"STUDY OF CLINICAL PROFILE AND SHORT-TERM OUTCOME OF DISSOCIATIVE DISORDER IN CHILDREN AND ADOLESCENTS – AN OBSERVATIONAL STUDY IN A TERTIARY CARE CENTRE"

BY

REG NO: BQ0120005

Dissertation

Submitted to the

KLE Academy of Higher Education and Research

Belagavi, Karnataka

In partial fulfilment of the requirements for the degree of

DOCTOR OF MEDICINE

IN

PSYCHIATRY

JAWAHARLAL NEHRU MEDICAL COLLEGE
BELAGAVI-590010, KARNATAKA

JUNE/JULY - 2023

KLE Academy of Higher Education and Research

Belagavi, Karnataka

Endorsement by the Head of Department, Principal/ Head of the Institution

This is to certify that the dissertation entitled **"STUDY OF CLINICAL PROFILE AND SHORT-TERM OUTCOME OF DISSOCIATIVE DISORDER IN CHILDREN AND ADOLESCENTS – AN OBSERVATIONAL STUDY IN A TERTIARY CARE CENTRE"** is a bonafide research work done by **REG NO. BQ0120005.**

Dr. S. S. CHATE
Professor & Head
Dept. of Psychiatry
J.N. Medical College, BELAGAVI - 590 010
KMC Reg No. 48916

Dr. S. S. CHATE, M.D., D.P.M.
Professor & Head,
Department of Psychiatry,
Jawaharlal Nehru Medical College,
Belagavi - 590010

Date: 2/1/2023
Place: Belagavi

PRINCIPAL
J.N. Medical College,
BELAGAVI- 590 010

Dr. N. S. MAHANTSHETTI, M.D.
Principal, Jawaharlal Nehru Medical College,
Belagavi - 590010

Date: 2/1/2023
Place: Belagavi

KAHER
BELAGAVI
J.N. MEDICAL COLLEGE

UNDER TAKING

I, **REG NO: BQ0120005** hereby declare that the information and the data mentioned in my thesis entitled **"STUDY OF CLINICAL PROFILE AND SHORT-TERM OUTCOME OF DISSOCIATIVE DISORDER IN CHILDREN AND ADOLESCENTS – AN OBSERVATIONAL STUDY IN A TERTIARY CARE CENTRE"** belongs to me and is original.

I am aware of the definition of plagiarism as detailed below:

- An act or instance of using or closely imitating the language and thoughts of another author without authorization and the representation of that author's work as one's own, as by not crediting the original author.
- A piece of writing or other work reflecting such unauthorized use or imitation.
- The deliberate or reckless representation of another's words, thoughts or ideas as one's own without attribution in connection with submission of academic work, whether graded or otherwise.

I hereby declare that the thesis prepared by me is original-one and does not involve plagiarism anywhere. In case at a later stage it is found that I have indulged in plagiarism, then I am solely responsible for the same and the Institution is at liberty to take any disciplinary action against me including cancellation of dissertation or any other penalties imposed by the University.

Date: 2/1/2023

Place: Belagavi

REG NO: BQ0120005

PLAGIARISM ACCEPTANCE LETTER

KLE ACADEMY OF HIGHER EDUCATION AND RESEARCH

JAWAHARLAL NEHRU MEDICAL COLLEGE

(Recognized by Medical Council of India, New Delhi)

Accredited 'A+' Grade by NAAC (3rd Cycle) Placed in Category 'A' by MHRD (GoI)

Nehru Nagar, Belagavi- 590 010, Karnataka, INDIA

0831 - 2471350 0831 - 2470759 www.jnmc.edu principal@jnmc.edu

Ref No: MDC/PG/ Date: 08-12-2022.

ACCEPTANCE LETTER

The softcopy of thesis entitled: **"STUDY OF CLINICAL PROFILE AND SHORT-TERM OUTCOME OF DISSOCIATIVE DISORDER IN CHILDREN AND ADOLESCENTS - AN OBSERVATIONAL STUDY IN A TERTIARY CARE CENTRE"** has been submitted for Anti-Plagiarism check through Turnitin software. The scan has been carried out and the scanned output reveals a match percentage of **02%** which is within the acceptable limits of **10%** as per the guidelines given by UGC.

Guide.

KAHER * BELAGAVI * J.N. MEDICAL COLLEGE

Dr. (Mrs.) N.S. Mahantashetti.
Chairperson-Antiplagiarism Committee &
Principal,
J. N. Medical College, Belagavi.

To,
Reg. No. BQ0120005,
Postgraduate Student,
2020-21 Batch,
Department of Psychiatry,
J. N. Medical College, Belagavi.

ETHICAL CLEARANCE CERTIFICATE

K.L.E. ACADEMY OF HIGHER EDUCATION AND RESEARCH
(Deemed – to- be- University)
Accredited 'A' Grade by NAAC (2nd Cycle) Placed in Category 'A' by MHRD (GoI)
JAWAHARLAL NEHRU MEDICAL COLLEGE,
NEHRU NAGAR, BELAGAVI-590010 (KARNATAKA-INDIA)
Website: http//www.jnmc.edu
E-Mail : dome@jnmc.edu
Phone: (+ 91-(0)831 Office : 2472550
Principal: 2471701
Fax No. +91 (0)831 – 2470759

Ref: MDC/DOME/ 44 **Date: 25/01/2021**

To

REG NO: BQ0120005

PG student in Psychiatry,
J.N.Medical College,
BELAGAVI.

Sub: Institutional Ethical Clearance for the study.

With reference to the above, we wish to inform you that your proposed research project titled **"STUDY OF CLINICAL PROFILE AND SHORT-TERM OUTCOME OF DISSOCIATIVE DISORDER IN CHILDREN AND ADOLESCENTS – AN OBSERVATIONAL STUDY IN A TERTIARY CARE CENTRE",** is ethical and justifiable.

The proposed research project has been cleared by the JNMC Institutional Ethics Committee on Human Subjects Research.

(Dr. Smita Sonoli)
Member Secretary
JNMC Institutional Ethics Committee
on Human Subjects Research,
J.N.Medical College, Belagavi.

(Dr. Harsha Hegde)
Chairman,
JNMC Institutional Ethics Committee
on Human Subjects Research,
J.N.Medical College, Belagavi.

160

ABSTRACT

Introduction: Dissociative disorder is a common condition in children and adolescents, especially in the Indian population. A diagnosis is made once all potential medical or physical causes have been ruled out and occurs largely in the background of an ongoing or immediate stressor. It is a disabling condition, with impairment in routine functioning, reduction in the number of days of school and causing a significant economic burden on the caregivers. Limited studies have been done in our population, especially regarding outcomes in children and adolescents.

Objective: To examine the demographic and clinical profile of children and adolescents with dissociative disorder. Also, to assess outcome with treatment as usual at the end of 1 month.

Methods: This was an observational study where 51 children and adolescents (less than 18), diagnosed with dissociative disorder were administered a semi-structured questionnaire to determine socio-demographic details, illness and patient characteristics. CGI-S (Children's Global Impression-Severity) scale was applied to assess baseline illness severity, CGAS (Children Global Assessment Scale) and SDQ (Strengths and Difficulties Questionnaire) for functioning. MINI-KID was used to assess and/or rule out any co-morbid psychiatric illnesses. These patients were given appropriate treatment as usual and were followed up after a month either through OPD visit or through voice/video calls due to the COVID-19 pandemic. After a month, CGAS and CGI-S scales were repeated and CGI-I (Children's Global Impression-Improvement) scale was applied to assess the level of improvement as per parents. The data was analysed with percentages for categorical variables, and standard deviation for continuous variables, and paired t-test was used to measure the

difference from baseline CGAS and CGI-S scores with scores after 1 month follow-up.

Results: In our study, the mean age was 14.2 years, 52.9% were from the age group 15-18 years. Females comprised 66.7% of the study population. Slow-to-warm-up temperament was present in 39.2% of cases. The most common stressor was familial (39.2%). Most common type was dissociative stupor (37.3%). Improvement in the severity of illness and functioning was seen at the end of 1 month with treatment as usual.

Conclusion: Significant (at least moderate improvement) was seen in 60-70% of patients after treatment as usual at the end of 1 month. There was more improvement in illness severity than in overall functioning at the end of 1 month. However, improvement in both was found to be statistically significant.

Keywords: Dissociative disorder, children, adolescents, characteristics, outcome

LIST OF ACRONYMS

BZD	Benzodiazepine
CDC	Child Development Clinic
CGAS	Children's Global Assessment Scale
CGI-I	Clinical Global Impression - Improvement
CGI-S	Clinical Global Impression – Severity
DSM-5	Diagnostic and Statistical Manual of Mental Disorder - 5
ICD-10	International Classification of Diseases - 10
ID	Intellectually Disabled
IPD	Inpatient Department
MINI Kid	Mini International Neuropsychiatric Interview for Children and Adolescents
OCD	Obsessive-Compulsive Disorder
OPD	Outpatient Department
SDQ	Strengths and Difficulties Questionnaire
SLD	Specific Learning Disability
SNRI	Serotonin and Norepinephrine Reuptake Inhibitors
SGA	Second Generation Antipsychotics
SSRI	Selective Serotonin Reuptake Inhibitors
TCA	Tricyclic Antidepressants

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

INTRODUCTION

Dissociation even though similar phenomena have been described from ancient times, we continue to have a limited understanding of the condition. In its most primitive understanding, dissociation is the "splitting" or loss of integration between various cognitive processes. Over time, other perspectives such as the "conversion" of underlying psychosocial stress into physical symptoms, were introduced by Freud. It is also been proposed as a defence mechanism.

In children, presentation is similar to adults but may have variance due to immature and underdeveloped cognitive systems. Also, the experience of stressors and the ability to identify them also differ. Prevalence is also higher in younger age groups (children, adolescents and young adults) as compared to adults, possibly due to a lesser capacity to deal with stressful situations. Addressing the root cause is necessary as a protracted course is not only difficult to manage, but they are at risk of developing other co-morbid psychiatric disorders and furthermore, may take on a "sick role", avoiding responsibilities, and attention-seeking. DSM IV includes "primary gain" and "secondary gain" in their description of conversion disorder. Primary gain is the immediate relief of anxiety due to the symptoms and secondary gain is the social attention that the person gets and is said to be more subtle. Both are said to occur by unconscious mechanisms[1]. Outcome is mainly determined by factors such as the age of presentation, good premorbid personality, presence of identifiable stressors, and co-morbid psychiatric illnesses. However, with early intervention and a cooperative support system, improvement is seen, even as early as 1 week. Although dissociative disorders have been described and diagnosed for some time, the availability of literature on the clinical profile in children and adolescents is limited. Very few Indian studies have examined the clinical profile and especially the short-

term outcome of children and adolescents with dissociative disorders. Existing literature on dissociative disorder in children and adolescents is limited in comparison with that on adults.

This observational study was undertaken in our population, as there are not many studies which have looked into various aspects like demographics, stressors, and treatment received, and outcome. This would help in adding information about needs in the treatment of dissociative disorder in children and adolescents.

OBJECTIVES

1. To examine the
    - Demographic &
    - Clinical profile in children and adolescents with dissociative disorder
2. To assess the outcome in children and adolescents with dissociative disorder with treatment as usual at the end of 1 month.

REVIEW OF LITERATURE

HISTORY AND CURRENT PERSPECTIVES

The phenomenon was first described 4000 years ago in Egyptian literature, cases of women suffering from indeterminate symptoms [2]. It was then described as "starvation of the uterus". The term "Hysteria" as it was later termed, was derived from Greek language, referring to the uterus. This was first termed by Hippocrates who believed the cause of the physical distress was due to the upward movement of the uterus[3]. This was a view carried from the Egyptian times until at least the Middle Ages as the symptoms were seen only in women at the time. The theories revolved around sexual dissatisfaction, and the main treatment at the time was to get married and have an adequate and satisfying sexual life. This lasted until the thirteenth century, when in Europe with more involvement of the church in the research sciences, hysteria was seen to be the manifestation of the Devil, and these women sufferers were subjected to exorcism.

This connection of hysterical symptoms with the uterus remained till the 16th century, where with the advent of modern medical science, Thomas Willis, a physician suggested the aetiology of hysteria to be related to the mind rather than the uterus, as both men and women suffer from it. This was further researched by Thomas Sydenham, who was the first to recognize that symptoms of hysteria are no different than forms of organic diseases. However not all were convinced by this theory, as even in the early 19th century, Phillipe Pinel, considered it to be "female genital neurosis" [2].

In the mid-19th century, Paul Briquet published one of the first major work on hysteria, which was a series of cases that definitively proved that hysteria is not only seen in women and is not related to the ailment of the uterus, but rather of the

brain. He also described the various manifestations such as pain and spasms. He also remarked on the impact of cordial family and social situations on the same and was one of the first to recommend protocols such as maintaining confidentiality, listening to the patient and avoidance from stressors [4 2].

Jean-Marie Charcot added upon the work already done by Briquet and added paralyses, gait disturbances, and contractures as other presentations and also introduced hypnosis to relieve attacks of hysteria. The premise that the uterus influenced presentations of hysteria was still considered at this time and Charcot did write on techniques to treat the diseased ovary.

This continued until the 19th century with French neuropsychiatrist Pierre Janet, along with being the first and foremost researcher into dissociation. He was the first to comprehensively link dissociative experiences to trauma and came up with the reason that the subconscious was the reason for dissociative symptoms. Janet's findings further influenced the early works of Sigmund Freud and Carl Jung [5].

Freud, in addition, asserted the presence of "male hysteria" and introduced a new concept: whereas earlier sexual or marital dissatisfaction was the proposed cause of hysteria, he reversed it saying that hysteria leads to dissatisfaction and the person is unable to carry a mature relationship. It was further refined with psychoanalysis that hysterical symptoms were the expression of the failure of sexual fulfilment, with the hysterical symptom being a "primary benefit" allowing for a release of the urge He was also the first to introduce the concept of "secondary advantage" which allowed the individual to influence the environment for their needs [5]. He was the first to suggest that hysterical symptoms are a byproduct of unconscious psychological conflicts being converted to physical symptoms and hence the term "Conversion" was coined.

When initially the link between trauma and dissociative experience was beginning to be established in the early 20th century, early studies were conducted on soldiers who were in the World War, due to the high number of soldiers presenting with dissociative symptoms. It was during this time the term "Shell Shock" was coined, to describe neurological or behavioural manifestations in the absence of a significant brain lesion[6]. Research during this period also accelerated as many soldiers were required at the war front. Psychotherapy and electrotherapies were most frequently used during this time[2].

With the World War, there were cross-cultural comparisons. With one of the first studies on hysteria conducted by Abse in 1950, 57% of the study population (644 patients) were diagnosed as to be suffering from hysteria. In similar studies, it was seen that hysteria was the most common form of neurotic disorder seen in Indian soldiers. However, towards the end of the 20th century, as rates of hysteria significantly decreased in western countries, it still was a significantly high portion of all psychiatric illnesses in Middle-Eastern and Asian countries, attributed to cultural differences and hysteria being one of the somatic conditions to express underlying distress [3].

ETIOLOGIES & THEORIES OF DISSOCIATION

NEUROBIOLOGY OF DISSOCIATION

As per ICD-10, a diagnosis of dissociative disorder can only be made after excluding all possible physical/medical causes [7]. In earlier studies, it was seen that 1/3rd of patients diagnosed with dissociative disorder, were eventually diagnosed to have organic disorders [8] but these rates have become lower in modern times[9] which could be because of increasing awareness regarding medically unexplained symptoms and improved diagnostics. This reinforces the fact that dissociative disorder is a diagnosis of exclusion. It is preferable to have both neurologist and a psychiatrist evaluate the patient independently before diagnosing it as dissociative disorder. This is relevant as most patients present to the neurologist primarily due to the physical nature of the illness.

Clinicians have tried to find delineations between dissociative symptoms, and true neurological signs and symptoms, which can help in early diagnosis and unnecessary intrusive investigations. Early EEG studies, showed inhibition of afferent stimuli and reduced somatosensory-evoked responses which disappeared after symptom resolution [10] [11]. This was further duplicated in other patients in 2004 [12]. But with only a handful of studies and poorly reproduced studies, this theory was rejected, and normal evoked potential is seen to be a hallmark of dissociative disorders [13]. Furthermore, studies using Magnetoencephalography (MEG) on patients with dissociative sensory loss have normal evoked potentials in secondary somatosensory cortex [14].

Further evidence was found from single-photon ECT and positron emission tomography, wherein two separate studies there was seen to be increased perfusion to the frontal regions [15] [16] which were assumed to inhibit motor and premotor areas.

Similar to earlier studies, reduced perfusion was also seen in subcortical structures in symptomatic patients in single-photon ECT studies, which reversed to normal on resolution of symptoms [17].

In a pilot study by Simeon et al to assess the relation of the HPA Axis in Depersonalization disorder it was seen that plasma cortisol levels were significantly suppressed, to a point of hypo suppression in patients with depersonalization disorder as compared to patients with depression [18] This might indicate that stress response inhibits reactivity in traumatic situations. But studies involving the HPA have inconsistent results, with another study by Simeon et al, in comparison with PTSD participants and healthy controls, the group with dissociative disorder had significant high urinary cortisol, and there were no significant changes in cortisol reactivity in all three groups, rather having an inverse relation with stress and cortisol reactivity.

Ketamine, a rapid antidepressant has been associated with dissociative experiences, similar to other drugs like marijuana, and hallucinogens. Ketamine is an NMDA antagonist that facilitates the release of glutamate, thereby producing its rapid anti-depressant action. Studies also suggest that the presence and severity of dissociative symptoms augment the anti-depressant effect [19], meaning that the dissociative experiences are possibly mediated through the "Glutamate Surge" as seen with the administration of ketamine [20]

In a study performed by Mathew et al about depersonalization after Marijuana smoking, one aspect noted the study was that drug-induced dissociative experiences are not rooted in the presumed theory of defence against trauma as the experiences were associated with euphoria. There was no associated unpleasantness of the experience as well, suggesting that the dissociative symptoms can be triggered through various pathways [21].

Another possible mechanism is serotonergic-enabled dissociative experiences. In studies where serotonin has been administered externally, there have been statistically significant increased levels of dissociation in subjects [22].

Emotional Under and Overmodulation

In individuals that experience trauma, later on, leading to PTSD symptoms, these individuals on reexperiencing, describing or hearing about the same exhibited significantly low activation in the medial prefrontal cortex and anterior cingulate cortex, which are areas of the brain responsible for arousal and emotional regulation. This is referred to as emotional undermodulation [23]. The undermodulation model has also been seen in patients experiencing dissociative amnesia, fugue and dissociative identity disorder, there is inhibition of the hippocampus along with the occipital cortex [23].

In emotional overmodulation, patients experiencing depersonalization and derealization symptoms, exhibited high activation in the anterior cingulate cortex and the medial prefrontal cortex leading to hyperinhibition of limbic regions including the amygdala [23].

Continuum/Taxon Model

Until William James and Morton Prince, the prevailing idea about dissociative disorders stemmed from Pierre Janet, who saw dissociative disorders as occurring only in individuals with mental disorders and were absent in healthy people[24]. James and Prince viewed dissociation as a range from physiologically occurring, such as daydreaming to disruptive and clinically diagnosable forms like dissociative disorders[25]. The taxon model takes it a little further and subdivides it into normal and pathological dissociation. The subtypes and "pathological" types were derived from the Dissociative Experiences Scale (DES) where 8 items were identified as

differentiating normal dissociative experiences from pathological ones or those who can be clinically diagnosed as dissociative disorder [26]. However, this classification is still under debate [27] [28].

Psychoanalytic Theories

Freud was the first proponent of the psychoanalytic theory, along with Breuer. Emphasizing unconscious urges, and the need for the expression of "prohibited needs". By expressing them as psychosocial symptoms, both qualities are satisfied, the expression of the urge or prohibited need and that it is also disguised in an acceptable manner [29]. The term "conversion" was developed from Freud's psychoanalytical theory, reflecting physical symptoms as an attempt to resolve underlying unconscious conflicts, hence "converting psychological symptoms to physical ones".

Learning Theories/ Trauma Models

The crux of this theory is that behaviour is shaped by the environment and its consequences and that dissociative symptoms are maladaptive learned behaviours. This behaviour is sustained by primary or secondary gains. This is most often seen in response to trauma [30] [31]. Another aspect of this theory is that dissociation could be an inherent evolutionary response in situations where the perceived threat level is high [32] [33]. Studies have linked the relationship between trauma, especially childhood trauma and the frequency and severity of dissociative symptoms [34]

Sociocultural Hypothesis

In some cultures, individuals tend to be somatic mind rather than psychologically minded. The direct expression of emotions or emotional distress may be frowned upon.

A prevailing idea is that dissociation is more prevalent in developing countries than in the Western population, as having a physical illness is a more culturally acceptable way of seeking help than psychological illness or as a symbolic expression of ideas which may not be permitted directly [29].

This idea is supported by various studies where prevalence in Western population studies is consistently lower than in the Asian population. In some studies, the prevalence in the Western population has been seen to be as low as 0.5 per cent of the total population[35] to 3% whereas in recent studies incidence rates have increased to 10%. In the Indian pediatric population, studies conducted are limited but prevalence is as high as 12.5% [36] to 31% in inpatient setting [37]. Psychologically minded individuals find it easier to express their emotional needs, another possible reason why dissociative disorder is becoming rarer in Western countries [38]. As described by Chacko, another reason could be the reluctance of parents to accept emotional needs or the influence of stressors on their child. However, causes in children are difficult to delineate and tend to be multifactorial.

Iatrogenic and Sociocognitive Model

This theory is of special interest in dissociative identity disorder and notes that dissociative states, especially DID are not genuine dissociative states, rather they are induced by therapists or treating professionals in highly suggestible individuals. The sociocognitive model differs in that instead of being influenced by treating staff, it is instead by mass media and trauma support groups. This model has come under criticism [39] for invalidating the influence of trauma, especially as it has been that DID is postulated as a symptom of PTSD or a variant, indicating that individuals who suffer from DID go through more severe, early onset and longer duration of trauma [40] [39] [41].

Animal Defensive Responses

Recent advances have proposed "Animal Defensive Responses" as a model of dissociation. Some researchers have found similarities in animal defence reactions and trauma-related dissociative symptoms. Keeping in line with this view, animals do not respond to trauma or threat to life in a single, repetitive manner, they have variable responsiveness with regard to different levels or types of traumas. This is similar to what is seen in humans as well [42].

Temperament and its influence

Temperamental factors have also been examined in a few studies on children with dissociative disorders. Nevertheless, the results are not consistent. Hinman in 1958, first noted that there may be a few traits that are characteristic in children with dissociative disorders. They tend to be immature, more prone to mood swings and impressionable. These children also tend to be unaware of any conflict, and if conflicts were present, they found it difficult to communicate emotional needs to their parents, hence resorting to the expression of a dramatic illness [43].

In one of the earliest studies on dissociative disorders in children conducted in 1981, Goodyear noted that in 15 children who were studied, all had some anxious traits, from anxiousness, and poor interpersonal relationships, to being introverted [35]. A study conducted in Lucknow showed that more than half of the children (69.2%) presenting with "hysteria" had neurotic traits such as nail biting, over-sensitivity, and temper tantrums [44].

Another study which examined personality factors in children and adolescents with dissociative disorders, it was seen that personality factors varied between the two groups. While children with dissociative disorders were seen to be more anxious, socially awkward, shy, less intelligent and found difficulty in trusting, adolescents

were seen to be emotionally unstable, and undisciplined with a tendency to get frustrated easily in face of conflict. This study also saw that occurrence of dissociative symptoms increased with age, possibly owing to these personality factors [45]. But the likelihood of personality or temperament influencing dissociative disorders is not established as there are no consistent findings. As seen in a study conducted in PGI Chandigarh in 2005, there were no temperamental disturbances that could be found in patients [46].

Raghuthaman et al, showed that children with predominant traits of negative mood, low rhythmicity, distractibility and persistence were found to be present in statistically significant rates in children with dissociative disorders [47]. However, in another study, temperamental factors did not influence rates of dissociative disorders rather suggesting that the severity of the stressor leads to dissociative symptoms[48].

As seen in multiple studies, dissociative disorders are more common in the adolescent age group than in children, In a study conducted in Lucknow mean age of subjects was found to be 12.6 [44], which was similar to results seen in a study where the mean age was 12 [48]. Even in a study conducted by Maloney in Ohio mean age was shown to be 12.1 years [49]. Similarly, in another study by Srinath et al, out of 38 inpatients with hysteria, 24 of them (63%) were from the age group of 12-16 years [37]. This was corroborated by another study conducted by Sethi and Gandhi, where 53% of the subjects were from 12-16 years [36]. However, these differences are not statistically significant as per Putnam who also noted the increasing rate of dissociative disorders with increasing age. Gross in 1976 remarked that the adolescent group is more vulnerable as they are in a stage of identity conflict, which can bring about significant internal turmoil [50]. Pierre Janet was the first to link dissociative

experiences to trauma. This was first noted in World War I veterans, where they linked experiences in the war to posttraumatic and dissociative symptoms

Influence of family dynamics

India, as noted by Geetha et al, has more closely knit families, with firmer family ties. Unlike in Western countries, families play a greater role in the development of the child. This is why nowadays the treatment is not solely for the child but also for the family. In her study conducted in Bengaluru in 1980, comparing "hysteria" with family dynamics wherein it was seen that in children with anxiety disorders, it was seen that relation between husband-wife was found to be impaired whereas in "hysteria" it was parent and child relations that were affected. More significantly, in "hysteria" there was no significant family dysfunction and difficulties were limited to the domination of the child over the parents and the mother having more control over the child as opposed to the father, which was seen to be disruptive to the power hierarchy in the family. However, no other studies have replicated these findings. And a limitation of the study, possibly owing to the prevailing outlook at the time, where "Normal" family was seen to have decreased communication and increased control over the child by the father. This was assumed to be culturally determined[51]. Similar to other psychosomatic conditions, Singh et al reported that there was a significant increase in somatic complaints following stressful events in the family[52]

TERMINOLOGIES SYNONYMOUS WITH DISSOCIATION

As of now, there is no universally accepted term for this cluster of symptoms. While psychiatrists and psychologists, restrict themselves to the DSM or ICD terminologies, various other terms are also used by epileptologists and neurologists, such as Psychogenic Nonepileptic Seizures (PNES), which explains that these symptoms imitate epileptic attacks, but are psychogenically induced. It is now an updated subtype of "conversion disorder" in the DSM-5 consisting of functional neurological symptoms. Most commonly used by neurologists, the prefix "psychogenic" indicate the psychological origin of the symptoms, thereby denoting that the "seizures" are possibly triggered by psychological factors. However, some authors have noted that the term seizure could induce a false sense of criticality of the condition in the patient and the family members [53]. This is the most common terminology used outside of psychiatry, by other health professionals, especially neurologists. It is also the most common term known by the general population, as seen by most searches in Google [54]. Pseudoseizure/Pseudo-epileptic attack is an older term, not commonly in use now as it implied that the patient was feigning their symptoms, which leads to further invalidation of the patient and may subsequently lead to inadequate treatment. A more sensitive term that has recently come in use is Functional Seizure/Functional Non-Epileptic Seizure/Functional Non-Epileptic Event, referring to a functional disturbance of the nervous system, removing the negative perception associated with the term "psychogenic". "Functional" is associated with the least negative connotations as compared to psychogenic, medically unexplained, and psychosomatic[55]. Authors have argued the use of psychogenic over functional as it conveys aetiology appropriately, whereas functional is deemed to be non-

offensive[56]. Non-Epileptic Attack Disorder (NEAD), is an earlier iteration of the term, used in the late 20th century, but not commonly in use now.

In history, when the phenomenon was being studied, and the aetiology was unknown, terms like hysterosis and hysterical seizures were used. Only in the late 20th century, the terminology of hysteria was changed to circumvent the negative meaning associated with it in DSM-I to "Conversion Reaction". Until DSM-III, both conversion and dissociative disorders were grouped as one. However, in DSM-III it was split according to phenomenology and further conversion was grouped under somatoform disorders. ICD-10 and DSM-V differ in their classifications of "hysteria". The classification of dissociative and conversion disorders was introduced in the 1980s to circumvent the negative meaning associated with it. In DSM-V it is separately classified as Dissociative and Conversion disorders. Dissociative disorders (according to DSM-V) are characterized by disruption of integration of consciousness, perception, behaviour etc. and conversion includes symptoms of altered voluntary motor or sensory function, incompatible with neurological/medical conditions[57] . In ICD-10 symptoms suggestive of conversion and other dissociative experiences are together described under Dissociative [Conversion] disorders and are together defined as partial or complete loss of normal integration between memories or past, awareness of identity and. Immediate sensations, and control of bodily movements[7]. Henceforth, the term dissociative disorders include both dissociative and conversion symptoms.

