PERCEIVED PARENTING BEHAVIOUR, PARENTAL AND YOUTH PSYCHOPATHOLOGY AND THE EFFICACY OF FAMILY-COGNITIVE BEHAVIOURAL THERAPY AT A YOUTH PSYCHIATRIC CLINIC IN KENYA

PhD DISSERTATION IN CLINICAL PSYCHOLOGY

DEPARTMENT OF PSYCHIATRY, THE UNIVERSITY OF NAIROBI

BY

DR. LINCOLN I. KHASAKHALA

MBchB (NRB), MSC Cl. Psychology (NRB)

DISSERTATION SUBMITTED IN FULFILMENT OF THE REQUIREMENTS OF THE DEGREE OF

DOCTOR OF PHILOSOPHY AT THE UNIVERSITY OF NAIROBI

University of NAIROBI Library
0380054 7

2012

UNIVERSITY OF NAIROBI
MEDICAL LIBRARY

DECLARATION

I, Dr. Lincoln I. Khasakhala, declare that this dissertation is my original work carried out in fulfilment of the requirement of the degree of doctor of Philosophy in Clinical Psychology of the University of Nairobi under the supervision and guidance of Professor David M. Ndetei and Dr Muthoni Mathai of the Department of Psychiatry, Medical School; the University of Nairobi. I further declare that this dissertation has not been submitted for award of any other degree or at any other university.

Author: Dr. Lincoln I. Khasakhala

Signature

Date 29/11/2014

COPYRIGHT

The author reserves publication rights. Neither the dissertation nor extracts from it may be printed or reproduced without the author's written permission.

Author: Dr. Lincoln I. Khasakhala

Sign..

Date 29/11/2012

APPROVAL

This is to certify that I, Dr. Lincoln Imbugwa Khasakhala, have carried out the dissertation work independently, under the supervision of University appointed supervisors, Professor David M. Ndetei and Dr. Muthoni Mathai. The dissertation research was approved by the Department of Psychiatry before submission and approval by the conjoint committee of Kenyatta National Hospital and the University of Nairobi Ethics and Review Board.

1. Professor David Musyimi Ndetei

   MBCHB (Nairobi.), D.P.M (London), F.R.C PSYCH. (U.K), MD (Nairobi)

   Certificate in Psychotherapy (London)

   Professor of Psychiatry,

   Department of Psychiatry,

   University of Nairobi

   Signed .... Date 29/11/12 ....

2. Dr. Muthoni Mathai

   MB. Ch. B; M. Med Psych; Dr. Phil.

   Lecturer,

   Department of Psychiatry,

   University of Nairobi

   Signed .... Date 29.11.2012 ....

DEDICATION

To my nuclear family members: parents, sisters and brothers for their prayers, continued support, understanding and encouragement during the period of study.

ACKNOWLEDGEMENT

The development, execution and final report writing of this dissertation would not have been possible without the enabling environment at the Africa Mental Health Foundation under the directorship of Professor David M. Ndetei who is also my first supervisor.

I thank Professor Ndetei for his inspiration, knowledge, sensitivity, patience, thoroughness, financial support and hard work.

I am deeply indebted to Dr Mathai, my second supervisor for her tireless efforts as she guided me through all the sections in this dissertation.

To Dr. Valarie Harder: I deeply appreciate the mental health epidemiology training, continued encouragement, understanding, wise counsel and guidance in data management that has made me have a clear picture on mental health research and its application.

To the clinical psychologists: Victoria Mutiso, Susan Muriungi, Margaret Gwada, Anne Mbwayo, John Nga'ng'a, Teresia Okumu and Esther Mungai for their contribution and support during assessment and treatment process of this study.

I also wish to thank the many participants recruited in this study whose voices were repeatedly heard at every session and for their tireless commitment to honour all their scheduled appointments. Special thanks go to the staff at the Youth Centre, Kenyatta National Hospital, who did outstanding work in identifying and enrolling all participants into the study.

Last, but not least, special thanks goes to Moses Mwangi for his commitment and patience during data analysis for this dissertation and Martha Nditi Kinyanyui for editing this work.

To all, I say thank you and may God bless you abundantly.

TABLE OF CONTENTS

DECLARATION....................ii

COPYRIGHT....................iii

APPROVAL....................iv

DEDICATION....................v

ACKNOWLEDGEMENT....................vi

DEFINITION OF TERMS....................xv

CHAPTER ONE....................1

1.1 INTRODUCTION....................1

1.2 Background Information....................5

1.3 Statement of the Problem....................9

1.4 Study objectives....................12

1.4.1 General objective....................12

1.4.2 Specific Objectives....................12

1.5 Main Research Questions (RQs)....................13

1.6 Study Hypothesis....................13

1.7. Study justification....................13

CHAPTER TWO....................15

2.0 LITERATURE REVIEW....................15

2.1 Theoretic Framework....................15

2.3 Psychiatric Disorders in a Family Setting....................20

2.5 Risk Factors for Alcohol Use and Dependence among Youth....................22

2.6 Substance Abuse among Youth 24

2.7 Suicide Behaviour in Youths 25

2.8 Interventions 27

2.9 Conceptual Framework 33

3.0 METHODS 35

3.1 Study design 35

3.2 Study site and Participants 35

3.3 Sample Size Calculation and Sampling Procedure 37

3.4.0 Instruments (Appendix 2) 38

3.5 Ethical considerations 41

3.6. Inclusion and exclusion Criteria 42

3.7 Recruitment and treatment Procedures 42

3.8. Data management 47

CHAPTER FOUR 49

4. 0: RESULTS AND FINDINGS 49

5.0 CHAPTER FIVE: DISCUSSION, CONCLUSION AND RECOMMENDATION 99

5.1 Discussion 99

5.2 Conclusions 112

5.3 Recommendations 114

REFERENCE 115

APPENDICES 145

APPENDIX 1: CONSENT FORMS 145

APPENDIX 2: QUESTIONNAIRES 150

APPENDIX 2a: Socio-demographic and Open ended structured interview schedule (unstructured interview) 150

Appendix 2b: MINI KID SCREEN MINI KID QUESTIONNAIRE 155

Appendix 2c:.MINI SCREEN and MINI PLUS FOR ADULTS 295

Appendix 2d: MINI-MENTAL STATE EXAMINATION (MMSE) QUESTIONNAIRE 300

APPENDIX 2e: MY MEMORIES OF UPBRINGING-(EMBU) QUESTIONNAIRE 304

APPENDIX 3: FAMILY- COGNITIVE-BEHAVIOURAL THERAPY (F-CBT) MODEL 310

APPENDIX 2: QUESTIONNAIRES 150

APPENDIX 2a: Socio-demographic and Open ended structured interview schedule (unstructured interview) 150

Appendix 2b: MINI KID SCREEN MINI KID QUESTIONNAIRE 155

Appendix 2c:.MINI SCREEN and MINI PLUS FOR ADULTS 295

Appendix 2d: MINI-MENTAL STATE EXAMINATION (MMSE) QUESTIONNAIRE 300

APPENDIX 2e: MY MEMORIES OF UPBRINGING-(EMBU) QUESTIONNAIRE 304

APPENDIX 3: FAMILY- COGNITIVE-BEHAVIOURAL THERAPY (F-CBT) MODEL 310

TABLE OF TABLES

Table 4.1.1: Social demographic characteristics of the youths per study group 51

Table 4.1.2: Parental characteristics per study group 52

Table 4.1.3: Parenting behaviour and psychiatric disorders among mothers 53

Table 4.1.4: Parenting behaviour and psychiatric disorders among fathers 54

Table 4.1.5: Mental health status of the youths per group 55

Table 4.1.6: Distribution of Socio-demographic characteristics of the youths by gender at baseline 56

Table 4.1.7: Distribution of Socio-demographic characteristics of the parents by gender of the youths 57

Table 4.1.8: Multiple disorders in youth (MDD, alcohol use and any anxiety disorder) in relation to socio-demographic characteristics 58

Table 4.1.9: Maternal Parenting behaviour in relation to paternal parenting behaviour and alcohol use 59

Table 4.1.10: Maternal MDD in relation to paternal alcohol use at baseline 59

Table 4.1.11: Distribution of parenting behaviour by gender of the youth 60

Table 4.1.12 Co-existence of common disorders in youth in relation to socio-demographic characteristics 61

Table 4.2.1.1: MDD among youths in relation to background characteristics of the youth 62

Table 4.2.1.2: MDD among youths in relation to mental health status of the parents 63

Table 4.2.1.3: MDD among youths in relation to other mental health status of the youths 64

Table 4.2.1.4: Predictors of occurrence of MDD among youths 65

Table 4.2.2.1: Alcohol use among youths in relation to background characteristics of the youth 67

Table 4.2.2.2: Alcohol use among youths in relation to mental health status of the parents........ 68

Table 4.2.2.3: Alcohol use among youths in relation to other mental health status of the youths 69

Table 4.2.2.4: Predictors of alcohol use among youths 70

TTable 4.2.2.5: Alcohol dependence among youths in relation to background characteristics of the youth.. 71

Table 4.2.2.6: Alcohol dependence among youths in relation to mental health status of the parents.. 72

Table 4.2.2.7: Alcohol dependence among youths in relation to other mental health status of the youths.. 73

Table 4.2.2.8: Predictors of severe alcohol dependence among youths 74

Table 4.2.3.1: Any drug abuse among youths in relation to background characteristics of the youth 75

Table 4.2.3.2: Drug abuse among youths in relation to mental health status of the parents 76

Table 4.2.3.3: Drug abuse among youths in relation to other mental health status of the youths 77

Table 4.2.3.4: Predictors of Drug abuse among youths... 78

Table 4.2.4.1: Suicide behaviour among youths in relation to background characteristics of the youth 79

Table 4.2.4.2: Suicide behaviour among youths in relation to mental health status of the parents 80

Table 4.2.4.3: Suicide behaviour among youths in relation to other mental health status of the youths.. 81

Table 4.2.4.4: Youth suicidal behaviour in relation to number of co-existing psychiatric disorders in youths... 82

Table 4.2.4.5: Predictors of Suicide behaviour among youths 83

Table 4.2.5.1: Any anxiety disorder among youths in relation to background characteristics of the youth 84

Table 4.2.5.2: Any anxiety disorder among youths in relation to mental health status of the parents.. 85

Table 4.2.5.3: Any anxiety disorder among youths in relation to other mental health status of the youths 86

Table 4.2.5.4: Predictors of anxiety disorder among youths 87

Table 4.2.6.1: MDD in mothers in relation to characteristics of the fathers 88

Table 4.2.6.2: Predictors of MDD in mothers 89

Table 4.3.1: Efficacy of the intervention on MDD in youths 90

Table 4.3.2.2: Efficacy of the intervention on Suicide behaviour in youths 91

Table 4.3.3: Efficacy of the intervention on Psychotic disorder in youths 92

Table 4.3.4.2: Efficacy of the intervention on Alcohol use in youths 93

Table 4.3.5: Efficacy of the intervention on any drug abuse in youths 94

Table 4.3.6.2: Efficacy of the intervention on MDD in mothers 95

Table 4.3.7: Efficacy of the intervention on MDD in fathers 96

Table 4.3.8: Efficacy of the intervention on Alcohol use among fathers 97

Table 4 3.9: Power Calculations 98

TABLE OF FIGURES

Figure 1: Conceptual framework-Khasakhala, May 2007 34

Figure 2: Participants sampling frame and flow during the study (flow chart) 46

Figure 3a: Summary of data set variables included in Analysis process 48

Figure 3b: Summary of data set variables included in Analysis process: testing the efficacy of F-CBT 48

Figure 4: Stepwise F-CBT Process 388

Figure 5: The Cognitive Triangle 396

ABBREVIATION AND ACRONYMS

ADHD:	Attention Deficit Hyperactivity Disorder
BMD:	Bipolar Mood Disorder
CBT:	Cognitive Behaviour Therapy
CDI:	Children Depression Inventory
DSM-IV:	Diagnostic and Statistical Manual 4th Edition
EMBU:	Egna Minnen Betraffande Uppfostran (My Memories of upbringing)
ENT:	Ear, Nose and Throat
F-CBT:	Strategic Functional family Cognitive Behaviour Therapy
ICD 10:	International Classification of Diseases, 10th Edition
IQ:	Intelligence Quotient
KNH:	Kenyatta National Hospital
MDD:	Major Depressive Disorder
MINI-KID:	Mini International Neuropsychiatric Interview for Youths and Adolescents
MINI-PLUS	Mini International Neuropsychiatric Interview for Adults
MMSE:	Mini Mental State Examination
MOPC:	Medical Out Patient Clinic
POPC:	Psychiatric Out Patient Clinic
PTSD:	Post Traumatic Stress Disorder
RQ:	Research Question

SCID:	Structured Clinical Interview for Diagnostic and Statistical Manual IV
SED:	Severe Emotional Disorders
SOPC:	Surgical Out Patient Clinic
SPTM:	Standard Psychiatric Treatment Methods
STI:	Sexually Transmitted Infection
SUD:	Substance Use Disorders
VCT:	Voluntary Counselling and Testing
WAIS:	Wechsler Adult Intelligence Scale
WHO:	World Health Organization

DEFINITION OF TERMS

Attachment: A term used to describe the emotional relationship that develops between an infant and the primary caregiver, most often a parent, during the infant's first year of life. It is a relationship that develops over time and is the result of many interactions and care giving experiences, particularly those in response to the infant's needs, bids for attention, comfort and protection.

Authoritarian parents: Parents who display low responsiveness and high demandingness. They are often cold, unsupportive, insensitive to their youth's needs, and demanding in their control.

Authoritative parents: Parents who display high levels of both responsiveness and demandingness. They are warm, nurturing and sensitive to their youth's needs and consistently consider the youth's age and maturity when forming behavioural expectations.

Burden of disease: The impact of a health problem in an area measured by financial cost, mortality, morbidity or other indicators.

Caregivers: These are adults who provide care for youth and young people. A caregiver can be a biological parent or in the case of alternative care, a specially-trained adult who works under supervision and support of other care professionals. During the period of alternative care, a youth's caregiver should be changed as few times as possible.

Orphan: The term can be used to describe youths who have lost one or both parents.

Cognitive triad: This is a thought recording process carried out by asking participants to make a note of automatic thoughts that occur in stressful situations and identify their emotions and behaviour associated with these thoughts.

Family dysfunctions: Character of poor communication, poor problem solving, and the presence of hostility and criticism among family members.

DEFINITION OF TERMS

Attachment: A term used to describe the emotional relationship that develops between an infant and the primary caregiver, most often a parent, during the infant's first year of life. It is a relationship that develops over time and is the result of many interactions and care giving experiences, particularly those in response to the infant's needs, bids for attention, comfort and protection.

Authoritarian parents: Parents who display low responsiveness and high demandingness. They are often cold, unsupportive, insensitive to their youth's needs, and demanding in their control.

Authoritative parents: Parents who display high levels of both responsiveness and demandingness. They are warm, nurturing and sensitive to their youth's needs and consistently consider the youth's age and maturity when forming behavioural expectations.

Burden of disease: The impact of a health problem in an area measured by financial cost, mortality, morbidity or other indicators.

Caregivers: These are adults who provide care for youth and young people. A caregiver can be a biological parent or in the case of alternative care, a specially-trained adult who works under supervision and support of other care professionals. During the period of alternative care, a youth's caregiver should be changed as few times as possible.

Orphan: The term can be used to describe youths who have lost one or both parents.

Cognitive triad: This is a thought recording process carried out by asking participants to make a note of automatic thoughts that occur in stressful situations and identify their emotions and behaviour associated with these thoughts.

Family dysfunctions: Character of poor communication, poor problem solving, and the presence of hostility and criticism among family members.

Family: A social group connected by kinship, marriage, adoption or choice, defined responsibilities, long term commitments, mutual obligations and responsibilities, and a shared sense of togetherness.

Mental Health: This is a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

No symptom reduction: The presence of specific DSM IV criteria symptoms of a psychiatric disorder during the period of treatment or no psychiatric symptoms.

Parenting behaviour: This is defined as specific content and socialization goals (e.g. school achievement) used by parents and reported by youths.

Parenting styles: An attitude toward the youth that is communicated to the youth and creates an emotional climate in which parents' behaviour is expressed. The four documented parenting styles are;-authoritative, authoritarian, permissive and indifferent or neglectful.

Parent-youth connectedness: A social support that growing youths perceive as an adaptive parenting behaviour which protects a youth from a wide range of adversities.

Physical youth abuse: Physical aggression directed at a youth by an adult. It can involve punching, striking, kicking, shoving, slapping, burning, bruising, pulling ears or hair, stabbing, choking, belting or shaking a youth.

Psychological youth abuse (also called emotional youth abuse): This is any attitude, behaviour, or failure to act that interferes with a youth's mental health or social development ranging from a simple verbal insult to an extreme form of punishment.

Social Skills: A set of competencies that provide individuals with the ability to recognize and manage their emotions, develop care and concern for others and establish positive relationships.

This paper will focus on three social skills; emotional management, interrelationships and self-esteem.

Standard psychiatric treatment methods: Psychiatric management consists of interventions and activities that should be initiated and provided during all phases of treatment. First, complete psychiatric assessment is done to make a complete DSM-IV TR diagnosis by addressing the following: The presenting complains, history of the present illness and current symptoms; psychiatric history; general medical history; previous treatments and medications use; history of substance use and treatment for substance use disorders; personal history (e.g., psychological development, response to life transitions, major life events); social, occupational, and family histories; review of systems; mental status examination; physical examination (by psychiatrist or by other health care professional) and diagnostic tests as indicated to rule out general medical causes of the psychiatric symptoms. Information to address functional impairments and quality of life is assessed. This includes: Identifying impairments in domains such as work, school, family, social relationships, leisure activities, and maintenance of health and hygiene; providing interventions to maximize the patient's level of functioning and quality of life; and helping the patient to set goals appropriate for his or her level of functioning and symptom severity. Also, all clinicians involved in the patient's care should have sufficient ongoing contact with the patient and with one another to ensure that care is coordinated, relevant information is available to guide treatment decisions, and treatments are synchronized. This is followed by initiation into treatment which starts with establishing and maintaining a therapeutic alliance, i.e., collaborate with the patient in decision making and attend to the patient's preferences and concerns about treatment and be aware of transference and counter-transference issues.

Other considerations in standard psychiatric treatments include:

1. Monitoring a patient's psychiatric status by:

   a) Carefully monitoring the patient's response to treatment, including;

      a.1. symptomatic status, including functional status and quality of life;

      a.2. degree of danger to self and others;

      a.3. signs of "switch" to mania;

      a.4. other mental disorders, including alcohol and other substance use disorders;

      a.5. general medical conditions;

      a.6. side effects of treatment; and

      a.7. adherence to treatment plan.

   b) Carefully monitoring significant symptoms change or if new symptoms emerge, considering diagnostic re-evaluation.

   c) Often involving family members or caregivers who notice changes in the status of the patient first and are therefore able to provide valuable input.

2. Integrating measurements into psychiatric treatment by matching the treatment plan to the needs of the patient by systematically assessing symptoms of the illness and effects of treatment.

3. Enhancing treatment adherence by:

   a) Assessing potential barriers to treatment adherence—side effects of treatment; problems in the therapeutic relationship; and logistical, economic, or cultural barriers to treatment.

   b) Collaborating with the patient (and, if possible, the family) to minimize barriers.

c) Encouraging the patient to articulate concerns about treatment or its side effects, and considering the patient's preferences when developing or modifying the treatment plan.

d) Recognizing that during the acute phase, psychiatric patients may be poorly motivated and unduly pessimistic and may suffer deficits of memory.

Symptom reduction: A period of at least two weeks but less than two months with few psychiatric symptoms that do not meet specific criterion for DSM-IV axis 1 disorder.

Symptom Remission: Absence of significant symptoms of psychiatric (e.g., no more than 1–2 symptoms) for >2 months.

Time-out: Time-out involves having a child go to a place – a corner, chair or room – that is far apart from interesting activities or from people for a short period of time. Time-out is a very powerful and effective way of teaching children what behaviours are unacceptable. The approach makes sense to children as young as two or three years. They can understand that when they act in a way that is unacceptable, they temporarily lose the privilege of being around other people or continue with an interesting activity. It is basically a form of punishment that is effective, humane and which can only teach children what not to do. It can't teach them what to do. To learn what to do, children need to be rewarded, not punished. They need to receive praise, not just criticism. Time-out is a non-hurtful and non-violent disciplining approach. Smacking and other hurtful punishments on the other hand tend to bring out strong negative emotions in children – usually anger, shame and fear. When these negative emotions are strong enough, they take over the child's thinking, leaving no room for the child to consider what he did wrong. Time-out is unpleasant enough to teach children a lesson, but it doesn't overwhelm them with negative emotions that make real learning impossible.

Uninvolved parents (also called indifferent or neglectful): They display low levels of both responsiveness and demandingness. They are emotionally detached and withdrawn, and have few rules and expectations.

Well-being: Attitudes, perceptions, thoughts, self-evaluations, feelings and behavioural tendencies aimed toward a person, this has a positive effect in the development of self efficacy.

Youth abuse: Any act or series of acts of commission or omission by a parent or other caregiver that result in harm. potential for harm, or threat of harm to a youth. Youth abuse can be in form of neglect, physical abuse, psychological/emotional abuse, and youth sexual abuse.

Youth neglect: Youth neglect is where the responsible adult does not provide adequately for various needs, including physical, emotional, educational, or medical.

Youth sexual abuse: Youth sexual abuse is a form of youth abuse in which an adult or older adolescent abuses a youth for sexual stimulation. It is any sexual act between an adult and a youth, including penetration, intercourse, incest, rape, oral sex, and sodomy; include asking or pressuring a youth to engage in sexual activities, indecent exposure of the genitals to a youth, displaying pornography to a youth, actual sexual contact; physical contact with the youth's genitals, viewing of the youth's genitalia without physical contact, or using a youth to produce youth pornography.

Youth: An individual aged 13- 25 years as per this study.

ABSTRACT

Background: The association between psychiatric illness in parents and their ability to parent, as well as the effect of the parenting behaviour on their children has both clinical and public mental health policy relevance. Cognitive Behaviour Therapy (CBT) is an evidence-based psychological practice that reduces relapse rates and facilitates the recovery of persons who have mental illness when combined with standard psychiatric treatment methods.

Objectives: This clinical trial study was conducted to determine whether: (1) Maladaptive parenting behaviour is associated with parental and youths' psychiatric disorders; (2) Combined Family Cognitive Behaviour Therapy (F-CBT) with Standard Methods of Psychiatric Treatment Methods (SPTM) have better outcome in treating Diagnostic and Statistical Manual 4th Edition (DSM-IV) axis 1 psychiatric disorders found among family members than the SPTM alone.

Methodology: History, psychological examinations and structured psychiatric interviews were carried out on a total sample of 678 participants; 250 youths, 226 mothers and 202 fathers to determine psychiatric disorders at; baseline, follow up 1 and follow up 2. Maladaptive parenting behaviours and mental state functioning were assessed using the Egna Minnen Betraffande Uppfostran (Swedish acronym of My Memories of upbringing-EMBU) and Mini Mental State Examination (MMSE) questionnaires respectively. Psychiatric disorders were assessed using the Mini International Neuropsychiatric Interview for Youths and Adolescents (MINI -Kid) administered to youth and Mini International Neuropsychiatric Interview for Adults (MINI-PLUS) administered to parents. Participants were divided into two groups randomly: intervention and control where intervention group received both F-CBT and SPTM and control received only SPTM.

Results: Most of the youth in the study perceived their parents to have high levels of maladaptive parenting behaviour, whether or not the parents had a psychiatric disorder: 55.1%, of mothers were perceived to have rejecting, while 23.9% and 12.4% of them were perceived to be under protective and no emotional connectedness parenting behaviour. Among fathers: 53.8% were perceived to be under protective while 24.9%, and 7.6% were perceived to have rejecting and no emotional connectedness parenting behaviour. Most of the mothers had depressive disorders (51.3%).The presence of maternal depressive disorder was associated with increased odds (2.14 times greater) to have Major Depressive disorder (MDD) and suicidal behaviour among the youth. Fathers with alcohol use disorders had higher levels of maladaptive paternal parenting behaviour than did fathers without alcohol use disorders. Youths who had seen their father drunk/using alcohol excessively had high odds (2.82 times greater) of having alcohol dependence than youths who had not seen their father drunk/use alcohol excessively. The proportion of youths with alcohol use disorders that had peers using alcohol also (44.4%) was higher than the proportion of youths with alcohol use disorders (8.3%) but did not have peers using alcohol. An alcohol use disorder among fathers was also associated with increased maternal odds (2.42 times greater) of having depressive disorder. The families allocated to the experimental group had better outcome in terms of response to treatments as compared to the control group.

Conclusion: These results provide significant vital insights into the effects of parenting behaviour and parents' psychopathology on the development of psychopathology in their youths.

CHAPTER ONE

1.1 INTRODUCTION

Mental well-being is fundamental to a good quality of life. Happy confident youths are most likely to grow into happy and confident adults, who in turn contribute to the health and well-being of nations.[1] Emotional health and well-being in young people has implications for self-esteem, behaviour, attendance at school, educational achievement, social cohesion and future health and life chances. Young people with a good sense of mental well-being possess problem-solving skills, social competence and a sense of purpose; consequently they resolve crises in their life with assertiveness and without resorting to violence.[2] These strengths help youths to rebound from setbacks, thrive in the face of poor circumstances, avoid risk-taking behaviour like substance use or suicide and generally live productive lives.[3-4]

Unfortunately, there are usually many new pressures and challenges for young people to deal with at this time of development in their life. These include: high academic expectations, changing social relationships with family and peers, and physical and emotional changes associated with maturation. Many factors have an impact on youths' ability to deal with these changes in life. These are specific to the youth, to their family (in particular parenting behaviour and parental mental well-being), to their environment (particularly their school) and to different occurrences of life events.[5]

The idea of risk and protective factors can help to understand the likelihood of young people's ability to achieve and sustain a state of mental well-being. If young people have opportunities in childhood and adolescent years to experience and accumulate the positive effects of protective factors to outweigh negative risk factors, they are more likely to achieve and sustain mental health and well-being later in life. A key protective factor for positive mental health is a sense of parent-youth connectedness. This is a social support that growing children perceive as an adaptive parenting behaviour which protects a youth from a wide range of adversities.[6] In giving social support, parents consequently play a pivotal role in the development of a healthy bond and therefore remain connected to their youths. This pivotal role has been shown to be "a super protective" factor which leads to good and optimal developmental outcomes later in life.[7-10] However,

If a parent is perceived not to give social support, they are seen to portray maladaptive parenting behaviour. Youths raised in a home where parents are perceived to have maladaptive parenting behaviour in turn develop poorly and are at high risk to develop psychiatric disorders.[7-17]

Therefore, parents who cannot give psychosocial support i.e. are not connected to their youths but interact in maladaptive parenting style, increase the likelihood that their youths may develop psychopathology.[7-17] Adaptive parenting behaviour on the other hand offsets a range of risk factors, including child abuse, family conflict, parental alcohol/substance use and youth alcohol/substance abuse. Worldwide, in the last two decades, attention has been focused on mechanisms by which parent-youth connectedness work so as to promote more deliberately, systematically and proactively normal youth development that is devoid of conflict or psychopathology.[14-17] Consequently, a high degree of adaptive parenting behaviour is a protective factor in preventing maladjustment problems in youths such as drug abuse/misuse, violent behaviour, suicidal behaviour, depression, unintended pregnancy, antisocial or conduct behaviour, and truancy or delinquency.[18-22]

According to the World Health Organization (WHO), the prevalence of many psychiatric disorders previously seen in adults have increased enormously in children and youths over the past few years.[23-26] Up to 20% of children and youth have disabling mental health problems.[24] Four percent of 12-17 year olds and 9% of 18-24 year olds suffer from depression, making it one of the most prevalent psychiatric disorders with wide reaching consequences worldwide.[25-26] Other studies have documented that youths with drug abuse disorders have higher rates of depression (15%-24%) than youth in the general population (2%-8%).[27-31] It has also been shown that youths with co-morbid depression come from dysfunctional families and have severe substance abuse, poorer drug treatment outcomes and higher relapse rates.[32-33] Depression has been shown to be associated with youth suicide behaviour which is a major problem in many countries as it is the third leading cause of death in young people.[34] Studies carried out on youth with psychiatric disorders also indicate that untreated depression is associated with later development of anxiety disorders, bipolar mood disorders and substance use.[35-37]

Findings of a longitudinal research from the United States reveal that after 12 years of age, girls' rates of depression, social phobia, and drug abuse disorders increase, whereas only the prevalence of drug abuse disorders increase for boys.[38] Thus, the diagnosis of a Serious Emotional Disorder (SED) increases dramatically for both genders toward mid and late adolescent years.[38] In India, it is estimated that 10-20% of youths and adolescents are affected annually by psychiatric problems and their psychiatric morbidity accounts for five of the ten leading causes of disability for those aged five years and above.[39] Studies among adolescents in Australia weighted three-month prevalence rates across the three consecutive years for overall psychiatric disorders and the results were: 20.3%, 22.7%, and 14.8% in the three years respectively.[40] The most prevalent psychiatric condition in this study was Attention Deficit Hyperactivity Disorder (ADHD) before adolescent years and drug abuse disorders increased in teen years.[40] During late childhood (8-12 years in age), the rates for ADHD, specific phobia, and social phobia decreased, but the rates for major depression and drug abuse disorders conversely increased. Although conduct disorder, ADHD, and drug abuse disorders are more prevalent among boys, the rates for major depression, social phobia, specific phobia, and adjustment disorder are higher among girls.[40] A study in Nigeria stipulates that the commonest psychiatric disorder is schizophrenia (49.4%) although unspecified psychosis (32.2%), bipolar affective disorder (6.1%), depressive episode (4.8%), organic psychiatric disorders (4.4%) and substance induced psychosis (3.4%) were included as schizophrenic episode.[41]

In Kenya, studies carried out indicate that 41.3% of adolescents and 25.5% of young people (below 40 years of age) attending general health facilities have depressive disorders and pathological alcohol use bordering harmful and dependence syndrome respectively.[42-44] Studies conducted in public schools in Nairobi indicate the prevalence for Post Traumatic Stress Disorder (PTSD), clinical diagnostic scores for depressive disorders, anxiety disorders, suicidal thoughts, suicidal plans and obsessive compulsive disorder are 50.5%, 12.9%, 69.1%, 4.9%, 5.5% and 43.7% in the five disorders respectively.[46-47] Also, studies on drug use in public schools in the country have revealed that 3.1% of students smoke cigarettes actively while 9.3% use

alcohol daily with a lifetime use of 38.6%.[48] Despite this high prevalence levels of psychiatric and alcohol/drug abuse disorders in general health facilities and schools among youths in Kenya, there is a limited scale of mental health services that reach this population, hence most of the youth have unrecognized mental illnesses, cannot access treatment services and therefore remain untreated.

In adults, mental health problems compromise a mother's or a father's parenting abilities and represent a threat to their youths' adjustment and behaviour.[6,32-33, 49-50] Thus, different health problems initiate specific paths between parental and youth mental-health problems. Evidence from research has shown that parents of depressed youth often have depression and parents of youth with conduct disorder often have evidence of antisocial behaviour.[51-53] Other studies have shown that youths from families where one or both parents have a psychiatric disorder, are at a high risk of developing psychiatric disorders.[54-55] Thus intra-familial transmission of psychopathology is one of the risk factors in aetiology of psychiatric disorders in children and the youths.[32-33, 49-55]

In order to promote wellness and, therefore, prevent psychopathology in a given community, treatment programs need to be developed to focus on creation of awareness about adaptive parenting behaviour. This is important in promotion of mental well-being because psychiatric disorders are responsible for a high burden of unmet needs to families and communities.[23, 56] Maladaptive parenting behaviour is one of the aspects in a youth's environment that accounts for the increase in the risk for psychiatric disorders among youths whose parents have psychiatric disorders.[8-11,49-55,57-58] In previous studies, it has been shown that maladaptive parenting behaviours are over-represented in populations with significant family dysfunctions and that these behaviours slow the rate of recovery from any psychiatric illness.[59-62] Again, parental psychopathology has been shown to be associated with maladaptive parenting behaviour,[32-33] which in turn is associated with an increased risk of psychiatric disorders in youths.[49-56,57-62] Family dysfunction is therefore characterized by poor communication, poor problem solving, and the presence of hostility and criticism.

Conversely, good family functioning has been shown to improve outcomes in clients with Major Depressive Disorder (MDD) especially in three areas of family functioning which are: the ability to meet practical and emotional needs, the level of interest that family members show about each other, and the ability to maintain behaviour that promotes health.[63-64]To reduce the burden of psychiatric disorders on families, effective mental illness prevention and mental health promotional measures should be taken into account to ease the impact of disorders on youths, family and society at large. Untreated psychiatric disorders in youths has also been shown to be associated with substantial morbidity, including school dropout, teenage pregnancy, suicide, and substance abuse, [64-65] as well as considerable health expenditure.[66] Of particular importance is depressive and alcohol use disorders which are the most common psychiatric disorders and are significantly associated with youth suicidal behaviour and completed suicide.[34,57,63, 67-72] Furthermore, presence of any other psychiatric disorder in youth is a major risk factor for the development of MDD and long-term psychosocial impairment in adulthood.[63-65] Thus, improvements in the treatment of psychiatric disorders should positively impact public health.

1.2 Background Information

In Africa, a parent is identified as the authority figure in a family setting.[13] A parent is expected to filter the beliefs, attitudes and practices of the society in general in order to instruct children on what to do to become acceptable members of the family and the society at large. This because children learn through observation and modelling; hence, the way a parent relates to their youths determines how youths respond to authority as well as how the youth relates to other people outside the home. The parenting behaviour partly influences outcome of the youths' ability to relate to them and the larger community because the attitudes towards other people and modes of behaviour used are developed in the first six years of life. This is what Dubin and Dubin in 1964[14] called the "authority inception period". In the African setting, parenting of children includes other clan members in which the child is brought up specifically the extended family members (grandparents, aunties and uncles) and parentification also takes place where older siblings take care of the

younger ones. In urban settings, employing house-help/maids is on the increase and the role of parents is being left to them. The implication of these parenting roles by other relatives is not clear.

As indicated earlier, many families of youths with any form of psychiatric disorder tend to be disturbed.[27-33, 50-55] The disturbances include unhealthy quality of marital interactions and maladaptive parenting behaviours, which have been shown to be mediating factors for psychiatric disorders in youths in such dysfunctional family settings.[57-72] These family dysfunctional situations have been shown to be associated with high rates of parent-youth conflict, which makes youths raised in these environments highly vulnerable to develop mental health problems.[20-21,27-33, 57-72] The mediating factors for youths to develop any mental health problem have been shown to include: poor parenting styles, child abuse and psychiatric disorders among parents[57-72] Studies have also shown that youth who have one psychiatric disorder often have one or more undiagnosed comorbid psychiatric disorders.[30-31,35-37] This effect seems to be stronger for youths with both parents suffering from any psychiatric disorder.[57-72]

In studies conducted in family settings, results have indicated that mothers who have depression fail to monitor their youths, while fathers with depressive symptoms (e.g. irritability and pessimism) are less nurturing and more punitive in their parenting behaviour.[68-70] To escape these depressive feelings and thoughts, youths from these family settings engage in high risk behaviour such as suicidal behaviour to internalize their problems or substance/alcohol use and conduct disorder to externalize their problems.[11,34,50,64] Studies from Nigeria have shown that parents from families with poor behaviours such as extreme conflict, violence and divorced parents end up physically or sexually abusing their youth or neglecting them. This may trigger the youth to start abusing substances, affect access to treatment and or reduce/prevent the effectiveness of the treatment.[73-74]

Psychiatric disorders are recurrent and are associated with significant economic hardship and long-term impairment to the affected family.[75-77]Some of these complications/impairments as documented in a baseline study at the Kangemi slum area of Nairobi (Kenya) include early parenthood (adolescent pregnancy), divorce, work and legal difficulties, substance abuse and suicidal behaviour.[78] Providing treatment to youth

with any psychiatric disorder has major public health implications. Almost all published treatment trials in clinically referred youth with psychiatric disorders have focused on psychopharmacological treatments.[79-81] In contrast to the psychopharmacological literature, most of the published psychosocial treatment studies for psychiatric disorders in youth have focused on samples obtained through screenings in schools. [82-85]In this study, the focus was on youth attending a psychiatric outpatient clinic.

Cognitive Behaviour Therapy (CBT) methods were initially developed for depression and anxiety disorders and were later modified for many other conditions, including personality disorders, eating disorders and substance abuse. They have also been adapted for use as an adjunct to medication in the management of schizophrenia and bipolar mood disorder.[86-92] When CBT is used as a family psychotherapeutic method, it reduces relapse rates and facilitates the recovery of persons who have serious mental illness when combined with SPTM.[93-96]A core set of characteristics of effective family CBT programs have been developed including specific psycho-therapeutic approaches, provision of emotional support, psycho-education, and problem solving skills during periods of psychotherapy.[93] CBT methods are often used because of the role they play in correcting cognitive distortion that is often present at the onset of any psychiatric disorder.[95] CBT is therefore a practical, action-oriented treatment approach used widely for major psychiatric disorders.[93-96] A major goal in giving CBT as an adjunct to pharmacotherapy is to improve family communication and supportiveness.[93-94] The other goal is to decrease the intense negativity or severe expression of emotions that, so often, characterises dysfunctional families, or those in which a family member has a mental illness.[95-96] Additionally, this structured therapy has a capacity to help family members to identify what they desire from each other, institute behaviour change and develop possible strategies to solve the family problem(s) that put family members at a risk of developing psychiatric disorders.[81-83,94]

Studies on depression have confirmed that when CBT is used together with antidepressant medication, it is more effective than either pharmacotherapy treatment alone or when CBT is combined with family therapy.[85, 93-94] Extensive research by Blackburn et al., in 1981 demonstrated that structured CBT treatment is effective in helping the youth and their parents successfully adapt to new ways of communication, thereby

reducing relapse rates in their diagnosed psychiatric disorders.[93] Family Cognitive Behaviour Therapy (F-CBT) as an adapted model in this study (see appendix 3) is a set of psychosocial treatments that increases compliance to treatment and modifies inappropriate behaviour. The overall objective of the model is to improve functioning including: psychologically, interpersonally, behaviourally and physically by the end of treatment. Studies in this area have indicated that this model communicates the fundamental CBT principles as a key element in clinical treatments in a clear language.[93-96] Thus the F-CBT model, in this study, offered family members (youth and parents participating in the study) interpersonal treatments (psychosocial) across the range of psychiatric disorders whereby both cognitive and behavioural psychotherapy methods were applied. The cognitive methods focused on the thinking patterns of participants which are usually extreme and unhelpful.[95]In family therapy sessions, the patient focused on themes in which they saw themselves as worthless, incompetent, failures, bad or vulnerable. Behavioural methods focused on behaviour patterns that were maladaptive and eventually reduced or made the affected person avoid adaptive activity hence the commencement of unhelpful behaviours (e.g. excessive drinking, self-cutting and reassurance-seeking) that worsen the psychiatric problems.

Focus on the family in this study formed a strategy to make the family functional by changing the cognitions and behaviour. This strategy helped participants with psychiatric disorders build an understanding of their interpersonal family relationship which is vital in the successful management of any illness. There were on average 14 sessions of F-CBT carried out with participants allocated to the experimental group. The F-CBT processes began by educating members on their DSM-IV TR axis 1 psychiatric disorders. Information shared in the first session of F-CBT included: diagnosed DSM-IV-TR specific symptoms, the associated predisposing, precipitating and aggravating or vulnerability factors. Further; the relationship between perceived maladaptive parenting behaviour by the youth and how to help the family members adapt to more effective ways of family communication through social skills training, and understanding each family member's behaviour was discussed. Thus, when families learn about their mental health problems, they may be able to notice early signs of a relapse and create an action plan that involves all family members. The

family members were taught on how to communicate negative emotions in a safer way, and therefore learnt the most effective ways of becoming stable to prevent relapses.

This model of psychosocial treatment is fully compatible with biological treatment when used together with medication. This therapy has been used in majority of psychiatric disorders because of its effectiveness as a psychosocial treatment that is able to provide: a focus on current relevant problems of the family; a clear underlying model, structure or plan for the treatment being offered; and delivery that is built on an effective relationship with the practitioner. F-CBT is easy to follow because the principles of CBT are used in formulation of the psycho-education format in the treatment. The main purposes in giving psycho-education in this study was to educate the dysfunctional families (adolescents and their parents) to learn new skills of self-management which formed the pillar in each session as the participants put them into practice for everyday living. In this study, the F-CBT adopted a collaborative stance which encouraged individual family members (youth, their father and mother) to work on changes they felt put into practice what they had learned.

This clinical trial was designed to link the data from perceived maladaptive parenting behaviour and parental psychopathology to psychiatric disorders in the youths' data in a family setting in Kenya. It examined in detail perceived maladaptive parenting behaviour as a possible predictive factor for the development of psychopathology in youth which is confounded by parental psychiatric disorders, excessive use of alcohol by parents (fathers) and youth having peers who use alcohol. The study instituted F-CBT as an adjunct treatment approach to manage both youths and parents' psychopathology in addition to SPTM offered at Kenyatta National Hospital (KNH) in the experimental group. The control received only the SPTM offered at KNH.

1.3 Statement of the Problem

In the last decade, there have been many critical incidences of rebellion and atrocities in high schools and public universities in Kenya. For example, on the night of 25/26 March 2001, 67 students died when a fierce fire gutted down the dormitory they were sleeping in at Kyanguli Secondary School (Top Story, Nation

Newspaper, 26 March 2001). It was alleged that two students started the fire.[97] Between January and July of 2001, 48 high schools in the country had problems with students defying authority or rejecting disciplinary measures implemented by the school system. Almost all the public universities in Kenya have had student riots or some form of student unrest in the last 10 years. This trend still continues in schools and public universities in Kenya with almost similar intensity. Whatever the cause of the problem, the response of the community in each of the above-mentioned incidences has been "this is an unacceptable behaviour from young people."

Different groups interviewed by the media including the church ministers/leaders, politicians, parent associations and school authorities give many reasons for the behaviour described above. These reasons include use of drugs by the young people, parental failure to instruct youths on how to behave, youth rebellion, inadequate school disciplinary measures, and copying bad examples from leaders. Ndetei states that at Kyanguli School, drugs did not play a significant role, however, some community members speculated that "the fire was the work of unhappy spirits taking revenge on the community for unspecified sins" partly because the fire raged on despite a heavy down pour of rain.[97] Within any community, there are those who will think this way and desire to respond to situations from this perspective and who cannot be ignored when relationship dynamics are discussed. However, harmony has to be maintained in homes so that a positive and healthy attitude is built within the family. This is a process of forming connectedness within family members which is extended to the society. Parents' behaviour towards their youths affects developments as well as developing various states and reactions later in life. As indicated in many studies, if parents' interactive behaviour is crude and unhealthy, it will in turn affect the youths negatively with an end result of developing a psychiatric disorder.[49-55, 57-73]

In Kenya, children and youths constitute a large percentage of the population. However, their mental health care has received scanty attention in the provision of mental health services; research and training. Observations particularly from electronic and print media indicate that there is an increased rate of school and college interruptions, HIV/AIDS infections and abortion among youth. The few studies conducted

among youth in Kenya reveal that there is high prevalence of mental and alcohol/ drug abuse disorders in this population.[42-48] Consequently, there is increased burden of disease and care in families where both youths and parents have psychiatric disorders.[24,56] A number of consequences can occur as a result of limited access to care, for example school strikes, arson, increased discipline problems, poor performance, school dropouts, increased substance use and rising crimes which are associated with these challenges (as shown in school and public universities unrests in Kenya). There is a great need, therefore, for such information to be used in sensitising policy makers in government and civil society about the magnitude and complexity of the economic burden of mental and behavioural disorders in youths and parents.

Like in adults, youth have mental health disorders that interfere with the way they think, feel and act and when untreated can lead to devastating effects at individual level, the families, the health systems and the wider society. These observations and evidence from research are pointers to poor mental well-being in family settings in Kenya. Most youths who develop any psychiatric disorder, as pointed out in the introduction and background information, come from a family setting where parents have maladaptive parenting behaviour and/or have psychiatric disorders. Again as pointed earlier, lack of emotional and social support (youth-parent connectedness) in early childhood development as a result of the maladaptive parenting behaviour pushes youths into inappropriate and maladjusted behaviours and consequently to the development of psychiatric disorders. This maladaptive parent-youth disconnection persists on like a scar that inhibits healthy attitudes towards others, which in turn affects intrapersonal and interpersonal relationships with ultimate abnormal family functioning/structure.

The quality of the relationship between youths and their parents as manifested by the security of attachment, has long been shown to be of paramount importance to mental health across the life span.[12] Rutter in 1979 indicated that dysfunctional aspects of family life predispose youths to develop psychiatric disorders, especially if a youth does not have a loving relationship with at least one of the parents.[63] Studies have also indicated that if a parent is not connected to their youths, there occurs poor care giving practices and maladaptive parenting behaviour.[19-22] This has been documented to be a risk factor for youths and the

affected parent to develop depressive disorders.[98] In this regard, the relationship between parental problems and those factors in youth that predispose youths to disconnect from their parents, impacts negatively on the psychosocial well being of both the parent and the youths. Investigations have shown that the nature and the outcome of the un-connectedness process in a family setting are related to later depression and increased treatment relapse rates, especially when the youth is raised in an abusive environment.[99-101]

Psychosocial experiences of a person in his or her early life with the primary caregiver therefore remain the origin of his/her learned behaviour, motives, desires and perceptions, which affect the person's psycho-dynamics, cognitive development and behaviour throughout life.[102-104] This study was designed to document the relationship between maladaptive parenting behaviour with/without parental psychiatric disorders and youth psychiatric disorders. It was also designed to test the efficacy of F-CBT in the management of the psychiatric disorders in combination with SPTM compared to SPTM alone in family setting sessions.

1.4 Study objectives

1.4.1 General objective

The main objective of the study was to determine the association between perceived parenting behaviour and: psychiatric disorders among parents; psychiatric disorders among youths; and test the efficacy of F-CBT in the study population.

1.4.2 Specific Objectives

1. Determine the socio-demographic characteristics, perceived parenting behaviour and DSM-IV axis 1 disorders and their co-morbidity including suicidal behaviour among youth and their parents.
2. Determine the association between:
    a) Socio-demographic characteristics and DSM-IV axis 1 disorders among youth;
    b) Socio-demographic characteristics and DSM-IV axis 1 disorders among parents;
    c) DSM-IV axis 1 disorders among youth and DSM-IV axis 1 disorders among parents;
    d) Socio-demographic characteristics and perceived parenting behaviour among youth;

e) Socio-demographic characteristics and perceived parenting behaviour among parents;

f) Perceived parenting behaviour and DSM-IV axis I disorders among youth; and

g) Perceived parenting behaviour and DSM-IV axis I disorders among parents.

3. Determine the efficacy of F-CBT in the treatment of psychiatric disorders in youth and parents.

1.5 Main Research Questions (RQs)

RQ 1 Does maladaptive parenting behaviour play a significant role in the development of DSM-IV axis I disorders in their youth?

RQ 2 Does DSM-IV axis I disorders among parents play a significant role in the development of DSM-IV axis I disorders in their youth?

RQ 3 Are standard methods of psychiatric treatments offered at the Youth Centre at KNH combined with F-CBT more effective in the management of psychiatric disorders among youth and their parents than the standard methods of psychiatric treatments alone?

1.6 Study Hypothesis

Null Hypothesis: There is no significant difference between families who received F-CBT plus standard methods of psychiatric treatments and those who only received standard methods of psychiatric treatments at KNH Youth Centre.

Alternative Hypothesis: There is a significant difference between families who received F-CBT plus standard methods of psychiatric treatments and those who only received standard methods of psychiatric treatments at KNH Youth Centre.

1.7. Study justification

The magnitude of the burden of disease related to psychiatric disorders in a family setting remains unrecognized and therefore undertreated in Kenya.[43-49, 58] Studies carried out in developed countries as indicated in the introduction and background information, indicate that parental psychopathology is associated with maladaptive parenting behaviour [18-53] and that maladaptive parenting behaviour is associated

with an increased likelihood of youths developing psychiatric disorders.[7-11, 17-21] Maladaptive parenting behaviour plays a significant role in the development of psychiatric disorders in the youths. Psychiatric disorders in both parents and their youths can therefore affect personal growth/work, relationships in a family (parenting behaviour) setting and quality of life. Studies have also shown that youths of parents with psychiatric disorders are at a higher risk of developing psychiatric disorders than those whose parents have no psychiatric disorders. Safe and effective treatments that can help prevent youths of parents with maladaptive parenting behaviour and/or having psychiatric disorders from developing psychiatric disorder and drug abuse disorders are needed.

The association between maladaptive parenting behaviour together with psychiatric disorders in both parents and their youths in low resource countries are compounded by numerous crises that have affected youths, impacted by human conflicts for example tribal clashes/post election violence of 2007, exploitation for labour and sex, orphan hood as a result of HIV/ AIDS, and being forced to migrate for economic and political reasons. In Kenya, no previous studies have assessed the association between parenting behaviour and youths psychopathology controlling for age, gender of youths, parental psychopathology, parental marital status or occupation. In this regard, important questions remain unanswered about the role of parenting behaviour in the intra-familial transmission of psychiatric disorders for families in Kenya and other developing countries. The nature of this association is also of considerable interest to mental health workers and scientists, in part because it may be possible to reduce the likelihood that youths will develop psychiatric disorders by helping parents to modify their parenting behaviour or access psychiatric treatment in case the parent has a psychiatric disorder. There is need, therefore, to document the negative and important roles that parents/ caregivers play not only to help their youths to successfully transit into teenage/adulthood but also that this transition should be a healthy relationship void of psychopathology.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Theoretic Framework

Different parents adapt different parenting behaviour for raising their youths. Some types of family structure affect the quality of family relationships and in particular parenting behaviours which can be risk factors for behavioural problems in children. The impact of parenting on learning and personality development has been a subject of clinical research for many years. Children upbringing mostly comprises two dimensions which can be described as "acceptance/warmth vs. rejection" and "psychological autonomy vs. control/ overprotection". The first factor comprises negative or hostile feelings by the parent towards the child, while the second factor comprises behaviour designed for protecting the child from possible harm. A third, often inconsistent factor describes items related to firmness, discipline and punishment.[15-20]The theoretical framework in this study uses both Bowlby's attachment theory and Bandura's social learning theory. Bowlby's theory highlights the importance of specific perceived parenting behaviour; the connectedness or un-connectedness between a child and their parents[12] while the social learning theory by Bandura highlights learning of social skills and development of self efficacy.[105-107] Thus, to understand the context under which mental health problems develop, one should first understand the various conditions that affect attachment and learning in childhood. In addition, it is crucial to understand how attachment in early years of life influences the development of social skills and self efficacy.[12, 105-107]Ainsworth's typology of mother-infant attachment grew out of her observational research on mother-infant (12 and 18 months) pairs in Uganda where she coined the different attachments between infants and their mothers: secure, anxious-ambivalent and anxious-avoidant insecure attachment.[108]

The research problem in this study anchors the entire study and forms a basis from which the construct to develop a theoretical framework was made. The attachment and social learning theories were selected since children from a family that has un-connectedness have no protection or role models in their environment. Therefore, later in life, these children develop poor self efficacy, a precursor of multiple mental health

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Theoretic Framework

Different parents adapt different parenting behaviour for raising their youths. Some types of family structure affect the quality of family relationships and in particular parenting behaviours which can be risk factors for behavioural problems in children. The impact of parenting on learning and personality development has been a subject of clinical research for many years. Children upbringing mostly comprises two dimensions which can be described as "acceptance/warmth vs. rejection" and "psychological autonomy vs. control/ overprotection". The first factor comprises negative or hostile feelings by the parent towards the child, while the second factor comprises behaviour designed for protecting the child from possible harm. A third, often inconsistent factor describes items related to firmness, discipline and punishment.[15-20]The theoretical framework in this study uses both Bowlby's attachment theory and Bandura's social learning theory. Bowlby's theory highlights the importance of specific perceived parenting behaviour; the connectedness or un-connectedness between a child and their parents[12] while the social learning theory by Bandura highlights learning of social skills and development of self efficacy.[105-107] Thus, to understand the context under which mental health problems develop, one should first understand the various conditions that affect attachment and learning in childhood. In addition, it is crucial to understand how attachment in early years of life influences the development of social skills and self efficacy.[12, 105-107]Ainsworth's typology of mother-infant attachment grew out of her observational research on mother-infant (12 and 18 months) pairs in Uganda where she coined the different attachments between infants and their mothers: secure, anxious-ambivalent and anxious-avoidant insecure attachment.[108]

The research problem in this study anchors the entire study and forms a basis from which the construct to develop a theoretical framework was made. The attachment and social learning theories were selected since children from a family that has un-connectedness have no protection or role models in their environment. Therefore, later in life, these children develop poor self efficacy, a precursor of multiple mental health

problems. Hence, the study was designed to assess parent-youth un-connectedness as a precursor of psychopathology in youth. The theoretical framework was used to focus on relevant published studies that have epidemiological data with specific variables (independent, confounder and dependent) used in the design of this study. There is scarcity of literature on research studies on parenting behaviour and there association with parental psychopathology in Africa. However in western countries, this epidemiological work was done before the year 2000.

