World ▮ Cultural ▮ Psychiatry ▮ Research ▮ Review
OFFICIAL JOURNAL OF
WORLD ASSOCIATION OF CULTURAL PSYCHIATRY

Original Article

Religious beliefs, prayer attendance and mental health among Somali immigrants: Cross-Sectional international study

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Abstract *This manuscript provides insights into the associations between religion and mental health. It presents data from an international cross-sectional study carried out with 189 Somali immigrants living in London (UK) and Minneapolis, Minnesota (USA). We used the Somali version of MINI International Neuropsychiatric Interview (MINI,) which produces ICD-10 and DSM-IV equivalent diagnostic mental disorders. We also used a Religious and Spirituality questionnaire which taps on the importance of religion, religious beliefs, strength of religious beliefs, prayer attendance and spiritual practices. We found positive associations between spirituality and mental health with Somali Muslim participants who prayed the most reporting the fewest PTSD conditions and fewest aggregated mental health problems, compared with the occasional prayers, or those who hardly prayed. This highlights the beneficial associations between religion and mental health, and the need to respect and promote cultural and religious beliefs that are good for mental wellbeing.*

Keywords: Religion and Mental Health, Prayer Attendance and PTSD, Islam and Mental health

WCPRR Apr 2024: 53-65 © 2024 WACP
ISSN: 1932-6270

INTRODUCTION

Several reviews and epidemiological studies have identified religion and spirituality as a protective factor for mental health. Skoko and colleagues (2021) defined religion as "an institutional phenomenon which has social entities and

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institutions", with different religions having different life concepts, beliefs, practices, norms, rules and demands (Skoko et al., 2021). 'They' went on to describe spirituality as a closely linked phenomenon or concept, a concept that involves wide orientation to intangible features of life, which are also considered to be positive for mental health (Kaushal et al., 2021). Kaushal and colleagues cited from a meta-analysis study with 48 longitudinal studies which found a positive effect of religiosity and spirituality. Likewise, Malviya, 2023, carried out a rapid review into the process by which immigrant populations with cultural and linguistic background integrate religion and spirituality into mental health in Australia. Immigrants living in the west face additional life difficulties than those experienced by the non-migrant populations. These difficulties include cultural shock, acculturation and linguistic stressors and various barriers in accessing mental health services. From Malviya's rapid review (2023), the practices and beliefs of religion and spirituality were crucial in the lives of these culturally and linguistically diverse populations. Key findings from Malviya's study include:

- Religion and spirituality provided meaning during times of adversities and distress.
- Religion and spirituality were identified as a source of strengths against feelings of isolation and sadness.
- Religious identity was directly predictive of psychological wellbeing of participants from the Middle-East.
- Religion and Spirituality was important for Vietnamese Australians recovering from psychosis.
- Religion and spirituality were found to be a resourceful factor for developing mental resilience.

In other words, for immigrant communities with diverse cultural and linguistic backgrounds with limited access to mental health services, religion and spirituality provided a coping and protective mechanism for poor mental health. Somali Muslims arrived in the West in large numbers since the collapse of the Somali State in 1991 (Warfa et al., 2012). Almost hundreds of research articles have been written about the life experiences of Somali immigrants, mostly focusing on their acculturation experiences and health status (Bhui et al., 2002; Bhui et al., 2012; McCrone at el., 2005; Warfa et al., 2006; Bhui and Warfa, 2010). Somalis follow the Islamic religion. Islamic teaching concentrates bonding and attachment principles that can contribute to better mental health. For example, there is "the belief (Tawhid) of a single, all powerful and merciful Allah" who can provide a sense of security and purpose in life (Ali, 2020), essentially, a provision of a secure attachment bonding with the almighty Allah. One of the five pillars of Islam is praying five times a day. This involves (a) morning prayer, (b) noon prayer, (c) afternoon prayer, (d) just after sunset prayer and (e) evening prayer. A prayer is called Rakcad and involves both spiritual connection with a higher being (Allah) and a range of body movements. Apart

from spiritual attunement, each Rakcad consists of a series of movements including up to or over one minute standing, face touching down the ground and sitting for over a minute. Praying five times a day and being very close to Allah may provide those with lived traumatic experiences and mild to moderate mental health conditions to have access to structured routine exercise, a place of harmony and tranquillity, and strong self-discipline that are all linked with good mental health.

