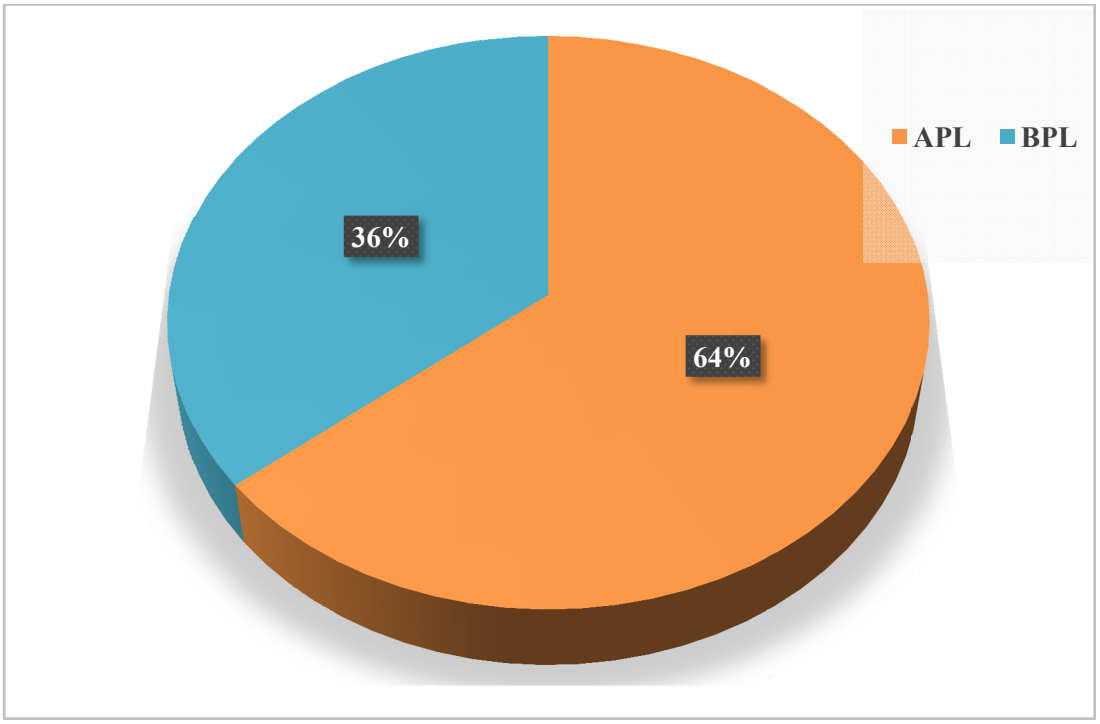


Table 9:- Distribution of subjects according to Psychiatric comorbidities

Psychiatric comorbidities	Frequency	Percent
No	59	20.1
Yes	234	79.9
Total	293	100.0

Most of the patients referred to consultation liaison services had Psychiatric Comorbidities 79.9%[234], and about 20.1% had nil Psychiatric Comorbidities[59]

Figure 9:- Graph showing the Distribution of subjects according to Psychiatric comorbidities.

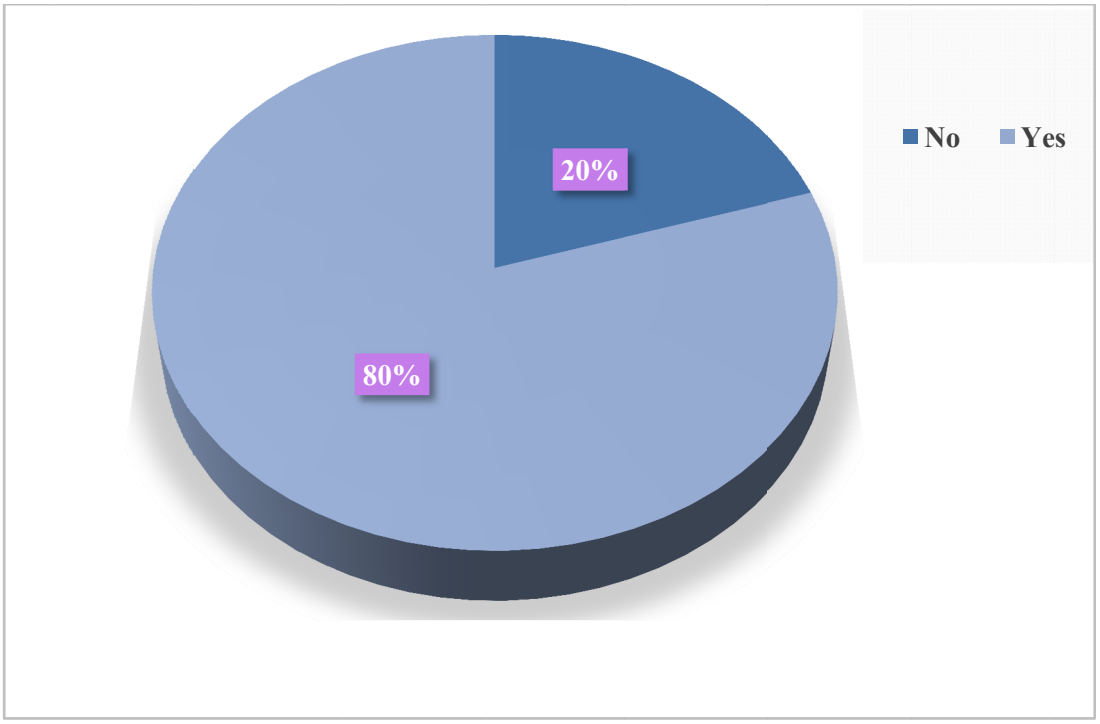


Table 10:- Distribution of subjects according to referral

	Frequency	Percent
Cardiology	1	.3
EMD	13	4.4
ENT	9	3.1
Medicine	218	74.4
OBG	6	2.0
Ophthalmology	2	.7
Orthopedic	9	3.1
Surgery	35	11.9
Total	293	100.0

Patients who are referred from Medicine Department are the Overwhelming majority at 74.4%. Followed by Surgery Referrals at 11.9%. Other departments include Cardiology, Ophthalmology, Orthopedics, OBG, ENT, EMD at 0.3%,0.7%,3.1%,2.0%,3.1%, and 4.4%, respectively.

Figure 10:Graph showing the Distribution of Patients according to Place of referral.

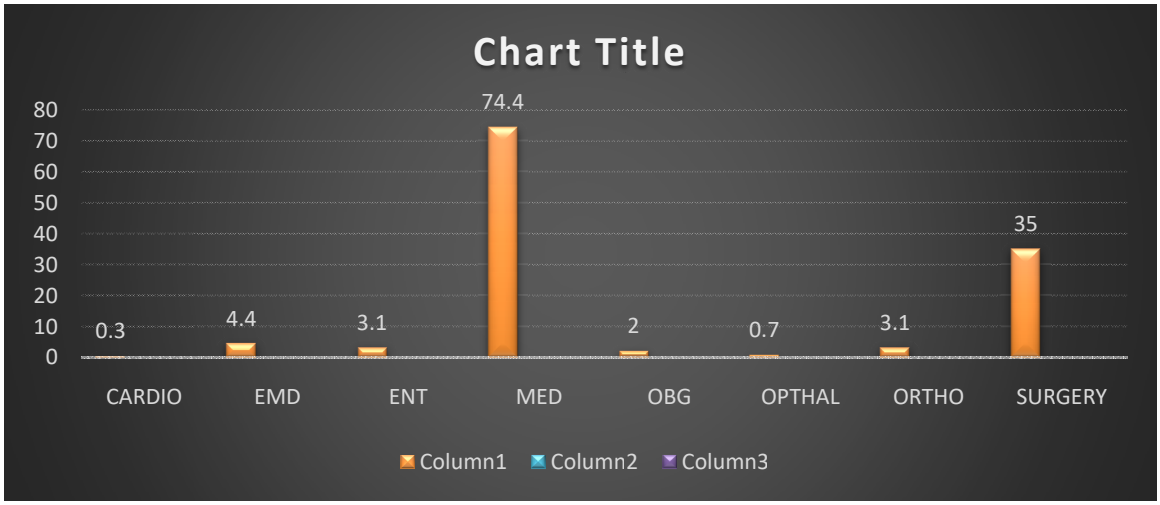


Table 11:- Distribution of subjects according to Mini Scale

	Frequency	Percent
ADS	63	21.5
ADS,ASPD	1	.3
ADS,MDD	1	.3
ADS,MDD[CURR]	3	1.0
ADS,SUI-MILD	1	.3
ADS,SUI-MOD	2	.7
ADS,SUI,MDD[CURR]	1	.3
AL ABU	10	3.4
CAN DEP,ADS,PSY[CURR]	1	.3
CAN DS	2	.7
DEP DIS	1	.3
DEP DIS SUI-MOD	1	.3
GAD	1	.3
MANIA -PAST	1	.3
MANIA [CURR]	1	.3
MDD,SUI-MOD	1	.3
MDD[CURR]	27	9.2
MDD[CURR], SUI-MOD	1	.3
MDD[CURR],AL ABU	1	.3
MDD[CURR],SUI-HIGH	1	.3
MDD[CURR],SUI-MOD	1	.3
MDD[CURR]SUI-MILD	1	.3
MISC	2	.7
MOOD PSY	2	.7

MOOD WOT PSY[CURR]	1	.3
NDS	1	.3
PANIC DIS	7	2.4
PSYCHOSIS-CURR	4	1.4
PSYCHOSIS-LIFE	10	3.4
PSYCHOSIS,AL ABU	1	.3
PTSD	1	.3
RDD	2	.7
RDD[CURR]	1	.3
SOCI PHOB	3	1.0
SUB ABU-OPIOID	1	.3
SUI- LOW	18	6.1
SUI- MILD	6	2.05
SUI- MOD	24	8.2
SUI-HIGH	9	3.1
SUI-HIGH,MDD[CURR]	4	1.4
SUI-LOW,AL ABU	1	.3
SUI-MILD,AL ABU	1	.3
SUI-MILD,ASPD	1	.3
SUI-MOD, MDD[CURR]	1	.3
SUI-MOD,ADS	2	.7
SUI-MOD,AL ABU	1	.3
SUI-MOD,MDD[CURR]	4	1.4
SUI-MOD,OSDD	1	.3
SUI,ADS	1	.3
SUI,ASPD	1	.3

The majority of Patients diagnosed to have Alcohol Dependence syndrome 21.5% [63], followed by Major Depressive Disorder 9.2%[27]. Patients who had Moderate Suicidality were 8.2% [24], and Lower suicidality was 6.1%[18]. Higher suicidality would be 3.1%[9]. Patients who had higher suicidality with comorbid Major depressive disorder amounting to 1.4%.[4] Patients who had a Psychosis lifetime diagnosis, as well as Alcohol Abuse, is at 3.4% [10]. Major Depressive disorder and Suicidality are closely linked. Panic Disorder amounts up to 2.4[7]. Suicidality and Alcohol abuse seems to be associated with each other as well. Overall, Alcohol dependence syndrome and Suicidality are the most diagnosed disorders in most cases who were referred for consultation services. Panic Disorder diagnosis amounts to 2.4%[7]. Other Disorders like Post-traumatic Stress Disorder[PTSD], Generalized Anxiety disorder are at 0.3%[1]. Mood Disorder like Mania in the past as well as the current episode, amounts to 0.3%[1]

Table 12:- Frequency Distribution of Previous History, Previous Family History, and Suicidal attempt

	Frequency	Percent
Previous History	17	5.8
Previous Family History	17	5.8
Suicidal attempt	10	3.4

Patients who had Previous Family History of Psychiatric Illness amount to 5.8%[17] and Patients who had Previous History of Psychiatric illness amount to 5.8%[17] as

well. Patients who had previous suicidal attempt are less at 3.4%[10]

Figure 13:- Graph showing Frequency Distribution of Previous History, Previous Family History, and Suicidal attempt

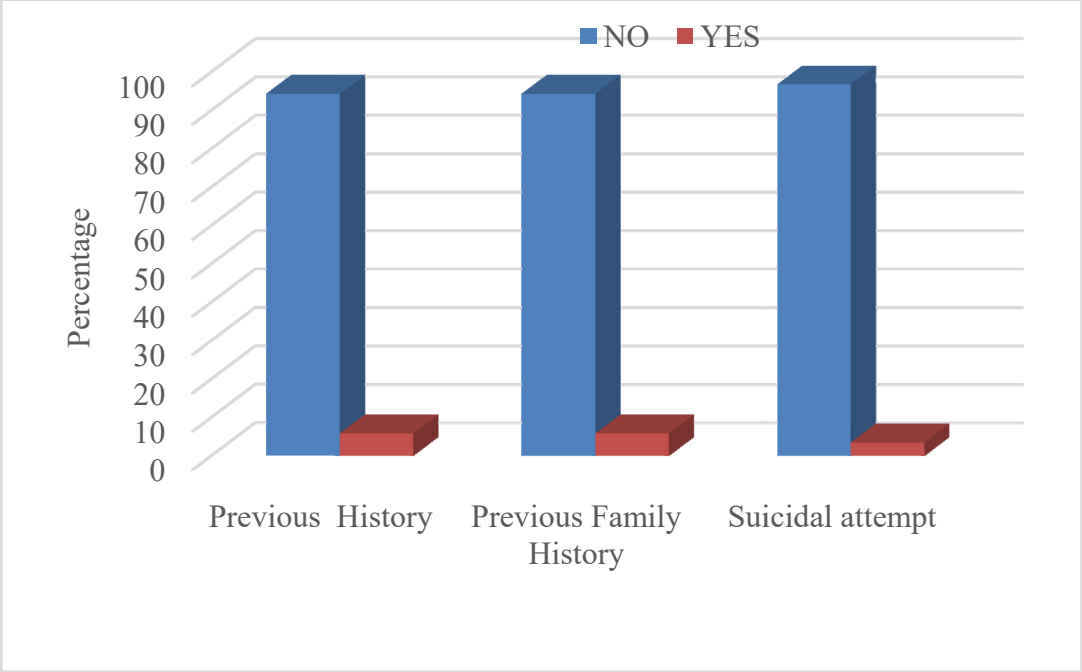


Table 13:- Comparison of mean age according to Psychiatric comorbidities.

Psychiatric comorbidities	Mean age	Std. Deviation	P value
Absent	35.12	14.877	0.082
Present	38.42	12.507	

Patients who had Psychiatric Comorbidities in comparison to mean age at Standard Deviation 12.507. Patients who did not have any Psychiatric comorbidities in comparison to mean age at Standard deviation 14.877.

The p-value is 0.082.

Figure 14:- graph showing Comparison of mean age according to Psychiatric

comorbidities.

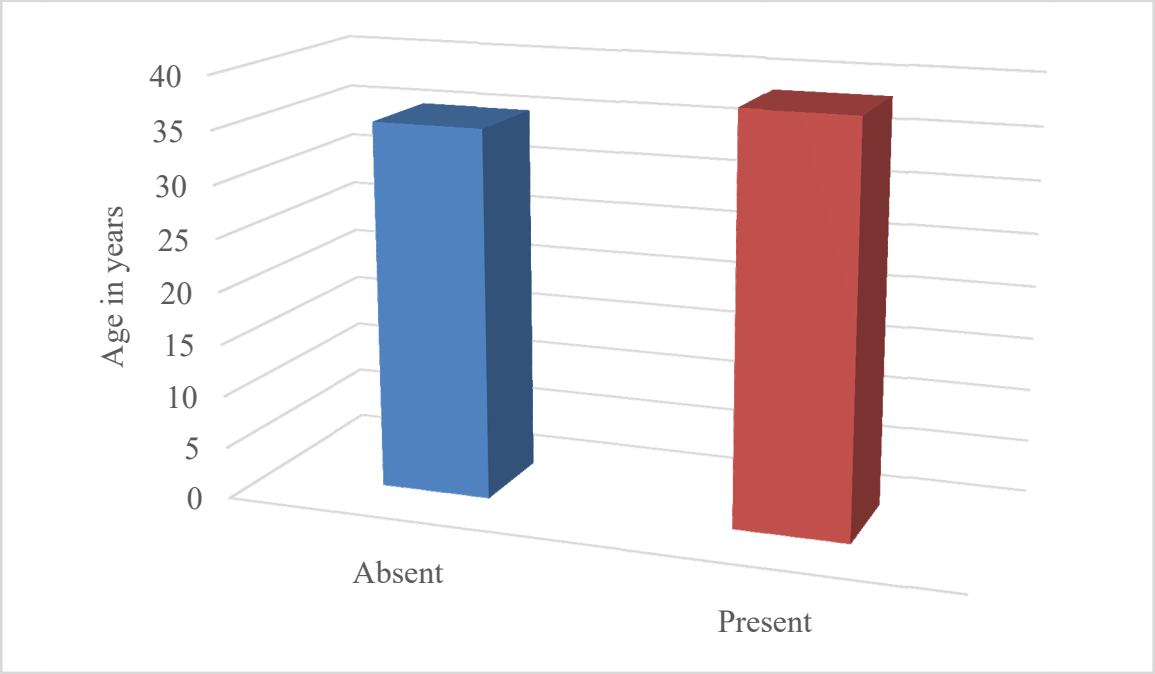


Table 14:- Distribution of subjects according to Psychiatric comorbidities and sex

	Absent		Present	
	N	%	N	%
FEMALE	44	40.0%	66	60.0%
MALE	15	8.2%	168	91.8%

When compared to females, males had more psychiatric comorbidities and a P Value of 0.001; there was a statistically significant difference found between Psychiatric comorbidities and sex.

Figure 13:- Graph showing Distribution of subjects according to Psychiatric comorbidities and sex.

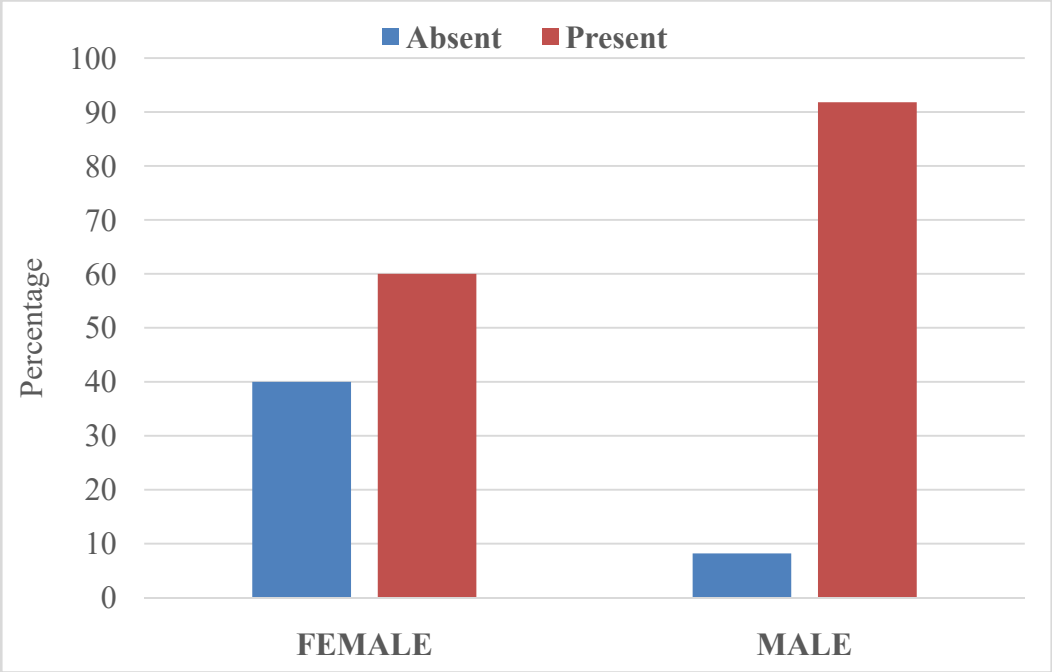


Table 15:- Distribution of subjects according to Psychiatric comorbidities and education

	Absent		Present	
	N	%	N	%
Illiterate	9	26.5%	25	73.5%
Primary	13	21.0%	49	79.0%
10^{TH}	18	24.7%	56	75.3%
12^{TH}	11	13.8%	69	86.3%
Graduate	7	17.5%	33	82.5%
Post Graduate	1	33.3%	2	66.7%

P Value 0.598, there was no statistically significant difference found between Psychiatric comorbidities and education.

Figure 16:- Graph showing the Distribution of subjects according to Psychiatric comorbidities and education

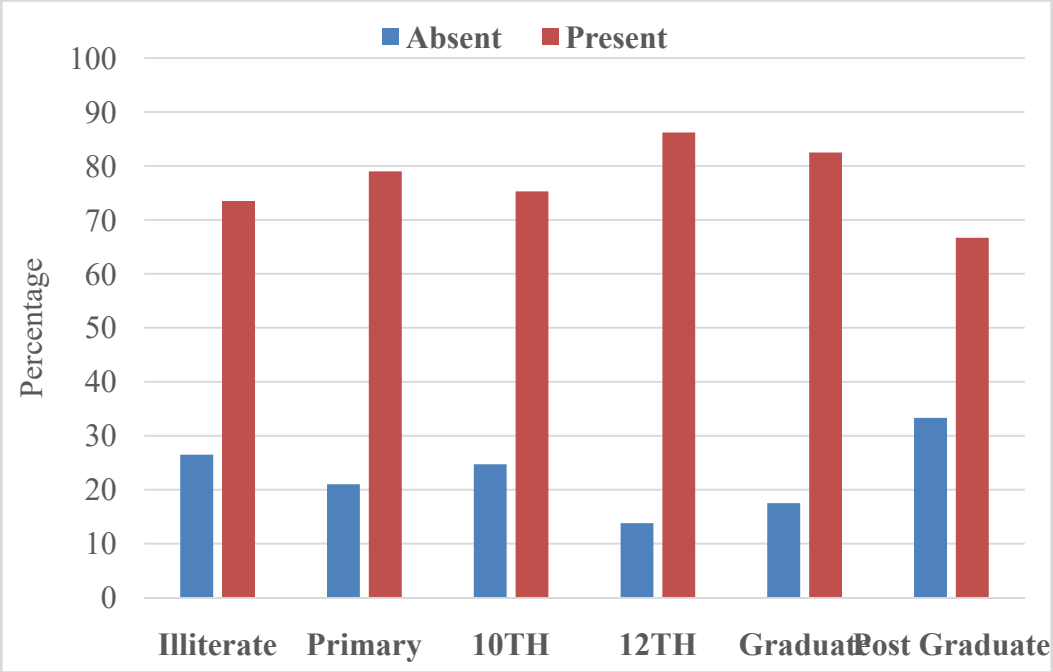


Table 16:- Distribution of subjects according to Psychiatric comorbidities and occupation.