Recently in ICD-11, there have been more renovations to the classification of dissociative disorders. While there has been no major overhaul in concepts, there are some classificatory differences. The term "conversion" has been removed from the title and is grouped commonly under neurological symptom disorder with sub-

classification such as visual or auditory disturbance, vertigo or dizziness, sensory disturbances, non-epileptic seizures (replacing dissociative convulsions), speech disturbance, paresis or weakness, gait disturbances, cognitive symptoms. A new category of dissociative neurological disorder with movement disturbance such as chorea, myoclonus, tremor, dystonia, and parkinsonism that are not correlating with typical neurological manifestations. Dissociative fugue and amnesia have been combined under the classification of Dissociative amnesia with fugue as a qualifier under it. Trance and possession disorder is divided into two separate entities, with trance state indicating only alteration in consciousness with loss of personal identity. Whereas in possession disorder, emphasis is laid on the person being "possessed by" an external agent and must not be a part of cultural or religious practice. Partial dissociative identity disorder is a new classification which differs from dissociative identity disorder in that the dissociative identities are non-dominant and are "intrusions" which do not take control of the persons functioning, unlike dissociative identity disorder. Depersonalization and derealization disorder, earlier classified separately are added under dissociative disorders in ICD-11. Overall the change is more clinician-focused, with symptom dimension given priority[58 59].

SIGNS & SYMPTOMS OF DISSOCIATIVE DISORDERS

According to ICD-10, the core disturbance in dissociative disorders is the partial or complete loss of conscious control over memories and sensations. These are in relation to a stressful event, and hence usually seen in individuals who are unable to deal with certain levels of stress, or are generally sensitive in nature.

Right from history, we can observe that dissociative symptoms correlate with either an immediately preceding stressor, or an ongoing stressor. This is also a diagnostic criterion in ICD-10, along with the absence of a physical disorder [7]. In various observational studies, the frequency and severity of traumatic experiences influence the characteristic of dissociative symptoms, seen as increased frequency of episodes and persistence into adulthood [60].

Subtypes of dissociation as per ICD-10, include

- Dissociative Amnesia – The core symptom is the loss of memory, of immediate events and is usually selective for the traumatic events. The level of this memory loss is generally variable and inconsistent.
- Dissociative Fugue – Memory loss along with wandering episodes away from home, or known place associated with the assumption of a new identity. Fugue states generally last for a few days. However, self-care and functioning are intact in this state.
- Dissociative Stupor – Resembles stuporous states seen in organic conditions. There is a decrease or absence of controlled movements along with responsiveness, because of which they appear to be motionless for extended periods of time. Unprompted speech is also usually absent during this time.

- Trance and Possession disorders – Brief loss of personal identity and awareness of surroundings. The individual usually acts as if they are another person, most commonly seen are deities or recently deceased relatives. However, following this episode, they may have complete or partial loss of recollection regarding the events that occurred in the episode. The unique aspect is that cultural and religious episodes must be excluded before making the diagnosis, as spirit possession is a culturally accepted belief, especially in Asian cultures [61]
- Dissociative motor disorder – In this subtype, there is a loss or impairment in voluntary movements, resembling paralysis. They may present with complete loss of movement of limb or part of limbs for a prolonged period of time, or with abnormal gait. In some cases, they may present with exaggerated tremors of extremities or of the whole body.

  Astasia Abasia, derived from the Greek term, literally translates to "inability to stand and to walk" defined as the inability to stand or walk, despite no neurological cause. Initially described by Paul Blocq who considered it a separate disease [62]. However, this symptom is not limited to dissociation and is also seen in some organic neurological conditions. However, a pointer that suggests dissociation is that even due to this unsteady gait, the patient does not sustain any falls or serious injuries due to these falls, unlike what is seen in organic conditions.
- Dissociative Convulsions – Mimic epileptic seizures, however, symptoms like tongue bite resulting in laceration and bleeding fall resulting in serious injury, incontinence, and post-episodic confusion or loss of consciousness are scarce.

- Dissociative anaesthesia and sensory loss - the loss of sensation is often restricted to superficial cutaneous sensation, whereas pain and deep sensations are still intact. They do not follow any dermatomal delineation. These anaesthesias are usually accompanied by paresthesia. Loss of vision (Hysterical blindness) as a presentation is rare, and not generally associated with the expected level of impairment in functioning.
- Ganser's syndrome – Also termed as "Vorbeigehen" or "Vorbeireden", the distinct feature being approximate answers to simple questions, along with other dissociative symptoms, such as amnesia, and loss of consciousness [63]. Described by Sigbert Josef Maria Ganser in 1897, a German psychiatrist, this condition is still under heavy debate, as no conclusive evidence of dissociation or other possible psychiatric conditions has been noted. Whether it is a phenomenon requiring separate discussion is also highly controversial as in its essence, Ganser's syndrome is akin to failing in tests performed in a hospital setting, which is not specific. [63].
- Dissociative Identity Disorder (DID) – Previously called multiple identity disorder, commonly makes its appearance during adolescence. However, not commonly diagnosed until adulthood. Presents with identity disruption characterized by two or more than two personalities, which the patient may or may not be aware of. Frequently associated with severe and often long-standing childhood trauma, such as sexual abuse, and physical abuse[64]. Some researchers have also hypothesized that DID is a part of borderline personality[65] as they found that as much as 70 per cent of patients with DID also had a co-morbid diagnosis of borderline personality disorder, however, this is not a consistent finding, and the debate persists [66].

- Depersonalization – The individual experiences themselves to be detached from reality, i.e., lack of sense of being alive, unable to experience emotions, and distorted sense of time, as if they are observing themselves as an outsider.
- Derealization – The individual feels removed from the surroundings, they perceive objects or events around them in a distorted manner.

Common themes amongst all the variable presentations most often, but is not a dictum

- Symptoms are not usually as per typical medical presentations; they usually represent the patient's ideas and knowledge regarding the same.
- Inconsistent and variable symptoms, usually worsening in face of a stressful event, the anticipation of a stressful event or even in front of other people
- La Belle Indifférence – Described as "striking" calm behaviour in the face of serious disability. Initially dubbed as a "useful clinical sign" recent studies have shown that is not associated with dissociative disorders and must not be taken into consideration while diagnosing [67].
- Hoover's Sign – Test is used in dissociative motor disorders, to differentiate between functional (psychogenic) or organic lesions. In organic conditions, when the patient is asked to flex the hip normally against resistance, there will be no change in the hip strength of the affected limb. In non-organic or psychogenic causes, the affected hip will exert resistance on testing. This is probably due to crossed extensor reflex or the principle of synergistic contraction[68].
- Maladaptive premorbid personalities, such as difficulty in adapting to new situations, or low threshold for criticism.

Signs and symptoms in children and adolescents

Assessing dissociative symptoms is difficult as presentation differs from age group and diagnosis must take into account age-expected behaviour. Young children's sense of ego and self-identity is still immature and may end up projecting distress through inanimate objects or through child-like behaviour. Perplexity, trance-like states and behavioural instabilities including temper tantrums are frequently seen [45]. The adolescent pattern of presentation more resembles adults with gender-appropriate symptoms. Stressors also have to be analyzed differently in children and adolescents. They need not be significant or exceptional and are more commonly daily events such as difficulty in school, family relationships, and friendship issues.

CULTURAL INFLUENCES ON DISSOCIATIVE SYMPTOMS

In early studies of the relationship between culture and dissociation, a difficulty arose in defining what a culture is. Whether it is bound by racial or ethnic divisions, or by shared experiences? Some authors have argued that viewing dissociation from solely a cultural point of view dismisses the psychophysiological mechanisms underlying the same [69]. But ignoring the impact of cultural variations and cultural expressions of distress on dissociative experiences hinders the rounded treatment of the individual. As psychiatry is essentially differentiating between normal and abnormal behaviour, early clinicians had a western bias towards symptomatology, without being culturally sensitive [70]. P. M. Yap was a pioneer in culture-bound syndromes [71]. In one of his first papers on cultural psychiatry, he argued against the Western-centric classification and notions of abnormal behaviour, and introduced, as they are referred to now – Culture-Bound Syndromes [72].

Lewis-Fernandez concluded that since 80% of the non-western world exhibit dissociative syndromes, that in some cultures, could be culturally variable forms of the idiom of distress [73]. In India, around 75% of patients experiencing dissociative possession symptoms consult religious healers, as these are considered as possession by a spirit [74]. In their study, Alexander & Das concluded that ICD-10 and DSM-IV diagnoses were of restricted use in India as the majority of patients do not fall into any of the defined sub-types [75]. In a study comparing dissociative experiences in students from India and Australia, it was found that there was a statistically significant correlation was found between religious practice and dissociation, and regression analysis confirmed religious rituals to be a predictor of dissociation [76].

It is thought that traditional forms of medicine, such as Ayurveda in India, or traditional Chinese medicine, do not acknowledge the psychological model of illness as a concept. This is probably because they tend to be "somatic-minded"[77]. Accordingly, somatic symptoms are often seen as a help-seeking idiom. Some studies have also acknowledged with more development in Central Asia and Eastern countries, the presentation of the symptoms has become similar to that seen in the Western world, with fewer culture-specific symptoms[78].

TREATMENT MODALITIES

There is no gold standard approach to treating dissociative symptoms. A multi-modal strategy is preferred using behavioural management, pharmacotherapy and psychosocial interventions. Hypnosis was one of the earliest used methods. It works on the principle that patients with dissociative disorders and other somatoform group disorders are more suggestible than general psychiatric patients, thereby more suggestible to the effects of hypnotizing [79]. Recent imaging studies have suggested

that the neurobiology underlying both are similar [80], possibly validating hypnotic suggestion as a treatment modality. Some studies have suggested that hypnotizibility is a mechanism underlying dissociation [81]. But this is under debate, with researchers stating that by associating hypnotizability and dissociative phenomena, the muti-factorial aetiology is ignored [82]. Few studies have shown the promise of hypnotism as an effective treatment, such as a study by Moene et al, which showed significant improvement as compared to another treatment group [83]. But in a more comprehensive treatment setting, hypnosis shows no added benefit[84]. A case report from India also showed a reduction in symptoms in a patient with dissociative disorder treated with hypnotism [85].

Although hypnotherapy as a practice is not widely practised, the core principle of suggestibility has been in use as behavioural therapy, with good results [86]. Cognitive behavioural therapy (CBT) has been useful, as seen in a retrospective study conducted in London, patients receiving CBT had good outcomes in functioning [87] Although few prospective studies have been conducted on the same, results consistently show the efficacy of CBT [88] [89]. Yet, in one major study conducted by Goldstein et al, there was no statistically significant added advantage over other modalities but has improvement in clinically important outcomes. This study suggested the use of CBT as an adjuvant can benefit patients [90]. Nevertheless, psychotherapy has an important role in conflict resolution, which is one of the etiologies of dissociative disorder.

Physical therapy has also been seen to help with dissociative disorder, in the motor subtypes. In studies where physical therapy as an add-on has been compared with treatment without physical therapy, there was statistically significant improvement with physical therapy [91] Consistent findings have been seen in

replications of similar study designs [92] [93] [94]. But if this improvement is negligent or invalidating of the psychosocial factors, and leaning purely into the physical aspect of dissociative disorders is up for discussion.

Pharmacotherapy is mainly to address underlying or co-morbid anxiety/depressive disorders, as comorbid diagnoses are high in dissociative disorder [95]. Antidepressants have shown improvement in dissociative symptoms, most likely through the resolution of depressive/anxiety symptoms[96]. Currently, there is no specific pharmacologic treatment for dissociation

Transcranial Magnetic Stimulation (TMS) has shown some promise, especially in dissociative motor disorders. Research shows that at least 75% of patients show more than 50% improvement [97]. Still, more evidence is required to establish TMS as an effective treatment [98].

No single mode of treatment is seen to be superior to others definitively. For best outcomes, an integrated approach is preferred and utilized in most clinical settings [99]

Differences in treatment protocols for children and adolescents

In a study conducted by Srinath et al in NIMHANS, they developed a model for the management of dissociative disorders in children and adolescents. A stepwise approach is initiated by "Normalization" which is to remove the dissociative symptoms and follow a normal routine. This is achieved by countering illness behaviour, selective inattention of dissociative symptoms and removal of secondary gain. Once this is attained, we move on to the next steps, i.e., family crisis resolution where parents are psychoeducated and made knowledgeable about the nature of illness thereby empowering them with the skillset required for behavioural intervention, individual psychotherapy and family counselling and intervention. The

choice of intervention is dependent on the patient's age and cognitive competency and family factors. This approach led to rapid improvement in dissociative in 2 weeks.

An assumption as to why dissociative symptoms are more common in children, adolescents and young adults is that these symptoms are part of a defence mechanism and reduce distress. These are termed primary gain, where there is immediate relief from the underlying psychological distress and attention is towards the physical symptoms. Primary gain occurs unconsciously. Secondary gain is described as the external gratification or societal consequences as a result of their symptoms, such as missing school, and avoidance of any interpersonal issues.

PROGNOSIS & OUTCOMES OF DISSOCIATIVE SYMPTOMS

Malhi et al studied the short-term outcome of 50 children diagnosed with dissociative disorder, 84% of participants had significant improvement in symptoms, with 16% of parents reporting some improvement. No participant's condition had worsened and in fact improvement in functioning was seen within 3 months of initiating treatment[100]. In an earlier study conducted by Malhi, in a study population of 16 children followed for a period of a year, 25% of children fully recovered within 6 weeks of treatment initiation. Similarly, in a study conducted by Sethi and Gandhi, 72% of children were asymptomatic within one week of treatment and by the end of a month, 93% were in complete remission[36]. These results were kept in line with results seen in the Western population, where although no significant improvement was noted, overall, there were improvements in the main dissociative symptoms. They also noted that the improvement in children was better than that of adult patients with dissociative disorder[101]. In a similar study conducted in Turkey, on 4-year follow-ups in children and adolescents diagnosed with dissociative disorder, 85% of total patients

had completely recovered, indicating a favourable outcome in younger age. But in this study another 35% went on to receive a mood/ anxiety disorder diagnosis, suggesting that they are at higher risk of developing other psychiatric disorders [102]. In a study conducted by Gupta et al, 73.3% of patients showed improvement only with counselling by a mental health professional. 17.6% of patients had a recurrence of symptoms, and out of 45 patients 2 required pharmacotherapy[103]. Prabhuswamy et al showed that 54% of participants has good functioning on subsequent follow-ups as compared to baseline[48]

Younger age of presentation along with early diagnosis and intervention, good premorbid temperament, identifiable stressor, and cooperative child and family are good prognostic \factors; while polymorphic symptoms, chronic presentation with comorbid psychiatric or medical illness, poor insight and difficult family dynamics are poor prognostic factors [104].

PREVIOUS STUDIES ON CHILDREN

Prevalence of dissociative disorders has been noted to be more in the Eastern population than in the west [105], with prevalence in India in children and adolescents as high as 15% in outpatient settings [37].

Authors	Year of Study	Type of Study	Result
Hinman[43]	1957	Descriptive study	• The average age was 9 years, 21 girls as compared to 7 boys • 9 patients had mixed presentations
Gross [50]	1979	Descriptive study	Examined 19 adolescents (14 girls and 5 boys) with hysterical seizures: • Mean age 15.79 • 13 patients were previously treated with antiepileptic medication
Geetha et al [51]	1980	Comparative study	Comparison between anxiety and hysteria patient groups: • Anxiety group: Parent interaction is more impaired, • Hysteria group: Abnormal parent-child interaction
Goodyear [35]	1981	Prospective cohort; Characteristics and outcome study	15 cases were taken in the study: • 60% were female • The commonest symptom was limb weakness and disturbance of gait • 60% of parents had anxiety • 80% of patients had psychiatric disorder history • 66% were asymptomatic at 12 months follow up
Trivedi et al [44]	1982	Descriptive study	Analyzed 26 cases diagnosed as hysteria • Mean age was 12.6 • 88% were from unitary (nuclear) family

			• Neurotic traits are seen in 18 pts • The majority (38.5%) had an illness duration of 1-3 months • Precipitating factors were known in 65.4% of patients • 26.9% of patients had previous history of hysteric illness • 57.7% had unconsciousness as presenting complaint
Uma H & Kapur [106]	1987	Retrospective descriptive cohort	• Mean age was 11.3 years, with the majority of cases in the age group of 8-12 years • Equally present in boys and girls (51% vs 49%) • The most common symptoms were motor disorders (34%) and unresponsiveness (20%) • The majority (69%) were well adjusted • 39% of participants had school-related stress and 36% had overinvolved family as the stressor
Grattan-Smith et al[107]	1988	Cross-sectional descriptive study	• The mean age was 10 years, and 39 cases were girls • 22 cases had < 1-week duration of illness, 19 had >1 month • 32 cases had a mixed presentation, with 36 having predominant gait disturbance • Sensory abnormalities such as pain and paresthesia was seen in 40 children • 32 were completely recovered (23) or had appreciably improved at discharge (9) • 13 had moderate - minimal improvement at the time of discharge

Turgay[104]	1990	Retrospective follow up	• Most patients are from 13-17, 77 in number with girls making up 71.5% • Most patients had 1-2weeks duration of illness (41.5%) • 63 patients had pseudoseizures • Out of 89 cases, more than half had symptom recovery in the first two weeks. Remaining required up to 4 weeks.
Speirings et al[108]	1990	Retrospective follow up	• The mean age was 12.1 years, female to male ratio was 2.2:1 • A majority (33) of patients had sensory disturbances, and 25 had pseudoseizures • EEG abnormalities were present in 51% of children but were not clinically correlated to the symptoms • 72% of patients who responded to follow-up had improved – but 54% of them still had some persisting complaints
Srinath et al[37]	1993	Prospective cohort; Incidence, Clinical features and outcomes	Examined 38 cases of hysteria • 63% were from the 12-16 age group • 48% were female • 44.7% had an illness duration of <2 weeks • The most common stressors were academic difficulties (51.9%) and punitive parenting (37%) • 71.1% of patients reported stressors vs 42.1% of parents • 43% had inpatient stays between 8-30 days • 71.1% had symptom resolution within 7 days • 21.1 % had minimally improved and 2.6%

			unchanged at the time of discharge
Chandra et al[109]	1993	Descriptive study; Prevalence	Out of 313 children, 31% had conversion disorder – The most common among all psychiatric conditions • 74% were >8 years of age and 58% were boys • Focal seizures were the most common presenting symptom. • 24 out of 31 children diagnosed with conversion had precipitating factors • Most common being learning difficulties (12) and punitive parenting (10)
Sharma & Chaturvedi[110]	1995	Descriptive study	• Out of 54 cases, 22 (41%) were from the age group 15-19, with 74% females • 82.5% of cases were from nuclear family • 40% of patients had family-related stressors, followed by 30% study-related stressors
Bhatia et al [111]	2000	Descriptive study	25 cases of aphonia • 18.4 mean age in females and 21.2 mean age in males • The most common stressor was examination related followed by peer/spouse quarrels.
Malhi & Singhi [112]	2002	Prospective cohort	• Mean age 11 years, range 8.2 to 14.6 • More male patients than female (1.6:1) • Pseudoseizures were most common presenting sx • Out of 40, 13 patients had reported significant stressors • 25% of patients recovered within 6 weeks • 31.3% of patients recovered within 3 months

Pehlivantürk & Unal[102]	2002	Prospective cohort	4-year follow-up study • Out of 40 patients, 30 were females and 10 were males. • The mean age at follow-up was 17 • Pseudoseizures were most common (82.5%) • 90% of patient had psychosocial stressor • Comorbid conditions were present for 45% of patients • 85% of patients improved on 4 year-follow up • Recovery time and school functioning were better in patients without co-morbidities
Sharma et al [113]	2005	Descriptive study	40 patients diagnosed with Conversion disorder • 67% of patients are 9-12, 55% of patients are female • Contributory stressors were present in 37.5% of cases • 40% of patients had borderline intellectual functioning, improper schooling, and family stressors
Malhotra et al[46]	2005	Comparative study	Characteristics of 49 patients with dissociation were compared with patients with somatoform • Mean age 11.6 and IQ 90.06 which were significantly lower as compared to patients with somatoform
Prabhuswamy et al[48]	2006	Retrospective chart based. Prevalence, characteristics and outcomes	Retrospective chart review of paediatric inpatient population with dissociative disorder. • Inpatient prevalence was 10.4% • 89% of the subjects were > 10 years of age, • 61% were females.

			• Difficult or anxious temperament was found in half of the subjects. • 82% of subjects had stressors • Pseudoseizures were the most common presenting symptom. • 68% of patients had a co-morbid psychiatric diagnosis, the commonest being depressive disorder. • 80% of subjects had remission in symptoms at the time of discharge. • Subjects who followed up had a significant increase in mean CGAS scores
Deka et al [114]	2007	Descriptive study	40 subjects were analyzed • 92.5% were females • 57.5% were from the age group of 18-29
Kozlowska et al [115]	2007	Descriptive study; Incidence and clinical features	Out of 194 children studied: • 11.8 was the mean age, and 71% were females • 55% had mixed presentation – Predominant was motor symptoms (64%) • Antecedent life stressors were present in 63% of cases – of which 34% had 2 or more • Family separation/loss followed by family issues/violence was the most predominant stressor. • School/learning stressors were only 14%

Kumar et al[116]	2008	Retrospective Cohort; Characteristics & Outcome	40 patients • Mean age 10.3, male to female ratio 0.9:1, but pre-pubertal 1.35:1 • 35% had comorbid illnesses • Amongst boys, scholastic problems were the most common stressor, whereas in girls it was preferential treatment.
Huang et al [117]	2009	Retrospective & consecutive chart review	• In the first decade (1987-1996), female patients were more (84.2%), but in the second decade(1997-2006), male patients were more (52.2%) – A significant difference in sex distribution • In the first decade, common symptoms were motor symptoms in (47.4%) of patients • In the second decade of patients, the most common symptom was non-epileptic seizures (43.5%) • Statistically significant higher rates of depression in second-decade patients • The most common stressors were family and individual-related. No statistically significant difference in prevalence. • The proportion of patients experiencing abuse, bullying or multiple stressful life events increased in the second decade which was statistically significant.
Sethi et al [36]	2010	Prospective cohort; Prevalence, clinical features	Out of 332 patients examined, 41 (12.5%) had a diagnosis of conversion • 53% were in the age group of 12-16 • 61% were girls

		and outcome	• The most common symptom was convulsions • 90% of subjects had identifiable psychosocial stressors • 72% were symptom-free within 1 week • 93% had complete improvement in 4 weeks
Gupta et al[103]	2011	Prospective cohort; Characteristics and outcome study	Out of 45 children diagnosed with somatoform disorders • Dissociation was found to be the most prevalent (48.9%). • Pseudoseizures and fainting attacks were the commonest presentations • Stressors identified in 71.1% of patients, commonly related to school
Ani et al [101]	2013	Prospective cohort; Incidence and outcome study	Incidence and outcomes of non-transient conversion • 12-month incidence of 1.30/100,000 – Overall • <10 years – 0.26/100,000 • 10-15 years – 3.04/100,000 Out of 204 confirmed cases • Median age – 12.5 years, age range 7-15 years • 75% female • 82% - the first instance of conversion • Motor weakness was the most common symptom (63.3%) • 691% had a mixed presentation • Stressors reported in 80.9% of patients – Bullying was the most common (23.8%),

			followed by parental separation (19%) Outcome after 1 year was studied for 147 patients • 75-100% improvement in symptoms
Ranjan et al [118]	2016	Cross-sectional descriptive study	• The mean IQ in the study sample was below the normal population level, with the most difficulty seen in the self domain • Dissociative convulsions were the most common presenting symptoms • 50% of the sample had a comorbid psychiatric diagnosis.
Madaan et al[119]	2018	Cross-sectional Observational study	• The commonest type of dissociation – Dissociative Stupor (48.8) • Family stressors are the most common (48.8%), with school (21%) and self-problems (16%) making up the rest. • Out of 80 patients, 11 were noted to have psychiatric co-morbidities,
Reddy et al[120]	2018	Cross-sectional descriptive study; Clinical, sociodemographic profile and stressors	• 50.9% of subjects were below 19 years and students • 41.82% had family-related stressors, with educational stressors making up 29.09% • Dissociative stupor is most common presentation (60%)
Malhi et al[100]	2021	Prospective cohort; Characteristics	50 children were assessed before and after treatment (3-month duration) • 6-12 year range, mean age 10.2 year

		and outcome	• 60% of the children were boys • 58% presented with pseudoseizures • 84% experienced significant improvement in symptoms • CPMS scores (Childhood Psychopathology Measurement Scale) scores (emotional and behavioural) significantly improved after the intervention • PAAS (Pre-Adolescent Adjustment Scale) had significant improvement after treatment
Bammidi et al[121]	2021	Cross-sectional descriptive study; Clinical, sociodemographic profile and stressors	• The majority of patients were young adults (38%) followed by children (36%). • Syncopal attacks/ loss of consciousness (20%) was the commonest presenting complaint, followed by pseudoseizures (18%). • In children and young adults, scholastic-related stressors were the most common (39.1%)
Fang et al[122]	2021	Retrospective Cohort; Characteristics & Outcome	The clinical characteristics of 66 patients were studied • The mean age was 9.97, age range from 7-15 • 38 (57.6%) male patients • 46 (69.7%) had an antecedent stressor • 38 patients (59.4%) had an introverted personality • 34 (53.1%) had unstable emotions. • 89.4% had conversion disorder – the most common being pseudoseizures and motor symptoms

			• Significant bivariate variables were the parent-child relationship, the education level of the father, level of cooperation from the family. • Multivariate analysis revealed that these variables had better curative outcomes

MATERIALS AND METHODS

The study was designed as an observational study, to analyse the clinical profile and short-term outcome in children and adolescents with dissociative disorder. It was conducted at the Department of Psychiatry over a period of one year from 1st January 2021 to 31st December 2021.

The Source of samples were patients under the age of 18 who attended the outpatient department of the department of psychiatry and child development centre (CDC), and those admitted to psychiatry and pediatric free ward.

Inclusion Criteria

1. Children and Adolescents under the age of 18 years.
2. Diagnosed as Dissociative Disorder as per International Classification of Mental and Behavioural Disorders (ICD-10) Diagnostic Criteria for Research (DCR).

Exclusion Criteria

1. Patients with intellectual developmental disorder.
2. Uncooperative patients.
3. Patients with severe mental illnesses like Bipolar Affective Disorder, Schizophrenia, and Severe Depression as assessed through Mini-International Neuropsychiatric Interview for Children and Adolescents (MINI Kid).

Ethical Clearance

Prior to commencement, ethical clearance was obtained from Institutional Ethics Committee, Jawaharlal Nehru Medical College, Belagavi with Ethical Clearance number MDC/DOME/44.

Informed Consent

Informed consent was obtained from the parents of patients who fulfilled the inclusion criteria and assent was obtained from the participants.

Sample Size

Based on the formula,

Sample size(n)=$(Z_{1-\alpha/2})^2(p)(q)/(d)^2$

n = Desired sample size

$Z_{1-\alpha/2}$ = Critical value and a standard value for the corresponding level of confidence. (At 95% CI or 5% level of significance (type-I error) it is 1.96 and at 99% CI it is 2.58)

P = Expected prevalence or based on previous research

q = 1-p

d = Margin of error or precision

Here, at 95% CI, $Z_{1-\alpha/2}$ =1.96, p = 0.05, q= 1-0.05, d=0.05

With a 10% dropout rate,

Therefore, the sample size was obtained as 77.

The sampling procedure used was purposive sampling.

Due to the COVID-19 pandemic, adequate samples were not obtained, and the final sample size was 51.