From the Somali Mobility and Mental Health Study we carried out with two samples of Somalis, one sample from the UK and the other from the US, we found that Somalis with post-migration difficult life events were more likely to have major depression and aggregated mental disorders than those with fewer acculturation stressors such as unemployment and language challenges. We reported that although a significant number of Somalis were experiencing mental health problems, they hardly used conventional mental health services as they were more likely to utilise religious and cultural treatments and community-based services (McCrone et al., 2006). This paper aims to assess the associations between religion and spirituality and mental health status among 189 Somali immigrants living in the UK and US. We asked the following key research question: is the practice of religion and spirituality associated with better or poorer mental health status among Somali Muslims?

METHODS

The data we are using in this 'manuscript partly' came from the Somali Mobility and Mental Health Study. The Somali Mobility and Mental Health Study utilized several measures to address different questions. We used culturally validated MINI Neuropsychiatric Interview and religion and spirituality measures to assess levels of mental disorders and the associations with religion and spirituality as either a risk or protective factor. "Researchers and clinicians working in nonprofit or publicly owned settings (including universities, nonprofit hospitals, and government institutions)" are allowed to use the M.I.N.I instrument for nonprofit making clinical interviews and research (Appendix 1).

The various research processes we undertook to validate and adapt MINI Neuropsychiatric Interview have been reported elsewhere (Warfa et al., 2012). Briefly, the DSM-IV diagnostic codes for the conditions we examined included the following:

F43.1 – post-traumatic stress disorder
F32 – depressive episodes
F34-1– dysthymia
F40.0-F41.0 – panic disorders

F40 – agoraphobia
F40 – social phobia
F43-1 – obsessive compulsive disorder
F20-F29 – psychotic disorders
F41.1 – generalised anxiety disorder
(See Appendix A for a more detailed list of DSM-IV diagnostic codes used in the Somali Mobility and Mental Health Study)

The English version of the psychiatric measure was translated into Somali and then back translated into English by Somali and none-Somali mental health experts and allied professionals. In line with the guidance set by WHO in translating and adapting clinical measures, we used several focus group discussions and scientific steering group meetings to produce a culturally adapted Somali version of MINI Neuropsychiatric Interview (Bhui et al., 2006). Also, we utilised simple religion and spirituality questionnaires which tapped on questions related to religious beliefs, strength of the beliefs, importance of religion, spiritual practices, frequency of religious attendance and prayer times, attachment to Allah, believing the influential power of Allah and communications with Allah.

RESULTS

Of the 189 participants, 75.7%, (143) were from London (UK) and 24.3%, (46) from Minneapolis, Minnesota (US). 52% (99) were female and 47.6% (90) male participants. 24.9% (47), 41.8% (79), 21.2% (40) and 12.2% (23) were in the age groups of 18-25, 26-35, 36-45 and 46+, respectively. In terms of marital status, 39.2% (74) were never married, 52.9% (100) participants were married and 7.9% (15) were in the category of others, including divorced individuals. From employment perspectives, 74.1% (140) were unemployed, and 5.9% (49) in employment.

Table 1 provides more demographic details of the participants including data on education and immigration characteristics.