Clinical research in psychology and psychiatry regards the quality of perceived parenting behaviour by children as a significant predictive factor within which predisposition, precipitation and vulnerability might induce psychopathology.[17, 21] In previous studies, it has been shown that the experience of rejection, lack of emotional warmth and care, and under protection ("no affectionless control") during childhood, are important risk factors for the development of psychopathology later on in life.[19-22] The relevance of dysfunctional families and in particular regarding parental psychiatric disorders has been shown to be a confounding factor for the development of psychiatric disorders in youths[27-34] and also for children to develop multiple co-morbid disorders.[35-35] These research findings suggest that the perceived maladaptive parenting behaviour can be regarded as an important predisposing factor which is mediated by cognitive mechanisms that are related to problem-solving and coping strategies or influences the individual's predisposition, precipitation or vulnerability.[20-22]

All these factors are documented in Bowlby's theory as factors leading to resistant/insecure attachment behaviours, and therefore precursors for youths to develop psychiatric disorders.[12] Bandura emphasizes modelling or observational learning as a powerful source of development.[105] In general, social development is seen as a continuous learning process, rather than as happening in stages.[102-108] Observational learning is governed by the processes of attention, retention, production and motivation. Attention refers to one's ability to selectively observe the actions of a model. For a child to reproduce observed behaviours, recall and retrieve of retained memory, the environment should be conducive to enable this chain of memory processing. Hence, if a child's environment is not conducive for learning, observed behaviour cannot be

reproduced because the process of memory formation and retrieval is interfered with. Poor memory process leads to low-self esteem in the affected youth/child. Thus, between ages 6-13 years when children become industrious[108] and every social skill learned is concretely grounded[103], poor memory processing at this stage in life as result of un-conducive home environment can make children become inferior[108] and therefore cannot compare themselves to their peers resulting into development of low self-esteem.[107]

Evidence on parenting behaviour and its association with parental and child pschopathology in developed countries was done before the year 2000. However in Africa, this work is currently being developed. Literature review in this study is therefore informed by:

a) Insecure attachment and lack of social network as a result of maladaptive parenting behaviour is a precursor to develop poor mental well-being in youths; the outcome variable of the study (psychiatric disorders).

b) Perceived maladaptive parenting behaviour which is the main indicator (independent) variable in this study disconnects youths from their parents and therefore hinders the youth from learning and modelling adaptive behaviours. This perceived maladaptive (rejecting) parenting behaviours make the child/youth develop poor self efficacy, a precursor to develop depressive disorder. This is the most common psychiatric disorder in dysfunctional family settings and therefore for the youth to escape this un-conducive home environment and feelings associated with depressive disorder they externalize their behaviour by using alcohol/substances, changing their conduct (develop conduct disorder) and/or exhibit suicidal behaviour; these are common behavioural problems in youth.

c) Parental psychiatric disorders, a second indicator (confounding) variable which is a main hindrance that blocks a parent from connecting to their children/youths, results in poor social support network, a mediating factor for persistence of common psychiatric disorder in a dysfunctional family. Maladaptive parental behavior is likely to be one of the important aspects of the childhood environment that accounts for the increase in risk for psychiatric disorders among the children (youth) of parents with psychiatric disorders. Two bodies of research support this inference. First, research has indicated that parental

psychopathology is associated with maladaptive parental behaviour.[11, 13] Second, research has demonstrated that maladaptive parental behaviour is associated with increased offspring risk for psychiatric disorders.[14, 15, 16, 17] It can thus be hypothesized that maladaptive parental behaviour plays a significant role in the association between parental and youth psychiatric disorder.[18, 19, 20] To proactively break these mediating factors in homes and families, cognitions and behaviours towards each other must change and therefore in this study testing the efficacy of CBT.

2.2 Parenting behaviour

Parenting behaviour influences family life. The process of socialization defines important tasks that the growing youth needs to achieve and also places responsibilities and obligations that he needs to meet and fulfil for acceptance in the given society and for self-esteem. Early childhood experiences are formative. Early life experiences have more lasting effects in personality development than later life experiences. The seeds of juvenile delinquency and antisocial personality in later life, for example, are sown in early life in the absence of consistent and warm parenting and disturbed relationship with care givers and stress associated with changing foster homes without clear-cut directions and inappropriate and abusive relationships with adults.[14] It has been shown that some forms of parenting styles are associated with child abuse. Thus in childhood years, as a parent instils discipline in their children; abuse to the child may occur either by commission or omission. There are four styles of parenting: authoritarian, authoritative, permissive and uninvolved.[109] The types of abuse include: emotional abuse or neglect, physical abuse including sexual or physical neglect.

An authoritarian parent is rated high on control but low on warmth by the children who tend to be in conflict with the parent's authority leading to mood problems.[109] A parent interacting with this style uses severe discipline in form of physical punishment and emotional abusive behaviour to the child. This perceived parenting behaviour tends to induce aggressive behaviour in a child since the child emulates and incorporates this behaviour into their own self schemas. This is an emotional un-connectedness from a parent.[110] Authoritative parents: their children rate them very warm and are always careful to set clear limits

regarding behaviour by: formulating clear goals, keeping track record of progress, allowing room for negotiation and gives positive response to a child's success. This style is associated with most positive early childhood social development, where children tend to be energetic, friendly and show skills of increased competence on dealing with other people and their environment. This forms effective parent-child connectedness, an adaptive parenting behaviour.[109] Thus this style advances a child's positive attitude towards achievement and promotes school performance.[111] In permissive parenting style, children rate their parents high on warmth but low on discipline and control, and therefore developmentally children tend to be impulsive and aggressive.[110] Uninvolved parents: Is rated both low on warmth and control, this causes disruption in attachment leading to parent-child un-connectedness. Both permissive and uninvolved parenting styles lead to parent-child un-connectedness during childhood development and later children/youth have problems with peer relationship and academic performance. This un-connectedness in child development indicates that the parent does not protect their child, hence a parent is perceived to interact with under-protective parenting behaviour.[110] Perceived rejecting parenting behaviour occurs when a parent emotionally and physically neglects the child. The neglects can either be by commission or omission asthe parent interacts with the child, a serious form of parent-child un-connectedness.

A study by Khasakhala[112] found that there were statistically significant differences ($p<0.05$) between: perceived paternal permissive parenting behaviour with emotional and physical neglect of the youths; perceived paternal authoritarian parenting behaviour with emotional and physical abuse of the youths, while perceived uninvolved parenting behaviour was found to be associated with both emotional and physical neglect of the youths. In that study, mothers who had authoritarian parenting style emotionally and physically abused their youths while those who were uninvolved, emotionally and physically neglected their youths.[112] Uninvolved parents give negative attention to the behaviours and activities their youth display; this is the opposite of approval and therefore this behaviour does not protect the youth from developing psychiatric disorders.

2.3 Psychiatric Disorders in a Family Setting

Landmark studies by Leinonen et al [62] in 2003 and Rutter [63] in 1979 on risks from the environment showed that several factors can endanger a youth's mental health. In these two studies, dysfunctional aspects of family life i.e. severe parental discord, a parent's psychopathology or criminality, overcrowding or large family size were shown to be predisposing factors for youths to develop psychiatric disorders. Beardslee [53, 70] documented that parental depression had a negative impact on the emotional and behavioural functioning of youths. This is because parental depression leads to family disruption and marital discord which impacts negatively on youths' mental well-being. Studies by Conger et al [76-77,113] in 1992-1995 documented that depressed parents responded negatively and inadequately to their youths' effort to engage their attention since the parents were irritable and lacked energy.

A study by Keller et al [114] in 2005 showed that youths from parents who abused alcohol had an increased risk of maladjustment. In this study, it was shown that parental alcohol use was associated with reduced family functioning and increased marital conflict which in turn made the youths disconnect from their parents. A study by Naomi & Williamson[115] also showed that parental psychopathology is associated with family conflict which is a precursor for youths to develop psychiatric disorders. Roosa et al [72] in 1993 showed that alcohol dependence has deleterious effects on youths. In that study, it was revealed that alcohol dependence causes a parent to exhibit unsupportive parenting behaviour, for example, inconsistent discipline, which is a predictive factor for the development of depressive disorder in youths.[72]

Studies have also indicated that parental mental health problems compromise a mother's or a father's parenting abilities and this represents a threat to their youths' adjustment. Frick et al [116] in 1992 showed that among youth with conduct disorder, 73% of their parents had some evidence of antisocial behaviour while Neuman et al [87] in 1997 documented that most mothers (64.6%) who had depressive illness had youth with depression. Naomi & Williamson[115] in 2004 found out that the rate of antisocial personality disorders among the relatives of the youth with depression and conduct disorder was elevated compared to the rate among relatives of youth with depression only and the social interactions of these families with mental health

problems were disturbed conflict. Thus, the presence of psychiatric disorder in the youth is directly related to increased parental psychiatric disorders and in turn associated with high parent-youth conflict.

2.4 Major Depressive Disorders in youth

Studies on mental health problems during childhood and adolescence development phases indicate that families of youths diagnosed with a depressive disorder tend to be dysfunctional.[1,5-10] Previous studies in this area also show that the youths brought up in dysfunctional homes, where one parent has a psychiatric disorder often have one or more co-occurring psychiatric disorders.[116-120] This effect seems to be stronger where both parents suffer from any psychiatric disorder.[10,33-35,53-55] Compared to depressed youth of non-depressed parents, youth with a family history of depression have been found to suffer more severe and chronic forms of depression, more relapses, psychiatric co-morbidity, impaired psychosocial functioning and suicidal behaviour.[121-124]

Studies carried out by WHO also indicate that depression is the most prevalent disorder worldwide with wide reaching consequences in youth.[23-26] The primary question addressed in this study is whether the presence of parental psychiatric morbidity and perceived maladaptive parental behaviour serve as useful indicators for predicting depression in youth. Studies also indicate that untreated depression in youth is associated with later development of anxiety disorders, bipolar mood disorders and drug abuse disorders in youth.[115-118] In Kenya, the prevalence of depression among youth attending general health facilities and those in secondary schools has been found to be high.[42-46] The prevalence of clinically significant depressive symptoms in Kenya is 43.7% among students in public schools in Nairobi province while the prevalence for those attending general health facilities is 41.3%.[12,46] As shown by Khasakhala et al [112] more than a quarter of students in high school suffer from MDD which has a relationship with aspects of perceived maladaptive parenting behaviour.

Few studies in Kenya have investigated the association between MDD in youth and parental psychiatric disorders or perceived maladaptive parental behaviour.[112] Anecdotal evidence in Kenya indicates that there

is a clinically significant relationship between MDD in youths and adolescents who have other co-morbid psychiatric disorders with either maladaptive parental behaviour or psychopathology in the parents. In this regard, important questions remain unanswered about the role of parenting behaviour in the intra-familial transmission of mental disorders for families which have youths with severe psychiatric disorders. The nature of this association is of considerable interest to mental health workers and scientists alike, in part because it may be possible to reduce the odds that youths will develop psychiatric disorders if parents are helped to modify their parental behaviour or access psychiatric treatment in case the parent has a psychiatric disorder. There is need, therefore, to document the negative and important roles that parents/ caregivers play not only to help their youths successfully transit into teenage/adulthood but also that this transition should be a healthy relationship void of psychopathology.

2.5 Risk Factors for Alcohol Use and Dependence among Youth

The prevalence of drug use among youth in the contemporary world is enormous, and what began as the use of drugs in African standard society for social relations and functions has evolved over time into a problem of dependence and abuse.[125] Worldwide, studies indicate that youth with alcohol use disorders have higher rates of depression (15%-24%) than youth in the general population (2%-8%) and co-morbid depression is also associated with more severe substance abuse.[44,126-134] Problem drinking behaviour in youth carries substantial costs at individual and societal levels. Numerous health problems are associated with heavy use of alcohol including chronic liver disease, heart disease, sexually transmitted diseases, stroke, depression, unintentional injuries and death affecting more males than females.[135] Findings such as these regarding gender differences in alcohol use behaviours and disorders have been reported consistently in the literature.[136-137] More specifically, males tend to drink in larger quantities and have more alcohol-related problems than females and they are also more likely to meet criteria for alcohol abuse and alcohol dependence.[137]

The use and abuse of drugs, especially alcohol and cannabis, by Kenyan school youths seems to be widespread and on the increase, even though the minimum age allowed is 18 years.[44,48,138-140] Concerns about

the increasing use of alcohol in Kenyan school youths have been repeatedly expressed and this has been supported by several studies which have shown a high prevalence of alcohol problems among high school students both in rural and urban schools.[44, 48,139-141] Drinking by secondary and college-aged students remains a major issue not only in Kenya but also in other countries.[139-142] On psychosocial effects of drugs in Kenya, Ndetei et al [48] indicates that 33.9% of the students are involved with substances, and their substance abuse problems significantly correlate with type of school, school attendance, age of the student and gender. Studies have indicated that cigarette and alcohol use are the commonest drugs abused with first use around 11 years of age.[48,142-143] Other drugs abused among youth in Kenya as indicated in school surveys and youth attending general health facilities include: cocaine, heroin, Khat and sedatives.[44,48,138-143] Among youth attending general health facilities, who were identified to abuse alcohol, findings showed pathological use.[44] Provision of mental health services for this population in Kenya is very low and many cases go unrecognized.[44,144]

Research examining developmental predictors of alcohol use has found a number of risk and protective factors associated with alcohol use in youth. These factors include demographic variables (gender), individual variables (delinquent activity, depression), parenting variables (parents' alcohol use, perceived maladaptive parenting practices/ parent–youth relationships) and peer variables (peers' alcohol use).[145-150] Because alcohol use fluctuates from youth to adulthood, it may be that childhood risk and protective factors may differ when examining drinking behaviour in adulthood rather than youth.[146] In order to identify the roots of varying levels of youth alcohol use, it is essential to examine developmental precursors in childhood, prior to initiation of alcohol use, as well as precursors in youth.[151-155] Findings from previous studies suggest that some predictors may vary by gender and having parents who have alcohol dependency disorder or who abuse alcohol; this is a strong predictor of alcohol use/dependence in youths particularly in early adulthood.[32,136-137,156-157] A study by Hill et al [152] in 2000 revealed that youths brought up in an alcoholic family developed alcohol disorders and dependence than youths without a family history of alcoholic parents.

Parenting factors have been linked to the onset of drinking in youth; levels of alcohol use in youth and problems with alcohol use in adolescence life and early adulthood. Parental rejection and under protection have emerged as important predictors of alcohol problems in youth.[5-8,49, 146-147, 150,152] Parental alcohol use has also been associated with youth alcohol use, such that higher levels of alcohol use by parents foretells higher levels of alcohol use by their youths.[128-129,148-149,151] Of particular interest are the combined contributions of childhood and youth variables to drinking behaviour across youth's life (13-25 years), and whether these predictors vary by gender and age of outcome. Additionally, gender predicts youth alcohol use[31, 134-135, 155] i.e. men tend to drink more and have higher rates of alcohol use disorders than women.[31, 135-136,157]

2.6 Substance Abuse among the Youth

The population of youth between ages 13 and 25 years with drug abuse disorders is heterogeneous with the largest subgroup across lifespan composed of those with one or more dual diagnosis.[126 155,158-161] The dual diagnosis in this age group is the rule rather than an exception and accounts for 70 to 80 percent in clinical samples.[161-164] Majority of youth with drug abuse disorders, as studies indicate, manifest with psychiatric co-morbidity.[161-164] In Kenya, little research pertaining to dual diagnosis between substance abuse and other psychiatric disorders has been reported. Substantial literature currently exists showing that youths from families where parents have alcohol use disorders are at greater risk for the development of psychiatric and psychosocial difficulties. [128-129, 148-149,151] Further, youths who have parents with drug abuse disorders have been shown to be at greater risk for developing drug and alcohol abuse problems co-morbid with anxiety disorders, depressive disorders, conduct and suicidal behavioural problems that result into low self-esteem, poor relationships, and poor global functioning among the users. [165-174] Therefore, youths raised in a family setting where parents have drug abuse disorders are generally at a greater risk of developing drug abuse disorders and psychiatric disorders than their peers whose parents who do not have substance use disorders.[165-176]

Given the dearth of literature on the relationship between drug abuse in youth and co-morbid psychiatric disorders in Kenya, it should come as no surprise that there is little information about the role of factors that

predict drug abuse such as age, gender, peer influence, psychiatric disorders in both parents and their youths, perceived maladaptive parenting behaviour and drug abuse/use among youth's parents.

2.7 Suicide Behaviour in Youths

Worldwide, suicide is among the top five causes of mortality. In the 15-19 year olds, it ranks first or second as a cause of death among both boys and girls.[177-179] It is the third leading cause of death worldwide in people aged between 15-34 years and represents 1.4% of disease burden globally.[180-191] A history of admission or attendance to a medical facility has been found to be the strongest risk factor for suicide in young people aged 10 to 19 years and is also associated with covariates such as a dysfunctional family background, poor socioeconomic status of the parents, and parental history of psychiatric illness.[181-185] These aspects of family dysfunction/instability and negative life events is often found in suicidal adolescents. They include: parental alcohol use, a violent and abusive family, poor care provided by parents/guardians, poor communication within the family and divorce, separation or death of parents/guardians.[180-18177-178]

The relationship between psychiatric or substance misuse problems and suicide behaviour among youth has been primarily studied in the developed world, with little data from low and middle income countries.[184-192] The development of adequate screening, prevention and intervention tools in low income countries would benefit from a more in-depth understanding of psychiatric or substance misuse disorders as a risk factor for suicide among youth. Therefore, screening for substance misuse, increased availability of methods used for suicide, HIV infection, family breakdown, lessened social interaction, increased psychiatric disorders, and greater acceptability of suicide as an option to solve the youth's problems must be documented to show evidence that youth suicide behaviour is associated with multiple family dysfunctions. In 2006, Bridge et al [193] showed that up to 80-90% of adolescent deaths due to suicide and attempters from both community and clinical settings had co-morbid psychiatric disorders. Again, research findings in both completed and attempted suicide have found the most common psychiatric conditions as mood, anxiety, conduct, and substance abuse (alcohol and drug) disorders. Therefore co-morbidity of psychiatric disorders, particularly

of mood, disruptive, and drug abuse disorders significantly increase the risk for youth to develop suicidal behaviour.[194-197]

A Finnish longitudinal population-based study found that among boys, the strongest predictor of completed suicide or making a severe suicide attempt by age 24 years was co-morbid conduct and emotional disorders.[198] This study found that one in 20 boys with co-morbid conduct and emotional disorders completed suicide or made a serious suicide attempt during adolescence or early adulthood, compared with only one in 250 boys without such problems. A prospective cohort study done in 2008 also found that anxious-disruptive girls and disruptive boys are more likely than their peers to attempt suicide by early adulthood, suggesting that gender-based differences in risk for suicidal behaviour should be considered both from a clinical perspective and in future research.[199] Substance abuse (alcohol/drug abuse) disorders contribute substantially to risk of suicide, especially in older adolescent males when co-occurring with mood disorders or disruptive disorders.[193-199] In 2009, Aseltine et al [200] examined the relationship between Heavy Episodic Drinking (HED) and adolescent suicide attempts. They found that adolescents who were 13 years or younger and who participated in HED had 2.6 times greater risk of reporting a suicide attempt as compared to those who did not participate in HED. For those youth who were 18 years and older, HED increased their suicide attempt risk by 1.2 times as compared to adolescents of this same age who did not participate in HED.[200] Schilling and colleagues found that drinking when one is depressed resulted in a threefold increase in the risk of self-reported suicide attempts.[201]

In Africa, Ndosi[202] identified schizophrenia, substance abuse, HIV/AIDS and personality disorder as the psychiatric and medical conditions associated with suicide. As observed by Viilo et al. [182] Ndosi indicated that 90% of people who die of suicide suffer from underlying psychiatric disorder, while at the same time emphasizing social factors as having the predominant influence on suicide.[202] It may be that these social factors could explain any differences between suicidal behaviours of those in Africa and other parts of the world, despite having similar psychiatric disorders. Existing data from the South African Stress and Health Study (SASH) investigating the prevalence and correlates of suicide behaviour reveal that having a

psychiatric disorder is a risk factor for suicide behaviour.[203] In this South African study, participants with at least one DSM–IV disorder were four times (95% CI 2.6–6.2) more likely to attempt suicide than those with no disorder.[216] Participants with three or more disorders were eight times more likely to attempt suicide (OR=8.3, 95% CI 4.8–14.2) and to develop suicidal ideation (OR=8.3, 95% CI 4.3–15.8) than were participants with no psychiatric disorder.[201]

In Kenya, Onyango found an increase in parasuicide in a retrospective study conducted in Nairobi.[204] In 1984, Mengech and Dhadphale[205] found a parasuicide incidence of 3.4% cases per month which rose to 13.3% cases per month in 1990 as was indicated by Nguithi.[206] To obtain a better understanding of the direct relationship between psychiatric disorders and suicide behaviour among youth in Kenya, studies accounting for the effects of co-occurring psychiatric disorders are essential to be undertaken.

2.8 Interventions

A major goal in giving CBT as an adjunct to standard methods of psychiatric treatments is to improve family communication and supportiveness.[92-96] The other added advantage is to decrease the intense negativity or severe expression of emotions that so often characterizes dysfunctional families, or those in which a family member has mental illness.[92-96] Additionally, since CBT methods are structured, there is capacity to help family members to identify what they desire from each other, institute behaviour change and develop possible strategies to solve most of the family problem(s) that put family members at a risk of developing psychiatric disorders.[94-96] Thus, when CBT is used in the management of depressive disorders in a youth-parent setting, the methods used during the therapeutic process act as mediating factors to solve problems associated with poor interaction among the family members, maladaptive parenting behaviour, youth maltreatment and psychiatric disorders in both parents and youths.[51-55,63,123,207-209]

Psychosocial interventions for alcohol and drug problems in youths and youth covers a diverse array of treatment interventions.[210-214] These interventions generally focus on the individual (their beliefs, feelings and behaviour), their social context, including family, community and cultural factors and the interaction between the domains. The F-CBT has been described in several studies.[210-211,214-218] CBT extends behavioural

therapy by integrating the impact of cognitive elements in addressing alcohol use. CBT is based on social learning theories and emphasizes functional analyses by addressing drug use in the context of its antecedents and consequences. The mainstay of CBT is the recognition of high-risk situations and the acquisitions of skills aimed at addressing those in high-risk situations or have alcohol use problems/disorders.

CBT has a clear underlying model that is structured.[216-218] Interventions in F-CBT process are delivered according to the structure where a strong therapeutic relationship is build between the therapist who trains the substance /alcohol users on social skills to change their substance/alcohol consumption behaviour and at the same time cognitively restructure maladaptive thoughts on the use of substances/alcohol through motivational interveiwing.[216-217]The main purpose of choosing this therapy was to educate the dysfunctional families (youth and their parents) about their alcohol use problems and at the same time to learn new skills of self-management which forms the pillar in each session as the participants put what they learn into practice for everyday living. It adopted a collaborative stance which encouraged individual family members (youth, their fathers and mothers) change their behaviour as what is learned in sessions is put into practice.

CBT comprises a range of approaches that are broadly based on learning principles and the idea that behaviour is influenced by cognitive processes.[218]The cognitive-behavioural approach implies that excessive alcohol use is a maladaptive way of coping with problems.[219] Inability to cope with life stresses in general and alcohol cues in particular are thought to maintain excessive drinking and lead to a resumption of drinking following unsuccessful cessation attempts. This learned behaviour can be changed through the application of combined cognitive and behavioural interventions.[218]In order to enhance patient (Youth-Parent) motivation to stop or reduce drinking, F-CBT model increases a patient's understanding of alcohol effect and consequences associated with excessive drinking and challenges maladaptive beliefs and thought patterns that lead to problematic alcohol use. Social skill training is incorparated in the therapy as the main behaviour therapy approach. Patients are trained on coping skills which are based on Bandura's [105-107] Social Learning Theory, the explanatory and predictive scope of self-efficacy theory and exercise of self control. Skills training assumes that developing effective coping skills can help individuals deal with stressful social

situations.[220] Coping skills training is based on the premise that drinking has become a way of coping with interpersonal stress.[221] Skills training provides alternative strategies to cope with social skills deficits and teaches clients to deal with interpersonal stress without excess drinking. Social skills (behavioural approaches) training used in this study included communication skills, listening techniques, assertiveness, problem solving, drink refusal skills, coping with urges to drink, relaxation, anger management and stress management skills training.

Coping skills training combined with cognitive restructuring using motivational interviewing approach has been regarded as one of the best-established and empirically supported interventions.[216,222] A number of earlier reviews have stated that there is consistent evidence that coping skills training and cognitive restructuring are effective in reducing alcohol consumption among alcohol dependent people.[211-217,221,223] It has also been suggested that skills training is more effective than other approaches when included as a component of a more comprehensive treatment program, but not when delivered as a stand-alone treatment or as aftercare.[220-221] Social skills training and cognitive restructuring have been identified as best supported treatment for alcohol use disorders in the Mesa Grand review.[215]

In a study combining integrated family therapy with CBT, 43 youths were randomly assigned to receive integrated family therapy with CBT or a drug harm psycho-education curriculum during a 16-week treatment period.[224]This study used an integrated family therapy with CBT problem-focused family therapy that promoted drug abstinence by fostering adaptive family communication, age-appropriate roles, and effective parenting skills. Behavioural approaches in the study used contracts, and the cognitive component introduced youths to rational-emotive and problem-solving principles. The drug harm psycho-education used drug information from the National Institute on Drug Abuse, which included harmful effects and negative consequences associated with drug use. Treatment duration was 16 weeks, with 1-, 3-, and 6-month follow-up evaluations. Alcohol and illicit drugs of all types were targeted for use reduction. Assessment instruments were validated specifically for use with the youths. The drug harm psycho-education group had an average alcohol use rate of 6.06 days/month, compared with 2.03 days/month for the integrated family therapy with

CBT group.[222] Liddle et al [225] conducted a study among alcohol-abusing youths (n = 182) between the ages of 13 and 18 years who were randomly assigned to receive weekly multidimensional family therapy, youth group therapy, or multifamily educational intervention for a 14- to 16-week period. At the end of the treatment period, subjects in the multidimensional family therapy group showed the most improvement overall, with 42% of participants reporting drug use reduction, while youth group therapy showed 25% reduction and multifamily educational intervention 32% reduction.[225]

Kaminer et al [226] randomly assigned 32 youths with dual diagnoses (age range: 13–18 years) to a 12-week treatment with CBT versus interactional group therapy in an outpatient setting. CBT included educational presentations, modelling, role playing, and homework exercises. The primary outcome variables were urine drug screen results, scores on the Teen Addiction Severity Index, [227] and self-report of quantity and frequency of drug use. In this study although there was no treatment-matching effect, youths in the CBT group showed significant reductions in severity of substance use on the Teen Addiction Severity Index tool.[226] In another larger, randomized, controlled trial by Kaminer et al [228] comparing CBT with psycho-educational therapy in treating youths with substance use disorders, overall, alcohol use decreased significantly from baseline to 3 months, favouring the psycho-educational therapy group, whereas the reduction in use of other substances favoured CBT. This study had youths (n = 88) with dual diagnoses and were randomly assigned to 8 weeks of either CBT or psycho-educational group therapy, for 75 to 90 minutes/week.[228] The age of the subjects ranged from 13 to 18 years (mean: 15.4 ± 1.3 years). Both conditions revealed improvements in self-reported substance use measures from baseline to 3- and 9-month follow-up periods.

In another 9-month follow-up study of 74 subjects (age range: 13–43 years) with drug abuse disorders who received behavioural therapy versus supportive therapy, it was found out that the behavioural therapy group had significantly greater reductions in drug use at the end of treatment and the follow-up period.[229] Furthermore, in that study, the behavioural therapy group showed more days worked, less alcohol use, and more days in school than did the supportive therapy group.[229] In another study where behavioural therapy

was expanded in the context of the family to treat youth with a dual diagnosis of substance abuse and conduct behavioural problems, results of the study showed that behaviour therapy is as effective as individual cognitive problem-solving in treating youths with substance dependence.[230]

Although clinicians are not reluctant to use pharmacotherapy to treat youths with psychiatric disorders, medications are rarely used to target alcohol use disorders directly. When medications are used in this population, they are often used to counteract adverse effects of alcohol withdrawal or to treat co-occurring psychiatric disorders. Deas et al [231] sought to evaluate the efficacy, safety, and tolerability of sertraline in treating youths with alcohol dependence with co-occurring depression. Ten outpatient treatment-seeking youths were randomly assigned to 12 weeks of either sertraline or placebo treatment. In addition, all subjects received 12 weeks of group CBT. Outcome variables were quantity and frequency of alcohol use (drinks per drinking day and proportion of days drinking) and changes in depression scores measured with the Hamilton depression scale. Overall, there were significant reductions in depression scores and alcohol use, although there were no group differences. The lack of differences between the groups may be accounted for by the use of CBT, a treatment already proven to be effective for alcohol dependence.

Accurate assessment of suicidality is of major importance in both clinical and research settings. Youth suicide behaviour occurs usually in the context of an active, often treatable, but unrecognized or untreated mental illness.[194, 204,232-233] Patients with mental disorders, particularly depressive disorders, are at much greater risk for suicide than those in the general population.[234-236] Suicidal ideation, self-harming, suicide attempts and completed suicides are different forms of suicidality. Although the domain of suicidal behaviour probably is multidimensional [237] a continuum from suicide ideation to suicide attempts has been reported in youthful clinical populations.[238-239] Thus, although most patients with suicidal ideation do not attempt suicide, identification and assessment of severity of suicidal ideation is therefore of major importance in any psychiatric clinical setting whether as outpatient or inpatient.

Intervention for suicide among youths is vital because these behaviours are predictive of future suicidal behaviour and risk of repetition is highest in the first 3–6 months post-attempt.[204, 240-242] Prior suicidal

behaviour elevates the risk for subsequent death by suicide 10–60 fold.[206, 243-244] Suicidal ideation is part of the diagnostic description of major depression (DSM-IV), but completed suicide is not limited to people with depressive disorder.[245-246] Therefore, the persistence of suicide behaviour is an adverse outcome of psychiatric illness.[247] However, there may be subpopulations of individuals that are constitutionally much more vulnerable or resistant to suicide. A psychiatric disorder or high level of psychological distress in combination with high suicide vulnerability may result in a dramatically increased risk of death by suicide.[247-249] Moreover, youths with depressive disorders or any psychiatric disorder and a history of suicidal behaviour are a particularly high risk group for repeated and completed suicide.[243-245,250-251] Despite this public health problem, there are no scientifically supported individual psychotherapies for youths which are effective in reducing suicidal behaviour through randomized controlled trials (RCT).[252]

Family, group-oriented and brief, adjunctive psychosocial intervention models have been tested in suicidal youths. Wood et al [253] in 2001 evaluated the efficacy of developmental group therapy for youths with self-injury behaviour, using problem solving and cognitive behaviour therapy, and psychodynamic group psychotherapy strategies. Patients attended six "acute" group sessions organized around specific themes (i.e., relationships, school problems and peer relationships, family problems, anger management, depression and self-harm, hopelessness and feelings about the future), followed by weekly group therapy. The experimental treatment, compared to routine care, showed a reduction in episodes of self-harm, time to first repetition of self-harm was also delayed and school attendance was improved. There was no differential treatment effect on depression, suicidal ideation, or global outcome. Harrington et al [254] compared a 5-session home-based family intervention plus routine care to routine care alone for youth who made suicide attempts. Although the experimental intervention was no better than routine care for reducing ideation or reattempts, among the non-depressed subgroup, the home-based treatment reduced suicidal ideation more than usual care. King et al [255] developed a novel intervention in which suicidal youths identified adults in their life who would be a source of ongoing support. Although there was no main effect for suicide ideation or attempts, females in the study intervention group reported greater decreases in suicide ideation than females in the control.[256]

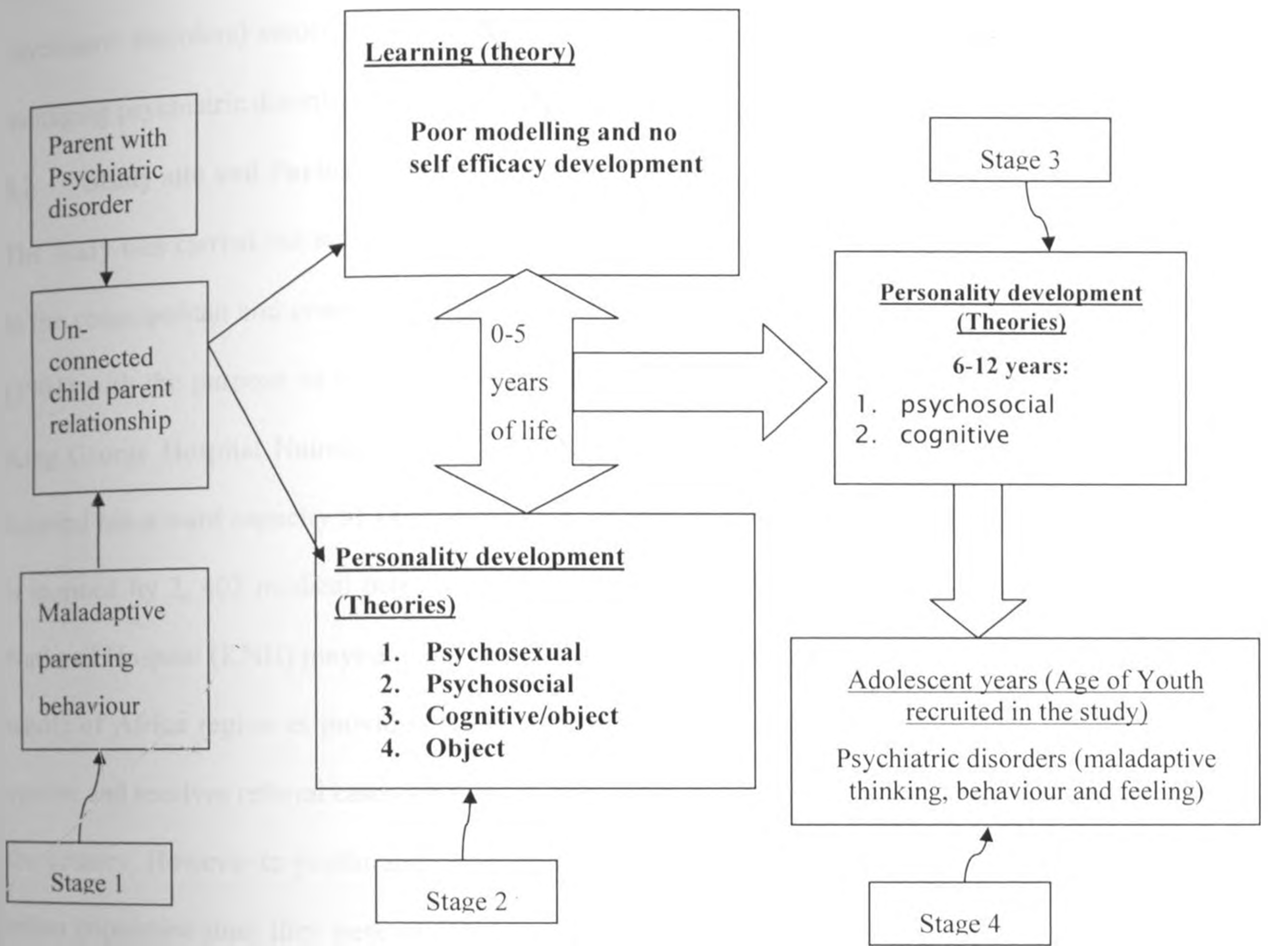
Therefore, interventions that aim to reduce the severity of established risk factors for suicidal behaviour such as depression/psychiatric disorder, suicide ideation and impulsivity may be beneficial. Such interventions are likely to be most effective if youth's support systems are involved during the intervention.

2.9 Conceptual Framework

The attitudes and behaviours learned in childhood within a family environment where the youth's personality is shaped lay a foundation on which youths develop their thinking, feelings and behaviour patterns. The types of authority youths are exposed to in the early years of their lives greatly determine how they think, feel and behave later in life. Youths growing in dysfunctional family settings suffer multiple deprivations. These deprivations could be physical or emotional and are associated with lack of social support network that has been shown to mitigate many stresses of life leading to poor self esteem.[106-107,207] If not rescued, many of the youths growing up in a dysfunctional family continue to experience varying degrees of difficulties in forming trusting relationship with people, in particular, learning from experience and therefore develop maladaptive patterns of thinking, feeling and behaving. The conceptual framework in this study is drawn from a combination of attachment and learning theories as illustrated in Figure 1 below. This framework is built on theoretical framework (attachment theory) whereby unconnected parent-youth relationship does interrupt personality development and learning processes throughout the infancy and childhood period.[12] Consequently, in adolescent years, youth brought up in a dysfunctional family setting develop maladaptive patterns in their behaviour, feelings and thinking; the multiple symptoms presentation of their psychiatric disorders.

To conceptualize participants' psychiatric problems and plan the intervention for each family setting, the clinical evaluation for each family member, their maladaptive behaviour, feelings and thoughts were assessed. To change maladaptive cognitions or maladaptive behaviour, the abnormal findings were identified first before changing them through cognitive methods or reversing maladaptive behaviour through the behaviour methods of CBT processing.[216] Three major levels of cognitions in CBT are full consciousness, automatic thoughts and schemas.[217]

Figure 1: Conceptual framework-Khasakhala, May 2007



Note: Stage - From the theoretical frame work, a child growing in this environment has no connection with the parent.Stage 2- Throughout early childhood years, without connection to the parent, the child has no appropriate parental model to learn from and therefore develops through the environment without understanding consequences of their behaviour as they manipulate the environment. Stage 3- Late childhood (6-12 years) where the parents have laid no concrete ground for cognitive development and not industrious, hence inferior, develop low self esteem. Stage4: With poor childhood (un-connectedness), there are multiple cognitive distortions, maladaptive feelings and behaviour- resulting in psychopathology in youths.

CHAPTER THREE

3.0 METHODS

3.1 Study design:

This was a clinical trial design that assessed parental factors (maladaptive parenting behaviour and psychiatric disorders) associated with psychiatric disorders in youth and also tested the efficacy of F-CBT in managing psychiatric disorders in this sample population.

3.2 Study site and Participants

The study was carried out at the Youth Centre at Kenyatta National Teaching and Referral Hospital located in the cosmopolitan and commercial capital city of Kenya. The hospital was built during the colonial days (1901) with the purpose of rendering services to indigenous people (Africans and Indians). It was named King George Hospital Nairobi in 1952. It is currently a National, Teaching and Referral Hospital. The hospital has a ward capacity of 1800 in-patients and 40,000 patients are seen in the outpatient per month. It is manned by 2, 402 medical personnel (1002 medical practitioners/clinicians and 1400 nurses). Kenyatta National Hospital (KNH) plays a major role in healthcare delivery system in the country, East Africa and the whole of Africa region as provided for in its mandate. The hospital has an efficient and effective referral system and receives referral cases for specialized healthcare from other health institutions within and outside the country. However to youths and participants included in the study represents families in urban and peri-urban population since they were required to attend clinic appointment fortinightly.

KNH is the hospital of choice for the majority of the population in the capital city, Nairobi, and the surrounding environs due to its affordability and quality healthcare. The institution facilitates medical training for students of the College of Health Sciences of the University of Nairobi, The Kenya Medical Training College, and other higher learning institutions. This is in addition to facilitating research either directly and/or through other cooperating health institutions. The hospital also participates in national health policy formulation.

UNIVERSITY OF NAIROBI
MEDICAL LIBRARY

Kenyatta National Hospital is well equipped to set stage for attaining continental and international healthcare standards. This has led to efficient diagnosis and patient management for better medical outcomes as well as enhanced its competitiveness in the contemporary healthcare industry at local, regional and international level. KNH has a comprehensive care centre that handles HIV/AIDS patients, dispensing medicine, monitoring viral loads and counselling.

The hospital has a patient support centre devoted to recovery of gender violence victims. It also has an Accident and Emergency facility which has been expanded to improve patient flow. Improved integration of emergency and support services has made it a one stop patient management complex. The complex has an acute room, six emergency beds, laboratory and three spacious operating theatres dedicated to emergencies and surgery trauma patients as well as financial services, counselling and pharmacy. The hospital also has improved other services such as Radiology, Cardiology, Neonatal, and Critical Care Unit, laundry and power upgrade. KNH provides specialized services like open-heart operations, brain surgery, complicated eye surgery (intra-ocular), skin operations using laser and plastic surgery.

The Youth Centre was started in 1990 at the hospital as a project funded by Pathfinder International and handed over to Kenyatta National Hospital in 2000. The main objective of the centre was to provide the youth with preventive, promotional and curative services in order to reduce morbidity and mortality associated with high risk behaviours. The areas of priority for medical attention and counselling services offered are psychiatric morbidity and youth reproductive health; abortion and post abortion complications and their management, unplanned youth pregnancies, post-natal, family-planning services, behaviour modification, sexually transmitted diseases and voluntary counselling and testing (VCT). The clinic operates from Monday to Saturday between 8.00am to 5.00pm, handling an average of 360 youth per month. In the year 2006, the clinic received a total of 6446 youth. At the time of data collection, the clinic had four full-time staff members (a matron (administrator), 3 nurses/counsellors, and one support staff). The psychiatric, obstetrics and gynaecological services are offered by consultant specialists in psychiatry and gynaecology/obstetrics from the hospital and the University of Nairobi. The clinic also accommodates

students from various institutions of higher learning who carry out research and practicum sessions at the centre.

The selected population in the study included all the youth aged 13 to 22 years old and their parents who visited the clinic for psychiatric and behaviour modification services, either as self referrals or as referrals from other hospital departments or from external institutions. The choice of KNH as the study area was advantageous due to the following reasons: The youth centre runs on a daily basis from Monday through Saturday for any youth requiring any attention/information, this increased the probability of enrolling many participants for the study and since the hospital serves as a major referral hospital in the region, youth from different parts of the country are referred. Therefore youth from different parts of the country had equal opportunities of being recruited into the study.

3.3 Sample Size Calculation and Sampling Procedure

This research used Cochran's sample size formula.[257] This formula addresses both continuous and categorical statistical variables which are the independent, confounders and outcome data measures in this study. This formula also applies a key risk factor the researcher is willing to accept at 95% confident interval; the error margin, an acceptable risk that is within a true margin error, type I error also called alpha, a value usually estimated at 0.05 (5%). This is a statistical measure set to detect a statisticaly significant difference between the test groups i.e the likelihood that the study will detect a deviation from the null hypothesis given that there is difference between the study groups. Sample size for the study was therefore determined by Cochran's sample size formula:

$$N=\frac{Z^2 p(1-p)}{d^2}$$

Where: Z is the standard normal distribution set at 1.96 which corresponds to 95% confidence level. P is the proportion in the population with characteristics (prevalence) under investigation which is the prevalence of psychiatric disorders among youth attending the psychiatric clinic at 80% (0.8) and d is the degree of accuracy desired or the error margin set at 5% (0.05).

The youth under investigation were seen at the youth centre whereby 80% presented with mental illnesses that required treatments. The other 20% are seen at the centre for other reasons including VCT, family planning and general information as it pertains to youth needs at this stage in life. Therefore N was calculated as:

$$\frac{(1.96^2) \times 0.8(1-0.8)}{(0.05)^2} = 246$$

The calculated sample size was 246 per subgroup: youth, mothers and fathers, however the sample was estimated up by 10% because of expected attrition rate of 10%; youth with severe psychosis or parents who were anticipated not to give informed consent (see exclusion criteria below).Therefore, 271 participants per group were expected to be enrolled into the study giving a total sample size of 813 participants. To pre-select participants in the study, judgment sampling procedure, a non-probability technique was applied which assumes that there is an even distribution of characteristics within the population under the investigation. This was achieved on the first day of meeting youth and there parent(s) by carrying out intake interviews as part of patient records into the clinic to pre-select the study subjects daily when the clinic operates using the socio-demographic and open ended clinical interview schedule (appendix B1). Only youth with any DSM-IV axis I psychiatric disorder were pre-selected and second appointment given, and youth were informed that they were to come with both parents on the next visit. [258-259]

3.4.0 Instruments (Appendix 2)

3.4.1. Socio-demographic and Open Ended Clinical Interview Schedule (Appendix 2a). This was a researcher developed instrument that captured the socio-demographic characteristics among the participants in part A of the questionnaire. The questionnaire captures socio-demographic characteristics of youth and their parents. These include age, gender, highest education level attained, occupation, marital status, number of youths, if youth has peers who use alcohol, if youth has ever seen the father drunk or use alcohol excessively and income. It was followed by an open ended structured clinical interview schedule in part B. This was used to gather descriptive data in the participant's own words so that the researcher could develop

understanding on how the participants interpret situations and phenomena in their own words and classified the disorders according to DSM-IV diagnoses of Axis 1 disorders after the clinical psychological assessment.[258-259]This provided opportunities that assisted the researcher in establishing human-to-human relations; a rapport building process and establishment of therapeutic relationship with the participants.

3.4.2. Mini International Neuropsychiatric Interview for Youths and Adolescents (M.I.N.I. Kid) - administered to youth and Mini International Neuropsychiatric Interview for Adults- M.I.N.I. Plus (Appendix 2b and 2c) [260-261]These are structured diagnostic interview schedules developed for diagnoses of DSM-IV and ICD-10 psychiatric disorders. With an administration time of approximately 15 minutes, it was designed to meet the need for a short but accurate structured psychiatric interview for multi-centre clinical trials and epidemiology studies and the schedules were used in this study as a first step in outcome tracking and confirming the axis 1 DSM-IV [259]co-morbid disorders as formulated using the open-ended structured clinical interview schedule above among the study population.

The interview questions are designed to elicit specific diagnostic criteria according to DSM-IV diagnosis.[258-259]The questions are read in verbatim. If the respondent does not understand a particular word or concept, the interviewer may explain what it means or give examples that capture its essence. If respondent is unsure if s/he has a particular symptom, the interviewer may ask him /her to provide an explanation, for 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 respondent time to respond. Questions about the duration of symptoms are included for diagnoses when the time frame of symptoms is a critical element. Because the respondent may have difficulty estimating time, the researcher assists 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. All questions are rated. The rating is done at the right of each question by circling either Yes or No. Clinical judgment by the interviewer should be used in coding the responses. The interviewer should ask for examples when necessary, to ensure accurate coding. The participants were encouraged to ask for

clarification on any questions that were 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 and MINI PLUS.[260-261]

3.4.3 The Mini-Mental State Examination (MMSE) (Appendix B3)[260]: The Mini Mental State Examination (MMSE) is the most commonly used test for memory problems and cognition. It also contributes to the diagnosis of dementia. It is not only used as a test for Alzheimer's disease but also to screen for the presence of cognitive impairment on mental activities such as memory, thinking, calculation, language, constructional ability, reasoning, decision making, orientation to time, place, attention, immediate and recall memory and dealing with concepts i.e. abstraction.[60] Developed by Dr. Marshal Folstein in the 1970s [262], the MMSE has been used not only as a clinical tool, but as a research tool in developed countries such as Europe and America[263-269] and in developing countries including Kenya and South Africa.[270-271] It is a very useful broad screening test, especially when it is suspected that mental functions are severely compromised.[272] It was filled out in this study by the youth before allocation to either experimental or control, after 1st phase (3 months of treatment) and 2nd phase (9 months) of treatment. The maximum score is 30 and a score of 24 or less raises the possibility of dementia in older persons, especially if they have had nine or more years of education. As a rule, scores of 24 or lower indicate delirium, dementia, severe current schizophrenic or a mood episode. The MMSE is a brief quantitative measure of cognitive status in adults and youth, and can be used to estimate the severity of cognitive impairment at a given point in time, which predicts incapacity of cognitive impairment ability for the affected person not to form a therapeutic alliance with the therapist.[273] The MMSE has demonstrated validity and reliability in psychiatric, neurological, geriatric and other medical populations.[263,265-266,268] It takes 5-10 minutes to be filled out by the participants.

3.4.4 Egna Minnen Betraffande Uppfostran (EMBU) questionnaire (Appendix B4): This was developed by the Department of Psychiatry, Umea University, Sweden and WHO Collaborating Centre for Research and Training in Mental Health.[14-21] This questionnaire of recalled parental rearing behaviour

comprises 81 items, which have to be answered separately for the mother and father according to likert-type categories: "no, never"=1, "sometimes"=2, "yes, often"=3 and "yes, always"=4.[17] From each of these four scales, the eight items are selected for showing the highest factor loading, "Rejection or punishment", "emotional warmth or rejection" and "control or overprotection". This was adopted from a factor-analysis and trans-culturally generalizable factor structure, with the scales "rejection", "emotional warmth" and overprotection.[17]The questions are grouped into eight constructs following factor analysis: Parental emotional abuse/neglect, parental physical abuse/neglect, authoritarian parent, under involved parent, permissive parent and authoritative parent. The constructs were further factually derived into four perceived parenting behaviour dimensions: emotionally attached parent (emotionally/physically abusing and authoritarian parenting behaviour); Rejecting parent (emotionally and physically neglecting parenting behaviour); under protective parent (Permissive or under involved parenting behaviour) and adaptive parenting behaviour (authoritative parenting behaviour) which are distributed across the four scales.[112] This questionnaire is self administered and has been used in Kenya in a similar age group population.[112]

3.5 Ethical considerations

The youth are a vulnerable group and therefore every effort was put into place to ensure that they and their parents participated voluntarily.

a) The researcher was taken through intensive training by the lead supervisor not only on the instruments but also on interview evolvement to allow collection of credible data.

b) Informed consent: an explanation of the purposes of the research and the expected duration of the subject's participation, a description of the procedures to be followed, and identification of any procedures which are experimental; and the risks involved were explained in the consent explanation (appendix A), namely invasion of personal and family life on questions related to psychiatric disorders, substance use, family relationships and family interactions.

c) The benefits to the participants in the study were explained in detail. The explanations described investigations, biological treatments, psychosocial treatments and referrals to be offered at Kenyatta National Hospital to manage psychiatric disorders found in a family setting of the participants.

d) Privacy and confidentiality: Confidentiality was maintained throughout the study whether on a one on one basis with individual clients or as a family. Participants were assured that the deliberations discussed during the sessions would go into medical records and remain private and confidential as patient information which can only be released on medical legal basis if requested by a court of law.

e) Voluntary participation: that participation was voluntary, refusal to participate would not attract penalty or loss of benefits to which the respondent was otherwise entitled and that the subject could discontinue participating in the study any time without penalty or loss of benefits.

3.6. Inclusion and exclusion Criteria

Those recruited in the study were youths aged 13-25 years and their biological parents. The criteria to be recruited into the study was that they must have registered at the clinic, were able to understand either English or Kiswahiii and had assented or consented to the study. Before participating in the study the parents had to have given a written informed consent and were able to understand either English or Kiswahili (or both). For youth below 17 years who assented to participate, one of their parents was asked to give informed consent before participating in the study.

Exclusions criteria: Youth attending the clinic who were below 13 years or above 25 years; those who scored less than 25 points on the Mini mental state examination; those who did not understand either English or Kiswahili, those who had no living biological parent, those whose biological parent(s) did not come and therefore did not consent and those who did not give consent or assent.

3.7 Recruitment and treatment Procedures

At intake, the youth were first assessed clinically by taking their history and psychological examination qualitatively. Since most youth presented with severe symptoms for any psychiatric disorder, they were put on the standard psychiatric treatments provided at KNH. At this first visit, the purpose of the study was

explained to youth and DSM-IV axis 1 psychiatric disorders were assessed. Before coming for the second appointment, youth were requested to explain the purpose of the study to their parents (if they were unaccompanied on first day) and on appointment day were to come accompanied with their parents. On this second appointment since the participants were pre-selected and were eligible to participate into the study, the researcher introduced and explained the purpose of the study to the youth and his/her parents as shown in the flow chart below (figure 1). If the youth and the parent(s) voluntarily accepted to participate in the study; informed consent from parents and youth, 18 years and above, was sought before proceeding to the private counselling rooms. Youth aged 17 years and below gave assent and the informed consent sought from their parents. Once informed consent and assent were obtained, youth were reassessed using the structured clinical interview (MINI KID) before filling out the EMBU questionnaire and parents were assessed with MINI PLUS to document any psychiatric disorder as a baseline assessment for axis 1 DSM-IV disorder.