Tools

1. Mini-International Neuropsychiatric Interview for Children and Adolescents (MINI Kid)

It is a structured diagnostic interview as per DSM-IV and ICD-10 criteria designed for use in clinical and research settings. Used in a pediatric population, it examines the 30 most common and clinically relevant disorders or disorder subtypes. MINI Kid disorder subtyping has been shown to have validity and test-retest reliability, which renders it useful in diagnostic screening in paediatric psychiatry. It requires on average, 15 minutes to administer and is preferred to interview both parent and child. However, interviewing the parent either with the separate parent module or not interview is at the discretion of the interviewer. There are other versions of the MINI Kid used for a specific disorder, such as psychotic disorders, depressive disorders, eating disorders and suicidality. In our study, we have used English version 6.0.[123]

2. Strengths and Difficulties Questionnaire (SDQ)

A self-report brief assessment behavioural screening questionnaire was developed for age groups 2-17. It covers a broad range of mental health symptoms, mainly focusing on ADHD, Conduct Issues. It is one of the most widely used child mental health measures. 25 items on the questionnaire are on psychological attributes, which are further divided amongst 5 scales, namely emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behaviour.[124]

3. Children's Global Assessment Scale (CGAS)

An adaptation of the Global Assessment Scale for adults, it focuses on the rating of the overall functioning of children from ages 6-17 years. They are scored from 0-100, with lower scores indicating poorer functioning and higher scores associated with good functioning. Scores above 70 indicate normal functioning. The scale is divided into 10-point intervals. The rating must be the lowest score that describes the psychosocial impact of the illness over the past month. This rating is independent of any psychiatric or medical diagnosis and is applicable for use in both situations.[125]

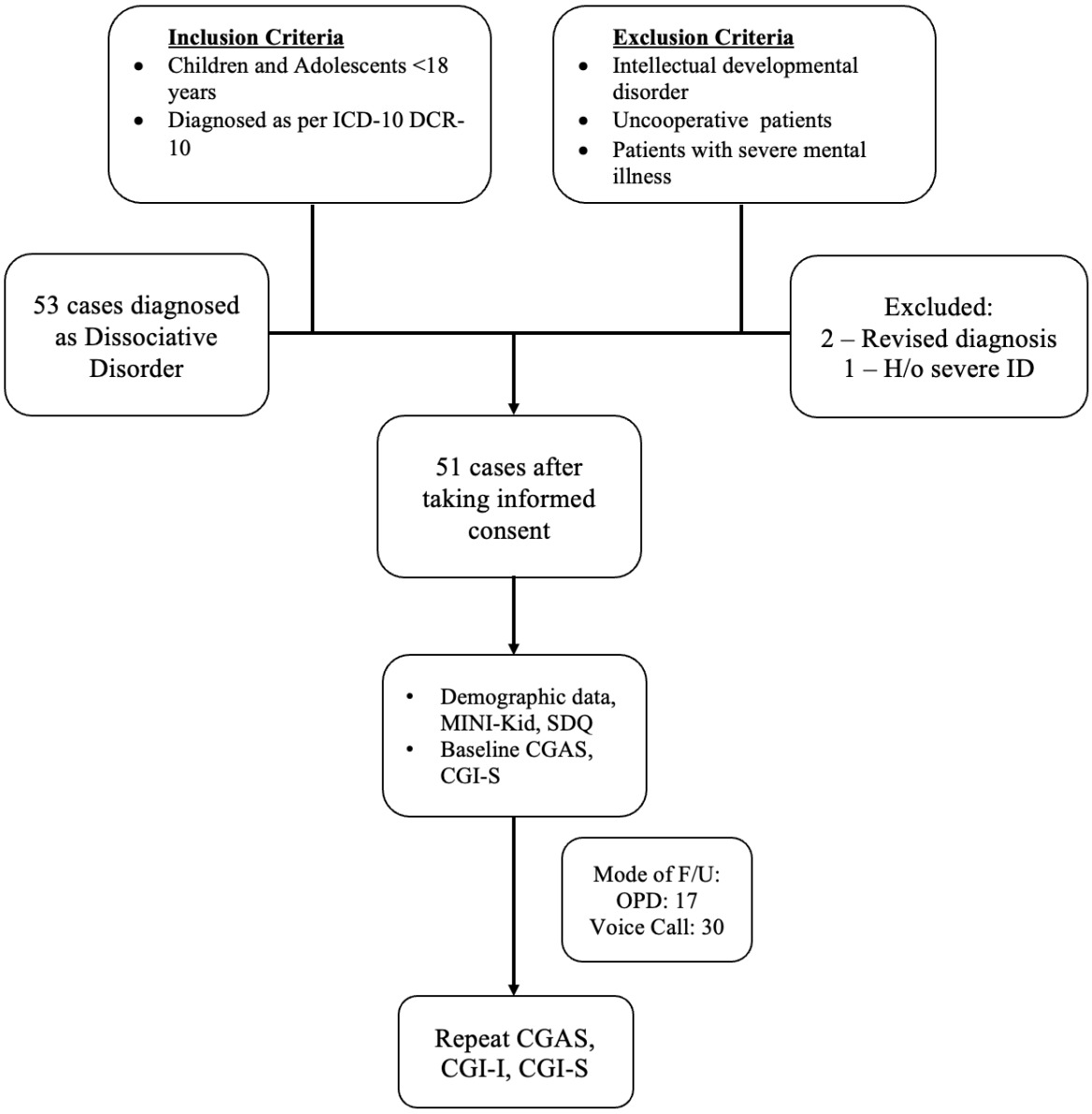
4. Clinical Global Impression-Improvement Scale (CGI-I)

Developed as a tool for clinicians to assess functioning differences after treatment, it is a seven-point Likert scale that requires the clinician to assess how much the patient's illness has improved or worsened relative to a baseline state at the beginning of the intervention. It is commonly used to monitor treatment outcomes for mental disorders. It is generally preferred that the clinician who has initiated treatment also administers the scale for more reliability. It is rated for seven days prior to follow up.[126]

5. Clinical Global Impression-Severity Scale (CGI-S)

It is a clinician-applied tool to determine how severely ill the patient is at the moment of assessment, which is rated on a seven-point scale. Observed and reported levels of behaviour and functioning is rated in the past seven days. Score, in general reflects the average severity level.[126]

PROCEDURE



The parents and children diagnosed with Dissociative Disorder as per ICD 10 would be interviewed by the Principal Investigator (PI). They were explained regarding the study and its implications. A written informed consent was obtained from the parents, along with assent from the patients in their own vernacular language. Following this, study participants meeting inclusion and exclusion criteria will be assessed using detailed proforma to collect socio-demographic and clinical features including stressors on the first interview, and questionnaires such as MINI

Kid, SDQ, CGAS, CGI-S were applied to assess baseline functioning and other co-morbidities.

At the end of 1 month, outcomes following treatment will be assessed by follow up visit in person. If follow up visit is not possible, interview will be conducted through video call or voice call. CGAS and CGI-S will be repeated to evaluate improvement in functioning. CGI-I will be applied to assess improvement.

DATA ANALYSIS

The data obtained was tabulated in Microsoft Excel version 16.64 and appropriate statistical analysis was done using IBM SPSS 25. The socio-demographic and clinical details of the patients (descriptive statistics) was described using percentages for categorical variables or as mean and standard deviation for continuous variables. Significant association was done using paired t-test, and all tests were 2-tailed. P value of <0.005 was considered to be significant.

RESULTS

TABLE 1: Socio-Demographic Profile of Participants

S. NO.	VARIABLES		CASES N=51 (%)
1.	**Age**	**Mean±SD**	**14.2 ± 2.050**
		0-5 years	0
		6-9 years	2 (3.9)
		10-14 years	22 (43.2)
		15-18 years	27 (52.9)
2.	**Sex**	Female	34 (66.7)
		Male	17 (33.3)
3.	**Socioeconomic Status**	Upper Middle	17 (33.3)
		Lower Middle	23 (45.1)
		Upper Lower	11 (21.6)
4.	**Education (in years)**	4	1 (2)
		5	4 (7.8)
		6	4 (7.8)
		7	5 (9.8)
		8	11 (21.6)
		9	10 (19.6)
		10	9 (17.6)
		11	5 (9.8)
		12	1 (2)
		13	1 (2)

Table 1 illustrates the socio-demographic profile of the study sample. Mean age of the study sample was 14.2 (± 2.050) years. Out of 51, most of the patients were from age group 15-18 years (52.9%), followed by 10-14 years (43.2%), and 6-9 years (3.9%). 66.7% were female and about 33.3% were male According to family's socio-economic status, almost 33.3% (17) were upper middle class and 45.1% (23) were lower middle class, with 21.6% (11) from upper lower class, as per Modified Kuppuswamy's scale.

TABLE 2: Patient Characteristics

S. NO.	VARIABLES			CASES N=51 (%)
1	**Type of Family**	Nuclear		46 (90.2)
		Joint		5 (9.8)
2	**Family history of illness**	Psychiatric	Yes	4 (7.8)
			No	47 (92.2)
		Neurological	Yes	2 (3.9)
			No	49 (96.1)
		Medical	Yes	5 (9.8)
			No	46 (90.2)
3	**Parenting Style**	Authoritative		9 (18)
		Authoritarian		39 (78)
		Permissive		2 (4)
4	**Consulted spiritual healers**	Yes		5 (9.8)
		No		46 (90.2)
5	**Co-existing illness**	Medical	Yes	7(13.7)
			No	44 (86.3)
		Psychiatric	Yes	16 (31.4)
			No	35 (68.6)
6	**Co-existing psychiatric illness***	Anxiety Disorder		7 (13.7)
		Depressive Disorder		5 (9.8)
		SLD		8 (15.6)
		OCD		1 (2.0)
7	**Temperament**	Slow-to-warm up		20 (39.2)
		Difficult		14 (27.5)
		Easy		17 (33.3)
8	**SDQ Score**	Close to average		13 (25.5)
		Slightly raised(/Slightly lowered)		13 (25.5)
		High(/Low)		21 (41.2)
		Very high(/Very low)		4 (7.8)

SLD: Specific Learning Disability; OCD: Obsessive-Compulsive Disorder; SDQ: Strengths and Difficulties Questionnaire; *indicates not-mutually exclusive

Table 2 describes the clinical profile of the participants. Most of the children were living in nuclear family (90.2%) and only 9.8% in a joint family. 3.9% had family history of neurological illnesses whereas 7.8% had psychiatric disorder and medical

condition each. Authoritarian parenting was the most common parenting style (78% of study subjects), with Authoritative and Permissive comprising of 18% and 4% respectively.

13.7 % had co-existing medical conditions, most common being seizure disorder, seen in 5 participants. However 31.4% participants had co-morbid psychiatric conditions, with SLD (Specific Learning Disability) being most common 8 (15.6), followed by anxiety disorders 7 (13.7), depressive disorder 5 (9.8) and 1 (2.0) participant having OCD (Obsessive-Compulsive Disorder). Patients most commonly had slow-to-warm up temperament, (39%), followed by easy and difficult temperament having 33.3% and 27.5% respectively. Majority of patients 41.2% had high(/low) SDQ scores with 25.5% having close to average and slightly raised/slightly lowered scores each. This means that 41.2% had scores higher than general population (under 18), 25.5% had scores close to average score of general population (under 18) and only slightly raised scores as compared to general population (under 18).

TABLE 3: Illness Characteristics

S. NO.	VARIABLES		CASES N=51 (%)
1	**Type of stressor**	Familial	20 (39.2)
		Friendship/Relationship	1 (2)
		School	9 (17.6)
		Academic	19 (37.3)
		Other	2 (3.9)
2	**Type of dissociation**	Dissociative Motor Disorder	7 (13.7)
		Dissociative Convulsions	11 (21.6)
		Dissociative Stupor	19 (37.3)
		Trance and Possession	5 (9.8)
		Mixed	4 (7.8)
		Other	5 (9.8)
3	**Duration of illness at time of consultation**	0-7 days (<1 week)	9 (17.6)
		1 week-2 weeks	7 (13.7)
		2 weeks-1 month	5 (9.8)
		1month-6months	15 (29.4)
		6months-<1year	7 (13.7)
		>1 year	8 (15.6)
4	**Duration of episodes**	0 - 1 min	10 (19.6)
		1-10 min	19 (37.3)
		10 min - 1 hour	14 (27.5)
		>1 hour	2 (3.9)
		Continuous	6 (11.8)
5	**Treatment Location**	OPD	15 (29.4)
		IPD	33 (64.7)
		Emergency	3 (5.9)
6	**Referrals**	Yes	34 (66.7)
		No	17 (33.3)
7	**Treatment Modality**	Psychotherapy	51 (100)
		Pharmacotherapy	51 (100)
		Physical therapy	8 (15.6)
8	**Pharmacotherapy***	SSRI	30 (58.8)
		SNRI	3 (5.9)
		TCA	1 (2.0)
		SGA	5 (9.8)
		BZD	17 (33.3)
		Non-BZD	25 (49)
		Other	7 (13.7)
9	**Mode of Follow Up**	OPD	19 (37.3)
		Voice Call	32 (62.7)

OPD: Outpatient Department; IPD: Inpatient Department; SSRI: Selective Serotonin Reuptake Inhibitor; SNRI: Serotonin and Norepinephrine Reuptake Inhibitor; TCA: Tricyclic Antidepressants; BZD: Benzodiazepine; *indicates not mutually exclusive

Table 3 covers of illness characteristics. Most of the stressors were intrafamilial and academic, comprising 39.2% and 37.3% respectively. Other stressors were school 17.6% and 3.9% having other which includes surgical procedure and viewing violent images. Most common type of dissociation was Dissociative Stupor (37.3%), followed by Dissociative Convulsions (21.6%), Dissociative Motor Disorder (13.7%), Trance and Possession and Unspecified making up (9.8%) and Mixed type with (7.8%). Most patients (29.4%) had duration of illness ranging from 1 month to 6 months at time of consultation, 17.6% of patients had duration from <1 week, 15.6% had >1 year of duration, 13.7% of patients each had duration of 1 – 2 weeks and 6 months to < 1 year. Majority of patients (37.3%) had episodes lasting from 1-10 minutes, followed by episodes lasting for 10 minutes to 1 hour in 27.5% of patients. Very few patients (3.9%) had episodes that lasted for more than 1 hour. Most patients were inpatient (64.7%), followed by outpatient (37.3%) and 5.9% in emergency. 66.7% were referrals (including both within and from outside the hospital). All patients were administered some form of psychotherapy, family therapy and pharmacotherapy, 15.6% of patients were also given physical therapy along with other usual modes of treatment. In pharmacotherapy, largely patients were given SSRI (Selective Serotonin Reuptake Inhibitor) (58.8%) followed by Non-BZD (Etizolam) (49%), BZD (33.3%), Other (includes beta blockers, ADHD medication) (13.7%), SGA (9.8%), SNRI (5.9%), TCA (2%). Patients were given either one or more pharmacological interventions. Most patients (62.7%) were followed up via voice call, and 37.3% followed up in OPD.

FIGURE 1: Frequency of types of dissociation

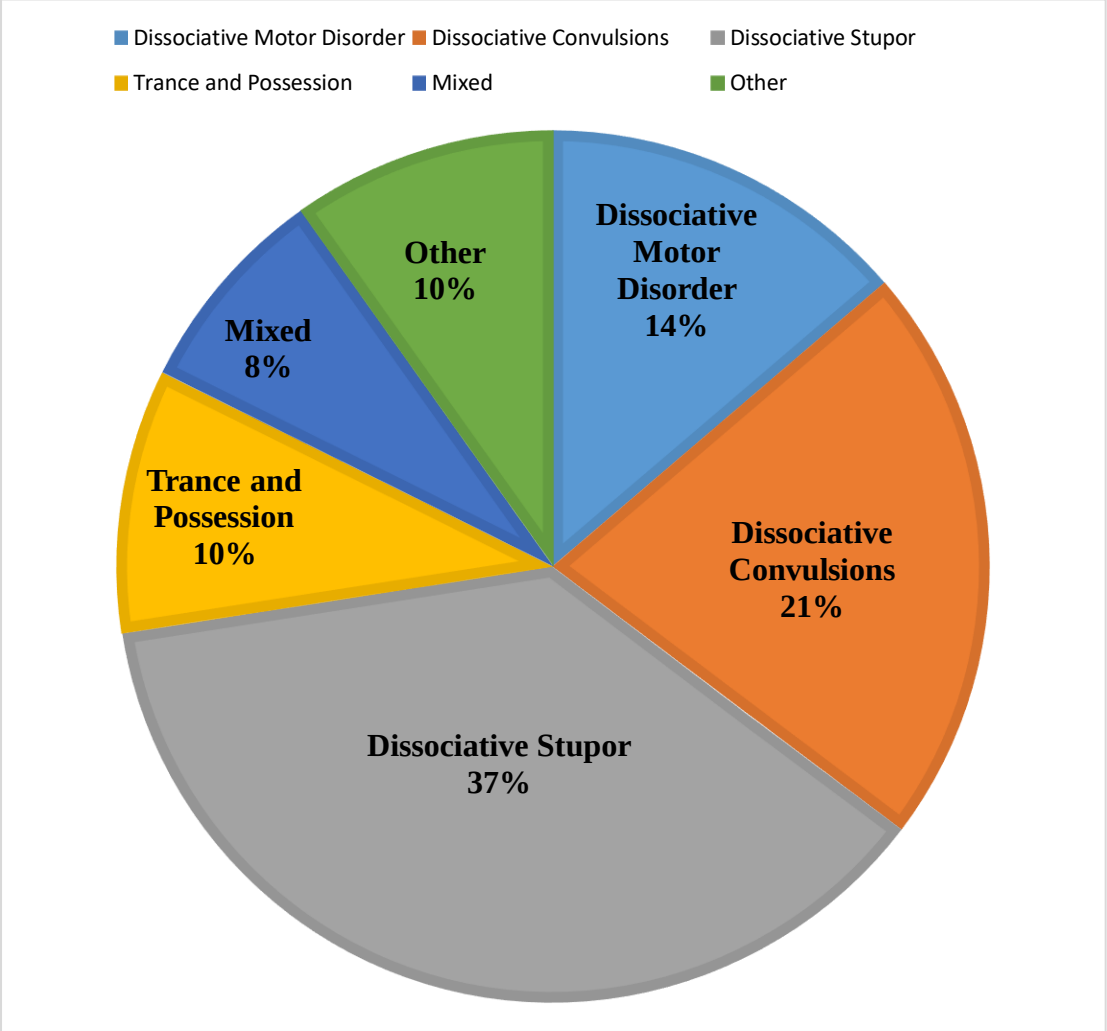


TABLE 4: CGI-S – Baseline and 1 month follow up

CGI-S	BASELINE N=51 (%)	AFTER 1 MONTH N=51 (%)
1: Normal, not at all ill	0	15 (29.4)
2: Borderline mentally ill	1 (2.0)	15 (29.4)
3: Mildly ill	10 (19.6)	10 (19.6)
4: Moderately ill	18 (35.3)	11 (21.6)
5: Markedly ill	22 (43.1)	0
6: Severely ill	0	0
7: Extremely ill	0	0

Table 4 shows comparison in CGI-S scores baseline and after 1 month of treatment. 78.3% of patients had CGI-S scores of moderately and markedly ill at the time of enrolment. After 1 month no patients were markedly ill, only 21.6% were moderately ill, whereas 78.4% were either normal, borderline or mildly ill, showing that 56.8% have improved on follow up.

FIGURE 2: CGI-S scores – Baseline and 1 month follow up

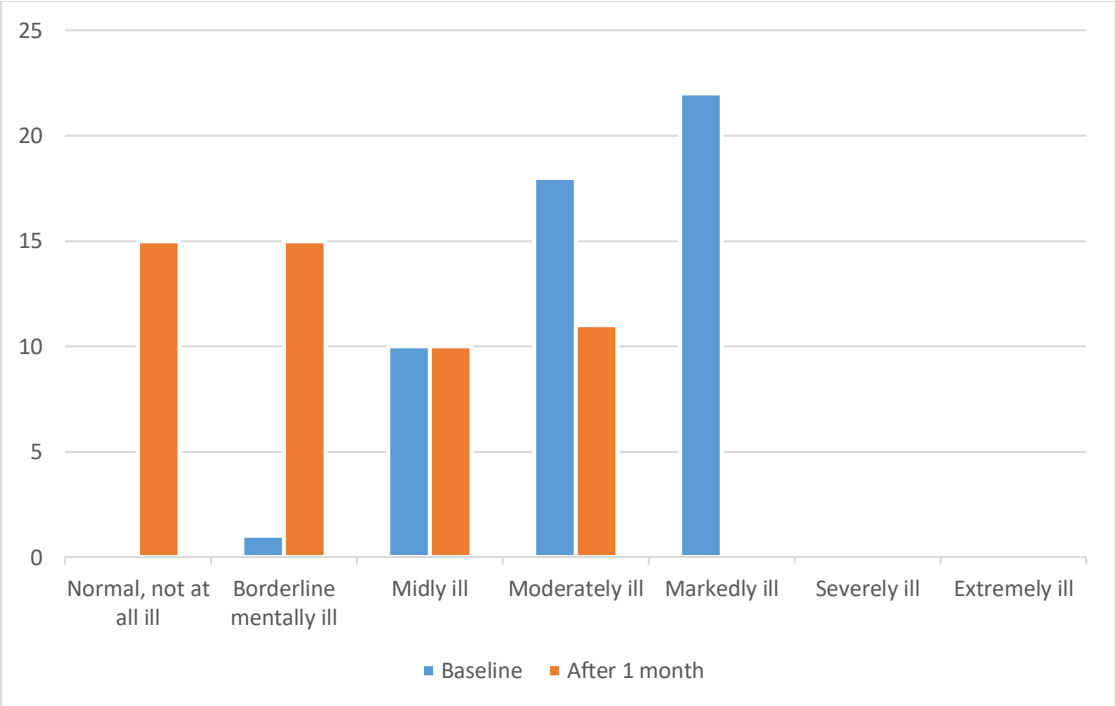


TABLE 5: CGAS scores – Baseline and 1 month follow up

CGAS SCORE	BASELINE N=51 (%)	AFTER 1 MONTH N=51 (%)
100-91: Doing very well	0	0
90-81: Doing well	0	7 (13.7)
80-71: Doing all right	1 (2.1)	18 (35.3)
70-61: Some problems	9 (17.6)	11 (21.6)
60-51: Some noticeable problems	23 (45.1)	11 (21.6)
50-41: Obvious problems	12 (23.5)	3 (5.9)
40-31: Serious problems	6 (11.8)	1 (2)
30-21: Severe problems	0	0
20-11: Very severely impaired	0	0
10-1: Extremely impaired	0	0

Table 5 displays baseline CGAS score (at the time of consultation) and scores after 1 month follow up. At, the first visit 35.3% had obvious or serious problems and 64% had problems ranging from some to some noticeable problems. At time of follow up proportion of obvious or serious patients reduced to 7.9% and the proportion of patients who were doing well, some or some noticeable problems increased to 92.2%.

FIGURE 3: CGAS scores – Baseline and 1 month follow up

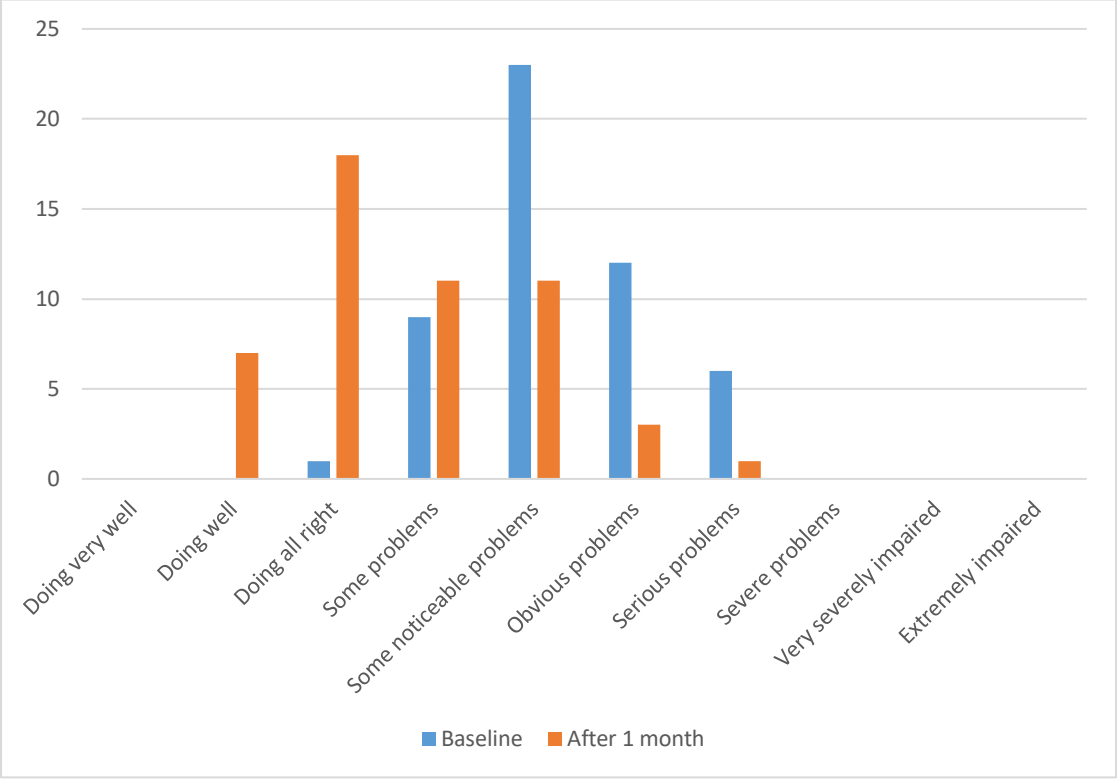


TABLE 6: CGI-I scores at 1 month follow up

CGI-I SCORE	AFTER 1 MONTH N=51 (%)
Mean±SD	**2.16±0.674**
0: Not assessed	0
1: Very much improved	9 (19.1)
2: Much improved	26 (51)
3: Minimally improved	16 (31.4)
4: No Change	0
5: Minimally worse	0
6: Much worse	0
7: Very much worse	0

Table 6 shows the CGI-I scores at the time of follow up. Majority of the patients (51%) had much improvement from baseline, 31.4% had minimally improved and 19.1% had very much improved at the time of follow up.

TABLE 7: Change in CGAS score at 1 month follow-up

	Mean ± SD	**P value**
BCGAS - CGAS after 1 month	-1.49 ± 0.80	**<0.001***

BCGAS: Baseline CGAS; * Statistically significant

Table 7 shows association of baseline and follow up scores for CGAS. Paired t-test was used to compare the two scores. Mean change in CGAS scores was -1.49 ± 0.80. There was significant difference in terms of scores at baseline and follow up CGAS with p=<0.001.

TABLE 8: Change in CGI-S score at 1 month follow-up

	Mean ± SD	**P value**
BCGI-S - CGI-S after 1 month	1.86 ± 0.89	**<0.001***

BCGI-S: Baseline CGI-S; *Statistically significant

Table 8 shows change in baseline and follow up scores for CGI-S. Paired t-test was used to compare the two scores. Mean change in CGI-S scores was 1.86 ± 0.89. There was significant difference in terms of scores of baseline and follow up CGI-S with p=0.<001.

DISCUSSION

Our study was an observational study to assess the socio-demographic, clinical profile and short-term outcome of children and adolescents with dissociative disorders. Dissociative disorder in children generally have better outcomes if intervened early. In this study, children and adolescents diagnosed with dissociative disorder were followed for a month with usual treatment.

Socio-Demographic Data

In our study, the mean age of cases was 14.2 (± 2.050) years, with most of the cases from 15-18 age group (52.9%). Findings were similar to Srinath et al [37] and Sethi et al [36], where 63% and 53% were from 12-16 age group respectively. In Malhi & Singhi [112], the mean age was lower, being 11 years, ranging from 8.2-14.6. Ani et al[101] had median age of 12.5 years with range from 7-15 years. In another study by Malhi et al [100], mean age was 10.2 year with 6-12 year age range. Adolescent age is also time of puberty and growth where they have face new situations, possibly contributing to the higher number. 66.7 % of participants were female as compared to 31.9% of male participants in our study. Only few studies such as Sethi et al [36] and Ani et al [101] had comparable female predominance (61% and 75%), whereas in other studies, most patients were boys, with Malhi et al [100] reporting 60% of patients being boys, Srinath et al [37] reporting 52% boys and Malhi & Singhi[112] reporting male to female ratio being 1.6:1. Malhi & Singhi[112] have remarked that being a referral centre in North India, where culturally males have preference for seeking treatment, could be a reason for the variance. 45.1% of cases were from lower middle SES group. We could not find other studies which have assessed SES, rather studies have enquired whether rural or urban background. In Malhi & Singhi[112], majority (62.5%) were from urban background. They have taken into account mean socio-economic index, which

was 3.4 indicating low middle class. In Sethi et al[36], majority were from rural background (71%). In Srinath et al[37] 74% were from urban population. Majority of patients (21.6%) in our study had 8 years of education. In Srinath et al[37], 74% were enrolled in school similar to Sethi et al[36] which had 85% of its participants enrolled in school.

Patient Characteristics

Coming to patient characteristics, most of the patients (90.2%) were living in nuclear families. This is similar to Sethi et al[36], where 66% of cases were also in nuclear families. In our study positive neurological (3.9%), medical (9.8%) or psychiatric (7.8%) family history. In a study by Sethi et al[36], 30% of parents had co-morbid psychiatric illness, with majority having mood and dissociative disorders. In Ani et al[101] this percentage was 26%, most common psychiatric illnesses were depressive and anxiety disorders (16% and 9%). In our study 31.4% of participants had co-existing psychiatric illness, majority being SLD (Specific Learning Disability) (15.6%) and anxiety disorders (13.7%) which was similar to Ani et al[101], where 18.2% had either co-morbid or previous history of psychiatric illness, majority being depressive (8.8%) or anxiety disorders (18.2%). Authoritarian parenting style was seen dominating (78%) as compared to authoritative (18%) or permissive parenting (4%). With respect to temperament, most common was slow-to-warm up (39%), followed by easy (33.3%) and difficult temperament (27.5%). This was contrary to what was seen in Prabhuswamy et al[48] where 52.3% of patients had easy temperament. But another study by Rana et al[45] that examined personality in children and adolescent with dissociation. They found that personality of children and adolescents with dissociation differed from each other. In children, overall, they were seen to be more serious, apprehensive and troubled while facing a situation with a

tendency to be restrained. Whereas in adolescent's aggression, stubbornness, and assertiveness was more predominant. Adolescents were seen to be reserved, emotionally less stable with tendency to get upset and frustrated easily in face of conflict. Even though in our study there is no clear majority, the preponderance for slow-to-warm up is possibly because these individuals have impaired coping and adaptive skills, which can also predispose to dissociative disorders. More studies are required to examine this. Further, out of 51 subjects, 9.8% participants consulted spiritual healers prior to visit. 19.6 % had co-existing medical conditions. Majority of patients (41.2%) had high/low SDQ scores with 25.5% having close to average and slightly raised/slightly lowered scores each, indicating that they had higher difficulties than the general population (under 18).