Demographic Data

Table1	**Number**	**Percentage**
Location of Residence		
UK	143	75.7
US	46	24.3
Legal Status		
Pending	26	13.8
Resolves	163	86.2
Age Groups		
18-25	47	24.9
26-35	79	41.8
36-45	40	21.2
46+	23	12.2
Gender		
Male	99	52.4
Female	90	47.6

Marital Status		
Married	100	52.9
Never Married	74	39.2
Others	15	7.9
Education in UK & US		
None	75	39.7
College/Training Centres	114	60.3
Qualifications		
Certificate/Diploma	87	46
No Qualifications	102	54
Employment in UK & US		
Not working	140	74.1
Working	49	25.9
Claimed asylum on entry		
Yes	80	42.3
No	109	57.7
Family separation		
Yes	67	35.4
No	110	58.2
Missing	12	6.3
Still separated		
Yes	104	55.0
No	73	38.6
Missing	12	6.3

Of the 189 participants, 98.4% of subjects believed in religion with 98.6% of the participants stating that religion was `very' important to them. Only 1.1% stated that religion was not important to them. Majority of the participants were Muslims (97.9%). 27.5% stated that they attended prayer meetings every day, 41.3% once a week, 10% once a month and 21.1% hardly ever (Table 2).

Table 2: Religion and Spirituality

Variable	Label	Number	Percentage (%)
Have religious beliefs	No	3	1.6
	Yes	186	98.4
Hold religious beliefs strongly	No	3	1.6
	Yes	186	98.4
How important is religion to you	Important	187	98.9
	Not Important	2	1.1
How important is practice to your religion	Important	187	98.1
	Not Important	2	1.1
How often do you attend prayer meetings	Once every day	52	27.5
	Once a week	78	41.3
	Once a month	19	10.1
	Hardly ever	40	21.1
Believe in Allah or other force	No	2	1.1
	Yes	186	98.9
Believe Allah enables you to cope	No	2	1.1
	Yes	187	98.9
Believe Allah or other power influence the World	No	5	2.6
	Yes	184	97.4
Influence natural disasters like earthquakes	No	3	1.6
	Yes	186	98.4
Communicate Allah or power via prayer	No	3	1.6
	Yes	186	98.4

We found no associations between major depression and religious beliefs and between major depression and attending prayer meetings. However, the participants who prayed everyday had the lowest cases of PTSD, with the highest cases found in the participants who hardly prayed. Those who prayed once a week had less PTSD cases than the participants who only prayed occasionally or those who hardly pray. Furthermore, frequency of prayer meetings was associated with better mental health, overall. In other words, participants attending prayer meetings more frequently than their counterparts reported better mental health outcomes. There were other dissimilarities between those who held strong religious beliefs and those who did not, with the later individuals having more aggregated mental disorders. All mental disorders were associated with the importance of religion to oneself. For instance, aggregate mental health problems were lower amongst the participants who stated that religion was important to them than those who gave religion no importance.

Table3: aggregated mental disorder by religion			**PTSD by religion**			
Variable labels	**All mental disorders*Religion%(n)** **No**	**Yes**	**P-value**	**PTSD* Religion %(n)** **No**	**Yes**	**P-value**
Have religious beliefs			0.16			0.53
No	33.3 (1)	66.7 (2)		100 (3)		
Yes	70.4 (131)	29.6 (55)		88.2 (164)	11.8 (22)	
Hold religious beliefs strongly			0.008			0.23
No		100 (3)		66.7 (2)	33.3 (1)	
Yes	71.0 (132)	29.0 (54)		88.7 (165)	11.3 (21)	
How important is religion to you			0.03			0.61
Important	70.6 (132)	29.4 (55)		88.2 (165)	11.8 (22)	
Not Important		100 (2)		100 (2)		
How often do you attend prayer meetings			0.052			0.009
Once every day	76.9 (40)	23.11 (12)		92.3 (48)	7.7 (4)	
Once a week	74.4 (58)	25.6 (20)		93.6 (73)	6.4 (5)	
Once a month	68.4 (13)	31.6 (6)		68.4 (13)	31.6 (6)	
Hardly ever	52.5 (21)	47.5 (19)		82.5 (33)	17.5 (7)	
Believe in Allah or other force			0.54			0.61
No	50.0 (1)	50.0 (1)		100 (2)		
Yes	69.9 (130)	30.1 (56)		88.2 (164)	11.8 (22)	
Believe Allah enables you to cope			0.53			0.61
No	50.0 (1)	50.0 (1)		100 (2)		
Yes	70.1 (131)	29.9 (56)		88.2 (165)	11.8 (22)	
Believe Allah or other power influence the World			0.14			0.41
No	40.0 (2)	60.0 (3)		100 (5)		
Yes	70.7 (130)	29.3 (54)		88.0 (162)	12 (22)	
Influence natural disasters like earthquakes			0.16			0.24
No	33.3 (1)	66.7 (2)		66.7 (2)	33.3 (1)	
Yes	70.4 (131)	29.6 (55)		88.7 (165)	11.3 (21)	