	Absent		Present	
	N	%	N	%
Unemployed	40	36.0%	71	64.0%
Homemaker	0	.0%	7	100.0%
Professional	1	100.0%	0	.0%
Semi Professional	1	25.0%	3	75.0%
Skilled Worker	1	6.3%	15	93.8%
Unskilled Worker	16	10.4%	138	89.6%

P Value <0.001, there was a statistically significant difference found between

Psychiatric comorbidities and occupation.

Figure 17:- Graph showing the Distribution of subjects according to Psychiatric comorbidities and occupation.

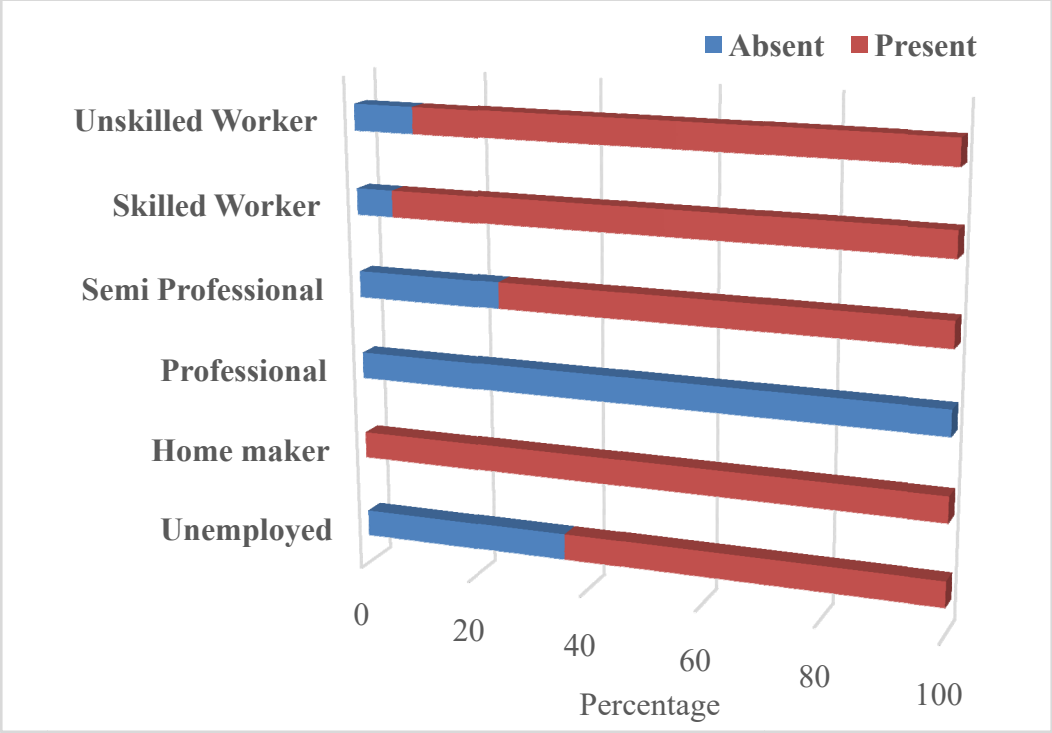


Table 17:- Distribution of subjects according to Psychiatric comorbidities and marital status

	Absent		Present	
	N	%	N	%
Married	45	20.6%	173	79.4%
Single	14	18.7%	61	81.3%

P Value 0.868, there was no statistically significant difference found between Psychiatric comorbidities and marital status

Figure 18:- Graph showing the Distribution of subjects according to Psychiatric

comorbidities and marital status

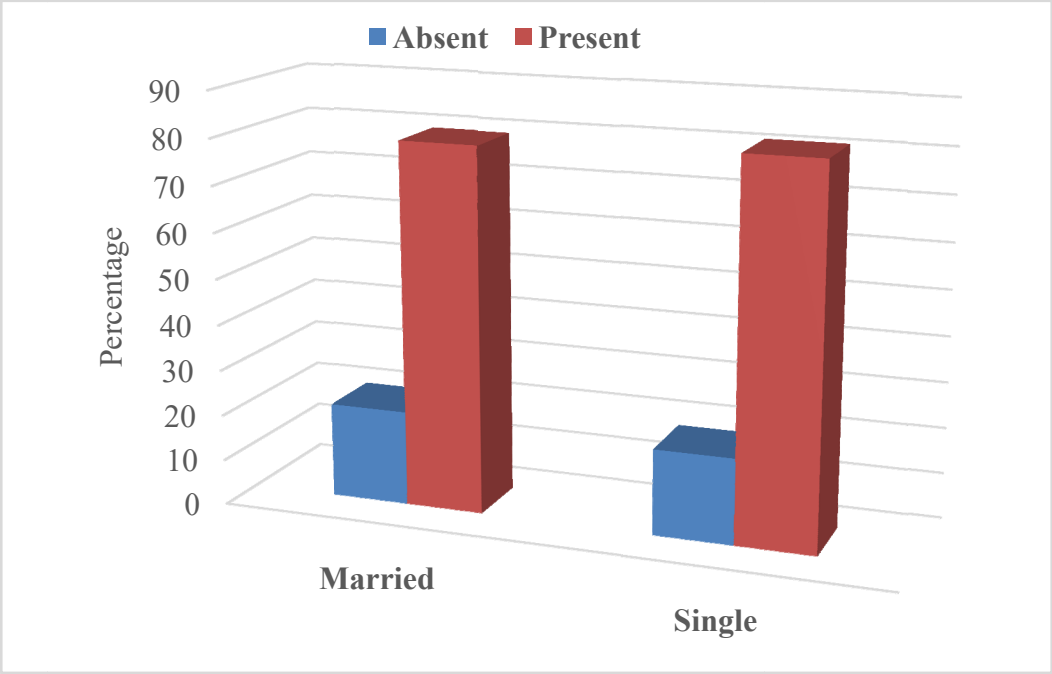


Table 18:- Distribution of subjects according to Psychiatric comorbidities and area

	Absent		Present	
	N	%	N	%
RURAL	58	20.6%	223	79.4%
URBAN	1	8.3%	11	91.7%

P Value 0.470, there was no statistically significant difference found between Psychiatric comorbidities and area

Figure 17:- Graph showing the Distribution of subjects according to Psychiatric comorbidities and area

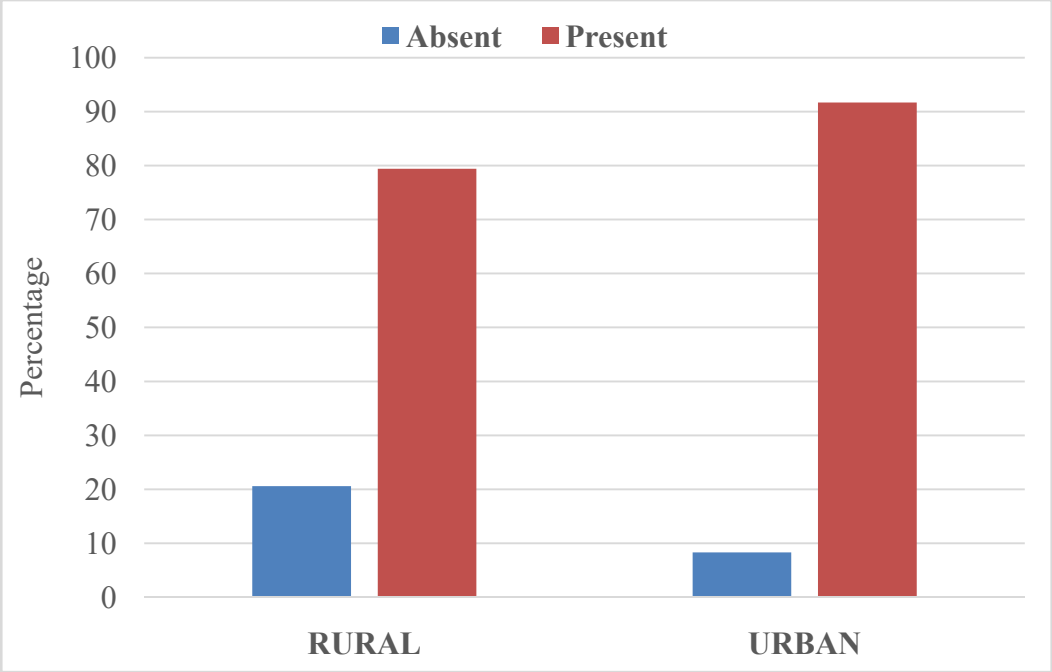


Table 19:- Distribution of subjects according to Psychiatric comorbidities and religion

	Absent		Present	
	N	%	N	%
Christian	2	66.7%	1	33.3%
Hindu	52	19.0%	221	81.0%
Muslim	5	29.4%	12	70.6%

P Value 0.103, there was no statistically significant difference found between Psychiatric comorbidities and religion.

Figure 19:- Graph showing the Distribution of subjects according to Psychiatric comorbidities and religion

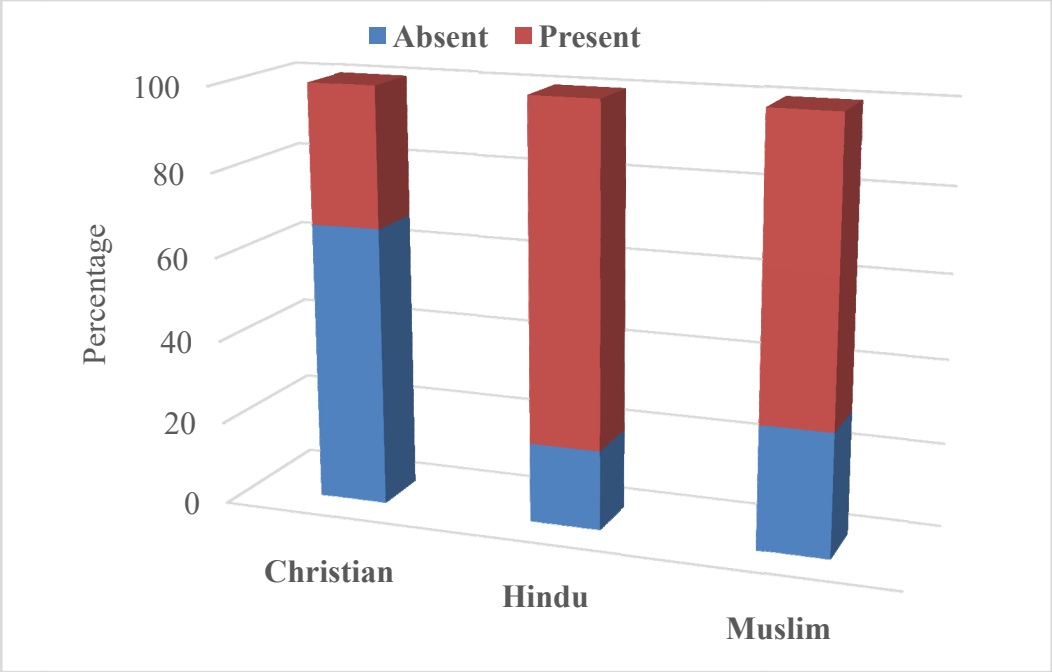


Table 20:- Distribution of subjects according to Psychiatric comorbidities and income

	Absent		Present	
	N	%	N	%
APL	46	24.5%	142	75.5%
BPL	13	12.4%	92	87.6%

P Value 0.015, there was a statistically significant difference found between Psychiatric comorbidities and income

Figure 21:- Graph showing the Distribution of subjects according to Psychiatric comorbidities and income

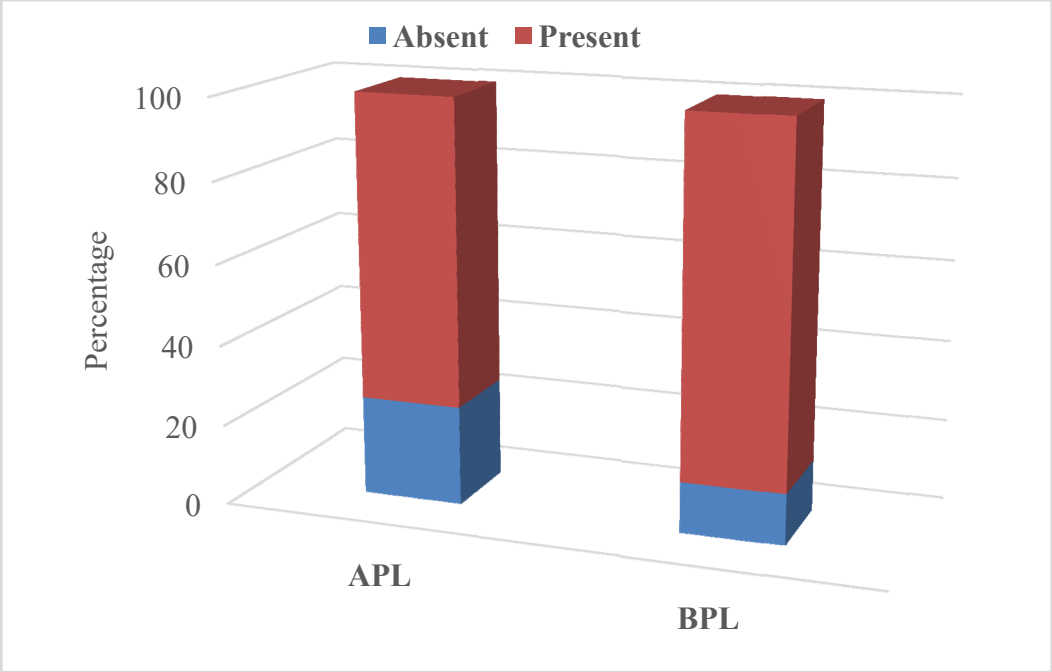


Table 21:- Distribution of subjects according to Psychiatric comorbidities and previous history

	Absent		Present	
	N	%	N	%
NO	58	21.0%	218	79.0%
YES	1	5.9%	16	94.1%

P Value 0.210, there was no statistically significant difference found between Psychiatric comorbidities and previous history

Figure 22:- Graph showing the Distribution of subjects according to Psychiatric comorbidities and previous history

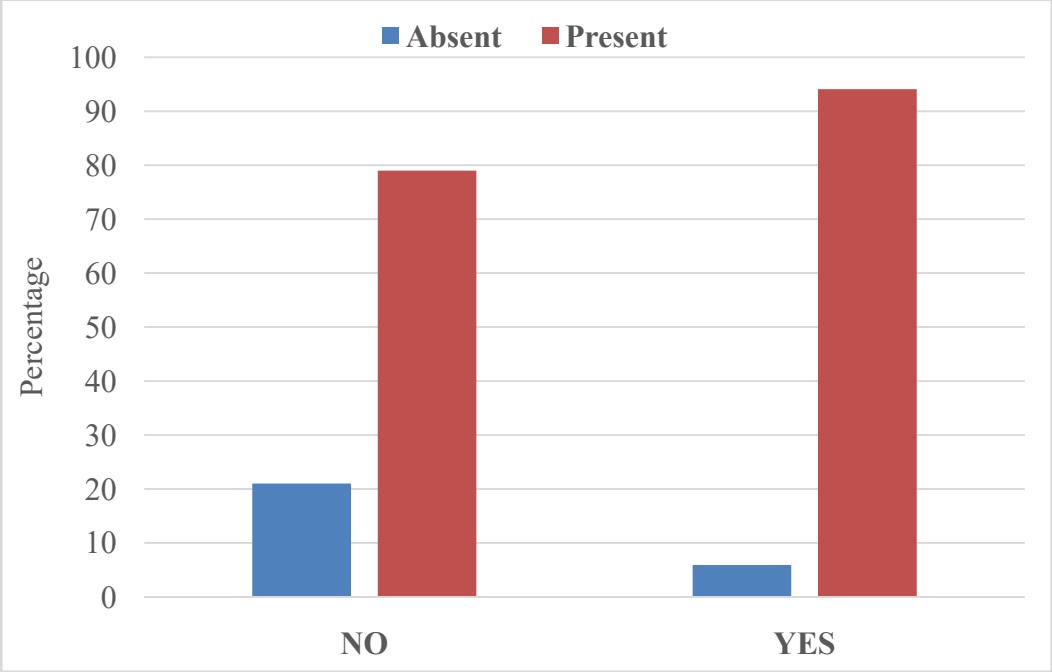


Table 22:- Distribution of subjects according to Psychiatric comorbidities and previous family history

	Absent		Present	
	N	%	N	%
NO	57	20.65%	219	79.45%
YES	2	11.8%	15	88.2%

P Value 0.095, there was no statistically significant difference found between Psychiatric comorbidities and Psychiatric comorbidities and previous family history

Figure 22:- Graph showing the Distribution of subjects according to Psychiatric comorbidities and Psychiatric comorbidities and previous family history.

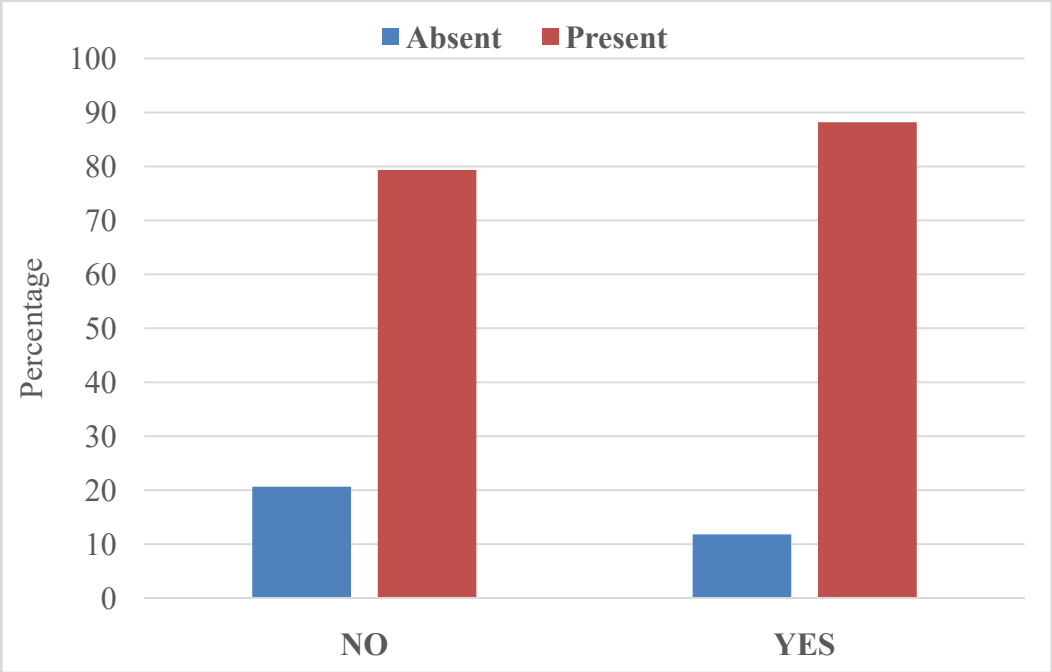


Table 23:- Distribution of subjects according to Psychiatric comorbidities and suicidal attempt

	Absent		Present	
	N	%	N	%
NO	59	20.8%	224	79.2%
YES	0	.0%	10	100.0%

P Value 0.221, there was no statistically significant difference found between Psychiatric comorbidities and suicidal attempt

Figure 23:- Graph showing Distribution of subjects according to Psychiatric comorbidities and suicidal attempt

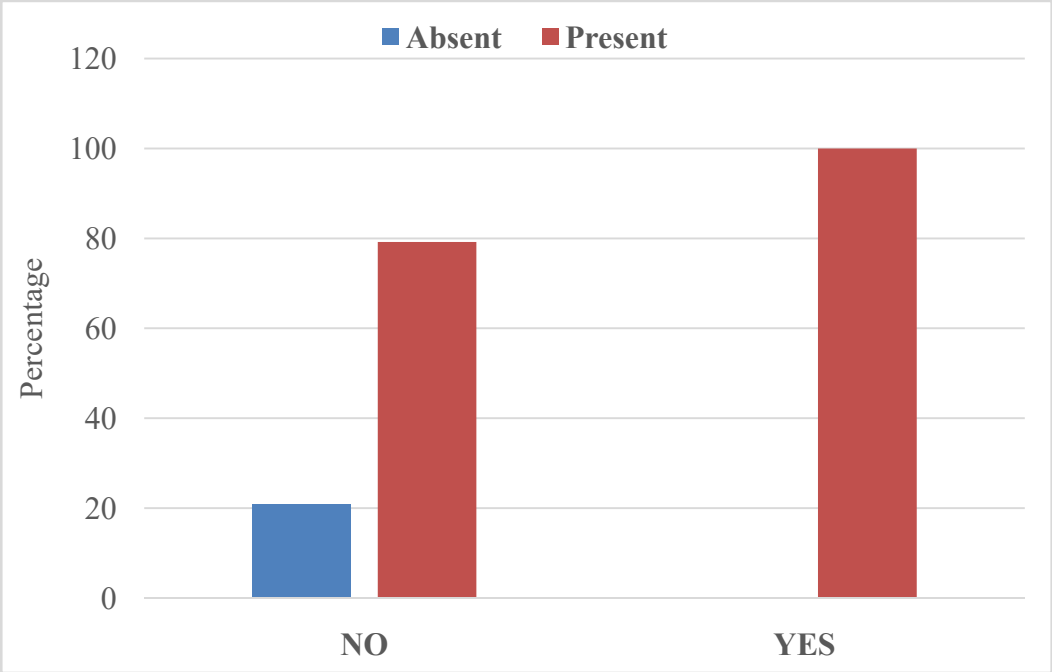
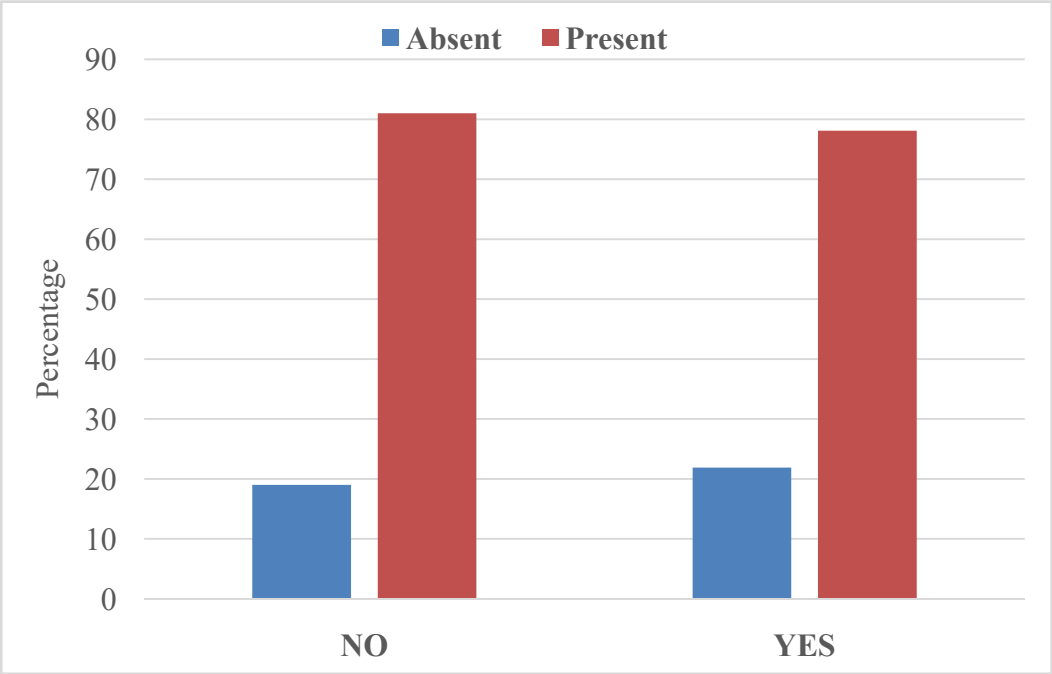


Table 24: - Distribution of subjects according to Psychiatric comorbidities and other comorbidities.