On the 3rd appointment, youth and their parents were reassessed using the MMSE to test cognitive functioning. On completion of the 3rd assessment, youth and parents who scored 25 points and above on MMSE were allocated either to experimental or control groups; those with odd number were allocated to experimental and those with even numbers to the control (the serial numbers were obtained from clinic register records whereby on any material day all clients who attend the clinic are registered). Emphasis on need for follow-up at the clinic for the next 9 months was explained. To minimize on the herd effect, families allocated to experimental group, all bookings for F-CBT scheduled Thursday, Friday or Saturday for families were booked on each therapy day; therefore per week a total number of 12 therapy sessions were processed. Also in experimental group, Follow up 1 and 2 were done within scheduled times on the day a family was attending F-CBT. Tuesday was specifically for recruitment, assessment at baseline for both groups, allocation into the two treatment groups and Follow up 1 and 2 for control group only. Otherwise, participants allocated in experimental group would have mixed with those allocated to control group. Thus F-CBT was not instituted on Tuesday because the SPTM by other clinicians were provided on this day.

The youth and their parents allocated to experimental group were introduced to F-CBT and the first session

for treatment was commenced: psycho-education about the psychiatric disorders found either in the youth or parent (appendix C). Also introduced were basic coping skills in stress management and behavioural modifications (for both parents and their youth family setting). This session was used to form a therapeutic alliance. Emphasis was re- laid on their involvement on a two weekly appointment for experimental group while those in control group were given specific appointment dates after three and nine months respectively for mid and final assessments (See figure 2). Thus study assessment occurred at entry point (baseline, follow up 1 and follow up 2), after three months into treatment (follow up 1) and at end point (9 months of treatment-follow up 2). Several follow-up visits at the youth clinic occurred every two weeks for the experimental group while the control was re-assessed at the point of entry into the study, three months and at nine months. Youth in the control continued with their follow-up using the SPTM offered at KNH Youth Centre while their parents with psychiatric disorders were referred to the adult psychiatric outpatient clinic or patient support centre at KNH for SPTM. Sessions in the experimental group were typically conducted with individual family members-parents and the youths. Parents and the youths participated every fortnight in a 40-60 minute session (average number of sessions were 14). The program consisted of a series of parenting skills designed (Appendix c) to help the parent break from their coercive cycle of interaction with the youth by increasing positive attention to appropriate youth behaviour, ignoring minor inappropriate behaviours, providing clear instructions to the youth, and providing appropriate consequences for compliance (positive attention) as well as noncompliance by giving time-out. Skills were taught using demonstration, role plays, and direct practice with the youth at the youth centre and at home (assigned homework). Progression from one skill to the next was based upon demonstrated positive interaction between the youth and parent.

Data collection procedure

There were four data sets (figure 2-flow chart):

(i) Open ended structured interview schedule (Appendix B1: History and Psychological examination). This encouraged youth in the study to give open-ended accounts of psychological and behavioural problems,

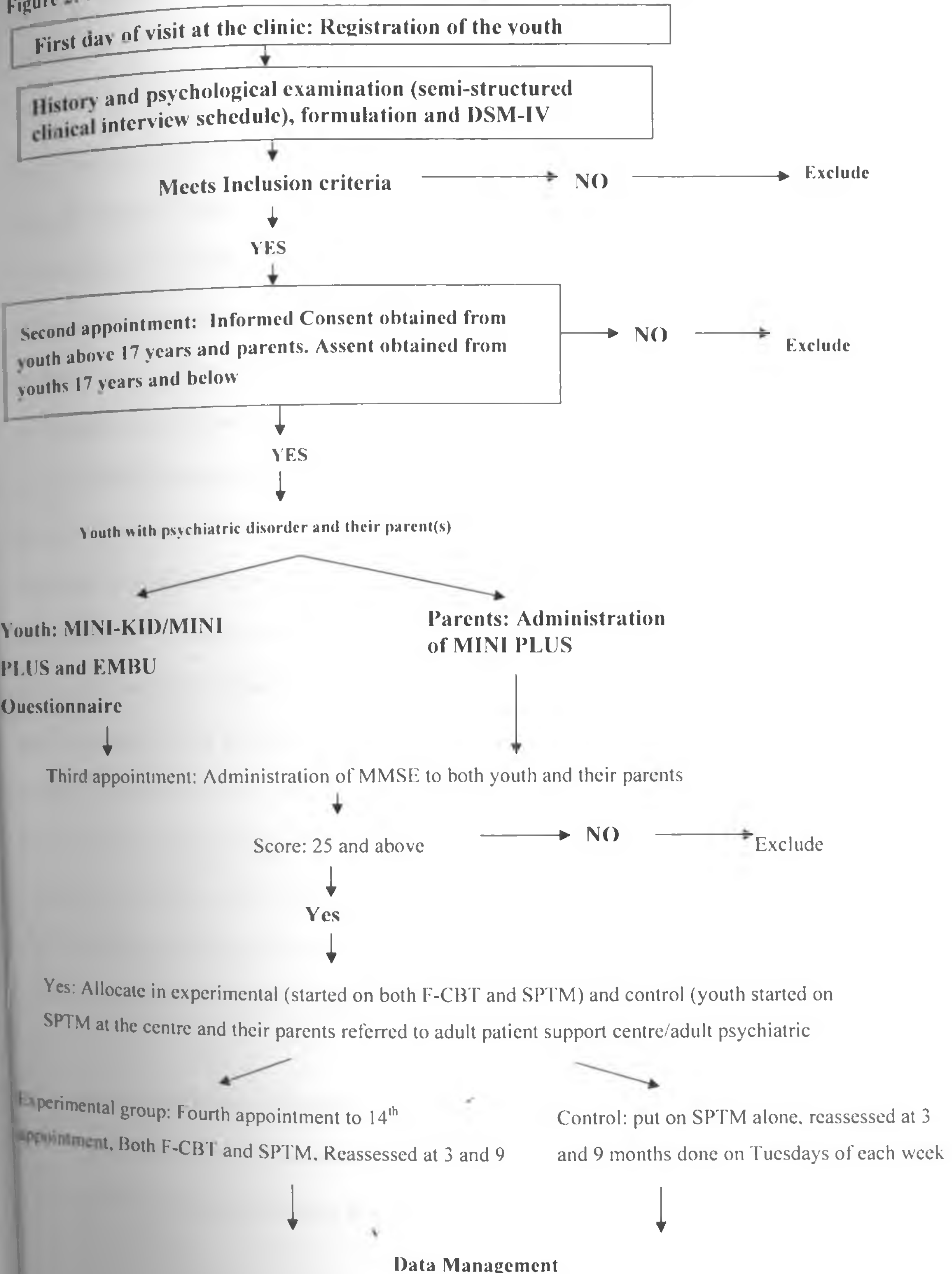
which was captured qualitatively to pre-select participants into the study. This open ended structured psychological interview schedule was used at baseline to gather descriptive data in the research participant's own words. This was done to enable the researcher to understand how the participants interpreted situations and phenomena in their own words. This provided qualitative information, established human-to-human relations and identification (therapeutic alliance) between the participants and the researcher.

(ii) Structured interview schedule (MINI KID and MINI PLUS-appendix B2 and B3), used at baseline, Follow up 1 and 2. All youth and their parents recruited into the study were asked the same series of pre-established questions in each category that had a limited set of responses. This interview provided little room for variation in responses. The responses were recorded according to a pre-determined coding scheme so as to reduce the researcher's influence on the participant's answers i.e. a yes or no response. It was considered that these interviewing sessions were the most critical in facilitating the psychosocial interventions. These included active listening which encouraged the participants' participation without evaluating their responses, and motivational interviewing which involve a high order combination of observation, empathetic sensitivity and intellectual ability to judge what the interviewee said. By using reflections, the researcher clarified and positively gave a feedback to the participants. This was administered on the second day of appointment.

(iii) **MMSE B4:** This was administered on the third visit at baseline only. If the youth or parent scored less than 25 points, then they were excluded from the study.

(iv) Structured interviews (EMBU questionnaire, appendix B5): This self administered questionnaire was filled out by youth recruited in the study at baseline. This was a self administered questionnaire, given to the youth, done on second day of appointment.

Figure 2: Participants sampling frame and flow during the study (flow chart)



3.8. Data management

All data was entered into a computer system using the SPSS data builder in codes and analysed using SPSS version 18.

Data of MINI kid and MINI plus was computed selectively for cases that illustrated themes that classify each DSM-IV disorder category. This was done by selecting all "yes" responses for each respondent on the structured interview schedule for each specific psychiatric disorder. A specific axis I DSM-IV disorder for each respondent was arrived at if the "yes" responses met the criterion for the specific psychiatric disorder. During selective coding, common (depressive, anxiety and substance/alcohol abuse disorders) and severe (schizophrenia and bipolar I mood disorders) disorders ultimately guided the analysis and thereafter the data was reorganized into specific DSM-IV categories to build on major quantifiable DSM-IV axis I psychiatric disorders. During quantitative analysis, the data presented in these results were broken into different proportion of youth and their parents who were treated at the KNH Youth Centre and all outcomes are in binary format. The proportions of youth participants were broken down further according to DSM-IV diagnostic criteria to compare clinical classification of the psychiatric disorders delineated among the youth and their parents, and also analyzed their associations in relation to perceived parenting behaviour and parental psychiatric disorders. The chi-squared statistical test was used to test this comparison of proportions between perceived parenting behaviour and psychopathology among the participants. Where the number of participants in a given cell was less than 6, Fisher's exact test was used to test the statistical chi square test. All the possible characteristics of the study population were processed to reach generalizations about the youth by applying the statistical measures and testing the hypotheses. Descriptive analysis was carried out to:

i. describe the socio-demographic characteristics of the study population;
ii. establish parenting behaviour across the study population;
iii. classify psychiatric disorders and substance abuse in both the youth and their parents; and

iv. Inferential statistics; chi square test and multiple logistic regression analysis were used to ascertain significant differences between parenting behaviour, psychiatric disorders and effectiveness of F-CBT between the experimental and control as indicated in figure 3a and 3b below.

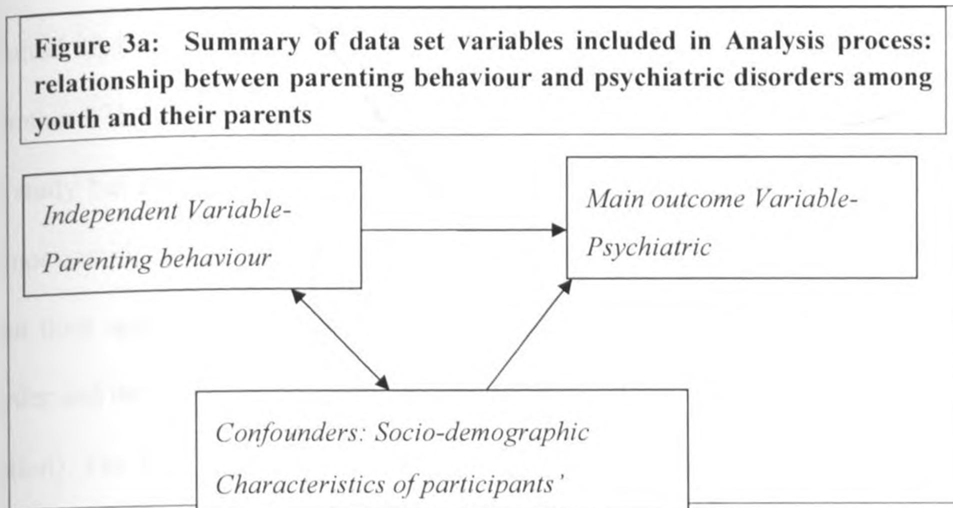


Figure 3a

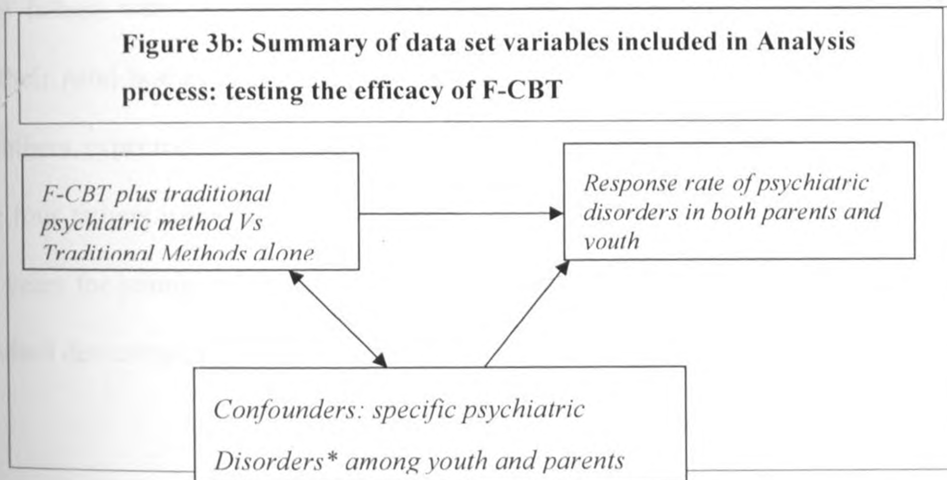


Figure 3b

*psychiatric disorders among youth and parents which had significant statistical difference between experimental and controls

CHAPTER FOUR

4.0: RESULTS AND FINDINGS

The study recruited 82.4% (670) participants out of an expected 813 calculated sample size (271 youth, 271 mothers and another 271 fathers). A total number of 267 youth were recruited at the beginning, 95.5% (255) completed the study but 250 (93.6%) were included in the analysis at baseline, Follow up 1 and 2. Out of those who did not complete 4.5% (12); 5 did not return to the clinic for follow-up despite several telephone reminders about their appointment, 4 parents did not sign up the consent forms, and 3 youths had severe psychotic disorder and therefore did not meet the final criteria (scored less than 25 points on the Mini Mental State Examination). The five youths were not included in the analyses; two had PTSD as a result of sexual abuse within their family setting and therefore did not consent for their parents to be involved in their therapy. Three others had witnessed their family members murdered and therefore had traumatic grief which warranted grief therapy. Out of the 250 total numbers of mothers expected to participate, 90.4 %(226) were recruited: nine fathers were widowers, two mothers were unknown to their children and twelve lived upcountry in their rural homes and therefore were unavailable to participate fully in the study. Among a total of 250 fathers expected to be recruited in the study, 80.8% (202) were recruited: 38 mothers were widows while four fathers were unknown to their children. The age range of the youth who completed the study was 13 years for youngest and 22 years for the oldest with a mean age of 16.92 years, median of 17 years and standard deviation of 2.151.

4.1 Characteristics of the study participants

A total of 250 participants from two sites namely E (Experimental) and C (Control) were recruited and completed the study. Three assessments were done from baseline to end line (follow up 2) on different population characteristics. Baseline assessment was done on selected social demographic characteristics and various psychological health statuses of youths and their parents. Among other assessed mental conditions in

youths, the main focus was on major depressive disorders (MDD), suicidal behaviour, conduct disorders, any drug abuse, alcohol abuse, anxiety disorders and psychotic disorders. The disorders found in both parents were MDD in both parents and alcohol abuse in fathers, only one mother had alcohol abuse disorder. Therefore the main focuses on disorders found in parents in the study were MDD and alcohol use disorders. Subsequent assessments were done on the psychological health status in order to establish any changes between and within the two study groups. The total number of youth per arm who participated in the study at baseline was 124 from arm E and 126 from arm C of the study.

4.1 Social demographic characteristics of the study participants at baseline

Table 4.1.1 presents the distribution of social demographic characteristics of the youths and table 4.1.2 presents the parental characteristics of the two study groups at baseline respectively.

Table 4.1.1: Social demographic characteristics of the youths per study group

Variable	Total (N=250) n	%	Experimental (N=124) n	%	Control (N=126) n	%	χ^2 value	df	p value*
Age in years									
13 - 15	61	24.4	26	21.0	35	27.8			
16 - 18	130	52.0	62	50.0	68	54.0	4.45	2	0.108
19 – 22	59	23.6	36	29.0	23	18.3			
Sex									
Female	102	40.8	50	40.3	52	41.3	0.02	1	0.879
Male	148	59.2	74	59.7	74	58.7			
Position of birth									
Only youth/1st born	114	45.6	60	48.4	54	42.9			
2nd born	55	22.0	25	20.2	30	23.8			
3rd born	37	14.8	22	17.7	15	11.9	5.17	4	0.270
4th born	22	8.8	7	5.6	15	11.9			
5th born or higher	22	8.8	10	8.1	12	9.5			
Level of Education									
Primary	68	27.2	36	29.0	32	25.4			
Secondary	154	61.6	71	57.3	83	65.9	2.44	2	0.295
College	28	11.2	17	13.7	11	8.7			
Ever seen father drunk/using alcohol excessively									
Yes	38	15.6	17	14.5	21	16.7	0.21	1	0.647
No	205	84.4	100	85.5	105	83.3			
Unknown	7		7		0				
Having peers who drink alcohol									
Yes	46	18.9	25	21.4	21	16.7	0.87	1	0.350
No	197	81.1	92	78.6	105	83.3			
Unknown	7		7		0				
Duration of illness									
1-6 months	29	11.9	16	13.6	13	10.3			
7 12 months	46	18.9	22	18.6	24	19.0			
>1- 2 years	72	29.5	38	32.2	34	27.0	2.30	5	0.806
>2 - 5 years	59	24.2	25	21.2	34	27.0			
>5 - 10 years	28	11.5	12	10.2	16	12.7			
>10 years	10	4.1	5	4.2	5	4.0			
Unknown	6		6		0				

*Significant at p<0.05 bolded.

There were no significant differences in the socio-demographic characteristics between the two study group (p>0.05) for all variables at baseline.

Table 4.1.2 presents the parental characteristics

Table 4.1.2: Parental characteristics per study group

Variable	Total (N=250) n	%	Experimental (N=124) n	%	Control (N=126) n	%	χ^2 value	df	p value*
Marital status of parents									
Single/separated/widowed	66	26.4	39	31.5	27	21.4	6.01	2	0.050
Currently married	176	70.4	79	63.7	97	77.0			
Total orphan	8	3.2	6	4.8	2	1.6			
Level of education attained by mother									
None	22	8.9	11	8.9	11	8.8	6.62	4	0.157
Primary	57	23.0	32	26.0	25	20.0			
Secondary	80	32.3	33	26.8	47	37.6			
College/university	69	27.8	33	26.8	36	28.8			
Unknown	2		1		1				
Level of education attained by father									
None	4	1.6	1	0.8	3	2.4	4.49	4	0.356
Primary	15	6.1	8	6.6	7	5.6			
Secondary	58	23.6	23	19.0	35	28			
College/University	97	39.4	49	40.5	48	38.4			
Unknown	4		3		1				
Occupation of the mother									
Farmer	30	12	21	16.9	9	7.1	22.20	4	<0.001
Business Lady	112	44.8	38	30.6	74	58.7			
Employed	56	22.4	31	25.0	25	19.8			
House wife	35	14	22	17.7	13	10.3			
Deceased	17	6.8	12	9.7	5	4.0			
Occupation of the father									
Farmer	11	4.5	6	5.0	5	4.1	8.05	4	0.090
Business Man	88	36.4	34	28.6	54	43.9			
Employed	85	35.1	43	36.1	42	34.1			
Retired	9	3.7	6	5.0	3	2.4			
Deceased	49	20.2	30	25.2	19	15.4			
Unknown	8		5		3				

*Significant at p<0.05 bolded.

Results indicated that there were significantly more currently married mothers in the control (p=0.050) and more mothers doing business in the control (p<0.001) than in the experimental group at baseline.

Table 4.1.3 summaries of the mental health status for the mothers in both study groups.

Table 4.1.3: Parenting behaviour and psychiatric disorders among mothers

Variable	Total (N=250) n	%	Experimental (N=124) n	%	Control (N=126) n	%	χ^2 value	df	p value*
Parenting Behaviour									
adaptive	20	8.5	11	9.5	9	7.6			
Emotional un-connectedness	29	12.4	22	19.0	7	5.9	13.43	3	0.004
Rejecting	129	55.1	52	44.8	77	65.3			
Under protective	56	23.9	31	26.7	25	21.2			
Unknown	16		8		8				
MDD									
Present	117	47.8	50	41.0	67	54.5			
Absent	111	45.3	60	49.2	51	41.5	6.08	2	0.048
Deceased	17	6.9	12	9.8	5	4.1			
Unknown	5		2		3				
PTSD									
Present	5	2.0	2	1.6	3	2.4			
Absent	223	91.0	108	88.5	115	93.5	3.30	2	0.192
Deceased	17	6.9	12	9.8	5	4.1			
Unknown	5		2		3				
Alcohol use									
Present	3	1.2	2	1.6	1	0.8			
Absent	225	91.8	108	88.5	117	95.1	3.57	2	0.168
Deceased	17	6.9	12	9.8	5	4.1			
Unknown	5		2		3				
Dysthymia									
Present	43	17.6	20	16.4	23	18.7			
Absent	185	75.5	90	73.8	95	77.2	3.22	2	0.200
Deceased	17	6.9	12	9.8	5	4.1			
Unknown	5		2		3				

*Significant at p<0.05 bolded.

Maternal rejection behaviour was significantly more in the control group than the experimental group (p=0.004). Mothers in the control group had significantly more MDD than the experimental group (p=0.048).

Distributions of specific mental disorders in fathers of the enrolled youths are presents Table 4.1.4.

Table 4.1.4: Parenting behaviour and psychiatric disorders among fathers

	Total (N=250)		Experimental (N=124)		Control (N=126)		χ^2		
Variable	n	%	n	%	n	%	value	df	P value*
Parenting behaviour									
Adaptive	27	13.7	13	14.0	14	13.5			
Emotional Un-connectedness	106	53.8	45	48.4	61	58.7	2.42	3	0.489
Rejecting	49	24.9	27	29.0	22	21.2			
Under protective	15	7.6	8	8.6	7	6.7			
Unknown	53		31		22				
MDD									
Present	38	15.5	13	10.7	25	20.3			
Absent	160	65.3	79	64.8	81	65.9	7.41	2	0.025
Deceased	47	19.2	30	24.6	17	13.8			
Unknown	5		2		3				
PTSD									
Present	2	0.8	1	0.8	1	0.8			
Absent	196	80.0	91	74.6	105	85.4	4.59	2	0.101
Deceased	47	19.2	30	24.6	17	13.8			
Unknown	5		2		3				
Alcohol use									
Present	96	39.2	45	36.9	51	41.5			
Absent	102	41.6	47	38.5	55	44.7	4.59	2	0.101
Deceased	47	19.2	30	24.6	17	13.8			
Unknown	5		2		3				

*Significant at $p<0.05$ bolded

MDD was significantly more in the control group than the experimental group ($p=0.025$).

Assessment of youth mental health status was analysed as presented in Table 4.1.5.

Table 4.1.5: Mental health status of the youths per group

Variable	Total (N=250) n	%	Experimental (N=124) n	%	Control (N=126) n	%	χ^2 value	df	P value*
MDD									
Present	133	54.3	56	45.9	77	62.6	6.88	1	0.009
Absent	112	45.7	66	54.1	46	37.4			
BMD									
Present	23	9.4	13	10.7	10	8.1	0.46	1	0.498
Absent	222	90.6	109	89.3	113	91.9			
Schizophrenia									
Present	15	6.1	12	9.8	3	2.4	5.83	1	0.016
Absent	230	93.9	110	90.2	120	97.6			
PTSD									
Present	22	9.0	16	13.1	6	4.9	5.08	1	0.024
Absent	223	91.0	106	86.9	117	95.1			
Multiple drug abuse									
Yes	18	7.3	9	7.4	9	7.3	<0.01	1	0.986
No	227	92.7	113	92.6	114	92.7			
Unknown	5		2		3				
Conduct disorder									
Present	21	8.6	13	10.7	8	6.5	1.35	1	0.246
Absent	224	91.4	109	89.3	115	93.5			
Anxiety disorder									
Yes	45	18.4	28	23.0	17	13.8	3.41	1	0.065
No	200	81.6	94	77.0	106	86.2			
Drug Abuse									
Yes	127	51.8	53	43.4	74	60.2	6.86	1	0.009
No	118	48.2	69	56.6	49	39.8			
Alcohol use									
Yes	117	47.8	48	39.3	69	56.1	6.89	1	0.009
No	128	52.2	74	60.7	54	43.9			
Suicide behaviour									
Present	205	83.7	86	70.5	119	96.7	30.91	1	<0.001
Absent	40	16.3	36	29.5	4	3.3			

*Significant at $p<0.05$ bolded

Prevalence of MDD was 54.3% (133) among youths at baseline with significantly more cases in control group (62.6%) than in experimental (45.9%), p=0.009.

Prevalence of Schizophrenia and PTSD was relatively low (6.1% and 9.0% respectively) in the study at baseline. However, distribution of schizophrenia was significantly more (9.8%) in experimental group than

the control group (2.4%), p=0.016. Similarly PTSD was significantly higher in experimental group (13.1%) than control group (4.9%), p=0.02. The prevalence of drug abuse was 51.8% (127) and there were significantly more cases in the control group (60.2%) than experimental group (43.4%), p=0.009. The prevalence of alcohol use disorders in youths was 47.8% (117); cases were significantly more in the control group (56.1%) than experimental group (39.3%), p=0.009, Similarly, Suicide behaviour was highly prevalent in this study 83.7% (205) with significantly more cases in the control group (96.7%) than in experimental group (70.5%), p<0.001.

Distribution of Socio-demographic characteristics of the youths by gender at baseline is presented in table 4.1.6.

Table 4.1.6: Distribution of Socio-demographic characteristics of the youths by gender at baseline

	Total (n=250)		Female (n=102)		Male (n=148)				P*
Variables	n	%	n	%	n	%	χ^2 value	df	value
Age in years									
13 - 15	61	24.4	30	29.4	31	20.9			
16 - 18	130	52.0	56	54.9	74	50.0	6.62	2	0.036
19 - 22	59	23.6	16	15.7	43	29.1			
Position of birth									
Only youth/1st born	114	45.6	44	43.1	70	47.3			
2nd born	55	22.0	22	21.6	33	22.3			
3rd born	37	14.8	16	15.7	21	14.2	1.11	4	0.893
4th born	22	8.8	11	10.8	11	7.4			
5th born or higher	22	8.8	9	8.8	13	8.8			
Level of Education									
Primary	68	27.2	33	32.4	35	23.6	12.44	2	0.002
Secondary	154	61.6	66	64.7	88	59.5			
College	28	11.2	3	2.9	25	16.9			

*Significant at p<0.05 bolded

Older male youths (19-22 years) were significantly more (29.1%) than girls (15.7%) in the study, p=0.036. There were significantly more male youths in the study from colleges (16.9%) than girls (2.9%), p=0.002.

Distribution of Socio-demographic characteristics of the parents by gender of the youths is presented in 4.1.7 at baseline.

Table 4.1.7: Distribution of Socio-demographic characteristics of the parents by gender of the youths

Variables	Total (n=250)		Female (n=102)		Male (n=148)		χ^2 value	df	P value
	n	%	n	%	n	%			
Marital Status of parents									
Single mother, never married	16	6.4	7	6.9	9	6.1			
Widower Widow	40	16.0	14	13.7	26	17.6			
Orphans	6	2.4	1	1.0	5	3.4	4.81	4	0.307
Separation	7	2.8	5	4.9	2	1.4			
Married	181	72.4	75	73.5	106	71.6			
Occupation of the mother									
Farmer	30	12.0	13	12.7	17	11.6			
Business Lady	111	44.6	48	47.1	63	42.9			
Employed	58	23.3	27	26.5	31	21.1	4.66	4	0.324
House wife	30	12.0	9	8.8	21	14.3			
Deceased Orphans	20	8.0	5	4.9	15	10.2			
Unknown	1		0		1				
Occupation of the father									
Farmer	11	4.6	4	4.1	7	4.9			
Business Man	89	36.9	35	35.7	54	37.8			
Employed	87	36.1	37	37.8	50	35.0	1.31	4	0.859
Retired	11	4.6	3	3.1	8	5.6			
Deceased Orphans	43	17.8	19	19.4	24	16.8			
Unknown	9		4		5				
Age range of the mother									
45 years or below	109	48.4	53	55.8	56	43.1	3.55	1	0.059
Above 45 years	116	51.6	42	44.2	74	56.9			
Unknown	25		7		18				
Age range of the father									
45 years or below	56	28.0	29	36.3	27	22.5	4.50	1	0.034
Above 45 years	144	72.0	51	63.8	93	77.5			
Unknown	50		22		28				

*Significant at $p<0.05$ bolded

Fathers above age 45 years (77.5%) were significantly more in the study than mothers above 45 years (63.8%), p=0.034.

Co-existing common disorders in youth (MDD, alcohol use and any anxiety disorder) in relation to socio-demographic characteristics are presented in table 4.1.8 at baseline.

Distribution of Socio-demographic characteristics of the parents by gender of the youths is presented in 4.1.7 at baseline.

Table 4.1.7: Distribution of Socio-demographic characteristics of the parents by gender of the youths

	Total (n=250)		Female (n=102)		Male (n=148)		χ^2		P
Variables	n	%	n	%	n	%	value	df	value
Marital Status of parents									
Single mother, never married	16	6.4	7	6.9	9	6.1			
Widower Widow	40	16.0	14	13.7	26	17.6			
Orphans	6	2.4	1	1.0	5	3.4	4.81	4	0.307
Separation	7	2.8	5	4.9	2	1.4			
Married	181	72.4	75	73.5	106	71.6			
Occupation of the mother									
Farmer	30	12.0	13	12.7	17	11.6			
Business Lady	111	44.6	48	47.1	63	42.9			
Employed	58	23.3	27	26.5	31	21.1	4.66	4	0.324
House wife	30	12.0	9	8.8	21	14.3			
Deceased Orphans	20	8.0	5	4.9	15	10.2			
Unknown	1		0		1				
Occupation of the father									
Farmer	11	4.6	4	4.1	7	4.9			
Business Man	89	36.9	35	35.7	54	37.8			
Employed	87	36.1	37	37.8	50	35.0	1.31	4	0.859
Retired	11	4.6	3	3.1	8	5.6			
Deceased/Orphans	43	17.8	19	19.4	24	16.8			
Unknown	9		4		5				
Age range of the mother									
45 years or below	109	48.4	53	55.8	56	43.1	3.55	1	0.059
Above 45 years	116	51.6	42	44.2	74	56.9			
Unknown	25		7		18				
Age range of the father									
45 years or below	56	28.0	29	36.3	27	22.5	4.50	1	0.034
Above 45 years	144	72.0	51	63.8	93	77.5			
Unknown	50		22		28				

*Significant at $p<0.05$ bolded

Fathers above age 45 years (77.5%) were significantly more in the study than mothers above 45 years (63.8%), p=0.034.

Co-existing common disorders in youth (MDD, alcohol use and any anxiety disorder) in relation to socio-demographic characteristics are presented in table 4.1.8 at baseline.

Table 4.1.8: Multiple disorders in youth (MDD, alcohol use and any anxiety disorder) in relation to socio-demographic characteristics

Variables	None (n=63) n	%	1 disorder (n=95) n	%	2 disorders (n=61) n	%	3 disorders (n=26) n	%	χ^2 value	df	P value
Overall	63	25.7	95	38.8	61	24.9	26	10.6	-	-	-
Sex											
Female	29	29.0	33	33.0	25	25.0	13	13.0	3.07	3	0.381
Male	34	23.4	62	42.8	36	24.8	13	9.0			
Age in years											
13 – 15	18	29.5	23	37.7	16	26.2	4	6.6			
16 – 18	30	23.8	48	38.1	31	24.6	17	13.5	2.86	6	0.826
19 - 22	15	25.9	24	41.4	14	24.1	5	8.6			
Level of Education											
Primary	21	30.9	23	33.8	17	25.0	7	10.3			
Secondary	36	24.0	58	38.7	41	27.3	15	10.0	5.55	6	0.475
College	6	22.2	14	51.9	3	11.1	4	14.8			
Position of birth											
Only youth/1st born	26	23.4	36	32.4	34	30.6	15	13.5			
2nd or 3rd born	25	27.5	42	46.2	18	19.8	6	6.6	7.85	6	0.249
4th born or higher	12	27.9	17	39.5	9	20.9	5	11.6			

*Significant at $p<0.05$ bolded

There was no statistical significant difference in distribution of social demographic characteristics of the youths (P>0.05) according to psychiatric disorders at baseline.

Maternal parenting behaviour in relation to paternal parenting behaviour and paternal alcohol use are presented in table 4.1.9 at baseline.

Table 4.1.9: Maternal Parenting behaviour in relation to paternal parenting behaviour and alcohol use

Maternal Parenting behaviour	Normal (n=20)		No emotional (n=29)		Rejecting (n=129)		Under protective (n=56)		χ^2 value	df	P value
	n	%	n	%	n	%	n	%			
Overall	20	8.0	29	11.6	129	51.6	56	22.4			
Parenting behaviour in father											
connected	9	34.6	4	15.4	11	42.3	2	7.7			
Emotional un-connectedness	6	5.7	7	6.7	72	68.6	20	19.0	40.83	9	<0.001
Rejecting	2	4.1	7	14.3	21	42.9	19	38.8			
under protective	2	13.3	4	26.7	6	40.0	3	20.0			
Alcohol use in fathers											
Present	7	7.3	10	10.4	53	55.2	26	27.1			
Deceased	3	7.9	10	26.3	16	42.1	9	23.7	11.37	6	0.048
Absent	10	10.3	8	8.2	60	61.9	19	19.6			
Unknown	0		1		0		2				

*Significant at $p<0.05$ bolded

The proportion of mothers who had rejecting maternal parenting behaviour (51.6%) was significantly different from the proportion of fathers with no emotional un-connectedness parenting behaviour (68.6%), $p<0.001$. The proportion of mothers with rejecting parenting behaviour married to husbands with alcohol use disorders (55.2%) was significantly different from proportion of mothers married to husbands without alcohol use disorders (61.9%), p=0.048.

Maternal MDD in relation to paternal alcohol use is presented in table 4.1.10

Table 4.1.10: Maternal MDD in relation to paternal alcohol use at baseline

Maternal MDD	Present (n=117)		Absent (n=111)		χ^2 value	df	P value
	n	%	n	%			
Overall	117	51.3	111	48.7			
Alcohol use in fathers							
Present	58	62.4	35	37.6			
Deceased	20	51.3	19	48.7	8.94	2	0.011
Absent	39	40.6	57	59.4			

*Significant at $p<0.05$ bolded

The proportion of mothers with MDD married to husbands with alcohol use disorders (62.4%) was than the proportion of mothers without MDD married to husbands with no alcohol use disorders (37.6%), p=0.011.

Distribution of perceived parenting behaviour by gender of the youth is tabulated in table 4.1.11 at baseline

Table 4.1.11: Distribution of parenting behaviour by gender of the youth

	Total (n=234)		Female (n=94)		Male (n=140)				
Variables	n	%	n	%	n	%			
Parenting behaviour in Mothers									
Normal	20	8.5	8	8.5	12	8.6			
No emotional	29	12.4	9	9.6	20	14.3			
Rejecting	129	55.1	51	54.3	78	55.7	1.94	3	0.585
under protective	56	23.9	26	27.7	30	21.4			
Parenting behaviour in fathers									
Normal	27	13.7	11	14.3	16	13.3			
No emotional	106	53.8	43	55.8	63	52.5			
Rejecting	49	24.9	18	23.4	31	25.8	0.45	3	0.930
under protective	15	7.6	5	6.5	10	8.3			
Not assessed	37		17		20				

*Significant at p<0.05 bolded

There was no significant difference in distribution of perceived parenting behaviour by youths according to gender (P>0.05).

Comorbid psychiatric disorders in youth (MDD, alcohol use and any anxiety disorder) in relation to socio-demographic characteristics as presented in table 4.1.12

Distribution of perceived parenting behaviour by gender of the youth is tabulated in table 4.1.11 at baseline

Table 4.1.11: Distribution of parenting behaviour by gender of the youth

Variables	Total (n=234)		Female (n=94)		Male (n=140)				
	n	%	n	%	n	%			
Parenting behaviour in Mothers									
Normal	20	8.5	8	8.5	12	8.6			
No emotional	29	12.4	9	9.6	20	14.3	1.94	3	0.585
Rejecting	129	55.1	51	54.3	78	55.7			
under protective	56	23.9	26	27.7	30	21.4			
Parenting behaviour in fathers									
Normal	27	13.7	11	14.3	16	13.3			
No emotional	106	53.8	43	55.8	63	52.5	0.45	3	0.930
Rejecting	49	24.9	18	23.4	31	25.8			
under protective	15	7.6	5	6.5	10	8.3			
Not assessed	37		17		20				

* Significant at p<0.05 bolded

There was no significant difference in distribution of perceived parenting behaviour by youths according to gender (P>0.05).

Comorbid psychiatric disorders in youth (MDD, alcohol use and any anxiety disorder) in relation to socio-demographic characteristics as presented in table 4.1.12

Distribution of perceived parenting behaviour by gender of the youth is tabulated in table 4.1.11 at baseline

Table 4.1.11: Distribution of parenting behaviour by gender of the youth

	Total (n=234)		Female (n=94)		Male (n=140)				
Variables	n	%	n	%	n	%			
Parenting behaviour in Mothers									
Normal	20	8.5	8	8.5	12	8.6			
No emotional	29	12.4	9	9.6	20	14.3	1.94	3	0.585
Rejecting	129	55.1	51	54.3	78	55.7			
under protective	56	23.9	26	27.7	30	21.4			
Parenting behaviour in fathers									
Normal	27	13.7	11	14.3	16	13.3			
No emotional	106	53.8	43	55.8	63	52.5	0.45	3	0.930
Rejecting	49	24.9	18	23.4	31	25.8			
under protective	15	7.6	5	6.5	10	8.3			
Not assessed	37		17		20				

*Significant at p<0.05 bolded

There was no significant difference in distribution of perceived parenting behaviour by youths according to gender (P>0.05).

Comorbid psychiatric disorders in youth (MDD, alcohol use and any anxiety disorder) in relation to socio-demographic characteristics as presented in table 4.1.12

Table 4.1.12 Co-existence of common disorders in youth in relation to socio-demographic characteristics

Variables	Only one disorder (n=63)		1 disorder (n=95)		2 disorders (n=61)		3 disorders (n=26)		χ^2 value	df	P value
	n	%	n	%	n	%	n	%			
Overall	63	25.7	95	38.8	61	24.9	26	10.6	-	-	-
Sex									3.07	3	0.381
Female	29	29.0	33	33.0	25	25.0	13	13.0			
Male	34	23.4	62	42.8	36	24.8	13	9.0			
Age in years											
13 – 15	18	29 5	23	37.7	16	26.2	4	6.6	2.86	6	0.826
16 – 18	30	23.8	48	38.1	31	24.6	17	13.5			
19 – 22	15	25.9	24	41.4	14	24.1	5	8.6			
Level of Education											
Primary	21	30.9	23	33.8	17	25.0	7	10.3	5.55	6	0.475
Secondary	36	24.0	58	38.7	41	27.3	15	10.0			
College	6	22.2	14	51.9	3	11.1	4	14.8			
Position of birth											
Only child/1st born	26	23.4	36	32.4	34	30.6	15	13.5	7.85	6	0.249
2nd or 3rd born	25	27.5	42	46.2	18	19.8	6	6.6			
4th born or higher	12	27.9	17	39.5	9	20.9	5	11.6			

* Significant at p<0.05 bolded

There was no statistical significant difference in distribution of co-existing psychiatric disorders among the youths (P>0.05) according to their social demographic profile at baseline.

4.2 Determinants of mental disorders among the study participants

4.2.1 Factors associated with major depressive disorders (MDD) in youths

Table 4.2.1 1 presents analysis of MDD among youths in relation to background characteristics. Four factors were identified to associate significantly with occurrence of MDD.

Table 4.2.1.1: MDD among youths in relation to background characteristics of the youth

Variables	Present (N=133) n	%	Absent (N=112) n	%	OR ψ	95% CI φ Lower	Upper	p value*
Age in years								
13 – 15	33	54.1	28	45.9	1.93	0.93	4.01	0.078
16 – 18	78	61.9	48	38.1	2.66	1.4	5.05	0.003
19 – 22	22	37.9	36	62.1	Reference			
Sex								
Female	53	53	47	47	0.92	0.55	1.53	0.737
Male	80	55.2	65	44.8	Reference			
Position of birth								
Only youth/1st born	68	61.3	43	38.7	1.74	0.68	4.44	0.247
2nd born	37	67.3	18	32.7	2.26	0.81	6.3	0.119
3rd born	10	27.8	26	72.2	0.42	0.14	1.3	0.134
4th born	8	36.4	14	63.6	0.63	0.19	2.13	0.456
5th born or higher	10	47.6	11	52.4	Reference			
Level of Education								
Primary	37	54.4	31	45.6	2.03	0.81	5.07	0.130
Secondary	86	57.3	64	42.7	2.28	0.98	5.32	0.055
College	10	37.0	17	63.0	Reference			
Marital Status of parents								
Single mother, never married	7	43.8	9	56.3	0.68	0.24	1.9	0.463
Widower/Widow	22	55.0	18	45.0	1.07	0.54	2.13	0.852
Orphans	6	100.0	0	0.0	UDθ	UD	UD	0.999
Separation	3	60.0	2	40.0	1.31	0.21	8.03	0.770
Married	95	53.4	83	46.6	Reference			
Ever seen father drunk/using alcohol excessively								
Yes	11	30.6	25	69.4	Reference			
No	115	56.9	87	43.1	3.00	1.40	6.44	0.003
Unknown	7		0					
Having peers drink alcohol								
Yes	15	33.3	30	66.7	Reference			
No	111	57.5	82	42.5	2.71	1.37	5.36	0.003
Unknown	7		0					
Unknown	6		0					

*Significant at $p<0.05$ bolded: ψ Odds ratio; φ 95% Confidence Interval; θ Undefined

Results indicated that youths in age group 16-18 years who had MDD (OR=2.66; 95% CI: 1.40 – 5.05; p=0.003) were significantly different from youths in age group 13-15 years (OR=0.93; 95%CI: 0.93-4.01; p=0.078) and those in age group 19-22 years. The youths in age group 16-18 years had 2.66 times greater odds of developing MDD than youths in age group 19-22 years. Youths who had not seen their father drunk/use alcohol excessively was significantly different from youths who had seen their father drunk/use alcohol excessively (OR=3.00; 95% CI: 1.40 – 6.44; p=0.003). Youths with MDD who had peers who use

alcohol were significantly different from the youths with MDD who had peers that use alcohol (OR=2.71; 95% CI: 1.37 – 5.36; p=0.003).

Table 4.2.1.2 presents analysis of MDD among youths in relation to health status of the parents.

Table 4.2.1.2: MDD among youths in relation to mental health status of the parents

	Present (N=133)		Absent (N=112)			95% CI [φ]		
Variables	n	%	n	%	OR [ψ]	Lower	Upper	p value*
Behaviour in mothers								
No emotional	9	32.1	19	67.9	0.71	0.21	2.35	0.575
Rejecting	81	62.8	48	37.2	2.53	0.97	6.63	0.059
Under protective	25	46.3	29	53.7	1.29	0.46	3.67	0.629
Normal	8	40.0	12	60.0	Reference			
Unknown	10		4					
MDD in mothers								
Present	64	54.7	53	45.3	1.14	0.68	1.93	0.613
Absent	57	51.4	54	48.6	Reference			
Deceased	12	70.6	5	29.4	2.27	0.75	6.88	0.146
Dysthymia in mothers								
Present	26	60.5	17	39.5	1.45	0.74	2.85	0.282
Absent	95	51.4	90	48.6	Reference			
Deceased	12	70.6	5	29.4	2.27	0.77	6.71	0.137
Behaviour in fathers								
Normal	17	63.0	10	37.0	Reference			
No emotional	60	57.7	44	42.3	0.80	0.34	1.92	0.620
Rejecting	26	53.1	23	46.9	0.66	0.25	1.74	0.406
Under protective	3	21.4	11	78.6	0.16	0.04	0.72	0.017
Unknown	27		24					
MDD in fathers								
Present	18	47.4	20	52.6	0.86	0.42	1.74	0.667
Absent	82	51.3	78	48.8	Reference			
Deceased	33	70.2	14	29.8	2.24	1.12	4.51	0.023
Alcohol use among fathers								
Present	50	52.1	46	47.9	1.13	0.65	1.97	0.667
Absent	50	49.0	52	51.0	Reference			
Deceased	33	70.2	14	29.8	2.45	1.17	5.12	0.017

* Significant at $p<0.05$ bolded; [ψ] Odds ratio; [φ] 95% Confidence Interval

Youths with MDD who perceived that their father had under protective parenting behaviour (21.4%) were significantly different from youths without MDD and perceived their fathers had under protective parenting behavior (78.4%) with reference to perceived normal paternal parenting behaviour (OR=0.16; 95% CI: 0.04 – 0.72; p=0.017). Youths with MDD (70.2%) who had lost their father (deceased) were significantly different from youths without MDD (29.8%) and their fathers were also deceased with reference to MDD in

alcohol were significantly different from the youths with MDD who had peers that use alcohol (OR=2.71; 95% CI: 1.37 – 5.36; p=0.003).

Table 4.2.1.2 presents analysis of MDD among youths in relation to health status of the parents.

Table 4.2.1.2: MDD among youths in relation to mental health status of the parents

	Present (N=133)		Absent (N=112)			95% CI [φ]		
Variables	n	%	n	%	OR [ψ]	Lower	Upper	p value*
Behaviour in mothers								
No emotional	9	32.1	19	67.9	0.71	0.21	2.35	0.575
Rejecting	81	62.8	48	37.2	2.53	0.97	6.63	0.059
Under protective	25	46.3	29	53.7	1.29	0.46	3.67	0.629
Normal	8	40.0	12	60.0	Reference			
Unknown	10		4					
MDD in mothers								
Present	64	54.7	53	45.3	1.14	0.68	1.93	0.613
Absent	57	51.4	54	48.6	Reference			
Deceased	12	70.6	5	29.4	2.27	0.75	6.88	0.146
Dythymia in mothers								
Present	26	60.5	17	39.5	1.45	0.74	2.85	0.282
Absent	95	51.4	90	48.6	Reference			
Deceased	12	70.6	5	29.4	2.27	0.77	6.71	0.137
Behaviour in fathers								
Normal	17	63.0	10	37.0	Reference			
No emotional	60	57.7	44	42.3	0.80	0.34	1.92	0.620
Rejecting	26	53.1	23	46.9	0.66	0.25	1.74	0.406
Under protective	3	21.4	11	78.6	0.16	0.04	0.72	0.017
Unknown	27		24					
MDD in fathers								
Present	18	47.4	20	52.6	0.86	0.42	1.74	0.667
Absent	82	51.3	78	48.8	Reference			
Deceased	33	70.2	14	29.8	2.24	1.12	4.51	0.023
Alcohol use among fathers								
Present	50	52.1	46	47.9	1.13	0.65	1.97	0.667
Absent	50	49.0	52	51.0	Reference			
Deceased	33	70.2	14	29.8	2.45	1.17	5.12	0.017

* Significant at p<0.05 bolded: [ψ] Odds ratio; [φ] 95% Confidence Interval

Youths with MDD who perceived that their father had under protective parenting behaviour (21.4%) were significantly different from youths without MDD and perceived their fathers had under protective parenting behavior (78.4%) with reference to perceived normal paternal parenting behaviour (OR=0.16; 95% CI: 0.04 – 0.72; p=0.017). Youths with MDD (70.2%) who had lost their father (deceased) were significantly different from youths without MDD (29.8%) and their fathers were also deceased with reference to MDD in

alcohol were significantly different from the youths with MDD who had peers that use alcohol (OR=2.71; 95% CI: 1.37 – 5.36; p=0.003).

Table 4.2.1.2 presents analysis of MDD among youths in relation to health status of the parents.

Table 4.2.1.2: MDD among youths in relation to mental health status of the parents

Variables	Present (N=133) n	%	Absent (N=112) n	%	OR ᴪ	95% CI φ Lower	Upper	p value*
Behaviour in mothers								
No emotional	9	32.1	19	67.9	0.71	0.21	2.35	0.575
Rejecting	81	62.8	48	37.2	2.53	0.97	6.63	0.059
Under protective	25	46.3	29	53.7	1.29	0.46	3.67	0.629
Normal	8	40.0	12	60.0	Reference			
Unknown	10		4					
MDD in mothers								
Present	64	54.7	53	45.3	1.14	0.68	1.93	0.613
Absent	57	51.4	54	48.6	Reference			
Deceased	12	70.6	5	29.4	2.27	0.75	6.88	0.146
Dythymia in mothers								
Present	26	60.5	17	39.5	1.45	0.74	2.85	0.282
Absent	95	51.4	90	48.6	Reference			
Deceased	12	70.6	5	29.4	2.27	0.77	6.71	0.137
Behaviour in fathers								
Normal	17	63.0	10	37.0	Reference			
No emotional	60	57.7	44	42.3	0.80	0.34	1.92	0.620
Rejecting	26	53.1	23	46.9	0.66	0.25	1.74	0.406
Under protective	3	21.4	11	78.6	0.16	0.04	0.72	0.017
Unknown	27		24					
MDD in fathers								
Present	18	47.4	20	52.6	0.86	0.42	1.74	0.667
Absent	82	51.3	78	48.8	Reference			
Deceased	33	70.2	14	29.8	2.24	1.12	4.51	0.023
Alcohol use among fathers								
Present	50	52.1	46	47.9	1.13	0.65	1.97	0.667
Absent	50	49.0	52	51.0	Reference			
Deceased	33	70.2	14	29.8	2.45	1.17	5.12	0.017

* Significant at p<0.05 bolded; ᴪ Odds ratio; φ 95% Confidence Interval

Youths with MDD who perceived that their father had under protective parenting behaviour (21.4%) were significantly different from youths without MDD and perceived their fathers had under protective parenting behavior (78.4%) with reference to perceived normal paternal parenting behaviour (OR=0.16; 95% CI: 0.04 – 0.72; p=0.017). Youths with MDD (70.2%) who had lost their father (deceased) were significantly different from youths without MDD (29.8%) and their fathers were also deceased with reference to MDD in

fathers (OR=2.24; 95% CI: 1.12 – 4.51; p=0.023). Youths with MDD who had lost their father (deceased) were significantly different from youths without MDD and their fathers were deceased with reference to alcohol use disorders among fathers (OR=2.45; 95% CI: 1.17 – 5.12; p=0.017).

Bivariate analysis of MDD among youths in relation to other mental health status of the youths is presented in Table 4.2.1.3.

Table 4.2.1.3: MDD among youths in relation to other mental health status of the youths

	Present (N=133)		Absent (N=112)			95% CI [φ]		
Variables	n	%	n	%	OR [ψ]	Lower	Upper	p value*
Conduct Disorder								
Yes	16	76.2	5	23.8	2.93	1.04	8.26	0.035
No	117	52.2	107	47.8	Reference			
Anxiety disorder								
Yes	32	71.1	13	28.9	2.41	1.2	4.87	0.012
No	101	50.5	99	49.5	Reference			
Drug Abuse disorder								
Yes	87	68.5	40	31.5	3.40	2.01	5.76	<0.001
No	46	39.0	72	61.0	Reference			
Alcohol use disorder								
Yes	81	69.2	36	30.8	3.29	1.94	5.57	<0.001
No	52	40.6	76	59.4	Reference			
Suicide behaviour								
Yes	124	60.5	81	39.5	5.27	2.39	11.66	<0.001
No	9	22.5	31	77.5	Reference			

*Significant at p<0.05 bolded; [ψ] Odds ratio; [φ] 95% Confidence Interval

Youths with MDD co-existing with conduct disorder (76.2%) were significantly different from youths without MDD and had conduct disorder (23.8%) with reference to no conduct disorder (OR=2.93; 95% CI: 1.04 – 8.26; p=0.035). Youths with MDD co-existing with anxiety disorder (71.1%) were significantly different from youths without MDD and had anxiety disorder (28.9%) with reference to no anxiety disorder (OR=2.41; 95% CI: 1.20 – 4.87; p=0.012). Youths with MDD co-existing with drug abuse disorder (68.5%) were significantly different from youths without MDD and had drug abuse disorder (31.5%) with reference to no drug abuse (OR=3.40; 95% CI: 2.01 – 5.76; p<0.001). Youths with MDD co-existing alcohol use

disorders (69.2%) were significantly different from youths without MDD and had alcohol use disorder (30.8%) with reference to alcohol use disorders (OR=3.29; 95% CI: 1.94 – 5.57; p<0.001). Youths with MDD who had suicide behaviour (60.5%) were significantly different from youths without MDD and had suicide behaviour (39.5%) with reference to no suicide behaviour (OR=5.27; 95% CI: 2.39 – 11.66; p<0.001). Binary logistic regression (multivariate analysis) was used to model occurrence of MDD using factors identified to be significant at P<0.05 during bivariate analysis. Backward conditional method was specified with removal at P<0.05. Seven independent predictors of MDD among youths were identified as presented in Table 4.2.1.4.