Table 4: Major depression by religion and spirituality					
Variable	**Major depression % (n)** **No**	**Yes**	**Pearson Chi-square**	**df**	**P value**
Have religious beliefs			0.24	1	0.622
No	66.7 (2)	33.3 (1)			
Yes	78.5 (146)	21.5 (40)			
Hold religious beliefs strongly			3.63	1	0.057
No	33.3 (1)	66.7 (2)			
Yes	79.0 (147)	21 (39)			
How important is religion to you			0.95	1	0.33
Important	78.6 (147)	21.4 (40)			
Not Important	50.0 (1)	50.0 (1)			
How important is practice to your religion			0.95	1	0.33
Important	78.6 (147)	21.4 (40)			
Not Important	50.0 (1)	50.0 (1)			
How often do you attend prayer meetings			6.15	3	0.1
Once every day	82.7 (43)	17.3 (9)			
Once a week	83.3 (65)	16.7 (13)			
Once a month	73.7 (14)	26.3 (5)			
Hardly ever	65.0 (26)	35.0(14)			
Believe in Allah or other force			0.94	1	0.33
No	50.0(1)	50.0 (1)			
Yes	78.5 (146)	21.5 (40)			
Believe Allah enables you to cope			0.95	1	0.33
No	50.0 (1)	50.0 (1)			
Yes	78.6 (147)	21.4 (40)			
Believe Allah or other power influence the World					
No	60 (3)	40 (2)	1.01	1	0.31
Yes	78.8 (145)	21.2 (39)			
Influence natural disasters like earthquakes			3.63	1	0.057
No	33.3 (1)	66.7 (2)			
Yes	79.0 (147)	21.0 (39)			
Communicate Allah or power via prayer			0.24	1	0.62
No	66.7 (2)	33.3 (1)			
Yes	78.5 (146)	21.5 (40)			

DISCUSSION

We tasted the hypothesis of whether (or not) strong religious beliefs and practices have a positive or negative impact on the mental wellbeing of Somali immigrants. There was no association between religion, spirituality and major depression. However, there were positive associations between spirituality and mental health with the participants who prayed the most reporting the fewest PTSD conditions and fewest aggregated mental health problems, compared with the occasional prayers, or those who hardly prayed. These results are supported by a string of other epidemiological studies which highlighted the positive impact of religiosity and spirituality on mental health. One suggestion to explain

why people with major depression were least likely to benefit from spirituality and prayer attendance could be that their mental health conditions were too serious and therefore needed conventional clinical treatment (for example, anti-depression medication). An alternative view is that their suffering was linked with the unresolved major social problems that triggered depression in the first place, and until such major problems (for instance, unemployment) were addressed and resolved, the practice of religion and spirituality alone did not help much. From this cross-sectional study, 74% of the participants had no employment (and were mainly from London where migrant communities struggle obtaining meaningful employment status). Unemployment is a known risk factor for major depression. To this end, religion and spirituality may provide limited protection if you are unemployed and have major depression.