Illness Characteristics

Most of the patients had intrafamilial (39.2%) or academic stressors (37.3%). This is similar to other studies as well. Prabhuswamy et al[48] found familial stressors as most common. Malhi et al noted the academic difficulties and parental issues were most common stressors. In our study most common type of dissociation was Dissociative Stupor, 37.3%, followed by Dissociative Convulsions 21.6%. In a similar study conducted by Sethi et al[36], dissociative convulsions were the most common (49%) [36]. Higher number of stupor presentations could indicate higher stress since stuporous episodes are prolonged, causing significant disruption to function and family life, warranting more urgency from family to seek treatment. In our study most patients 29.4% had duration of illness ranging from 1 month to 6 months at time of consultation. 17.6% of patients had duration from <1 week, 15.6% had >1 year of duration, 13.7% of patients each had duration of 1 – 2 weeks and 6 months to < 1 year. This is in line with the study conducted by Malhi & Singhi[112], out of sixteen

children 4 were symptomatic for <3 months, 4 for > 3months, 6 children for >1 year. Overall half of the patients had duration ranging from < 3months-6months. In Sethi et al[36], majority of patients had less than 2 weeks duration of illness. Majority of patients (37.3%) had episodes lasting from 1-10 minutes, followed by episodes lasting for 10 minutes to 1 hour in 27.5% of patients. Very few patients (3.9%) had episodes that lasted for more than 1 hour. Most patients were inpatient (64.7%), with outpatients making up 37.3% of cases. Out of all cases, 66.7% were referred from either other department from within the hospital or from outside practitioners. In Malhi & Singhi [112], the patients who had duration of illness for >1 year had prior consultation by multiple physicians and neurologists. Our findings were similar to Sethi et al[36], about 60% had consulted local faith-healer and/or general practitioner before seeking psychiatric consultation and almost every child was referred to psychiatric services from other departments. All patients were administered some form of psychotherapy, and pharmacotherapy, 15.6% of patients were also given physical therapy in the form of physio therapy along with other usual modes of treatment. In pharmacotherapy, largely patients were given SSRI (58.8%) followed by Non-BZD (Etizolam) (49%), BZD (33.3%), Other (includes beta blockers, ADHD medication) (13.7%), SGA (9.8%), SNRI (5.9%), TCA (2%). Patients were given either one or more pharmacological interventions. To the best of our knowledge, we are not aware of other studies that have assessed what kind of pharmacological treatments were given. Most patients (62.7%) were followed up via voice call, and 37.3% followed up in OPD.

Outcomes

CGAS measures overall functioning of the patient. In our study, at the time of presentation, 35.3% had significant issues (obvious or serious problems) and at the

time of follow up this reduced to 7.9%. The mean change in score was -1.49 ± 0.80 which was found to be statistically significant. By the end of 1 month, 92.2% of patients were either doing well or had minimal issues. This was also seen as the change in CGI-S scores which indicate severity, where at the time of consultation 78.3% had serious problems, which reduced to 21.6% after 1 month. Mean change in score was 1.86 ± 0.89 which was also found to be statistically significant. Overall, it was seen more than half of the patients had significant improvement or reduction in symptoms after 1 month.

On assessing improvement levels with CGI-I, 70% of patients had some form of improvement from baseline. This was in line to other studies like Malhi et al[100], where majority of patients had significant reduction in symptoms after 3 months of initiating treatment. They had assessed outcomes by applying the Childhood Psychopathology Measurement Scale (CPMS) and Pre-Adolescent Adjustment Scale (PAAS) and comparing scores after 3 months of treatment. It was seen that mean CPMS score was 6.0 and PAAS score was 22.1, and post-intervention, CPMS score reduced to 3.0 and PAAS score increased to 27.2, which was significant. Malhi and Singhi[112], quarter of the total patients (16 participants) had recovered within 6 weeks and 31.3% recovered within 3 months. 12.5% had some improvement. Sethi et al, in their study had complete remission in 93% of participants at 1 month. However, in these studies, no tools were used to assess improvement objectively. In a study by1 Prabhuswamy et al[48] which was a retrospective study, they had assessed functioning with baseline and follow up CGAS scores, where mean score was 36 at baseline and at follow up was 68 which was found to be significant improvement. Overall, in our study majority of patients has some form of improvement after 1 month follow up.

CONCLUSION

Our study shows the dissociative disorders in a tertiary care hospital majority patients were girls from adolescent age group, in individuals with slow-to-warm up temperament. Most common stressors were seen to be intrafamilial or academic, with most common type being dissociative stupor. Most common comorbidity seen was specific learning disability, authoritative parenting was seen in majority.

At least moderate improvement was seen in 60-70% of patients after treatment as usual at the end of 1 month, seen as improvement in both CGAS and CGI-S scores.

STRENGTHS OF THE STUDY

1. Use of structured assessment tools at presentation and follow up allow for more objective assessment of outcome.

2. Variables such as temperament, parenting, and more details regarding illness characteristics were studied, which have not been well studied previously.

3. Minimized dropouts due to different modes of follow-up (voice/video calls)

4. No bias in treatment approach – all patients received some form of treatment

LIMITATIONS OF THE STUDY

1. Small sample size.

2. Tools used may not be validated for voice calls.

3. Lack of blind rating on follow up

SUMMARY

This was a observational study conducted in the Department of Psychiatry, KLES Prabhakar Kore Hospital and MRC from 1st January to 31st December 2021. 51 children and adolescents less than 18, who presented directly or referred to the department who were diagnosed according to ICD-10 DCR, and willing, did not have any severe mental illness or intellectual disability, with due consent was taken up. At the time of presentation, a semi-structured questionnaire to determine socio-demographic details, illness and patient characteristics was used. CGI-S (Children's Global Impression-Severity) Scale was applied to assess baseline illness severity, CGAS (Children Global Assessment Scale) and SDQ (Strengths and Difficulties Questionnaire) for functioning. MINI-KID was used to assess and/or rule out any co-morbid psychiatric illnesses. These patients were given appropriate treatment as usual and were followed up after a month either through OPD visit or through voice/video call due to the COVID-19 pandemic. After a month, CGAS and CGI-S scales were repeated and CGI-I (Children's Global Impression-Improvement) scale was applied to assess level of improvement as per parents. The data was analysed with percentages for categorical variables, standard deviation for continuous variables, and paired t-test was used to measure difference from baseline CGAS and CGI-S scores with scores after 1 month follow up.

It was seen that mean age of the cases were 14.2, majority of children (52.9%) were from the age group 15-18 years, and were female. Only a small proportion of patients had family history of neurological, psychiatry and medical illnesses or had a co-existing psychiatric or medical illness. Major share of the cases (39.2%) had slow-to-warm up temperament. Coming to illness characteristics, most common stressor was family (39.2%) or academic (37.3%) related. Dissociative stupor was the most

common presentation (37.3%) with Dissociative convulsions being second most common (21.6%), both together comprising of almost 60% of cases. Majority of patients were treated on inpatient basis, with most of them being referred from other departments. All patients received some form of psycho and pharmacotherapy.

At the time of presentation, around 80% of patients were classified as moderately or markedly ill according to CGI-S which reduced to 21% after 1 month. According to CGAS scores, 35% had obvious or serious problems which reduced to around 8% during follow up. This indicates that while illness severity had marked improvement, change in functioning was still slower in comparison. However the change in scores was found to be statistically significant. CGI-I scores indicated that 70% of patients had significant or moderate improvement, while 30% of parents reported minimal improvement.

BIBLIOGRAPHY

1. Feinstein A. Conversion disorder: Advances in our understanding. Can Med Assoc J. 2011 May 17;183(8):915–20. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3091899/
2. Broussolle E, Gobert F, Danaila T, Thobois S, Walusinski O, Bogousslavsky J. History of physical and "Moral" treatment of hysteria. Front Neurol Neurosci. 2014;35:181–97. Available from: https://pubmed.ncbi.nlm.nih.gov/25273500/
3. Tasca C, Rapetti M, Carta MG, Fadda B. Women And Hysteria In The History Of Mental Health. Vol. 8. 2012 p. 110–9. Available from: http://dx.doi.org/10.2174/1745017901208010110
4. Mai FM, Merksey H. Briquet's Treatise on hysteria. A synopsis and commentary. Arch Gen Psychiatry. 1980;37(12):1401–5. Available from: https://pubmed.ncbi.nlm.nih.gov/7447620/
5. Pérez-Rincón H. Pierre Janet, Sigmund Freud and Charcot's Psychological and Psychiatric Legacy. Charcot Forgot Hist Neurol Psychiatry [Internet]. 2011 [cited 2022 Jul 20];29:115–24. Available from: https://www.karger.com/Article/FullText/321781
6. Myers C. A Contribution to the study of Shell Shock. The Lancet. 1915 Feb 13;185(4772):316–20. Available from: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(00)52916-X/fulltext
7. World Health Organization. International Classification of Mental and Behavioural Disorders (ICD-10) Diagnostic Criteria for Research (DCR-10) Geneva: Oxford University Press; 1992.

8. Slater ETO, Glithero E. A follow-up of patients diagnosed as suffering from "hysteria." J Psychosom Res. 1965 Sep;9(1):9–13. Available from: https://linkinghub.elsevier.com/retrieve/pii/0022399965900048

9. Stone J, Smyth R, Carson A, Lewis S, Prescott R, Warlow C, et al. Systematic review of misdiagnosis of conversion symptoms and "hysteria." BMJ. 2005 Oct 27;331(7523):989. Available from: https://www.bmj.com/content/331/7523/989

10. Levy R, Mushin J. The somatosensory evoked response in patients with hysterical anaesthesia. J Psychosom Res. 1973;17(2):81–4.

11. Hernandez Peon R, Chavez Ibarra G, Aguilar Figueroa E. Somatic Evoked Potentials in one case of Hysterical Anaesthesia. Electroencephalogr Clin Neurophysiol. 1963 Oct; 15:889–92.

12. Yazici KM, Demirci M, Demir B, Ertugrul A. Abnormal somatosensory evoked potentials in two patients with conversion disorder. Psychiatry Clin Neurosci. 2004 Apr;58(2):222–5.

13. Sierra M, Berrios GE. Towards a Neuropsychiatry of Conversive Hysteria. Cognit Neuropsychiatry. 1999 Aug 1;4(3):267–87. Available from: https://doi.org/10.1080/135468099395963

14. Hoechstetter K, Meinck HM, Henningsen P, Scherg M, Rupp A. Psychogenic Sensory loss: Magnetic Source Imaging Reveals Normal Tactile Evoked Activity of the Human Primary and Secondary Somatosensory Cortex. Neurosci Lett. 2002 Apr 26;323(2):137–40.

15. Tiihonen J, Kuikka J, Viinamäki H, Lehtonen J, Partanen J. Altered Cerebral Blood Flow During Hysterical Paresthesia. Biol Psychiatry. 1995;37(2):134–5.

16. Marshall JC, Halligan PW, Fink GR, Wade DT, Frackowiak RS. The Functional Anatomy of a Hysterical Paralysis. Cognition. 1997 Jul;64(1):B1-8.

17. Vuilleumier P, Chicherio C, Assal F, Schwartz S, Slosman D, Landis T. Functional neuroanatomical correlates of hysterical sensorimotor loss. Brain J Neurol. 2001 Jun;124(Pt 6):1077–90.

18. Simeon D, Guralnik O, Knutelska M, Hollander E, Schmeidler J. Hypothalamic-pituitary-adrenal Axis Dysregulation in Depersonalization Disorder. Neuropsychopharmacology. 2001 Nov;25(5):793–5. Available from: https://www.nature.com/articles/1395731

19. Luckenbaugh DA, Niciu MJ, Ionescu DF, Nolan NM, Richards EM, Brutsche NE, et al. Do the dissociative side effects of ketamine mediate its antidepressant effects? J Affect Disord. 2014 Apr 20;159:56–61. Available from: https://www.sciencedirect.com/science/article/pii/S016503271400055X

20. Abdallah CG, De Feyter HM, Averill LA, Jiang L, Averill CL, Chowdhury GMI, et al. The effects of ketamine on prefrontal glutamate neurotransmission in healthy and depressed subjects. Neuropsychopharmacology. 2018 Sep;43(10):2154–60. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6098048/

21. Mathew RJ, Wilson WH, Humphreys D, Lowe JV, Weithe KE. Depersonalization after marijuana smoking. Biol Psychiatry. 1993 Mar;33(6):431–41. Available from: https://linkinghub.elsevier.com/retrieve/pii/0006322393901719

22. Simeon D, Hollander E, Stein DJ, DeCaria C, Cohen LJ, Saoud JB, et al. Induction of depersonalization by the serotonin agonist meta-chlorophenylpiperazine. Psychiatry Res. 1995 Sep;58(2):161–4. Available from: https://linkinghub.elsevier.com/retrieve/pii/0165178195025388

23. Brand BL, Lanius R, Vermetten E, Loewenstein RJ, Spiegel D. Where Are We Going? An Update on Assessment, Treatment, and Neurobiological Research in Dissociative Disorders as We Move Toward the *DSM-5*. J Trauma Dissociation. 2012 Jan;13(1):9–31. Available from: http://www.tandfonline.com/doi/abs/10.1080/15299732.2011.620687

24. Putnam FW. Pierre Janet and modern views of dissociation. J Trauma Stress. 1989 Oct 1;2(4):413–29. Available from: https://doi.org/10.1007/BF00974599

25. Spitzer C, Barnow S, Freyberger HJ, Grabe HJ. Recent developments in the theory of dissociation. World Psychiatry. 2006 Jun;5(2):82–6. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1525127/

26. Waller N, Putnam FW, Carlson EB. Types of dissociation and dissociative types: A taxometric analysis of dissociative experiences. Psychol Methods. 1996;1(3):300–21.

27. Modestin J, Erni T. Testing the dissociative taxon. Psychiatry Res. 2004 Apr 15 ;126(1):77–82. Available from: https://www.sciencedirect.com/science/article/pii/S0165178104000253

28. Simeon D, Knutelska M, Nelson D, Guralnik O, Schmeidler J. Examination of the Pathological Dissociation Taxon in Depersonalization Disorder. J Nerv Ment Dis. 2003 Nov;191(11):738–44. Available from: https://journals.lww.com/jonmd/Abstract/2003/11000/Examination_of_the_Pathological_Dissociation_Taxon.6.aspx

29. Owens C, Dein S. Conversion disorder: the modern hysteria. Adv Psychiatr Treat. 2006 Mar;12(2):152–7. Available from: https://www.cambridge.org/core/journals/advances-in-psychiatric-

treatment/article/conversion-disorder-the-modern-hysteria/73F77976DFC9802B4C0E3EC7CA88F1A9

30. Şar V, Akyüz G, Kundakçi T, Kiziltan E, Doğan O. Childhood trauma, dissociation, and psychiatric comorbidity in patients with conversion disorder. Am J Psychiatry. 2004 Dec;161(12):2271–6.
31. Chu JA, Dill DL. Dissociative symptoms in relation to childhood physical and sexual abuse. Am J Psychiatry. 1990 Jul;147(7):887–92.
32. Vermetten E, Spiegel D. Trauma and dissociation: implications for borderline personality disorder. Curr Psychiatry Rep. 2014 Feb;16(2):434.
33. Krause-Utz A, Frost R, Winter D, Elzinga BM. Dissociation and Alterations in Brain Function and Structure: Implications for Borderline Personality Disorder. Curr Psychiatry Rep. 2017;19(1):6. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5283511/
34. Vonderlin R, Kleindienst N, Alpers GW, Bohus M, Lyssenko L, Schmahl C. Dissociation in victims of childhood abuse or neglect: a meta-analytic review. Psychol Med. 2018 Nov;48(15):2467–76.
35. Goodyer I. Hysterical Conversion Reactions in Childhood. J Child Psychol Psychiatry. 1981 Apr;22(2):179–88. Available from: https://onlinelibrary.wiley.com/doi/10.1111/j.1469-7610.1981.tb00541.x
36. Sethi S, Gandhi R. Dharmendra. Clinical Features and Outcome of Conversion Disorders in Children and Adolescents. J Indian Assoc for Child Adolesc Ment Health. 2010;6(3):49-54.
37. Srinath S, Bharat S, Girimaji S, Seshadri S. Characteristics of a Child Inpatient Population with Hysteria in India. J Am Acad Child Adolesc Psychiatry. 1993;32(4):822–5. Available from:

https://www.sciencedirect.com/science/article/abs/pii/S0890856709648735?via%3Dihub

38. Tseng WS. Handbook of Cultural Psychiatry. Academic Press; 2001. 877 p.
39. Lilienfeld SO, Lynn SJ, Kirsch I, Chaves JF, Sarbin TR, Ganaway GK, et al. Dissociative identity disorder and the sociocognitive model: Recalling the lessons of the past. Psychol Bull. 1999;507–23.
40. Floris J, McPherson S. Fighting the Whole System: Dissociative Identity Disorder, Labeling Theory, and Iatrogenic Doubting. J Trauma Dissociation. 2015 Aug 8;16(4):476–93. Available from: http://www.tandfonline.com/doi/full/10.1080/15299732.2014.990075
41. Brand BL, Sar V, Stavropoulos P, Krüger C, Korzekwa M, Martínez-Taboas A, et al. Separating Fact from Fiction: An Empirical Examination of Six Myths About Dissociative Identity Disorder. Harv Rev Psychiatry. 2016 Jul;24(4):257–70. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4959824/
42. Nijenhuis ERS, Vanderlinden J, Spinhoven P. Animal defensive reactions as a model for trauma-induced dissociative reactions. J Trauma Stress. 1998 Apr;11(2):243–60. Available from: http://doi.wiley.com/10.1023/A%3A1024447003022
43. Hinman A. Conversion Hysteria in Childhood. AMA J Dis Child. 1958;95(1, Part 1):42-5 Available from: https://pubmed.ncbi.nlm.nih.gov/13487077/.
44. Trivedi K, Singh H, Sinha PK. A Clinical Study of Hysteria In Children and Adolescents. Indian J Psychiatry. 1982;24(1):70–4. Available from: https://pubmed.ncbi.nlm.nih.gov/21965888/ :5.

45. Rana S, Garg S, Mishra P, Kumar M, Pandey J. Dissociative disorder in children and adolescents and their personality profile: a comparative study. Int J Res Med Sci. 2015;2639–42.

46. Malhotra S, Singh G, Mohan A. Somatoform and dissociative disorders in children and adolescents: A comparative study. Vol. 47, Indian Journal of Psychiatry. 2005 p. 39–43. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2918316/

47. Raghuthaman G, Cherian A. Temperament of Children and Adolescents Presenting with Unexplained Physical Symptoms. Indian J Psychiatry. 2003; 45(1):43-7. Available from: https://pubmed.ncbi.nlm.nih.gov/21206813/

48. Prabhuswamy M, Jairam R, Srinath S, Seshadri SP. A systematic chart review of inpatient population with childhood dissociative disorder. J Indian Assoc Child Adolesc Ment Health. 2006;2(3):72–7. Available from: http://dx.doi.org/10.1177/0973134220060302 :7.

49. Maloney MJ. Diagnosing hysterical conversion reactions in children. J Pediatr. 1980;97(6):1016–20. Available from: http://dx.doi.org/10.1016/s0022-3476(80)80450-1.

50. Gross M. Pseudoepilepsy: a study in adolescent hysteria. Am J Psychiatry. 1979 Feb;136(2):210–3.

51. Geetha PR, Shetty G, Venkataramiah V. A Comparative Study of Family Interaction in Childhood Hysteria-Childhood Anxiety and Normal Children. Indian J Psychol Med. 1980 Jan;3(1):5–13.

52. Singh H, Soni PK, Gill PJ, Kaur L. Stressful family life events and nonspecific somatic complaints in school children. Indian Pediatr. 1991 Dec;28(12):1483–7.

53. Benbadis SR. Psychogenic nonepileptic “seizures” or “attacks”?: It’s not just semantics: Attacks. Neurology. 2010 Jul 6;75(1):84–6. Available from: https://n.neurology.org/content/75/1/84

54. Brigo F, Igwe SC, Ausserer H, Nardone R, Tezzon F, Bongiovanni LG, et al. Terminology of psychogenic nonepileptic seizures. Epilepsia. 2015;56(3):e21–5. Available from: https://onlinelibrary.wiley.com/doi/abs/10.1111/epi.12911

55. Edwards MJ, Stone J, Lang AE. From psychogenic movement disorder to functional movement disorder: It’s time to change the name: Psychogenic to Functional Movement Disorder. Mov Disord. 2014 Jun;29(7):849–52. Available from: https://onlinelibrary.wiley.com/doi/10.1002/mds.25562

56. Trimble MR. Functional diseases. Br Med J Clin Res Ed. 1982 Dec 18;285(6357):1768–70.

57. American Psychiatric Association, American Psychiatric Association, editors. Diagnostic and statistical manual of mental disorders: DSM-5. 5th ed. Washington, D.C: American Psychiatric Association; 2013. 947 p.

58. ICD-11 for Mortality and Morbidity Statistics. Available from: https://icd.who.int/browse11/l-m/en

59. Reed GM, First MB, Kogan CS, Hyman SE, Gureje O, Gaebel W, et al. Innovations and changes in the ICD-11 classification of mental, behavioural and neurodevelopmental disorders. World Psychiatry. 2019;18(1):3–19. Available from: https://onlinelibrary.wiley.com/doi/abs/10.1002/wps.20611

60. Putnam FW. Dissociative disorders in children: Behavioral profiles and problems. Child Abuse Negl. 1993 Jan;17(1):39–45. Available from: https://linkinghub.elsevier.com/retrieve/pii/014521349390006Q

61. Castillo RJ. Spirit possession in South Asia, dissociation or hysteria?: Part 1: Theoretical background. Cult Med Psychiatry. 1994 Mar;18(1):1–21. Available from: http://link.springer.com/10.1007/BF01384875

62. Okun MS, Koehler PJ. Paul Blocq and (psychogenic) astasia abasia. Mov Disord. 2007;22(10):1373-8. Available from: https://movementdisorders.onlinelibrary.wiley.com/doi/10.1002/mds.21474

63. Dieguez S. Ganser Syndrome. In: Bogousslavsky J, editor. Frontiers of Neurology and Neuroscience. S. Karger AG; 2018. p. 1–22. Available from: https://www.karger.com/Article/FullText/475676

64. Gillig PM. Dissociative Identity Disorder. Psychiatry Edgmont. 2009 Mar;6(3):24–9. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2719457/

65. Lauer J, Black DW, Keen P. Multiple personality disorder and borderline personality disorder. Distinct entities or variations on a common theme? Ann Clin Psychiatry Off J Am Acad Clin Psychiatr. 1993 Jun;5(2):129–34.

66. Horevitz RP, Braun BG. Are multiple personalities borderline? An analysis of 33 cases. Psychiatr Clin North Am. 1984 Mar;7(1):69–87.

67. Stone J, Smyth R, Carson A, Warlow C. La belle indifférence in conversion symptoms and hysteria: Systematic review. Br J Psychiatry. 2006 Mar;188(3):204–9. Available from: https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/la-belle-indifference-in-conversion-symptoms-and-hysteria/2C2DF6AE65AB10C9C33DDC0CEB14B324

68. Mehndiratta MM, Kumar M, Nayak R, Garg H, Pandey S. Hoover's sign: Clinical relevance in Neurology. J Postgrad Med. 2014 Jul 1;60(3):297.

Available from: https://www.jpgmonline.com/article.asp?issn=0022-3859;year=2014;volume=60;issue=3;spage=297;epage=299;aulast=Mehndiratta;type=0

69. Seligman R, Kirmayer LJ. Dissociative Experience and Cultural Neuroscience: Narrative, Metaphor and Mechanism. Cult Med Psychiatry. 2008 Mar;32(1):31–64. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5156567/
70. Somer E. Culture-Bound Dissociation: A Comparative Analysis. Psychiatr Clin North Am. 2006 Mar;29(1):213–26. Available from: https://linkinghub.elsevier.com/retrieve/pii/S0193953X05000924
71. Yap PM. Classification of the Culture-Bound Reactive Syndromes. Aust N Z J Psychiatry. 1967;1(4):172-9. Available from: https://journals.sagepub.com/doi/10.3109/00048676709159191
72. Yap PM. Mental Diseases Peculiar to Certain Cultures: A Survey of Comparative Psychiatry. J Ment Sci. 1951 Apr;97(407):313–27. Available from: https://www.cambridge.org/core/product/identifier/S0368315X00044091/type/journal_article
73. Lewis-Fernández R. The Proposed DSM-IV Trance and Possession Disorder Category: Potential Benefits and Risks. Transcult Psychitr Res Rev.1992;29(4):301-17 Available from: https://journals.sagepub.com/doi/abs/10.1177/136346159202900403
74. Campion J, Bhugra D. Experiences of religious healing in psychiatric patients in south India. Soc Psychiatry Psychiatr Epidemiol. 1997 May;32(4):215–21.
75. Alexander PJ, Joseph S, Das A. Limited utility of ICD-10 and DSM-IV classification of dissociative and conversion disorders in India. Acta Psychiatr

Scand. 1997 Mar;95(3):177–82. Available from: https://onlinelibrary.wiley.com/doi/10.1111/j.1600-0447.1997.tb09617.x

76. Dorahy MJ, Schumaker JF, Krishnamurthy B, Kumar P. Religious Ritual and Dissociation in India and Australia. J Psychol. 1997 Sep 1;131(5):471–6. Available from: https://doi.org/10.1080/00223989709603534
77. Grover S, Ghosh A. Somatic symptom and related disorders in Asians and Asian Americans. Asian J Psychiatry. 2014 Feb;7:77–9. Available from: https://linkinghub.elsevier.com/retrieve/pii/S1876201813003687
78. Sethi BB, Lal N. Hysteria in India: Clinical Aspects. J Genet Psychol. 1976 Dec 1;129(2):291–300. Available from: https://www.tandfonline.com/doi/full/10.1080/00221325.1976.10534040
79. Dell PF. Is high hypnotizability a necessary diathesis for pathological dissociation? J Trauma Dissociation Off J Int Soc Study Dissociation ISSD. 2017 Feb;18(1):58–87.
80. Halligan PW, Athwal BS, Oakley DA, Frackowiak RS. Imaging hypnotic paralysis: implications for conversion hysteria. Lancet Lond Engl. 2000 Mar 18;355(9208):986–7.
81. Bliss EL. Spontaneous Self-Hypnosis in Multiple Personality Disorder. Psychiatr Clin North Am. 1984 Mar;7(1):135–48. Available from: https://linkinghub.elsevier.com/retrieve/pii/S0193953X1830786X
82. Terao T, Collinson S. Imaging hypnotic paralysis. The Lancet. 2000 Jul 8;356(9224):162–3. Available from: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(05)73174-3/fulltext

83. Moene FC, Spinhoven P, Hoogduin KAL, Dyck RV. A Randomized Controlled Clinical Trial of a Hypnosis-Based Treatment for Patients with Conversion Disorder, Motor Type. Int J Clin Exp Hypn. 2003 Jan 1;51(1):29–50.

84. Moene FC, Spinhoven P, Hoogduin KAL, van Dyck R. A randomised controlled clinical trial on the additional effect of hypnosis in a comprehensive treatment programme for in-patients with conversion disorder of the motor type. Psychother Psychosom. 2002 Apr;71(2):66–76.

85. Kundalia C, Agila C, Chandrani K. Hypnotherapy in the treatment of conversion disorder blindness and deafness type. Ann Ind Psychiatr. 2019;3(2):173Available from: https://www.anip.co.in/article.asp?issn=2588-8358;year=2019;volume=3;issue=2;spage=173;epage=175;aulast=Kundalia

86. Speed J. Behavioral management of conversion disorder: Retrospective study. Arch Phys Med Rehabil.1996 Feb 1;77(2):147–54. Available from: https://www.sciencedirect.com/science/article/pii/S0003999396901598

87. McCormack R, Moriarty J, Mellers JD, Shotbolt P, Pastena R, Landes N, et al. Specialist inpatient treatment for severe motor conversion disorder: a retrospective comparative study. J Neurol Neurosurg Psychiatry. 2014 Aug 1;85(8):895–900.

88. Goldstein LH, Deale AC, Mitchell-O'Malley SJ, Toone BK, Mellers JDC. An evaluation of cognitive behavioral therapy as a treatment for dissociative seizures: a pilot study. Cogn Behav Neurol Off J Soc Behav Cogn Neurol. 2004 Mar;17(1):41–9.

89. Aboukasm A, Mahr G, Gahry BR, Thomas A, Barkley GL. Retrospective analysis of the effects of psychotherapeutic interventions on outcomes of psychogenic nonepileptic seizures. Epilepsia. 1998 May;39(5):470–3.

90. Goldstein LH, Robinson EJ, Mellers JDC, Stone J, Carson A, Reuber M, et al. Cognitive behavioural therapy for adults with dissociative seizures (CODES): a pragmatic, multicentre, randomised controlled trial. Lancet Psychiatry. 2020 Jun;7(6):491–505.

91. Jordbru AA, Smedstad LM, Klungsøyr O, Martinsen EW. Psychogenic gait disorder: a randomized controlled trial of physical rehabilitation with one-year follow-up. J Rehabil Med. 2014;46(2):181-7. Available from: https://pubmed.ncbi.nlm.nih.gov/24248149/

92. Ness D. Physical therapy management for conversion disorder: case series. J Neurol Phys Ther JNPT. 2007 Mar;31(1):30–9.