Table 4.2.1.4: Predictors of occurrence of MDD among youths

Predictors	AOR[ψ]	95% CI[φ] Lower	Upper	p value[*]
Age in years				
13 – 15	1.64	0.58	4.60	0.348
16 – 18	2.74	1.09	6.93	**0.033**
19 – 22	Reference			
Ever seen father drunk/using alcohol excessively				
Yes	Reference			
No	4.44	1.76	11.24	**0.002**
MDD in father				
Present	0.51	0.21	1.23	0.135
Absent	Reference			
Deceased	4.69	1.50	14.69	**0.008**
Any anxiety in youth				
Yes	4.03	1.47	11.08	**0.007**
No	Reference			
Alcohol use				
Yes	2.41	1.19	4.89	**0.015**
No	Reference			
Suicide behaviour				
Yes	4.52	1.38	14.81	**0.013**
No	Reference			

[*] Significant at p<0.05 bolded; [ψ] Adjusted odds ratio; [φ] 95% Confidence Interval

Youths in age group 16-18 years had greater odds of having MDD than youths with MDD but in age category 13-15 years or 19-22 years when other factors were adjusted (AOR=2.74; 95% CI: 1.09 – 6.93; p=0.033). Youths who had

never seen their father drunk/use alcohol excessively had greater odds of having MDD than youths with MDD who had seen their father drunk/use alcohol excessively when other factors are adjusted (AOR=4.44; 95% CI: 1.76 – 11.24; p=0.002). Youths who had a deceased father had greater odds of having MDD than youths whose fathers were alive when other factors were controlled (AOR=4.69; 95% CI: 1.50 – 14.69; p=0.008). Other mental health disorders of the youths identified to predict their MDD status include, any anxiety (AOR=4.03; 95% CI: 1.47 – 11.08; p=0.007), alcohol use (AOR=2.41; 95% CI: 1.19 – 4.89; p=0.015) and suicide behaviour (AOR=4.52; 95% CI: 1.38 – 14.81; p=0.013). The number of deceased mothers was too small to be build into the logistic regression model since in the binary analysis; most of the cells were empty.

4.2.2 Factors associated with alcohol use in youths

Table 4.2.2.1 presents bivariate analysis of alcohol use among the youths in relation to background characteristics. Three factors were identified to associate significantly with alcohol use among the youths.

Table 4.2.2.1: Alcohol use among youths in relation to background characteristics of the youth

Variables	Present (N=117)		Absent (N=128)			95% CI[φ]		
	n	%	n	%	OR[ψ]	Lower	Upper	p value[*]
Age in years								
16 – 18	62	49.2	64	50.8	1.49	0.80	2.78	0.206
19 – 22	31	53.4	27	46.6	1.77	0.85	3.67	0.124
13 – 15	24	39.3	37	60.7	Reference			
Sex								
Female	48	48.0	52	52.0	1.02	0.61	1.69	0.949
Male	69	47.6	76	52.4	Reference			
Position of birth								
Only youth/1st born	56	50.5	55	49.5	Reference			
2nd born	26	47.3	29	52.7	0.88	0.46	1.68	0.700
3rd born	11	30.6	25	69.4	0.43	0.19	0.96	**0.400**
4th born	13	59.1	9	40.9	1.42	0.56	3.59	0.460
5th born or higher	11	52.4	10	47.6	1.08	0.42	2.75	0.871
Level of Education								
Secondary	76	50.7	74	49.3	1.47	0.82	2.62	0.195
College	13	48.1	14	51.9	1.33	0.54	3.25	0.537
Primary	28	41.2	40	58.8	Reference			
Marital Status of parents								
Single mother, never married	6	37.5	10	62.5	0.70	0.24	2.02	0.511
Widower/Widow	20	50.0	20	50.0	1.17	0.59	2.33	0.653
Orphans	6	100.0	0	0.0	UD[θ]	UD	UD	0.999
Separation	3	60.0	2	40.0	1.76	0.29	10.77	0.543
Married	82	46.1	96	53.9	Reference			
Ever seen father drunk/using alcohol excessively								
Yes	20	55.6	16	44.4	1.52	0.75	3.11	0.244
No	91	45.0	111	55.0	Reference			
Unknown	6		1					
Having peers who consume alcohol								
Yes	30	66.7	15	33.3	2.77	1.40	5.47	0.003
No	81	42.0	112	58.0	Reference			
Unknown	6		1					

[*] Significant at p<0.05 bolded; [ψ] Odds ratio; [φ] 95% Confidence Interval; [θ] Undefined

The proportions of youths with alcohol use disorders and had peers consuming alcohol (66.7%) was significantly different from youths without alcohol use disorders but had peers consuming alcohol (33.4%) OR=2.77; 95% CI: 1.40 – 5.47; p=0.003, with reference to youths without alcohol use disorders.

Table 4.2.2.2 presents analysis of alcohol use among youths in relation to mental health status of parents.

Table 4.2.2.2: Alcohol use among youths in relation to mental health status of the parents

Variables	Present (N=117) n	%	Absent (N=128) n	%	OR $^{\psi}$	95% CI $^{\varphi}$ Lower	Upper	p value*
Parenting style								
No emotional	13	46.4	15	53.6	4.91	1.17	20.62	0.030
Rejecting	67	51.9	62	48.1	6.12	1.71	21.92	0.005
Under protective	24	44.4	30	55.6	4.53	1.19	17.31	0.027
Normal	3	15.0	17	85.0	Reference			
Unknown	10		4					
Mothers: MDD								
Present	54	46.2	63	53.8	0.97	0.58	1.64	0.916
Deceased	11	64.7	6	35.3	2.08	0.72	6.02	0.177
Absent	52	46.8	59	53.2	Reference			
Mothers: Dythymia								
Present	22	51.2	21	48.8	1.26	0.65	2.45	0.496
Deceased	11	64.7	6	35.3	2.20	0.78	6.21	0.135
Absent	84	45.4	101	54.6	Reference			
Paternal behaviour								
No emotional	55	52.9	49	47.1	1.40	0.60	3.29	0.435
Rejecting	15	30.6	34	69.4	0.55	0.21	1.46	0.230
Under protective	8	57.1	6	42.9	1.67	0.45	6.13	0.442
Normal	12	44.4	15	55.6	Reference			
Unknown	27		24					
Fathers: MDD								
Present	20	52.6	18	47.4	1.29	0.64	2.62	0.479
Deceased	23	48.9	24	51.1	1.11	0.58	2.14	0.746
Absent	74	46.3	86	53.8	Reference			
Fathers: Alcohol use								
Present	46	47.9	50	52.1	1.03	0.59	1.81	0.904
Deceased	23	48.9	24	51.1	1.08	0.54	2.15	0.831
Absent	48	47.1	54	52.9	Reference			

*Significant at $p<0.05$ bolded; $^{\psi}$ Odds ratio; $^{\varphi}$ 95% Confidence Interval

The proportion of the youths with alcohol use disorders who perceived that their mothers had: under protective 46.4% (OR=4.53; 95% CI: 1.19 – 17.31; p=0.027), rejecting 51.9% (OR=6.12; 95% CI: 1.71 – 21.92; p=0.005) and no emotional attachment 44.4% (OR=4.93; 95% CI: 1.17 – 20.62; p=0.032) parenting behaviours were significantly different from the population of youths with alcohol use disorders (15.0%) and perceived their mothers to have normal parenting behaviour.

Analysis of alcohol use among the youths in relation to other mental health status of the youths is presented in Table 4.2.2.3.

Table 4.2.2.3: Alcohol use among youths in relation to other mental health status of the youths

Variables	Present (N=117)		Absent (N=128)			95% CI [φ]		
	n	%	n	%	OR [ψ]	Lower	Upper	p value [*]
MDD								
Yes	81	60.9	52	39.1	3.29	1.94	5.57	<0.001
No	36	32.1	76	67.9	Reference			
Conduct Disorder								
Yes	16	76.2	5	23.8	3.90	1.38	11.00	0.006
No	101	45.1	123	54.9	Reference			
Any Anxiety disorder								
Yes	26	57.8	19	42.2	1.64	0.85	3.15	0.136
No	91	45.5	109	54.5	Reference			
Drug abuse disorder								
Yes	116	91.3	11	8.7	UD	UD	UD	<0.001
No	0	0.0	118	100.0	Reference			
Suicide behaviour								
Yes	111	54.1	94	45.9	6.69	2.69	16.63	<0.001
No	6	15.0	34	85.0	Reference			

[*] Significant at p<0.05 bolded; [ψ] Odds ratio; [φ] 95% Confidence Interval; [θ] Undefined

The proportion of the youths with alcohol use disorders co-existing with MDD 60.9% was significantly different from the proportion of the youths with MDD but they do not have alcohol use disorders 29.1% (OR=3.29; 95% CI: 1.94 – 5.57; p<0.001) with reference to youths with no MDD. The proportion of the youths with alcohol use disorders co-existing with conduct disorder 76.2% was significantly different from youths with conduct disorder but without alcohol use disorder 23.8% (OR=3.90; 95% CI: 1.38 – 11.00; p=0.006). with reference to youths with no conduct disorder. Also, the proportion of youth with alcohol use disorder co-existing with suicide behaviour (54.1%) was significantly different from youths with suicide behaviour but without alcohol use disorder 45.9% (OR=5.27; 95% CI: 2.39 – 11.66; p<0.001) with reference to youths with no suicide behaviour.

Binary logistic regression (multivariate analysis) was used to model alcohol use using factors identified to be significant at P<0.05 during bivariate analysis. Backward conditional method was specified with removal at P<0.05. Four independent predictors of alcohol use among youths were identified as presented in Table 4.2.2.4.

Table 4.2.2.4: Predictors of alcohol use among youths

Variables	AOR[ψ]	95% CI[φ] Lower	Upper	p value[*]
Having peers who consume alcohol				
Yes	4.21	1.92	9.23	<0.001
No	Reference			
MDD				
Yes	3.13	1.67	5.89	<0.001
No	Reference			
Conduct Disorder				
Yes	3.22	1.08	9.58	0.035
No	Reference			
Suicide behaviour				
Yes	3.50	1.32	9.30	0.012
No	Reference			

[*] Significant at $p<0.05$ bolded; [ψ] Adjusted odds ratio; [φ] 95% Confidence Interval

The youths with peers who consumed alcohol had 4.21 times greater odds of having alcohol use disorders than youths who did not have peers that used alcohol (AOR=4.21; 95% CI: 1.92 – 9.23; $p<0.001$). The youths who had MDD had 3.13 times greater odds of having alcohol use disorders than youths who did not have MDD. (AOR=3.13; 95% CI: 1.67 – 5.89; $p<0.001$). The youths who had conduct disorder had 3.22 times greater odds of having alcohol use disorders than youths who did not have conduct disorder (AOR=3.22; 95% CI: 1.08 – 9.58; $p=0.035$), and the youths who had suicide behaviour had 3.5 times greater odds of having alcohol use disorder than youths without suicide behaviour (AOR=3.50; 95% CI: 1.32 – 9.30; $p=0.012$).

Table 4.2.2.5 presents bivariate analysis of severe alcohol dependence among the youths in relation to background characteristics.

Table 4.2.2.5: Alcohol dependence among youths in relation to background characteristics of the youth

Variables	Present (N=36)		Absent (N=209)			95% CI [φ]		
	n	%	n	%	OR [ψ]	Lower	Upper	p value*
Age in years								
13 – 15	5	8.2	56	91.8	Reference			
16 – 18	16	12.7	110	87.3	1.63	0.57	4.68	0.364
19 – 22	15	25.9	43	74.1	3.91	1.32	11.59	0.014
Sex								
Female	13	13.0	87	87.0	Reference			
Male	23	15.9	122	84.1	1.27	0.61	2.63	0.534
Position of birth								
Only youth/1st born	9	8.1	102	91.9	Reference			
2nd born	7	12.7	48	87.3	1.65	0.58	4.70	0.346
3rd born	8	22.2	28	77.8	3.24	1.14	9.16	0.027
4th born	6	27.3	16	72.7	4.25	1.33	13.55	0.014
5th born or higher	6	28.6	15	71.4	4.53	1.41	14.56	0.011
Marital Status of parents								
Single mother, never married	2	12.5	14	87.5	0.80	0.17	3.72	0.775
Widower/Widow	7	17.5	33	82.5	1.19	0.48	2.95	0.714
Orphans	0	0.0	6	100.0	UD [θ]	UD	UD	0.999
Separation	0	0.0	5	100.0	UD	UD	UD	0.999
Married	27	15.2	151	84.8	Reference			
Ever seen father drunk/using alcohol excessively								
Yes	14	38.9	22	61.1	5.21	2.33	11.62	<0.001
No	22	10.9	180	89.1	Reference			
Unknown			7					
Having peers who consumes alcohol								
Yes	20	44.4	25	55.6	8.85	4.06	19.30	<0.001
No	16	8.3	177	91.7	Reference			
Unknown			7					

*Significance at $p<0.05$ bolded; [ψ] Odds ratio; [φ] 95% Confidence Interval; [θ] Undefined

Youths in age category 19 – 22 years had 3.91times greater odds of having alcohol dependence than youths in age category 13 – 15 years (OR=3.91; 95% CI: 1.32 – 11.59; p=0.014). Youths who were third, fourth and fifth born or higher in birth order in their family had 3.24, 4.25 and 4.53 times greater odds of having alcohol dependence than either the only child or first born, third born (OR=3.24; 95% CI: 1.14 – 9.16; p=0.027), 4th born (OR=4.25; 95% CI: 1.33 – 13.55; p=0.014) and 5th or higher born (OR=4.53; 95% CI: 1.41 – 14.56; p=0.011).

Youths who had seen their father drunk/use alcohol excessively had 5.21 times greater odds of having alcohol dependence than youths who had not seen their father drunk or use alcohol excessively (OR=5.21; 95% CI: 2.33 – 11.62; p<0.001). Similarly, youths with peers who consumed alcohol had 8.85 times greater odds of having alcohol dependence than youths who did not have peers using alcohol (OR=8.85; 95% CI: 4.06 – 19.30; p<0.001).

Table 4.2.2.6 presents analysis of alcohol dependence among youths in relation to mental health status of the parents.

Table 4.2.2.6: Alcohol dependence among youths in relation to mental health status of the parents

	Present (N=36)		Absent (N=209)			95% CI [φ]		
Variables	n	%	n	%	OR [ψ]	Lower	Upper	p value*
Behaviour in mothers								
Normal	1	5.0	19	95.0	Reference			
No emotional	7	25.0	21	75.0	6.33	0.71	56.32	0.098
Rejecting	20	15.5	109	84.5	3.49	0.44	27.53	0.236
Under protective	7	13.0	47	87.0	2.83	0.33	24.59	0.346
Unknown	1		13					
MDD in mothers								
Present	18	15.4	99	84.6	1.01	0.49	2.07	0.988
Absent	17	15.3	94	84.7	Reference			
Deceased	1	5.9	16	94.1	0.35	0.04	2.78	0.318
Dysthymia in mothers								
Present	5	11.6	38	88.4	0.68	0.25	1.87	0.454
Absent	30	16.2	155	83.8	Reference			
Deceased	1	5.9	16	94.1	0.32	0.04	2.53	0.282
Behaviour in fathers								
Normal	3	11.1	24	88.9	Reference			
No emotional	13	12.5	91	87.5	1.14	0.30	4.34	0.844
Rejecting	7	14.3	42	85.7	1.33	0.32	5.64	0.696
Under protective	7	19.4	7	3.3	8.00	1.63	39.35	0.011
Unknown	6		45					
MDD in fathers								
Present	8	21.1	30	78.9	1.67	0.68	4.12	0.263
Absent	22	13.8	138	86.3	Reference			
Deceased	6	12.8	41	87.2	0.92	0.35	2.42	0.862
Alcohol use among fathers								
Present	12	12.5	84	87.5	0.67	0.30	1.47	0.315
Absent	18	17.6	84	82.4	Reference			
Deceased	6	12.8	41	87.2	0.68	0.25	1.85	0.453

* Significance at p<0.05 bolded; ψ Odds ratio; φ 95% Confidence Interval

Youths with alcohol dependence who perceived that their father had under protective parenting behaviour (19.4%) is significantly different from youth without alcohol dependence but perceived that their fathers had under protective parenting behaviour (3.3%) (OR=8.00; 95% CI: 1.63 – 39.35; p=0.011).

Table 4.2.2.7 presents analysis of alcohol dependence among youths in relation to mental health status of the youths

Table 4.2.2.7: Alcohol dependence among youths in relation to other mental health status of the youths

	Present (N=36)		Absent (N=209)			95% CI $^{\varphi}$		
Variables	n	%	n	%	OR $^{\psi}$	Lower	Upper	p value*
Conduct Disorder								
Yes	2	9.5	19	90.5	0.59	0.13	2.64	0.484
No	34	15.2	190	84.8	Reference			
Anxiety disorder								
Yes	0	0.0	45	100.0	UD $^{\theta}$	UD	UD	0.002
No	36	18.0	164	82.0	Reference			
Any Drug Abuse								
Yes	36	28.3	91	71.7	UD	UD	UD	0.002
No	0	0.0	118	100.0	Reference			
Suicide behaviour								
Yes	34	16.6	171	83.4	3.78	0.87	16.41	0.058
No	2	5.0	38	95.0	Reference			

*Significance at p<0.05 bolded; $^{\psi}$ Odds ratio; $^{\varphi}$ 95% Confidence Interval; $^{\theta}$ Undefined

None of the factors was significantly associated with severe alcohol dependence (P<0.05), as most cells had less than 5 counts.

Binary logistic regression (multivariate analysis) was used to model severe alcohol dependence using factors identified to be significant at P<0.05 during bivariate analysis. Backward conditional method was specified with removal at P<0.05. Three independent predictors of severe alcohol dependence among youths were identified as presented in Table 4.2.2.8.

Table 4.2.2.8: Predictors of severe alcohol dependence among youths

Variables	AOR $^{\psi}$	95% CI $^{\varphi}$ Lower	Upper	p value*
Position of birth				
Only youth/1st born	Reference			
2nd born	1.67	0.53	5.30	0.385
3rd born	3.14	1.01	9.75	0.048
4th born	3.32	0.88	12.47	0.075
5th born or higher	5.69	1.52	21.32	0.010
Ever seen father drunk/using alcohol excessively				
Yes	2.82	1.07	7.41	0.035
No	Reference			
Having peers who drink alcohol				
Yes	5.88	2.43	14.22	<0.001
No	Reference			

* Significance at $p<0.05$ bolded; $^{\psi}$ Odds ratio; $^{\varphi}$ 95% Confidence Interval

With reference to only youth/1st born birth position, alcohol dependence among the youths: 3rd born had 3.14 times greater odds of developing alcohol dependence than the first born (AOR=3.14; 95% CI: 1.01 – 9.75; p=0.048), 4th had 3.32 times greater odds of developing alcohol dependence than the first born (AOR=3.32; 95% CI: 0.88 – 12.47; p=0.075) and 5th or higher had 5.69 times greater odds of developing alcohol dependence than the first born (AOR=5.69; 95% CI: 1.52 – 21.32; p=0.010).

Youths who had seen their father drunk/using alcohol excessively had 2.82 times greater odds of developing alcohol dependence than youths who had not seen their father drunk/use alcohol excessively (AOR=2.82; 95% CI: 1.07 – 7.41; p<0.035). Youths who had peers consuming alcohol had 5.88 times greater odds of developing alcohol dependence than youths who had no peers consuming alcohol. (AOR=5.88; 95% CI: 2.43 – 14.22; p<0.001).

4.2.3 Factors associated with drug abuse in youths

Table 4.2.3.1 presents analysis of any drug abuse among the youths in relation to background characteristics.

Table 4.2.3.1: Any drug abuse among youths in relation to background characteristics of the youth

Variables	Present (N=127) n	%	Absent (N=118) n	%	OR $^{\Psi}$	95% CI $^{\varphi}$ Lower	Upper	p value*
Age in years								
13 – 15	26	42.6	35	57.4	0.65	0.31	1.33	0.238
16 – 18	70	55.6	56	44.4	1.09	0.58	2.03	0.790
19 - 22	31	53.4	27	46.6	Reference			
Sex								
Female	50	50.0	50	50.0	0.88	0.53	1.47	0.633
Male	77	53.1	68	46.9	Reference			
Position of birth								
Only youth/1st born	60	54.1	51	45.9	0.88	0.34	2.26	0.794
2nd born	29	52.7	26	47.3	0.84	0.30	2.30	0.730
3rd born	13	36.1	23	63.9	0.42	0.14	1.27	0.126
4th born	13	59.1	9	40.9	1.08	0.32	3.64	0.897
5th born or higher	12	57.1	9	42.9	Reference			
Level of Education								
Secondary	81	54.0	69	46.0	1.32	0.74	2.35	0.343
College	14	51.9	13	48.1	1.21	0.50	2.96	0.673
Primary	32	47.1	36	52.9	Reference			
Marital Status of parents								
Single mother, never married	7	43.8	9	56.3	0.76	0.27	2.13	0.603
Widower/Widow	21	52.5	19	47.5	1.08	0.54	2.15	0.825
Orphans	6	100.0	0	0.0	UD	UD	UD	0.999
Separation	3	60.0	2	40.0	1.47	0.24	8.99	0.679
Married	90	50.6	88	49.4	Reference			
Ever seen father drunk/using alcohol excessively								
Yes	22	61.1	14	38.9	1.63	0.79	3.37	0.181
No	99	49.0	103	51.0	Reference			
Unknown	6		1					
Do your peers drink								
Yes	30	66.7	15	33.3	2.24	1.13	4.43	0.018
No	91	47.2	102	52.8	Reference			
Unknown	6		1					

*Significance at $p<0.05$ bolded; $^{\Psi}$ Odds ratio; $^{\varphi}$ 95% Confidence Interval

Youths with drug abuse disorder who had peers consuming alcohol (66.7%) were significantly different from youths who were not abusing drugs (33.3%) but had peers consuming alcohol, p=0.018 with reference to peers who were not consuming alcohol.

Drug abuse among youths in relation to mental health status of the parents is presented in Table 4.2.3.2.

Table 4.2.3.2: Drug abuse among youths in relation to mental health status of the parents

Variables	Present (N=127) n	%	Absent (N=118) n	%	OR ᵠ	95% CI ᵠ Lower	Upper	p value*
Parents behaviour (Mother)								
No emotional	14	50.0	14	50.0	3.00	0.86	10.52	0.086
Rejecting	73	56.6	56	43.4	3.91	1.34	11.40	0.013
Under protective	25	46.3	29	53.7	2.59	0.82	8.13	0.104
Normal	5	25.0	15	75.0	Reference			
Unknown	10		4					
MDD in mothers: Baseline								
Present	59	50.4	58	49.6	1.00	0.59	1.68	0.997
Deceased	12		5		2.36	0.71	8.29	0.121
Absent	56	50.5	55	49.5	Reference			
Mothers: Dythymia								
Present	23	53.5	20	46.5	1.16	0.60	2.26	0.657
Deceased	12	70.6	5	29.4	2.43	0.82	7.16	0.109
Absent	92	49.7	93	50.3	Reference			
Parents behaviour (father)								
No emotional	58	55.8	46	44.2	1.17	0.50	2.73	0.716
Rejecting	19	38.8	30	61.2	0.59	0.23	1.52	0.273
Under protective	8	57.1	6	42.9	1.24	0.34	4.54	0.747
Normal	14	51.9	13	48.1	Reference			
Unknown	28		23					
MDD in fathers: Baseline								
Present	21	55.3	17	44.7	1.24	0.61	2.51	0.560
Deceased	26	55.3	21	44.7	1.24	0.64	2.38	0.522
Absent	80	50.0	80	50.0	Reference			
Alcohol use in fathers: Baseline								
Present	49	51.0	47	49.0	1.00	0.57	1.75	0.993
Deceased	26	55.3	21	44.7	1.19	0.59	2.38	0.622
Absent	52	51.0	50	49.0	Reference			
Fathers: Any disorder								
Present	72	52.9	64	47.1	1.28	0.70	2.34	0.421
Deceased	26	55.3	21	44.7	1.41	0.66	3.02	0.377
Absent	29	46.8	33	53.2	Reference			

*Significance at p<0.05 bolded; ᵠ Odds ratio; ᵠ 95% Confidence Interval

Youths who had drug abuse disorder and perceived their mothers to have rejecting parenting behaviour (56.6%) were significantly different from youths who did not have drug abuse but perceived their mothers to have rejecting parenting behaviour (43.4%), (OR=3.91; 95% CI: 1.34 – 11.40; p<0.013).

Analysis of drug abuse among the youths in relation to other mental health status of the youths is presented in Table 4.2.3.3.

Table 4.2.3.3: Drug abuse among youths in relation to other mental health status of the youths

Variables	Present (N=127) n	%	Absent (N=118) n	%	OR $^{\psi}$	95% CI $^{\varphi}$ Lower	Upper	p value*
MDD								
Present	87	65.4	46	34.6	3.40	2.01	5.76	<0.001
Absent	40	35.7	72	64.3	Reference			
Conduct Disorder								
Present	17	81.0	4	19.0	4.40	1.44	13.50	0.005
Absent	110	49.1	114	50.9	Reference			
Any Anxiety disorder								
Yes	27	60.0	18	40.0	1.50	0.78	2.90	0.225
No	100	50.0	100	50.0	Reference			
Alcohol use								
Present	116	99.1	1	0.9	1233.82	156.76	9711.14	<0.001
Absent	11	8.6	117	91.4	Reference			
Psychotic disorder								
Present	0	0.0	37	100.0	UD	UD	UD	<0.001
Absent	127	61.1	81	38.9	Reference			
Suicide behaviour								
Present	120	58.5	85	41.5	6.67	2.78	16.67	<0.001
Absent	7	17.5	33	82.5	Reference			

* Significance at p<0.05 bolded; $^{\psi}$ Odds ratio; $^{\varphi}$ 95% Confidence Interval

Youths who had drug abuse disorder had 3.40 times greater odds of having co-existing MDD than youths with MDD but no co-existing drug abuse disorder (OR=3.40; 95% CI: 2.01 – 5.76; p<0.001). Youths who had drug abuse disorder had 4.40 times greater odds of having co-existing conduct disorder than youths with conduct disorder but no co-existing drug abuse disorder (OR=4.40; 95% CI: 1.44 – 13.50; p=0.005). Youths who had drug abuse disorder had 1233.82 times greater odds of having co-existing alcohol use disorders than youths with alcohol use disorder but no co-existing drug abuse disorder (OR=123.82; 95% CI: 156.76 – 9711.14; p<0.001). Youths who had drug abuse disorder had 6.67 times greater odds of having suicide behaviour than youths with suicide behaviour but no drug abuse disorder (OR=6.67; 95% CI: 2.78 – 16.67; p<0.001).

Multivariate logistic regression was used to model any drug abuse using factors identified to be significant at p<0.05 during bivariate analysis. Backward conditional method was specified with removal at P<0.05. Four independent predictors of any drug abuse among youths were identified as presented in Table 4.2.3.4.

Table 4.2.3.4: Predictors of Drug abuse among youths

Predictors	AOR[ψ]	95% CI [φ] Lower	Upper	p value[*]
Having peers who consume alcohol				
Yes	3.19	1.47	6.91	0.003
No	Reference			
MDD				
Yes	2.99	1.62	5.53	<0.001
No	Reference			
Conduct Disorder				
Yes	3.51	1.10	11.22	0.035
No	Reference			
Suicide behaviour				
Yes	3.55	1.41	8.94	0.007
No	Reference			

[*] Significance at p<0.05 bolded; [ψ] Adjusted odds ratio; [φ] 95% Confidence Interval

Youths who had peers consuming alcohol had 3.19 times greater odds of abusing other drugs than youths who used alcohol but did not have peers consuming alcohol when other factors were controlled for (AOR=3.19; 95% CI: 1.47 – 6.91; p=0.003). Also, youths who had MDD had 2.99 times greater odds of abusing drugs than youths who abused drugs but did not have MDD when other factors are controlled for (AOR=2.99; 95% CI: 1.62 – 5.53; p<0.001). Youths who had conduct disorder had 3.51 times greater odds of abusing drugs than youths who abused drugs but did not have conduct disorder when other factors are controlled for (AOR=3.51; 95% CI: 1.10 – 11.22; p=0.035). Similarly youths who had Suicide behaviour had 3.55 times greater odds of abusing drugs than youths who did not have suicide behaviour but abused drugs when other factors are controlled for (AOR=3.55; 95% CI: 1.41 – 8.94; p=0.007).

4.2.4 Factors associated with suicide behaviour in youths

Bivariate analysis

Table 4.2.4.1 presents analysis of Suicide behaviour among the youths in relation to background characteristics.

Table 4.2.4.1: Suicide behaviour among youths in relation to background characteristics of the youth

Variables	Present (N=205) n	%	Absent (N=40) n	%	OR ψ	95% CI φ Lower	Upper	P value*
Age in years								
13 – 15	50	82.0	11	18.0	1.73	0.73	4.13	0.216
16 – 18	113	89.7	13	10.3	3.31	1.47	7.47	0.004
19 – 22	42	72.4	16	27.6	Reference			
Sex								
Female	82	82.0	18	18.0	0.81	0.41	1.61	0.556
Male	123	84.8	22	15.2	Reference			
Position of birth								
Only youth/1st born	94	84.7	17	15.3	2.21	0.75	6.50	0.149
2nd born	49	89.1	6	10.9	3.27	0.92	11.64	0.068
3rd born	28	77.8	8	22.2	1.40	0.41	4.79	0.592
4th born	19	86.4	3	13.6	2.53	0.54	11.85	0.238
5th born or higher	15	71.4	6	28.6	Reference			
Level of Education								
Secondary	132	88.0	18	12.0	2.08	0.97	4.42	0.058
College	20	74.1	7	25.9	0.81	0.29	2.27	0.687
Primary	53	77.9	15	22.1	Reference			
Marital Status of parents								
Single mother, never married	13	81.3	3	18.8	0.88	0.24	3.27	0.847
Widower/Widow	33	82.5	7	17.5	0.96	0.39	2.36	0.922
Orphans	6	100.0	0	0.0	UD	UD	UD	0.999
Separation	5	100.0	0	0.0	UD	UD	UD	0.999
Married	148	83.1	30	16.9	Reference			
Ever seen father drunk/using alcohol excessively								
Yes	30	83.3	6	16.7	0.98	0.38	2.53	0.961
No	169	83.7	33	16.3	Reference			
Unknown	6		1					
Having peers who consume alcohol								
Yes	40	88.9	5	11.1	1.71	0.63	4.65	0.288
No	159	82.4	34	17.6	Reference			
Unknown	6		1					

* Significance at $p<0.05$ bolded; ψ Odds ratio; φ 95% Confidence Interval

The proportion of the youths with suicide behaviour in age group 16 – 18 years (89.7%) was significantly different from the proportion of youths in age group 19-22 years (72.4%) with suicide behaviour (OR=3.31; 95% CI: 1.47 – 7.47; p=0.004).

Table 4.2.4.2 presents analysis of Suicide behaviour among youths in relation to mental health status of the parents.

Table 4.2.4.2: Suicide behaviour among youths in relation to mental health status of the parents

Variables	Present (N=205) n	%	Absent (N=40) n	%	OR ψ	95% CI φ Lower	Upper	P value*
Parents behaviour (Mother)								
No emotional	22	78.6	6	21.4	1.57	0.42	5.85	0.501
Rejecting	115	89.1	14	10.9	3.52	1.17	10.64	0.026
Under protective	42	77.8	12	22.2	1.50	0.47	4.74	0.490
Normal	14	70.0	6	30.0	Reference			
Unknown	12		2					
Mothers: MDD								
Present	103	88.0	14	12.0	2.14	1.05	4.37	0.037
Deceased	16	94.1	1	5.9	4.65	0.59	36.81	0.145
Absent	86	77.5	25	22.5	Reference			
Mothers: Dythymia								
Present	36	83.7	7	16.3	1.08	0.44	2.63	0.873
Deceased	16	94.1	1	5.9	3.35	0.43	26.15	0.250
Absent	153	82.7	32	17.3	Reference			
Parents behaviour (father)								
No emotional	89	85.6	15	14.4	1.35	0.44	4.11	0.599
Rejecting	42	85.7	7	14.3	1.36	0.39	4.80	0.629
Under protective	10	71.4	4	28.6	0.57	0.13	2.58	0.464
Normal	22	81.5	5	18.5	Reference			
Unknown	42		9					
Fathers: MDD								
Present	35	92.1	3	7.9	3.03	0.88	10.47	0.080
Deceased	43	91.5	4	8.5	2.79	0.94	8.34	0.066
Absent	127	79.4	33	20.6	Reference			
Fathers: Alcohol use								
Present	83	86.5	13	13.5	1.86	0.88	3.92	0.104
Deceased	43	91.5	4	8.5	3.13	1.02	9.64	0.047
Absent	79	77.5	23	22.5	Reference			

*Significance at $p<0.05$ bolded; ψ Odds ratio; φ 95% Confidence Interval

Proportion of youths with suicide behaviour and perceived that their mother had rejecting parenting behaviour (89.1%) was significantly different from proportion of youths without suicide behaviour but

perceived that their mother had rejecting parenting behaviour (10.9%) (OR=3.52; 95% CI: 1.17 – 10.64; p=0.026). Likewise, proportion of the youths with suicide behaviour who had mothers with MDD (88.0%) was significantly different from proportion of the youths with suicide behaviour (12.0%) but did not have mothers with MDD (OR=2.14; 95% CI: 1.05 – 4.37; p=0.037). The total number of deceased mothers was small (16) for binary analysis, a cell had less than 3 to run the chi square test. Suicide behaviour among the youths who had deceased fathers (91.5%) was significantly different from youths without suicide behaviour but had also lost their fathers through death (8.5%) with reference to non-use of alcohol in fathers (OR=3.13; 95% CI: 1.02 – 9.64; p=0.047).

Analysis of Suicide behaviour among the youths in relation to other mental health status of the youths is presented in Table 4.2.4.3.

Table 4.2.4.3: Suicide behaviour among youths in relation to other mental health status of the youths

	Present (N=205)		Absent (N=40)			95% CI $^{\varphi}$		p
Variables	n	%	n	%	OR $^{\Psi}$	Lower	Upper	value*
MDD								
Yes	124	93.2	9	6.8	5.27	2.39	11.66	<0.001
No	81	72.3	31	27.7	Reference			
Conduct Disorder								
Yes	20	95.2	1	4.8	4.22	0.55	32.36	0.134
No	185	82.6	39	17.4	Reference			
Anxiety disorder								
Yes	32	71.1	13	28.9	0.38	0.18	0.82	0.012
No	173	86.5	27	13.5	Reference			
Drug abuse								
Yes	120	94.5	7	5.5	6.66	2.81	15.75	<0.001
No	85	72.0	33	28.0	Reference			
Alcohol use								
Yes	111	94.9	6	5.1	6.69	2.69	16.63	<0.001
No	94	73.4	34	26.6	Reference			

*Significance at p<0.05 bolded; $^{\Psi}$ Odds ratio; $^{\varphi}$ 95% Confidence Interval

The proportion of youths with MDD and suicide behaviour (93.2%) was significantly different from youths with MDD who did not have suicide behaviour, 6.8%, (OR=5.27; 95% CI: 2.39 – 11.66; p<0.001). The proportion of the youths with anxiety disorder and suicide behaviour (71.1%) was significantly different from the proportion with anxiety disorder who did not have suicide behaviour 28.9%, (OR=0.38; 95% CI:

0.18 – 0.82; p=0.012). The proportion of the youths with drug abuse with suicide behaviour (94.5%) was significantly different from the proportion with drug abuse who did not have suicide behaviour 5.5%, (OR=6.66; 95% CI: 2.81 – 15.75; p<0.001). Similarly, the proportion of the youths with alcohol use disorders with suicide behaviour (94.9%) was significantly different from the proportion with alcohol use disorders who did not have suicide behaviour 5.1%, (OR=6.69; 95% CI: 2.69 – 16.63; p<0.001).

Table 4.2.4.4: Youth suicidal behaviour in relation to number of co-existing psychiatric disorders in youths

	Present (n=205)		Absent (n=40)			95% CI		
Variables	n	%	n	%	OR	Lower	Upper	p value
Patterns of psychiatric condition in youths								
1 Disorder	52	65.8	27	34.2	Reference			
2 – 3 Disorders	42	87.5	6	12.5	3.63	1.37	9.62	0.009
4 Disorders	111	94.1	7	5.9	8.23	3.37	20.13	<0.001

The youths who had four co-existing psychiatric disorders had 8.23 times greater odds of having suicidal behaviour (OR 8.23; 95%CI: 3.37-20.13 ;< 0.001) than the youths with only one disorder. While the youths who had 2-3 co-existing psychiatric disorders had 3.63 times greater odds of having suicidal behaviour (OR 3.63; 95%CI: 1.37-9.62; p=0.009) than the youths with only one disorder

Binary logistic regression (multivariate analysis) was used to model suicide behaviour using factors identified to be significant at P<0.05 during bivariate analysis. Backward conditional method was specified with removal at P<0.05. Three independent predictors of suicide behaviour among youths were identified as presented in Table 4.2.4.5.

Table 4.2.4.5: **Predictors of Suicide behaviour among youths**

Predictors	AOR[ψ]	95% CI[φ] Lower	Upper	p value*
MDD				
Yes	4.63	1.68	12.73	0.003
No	Reference			
Any Anxiety disorder				
Yes	0.20	0.07	0.59	0.003
No	Reference			
Alcohol use				
Yes	4.25	1.49	12.14	0.007
No	Reference			

* Significance at $p<0.05$ bolded; [ψ] Adjusted odds ratio; [φ] 95% Confidence Interval

The youths who had MDD had 4.63 times greater odds of having suicide behaviour than the youths without MDD when other factors were adjusted for (AOR=4.63; 95% CI: 1.68 – 12.73; p=0.003). The youths who had alcohol use disorders had 4.25 times greater odds of having suicide behaviour than the youths without alcohol use disorders when other factors were adjusted for (AOR=4.25; 95% CI: 1.49 – 12.14; p=0.007). Any Anxiety disorder was associated with reduced cases of suicide behaviour (AOR=0.20; 95% CI: 0.07 – 0.59; p=0.003).

4.2.5 Factors associated with anxiety disorders in youths

Table 4.2.5.1 presents binary analysis of anxiety disorders among the youths in relation to background characteristics.

Table 4.2.5.1: Any anxiety disorder among youths in relation to background characteristics of the youth

Variables	Present (N=45) n	%	Absent (N=200) n	%	OR [ψ]	95% CI [φ] Lower	Upper	p value [*]
Age in years								
13 - 15	10	16.4	51	83.6	0.62	0.25	1.53	0.295
16 – 18	21	16.7	105	83.3	0.63	0.29	1.35	0.233
19 – 22	14	24.1	44	75.9	Reference			
Sex								
Female	21	21.0	79	79.0	1.34	0.70	2.57	0.377
Male	24	16.6	121	83.4	Reference			
Position of birth								
Only youth/1st born	25	22.5	86	77.5	0.93	0.31	2.79	0.897
2nd born	8	14.5	47	85.5	0.54	0.16	1.91	0.342
3rd born	4	11.1	32	88.9	0.40	0.09	1.70	0.214
4th born	3	13.6	19	86.4	0.51	0.10	2.45	0.397
5th born or higher	5	23.8	16	76.2	Reference			
Level of Education								
Primary	13	19.1	55	80.9	Reference			
Secondary	23	15.3	127	84.7	0.77	0.36	1.62	0.487
College	9	33.3	18	66.7	2.12	0.78	5.77	0.143
Marital Status of parents								
Single mother, never married	3	18.8	13	81.3	0.88	0.24	3.25	0.847
Widower/Widow	5	12.5	35	87.5	0.54	0.20	1.49	0.235
Orphans	0	0.0	6	100.0	UD [θ]	UD	UD	0.999
Separation	0	0.0	5	100.0	UD	UD	UD	0.999
Married	37	20.8	141	79.2	Reference			
Ever seen father drunk/using alcohol excessively								
Yes	3	8.3	33	91.7	0.36	0.10	1.22	0.088
No	41	20.3	161	79.7	Reference			
Unknown	1		6					
Having peers who consume alcohol								
Yes	4	8.9	41	91.1	0.37	0.13	1.10	0.065
No	40	20.7	153	79.3	Reference			
Unknown	1		6					

[*] Significance at $p<0.05$ bolded; [ψ] Odds ratio; [φ] 95% Confidence Interval; [θ] undefined

There was no significant difference in distribution of anxiety disorder according to youths socio-demographic characteristic ($P>0.05$).

Table 4.2.5.2 presents binary analysis of anxiety disorder among the youths in relation to mental health status of the parents.

Table 4.2.5.2: Any anxiety disorder among youths in relation to mental health status of the parents

Variables	Present (N=45) n	%	Absent (N=200) n	%	OR $^{\Psi}$	95% CI $^{\varphi}$ Lower	Upper	p value*
Parents behaviour (Mother)								
Emotional un-connectedness	8	28.6	20	71.4	1.20	0.33	4.41	0.784
Rejecting	20	15.5	109	84.5	0.55	0.18	1.69	0.296
Under protective	11	20.4	43	79.6	0.77	0.23	2.57	0.668
Connectedness (adaptive)	5	25.0	15	75.0	Reference			
Mothers: MDD								
Present	21	17.9	96	82.1	0.84	0.43	1.62	0.596
Absent	23	20.7	88	79.3	Reference			
Unknown	1		16					
Mothers: Dythymia								
Present	6	14.0	37	86.0	0.63	0.25	1.60	0.328
Deceased	1	5.9	16	94.1	0.24	0.03	1.88	0.175
Absent	38	20.5	147	79.5	Reference			
Parents behaviour (father)								
No emotional	19	18.3	85	81.7	0.98	0.33	2.93	0.976
Rejecting	13	26.5	36	73.5	1.59	0.50	5.07	0.434
Under protective	0	0.0	14	100.0	UD $^{\theta}$	UD	UD	0.999
Normal	5	18.5	22	81.5	Reference			
Fathers: MDD								
Present	9	23.7	29	76.3	1.53	0.65	3.59	0.330
Deceased	9	19.1	38	80.9	1.17	0.51	2.69	0.718
Absent	27	16.9	133	83.1	Reference			
Fathers: Alcohol use								
Present	14	14.6	82	85.4	0.62	0.30	1.30	0.205
Deceased	9	19.1	38	80.9	0.86	0.36	2.05	0.735
Absent	22	21.6	80	78.4	Reference			

*Significance at $p<0.05$ bolded; $^{\Psi}$ Odds ratio; $^{\varphi}$ 95% Confidence Interval; $^{\theta}$ undefined

There was no significant difference in distribution of anxiety disorder according to mental health status of parents (P>0.05).

Analysis of anxiety disorder among the youths in relation to other mental health status of the youths is presented in Table 4.2.5.3.

Table 4.2.5.3: Any anxiety disorder among youths in relation to other mental health status of the youths

Variables	Present (N=45)		Absent (N=200)			95% CI φ		
	n	%	n	%	OR ψ	Lower	Upper	p value*
MDD								
Yes	32	24.1	101	75.9	2.41	1.20	4.87	0.012
No	13	11.6	99	88.4	Reference			
Conduct Disorder								
Yes	16	76.2	5	23.8	21.52	7.33	63.19	<0.001
No	29	12.9	195	87.1	Reference			
Any drug abuse								
Yes	27	21.3	100	78.7	1.50	0.78	2.90	0.225
No	18	15.3	100	84.7	Reference			
Alcohol abuse								
Yes	26	22.2	91	77.8	1.64	0.85	3.15	0.136
No	19	14.8	109	85.2	Reference			
Suicide behaviour								
Yes	32	15.6	173	84.4	0.38	0.18	0.82	0.012
No	13	32.5	27	67.5	Reference			

* Significance at p<0.05 bolded; ψ Odds ratio; φ 95% Confidence Interval

The proportion of the youths with anxiety disorder (24.1%) co-existing with MDD (24.1%) was significantly different from the proportion of youths with anxiety disorder (11.6%) not co-existing with MDD (OR=2.41; 95% CI: 1.20 – 4.87; p=0.012). The proportion of the youths with anxiety disorder (76.2%) co-existing with conduct disorder was significantly different from the proportion of youths with anxiety disorder (12.9%) not co-existing with conduct disorder, (OR=12.52; 95% CI: 7.33 – 63.19; p<0.001).

The proportion of the youths with both anxiety disorder (15.6%) and suicide behaviour was significantly different (smaller) from the proportion of the youths with anxiety disorder (32.5%) but not having suicide behaviour (OR=0.38; 95% CI: 0.18 – 0.82; p=0.012).

Binary logistic regression (multivariate) was used to model anxiety disorder using factors identified to be significant at P<0.05 during bivariate analysis. Backward conditional method was specified with removal at P=0.05. Three independent predictors of anxiety disorder among youths were identified as presented in Table 4.2.5.4.

Table 4.2.5.4: Predictors of anxiety disorder among youths

Predictors	AOR[ψ]	95% CI[φ] Lower	Upper	p value[*]
MDD				
Yes	3.97	1.57	10.02	0.004
No	Reference			
Conduct Disorder				
Yes	30.86	9.50	100.27	<0.001
No	Reference			
Suicide behaviour				
Yes	0.12	0.04	0.32	<0.001
No	Reference			

[*] Significance at p<0.05 bolded; [ψ] Adjusted odds ratio; [φ] 95% Confidence Interval

The youths who had MDD had 3.97 times greater odds of having anxiety disorder than the youths without MDD when other factors are adjusted for (AOR=3.97; 95% CI: 1.57 – 10.02; p=0.004). The youths who had conduct disorder had 30.86 times greater odds of having anxiety disorder than the youths who did not have conduct disorder when other factors are adjusted for, (AOR=30.86; 95% CI: 9.50 – 100.27; p<0.001). The youths who had suicide behaviour had **-0.88** times lesser odds of having anxiety disorder than the youths without suicide behaviour when other factors are adjusted for (AOR=0.12; 95% CI: 0.04 – 0.32; p<0.001).

4.2.6 Paternal factors associated with maternal MDD

Table 4.2.6.1 presents bivariate analysis of maternal MDD in relation to paternal characteristics.

Table 4.2.6.1: MDD in mothers in relation to characteristics of the fathers

	Present (N=117)		Absent (N=111)			95% CI		
Variables	n	%	n	%	OR	Lower	Upper	p value*
Parenting behaviour in fathers								
connected	11	47.8	12	52.2	1.65	0.42	6.46	0.472
Emotional un-connectedness	55	54.5	46	45.5	2.15	0.67	6.87	0.196
Rejecting	24	50.0	24	50.0	1.8	0.53	6.16	0.349
Under protective	5	35.7	9	64.3	Reference			
Unknown	22		20					
MDD in fathers								
Present	23	69.7	10	30.3	2.55	1.14	5.71	0.023
Deceased	20	51.3	19	48.7	1.17	0.58	2.35	0.667
Absent	74	47.4	82	52.6	Reference			
Alcohol use in fathers								
Present	58	62.4	35	37.6	2.42	1.35	4.35	0.003
Deceased	20	51.3	19	48.7	1.54	0.73	3.25	0.259
Absent	39	40.6	57	59.4	Reference			
Unavailable fathers								
Deceased	20	51.3	19	48.7	3.03	1.30	7.06	0.010
Absent	16	25.8	46	74.2	Reference			

*Significance at p<0.05 bolded; Ψ Adjusted odds ratio; φ 95% Confidence Interval

The proportion of mothers with MDD married to husbands with MDD (69.7%) was significantly different from the proportion of mothers who did not have MDD but were married to husband with MDD (30.3%), OR=2.55; 95% CI: 1.14 – 5.71; p=0.023). The proportion of mothers with MDD married to husbands with alcohol use disorders (62.4%) was significantly different from the proportion of mothers who did not have MDD but were married to husband with alcohol use disorders (37.6%), (OR=2.42; 95% CI: 1.35 – 4.35; p=0.003). The proportion of mothers with MDD who had deceased husbands (51.3%) was significantly different from the proportion of mothers who did not have MDD but had also deceased husbands 48.7% (OR=3.03; 95% CI: 1.30 – 7.06; p=0.010) in reference to fathers who had no mental health problems.

Table 4.2.6.2 summaries predictors (multivariate analysis) of MDD in mothers (in both groups) using multivariate logistic regression model to determine paternal factors that predict maternal MDD. Backward conditional method was specified with removal at P<0.05.

Table 4.2.6.2: Predictors of MDD in mothers

		95% CI		
Predictors	AOR	Lower	Upper	P value
MDD in fathers				
Present	5.56	2.09	14.76	0.001
Deceased	2.14	0.82	5.62	0.122
Absent	Reference			
Alcohol use in fathers				
Yes	4.20	1.99	8.84	<0.001
No	Reference			

Mothers married to husbands with MDD had 5.56 times greater odds of having MDD than mothers married to husbands who did not have MDD (AOR=5.56; 95% CI: 2.09 – 14.76; p=0.001). Mothers married to husband with alcohol use disorders had 4.20 times greater odds of having MDD than mothers married to husbands who did not have alcohol use disorders (AOR=4.20; 95% CI: 1.99 – 8.84; p<0.001).

4.3 Assessing efficacy of the intervention on different mental disorders

Assessment of efficacy of the intervention on different mental disorders is presented in the following sections starting with section 4.3.1 to section 4.3.8. In each section the analysis of each mental disorder demonstrates efficacy of the intervention.

4.3.1 Efficacy of the intervention on MDD in youths

Table 4.3.1.1 presents the efficacy of the intervention on MDD in youths.

Table 4.3.1: Efficacy of the intervention on MDD in youths

Time point	Total (N=237) n	%	Experimental (N=116) n	%	Control (N=121) n	%	χ^2 value	df	p value*
MDD in youths at Baseline									
Present	126	53.2	50	43.1	76	62.8	9.24	1	0.002
Absent	111	46.8	66	56.9	45	37.2			
MDD in youths at Follow up 1									
Present	84	35.4	9	7.8	75	62.0	76.11	1	<0.001
Absent	153	64.6	107	92.2	46	38.0			
			χ^2 =38.21, df=1, p<0.001		χ^2 =0.02, df=1, p=0.894				
MDD in youths at Follow up 2									
Present	60	25.3	3	2.6	57	47.1	62.09	1	<0.001
Absent	177	74.7	113	97.4	64	52.9			
			χ^2 =54.02, df=1, p<0.001		χ^2 =6.03, df=1, p=0.014				

* Significance at p<0.05 bolded

The proportion of youths with MDD at baseline in the experimental group (43.1%) was significantly different from the proportion in control group (62.8%), p=0.002. There were more youths with MDD in the control group at Follow up 1 and Follow up 2 than in experimental group (p<0.001). In the control group, there was hardly any reduction in prevalence of MDD between baseline and Follow up 1 and minimal to moderate reduction (18%) between Follow up 1 and Follow up 2. However in the experimental group there was significant reduction in prevalence of MDD from baseline to Follow up 1 (by 35.3%) and also from Follow up 1 to Follow up 2 from 7.8% to 2.6% respectively.

4.3.2 Efficacy of the intervention on Suicide behaviour in youths

Table 4.3.2 presents the efficacy of the intervention on Suicide behaviour in youths.

Table 4.3.2.2: Efficacy of the intervention on Suicide behaviour in youths

	Total (N=237)		Experimental (N=116)		Control (N=121)				
Time point	n	%	n	%	n	%	χ^2 value	df	p value*
Suicide behaviour in youths at Baseline									
Present	197	83.1	80	69.0	117	96.7	32.46	1	<0.001
Absent	40	16.9	36	31.0	4	3.3			
Suicide behaviour in youths at Follow up 1									
Present	57	24.1	0	0	57	47.1	71.95	1	<0.001
Absent	180	75.9	116	100	64	52.9			
			χ^2=122.11, df=1, p<0.001		χ^2=73.63, df=1, p<0.001				
Suicide behaviour in youths at Follow up 2									
Present	56	23.6	0	0	56	46.3	70.30	1	<0.001
Absent	181	76.4	116	100	65	53.7			
			χ^2=122.11, df=1, p<0.001		χ^2=75.44, df=1, p<0.001				

*Significance at p<0.05 bolded.