Nevertheless, there is some evidence from the present study to suggest that religion and spirituality protected participants (through daily prayer attendance and strong religious beliefs) who were exposed to traumatic life events and war trauma from developing full-blown Post Traumatic Stress Disorder and aggregated mental disorders. A few studies highlighted the mechanism through which religion and spirituality may provide protective factors for mental health. For example, the consistent attendance of religious places, consistent prayers and reading and listening religious and spiritual scriptures and audios are well documented strategies for protecting psychological wellbeing (Malviva, 2023).

Charnick et al (2021) wrote an interesting theoretical paper in which they detailed the normative processes in which God is constructed as an "attachment-figure". The attachment theory is the work of Bowlby (1988) and Ainsworth (1979). I and our colleagues have outlined and summarised the theoretical foundation behind the attachment theory in several papers (Warfa, et al., 2022; Ozden et al., 2019; Warfa, et al., 2015). The main pillar of the attachment theory is to understand the development of emotional bonds, relationships, and healthy growth. The theory centres around the foundation of providing a secure attachment system where one (often children) can benefit from healthy emotional development through the management of emotional regulations such as fear (under the supervision of a wiser and knowledgeable caregiver). For instance, for a strong mental health development of an infant child, they need to have access to caring and loving relationships (secure base attachment) from a wiser and more experienced adult caregiver. In other words, this bonding relationship is carefully constructed through a caring process where the child eventually develops a safe and secure fear regulation mechanism (Warfa, et al., 2022; 2015). This new confidence and safe emotions are then what allows the child to cope better with stressful emotions and difficult life situations, compared to those who developed an insecure attachment system behaviour. Using the attachment theory as a good example, Kirkpatric and Shaver proposed that believers of religion have a special bonding and

attachment relationship with God. Through prayers and regular religious practices, God acts as a caregiver and protector (Charnick, et al. , 2021). God provides comfort, resilience, and safe attachment systems to the believers. In other words, there is a secure bonding relationship between the prayer and God through spirituality and prayer attendance. Having a safe and secure attunement relationship with God means the development of better and healthier emotions. This provision of a secure attachment bonding with God is then conceptualised as a protective factor for mental health.

This may explain why Somali Muslims with traumatic life experiences and who frequently attended prayers were least likely to develop post-stress-traumatic disorder and aggregated mental health problems. In Islam, there is the understanding that social and emotional problems and challenges are part of Allah's divine plan (Ali, 2020), and this is what allows the followers of Islam to foster a reliance and acceptance behavioural system that reduces stress levels. In other words, by accepting that social problems and life challenges are part of life's inherent components, and by seeking quiet time to get closer to Allah both spiritually and physically, the stressors associated with these life challenges and difficulties are reduced (Hasan, 2019). The prayer place itself provides an environment of tranquillity and harmony, a place where the prayer connects with a higher being who can provide guidance on positive life outlooks. The result is a better regulation of negative traumatic emotions and the development of stronger appreciation for life, which may then lead to a reduction in PTSD levels.

LIMITATION

This manuscript assessed the associations between religion and mental health. It presents data from an international cross-sectional study carried out with 189 Somali immigrants living in London (UK) and Minneapolis, Minnesota (USA), using the Somali version of MINI International Neuropsychiatric Interview (MINI,) which produces ICD-10 and DSM-IV equivalent diagnostic mental disorders. The outcomes highlighted a positive link between religion, spirituality and mental health. Nevertheless, As with the case of cross-sectional designs, the findings of the study cannot be generalized beyond the reference group, although these findings are also consistent with those done with other populations where religion and spirituality factors were found to be protective factors for mental health. Further investigations with longitudinal methods and bigger sample sizes will be essential to identify the long-term effects of religion on mental health.