	Absent		Present	
	N	%	N	%
NO	34	19.0%	145	81.0%
YES	25	21.9%	89	78.1%

Patients P Value 0.553, there was no statistically significant difference found between Psychiatric comorbidities and other comorbidities.

Figure 24:- Graph showing the Distribution of subjects according to Psychiatric comorbidities and other comorbidities.



DISCUSSION

Consultation Liaison Psychiatry deals with Treating other medical or surgical comorbidities in a patient with Psychiatric illness or vice versa. The psychiatry unit of a general hospital is not adequate without C-L services. According to biopsychosocial theory, every disorder has a psychological and social component. As a result, its importance is seen in the context of a holistic approach to care that considers both the factors of the psychological and physical aspects of any condition.[83] This collective environment is not possible to only minimize hospital stays but also better patient quality and essence of life and lessen the economic burden of medical conditions.

GENDER

In our study, Males 62.5% of [183] Encompass people were an inclusive part of the study. In the other Study by Gopal Goyal, it was found that Females 51.2% of [81] were more in the Number who were referred for consultation-liaison services.[82] In a study by Santosh Ramdurg, It was found that Males are the most referred people in the Hospital compared to females in Psychiatry.[83,85,86], Which is Comparable to our Study.

MARITAL STATUS

In our Study, the Majority of the people who have been referred had been married, which is in concordance with the other two studies as well. [82,83] In a study by Mudgal V, Similar to our Study, the Number of people who were referred to the department who were single less when compared to Married people, which is concordance with our Study. [84]

AGE RANGE:

In our Study, the Predominant age group of people who were referred belonged to 21 -30 years, 30.7%. In the other Study, most of the people referred belonged to 31-45

years.[82] In a study by P Patra, most of the patients referred for consultation belong to middle age.[88]

In a study by G.S Bhogale, 70.26% of patients belonged to the range of age group of 16 years to 45 years, as noted for the psychiatric inpatients, which, when compared to our Study, is within the age range of our Study.

RELIGION:

More Patients follow Hinduism in our Study, 93.2%, which is comparable to other studies as well.[82,83] In our Study, after Hinduism, some people follow the Muslim religion, 5.8%, which is in concordance with the other Study. [84]

EDUCATIONAL STATUS:

Predominantly Educational status of the patient is up to 12^{th} standard [2^{nd} PU] followed by 10^{th} std 24.9%. Whereas in another study, most of the people referred to belong to the 10^{th} standard.[82] In another study by Mudgal V, Most of the patients Studied up to Primary School followed by Illiterate, which is contrary to our Study. Comparatively, this shows a better literacy rate in Rural Kolar.

OCCUPATION:

Most of the population occupation is unskilled workers in our Study, whereas, in another study, it is Homemaker [83.] In another study conducted by Varchasvi Mudgal et al. Most of the people referred are unemployed. [84]

LOCALITY:

In our Study, the Rural population of 95.9% [281] is the most predominant compared to the urban population of 4.1%[12], which is an expected outcome since the Study takes place in a Rural Tertiary care center. But in another Urban study population are the Majority compared to the Rural Population. [84] In our Study,Patients belonging Above Poverty Line are the Majority at 64.2% when compared to the below poverty

line at 35.8%.

ORIGIN OF REFERRAL:

In our research study, the main origin of referral is Medicine, an overwhelming majority when compared to other sources of referrals, which is comparable to another study as well.[82,84,85]

REASON FOR REFERRAL:

In a study done by P.Patra, the main issue for referral to consultation Liaison Psychiatry included altered sensorium behavioural abnormalities (21.65%), followed by alcohol-related cases (18.47%). [87] Whereas in another study, the most common contributory concern for this referral is baffling somatic symptoms.[86,] which is contrary to our Study. In another study done in Europe, the most common rationale and grounds for referral is suicide attempts 31%[88,] which is in concordance with our Study.

In another conducted Study, the most common rationale for the purpose of referral was thatpsychiatric clearance was defined from the prospective of a kidney donor and bone marrow transplant (BMT). The total amount of stem cell transplant recipients was noted to be 23.1%. This was mainly followed by the overall assessment of current suicidal ideation and suicidal behaviourat 16.9%

PAST HISTORY OF PSYCHIATRIC ILLNESS:

In a study done by De Giorgio et al., 41.3% of the people who were referred had a Past History of Psychiatric Illness[88], whereas, in our Study, Past history amounts to as low as 5.8%**.**

In our Study, Patients having psychiatric comorbidities who were referred amounted to79.9%, and Patients who had nil Psychiatric illness amounted to 20.1%.

MOST COMMON PSYCHIATRIC DIAGNOSIS:

The study conducted by us mainly focused on noting the most common Psychiatric diagnosis is Nil Psychiatric illness 23.9% according to the Screening by MINI scale. Whereas, after Applying the ICD 10 criteria, most patients diagnosed have substance use disorders at 34.4%, followed by Intentional self-harm at 30%. Neurotic and stress-related disorders are the third most common diagnosis at 20.8%. Whereas in the other Study, Neurotic and stress-related disorders 41.7% are the Majority, followed by substance use disorders 12.7%, which cannot be considered within concordance with the findings of our study.[86]

In another study conducted for a similar subject, the focus was laid on overall Alcohol dependence syndrome (ADS) and intentional self-harm. Both of these findings contributed to the overall percentage of (21% each). This was also noted commonly for the two psychiatric disorders which are defined under the sub-category of C-L psychiatry.[8]These results were found to be most resonating with our study.

In another study, Depression seems to be the most commonly diagnosed Psychiatric condition at 24.4%, this was secondary to drug use disorder at 19.7%. Being one of the most common diagnoses, substance use disorder is hence in concordance with our Study.

PHYSICAL DIAGNOSIS:

According to this study, endocrine problems are the most common nonpsychiatric diagnosis, accounting for 49% of the referred population. This represents almost half of the total population. The second most frequent label is "others," which accounts for 34% of cases. Whereas, other studies have found that poisoning, injury, or burns are the most common physical diagnoses (at 36.6%), followed by central nervous system abnormalities (10.5%). 84

ASSOCIATION OF OTHER VARIABLES:

In our study, there seems to be a statistically significant difference found between Psychiatric Comorbidities and Sex at a P value of 0.001. there was a statistically significant difference found between Psychiatric comorbidities and occupation at P Value <0.001, and there was no statistically significant difference found between Psychiatric comorbidities and marital status at a P-Value of 0.868.

SUMMARY AND CONCLUSION

CONCLUSION:

Patients who were referred to Consultation Liaison Psychiatry were screened for Psychiatric illnesses. Patients who have been admitted to nonpsychiatric wards need to be screened thoroughly for the possibility of mental disorders. The Majority of Patients diagnosed have Alcohol Dependence syndrome 21.5% followed by Major Depressive Disorder 9.2% Patients who had Moderate Suicidality were 8.2%, and Lower Suicidality 6.1%. Higher Suicidality would be 3.1% Patients who had higher Suicidality with comorbid Major depressive disorder amounting to 1.4% Patients who had a Psychosis lifetime diagnosis, as well as Alcohol Abuse, is at 3.4%. Major Depressive disorder and Suicidality are closely linked. Warning signs of Suicide need to be identified on time, and measures need to be taken to prevent the same from occurring on the premises of the Hospital as well as in the future. Hence training of nonpsychiatric doctors, Junior residents, and Interns about Psychiatric illnesses is integral for prompt identification, referral of such identified cases to Psychiatry, and commencing the treatment. If needed, Patients who have Psychiatric emergencies need to be shifted to Psychiatric wards for Monitoring and treatment.

SUMMARY

The following study was based on a cross-sectional observation which was conducted in a rural area of Kolar to study the sociodemographic profile of the patients with comorbid psychiatric conditions referred to the psychiatry department and to identify the pattern of psychiatric illnesses in these patients. Most of the patients referred to the department is males at 62.5% and females are about 37.5%. Most of the Patients who were referred for consultation belonged between 21 to 30 years old at 30.7%. It was found people who belonged to the geriatric population had fewer referrals compared with other populations. Most of the patients have completed Higher secondary schooling at 27.6%, followed by secondary schooling 24.9%Very few have completed their post-Graduation at 1.0% People who are illiterate at 11.6%. Many of the Patients are unskilled workers at 52.6%, followed by Unemployed at 37.9%. Only very few patients are Professionals, and Semi Professionals at 0.3%

And 1.4%. The Majority of the Study sample belonged to Rural areas. 95.9% Urban population comprises a small percentage. Patients who are referred from Medicine Department are the Overwhelming Majority at 74.4%. Followed by Surgery Referrals at 11.9%. Other departments include Cardiology, Ophthalmology, Orthopedics, OBG, ENT, and EMD at 0.3%,0.7%,3.1%,2.0%,3.1%, and 4.4%, respectively.

The Majority of Patients diagnosed to have Alcohol Dependence syndrome 21.5% followed by Major Depressive Disorder 9.2%. Patients who had Moderate Suicidality were 8.2%, and Lower Suicidality was 6.1%. Higher Suicidality would be 3.1%. Patients who had higher Suicidality with comorbid Major depressive disorder amounting to 1.4%

BIBLIOGRAPHY

BIBLIOGRAPHY:

1. Jayasankar P, Manjunatha N, Rao GN, Gururaj G, Varghese M, Benegal V; NMHS India National Collaborator Group. Epidemiology of common mental disorders: Results from "National Mental Health Survey" of India, 2016. Indian J Psychiatry. 2022 Jan-Feb;64(1):13-19.

2. Lipowski ZJ. Current trends in consultation-liaison psychiatry. The Canadian Journal of Psychiatry. 1983 Aug;28(5):329-38.

3. Sadock BJ, Sadock VA, Ruiz P. Kaplan and Sadock's comprehensive textbook of psychiatry. 10th ed. Baltimore, MD: Wolters Kluwer Health; 2017.

4.El Hayek S, Kassir G, Zalzale H, Gonzalez-Diaz JM, Bizri M. Emerging Psychiatric Themes in Post-COVID-19 Patients on a Psychiatry Consultation-liaison Service. Psychiatric Quarterly. 2021 Dec;92(4):1785-96.

5.Turan Ş, Poyraz BÇ, Poyraz CA, Demirel ÖF, Aydın ET, Bostan BU, Demirel Ö, Ali RK. Characteristics and outcomes of COVID-19 inpatients who underwent psychiatric consultations. Asian journal of psychiatry. 2021 Mar 1;57:102563.

6.Nikooie R, Neufeld KJ, Oh ES, Wilson LM, Zhang A, Robinson KA,

Needham DM. Antipsychotics for treating delirium in hospitalized adults: a systematic review. Annals of Internal Medicine. 2019 Oct 1;171(7):485-95.

7. Delgado-Parada E, Alonso-Sánchez M, Ayuso-Mateos JL, Robles-Camacho M, Izquierdo A. Liaison psychiatry before and after the COVID-19 pandemic. Psychiatry Research. 2022 May 22:114651.

8. Vadlamani LN, Gowda M. Practical implications of Mental Healthcare Act 2017: Suicide and suicide attempt. Indian journal of psychiatry. 2019 Apr;61(Suppl 4):S750.

9. Kumar KK, Sattar FA, Bondade S, Hussain MM, Priyadarshini M. A gender-specific analysis of suicide methods in deliberate self-harm. Indian Journal of Social Psychiatry. 2017 Jan 1;33(1):7.

10.Klonsky ED. The functions of deliberate self-injury: A review of the evidence. Clinical psychology review. 2007 Mar 1;27(2):226-39.

11.Klonsky ED, Oltmanns TF, Turkheimer E. Deliberate self-harm in a nonclinical population: Prevalence and psychological correlates. American Journal of Psychiatry. 2003 Aug 1;160(8):1501-8.

12. Wilkinson PO. Nonsuicidal self-injury: a clear marker for suicide risk. J Am

Acad Child Adolesc Psychiatry. 2011;50(8):741–43.

13.Klonsky ED, Muehlenkamp JJ. Self-injury: A research review for the practitioner. Journal of clinical psychology. 2007 Nov;63(11):1045-56.

14.Klonsky ED, Victor SE, Saffer BY. Nonsuicidal self-injury: What we know, and what we need to know. The Canadian Journal of Psychiatry. 2014 Nov;59(11):565-8.

15.Clarke S, Allerhand LA, Berk MS. Recent advances in understanding and managing self-harm in adolescents. F1000Research. 2019;8.

16.Poudel A, Lamichhane A, Magar KR, Khanal GP. Non suicidal self injury and suicidal behavior among adolescents: co-occurrence and associated risk factors. BMC psychiatry. 2022 Dec;22(1):1-2.

17. Austin GA. Alcohol in western society: From antiquity to 1800 - a chronological history. Oxford, England: ABC-CLIO; 1985. pp. 251- 366.

18.Centers for Disease Control and Prevention. Alcohol-Related Disease Impact Application website. Accessed April 19, 2022.Moussas G, Christodoulou C, Douzenis

19. Grant BF, Goldstein RB, Saha TD, Chou SP, Jung J, Zhang H, Pickering

RP, Ruan WJ, Smith SM, Huang B, Hasin DS. Epidemiology of DSM-5 alcohol use disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions III. JAMA psychiatry. 2015 Aug 1;72(8):757-66.

20. Moussas G, Christodoulou C, Douzenis A. A short review on the aetiology and pathophysiology of alcoholism. Annals of general psychiatry. 2009 Dec;8(1):1-4.

21.Arias AJ, Kranzler HR. Treatment of co-occurring alcohol and other drug use disorders. Alcohol Research & Health. 2008;31(2):155.

22. Mental and behavioural disorders due to use of alcohol. In: The ICD-10 classification of mental and behavioural disorders: Diagnostic Criteria for Research. Geneva: World Health Organization; 2003. p. 70–6.

23.Cohen SM, Alexander RS, Holt SR. The Spectrum of Alcohol Use: Epidemiology, Diagnosis, and Treatment. Medical Clinics. 2022 Jan 1;106(1):43-60.

24.Romeo J, Wärnberg J, Nova E, Díaz LE, Gómez-Martinez S, Marcos A. Moderate alcohol consumption and the immune system: a review. British

Journal of Nutrition. 2007 Oct;98(S1):S111-5.

25.Dani JA, Balfour DJ. Historical and current perspective on tobacco use and nicotine addiction. Trends in neurosciences. 2011 Jul 1;34(7):383-92.

26.US Department of Health and Human Services. The health consequences of smoking: a report of the Surgeon General.

27. Mishra A, Chaturvedi P, Datta S, Sinukumar S, Joshi P, Garg A. Harmful effects of nicotine. Indian Journal of Medical and Paediatric Oncology. 2015 Jan;36(01):24-31.

28. Barua RS, Rigotti NA, Benowitz NL, Cummings KM, Jazayeri MA, Morris PB, Ratchford EV, Sarna L, Stecker EC, Wiggins BS. 2018 ACC expert consensus decision pathway on tobacco cessation treatment: a report of the American College of Cardiology Task Force on Clinical Expert Consensus Documents. Journal of the American College of Cardiology. 2018 Dec 25;72(25):3332-65.

29.Crocq MA. History of cannabis and the endocannabinoid system. Dialogues in clinical neuroscience. 2022 Apr 1.

30. Pouliquen M, Auriacombe M. Psychotherapeutic interventions for cannabis use disorder. What do we know and what should we do?.L'encephale. 2022 Feb 1;48(1):70-7.

31. Kirkland AE, Fadus MC, Gruber SA, Gray KM, Wilens TE, Squeglia LM. A scoping review of the use of cannabidiol in psychiatric disorders. Psychiatry

Research. 2021 Dec 20:114347.

32.Jengsuebsant N, Benjachaya S, Vuthiwong J, Tangsuwanaruk T. Penile self-amputation due to cannabis-induced psychosis: a case report. Journal of medical case reports. 2022 Dec;16(1):1-4.

33.Andréasson S, Allebeck P, Rydberg U. Schizophrenia in users and nonusers of cannabis: A longitudinal study in Stockholm County. Acta Psychiatrica Scandinavica. 1989 May;79(5):505-10.

34.Chesney E, Oliver D, McGuire P. Cannabidiol (CBD) as a novel treatment in the early phases of psychosis. Psychopharmacology. 2021 Jul 13:1-2.

35.Center for Drug Evaluation and Research. Opioid medications [Internet]. U.S. Food and Drug Administration. FDA; https://www.fda.gov/drugs/information-drug-class/opioid-medications

36. Jones MR, Viswanath O, Peck J, Kaye AD, Gill JS, Simopoulos TT. A brief history of the opioid epidemic and strategies for pain medicine. Pain and therapy. 2018 Jun;7(1):13-21.

37.Manchikanti L. Health care reform in the United States: Radical surgery needed now more than ever. Pain Physician. 2008 Jan 1;11(1):13-42.

38.Rosenblum A, Marsch LA, Joseph H, Portenoy RK. Opioids and the treatment of chronic pain: controversies, current status, and future directions. Experimental and clinical psychopharmacology. 2008 Oct;16(5):405.

39. Jackson SW. Melancholia and depression: From Hippocratic times to modern times. New Haven, CT: Yale University Press; 1986..

40.Berrios GE. Depressive and manic states during the nineteenth century. Depression and mania. 1988:13-25.

41. CullenW. Amethodical system of nosology: translated from Latin by Dr Eldad Lewis. Stockbridge, MA: Cornelius Sturtevant; 1807.

42.Pinel P. A Treatise on Insanity: In which are Contained the Principles of a New and More Practical Nosology of Maniacal Disorders Than Has Yet Been Offered to the Public... W. Todd; 1806.

43.Esquirol E. Des Maladies Mentales: Considérées Sous Les Rapports: Médical, Hygiénique Et Médico-Légal. Tome Premier ed. Bruxelles: LibrairieMédicale et Scientifique de J. B. Tircher; 1838.

44.Esquirol E. Mental maladies; a treatise on insanity. Lea and Blanchard; 1845.

45.Guislain J. Leçonsorales sur les phrénopathiesouTraitéthéorique et pratique des maladies mentales: coursdonné à la clinique des établissementsd'aliénés à Gand. Vanderhaeghen; 1880.

46. Krafft-Ebing Rv. Die Melancholie: Eine Klinische Studie. Erlangen: Verlag

Von Ferdinand Enke; 1874.

47. Spijker J, De Graaf R, Bijl RV, Beekman AT, Ormel J, Nolen WA. Functional disability and depression in the general population. Results from the Netherlands Mental Health Survey and Incidence Study (NEMESIS). Acta Psychiatrica Scandinavica. 2004 Sep;110(3):208-14.

48. Murray CJ, Lopez AD. Evidence-based health policy--lessons from the Global Burden of Disease Study. Science. 1996; 274:740–743.

49.Hardeveld F, Spijker J, De Graaf R, Nolen WA, Beekman AT. Prevalence and predictors of recurrence of major depressive disorder in the adult population. Acta Psychiatrica Scandinavica. 2010 Sep;122(3):184-91.

50.Moffitt TE, Caspi A, Taylor A, Kokaua J, Milne BJ, Polanczyk G, Poulton R. How common are common mental disorders? Evidence that lifetime prevalence rates are doubled by prospective versus retrospective ascertainment. Psychological medicine. 2010 Jun;40(6):899-909.

51.Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Ustun TB. Age of onset of mental disorders: a review of recent literature. Current opinion in psychiatry. 2007 Jul;20(4):359.

52. Kessler RC, Bromet EJ. The epidemiology of depression across cultures. Annual review of public health. 2013;34:119.

53.Kessler RC. The effects of stressful life events on depression. Annual review of psychology. 1997 Feb;48(1):191-214.

54.Li M, D'Arcy C, Meng X. Maltreatment in childhood substantially increases the risk of adult depression and anxiety in prospective cohort studies: systematic review, meta-analysis, and proportional attributable fractions. Psychological medicine. 2016 Mar;46(4):717-30.

55.Meaney MJ. Maternal care, gene expression, and the transmission of individual differences in stress reactivity across generations. Annual review of neuroscience. 2001 Mar;24(1):1161-92.

56.Stetler C, Miller GE. Depression and hypothalamic-pituitary-adrenal activation: a quantitative summary of four decades of research. Psychosomatic medicine. 2011 Feb 1;73(2):114-26.

57. Mood and affective disorders . In: ICD 10: International Statistical Classification of Diseases and Related Health problems. Geneva: World Health Organization; 2009. p. 119–130.

58. Singh T, Williams K. Atypical depression. Psychiatry (Edgmont). 2006 Apr 1;3(4):33.

59. Robinson RG, Starr LB, Kubos KL, et al: A two-year longitudinalvstudy of post-stroke mood disorders: findings during the initial evaluation. Stroke 1983; 14:736–741

60. Robinson RG, Spalletta G. Poststroke depression: a review. The Canadian Journal of Psychiatry. 2010 Jun;55(6):341-9.

61. Rush AJ. The varied clinical presentations of major depressive disorder. Journal of Clinical Psychiatry. 2007 Jan 1;68(8):4.

62 Cleare, A. *et al.* Evidence-based guidelines for treating depressive disorders with antidepressants: a revision of the 2008 British Association for Psychopharmacology guidelines. *J. Psychopharmacol.* **29**, 459–525 (2015).

63.Otte C, Gold SM, Penninx BW, Pariante CM, Etkin A, Fava M, Mohr DC, Schatzberg AF. Major depressive disorder. Nature reviews Disease primers. 2016 Sep 15;2(1):1-20.

64. Mood and affective disorders . In: ICD 10: International Statistical Classification of Diseases and Related Health problems. Geneva: World Health Organization; 2009. p. 110–8.

65.Hardeveld F, Spijker J, De Graaf R, Nolen WA, Beekman AT. Prevalence and predictors of recurrence of major depressive disorder in the adult

population. Acta Psychiatrica Scandinavica. 2010 Sep;122(3):184-91.

66. Wittchen HU, Mühlig S, Pezawas L. Natural course and burden of bipolar disorders. International Journal of Neuropsychopharmacology. 2003 Jun 1;6(2):145-54.