93. Nielsen G, Ricciardi L, Demartini B, Hunter R, Joyce E, Edwards MJ. Outcomes of a 5-day physiotherapy programme for functional (psychogenic) motor disorders. J Neurol. 2015 Mar;262(3):674–81.

94. Nielsen G, Stone J, Matthews A, Brown M, Sparkes C, Farmer R, et al. Physiotherapy for functional motor disorders: a consensus recommendation. J Neurol Neurosurg Psychiatry. 2015 Oct;86(10):1113–9.

95. Bozkurt H, Duzman Mutluer T, Kose C, Zoroglu S. High psychiatric comorbidity in adolescents with dissociative disorders: Adolescents with dissociative disorders. Psychiatry Clin Neurosci. 2015 Jun;69(6):369–74. Available from: https://onlinelibrary.wiley.com/doi/10.1111/pcn.12256

96. LaFrance Jr. WC, Devinsky O. The Treatment of Nonepileptic Seizures: Historical Perspectives and Future Directions. Epilepsia. 2004;45(s2):15–21. Available from: https://onlinelibrary.wiley.com/doi/abs/10.1111/j.0013-9580.2004.452002.x

97. Garcin B, Roze E, Mesrati F, Cognat E, Fournier E, Vidailhet M, et al. Transcranial magnetic stimulation as an efficient treatment for psychogenic movement disorders. J Neurol Neurosurg Psychiatry. 2013 Sep;84(9):1043–6.

98. Pollak TA, Nicholson TR, Edwards MJ, David AS. A systematic review of transcranial magnetic stimulation in the treatment of functional (conversion) neurological symptoms. J Neurol Neurosurg Psychiatry. 2014 Feb;85(2):191–7.

99. O'Neal MA, Baslet G. Treatment for Patients With a Functional Neurological Disorder (Conversion Disorder): An Integrated Approach. Am J Psychiatry. 2018 Apr;175(4):307–14. Available from: https://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2017.17040450

100. Malhi P, Kumar C, Singhi P, Sankhyan N. Outcome of Conversion Symptoms in Children. Indian J Pediatr. 2021 Apr;88(4):367–9. Available from: https://link.springer.com/10.1007/s12098-020-03465-y

101. Ani C, Reading R, Lynn R, Forlee S, Garralda E. Incidence and 12-Month Outcome of Non-Transient Childhood Conversion Disorder in the Uk and Ireland. Br J Psychiatry. 2013 Jun;202(6):413–8. Available from: https://www.cambridge.org/core/product/identifier/S0007125000274680/type/journal_article

102. Pehlivantürk B, Unal F. Conversion disorder in children and adolescents A 4-year follow-up study. J Psychosom Res. 2002;52(4):187-91. Available from: https://www.sciencedirect.com/science/article/abs/pii/S0022399901003063?via%3Dihub

103. Gupta V, Singh A, Upadhyay S, Bhatia B. Clinical Profile of Somatoform Disorders in Children. Indian J Pediatr. 2011 Mar;78(3):283–6. Available from: http://link.springer.com/10.1007/s12098-010-0282-z

104. Turgay A. Treatment Outcome for Children and Adolescents with Conversion Disorder. Can J Psychiatry.1990 Oct;35(7):585–9. Available from: http://journals.sagepub.com/doi/10.1177/070674379003500704

105. Kumar S. Conversion disorder in childhood. J R Soc Med. 2004 Feb;97(2):98.

106. Uma H, Kapur M. A retrospective study of hysteria in a child guidance clinic. Indian J Psychiatry. 1987 Jul;29(3):283–6.

107. Grattan-smith P, Fairley M, Procopis P. Clinical features of conversion disorder. Arch Child. :63–408.

108. Spierings C, Poels PJE, Sijben N, Gabreëls FJM, Renier WO. Conversion Disorders in Childhood: A Retrospective follow-up study of 84 inpatients. Dev Med Child Neurol. 2008 Nov 12;32(10):865–71. Available from: https://onlinelibrary.wiley.com/doi/10.1111/j.1469-8749.1990.tb08098.x

109. Chandra R, Srinivasan S, Chandrasekaran R, Mahadevan S. The prevalence of mental disorders in school-age children attending a general paediatric department in southern India. Acta Psychiatr Scand. 1993 Mar;87(3):192–6.

110. Sharma P, Chaturvedi SK. Conversion disorder revisited. Acta Psychiatr Scand. 1995 Oct;92(4):301–4.

111. Bhatia MS, Vaid L. Hysterical aphonia--an analysis of 25 cases. Indian J Med Sci. 2000 Aug;54(8):335–8.

112. Malhi P, Singhi P. Clinical characteristics [correction of characterstics] and outcome of children and adolescents with conversion disorder. Indian Pediatr. 2002 Aug;39(8):747–52.

113. Sharma I, Giri D, Dutta A, Mazumder P. Psychosocial Factors in Children and Adolescents with Conversion Disorder. J Indian Assoc Child Adolesc Ment

Health. 2005 Oct;1(4):13–9. Available from: http://journals.sagepub.com/doi/10.1177/0973134220050403

114. Deka K, Chaudhury PK, Bora K, Kalita P. A study of clinical correlates and socio-demographic profile in conversion disorder. Indian J Psychiatry. 2007;49(3):205–7. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2902095/
115. Kozlowska K, Nunn KP, Rose D, Morris A, Ouvrier RA, Varghese J. Conversion Disorder in Australian Pediatric Practice. J Am Acad Child Adolesc Psychiatry. 2007 Jan;46(1):68–75. Available from: https://linkinghub.elsevier.com/retrieve/pii/S0890856709619596
116. Ghosh JK, Majumder P, Pant P, Dutta R, Bhatia BD. Clinical Profile and Outcome of Conversion Disorder in Children in a Tertiary Hospital of North India. J Trop Pediatr. 2007;53(3):213–4. Available from: http://dx.doi.org/10.1093/tropej/fml088
117. Huang KL, Su TP, Lee YC, Bai YM, Hsu JW, Yang CH, et al. Sex Distribution and Psychiatric Features of Child and Adolescent Conversion Disorder Across 2 Decades. J Chin Med Assoc. 2009 Sep;72(9):471–7. Available from: https://journals.lww.com/02118582-200909000-00005
118. Ranjan R, Mehta M, Sagar R, Sarkar S. Relationship of cognitive function and adjustment difficulties among children and adolescents with dissociative disorder. J Neurosci Rural Pract. 2016 Apr;07(02):238–43. Available from: http://www.thieme-connect.de/DOI/DOI?10.4103/0976-3147.176197
119. Madaan P, Gulati S, Chakrabarty B, Sapra S, Sagar R, Mohammad A, et al. Clinical spectrum of psychogenic non epileptic seizures in children; an

observational study. Seizure - Eur J Epilepsy. 2018 Jul 1;59:60–6. Available from: https://www.seizure-journal.com/article/S1059-1311(17)30623-4/fulltext

120. Reddy L, Patil N, Nayak R, Chate S, Ansari S. Psychological dissection of patients having dissociative disorder: A cross-sectional study. Indian J Psychol Med. 2018 Jan 1;40(1):41–6.
121. Bammidi R, Ravipati LP, Bashar MA, Kumar KS. Clinical, sociodemographic profile and stressors in patients with conversion disorders: An exploratory study from southern India. Ind Psychiatry J. 2020 Dec;29(2):222–7.
122. Fang Z, Li Y, Xie L, Cheng M, Ma J, Li T, et al. Characteristics and outcomes of children with dissociative (conversion) disorders in western China: a retrospective study. BMC Psychiatry. 2021 Dec 1;21(1).
123. Sheehan DV, Sheehan KH, Shytle RD, Janavs J, Bannon Y, Rogers JE, et al. Reliability and Validity of the Mini International Neuropsychiatric Interview for Children and Adolescents (MINI-KID). J Clin Psychiatry. 2010 Mar 15;71(3):17393. Available from: https://www.psychiatrist.com/jcp/assessment/diagnostic-tools/reliability-validity-mini-international-neuropsychiatric/
124. Goodman R. Psychometric Properties of the Strengths and Difficulties Questionnaire. J Am Acad Child Adolesc Psychiatry. 2001 Nov;40(11):1337–45. Available from: https://linkinghub.elsevier.com/retrieve/pii/S0890856709605438
125. Shaffer D. A Children's Global Assessment Scale (CGAS). Arch Gen Psychiatry. 1983 Nov 1;40(11):1228. Available from: http://archpsyc.jamanetwork.com/article.aspx?doi=10.1001/archpsyc.1983.01790100074010

126. Busner J, Targum SD. The Clinical Global Impressions Scale: Applying a Research Tool in Clinical Practice. Psychiatry (Edgmont). 2007;4(7):28-37. Available from: https://pubmed.ncbi.nlm.nih.gov/20526405/

ANNEXURE I

INFORMED CONSENT

"STUDY OF CLINICAL PROFILE AND SHORT-TERM OUTCOME OF DISSOCIATIVE DISORDER IN CHILDREN AND ADOLESCENTS – A 1 YEAR OBSERVATIONAL STUDY IN A TERTIARY CARE CENTRE"

Principal Investigator (PI): REG. NO. BQ0120005

Objective/Purpose of the study: Your child is being requested to be a subject in an observational study, the purpose of which is to study clinical profile and short-term outcomes of dissociative disorder in children in Belagavi city conducted between 1st January 2021 and 31st December 2021, by BQ0120005, a postgraduate student in the Department of Psychiatry at Jawaharlal Nehru Medical College, KLE University, Belgaum, Karnataka.

Your child has been requested to participate in this study as your child is suffering from a psychiatric disorder which needs intervention. Therefore, the above study helps provide better quality of care for effective integration of the patients back into the society.

Procedure involved: If you agree your child to be a part of the study, the PI will interview you/your child and take the details according to predesigned proforma and questionnaires You will also be interviewed after 1 month during follow up/voice/video call.

Risks and benefits involved: There are no risks involved. During the period of study, the existence or development of any significant findings in terms of psychiatric disorders

will be informed by the PI to you as well as the parent consultant for the appropriate action.

Alternatives: Your/your child's participation in this study is a completely voluntary decision. If you/your child do/does not want to be a part of the study, you/your child may refuse for the same or if you/your child are/is already a part of the study and if you/your child want/wants to withdraw from the study for any reason, you/your child may do so without any hesitation. Discontinuation from the study for any reason will not affect your/your relative's current or future relationship with KLES Dr. Prabhakar Kore Hospital, Belgaum.

Privacy and confidentiality: The information provided by you/your child will be known to the PI and the members of the research team. This information will remain confidential and will be disclosed to others only with your written permission or if required by the law.

Financial incentives for participation: You/your child will not be paid/offered any gifts for participation in the research. There will not be any remuneration for participating in the research and you/your relative will not be reimbursed for any expenses, such as bus/train travelling /companion/assistant etc.

Authorization to publish results: When the results of the research are to be published or discussed in conferences by the PI, no information will be disclosed that will reveal your/your child's identity.

You/your relative will be given a copy of this consent form for your/your relative's information and records.

If you have any questions about this study, you may contact:

REG NO. BQ00120005

Postgraduate

Department of Psychiatry

Jawaharlal Nehru Medical College

KAHER, Belagavi – 590010

Karnataka

Dr. _____

Professor,

Department of Psychiatry,

Jawaharlal Nehru Medical College,

KAHER, Belagavi - 590010

Karnataka

STATEMENT OF CONSENT

PRIMARY INVESTIGATOR: BQ0120005

Dear Mr./Mrs./Dr. _____, you are kindly requested to enroll your child in a research study tilted, **"STUDY OF CLINICAL PROFILE AND SHORT-TERM OUTCOME OF DISSOCIATIVE DISORDER IN CHILDREN AND ADOLESCENTS – A 1 YEAR OBSERVATIONAL STUDY IN A TERTIARY CARE CENTRE"** being conducted by, a post graduate student in M.D. Psychiatry and the study will be carried in the Department of Psychiatry, Jawaharlal Nehru Medical College, Belagavi.

Your child has been requested to participate in this as they fit into the laid-out criteria for a study 'subject'/ participant.

You and your child's participation in study is voluntary. During the study you and your child will be undergoing an interview session. Your decision whether or not to participate in the study will not affect your treatment in any form. If you decide to participate you are free to withdraw at any time.

My signature/thumb impression below indicates that I have read or have been told about this entire consent form including the risks and benefits and have had all my questions answered. I will be given a copy of this consent form.

Participant details:

Name of authorized representative/parent:

_____

Signature/Thumb Impression of the authorized representative/parent:

_____

Relation to the subject:

Date:

Name of witness:

_____

Signature of the witness:

_____

Date:

Signature of investigator: _____

Date:

अनुसंधान अध्ययन में भाग लेने के लिए सहमति

मैं समझता हूं कि मेरा बच्चा अध्ययन में भाग ले रहा है।

मैं पुष्टि करता हूं कि मैंने रोगी सूचना पत्र में जानकारी पढ़ी और समझी है। अध्ययन ने बताया कि मुझे अध्ययन में भाग लेने के फायदे और नुकसान के बारे में जानकारी के साथ-साथ विस्तार से बताया गया है। मुझे परीक्षण के सभी पहलुओं पर चर्चा करने, सवाल पूछने और इस तरह ऊपर परीक्षण में भाग लेने के लिए सहमति देने का अवसर दिया गया है।

यह समझें कि इस अध्ययन में भाग लेने का निर्णय पूरी तरह से स्वैच्छिक है और मुझे पता है कि मैं एक समय में अध्ययन सेवाएं लेने का विकल्प चुन सकता हूं

चिकित्सा, वैज्ञानिक या शैक्षिक उद्देश्यों के लिए मेरे शरीर के उपयुक्त भाग के साथ काम करने के लिए प्रक्रिया को फोटो या रिकॉर्ड करने की अनुमति दी जाती है, बशर्ते मेरी पहचान चित्रों में या उनके साथ आने वाले वर्णनात्मक ग्रंथों में प्रकट न हो।

मैं समझता हूं कि यह अध्ययन किसी महत्वपूर्ण जोखिम को कवर नहीं करता है।

परिणाम के अनुसार किसी भी व्यक्ति द्वारा कोई गारंटी या आश्वासन नहीं दिया जाता है।

इस फॉर्म पर मेरा हस्ताक्षर दर्शाता है कि मैंने उपरोक्त जानकारी को समझने के बाद सहर्ष निर्णय लिया है।

प्रतिभागी / कानूनी रूप से अधिकृत प्रतिनिधि का नाम:

हस्ताक्षर का नाम:

गवाह के हस्ताक्षर:

साक्षात्कारकर्ता का नाम और हस्ताक्षर:

तारीख:

स्थान:

[illegible]

संशोधन सहभागी होण्यासाठी संमती विधान

या अभ्यासात मी माझ्या मुलाचा सहभाग स्वेच्छेने स्वीकारतो.

जरी मी माझ्या मुलास या अभ्यासामध्ये भाग घेण्याची परवानगी देत असलो तरी मला हे समजले आहे की मला कधीही माघार घेण्याचे स्वातंत्र्य आहे.

मला संशोधनात भाग घेण्यासाठी पैसे दिले जाणार नाहीत. प्रवासासारख्या कोणत्याही खर्चासाठी मला / माझ्या नातेवाईकांना परतफेड केली जाणार नाही.

या अभ्यासात मी / माझ्या मुलाचा सहभाग हा पूर्णपणे ऐच्छिक निर्णय आहे.

मी / माझे मुल जर कोणत्याही कारणास्तव अभ्यासामधून माघार घेऊ इच्छित असेल तर मी हे न डगमगता करू शकतो.

कोणत्याही कारणास्तव, हा अभ्यास बेळगावच्या डॉ. केएलईएसने बंद केला होता. मला समजले आहे की प्रभाकर कोरी हॉस्पिटलशी माझे संबंध प्रभावित होणार नाहीत.

मला समजले की अभ्यासामध्ये कोणतीही जोखीम नाही. अभ्यासाच्या काळात कोणत्याही महत्त्वपूर्ण निष्कर्षांवर लक्ष दिले जाईल.

मी / माझ्या मुलाद्वारे प्रदान केलेली माहिती शोध पथकाच्या सदस्यांना माहिती असेल. ही माहिती गोपनीय राहील आणि कायद्याद्वारे किंवा माझ्या लेखी संमतीने इतरांना जाहीर केली जाईल.

कॉन्फरन्समध्ये संशोधन निकाल प्रकाशित करणे किंवा त्यावर चर्चा करण्याची वेळ येते तेव्हा माझ्या मुलाची ओळख जाहीर केली जाऊ शकत नाही.

मला या संमती पत्राची एक प्रत दिली जाईल.

खाली माझी स्वाक्षरी / अंगठ्याचा ठसा सूचित करतो की मी जोखीम आणि फायद्यांसह हा संपूर्ण संमती फॉर्म वाचला आहे किंवा सांगितले आहे आणि माझ्या सर्व प्रश्नांची उत्तरे दिली आहेत.

सहभागींची नावे / कायदेशीर अधिकृत प्रतिनिधीः

पालक / पालकांची सही / अंगुठा

तारीख आणि ठिकाण:

VERBAL ASSENT

[FOR AGES 7-12]

Title of Research Study: STUDY OF CLINICAL PROFILE AND SHORT-TERM OUTCOME OF DISSOCIATIVE DISORDER IN CHILDREN AND ADOLESCENTS – A 1 YEAR OBSERVATIONAL STUDY IN A TERTIARY CARE CENTRE

Principal Investigator: BQ0120005

Why are we meeting with you?

We want to tell you about something we are doing called a research study. A research study is when doctors collect a lot of information to learn more about something. We are doing a study to learn more about children with a condition called dissociative disorder. After we tell you about it, we will ask if you'd like to be in this study or not.

Why are we doing this study?

We want to find out any reasons and how well treatment is working for your condition. So, we are getting information from lots of boys and girls like you.

In the whole study, there will be about 77 children who have the same condition as you.

What will happen to you if you are in this study?

Only if you agree, I will be asking you and your parents some questions about yourself and your family.

Will this study hurt?

No, I will not be doing anything that will hurt you.

Will you get better if you are in this study?

No, this study won't make you feel better or get well. But the doctors might find out something that will help other children like you later.

Do you have to be in this study?

No, you don't. If you don't want to be in this study, just tell us. Or if you do want to be in the study, tell us that. And, remember, you can say yes now and change your mind later. It's up to you.

Some of the things that I will ask might make you uncomfortable. Some of the questions or tests might be hard to answer. If you get too tired or uncomfortable, just let me know. If you want to stop at any time, just tell me and we will stop.

Your parents say it is okay for you to be in this study. If you have questions for me or for your parents you can ask them now or later.

Do you have any questions? Are you willing to take part in this?

Child's/Participant's response**:** ☐Yes ☐No

Check which applies below:

☐ The child is capable of understanding the study

☐ The child is not capable of understanding the study

☐ The child's parent or guardian has already signed a consent document.

_____

Name of Child Participant

Principal Investigator's Signature

I have fully explained the research study described by this form. I have answered the participant and/or parent/guardians' questions and will answer any future questions to the best of my ability. I will tell the family and/or the person taking part in this research of any changes in the procedures or in the possible harms/possible benefits of the study that may affect their health or their willingness to stay in the study.

_____

Name of Investigator Obtaining Assent

_____

Signature of Investigator Date Time

ADOLESCENT ASSENT FORM

[FOR AGES 13-18]

Your parent has given permission for you to be in a project called a research study. But first, we want to tell you all about it so you can decide if you want to be in it. If you don't understand, please ask questions. You can choose to be in the study, not be in the study or take more time to decide.

What is the name of the study?

STUDY OF CLINICAL PROFILE AND SHORT-TERM OUTCOME OF DISSOCIATIVE DISORDER IN CHILDREN AND ADOLESCENTS – A 1 YEAR OBSERVATIONAL STUDY IN A TERTIARY CARE CENTRE

Who is in charge of the study?

The doctor in charge of the study is REG. NO. BQ0120005

What is the study about?

We would like to find out what are some the factors that may be leading to your condition, and how better you feel after 1 month of treatment.

Why are you asking me to be in this study?

You are being asked to be in the study because you are between the ages of 13 and 18, and have this condition we are studying about.

What will happen to me in the study?

If you decide to be in the study, I will be asking you and your parents/guardian some questions regarding your family and yourself, which will be repeated after 1 month either when you visit or by voice/video call.

Will I be paid to be in this study?

You/your family will not be paid for being in this study.

Do I have to be in the study?

You don't have to do the study if you don't want to. If you are in the study, you can stop being in it at any time. Nobody will be upset with you if you don't want to be in the study or if you want to stop being in the study. The doctors and nurses will take care of you as they have in the past. If you have any questions or don't like what is happening, please tell the doctor or nurse. You have had the study explained to you. You have been given a chance to ask questions. By writing your name below, you are saying that you want to be in the study.

Signature of Adolescent: _____

Name of Adolescent:

Signature of Investigator: _____

Name of Investigator:

ANNEXURE II

PROFORMA

SOCIO-DEMOGRAPHIC DETAILS

PATIENT NUMBER					
NAME					
DATE OF BIRTH OR AGE					
SEX					
ADDRESS					
RELIGION					
FATHER'S NAME					
FATHER EDUCATION LEVEL	UNEDUCATED	HIGH SCHOOL	BACHELORS	MASTERS	OTHER
FATHER OCCUPATION					
MOTHERS NAME					
MOTHERS EDUCATION LEVEL	UNEDUCATED	HIGH SCHOOL	BACHELORS	MASTERS	OTHER
MOTHERS OCCUPATION					
SOCIO-ECONOMIC STATUS	UPPER CLASS	UPPER MIDDLE	LOWER MIDDLE	UPPER LOWER	LOWER
TYPE OF FAMILY	NUCLEAR	JOINT	SINGLE PARENT		
NUMBER OF MEMBERS IN FAMILY					

CLINICAL HISTORY

Nature of the stressor	As per child As per parent Inference of others				
Type of stressor	FAMILY	SCHOOL	STUDIES	FRIENDSHIP/RELATIONSHIP	OTHER
Did they have symmetrical limb movements?	YES		NO		
Any other body movements?	YES		NO		
Any drooling of saliva?	YES		NO		
Loss of consciousness?	YES		NO		
Any serious injury at the time of this event?	YES		NO		
Loss of bodily functions?	YES		NO		
Presence of tongue bite?	YES		NO		
At the time, do they hear any voices/aware of anything happening in immediate surroundings?	YES		NO		
Was there any significant loss of memory more than normal?	YES		NO		
Has the child any complete forgetfulness of his/her identity?	YES		NO		
Did the child forget basic self-care like brushing teeth, bathing?	YES		NO		
Was the child found lost from home/school and wandering?	YES		NO		
Did the child forget basic conversational skills?	YES		NO		
Has the child ever been unresponsive to stimuli (calling their name/external light/outside noise)	YES		NO		
At that time was the child motionless/remaining in one position for a prolonged period of time?	YES		NO		
Did the child ever declare her/himself to be another person?	YES		NO		
Have they ever claimed that they are not your child, but another person?	YES		NO		
Have they claimed that another person's spirit is inside them?	YES		NO		
At that moment do they repeat any specific phrases/movements or words	YES		NO		
Has the child ever reported any loss of sensation in any body parts	YES		NO		
Has the child ever reported any loss of movement in any limbs	YES		NO		

Has the child ever displayed any difficulty in walking/ inability to walk?	YES		NO	
Did the child have an inability to stand unaided?	YES		NO	
Has she/he ever complained of loss of vision?	YES		NO	
Duration of these symptoms?	>10min	5-10min	0-5min	0-60sec
If >10min, elaborate duration	HOURS	THROUG HOUT THE DAY	MULTIPLE DAYS TOGETHER	
Frequency of the episodes	>4	3-4	2-3	1
During sleep?	YES		NO	
Alone	YES		NO	
Only in presence of family	YES		NO	
In presence of strangers	YES		NO	
Similar episodes previously?	YES		NO	
Other symptoms previously?	YES		NO	
If yes, describe				

TEMPERAMENT

(CHECK WHICH APPLICABLE)		**EASY CHILD**	**DIFFICULT CHILD**	**SLOW TO WARM UP CHILD**
ACTIVITY LEVEL			HIGH	LOW
BIOLOGICAL REGULARITY		REGULAR	IRREGULAR	
	SLEEP WAKE CYCLE			
	HUNGER			
	BOWEL AND BLADDER MOVEMENTS			
ADAPTIBILITY		QUICKLY	SLOWLY	SLOWLY
APPROACH/WITHDRAWAL		POSITIVE	NEGATIVE	NEGATIVE
SENSITIVITY THRESHOLD		LOW	HIGH	
INTENSITY OF EMOTIONAL RESPONSE		LOW TO MODERATE	HIGH	LOW

DISTRACTIBILITY	LOW	HIGH	
QUALITY OF MOOD	POSITIVE	NEGATIVE/SERIOUS	
PERSISTENCE/ATTENTION SPAN	LOW	HIGH	

PARENTING STYLE (CHECK WHICH APPLICABLE)

AUTHORITARIAN	
PERMISSIVE/INDULGENT	
UNINVOLVED	
AUTHORITATIVE	

FAMILY HISTORY

PSYCHIATRIC ILLNESS	YES		NO	
DEGREE RELATION	1ST	2ND	3RD	4^{TH}
CURRENTLY SYMPTOMATIC	YES		NO	
TREATMENT DETAIL				
NEUROLOGICAL ILLNESS	YES		NO	
DEGREE RELATION	1ST	2ND	3RD	4^{TH}
CURRENTLY SYMPTOMATIC	YES		NO	
TREATMENT DETAIL				
MEDICAL ILLNESS	YES		NO	
DEGREE RELATION	1ST	2ND	3RD	4^{TH}
TREATMENT DETAIL				

TREATMENT HISTORY

FAITH HEALERS/SPIRITUAL TREATMENT	YES	NO
CONSULTED ELSEWHERE	YES	NO
MEDICATION TAKEN, IF ANY		
DETAILS OF TREATMENT TAKEN		
COMORBID ILLNESS	YES	NO
DETAILS		
TREATMENT HISTORY		

DIAGNOSIS

AXIS I – CLINICAL DISORDERS	
AXIS II – PERSONALITY DISORDERS	
AXIS III – GENERAL MEDICAL DISORDERS	
AXIS IV – PSYCHOSOCIAL AND ENVIRONMENTAL FACTORS	
AXIS V - GLOBAL ASSESMENT OF FUNCTIONING	

FOLLOW UP - 1

MODE OF FOLLOW UP		
DATE		
COMPLIANCE TO MEDICATION		
AREAS OF IMPROVEMENT		
IMPROVEMENT IN FUNCTIONING	YES	NO
BIOLOGICAL FUNCTIONS		
TREATMENT HISTORY		

ANNEXURE III – TOOLS

1. MINI-KID: Mini International Neuropsychiatric

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

	MODULES	TIME FRAME	MEETS CRITERIA	DSM-IV	ICD-10	
A	MAJOR DEPRESSIVE EPISODE	Current (Past 2 weeks)	☐			
		Past	☐			
		Recurrent	☐			
	MAJOR DEPRESSIVE DISORDER	Current (Past 2 weeks)	☐	296.20-296.26 Single	F32.x	☐
		Past	☐	296.20-296.26 Single	F33.x	☐
		Recurrent	☐	296.30-296.36 Recurrent	F33.x	☐
B	SUICIDALITY	Current (Past Month) ☐ Low ☐ Moderate ☐ High	☐	N/A	N/A	
C	DYSTHYMIA	Current (Past 1 year)	☐	300.4	F34.1	☐
D	MANIC EPISODE	Current	☐			
		Past	☐			
	HYPOMANIC EPISODE	Current	☐			
		Past	☐	☐ Not Explored		
	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	☐
E	PANIC DISORDER	Current (Past Month)	☐	300.01/300.21	F40.01-F41.0	☐
		Lifetime	☐	300.01/300.21	F40.01-F41.0	☐
F	AGORAPHOBIA	Current	☐	300.22	F40.00	☐
G	SEPARATION ANXIETY DISORDER	Current (Past Month)	☐	309.21	F93.0	☐
H	SOCIAL PHOBIA (Social Anxiety Disorder)	Current (Past Month)				
		Generalized	☐	300.23	F40.1	☐
		Non-Generalized	☐	300.23	F40.1	☐
I	SPECIFIC PHOBIA	Current (Past Month)	☐	300.29	N/A	☐
J	OBSESSIVE COMPULSIVE DISORDER	Current (Past Month)	☐	300.3	F42.8	☐
K	POST TRAUMATIC STRESS DISORDER	Current (Past Month)	☐	309.81	F43.1	☐
L	ALCOHOL DEPENDENCE	Past 12 Months	☐	303.9	F10.2x	☐
L	ALCOHOL ABUSE	Past 12 Months	☐	305.00	F10.1	☐

M	SUBSTANCE DEPENDENCE (Non-alcohol)	Past 12 Months	☐	304.00-.90/305.20-.90	F11.2X-F19.2X	☐
M	SUBSTANCE ABUSE (Non-alcohol)	Past 12 Months	☐	304.00-.90/305.20-.90	F11.1-F19.1	☐
N	TOURETTE'S DISORDER	Current	☐	307.23	F95.2	☐
	MOTOR TIC DISORDER	Current	☐	307.22	F95.1	☐
	VOCAL TIC DISORDER	Current	☐	307.22	F95.1	☐
	TRANSIENT TIC DISORDER	Current	☐	307.21	F95.0	☐
O	ADHD COMBINED	Past 6 Months	☐	314.01	F90.0	☐
	ADHD INATTENTIVE	Past 6 Months	☐	314.00	F98.8	☐
	ADHD HYPERACTIVE/IMPULSIVE	Past 6 Months	☐	314.01	F90.0	☐
P	CONDUCT DISORDER	Past 12 Months	☐	312.8	F91.x	☐
Q	OPPOSITIONAL DEFIANT DISORDER	Past 6 Months	☐	313.81	F91.3	☐
R	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	F20.xx-F29	☐
	MOOD DISORDER WITH PSYCHOTIC FEATURES	Lifetime	☐	296.24/296.04-296.94	F32.3/F33.3/	☐
		Current	☐	296.24/296.04-296.94	F30.2/F31.2/F31.5/ F31.8/F31.9/F39	☐
S	ANOREXIA NERVOSA	Current (Past 3 Months)	☐	307.1	F50.0	☐
T	BULIMIA NERVOSA	Current (Past 3 Months)	☐	307.51	F50.2	☐
	ANOREXIA NERVOSA, BINGE EATING/PURGING TYPE	Current	☐	307.1	F50.0	☐
U	GENERALIZED ANXIETY DISORDER	Current (Past 6 Months)	☐	300.02	F41.1	☐
V	ADJUSTMENT DISORDERS	Current	☐	309.24/309.28 309.3/309.4	F43.xx	☐
W	MEDICAL, ORGANIC, DRUG CAUSE RULED OUT		☐ No	☐ Yes	☐ Uncertain	
X	PERVASIVE DEVELOPMENTAL DISORDER	Current	☐	299.00/299.10/299.80	F84.0/.2/.3/.5/.9	☐

PRIMARY DISORDER

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

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.