ETHICAL APPROVAL

The SOMMER study received ethical approval from the NHS Institutional Review Boards of London Boroughs of Tower Hamlets and Lambeth. The study

received funding from the Department of Health through its London Region NHS R&D Project, reference no: RCC01924. Ethical Approval was also obtained from the University of Kent for the PhD study. Consent was sought in writing (and verbally) from all those who met the inclusion criteria. Only participants who agreed to take part and give their consent were interviewed.

ACKNOWLEDGEMENT

It is impossible to name all the colleagues and friends who supported us over the course of completing this study, both practically and academically. Particularly, it would have been almost impossible to carry out this study successfully without the kind support and enthusiasm of the Somali community, Somali community organizations and multi-ethnic professionals working with migrant communities in London (UK) and Minneapolis, Minnesota (USA). Many thanks also go to the UK Health Department, Economic and Social Science Research Council (ESRC) and University of Kent who funded this programme as part of the Somali Mobility and Mental Health Study. This was a collaborative study jointly carried out by Queen Mary University and King's College London. The PhD programme was completed at University of Kent. Finally, thank you to everyone who helped us with the study.

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APPENDIX A

MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW
English Version 5.0.0
DSM-IV

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M.I.N.I. 5.0.0 (January 1, 2000)

MODULES	TIME FRAME	CRITERIA	DSM-IV	ICD-10	
R SOMATISATION	Lifetime		•		
	Current		•		
A MAJOR DEPRESSIVE EPISODE	Current (2 weeks)	□	296.20-296.26	Single	F32.x
	Recurrent	□	296.30-296.36	Recurrent	F33.x
MDE WITH MELANCHOLIC FEATURES	Current (2 weeks)	□	296.20-296.26	Single	F32.x
Optional			296.30-296.36	Recurrent	F33.x
B DYSTHYMIA	Current (Past 2 years)	□	300.4		F34.1
C SUICIDALITY	Current (Past Month)	□			
	Risk: □ Low □ Medium □ High				
D MANIC EPISODE	Current	□	296.00-296.06	F30.x-F31.9	
	Past	□			
HYPOMANIC EPISODE	Current	□	296.80-296.89	F31.8-F31.9/F34.0	
	Past	□			
E PANIC DISORDER	Current (Past Month)	□	300.01/300.21	F40.01-F41.0	
	Lifetime	□			
F AGORAPHOBIA	Current	□	300.22	F40.00	
G SOCIAL PHOBIA (Social Anxiety Disorder)	Current (Past Month)	□	300.23	F40.1	
H OBSESSIVE-COMPULSIVE DISORDER	Current (Past Month)	□	300.3	F42.8	
I POSTTRAUMATIC STRESS DISORDER	Current (Past Month)	□	309.81	F43.1	
Optional					
J ALCOHOL DEPENDENCE	Past 12 Months	□	303.9	F10.2x	
ALCOHOL ABUSE	Past 12 Months	□	305.00	F10.1	
K SUBSTANCE DEPENDENCE (Non-alcohol)	Past 12 Months	□	304.00-.90/305.20-.90		F11.1-F19.1
SUBSTANCE ABUSE (Non-alcohol)	Past 12 Months	□	304.00-.90/305.20-.90		F11.1-F19.1

L	PSYCHOTIC DISORDERS	Lifetime Current	□ □	295.10-295.90/297.1/ 297.3/293.81/293.82/ 293.89/298.8/298.9	F20.xx-F29
	MOOD DISORDER WITH PSYCHOTIC FEATURES	Current	□	296.24	F32.3/F33.3
M	ANOREXIA NERVOSA	Current (Past 3 Months)	□	307.1	F50.0
N	BULIMIA NERVOSA	Current (Past 3 Months)	□	307.51	F50.2
	ANOREXIA NERVOSA, BINGE EATING/PURGING TYPE	Current	□	307.1	F50.0
O	GENERALIZED ANXIETY DISORDER	Current (Past 6 Months)	□	300.02	F41.1
P	ANTISOCIAL PERSONALITY DISORDER Optional	Lifetime	□	301.7	F60.2