67. Geddes JR, Miklowitz DJ. Treatment of bipolar disorder. The lancet. 2013 May 11;381(9878):1672-82.

68.Stein MB, Sareen J. Generalized anxiety disorder. New England Journal of Medicine. 2015 Nov 19;373(21):2059-68.

69. Wittchen HU. Generalized anxiety disorder: prevalence, burden, and cost to society. Depression and anxiety. 2002;16(4):162-71.

70. Harold Irwin Kaplan, Benjamin James Sadock. Modern synopsis of Comprehensive textbook of psychiatry /III. Baltimore: Williams & Wilkins; 1983.

71. Roy-Byrne PP. Panic disorder in adults: Epidemiology, clinical manifestations, and diagnosis.

72. Roy-Byrne PP, Craske MG, Stein MB. Panic disorder. The Lancet. 2006 Sep 16;368(9540):1023-32.

73.Botella C, Villa H, García Palacios A, Quero S, Baños RM, Alcaniz M. The use of VR in the treatment of panic disorders and agoraphobia. Stud Health

Technol Inform. 2004;99:73-90. PMID: 15295147.

74. Eaton WW, Bienvenu OJ, Miloyan B. Specific phobias. The Lancet Psychiatry. 2018 Aug 1;5(8):678-86.

75. Yehuda R. Post-traumatic stress disorder. New England journal of medicine. 2002 Jan 10;346(2):108-14.

76. Arciniegas DB. Psychosis. Continuum: Lifelong Learning in Neurology. 2015 Jun;21(3 Behavioral Neurology and Neuropsychiatry):715.

77. International Early Psychosis Association Writing Group. International clinical practice guidelines for early psychosis. The British Journal of Psychiatry. 2005 Aug;187(S48):s120-4.

78. Fisher KA, Hany M. Antisocial Personality Disorder.

79. Glenn AL, Johnson AK, Raine A. Antisocial personality disorder: a current review. Curr Psychiatry Rep. 2013 Dec;15(12):427.

80. Kornfeld DS. Consultation-liaison psychiatry: contributions to medical practice. American Journal of Psychiatry. 2002 Dec 1;159(12):1964-72.

81. Grover S, Avasthi A. Consultation–liaison psychiatry in India: Where to go from here?. Indian Journal of Psychiatry. 2019 Mar;61(2):117.

82. Goyal SG, Sagar R, Sharan P. Sociodemographic profile and psychiatric diagnosis of patients referred to consultation-liaison psychiatric services of general hospital psychiatric unit at a Tertiary Care Center. J Mental Health Hum Behav2017;22:45-9.

83. Ramdurg S, Goyal S, Goyal P, Sagar R, Sharan P. Sociodemographic profile, clinical factors, and mode of attempt in suicide attempters in consultation liaison psychiatry in a tertiary care center. Ind Psychiatry J. 2011 Jan;20(1):11-6.

84. Mudgal V, Rastogi P, Niranjan V, *et al*. Pattern, clinical and demographic profile of inpatient psychiatry referrals in a tertiary care teaching hospital: a descriptive study. *General Psychiatry* 2020;33:e100177.

85. Ranjan S, Poudel R, Pandey P. Consultation-liaison psychiatry in tertiary level hospital in Nepal. Health Renaissance. 2014;12(3):170-4.

86.Keertish N, Sathyanarayana MT, Kumar BH, Singh N, Udagave K. Pattern of psychiatric referrals in a tertiary care teaching hospital in southern India. Journal of clinical and diagnostic research: JCDR. 2013 Aug;7(8):1689.

87. Patra P, Divinakumar KJ, Prakash J, Patra B, Chakraborty R. Clinico-psycho-social profile of patients brought under consultation-liaison psychiatry care in a large tertiary care referral hospital. Ind Psychiatry J. 2017 Jan-Jun;26(1):24-27.

88. De Giorgio, G., Quartesan, R., Sciarma, T. *et al.* Consultation-Liaison Psychiatry—from theory to clinical practice: an observational study in a general hospital. *BMC Res Notes* **8**, 475 (2015).

ANNEXURE 1

SOCIODEMOGRAPHIC DATA

1. **NAME:**

2. **AGE:**

3. **GENDER:**

4. **EDUCATION:** Illiterate/ Primary/ Upto 10TH Std / upto 12th std/Graduate/Postgraduate

5. **OCCUPATION:** Professional /Semi-professional / Skilled worker/ Unskilled worker/ Unemployed/Homemaker

6. **ADDRESS:**

7. **LOCALITY: RURAL/URBAN**

8. **RELIGION: HINDU/MUSLIM/CHRISTIAN/OTHER**

9. **UHID NO:**

10. WARD:

11. DIAGNOSIS OF THE PATIENT:

12. DEPARTMENT THEY ARE REFERRED FROM:

13. MARITAL STATUS:

14. CHIEF COMPLAINTS:

15. PREVIOUS H/O PSYCHIATRIC ILLNESS:

16. FAMILY H/O PSYCHIATRIC ILLNESS:

17. **PREVIOUS HISTORY OF SUICIDAL ATTEMPT [FOR DELIBRATE SELF HARM CASES/DEPRESSION]**

18. COMORBID MEDICAL HISTORY:

19. SUBSTANCE ABUSE HISTORY:

20. Sleep- adequate/ disturbed

Appetite-

GENERAL PHYSICAL EXAMINATION :

- Built and nourishment
    - VITALS
    - Pulse :
    - BP :

M.I.N.I.

MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW

English Version 6.0.0

DSM-IV

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DISCLAIMER

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

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

M.I.N.I. 6.0.0 (January 1, 2009)

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

	MODULES	TIME FRAME	MEETS CRITERIA	DSM-IV-TR	ICD-10	PRIMARY DIAGNOSIS
A	MAJOR DEPRESSIVE EPISODE	Current (2 weeks)	☐	296.20-296.26 Single	F32.x	☐
		Past	☐	296.20-296.26 Single	F32.x	☐
		Recurrent	☐	296.30-296.36 Recurrent	F33.x	☐
B	SUICIDALITY	Current (Past Month) ☐ Low ☐ Moderate ☐ High	☐			
C	MANIC EPISODE	Current	☐	296.00-296.06	F30.x-F31.9	☐
		Past	☐			
	HYPOMANIC EPISODE	Current	☐	296.80-296.89	F31.8-F31.9/F34.0	☐
		Past	☐			
	BIPOLAR I DISORDER	Current	☐	296.0x-296.6x	F30.x-F31.9	☐
		Past	☐	296.0x-296.6x	F30.x-F31.9	☐
	BIPOLAR II DISORDER	Current	☐	296.89	F31.8	☐
		Past	☐	296.89	F31.8	☐
	BIPOLAR DISORDER NOS	Current	☐	296.80	F31.9	☐
		Past	☐	296.80	F31.9	☐
D	PANIC DISORDER	Current (Past Month)	☐	300.01/300.21	F40.01-F41.0	☐
		Lifetime	☐			
E	AGORAPHOBIA	Current	☐	300.22	F40.00	☐
F	SOCIAL PHOBIA (Social Anxiety Disorder)	Current (Past Month)				
		Generalized	☐	300.23	F40.1	☐
		Non-Generalized	☐	300.23	F40.1	☐
G	OBSESSIVE-COMPULSIVE DISORDER	Current (Past Month)	☐	300.3	F42.8	☐
H	POSTTRAUMATIC STRESS DISORDER	Current (Past Month)	☐	309.81	F43.1	☐
I	ALCOHOL DEPENDENCE	Past 12 Months	☐	303.9	F10.2x	☐
	ALCOHOL ABUSE	Past 12 Months	☐	305.00	F10.1	☐
J	SUBSTANCE DEPENDENCE (Non-alcohol)	Past 12 Months	☐	304.00-.90/305.20-.90	F11.1-F19.1	☐
	SUBSTANCE ABUSE (Non-alcohol)	Past 12 Months	☐	304.00-.90/305.20-.90	F11.1-F19.1	☐
K	PSYCHOTIC DISORDERS	Lifetime	☐	295.10-295.90/297.1/	F20.xx-F29	☐
		Current	☐	297.3/293.81/293.82/ 293.89/298.8/298.9		
	MOOD DISORDER WITH	Lifetime	☐	296.24/296.34/296.44	F32.3/F33.3/	☐
	PSYCHOTIC FEATURES	Current	☐	296.24/296.34/296.44	F30.2/F31.2/F31.5	
					F31.8/F31.9/F39	☐
L	ANOREXIA NERVOSA	Current (Past 3 Months)	☐	307.1	F50.0	☐
M	BULIMIA NERVOSA	Current (Past 3 Months)	☐	307.51	F50.2	☐
	ANOREXIA NERVOSA, BINGE EATING/PURGING TYPE	Current	☐	307.1	F50.0	☐
N	GENERALIZED ANXIETY DISORDER	Current (Past 6 Months)	☐	300.02	F41.1	☐
O	MEDICAL, ORGANIC, DRUG CAUSE RULED OUT		☐ No	☐ Yes ☐ Uncertain		
P	ANTISOCIAL PERSONALITY DISORDER	Lifetime	☐	301.7	F60.2	☐

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

The translation from DSM-IV-TR to ICD-10 coding is not always exact. For more information on this topic see Schulte-Markwort. Crosswalks ICD-10/DSM-IV-TR. Hogrefe & Huber Publishers 2006.

A. MAJOR DEPRESSIVE EPISODE

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

A1	a	Were you <u>ever</u> depressed or down, most of the day, nearly every day, for two weeks?	NO	YES
		IF NO, CODE NO TO **A1b**: IF YES ASK:		
	b	<u>For the past two weeks,</u> were you depressed or down, most of the day, nearly every day?	NO	YES
A2	a	Were you <u>ever</u> much less interested in most things or much less able to enjoy the things you used to enjoy most of the time, for two weeks?	NO	YES
		IF NO, CODE NO TO **A2b**: IF YES ASK:		
	b	In the <u>past two weeks</u>, were you much less interested in most things or much less able to enjoy the things you used to enjoy, most of the time?	NO	YES
		➡ IS **A1a** OR **A2a** CODED YES?	NO	YES

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

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

		<u>Past 2 Weeks</u>		<u>Past Episode</u>	
a	Was your appetite decreased or increased nearly every day? Did your weight decrease or increase without trying intentionally (i.e., by ±5% of body weight or ±8 lbs. or ±3.5 kgs., for a 160 lb./70 kg. person in a month)? IF YES TO EITHER, CODE YES.	NO	YES	NO	YES
b	Did you have trouble sleeping nearly every night (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)?	NO	YES	NO	YES
c	Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still almost every day?	NO	YES	NO	YES
d	Did you feel tired or without energy almost every day?	NO	YES	NO	YES
e	Did you feel worthless or guilty almost every day?	NO	YES	NO	YES
	IF YES, ASK FOR EXAMPLES. THE EXAMPLES ARE CONSISTENT WITH A DELUSIONAL IDEA. Current Episode ☐ No ☐ Yes; Past Episode ☐ No ☐ Yes				
f	Did you have difficulty concentrating or making decisions almost every day?	NO	YES	NO	YES
g	Did you repeatedly consider hurting yourself, feel suicidal, or wish that you were dead? Did you attempt suicide or plan a suicide? IF YES TO EITHER, CODE YES.	NO	YES	NO	YES
A4	Did these symptoms cause significant problems at home, at work, socially, at school or in some other important way?	NO	YES	NO	YES

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

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

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

IF A5 IS CODED YES, CODE YES FOR RECURRENT.

NO	YES
MAJOR DEPRESSIVE EPISODE	
CURRENT	❐
PAST	❐
RECURRENT	❐

A6 a How many episodes of depression did you have in your lifetime? _____

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

B. SUICIDALITY

				Points
	In the past month did you:			
B1	Suffer any accident? IF NO TO B1, SKIP TO B2; IF YES, ASK B1a:	NO	YES	0
B1a	Plan or intend to hurt yourself in that accident either actively or passively (e.g. not avoiding a risk)? IF NO TO B1a, SKIP TO B2: IF YES, ASK B1b:	NO	YES	0
B1b	Intend to die as a result of this accident?	NO	YES	0
B2	Feel hopeless?	NO	YES	1
B3	Think that you would be better off dead or wish you were dead?	NO	YES	1
B4	Want to harm yourself or to hurt or to injure yourself or have mental images of harming yourself?	NO	YES	2
B5	Think about suicide? IF NO TO B5, SKIP TO B7. OTHERWISE ASK:	NO	YES	6

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

	Can you state that you will not act on these impulses during this treatment program?	NO	YES	
B6	Feel unable to control these impulses?	NO	YES	8
B7	Have a suicide plan?	NO	YES	8
B8	Take any active steps to prepare to injure yourself or to prepare for a suicide attempt in which you expected or intended to die?	NO	YES	9
B9	Deliberately injure yourself without intending to kill yourself?	NO	YES	4
B10	Attempt suicide? IF NO SKIP TO B11: Hope to be rescued / survive ❒ Expected / intended to die ❒	NO	YES	9
	In your lifetime:			
B11	Did you ever make a suicide attempt?	NO	YES	4

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

IF YES, ADD THE TOTAL POINTS FOR THE ANSWERS (B1-B11) CHECKED 'YES' AND SPECIFY THE SUICIDALITY SCORE AS INDICATED IN THE DIAGNOSTIC BOX:

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

NO YES

SUICIDALITY CURRENT

1-8 points	Low	❒
9-16 points	Moderate	❒
≥ 17 points	High	❒

C. MANIC AND HYPOMANIC EPISODES

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

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

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

IF YES, PLEASE SPECIFY WHO:_____

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

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

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

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

		Current Episode		Past Episode	
e	Become easily distracted so that any little interruption could distract you?	NO	YES	NO	YES
f	Have a significant increase in your activity or drive, at work, at school, socially or sexually or did you become physically or mentally restless?	NO	YES	NO	YES
g	Want so much to engage in pleasurable activities that you ignored the risks or consequences (for example, spending sprees, reckless driving, or sexual indiscretions)?	NO	YES	NO	YES
C3	SUMMARY: WHEN RATING CURRENT EPISODE: IF C1b IS NO, ARE 4 OR MORE C3 ANSWERS CODED YES? IF C1b IS YES, ARE 3 OR MORE C3 ANSWERS CODED YES?	NO	YES	NO	YES
	WHEN RATING PAST EPISODE: IF C1a IS NO, ARE 4 OR MORE C3 ANSWERS CODED YES? IF C1a IS YES, ARE 3 OR MORE C3 ANSWERS CODED YES?				
	CODE YES ONLY IF THE ABOVE 3 OR 4 SYMPTOMS OCCURRED DURING THE SAME TIME PERIOD.				
	RULE: ELATION/EXPANSIVENESS REQUIRES ONLY THREE C3 SYMPTOMS, WHILE IRRITABLE MOOD ALONE REQUIRES 4 OF THE C3 SYMPTOMS.				
C4	What is the longest time these symptoms lasted?				
	a) 3 days or less		❒		❒
	b) 4 to 6 days		❒		❒
	c) 7 days or more		❒		❒
C5	Were you hospitalized for these problems?	NO	YES	NO	YES
	IF YES, STOP HERE AND CIRCLE YES IN MANIC EPISODE FOR THAT TIME FRAME.				
C6	Did these symptoms cause significant problems at home, at work, socially in your relationships with others, at school or in some other important way?	NO	YES	NO	YES

ARE C3 SUMMARY AND C5 AND C6 CODED YES AND EITHER C4a or b or c CODED YES?

OR

ARE C3 SUMMARY AND C4c AND C6 CODED YES AND IS C5 CODED NO?

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

NO YES

MANIC EPISODE

CURRENT ❒
PAST ❒

ARE C3 SUMMARY AND C5 AND C6 CODED NO AND EITHER C4b OR C4C CODED YES?

OR

ARE C3 SUMMARY AND C4b AND C6 CODED YES AND IS C5 CODED NO?

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

NO YES

HYPOMANIC EPISODE

CURRENT ❒
PAST ❒

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

HYPOMANIC SYMPTOMS

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

CURRENT ❒
PAST ❒

C7 a) IF MANIC EPISODE IS POSITIVE FOR EITHER CURRENT OR PAST ASK:
Did you have 2 or more manic episodes (**C4c**) in your lifetime (including the current episode if present)? NO YES

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

c) IF PAST "HYPOMANIC SYMPTOMS" IS CODED POSITIVE ASK:
Did you have 2 or more episodes of hypomanic SYMPTOMS (**C4a**) in your lifetime
(including the current episode if present)? NO YES

D. PANIC DISORDER

(➡ MEANS : CIRCLE NO IN D5, D6 AND D7 AND SKIP TO E1)

D1	a	Have you, on more than one occasion, had spells or attacks when you **suddenly** felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way?	➡ NO	YES
	b	Did the spells surge to a peak within 10 minutes of starting?	➡ NO	YES
D2		At any time in the past, did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?	➡ NO	YES
D3		Have you ever had one such attack followed by a month or more of persistent concern about having another attack, or worries about the consequences of the attack - or did you make a significant change in your behavior because of the attacks (e.g., shopping only with a companion, not wanting to leave your house, visiting the emergency room repeatedly, or seeing your doctor more frequently because of the symptoms)?	NO	YES
D4		**During the worst attack that you can remember:**		
	a	Did you have skipping, racing or pounding of your heart?	NO	YES
	b	Did you have sweating or clammy hands?	NO	YES
	c	Were you trembling or shaking?	NO	YES
	d	Did you have shortness of breath or difficulty breathing?	NO	YES
	e	Did you have a choking sensation or a lump in your throat?	NO	YES
	f	Did you have chest pain, pressure or discomfort?	NO	YES
	g	Did you have nausea, stomach problems or sudden diarrhea?	NO	YES
	h	Did you feel dizzy, unsteady, lightheaded or faint?	NO	YES
	i	Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from part or all of your body?	NO	YES
	j	Did you fear that you were losing control or going crazy?	NO	YES
	k	Did you fear that you were dying?	NO	YES
	l	Did you have tingling or numbness in parts of your body?	NO	YES
	m	Did you have hot flushes or chills?	NO	YES
D5		ARE BOTH **D3**, AND **4** OR MORE **D4** ANSWERS, CODED YES? IF YES TO D5, SKIP TO D7.	NO	YES *PANIC DISORDER LIFETIME*
D6		IF **D5 = NO**, ARE ANY D4 ANSWERS CODED YES? THEN SKIP TO **E1.**	NO	YES *LIMITED SYMPTOM ATTACKS LIFETIME*

D7	In the past month, did you have such attacks repeatedly (2 or more), and did you have persistent concern about having another attack, or worry about the consequences of the attacks, or did you change your behavior in any way because of the attacks?	NO	YES *PANIC DISORDER CURRENT*

E. AGORAPHOBIA

E1	Do you feel anxious or uneasy in places or situations where help might not be available or escape might be difficult, like being in a crowd, standing in a line (queue), when you are alone away from home or alone at home, or when crossing a bridge, or traveling in a bus, train or car or where you might have a panic attack or the panic-like symptoms we just spoke about?	NO	YES

IF **E1 = NO**, CIRCLE **NO** IN **E2**.

E2	Do you fear these situations so much that you avoid them, or suffer through them, or need a companion to face them?	NO	YES *AGORAPHOBIA CURRENT*

IS **E2** (CURRENT AGORAPHOBIA) CODED **YES**

and

IS **D7** (CURRENT PANIC DISORDER) CODED **YES**?

NO YES

PANIC DISORDER with Agoraphobia CURRENT

IS **E2** (CURRENT AGORAPHOBIA) CODED **NO**

and

IS **D7** (CURRENT PANIC DISORDER) CODED **YES**?

NO YES

PANIC DISORDER without Agoraphobia CURRENT

IS **E2** (CURRENT AGORAPHOBIA) CODED **YES**

and

IS **D5** (PANIC DISORDER LIFETIME) CODED **NO**?

NO YES

AGORAPHOBIA, CURRENT *without history of Panic Disorder*

F. SOCIAL PHOBIA (Social Anxiety Disorder)

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

F1	In the past month, did you have persistent fear and significant anxiety at being watched, being the focus of attention, or of being humiliated or embarrassed? This includes things like speaking in public, eating in public or with others, writing while someone watches, or being in social situations.	➡ NO	YES
F2	Is this social fear excessive or unreasonable and does it almost always make you anxious?	➡ NO	YES
F3	Do you fear these social situations so much that you avoid them or suffer through them most of the time?	➡ NO	YES
F4	Do these social fears disrupt your normal work, school or social functioning or cause you significant distress?	NO	YES

SUBTYPES

Do you fear and avoid 4 or more social situations?

If YES Generalized social phobia (social anxiety disorder)

If NO Non-generalized social phobia (social anxiety disorder)

EXAMPLES OF SUCH SOCIAL SITUATIONS TYPICALLY INCLUDE

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

NOTE TO INTERVIEWER: PLEASE ASSESS WHETHER THE SUBJECT'S FEARS ARE RESTRICTED TO NON-GENERALIZED ("ONLY 1 OR SEVERAL") SOCIAL SITUATIONS OR EXTEND TO GENERALIZED ("MOST") SOCIAL SITUATIONS. "MOST" SOCIAL SITUATIONS IS USUALLY OPERATIONALIZED TO MEAN 4 OR MORE SOCIAL SITUATIONS, ALTHOUGH THE DSM-IV DOES NOT EXPLICITLY STATE THIS.