There were more youths with suicidal behaviour in the control group in all baseline to Follow up 2 than in experimental group (p<0.001). However, there was no suicidal behaviour in the experimental group in Follow up 1 and Follow up 2. In the control, there was a 50% reduction between baseline and Follow up 1 and hardly any reduction between Follow up 1 and Follow up 2.

4.3.2 Efficacy of the intervention on Suicide behaviour in youths

Table 4.3.2 presents the efficacy of the intervention on Suicide behaviour in youths.

Table 4.3.2.2: Efficacy of the intervention on Suicide behaviour in youths

	Total (N=237)		Experimental (N=116)		Control (N=121)				
Time point	n	%	n	%	n	%	χ^2 value	df	p value*
Suicide behaviour in youths at Baseline									
Present	197	83.1	80	69.0	117	96.7	32.46	1	<0.001
Absent	40	16.9	36	31.0	4	3.3			
Suicide behaviour in youths at Follow up 1									
Present	57	24.1	0	0	57	47.1	71.95	1	<0.001
Absent	180	75.9	116	100	64	52.9			
			χ^2=122.11, df=1, p<0.001		χ^2=73.63, df=1, p<0.001				
Suicide behaviour in youths at Follow up 2									
Present	56	23.6	0	0	56	46.3	70.30	1	<0.001
Absent	181	76.4	116	100	65	53.7			
			χ^2=122.11, df=1, p<0.001		χ^2=75.44, df=1, p<0.001				

*Significance at p<0.05 bolded.

There were more youths with suicidal behaviour in the control group in all baseline to Follow up 2 than in experimental group (p<0.001). However, there was no suicidal behaviour in the experimental group in Follow up 1 and Follow up 2. In the control, there was a 50% reduction between baseline and Follow up 1 and hardly any reduction between Follow up 1 and Follow up 2.

4.3.3 Efficacy of the intervention on Psychotic disorder (BMD or Schizophrenia) in youths

Table 4.3.3 presents the efficacy of the intervention on Psychotic disorder (bipolar mood disorder and schizophrenic disorders) in youths.

Table 4.3.3: Efficacy of the intervention on Psychotic disorder in youths

Time point	Total (N=237) n	%	Experimental (N=116) n	%	Control (N=121) n	%	χ^2 value	df	p value*
Psychotic disorder in youths at Baseline									
Present	37	15.6	25	21.6	12	9.9	6.08	1	0.014
Absent	200	84.4	91	78.4	109	90.1			
Psychotic disorder in youths at Follow up 1									
Present	37	15.6	25	21.6	12	9.9	6.08	1	0.014
Absent	200	84.4	91	78.4	109	90.1			
			χ^2=0.00, df=1, p=1.000		χ^2=0.00, df=1, p=1.000				
Psychotic disorder in youths at Follow up 2									
Present	30	12.7	18	15.5	12	9.9	1.68	1	0.195
Absent	207	87.3	98	84.5	109	90.1			
			χ^2=1.40, df=1, p=0.237		χ^2=0.00, df=1, p=1.000				

* Significance at p<0.05 bolded

There were more youths with psychotic disorder in the experimental group in baseline and Follow up 1 than in control group (p<0.014). However, there was no significant difference in the number of participants with Psychotic disorder at Follow up2, p=0.195. There was no reduction in the prevalence of psychotic disorders between baseline and Follow up 1 in both experimental and control group, p=1.00. There was no significant change in prevalence of psychotic disorders in the experimental between Follow up 1 and 2, p=0.237. In the control, there was no symptom reduction between Follow up 1 and 2, p=1.000.

4.3.4 Efficacy of the intervention on Alcohol use in youths

Table 4.3.4 presents the efficacy of the intervention on alcohol consumption in youths.

Table 4.3.4.2: Efficacy of the intervention on Alcohol use in youths

Time point	Total (N=237) n	%	Experimental (N=116) n	%	Control (N=121) n	%	χ^2 value	df	p value*
Alcohol use in youths at Baseline									
Present	110	46.4	42	36.2	68	56.2	9.52	1	0.002
Absent	127	53.6	74	63.8	53	43.8			
Alcohol use in youths at Follow up 1									
Present	86	36.3	20	17.2	66	54.5	35.65	1	<0.001
Absent	151	63.7	96	82.8	55	45.5			
			χ^2=10.65, df=1, p=0.001		χ^2=0.07, df=1, p=0.796				
Alcohol use in youths at Follow up 2									
Present	44	18.6	0	0.0	44	36.4	51.8	1	<0.001
Absent	193	81.4	116	100.0	77	63.6			
			χ^2=51.28, df=1, p<0.001		χ^2=9.57 df=1, p=0.002				

* Significance at p<0.05 bolded

There were more youths with alcohol use disorders in the control group in at baseline, Follow up 1 and Follow up 2 than in experimental group (p=0.002, p<0.001 and p<0.001 respectively). However, there was drastic reduction in prevalence in the experimental group between baseline and Follow up1 (p=0.001) and also between Follow up 1 and 2 resulting in no alcohol use disorder at 3, p<0.001. In the control, there was a hardly any reduction between baseline and Follow up 1 (p=0.796) and significant reduction between Follow up 1 and 2 (p=0.002).

4.3.5 Efficacy of the intervention on any drug abuse in youths

Table 4.3.5 presents the efficacy of the intervention on drug abuse in youths.

Table 4.3.5: Efficacy of the intervention on any drug abuse in youths

	Total (N=237)		Experimental (N=116)		Control (N=121)				
Time point	n	%	n	%	n	%	χ^2 value	df	p value*
Any drug abuse in youths at Baseline									
Present	120	50.6	47	40.5	73	60.3	9.30	1	0.002
Absent	117	49.4	69	59.5	48	39.7			
Any drug abuse in youths at Follow up 1									
Present	91	38.4	21	18.1	70	57.9	39.56	1	<0.001
Absent	146	61.6	95	81.9	51	42.1			
			χ^2=14.06, df=1, p<0.001		χ^2=0.15, df=1, p=0.695				
Any drug abuse in youths at Follow up2									
Present	47	19.8	0	0.0	47	38.8	56.20	1	<0.001
Absent	190	80.2	116	100.0	74	61.2			
			χ^2=58.94, df=1, p<0.001		χ^2=11.17, df=1, p=0.001				

*Significance at p<0.05 bolded

There were more youths with drug abuse disorders in the control group in all baseline, Follow up 1 to Follow up 2 than in experimental group (p=0.002, p<0.001 and p<0.001 respectively). However, there was more than half reduction in prevalence in the experimental group between baseline and Follow up 1(p<0.001) and also between Follow up 1 and Follow up 2 resulting in no drug abuse disorder at 3, p<0.001. In the control, there was hardly any reduction between baseline and Follow up 1 (p=0.695) and but a significant reduction between Follow up 1 and 2 (p=0.001).

4.3.6 Efficacy of the intervention on MDD in mothers

Table 4.3.6 presents the efficacy of the intervention on MDD in mothers.

Table 4.3.6.2: Efficacy of the intervention on MDD in mothers

Time points	Total (N=228) n	%	Experimental (N=110) n	%	Control (N=118) n	%	χ^2 value	df	p value*
MDD in mothers at Baseline									
Present	117	51.3	50	45.5	67	56.8	2.92	1	0.087
Absent	111	48.7	60	54.5	51	43.2			
MDD in mothers at Follow up 1									
Present	98	43.0	32	29.1	66	55.9	16.74	1	<0.001
Absent	130	57.0	78	70.9	52	44.1			
			χ^2=6.30, df=1, p=0.012		χ^2=0.02, df=1, p=0.896				
MDD in mothers at Follow up 2									
Present	48	21.1	3	2.7	45	38.1	42.94	1	<0.001
Absent	180	78.9	107	97.3	73	61.9			
			χ^2=54.91, df=1, p<0.001		χ^2=8.22, df=1, p=0.004				

* Significance at p<0.05 bolded

There was no significant difference in the prevalence of MDD in mothers at baseline, p=0.087. There was significant difference in prevalence of MDD in mothers in the experimental group at Follow up 1 and Follow up 2 compared to the control group (p<0.001). In the experimental group, there was significant reduction in the prevalence of MDD in mothers between baseline and Follow up 1, p=0.012 and also between Follow up 1 and 2, p<0.001. In the control, there was a hardly any reduction between baseline and Follow up 1 (p=0.896) and but a significant reduction between Follow up1 and Follow up 2, (p=0.004).

4.3.7 Efficacy of the intervention on MDD in fathers

Table 4.3.7 presents the efficacy of the intervention on MDD in fathers.

Table 4.3.7: Efficacy of the intervention on MDD in fathers

	Total (N=198)		Experimental (N=92)		Control (N=106)		χ^2 value	df	p value*
Time points	n	%	n	%	n	%			
MDD in fathers at Baseline									
Present	38	19.2	13	14.1	25	23.6	2.84	1	0.092
Absent	160	80.8	79	85.9	81	76.4			
MDD in fathers at Follow up 1									
Present	38	19.2	13	14.1	25	23.6	2.84	1	0.092
Absent	160	80.8	79	85.9	81	76.4			
			χ^2=0.00, df=1, p=1.000		χ^2=0.00, df=1, p=1.000				
MDD in fathers at Follow up 2									
Present	25	12.6	1	1.1	24	22.6	20.74	1	<0.001
Absent	173	87.4	91	98.9	82	77.4			
			χ^2=11.13, df=1, p=0.001		χ^2=0.03, df=1, p=0.871				

*Significance at p<0.05 bolded.

The prevalence of MDD in the fathers was similar in both study groups at baseline and Follow up 1 (at 3 months of intervention). At 9 months, the control had significantly more fathers with MDD than the experimental group (p<0.001).

4.3.8 Efficacy of the intervention on Alcohol use in fathers

Table 4.3.8 presents the efficacy of the intervention on alcohol consumption in fathers.

Table 4.3.8: Efficacy of the intervention on Alcohol use among fathers

	Total (N=198)		Experimental (N=92)		Control (N=106)		χ^2		p
Time points	n	%	n	%	n	%	value	df	value*
Alcohol use among fathers at Baseline									
Present	96	48.5	45	48.9	51	48.1	0.01	1	0.911
Absent	102	51.5	47	51.1	55	51.9			
Alcohol use among fathers at Follow up 1									
Present	96	48.5	45	48.9	51	48.1	0.01	1	0.911
Absent	102	51.5	47	51.1	55	51.9			
			χ^2=0.00, df=1, p=1.000		χ^2=0.00, df=1, p=1.000				
Alcohol use among fathers at Follow up 2									
Present	46	23.2	3	3.3	43	40.6	38.43	1	<0.001
Absent	152	76.8	89	96.7	63	59.4			
			χ^2=49.72, df=1, p<0.001		χ^2=1.22, df=1, p=0.269				

Significance at p<0.05 bolded.

The prevalence of alcohol use disorders in the fathers was similar in both study groups at baseline and Follow up 1 (at 3 months of intervention). At Follow up 2 after 9 months, the control had significantly more fathers with alcohol use disorders than the experimental group (p<0.001). The fathers in experimental group had significant reduction in alcohol use, p<0.001.

The results on power analysis to assess the efficacy of intervention between the experimental and control group are presented in table 4.3.9.

Table 4.3.9: Power Calculations

Outcome	Sample size (n)	Proportion before intervention (P_1)	Proportion after intervention (P_2)	Power achieved (β)
MDD in youths	116	43.1%	2.6%	100%
Suicide behaviour in youths	116	69.0%	0%	100%
Psychotic disorder in youths	116	21.6%	15.5%	22%
Alcohol use in youths	116	36.2%	0%	100%
Any drug abuse in youths	116	40.5%	0%	100%
MDD in mothers	110	45.5%	2.7%	100%
MDD in fathers	92	14.1%	1.1%	93%
Alcohol use among fathers	92	48.9%	3.3%	100%

Difference between the experimental and control group exceeded the 80% statistical power apart from the youths who had psychotic disorders; schizophrenia and bipolar mood disorder.

5.0 CHAPTER FIVE: DISCUSSION, CONCLUSION AND RECOMMENDATION

5.1 Discussion

Common psychiatric disorders, namely depression, alcohol/substance abuse and anxiety disorders were highly prevalent in both the youth and parents in this study (Table 4.1.3-4.1.5.) They were also co-morbid with other conditions (Table 4.1.12). This high prevalence and co-morbidity in both the youths and parents are comparable to other similar studies done in USA, UK, Switzerland and Sweden. [27-28, 35-38] However in this study, disorders occurring in parents were not recognized before the assessment and therefore would have remained unmanaged. This also compares to WHO findings which have indicated that common psychiatric disorders are highly prevalent and tend to co-exist,[23-24, 26] even in situations that are not similar to the one in which this study was conducted.

Fourty seven point eight percent (47.8%) of the mothers had depressive disorder, 15.5% of the fathers had depressive disorder and another 39.2% of fathers had alcohol dependency syndrome. These finding compares to studies conducted in developed countries which have found that youths with psychiatric disorders tend to come from families where parents have a psychiatric disorder.[5-7, 9-10, 32-42] This is also comparable to many study findings which have shown that youths with psychiatric disorders come from homes where parents have maladaptive parenting behaviours and psychiatric disorders.[49-55, 58, 60-72]

The interpersonal impairment as a result of maladaptive parenting behaviour and psychiatric disorders in parents as was shown by Hammen studies [6-7] can, therefore, explain the confounding risk factor (a psychiatric disorder in parent) that mediates the development and maintains the cycle of psychological and social dysfunctioning (interpersonal and intra-personal) in affected family setting. These findings indicate that both the youths and their parents have strained interpersonal interactions which yield to severe emotional responses and maintain the circle of abnormal family (social) functioning. However the results revealed that there was no significant difference between the marital statuses of parents. These findings are also comparable to studies that used the "bottom-up" approach by examining parents of children and

adolescents diagnosed with common mental disorders and showed increased rate of depression and other forms of psychopathology in parents. [49-55, 60-62, 65-68] The results are also comparable to "top-down" approach which consistently showed that youths referred from families where parents have psychiatric disorders especially depression have also substantially increased risk for experiencing not only depressive disorders, but other DSM-IV disorders. [70-72]

A higher proportion of youths with MDD had a father abusing alcohol and a mother with depression, meaning that they were at greater odds of developing common psychiatric disorders. This could be associated with reduced family functioning as a result of increased marital conflict between parents because of parental psychopathology and maladaptive parenting behaviour. Therefore the child/youth in this setting becomes helpless. As it has been indicated in previous studies[142-146], parental alcohol dependence has damaging effects on children causing unsupportive parenting behaviours (rejecting, under protective or no emotional attachment) which is a precursor for the development of psychopathology in the affected children. This finding is similar to studies by Emmelkamp and Heeres in1988 and Gerlsma et al in 1994, where it was shown that parent(s) with drinking problems have enmeshed communication practices.[19] A family history of substance use in parents is therefore a predictor of the youths to develop mental illness. These findings are reflected in many previous studies[27-31, 50-54] which suggest that different mental health problems in parents can initiate specific psychiatric disorders in youths. A finding that psychiatric disorders in parents are significantly associated with a raised rate of youths have psychiatric disorders can be used to define the impaired quality of parenting behaviour.

Overall, these findings indicate that youths with MDD and alcohol/substance abuse disorders in this specific population come from families that are dysfunctional. The finding that youth with MDD also had other co-existing disorders (substance abuse, any anxiety and conduct), could suggest that the co-occurring psychiatric disorders may arise in response to the depressive disorder in the youths. The maternal behaviour in this case, as indicated by Rankin Williams et al in 2009[271], is a negative factor inducing severe psychological distress. A youth with depressive disorder tries to escape from internalizing their feelings

(depression) by acting out (externalizing them), and in the process starts abusing alcohol/substances. This raises the possibility that parental behaviour may be an added risk factor for the development of multiple psychiatric disorders in the same youth. The associations of rejecting maternal parenting behaviour and maternal MDD with youth MDD that co-exists with other common psychiatric disorders can also explain the confounding effect of the risk factor that mediates the development and maintains the cycle of psychiatric disorders in affected families. These findings can further indicate that a strained interaction between youths and their parents affects interpersonal associations in a family setting.

The findings of this study in relation to other similar studies can be summarized as follows:

1) Ill health of parents directly impairs the quality of parental care. This is comparable to findings from other studies in similar settings.[33, 55, 66,117,119, 124, 274-276]
2) Parental ill health (psychiatric or alcohol abuse specifically) predisposes to the development of psychiatric disorders in the youths as found in other studies[5-10, 27-42, 55,66,117,119, 124, 274-275]
3) Parental psychopathology is associated with higher illness severity (suicidal behaviour) in the youths. This is consistent with observations found in other clinical studies.[32, 58]
4) Youths raised by mothers with depression had increased occurrence of family disruption and marital discord which impacted negatively on the family mental well-being. This is similar to other findings.[110-115]
5) A youth who has psychopathology most likely has parents with psychopathology and therefore is at high risk of portraying severe suicidal behaviour. This finding is also comparable to the results by Conger, Patterson, & Ge[113] who showed that depression in mothers affected their parenting behaviour and cognitions and/or emotions which directly undermined the parents' ability to nurture, supervise and protect the growing youth.
6) Alcohol use disorder among fathers is a major risk factor for youths to develop psychiatric disorders.

7) Mothers with a depressive disorder, had partners (fathers) with alcohol abuse disorder. This indicates that presence of depressive disorders in mothers has significant association with alcohol use among fathers. This is a risk factor for youths to develop psychiatric disorders.

These findings should however be interpreted with caution. This is because the inclusion of family history information might have produced biased estimates of parental psychopathology in retrospect given that the EMBU relies on long term memory. However, this was mitigated by the fact that this study arrived at similar findings as documented in other studies that have used similar structured clinical interview tools.[258-259]

5.1.1 Parenting behaviour

This study established that maladaptive parenting plays an important role in the development of psychiatric disorders in the youths. This maladaptive parenting behaviour is as a result of parental psychopathology, in particular depressive disorder in mothers and alcohol use in fathers.

The perceived maternal parental rejection or paternal under-protection obstructs interaction between parents and their youths. The parenting behaviour in such a family setting is perceived by children to be a poor emotional expression- "I have no interest in you". This therefore disconnects children from their parents, creating a barrier for children to explore and form connecting bonds with their parent(s). This barrier results into insecure attachment which was described earlier by Bowlby.[12] This un-connectedness between the child and a parent leads to confusion, conflict and frustration in the growing child, a precursor for a youth/child to develop psychopathology which present as either an internalizing (depression/anxiety) or externalizing disorder (alcohol abuse/conduct disorder).

In this study, a high proportion of youths who perceived that their mother had rejecting parenting behaviour or their father had under-protective parenting behaviour had greater odds of developing depression, abuse alcohol/substance (multiple substance) and exhibiting suicidal behaviour. This finding is comparable to prior family studies in patient samples [22, 49-55, 60-62, 66-70] which revealed that parental psychopathology is associated with maladaptive parenting behaviour and in turn associated with increased odds of psychopathology among

the youths in this kind of family setting. This demonstrates that youths who perceive their mother to have rejecting parenting behaviour are more likely to develop MDD than youths of parents with adaptive parenting behaviour. Similarly, perceived under-protective paternal parenting behaviour can be mis-interpreted by the youths, predisposing the youths to indulging into alcohol/substances. This is shown in the finding that fathers who had alcohol use disorder and married to a partner (mothers) with depressive disorder had youth who had co-morbid common psychiatric disorders and severe suicidal behaviour.

These results provide evidence that perceived maladaptive parenting behaviour by the children has significant association with psychopathology in both youth and the parents and that these associations are not merely the result of recall bias. This was indicated in all associations between perceived parenting behaviour and youth psychiatric disorders. These associations remained stable when parental psychopathology, gender and age of youths were controlled in logistic regression models. This suggests that maternal parental rejection or no emotional maternal parenting behaviour and both paternal and maternal parental under-protection may be additional family-environment risk factors for youth to develop MDD, alcohol/drug abuse disorders and increased suicidal behaviour independent of parental psychopathology.

Similar studies done in Western countries suggest potential explanations for how parental characteristics may contribute to MDD in their youths.[55,58,62,72] Rejecting maternal behaviour may restrict the child in early years and therefore cannot develop autonomy hence the child becomes inferior as suggested by Erik Erikson's theory.[108] This inferiority complex does not allow the developing child to explore their environment[12], and later in childhood developmental stages the child becomes inferior as he/she compares to others and therefore develops low self esteem.[106-108] The combination of perceived rejection in the mother and perceived under protection parenting behaviour by the father in the same child may lead to a dysfunctional parent-child bond, which may cause difficulties for the child to explore the environment leading to helplessness states.

In addition, rejection may keep the child away from engaging in social situations, thereby restricting the opportunities to learn social skills and therefore remain inferior/incompetent.[218-219] This finding is

comparable to other studies done in Western countries.[159-160,163] These findings are of interest in particular if the onset of psychiatric disorders among the youths can be prevented as suggested by Bowlby;[12] whereby parents can be assisted to modify their child rearing practices. More important from this study, is that maladaptive parenting behaviours may play a significant role in the development of psychopathology in the youths whether or not a parent had psychopathology. This is because some of these maladaptive parenting behaviours are relatively common in Kenya.[112,274] Therefore, it is important to educate the public about these abnormal parenting styles that are associated with an increased risk of youths to develop psychopathology. These Kenyan findings are consistent with other findings from developed countries which have indicated that parental psychopathology is associated with maladaptive parenting behaviours that has been found in other studies from different countries.[17,53,58,116,275]

5.1.2 Alcohol use and drug abuse disorders in youths

The main findings among youths abusing alcohol indicated that common co-morbid psychiatric disorders in youths are significantly associated with alcohol use (table 4.2.2.3). Logistic regression results revealed that youths who had common co-morbid psychiatric disorder show greater odds of using alcohol than youths without a co-morbid psychiatric disorder (table 4.2.2.4). These findings are comparable to other worldwide studies which have indicated that youths with alcohol use disorders have higher rates of depression or other common mental disorders than youths in the general population.[27,29,30-31,81,126-127,132-133,135] Also co-morbid depression conduct behaviour is associated with severe substance abuse.[153,155,160,161,,163-164] These results compare to other study findings which have indicated that youths who have alcohol use problems have other co-morbidities and suicidal behavioural symptoms.[27,34,43-44,99,177-178,183-192,193,196-199,201,203,244,249,251,252]

The second main findings on alcohol use and dependence in the youths are the significant association between a youth having peers who drink, and a father who drinks excessively/ever having seen their father drunk (Tables 4.2.2.1, 4.2.2.5 mad 4.2.2.8). Having peers who drink, seeing a father drink excessively and a father who has alcohol dependent disorder are strong predictors of alcohol use and dependence in the youths (Tables 4.2.2.5 and 4.2.2.8) These results are comparable to similar studies which have documented that

having peers who drink and/or parents with drinking problems increase the risk for alcohol use in the youths.[129,131-132,135,145-152,277-284] The results are also comparable to studies in youths from families with history of alcoholism who developed alcohol use disorders and dependence than youths without a family history of alcoholic parents.[5,33,49,50,55,72,114,145-146,168-170,176,179] These associations can be explained using Bandura's social theory on modelling. Thus youths who start using alcohol are imitating their parents' or their peers' drinking behaviour.[105] Other explanations which have been proposed in previous studies is that parental substance abuse may impair parenting abilities[133, 147,151] which subsequently may affect youth alcohol consumption. In addition, substance use alters the state of consciousness, memory, affect, and impulse control, each of which may impair the adult's parenting capacities. Indeed as projected in the Global Burden of Disease and Injury Series[285], the youths from families where parents use/have alcohol dependence receive less discipline and less emotional support. In addition, Chassin and Ritter in 2001[133] found that parental alcoholism decreased the amount of parental monitoring.

The third main finding on alcohol use in the youths was perceived maladaptive maternal behaviours which were significantly associated with the youths' alcohol use: under protective, emotional un-connectedness, rejecting and under protective paternal behaviour (Table 4.2.2.6). This is comparable to results from similar studies which have indicated that parental rejection and under protection are important predictors of alcohol problems in youth.[145-150] In this study, maladaptive maternal parenting factors are linked to youths' alcohol use. This could be that in African culture, the father is an authority figure and therefore youths are left primarily in the care of the mothers.[13] Therefore, if the mother as the primary caregiver is perceived to have maladaptive parental behaviour, the youths end up with poor emotional development because of poor attachment. Thus, the perceived maladaptive maternal parental behaviour results into parent-youth un-connectedness leading to family relationship problems which are risk factors for youths to involving themselves in substance abuse. This finding is comparable to previous studies which indicated that substance use problems in youth are linked to lower closeness (un-connectedness) and poor communication with parents and greater family conflict.[56-58]

The fourth main finding in alcohol use disorders is that there was no significant difference according to gender among youth. However, other studies have shown gender differences in alcohol use, specifically among males where it has been documented that they have more alcohol-related problems than females and the males have been shown to meet criteria for alcohol abuse and alcohol dependence.[135-137] This no difference by gender in this study could be that youths recruited had severe psychiatric disorders.

In general, the findings on alcohol use among youths in this study are comparable to previous numerous cross-sectional studies which have demonstrated associations between parental alcohol use, parental rearing behaviour, and youths alcohol consumption.[143-153] This study further found that severity of alcohol use problems in youths increases with increasing age; older youth had higher alcohol dependence disorder (19-22 years) than the younger age groups (13-18 years). In explaining this pattern, it might be that parenting exerts influence before and during the initiation phase of alcohol use, which in this study is between 13-18 years when youth form identity. However, once the habitual drinking pattern which develops as the youth continues to abuse alcohol into adulthood, alcohol dependence disorder is established. Moreover, during adolescence, parental factors decrease in significance to the youths, whereas the influence of peers increases, making the latter a stronger determinant for youth drinking habit.[280]

Drug abuse disorders among the youths in this study are co-morbid with other psychiatric disorders and had significant associations with other covariates including perceived rejecting maternal parenting behaviour, having peers who consume alcohol and alcohol use behaviour in youths. In general, there are increased odds of youths with drug abuse disorders to have other psychiatric disorders than youths who did not abuse any substance. These results are comparable to previous studies done in developed countries which showed significant associations, where there were greater odds for the youths with drug abuse to have disruptive disorders.[31, 280]

5.1.3: Suicidal Behaviour in Youth

This study shows a highly significant tendency toward an increased rate of suicidal behaviour (prevalence of 82.3%) among youths which has also been documented in other studies.[180-185, 188-196] The high prevalence in this study can be explained by the family dysfunctions observed which included: youths from single parent family (never married, separated widows/widowers); youth who have parents with psychiatric disorders (alcohol use, mood disorders); and un-connecting family structures- no emotional attachment parenting behaviour, rejecting parenting behaviour and under protective parenting behaviour. These family patterns characterize cases of the youths who resort to violent behaviour (suicidal behaviour) as a means of coping with multiple and cumulative problems that are negative life stressors. Similar findings have been reported else where.[183-188, 191-199] Beautrais et al., similarly found precipitating factors and life events in serious suicide attempters among youths aged 13 through 24 years from dysfunctional families.[286]

There was no gender difference in the relationship between co-morbidity of MDD, alcohol/substance use disorder and suicidal behaviour among the youths. These results are comparable to findings by Buglass & Horton in 1974 and Appleby in 1992, who documented no gender differences in similar settings.[287-288] However they differ from other studies which have found female youths more likely to engage in suicidal behaviours than male youths, probably because they have a higher prevalence of depression, which is a strong predictor of suicide behaviour.[289-290]

The study also showed that the presence of multiple disorders is associated with an increased risk for suicide behaviour compared to only one disorder (Table 4.2.4.4). This indicates that increasing presence of co-morbid psychiatric disorders increases the number of psychiatric symptoms and therefore difficulty to tolerate, hence the increased odds of suicidal behaviour. This is consistent with other studies.[34, 36-37, 56, 81-82, [illegible], 115, 120, 121, 153-155]

These results suggest the need for further studies on gender in relation to psychopathology and suicide in relation to the differences between community and psychiatric populations.

5.1.3: Suicidal Behaviour in Youth

This study shows a highly significant tendency toward an increased rate of suicidal behaviour (prevalence of 82.3%) among youths which has also been documented in other studies.[180-185 188-196] The high prevalence in this study can be explained by the family dysfunctions observed which included: youths from single parent family (never married, separated widows/widowers); youth who have parents with psychiatric disorders (alcohol use, mood disorders); and un-connecting family structures- no emotional attachment parenting behaviour, rejecting parenting behaviour and under protective parenting behaviour. These family patterns characterize cases of the youths who resort to violent behaviour (suicidal behaviour) as a means of coping with multiple and cumulative problems that are negative life stressors. Similar findings have been reported else where.[183-188, 191-199] Beautrais et al., similarly found precipitating factors and life events in serious suicide attempters among youths aged 13 through 24 years from dysfunctional families.[286]

There was no gender difference in the relationship between co-morbidity of MDD, alcohol/substance use disorder and suicidal behaviour among the youths. These results are comparable to findings by Buglass & Horton in 1974 and Appleby in 1992, who documented no gender differences in similar settings.[287-288] However they differ from other studies which have found female youths more likely to engage in suicidal behaviours than male youths, probably because they have a higher prevalence of depression, which is a strong predictor of suicide behaviour.[289-290]

The study also showed that the presence of multiple disorders is associated with an increased risk for suicide behaviour compared to only one disorder (Table 4.2.4.4). This indicates that increasing presence of co-morbid psychiatric disorders increases the number of psychiatric symptoms and therefore difficulty to tolerate, hence the increased odds of suicidal behaviour. This is consistent with other studies. [34, 36-37, 56, 81-82, [illegible] 115 120, 121, 153-155]

These results suggest the need for further studies on gender in relation to psychopathology and suicide in relation to the differences between community and psychiatric populations.

5.1.3: Suicidal Behaviour in Youth

This study shows a highly significant tendency toward an increased rate of suicidal behaviour (prevalence of 82.3%) among youths which has also been documented in other studies.[180-185 188-196] The high prevalence in this study can be explained by the family dysfunctions observed which included: youths from single parent family (never married, separated widows/widowers); youth who have parents with psychiatric disorders (alcohol use, mood disorders); and un-connecting family structures- no emotional attachment parenting behaviour, rejecting parenting behaviour and under protective parenting behaviour. These family patterns characterize cases of the youths who resort to violent behaviour (suicidal behaviour) as a means of coping with multiple and cumulative problems that are negative life stressors. Similar findings have been reported else where.[183-188, 191-199] Beautrais et al., similarly found precipitating factors and life events in serious suicide attempters among youths aged 13 through 24 years from dysfunctional families.[286]

There was no gender difference in the relationship between co-morbidity of MDD, alcohol/substance use disorder and suicidal behaviour among the youths. These results are comparable to findings by Buglass & Horton in 1974 and Appleby in 1992, who documented no gender differences in similar settings.[287-288] However they differ from other studies which have found female youths more likely to engage in suicidal behaviours than male youths, probably because they have a higher prevalence of depression, which is a strong predictor of suicide behaviour.[289-290]

The study also showed that the presence of multiple disorders is associated with an increased risk for suicide behaviour compared to only one disorder (Table 4.2.4.4). This indicates that increasing presence of co-morbid psychiatric disorders increases the number of psychiatric symptoms and therefore difficulty to tolerate, hence the increased odds of suicidal behaviour. This is consistent with other studies. [34, 36-37, 56, 81-82, [illegible] 120, 121, 153-155]

These results suggest the need for further studies on gender in relation to psychopathology and suicide in relation to the differences between community and psychiatric populations.

5.1.4 Interventions

This study used a combination of the structured F-CBT and SPTM model to treat youth and their parents in the experimental group, while applying SPTM alone in the control group. The clinical improvement assessed using symptom ratings at Follow up 1 and 2 was significantly different ($p<0.05$) in the experimental group compared to the control group. Thus, combined pharmacotherapy and psychotherapy is efficacious in the management of psychiatric disorders even in the face of co-morbidity and suicidal behaviour than pharmacotherapy alone. This indicates the importance of assessing youths and parents for psychopathology and combining psychotherapy and pharmacotherapy appropriately in the treatment of disorders as a family-based intervention. These findings are comparable to studies carried out in developed countries which used similar family-based intervention approaches.[207, 210,254, 256]

The retention rate (97%) of youths and their parents during the whole period of the study, despite the nature of the patient population, was remarkably high. The reasons for this can be speculated. Firstly, they were sensitized on the nature and duration of the intervention at intake. Secondly, this was carried out at the country's main referral hospital and the families did not wish to miss the opportunity of being treated at this facility more so at no charges for the services given. The same observation was made by Muriungi [291]in a study of referrals to the same clinic from KMTC. Pa rents and the youths appreciated the therapy because they were learning specific coping skills to cope with their disorders as opposed to "just talking" about their problems and in the process brought the families together and also to listen to each other. This led to remission of symptoms over the period the family was engaged in therapy.

This efficacious family intervention in the experimental group is comparable to studies done in western countries where participants with major depressive disorder and or alcoholism were able to respond to treatment better than families which had pharmacology alone or psychotherapy alone[27-28, 30, 50, 68, 81, 86-89, 91,148 158,208-209,212-217,219-220]. These results are also comparable to other studies that have shown significant reduction in relapse rates and improvement in quality of life. [94 101] The results are also similar to meta-

analyses studies which have shown that CBT is effective in treating youths with MDD.[84, 189,235] The findings of this study are similar in particular to studies that combined CBT and fluoxetine, which showed more rapid decline in depressive symptoms, and therefore resulted in a greater rate of remission than in pharmacology alone.[19, 85, 93-94,236]Most the youths with MDD in this study were put on fluoxetine. These results are also clinically consistent with a study by Keller et al.,[292] done among adults with depressive disorders, where the results showed that the group which was put on combination of CBT and medication was superior to the group on medication alone.

Results for the control group yielded poorer findings than the experimental group. This is because the parents had psychiatric disorders but did not receive any intervention and therefore continued to be irritable. Also they lacked the motivation that is trained and gained during F-CBT that changes the way a family member relates to other family members. This finding has been shown in other similar studies from other countries.[5,51,61,113,124,145,154,169-170]This could have caused persistent impact in affectionless control (maladaptive parenting behaviour) to their youths which led to persistence of psychopathology in the youths and therefore poor response to SPTM offered at the centre.

It is worthy to note that the experimental group significantly improved in all parameters of depression and substance abuse, suicide behaviour at three but best at nine months except psychotic disorders i.e. schizophrenia and bipolar mood disorders; where the statistical power was below 80% (Table 4.3.9.) This could be due to the fact that the time needed to reduce psychotic symptoms to full remission in these illnesses is prolonged beyond time limit for this study. The reason for this prolonged recovery period among clients with psychotic disorder is the fact that these disorders are likely to have co-morbid disorders. This finding has been documented by other studies and hence these clients present with multiple symptoms.[292-293] As shown from other studies, patients with psychotic disorders always have co-morbid disorders that include: anxiety, substance use, or disruptive/personality disorders have poorer long-term prognoses than patients without co-morbid disorders.[294-296] Indeed, other studies have suggested that for psychotic disorders you need a period of 12 to 18 months of CBT to produce significant different outcomes.[80, 297-306]

These results indicate that the intervention process in F-CBT model of psychotherapy in this study was effective in training the participants in social skills and cognitive restructuring. This outcome is comparable to previous studies that have done clinical trials of treating participants with alcohol use disorders.[27,148,212-220,222-225,231] The results are also comparable to findings by Kaminer et al, where CBT approach included educational presentations, modelling, role playing, and homework exercises.[226,228] The respondents in Kaminer's CBT group study showed significant reductions in severity of substance use on the Teen Addiction Severity Index tool.[226] These results are comparable to the larger, randomized, controlled trial by Kaminer et al, which compared CBT with psycho-educational therapy in treating youths with substance use disorders, which indicated overall alcohol use reduction that was significantly shown between baseline to Follow up 1; assessments in 3 months, favouring the psycho-educational therapy group.[228] The results in this study also indicate that comprehensive interventions combining CBT and SPTM provide coordinated treatment. This is to target multiple pathways for risk factors that predispose youth to get involved in the use of drugs. This finding is comparable to previous studies that have combined medications to counteract adverse effects of alcohol withdrawal or to treat co-occurring psychiatric disorders.[228-230]

5.1.5 Limitations

Despite the advantages of this study of having multi-informant data, longitudinal design and the testing of reciprocal associations in the analyses, it had some limitations. The main limitation of this study was reliance on self-report data by youth on perceived parenting behaviour. This assessment measure did not provide more detailed information about the parent-youth relationship. Additional information on the nature or quality of the relationship parents have with their youths would help provide a clearer picture of how parents with or without a psychiatric disorder influence youth to develop a psychiatric disorder. This information would allow studying the potential effects of parenting qualities. Nevertheless, this study suggests that parenting behaviour as perceived by youths and parental psychiatric disorders have a powerful influence on youths to developing a psychiatric disorder.

Another limitation in this study was that further analysis of the data was not performed to examine relationships in subgroups (for example, sex differences) because of a lack of statistical power and, subsequently, the risk of committing Type II errors. Nonetheless it should be stressed that in this study of a full-family design, the sample size was substantial.

Another limitation could be that parental factors could only be contributing to a small part of the variance in particular youths' drinking disorder. However, when youths witness their father use alcohol excessively or seen their father drunk, they imitate his behaviour by starting to consume alcohol in large amounts, a practical implication as revealed by these results. Mothers in this study may have under-reported their alcohol-related problems because of social desirability. In an attempt to anticipate these biases, and to ensure confidentiality, the questionnaires were completed individually, without the possibility for family members discussing the answers. In addition, studies have shown that self-reports concerning mental health illness is a reliable source of information whether reported by the patient or family caregiver.[250]

The next limitation for this study is that in Kenya, the legal age to drink (beer, wine and liquor) is 18 years. This may make it difficult to compare previous research from Western countries; USA or Netherlands, where the legal age to drink is 21 and 16 years respectively. Both MINI Kid and MINI Plus questionnaires did not quantify amount of alcohol consumed by each respondent. This may also have led to a reporter bias in the exact amount of alcohol consumed. However, measurement of the precise amount of alcohol consumed in Kenya is rather difficult to realize because there is easy accessibility and availability of non-commercial alcohol which has no standard measures. Future experimental designs or diary studies can be able to accurately quantify quantity of consumed alcohol.

Taking these limitations into account, this study was carried out at a teaching and referral hospital in Kenya and was the first to separate the relations between parental alcohol-related problems, parenting behaviour, and youth substance use and psychiatric disorders in a sample using multi-informant data. This implies that shared environmental factors (e.g., parenting and modelling effects) influence the development of drug use and psychiatric disorder in young people.

In the course of intervention, even when the respondents had met the inclusion criteria in baseline, other issues emerged among some respondents that did not allow the youths to freely interact with their parents in the course of F-CBT. This led to another limitation among anxiety disorder (PTSD) cases that the causative factors led to severe strained relationships in the family setting or the severe traumatic event that resulted into traumatic grief. In this study, two cases among the youth were survivors of rape by a family member in the experimental group and three cases of traumatic grief made it difficult to institute F-CBT. The affected survivors of rape confidentially did not want their parents in therapy sessions and the three youths who had lost their loved ones required grief therapy. To overcome these two barriers in a family setting, another structured model of CBT, Trauma-Focused CBT (appendix 4) can be used to manage these cases. This means not all psychiatric disorders t can be treated usingF-CBT model; case selection is paramount.

5.2 CONCLUSIONS

These results provide vital insights into parenting behavioural effects on child and youth development. The study adds to the body of research on the role of parenting behaviour and parental psychiatric disorders by focusing on youths' psychiatric and substance use disorders including alcohol use and dependence as outcomes in the study. Collectively, these findings indicate that perceived maladaptive rejecting maternal parenting behaviour and maternal depressive disorder are risk factors in a family setting that make youth vulnerable to develop common mental disorders. Although perceived parenting behaviour models play different roles for different youth psychosocial outcomes, overall, the results support attachment theory. Having a mother with depression and maladaptive rejecting parenting behaviour is a precursor for a child, and subsequently the youth, to develop psychiatric disorders. These findings are consistent with the notion that mothers may be vital resources to help protect youth from the noxious effects of the risks they face. The findings also suggest that efforts to develop and improve child-parent relationships may be beneficial.

There is a strong evidence for associations between SUDs and other psychiatric disorders; MDD, conduct disorder, suicide behaviour and alcohol use among youth and other factors such as rejecting perceived

maternal parenting behaviour and having peers who use alcohol.[27-28, 31 35-38, 54,120,159,185,197,292,295-296] These results provide further specification of the association between SUDs and other psychiatric disorders, perceived parenting behaviour and having peers who use alcohol.

These results have also multiple clinical implications in the management of substance use disorders. In general, this work informs the development of interventions to prevent individuals from engaging in behaviour that is destructive to self and to others. Psychiatric and substance abuse disorders are strong predictors of suicidal behaviour, and these associations are more often pronounced when there is more than the one co-morbid psychiatric or substance abuse disorder. This suggests some universality of the relevant mechanisms underlying the genesis of suicidal behaviour. Suicide behaviour is therefore a common problem among youth presenting with psychiatric or substance abuse disorder and these results suggest that clinicians and treatment providers would manage their clients better by paying closer attention to the assessment of suicidal impulses in youth seen with psychiatric disorders.

The youths in the study also had an experience of additional risk of having a father who was using alcohol, thus had alcohol use disorder. Parental depression is a strong and consistent risk factor for youths with MDD and anxiety disorder, meaning that depressive disorders are often familial recurrent illnesses associated with increased psychosocial morbidity. The results on suicide behaviour have clinical implications. In general, this work informs the development of interventions to prevent individuals from engaging in behaviour that is destructive to self and to others. Psychiatric and drug abuse disorders are strong predictors of suicidal behaviour, and these associations are more often pronounced when there is more than one co-existing psychiatric or substance abuse disorders.

Finally, these results support the feasibility and acceptability of implementing the F-CBT in the context of an open clinical trial among youth with psychiatric and substance use disorders. F-CBT promises to be a flexible and appropriate treatment to prevent recurrence of suicidal behaviour in youths with psychiatric or substance use disorders. Testing its efficacy in a random clinical trial in our setting has been an important milestone.

5.3 RECOMMENDATIONS

1. Combination of F-CBT and SPTM should be applied routinely on youth who have behavioural problems.
2. The highly specialized human resources in mental health at KNH will not be available at other public health facilities and therefore the need to task shift the skills of the now evidence based F-CBT in Kenya to other non-specialized health care providers.
3. There is need to validate the EMBU questionnaire in the Kenyan psycho-social and cultural context.
4. There is need for further studies to delineate all factors related to psychopathology in the youth in relations to their parents in Kenyan family setting.
5. There is need to psycho-educate parents and youth on the importance of effective communication within families as a way of averting family related psychopathology
6. There is need for more studies in various settings to confirm the findings of this pioneering study on efficacy of F-CBT.

REFERENCE

1. Moore KA. Family strengths and youth behaviour problems: Analyses of three national survey databases. In G. E. Hendershot and F.B. LeClere, Family health: From data to policy. Minneapolis, MN: National Council on Family Relations. 1993: 64-74.
2. Franke TM. Adolescent violent behaviour: An analysis across and within racial/ethnic groups. Journal of Multicultural Social Work. 2000; 8(1-2): 47-70.
3. McBride MV. Variation in adolescent pregnancy status: A national tri-ethnic study. In McCubbin, H.I. et al. (Eds.). Resiliency in African American families. Thousand Oaks, CA: Sage Publications 1998.
4. Kim K. Rohner R. Parental warmth, control and involvement in schooling: Predicting academic achievement among Korean American adolescents. Journal of Cross Cultural Psychology. 2002; 33: 127-140.
5. Johnson JG, Cohen P, Kasen S, Smailes E, Brook JS. Association of maladaptive parental behaviour with psychiatric disorder among parents and their offspring. Arch Gen Psychiatry. 2001; 58:453–460.
6. Hammen C, Shih J, Altman T, Brennan PA. Interpersonal impairment and the prediction of depressive symptoms in adolescent children of depressed and non depressed mothers. J Am Acad Child Adolesc Psychiatry. 2003; 42:571–577.
7. Hammen C, Brennan PA, Shih JH. Family discord and stress predictors of depression and other disorders in adolescent children of depressed and non depressed women. J Am Acad Child Adolesc Psychiatry. 2004; 43:994--1002.
8. Fombonne E, Wostear G, Cooper V, Harrington R, Rutter M. The Maudsley long-term follow-up of child and adolescent depression. Suicidality, criminality and social dysfunction in adulthood. Br J Psychiatry. 2000; 179:218–223.
9. Keitner GI, Miller IW. Family functioning and major depression: an overview. Am J Psychiatry 1990; 147:1128–1137.

10. Miller IW, Keitner GI, Whisman MA, Ryan CE, Epstein NB, Bishop DS. Depressed patients with dysfunctional families: description and course of illness. J Abnorm Psychol. 1992; 101:637–646.

11. Keitner GI, Ryan CE, Miller IW, and Norman WH. Recovery and major depression: factors associated with twelve-month outcome. Am J Psychiatry. 1992; 149:93–99.

12. Bowlby J. Attachment loss; Basic books, Volumes 1, 2, 3. International psycho-analytical library London: Hogarth Press; 1969, 1973, 1980.

13. Nsamenang AB. A west African Perspective. In M. Lamb (ed.). The father's role: cross cultural perspective London: Lawrence Erlbaum Associates; 1987 p.273-287.

14. Dubin ER. Dubin R. The authorityinception period of socialization. Child development. 1964; 34: 885-898.

15. Arrindell WA. van der Ende J. Replicability and invariance of dimensions of parental rearing behaviour: Further Dutch experiences with the EMBU. Personality and Individual Differences. 1984; 671-682.

16. Arrindell WA. Sanavio E, Aguilar G, Sica C, Hatzichristou C, Eisemann M, et al., The development of a short form of the EMBU: its appraisal with students in Greece, Guatemala, Hungary and Italy. Personality and Individual Differences. 1999; 27: 613-628.

17. Arrindell WA, Perris C. Eisemann M, vander Ende J, Gaszner P, Iwawaki S, et al., Parental rearing behaviour from across-cultural perspective: A summary of data obtained in 14 nations. In C. Perris, W. A. Arrindell& M. Eisemann (eds.), Parenting and psychopathology. New York: Wiley; 1994. P.145-171.

18. Stan K, David V. why youth mental health is so important. Journal med. 2008; 10(12):275.

19. Gerlsma C, Kramer JJAM. Scholing A, Emmelkamp PMG. The influence of mood on memories of parental rearing practices. British Journal of Clinical Psychology. 1994; 33: 159-172.

20. Halverson CF. Reme Ainsworth's typology of mother-infant attachment states grew out of her observational research on mother-infant (12 and 18 months) pairs in Uganda, gathered in her Infancy in Uganda (Baltimore: Johns Hopkins, 1967). In these studies, she coiled the different attachments between

infants and their mothers: secure, anxious-ambivalent and anxious-avoidant insecure attachment mbering your parents: Reflections on the retrospective method. Journal of Personality. 1988; 56: 435-443.

21. Perris C. Jacobsson L, Lindstrom H, Von Knorring L, Perris H. Development of a new inventory for assessing memories of parental rearing behaviour. Acta Psychiatrica Scandinavica. 1980; 61:265-274.

22. Jörg R, Martin E. Stability of Memories of Parental Rearing among Psychiatric Inpatients: A Replication Based on EMBU Subscales. Internal journal of descriptive and experimental psychopathology. 2001; 34:318-325.

23. The world health report. Mental health: new understanding, new hope. Geneva, World Health Organization, 2001 (http://www.who.int/whr/2001/en/whr01_en.pdf, accessed 28 July 2008).

24. WHO. World Mental Health Survey Consortium. Prevalence, severity, and unmet need for treatment of psychiatric disorders in the World Health Organization World Mental Health Surveys. Journal of the American Medical Association. 2004; 291: 2581- 2590.

25. WHO/WONCA. Integrating mental health into primary care: a global perspective. WHO and World Organization of Family Doctors (WONCA), Geneva: World Health Organization and World Organization of Family Doctors (WONCA); 2008.

26. Atlas: child and adolescent mental health resources: global concerns. Geneva: World Health Organization; 2005.

27. Mojtabai R. Which substance abuse treatment facilities offer dual diagnosis programs? Am J Drug Alcohol Abuse. 2004; 30(3):525-536.

28. Grella CE, Hser YI, Joshi V, Rounds-Bryant J. Drug treatment outcomes for adolescents with comorbid mental and substance use disorders. J Nerv Ment Dis. 2001; 189(6):384-392.

29. Aarons GA, Goldman MS, Greenbaum PE, Coovert MD. Alcohol expectancies: integrating cognitive science and psychometric approaches. Addict Behav. 2003; 28(5):947-961.

30. Wise BK, Cuffe SP, Fischer T. Dual diagnosis and successful participation of adolescents in substance abuse treatment. J Subst Abuse Treat. 2001; 21(3):161-165.

31. Rohde P, Lewinsohn PM, Seeley JR. Psychiatric co-morbidity with problematic alcohol use in high school students. J Am Acad Child Adolesc Psychiatry. 1996; 35(1):101-109.

32. Weissman MM, Wickramaratne P, Nomura Y, et al. Families at high and low risk for depression: a 3-generation study. Arch Gen Psychiatry. 2005; 62:29–36.

33. Pilowsky DJ, Wickramaratne P, Nomura Y, Weissman MM. Family discord, parental depression, and psychopathology in offspring: 20-year follow-up. J Am Acad Child Psychiatry 2006; 45:452–460.

34. Shaffer D, Gould MS, Fisher P, et al. Psychiatric diagnosis in child and adolescent suicide. Arch Gen Psychiatry. 1996; 53(4):339-348.

35. Kovacs M, Gatsonis C, Paulauskas S, Richards C. Depressive disorders in childhood: A longitudinal study of comorbidity with and risk for anxiety disorders. Arch Gen Psychiatry. 1989; 46:776–782.

36. Haley G, Fine S, Marriage K. Psychotic features in adolescents with major depression. J Am Acad Child Adolesc Psychiatry. 1988; 27:489–493.

37. Strober M, Carlson G. Bipolar illness in adolescents with major depression. Arch Gen Psychiatry. 1982; 39:549–555.

38. Angold A, Erklani A, Farmer EMZ, Fairbank JA, Burns B J, Keeler G, et al., Psychiatric disorder, impairment, and service use in rural African American and White youth. Archives of General Psychiatry. 2002; 59: 893- 901.

39. Malhotra S, Kohli A, Arun P. Prevalence of psychiatric disorders in school children in Chandigarh, India. Indian J Med Res. 2002; 116:21

40. McKelvey RS, Sang DL, Baldassar L, Davies L, Roberts L, Cutler N. The prevalence of psychiatric disorders among Vietnamese children and adolescents. Medical Journal of Australia. 2002; 17: 410-3.

41. Ajiboia PO, Yussuf AD, Issa BA, and Parakoyi MA. A Five-year Retrospective Study of Inpatient Adolescents and Young Adults with Psychiatric Disorders in a Nigerian Teaching Hospital. Nigerian Journal of Psychiatry. 2008; 6(2)

42. Ndetei DM, Khasakhalsa L, Mutiso V, Mbwayo A. Recognition of Depression in Children in General Hospital Based Units in Kenya – Practice and Policy Implications. Annals of General Psychiatry. 2009; 8:25 Available online at http://www.annals-general-psychiatry.com/content/8/1/25

43. Ndetei DM. Khasakhala L, Kuria M, Mutiso V, Ongecha FA, Kokonya D. The Prevalence of Psychiatric disorders in Adults in Different Level General Medical Facilities in Kenya: A Cross-Sectional Study. Annals of General Psychiatry. 2009; 8:1. Available online at http://www.annals-general-psychiatry.com/content/8/1/1

44. Ndetei DM, Khasakhala LI, Ongecha-Owuor FA, Kuria MW, Mutiso V, Kokonya DA. Prevalence of Substance Abuse among Patients in General Medical Facilities in Kenya. Journal of Substance Abuse. 2009; 30(1): 182-190.

45. Ndetei DM, Ongecha FA, Khasakhala L, Mutiso V, Othieno CJ, Syanda J, et al., Traumatic Experiences of Kenyan Secondary School Students. J Child Adol Mental Health. 2007; 19 (12): 147-55.

46. Ndetei DM, Khasakhala L, Nyabola L, Ongecha-Owuor F, Seedat S, Mutiso V, et al., The prevalence of anxiety and depression symptoms and syndromes in Kenyan adolescents. Journal of Child and Adolescent Mental Health. 2008; 20(1): 33-51.

47. Ndetei DM, Ongecha FA, Khasakhala LI, Maru H, Mutiso V, Kokonya DA. Obsessive-Compulsive (OC) Symptoms in Psychiatric In-patients at Mathari Hospital, Kenya. African Journal of Psychiatry. 2008; 11: 182-186.