INTERVIEWER INSTRUCTIONS

INTRODUCING THE INTERVIEW

The nature and purpose of the interview should be explained to the child or adolescent prior to the interview. A sample introduction is provided below:

"I'm going to ask you a lot of questions about yourself. This is so that I can get to know more about you and figure out how to help you. Most of the questions can be answered either 'yes' or 'no'. If you don't understand a word or a question, ask me, and I'll explain it. If you are not sure how to answer a question, don't guess - just tell me you are not sure. Some of the questions may seem weird to you, but try to answer them anyway. It is important that you answer the questions as honestly as you can so that I can help you. Do you have any questions before we start?"

For children under 13, we recommend interviewing the parent and the child together. Questions should be directed to the child, but the parent should be encouraged to interject if s/he feels that the child's answers are unclear or inaccurate. The interviewer makes the final decision based on his/her best clinical judgment, whether the child's answers meet the diagnostic criterion in question. With children you will need to use more examples than with adolescents and adults.

GENERAL FORMAT:

The MINI Kid is divided into **modules** identified by letters, each corresponding to a diagnostic category.
•At the beginning of each diagnostic module (except for psychotic disorders module), screening question(s) corresponding to the main criteria of the disorder are presented in a **gray box**.
•At the end of each module, diagnostic box(es) permit the clinician to indicate whether diagnostic criteria are met.

CONVENTIONS:

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

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

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

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

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

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

FORMAT OF THE INTERVIEW

The interview questions are designed to elicit specific diagnostic criteria. The questions should be read verbatim. If the child or adolescent does not understand a particular word or concept, you may explain what it means or give examples that capture its essence. If a child or adolescent is unsure if s/he has a particular symptom, you may ask him/her provide an

explanation or example to determine if it matches the criterion being investigated. If an interview item has more than one question, the interviewer should pause between questions to allow the child or adolescent time to respond.

Questions about the duration of symptoms are included for diagnoses when the time frame of symptoms is a critical element. Because children may have difficulty estimating time, you may assist them by helping them connect times to significant events in their lives. For example, the starting point for "past year" might relate to a birthday, the end or beginning of a school year, a particular holiday or another annual event.

RATING INSTRUCTIONS:

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

The clinician should take each dimension of the question into account (for example, time frame, frequency, severity, and/or alternatives).

Symptoms better accounted for by an organic cause or by the use of alcohol or drugs should not be coded positive in the MINI KID.

For any questions, suggestions, training, or information about updates of the M.I.N.I. KID, please contact:

David V Sheehan, M.D., M.B.A.
University of South Florida College of Medicine
3515 East Fletcher Avenue
Tampa, FL USA 33613-4706
tel : +1 (813) 956 - 8437
fax : +1 (813) 974 - 4575
e-mail: dsheehan@health.usf.edu

Juris Janavs MD
University of South Florida College of Medicine
3515 East Fletcher Avenue
Tampa, FL USA 33613-4706
tel :+1 (813) 974 - 2848/(813) 974 - 4544
fax:+1 (813) 974 -4575
e-mail: jjanavs@health.usf.edu

A. MAJOR DEPRESSIVE EPISODE

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

At any time in your life:

A1 a Did you feel sad or depressed? Felt down or empty? Felt grouchy or annoyed?
Did you feel this way most of the time, for at least 2 weeks?
IF **YES** TO ANY, CONTINUE. IF **NO** TO ALL, CODE **NO TO A1a AND A1b**. NO YES

b For the past 2 weeks, did you feel this way, most of the day, nearly every day? NO YES

At any time in your life:

A2 a Were you bored a lot or much less interested in things (Like playing your favorite games)?
Have you felt that you couldn't enjoy things?
Did you feel this way most of the time, for at least 2 weeks?
IF **YES** TO ANY, CONTINUE. IF **NO** TO ALL, CODE **NO TO A2a AND A2b**. NO YES

b For the past 2 weeks, did you feel this way, most of the day, nearly every day? NO YES

\

IS **A1** OR **A2** 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

	In the past two weeks, when you felt depressed / grouchy / uninterested:	Past 2 Weeks		Past Episode	
a	Were you less hungry or more hungry most days? Did you lose or gain weight without trying? [i.e., by ± 5% of body weight in the past month]? IF **YES** TO EITHER, CODE **YES**	NO	YES	NO	YES
b	Did you have trouble sleeping almost every night ("trouble sleeping" means trouble falling asleep, waking up in the middle of the night, waking up too early or sleeping too much)?	NO	YES	NO	YES
c	Did you talk or move slower than usual? Were you fidgety, restless or couldn't sit still almost every day? IF **YES** TO EITHER, CODE **YES**	NO	YES	NO	YES
d	Did you feel tired most of the time?	NO	YES	NO	YES
e	Did you feel bad about yourself most of the time? Did you feel guilty most of the time? IF **YES** TO EITHER, CODE **YES** 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
f	Did you have trouble concentrating or did you have trouble making up your mind?	NO	YES	NO	YES

	g	Did you feel so bad that you wished that you were dead? Did you think about hurting yourself? Did you have thoughts of death? you think about killing yourself? IF **YES** TO ANY, CODE **YES**	NO	YES	NO	YES	Did
A4		Did these sad, depressed feelings cause a lot of problems at home? At school? With friends? With other people? Or in some other important way?	NO	YES	NO	YES	
A5		In between your times of depression, were you free of depression for of at least 2 months?			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** AND MAJOR DEPRESSIVE EPISODE PAST 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	Have any accident? This includes taking too much of your medication accidentally. IF NO TO B1, SKIP TO B2; IF YES, ASK B1a:	NO	YES	0
B1a	Plan or intend to hurt yourself in any accident either actively or passively by not avoiding a risk)? IF NO TO B1a, SKIP TO B2: IF YES, ASK B1b:	NO	YES	(e.g. 0
B1b	Intend to die as a result of any 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	Think about hurting or injuring yourself or have mental images of harming yourself, with at least a slight intent to die?	NO	YES	4
B5	Think about killing yourself?	NO	YES	6

IF NO TO B5, SKIP TO B7. OTHERWISE ASK:

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

B6	Have difficulty restraining yourself or holding back from acting on these impulses?	NO	YES	8
B7	Have a method or a way to kill yourself in your mind (e.g. how)?	NO	YES	8
B8	Have plan to kill yourself in your mind (e.g. when or where)?	NO	YES	8
B9	Intend to act on thoughts of killing yourself?	NO	YES	8
B10	Intend to die as a result of trying to kill yourself?	NO	YES	8
B11	Do things to prepare or to get ready to kill yourself? This includes times when you were going to kill yourself, but were interrupted or stopped yourself, before hurting yourself.	NO	YES	9

IF NO TO B11, SKIP TO B12.

B11a	Do things to **get ready** to kill yourself, but did not start to kill yourself?	NO	YES
B11b	Start to try to kill yourself, but then **stop yourself** before you hurt yourself (aborted attempt)?	NO	YES
B11c	Start to try to kill yourself, but then **someone or something stopped you** before you hurt yourself (interrupted attempt)?	NO	YES

B12	Injure yourself on purpose without intending to kill yourself?	NO	YES	4

B13	Attempt suicide (try to kill yourself)? A suicide attempt means you did something where you could possibly be injured, with at least at least a slight intent to die.	NO	YES	10

IF NO, SKIP TO B14:

Hope to be rescued / survive ☐
Expected / intended to die ☐

In your lifetime:

B14	a) Did you ever feel so bad that you wished you were dead or felt like killing yourself?	NO	YES	4
	b) Did you ever do things to prepare or to get ready to kill yourself?	NO	YES	4
	c) Did you ever try to kill yourself? How many times? _____	NO	YES	4

"A suicide attempt is any self-injurious behavior, with at least some intent (> 0) to die as a result or if intent can be inferred, e.g. if it is clearly not an accident or the individual thinks the act could be lethal, even though denying intent."
(C-CASA definition). Posner K et al. Am J Psychiatry 164:7, July 2007.

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

IF YES, ADD THE TOTAL POINTS FOR THE ANSWERS (B1-B14) CHECKED 'YES' AND SPECIFY THE SUICIDALITY SCORE AS INDICATED IN THE BOX:

MAKE 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. DYSTHYMIA

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

IF PATIENT'S SYMPTOMS MEET CRITERIA FOR MAJOR DEPRESSIVE EPISODE IN THE PAST YEAR, DO NOT EXPLORE THIS MODULE.

C1	Have you felt sad or depressed, or felt down or empty, or felt grouchy or annoyed, most of the time, for the past year?	\ NO	YES
C2	**In the past year**, have you felt OK for two months or more in a row? OK MEANS NOT ALWAYS BEING GROUCHY OR FREE OF DEPRESSION.	NO	\ YES
C3	**During the past year**, most of the time:		
a	Were you less hungry than you used to be? Were you more hungry than you used to be? IF **YES** TO EITHER, CODE **YES**	NO	YES
b	Did you have trouble sleeping ("trouble sleeping" means trouble falling asleep, waking up in the middle of the night, waking up too early or sleeping too much)?	NO	YES
c	Did you feel more tired than you used to?	NO	YES
d	Did you feel less confident of yourself? Did you feel bad about yourself? IF **YES** TO EITHER, CODE **YES**	NO	YES
e	Did you have trouble paying attention? Did you have trouble making up your mind? IF **YES** TO EITHER, CODE **YES**	NO	YES
f	Did you feel that things would never get better?	NO	YES
	ARE **2** OR **MORE C3** ITEMS CODED **YES?**	\ NO	YES
C4	Did these feelings of being depressed / grouchy / uninterested upset you a lot? Did they cause you problems at home? At school? With friends? IF **YES** TO ANY, CODE **YES**	**NO**	**YES** ***DYSTHYMIA*** **CURRENT**

D. (HYPO) MANIC EPISODE

(\ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE NO TO THE RELEVANT TIME FRAME IN THE DIAGNOSTIC BOXES AND THEN MOVE TO THE NEXT MODULE)

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

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

IF YES, PLEASE SPECIFY WHO:_____

D1	a	Has there **ever** been a time when you were so happy that you felt 'up' or 'high' or 'hyper'? By 'up' or 'high' or 'hyper' I mean feeling really good; full of energy; needing less sleep; having racing thoughts or being full of ideas. DO NOT CONSIDER TIMES WHEN THE PATIENT WAS INTOXICATED ON DRUGS OR ALCOHOL OR DURING SITUATIONS THAT NORMALLY OVER STIMULATE AND MAKE CHILDREN VERY EXCITED LIKE CHRISTMAS, BIRTHDAYS, ETC. 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 TO ALL, CODE NO TO **D1b**: IF YES **TO ANY,** ASK:	NO	YES
	b	Are you currently feeling 'up' or 'high' or 'hyper' or full of energy?	NO	YES
D2	a	Has there **ever** been a time when you were so grouchy or annoyed for several days, that you yelled or started fights with people outside your family? Have you or others noticed that you have been more grouchy than other kids, even when you thought you were right to act this way? DO NOT CONSIDER TIMES WHEN THE PATIENT WAS INTOXICATED ON DRUGS OR ALCOHOL. IF NO TO ALL, CODE NO TO **D2b**: IF **YES** TO ANY, ASK:	NO	YES
	b	Are you currently feeling grouchy or annoyed most of the time?	NO	YES
		IS **D1a** or **D2a** CODED **YES?**	\ NO	YES

D3 IF **D1b** OR **D2b** = **YES**: EXPLORE THE **CURRENT** AND THE MOST SYMPTOMATIC **PAST** EPISODE, OTHERWISE
IF **D1b** AND **D2b** = **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? Feel that you are a very important person? IF **YES** TO EITHER, CODE **YES**. 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 (Did you feel rested after only a few hours of sleep)?	NO	YES	NO	YES
c	Talk too much without stopping? Talk so fast that people couldn't understand or follow what you were saying?	NO	YES	NO	YES
d	Have racing thoughts or too many thoughts switching quickly?	NO	YES	NO	YES
e	Get distracted very easily by little things?	NO	YES	NO	YES
f	Get much more involved in things than others or much more fidgety or restless?	NO	YES	NO	YES
g	Want to do fun things even if you could get hurt doing them? Want to do things even though it could get you into trouble? (Like staying out late, skipping school, driving dangerously or spending too much money)? IF **YES** TO ANY, CODE **YES**	NO	YES	NO	YES
D3 SUMMARY:	WHEN RATING CURRENT EPISODE: IF D1b IS NO, ARE 4 OR MORE D3 ANSWERS CODED YES? IF D 1b IS YES, ARE 3 OR MORE D3 ANSWERS CODED YES? WHEN RATING PAST EPISODE: IF D1a IS NO, ARE 4 OR MORE D3 ANSWERS CODED YES? IF D1a IS YES, ARE 3 OR MORE D3 ANSWERS CODED YES? CODE YES ONLY IF THE ABOVE 3 OR 4 SYMPTOMS OCCURRED DURING THE SAME TIME PERIOD.	NO	YES	NO	YES
	RULE: ELATION/EXPANSIVENESS REQUIRES ONLY THREE D3 SYMPTOMS, WHILE IRRITABLE MOOD ALONE REQUIRES 4 OF THE D3 SYMPTOMS.				
D4	What is the longest time these symptoms lasted?				
	a) 3 days or less		☐		☐
	b) 4 to 6 days		☐		☐
	c) 7 days or more		☐		☐
D5	Were you put in the hospital for these problems? IF YES, CIRCLE YES IN MANIC EPISODE FOR THAT TIME FRAME AND GO TO C7.	NO	YES	NO	YES
D6	Did these symptoms cause a lot of problems at home? At school?	NO	YES	NO	YES

IF **YES** TO ANY, CODE **YES**

ARE **D3** SUMMARY AND **D5** AND **D6** CODED **YES**?

OR

ARE **D3** SUMMARY AND **D4c** AND **D6** CODED **YES** AND IS **D5** CODED **NO**?

OR

ARE **D3** SUMMARY AND **D5** CODED **YES** AND IS **D6** CODED **NO**?

OR

ARE **D3** SUMMARY AND A DELUSIONAL IDEA IN D3a AND D4c CODED **YES** AND IS **D5 AND D6** CODED **NO**?

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

NO **YES**

MANIC EPISODE

CURRENT ☐
PAST ☐

Is D3 summary and D4b coded YES and are D5 and D6 and a delusional idea in D3a coded no?

OR

ARE **D3** SUMMARY AND **D4b** AND **D6** CODED **YES** AND IS **D5** CODED **NO?**

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

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

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

HYPOMANIC EPISODE

CURRENT ☐ **NO**
☐ **YES**

PAST ☐ **NO**
☐ **YES**
☐ **NOT EXPLORED**

ARE **D3** SUMMARY AND **D4a** CODED **YES** AND ARE **D5 AND A DELUSIONAL IDEA IN D3A CODED NO**?

HYPOMANIC SYMPTOMS

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

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

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

CURRENT ☐ **NO**

☐ **YES**

PAST ☐ **NO**

☐ **YES**

☐ **NOT EXPLORED**

D7 a) IF MANIC EPISODE IS POSITIVE FOR EITHER CURRENT OR PAST ASK:
Did you have 2 or more of these (manic) episodes lasting 7 days or more (**D4c**) in your lifetime (including the current episode if present) or did you have two or more hospitalizations for Manic Episodes like this in your lifetime. NO YES

b) IF MANIC OR HYPOMANIC EPISODE IS POSITIVE FOR EITHER CURRENT OR PAST ASK:
Did you have 2 or more of these (hypomanic) episodes lasting just 4 to 6 days (**D4b**) in your lifetime (including the current episode)? NO YES

c) IF THE PAST "HYPOMANIC SYMPTOMS" CATEGORY IS CODED POSITIVE ASK:
Did you have (hypomanic) symptoms like these lasting only 1 to 3 days (**D4a**), 2 or more times in your lifetime, (including the current episode if present)? NO YES

E. PANIC DISORDER

(\ MEANS : CIRCLE NO IN E5, E6 AND E7 SUMMARY AND SKIP TO F1)

E1 a Have you ever been really frightened or nervous for no reason; or have you ever been really frightened or nervous in a situation where most kids would not feel that way? \ NO YES
IF **YES** TO EITHER, CODE **YES**. IF NO TO ALL CODE **NO.**

b Did this happen more than one time? \ NO YES

c Did this nervous feeling increase quickly over the first few minutes? \ NO YES

E2		Has this ever happened when you didn't expect it?	NO	YES
E3	a	After this happened, were you afraid it would happen again or that something bad would happen as a result of these attacks? Did you change what you did because of these attacks? (e.g., going out only with someone, not wanting to leave your house, going to the doctor more frequently)?	NO	YES
	b	Did you have these worries for a month or more?	NO	YES
		E3 SUMMARY: IF **YES** TO BOTH E3a AND E3b QUESTIONS, CODE **YES**	NO	YES
E4		**Think about the time you were the most frightened or nervous for no good reason:**		
	a	Did your heart beat fast or loud?	NO	YES
	b	Did you sweat? Did your hands sweat a lot? IF **YES** TO EITHER, CODE **YES**	NO	YES
	c	Did your hands or body shake?	NO	YES
	d	Did you have trouble breathing?	NO	YES
	e	Did you feel like you were choking? Did you feel you couldn't swallow? IF **YES** TO EITHER, CODE **YES**	NO	YES
	f	Did you have pain or pressure in your chest?	NO	YES
	g	Did you feel like throwing up? Did you have an upset stomach? Did you have diarrhea? IF **YES** TO ANY, CODE **YES**	NO	YES
	h	Did you feel dizzy or faint?	NO	YES
	i	Did things around you feel strange or like they weren't real? Did you feel or see things as if they were far away? Did you feel outside of or cut off from your body? IF **YES** TO ANY, CODE **YES**	NO	YES
	j	Were you afraid that you were losing control of yourself? Were you afraid that you were going crazy? IF **YES** TO EITHER, CODE **YES**	NO	YES
	k	Were you afraid that you were dying?	NO	YES
	l	Did parts of your body tingle or go numb?	NO	YES
	m	Did you feel hot or cold?	NO	YES
E5		ARE **BOTH E3 SUMMARY,** AND **4** OR MORE **E4** ANSWERS, CODED YES?	NO	YES

PANIC DISORDER LIFETIME

IF YES TO E5, SKIP TO E7

E6 IF **E5**=NO, ARE ANY E4 QUESTIONS CODED YES? NO YES

ATTACKS LIFETIME

THEN SKIP TO **F1.**

E7 a. **In the past month**, did you have these problems more than one time? NO YES

IF NO, CIRCLE NO TO E7 SUMMARY AND MOVE TO F1.

For the past month:

b. Did you worry that it would happen again? NO YES

c. Did you worry that something bad would happen because of the attack? NO YES

d. Did anything change for you because of the attack? NO YES
(e.g., going out only with someone, not wanting to leave your house, going to the doctor more frequently)?

E7 SUMMARY: IF **YES** TO E7b.or E7c.or E7d., CODE **YES** NO YES

PANIC DISORDER CURRENT

F. AGORAPHOBIA

F1 Do you feel anxious, scared, or uneasy in places or situations where you might become really frightened; like being in a crowd, standing in a line (queue), when you are all alone, or when crossing a bridge, or traveling in a bus, train or car? NO YES
IF **YES** TO ANY, CODE **YES**

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

NO YES

F2 Are you so afraid of these things that you try to stay away from them? Or you can only do them if someone is with you? Or you do them, but it's really hard for you?
IF **YES** TO ANY, CODE **YES**

AGORAPHOBIA CURRENT

IS **F2** (CURRENT AGORAPHOBIA) CODED **NO**

AND

IS **E7** (CURRENT PANIC DISORDER) CODED **YES**?

NO YES

PANIC DISORDER without Agoraphobia CURRENT

IS **F2** (CURRENT AGORAPHOBIA) CODED **YES**

AND

IS **E7** (CURRENT PANIC DISORDER) CODED **YES**?

NO **YES**

PANIC DISORDER with Agoraphobia CURRENT

IS **F2** (CURRENT AGORAPHOBIA) CODED **YES**

AND

IS **E5** (PANIC DISORDER LIFETIME) CODED **NO**?

NO **YES**

AGORAPHOBIA, CURRENT without history of Panic Disorder

G. SEPARATION ANXIETY DISORDER

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

G1	a	**In the past month,** have you been really afraid about being away from someone close to you; or have you been really afraid that you would lose somebody you are close to ? (Like getting lost from your parents or having something bad happen to them) IF **YES** TO EITHER, CODE **YES**	NO	YES
	b	Who are you afraid of losing or being away from _____ ?		
G2	a	Did you get upset a lot when you were away from _____ ? Did you get upset a lot when you thought you would be away from _____ ? IF **YES** TO EITHER, CODE **YES**	NO	YES
	b	Did you get really worried that you would lose _____ ? Did you get really worried that something bad would happen to _____ ? (like having a car accident or dying). IF **YES** TO EITHER, CODE **YES**	NO	YES
	c	Did you get really worried that you would be separated from _____ ? (Like getting lost or being kidnapped?)	NO	YES
	d	Did you refuse to go to school or other places because you were afraid to be away from _____ ?	NO	YES
	e	Did you get really afraid being at home if _____ wasn't there?	NO	YES
	f	Did you not want to go to sleep unless _____ was there?	NO	YES
	g	Did you have nightmares about being away from _____ ? Did this happen more than once? IF **NO** TO EITHER, CODE **NO**	NO	YES
	h	Did you feel sick a lot (like headaches, stomach aches, nausea or vomiting, heart beating fast or feeling dizzy) when you were away from _____ ? Did you feel sick a lot when you thought you were going to be away from _____ ? IF **YES** TO EITHER, CODE **YES**	NO	YES
		G2 SUMMARY: ARE AT LEAST **3** OF **G2a-h** CODED **YES**?	NO	YES
G3		Did this last for at least 4 weeks?	NO	YES
G4		Did your fears of being away from _____ really bother you a lot? Cause you a lot of problems at home? At school? With friends? In any other way? IF **YES** TO EITHER, CODE **YES**	NO	YES

ARE **G1**, **G2 SUMMARY, G3** AND **G4** CODED **YES**?

NO **YES**

SEPARATION ANXIETY DISORDER

H. SOCIAL PHOBIA (Social Anxiety Disorder)

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

H1	**In the past month**, were you afraid or embarrassed when others your age were watching you? Were you afraid of being teased? Like talking in front of the class? Or eating or writing in front of others? IF **YES** TO ANY, CODE **YES**	\ NO	YES
H2	Are you more afraid of these things than other kids your age?	\ NO	YES
H3	Are you so afraid of these things that you try to stay away from them? Or you can only do them if someone is with you? Or you do them but it's really hard for you?	\ NO	YES
H4	Do these social fears have a big effect on your life? Do they cause problems when you interact with others or in your relationships? Do they cause a lot of problems at school or at work? Do they cause you to feel upset and want to be alone? IF **YES** TO ANY, CODE **YES**	\ NO	YES
H5	Did this social fear / social anxiety last at least 6 months?		

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)

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.

EXAMPLES OF SUCH SOCIAL SITUATIONSTYPICALLY 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.

NO **YES**

SOCIAL PHOBIA
(Social Anxiety Disorder)
CURRENT

GENERALIZED ☐
NON-GENERALIZED ☐

I. SPECIFIC PHOBIA

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

I1	**In the past month,** have you been really afraid of something like: snakes or bugs? Dogs or other animals? High places? Storms? The dark? Or seeing blood or needles?	\ NO	YES
I2	List any specific phobia(s): _____		
I3	Are you more afraid of _____ than other kids your age are?	\ NO	YES
I4	Are you so afraid of _____ that you try to stay away from it / them? Or you can only be around it / them if someone is with you? Or can you be around it / them but it's really hard for you? IF **YES** TO ANY, CODE **YES**	\ NO	YES
I5	Does this fear really bother you a lot? Does it cause you problems at home or at school? Does it keep you from doing things you want to do? IF **YES** TO ANY, CODE **YES**	NO	YES

IS **I5** CODED **YES?**

NO	**YES**
SPECIFIC PHOBIA CURRENT	

J. OBSESSIVE COMPULSIVE DISORDER

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

J1 **In the past month**, have you been bothered by bad things that come into your mind that you couldn't get rid of? Like bad thoughts or urges? Or nasty pictures? For example, did you think about hurting somebody even though it disturbs or distresses you? Were you afraid you or someone would get hurt because of some little thing you did or didn't do? Did you worry a lot about having dirt or germs on you? Did you worry a lot that you would give someone else germs or make them sick somehow? Or were you afraid that you would do something really shocking?

IF **YES** TO ANY, CODE **YES**

DO NOT INCLUDE SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PROBLEMS.
DO NOT INCLUDE OBSESSIONS DIRECTLY RELATED TO EATING DISORDERS, SEXUAL BEHAVIOR, 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 **J4**

J2 Did they keep coming back into your mind even when you tried to ignore or get rid of them?

NO YES
↓
SKIP TO **J4**

J3 Do you think that these things come from your own mind and that they are not from outside of your head?

NO YES
obsessions

J4 **In the past month,** did you do something over and over without being able to stop doing it, like washing over and over? Straightening things up over and over? Counting something or checking on something over and over? Saying or doing something over and over?

IF **YES** TO ANY, CODE **YES**

NO YES
compulsions

IS **J3** OR **J4** CODED **YES**?

⌊
NO YES

J5 Did you have these thoughts or rituals we just spoke about, more than other kids your age?

⌊
NO YES

J6 Did these thoughts or actions cause you to miss out on things at home? At school? With friends? Did they cause a lot of problems with other people? Did these things take more than one hour a day?
IF **YES** TO ANY, CODE **YES**

NO **YES**

O.C.D. CURRENT

K. POSTTRAUMATIC STRESS DISORDER

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

K1	Has anything really awful ever happened to you? Like being in a flood, tornado or earthquake? Like being in a fire or a really bad accident? Like seeing someone being killed or badly hurt. Have you ever been attacked by someone?	NO	YES
K2	Did you respond with intense fear, or feel helpless or upset?	NO	YES
K3	**In the past month**, has this awful thing come back to you in some way? Like dreaming about it or having a strong memory of it or feeling it in your body?	NO	YES

K4 **In the past month**:

a	Have you tried not to think about or talk about this awful thing?	NO	YES
b	Have you tried to stay away from things that might remind you of it?	NO	YES
c	Have you had trouble remembering some important part of what happened?	NO	YES
d	Have you been much less interested in your hobbies or your friends?	NO	YES
e	Have you felt cut off from other people?	NO	YES
f	Have you noticed that your feelings are less than before?	NO	YES
g	Have you felt that your life will be shortened or that you will die sooner than other people?	NO	YES
	SUMMARY OF K4: ARE **3** OR MORE **K4** ANSWERS CODED **YES**?	NO	YES

K5 **In the past month**:

a	Have you had trouble sleeping?	NO	YES
b	Have you been moody or angry for no reason?	NO	YES
c	Have you had trouble paying attention?	NO	YES
d	Were you nervous or watching out in case something bad might happen?	NO	YES
e	Would you jump when you heard noises? Or when you saw something out of the corner of your eye? IF YES TO EITHER, CODE **YES**	NO	YES
	SUMMARY OF K5: ARE **2** OR MORE **K5** ANSWERS CODED **YES**?	NO	YES

K6 **In the past month,** have these problems upset you a lot? Have they caused you to have problems at school? At home? With your friends?