SOCIAL PHOBIA
(Social Anxiety Disorder)
CURRENT

GENERALIZED ❐

NON-GENERALIZED ❐

G. OBSESSIVE-COMPULSIVE DISORDER

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

G1	In the past month, have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive, or distressing? - (For example, the idea that you were dirty, contaminated or had germs, or fear of contaminating others, or fear of harming someone even though it disturbs or distresses you, or fear you would act on some impulse, or fear or superstitions that you would be responsible for things going wrong, or obsessions with sexual thoughts, images or impulses, or hoarding, collecting, or religious obsessions.) (DO NOT INCLUDE SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PROBLEMS. DO NOT INCLUDE OBSESSIONS DIRECTLY RELATED TO EATING DISORDERS, SEXUAL DEVIATIONS, PATHOLOGICAL GAMBLING, OR ALCOHOL OR DRUG ABUSE BECAUSE THE PATIENT MAY DERIVE PLEASURE FROM THE ACTIVITY AND MAY WANT TO RESIST IT ONLY BECAUSE OF ITS NEGATIVE CONSEQUENCES.)	NO YES ↓ SKIP TO G4
G2	Did they keep coming back into your mind even when you tried to ignore or get rid of them?	NO YES ↓ SKIP TO G4
G3	Do you think that these obsessions are the product of your own mind and that they are not imposed from the outside?	NO YES obsessions
G4	In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, arranging things, or other superstitious rituals?	NO YES compulsions
	IS G3 OR G4 CODED YES?	➡ NO YES
G5	At any point, did you recognize that either these obsessive thoughts or these compulsive behaviors were excessive or unreasonable?	➡ NO YES
G6	In the past month, did these obsessive thoughts and/or compulsive behaviors significantly interfere with your normal routine, your work or school, your usual social activities, or relationships, or did they take more than one hour a day?	NO YES *O.C.D. CURRENT*

H. POSTTRAUMATIC STRESS DISORDER

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

H1	Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? EXAMPLES OF TRAUMATIC EVENTS INCLUDE: SERIOUS ACCIDENTS, SEXUAL OR PHYSICAL ASSAULT, A TERRORIST ATTACK, BEING HELD HOSTAGE, KIDNAPPING, FIRE, DISCOVERING A BODY, WAR, OR NATURAL DISASTER, WITNESSING THE VIOLENT OR SUDDEN DEATH OF SOMEONE CLOSE TO YOU, OR A LIFE THREATENING ILLNESS.	➡ NO	YES
H2	Did you respond with intense fear, helplessness or horror?	➡ NO	YES
H3	During the past month, have you re-experienced the event in a distressing way (such as in dreams, intense recollections, flashbacks or physical reactions) or did you have intense distress when you were reminded about the event or exposed to a similar event?	➡ NO	YES
H4	**In the past month:**		
a	Have you avoided thinking about or talking about the event ?	NO	YES
b	Have you avoided activities, places or people that remind you of the event?	NO	YES
c	Have you had trouble recalling some important part of what happened?	NO	YES
d	Have you become much less interested in hobbies or social activities?	NO	YES
e	Have you felt detached or estranged from others?	NO	YES
f	Have you noticed that your feelings are numbed?	NO	YES
g	Have you felt that your life will be shortened or that you will die sooner than other people?	NO	YES
	ARE 3 OR MORE H4 ANSWERS CODED YES?	➡ NO	YES
H5	**In the past month:**		
a	Have you had difficulty sleeping?	NO	YES
b	Were you especially irritable or did you have outbursts of anger?	NO	YES
c	Have you had difficulty concentrating?	NO	YES
d	Were you nervous or constantly on your guard?	NO	YES
e	Were you easily startled?	NO	YES
	ARE 2 OR MORE H5 ANSWERS CODED YES?	➡ NO	YES

H6	During the past month, have these problems significantly interfered with your work, school or social activities, or caused significant distress?	NO	YES *POSTTRAUMATIC STRESS DISORDER CURRENT*

I. ALCOHOL DEPENDENCE / ABUSE

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

			➡ NO	YES
I1		**In the past 12 months**, have you had 3 or more alcoholic drinks, - within a 3 hour period, - on 3 or more occasions?		
I2		**In the past 12 months**:		
	a	Did you need to drink a lot more in order to get the same effect that you got when you first started drinking or did you get much less effect with continued use of the same amount?	NO	YES
	b	When you cut down on drinking did your hands shake, did you sweat or feel agitated? Did you drink to avoid these symptoms (for example, "the shakes", sweating or agitation) or to avoid being hungover? IF YES TO ANY, CODE YES.	NO	YES
	c	During the times when you drank alcohol, did you end up drinking more than you planned when you started?	NO	YES
	d	Have you tried to reduce or stop drinking alcohol but failed?	NO	YES
	e	On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovering from the effects of alcohol?	NO	YES
	f	Did you spend less time working, enjoying hobbies, or being with others because of your drinking?	NO	YES
	g	If your drinking caused you health or mental problems, did you still keep on drinking?	NO	YES

ARE 3 OR MORE I2 ANSWERS CODED YES?

* IF YES, SKIP I3 QUESTIONS AND GO TO NEXT MODULE. "DEPENDENCE PREEMPTS ABUSE" IN DSM IV TR.

NO	YES*
ALCOHOL DEPENDENCE CURRENT	

I3		**In the past 12 months**:		
	a	Have you been intoxicated, high, or hungover more than once when you had other responsibilities at school, at work, or at home? Did this cause any problems? (CODE YES ONLY IF THIS CAUSED PROBLEMS.)	NO	YES
	b	Were you intoxicated more than once in any situation where you were physically at risk, for example, driving a car, riding a motorbike, using machinery, boating, etc.?	NO	YES
	c	Did you have legal problems more than once because of your drinking, for example, an arrest or disorderly conduct?	NO	YES
	d	If your drinking caused problems with your family or other people, did you still keep on drinking?	NO	YES

➡

ARE 1 OR MORE I3 ANSWERS CODED YES?

NO	YES
	ALCOHOL ABUSE CURRENT

J. SUBSTANCE DEPENDENCE / ABUSE (NON-ALCOHOL)

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

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

			➡	
J1	a	**In the past 12 months, did you take any of these drugs more than once, to get high, to feel elated, to get "a buzz" or to change your mood?**	NO	YES

CIRCLE EACH DRUG TAKEN:

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

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

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

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

Phencyclidine: PCP ("Angel Dust", "PeaCe Pill", "Tranq", "Hog"), or ketamine ("special K").

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

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

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

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

SPECIFY THE MOST USED DRUG(S): _____

WHICH DRUG(S) CAUSE THE BIGGEST PROBLEMS?: _____

FIRST EXPLORE THE DRUG CAUSING THE BIGGEST PROBLEMS AND MOST LIKELY TO MEET DEPENDENCE / ABUSE CRITERIA.

IF MEETS CRITERIA FOR ABUSE OR DEPENDENCE, SKIP TO THE NEXT MODULE. OTHERWISE, EXPLORE THE NEXT MOST PROBLEMATIC DRUG.

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

	a	Have you found that you needed to use much more (NAME OF DRUG / DRUG CLASS SELECTED) to get the same effect that you did when you first started taking it?	NO	YES
	b	When you reduced or stopped using (NAME OF DRUG / DRUG CLASS SELECTED), did you have withdrawal symptoms (aches, shaking, fever, weakness, diarrhea, nausea, sweating, heart pounding, difficulty sleeping, or feeling agitated, anxious, irritable, or depressed)? Did you use any drug(s) to keep yourself from getting sick (withdrawal symptoms) or so that you would feel better?	NO	YES
		IF YES TO EITHER, CODE YES.		
	c	Have you often found that when you used (NAME OF DRUG / DRUG CLASS SELECTED), you ended up taking more than you thought you would?	NO	YES
	d	Have you tried to reduce or stop taking (NAME OF DRUG / DRUG CLASS SELECTED) but failed?	NO	YES
	e	On the days that you used (NAME OF DRUG / DRUG CLASS SELECTED), did you spend substantial time (>2 HOURS), obtaining, using or in recovering from the drug, or thinking about the drug?	NO	YES
	f	Did you spend less time working, enjoying hobbies, or being with family or friends because of your drug use?	NO	YES
	g	If (NAME OF DRUG / DRUG CLASS SELECTED) caused you health or mental problems, did you still keep on using it?	NO	YES

ARE 3 OR MORE J2 ANSWERS CODED YES?

SPECIFY DRUG(S): _____

* IF YES, SKIP J3 QUESTIONS, MOVE TO NEXT DISORDER.
"DEPENDENCE PREEMPTS ABUSE" IN DSM IV TR.

NO YES *

SUBSTANCE DEPENDENCE
CURRENT

Considering your use of (NAME THE DRUG CLASS SELECTED), in the past 12 months:

a Have you been intoxicated, high, or hungover from (NAME OF DRUG / DRUG CLASS SELECTED) more than once, when you had other responsibilities at school, at work, or at home? Did this cause any problem? NO YES

(CODE YES ONLY IF THIS CAUSED PROBLEMS.)

b Have you been high or intoxicated from (NAME OF DRUG / DRUG CLASS SELECTED) more than once in any situation where you were physically at risk (for example, driving a car, riding a motorbike, using machinery, boating, etc.)? NO YES

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

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

ARE 1 OR MORE J3 ANSWERS CODED YES?

SPECIFY DRUG(S): _____

NO YES

SUBSTANCE ABUSE
CURRENT

K. PSYCHOTIC DISORDERS AND MOOD DISORDER WITH PSYCHOTIC FEATURES

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

DELUSIONS ARE "BIZARRE" IF: CLEARLY IMPLAUSIBLE, ABSURD, NOT UNDERSTANDABLE, AND CANNOT DERIVE FROM ORDINARY LIFE EXPERIENCE.
HALLUCINATIONS ARE SCORED "BIZARRE" IF: A VOICE COMMENTS ON THE PERSON'S THOUGHTS OR BEHAVIOR, OR WHEN TWO OR MORE VOICES ARE CONVERSING WITH EACH OTHER.
THE PURPOSE OF THIS MODULE IS TO EXCLUDE PATIENTS WITH PSYCHOTIC DISORDERS. THIS MODULE NEEDS EXPERIENCE.

					BIZARRE
		Now I am going to ask you about unusual experiences that some people have.			
K1	a	Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you? NOTE: ASK FOR EXAMPLES TO RULE OUT ACTUAL STALKING.	NO	YES	YES
	b	**IF YES OR YES BIZARRE:** do you currently believe these things?	NO	YES	YES →K6
K2	a	Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking?	NO	YES	YES
	b	**IF YES OR YES BIZARRE:** do you currently believe these things?	NO	YES	YES →K6
K3	a	Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Have you ever felt that you were possessed? CLINICIAN: ASK FOR EXAMPLES AND DISCOUNT ANY THAT ARE NOT PSYCHOTIC.	NO	YES	YES
	b	**IF YES OR YES BIZARRE:** do you currently believe these things?	NO	YES	YES →K6
K4	a	Have you ever believed that you were being sent special messages through the TV, radio, newspapers, books or magazines or that a person you did not personally know was particularly interested in you?	NO	YES	YES
	b	**IF YES OR YES BIZARRE:** do you currently believe these things?	NO	YES	YES →K6
K5	a	Have your relatives or friends ever considered any of your beliefs odd or unusual? INTERVIEWER: ASK FOR EXAMPLES. ONLY CODE YES IF THE EXAMPLES ARE CLEARLY DELUSIONAL IDEAS NOT EXPLORED IN QUESTIONS K1 TO K4, FOR EXAMPLE, SOMATIC OR RELIGIOUS DELUSIONS OR DELUSIONS OF GRANDIOSITY, JEALOUSY, GUILT, RUIN OR DESTITUTION, ETC.	NO	YES	YES
	b	**IF YES OR YES BIZARRE:** do they currently consider your beliefs strange?	NO	YES	YES
K6	a	Have you ever heard things other people couldn't hear, such as voices?	NO	YES	
		IF YES TO VOICE HALLUCINATION: Was the voice commenting on your thoughts or behavior or did you hear two or more voices talking to each other?	NO		YES
	b	**IF YES OR YES BIZARRE TO K6a:** have you heard sounds / voices in the past month?	NO	YES	
		IF YES TO VOICE HALLUCINATION: Was the voice commenting on your thoughts or behavior or did you hear two or more voices talking to each other?	NO		YES →K8b

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

CLINICIAN: CHECK TO SEE IF THESE ARE CULTURALLY INAPPROPRIATE.

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

CLINICIAN'S JUDGMENT

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

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

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

K11 a ARE 1 OR MORE « a » QUESTIONS FROM K1a TO K7a CODED YES OR YES BIZARRE AND IS EITHER:

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

IF NO TO K11 a, CIRCLE NO IN BOTH 'MOOD DISORDER WITH PSYCHOTIC FEATURES' DIAGNOSTIC BOXES AND MOVE TO K13.

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

Were the beliefs and experiences you just described (SYMPTOMS CODED YES FROM **K1a** TO **K7a**) restricted exclusively to times when you were feeling depressed/high/irritable?

IF THE PATIENT EVER HAD A PERIOD OF AT LEAST 2 WEEKS OF HAVING THESE BELIEFS OR EXPERIENCES (PSYCHOTIC SYMPTOMS) WHEN THEY WERE NOT DEPRESSED/HIGH/IRRITABLE, CODE NO TO THIS DISORDER.

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

NO YES

MOOD DISORDER WITH
PSYCHOTIC FEATURES

LIFETIME

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

MAJOR DEPRESSIVE EPISODE, (CURRENT)
OR
MANIC OR HYPOMANIC EPISODE, (CURRENT) CODED YES?

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

NO YES

MOOD DISORDER WITH
PSYCHOTIC FEATURES

CURRENT

K13 ARE 1 OR MORE « b » QUESTIONS FROM K1b TO K6b, CODED YES BIZARRE?

OR

ARE 2 OR MORE « b » QUESTIONS FROM K1b TO K10b, CODED YES (RATHER THAN YES BIZARRE)?

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

NO YES

PSYCHOTIC DISORDER
CURRENT

K14 IS **K13** CODED YES

OR

ARE 1 OR MORE « a » QUESTIONS FROM K1a TO K6a, CODED YES BIZARRE?

OR

ARE 2 OR MORE « a » QUESTIONS FROM K1a TO K7a, CODED YES (RATHER THAN YES BIZARRE)

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

NO YES

PSYCHOTIC DISORDER
LIFETIME

L. ANOREXIA NERVOSA

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

L1	a	How tall are you?	❑ft ❑❑in. ❑❑❑cm.	
	b.	What was your lowest weight in the past 3 months?	❑❑❑lbs. ❑❑❑kgs.	
	c	IS PATIENT'S WEIGHT EQUAL TO OR BELOW THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT? (SEE TABLE BELOW)	➡ NO	YES
		In the past 3 months:		
L2		In spite of this low weight, have you tried not to gain weight?	➡ NO	YES
L3		Have you intensely feared gaining weight or becoming fat, even though you were underweight?	➡ NO	YES
L4	a	Have you considered yourself too big / fat or that part of your body was too big / fat?	NO	YES
	b	Has your body weight or shape greatly influenced how you felt about yourself?	NO	YES
	c	Have you thought that your current low body weight was normal or excessive?	NO	YES
L5		ARE 1 OR MORE ITEMS FROM L4 CODED YES?	➡ NO	YES
L6		FOR WOMEN ONLY: During the last 3 months, did you miss all your menstrual periods when they were expected to occur (when you were not pregnant)?	➡ NO	YES

FOR WOMEN: ARE L5 AND L6 CODED YES?

FOR MEN: IS L5 CODED YES?

NO	YES
	ANOREXIA NERVOSA CURRENT

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

Height/Weight														
ft/in	4'9	4'10	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10
lbs.	81	84	87	89	92	96	99	102	105	108	112	115	118	122
cm	145	147	150	152	155	158	160	163	165	168	170	173	175	178
kgs	37	38	39	41	42	43	45	46	48	49	51	52	54	55

Height/Weight					
ft/in	5'11	6'0	6'1	6'2	6'3
lbs.	125	129	132	136	140
cm	180	183	185	188	191
kgs	57	59	60	62	64

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

M. BULIMIA NERVOSA

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

M1	In the past three months, did you have eating binges or times when you ate a very large amount of food within a 2-hour period?	➡ NO YES
M2	In the last 3 months, did you have eating binges as often as twice a week?	➡ NO YES
M3	During these binges, did you feel that your eating was out of control?	➡ NO YES
M4	Did you do anything to compensate for, or to prevent a weight gain from these binges, like vomiting, fasting, exercising or taking laxatives, enemas, diuretics (fluid pills), or other medications?	➡ NO YES
M5	Does your body weight or shape greatly influence how you feel about yourself?	➡ NO YES
M6	DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?	NO YES ↓ Skip to M8
M7	Do these binges occur only when you are under (____lbs./kgs.)? INTERVIEWER: WRITE IN THE ABOVE PARENTHESIS THE THRESHOLD WEIGHT FOR THIS PATIENT'S HEIGHT FROM THE HEIGHT / WEIGHT TABLE IN THE ANOREXIA NERVOSA MODULE.	NO YES
M8	IS **M5** CODED YES AND IS EITHER **M6** OR **M7** CODED NO?	NO YES ***BULIMIA NERVOSA*** CURRENT
	IS **M7** CODED YES?	NO YES ***ANOREXIA NERVOSA*** *Binge Eating/Purging Type* CURRENT

N. GENERALIZED ANXIETY DISORDER

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

N1	a	Were you excessively anxious or worried about several routine things, over the past 6 months? IN ENGLISH, IF THE PATIENT IS UNCLEAR ABOUT WHAT YOU MEAN, PROBE BY ASKING (Do others think that you are a "worry wart") AND GET EXAMPLES.	➡ NO	YES
	b	Are these anxieties and worries present most days?	➡ NO	YES
		ARE THE PATIENT'S ANXIETY AND WORRIES RESTRICTED EXCLUSIVELY TO, OR BETTER EXPLAINED BY, ANY DISORDER PRIOR TO THIS POINT?	NO	➡ YES
N2		Do you find it difficult to control the worries?	➡ NO	YES
N3		FOR THE FOLLOWING, CODE NO IF THE SYMPTOMS ARE CONFINED TO FEATURES OF ANY DISORDER EXPLORED PRIOR TO THIS POINT.		
		When you were anxious over the past 6 months, did you, most of the time:		
	a	Feel restless, keyed up or on edge?	NO	YES
	b	Have muscle tension?	NO	YES
	c	Feel tired, weak or exhausted easily?	NO	YES
	d	Have difficulty concentrating or find your mind going blank?	NO	YES
	e	Feel irritable?	NO	YES
	f	Have difficulty sleeping (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)?	NO	YES
		ARE 3 OR MORE N3 ANSWERS CODED YES?	➡ NO	YES
N4		Do these anxieties and worries disrupt your normal work, school or social functioning or cause you significant distress?	NO	YES

GENERALIZED ANXIETY DISORDER CURRENT

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

IF THE PATIENT CODES POSITIVE FOR ANY CURRENT DISORDER ASK:

Just before these symptoms began:

O1a	Were you taking any drugs or medicines?	❒ No	❒ Yes	❒ Uncertain
O1b	Did you have any medical illness?	❒ No	❒ Yes	❒ Uncertain

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

O2	SUMMARY: HAS AN ORGANIC CAUSE BEEN RULED OUT?	❒ No	❒ Yes	❒ Uncertain

P. ANTISOCIAL PERSONALITY DISORDER

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

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

a	repeatedly skip school or run away from home overnight?	NO	YES
b	repeatedly lie, cheat, "con" others, or steal?	NO	YES
c	start fights or bully, threaten, or intimidate others?	NO	YES
d	deliberately destroy things or start fires?	NO	YES
e	deliberately hurt animals or people?	NO	YES
f	force someone to have sex with you?	NO	YES
		➡	
	ARE 2 OR MORE **P1** ANSWERS CODED YES?	NO	YES

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

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

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

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

NO YES

ANTISOCIAL PERSONALITY DISORDER
LIFETIME

THIS CONCLUDES THE INTERVIEW

ANNEXURE 3

INFORMED CONSENT FORM

I, Mr./Mrs. _____ have been explained in my own understandable language that I will be included in a study which is**PSYCHIATRIC MORBITIES IN PATIENTS AVAILING CONSULTATION LIAISON SERVICES IN A TERTIARY CARE HOSPITAL- A CROSS SECTIONAL STUDY**
I have been explained my participation in this study is entirely voluntary, and I can withdraw from the study at any time, and this will not affect my relation with my doctor or the treatment for my ailment.
I have been explained the reason for this study in my own understandable language.

I have understood that all my details found during the study are kept confidential and while publishing or sharing of the findings, my details will be masked.

I have principal investigator mobile number for enquiries.

I in my sound mind give full consent to be added in the part of this study.

Signature of the patient

Name:

Date:

Place:

Signature of the witness

Name:

Relation to patient:

NAME OF THE INVESTIGATOR:

SIGNATURE OF THE INVESTIGATOR

INFORMED CONSENT FORM KANNADA

ಮಾಹಿತಿಕಾನ್ಸೆಂಟ್ಫಾರ್ಮ್

ನಾನುಶ್ರೀ / ಶ್ರೀ. _____ ಅನ್ನುನನ್ನಸ್ವಂತಅರ್ಥವಾಗುವಭಾಷೆಯಲ್ಲಿವಿವರಿಸಲಾಗಿದೆ,
ಇದುರೋಗಿಗಳಲ್ಲಿಸೈಕಿಯಾಟ್ರಿಕ್ಕೊರ್ಬಿಟೀಸ್‌ಆಗಿರುತ್ತದೆ,
ಇದುತಾತ್ಕಾಲಿಕಆರೈಕೆಆಸ್ಪತ್ರೆಯಲ್ಲಿಕನ್ಸಲ್ಟೇಶನ್ಲೈಸನ್ಸೇವೆಗಳನ್ನುಪಡೆಯುತ್ತದೆ- ಕ್ರಾಸ್ಸೆಕ್ಷನಲ್ಸ್ಟಡಿ
ಈಅಧ್ಯಯನದಲ್ಲಿನನ್ನಭಾಗವಹಿಸುವಿಕೆಯುಸಂಪೂರ್ಣವಾಗಿಸ್ವಯಂಪ್ರೇರಿತವಾಗಿದೆಎಂದುನನಗೆವಿವರಿಸಲಾಗಿದೆ,
ಮತ್ತುನಾನುಯಾವುದೇಸಮಯದಲ್ಲಿಅಧ್ಯಯನದಿಂದಹಿಂದೆಸರಿಯಬಹುದುಮತ್ತುಇದುನನ್ನವೈದ್ಯರೊಂದಿಗಿನನನ್ನ
ಸಂಬಂಧಅಥವಾನನ್ನಕಾಯಿಲೆಗೆಚಿಕಿತ್ಸೆಯಮೇಲೆಪರಿಣಾಮಬೀರುವುದಿಲ್ಲ.
ನನ್ನಸ್ವಂತಅರ್ಥವಾಗುವಭಾಷೆಯಲ್ಲಿಈಅಧ್ಯಯನದಕಾರಣದಬಗ್ಗೆನನಗೆವಿವರಿಸಲಾಗಿದೆ.

ಅಧ್ಯಯನದಸಮಯದಲ್ಲಿಕಂಡುಬರುವನನ್ನಎಲ್ಲಾವಿವರಗಳನ್ನುಗೌಪ್ಯವಾಗಿಡಲಾಗಿದೆಮತ್ತುಸಂಶೋಧನೆಗಳನ್ನುಪ್ರ
ಕಟಿಸುವಾಗಅಥವಾಹಂಚಿಕೊಳ್ಳುವಾಗ,
ನನ್ನವಿವರಗಳನ್ನುಮರೆಮಾಚಲಾಗುತ್ತದೆಎಂದುನಾನುಅರ್ಥಮಾಡಿಕೊಂಡಿದ್ದೇನೆ.

ವಿಚಾರಣೆಗಾಗಿನನ್ನಬಳಿಪ್ರಧಾನತನಿಖಾಧಿಕಾರಿಮೊಬೈಲ್ಸಂಖ್ಯೆಇದೆ.