48. Ndetei DM, Mutiso V, Ongecha-Owuor FA, Kokonya DA, Khasakhala LI. Psychosocial and Health Aspects of Drug Use by Students in Public Secondary Schools in Nairobi, Kenya. Substance Abuse. 2009; 30(1): 61-68.

49. Emmelkamp PMG, Heeres H. Drug addiction and parental rearing style: A controlled study. International Journal of Addiction 1988; 23: 207-216.

50. Redmond C, Spoth R, Shin C, Lepper HS. Modelling long-term parent outcomes of two universal family-focused preventive treatments: one-year follow-up results. J Consult Clin Psychol. 1999; 67:975-984.

51. Downey G, Coyne JC. Children of depressed parents: an integrative review. Psychol Bull. 1990; 108:50-76.

52. Kendler KS, Gardner CO, Prescott CA. Clinical characteristics of major depression that predict risk of depression in relatives. Arch Gen Psychiatry. 1999; 56:322-327.

53. Beardslee WR, Keller MB, Lavori PW, Staley J, Sacks N. The impact of parental affective disorder on depression in offspring. J Am Acad Child Adolesc Psychiatry. 1993; 32:732-730.

54. Kendler KS, Davis CG, Kessler RC. The familial aggregation of common psychiatric and substance use disorders in the National Co-morbidity Survey: a family history study. Br J Psychiatry. 1997; 178:841-848.

55. Nomura Y, Wickramaratne PJ, Warner V, Mufson L, Weissman MM. Family discord, parental depression, and psychopathology in offspring: ten-year follow-up. J Am Acad Child Adolesc Psychiatry. 2002; 41:402–409.

56. Ngui EM, Flores G. Unmet needs for specialty, dental, mental, and allied health care among children with special health care needs: are there racial/ethnic disparities? Journal of Health Care for the Poor & Underserved. 2007; 18(4): 931-949.

57. Johnson JG, Cohen P, Brown J, Smailes EM, Bernstein DP. Childhood maltreatment increases risk for personality disorders during early adulthood. Arch Gen Psychiatry. 1999; 56: 600-606.

58. Browne MA, Joyce PR, Wells JC, Bushnell JA, Hornblow AR. Adverse parental behavior and other childhood experience as risk factors for depression in women aged 18-44 years. J Affect Disord. 1995;34:13-23

59. Lewinsohn PM, Rohde P, Klein DN, Seely JR. Natural course of adolescent major depressive disorder. I: continuity into young adulthood. J Am Acad Child Adolesc Psychiatry. 1999; 38:56-63.

UNIVERSITY OF NAIROBI
MEDICAL LIBRARY

60. Dierker LC, Merikangas KR, Szatmari P. Influence of parental concordance for psychiatric disorders on psychopathology in offspring. J Am Acad Child Adolesc Psychiatry. 1999;38:280-288.

61. Mitchell J. McCauley E, Burke P, Calderon R, Schloredt K. Psychopathology in parents of depressed children and adolescents. J Am Acad Child Adolesc Psychiatry. 1989;28:352-357.

62. Leinonen JA. Solantaus TS, Punamaki RL. Parental mental health and children's adjustment: the quality of marital interaction and parenting as mediating factors. Journal of child psychology and psychiatry. 2003; 44(2): 227-241.

63. Rutter M. Protecting factor in children's response to stress and disadvantage. Primary preventing in psychology vol. 3 University press of New England; 1979.

64. Puig-Antich J. Goetz D, Davies M, Kaplan T, Davies S, Ostrow L, et al., A controlled family history study of prepubertal major depressive disorder. Arch Gen Psychiatry. 1989;46:406-418.

65. Williamson DE, Ryan ND, Birmaher B, Dahl RE, Kaufman J, Rao U, et al., A case-control family history study of depression in adolescents. J Am Acad Child Adolesc Psychiatry. 1995;34:1596-1607.

66. Harrington R, Rutter M, Weissman MM, Fudge H, Groothues C, Bredenkamp D, et al., Psychiatric disorders in the relatives of depressed probands, I: comparison of prepubertal, adolescent and early adult onset cases. J Affect Disord. 1997;42:9-22.

67. Neuman R. Geller B, Rice JP, Todd R. Increased prevalence and earlier onset of mood disorders among relatives of prepubertal versus adult probands. J Am Acad Child Adolesc Psychiatry. 1997;36:466-473.

68. Kendler KS. Is seeking treatment for depression predicted by a history of depression in relatives? implications for family studies of affective disorder. Psychol Med. 1995;25:807-814.

69. Hammen C, Burge D, Burney E, Cheri A. Longitudinal study of diagnoses in children of women with unipolar and bipolar affective disorder. Arch Gen Psychiatry. 1990;47:1112-1117.

70. Beardslee WR. Keller MB. Seifer R, Lavori PW, Staley J. Podorefsky D, et al., Prediction of adolescent affective disorder: effects of prior parental affective disorders and child psychopathology. J Am Acad Child Adolesc Psychiatry. 1996; 35:279-288.

71. Kelly AB, Halford WK, Young RM. Couple communication and female problem drinking: A behavioural observation study. Psychology of addictive behaviours. 2002; 16: 269-271.

72. Roosa MW, Tein JY, Groppenbacher N, Michaels M, Dumka L. Mothers' parenting behaviour and child mantel health in families with a problem drinking parent. Journal of marriage and the family. 1993; 55: 107-118.

73. Gureje O. Jenkins R. Mental health in development: re-emphasising the link. The Lancet. 2007; 369(9560): 447-449.

74. Gureje O. Lasebikan VO. Use of mental health services in a developing country. Results from the Nigerian survey of mental health and well-being. Social Psychiatry & Psychiatric Epidemiology. 2006: 41(1): 44-49.

75. Greenberg PE, Stiglin LE, Finkelstein SN, Berbdt ER. The economic burden of depression in 1990. J Clin Psychiatry. 1993; 54:405-418.

76. Conger RD, Conger KL, Elder GHJ, Lorenz FO, Simons RL, Whitbeck LB. A family process model of economic hardship and adjustment of early adolescent girls. Child development. 1993; 29: 206-219.

77. Conger RD, Ge X, Elder GHJ, Lorenz FO, Simons RL. Economic stress, coercive family process, and developmental problems of adolescents. Child development. 1994; 65: 541-561.

78. Ndetei DM et al. Baseline Study: The Mental Health Situation in Kangemi informal settlement Nairobi-Kenya. May 2007. http://www.basicneeds.org.uk (cited 2012 Nov 17).

79. Schwartzberg AF, Rush AJ, Arnow BA, et al. Chronic depression: medication (nefazodone) or psychotherapy (CBASP) is effective when the other is not. Arch Gen Psychiatry. 2005; 62:513–520.

80. Miklowitz DL, Simoneau TL, Gearge EL, Richards JA, Kalbag A, Sachs-Ericsson N, et al., Family-focused treatment of bipolar disorder: 1-year effects of a psychoeducational program in conjunction with pharmacotherapy. Biol Psychiatry. 2000; 48:582–592.

81. National Institute on Drug Abuse (NIDA) & National Institute of Mental Health (NIMH). The impact of child psychopathology and childhood treatments on subsequent drug abuse; 2002.

82. Mojtabai R, Olfson M. National trends in psychotherapy by office-based psychiatrists. Arch Gen Psychiatry. 2008; 65:962-970.

83. Compton SN, March JS, Brent D, Albano AM, Weersing VR, Curry J. Cognitive behavioural psychotherapy for anxiety and depressive disorders in children and adolescents: an evidence based medicine review. J Am Acad Child Adolesc Psychiatry. 2004; 43:930–959.[Medline]

84. Harrington R, Campbell F, Shoebridge P, Whittaker J. Meta-analysis of CBT for depression in adolescents. J Am Acad Child Adolesc Psychiatry. 1998; 37:1005–1007.

85. March J, Silva S, Petrycki S, et al. Treatment for Adolescents with Depression Study (TADS) Team. Fluoxetine, cognitive-behavioural therapy, and their combination for adolescents with depression: Treatment for Adolescents with Depression Study (TADS) randomized controlled trial. JAMA. 2004; 292(7):807-820.

86. Beck AT. Thinking and depression. Arch Gen Psychiatry. 1963; 9:324–333.

87. Beck AT. Thinking and depression II: theory and therapy. Arch Gen Psychiatry. 1964; 10:561–571.

88. Beck AT. The current state of cognitive therapy: a 40-year retrospective. Arch Gen Psychiatry. 2005; 62:953–959.

89. Linehan MM, Armstrong HE, Suarez A, Allmon D, Heard HL. Cognitive behavioural treatment of chronically Para-suicidal borderline patients. Arch Gen Psychiatry. 1991; 48:1060–1064.

90. Fairburn CG, Norman PA, Welch SL, O'Connor ME, Doll HA, Peveler RC. A prospective study of outcome in bulimia nervosa and the long-term effects of three psychological treatments. Arch Gen Psychiatry. 1995; 52:304–312.

91. Wright JH, Beck AT, Thase ME. Cognitive therapy, in Textbook of Clinical Psychiatry, 4th ed. Edited by Hales RE, Yudofsky SC, Talbott JA. Washington, DC: American Psychiatric Publishing; 2003.P. 1245–1284

92. Turkington D, Dudley R, Warman D, Beck AT. Cognitive-behaviour therapy for schizophrenia: a review. J Psychiatric Pract. 2004; 10:5–16.

93. Blackburn IM, Bishop S, Glen I. M, et al .The efficacy of cognitive therapy in depression: a treatment trial using cognitive therapy and pharmacotherapy, each alone and in combination. British Journal of Psychiatry. 1981; 139: 181–189.

94. Evans MD, Hollon SD, DeRubeis RJ, et al. Differential relapse following cognitive therapy and pharmacotherapy for depression. Archives of General Psychiatry. 1992; 49: 802–808.

95. Williams CJ, Garland A. Identifying and challenging unhelpful thinking: a Five Areas approach. Advances in Psychiatric Treatment 2002; 8. In press.

96. Williams JMG, Watts TN, Macleod C, et al Cognitive Psychology and Emotional Disorders (2nd edn). Chichester: John Wiley & Sons; 1997.

97. Ndetei DM. Final report: Kyanguli Secondary School Fire Tradegy, 25/26 March 2001Machakos Kenya. Nairobi: NPSI. 2002.

98. Pommereau X. Quand l'adolescent va mal.[When things don't go well for adolescents]. 1997. Ed. J'ai lu. 123.

99. Gould MS, King R, Greenwald S, et al. Psychopathology associated with suicidal ideation and attempts among children and adolescents. J Am Acad Child Adolesc Psychiatry. 1998; 37(9):915–923.

100. Wearden AJ, Tarrier N, Barrowclough C, Zastowny TR, Rahill AA. A review of expressed emotion research in health care. Clin Psychol Rev. 2000; 20:633–666.

101. Butzlaff RL, Hooley JM. Expressed emotion and psychiatric relapse. Arch Gen Psychiatry. 1998; 55:547–552.

102. Freud S. The ego and the id. New York: W. W. Norton; 1961.

103. Piaget J. Science of education and the psychology of the child. New York: Orion; 1970.

104. Watson JB. Behaviorism (2nd Ed.). Oxford, England: Kegan Paul; 1931.

105. Bandura. Social learning theory. Englewood Cliffs: Prentice-Hall; 1977.

106. Bandura A. The explanatory and predictive scope of self-efficacy theory. Journal of Social & Clinical Psychology.1986; 4:359–373.

107. Ainsworth M DS. Attachments beyond Infancy. American Psychologist 1989; 44(4): 709-716.

108. Erikson EH. Childhood and Society. New York: Norton; 1950.

109. Baumrind D. Current patterns of parental authority. Developmental psychology monograph.1975; 4:2.

110. Baumrind D. Elective parent during the early and adolescent transition. In PA Cowan & EM Hetherington Editors. Advances in family research (vol. 2). Hillsdale, NJ: Erlbaum;1991

111. Baumrind D. Childcare practices antecedent three patterns of preschool behaviour. Genetic Psychology Monograph. 1967;75:43-88

112. Khasakhala L., Ndetei DM, Mutiso V, Mbwayo A., Mathai M. The Prevalence of Depression among Adolescents in Nairobi Public Secondary Schools: Association with Perceived Maladaptive Parenting Behaviour. Africa Journal of Psychiatry. 2012; *15*: 106-113.

113. Conger RD. Patterson GR, Ge X. It takes two to replicate. A mediational model for the impact of parents' stress on adolescent adjustment. Child development. 1995; 66: 80-97.

114. Keller PS, Cummings EM, Davies PT. The role of marital discord and parenting in relations between parental problem drinking and child adjustment. Journal of child psychology and psychiatry. 2005; 4691: 943-951.

115. Naomi RM. Williamson GI. Major depression and conduct disorder in youth: association with parental psychopathology and parent-child conflict. Journal of child psychology and psychiatry. 2004; 45(2): 377-386.

116. Frick PJ, Lahey BB, Loeber R, Stouthamer LM. Family risk factors to oppositional defiant disorder and conduct disorder: Parental psychopathology and maternal parenting. Journal of consulting and clinical psychology. 1992; 60: 49-55.

117. Harrington R, Rutter M, Weissman MM, Fudge H, Groothues C, Bredenkamp D, et al., Psychiatric disorders in the relatives of depressed probands, I: comparison of prepubertal, adolescent and early adult onset cases. J Affect Disord. 1997;42:9-22.

118. Todd R, Geller B, Neuman R, Fox LW, Hickok J. Increased prevalence of alcoholism in relatives of depressed and bipolar children. J Am Acad Child Adolesc Psychiatry. 1996;35:716-724.

119. Weissman MM, Fendrich M, Warner V, Wickramaratne PJ. Incidence of psychiatric disorders in offspring at high and low risk for depression. J Am Acad Child Adolesc Psychiatry. 1992;31:640-648.

120. Last CG, Hersen M, Kazdin AE, & Finkelstein. Comparison of DSM-III separation anxiety and overanxious disorders: Demographic characteristics and patterns of comorbidity. Journal of American Academy of Child and Adolescent Psychiatry 1987; 26: 557-531.

121. Marmorstein NR, Iacono WG. Major depression and conduct disorder in youth: Associations with parental psychopathology and parent-child conflict. Journal of Child Psychology and Psychiatry. 2004; 45:377–386.

122. Sheeber L, Sorenson E. Family relationships of depressed adolescents: A multi-method assessment. Journal of Clinical Child Psychology 1998; 27:268–277.

123. Cummings EM, Davies PT. Children and marital conflict: the impact of family dispute and resolution. New York: Guilford; 1994.

124. Warner V, Weissman MM, Mufson L, Wickramaratne PJ. Grandparents, parents, and grandchildren at high risk for depression: A three-generation study. Journal of the American Academy of Child and Adolescent Psychiatry. 1999; 38:289–296.

125. Obot IS. Alcohol use and related problems in Sub-Saharan Africa. African journal of Drugs and Alcohol studies. 2006; 5(1): 17-28

126. Kessler RC, Aguilar-Gaxiola S, Andrade L, et al. Mental-substance co-morbidities in the ICPE surveys. Psychiatria Fennica. 2001; 32(suppl 2):62–80.

127. Chassin L, Hussong A, Barrera M Jr, Molina BSG, Trim R, Ritter J. Youth substance use. In: Lerner R M, Steinberg L, editors. Handbook of Youth Psychology, 2nd edn. Hoboken, NJ: Wiley; 2004. P. 665–96.

128. Wills TA, McNamara G, Vaccaro D, Hirky AE. Escalated substance use: a longitudinal grouping analysis from early to middle youth. J Abnorm Psychol. 1996; 105: 166–80.

129. Alati R, Najman JM, Kinner SA, Mamun AA, Williams GM, O'Callaghan M, et al. Early predictors of adult drinking: a birth cohort study. Am J Epidemiol. 2005; 162: 1098–1107.

130. Chassin L, Pitts SC, Prost J. Binge drinking trajectories from youth to emerging adulthood in a high-risk sample: predictors and substance abuse outcomes. J Consult Clin Psychol. 2002; 70: 67–78.

131. Casswell S, Pledger M, Pratap S. Trajectories of drinking from 18 to 26 years: identification and prediction. Addiction. 2002; 97: 1427–37.

132. Pulkkinen L, Pitkänen T. A prospective study on the precursors to problem drinking in young adulthood. J Stud Alcohol. 1994; 55: 578–87.

133. Chassin L, Ritter J. Vulnerability to substance use disorders in childhood and youth. In: Ingram R. E., Price J. M, editors. Vulnerability to Psychopathology: Risk Across the Lifespan. New York: Guilford Press; 2001. p. 107–34.

134. Siebenbruner J, Englund MM, Egeland B, Hudson K. Developmental antecedents of late youth substance use patterns. Dev Psychopathol. 2006; 18: 551–71.

135. National Center for Chronic Disease Prevention and Health Promotion, Center for Disease Control. Alcohol and Public Health Fact Sheet [fact sheet on the internet]. 2006. Available at: http://www.cdc.gov/alcohol/factsheets/general_information.htm#01 (accessed 29 November 2007).

136. Holmila M, Raitasalo I. Gender differences in drinking: why do they still exist? Addiction. 2005; 100: 1763–9.

137. Nolen-Hoeksema S. Gender differences in risk factors and consequences for alcohol use and problems. Clin Psychol Rev. 2004; 24: 981–1010.

138. Kuria MW. Drug abuse among urban as compared to rural secondary schools students in Kenya: a short communication. East Afr Med J. 1996; 73:339.

139. Kwamanga DH, Odhiambo JA, Amukoye EI. Prevalence and risk factors of smoking among secondary school students in Nairobi. East Afr Med J. 2003; 80:207–212.

140. Odek-Ogunde M. Pande-Leak D. Prevalence of substance use among students in a Kenyan Universities: a preliminary report. East Afr Med J. 1999; 76:301–306.

141. Baldwin DC Jr, Hughes PH, Conard SE, Storr CL, Sheehan DV. Substance use among senior medical students. A survey of 23 medical schools. JAMA. 1991; 265:2074–2078.

142. Ndetei DM, Khasakhala LI, Mutiso V, Ongecha-Owuor FA, Kokonya DA. Patterns of Drug Abuse in Public Secondary Schools in Kenya. J of Substance Abuse. 2009; 30 (1); 69-78.

143. Ndetei DM. Khasakhala LI, Mutiso V, Ongecha-Owuor FA, Kokonya DA. Drug Use in a Rural Secondary School in Kenya. Journal of Substance Abuse. 2010; 31(3): 170 – 173.

144. Ndetei DM. Ongecha FA, Khasakhala L, Mutiso V. Kokonya DA. The Prevalence of Psychiatric disorders and the Attitude in General Medical Facilities in Kenya – A WHO Monograph: 2006.

145. Walden B, McGue M, Iacono WG, Burt SA, Elkins I. Identifying shared environmental contributors to early substance use: the respective roles of peers and parents. J Abnorm Psychol. 2004; 113: 440–50.

146. Barnow S, Schuckit MA, Lucht M, John U, Freyberger H. The importance of a positive family history of alcoholism, parental rejection and emotional warmth, behavioral problems and peer substance use for alcohol problems in teenagers: a path analysis. J Stud Alcohol. 2002; 63: 305–15.

147. Johnson V. Pandina RJ. Effects of the family environment on youth substance use, delinquency, and coping styles. Am J Drug Alcohol Abuse. 1991; 17: 71–88.

148. Pandina RJ. Schuele JA. Psychosocial correlates of alcohol and drug use of youth students and youth in treatment. J Stud Alcohol 1983; 44: 950–73.

149. Vicary JR. Lerner JV. Parental attributes and youth drug use. J Adolesc. 1986; 9: 115–22.

150. Wills TA, Cleary SD. How are social support effects mediated? A test with parental support and youth substance use. J Pers Soc Psychol. 1996; 71: 937–52.

151. Sher K J. Children of alcoholics: A critical appraisal of theory and research. Chicago: The University of Chicago Press; 1991.

152. Hill S Y, Shen S, Lowers L, Locke J. Factors predicting the onset of youth drinking in families at high risk for developing alcoholism. Biological Psychiatry. 2000; (48): 265–275.

153. Windle M. Coexisting problems and alcoholic family risk among youth. Ann NY Acad Sci. 1994; 708: 157–64.

154. Weissman MM, Gammon D, John K, Merikangas KR, Warner V, Prusoff et al. Children of depressed parents: Increased psychopathology and early onset of major depression. Archives of General psychiatry. 1987; 44:847-853.

155. Lewinsohn PM, Rohde P, Seeley JR. Adolescent psychopathology: III. The clinical consequences of co-existing. J Am Acad Child Adolesc Psychiatry. 1995; 34:510–519.

156. Hops H, Davis B, Lewin L. The development of alcohol and other substance use: a gender study of family and peer context. J Stud Alcohol. 1999; 13: 22–31.

157. Madu SN, Matla MQ. Illicit drug use, cigarette smoking and alcohol drinking behaviour among a sample of high school adolescents in the Pietersburg area of the Northern Province, South Africa. J Adolesc. 2003; 26:121–136.

158. Achenbach TM. Diagnosis, assessment, and co-existing in psychosocial treatment research. J Abnorm Child Psychol. 1995; 23:45–65.

159. Armstrong TD, Costello EJ. Community studies on adolescent substance use, abuse, or dependence and psychiatric comorbidity. J Consult Clin Psychol. 2002; 70:1224–1239.

160. Angold A, Costello EJ. Depressive co-existing in children and adolescents: empirical, theoretical, and methodological issues. Am J Psychol. 1993; 150:1779–1791.

161. Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. Prevalence, severity, and co-existing of 12-month DSM-IV disorders in the National Co-existing Survey Replication. Arch Gen Psychiatr. 2005; 62:617–627.

162. Grant BF, Dawson DA. Age of onset of drug use and its association with DSM-IV drug abuse and dependence: results from the National Longitudinal Alcohol Epidemiologic Survey. J Subst Abuse. 1998; 10:163–173.

163. Kandel DB, Johnson JG, Bird HR. Canino G, Goodman SH, Lahey BB, et al., Psychiatric disorders associated with substance use among children and adolescents: findings from the Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) Study. J Abnorm Child Psychol. 1997; 25:121–132.

164. Henry W, Feehan M. McGee R. Stanton W, Moffitt TE, Silva P. The importance of conduct problems and depressive symptoms in predicting adolescent substance use. J Abnorm Child Psychol. 1993; 21:469–480.

165 Merikangas KR, Stolar M, Stevens DE, Goulet J, Preisig M. Fenton B, et al., Familial transmission of substance use disorders. Arch Gen Psychiatry. 1998; 55:973–979.

166. Chilcoat HD, Breslau N, Anthony JC. Potential barriers to parent monitoring: social disadvantage, marital status, and maternal psychiatric disorder. Journal of the American Academy of Child and Adolescent Psychiatry. 1996; 35:1673-82.

167. Grant BF, Dawson DA. Age of onset of drug use and its association with DSM-IV drug abuse and dependence: results from the National Longitudinal Alcohol Epidemiologic Survey. J Subst Abuse. 1998; 10:163–173.

168. Barnard M, McKeganey N. The impact of parental problem drug use on children: What is the problem and what can be done to help? Addiction. 2004; 99:552-559.

169. Clark DB, Cornelius J, Wood DS, Vanyukov M. Psychopathology risk transmission of children of parents with substance use disorders. Am J Psychiatry. 2004; 161:689-691.

170. Connolly GM, Casswell S, Stewart J, Silva PA, O'Brien MK. The effect of parents' alcohol problems on children's behavior as reported by parents and by teachers. Addiction. 1993; 88:1383-1390.

171. Harter SL. Psychosocial adjustment of adult children of alcoholics. A review of the recent empirical literature. Clin Psychol Rev. 2000; 20:311-337.

172. Lynskey MT, Fergusson DM, Horwood LJ. The effect of parental alcohol problems on rates of adolescent psychiatric disorders. Addiction. 1994; 89:1277-1286.

173. Schuckit MA, Smith TL, Radziminski S, Heyneman EK. Behavioral symptoms and psychiatric diagnoses among 162 children in non alcoholic or alcoholic families. Am J Psychiatry. 2000; 157:1881-1883.

174. Cuijpers P, Langendoen Y, Bijl RV. Psychiatric disorders in adult children of problem drinkers: prevalence, first onset and comparison with other risk factors. Addiction. 1999; 94:1489-1498.

175. Kerr AS, Hill EW. An exploratory study comparing ACOAs to non-ACOAs on current family relationships. Alcohol Treat Q. 1992; 9:23-38.

176. Miller SI, Tuchfeld BS. Adult children of alcoholics. Hosp Community Psychiatry. 1986; 37:235-236.

177. WHO. Preventing suicide: a resource for teachers and other school staff: Psychiatric and Behavioural Disorders. Department of Psychiatric Health. Geneva: World Health Organization; 2000.

178. Centres for Disease Control and Prevention. (1999). Suicide deaths and rates per 100,000 Available: http://www.cdc.gov/ncipc/data/us9794/suic.htm (cited 2012 Nov 17)

179. HoyertD L, Kochanek K D, & Murphy S L. Deaths: Final data for 1997. National Vital Statistics Reports, 47(9). Hyattsville, MD: National Center for Health Statistics, 1999.

180. WHO. mhGAP Evidence Resource Centre. Geneva: World Health Organization; 2008. www.who.int/psychaitric_health/mhgap/evidence/en/

181. Sudak HS, Ford AB, Rushforth NB. Adolescent suicide: an overview. American journal of psychotherapy.1984; 38: 350-363.

182. Viilo KM, Timona MJ, Hakko HH, Sarkioja T, Meyer-Rochow VB, Rasem PK. Lifetime prevalence of physical diseases and psychiatric disorders in young suicide victims. Journal on Psychosom Med. 2005; 67(2): 241-245.

183. Gispert M, Wheeler K, Marsh L, Davis MS .Suicidal adolescents: factors in evaluation. Adolescence. 1985; 20:753-762

184. Gould MS, et al. Psychopathology associated with suicidal ideation and attempts among children and adolescents. Journal of the American Academy of Child and Adolescent Psychiatry. 1999; 37(9): 915-923.

185. Kessler RC, Borges G, Walters EE. Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey. Arch Gen Psychiatry. 1999; 56(7):617-26.

186. Weismann MM, Bland RC, Canino GJ, Greenwald S, Hwu H Geal. Prevalence of suicide ideation and suicide attempts in nine countries. Psychological Medicine. 1999; 29:9-17.

187. Roy A, Segal NL, Centerwall BS, Robinette CD. Suicide in twins. Arch Gen Psychiatry. 1991; 48:29-32.

188. Vijayakumar L. Suicide prevention: The urgent need in developing countries. World Psychiatry. 2004; 3:8159-159.

189. Bennett DS. Depression among children with chronic medical problems: a meta-analysis. J Pediatr Psychol. 1994; 19:149-169.

190. Frances RJ, Franklin J, Flavin DK. Suicide and alcoholism. Am J Drug Alcohol Abuse. 1987; 13:327-341.

191. Hodgman CH, McAnarney ER. Adolescent depression and suicide: rising problems. Hosp Pract (Off Ed). 1992; 27:73-76, 81, 84-85.

192. Cooley-Quille MR, Turner SM, Beidel DC. Emotional impact of children's exposure to community violence. a preliminary study. J Am Acad Child Adolesc Psychiatry. 1995; 34:1362-1368.

193. Bridge JA, Goldstein TR, Brent DA. Adolescent suicide and suicidal behaviour. J Child Psychol Psychiatry. 2006; 47(3/4):372–394.

194. Brent DA, Baugher M, Bridge J, Chen T, Chiappetta L. Age- and sex-related risk factors for adolescent suicide. J Am Acad Child Adolesc Psychiatry. 1999; 38:1497–1505.

195. Lewinsohn PM, Rohde P, Seeley JR. Adolescent suicidal ideation and attempts: prevalence, risk factors, and clinical implications. Clinical Psychology Science and Practice. 1996; 3:25–36.

196. Renaud J, Brent DA, Birmaher B, et al. Suicide in adolescents with disruptive disorders. J Am Acad Child Adolesc Psychiatry. 1999; 38(7):846–851.

197. Shafii M, Steltz-Lenarsky J, Derrick AM, et al. Comorbidity of psychaitric disorders in the post-mortem diagnosis of completed suicide in children and adolescents. J Affect Disord. 1988 ;15(3):227–233.

198. Sourander A, Klomek AB, Niemela S, et al. Childhood predictors of completed and severe suicide attempts: findings from the Finnish 1981 Birth Cohort Study. Arch Gen Psychiatry 2009 ;66(4):398–406.

199. Brezo J, Barker ED, Paris J, et al. Childhood trajectories of anxiousness and disruptiveness as predictors of suicide attempts. Arch Pediatr Adolesc Med. 2008; 162(11):1015–1021

200. Aseltine RH, Jr, Schilling EA, James A, et al. Age variability in the association between heavy episodic drinking and adolescent suicide attempts: findings from a large-scale, school-based screening program. J Am Acad Child Adolesc Psychiatry. 2009;48(3):262–270.

201. Schilling EA, Aseltine RH Jr, Glanovsky JL, et al. Adolescent alcohol use, suicidal ideation, and suicide attempts. J Adolesc Health. 2009; 44(4):335–341.

202. Ndosi NK. Perspectives on suicide in Africa. International Psychiatry. 2006; 3(1): 7 – 8.

203. Khasakhala L , Sorsdahl K, Harder VS, Williams D, Stein D, Ndetei D. Lifetime Psychiatric disorders and Suicide Behaviour. Afr J Psychiatry. 2011;14:134-139.

204. Onyango PP. Suicide in Kenya: determinants and impact of the victim and the family. [PhD thesis]. Nairobi: University of Nairobi; 1982.

205. Mengech. HNK, Dhadphale M. Attempted suicide (para suicide) in Nairobi, Kenya. Acta Psychiatric Scand. 1984; 69: 416-9.

206. Nguithi A. Parasuicide Attempted suicide at Kenyatta National Hospital. [M.Med Thesis], Nairobi: University of Nairobi; 1990.

207. Redmond C, Spoth R, Shin C, Lepper HS. Modelling long-term parent outcomes of two universal family-focused preventive interventions: one-year follow-up results. J Consult Clin Psychol. 1999; 67:975-984.

208. Van Schaik DJ, Klijn AF, van Hout HP, et al. Patients' preferences in the treatment of depressive disorder in primary care. Gen Hosp Psychiatry. 2004; 26:184-189.

209. Dwight-Johnson M. Sherbourne CD, Liao D, Wells KB. Treatment preferences among depressed primary care patients. J Gen Intern Med. 2000; 15:527-534.

210. Raistrick D, Tober G. Psychosocial interventions. Psychiatry. 2004; 3(1): 36-39.

211. Carroll KM, Onken LS. Behavioural therapies for drug abuse. Am J Psychiatry. 2005; 162:1452-1460.

212. Raistrick D, Heather N and Godfrey C. Review of the effectiveness of treatment for alcohol problems. London, UK: National Treatment Agency for Drug Abuse; 2006.

213. Bottlender M, Kohler J, Soyka M. The Effectiveness of Psychosocial Treatment Approaches for Alcohol Dependence - A Review. Fortschr Neurol Psychiatr. 2006;74(1): 19-31.

214. Miller W, Brown J, Simpson T, et al. What works? A methodological analysis of the alcohol treatment outcome literature. In: Hester, R and WR Miller (eds), 1995.

215. Miller WR, Wilbourne PL. Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders. Addiction. 2002; 97(3): 265-277.

216. Williams CJ, & Garland A. A cognitive–behavioural assessment model for use in everyday clinical practice. Advances in Psychiatric Treatment. 2002; 8: 172–179.

217. Wright B, Williams C J Garland. Using the Five Areas cognitive–behavioural therapy model in psychiatric in-patients. Advances in Psychiatric Treatment. 2002; 309-317.

218. Dobson KS. Handbook of cognitive-behavioral therapies. Second Edition.New York: Guilford Press; 2000

219. KaddenRM. Behavioral and cognitive-behavioral treatments for alcoholism: research opportunities. Addict Behav. 2001; 26(4): 489-507.

220. Monti P. Gulliver S.Myers M. Social skills training for alcoholics: assessment and treatment. Alcohol. 1994; 29(6): 949-964.

221. Monti PM. Barnett NP. Colby SM. et al. Motivational interviewing versus feedback only in emergency care for young adult problem drinking. Addiction. 2007; 102(8): 1234-1243.

222. Shand F. Gates J and Fawcett J.The treatment of alcohol problems: A review of the evidence. Canberra: Australian Commonwealth Department of Health and Ageing; 2003.

223. Longabaugh R. Woolard RE. Nirenberg TD et al. Evaluating the effects of a brief motivational intervention for injured drinkers in the emergency department. J Stud Alcohol 2001; 62(6): 806-816.

224. Latimer WW. Winters KC. D'Zurilla T, Nichols M. Integrated family and cognitive-behavioral therapy for adolescent substance abusers: a stage I efficacy study. Drug Alcohol Depend. 2003;71 (3):303– 317

225. Liddle HA. Dakof GA. Parker K. Diamond GS. Barrett K. Tejeda M. Multidimensional family therapy for adolescent drug abuse: results of a randomized clinical trial. Am J Drug Alcohol Abuse. 2001; 27 (4):651– 688.

226. Kaminer Y, Burleson J. Blitz C. Sussman J. Rounsaville B. Psychotherapies for adolescent substance abusers: a pilot study. J Nerv Ment Dis.1998; 186 (11):684– 690.

227. Kaminer Y. Buckstein OG. Tarter RE. The teen addiction severity index: rationale and reliability. Int J Addict.1991; 26 (2):219– 226.

228. Kaminer Y, Burleson J, Goldberger R. Cognitive-behavioural coping skills and psychoeducation therapies for adolescent substance abuse. J Nerv Ment Dis.2002; 190 (11):737– 745.

229. Azrin N, Acierno E, Kogan E, Donohue B, Besalel V, McMahon P. Follow-up results of supportive versus behavioral therapy for illicit drug use. Behav Res Ther.1996; 34 (1):41– 46.

230. Azrin N, Donohue B, Teichner G, Crum T, Howell J, DeCato L. A controlled evaluation and description of individual-cognitive problem solving and family-behavior therapies in dually-diagnosed conduct-disordered and substance-dependence youth. J Child Adolesc Subst Abuse. 2001;11 (1):1– 43

231. Deas D, Randall C, Roberts J, Anton R. A double-blind, placebo-controlled trial of sertraline in depressed adolescent alcoholics: a pilot study. Hum Psychopharmacol. 2000; 15 (6):461– 469.

232. Groholt B, Ekeberg O, Wichstrom L, Haldorsen T. Suicide among children and younger and older adolescents in Norway: a comparative study. J Am Acad Child Adolesc Psychiatry. 1998; 37:473–481.

233. Marttunen MJ, Aro HM, Henriksson MM, Lönqvist JK. Mental disorder in adolescent suicide. DSM-III-R axes I and II among 13 to 19 year olds in Finland. Arch Gen Psychiatry. 1991; 48:834–839.

234. Olfson M, Shaffer D, Marcus SC, Greenberg T. Relationship between antidepressant medication treatment and suicide in adolescents. Arch Gen Psychiatry. 2003; 60:978–982.

235. Whittington CJ, Kendall T, Fonagy P, Cottrell D, Cotgrove A, Boddington E. Selective serotonin reuptake inhibitors in childhood depression: systematic review of published versus unpublished data. Lancet. 2004; 363:1341–1345.

236. Clarke RV, Lester D. Suicide: Closing the Exits. New York: Springer Verlag; 1989.

237. Tardiff KJ, Leon AC, Marzuk P. Manual for clinical rating scales. American Psychiatric Association; 2000.

238. Brent DA, Perper JA, Goldstein CE, Kolko DJ, Allan MJ, Allman CJ, et al., Risk factors for adolescent suicide. A comparison of adolescent suicide victims with suicidal inpatients. Arch Gen Psychiatry. 1988; 45: 581–588.

239. Pelkonen M, Marttunen M, Pulkkinen E, Laippala P, Aro H. Characteristics of out-patient adolescents with suicidal tendencies. Acta Psychiatr Scand. 1997; 95:100–107.

240. Lipschitz DS, Winegar RK, Nicolaou AL, Hartnick E, Wolfson M, Southwick S. Perceived abuse and neglect as risk factors for suicidal behaviours in youth inpatients. J Nerv Ment Dis. 1999; 187(1):32–39.

241. Nock MK, Joiner TE, Jr, Gordon KH, Lloyd-Richardson E, Prinstein MJ. Non-suicidal self-injury among youths: Diagnostic correlates and relation to suicide attempts. Psychiatry Res. 2006; 144(1):65–72.

242. Larsson B, Sund AM. Prevalence, course, incidence, and 1-year prediction of deliberate self-harm and suicide attempts in early Norwegian school youth. Suicide Life Threat Behav. 2008; 38(2):152–65.

243. Goldston D, Daniel SS, Reboussin DM, Reboussin BA, Frazier PH, Kelley AE. Suicide attempts among formerly hospitalized youths: A prospective naturalistic study of risk during the first 5 years after discharge. J Am Acad Child Adolesc Psychiatry. 1999; 38(6): 660–671.

244. Lewinsohn PM, Rohde P, Seeley JR. Youth suicidal ideation and attempts: Prevalence, risk factors, and clinical implications. Clin Psychology Sci Pract. 1996; 3(1):25–46.

245. Lewinsohn PM, Rohde P, Seeley JR. Psychosocial risk factors for future youth suicide attempts. J Consult Clin Psychol. 1994; 62(2):297–305.

246. Wolraich ML, Felice ME, Drotar D, eds. The Classification of Child and Adolescent Mental Diagnoses in Primary Care: Diagnostic and Statistical Manual for Primary Care (DSM-PC) Child and Adolescent Version. Elk Grove Village, IL: American Academy of Pediatrics; 1996

247. McIntire MS, Angle CR, Wikoff RL, Schlicht ML. Recurrent adolescent suicidal behavior. Pediatrics. 1977; 60:605-608

248. Mathers CD, Bernard C, Iburg KM, et al. Global burden of disease in 2002: data sources, methods and results. (Global Programme on Evidence for Health Policy discussion paper no. 54). Geneva, Switzerland: World Health Organization; 2003.

249. World Health Organization. Prevention of suicide: guidelines for the formulation and implementation of national strategies. Geneva. Switzerland: World Health Organization, 1996.

250. Roberts RE, AlegriaM, Roberts CR, Chen IG. Mental health problems of adolescents as reported by their caregivers: a comparison of European, African, and Latino Americans. Journal of Behavioural Health. 2005; 32:1–13.

251. Gould MS, King R, Greenwald S, et al. Psychopathology associated with suicidal ideation and attempts among children and youths. J Am Acad Child Adolesc Psychiatry. 1998; 37(9):915–923.

252. Gould MS, Greenberg T, Velting D, Shaffer D. Youth suicide risk and preventive interventions: A review of the past 10 years. J Am Acad Child Adolesc Psychiatry. 2003;42 (4):386–405.

253. Wood A, Trainor G, Rothwell J, Moore A, Harrington R. Randomized trial of group therapy for repeated deliberate self-harm in youths. J Am Acad Child Adolesc Psychiatry. 2001;40 (11):1246–53.

254. Harrington R, Kerfoot M, Dyer E, McNiven F, et al. Randomized trial of a home-based family intervention for children who have deliberately poisoned themselves. J Am Acad Child Adolesc Psychiatry. 1998; 37(5):512–518.

255. King CA, Kramer A, Preuss L, Kerr DC, Weisse L, Venkataraman S. Youth- Nominated Support Team for Suicidal Youths (Version 1): a randomized controlled trial. J Consult Clin Psychol. 2006; 74(1):199–206.

256. Rotheram-Borus MJ, Piacentini J, Cantwell C, Belin TR, Song J. The 18-month impact of an emergency room intervention for youth female suicide attempters. J Consult Clin Psychol. 2000; 68(6):1081–93.

257. Bartlett JE, Kotrlik JW, Higgins CC. Organizational Research: Determining appropriate sample size in Survey Research. Information Technology, Learning and Performance Journal. 2001; 19 (1):43-51.

258. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th ed. Washington, DC: American Psychiatric Association; 1994

259. First MB, Spitzer RL, Gibbon M, Williamson JB. Structure Clinical Interview for DSM-IV Axis I Disorder Clinical Version, 1994. Washington DC American Psychiatric Press inc. American Psychiatric Association; 1996.

260. Sheehan DV, Lecrubier Y, Harnett-Sheehan K, Janavs J, Weiller E, Bonara I, et al., Reliability and Validity of the MINI International Neuropsychiatric Interview (M.I.N.I.): According to the SCID-P. European Psychiatry. 1997; 12:232-241.

261. Sheehan DV, Lecrubier Y, Harnett-Sheehan K, Amorim P, Janavs J, Weiller E, et al., The Mini International Neuropsychiatric Interview (M.I.N.I.): The Development and Validation of a Structured Diagnostic Psychiatric Interview. Journal of Clinical Psychiatry. 1998; 59(suppl 20):22-33.

262. Folstein MF, Folstein SE and McHugh PR. Mini-Mental State: A practical method for grading the state of patients for the clinician. Journal of Psychiatric Research. 1975;12: 189 incomplete

263. O'Connor DW, Pollitt PA, Hyde JB, Fellows JL, Miller ND, Brook CP, et al., The reliability and validity of the Mini-Mental State in a British community survey. J Psychiatr Res. 1989; 23:87-96.

264. Morales JM, Gonzalez-Montalvo JI, Bermejo F, Del-Ser T. The screening of mild dementia with a shortened Spanish version of the "Informant Questionnaire on Cognitive Decline in the Elderly". Alzheimer Dis Assoc Disord. 1995; 9:105-11.

265. Gagnon M, Letenneur L, Dartigues JF, Commenges D, Orgogozo JM, Barberger-Gateau P, et al., Validity of the Mini-Mental State examination as a screening instrument for cognitive impairment and dementia in French elderly community residents. Neuro epidemiology. 1990; 9:143-50.

266. Erzigkeit H, Lehfeld H, Pena-Casanova J, Bieber F, Yekrangi-Hartmann C, Rupp M, et al., The Bayer-activities of daily living scale (B-ADL): results from a validation study in three European countries. Dement Geriatr Cogn Disord. 2001; 12: 348-58.

267. Juby A, Tench S, Baker V. The value of clock drawing in identifying executive cognitive dysfunction in people with a normal mini-mental state examination score. Canadian Medical Association Journal. 2002; 168: 859 – 864.

268. TombaughT, Hubly A, McDowellI, Kristjansson B. Mini-Mental State Examination (MMSE) and the modified MMSE (3MS): a psychometric comparison and normative data. Psychological Assessment. 1996; 8: 48–59.

269. Strub R. Black F. The mental status examination in neurology. 2nd edition. F. A. Davis Company: Philadelphia; 1985.

270. Ndetei DM, Khasakhala L, Kuria M, Mutiso V, Ongecha FA, Kokonya D. The Prevalence of Mental Disorders in Adults in Different Level General Medical Facilities in Kenya: A Cross-Sectional Study. Annals of General Psychiatry. 2009; 8:1

271. Shuttle worth-Jordan AB. On not reinventing the wheel: A clinical perspective on culturally relevant test usage in South Africa. South African Journal of Psychology. 1996; 26: 96 –102.

272. Tomlinson AJC, Le Resche L, Niaz U, Von Korff MR, Folstein MF. Limits of the mini-mental state as a screening test for dementia and delirium among hospital patients. Psychological Medicine. 1982; 12: 397-408.

273. Hammen C, Shih J, Altman T, Brennan PA. Interpersonal impairment and the prediction of depressive symptoms in adolescent children of depressed and non depressed mothers. J Am Acad Child Adolesc Psychiatry. 2003; 42:571–577.

274. Khasakhala LI. The view of secondary school adolescents on the psychosocial interactions from infancy with their parents in Nairobi province, Kenya. (Msc Thesis). Nairobi: University of Nairobi; 2004.

275. Rankin W, Degnan LKA, Perez-Edgar, Henderson KE, Rubin HA, Pine KH, et al., Impact of Behavioral Inhibition and Parenting Style on Internalizing and Externalizing Problems from Early Childhood through Adolescence. Journal of Abnormal Child Psychology. 2009; 37(8): 1063-1075.

276. Weissman M, Payke E. The depressed woman. A study of social relationships. University of Chicago Press; 1974.

277. Bennett ME, McCrady B, Johnson V, Pandina RJ. Problem drinking from young adulthood to adulthood: patterns, predictors, and outcomes. J Stud Alcohol. 1999; 60: 605–14.

278. Chassin L, Curran P J, Hussong AM, Colder CR. The relation of parent alcoholism to youth substance use: A longitudinal study. Journal of Abnormal Psychology. 1996; 105: 70–80.

279. Harakeh Z, Scholte RHJ, De Vries H, Engels R. Parental rules and communication: their association with youth smoking. Addiction. 2005; 100: 862–870.

280. Fergusson DM, Horwood LJ, Lynskey M T. The prevalence and risk factors associated with abusive or hazardous alcohol consumption in 16-year-olds. Addiction. 1995; 90: 935–946.

281. Fergusson DM, Lynskey MT, Horwood JL. Co-existing between depressive disorders and nicotine dependence in a cohort of 16-year olds. Arch Gen Psychiatry. 1996; 53:1043–1047.

282. Lewinsohn PM, Rohde P, Seeley JR. Adolescent psychopathology: III. The clinical consequences of co-existing. J Am Acad Child Adolesc Psychiatry. 1995; 34: 510–519.

283. Costello EJ, Erkanli A, Federman E, Angold A. Development of psychiatric co-existing with substance abuse in adolescents: effects of timing and sex. J Clin Child Psychol. 1999; 28: 298–311. |

284. Kandel DB, Johnson JG, Bird HR, Weissman MM, Goodman SH, Lahey BB, et al., Psychiatric co-existing among adolescents with substance use disorders: findings from the MECA study. J Am Acad Child Adolesc Psychiatry. 1999; 38: 693–699.

285. Murray C, Lopez A, editors. Global Burden of Disease and Injury Series. The global burden of disease: A comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020; Cambridge, MA: Harvard School of Public Health on behalf of the World Health Organization and the World Bank; 1996.

286. Beautrais AL, et al. Precipitating factors and life events in serious suicide attempts among youths aged 13 through 24 years. Journal of the American Academy of Child and Adolescent Psychiatry. 1997; 36: 1543-1551.

287. Buglass D, Horton J. A scale for predicting subsequent suicidal behaviour. Br J Psychiat. 1974 ; 124: 573-78.

288. Appleby L. Suicide in psychiatric patients: risk and prevention. Br J Psychiat. 1992; 161: 749 -88.

289. Spruijt E, de Goede M. Transitions in family structure and adolescent well-being. Journal of adolescence. 1997; 32(128): 897-911.

290. Vandivort DS, Locke BZ. Suicide ideation, its relation to depression, suicide and suicide attempt. Suicide & life-threatening Behavior. 1979; 9: 205-218.

291. Muriungi S. Effectiveness of Psycho-Education on Common Mental Disorders in Students at the Kenya Medical Training Colleges in Kenya. (PhD thesis). Nairobi: University of Nairobi; 2011.

292. Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005b: 62:617–27.

293. Regeer EJ, ten Have M, Rosso ML, Hakkaartvan Roijen L, Vollebergh W, Nolen WA. Prevalence of bipolar disorder in the general population: a reappraisal study of the Netherlands Mental Health Survey and Incidence Study. Acta Psychiatr Scand. 2004; 110: 374–82.

294. Feske U, Frank E, Mallinger AG, Houck PR, Fagiolini A, et al. Anxiety as a correlate of response to the acute treatment of bipolar I disorder. Am J Psychiatry. 2000; 157: 956–62.

295. Otto MW, Simon NM, Wisniewski SR, Miklowitz DJ, Kogan J, et al. Prospective 12-month course of bipolar disorder in outpatients with and without anxiety comorbidity. Br J Psychiatry. 2006; 189; 20-25.

296. Masi G, Perugi G, Toni C, Millepiedi S, Mucci M, et al. Obsessive-compulsive bipolar comorbidity: focus on children and adolescents. J Affect Disord. 2004; 78:175–83.

297. Tohen M, Suppes T, Baker RW, Risser RC, Evans AR, Calabrese JR. Olanzapine combined with mood stabilizers in prevention of recurrence in bipolar disorder: an 18-month study. Eur Neuro-psycho-pharmacol. 2002; 12:530–37.

298. Tohen M, Chengappa KN, Suppes T, Zarate CAJ, Calabrese JR, et al. Efficacy of olanzapine in combination with valproate or lithium in the treatment of mania in patients partially nonresponsive to valproate or lithium monotherapy. Arch Gen Psychiatry. 2002; 59:62–69.

299. Frank E, Kupfer DJ, Thase ME, Mallinger AG, Swartz HA, et al. Two-year outcomes for interpersonal and social rhythm therapy in individuals with bipolar I disorder. Arch Gen Psychiatry. 2005; 62:996–1004.

300. Frank E, Swartz HA, Kupfer DJ. Interpersonal and social rhythm therapy: managing the chaos of bipolar disorder. Biol Psychiatry. 2000; 48:593–604.

301. Miklowitz DJ, George EL, Axelson DA, Kim EY, Birmaher B, et al. Family-focused treatment for adolescents with bipolar disorder. J Affect Disord. 2004; 82:113–28.

302. Miklowitz DJ, George EL, Richards JA, Simoneau TL, Suddath RL. A randomized study of family-focused psycho-education and pharmacotherapy in the outpatient management of bipolar disorder. Arch Gen Psychiatry. 2003; 60:904–12.

303. Miklowitz DJ, Goldstein MJ. Behavioural family treatment for patients with bipolar affective disorder. Behav Modif. 1990; 14:457–89.

304. Miklowitz DJ, Goldstein MJ, Nuechterlein KH, Snyder KS, Mintz J. Family factors and the course of bipolar affective disorder. Arch Gen Psychiatry. 1988; 45:225–31.

305. Miklowitz DJ, Otto MW. New psychosocial interventions for bipolar disorder: a review of literature and introduction of the Systematic Treatment Enhancement Program. J Cogn Psychother. 2006; 20(2): 215-230.

306. Miklowitz DJ, Richards JA, George EL, Suddath RL, Frank E, et al. Integrated family and individual therapy for bipolar disorder: results of a treatment development study. J Clin Psychiatry. 2003; 64:182–91.

307. Cohen JA, Mannarino AP, Deblinger E. TF-CBT treatment manual, Treating Trauma and Traumatic Grief in Children and Adolescents.NY: Guilford Press. 2006. Available from http://www.guilford.com or http://www.amazon.com).

This treatment manual:

308. • Describes

APPENDIX 1: CONSENT FORMS

CONSENT FORMS FOR PARTICIPANTS IN STUDY OF PSYCHIATRIC MORBIDITIES, SUBSTANCE ABUSE AND HIV AMONG PRISON POPULATIONS IN KENYA

CONSENT EXPLANATION: FOR YOUTHS ABOVE 17 YEARS

I work with the University of Nairobi at the Collage of Health Sciences, Department of psychiatry where we have no data on the prevalence of mental health disorders, substance abuse, parenting styles and forms of youth abuse among the youth attending the crisis and counseling at the Kenyatta National and Referral hospital. I will be interested in finding out how common these problems are among the youth populations, and thereafter plan ways on how best to handle those problems in the youth attending this clinic. I ask if you would like to be a part of this research study. If you agree, I would like to ask you some questions. The questions will be about mental illness, substance abuse, and your youthhood interactions with your parents.

Following you agreeing to participate in the research study, you can still refuse to answer any questions. You can stop being in the study at any time. There will be no loss of benefits or any victimization whatsoever.

Risk/Discomfort: Some of the questions, especially those to do with youthhood, this may be uncomfortable and make you remember painful youthhood experiences.

Benefits: Results of mental illness, parenting styles, forms of youth abuse and substance abuse will be ready within two months as you continue with your treatment. The results can help us plan treatment for your mental illness, substance abuse and any other form of treatments available at KNH. The study will also help us to learn how to better treat mental illness, substance abuse and counsel with parents on how to interact with their youths as a gesture to promote good parenting styles in the populations of Kenya

Confidentiality: What I talk about and your results will be kept private to the extent allowed by law. To protect your privacy, I will keep the records under a code number and not your name. We will keep the records in a safe place and only staffs attending to you in this clinic are allowed to look at them. You will not be paid to take part in the study.