IF **YES** TO ANY, CODE **YES**

NO	YES
	P T S D **CURRENT**

L. ALCOHOL DEPENDENCE / ABUSE

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

			\	
L1		**In the past year**, have you had 3 or more drinks of alcohol in a day? At those times, did you have 3 or more drinks in 3 hours? Did you do this 3 or more times in the past year? IF **NO** TO ANY, CODE **NO**	NO	YES
L2		**In the past year**:		
	a	Did you need to drink a lot more alcohol to get the same feeling you got when you first started drinking?	NO	YES
	b	Whenever you cut down on drinking or stopped drinking, did your hands shake? Did you sweat? Did you feel nervous or like you couldn't sit still? Did you ever drink to keep from getting those problems? Did you drink again to keep from getting a hangover? IF **YES** TO ANY, CODE **YES**	NO	YES
	c	When you drank alcohol, did you end up drinking more than you had planned to?	NO	YES
	d	Have you tried to cut down or stop drinking alcohol but were not able to?	NO	YES
	e	On days when you drank, did you spend more than three hours doing it? Count the time it took you to get the alcohol, drink it, and get over it.	NO	YES
	f	Did you spend less time on other things because of your drinking (Like school, hobbies, or being with friends)?	NO	YES
	g	Did your drinking cause problems with your health or your mind? Did you keep on drinking even though you knew that it caused these problems?	NO	YES

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

NO **YES***

* IF YES, SKIP L3 QUESTIONS, CIRCLE N/A IN THE ABUSE BOX AND MOVE TO THE NEXT DISORDER. DEPENDENCE PREEMPTS ABUSE.

ALCOHOL DEPENDENCE
CURRENT

In the past year:

L3	a	Were you drunk or hung-over more than once when you had something important to do, like schoolwork or responsibilities at home? Did this cause any problems? CODE **YES** ONLY IF THIS CAUSED PROBLEMS	NO	YES
	b	Were you drunk more than once while doing something risky (Like riding a bike, driving a car or boat, or using machines)?	NO	YES
	c	Did you have legal problems more than once because of your drinking (Like getting arrested or stopped by the police)?	NO	YES

d Did you kept drinking even if your drinking caused problems with your family or with other people?
IF **YES** TO EITHER, CODE **YES**

NO YES

ARE **1** OR MORE OF **L3** ANSWERS CODED **YES**?

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

ALCOHOL ABUSE
CURRENT

M. SUBSTANCE DEPENDENCE / ABUSE (NON-ALCOHOL)

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

			\ NO	YES
M1	a	Now I am going to read you a list of street drugs or medicines. Stop me if, **in the past year,** you have taken any of them more than one time to get high? To feel better or to change your mood?		

CIRCLE EACH DRUG TAKEN:

Stimulants: amphetamines, "speed", crystal meth, "crank", “rush”, Dexadrine, Ritalin, diet pills.

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

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

Hallucinogens: LSD ("acid"), mescaline, peyote, PCP ("angel dust", "Peace Pill"), psilocybin, STP, "mushrooms", “ecstasy”, MDA, MDMA or ketamine, (“Special K”).

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

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

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

Miscellaneous: Steroids, non-prescription sleep or diet pills. Cough medicine? Any others?

Specify MOST USED Drug(s): _____

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

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

IF PATIENT'S SYMPTOMS MEET CRITERIA FOR ABUSE /DEPENDENCE, SKIP TO NEXT MODULE. IF NOT, EXPLORE THE NEXT MOST PROBLEMATIC DRUG.

M2 Think about your use of (NAME OF DRUG/DRUG CLASS SELECTED) **over the past year:**

a	Did you need to take a lot more of the drug to get the same feeling you got when you first started taking it?	NO	YES
b	Whenever you cut down or stopped using the drug(s), did your body feel bad or did you go into withdrawal? ("Withdrawal" might mean feeling sick, achy, shaking, running a temperature, feeling weak, having an upset stomach or diarrhea, sweating, feeling your heart pounding, trouble sleeping, feeling nervous, moody or like you can't sit still.) Did you use the drug(s) again to keep from getting sick or to feel better? IF **YES** TO EITHER, CODE **YES**	NO	YES
c	When you used (NAME THE DRUG/DRUG CLASS SELECTED), did you end up taking more than you had planned to?	NO	YES

d Have you tried to cut down or stop taking (NAME THE DRUG/DRUG CLASS SELECTED)? Did you find out that you couldn't do it? NO YES
IF **NO** TO EITHER, CODE **NO**

e On days when you took (NAME THE DRUG/DRUG CLASS SELECTED), did you spend more than three hours doing it? Count the time it took you to get (NAME THE DRUG/DRUG CLASS SELECTED), use it and get over it. NO YES

f Did you spend less time on other things because of your use of (NAME THE DRUG/DRUG CLASS SELECTED)? Like school, hobbies or being with friends? NO YES

g Did your use of (NAME OF DRUG/DRUG CLASS SELECTED) cause problems with your health or your mind? Did you keep on using (NAME THE DRUG) even though you knew it caused problems? NO YES

ARE **3** OR MORE **M2** ANSWERS CODED YES?

SPECIFY DRUG(S)**:** _____

***** IF YES, SKIP M3 QUESTIONS, CIRCLE N/A IN ABUSE BOX
AND MOVE TO THE NEXT DISORDER. DEPENDENCE PREEMPTS ABUSE.

NO **YES***

SUBSTANCE DEPENDENCE
CURRENT

Think about your use of (NAME THE DRUG/DRUG CLASS SELECTED) over the past year:

In the past year:

M3 a Were you high or hung-over from the drug(s) more than once, when you had something important to do? Like schoolwork or responsibilities at home? Did this happen more than one time? Did this cause any problems? NO YES
CODE **YES** ONLY IF THIS CAUSED PROBLEMS

b Have you been high from the drug(s) more than once while doing something risky (Like riding a bike, driving a car or boat, or using machines)? NO YES

c Did you have legal problems because of your use of the (NAME THE DRUG/DRUG CLASS SELECTED) more than once? (Like getting arrested or stopped by the police)? NO YES

d Did you kept using the (NAME THE DRUG/DRUG CLASS SELECTED) even though it caused problems with your family or with other people? NO YES
IF **YES** TO EITHER, CODE **YES**

ARE **1** OR MORE **M3** ANSWERS CODED **YES?**

SPECIFY DRUG(S)**:** _____

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

SUBSTANCE ABUSE
CURRENT

N. TIC DISORDERS

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

N1	a	In the past month did you have movements of your body called "Tics"? "Tics" are quick movements of some part of your body that are hard to control. A tic might be blinking your eyes over and over, twitches of your face, jerking your head, making a movement with your hand over and over, or squatting, or shrugging your shoulders over and over.	NO	YES
	b	Have you ever had a tic that made you say something or make a sound over and over and was hard to stop? Like coughing or sniffling or clearing your throat over and over when you did not have a cold; or grunting or snorting or barking; having to say certain words over and over, having to say bad words, or having to repeat sounds you hear or words that other people say? IF BOTH **N1A** AND **N1B** ARE CODED **NO**, CIRCLE **NO** IN ALL DIAGNOSTIC BOXES AND SKIP TO **O1**	NO	YES
N2	a	Did these "tics" happen many times a day?	NO	YES
	b	Did they happen nearly every day for at least 4 weeks?	NO	YES
	c	Did they happen for a year or more?	NO	YES
	d	Did they ever go away completely for 3 months in a row during this time?	NO	YES
N3		Did these "tics" upset you a lot? Did they get in the way of school? Did they cause you problems at home? Did they cause you problems with friends? Did other kids pick on you because of your tics? IF **YES** TO ANY, CODE **YES**	NO	YES
N4		Did the tics only occur when you are taking Ritalin, Adderal, Cylert, Dexedrine, Provigil, Concerta or other medications for ADHD ?	NO	YES

N5 a ARE **N1a**+ **N1b** + **N2a** + **N2c** AND **N3** CODED **YES**?

NO **YES**

TOURETTE'S DISORDER, CURRENT

N5 b ARE **N1a** + **N2a** + **N2c** + **N3** CODED **YES** AND IS **N1b** CODED **NO?**

NO **YES**

MOTOR TIC DISORDER, CURRENT

N5 c ARE **N1b** + **N2a** + **N2c** + **N3** CODED YES and is **N1a** coded **NO**?

NO **YES**

VOCAL TIC DISORDER, CURRENT

N5 d ARE **N1 (a or b)** AND **N2a** AND **N2b** AND **N3** CODED **YES,** AND **N2c** CODED **NO**?

NO **YES**

TRANSIENT TIC DISORDER, CURRENT

O. ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

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

SCREENING QUESTION FOR 3 DISORDERS (ADHD, CD, ODD)

O1		Has anyone (teacher, baby sitter, friend or parent) ever complained about your behavior or performance in school? IF NO TO THIS QUESTION, ALSO CODE NO TO CONDUCT DISORDER AND OPPOSITIONAL DEFIANT DISORDER	\ NO	YES

In the past six months:

O2	a	Have you often not paid enough attention to details? Made careless mistakes in school?	NO	YES
	b	Have you often had trouble keeping your attention focused when playing or doing schoolwork?	NO	YES
	c	Have you often been told that you do not listen when others talk directly to you?	NO	YES
	d	Have you often had trouble following through with what you were told to do (Like not following through on schoolwork or chores)? Did this happen even though you understood what you were supposed to do? Did this happen even though you weren't trying to be difficult? IF **NO** TO ANY, CODE **NO**	NO	YES
	e	Have you often had a hard time getting organized?	NO	YES
	f	Have you often tried to avoid things that make you concentrate or think hard (like schoolwork)? Do you hate or dislike things that make you concentrate or think hard? IF **YES** TO EITHER, CODE **YES**	NO	YES
	g	Have you often lost or forgotten things you needed? Like homework assignments, pencils, or toys?	NO	YES
	h	Do you often get distracted easily by little things (Like sounds or things outside the room)?	NO	YES
	i	Do you often forget to do things you need to do every day (Like forget to comb your hair or brush your teeth)?	NO	YES
		O2 SUMMARY: ARE **6** OR MORE **O2** ANSWERS CODED **YES?**	NO	YES

In the past six months:

O3	a	Did you often fidget with your hands or feet? Or did you squirm in your seat? IF **YES** TO EITHER, CODE **YES**	NO	YES

b	Did you often get out of your seat in class when you were not supposed to?	NO	YES
c	Have you often run around or climbed on things when you weren't supposed to? Did you want to run around or climb on things even though you didn't? IF **YES** TO EITHER, CODE **YES**	NO	YES
d	Have you often had a hard time playing quietly?	NO	YES
e	Were you always "on the go"?	NO	YES
f	Have you often talked too much?	NO	YES
g	Have you often blurted out answers before the person or teacher has finished the question?	NO	YES
h	Have you often had trouble waiting your turn?	NO	YES
i	Have you often interrupted other people? Like butting in when other people are talking or busy or when they are on the phone?	NO	YES
	O3 SUMMARY: ARE **6** OR MORE **O3** ANSWERS CODED **YES?**	NO	YES
O4	Did you have problems paying attention, being hyper, or impulsive before you were 7 years old?	NO	YES
O5	Did these things cause problems at school? At home? With your family? With your friends? CODE **YES** IF T**WO** OR MORE ARE ENDORSED YES.	NO	YES

IS **O2** SUMMARY & **O3** SUMMARY CODED **YES**?

NO **YES**
Attention-Deficit/ Hyperactivity Disorder
COMBINED

IS **O2** SUMMARY CODED YES AND **O3** SUMMARY CODED **NO**?

NO **YES**
Attention-Deficit/ Hyperactivity Disorder
INATTENTIVE

IS **O2** SUMMARY CODED **NO** AND **O3** SUMMARY CODED **YES?**

NO	YES
Attention-Deficit/ Hyperactivity Disorder **HYPERACTIVE /IMPULSIVE**	

P. CONDUCT DISORDER

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

SCREENING QUESTION

P1 IF QUESTION O1 IN ADHD IS ANSWERED NO, CODE NO TO CONDUCT DISORDER

IF O1 WAS NOT ASKED ALREADY, ASK THE QUESTION BELOW

\

(Has anyone (teacher, baby sitter, friend, parent) ever complained about your behavior or performance in school?) NO YES

P2 **In the past year**:

a	Have you bullied or threatened other people (excluding siblings)?	NO	YES
b	Have you started fights with others (excluding siblings)?	NO	YES
c	Have you used a weapon to hurt someone? Like a knife, gun, bat, or other object?	NO	YES
d	Have you hurt someone (physically) on purpose (excluding siblings)?	NO	YES
e	Have you hurt animals on purpose?	NO	YES
f	Have you stolen things using force? Like robbing someone using a weapon or grabbing something from someone like purse snatching?	NO	YES
g	Have you forced anyone to have sex with you?	NO	YES
h	Have you started fires on purpose in order to cause damage?	NO	YES
i	Have you destroyed things that belonged to other people on purpose?	NO	YES
j	Have you broken into someone's house or car?	NO	YES
k	Have you lied many times in order to get things from people or to get out of things? Tricked other people into doing what you wanted? IF **YES** TO EITHER, CODE **YES**	NO	YES
l	Have you stolen things that were worth money (Like shoplifting or forging a check)?	NO	YES
m	Have you often stayed out a lot later than your parents let you? Did this start before you were 13 years old? IF **NO** TO EITHER, CODE **NO**	NO	YES

n	Have you run away from home two times or more?	NO	YES
o	Have you skipped school often? Did this start before you were 13 years old? IF **NO** TO EITHER, CODE **NO**	NO	YES
	P2 SUMMARY: ARE 3 OR MORE **P2** ANSWERS CODED **YES** WITH AT LEAST ONE PRESENT IN THE PAST 6 MONTHS?	NO	YES

P3 Did these behaviors cause big problems at school? At home? With your family? Or with your friends?

IF YES TO ANY, CODE YES

NO	**YES**
CONDUCT DISORDER CURRENT	

Q. OPPOSITIONAL DEFIANT DISORDER

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

ATTENTION: IF CODED POSITIVE FOR CONDUCT DISORDER, CIRCLE NO IN DIAGNOSITIC BOX AND MOVE TO THE NEXT MODULE.

SCREENING QUESTION

Q1 IF QUESTION O1 IN ADHD IS ANSWERED NO, CODE NO TO OPPOSITIONAL DEFIANT DISORDER

IF O1 WAS NOT ASKED ALREADY, ASK THE QUESTION BELOW

\

(Has anyone (teacher, baby sitter, friend, parent) ever complained about your behavior or performance in school?) NO YES

Q2 **In the past six months**:

a	Have you often lost your temper?	NO	YES
b	Have you often argued with adults?	NO	YES
c	Have you often refused to do what adults tell you to do? Refused to follow rules? IF **YES** TO EITHER, CODE **YES**	NO	YES
d	Have you often annoyed people on purpose?	NO	YES
e	Have you often blamed other people for your mistakes or for your bad behavior?	NO	YES
f	Have you often been "touchy" or easily annoyed by other people?	NO	YES
g	Have you often been angry and resentful toward others?	NO	YES
h	Have you often been "spiteful" or quick to "pay back" somebody who treats you wrong?	NO	YES
	Q2 SUMMARY: ARE **4** OR MORE OF **Q2** ANSWERS CODED **YES**?	NO	YES

\

Q3 Did these behaviors cause problems at school? At home? With your family? Or with your friends? NO YES
IF **YES** TO ANY, CODE **YES**

ARE **Q2** SUMMARY & **Q3** CODED **YES**?

NO **YES**

OPPOSITIONAL DEFIANT DISORDER
CURRENT

R. PSYCHOTIC DISORDERS AND MOOD DISORDERS 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.

					BIZARRE
		Now I am going to ask you about unusual experiences that some people have.			
R1	a	Have you ever believed that people were secretly watching you? Have you believed that someone was trying to get you, or hurt you? IF **YES** TO ANY, CODE **YES** **NOTE**: ASK FOR EXAMPLES TO RULE OUT ACTUAL STALKING	NO	YES	YES
	b	**IF YES OR YES BIZARRE**: Do you believe this now?	NO	YES	YES → **R6**
R2	a	Have you ever believed that someone was reading your mind or that someone could hear your thoughts? Or that you could actually read someone else's mind or hear what they were thinking? IF **YES** TO ANY, CODE **YES**	NO	YES	YES
	b	**IF YES OR YES BIZARRE**: Do you believe this now?	NO	YES	YES → **R6**
R3	a	Have you ever believed that someone or something put thoughts in your mind that were not your own? Have you believed that someone or something made you act in a way that was not your usual self? Have you ever felt that you were possessed? IF **YES** TO ANY, CODE **YES** **NOTE**: ASK FOR EXAMPLES AND DISCOUNT ANY THAT ARE NOT PSYCHOTIC	NO	YES	YES
	b	**IF YES OR YES BIZARRE**: Do you believe this now?	NO	YES	YES → **R6**
R4	a	Have you ever believed that you were being sent special messages through the TV, radio, internet, newspapers, books, magazines, or through your games or toys? Have you ever believed that a person you did not personally know was especially interested in you? IF **YES** TO ANY, CODE **YES**	NO	YES	YES
	b	**IF YES OR YES BIZARRE**: Do you believe this now?	NO	YES	YES → **R6**
R5	a	Have your family or friends ever thought that any of your beliefs were strange or weird? Please give me an example. INTERVIEWER:. ONLY CODE **YES** IF THE EXAMPLES ARE **CLEARLY** DELUSIONAL AND ARE NOT EXPLORED IN QUESTIONS R1 TO R4, FOR EXAMPLE, SOMATIC OR RELIGIOUS DELUSIONS OR DELUSIONS OF GRANDIOSITY, JEALOUSY GUILT, RUIN OR DESTITIUTION, ETC.	NO	YES	YES
	b	**IF YES OR YES BIZARRE**: Do they still think that your beliefs are strange?	NO	YES	YES

R6 a Have you ever heard things other people couldn't hear, such as voices? NO YES
[HALLUCINATIONS ARE SCORED "BIZARRE" ONLY IF PATIENT ANSWERS YES TO THE FOLLOWING]:

YES

IF YES: Did you hear a voice talking about you? Did you hear more than one voice talking back and forth? NO YES
↳ **R8b**

b **IF YES OR YES BIZARRE TO R6**: Have you heard these things in the past month? NO YES
HALLUCINATIONS ARE SCORED "BIZARRE" ONLY IF PATIENT ANSWERS **YES** TO THE FOLLOWING:

R7 a Have you ever had visions or have you ever seen things other people couldn't see? NO YES
NOTE: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

R8 b IS THE PATIENT CURRENTLY EXHIBITING INCOHERENCE, DISORGANIZED SPEECH, OR MARKED LOOSENING OF ASSOCIATIONS? NO YES

R9 b IS THE PATIENT CURRENTLY EXHIBITING DISORGANIZED OR CATATONIC BEHAVIOR? NO YES

R10 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

R11 a ARE 1 OR MORE « a » QUESTIONS FROM R1a TO R7a CODED **YES OR YES BIZARRE** AND IS EITHER:

MAJOR DEPRESSIVE EPISODE, (CURRENT OR RECURRENT)
OR
MANIC OR HYPOMANIC EPISODE, (CURRENT OR PAST) CODED **YES**? NO YES
↳ **R13**

IF NO TO R11 a, CIRCLE NO IN BOTH 'MOOD DISORDER WITH PSYCHOTIC FEATURES' DIAGNOSTIC BOXES AND MOVE TO R13.

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

Did you have the beliefs and experiences you just described [GIVE EXAMPLES TO PATIENT FROM SYMPTOMS CODED YES FROM R1a TO R7a] only when you were feeling depressed? high? very moody? very 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 R12 AND MOVE TO R13

NO YES

MOOD DISORDER WITH PSYCHOTIC FEATURES

LIFETIME

R12a ARE 1 OR MORE « b » QUESTIONS FROM R1b TO R7b 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 (CURRENT), CIRCLE NO TO R13 AND MOVE TO R14.

NO YES

MOOD DISORDER WITH PSYCHOTIC FEATURES

CURRENT

R13 ARE 1 OR MORE « b » QUESTIONS FROM R1b TO R6b, CODED **YES BIZARRE**?

OR

ARE 2 OR MORE « b » QUESTIONS FROM R1b TO R10b, 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

R14 IS **R13** CODED **YES**

OR

ARE 1 OR MORE « a » QUESTIONS FROM R1a TO R6a, CODED **YES BIZARRE**?

OR

ARE 2 OR MORE « a » QUESTIONS FROM R1a TO R7a, 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

S. ANOREXIA NERVOSA

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

S1	a	How tall are you?	☐ ft ☐☐ in. ☐☐☐ cm	
	b.	What was your lowest weight in the past 3 months?	☐☐☐ lb ☐☐☐ kg	
	c	IS PATIENT'S WEIGHT EQUAL TO OR BELOW THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT? (SEE TABLE BELOW) (THIS IS = A BMI OF ≤ 17.5 KG/M^2)	NO	YES
	d	Have you lost 5 lb or more (2.3 kg or more) in the last 3 months?	NO	YES
	e	If you are less than age 14, have you failed to gain any weight in the last 3 months? IF PATIENT IS 14 OR OLDER, CODE NO.	NO	YES
	f	Has anyone thought that you lost too much weight in the last 3 months?	NO	YES
		IF YES TO S1c OR d OR e OR f, CODE YES, OTHERWISE CODE NO.	\ NO	YES

In the past 3 months:

S2		Have you been trying to keep yourself from gaining any weight?	\ NO	YES
S3		Have you been very afraid of gaining weight? Have you been very afraid of getting too fat / big? IF **YES** TO EITHER, CODE **YES**	\ NO	YES
S4	a	Have you seen yourself as being too big / fat or that part of your body was too big / fat? IF **YES** TO EITHER, CODE **YES**	NO	YES
	b	Has your weight strongly affected how you feel about yourself? Has your body shape strongly affected how you feel about yourself? IF **YES** TO EITHER, CODE **YES**	NO	YES
	c	Did you think that your low weight was normal or overweight ?	NO	YES
S5		ARE **1** OR **MORE S4** ANSWERS CODED **YES**?	\ NO	YES
S6		FOR POST PUBERTAL **FEMALES** 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 GIRLS : ARE **S5** AND **S6** CODED YES?

FOR BOYS : IS **S5** 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	3'0	3'1	3'2	3'3	3'4	3'5	3'6	3'7	3'8	3'9	3'10	3'11	4'0	4'1
lb	32	34	36	38	40	42	44	46	48	50	53	55	57	60
cm	91	94	97	99	102	104	107	109	112	114	117	119	122	125
kg	15	15	16	17	18	19	20	21	22	23	24	25	26	27
ft/in	4'2	4'3	4'4	4'5	4'6	4'7	4'8	4'9	4'10	4'11	5'0	5'1	5'2	5'3
lb	62	65	67	70	72	75	78	81	84	87	89	92	96	99
cm	127	130	132	135	137	140	142	145	147	150	152	155	158	160
kg	28	29	31	32	33	34	35	37	38	39	41	42	43	45
ft/in	5'4	5'5	5'6	5'7	5'8	5'9	5'10	5'11	6'0	6'1	6'2	6'3		
lb	102	105	108	112	115	118	122	125	129	132	136	140		
cm	163	165	168	170	173	175	178	180	183	185	188	191		
kg	46	48	49	51	52	54	55	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.

T. BULIMIA NERVOSA

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

	In the past 3 months:	
T1	Did you have eating binges? An "eating binge" is when you eat a very large amount of food within two hours.	⟨ NO YES
T2	Did you have eating binges two times a week or more?	⟨ NO YES
T3	During an eating binge, did you feel that you couldn't control yourself?	⟨ NO YES
T4	Did you do anything to keep from gaining weight? Like making yourself throw up or exercising very hard? Trying not to eat for the next day or more? Taking pills to make you have to go to the bathroom more? Or taking any other kinds of pills to try to keep from gaining weight? IF **YES** TO ANY, CODE **YES**	⟨ NO YES
T5	Does your weight strongly affect how you feel about yourself? Does your body shape strongly affect how you feel about yourself? IF **YES** TO EITHER, CODE **YES**	⟨ NO YES
T6	DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?	NO YES ⟨ SKIP to T8
T7	Do these binges occur only when you are under (_____lb/kg)? INTERVIEWER: WRITE IN THE ABOVE ( ), THE THRESHOLD WEIGHT FOR THIS PATIENT'S HEIGHT FROM THE HEIGHT/WEIGHT TABLE IN THE ANOREXIA NERVOSA MODULE	NO YES
T8	IS **T5** CODED **YES** AND IS EITHER **T6** OR **T7** CODED **NO**?	**NO YES** ***BULIMIA NERVOSA*** **CURRENT**
T9	IS **T7** CODED **YES**?	**NO YES** ***ANOREXIA NERVOSA*** *Binge Eating Type* **CURRENT**

U. GENERALIZED ANXIETY DISORDER

(\ MEANS : GO TO END OF DISORDER, CIRCLE NO AND MOVE TO NEXT DISORDER)

U1	a	**For the past six months**, have you worried a lot or been nervous? Have you been worried or nervous about several things, (like school, your health, or something bad happening)? Have you been more worried than other kids your age? IF **YES** TO ANY, CODE **YES**	\ NO	YES
	b	Do you worry most days?	\ NO	YES
		IS THE PATIENT'S ANXIETY RESTRICTED EXCLUSIVELY TO, OR BETTER EXPLAINED BY, ANY DISORDER PRIOR TO THIS POINT?	NO	\ YES
U2		Do you find it hard to stop worrying? Do the worries make it hard for you to pay attention to what you are doing? IF **YES** TO EITHER, CODE **YES**	\ NO	YES
U3		FOR THE FOLLOWING, CODE **NO** IF THE SYMPTOMS ARE CONFINED TO FEATURES OF ANY DISORDER EXPLORED PRIOR TO THIS POINT.		
		When you are worried, do you, most of the time:		
	a	Feel like you can't sit still?	NO	YES
	b	Feel tense in your muscles?	NO	YES
	c	Feel tired, weak or exhausted easily?	NO	YES
	d	Have a hard time paying attention to what you are doing? Does your mind go blank?	NO	YES
	e	Feel grouchy or annoyed?	NO	YES
	f	Have trouble sleeping ("trouble sleeping" means trouble falling asleep, waking up in the middle of the night, wakening up too early or sleeping too much)?	NO	YES
		ARE **1** OR MORE **U3** ANSWERS CODED **YES**?	\ NO	YES
U4		Do these worries or anxieties cause a lot of problems at school or with your friends or at home or at work or with other people?	**NO**	**YES**

GENERALIZED ANXIETY DISORDER

CURRENT

V. ADJUSTMENT DISORDERS

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

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

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

V1 Are you stressed out about something? Is this making you upset or making your behavior worse? ⌊ NO YES
IF **NO** TO EITHER, CODE **NO**

[Examples include anxiety/depression/physical complaints; misbehavior such as fighting, driving recklessly, skipping school, vandalism, violating the rights of others, or illegal activity].

IDENTIFIED STRESSOR: _____

DATE OF ONSET OF STRESSOR: _____

V2 Did your upset/behavior problems start soon after the stress began? [Within 3 months of the onset of the stressor] ⌊ NO YES

V3 a Are you more upset by this stress than other kids your age would be? ⌊ NO YES

b Do these stresses or upsets cause you problems in school? Problems at home? Problems with your family or with your friends? ⌊ NO YES
IF **YES** TO ANY, CODE **YES**

V4 BEREAVEMENT IS PRESENT IF THESE EMOTIONAL/BEHAVIORAL SYMPTOMS ARE DUE ENTIRELY TO THE LOSS OF A LOVED ONE AND ARE SIMILAR IN SEVERITY, LEVEL OF IMPAIRMENT AND DURATION TO WHAT MOST OTHERS WOULD SUFFER UNDER SIMILAR CIRCUMSTANCES

HAS BEREAVEMENT BEEN RULED OUT? ⌊ NO YES

V5 Have these problems gone on for 6 months or more after the stress stopped? ⌊ NO YES

WHICH OF THESE EMOTIONAL / BEHAVIORAL SUBTYPES ARE PRESENT? **Mark all that apply**

A Depression, tearfulness or hopelessness. ☐

B Anxiety, nervousness, jitteriness, worry. ☐

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

D School problems, physical complaints or social withdrawal. ☐

IF MARKED:

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

IF **V1** AND **V2** AND **(V3a or V3b)** ARE CODED **YES,** AND **V5 I**S CODED **NO,** THEN CODE THE DISORDER **YES** WITH **SUBTYPES.**

IF **NO,** CODE **NO** TO ADJUSTMENT DISORDER**.**

NO	**N/A**	**YES**
Adjustment Disorder with_____		
(see above for subtypes)		

W. 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:

W1a Were you taking any drugs or medicines? ☐ No ☐ Yes ☐ Uncertain

W1b 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.

W2 **SUMMARY**: HAS AN ORGANIC CAUSE BEEN RULED OUT? ☐ No ☐ Yes ☐ Uncertain

X. PERVASIVE DEVELOPMENT DISORDER

X1	Since the age of 4, have you had difficulty making friends? Do you have problems because you keep to yourself? Is it because you are shy or because you don't fit in? IF **YES** TO ANY, CODE **YES**	NO	YES	UNSURE
X2	Are you fixated on routines and rituals or do you have interests that are special and interfere with other activities?	NO	YES	UNSURE
X3	Do other kids think you are weird or strange or awkward?	NO	YES	UNSURE
X4	Do you play mostly alone, rather than with other children?	NO	YES	UNSURE

X5 ARE ALL **X ANSWERS** CODED **YES**? IF SO, CODE YES.