ಈಅಧ್ಯಯನದಭಾಗದಲ್ಲಿಸೇರಿಸಲುನನ್ನಸಂಪೂರ್ಣಮನಸ್ಸಿನಲ್ಲಿನಾನುಸಂಪೂರ್ಣಒಪ್ಪಿಗೆನೀಡುತ್ತೇನೆ.

ರೋಗಿಯಸಹಿಸಾಕ್ಷಿಯಸಹಿ

ಹೆಸರು: ಹೆಸರು:

ದಿನಾಂಕ: ರೋಗಿಗೆಸಂಬಂಧ:

ಸ್ಥಳ:

ಇನ್ವೆಸ್ಟಿಗೇಟರ್ಹೆಸರು:

ಇನ್ವೆಸ್ಟಿಗೇಟರ್ನಸಿಗ್ನೇಚರ್

ANNEXURE 4

PATIENT INFORMATION SHEET

STUDY TITLE: PSYCHIATRIC COMORBIDITIES IN PATIENTS AVAILING CONSULTATION LIASION SERVICES OF PSYCHIATRY OPD IN A TERTIARY CARE HOSPITAL - A CROSS SECTIONAL OBSERVATIONAL STUDY

STUDY SITE: R.L JALAPPA HOSPITAL, TAMAKA, KOLAR.

AIM: to study the prevalence of psychiatric comorbidities in patients referred to psychiatry OPD.

Dr. V. Mano Ranjitha a postgraduate in psychiatry department is conducting a research/study about psychiatric illnesses that is prevalent among patients who also have some medical comorbid illnesses. please read the following information thoroughly then proceed to decide for your participation in the study. The primary treating physician suspects any kind of associated mental illnesses in his/her/their patients. They then proceed to refer the case to psychiatry outpatient department for further evaluation. Any number of cases like alcohol abuse/dependence, other substance abuse, neurotic illnesses such as obsessive-compulsive disorder, anxiety, depression, phobias, panic disorders and even psychotic disorders, eating disorders, suicidality are diagnosed. It is really important for a treating physician to be vigilant in quickly evaluating the patient so that they can refer to the consulting psychiatrist. The disorders are diagnosed by applying MINI [MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW]

You are required to sign/ provide thumb impression only if you voluntarily agree to participate in this study.

For any further clarification you can contact the study investigator:

Dr. Mano ranjitha
Mobile no: 8072411181
e-mail id: manoranjithambbs@gmail.com

PATIENT INFORMATION SHEET KANNADA

ರೋಗಿಯಮಾಹಿತಿಹಾಳೆ

ಅಧ್ಯಯನದಶೀರ್ಷಿಕೆ:
ತಾತ್ಕಾಲಿಕಕೇಹಾರ್ಸ್ಪಿಟಲ್‌ನಲ್ಲಿಸೈಕಿಯಾಟ್ರಿಆಪ್ತನಕನ್ಸಲ್ಟೇಶನ್ಸೈಸೇಶನ್ಸೇವೆಗಳಲಭ್ಯವಿರುವರೋಗಿಗಳಲ್ಲಿಸೈಕಿಯಾಟ್ರಿಕ್ಸಂಯೋಜನೆಗಳು - ಕ್ರಾಸ್ಸೆಕ್ಷನಲ್‌ಒಬ್ಸರ್ವೇಷನಲ್ಸ್ಟಡಿ

ಮನೋವೈದ್ಯಶಾಸ್ತ್ರವಿಭಾಗದಲ್ಲಿಸ್ನಾತಕೋತ್ತರಪದವೀಧರರಾದಡಾ. ವಿ.
ಮನೋರಂಜಿತಾಅವರುಕೆಲವುವೈದ್ಯಕೀಯಕೊಮೊರ್ಬಿಡ್ಸಾಯಿಲೆಗಳನ್ನುಹೊಂದಿರುವರೋಗಿಗಳಲ್ಲಿಪ್ರಚಲಿತದಲ್ಲಿರುವಮನೋವೈದ್ಯಕೀಯಕಾಯಿಲೆಗಳಬಗ್ಗೆಸಂಶೋಧನೆ / ಅಧ್ಯಯನವನ್ನುನಡೆಸುತ್ತಿದ್ದಾರೆ.
ದಯವಿಟ್ಟುಈಕೆಳಗಿನಮಾಹಿತಿಯನ್ನುಕೂಲಂಕಷವಾಗಿಓದಿನಂತರಅಧ್ಯಯನದಲ್ಲಿನಿಮ್ಮಭಾಗವಹಿಸುವಿಕೆಯನ್ನುನಿರ್ಧರಿಸಲುಮುಂದುವರಿಯಿರಿ. ಪ್ರಾಥಮಿಕಚಿಕಿತ್ಸೆಯವೈದ್ಯನುಅವನ / ಅವಳ /
ಅವರರೋಗಿಗಳಲ್ಲಿಯಾವುದೇರೀತಿಯಸಂಬಂಧಿತಮಾನಸಿಕಕಾಯಿಲೆಗಳನ್ನುಅನುಮಾನಿಸುತ್ತಾನೆ.
ನಂತರಅವರುಹೆಚ್ಚಿನಮೌಲ್ಯಮಾಪನಕ್ಕಾಗಿಮನೋವೈದ್ಯಕೀಯಹೊರರೋಗಿವಿಭಾಗಕ್ಕೆಪ್ರಕರಣವನ್ನುಉಲ್ಲೇಖಿಸಲುಮುಂದುವರಿಯುತ್ತಾರೆ. ಆಲ್ಕೊಹಾಲ್ನಿಂದನೆ / ಅವಲಂಬನೆ, ಇತರಮಾದಕದ್ರವ್ಯಸೇವನೆ, ಗೀಳು-
ಕಂಪಲ್ಸಿವ್ಡಿಸಾರ್ಡರ್, ಆತಂಕ, ಖಿನ್ನತೆ, ಫೋಬಿಯಾಸ್, ಪ್ಯಾನಿಕ್ಡಿಸಾರ್ಡರ್ಸ್ಮತ್ತುಮಾನಸಿಕಅಸ್ವಸ್ಥತೆಗಳು,
ತಿನ್ನುವಅಸ್ವಸ್ಥತೆಗಳು, ಆತ್ಮಹತ್ಯೆಯಂತಹನರರೋಗದಕಾಯಿಲೆಗಳು.
ಚಿಕಿತ್ಸೆಯವೈದ್ಯರುರೋಗಿಯನ್ನುತ್ವರಿತವಾಗಿಮೌಲ್ಯಮಾಪನಮಾಡುವಲ್ಲಿಜಾಗರೂಕರಾಗಿರುವುದುನಿಜವಾಗಿಯೂಮುಖ್ಯವಾಗಿದೆಇದರಿಂದಅವರುಸಲಹಾಮನೋವೈದ್ಯರನ್ನುಉಲ್ಲೇಖಿಸಬಹುದು. MINI [MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW]
ಅನ್ನುಅನ್ವಯಿಸುವಮೂಲಕಅಸ್ವಸ್ಥತೆಗಳನ್ನುಕಂಡುಹಿಡಿಯಲಾಗುತ್ತದೆ.
ನಿಮ್ಮಉತ್ತರಗಳನ್ನುಅವಲಂಬಿಸಿಅವರಸೊಸಿಯೊಡೆಮೊಗ್ರಾಫಿಕ್ಡೇಟಾಸೇರಿದಂತೆಕೆಲವುಪ್ರಶ್ನೆಗಳನ್ನುನಿಮಗೆನೀಡಲಾಗುತ್ತದೆ,
ಮನೋವೈದ್ಯಕೀಯರೋಗನಿರ್ಣಯವನ್ನುಮಾಡಲಾಗುತ್ತದೆಮತ್ತುಸಲಹಾಮನೋವೈದ್ಯರೊಂದಿಗೆದೃisೀಕರಿಸಲಾಗುತ್ತದೆ. ನಂತರನಿರ್ದಿಷ್ಟರೋಗನಿರ್ಣಯಕ್ಕೆಸೂಕ್ತವಾದಚಿಕಿತ್ಸೆಅಥವಾಚಿಕಿತ್ಸೆಯನ್ನುನೀಡಲಾಗುತ್ತದೆ.
ಕೆಲವುಪ್ರಶ್ನೆಗಳಿಗೆಉತ್ತರಿಸಲುನೀವುಬಯಸದಿದ್ದರೆ,
ನಿಮ್ಮಚಿಕಿತ್ಸೆಅಥವಾಯಾವುದೇಆರೋಗ್ಯಪ್ರಯೋಜನಗಳನ್ನುರಾಜಿಮಾಡಲಾಗುವುದಿಲ್ಲಎಂದುನೀವುಅಧ್ಯಯನದಿಂದಹಿಂದೆಸರಿಯಲುಆಯ್ಕೆಮಾಡಬಹುದುಎಂಬುದನ್ನುದಯವಿಟ್ಟುತಿಳಿದುಕೊಳ್ಳಿ.
ಈಅಧ್ಯಯನಕ್ಕೆಸಂಬಂಧಿಸಿದಂತೆನೀವುಯಾವುದೇಅನುಮಾನಗಳನ್ನುಕೇಳಬಹುದುಮತ್ತುತನಿಖಾಧಿಕಾರಿಅವರಿಗೆಉತ್ತರಿಸಲುಅರ್ಹನಾಗಿರುತ್ತಾನೆ.
ಈಅಧ್ಯಯನದಲ್ಲಿಭಾಗವಹಿಸಲುನೀವುಒಪ್ಪಿದರೆನಾವುನಿಮ್ಮಿಂದಮಾಹಿತಿಯನ್ನುಸಂಗ್ರಹಿಸುತ್ತೇವೆ
(ಪ್ರೊಫಾರ್ಮಾದಪ್ರಕಾರ). ಸಂಗ್ರಹಿಸಿದಈಮಾಹಿತಿಯನ್ನುಪ್ರಬಂಧಮತ್ತುಪ್ರಕಟಣೆಗೆಮಾತ್ರಬಳಸಲಾಗುತ್ತದೆ.

ANNEXURE 5

KEY TO MASTERCHART

OCCUPATION

USW-unskilled worker

SW-Skilled Worker

UN-Unemployed

HMR-Homemaker

SEMI-Semiprofessional

PROF-Professional

SEMI-Semi Professional

MARITAL STATUS

Married

Single

AREA

Rural

Urban

RELIGION

H-Hindu

M-Muslim

C-Christian

REFERRAL

MED-Medicine

ENT

ORTHO-Orthopedics

SURGERY

CARDIO-Cardiology

OBG-Obstetrics and Gynaecology

EMD-Emergency Medicine

OPHTHAL-Ophthalmology

MINI SCALE

AL ABU-Alcohol abuse

ADS-Alcohol Dependence syndrome

SUI-MOD-Suicide Moderate

CAN DS-Cannabis Dependence Syndrome

MDD-CURR-Major Depressive Disorder-Current

MISC-Miscellaneous

SUI-MILD-Suicide Mild

PSY CURR-Psychiatric Disorder-Current

MOOD PSY-Mood disorder with Psychotic Symptoms

PSY LIFE-Psychiatric Illness Lifetime

MOOD PSY CURR-Mood disorder with Psychotic Symptoms current

SUI HIGH-Suicide High

SUI LOW-Suicidality Low

ASPD- antisocial personality disorder

MOOD WOT PSY -CURR-Mood disorder without Psychotic Symptoms

RDD CURR-Recurrent Depressive disorder

MANIA PAST

MANIA CURRENT

SOCIAL PHOB-Social Phobia

PANIC DIS-panic disorder

GAD-Generalized Anxiety Disorder

PTSD-Post traumatic Disorder

Opioid abuse

REASON FOR REFERRAL:

DEADDIC-Deaddiction

SLEEP DIS-sleep disturbances

SUI ATT-Suicide Attempt

Agitation

Somatization

Counseling

Low Mood

Psychiatric Illness

Altered Behavior

anxiety

Unresponsiveness

PREVIOUS HISTORY OF PSYCHIATRIC ILLNESS

YES/NO

FAMILY H/O PSYCHIATRIC ILLNESS

YES/NO

PREVIOUS H/O SUICIDE ATTEMPT

YES/NO

COMORBIDITIES:

H-hematological

R-Respiratory

I-Infective

E-Endocrine

CNS

Metabolic

G-Gastrointestinal

OBG

GU-Genitourinary

O-Others

ICD 10 DIAGNOSIS

TDS- Tobacco Dependence Syndrome

AHU-Alcohol Harmful use

ADS SW-Alcohol dependence syndrome,

THU-Tobacco Harmful use

ISH-Intentional self-harm

ADJ-Adjustment disorder

MOD DEP-Moderate depression

OPIOD DEP-Opiod Dependence

CAN IN PSYCHOSIS-Cannabis-Induced Psychosis

ACUTE PSYCHOSIS

SEV D PSY-Severe depression with Psychotic symptoms

SCHIZO- Schizophrneia

PSYCHOSIS

MILD DEP- Mild depression

SEV D NO PSY- Severe Depression with no Psychotic symptoms

SEV D CATATONIA- Severe depression with Catatonia

RDD SEV D PSY- Recurrent depressive disorder- severe depression with Psychotic symptoms

RDD-MILD DEP-Recurrent depressive disorder- Mild depression

DYS-Dysthymia

MIXED ANX DEP-Mixed anxiety depression

ADJ BR ANX REAC-Adjustment disorder-Brief anxiety reaction

BR DEP REAC- Adjustment disorder-Brief depressive reaction

POST-STROKE DEP- Post-stroke depression

SEC INSOMNIA- Secondary insomnia

DEL PARASITOSIS-Delusional Parasitosis

BPAD-C.E SEV D NO PSYCH- Bipolar affective disorder- current episode- severe depression with no Psychotic symptoms.

BPAD-C.E: MANIA PSYCHOTIC- Bipolar affective disorder- current episode-Mania with Psychotic symptoms.

DIS MOTOR DIS- Dissociative motor disorder

DISSO DIS- Dissociative Disorder

DISSO DIS SEI- Dissociative Disorder Seizures

NIL PSY – Nil Psychiatric Illness

SOMATIZATION- Somatization

SOMATOFORM PAIN DIS – Somatoform pain disorder

HYPOCHON- Hypochondriasis

DHAT SYN Dhat Syndrome

SATYRIASIS

OPIOID HU- Opiod harmful use

ALCOHOL INDUC MOOD DIS- Alcohol-induced mood disorder

DIESEASE CATEGORY OF ICD 10

1] Substance use disorder

2] Intentional self harm

3] Mood disorders

4]Neurotic and stress related disorders

5] Personality Disorders

6] Schizophrenia

7] Nil Psychiatry

8] Sleep disorders

9] Others

MASTERCHART

NAME	UHID NO	AGE	GEN	EDU	OC	MS	AREA	RELI	INC	REFER	MINI SCALE	EASON REFERR.	PREV H/O	FAMILY H/O	SUI	COMOR	ICD 10	
SUNIL	92532	32	MALE	12TH	USW	S	RURAL	H	APL	ENT	AL ABU	DEADDIC	NO	NO	NO	NO	TDS,AHU	1
ARUN KUMAR	40522	29	MALE	12TH	USW	S	RURAL	H	APL	ORTHO	ADS	SLEEP DIS	NO	NO	NO	H	ADS SW,TDS	1
VENKATARAVANAPPA	41835	55	MALE	10TH	USW	M	RURAL	H	BPL	MED	ADS	SLEEP DIS	YES	NO	NO	NO	ADS SW	1
GOVINDA	41954	50	MALE	PRIM	USW	M	RURAL	H	APL	MED	AL ABU	DEADDIC	NO	NO	NO	R	TDS,AHU	1
SEENA	856547	45	MALE	GRAD	SW	M	RURAL	H	APL	MED	AL ABU	SLEEP DIS	NO	NO	NO	O	AHU,THU	1
SUBRAMANI	63682	25	MALE	10TH	USW	S	RURAL	H	APL	MED	ADS,SUI-MOD	SLEEP DIS	NO	YES	NO	NO	ADS,TDS,ISH	1,2
RAMANNA	937390	61	MALE	10TH	UN	M	URBAN	H	APL	MED	ADS	DEADDIC	NO	NO	NO	NO	ADS SW,TDS	1
NARAYANASWAMY	935497	40	MALE	GRAD	USW	M	RURAL	H	APL	MED	ADS	DEADDIC	NO	NO	NO	E	ADS SW TDS	1
RAVICHANDRAN	932069	58	MALE	PRIM	UN	M	RURAL	H	APL	MED	ADS	DEADDIC	NO	NO	NO	E	ADS,TDS	1
CHALAPATHI	62343	48	MALE	10TH	USW	M	RURAL	H	APL	MED	ADS	DEADDIC	NO	YES	NO	M	ADS	1
SHABEER PASHA	900354	45	MALE	10TH	USW	M	RURAL	M	APL	SURGERY	ADS	SLEEP DIS	NO	NO	NO	M	ADS SW	1
SUBRAMANI REDDY	899077	45	MALE	PRIM	USW	M	RURAL	H	APL	ORTHO	ADS	DEADDIC	NO	NO	NO	O	ADS SW	1
ADINARAYANASWAMY	59117	38	MALE	12TH	USW	M	RURAL	H	APL	SURGERY	ADS	DEADDIC	NO	NO	NO	E	ADS SW TDS	1
GANGADHAR	59210	54	MALE	10TH	USW	M	RURAL	H	APL	SURGERY	ADS	DEADDIC	YES	NO	NO	GU	ADS,TDS,ADJ	1,4
NARENDRA BABU	53898	45	MALE	12TH	USW	S	RURAL	H	APL	MED	ADS	DEADDIC	NO	NO	NO	NO	ADS,TDS,ADJ	1,4
VENKATESH	88856	38	MALE	IILIT	USW	M	RURAL	H	APL	ENT	ADS	SUI ATT	NO	NO	NO	NO	ADS,TDS,ADJ	1,4
MUNIRAJU	14037	33	MALE	GRAD	SW	M	RURAL	H	APL	MED	ADS	DEADDIC	NO	NO	NO	E	ADS SW	1
ARGAR PASHA	947959	38	MALE	12TH	USW	M	RURAL	M	APL	MED	NO	DEADDIC	NO	NO	NO	E	TDS	1
ANJAPPA	949071	63	MALE	IILIT	UN	M	RURAL	H	APL	MED	ADS	DEADDIC	NO	NO	NO	NO	ADS SW	1
NAGARAJA	948833	33	MALE	12TH	UN	M	RURAL	H	APL	SURGERY	ADS	DEADDIC	NO	NO	NO	E	ADS	1
SRINATHA	949209	25	MALE	12TH	UN	S	RURAL	H	APL	MED	ADS	DEADDIC	NO	NO	NO	NO	ADS SW	1
MANJUNATH	949409	40	MALE	12TH	UN	M	URBAN	H	APL	MED	ADS	DEADDIC	NO	NO	NO	NO	ADS SW	1
HANUMANAPPA	949431	35	MALE	12TH	USW	M	RURAL	H	APL	SURGERY	ADS	DEADDIC	NO	NO	NO	E	ADS	1
SONNALAPPA	949493	65	MALE	ILLIT	UN	M	URBAN	H	APL	MED	ADS	DEADDIC	NO	NO	NO	CNS	ADS	1
VENKATESH	951238	56	MALE	12TH	UN	M	RURAL	H	APL	MED	ADS	DEADDIC	NO	NO	NO	NO	ADS SW	1
SADIQ PASHA	38036	54	MALE	12TH	USW	M	RURAL	M	APL	MED	ADS	DEADDIC	NO	NO	NO	CVS,E	ADS SW TDS	1
SURESH	37258	28	MALE	12TH	UN	S	RURAL	H	APL	MED	CAN DS	DEADDIC	NO	NO	NO	E	CAN DS	1
VENKATA REDDY	922154	45	MALE	12TH	USW	M	RURAL	H	BPL	MED	MOD SUI,ADS	SUI ATT	NO	NO	NO	NO	ADS,TDS,ISH	1,2
CHARAN RAJ	931316	38	MALE	PRIM	USW	M	RURAL	H	BPL	MED	MOD SUI,MDD-(	DEADDIC	NO	YES	NO	NO	ADS,THU,ISH, MOD DEP	1,2,3
RAMANNA	900028	45	MALE	10TH	UN	M	RURAL	H	BPL	MED	ADS	DEADDIC	NO	YES	NO	NO	ADS SW	1
TANMOY MAITY	934304	24	MALE	GRAD	UN	S	RURAL	H	BPL	EMD	AL ABU	DEADDIC	NO	NO	NO	NO	AHU	1
CHANNA KRISHNA	44332	44	MALE	10TH	USW	M	RURAL	H	BPL	MED	ADS	DEADDIC	NO	NO	NO	M,E	ADS	1
MUKTHIYAR	46357	47	MALE	PRIM	USW	M	RURAL	H	BPL	SURGERY	ADS	AGITATIO	NO	NO	NO	CNS	ADS SW	1
SATHISHA	46480	33	MALE	12TH	USW	M	RURAL	H	APL	SURGERY	ADS	DEADDIC	NO	NO	NO	E,G	ADS SW	1
BHARATH	48537	23	MALE	12TH	UN	S	RURAL	H	APL	MED	AL ABU	DEADDIC	NO	NO	NO	NO	AHU	1
RAKESH	943211	45	MALE	PRIM	USW	M	RURAL	H	APL	SURGERY	ADS	DEADDIC	NO	NO	NO	O	ADS SW THU	1
CHAKRA	49880	36	MALE	POST GRAD	SEMI PRO	S	RURAL	H	APL	MED	ADS	DEADDIC	NO	NO	NO	E	ADS THU	1
MANJUNATH	50826	43	MALE	10TH	USW	M	RURAL	H	BPL	MED	ADS	DEADDIC	NO	NO	NO	E	ADS SW TDS	1
VENKATAMMA	936426	65	FEMALE	ILLIT	UN	M	RURAL	H	APL	EMD	NO	SOMATIZATION	NO	NO	NO	NO	TDS	1
SAHADEVALU	49441	52	MALE	PRIM	USW	M	RURAL	H	APL	SURGERY	ADS	SLEEP DIS	NO	NO	NO	O	ADS SW	1
SHAMANNA	52879	60	MALE	PRIM	USW	M	RURAL	H	APL	MED	ADS	DEADDIC	NO	NO	NO	R,O	ADS,TDS	1
MARI KUMAR	52493	44	MALE	PRIM	USW	M	RURAL	H	BPL	MED	AL ABU	DEADDIC	NO	NO	NO	NO	TDS,AHU	1