To be in this study is your choice. If you do not want to join the study, you will still get the best possible medical care here at the clinic. If you join the study, but then have questions or decide you don't want to go on in it, you can leave it. If you decide that you do not want to go on in the study, you will still get the best possible medical care at the clinic. If you have any questions about your rights as a subject, you can call on

2726300 (KNH crisis and counseling clinic) or 2723719 (Department of Psychiatry; University of Nairobi-Dr. Khasakhala)

CONSENT FORM:

Subject's name:

PARTICIPANT ID: |__|__|__|__|__|__|__|__| Date |__|__|/|__|__|/|__|__|

Subject's statement: The above study has been explained to me and I agree to take part. I understand that this is my choice. If I change my mind, I understand that I will continue to receive medical care.

Subject's signature*:

(Or mark of consent)

Witness signature*:

Investigator signature:______________________________

* Subject may sign or provide verbal consent in the presence of a witness who then signs.

CONSENT EXPLANATION FOR PARENTS/GUARDIANS

Consent Form: Consent for parent/guardian of youth in Borstal homes in Kenya participating in the study:

I work with the University of Nairobi at the Collage of Health Sciences, Department of psychiatry where we have no data on the prevalence of mental health disorders, substance abuse, parenting styles and forms of youth abuse among the youth attending the crisis and counseling at the Kenyatta National and Referral hospital. I will be interested in finding out how common these problems are among the youth populations, and thereafter plan ways on how best to handle those problems in the youth attending this clinic. The questions will be about mental illness, substance abuse, and the interactions of you with your youth during their youthhood. Will ask you if would like your youth to be a part of this research study. If you agree, we would like to ask you some questions about these problems. The questions will be about you're your youth's mental illness, substance use, your interaction with your youth, and how you have managed or have treated the problem(s).

Following your youth agreeing to participate in the research study, you can still refuse to answer any question. He/she can also stop being in the study at any time.

Risk/Discomfort: Some of the questions, especially those to do with your interaction with your youth from youthhood, this may be uncomfortable.

Benefits: Results of mental illness, parenting styles, forms of youth abuse and substance abuse will be ready within two months as you continue with your treatment. The results can help us plan treatment for the youth's and your mental illness, substance abuse and any other form of treatments available at KNH. The study will also help us to learn how to better treat mental illness, substance abuse and counsel with parents on how to interact with their youths as a gesture to promote good parenting styles in the populations of Kenya

Confidentiality: What I talk about and your results will be kept private to the extent allowed by law. To protect your privacy, I will keep the records under a code number and not your name. We will keep the records in a safe place and only staffs attending to you in this clinic are allowed to look at them. You will not be paid to take part in the study.

To be in this study is your choice. If you do not want to join the study, you will still get the best possible medical care here at the clinic. If you join the study, but then have questions or decide you don't want to go on in it, you can leave it. If you decide that you do not want to go on in the study, you will still get the best possible medical care at the clinic. If you have any questions about your rights as a subject, you can call on 2726300 (KNH crisis and counseling clinic) or 2723719 (Department of Psychiatry; University of Nairobi- Dr. Khasakhala)

CONSENT FORM

PARTICIPANT ID: |__|__|__|__|__|__|__|__| Date |__|__|/|__|__|/|__|__|

Parent/guardian's name:

Today's date __/__/

Parent/guardian's statement:

The above study has been explained to me and I agree to take part and have my youth take part. I understand that this is the youth's choice. If I change my mind, I understand that I and my youth will continue to receive medical care.

Parent/guardian's signature*:

(Or mark of consent)

Witness signature*:

Investigator signature: ______________________________

- Parent/guardian may sign or provide verbal consent in the presence of a witness who then signs.

3. ASSENT EXPLANATION FOR YOUTH BELOW 18 YEARS

I will read this consent to the youth at the time of enrolment.

Introduction

Although I got the permission of your parent/guardian to talk to you, I want to explain to you what I want so that you can decide yourself whether you want to participate.

I want you to join a research study about psychiatric morbidities, substance abuse, parenting styles and forms of youth abuse among the youth attending the crisis and counseling at the Kenyatta National and Referral hospital. I want to find out how big a problem it is and how to treat it. I will be interested in finding out how common these problems are among the youth populations, and thereafter plan ways on how best to handle those problems in the youth attending this clinic. The questions will be about mental illness, substance abuse, and the interactions of you with your youth during their youthhood. I will ask you if would like to be a part of this research study. If you agree, we would like to ask you some questions about these problems.

If you want to join the study you will be asked to do something. First, we will ask you some questions about mental illness and substance use, then how you interact with your parents.

Risk/Discomfort: Some of the questions, especially those to do with your interaction with your parents from youthhood, this may be uncomfortable.

Benefits: Results of mental illness, parenting styles, forms of youth abuse and substance abuse will be ready within two months as you continue with your treatment. The results can help us plan treatment for your mental illness, substance abuse and any other form of treatments available at KNH. The study will also help us to learn how to better treat mental illness, substance abuse and counsel with parents on how to interact with their youths as a gesture to promote good parenting styles in the populations of Kenya

Confidentiality: What I talk about and your results will be kept private to the extent allowed by law. To protect your privacy, I will keep the records under a code number and not your name. We will keep the records in a safe place and only staffs attending to you in this clinic are allowed to look at them. You will not be paid to take part in the study.

To be in this study is your choice. If you do not want to join the study, you will still get the best possible medical care here at the clinic. If you join the study, but then have questions or decide you don't want to go on in it, you can leave it. If you decide that you do not want to go on in the study, you will still get the best possible medical care at the clinic. If you have any questions about your rights as a subject, you can call on 2726300 (KNH crisis and counseling clinic) or 2723719 (Department of Psychiatry; University of Nairobi-Dr. Khasakhala)

If you have any further questions about this research study, please ask your guardians/parents.

Will you be a part of our study (CIRCLE, ONE) YES/ NO

CONSENT

PARTICIPANT ID: |__|__|__|__|__|__|__|__| Date |__|__|/|__|__|/|__|__|

____

Name of youth (Print)

_______________________   Date ____________________

Name of youth (Signature or mark of consent)

To be signed by witness:

The above statement has been read to the youth and the youth agrees to participate in the research project______________________Date_________________________

Name of witness (Print)____________________________

Name of witness (Signature or mark of consent)

Investigator signature:____

APPENDIX 2: QUESTIONNAIRES

APPENDIX 2a: Socio-demographic and Open ended structured interview schedule (unstructured interview)

Part A:

Specify whether consent and/or assesnt is signed and on record: Yes____ No____ If No do not continue with the interview. If yes continue

PARTICIPANT ID: |__|__|__|__|__|__|__|__| Date |__|__|/|__|__|/|__|__|

INTERVIEW START TIME: ____:____(24-hr)

SOCIO-DEMOGRAPHIC QUESTIONNAIRE

First, I am going to ask you about some basic information about yourself, your family and where you are from.

A1. Gender? Male................................1 Female 2

A2. Date of Birth? (D D M M Y Y Y Y) |__|__| |__|__| |__|__|__|__| Age in years |__|__|

A3. What is your nationality?

Kenyan... 1 Tanzanian 2

Ugandan...3 Other 4

Specify: ______________________

A4. What is your place of birth?

Name of the District: ________________________________

A4b. What is your ethnicity?

Mijikenda..............................1
Luhya....................................2
Luo...................................... 3
Kikuyu..................................4
Kamba...................................5
Masai 6
Meru 7
Embu....................................8
Kisli 9
Kalenjm 10
Samburu..............................11
Bajuni.......................... 12
Swahili..............................13
Arab 14
[illegible] 15
Euro-american 16
Other 17
Specify:____________________

A5. Who did you live with?

Spouse ☐ Partner ☐ Youths ☐ Friend/s ☐

Alone ☐ Both parents ☐ Others (specify)________________

A6. What is your parents' marital status? Married ☐ Single ☐ Divorced/ separated ☐

Other (Specify) ....

A7. What is your birth order in your family? ....

A8. How many a) brothers.............................b) sisters................ do you have

A9. What is the main problem you had before you came to this clinic?

____

A10. What is your highest education level you have attained?

Specify________________________________

A11. What level of education did your

Mother attain?____________________ Father attain______________

A12. Have you ever been send home from school or collage? Yes_____ No______

If yes, what was the reason(s)?

____

____

A13. The last two years you were in school, what position were you in class

Position Last term in school_______

Position 2nd last previous term in school_______

Position 3rd last previous term in school_______

Position 4th last previous term in school_______

Position 5th last previous term in school_______

Position 6th last previous term in school_______

A14. What final score did you attain in the last previous school exam? ____________ (specify the examination you did)

A15 Do you have peers who drink? Yes |__| No|__|

A16 Do you see your father use alcohol excessively/have ever seen your father drunk

Yes |__| No |__|

Part B Open ended structured interview schedule

1) Complains (Duration of the complaints)

i) Major Complaints

____

____

____

ii) Minor Complaints

____

____

2) Resource of referral and reasons for referral

____

3) History of presenting illness

____

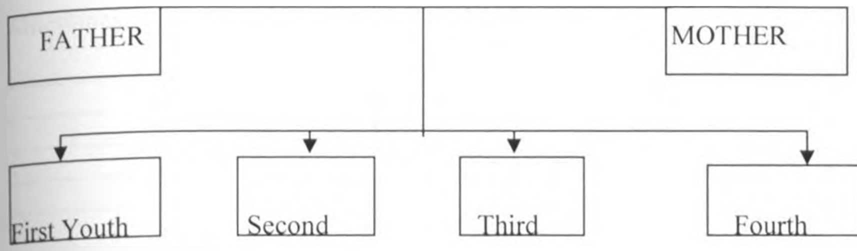
____

____

____

4) Family History

PATIENTS FAMILY TREE



Note: For each family member, provide the name, position in the family, age, highest education level attained history of substance use, psychiatric history, medical history, relationships within the family, marital status and occupation.

5) Past Medical History

6) Past Psychiatric History

7) History of Substance Use

8) Personal History

a) Pre-Conception

b) Gestation Period

c) Intra Partum Period

d) Post-Partum Period

e) Milestones

f) Schooling

g) Career

h) Occupation

Appendix 2b: MINI KID SCREEN MINI KID QUESTIONNAIRE

Patient Name : DATE OF BIRTH:

JINA LA MGONJWA ____________ TAREHE YA KUZALIWA ____________

DATE OF INTERVIEW:

TAREHE YA KUHOJIWA____________

If YES, go to the corresponding M.I.N.I. Kid module

QUESTIONNAIRE COMPLETED BY ____________

Question			
A 1. Have you felt sad or depressed, down or empty, or grouchy or annoyed, **most of the day, nearly every day** for the past two weeks? IF **YES** TO ANY, CODE **YES** Je umewahi huzunika, kujihisi mpweke ama kukasirika muda mwingi wa siku, karibu kila siku kwa muda wa wiki mbili ziilizopita ?	NO	YES	→ **A**
A 2. In the past two weeks, have you been bored a lot or much less interested in things (like playing your favorite games) for **most of the day, nearly every day**? Have u felt that you couldn't enjoy things? IF **YES** TO ANY, CODE **YES** Umepoteza hamu ya mambo {kama vile michezo uipendayo}unahisi haufurahishwi na chochote? Amaa keti enkata naaijo mishipakino anaa minyor intokitin oshu ake minyor ataasa aitoki tiatua iwikii are?	NO	YES	→ **A**
B. Have you **ever** felt so bad that you wished you were dead, tried to hurt yourself, or tried to kill yourself? IF **YES** TO ANY, CODE **YES** Je umewahi hisi vibaya sana hadi ulitamani heri kufa, ulijaribu kujiumiza, ama ukahisi kujiua ? IF YOU SAID **YES** TO THE FIRST QUESTION, SKIP THIS QUESTION. KAMA ULIKUBALIANA NA SWALI LA KWANZA USIJIBU HILI SWALI	NO	YES	→ **B**
C. **In the past year** have you felt sad or depressed, down or empty, or grouchy or annoyed, **most of the time**? IF **YES** TO ANY, CODE **YES** Je umewahi kuhuzunika,kujhisi mpweke ama kukasirika mara kwa mara kwa mda wa miakai mbili ziilizopita ?	NO	YES	→ **C**

IF YES, GO TO THE CORRESPONDING M.I.N.I. MODULE

NO YES → D

D.1.a) Has there **ever** been a period of time when (s)he was so happy that (s)he felt "up" or "high" or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usuall self ? (Do not consider times when you were intoxicated on drugs or alcohol)

IF PATIENT IS PUZZLED OR UNCLEAR ABOUT WHAT YOU MEAN BY "UP" OR "HIGH", CLARIFY AS FOLLOW : By "up" or "high" I mean : having elated mood, increased energy, needing less sleep, having rapid thoughts, being full of ideas, having an increase in productivity, creativity, motivation or impulsive behavior.

Je, ulishawahi kwa kipindi Fulani kujisikia una hali ya juu, au umejawa na nguvu au umesongwa kiasi cha kupatashida, au kwamba watu kukudhania kuwa sio mtu wa kawaida? (usichukulie muda ambao ulikuwa umedhurika kwa madawa au pombe)

KAMA MGONJWA ANAONEKANA KUTOELEWA MAANA YA "HALI YA JUU", FAFANUA KAMA IFUATAVYO : Hali ya juu ina maana ya kuwa na hali ya furaha; kuhitaji usingizi mchache;kuwa na fikra za haraka; kusongwa na mawazo; kuongezeka katika tija, ubunifu, motisha au tabia ya kuamua ghafla

NO YES → D

D.1.b) Are you currently feeling "up" or "high" or full of energy ?

Je, sasa hivi unajisikia kuwa na hali ya juu au kujawa na nguvu?

D.2.a) KAMA JIBU NI NDIYO :Has there **ever** been a time when you were so grouchy or annoyed, that you yelled or started fights; or yelled at people not counting 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? IF YES TO ANY, CODE **YES** — NO YES → **D**

Je, umeshawahi kuwa mwenye kuudhika upesi kwa muda mrefu, kwa siku nyingi, kiasi kwamba ukawa na mabishano, au mapigano kwa maneno au vitendo, au kuwapigia kelele watu wasiokuwa wa familia yako?

DO NOT CONSIDER TIMES WHEN YOU WERE INTOXICATED ON DRUGS OR ALCOHOL OR DURING SITUATIONS THAT NORMALLY OVERSTIMULATE AND MAKE CHILDREN VERY GROUCHY OR ANNOYED.

D.2.b) Are you **currently** feeling grouchy or annoyed? — NO YES → **D**

Je unajihisi mwenye mwenye hasira ?

NO YES → **E**

E. a)Has (s)he **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? IF **YES** TO EITHER, CODE **YES**

Je kwa mara zaidi ya moja, umekuwa na vipindi vya kujisikia au kupatwa na wasiwasi wa ghafla, hofu, kutotulia au mashaka, hata katika mazingira ambayo watu wengi hawajisikii hivyo?

IF YES, GO TO THE CORRESPONDING M.I.N.I. MODULE

E.b) Did this happen more than one time ? — NO YES → **E**

Je hii ilitendeka kuzidisha mara moja ?

E.c) Did this nervous feeling increase quickly over the first few minutes — NO YES → **E**

Je, hizi hisia za wasi wasi ziliongezeka baada ya dakika chache za kwanza ?

F. Do you feel anxious, scared or uneasy in places or situations where you might — NO YES → **F**

become really frightened: like being in a crowd, standing in a line (queue), when you are all alone, or when crossing a bridge, traveling in a bus, train or car? IF YES TO ANY, CODE YES

Je, wewe hujisikia wasiwasi au mashaka katika sehemu au mazingira ambapo unaweza kupata mshituko wa hofu kubwa au dalili zinazofanana na hofu kubwa tulizozizungumza hivi punde, na ambapo msaada unaweza usiwepo, au ambapo kukwepa kunaweza kuwa kugumu: kama kuwa kwenye kundi la watu wengi, kusimama kwenye foleni, ukiwa peke yako mbali na nyumbani, au upo nyumbani peke yako, au ukiwa unavuka daraja, kusafiri ndani ya basi, treni, au gari ?

G. 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 Je kwa muda wa mwezi mmoja uliyopita umehisi kuwa na woga kuwa mbali na mtu umpendaye ?	NO	YES	→ **G**
H. In the past month, were you afraid or embarrassed when others 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 Je kwa mda wa mwezi mmoja uliyopita umekuwa mwoga au kuihsi na aibu ulipoangaliwa na wenzako ?	NO	YES	→ **H**
I. 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? Je kwa mda wa mwezi mmoja uliyopita umekuwa na woga na kitu chochote kama vile nyoka,mbwa au wanyama wengine ? List the specific phobia : ________________	NO	YES	→ **I**

IF YES, GO TO THE CORRESPONDING M.I.N.I. MODULE

J. 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 you knew you didn't want to? 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** Katika mwezi ulioputa, je ulishawahi kukerwa na mawazo yenye kujirudiarudia, misukumo, au fikra ambazo hazihitajiki, za maudhi, zisizostahili, zenye kuingilia, au zenye kuleta shida? (mf: mawazo ya kwamba umchafu, umechafuliwa na vijidudu, au hofu ya kuwachafua wengine, au hofu ya kumdhuru mtu hata kama hukutaka kufanya hivyo, au kuhofia kutenda kwa msukumo, au hofu au imani za kichawi kwamba ungewajibika kwa mambo mabaya, au shauku yenye mawazo ya ngono, fikra au misukumo,au shauku ya kuhodhi, kukusanya au ya kidini). 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 YOU MAY DERIVE PLEASURE FROM THE ACTIVITY AND MAY WANT TO RESIS IT ONLY BECAUSE OF ITS NEGATIVE CONSEQUENCES	NO	YES	→ J
J. 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** Katika mwezi uliopita, je ulifanya kitu kwa kurudiarudia bila kuwa na uwezo wa kujizuia kufanya hivyo, kama vile kuosha au kusafisha sana, kuhesabu, kukagua	NO	YES	→ J

IF YES, GO TO THE CORRESPONDING M.I.N.I. MODULE

K.1. Has anything really awful happened to you? Like being in a flood, tornado or earthquake? Like being in a fire or a really bad accident? Like seeing someone get killed or hurt really bad? Like being attacked by someone?

Je kuna kitu chochote cha kutisha ambacho umeshuhudia ?

NO YES → K

NO YES → K

K.2. Did you respond with intense fear, feel helpless or horrified or did you feel

➢ L. 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 **YES** TO ANY, CODE **YES** **(All coded yes start with street names of the drink)**

NO YES → L

Je kwa mda wa mwaka mmoja umekuwa ukinywa pombe zaidi ya tatu kwa siku

READ THE LIST BELOW of street drugs or medicines.

amphetamines	speed	crystal meth	Dexedrine	Ritalin, diet pills
cocaine	crack	Freebase	speedball	
heroin	morphine, methadone	Opium	Demerol	codeine, Percodan, OxyContin
LSD	mescaline	PCP, angel dust	MDA,MDMA	ecstasy, ketamine
inhalants	glue	Ether	GHB	Steroids
THC, marijuana	cannabis, hashish	Grass	weed, reefer	barbiturates, Valium, Xanax, Ativan

M. In the past year, have you taken any of them more than one time to get high? To feel better or to change your mood?

je kwa mda wa mwaka mmoja umekunywa au kumeza daw yeyotekwa mara zaidi [illegible] ili ulewe ?

IF YES, GO TO THE CORRESPONDING M.I.N.I.

N. 1. 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.

Katika mwezi uliopita umekuwa na mitetemeko ya kasi katika sehemu fulani za mwili ambayo ni vigumu kuihimili ? inaweza kuwa kupepesa jicho tene na tena, shtuko la uso mkutuo wa kichwa.

NO YES → **N**

N 2 Has (s)he ever had a tic that made him/her say something or make a sond over and over it was hard to stop it? Like coughing or sniffing 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?

Umewahi kuwa na mtetemeko uliokufanya utoe sauti tena na tena am bayo haukuweza isimamisha kama kukohoa na kutoa kikohozi bila kuwa na homa au kurudia maneno

NO YES → **N**

- O. Has anyone (teacher, baby sitter, friend) complaied about your child's behaviour ?

Je. kuna mtu wowote(mwalimu wako.rafiki ama mzazi) hajafurahia tabia yako?

NO YES → **O**

IF NO TO THIS QUESTION, ALSO CODE NO TO CNDUC DISORDER AND OPPOSITIONAL DEFIANT DISORDER ?

- P. IF QUESTION 01 IN ANSWERED NO, CODE NO TO CONDUCT DISORDER

  IF O1 WAS NOT ASKED ALREADY, ASK THE QUESTIN BELOW

NO YES → **P**

Has anyone (teacher, baby sitter, friends, yourself) complained about your child's)

Je. kuna mtu wowote(mwalimu wako.rafiki ama mzazi) hajafurahia tabia yako?

- Q IF QUESTION O1 IN ADHD IS ANSWERED NO, CODE NO TO OPPOSITIOPNAL DEFIANT DISORDER

II O1 WAS NOT ASKED ALREADY , ASK THE QUESTION BELOW

NO YES → **Q**

(has anyone (teacher, baby sitter, friend, yourself) complained about your child's behaviour ?)

[illegible]

IF YES, GO TO THE CORRESPONDING M.I.N.I.

R.1. Have you ever heard things other people couldn't hear, such as voices? NO YES → R

Je umewahi sikia vitu ambavyo wenzako hawasikii kama aina za sauti ?

NO YES → R

R.2. Have your friends or family ever thought any of your beliefs were strange or weird?

Je jamii yako au marafiki wako wamewahi kufikiria ya kwamba mila zako ni za

S.a) How tall are you ?

Je una urefu gani ?

b) What was your lowest weight in the past 3 months ?

Je kilo yao ya chini kwa miezi mitatu ilikuwa ngapi ?

C) IS PATIENT'S WEIGHT LOWER THAN THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT? SEE TABLE BELOW NO YES → S

d) Have you lost 5 lbs. or more in the last 3 months? NO YES → S

Je umepoteza kilo----au zaidi kwa mda wa miezi mitatu?

e) If you are less than age 14, have you failed to gain any weight in the last 3 months? NO YES → S

Kama uko chini ya miaka kumi na nne umewahi kosa kuongeza kilo yako kwa mda wa miezi mitatu?

f) Has anyone thought that you lost too much weight in the last 3 months? NO YES → S

Je kuna mtu anadhani umepoteza kilo nyingi kwa mda wa miezi mitatu?

T In the past **three months**, did you have eating binges or times when you ate a very large amount of food within a **2-hour** period? NO YES → T

Je kwa mda wa miezi mitatu umekuwa ukila chakula kingi kwa mda wa masaa mawili ?

IF YES, GO TO THE CORRESPONDING M.I.N.I.

T.2 In the last **3 months**, did you have eating binges as often as twice a week? NO YES → T

Je kwa mda wa miezi mitatu umekuwa ukila chakula kingi kila mara kwa mda wa wiki mbili ?

U a)Have you worried **excessively** or been anxious about several things over the past 6 months? Je umekuwa na wasi wasi mwingi kwa mda wa miezi sita iliyopita ? b) does (s)he worry most days ?	NO	YES	→ **U**
V. Are you stressed out about something? Is this making you upset or making your behavior worse? Je una una mafikira yeyote kuhusu jombo ? je jambo hili lina kusumbua mpaka tabia yako kuzidi ?	NO	YES	→ **V**
W.1 Since the age of four has your child had difficulty making friends ? Does your child have problems becouse (s)he keeps to him/herself ? Is it becouse he or she is shy or becouse (s)he doesnt fit in ? Tangu umri wa miaka minne, mtoto wako amekuwa na shida ya kufanya urafiki ? Je, mtoto wako ana shida kwa sababu yeye hukaa peke yake ? Au kwa sababu huona haya ? au kwa sababu hana muingiliano mzuri na wengine ?	NO	YES	→ **W**
W.2 Is your child fixated on routine and rituals or does (s)he have interests that are special and intrude on other activities ? Je, mtoto wako ana hima ya kufanya mambo fulani kama desturi au kupendelea mambo ya kipekee na kutatiza shughuli nyingine?	NO	YES	→ **W**
W.3 Do other kids think your child is weird or strange or awkward ? Je, watoto weingine huona kama tabia ya mtoto wako sio ya kawaida ?	NO	YES	→ **W**
W.4 Does your child play mostly alone, rather than with other children ? Je, mtoto wako hucheza peke yake au na watoto wale wengine?	NO	YES	→ **W**

M.I.N.I. KID

MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW

For Children and Adolescents

English Version 5.0

USA: **D. Sheehan, D. Shytle, K. Milo**
University of South Florida - Tampa

FRANCE: **Y. Lecrubier, T Hergueta.**
Hôpital de la Salpetrière - Paris

© Copyright 1998-2005 Sheehan DV

All rights reserved. No part of this document may be reproduced or transmitted in any form, or by any means, electronic or mechanical, including photocopying, or by any information storage or retrieval system, without permission in writing from Dr. Sheehan. Researchers and clinicians working in nonprofit or publicly owned settings (including universities, nonprofit hospitals, and government institutions) may make single copies of a M.I.N.I. KID instrument for their own clinical and research use.

PATIENTS NAME *Jina la mgonjwa*	**Patient Number:** ***nambari ya mgonjwa***
DATE OF BIRTH *TAREHE YAKUZALIWA*	**Time Interview Began** ***Wakati mahojiano yalianza***
Interviewer's Name: *Jina la mhojianaji*	**Time Interview Ended:** ***Mwisho wa mahojiano***
DATE OF INTERVIEW *TAREHE YAKUHOJIWA*	**Total Time:** ***Mda uliochukua***

MODULES	TIME FRAME	MEETS CRITERIA	DSM-IV	ICD-10
A MAJOR DEPRESSIVE EPISODE	Current (Past 2 weeks)		296.20-296.26 Single	F32.x
B SUICIDALITY	Lifetime		N/A	N/A
	Current (Past Month)		N/A	N/A
	Risk: ☐ Low ☐ Medium ☐ High			
DYSTHYMIA	Current (Past 1 year)		300.4	F34.1
D (HYPO) MANIC EPISODE	Current Past		296.00-296.06	F30.x-F31.9
E PANIC DISORDER F41.0	Current (Past Month)		300.01/300.21	F40.01-
	Lifetime			
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)		300.23	F40.1
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
ALCOHOL DEPENDENCE	Past 12 Months		303.9	F10.2x
ALCOHOL ABUSE	Past 12 Months		305.00	F10.1

M SUBSTANCE DEPENDENCE (Non-alcohol)	Past 12 Months	304.00- 90/305.20- 90	F11 1-F19.1
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 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 F30 2 F31.2/F31 5/	Lifetime Current F31 8/F31 9/F39	296 24/296 34/296.44 296 24/296 34/296 44	F32.3/F33.3/
ANOREXIA NERVOSA	Current (Past 3 Months)	307.1	F50.0
BULIMIA NERVOSA	Current (Past 3 Months)	307.51	F50.2
GENERALIZED ANXIETY DISORDER	Current (Past 6 Months)	300.02	F41 1
ADJUSTMENT DISORDERS	Current	309.24/309 28 309.3/309.4	F43.xx
PERVASIVE DEVELOPMENTAL DISORDER F84 0. 2/ 3/ 5/.9	Current	299 00/299 10/299.80	

DISCLAIMER

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

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

M	SUBSTANCE DEPENDENCE (Non-alcohol)	Past 12 Months	304.00- 90/305.20- 90	F11.1-F19.1
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 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 F30.2 F31.2/F31.5/	Lifetime Current F31.8/F31.9/F39	296.24/296.34/296.44 296.24/296.34/296.44	F32.3/F33.3
S	ANOREXIA NERVOSA	Current (Past 3 Months)	307.1	F50.0
T	BULIMIA NERVOSA	Current (Past 3 Months)	307.51	F50.2
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	PERVASIVE DEVELOPMENTAL DISORDER F84.0/.2/.3/.5/.9	Current	299.00/299.10/299.80	

DISCLAIMER

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

[illegible] program is not designed or intended to be used in the place of a full medical and psychiatric evaluation by a qualified licensed [illegible] psychiatrist. It is intended only as a tool to facilitate accurate data collection and processing of symptoms elicited by [illegible] 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 judgement, 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 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 1 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, need for a training session, 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
Institute for Research in Psychiatry
3515 East Fletcher Avenue
Tampa, FL USA 33613-4788
tel +1 (813) 974 -4544
fax +1 (813) 974 -4575
e-mail: dsheehan@hsc.usf.edu

Doug Shytle, Ph.D. or Karen Milo Ph.D.
Child Psychiatry Research Center, MDC-14
University of South Florida
3515 East Fletcher Avenue
Tampa, FL USA 33613-4788
tel :+1 (813) 974- 1452
fax:+1 (813) 974 -1978
e-mail : dshytle@hsc.usf.edu or kmilo@hsc.usf.edu

A. MAJOR DEPRESSIVE EPISODE

TUKIO LA SONONA LILILOAMBATANA NA UZITO WA MOYO (HIARI)

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

In the past two weeks:

Kwa wiki mbili iliopita:

Have you felt sad or depressed? Felt down or empty? Felt grouchy or annoyed? NO YES

Umehisi ukiwa na huzuni au umejawa na mawazo? nilisikia kukasirika?

Have you felt this way, most of the day, nearly every day?

Umehisi hivi, kila wakati, karibu kila siku?

IF YES TO ANY, CONTINUE. IF **NO** TO ALL CODE **NO**

JE KIPENGELE A1 AU A2 KIMEJIBIWA NDIYO?

A2 Have you been bored a lot or much less interested in things (Like playing your favorite games)?

Have you felt that you couldn't enjoy things?

Umekuwa hauna haja na kiti chochote {kama vile mchezo upendao}unahisi haufurahishwi na chochote?

IF **YES** TO ANY CONTINUE. IF **NO** TO ALL CODE **NO**

Have you felt this way, most of the day, nearly every day? NO YES

Unahisi hivi kila wakati karibu kila siku?

IS **A1** OR **A2** CODED **YES?** NO YES

In the past two weeks, when you felt depressed / grouchy / uninterested:

Katika kipindi cha wiki mbili zilizopita, ulipojisikia kukosa raha na / au kutokuwa na ari:

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 or ±8 lbs. in the past month]? NO YES

Je, hamu yako ya kula ilipungua au kuongezeka, karibu kila siku? Uzito wako ulipungua au uliongezeka bila wewe kukusudia? (yaani ± 5 % ya uzito wako au kg. 3.5 katika mwezi)

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

Je umekuwa na shida ya kupata usingizi mara nyingi?(taabu ya kupata usingizi, kukosa usingizi katikati ya usiku, kuamka mapema sanaisivyo kawaida, au kulala mno)

c Did you talk or move slower than usual? Were you fidgety, restless or couldn't sit still? NO YES

Je, ulikuwa ukiongea au kutembea taratibu zaidi kuliko kawaida yako, au ulikuwa na hali ya kuhangaika, kutotulia, au kuwa na tatizo la kukaa kwa utulivu karibu kila siku?

d Did you feel tired most of the time? NO YES

Je, ulijisikia mchovu au kutokuwa na nguvu karibu kila saa?

e Did you feel bad about yourself most of the time? Did you feel guilty most of the time? NO YES

Je, ulijisikia huna thamani au kuwa na hali ya kujilaumu karibu kila siku?

f Did you have trouble paying attention? Did you have trouble making up your mind? NO YES

Je, ulikuwa na matatizo ya kuwa makini au shida ya kufanya maamuzi karibu kila siku?

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? Did you think about killing yourself? NO YES

Je, mara kwa mara ulifikiria kuhusu kujiumiza, au kutaka kujiua, au bora ufe?

IF YES TO ANY, CODE YES

ARE 5 OR MORE ANSWERS (A1, A2 AND A3a-g) CODED YES?

NO	YES

B. SUICIDALITY

HALI YA KUTAKA KUJIUA

(MEANS: GO TO THE SUICIDE RISK CURRENT BOX, CIRCLE NO IN THAT BOX, AND MOVE TO THE NEXT MODULE)

Points

a **Have you ever** felt so bad that you wished you were dead?

Ushawahi kuhisi vibaya kiasi kwamba uliona ni heri usingekuwa hai?

NO YES
1

b Have you ever tried to hurt yourself?

Je umeshawahi kujaribu kujiumiza?

NO YES
2

c Have you ever tried to kill yourself?

Je umeshawahi kujaribu kujitoa uhai?

If **YES** TO ANY, CODE **YES**

NO YES

In the past month did you:

Kwa mwezi mmoja uliopita

Amaa to lapa otulusoitie:

Points

Think you would be better off dead or wish you were dead? NO YES 1

Ulifikiria kwamba ni bora ungekufa?

B3 Want to harm yourself? Ulitaka kujidhuru?	NO	YES	2
B4 Think about suicide? umefikiria kujiua?	NO	YES	6
B5 Have a suicide plan? Umefikiria jinsi ya kujiua?	NO	YES	10
B6 Attempt suicide? Umejaribu kujiua?	NO	YES	10

IS AT LEAST 1 OF THE ABOVE (B1-B6) CODED **YES**?

IF YES ADD THE TOTAL NUMBER OF POINTS FOR THE ANSWERS (B1-B6) CHECKED 'YES' AND SPECIFY THE LEVEL OF SUICIDE RISK AS FOLLOWS:

NO **YES**

SUICIDE RISK CURRENT

1-8 points	Low	☐
9-12 points	Moderate	☐

C. DYSTHYMIA

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

IF PATIENT'S SYMPTOMS CURRENTLY MEET CRITERIA FOR MAJOR DEPRESSIVE EPISODE, DO NOT EXPLORE THIS MODULE.

Have you felt sad or depressed, or felt down or empty, or felt grouchy or annoyed, most of the time, for the last two years,? NO YES

Je ulijisikia huzuni, mnyonge au kukosa raha mwingi kwa kipindi cha miaka miwili iliyopita?

In the past two years, have you felt OK for two months or more in a row?

Kwa muda wa miaka miwili iliyopita umejihisi salama kwa miezi mbili ikifuatana? NO YES

During the past two years, most of the time:

Kwa miaka miwili, wakati mwingi:

Were you less hungry than you used to be? Were you more hungry than you used to be? NO YES

Je ulikuwa ukihisi njaa sana kuliko wakati mwingine?je hauhisi njaa sana kama kawaida?

IF YES TO EITHER, CODE YES

Did you have trouble sleeping or sleep excessively? NO YES

keaa nikindurr ijo ashuu irura oleng?

Ulikuwa na shida ya kupata usingizi au kulala mno?

c Did you feel tired or without energy? NO YES

Je. uulijihisi umchovu au umekosa nguvu?

d Did you lose your self-confidence? NO YES

Je. ulipoteza uwezo wa kujiamini?

e Did you have trouble concentrating or making decisions? NO YES

Je. ulipata shida ya kuwa makini au shida ya kutoa maamuzi?

f Did you feel hopeless? NO YES

Je ulijihisi kwamba huna ama umepoteza matumaini?

ARE 2 OR **MORE C3** ITEMS CODED **YES?**

NO YES

4 Did these feelings of being depressed / grouchy / uninterested upset you a lot?
Did they cause you problems at home? At school? With friends?

Amaa kulo bulabul loo ndamunot kitu ake kimitiki ias esiasi ashu ias siatin aishaa?
Amaa ekiyaka enyamali te sukuul?teang?iboitare ilchoreta?

NO	**YES**

D. (HYPO) MANIC EPISODE

TUKIO LA MANIA (MANIA NDOGO)

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

D1 a Has there **ever** been a time when you were so happy that you felt 'up' or 'high' or 'hyper'? NO YES

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

Je, ulishawahi kwa kipindi Fulani kujisikia una hali ya juu, au umejawa na nguvu au umesongwa kiasi cha kupatashida, au kwamba watu kukudhani kuwa sio mtu kawaida?(usichulie muda ambao ulikuwa umedhurika kwa madawa au pombe)

IF NO TO ALL, CODE NO TO **D1b** IF YES **TO ANY**, ASK

b Are you currently feeling 'up' or 'high' or 'hyper' or full of energy? NO YES

je, sasa hivi unajisikia kuwa na hali ya juu au kujawa na nguvu?

D2 a Has there **ever** been a time when you were so grouchy or annoyed, 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? NO YES

Je, umeshawahi kuwa kuudhika upesi kwa muda mrefu, kwa siku nyingi, kiasi kwamba ukawa na mabishano, au mapigano kwa manene au vitendo, au kuwapigia kelele watu wasiokuwa wa familia yako?

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

b Are you currently feeling grouchy or annoyed?

Je umekasirika sasa? NO YES

IS **D1a** or **D2a** CODED **YES?** NO YES

IF **D1b** OR **D2b** = **YES**: EXPLORE ONLY **CURRENT** EPISODE, OTHERWISE

IF **D1b** AND **D2b** = **NO**: EXPLORE THE MOST SYMPTOMATIC **PAST** EPISODE

During the time(s) when you felt up, high, full of energy or irritable did you:

Kwa muda ambao ulijisikia hali ya juu, kujawa na nguvu, au mwenye kuudhika upesi, je :

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

a Feel that you could do things others couldn't do? Feel that you are a very important person? NO YES

Ulijihisi kuwa na uwezo wa kufanya vitu ambavyo wengine hawawezi au kujiona kuwa mtu pekee muhimu

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

Ulihitaji usingizi mchache (kwa mfano, kujisikisa mapumziko baada ya muda mdogo tu wa kulala) ?

c Talk too much without stopping, or so fast that people had difficulty understanding? NO YES

Uliongea sana bila kunyamaza, au kwa haraka zaidi kiasi kwamba watu wakapata tabu ya kukuelewa?

d Have racing thoughts?

Umekuwa na mawazo ya harakaharaka NO YES

e Become easily distracted so that any little interruption could distract you? NO YES

Ulikuwa mwepesi wa kuvurugwa kiasi kwamba hata kukatizwa kidogo kunakuvuruga?

f Become so active or physically restless that others were worried about you? NO YES

Ulikuwa mwenye bidii kupita kiasi hivi kwamba hukuonyesha uchovu hadi watu wengine wakawa na hofu kukuhusu?

Want so much to engage in pleasurable activities that you ignored the risks or consequences (for example, spending sprees, reckless driving, or sexual indiscretions)? NO YES

Ulitaka sana kujiingiza katika shughuli za starehe na kutojali hatari zake au matokeo yake(mfano, kufanya shamrashamra , udereva wa kizembe, au ngono bila kujihadhari)?

ARE 3 OR MORE **D3** ANSWERS CODED **YES** (OR **4** OR MORE IF **D1a** IS **NO** [IN RATING PAST EPISODE] OR **D1b** IS **NO** [IN RATING CURRENT EPISODE])? NO YES

For at least one week or more:

Wiki moja au zaidi:

Did they cause problems at home? At school? With friends? With other people? NO YES

Were you put into the hospital for these problems?

Je ulifanya makosa yoyote nyumbani au shuleni?na marafiki zako?watu waingine?

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

☐ ☐

THE EPISODE EXPLORED WAS A: ☐ ☐

HYPOMANIC EPISODE *MANIC EPISODE*

IS D4 CODED **NO**?

NO	YES

HYPOMANIC EPISODE

SPECIFY IF THE EPISODE IS CURRENT OR PAST.

IS D4 CODED **YES**?

NO	YES

MANIC EPISODE

SPECIFY IF THE EPISODE IS CURRENT OR PAST.

E. PANIC DISORDER

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

---

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

Je ushawahi kuwa na vipindi vya kujisikkia au kupatwa na wasi wasi wa ghafla, hofu, kutotuliwa wa ghafla au mashaka , hata mazingira ambayo watu wengi hawajisikii hivyo?

b Did this happen more than one time? NO YES

je. hii ilitendeka kuzidisha mara moja?

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

je hizi hisia za wasi wasi ziliongezeka baada ya dakika kido

Has this ever happened when you didn't expect it?
Je iliwahi kutendeke kwako bila wewe kutarajia? NO YES

After this happened, were you afraid it would happen again or that something bad would happen as a result of these attacks? NO YES
Did you have these worries for a month or more?
Baada ya kufanyika hivi ulipata hofu kwamba itafanyika tena?
Je, ulishawahi kupata tukio moja kama hilo lililofuatiwa na kipindi cha mwezi mmoja au zaidi cha kujisikia hofu ya tukio jingine

IF **YES** TO BOTH QUESTIONS, CODE **YES**

Think about the time you were the most frightened or nervous for no good reason:

During the worst spell that you can remember:

Katika kipindi kibaya zaidi ambacho unakumbuka :

Did you have skipping, racing or pounding of your heart? Je moyo wako ulidUnda kwa nguvu?	NO	YES
Did you have sweating or clammy hands? Je ulitokwa na jasho?	NO	YES
Were you trembling or shaking? Je ulitetemeka?	NO	YES
Did you have shortness of breath or difficulty breathing? Je ulikuwa na shida ya kuvuta pumzi?	NO	YES
Did you have a choki- ng sensation or a lump in your throat? Je ulihisi umenyongwa	NO	YE
Did you have chest pain, pressure or discomfort? je ulihisi uchungu kifuani	NO	YES
Did you have nausea, stomach problems or sudden diarrhea? Je ulikuwa na matatizo ya tumbo au kuharisha kwa ghafla ?	NO	YES
Did you feel dizzy, unsteady, lightheaded or faint?	NO	YES

Je, ulijisikia kizunguzungu, kutetereka, kichwa chepesi, au kuzirai?

Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from part or all of your body? NO YES

Je, vitu vilivyokuzunguka uliviona ni vya ajabu, sio halisi, upweke au vya kigeni, au je, ulijisikia upo kando ya, au kujitenga kutoka katika sehemu au mwili wako wote?

Did you fear that you were losing control or going crazy? NO YES

Je, ulihofia kwamba umeshindwa kujizuia au umepata wazimu ?

Did you fear that you were dying? NO YES

Je ulijawa na woga kwamba utafariki

Did you have tingling or numbness in parts of your body? NO YES

Je, ulipatwa na msisimko au ganzi katika sehemu za mwili wako ?

Did you feel hot or cold?

Je ulihisi joto au baridi? NO YES

E5 ARE **BOTH E3**, 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

LIMITED SYMPTOM ATTACKS LIFETIME

THEN SKIP TO **F1**.

In the past month, did you have these problems more than one time? If this happened, NO YES

did you worry for a month or more that it would happen again? *PANIC DISORDER*

IF **YES** TO EITHER, CODE **YES** *CURRENT*

Katika mwezi mmoja uliopita, ulipatwa na matukio hayo kwa kujirudiarudia (mara 1 au zaidi) kufuatiwa na hofu ya kupata tukio jingine ?

F. AGORAPHOBIA

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, traveling in a bus, train or car? NO YES

IF YES TO ANY, CODE **YES**

Je, unajisikia wasi wasi au mashaka katika sehemu au mazingira ambapo unaweza kupata mshituko wa hofu kubwa au dalili zinazofanana na hofu kubwa tulizozizungumza hivi punde, na ambapo msaada unaweza usiwepo, au ambapo kukwepo kuna kugumu; kama kuwa kwenye jkundi la watu wengi, kusimama kwenye foleni, ukiwa peke yako mbali na nyumbani peke yako, au ukiwa unavuka daraja, kusafiri ndani ya basi, treni au gari?

IF **F1** = **NO**, CIRCLE **NO** IN **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? NO YES

AGORAPHOBIA

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

AND

NO **YES**

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

NO **YES**

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

AND

NO	YES
AGORAPHOBIA, CURRENT	

G. SEPARATION ANXIETY DISORDER

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

---

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) — NO YES

IF YES TO EITHER, CODE YES

Je kwa mda wa mwezi mmoja uliyopita umehisi kuwa na woga kuwa mbali namtu umpendaye?

b Who are you afraid of losing or being away from ________________ ?

Je unawoga wa kumpoteza nani?

---

a Did you get upset a lot when you were away from ______ ?

Je ulikasirika ulipokuwa mbali na? — NO YES

Did you get upset a lot when you <u>thought</u> you would be away from ______ ?

Je ulikasirika ulipodhania utakuwa mbali na?

IF YES TO EITHER, CODE YES

b Did you get really worried that you would lose ______ ?

Je ulikuwa na wasi wasi kuwa utampoteza? — NO YES

Did you get really worried that something bad would happen to ______ ?

(like having a car accident or dying).

Je umekuwa na wasi wasi kuwa kuna kitu kibaya kitafanyika?

IF YES TO EITHER, CODE YES

c Did you get really worried that you would be separated from ______ ? NO YES

(Like getting lost or being kidnapped?)

Je umekuwa na wasi wasi kuwa utatenganishwa na?

d Did you refuse to go to school or other places because you were afraid to be NO YES

away from ______ ?

Je ulikataa kwenda shule ame seheme zingine kwa sababu uliogopa kuengwa na?

e Did you get really afraid being at home if ___ wasn't there?

Je ulikuwa na uwoga kuwa nyumbani bila --------------------------kuwepo? NO YES

f Did you not want to go to sleep unless ______ was there?

Je ulikataa kwenda kulala bila-------------------------kuwpo?

NO YES

g Did you have nightmares about being away from ______ ?

Je ulikumbwa na mazingaombwe ulipo kuwa mbali na-------------------? NO YES

Did this happen more than once?

Je visa hii vimetendeka zaidi ya mara moja

IF NO TO EITHER, CODE **NO**

h Did you feel sick a lot (like headaches, stomach aches, nausea or vomiting, NO YES

heart beating fast or feeling dizzy) when you were away from ______ ?

Je ulijihisi mgonjwa mara kwa mara ulipokuwa mbali na----------------?

Did you feel sick a lot when you <u>thought</u> you were going to be away from ______ ?

Je ulijihisi mgonjwa ulipofikiri utakuwa mbali na---------------------?

IF YES TO EITHER, CODE **YES**

SUMMARY: ARE AT LEAST **3** OF **G2a-h** CODED **YES**? NO YES

G3 Has this persisted for at least 4 weeks?

Je jambo hili liliendelea kwa mda wa wiki nne? NO YES

G4 Did your fears of being away from ______ really bother you a lot?

Je uwoga wa kuwa mbali na --------------------------ilikukera sana?

Cause you a lot of problems at home? At school? With friends? NO YES

In any other way?

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

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

NO
YES
SEPARATION

H. SOCIAL PHOBIA (Social Anxiety Disorder)

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

In the past month, were you afraid or embarrassed when others were watching you? NO YES

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

Je, kwa mda wa mwezi mmoja uliyopita umekuwa mwoga au kuhisi na aibu ulipoangaliwa na mwenzako?

Kama ukiongea mbele ya darasa?

Are you more afraid of these things than other kids your age?

Je una uwoga wa vitu hivi kuliko watoto wenye umri wako? NO YES

Are you so afraid of these things that you try to stay away from them? NO YES

Or you can only do them if someone is with you? Or you do them but it's really hard for you?

Je unajiepusha na mambo haya kwa sababu ya uwoga?

Does this fear really bother you a lot? Does it cause you problems at home or at school? Does this make you afraid to go to school? Does this make you want to be alone?

NO	YES

I. SPECIFIC PHOBIA

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

In the past month, have you been really afraid of something like: snakes or bugs? NO YES

Dogs or other animals? High places? Storms? The dark? Or seeing blood or needles?

Je kwa muda wa mwezi mmoja uliyopita umekuwa na woga na kitu chochote kama vile nyoka

mbwa au wanyama wengine?

List any specific phobia(s): ______________________

Andika vitu unavyo ogopa:

Are you more afraid of __________ than other kids your age are? NO YES

Je una uwoga wa vitu hivi kuliko watoto wenye umri wako?

Are you so afraid of ___________ that you try to stay away from NO YES

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?

e. unaogopa ______________ mpaka unaiepuka? Ama unaweza kuikaribia ukiwa

na mtu mwingine? Ama unaweza kuikaribia lakini ni vigumu kwako?

IF YES TO ANY, CODE YES

Does this fear really bother you a lot? Does it cause you problems at home NO YES

or at school? Does it keep you from doing things you want to do?

Je uwoga huu inakukera sana? Je, unakuletea shida nyumbani au shuleni?

Je. unakuzuia kufanya mamo amabayo ungependa kuyafanya?

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

IS I5 CODED **YES**?

NO	YES

J. OBSESSIVE COMPULSIVE DISORDER

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

	NO	YES
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 you knew you didn't want to? 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?	☐ SKIP TO **J4**	

Katika mwezi uliyopita, je ulishawahi kukerwa na mawazo yenye kujirudiarudia, misukumo, au fikra ambazo hazihitajiki, za maudhi, zisizostahili, zenye kuingilia, au zanye kuleta shida?(mf. Mawazo ya umchafu, umechafuliwa na vijidudu, au hofu ya kuwachafua wengine, au hofu ya kumdhuru mtu hata kama hukutaka kufanya hivyo, au kuhofia kutenda kwa msukumo, au hofu hofu imani za kichawi kwamba ungewajibika kwa mambo mabaya, au shauku yenye mawazo ya ngono, fikra au misukumo, au shauku ya kuhodhi, kukusanya au ya kidini)

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

(Usichanganye na wasiwasi juu ya matatizo halisi ya maisha , usichanganye na shauku zinazoendana moja kwa moja na magonjwa ya kula chakula ,tabia za uasherati, kamari, au pombe au madawa ya kulevya kwa sababu , mgonjwa anaweza kupata starehe kutokana na tendo hilo na kutaka kujizuia kwa sababu tu ya matokeo hasi ya jambo hilo).

Did they keep coming back into your mind even when you tried to ignore or get rid of them? | NO | YES

Je yalizidi kuja hata baada ya wewe kujaribu kuyaepuka?

SKIP TO J4

Do you think that these things come from your own mind and not from outside of your head? | NO | YES

Je unadhani mambo haya yanatoka kwa ubongo wako?

obsessions

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? | NO | YES

compulsions

Katika mwezi uliyopita, je ulifanya kitu kwa kurudiarudia bila kuwa na uwezo wa kujizuia kufanya hivyo, kama vile kuosha au au kusafisha sana, kuhesabu, kukagua vitu mara kwa mara , au kurudia , kukusnya, kupanga vitu, au matambiko mangine ya kishirikina.

IF YES TO ANY, CODE **YES**

IS J3 OR J4 CODED **YES**? | NO | YES

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

Je ulikuwa na mawazo haya zaidi ya watoto umri wako? | NO | YES

Did these thoughts or actions cause you to miss out on things at home?

At school? With friends? Did they cause you problems with other people?

Did these things take more than one hour a day altogether?

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

Je kujawa na mawazo haya au tabia zisizodhibitika kwa kiasi kikubwa kunaingilia zako za kawaida, shughuli za kikazi, kazi za kawaida za kijamii, au mahusiano, au yamechukua

NO	**YES**
	O.C.D.

Did these thoughts or actions cause you to miss out on things at home?

At school? With friends? Did they cause you problems with other people?

Did these things take more than one hour a day altogether?

IF YES TO ANY, CODE YES

Je kujawa na mawazo haya au tabia zisizodhibitika kwa kiasi kikubwa kunaingilia zako za kawaida, shughuli za kikazi, kazi za kawaida za kijamii, au mahusiano, au yamechukua

NO	YES
O.C.D.	

K. POSTTRAUMATIC STRESS DISORDER (optional)

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

Has anything really awful happened to you? Like being in a flood, tornado or earthquake? Like being in a fire or a really bad accident? Like seeing someone get killed or hurt really bad. Like being attacked by someone? NO YES

Je kitu kibaya kimewahi kukutokea, kama vile mafuriko, upepo mkali au mtetemeko wa ardhi? Kama vile kuanguka motoni au kuwa katika ajali mbaya? Kama kuona mtu akiuawa au kuumizwa vibaya? Kama vile kushambuliwa na mtu?

Did you respond with intense fear, feel helpless or horrified? NO YES

Ulihisi uwoga nyingi?

In the past month, has this awful thing come back to you in some way? NO YES

Like dreaming about it or having a strong memory of it or feeling it in your body ?

Katika mwezi mmoja uliopita, jambo hili baya limekurudia kwa njia yoyote ile?

Kama ndoto au kuwa na ukumbusho wake au kulihisi mwilini?

In the past month:

1 Have you avoided thinking about or talking about the event ? NO YES

Je umejaribu kujiepusha na mawazo haya mabaya?

b Have you avoided activities, places or people that remind you of the event? NO YES

Je umejaribu kujiepusha na mambo ambayo itakukumbusha?

c Have you had trouble recalling some important part of what happened? NO YES

Je umekuwa na shida ya kukumbuka mambo muhimu yaliyo fanyika?

d Have you become much less interested in hobbies or social activities? NO YES

Je umekuwa na mvuto hafifu kwa mambo uyapendayo au kazi za kijamii?

e Have you felt detached or estranged from others? NO YES

Je umejihisi kujitenga na wengine?

f Have you noticed that your feelings are numbed? NO YES

Je umegundua hauna hisia zozote kwa vitu?

g Have you felt that your life will be shortened or that you will die sooner than other people? NO YES

Je umehisi maisha yako yatakuwa mafupi kuliko ya w engine?