IF ANY X ANSWERS ARE CODED UNSURE, CODE UNSURE.

OTHERWISE CODE NO.

NO **UNSURE** **YES** *

PERVASIVE DEVELOPMENT DISORDER

CURRENT

* Pervasive Developmental Disorder is possible, but needs to be more thoroughly investigated by a board certified child psychiatrist. Based on the above responses, the diagnosis of PDD cannot be ruled out. The above screening is to rule out the diagnosis, rather than to rule it in.

THIS CONCLUDES THE INTERVIEW

MOOD DISORDERS: DIAGNOSTIC ALGORITHM

Consult Modules:
- A Major Depressive Episode
- D (Hypo)manic Episode
- R Psychotic Disorders

MODULE R:

1a	IS **R11b** CODED YES?	NO	YES
1b	IS **R12a** CODED YES?	NO	YES

MODULES A and D:		Current	Past
2	a CIRCLE YES IF A DELUSIONAL IDEA IS IDENTIFIED IN **A3e**	YES	YES
	b CIRCLE YES IF A DELUSIONAL IDEA IS IDENTIFIED IN **D3a**	YES	YES

c Is a Major Depressive Episode coded YES (current or past)?
and
is Manic Episode coded NO (current and past)?
and
is Hypomanic Episode coded NO (current and past)?
and
is **"**Hypomanic Symptoms" coded NO (current and past)?

Specify:

- If the depressive episode is **current** or **past** or both
- **With Psychotic Features** Current: If 1b or 2a (current) = YES
  With Psychotic Features Past: If 1a or 2a (past) = YES

MAJOR DEPRESSIVE DISORDER

	current	past
MDD	☐	☐

With Psychotic Features

Current	☐
Past	☐

2. SDQ: Strengths and Difficulties Questionnaire

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months or this school year.

Child's Name ..... Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Signature ..... Date .....

Parent/Teacher/Other (please specify:)

Thank you very much for your help

3. CGAS – Children's Global Assessment Scale

Children's Global Assessment Scale (CGAS) David Shaffer, M.D., Madelyn S. Gould, Ph.D. Hector Bird, M.D., Prudence Fisher, B.A. Adaptation of the Adult Global Assessment Scale (Robert L. Spitzer, M.D., Nathan Gibbon, M.S.W., Jean Endicott, Ph.D.) **PLEASE RECORD A CGAS SCORE EVEN IF THIS IS BASED ON YOUR MEMORY OF THE YOUNG PERSON'S FUNCTIONING AT THE TIME OF REFERRAL. THE DATE OF RATING IS REQUIRED ONLY IF THIS WAS RECORDED CLOSE TO THE TIME OF THE 'INDEX' REFERRAL.**	
43a	**DATE OF CGAS RATING:** ……../……../…….. **OR** **FROM MEMORY** **(PLEASE INDICATE AS APPROPRIATE)** **(IF RECORDED CLOSE TO TIME OF 'INDEX' REFERRAL)**
100-91	**DOING VERY WELL** Superior functioning in all areas (at home, at school and with peers), involved in a range of activities and has many interests (e.g. has hobbies or participates in extracurricular activities or belongs to an organised group such as Scouts, etc.). Likeable, confident, everyday worries never get out of hand. Doing well in school. No symptoms.
90 – 81	**DOING WELL** Good functioning in all areas. Secure in family, school, and with peers. There may be transient difficulties and "everyday" worries that occasionally get out of hand (e.g. mild anxiety associated with an important exam, occasionally "blow-ups" with siblings, parents or peers).
80 – 71	**DOING ALL RIGHT –minor impairment** No more than slight impairment in functioning at home, at school or with peers. Some disturbance of behaviour or emotional distress may be present in response to life stresses (e.g. parental separations, deaths, birth of a sibling) but these are brief and interference with functioning is transient; such children are only minimally disturbing to others and are not considered deviant by those who know them.
70 – 61	**SOME PROBLEMS - in one area only** Some difficulty in a single area, but generally functioning pretty well, (e.g. sporadic or isolated antisocial acts such as occasionally playing hooky, petty theft; consistent minor difficulties with school work, mood changes of brief duration, fears and anxieties which do not lead to gross avoidance behaviour; self-doubts). Has some meaningful interpersonal relationships. Most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.
60 – 51	**SOME NOTICEABLE PROBLEMS – in more than one area** Variable functioning with sporadic difficulties or symptoms in several but not all social areas. Disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.
50 – 41	**OBVIOUS PROBLEMS – moderate impairment in most areas or severe in one area** Moderate degree of interference in functioning in most social areas or severe impairment functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, frequent episodes of aggressive or other antisocial behaviour with some preservation of meaningful social relationships.
40 – 31	**SERIOUS PROBLEMS – major impairment in several areas and unable to function in one area** Major impairment in functioning in several areas and unable to function in one of these areas, i.e. disturbed at home, at school, with peers or in the society at large, e.g. persistent aggression without clear instigation; markedly withdrawn and isolated behaviour due to either mood or through disturbance, suicidal attempts with clear lethal intent. Such children are likely to require special schooling and/or hospitalisation or withdrawal from school (but this is not a sufficient criterion for inclusion in this category).
30 – 21	**SEVERE PROBLEMS - unable to function in almost all situations** Unable to function in almost all areas, e.g. stays at home, in ward or in bed all day without taking part in social activities OR severe impairment in reality testing OR serious impairment in communication (e.g. sometimes incoherent or inappropriate).
20 – 11	**VERY SEVERELY IMPAIRED -considerable supervision is required for safety** Needs considerable supervision to prevent hurting others or self, e.g. frequently violent, repeated suicide attempts OR to maintain personal hygiene! OR gross impairment in all forms of communication, e.g. severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.
10 – 1	**EXTREMELY IMPAIRED - constant supervision is required for safety** Needs constant supervision (24-hour care) due to severely aggressive or self-destructive behaviour or gross impairment in reality testing, communication, cognition, affect or personal hygiene.
	Specified time period: 1 month
43b	**CGAS SCORE =**

4. CGI-S – Clinical Global Impression-Severity Scale

CGI-S guidelines

1 = Normal—not at all ill, symptoms of disorder not present past seven days

2 = Borderline mentally ill—subtle or suspected pathology

3 = Mildly ill—clearly established symptoms with minimal, if any, distress or difficulty in social and occupational function

4 = Moderately ill—overt symptoms causing noticeable, but modest, functional impairment or distress; symptom level may warrant medication

5 = Markedly ill—intrusive symptoms that distinctly impair social/occupational function or cause intrusive levels of distress

6 = Severely ill—disruptive pathology, behavior and function are frequently influenced by symptoms, may require assistance from others

7 = Among the most extremely ill patients—pathology drastically interferes in many life functions; may be hospitalized

Adapted from Kay SR. Positive and negative symptoms in schizophrenia: Assessment and research. Clin Exp Psychiatry Monograph No 5. Brunner/Mazel, 1991.

5. CGI-I – Clinical Global Impression-Improvement Scale

CGI-I guidelines

1 = Very much improved—nearly all better; good level of functioning; minimal symptoms; represents a very substantial change

2 = Much improved—notably better with significant reduction of symptoms; increase in the level of functioning but some symptoms remain

3 = Minimally improved—slightly better with little or no clinically meaningful reduction of symptoms. Represents very little change in basic clinical status, level of care, or functional capacity

4 = No change—symptoms remain essentially unchanged

5 = Minimally worse—slightly worse but may not be clinically meaningful; may represent very little change in basic clinical status or functional capacity

6 = Much worse—clinically significant increase in symptoms and diminished functioning

7 = Very much worse—severe exacerbation of symptoms and loss of functioning

Adapted from Spearing MK, Post RM, Leverich GS, et al. Modification of the Clinical Global Impressions (CGI) Scale for use in bipolar illness (BP): the CGI-BP.Psychiatry Res 1997;73(3):159–71.

S. No	Age	Religion	Gender	Type of family	SES	Education	Mixed?	Type of Dissociation	DoI	DoE	Parenting Style	Temperament Style	Type of stressor	Faith Healers/Spiritual Treatment	Consulted Elsewhere	Comorbid illess. If yes, describe	Psychiatric Illness in family?	Neurological Illness	Medical Illness	Co-Morbid Psychiatric Conditions
1	13	Hindu	Female	Nuclear	Lower Middle	9		Dissociative Convulsions	>1 year	0-1 min	Authoritative	Difficult	Family	No	No	Seizure disorder	No	No	No	No
2	15	Hindu	Female	Nuclear	Lower Middle	8	Mixed (Stupor+Convulsions)	Mixed	1 year	1-10 min	Authoritarian/Disciplinarian	Difficult	Family	No	Yes	Seizure disorder	No	No	No	No
3	17	Muslim	Male	Nuclear	Lower Middle	11		Dissociative Motor Disorder	1 month - 6 months	1-10 min	Authoritarian/Disciplinarian	Slow to warm up	Family	No	No	No	No	No	No	OCD, Panic disorder
4	16	Hindu	Female	Nuclear	Lower Middle	10	Mixed (Motor+Stupor+Convulsions)	Mixed	1 week - 2 weeks	10 min - 1 hour	Authoritarian/Disciplinarian	Difficult	Studies	No	No	No	No	ID in grandfather/cousin	No	adjustment, brief depressive reaction, mild mr with sld mod. dyslexia
5	9	Hindu	Female	Nuclear	Lower Middle	4		Dissociative Convulsions	0-7 days	1-10 min	Authoritarian/Disciplinarian	Easy	School	No	No	No	No	No	No	No
6	17	Hindu	Female	Nuclear	Upper Middle	12		Dissociative Stupor	0-7 days	0-1 min	Authoritarian/Disciplinarian	Difficult	School	No	Yes	No	No	No	DM father/HTN mother	No
7	13	Muslim	Female	Nuclear	Lower Middle	8		Dissociative Stupor	1 week - 2 weeks	1-10 min	Authoritarian/Disciplinarian	Easy	Studies	No	No	No	No	No	No	SLD
8	15	Hindu	Female	Joint	Lower Middle	9	with salivation	Mixed	6 months - 1 year	1-10 min	Authoritarian/Disciplinarian	Slow to warm up	Family	No	No	No	No	No	No	No
9	12	Hindu	Male	Nuclear	Lower Middle	6		Trance and Possesion	1 month - 6 months	1-10 min	Permissive/Indulgent	Difficult	School	Yes	No	No	No	No	No	SLD
10	12	Hindu	Male	Nuclear	Upper Middle	6		Dissociative Convulsions	1 year	0-1 min	Authoritarian/Disciplinarian	Easy	Family	Yes	No	No	No	No	No	No
11	13	Hindu	Male	Nuclear	Lower Middle	7		Dissociative Stupor	>1 year	1-10 min	Authoritarian/Disciplinarian	Easy	Studies	No	No	No	No	No	No	SLD
12	15	Muslim	Female	Joint	Upper Middle	9		Dissociative Motor Disorder	1 week - 2 weeks	1-10 min	Authoritarian/Disciplinarian	Difficult	Family	No	No	No	depression in mother	No	pcos mother, htn father	Mod. Depressive episode, EUPD traits
13	16	Hindu	Female	Nuclear	Upper Middle	10		Dissociative Convulsions	1 month - 6 months	10 min - 1 hour	Authoritarian/Disciplinarian	Slow to warm up	Family	No	No	?Seizure disorder	No	?seizure d/o	No	?borderline id
14	10	Muslim	Female	Nuclear	Upper Middle	5		Dissociative Convulsions	1 month - 6 months	10 min - 1 hour	Authoritarian/Disciplinarian	Difficult	Family	No	No	No	No	No	No	SLD
15	12	Muslim	Male	Nuclear	Lower Middle	7		Dissociative Stupor	2 weeks - 1 month	10 min - 1 hour	Authoritative	Difficult	Studies	No	No	No	No	No	No	SLD
16	14	Hindu	Female	Nuclear	Lower Middle	8		Dissociative Stupor	1 month - 6 months	>1 hour	Authoritarian/Disciplinarian	Easy	School	No	No	No	No	No	No	No
17	17	Hindu	Female	Nuclear	Lower Middle	10		Dissociative Stupor	0-7 days	1-10 min	Authoritarian/Disciplinarian	Difficult	School	No	No	No	No	No	No	No
18	9	Hindu	Female	Nuclear	Upper Middle	5		Dissociative Convulsions	6 months - 1 year	0-1 min	Authoritarian/Disciplinarian	Easy	Studies	No	No	Seizure disorder	No	No	No	No
19	17	Hindu	Female	Nuclear	Lower Middle	13		Dissociative Stupor	0-7 days	10 min - 1 hour	Authoritarian/Disciplinarian	Slow to warm up	Studies	No	No	No	No	No	No	No
20	15	Hindu	Female	Nuclear	Upper Middle	10	breathlessness	Other	0-7 days	10 min - 1 hour	Authoritarian/Disciplinarian	Difficult	Family	No	No	No	No	No	?pcos	No
21	17	Hindu	Female	Nuclear	Lower Middle	11		Dissociative Stupor	1 week - 2 weeks	10 min - 1 hour	Authoritarian/Disciplinarian	Slow to warm up	School	No	No	No	No	No	No	No
22	15	Hindu	Female	Nuclear	Upper Middle	9		Dissociative Stupor	6 months - 1 year	0-1 min	Authoritative	Slow to warm up	Family	No	No	No	No	No	No	No
23	14	Hindu	Male	Nuclear	Lower Middle	7		Dissociative Stupor	6 months - 1 year	1-10 min	Authoritarian/Disciplinarian	Easy	Studies	Yes	No	No	No	No	No	No
24	14	Hindu	Male	Nuclear	Upper Middle	8		Dissociative Motor Disorder	1 month - 6 months	Continuous	Authoritarian/Disciplinarian	Easy	Family	No	No	No	No	No	HTN and T2DM in father, Hypothyroidism in mother	No
25	15	Hindu	Female	Nuclear	Upper Middle	10		Dissociative Stupor	0-7 days	10 min - 1 hour	Authoritarian/Disciplinarian	Easy	Studies	No	No	No	No	No	No	No
26	12	Hindu	Female	Nuclear	Lower Middle	5		Dissociative Stupor	1 month - 6 months	1-10 min	Authoritarian/Disciplinarian	Slow to warm up	School	No	No	No	No	No	No	No
27	16	Hindu	Female	Nuclear	Lower Middle	10		Dissociative Stupor	1 week - 2 weeks	10 min - 1 hour	Authoritarian/Disciplinarian	Easy	Studies	No	No	No	No	No	No	No
28	14	Hindu	Male	Nuclear	Lower Middle	8		Trance and Possesion	0-7 days	10 min - 1 hour	Authoritarian/Disciplinarian	Easy	Family	No	No	No	No	No	No	No
29	15	Hindu	Female	Nuclear	Lower Middle	9		Dissociative Motor Disorder	1 month - 6 months	Continuous	Authoritative	Easy	Family	No	No	No	No	No	No	No
30	17	Hindu	Female	Nuclear	Upper Middle	11	cough	Other	1 month - 6 months	Continuous	Authoritarian/Disciplinarian	Slow to warm up	Studies	No	No	No	No	No	No	No
31	15	Hindu	Female	Nuclear	Upper Middle	10	breathlessness	Other	1 month - 6 months	1-10 min	Authoritarian/Disciplinarian	Easy	Studies	No	No	No	No	No	No	Anxiety Disorder
32	13	Hindu	Male	Nuclear	Lower Middle	6		Dissociative Motor Disorder	2 weeks - 1 month	Continuous	Authoritative	Slow to warm up	School	No	Yes	No	No	No	No	Anxiety Disorder
33	17	Hindu	Male	Nuclear	Lower Middle	10		Dissociative Convulsions	1 month - 6 months	1-10 min	Authoritarian/Disciplinarian	Difficult	Family	No	Yes	No	No	No	No	No
34	12	Hindu	Male	Nuclear	Upper Middle	7	Mixed (Stupor+Convulsions)	Dissociative Convulsions	6 months - 1 year	1-10 min	Authoritative	Slow to warm up	Studies	No	Yes	No	No	No	No	No
35	15	Hindu	Female	Nuclear	Lower Middle	9	?unspecified Mixed (Motor+Stupor+Convulsions)	Mixed	>1 year	1-10 min	Authoritative	Slow to warm up	Family	No	No	No	No	No	No	No
36	12	Hindu	Female	Nuclear	Upper Middle	6		Dissociative Stupor	1 week - 2 weeks	0-1 min		Easy	Studies	No	No	No	No	No	No	No
37	15	Hindu	Male	Nuclear	Lower Middle	9		Dissociative Motor Disorder	0-7 days	Continuous	Authoritative	Difficult	Family	No	No	Hydrocephalus d/t aqueduct stenosis, RVD +	No	No	Yes	No
38	16	Hindu	Female	Joint	Upper Middle	11	?breathlessness	Dissociative Motor Disorder	0-7 days	0-1 min	Authoritarian/Disciplinarian	Difficult	Other	No	No	No	No	No	No	No
39	16	Hindu	Male	Nuclear	Lower Middle	9		Trance and Possesion	1 year	0-1 min	Authoritarian/Disciplinarian	Slow to warm up	Family	Yes	No	Seizure disorder, Post GB syndrome	No	No	No	SLD, Mixed anxiety dep
40	16	Hindu	Female	Nuclear	Lower Middle	11		Dissociative Convulsions	6 months - 1 year	10 min - 1 hour	Authoritarian/Disciplinarian	Easy	School	No	No	No	No	No	No	No
41	15	Hindu	Female	Nuclear	Lower Middle	8		Trance and Possesion	1 year	10 min - 1 hour	Authoritarian/Disciplinarian	Slow to warm up	Family	No	No	No	Yes	No	No	Anxiety Disorder
42	13	Hindu	Male	Nuclear	Lower Middle	7		Dissociative Stupor	2 weeks - 1 month	0-1 min	Permissive/Indulgent	Slow to warm up	Other	No	No		No	No	No	Anxiety Disorder
43	15	Hindu	Female	Nuclear	Upper Middle	9	breathlessness	Other	1 month - 6 months	>1 hour	Authoritarian/Disciplinarian	Slow to warm up	Friendship/Relationship	No	No	No	No	No	No	No
44	13	Hindu	Female	Nuclear	Lower Middle	8		Dissociative Stupor	2 weeks - 1 month	1-10 min	Authoritarian/Disciplinarian	Slow to warm up	Family	No	Yes	No	ADS in father	No	No	Evolvng personality
45	13	Hindu	Female	Nuclear	Lower Middle	8		Dissociative Convulsions	2 weeks - 1 month	1-10 min	Authoritarian/Disciplinarian	Slow to warm up	Studies	No	No	Seizure disorder	No	No	No	No
46	15	Hindu	Male	Nuclear	Lower Middle	9	Mixed (Stupor+Convulsions)	Dissociative Convulsions	>1 year	10 min - 1 hour	Authoritarian/Disciplinarian	Slow to warm up	Studies	No	Yes	No	No	No	No	No
47	14	Hindu	Female	Nuclear	Upper Middle	8		Dissociative Stupor	1 month - 6 months	10 min - 1 hour	Authoritarian/Disciplinarian	Easy	Studies	No	No	No	No	No	No	No
48	14	Hindu	Female	Nuclear	Lower Middle	8		Dissociative Stupor	6 months - 1 year	1-10 min	Authoritative	Slow to warm up	Family	No	Yes	No	No	No	No	Depressive disorder with ISH attempt
49	14	Hindu	Male	Joint	Lower Middle	8	cough	Other	1 month - 6 months	Continuous	Authoritarian/Disciplinarian	Slow to warm up	Studies	No	Yes	No	No	No	No	Tic disorder, SLD
50	10	Hindu	Male	Joint	Upper Middle	5		Trance and Possesion	1 month - 6 months	1-10 min	Authoritarian/Disciplinarian	Difficult	Studies	Yes	Yes	No	No	No	No	ADHD and SLD
51	16	Hindu	Female	Nuclear	Lower Middle	10		Dissociative Stupor	1 week - 2 weeks	0-1 min	Authoritarian/Disciplinarian	Easy	Studies	No	No	No	ADS in father	No	No	Mod. Depressive Episode

Intervention (Antidepressant)	Antidepressant	Other Med	>2 MED	Intervention (Other Medications)	Physical Therapy	Psychotherapy	Parent SDQ Score	SDQ Category	Baseline CGAS	CGAS after 1 month	CGI-I Score (1 month)	CGI-I after 1 month	Mode of Follow Up	IPD/OPD/Emergency	Referral	Baseline CGI-S	CGI-S after 1 month
Sertraline	SSRI	BZD		Clonazepam	No	Yes	19	High/Low	40-31	60-51	3	Minimally improved (3)	OPD	OPD		5	4
Escitalopram	SSRI	BZD		Clonazepam	No	Yes	13	Close to ave	70-61	80-71	2	Much improved (2)	OPD	IPD	Referral	4	1
Desvenlafaxine	SNRI	BZD	BB	Clonazepam + Propranolol	No	Yes	17	High/Low	50-41	70-61	3	Minimally improved (3)	OPD	IPD		5	3
Desvenlafaxine	SNRI	BZD	BB	Clonazepam + Propranolol	No	Yes	18	High/Low	50-41	60-51	3	Minimally improved (3)	Voice Call	IPD		5	4
		BZD		Clonazepam	No	Yes	13	Close to ave	70-61	90-81	2	Much improved (2)	Voice Call	IPD	Referral	3	1
			NON-BZD		No	Yes	15	Slightly Rais	60-51	80-71	2	Much improved (2)	Voice Call	OPD	Referral	3	2
Sertraline	SSRI		NON-BZD	Etizolam	No	Yes	14	Slightly Rais	60-51	80-71	1	Very much improved (1)	Voice Call	IPD		3	1
					No	Yes	11	Close to ave	70-61	80-71	2	Much improved (2)	OPD	OPD	Referral	3	1
Sertraline	SSRI	BZD		Clonazepam	No	Yes	17	High/Low	40-31	50-41	3	Minimally improved (3)	OPD	IPD		5	4
				?	No	Yes	15	Slightly Rais	50-41	60-51	3	Minimally improved (3)	Voice Call	IPD	Referral	5	3
?			NON-BZD	?	Yes	Yes	13	Close to ave	70-61	80-71	1	Very much improved (1)	OPD	IPD		2	1
Desvenlafaxine				?	No	Yes	21	Very High/\	40-31	40-31	3	Minimally improved (3)	OPD	IPD		5	4
Amitryptiline	TCA	BZD	SGA	Aripiprazole, Clonazepam	Yes	Yes	22	Very High/\	40-31	50-41	3	Minimally improved (3)	OPD	IPD	Referral	5	3
Escitalopram	SSRI	BZD	NON-BZD	Clonazepam, Etizolam	Yes	Yes	16	Slightly Rais	50-41	70-61	2	Much improved (2)	Voice Call	IPD		4	3
Escitalopram	SSRI		NON-BZD	Etizolam	No	Yes	15	Slightly Rais	50-41	80-71	2	Much improved (2)	Voice Call	IPD	Referral	4	2
			NON-BZD	Etizolam	No	Yes	12	Close to ave	70-61	90-81	2	Much improved (2)	Voice Call	IPD	Referral	3	1
			NON-BZD	Etizolam	No	Yes	16	Slightly Rais	60-51	80-71	2	Much improved (2)	Voice Call	OPD		3	2
Escitalopram	SSRI			?	No	Yes	17	High/Low	60-51	60-51	3	Minimally improved (3)	OPD	OPD		5	4
Escitalopram	SSRI		NON-BZD	Etizolam	No	Yes	16	Slightly Rais	60-51	80-71	2	Much improved (2)	Voice Call	IPD	Referral	4	2
			NON-BZD	Etizolam	No	Yes	18	High/Low	60-51	80-71	2	Much improved (2)	Voice Call	Emergency		4	2
Escitalopram	SSRI	BZD		Clonazepam	No	Yes	15	Slightly Rais	60-51	80-71	2	Much improved (2)	Voice Call	IPD	Referral	5	2
Escitalopram	SSRI	BZD		Clonazepam	No	Yes	15	Slightly Rais	60-51	90-81	1	Very much improved (1)	Voice Call	OPD		4	1
Escitalopram	SSRI				No	Yes	13	Close to ave	60-51	80-71	2	Much improved (2)	Voice Call	OPD	Referral	5	2
?			NON-BZD	?	Yes	Yes	12	Close to ave	60-51	90-81	1	Very much improved (1)	OPD	IPD		5	1
Sertraline	SSRI		NON-BZD	Etizolam	No	Yes	12	Close to ave	70-61	90-81	1	Very much improved (1)	Voice Call	IPD		3	1
Sertraline	SSRI	BZD		Clonazepam	No	Yes	13	Close to ave	60-51	70-61	2	Much improved (2)	Voice Call	OPD		5	2
		NON-BZD		Etizolam	No	Yes	13	Close to ave	70-61	80-71	2	Much improved (2)	Voice Call	OPD		3	1
Escitalopram	SSRI	BZD	SGA	Clonazepam, Olanzapine	No	Yes	14	Slightly Rais	60-51	70-61	2	Much improved (2)	Voice Call	IPD	Referral	5	2
Escitalopram	SSRI	NON-BZD	BB	Etizolam+Propranolol	No	Yes	15	Slightly Rais	60-51	70-61	2	Much improved (2)	Voice Call	OPD		5	2
Sertraline	SSRI	BZD	SGA	Clonazepam, Olanzapine	Yes	Yes	14	Slightly Rais	60-51	90-81	1	Very much improved (1)	OPD	IPD		4	2
Sertraline	SSRI	BB		Propranolol	No	Yes	17	High/Low	60-51	70-61	3	Minimally improved (3)	Voice Call	OPD		5	3
Escitalopram	SSRI	NON-BZD	BB	Etizolam+Propranolol	Yes	Yes	19	High/Low	40-31	70-61	3	Minimally improved (3)	OPD	IPD	Referral	5	4
Escitalopram	SSRI				No	Yes	15	Slightly Rais	60-51	70-61	2	Much improved (2)	Voice Call	IPD	Referral	4	3
Escitalopram	SSRI	NON-BZD		Etizolam	Yes	Yes	15	Slightly Rais	50-41	60-51	3	Minimally improved (3)	OPD	IPD		5	4
		NON-BZD		Etizolam	No	Yes	17	High/Low	50-41	60-51	2	Much improved (2)	Voice Call	OPD		5	3
					No	Yes	16	Slightly Rais	60-51	80-71	2	Much improved (2)	Voice Call	IPD	Referral	4	1
Escitalopram	SSRI	NON-BZD		Etizolam	No	Yes	17	High/Low	50-41	60-51	3	Minimally improved (3)	Voice Call	IPD	Referral	4	4
Escitalopram	SSRI	BZD		Clonazepam	No	Yes	12	Close to ave	80-71	80-71	1	Very much improved (1)	Voice Call	Emergency		3	1
Escitalopram	SSRI	BZD	BB	Clonazepam+Propranolol	No	Yes	17	High/Low	50-41	60-51	3	Minimally improved (3)	OPD	IPD	Referral	4	4
?			NON-BZD	?	No	Yes	13	Close to ave	60-51	70-61	2	Much improved (2)	Voice Call	OPD		4	2
Escitalopram	SSRI				No	Yes	13	Close to ave	60-51	80-71	2	Much improved (2)	OPD	OPD		4	1
		NON-BZD		Etizolam	No	Yes	14	Slightly Rais	60-51	70-61	2	Much improved (2)	OPD	IPD	Referral	4	3
		BZD	NON-BZD	Clonazepam, Etizolam	No	Yes	13	Slightly Rais	60-51	80-71	2	Much improved (2)	Voice Call	Emergency		4	1
?			NON-BZD	?	Yes	Yes	18	High/Low	50-41	50-41	3	Minimally improved (3)	OPD	IPD		4	3
		NON-BZD		Etizolam	No	Yes	16	Slightly Rais	70-61	80-71	2	Much improved (2)	Voice Call	IPD	Referral	3	1
Sertraline	SSRI				No	Yes	20	Very High/\	40-31	60-51	2	Very Much improved (2)	OPD	IPD	Referral	5	2
Sertraline	SSRI	NON-BZD		Etizolam	No	Yes	15	Slightly Rais	60-51	80-71	2	Much improved (2)	Voice Call	OPD		4	2
Escitalopram	SSRI	SGA		Olanzapine	No	Yes	17	High/Low	50-41	60-51	2	Much improved (2)	Voice Call	IPD	Referral	5	3
Sertraline	SSRI	NON-BZD		Etizolam, Risperidone	No	Yes	15	Slightly Rais	60-51	70-61	3	Minimally improved (3)	Voice Call	IPD	Referral	5	4
Escitalopram	SSRI	BZD	SGA, ADHD	MPH, Risperidone, Clonazepam	No	Yes	20	Very High/\	50-41	60-51	3	Minimally improved (3)	Voice Call	IPD		5	4
Escitalopram	SSRI	NON-BZD		Etizolam	No	Yes	14	Slightly Rais	70-61	90-81	1	Very much improved (1)	OPD	IPD	Referral	4	2