MUNISAMI REDDY	921764	59	MALE	10TH	USW	M	RURAL	H	APL	MED	ADS	DEADDIC	NO	NO	NO	NO	ADS SW ADJ	1,4
SRI RAMAYYA	925026	50	MALE	10TH	USW	M	RURAL	H	BPL	SURGERY	ADS	SLEEP DIS	NO	NO	NO	E	ADS SW TDS	1
KANTHAMMA	94581	53	FEMALE	12TH	USW	M	RURAL	H	APL	SURGERY	MISC	SLEEP DIS	NO	NO	NO	E	OPIOD DEP	1
NAGARAJ	946131	40	MALE	GRAD	USW	M	RURAL	H	BPL	MED	ADS	DEADDIC	NO	NO	NO	I	ADS SW TDS	1
RAJA	92625	35	MALE	PRIM	USW	M	RURAL	H	BPL	MED	ADS	DEADDIC	NO	NO	NO	NO	ADS	1
MUNICHANDRAPPA	57937	47	MALE	PRIM	USW	M	RURAL	H	BPL	MED	ADS	DEADDIC	NO	NO	NO	NO	ADS,TDS	1
RAMA MANI NAIDU	60337	54	MALE	12TH	USW	M	RURAL	H	APL	MED	ADS	SLEEP DIS	NO	NO	NO	G	ADS,TDS	1
CHALAPATHI	60343	44	MALE	10TH	USW	M	RURAL	H	BPL	MED	ADS	SLEEP DIS	NO	NO	NO	E	ADS SW TDS	1
KRISHNAPPA	39599	37	MALE	10TH	USW	M	RURAL	H	APL	MED	ADS	DEADDIC	NO	NO	NO	NO	ADS,TDS	1
RAMESH	932967	48	MALE	PRIM	USW	M	RURAL	H	BPL	MED	ADS	DEADDIC	YES	NO	NO	NO	ADS	1
SRINIVAS	59959	26	MALE	12TH	SW	M	RURAL	H	APL	SURGERY	ADS	SLEEP DIS	NO	NO	NO	E,R	ADS SW TDS	1
SURENDRA BABU	54376	30	MALE	12TH	USW	S	RURAL	H	BPL	MED	ADS	DEADDIC	NO	NO	NO	NO	ADS,TDS	1
RAJAPPA	942112	55	MALE	PRIM	USW	M	RURAL	H	APL	MED	ADS	DEADDIC	NO	YES	NO	E	ADS,TDS	1
SASHI KUMAR	928990	26	MALE	12TH	USW	S	RURAL	H	BPL	MED	ADS	DEADDIC	NO	NO	NO	NO	ADS SW	1
THIPPANNA	934260	60	MALE	ILLIT	USW	M	RURAL	H	BPL	MED	ADS	DEADDIC	NO	NO	NO	E	ADS,TDS	1
ASHOK	924427	42	MALE	10TH	USW	M	RURAL	H	APL	MED	ADS	DEADDIC	NO	YES	NO	NO	ADS,THU,ISH	1,2
PRASANNA KUMAR	872625	45	MALE	10TH	SW	M	RURAL	H	APL	MED	ADS	DEADDIC	YES	NO	NO	NO	ADS SW TDS	1
RAJESH	886993	30	MALE	12TH	USW	S	RURAL	H	APL	MED	ADS,SUI-MOD	DEADDIC,COUN	NO	NO	NO	NO	ADS,TDS,ISH	1,2
MURALI	937818	30	MALE	10TH	USW	M	RURAL	H	APL	MED	ADS	DEADDIC	NO	NO	NO	NO	ADS SW,TDS	1
MUNIYAPPA	936999	48	MALE	10TH	USW	M	RURAL	H	BPL	SURGERY	ADS	DEADDIC	NO	NO	NO	G,E	ADS SW TDS	1
VASUDEV	911213	32	MALE	GRAD	USW	M	RURAL	H	APL	MED	ADS	DEADDIC	NO	NO	NO	GU,E	ADS SW	1
RAMIAH	826275	31	MALE	10TH	USW	S	RURAL	H	APL	SURGERY	ADS	SLEEP DIS	NO	NO	NO	NO	ADS SW TDS	1
HARISH	932010	35	MALE	12TH	USW	M	RURAL	H	BPL	SURGERY	ADS	DEADDIC	NO	NO	NO	E	ADS	1
ANTONY	932968	52	MALE	PRIM	USW	M	RURAL	H	BPL	SURGERY	ADS	DEADDIC	NO	NO	NO	GE	ADS,TDS	1
MUNIVENKATAPPA	877646	60	MALE	ILLIT	UN	M	RURAL	H	BPL	MED	MISC	DEADDIC	NO	NO	NO	O	OPIOD DEP	1
SENAPPA	981299	45	MALE	PRIM	USW	M	RURAL	H	BPL	MED	ADS,SUI-MILD	DEADDIC	NO	NO	NO	NO	ADS,TDS,ISH	1,2
VENKATESH	928777	42	MALE	PRIM	USW	M	RURAL	H	BPL	MED	ADS	DEADDIC	NO	NO	NO	NO	ADS SW	1
HANUMANTHAPPA	928535	38	MALE	PRIM	USW	M	RURAL	H	BPL	MED	ADS	DEADDIC	YES	NO	NO	NO	ADS SW	1
SURESH	924057	40	MALE	PRIM	USW	M	RURAL	H	APL	SURGERY	ADS	DEADDIC	NO	NO	NO	NO	ADS,NDS	1
YELLAPPA	932544	45	MALE	ILLIT	USW	M	RURAL	H	BPL	MED	ADS	DEADDIC	NO	NO	NO	E	ADS SW	1
MANJUNATHAN	863153	29	MALE	PRIM	USW	S	RURAL	H	BPL	MED	AL ABU	COUNSE	NO	YES	NO	R	AHU	1
MUNISWAMY	934224	55	MALE	ILLIT	USW	M	RURAL	H	BPL	MED	AL ABU	AGITATION	NO	NO	NO	O	AHU,TDS	1
RAJA.M	924042	26	MALE	ILLIT	USW	M	URBAN	H	APL	ORTHO	ADS	DEAADIC	NO	NO	NO	NO	ADS SW,TDS	1
SHIKHAR GOWDAM	51444	24	MALE	12TH	UN	S	URBAN	H	APL	EMD	N DEP,ADS,PSY-CU	AGITATION	NO	NO	NO	NO	CAN IN PSY	1
RAMCHARAN RATHOD	910830	25	MALE	12TH	UN	S	URBAN	H	APL	EMD	PSY-CURR	AGITATION	NO	NO	NO	NO	ACUTE PSYCHOSIS	6
VENKATESH	899625	58	MALE	ILLIT	USW	M	RURAL	H	APL	MED	MOOD PSY	LOW MOOD	YES	NO	YES	NO	SEV D PSY	3
CHANDRA KUMAR	47250	38	MALE	12TH	USW	M	RURAL	H	APL	MED	PSY-LIFE	PSY ILLNESS	NO	YES	NO	NO	SCHIZO	6
PRADEEP KUMAR	94311	28	MALE	GRAD	UN	S	RURAL	H	APL	EMD	PSY-LIFE	PSY ILLNESS	NO	NO	NO	NO	PSYCHOSIS	6
YELLAMMA	37215	42	FEMALE	PRIM	UN	M	RURAL	H	APL	MED	PSY-LIFE,AL ABU	AGITA,SUSP	NO	NO	NO	NO	AHU, PSYCHOSIS	1,6
BHARATHI	950412	43	FEMALE	1OTH	UN	M	RURAL	H	APL	MED	PSY-LIFE	PSY ILLNESS	YES	NO	NO	NO	SCHIZO	6
RAMARATHNAMMA	929438	55	FEMALE	PRIM	UN	M	RURAL	H	BPL	MED	PSY-LIFE	AGITATION	NO	NO	NO	E,O	SCHIZO	6

PARVATHAMMA	891465	60	FEMALE	ILLIT	UN	M	RURAL	H	BPL	MED	PSY-CURR	AGITATION	NO	NO	NO	R,E	ACUTE PSYCHOSIS	6
LAKSHMIDEVAMMA	25074	63	FEMALE	ILLIT	UN	M	RURAL	H	BPL	SURGERY	PSY-LIFE	PSY ILLNESS	NO	NO	NO	O	SCHIZO	6
BADRINATH	944055	37	MALE	12TH	USW	S	RURAL	H	BPL	SURGERY	PSY-LIFE	PSY ILLNESS	NO	NO	NO	E	SCHIZO	6
RUKMANI	927875	45	FEMALE	PRIM	UN	M	RURAL	H	BPL	ORTHO	PSY-LIFE	PSY ILLNESS	NO	NO	NO	CVS,E	SCHIZO	6
SAMPATH KUMAR	927661	64	MALE	GRAD	SW	M	RURAL	H	APL	CARDIO	PSY-LIFE	PSY ILLNESS	NO	NO	NO	CVS	SCHIZO	6
SHAHID	888310	26	MALE	10TH	UN	S	RURAL	M	BPL	ENT	MOOD PSY CURR	SUI ATT	YES	NO	YES	NO	SEVERE D PSY	3
YUGESH	873667	23	MALE	12TH	USW	S	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH	2
MARUTHI PRASAD	937793	19	MALE	12TH	UN	S	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH	2
SUDHAKAR	934640	25	MALE	GRAD	USW	S	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH	2
ANITHA	867097	30	FEMALE	PRIM	UN	M	RURAL	H	BPL	MED	SUI-HIGH	SUI ATT	NO	NO	NO	NO	ISH	2
GOWTHAMI	866312	24	FEMALE	PRIM	UN	M	RURAL	H	BPL	MED	SUI-HIGH	SUI ATT	NO	NO	NO	CNS	ISH	2
CHANDRU	928730	28	MALE	12TH	UN	S	URBAN	H	BPL	MED	SUI-LOW	SUI ATT	NO	NO	NO	NO	ISH	2
REETHIKA	928298	20	FEMALE	10TH	UN	S	RURAL	H	BPL	MED	SUI-MOD	SUI ATT	NO	NO	NO	CNS	ISH	2
KALYANI	938702	26	FEMALE	12TH	USW	M	RURAL	H	APL	MED	SUI-MOD	SUI ATT	YES	NO	YES	NO	ISH	2
ROOPA	943211	24	FEMALE	12TH	HMR	M	RURAL	H	APL	MED	SUI-LOW	SUI ATT	NO	NO	NO	NO	ISH	2
NAJUMUNISSA	51489	34	FEMALE	GRAD	HMR	M	RURAL	M	APL	MED	SUI-LOW	SUI ATT	NO	NO	NO	NO	ISH	2
VISHALAMMA	51209	42	FEMALE	10TH	HMR	M	RURAL	H	APL	MED	SUI-LOW	SUI ATT	NO	NO	NO	NO	ISH	2
JAYAMMA	920361	50	FEMALE	PRIM	UN	M	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	E	ISH	2
RAMADEVI	44400	32	FEMALE	12TH	HMR	M	RURAL	H	APL	MED	SUI-HIGH	SUI ATT	NO	NO	NO	CNS	ISH	2
SAHANA	50758	19	FEMALE	10TH	USW	S	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH	2
RUPA	93125	28	FEMALE	12TH	SW	M	RURAL	H	APL	MED	SUI-HIGH	SUI ATT	NO	NO	NO	NO	ISH	2
YALLAMMA	37275	35	FEMALE	12TH	USW	M	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH	2
SHOBHA	948763	28	FEMALE	10TH	UN	S	RURAL	H	APL	MED	SUI-LOW	SUI ATT	NO	NO	NO	NO	ISH	2
SADIKUNNISA	890212	21	FEMALE	PRIM	UN	S	RURAL	H	BPL	MED	SUI-HIGH	SUI ATT	NO	NO	NO	NO	ISH	2
RAMIYAMMA	930372	35	FEMALE	10TH	UN	M	RURAL	H	APL	MED	SUI-LOW	SUI ATT	NO	NO	NO	NO	ISH	2
LAKSHMAMMA	936054	38	FEMALE	PRIM	USW	M	RURAL	H	APL	MED	SUI-LOW	SUI ATT	NO	NO	NO	NO	ISH	2
SUJATHA	940126	45	FEMALE	ILLIT	UN	M	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH	2
KATHICK	923075	21	MALE	GRAD	SEMI PRO	S	RURAL	H	APL	MED	SUI-LOW	SUI ATT	NO	NO	NO	NO	ISH	2
PUSHPA	937583	45	FEMALE	PRIM	USW	M	RURAL	H	BPL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH	2
FATHIMA UNNISA	938756	31	FEMALE	10TH	UN	M	RURAL	M	APL	MED	SUI-MOD, MDD-CURR	SUI ATT	NO	NO	NO	O	ISH,MILD DEP	2,3
LALITHA	885507	32	FEMALE	PRIM	UN	M	RURAL	H	BPL	MED	SUI-HIGH, MDD-CURR	SUI ATT	NO	NO	YES	NO	ISH,MOD DEP	2,3
SHILPA	943838	22	FEMALE	12TH	UN	M	RURAL	H	APL	MED	SUI- LOW	SUI ATT	NO	NO	NO	NO	ISH	2
CHITHRA	948921	28	FEMALE	12TH	USW	M	RURAL	H	BPL	MED	SUI- LOW	SUI ATT	NO	NO	NO	NO	ISH	2
SHOBHA	949763	25	FEMALE	12TH	UN	M	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH	2
SAVITHRI	864961	28	FEMALE	PRIM	UN	M	RURAL	H	APL	MED	SUI-HIGH, MDD-CURR	SUI ATT	NO	NO	NO	NO	ISH,MOD DEP	2,3
NANDANA	924205	45	FEMALE	10TH	HMR	M	RURAL	H	BPL	MED	SUI-LOW	SUI ATT	NO	NO	NO	NO	ISH	2
VIJAYALAKSHMI	933702	27	FEMALE	PRIM	HMR	M	RURAL	H	BPL	MED	SUI-LOW	SUI ATT	NO	NO	NO	NO	ISH	2
SALMA SULTHANA	937609	35	FEMALE	10TH	HMR	M	RURAL	M	BPL	MED	SUI- LOW	SUI ATT	NO	NO	NO	NO	ISH	2
PREM KUMAR	945412	23	MALE	12TH	USW	S	RAL HIN	H	BPL	MED	SUI-LOW	SUI ATT	NO	NO	NO	NO	ISH	2

NAGENDRA	87877	22	MALE	GRAD	SW	S	URBAN	H	APL	MED	SUI-LOW	SUI ATT	NO	NO	NO	NO	ISH	2
SOUMYA	63645	22	MALE	12TH	UN	M	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH	2
BHARATH	926869	28	MALE	GRAD	SW	S	RURAL	H	APL	MED	SUI-MOD, MDD-CURR	SUI ATT	NO	NO	NO	NO	ISH,MILD DEP	2,3
PRITHVIRAJ	890428	30	MALE	GRAD	USW	M	RURAL	H	APL	MED	SUI-HIGH	SUI ATT	NO	NO	NO	NO	ISH	2
NARAYANASWAMY	60007	25	MALE	12TH	USW	S	RURAL	H	APL	MED	SUI-HIGH	SUI ATT	NO	NO	NO	NO	ISH	2
VENKATESHAPPA	929822	62	MALE	ILLIT	USW	M	RURAL	H	BPL	MED	SUI- MOD	SUI ATT	NO	NO	NO	NO	ISH	2
AMBARISH	55462	30	MALE	12TH	USW	M	RURAL	H	APL	MED	SUI-MOD, AL ABU	SUI ATT	NO	NO	NO	NO	ISH,AHU	1,2
SRINIVAS MURTHY	55941	38	MALE	PRIM	USW	M	RURAL	H	BPL	MED	SUI-MILD	SUI ATT	NO	NO	NO	NO	ISH	2
KRISHNA MURTHY	59262	30	MALE	GRAD	SW	M	RURAL	H	BPL	MED	SUI-LOW, AL ABU	SUI ATT	NO	NO	NO	NO	AHU,ISH	1,2
GOPAL	926886	28	MALE	10TH	USW	M	RURAL	H	BPL	MED	SUI-LOW	SUI ATT	NO	NO	NO	NO	ISH	2
RAKESH	999988	28	MALE	GRAD	USW	S	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH	2
RAKESH	913241	34	MALE	GRAD	USW	M	RURAL	H	APL	MED	SUI-LOW	SUI ATT	NO	NO	NO	NO	ISH	2
CHALAPATHI	945193	38	MALE	10TH	USW	M	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH	2
RAMACHANDRA	944080	48	MALE	12TH	USW	M	RURAL	H	APL	MED	SUI-MOD,ADS	SUI ATT	NO	NO	NO	NO	ADS,ISH	1,2
NARAYANASWAMY	943858	40	MALE	PRIM	USW	M	RURAL	H	BPL	MED	SUI-MILD	SUI ATT	NO	NO	NO	NO	ISH	2
NAGARAJ	945540	45	MALE	PRIM	USW	M	RURAL	H	APL	MED	SUI-HIGH	SUI ATT		NO	NO	NO	ISH	2
AMBARISHA K.V	48771	32	MALE	GRAD	USW	M	RURAL	H	BPL	MED	SUI-LOW	SUI ATT	NO	NO	NO	NO	ISH	2
CHALAPATHI	52484	27	MALE	10TH	USW	M	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH	2
VENKATESH	42813	45	MALE	12TH	USW	M	RURAL	H	APL	MED	SUI- MILD	SUI ATT	NO	NO	NO	NO	ISH	2
VINODH KUMAR	42542	21	MALE	10TH	USW	S	RURAL	H	BPL	MED	SUI-MOD, AL ABU	SUI ATT	NO	YES	NO	NO	AHU,ISH	1,2
KIRAN	42870	25	MALE	GRAD	USW	S	RURAL	H	APL	MED	SUI-MILD	SUI ATT	NO	NO	NO	NO	ISH	2
NARAYANASWAMY	94112	29	MALE	12TH	USW	S	RURAL	H	APL	MED	SUI-MILD	SUI ATT	NO	NO	NO	NO	ISH	2
ANAND	958802	25	MALE	12TH	USW	M	RURAL	H	BPL	MED	SUI-MILD, ADS,ASPD	SUI ATT	NO	NO	NO	E	ADS,ISH,ASPD	1,2,5
RAMAREDDY	946785	38	MALE	10TH	USW	M	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH	2
PRAJWAL	949410	19	MALE	12TH	UN	S	RURAL	H	APL	MED	SUI-MILD	SUI ATT	NO	NO	NO	NO	ISH	2
MUNENDRA	853212	20	MALE	12TH	UN	S	RURAL	H	BPL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH	2
GANGARAJ	947584	23	MALE	10TH	USW	S	RURAL	H	BPL	MED	SUI-HIGH	SUI ATT	NO	YES	NO	NO	ISH	2
PREM KUMAR	945412	23	MALE	12TH	USW	S	RURAL	H	APL	MED	SUI-MILD	SUI ATT	NO	NO	NO	NO	ISH	2
ARUN	930017	35	MALE	12TH	USW	M	RURAL	H	APL	MED	SUI-MOD,ADS	SUI ATT	NO	NO	NO	NO	ADS,ISH	1,2
RASAPPA	654321	65	MALE	ILLIT	USW	M	RURAL	H	APL	ENT	SUI-HIGH	SUI ATT	NO	NO	NO	NO	ISH	2
RAMESH	919185	37	MALE	10TH	USW	M	RURAL	H	BPL	ENT	NIL	LOW MOOD	NO	NO	NO	E	ADJ DIS	4
RAMESHA	923521	53	MALE	10TH	USW	M	RURAL	H	APL	ENT	MDD-CURR	ALT BEHA	NO	NO	NO	E,I	SEV D PSY	3
NANJUNDA CHARI	5608	63	MALE	PRIM	SW	M	RURAL	H	APL	SURGERY	NIL	LOW MOOD	NO	NO	NO	DM	ADJ DIS	4
RATHNAMMA	83621	65	FEMALE	PRIM	UN	M	RURAL	H	APL	SURGERY	MDD-CURR	LOW MOOD	NO	NO	NO	E,O	MILD DEP	3
RATHNAMMA	46516	46	FEMALE	PRIM	UN	M	RURAL	H	APL	SURGERY	MDD-CURR	LOW MOOD	YES	NO	NO	E.O	MOD DEP	3
RATHNAMMA	38621	64	FEMALE	ILLIT	UN	M	RURAL	H	APL	SURGERY	MDD-CURR	LOW MOOD	NO	NO	NO	E,O	MOD DEP	3
PILLAMMA	950958	69	FEMALE	ILLIT	UN	M	RURAL	H	BPL	SURGERY	MDD-CURR	LOW MOOD	NO	NO	NO	O	MILD DEP	3
SUMITHA	951499	42	FEMALE	10TH	UN	M	RURAL	H	APL	SURGERY	MOOD WOT PSY-CURR	PSY ILLNESS	NO	NO	NO	O	SEV D NO PSY	3

NIRUPA	52270	20	FEMALE	1OTH	USW	M	RURAL	H	APL	OBG	MDD-CURR	ALT BEHA	NO	NO	NO	H	SEV D CATATONIA	3
SHAM RAO	51435	60	MALE	12TH	USW	M	RURAL	H	APL	EMD	RDD-CURR	ALT BEHA	NO	NO	NO	NO	RDD-SEV D PSY	3
SHAHEENA SULTANA	937971	24	FEMALE	GRAD	UN	M	RURAL	M	APL	MED	RDD-CURR	SLEEP DIS	YES	NO	NO	NO	RDD-MILD DEP	3
LALITHA	909432	35	FEMALE	12TH	UN	M	URBAN	H	APL	EMD	PSY-CURR	ALT BEHA	NO	YES	NO	NO	ACUTE PSYCHOSIS	6
RAMANJINJA BABU	50975	48	MALE	10TH	USW	M	RURAL	H	BPL	ORTHO	NIL	SLEEP DIS	NO	NO	NO	NO	ADJ	4
SHANTHAMMA	14183	37	FEMALE	PRIM	UN	M	RURAL	H	BPL	ORTHO	MDD-CURR	LOW MOOD	NO	NO	NO	O	MOD DEP	3
SELVI	40183	28	FEMALE	10TH	UN	M	RURAL	H	APL	MED	SUI-MOD,MDD	SUI ATT	NO	YES	YES	NO	ISH,MILD DEP	2,3
FATHIMA	444698	55	FEMALE	10TH	UN	M	RURAL	H	APL	MED	MDD-CURR	LOW MOOD	NO	NO	NO	NO	MILD DEP	3
GULLAMMA	948840	55	FEMALE	PRIM	UN	M	RURAL	H	APL	MED	MDD-CURR	LOW MOOD	NO	NO	NO	NO	MOD DEP	3
SUGUNAMMA	61932	34	FEMALE	GRAD	USW	M	RURAL	H	BPL	MED	MDD-CURR	SUI ATT	NO	NO	YES	NO	ISH,SEV D NO PSY	2,3
KAVITHA	933713	25	FEMALE	10TH	USW	S	RURAL	H	APL	MED	MDD-CURR	LOW MOOD	NO	NO	NO	CNS	MOD DEP	3
ANITHA	929134	30	FEMALE	GRAD	UN	M	RURAL	H	APL	MED	MDD-CURR	SUI ATT	NO	NO	NO	NO	ISH,MOD DEP	2,3
NAGARATHNA	937343	32	FEMALE	10TH	USW	S	RURAL	H	BPL	MED	MDD-CURR	LOW MOOD	NO	NO	YES	NO	RDD-SEV D PSY	3
MUNIRATHNAMMA	910367	43	FEMALE	ILLIT	UN	M	RURAL	H	BPL	MED	SUI-MOD	SUI ATT	NO	NO	NO	E,OBG	ISH,DYS	2,3
MARIYA DAS	923144	23	FEMALE	GRAD	SW	S	RURAL	CH	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	G	ISH,ADJ DIS	2,4
BHARATHI	932628	42	FEMALE	12TH	USW	M	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH,DYS	2,3
VENKATESHAPPA	928904	47	MALE	PRIM	USW	M	RURAL	H	APL	MED	MDD	LOW MOOD	NO	NO	NO	NO	SEV DEP NO PSY	3
RAJANNA	926377	50	MALE	ILLIT	USW	M	RURAL	H	BPL	MED	NIL	SLEEP DIS	NO	NO	NO	GU,E	MIXED ANX DEP	4
SANJAY S N	924743	20	MALE	GRAD	UN	S	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH,ADJ DIS	2,4
SANJAY	94367	25	MALE	12TH	UN	S	RURAL	H	BPL	MED	MDD-CURR, SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH,MILD DEP	2,3
SONNAMMA	54377	56	FEMALE	ILLIT	UN	M	RURAL	H	BPL	SURGERY	NIL	AGITATION	NO	NO	NO	GU	ADJ BR ANX REAC	4
MANJULA	947511	32	FEMALE	10TH	UN	M	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	YES	NO	NO	ISH,ADJ-BR DEP REAC	2,4
NIRMALA	945862	44	FEMALE	10TH	UN	M	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH,ADJ	2,4
LAKSHMAMMA	60110	39	FEMALE	PRIM	USW	M	RURAL	H	APL	MED	NIL	LOW MOOD	NO	NO	YES	O	ADJ- BR ANX REAC	4
MUNIRAJU	38624	30	MALE	12TH	USW	M	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH,ADJ DIS	2,4
SHIVASHANKAR	47439	32	MALE	12TH	UN	S	RURAL	H	BPL	MED	NIL	DEADDIC	NO	NO	NO	NO	NDS,ADJ DIS	1,4
YADARAJA GOWDA	948031	40	MALE	10TH	USW	M	RURAL	H	APL	MED	SUI-HIGH, MDD-CURR	LOW MOOD	NO	NO	YES	NO	ISH,SEV D NO PSYC	2,3
SURYA	41370	26	MALE	10TH	USW	M	RURAL	H	BPL	MED	MDD-CURR, SUI-HIGH	LOW MOOD	NO	NO	NO	NO	SEV D NO PSYC,ISH	3,2
NIRESH KARKARI	924646	55	FEMALE	GRAD	USW	M	RURAL	H	BPL	EMD	RDD-CURR	SLEEP DIS	YES	NO	NO	NO	SEV D NO PSYC	3
PUTTA NAGARAJIAH	59486	63	MALE	10TH	SW	M	RURAL	H	APL	MED	MDD-CURR	LOW MOOD	NO	NO	NO	CNS	POST STROKE DEP	9
MUNIYAPPA	39285	64	MALE	ILLIT	UN	M	RURAL	H	APL	MED	MDD-CURR	SLEEP DIS	NO	NO	NO	NO	MILD DEP	3
RAMACHANDRACHARI	99945	42	MALE	PRIM	USW	M	RURAL	H	BPL	MED	SUI-MILD	SLEEP DIS	NO	NO	NO	CNS	ISH,ADJ DIS	2,4
MANOJ KUMAR	94781	29	MALE	12TH	USW	S	RURAL	H	BPL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH,ADJ DIS	2,4

ANIL	930924	25	FEMALE	PRIM	USW	S	RURAL	H	BPL	MED	AL ABU,ASPD	DEADDIC	NO	NO	NO	NO	AHU,TDS, ADJ,ASPD	1,4,5
SHIVANAND	939574	53	MALE	GRAD	SEMI PRO	M	RURAL	H	APL	ORTHO	NIL	SLEEP DIS	NO	N0	NO	NO	SEC INSOMNIA	8
SYED MUNAWAR	50604	62	MALE	10TH	USW	M	RURAL	H	APL	SURGERY	NIL	SLEEP DIS	NO	NO	NO	R	TDS,SEC INSOMNIA	1,8
RAGHUNATH	54082	35	MALE	GRAD	USW	M	RURAL	H	APL	MED	NIL	SLEEP DIS	NO	NO	NO	CNS,GU	SEC INSOMNIA	8
NAGARAJ	955142	45	MALE	10TH	UN	M	RURAL	H	APL	MED	NIL	SLEEP DIS	NO	NO	NO	O	SEC INSOMNIA	8
NANDHITHA	869816	19	FEMALE	12TH	UN	S	RURAL	H	BPL	MED	NIL	SLEEP DIS	NO	NO	NO	NO	INSOMNIA	8
MANJUNATHA M	910800	30	MALE	12TH	USW	S	RURAL	H	APL	MED	AL ABU	SLEEP DIS	NO	NO	NO	O	DEL PARASITOSIS	6
NAGESH	927716	38	MALE	GRAD	SW	M	URBAN	H	APL	MED	MANIA -PAST	PSY ILLNESS	YES	NO	NO	NO	ADS,BPAD-C.ESEV D NO PSYCH	1,3
SATHISH KUMAR	902266	27	MALE	12TH	USW	S	RURAL	H	APL	EMD	MANIA-CURR	AGITATION	YES	NO	NO	NO	BPAD-C.E MANIA PSYCHOTIC	3
SAMPATH KUMAR	938322	29	MALE	GRAD	USW	S	RURAL	H	BPL	MED	PSY-CURR	ALTERED BE	NO	NO	NO	NO	PSYCHOSIS	6
VENKATAPPA	46187	62	MALE	PRIM	USW	M	RURAL	H	APL	OPTHAL	SOCI PHOB	ANXIETY	YES	NO	NO	O	SOCI PHOB	4
NARAYANAMMA	932941	40	FEMALE	ILLIT	UN	M	RURAL	H	BPL	MED	PANIC DIS	SOMATIZATION	NO	NO	NO	O	PANIC DIS	4
NAGARAJ	946735	37	MALE	GRAD	SW	M	RURAL	H	BPL	SURGERY	PANIC DIS	ANXIETY	NO	NO	NO	NO	PANIC DIS	4
LALITHA	927406	36	FEMALE	12TH	USW	M	RURAL	H	BPL	MED	PANIC DIS	SLEEP DIS	NO	NO	NO	NO	PANIC DIS	4
CHANDANA	938110	29	FEMALE	PGRAD	SEMI PRO	M	RURAL	H	APL	MED	SOCI PHOB	ANXIETY	NO	NO	YES	NO	SOCI PHOB	4
THARUN KUMAR	59810	24	MALE	GRAD	USW	S	RURAL	H	APL	MED	PANIC DIS	SLEEP DIS	NO	NO	NO	NO	PANIC DIS	4
PILLANANJAPPA	952173	55	MALE	ILLIT	USW	M	RURAL	H	APL	MED	SOCI PHOB	ANXIETY	YES	NO	NO	NO	SOCI PHOB	4
NITHIN KUMAR	928552	23	MALE	GRAD	USW	S	RURAL	H	APL	MED	PANIC DIS	SLEEP DIS	NO	NO	NO	I	PANIC DIS	4
CHINNAPPA	791851	65	MALE	PRIM	USW	M	RURAL	H	APL	MED	PANIC DIS	ANXIETY	NO	NO	NO	CVS,O	PANIC DIS	4
SADIQ PASHA	923194	33	MALE	12TH	USW	M	RURAL	M	APL	ENT	PANIC DIS	SLEEP DIS	NO	NO	NO	NO	PANIC DIS	4
MURALI	926676	40	MALE	12TH	USW	M	RURAL	H	BPL	SURGERY	GAD	SLEEP DIS	NO	NO	NO	NO	GAD	4
ZAHIYA FIRDOSE	927162	32	FEMALE	PRIM	UN	M	RURAL	M	APL	ENT	NIL	UNRESPONS	NO	NO	NO	I	DIS MOTOR DIS	4
CHAITRA	62459	18	FEMALE	10TH	UN	S	RURAL	H	APL	EMD	MDD-CURR	UNRESPONS	NO	NO	NO	NO	MILD DEP, DISSO	3,4
SHWETHA	50310	26	FEMALE	PGRAD	PROF	S	RURAL	H	APL	EMD	NIL	ALT BEHA	NO	NO	NO	CNS	DISSO DIS	4
GAYATHRI	57988	19	FEMALE	10TH	UN	M	RURAL	H	BPL	EMD	NIL	ALT BEHA	NO	NO	NO	NO	DISSO DIS	4
MONISHA	950307	22	FEMALE	GRAD	UN	S	RURAL	H	APL	MED	NIL	ALT BEHA	YES	NO	NO	NO	DISSO DIS SEI	4
AMRUTHAVARSHINI	42237	18	FEMALE	12TH	UN	S	RURAL	C	APL	MED	NIL	ALT BEHA	NO	NO	NO	NO	DISSO MOTOR DIS	4
ROHI	42760	37	FEMALE	12TH	UN	M	RURAL	H	APL	MED	NIL	ALT BEHA	NO	NO	NO	NO	DISSO MOTOR DIS	4
ASHA	46883	30	FEMALE	PRIM	UN	M	RURAL	H	APL	MED	NIL	UNRESPONS	NO	NO	NO	NO	DISSO DIS	4
SHARUBAI	98305	24	FEMALE	PRIM	UN	M	RURAL	H	BPL	MED	NIL	ALT BEHA	NO	NO	NO	CNS	NIL PSY	7
PRABHAVATHI	944321	40	FEMALE	GRAD	USW	M	RURAL	H	APL	MED	NIL	ANXIETY	NO	NO	NO	NO	DISSO MOTOR DIS	4
MANJULA	929016	22	FEMALE	10TH	UN	S	RURAL	H	APL	EMD	NIL	ANXIETY	NO	NO	NO	NO	DISSO DIS	4

GEETHA	868788	32	FEMALE	12TH	UN	M	RURAL	H	APL	MED	NIL	LOW MOOD	NO	NO	NO	OBG	DYS, SOMATIZATION	3,4
PUSHPA	948456	30	FEMALE	10TH	USW	M	URBAN	H	APL	MED	NIL	SLEEP DIS	NO	NO	NO	NO	SOMATIZATION	4
PUSHPAVATHI	845656	32	FEMALE	10TH	UN	M	RURAL	H	APL	MED	NIL	SLEEP DIS	NO	NO	NO	NO	SOMATIZATION	4
SONAPPA	44334	37	MALE	12TH	USW	M	RURAL	H	APL	MED	NIL	SLEEP DIS	NO	NO	NO	E	ADJ DIS	4
RAMACHANDRAPPA	927307	62	MALE	ILLIT	USW	M	RURAL	H	APL	MED	NIL	LOW MOOD	NO	NO	NO	E,GU	SOMATOFORM PAIN DIS	4
NARAYANASWAMY	94542	45	MALE	PRIM	USW	M	RURAL	H	APL	SURGERY	NIL	LOW MOOD	NO	NO	NO	NO	NIL PSY	7
RAJANNA	921289	47	MALE	PRIM	USW	M	RURAL	H	BPL	ORTHO	NIL	AGITATION	NO	NO	NO	E,O	NIL PSY	7
THIMMAPPA	940165	64	MALE	PRIM	USW	M	RURAL	H	APL	MED	NIL	ALT BEHA	NO	NO	NO	R,GU	NIL PSY	7
SARASAMMA	923414	53	FEMALE	10TH	UN	M	RURAL	H	APL	ENT	NIL	AGITATION	NO	NO	NO	R,E	NIL PSY	7
VARALAKSHMI	923976	20	FEMALE	12TH	UN	M	RURAL	H	BPL	MED	NIL	COUNS	NO	NO	NO	NO	NIL PSY	7
ASMATH UNNISA	944698	64	FEMALE	ILLIT	UN	M	RURAL	M	BPL	MED	NIL	COUNS	NO	NO	NO	NO	NIL PSY	7
LAVANYA	53918	21	FEMALE	12TH	USW	S	RURAL	H	APL	MED	NIL	SOMATIZATION	NO	NO	NO	NO	NIL PSY	7
NAVANITHA	58450	19	FEMALE	10TH	UN	M	RURAL	H	APL	MED	NIL	SOMATIZATION	NO	NO	NO	CNS	NIL PSY	7
MARIYA	92721	32	FEMALE	10TH	UN	M	RURAL	CH	APL	OBG	NIL	ALT BEHA	NO	NO	NO	CNS	NI PSY	7
PRATHIMA	905657	24	FEMALE	ILLIT	UN	M	RURAL	H	APL	OBG	NIL	UNRESPONS	NO	NO	NO	H	NIL PSY	7
VENKATALAKSHMA	38582	60	FEMALE	PRIM	UN	M	RURAL	H	APL	SURGERY	NIL	LOW MOOD	NO	NO	NO	O	NIL PSY	7
RAMEEZA	42229	40	FEMALE	10TH	USW	M	RURAL	M	APL	OBG	NIL	ALT BEHA	NO	NO	NO	O	NIL PSY	7
CHINNAMMA	85321	64	FEMALE	ILLIT	UN	M	RURAL	H	APL	MED	NIL	UNRESPONS	NO	NO	NO	O	NIL PSY	7
AMBIGA	9485881	40	FEMALE	PRIM	UN	M	RURAL	H	APL	MED	NIL	UNRESPONS	NO	NO	NO	O	NIL PSY	7
SOUNDARYA	973221	18	FEMALE	10TH	UN	S	RURAL	H	APL	MED	NIL	COUNS	NO	NO	NO	NO	NIL PSY	7
CHAITRA	56437	20	FEMALE	10TH	UN	S	RURAL	H	APL	MED	NIL	SOMATIZATION	NO	NO	NO	O	NIL PSY	7
BHULAKSHMI	933447	30	FEMALE	12TH	UN	M	RURAL	H	BPL	MED	NIL	COUNS	NO	NO	NO	NO	NIL PSY	7
RAJAMMA	930959	50	FEMALE	ILLIT	UN	M	RURAL	H	APL	MED	NIL	COUNS	NO	NO	NO	E,O	NIL PSY	7
SHIVAMULLIKA	931087	20	FEMALE	GRAD	SW	M	RURAL	H	APL	MED	NIL	COUNS	NO	NO	NO	E	NIL PSY	7
VARALAKSHMI ANAND	933976	28	FEMALE	10TH	UN	M	RURAL	H	BPL	MED	NIL	COUNS	NO	NO	NO	NO	NIL PSY	7
MUNIYAMMA	930648	60	FEMALE	ILLIT	UN	S	RURAL	H	APL	MED	NIL	COUNS	NO	NO	NO	E,O	NIL PSY	7
JAYADAMBA	947560	20	FEMALE	GRAD	UN	S	RURAL	H	APL	MED	NIL	COUNS	NO	YES	NO	NO	NIL PSY	7
RATHNAMMA	44947	55	FEMALE	PRIM	UN	M	RURAL	H	BPL	MED	NIL	COUNS	NO	NO	NO	NO	TDS	1
SAVITHRI	864961	28	FEMALE	PRIM	USW	M	RURAL	H	BPL	MED	NIL	SUI ATT	NO	NO	NO	NO	ACUTE STRESS REAC	4
SUJATHAMMA	929841	25	FEMALE	PRIM	UN	M	RURAL	H	APL	MED	NIL	SUI ATT	NO	NO	NO	NO	ACUTE STRESS REAC	4
ASHA	937360	31	FEMALE	10TH	UN	M	RURAL	H	APL	MED	NIL	SUI ATT	NO	NO	NO	NO	ACUTE STRESS REAC	4
TULASIMALLA	927678	42	FEMALE	PRIM	UN	M	RURAL	H	BPL	MED	NIL	SUI ATT	NO	YES	NO	O	ACUTE STRESS REAC	4
LAYASHREE	945735	20	FEMALE	PRIM	UN	S	RURAL	H	APL	MED	NIL	SUI ATT	NO	NO	NO	NO	ACUTE STRESS REAC	4
ANUSHA	48295	32	FEMALE	10TH	UN	M	RURAL	H	APL	MED	NIL	SUI ATT	NO	NO	NO	NO	ACUTE STRESS REAC	4
GEETHA	53550	32	FEMALE	10TH	UN	M	RURAL	H	APL	MED	NIL	SUI ATT	NO	NO	NO	NO	ACUTE STRESS REAC	4
NOOR FATHIMA	59737	19	FEMALE	12TH	UN	S	RURAL	M	APL	MED	NIL	SUI ATT	NO	NO	NO	NO	ACUTE STRESS REAC	4
CHANDRA KESHAVA REDD	928785	22	MALE	10TH	UN	S	RURAL	H	APL	MED	NIL	SUI ATT	NO	NO	NO	NO	ACUTE STRESS REAC	4
GOPAL	926881	28	MALE	ILLIT	USW	M	RURAL	H	BPL	MED	NIL	SUI ATT	NO	NO	NO	NO	ACUTE STRESS REAC	4
NARAYANASWAMY	43118	26	MALE	10TH	USW	M	RURAL	H	APL	MED	NIL	SUI ATT	NO	NO	NO	NO	ACUTE STRESS REAC	4
SAHITH BASHA	94311	39	MALE	12TH	USW	M	RURAL	M	APL	MED	NIL	SUI ATT	NO	NO	NO	NO	ACUTE STRESS REAC	4
VENKATACHALAPHI	54952	28	MALE	12TH	USW	M	RURAL	H	APL	MED	NIL	SUI ATT	NO	NO	NO	NO	ACUTE STRESS REAC	4
AKHILA	51178	21	FEMALE	12TH	UN	M	RURAL	H	APL	OBG	NIL	SUI ATT	NO	NO	NO	H	ACUTE STRESS REAC	4

PRABHAVATHI	898696	40	MALE	PRIM	USW	M	RURAL	H	APL	MED	PTSD	SLEEP DIS	NO	NO	NO	NO	PTSD	4
SURESH	947584	26	MALE	GRAD	UN	S	RURAL	H	APL	MED	NIL	SLEEP DIS	NO	NO	NO	NO	HYPOCHON, DHAT SYN	9
ANJANAPPA	154751	41	MALE	GRAD	USW	M	RURAL	H	APL	MED	MDD -CURR	LOW MOOD	NO	NO	NO	NO	SEV D NO PSY	3
SUKUMAR	98985	23	MALE	10TH	USW	S	RURAL	H	BPL	SURGERY	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH	2
HARISH	95176	32	MALE	12TH	SW	M	URBAN	H	APL	SURGERY	ADS	DEADDIC	NO	YES	NO	NO	ADS,TDS, SATYRIASIS	1,9
CHINNAYYA	93073	37	MALE	10TH	USW	M	RURAL	H	BPL	MED	ADS	DEADDIC	NO	NO	NO	G	ADS,TDS	1
MUNISKRISHNA	90636	25	MALE	GRAD	UN	S	RURAL	H	APL	MED	OPIOD ABUSE	DEADDIC	NO	NO	NO	E,O	OPIOD HU	1
NAVEEN KUMAR	86623	29	MALE	GRAD	UN	S	RURAL	H	APL	MED	ADS	DEADDIC	NO	YES	NO	R,G	AL INDUC MOOD DIS,ADS,TDS	1
BUJJANNA	98193	50	MALE	12TH	UN	M	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	E	ISH	2
VENKATALAKSHMA	94086	50	MALE	ILLIT	UN	M	RURAL	H	BPL	MED	NIL	SLEEP DIS	NO	NO	NO	O	ADJ DIS	4
BASKAR AHMED	98215	60	MALE	PRIM	USW	M	RURAL	M	BPL	MED	PSY-LIFE	ALT BEHA	NO	NO	NO	NIL	DEL PARASITOSIS	6
BABA JHAN	96128	34	MALE	PRIM	USW	M	RURAL	M	BPL	MED	CAN DS	AGITATION	NO	NO	NO	NO	CDS,TDS	1
KUMAR VELU	81633	32	MALE	10TH	USW	M	RURAL	H	APL	MED	SUI-MOD	SUI ATT	NO	NO	NO	NO	ISH	2
UMADEVA	78623	38	FEMALE	12TH	UN	M	RURAL	H	APL	MED	MDD-CURR	LOW MOOD	NO	NO	NO	CNS,E	SEV D NO PSY	3
RAJAPPA	76894	40	MALE	10TH	USW	M	RURAL	H	BPL	OPTHAL	ADS	DEADDIC	NO	NO	NO	O	ADS SW,TDS	1
SURESH	76965	35	MALE	12TH	USW	M	RURAL	H	BPL	MED	ADS	DEADDIC	NO	NO	NO	NO	ADS,TDS	1
JACINTHA	76513	54	FEMALE	ILLIT	UN	M	RURAL	H	BPL	MED	PSY- LIFE	ALTERED BE	NO	NO	NO	E	PARANOID SCHIZO	6
KRISHNA	72990	28	MALE	12TH	USW	S	RURAL	H	BPL	MED	ADS	DEADDIC	NO	NO	NO	NO	ADS,TDS	1
SATHISH KUMAR	62515	31	MALE	10TH	USW	S	RURAL	H	APL	SURGERY	ADS	DEADDIC	NO	NO	NO	E	ADS SW,TDS	1
HARISH	69207	35	MALE	12TH	USW	M	RURAL	H	BPL	ORTHO	ADS	DEADDIC	NO	NO	NO	O	ADS,TDS	1
SRINIVAS	68322	40	MALE	PRIM	USW	M	RURAL	H	BPL	MED	ADS	DEADDIC	NO	NO	NO	O	ADS,TDS	1
NAVEEN	67071	22	MALE	12TH	UN	S	RURAL	H	BPL	MED	MOD SUI,ASPD	SUI ATT	NO	NO	NO	NO	ISH,ASPD	2,5
LAKSHMAN	62479	55	MALE	ILLIT	USW	M	RURAL	H	BPL	MED	NIL	SLEEP DIS	NO	NO	NO	NO	NIL	7
THASEEM TAJ	54472	51	FEMALE	ILLIT	UN	M	RURAL	M	BPL	OBG	NIL	COUNS	NO	NO	NO	NO	ADJ DIS	4
GANGADHAR	59210	50	MALE	10TH	USW	M	RURAL	H	BPL	SURGERY	ADS,MDD	DEADDIC	NO	NO	NO	G	ADS,NDS,MOD DEP	1,3
MAHESH KUMAR	150430	24	MALE	10TH	USW	S	RURAL	H	BPL	MED	ADS,ASPD	DEADDIC	NO	NO	NO	NO	ADS,NDS,ASPD	1,5