SUMMARY OF K4: ARE 3 OR MORE **K4** ANSWERS CODED **YES**? NO YES

In the past month:

Katika mwezi uliopita:

a Have you had difficulty sleeping? NO YES

Je umekuwa na shida ya kulala

b Were you especially irritable or did you have outbursts of anger? NO YES

Je umekuwa na hasira bila sababu?

c Have you had difficulty concentrating? NO YES

Je umekuwa na shida ya kuzingatia vitu maanani?

d Were you nervous or constantly on your guard? NO YES

Je ulikuwa na wasi wasi?

e Were you easily startled? NO YES

Je utaruka ukiyasikia makelele?

IF YES TO EITHER, CODE **YES**

SUMMARY OF K5: ARE **2** OR MORE **K5** ANSWERS CODED **YES**? NO YES

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?

Katika mwezi uliopita, je matatizo haya kwa kiasi kikubwa yalivuruga utendaji wa

NO	**YES**
PTSD	

L. ALCOHOL ABUSE AND DEPENDENCE

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

In the past year, have you had 3 or more drinks of alcohol in a day? NO YES

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?

Katika miezi 12 iliyopita, ulishawahi kuwa na vinywaji vitatu au zaidi vya pombe ndani ya kipindi cha masaa matatu katika matukio matatu au zaidi

IF NO TO ANY, CODE **NO**

In the past year

In the past 12 months:

Katika miezi 12 iliyopita:

a Did you need to drink more in order to get the same effect that you got when you first started drinking? NO YES

Je ulikunywa pombe nyingi ili upate hisia ya kwanza ulipoanza kunywa pombe?

b When you cut down on drinking, did your hands shake, did you sweat or feel agitated? NO YES

Did you drink to avoid these symptoms or to avoid being hungover, for example, "the shakes", sweating or agitation? If **YES** to either question, code **YES**.

Je, wakati ulipoacha kunywa mikono yako ilitetemeka ulitokwa na jasho, au kujisikia wasiwasi?

Je, ulikunywa ili kuondoa dalili hizi au kuepuka kuwa mchovu, mfano mtetemeko, kutokwa na jasho au wasiwasi?

c During the times when you drank alcohol, did you end up drinking more than you planned when you started? NO YES

Wakati ambapo umelewa pombe, je uliishia kunywa zaidi kuliko ulivyopanga mwanzoni?

d Have you tried to reduce or stop drinking alcohol but failed? NO YES

Je umejaribu kuwacha kunywa pombe ukashindwa?

e On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovering from the effects of alcohol? NO YES

Katika siku ambazo umelewa, je ulipoteza muda mwingi kupata pombe, kunywa au kupata nafuu kutoka katika athari za pombe?

f Did you spend less time working, enjoying hobbies, or being with others because of your drinking? NO YES

Je ulitumia muda mchache kufanya kazi kufurahia uvipendavyo au kuwa na wenzako kwa sababu ya ulevi wako?

g Have you continued to drink even though you knew that the drinking caused you health or mental problems? NO YES

Je uliendelea kulewa japo kuwa ulifahamu kuwa ulevi ulikusababishia matatizo ya kiafya na kiakili?

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

NO
YES*

* IF YES, SKIP L3 QUESTIONS, CIRCLE N/A IN THE ABUSE BOX AND

In the past year:

In the past 12 months:

Katika miezi 12 iliyopita:

a Have you been drunk or hung-over more than once when you had something important NO YES

to do, like schoolwork or responsibilities at home? Did this cause any problems?

Je umekuwa ukilewa hata wakati una mambo muhimu ya kufanya?kama kazi yashule au nyumbani ? ilikuletea shida?

CODE **YES** ONLY IF THIS CAUSED PROBLEMS

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

Je umelewa zaidi ya mara moja ukifanya mambo hatari kama kuendesha gari, kuendesha pikipiki, kutumia mashine?

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

Je umekuwa na shida na serikali sababu ya ulevi?

d Did you continue to drink even though your drinking caused problems with your family or other people? NO YES

Je umekuwa ukiendelea na ulevi hata baada ya kuwa na shida na jamii yako, wazazi ?

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

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

NO **N/A**
YES

M. NON-ALCOHOL PSYCHOACTIVE SUBSTANCE USE DISORDERS

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

a Now I am going to read you a list of street drugs or medicines. **NO** **YES**

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?

Je kwa mda wa mwaka mmoja umekunywa au kumeza dawa yeyote kwa mara zaidi ya mmoja ili ulewe?

CIRCLE EACH DRUG TAKEN:

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

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

Narcotics: heroin, morphine, Dilaudid, opium, Demerol, methadone, codeine, Percodan, Darvon, 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, nonprescription sleep or diet pills. Any others?

Specify **MOST USED Drug(s):** ______________________________

CHECK ONE BOX

ONLY ONE DRUG / DRUG CLASS HAS BEEN USED ☐

KILA KUNDI LA DAWA KUTUMIKA PEKE YAKE

ONLY THE MOST USED DRUG CLASS IS INVESTIGATED.

KUNDI LA DAWA LINALOTUMIKA ZAIDI TU

EACH DRUG CLASS USED IS EXAMINED SEPARATELY (PHOTOCOPY M2 AND M3 AS NEEDED)

NI DAWA MOJA TU / KUNDI LA DAWA IMETUMIKA

b SPECIFY WHICH DRUG/DRUG CLASS WILL BE EXPLORED IN THE INTERVIEW BELOW IF THERE IS CONCURRENT OR SEQUENTIAL POLYSUBSTANCE USE:______________________

ELEZA DAWA / MADAWA UTUMIAYO ZAIDI

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

Fikiria matumizi yako ya madawa (TAJA JINA LA DAWA / KUNDI LA DAWA LILILOCHAGULIWA). katika miezi 12 iliyopita:

a Did you need to take more of the drug to get the same feeling you got when you first started taking it? — NO YES

Je, uliona kwamba unahitaji kutumia zaidi ili kupata athari sawa na ile ulipotumia mara ya kwanza?

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? — NO YES

Wakati ulipopunguza au kutotumia Je, ulipatwa na dalili zinazotokana na kuacha madawa?

(Maumivu, kutetemeka, homa, udhaifu, kuharisha, kichefuchefu, kutokwa jacho, moyo kudunda, tabu ya usingizi, kujisikia wasiwasi, dukuduku, mwenye kuudhika upesi, au mwenye huzuni).

Je ulitumia dawa/madawa yeyote ili kukufanya usiumwe (dalili za kuacha dawa) au kukufanya ujisikie vizuri zaidi?

IKIWA JIBU NI **NDIYO** KWA SWALI LOLOTE, JAZA **NDIYO**

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

c When you used (NAME THE DRUG/DRUG CLASS SELECTED), did you end up taking more than you had planned to? NO YES

Je, mara kwa mara ulijiona kwamba wakati unatumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), uliishia kutumia nyingi zaidi kuliko uwezo wako?

d Have you tried to reduce or stop taking (name of drug / drug class selected), but failed? NO YES

Je, ulijaribu kupunguza/kuacha kutumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA) lakini ukashindwa?

e On the days that you used (name of drug / drug class selected), did you spend substantial time (> 2 hours) in obtaining, using or in recovering from drug(s), or thinking about drug(s)? NO YES

Katika siku ambazo ulitumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA) Je, ulipoteza muda mwingi (> masaa 2) kupata, kutumia au kupata nafuu kutoka katika madawa au kufikiria juu ya madawa?

f Did you spend less time working, enjoying hobbies, or being with family or friends because of your drug use? NO YES

Je, ulitumia muda mchache kufanya kazi, kufurahia uvipendavyo, au kuwa na familia yako au marafiki kwa sababu ya kutumia kwako madawa?

g Have you continued to use (name of drug / drug class selected) even though it caused you health or mental problems? NO YES

Wakati ulipopunguza au kutotumia Je, ulipatwa na dalili zinazotokana na kuacha madawa? (Maumivu, kutetemeka, homa, udhaifu, kuharisha, kichefuchefu, kutokwa jacho, moyo kudunda, tabu ya usingizi, kujisikia wasiwasi, dukuduku, mwenye kuudhika upesi, au mwenye huzuni).

Je ulitumia dawa/madawa yeyote ili kukufanya usiumwe (dalili za kuacha dawa) au kukufanya ujisikie vizuri zaidi?

IKIWA JIBU NI **NDIYO** KWA SWALI LOLOTE, JAZA **NDIYO**

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

c When you used (NAME THE DRUG/DRUG CLASS SELECTED), did you end up taking more than you had planned to? NO YES

Je mara kwa mara ulijiona kwamba wakati unatumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), uliishia kutumia nyingi zaidi kuliko uwezo wako?

d Have you tried to reduce or stop taking (name of drug / drug class selected), but failed? NO YES

Je, ulijaribu kupunguza/kuacha kutumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA) lakini ukashindwa?

e On the days that you used (name of drug / drug class selected), did you spend substantial time (> 2 hours) in obtaining, using or in recovering from drug(s), or thinking about drug(s)? NO YES

Katika siku ambazo ulitumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA) Je, ulipoteza muda mwingi (> masaa 2) kupata, kutumia au kupata nafuu kutoka katika madawa au kufikiria juu ya madawa?

f Did you spend less time working, enjoying hobbies, or being with family or friends because of your drug use? NO YES

Je ulitumia muda mchache kufanya kazi, kufurahia uvipendavyo, au kuwa na familia yako au marafiki kwa sababu ya kutumia kwako madawa?

g Have you continued to use (name of drug / drug class selected) even though it caused you health or mental problems? NO YES

Je, uliendelea kutumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), japokuwa ilikusababishia matatizo ya kiafya na kiakili?

ARE 3 OR MORE M2 ANSWERS CODED YES?

SPECIFY DRUG(S): ______________________________

NO	YES*
SUBSTANCE DEPENDENCE	

[illegible] about your use of (NAME THE DRUG/DRUG CLASS SELECTED) over the last year:

In the past year:

Katika miezi 12 iliyopita:

[illegible] a [illegible] you been high or hungover 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

Je, umewahi kurukwa akili, kuwa na hali ya juu, au kuwa na uchovu wa dawa, zaidi ya

mara moja, wakati ambapo ulikuwa na majukumu mengine shuleni, kazini au nyumbani?

Je hili lilileta matatizo yeyote?

(JAZA NDIYO IKIWA TU HILI LILILETA MATATIZO)

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

Je, umewahi kujisikia na hali ya juu au kurukwa akili kutokana na katika mazingira yeyote ambapo ulikuwa hatarini (mfano, kuendesha gari, kuendesha pikipiki, kutumia machine, kusafiri kwa mashua, nk).

c Have you had 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

Je, ulipata matatizo yeyote ya kisheria kwa sababu ya matumizi ya madawa mf. Kutiwa mbaroni au kufanya vurugu.

d Have you kept using the (NAME THE DRUG/DRUG CLASS SELECTED) even though it caused problems with your family? With other people? NO YES

Je uliendelea kutumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA). ingawa ilisababisha matatizo kwa familia yako au watu wengine

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

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

NO	N/A	YES

SPECIFY DRUG(S): ______________________________

N. TIC DISORDERS

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

---

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

Katika mwezi uliopita, umekuwa na mitetemeko ya kasi katika sehemu Fulani za mwili ambayo ni vigumu kuihimili? Inaweza kuwa kupepesa jicho tena na tena, shtuko la uso, mkutuo wa kichwa ama kufanya rusha rusha mikono.

b Have you ever had a tic that made you say something or make a sound over and over and it was hard to stop it? 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? NO YES

Umewahi kuwa na mtetemeko uliokufanya utoe sauti tena na tena ambayo haukuweza simamisha kama kukohoa na kutoa kikohozi bila kuwa na homa au kurudia maneno. maneno machafu au kurudia sauti au maneno yaliyosemwa na wengine?

IF BOTH N1A AND N1B ARE CODED NO,

CIRCLE NO IN ALL DIAGNOSTIC BOXES AND SKIP TO O1

a Did these "tics" happen many times a day? NO YES

Je, mitetemeko hii hufanyika mara ngapi wa siku?

b Did they happen nearly every day for at least 4 weeks? NO YES

N. TIC DISORDERS

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

---

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

Katika mwezi uliopita, umekuwa na mitetemeko ya kasi katika sehemu Fulani za mwili ambayo ni vigumu kuihimili? Inaweza kuwa kupepesa jicho tena na tena, shtuko la uso, mkutuo wa kichwa ama kufanya rusha rusha mikono.

b Have you ever had a tic that made you say something or make a sound over and over and it was hard to stop it? 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? — NOYES

Umewahi kuwa na mtetemeko uliokufanya utoe sauti tena na tena ambayo haukuweza isimamisha kama kukohoa na kutoa kikohozi bila kuwa na homa au kurudia maneno, maneno machafu au kurudia sauti au maneno yaliyosemwa na wengine?

IF BOTH **N1A** AND **N1B** ARE CODED **NO**,

CIRCLE **NO** IN ALL DIAGNOSTIC BOXES AND SKIP TO **O1**

a Did these "tics" happen many times a day? NO — YES

Je, mitetemeko hii hufanyika mara ngapi wa siku?

b Did they happen nearly every day for at least 4 weeks? — NOYES

Je, ilifanyika karibu kila siku kwa angalau wiki nne?

c Did they happen for a year or more? NO YES

Je, imefanyika kwa mwaka mmoja au zaidi?

d Did they ever go away completely for 3 months in a row during this time? NO YES

Je, iliwahi kupotea kwa miezi mitatu ikifuatana?

Did these "tics" upset you a lot? Did they get in the way of school? NO YES

Did they cause you problems at home? Did they cause you problems

with friends? Did other kids pick on you because of your tics?

Je, mitetemeko hii ilikusumbua sana? Je, ilikutatiza shuleni? Je, ilikuletea

shida nyumbani?

Je, ilikuletea shida na marafiki? Je, ulisumbuliwa na watoto wengine kwa

sababu ya mitetemeko hii?

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

Did the tics only occur when you are taking Ritalin, Adderal, Cylert, Dexedrine,

Provigil, Concerta or other medications for ADHD ? NO YES

Je, mitetemeko hii ilitokea ulipokuwa ukitumia aidha Ritalin, Addera, Cylert, Dexedrine

Provigil, Concerta au dawa nyingine za ADHD?

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

NO **YES**

TOURETTE'S DISORDER

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

NO **YES**

MOTOR TIC

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

NO **YES**

VOCAL TIC

ARE **N1 (a or b)** AND **N2a** AND **N2b** AND **N3** CODED **YES**, AND **N2c** CODED

NO	YES
	TRANSIENT TIC

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)

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

Je, kuna mtu wowote(mwalimu wako,rafiki ama mzazi) hajafurahia tabia yako?

IF NO TO THIS QUESTION, ALSO CODE NO TO CONDUCT DISORDER AND OPPOSITIONAL DEFIANT DISORDER?

In the past six months:

O1 a Failed to pay attention to details or made careless mistakes in school, work or other activities? NO YES

Je umekuwa na shida ya kuzingatia itu maanani mara kwa mara ?

b Had difficulty paying attention when playing or doing some work? NO YES

Je umekuwa na shida ya kuzingatia maadili yako wakati unacheza au unao fanya kazi zako za nyumbani

c Seemed not to listen when spoken to directly? NO YES

Je umeambiwa mara kwa mara kuwa huwasikii wenzako wanapo kuongelesha

d Not followed instructions, or failed to finish schoolwork or chores (even though you understood the instructions and weren't trying to be difficult)? NO YES

Kutofuata maagiza, au kukosa kumaliza kazi ya ziada au kazi za nyumbani (ingawa ulikuwa umeelewa maagizo na haukuwa unataka kuwa mkaidi)?

e Had difficulty getting organized? NO YES

Je umekua na mda mgumu kujipanga

f Avoided or disliked things that require a lot of thinking (like schoolwork or homework)? NO YES

umekuwa ukijiepusha na v itu ambavyo vinahitaji uyafkirie sana

g Lost things you needed? NO YES

Je mara kwa mara umepoteza au kusahau vitu ambavyo umekuwa ukuhitaji

h Become easily distracted by little things? **NO YES**

Je wewe husumbuliwa na vitu vidogo kwa haraka

i Become forgetful in your day to day activities? or doing schoolwork NO YES

Je mara kwa mara umepoteza au kusahau vitu ambavyo umekuwa ukivihitaji

SUMMARY: ARE 6 OR MORE **O2** ANSWERS CODED **YES?** NO YES

In the past six months:

In the past 6 months have you often:

Miezi sita iliyopita:

Squirmed in your seat or fidgeted with your hands or feet NO YES

Je umekuwa ukitetemeka mikono au miguu mara kwa mara

Left your seat in class when you were not supposed to? NO YES

Je umekuwa ukisimama darasani wakati ambapo haustahili

Run around and climbed a lot when you shouldn't or others didn't want you to? NO YES

Je. umekuwa ukikimbia na kupanda juu wakati usiofaa au usipokubaliwa na wengine?

d Had difficulty playing quietly? NO YES

Je umekuwa na wqakati mgumu kucheza pole pole?

e Felt like you were "driven by a motor" or were always "on the go"? NO YES

Ulihisi ni kama "unaendeshwa na mtambo" ama ni kama kila wakati uko mbioni?

f Talked too much? NO YES

Je umekuwa ukizungumza sana?

g Blurted out an answer before the question was completed? NO YES

Je umekuwa ukiwakatiza watu au mwalimu kabla hawajamaliza kuuliza maswali?

h Had difficulty waiting your turn? NO YES

Je umekuwa na shida kungoja mda wako

Interrupted or intruded on others? NO YES

Je umekuwa ukiwakatiza wakiwa wanazungumza?

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

O3 SUMMARY: ARE **6** OR MORE **O3** ANSWERS CODED **YES?** NO YES

Did you have problems paying attention, being hyper, or impulsive before you were 7 years old? NO YES

Je, uko na shida ya kuwa makini, kuwa na pupa kabla hujafika miaka 7?

Did these things cause you problems at school? At home? With your family? With your friends? NO YES

Je, mambo haya yalikuletea shida shuleni? Nyumbani? Katika Jamii? Na marafiki?

CODE **YES** IF TWO OR MORE ARE ENDORSED YES

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

NO	**YES**
	Attention Deficit/

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

NO	**YES**
	Attention Deficit/

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

NO	**YES**
	Attention Deficit/

P. CONDUCT DISORDER

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

SCREENING QUESTION

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?) NO YES

(Je, kuna mtu wowote (mwalimu wako,rafiki ama mzazi) hajafurahia tabia yako?)

In the past 12 months have you:

bullied, threatened or intimidated others NO YES

Je, umewatishia wengine

started fights NO YES

Je, umeanzisha vita?

used a weapon that could harm someone (for example, knife, gun, bat, broken bottle) NO YES

Je. umetumia silaha kuumiza mtu

d deliberately hurt people NO YES

je. umeumiza watu ukitaka

e deliberately hurt animals NO YES

Je umemuumiza mnyama ukitaka?

f stolen things using force (for example, armed robbery, mugging, purse snatching, extortion) NO YES

kuiba vitu kwa kutumia nguvu (kwa mfano wizi wa mabavu, ngeta, kunyang'anya, kuhadaa)

g forced anyone to have sex with you NO YES

Je umelazimisha mtu kufanya mapenzi

h deliberately started fires to damage property NO YES

kuanzisha moto kimaksudi ili kuharibu mali

i deliberately destroyed things belonging to others NO YES

Je umeharibu vitu vya wenyewe na sababu?

j broken into someone's house or car NO YES

Je umemwibia mtukwa nyamba au gari lake?

k lied repeatedly to get things or "conned" (tricked) other people NO YES

kudanganya mara kwa mara ili kupata vitu au kutapeli watu wengine

l stolen things | NO | YES

umewahi kuiba

m stayed out late at night in spite of your parents forbidding you, starting before age 13 years | NO | YES

kukaa nje usiku bila ruhusa ya wazazi, kabla ya kufika miaka 13

n run away from home at least twice | NO | YES

kutoroka nyumbani mara mbili au zaidi

o often skipped school, starting before age 13 years | NO | YES

kutokwenda shuleni, kabla ya miaka 13

IF NO TO EITHER, CODE **NO**

P2 SUMMARY: ARE 3 OR MORE **P2** ANSWERS CODED **YES** WITH AT LEAST ONE PRESENT IN THE PAST 6 MONTHS? | NO | YES

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

Je tabia hizi zilisababisha shida kubwa shuleni? Nyumbani?

NO	**YES**

Q. OPPOSITIONAL DEFIANT DISORDER

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

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

SCREENING QUESTION

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 behaviour?) NO YES

(Je, kuna mtu wowote(mwalimu wako,rafiki ama mzazi) hajafurahia tabia yako?)

IF YES TO EITHER, CODE YES

In the past six months:

a Have you often lost your temper? NO YES

Je umeshikwa na hasira mara kwa mara?

b Have you often argued with adults? NO YES

Je umegombana na watu wazima mara kwa mara?

c Have you often refused to do what adults tell you to do? Refused to follow rules? NO YES

Je umekataa kuwatii wakubwa wako? kukataa kufuata sheria?

d Have you often annoyed people on purpose? NO YES

Je umewakasirisha watu na sababu?

e Have you often blamed other people for your mistakes or for your bad behavior? NO YES

Je umewalaumu wenzako kwa shida zako?

f Have you often been "touchy" or easily annoyed by other people? NO YES

Je umekasirishwa na watu kwa haraka?

g Have you often been angry and resentful toward others? NO YES

Je umekuwa na hasira kwa wenzako Kelo nigoro?

h Have you often been "spiteful" or quick to "pay back" somebody who treats you wrong? NO YES

Je. umekuwa na kinyongo au kutaka kulipiza kisasi kwa mtu anayekufanyia mabaya?

Q2 SUMMARY: ARE **4** OR MORE OF **Q2** ANSWERS CODED **YES**? NO YES

3 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	

R. PSYCHOTIC DISORDERS AND MOOD DISORDERS WITH PSYCHOTIC FEATURES

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

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.

ULIZA MFANO KWA KILA SWALI LINAJIBIWA NDIYO. JAZA NDIO IWAPO TU MIFANO INAONYESHA WAZI MABADILIKO YA MAWAZO AU UTAMBUZI AU KAMA HAIHUSIANI NA MILA NA DESTURI KABLA YA KUJAZA CHUNGUZA IWAPO IMANI ZA UWONGO ZINA SIFA ZA KUWA SI ZA KAWAIDA.

IMANI POTOFU AMBAZO "SI ZA KAWAIDA" KAMA: ISIYOWEZEKANA KUWA KWELI, UPUUZI, ISIYOELEWEKA, NA ISIYOTOKANA NA MAISHA YA KAWAIDA.

SAUTI POTOFU AMBAZO "SI ZA KAWAIDA" NI KAMA: SAUTI KUELEZEA JUU YA MAWAZO YA MTU AU TABIA, AU WAKATI SAUTI 2 AU ZAIDI ZINAZUNGUMZA ZENYEWE.

		BIZARRE
Now I am going to ask you about unusual experiences that some people have.		
Sasa ninakuuliza kuhusu matukio yasiyo ya kawaida ambayo watu wanapata.		
R1 a Have you ever believed that people were secretly watching you?	NO YES	
Have you believed that someone was trying to get you, or hurt you?		
Je, umewahi kuamini kwamba watu wanakupeleleza, au kwamba mtu anapanga njama juu yako, au kujaribu kukudhuru?		
IF YES TO ANY, CODE YES	NO YES	

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? Je, umewahi kuamini kwamba mtu alikuwa anasoma mawazo yako au kuweza kusikia mawazo yako, au kwamba wewe kuweza kusoma mawazo ya mtumwingine au kusikia kile anachowaza mtu mwingine?	NO	YES	YES
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? Je , umewahi kuamini kwamba mtu au nguvu Fulani kutoka nje zimeweka mawazo ndani yako na kwamba umekuwa siyo wewe mwenyewe, au imekufanya utende matendo ambapo haikuwa kawaida yako?	NO	YES	YES
a Have you ever believed that you were being sent special messages through the TV or radio? Through your toys? Je, umewahi kuamini kwamba umekuwa ukipokea ujumbe maalum kupitia TV, redio, au magazeti, au kwamba mtu usiyemjua akawa amevutiwa na wewe? IF YES TO ANY CODE YES			YES
a Have your family or friends ever thought that any of your beliefs were strange or weird? Please give me an example. Je, ndugu zako au marafiki walishawahi kuona kwamba imani zako ni za ajabu au si za kawaida? Tafadhali, naomba mifano.	NO	YES	YES
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 DESTITUTION, ETC.	NO	YES	YES

Have you ever heard things other people couldn't hear, such as voices?

[HALLUCINATIONS ARE SCORED "BIZARRE" ONLY IF PATIENT ANSWERS YES TO THE FOLLOWING]:

Je umewahi kusikia mambo ambayo wengine hawasikii, kama vile sauti?

HISIA POTOFU ZINAKUWA "SI ZA KAWAIDA" IKIWA TU MGONJWA ANAJIBU NDIYO KATIKA SWALI LIFUATALO: YES

YES

R8b

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

Je, umewahi kuwa na ndoto wakati yu macho au kuona vitu ambapo watu wengine hawavioni?

NOTE CHECK TO SEE IF THESE ARE CULTURALLY INAPPROPRIATE

IF YES: Have you seen these things in the past month?

Je umeona mambo haya kwa mwezi mmoja uliyopita? NO YES

...ICIAN'S JUDGMENT

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

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

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

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?

NO	**YES**
MOOD DISORDER WITH PSYCHOTIC FEATURES	

R12 a 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**?

NO	YES
MOOD DISORDER WITH PSYCHOTIC FEATURES	

R13 ARE 1 OR MORE « b » QUESTIONS CODED **YES BIZARRE**?

OR

ARE 2 OR MORE « b » QUESTIONS CODED **YES** (RATHER THAN **YES BIZARRE**)?

NO	YES
PSYCHOTIC DISORDER **CURRENT**	

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

OR

ARE 1 OR MORE « a » QUESTIONS FROM R1a TO R7a, 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 TIME 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)

---

a How tall are you? O ft OO in.

Una urefu kiasi gani?

b. What was your lowest weight in the past 3 months? O O O lbs.

Ni uzito upi mdogo kuliko wote katika miezi mitatu iliyopita.

c IS PATIENT'S WEIGHT EQUAL TO OR BELOW THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT? (SEE TABLE BELOW) (THIS IS = A BMI OF $\leq$ 17.5 KG/M^2) NO YES

JE, UZITO WA MGONJWA NI MDOGO KULIKO KIWANGO KINACHOLINGANA NA UREFU WAKE? (ANGALIA JEDWALI CHINI)

d Have you lost 5 lbs. or more (2.3 kgs. or more) in the last 3 months? NO YES

Je, umepunguza uzito kwa pauni 5 au zaidi (kilo 2.3 au zaidi) katika miezi mitatu iliyopita?

e If you are less than age 14, have you failed to gain any weight in the last 3 months? NO YES

If over 14, code NO.

Kama una umri wa chini ya miaka 14, umekosa kuongeza uzito katika miezi mitatu iliyopita?

f Has anyone thought that you lost too much weight in the last 3 months? NO YES

Je, kuna mtu yeyote aliyedhani kuwa umepunguza uzito kupita kiasi katika miezi mitatu iliyopita?

IF YES TO S1c OR d OR e OR f, CODE YES, OTHERWISE CODE NO. NO YES

In the past 3 months:

Amaa tiatua ilapaitin okuna ootulusoitie:

Have you been trying to keep yourself from gaining any weight?

Je umekuwa ukijiepusha kunenepa? NO YES

Have you been very afraid of gaining weight? Have you been very afraid of getting fat?

Je, ulihofia kuongezeka uzito au kuwa mnene hata kama ulikuwa na uzito mdogo? NO YES

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

a Have you seen yourself as being too big / fat or that part of your body was too big / fat?

Je ulijiona wewe mwenyewe mnene, au sehemu ya mwili wako nene sana? NO YES

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

b Has your weight strongly affected how you feel about yourself? Has your body shape strongly affected how you feel about yourself? NO YES

Je, uzito wa mwili wako au umbile umeathiri kwa kiasi kikubwa jinsi unavyojiona?

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

c Did you think that your low weight was normal or overweight ?

Je, ulifikiria kwamba uzito wako mdogo wa sasa ni kawaida au umezidi? NO YES

ARE 1 OR **MORE S4** ANSWERS CODED **YES**? NO YES

)R POST PUBERTAL **FEMALES** ONLY: During the last 3 months, did you miss all ur menstrual periods when they were expected to occur (when you were not pregnant)? NO YES

'UAK AKE:Ama too lpaitin o kuni otulusoitie itala ake osarge lo lapa terishata naishakino neponu {ake taa minuta}

)R GIRLS : ARE **S5** AND **S6** CODED YES?

NO **YES**

:IGHT / WEIGHT TABLE CORRESPONDING TO A BMI THRESHOLD OF 17.5 KG/M²

ght												
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
34	36	38	40	42	44	46	48	50	53	55	57	60
94	97	99	102	104	107	109	112	114	117	119	122	125
15	16	17	18	19	20	21	22	23	24	25	26	27
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
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
kgs	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
lbs.	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
kgs	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:

Did you have eating binges? An "eating binge" is when you eat a very large amount of food within two hours. NO YES

je uliwahi kula kupita kiasi au wakati ambapo umekula chakula kingi sana ndani ya masaa mawili?

Did you have eating binges two times a week or more? NO YES

je umewahi kula kupita kiasi kila mara, mara 2 kwa wiki?

T3 During these binges, did you feel that your eating was out of control?

Katika milo hii, ulijisikia kwamba kula kwako ni kwa kushindwa kujitawala? NO YES

T4 Did you do anything to compensate for, or to prevent a weight gain from these binges, like vomiting, fasting, exercising or taking laxatives, enemas, diuretics (fluid pills), or other medications? NO YES

Je ulifanya kitu chochote kufidia, au kuzuia kuongezeka uzito kutokana na milo hii, kama vile kutapika, kushinda na njaa, kufanya mazoezi, kumeza dawa za kuharisha, enema, kuongeza mkojo au dawa nyinginezo?

IF YES TO ANY, CODE YES

Does your body weight or shape greatly influence how you feel about yourself? NO YES

Je uzito wako au umbile lako linaathiri kwa kiasi kikubwa jinsi unavyojiona?

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

DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA? NO YES

☐

Skip to O8

Do these binges occur only when you are under (_____lbs./kgs.)? NO YES

Je, milo hii ya kupita kiasi hutokea pale tu una uzito chini ya kilo ______ ?

ANDIKA KIWANGO CHA UZITO KINACHOLINGANA NA UREFU WA MGONJWA KUTOKA KATIKA JEDWALILILILOPO KWENYE KIHUNZI CHA UGONJWA WA KUTOKULA

INTERVIEWER: WRITE IN THE ABOVE ( ), THE THRESHOLD WEIGHT

FOR THIS PATIENT'S HEIGHT FROM THE HEIGHT/WEIGHT TABLE IN

THE ANOREXIA NERVOSA MODULE

IS T5 CODED **YES** AND IS EITHER **T6** OR **T7** CODED **NO**?

NO **YES**

IS T7 CODED **YES**?

NO **YES**

ANOREXIA NERVOSA

U. GENERALIZED ANXIETY DISORDER

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

SKIP THIS DISORDER IF THE PATIENT'S ANXIETY IS RESTRICTED TO OR BETTER EXPLANINED BY ANY DISORDER PRIOR TO THIS POINT

a **For the past six months**, have you worried a lot or been nervous? NO YES

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**

JE, ulikuwa na woga sana au kupata wasi wasi juu ya mambo mawili au zaidi

(m.f shule, afya ama kitu inatendeka sasa)

Je umekuwa nauoga kuliko watoto wengine umri sawa na wewe?

b Do you worry most days?

Je woga huu unakuwepo karibu siku zote? NO YES

IS THE PATIENT'S ANXIETY RESTRICTED EXCLUSIVELY TO,

OR BETTER EXPLAINED BY, ANY DISORDER PRIOR TO THIS POINT? NO YES

Do you find it hard to stop worrying? Do the worries make it hard for NO YES

you to pay attention to what you are doing?

Je uwa na hisi ni ngumu kukosa kuwa na wasiwasi? Na wasiwasi yako inakufanya

usifanye kazi kwa makini?

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

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:

Waakati ulipokuwa na wasiwasi katika miezi 6 iliyopita, je, muda mwingi:

Feel like you can't sit still?

Huwezi keti ukiwa mtulivu? NO YES

b Feel tense?

Umejaa wasiwasi? NO YES

c Feel tired, weak or exhausted easily?

Unahisi mchovu? NO YES

d Have a hard time paying attention to what you are doing? Does your mind go blank? NO YES

umekuwa na wakati mugumu wa kusikiza au kuwa makini kwa chochote ufanyalo?

Kuna wakati una hisi huwezi kufikiria tena?

e Feel grouchy or annoyed?

-Unahisi mwenye hasira? NO YES

f Have trouble sleeping almost every night ("trouble sleeping" NO YES

means trouble falling asleep, waking up in the middle of the night,

wakening up too early or sleeping too much)?

Ulipata tabu ya usingizi (tabu ya kupata usingizi, kuamka katikati ya usiku, kuamka mapema

asubuhi, au kulala mno)?

ARE **3** OR MORE **U3** ANSWERS CODED **YES**?

NO	**YES**
GENERALIZED ANXIETY DISORDER	

V. ADJUSTMENT DISORDERS

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

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. 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

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

Are you stressed out about something? Is it making you upset or making your behavior worse? NO YES

Je kuna jambo ambalo limekukasirisha?

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]. [kipigana, kuwa na mafikira, kukosa shule kufanya itu kinye cha matarajio,kuendesha gari vibaya na kupiga makelele?

IDENTIFIED STRESSOR: ______________________

DATE OF ONSET OF STRESSOR: ______________________

Did your upset/behavior problems start soon after the stress began? NO YES

[Within 3 months of the onset of the stressor]

Je hii shida ilianza tu punde tu wakati ulianza kuwa na mafikira?

V7 a Are you more upset by this stress than other kids your age would be?

Je mambo hayo yanakukera zaidi kuliko wenzako? NO YES

b Are these problems causing you to have trouble in school? NO YES

Trouble at home? Trouble with your family or with your friends?

Je hii shida ina kusumbua shuleni

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

V8 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

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

Je hii shida imekuwa wepo kwa muda wa miezi sita au zaidi wakati mafikira yalianza?

HAS UNCOMPLICATED BEREAVEMENT BEEN RULED OUT? NO YES

Mark all that apply

A Depression, tearfulness or hopelessness. ☐

upweke

B Anxiety, nervousness, jitteriness, worry. ☐

wasiwasi

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 IS** CODED **NO**, THEN CODE DISORDER **YES** WITH **SUBTYPES**.

NO	**YES**
Adjustment Disorder	

W. PERVASIVE DEVELOPMENT DISORDER

Since the age of 4, have you had difficulty making friends? NO YES UNSURE

Do you have problems because you keep to yourself?

Je tangu ukiwa miaka nne imekua ngumu kupata marafiki?

Je unapata shida sana kwasababu ya kiweka siri?

Is it because you are shy or because you don't fit in?

Je ni kwasababu una haya au kwasababu hawa kufai?

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

Are you fixated on routines and rituals or do you have interests that are NO YES UNSURE

special and intrude on other activities?

Je kuna vitu ambavyo una mpenda kuyafanya kuliko mengine?

Do other kids think you are weird or strange or awkward? NO YES UNSURE

Je watoto wengine wanakuona ukiwa tafauti?

Do you play mostly alone, rather than with other children? NO YES UNSURE

Je unapenda kucheza peke yako kuliko ukiwa na wengine?

W5 ARE ALL W ANSWERS CODED YES? IF SO, CODE YES.

IF ANY W ANSWERS ARE CODED UNSURE, CODE UNSURE.

OTHERWISE CODE NO.

NO	UNSURE	YES *

PERVASIVE DEVELOPMENT

* 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

Acknowledgments:
We would like to thank Mary Newman, Berney Wilkinson, and Marie Salmon for their help and suggestions.

We are grateful to Pauline Powers MD and Yvonne Bannon RN for their valuable assistance in improving the Anorexia Nervosa module.

REFERENCES

Sheehan DV, Lecrubier Y, Harnett-Sheehan K, Janavs J, Weiller E, Bonara I, Keskiner A, Schinka J, Knapp E, Sheehan MF, Dunbar GC. Reliability and Validity of the MINI International Neuropsychiatric Interview (M.I.N.I.): According to the SCID-P. European Psychiatry. 1997; 12:232-241.

Lecrubier Y, Sheehan D, Weiller E, Amorim P, Bonora I, Sheehan K, Janavs J, Dunbar G. The MINI International Neuropsychiatric Interview (M.I.N.I.) A Short Diagnostic Structured Interview: Reliability and Validity According to the CIDI. European Psychiatry. 1997; 12: 224-231.

Sheehan DV, Lecrubier Y, Harnett-Sheehan K, Amorim P, Janavs J, Weiller E, Hergueta T, Baker R, Dunbar G: The Mini International Neuropsychiatric Interview (M.I.N.I.): The Development and Validation of a Structured Diagnostic Psychiatric Interview. J. Clin Psychiatry, 1998;59(suppl 20):22-33.

Amorim P, Lecrubier Y, Weiller E, Hergueta T, Sheehan D: DSM-III-R Psychotic Disorders: procedural validity of the Mini International Neuropsychiatric Interview (M.I.N.I.). Concordance and causes for discordance with the CIDI. European Psychiatry. 1998; 13:26-34.

International Advisory Committee for MINI Kid version 2.0

Manuel Bouvard
Lars von Knorring
Naomi Breslau
Martine Flament
Donald Klein
Rachel Gittelman Klein
Phillipe Mazet
Marie Christine Mouren-Simeoni
Stephan Renou
Frank Verhulst
Lars von Knorring
Anne-Liis von Knorring

Translations

M.I.N.I. KID

D. Sheehan, D. Shytle, K.Milo, J.Janavs.
M. Soto

Y. Lecrubier, T. Hergueta
J. Balazs
A. Engeler
B. Plattner

[illegible] – abnormal mood
[illegible] disorder- having an increase mood- too talkative
[illegible] disorder – unreasonable fear
[illegible] fear of hights
[illegible] anxiety disorder -Fear of being left alone
[illegible] disorder- fear of talking in public
[illegible] compulsive- doing thing repeatedly many times
[illegible] dependence cannot work without alcohol
[illegible] abuse- doing things that affects your social life
[illegible] breaking into uncontrolled offensive speech
[illegible] ATTENTION DEFISITE HIPER ACTIVE DISORDER
[illegible] eating to avoid becoming fat
[illegible] eating too much then you feel guilty

MINI KID SCORE SHEET (CHILDREN AND ADOLESCENTS)

Name ________________ Study Number	*DATE OF BIRTH:* ________________
DATE OF INTERVIEW: ________________	**If YES, go to the corresponding M.I.N.I. Kid module**
QUESTIONNAIRE COMPLETED BY : ______________	

SCREEN (PART 1)

A_1__ A_2 ___ B___ C___ D_{1A} ___D_{1B} ___D_{2A} ___ D_{2B}___E_A ___E_B___E_C ___ F ___ G ___

H __ I ___ J_1___J_2 ___ K_1___ K_2___ K_3 ___ L ___(Start by street name, then amount taken of the alcoholic drink) Street name--------------- Amount taken---------, Street name ---------------- Amount taken --------- Street name---------------------- Amount taken -----Street name --------------------- Amount taken -------------------

M) Drugs of abuse: (Start with street name of the drug, then follw by chemical Name)

Street $name_1$---------------------- Amount taken---------, Street $name_2$ -------------------- Amount taken -------------------- Street $name_3$---------------------- Amount taken ------- Street $name_4$ --------------------- Amount taken --------------------

Chemical Name (all drugs Mentioned): Chemical $Name_1$ --------------,- Chemical Name ---------, Chemical $Name_3$ -------------------, Chemical $Name_4$ -----------------

N_1 __ N_2 __ O ___ P___ Q ___ R_1 ___ R_2___Sa___Sb ___Sc ___ Sd___Se ___Sf ___ T_1 __ T_2___U ___V ___ W_1 ___ W_2 ___ W_3___W_4 ___

v

MAIN QUESTIONNAIRE

A. MAJOR DEPRESSIVE EPISODE

A1___ A2___ A3: a____ b ___ c ___ d ___ e ___ f ___ g ___

B. SUICIDALITY

B1: a ___ b ___ c ___ B2 ___ B3 ___ B4 ___ B5 ___ B6 ___

C. DYSTHYMIA

C1___ C2 ___ C3 : a ___ b ___ c ___ d ___ e ___ f ___

D. (HYPO) MANIC EPISODE

D1: a ___ b ___ D2: a ___b ___ D3: a____ b ___ c ___ d ___ e ___ f ___ g ___

D4 ___

E. PANIC DISORDER

E1: a ___ b ___ c ___ E2 ___ E3 ___ E4: a____ b ___ c ___ d ___ e ___ f ___ g ___ h ___ i ___ j ___ k ___ m ___ E5 ___ E6 ___ E7 ___

F. AGORAPHOBIA

F1 ___ F2 ___

G. SEPARATION ANXIETY DISORDER

G1: a ___ b ___ G2: a(i) ___ a(ii) ___ b(i) ___ b(ii) ___ c ___ d ___ e ___ f ___ g ___ h ___ G3 ___ G4 ___

H. SOCIAL PHOBIA (Social Anxiety Disorder)

H1 ___ H2 ___ H3 ___ H4 ___

I. SPECIFIC PHOBIA

I1 ___ I2 ___ I3 ___ I4 ___ I5 ___

J. OBSESSIVE COMPULSIVE DISORDER

J1 ___ J2 ___ J3 ___ J4 ___ J5 ___ J6 ___

K. POSTTRAUMATIC STRESS DISORDER (optional

K1 ___ K2 ___ K3 ___ K4: a ___ b ___ c ___ d ___ e ___ f ___ g ___

K5: a ___ b ___ c ___ d ___ e ___ K6 ___

L. ALCOHOL ABUSE AND DEPENDENCE

L1 ___ L2: a____ b ___ c ___ d ___ e ___ f ___ g ___ L3: a____ b ___ c ___ d ___

NON-ALCOHOL PSYCHOACTIVE SUBSTANCE USE DISORDERS

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

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

Narcotics: heroin, morphine, Dilaudid, opium, Demerol, methadone, codeine, Percodan, Darvon, 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. Any others?

Specify MOST USED Drug(s): ______________________________

ONLY ONE DRUG / DRUG CLASS HAS BEEN USED ☐

ONLY THE MOST USED DRUG CLASS IS INVESTIGATED. ☐

EACH DRUG CLASS USED IS EXAMINED SEPARATELY (PHOTOCOPY M2 AND M3 AS NEEDED) ☐

M1b ______________________________

M2: a___ b ___ c ___ d ___ e ___ f ___ g ___ M3: a____ b ___ c ___ d ___

N. TIC DISORDERS

N1: a ___ b ___ N2: a____ b ___ c ___ d ___ N3 ___ N4 ___ N5: a____ b ___ c ___ d ___

O. *ATTENTION DEFICIT/HYPERACTIVITY DISORDER*

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

O1 __ O2: a____ b ___ c ___ d ___ e ___ f ___ g ___ h ___ i ___ O3: a____ b ___ c ___ d ___ e ___ f ___ g ___ h ___ i ___ O4 ___ 05 ___

P. *CONDUCT DISORDER*

P1 __ P2: a____ b ___ c ___ d ___ e ___ f ___ g ___ h ___ i ___ j ___ k ___ m ___ n ___ o __ P3 ___

Q. *OPPOSITIONAL DEFIANT DISORDER*

Q1 __ Q2: a____ b ___ c ___ d ___ e ___ f ___ g ___ h ___ Q3 ___

R. *PSYCHOTIC DISORDERS AND MOOD DISORDERS WITH PSYCHOTIC FEATURES*

R1: a __ b ___ R2: a ___ b ___ R3: a ___ b ___ R4: a ___ b ___ R5: a ___ b ___

R6: a __ b ___ R7: a ___ b ___ R8: b ___ R9: b ___ R10: b ___ R11: a___ b ___

R12: a __ R13 ___ R14 ___

ANOREXIA NERVOSA

a___ b ___ c ___ d ___ e ___ f ___ g ___ S2 ___ S3 ___ S4: a____ b ___ c ___ S5 ___ S6 ___

BULIMIA NERVOSA

___ T2 ___ T3 ___ T4 ___ T5 ___ T6 ___ T7 ___ T8 ___ T9 ___

GENERALIZED ANXIETY DISORDER

a ___ b ___ U2 ___ U3: a____ b ___ c ___ d ___ e ___ f ___

ADJUSTMENT DISORDERS

___ V2 ___ V3: a ___ b___ V4 ___ V5: a____ b ___ c ___ d ___ e ___ f ___

PERVASIVE DEVELOPMENT DISORDER

___ W2 ___ W3 ___ W4 ___ W5 ___

Mini International Neuropsychiatric Interview

English Version 5.0.0

DSM-IV

Y. Lecrubier, E. Weiller, T. Hergueta, P. Amorim, L.I. Bonora, J.P. Lépine
Hôpital de la Salpétrière - Paris - FRANCE.

D. Sheehan, J. Janavs, R. Baker, K.H. Sheehan, E. Knapp, M. Sheehan
University of South Florida - Tampa - USA.

1992, 1994, 1998 Sheehan DV & Lecrubier Y.

ll rights reserved. No part of this document may be reproduced or transmitted in any form, or by any means, ectronic or mechanical, including photocopying, or by any information storage or retrieval system, without ermission in writing from the authors. Researchers and clinicians working in nonprofit or publicly owned ttings (including universities, nonprofit hospitals, and government institutions) may make copies of a M.I.N.I. ment for their own clinical and research use.

er advice on the modules on Anorexia nervosa and Bulimia. Printed. 3 December, 2012

'S NAME :	______	*PROTOCOL NUMBER :*	______
MGONJWA:	______	*NAMBA YA PROTOKALI:*	______
F BIRTH :	______	*Time Interview Began :*	______
E YA KUZALIWA:	______	*Muda wa Kuanza Usaili :*	______
IEWER'S NAME :	______	*Time Interview Ended :*	______
A MSAILI :	______	*Muda wa Kumaliza Usaili :*	______
OF INTERVIEW :	______	*TOTAL TIME :*	______
E YA USAILI :	______	*MUDA ULIOTUMIKA :*	______

MODULES VIHUNZI HURU	TIME FRAME MUDA	
A. MAJOR DEPRESSIVE EPISODE A. TUKIO LA SONONA	Current (past 2 weeks) + Lifetime Kwa sasa(wiki 2) +siku za nyuma	
MDE with melancholic features TUKIO LA SONONA lenye uzito wa moyo(hiari)	Current (past 2 weeks)	Optional
B. DYSTHYMIA B. DISTHIMIA	Current (past 2 years)	
C. SUICIDALITY C. HALI YA KUTAKA KUJIUA	Current (past month)	
D. (HYPO) MANIC EPISODE D. TUKIO LA MANIA(MANIA NDOGO)	Current + Lifetime	
E. PANIC DISORDER E. UGONJWA WA HOFU KUBWA	Lifetime + current (past month)	
F. AGORAPHOBIA F. WOGA WA NAFASI ZA WAZI	Current	
G. SOCIAL PHOBIA G. WOGA WA MKUSANYIKO WA WATU	Current (past month)	
H. OBSESSIVE-COMPULSIVE DISORDER H. UGONJWA WA SHAUKU LAZIMISHO	Current (past month)	
I. POSTTRAUMATIC STRESS DISORDER I. UGONJWA WA MSONGO BAADA YA MATUKIO MABAYA	Current (past month)	Optional
J. ALCOHOL DEPENDENCE / ABUSE J. KUTAWALIWA NA POMBE / MATUMIZI MABAYA YA POMBE	Current (past 12 months)	
K. DRUG DEPENDENCE / ABUSE (Non-alcohol) K. KUTAWALIWA / MATUMIZI MABAYA YA MADAWA YA KULEVYA (isiyo pombe)	Current (past 12 months)	
L. PSYCHOTIC DISODERS L. MAGONJWA YA SAIKOSIS	Lifetime + Current	
M. ANOREXIA NERVOSA M. UGONJWA WA TAFSIRI YA MAUMBILE BINAFSI UNAOHUSIANA NA KUTOKULA	Current (past 3 months)	
N. BULIMIA NERVOSA	Current (past 3 months)	

N.	UGONJWA WA TAFSIRI YA MAUMBILE BINAFSI UNAOHUSIANA NA KULA MNO		
O.	GENERALIZED ANXIETY DISORDER	Current (past 3 months)	
O.	UGONJWA WA WASIWASI MKUBWA		
P.	ANTISOCIAL PERSONALITY DISORDER	Lifetime	Optional
P.	UGONJWA WA MAKUZI YA HULKA NA TABIA ZINAZOPINGANA NA JAMII		

GENERAL INSTRUCTIONS

The M.I.N.I. was designed as a brief structured interview for the major Axis I psychiatric disorders in DSM-IV and ICD-10. Validation and reliability studies have been done comparing the M.I.N.I. to the SCID-P and the CIDI. The results of these studies show that the M.I.N.I. has acceptably high validation and reliability scores, but can be administered in a much shorter period of time (mean 18.7 ± 11.6 min., median 15 min.) than the above referenced instruments. It can be used by clinicians, after a brief training session. Lay interviewers require more extensive training.

Interview :

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

General format :

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

- At the beginning of each 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(s) the clinician to indicate whether the 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 to 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.

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

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, to circle « **NO** » in all the diagnostic boxes and move to the next module.

When terms are separated by a *slash (/)*, the interviewer should read only those symptoms known to be present in the patient (for example, question A3).

Rating instructions:

All questions read must be rated. The rating is done at the right of each question by circling either YES or NO.

The clinician should be sure that each dimension of the question is taken into account by the patient (i.e.: time frame, frequency, severity, « and/or » alternatives).

Symptoms better accounted for by an organic cause or by the use of alcohol or drugs should not be coded positive in the M.I.N.I.. The M.I.N.I. Plus has questions that investigate these issues.

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

David SHEEHAN, M.D., M.B.A.
University of South Florida
Institute for Research in Psychiatry
3515 East Fletcher Avenue
Tampa , FL USA 33613-4788
tel : +1 813 974 4544
fax : +1 813 974 4575
e-mail : dsheehan@com1.med.usf.edu

Yves LECRUBIER, M.D. / Thierry HERGUETA, PsyD
INSERM U302
Hôpital de la Salpetrière
47, boulevard de l'Hôpital
F. 75651 PARIS - FRANCE
tel : +33 (0) 1 42 16 16 59
fax : +33 (0) 1 45 85 28 00
e-mail : hergueta@ext.jussieu.fr

➔ MEANS **GO** TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, **CIRCLE NO** IN ALL OF THEM AND **MOVE** TO THE NEXT MODULE

A. MAJOR DEPRESSIVE EPISODE

TUKIO LA SONONA

Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks?	NO	YES	1
Je, ulishawahi kukosa raha muda mwingi wa siku, karibu kila siku, kwa muda wa wiki mbili zilizopita?	HAPANA	NDIYO	1
In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time ?	NO	YES	2
Katika wiki mbili zilizopita, je, umekosa hamu/ari katika vitu vingi au kukosa raha kwa muda mwingi katika vitu vilivyokuwa vikikufurahisha?	HAPANA	NDIYO	2
	➔		
IS **A1** OR **A2** CODED **YES**?	NO	YES	
JE, KIPENGELE **A1** AU **A2** KIMEJIBIWA NDIYO?	HAPANA	NDIYO	

Over the past two weeks, when you felt depressed and/or uninterested :

Katika kipindi cha wiki mbili zilizopita, ulipojisikia kukosa raha na / au kutokuwa na ari:

Was your appetite decreased or increased nearly every day or did your weight decrease or increase without trying intentionally? (i.e., ± 5 % of body weight or ± 3.5 kg or ± 8 lbs., for a 70 kg / 120 lbs. person in a month)	NO	YES	3
Je, hamu yako ya kula ilipungua au kuongezeka, karibu kila siku? Uzito wako ulipungua au uliongezeka bila wewe kukusudia? (yaani ± 5 % ya uzito wako au kg. 3.5 katika mwezi) IF **YES** TO EITHER, CODE **YES** IWAPO JIBU NI NDIYO KWA LOLOTE, JAZA NDIYO	HAPANA	NDIYO	3
Did you have trouble sleeping nearly every night (difficulty falling asleep, waking up in the middle of the night, early morning wakening, or sleeping excessively)?	NO	YES	4
Je, ulipata shida ya usingizi karibu kila siku? (taabu ya kupata usingizi, kupoteza usingizi katikati ya usiku, kuamka mapema sana, au kulala mno)	HAPANA	NDIYO	4
Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still, almost every day?	NO	YES	5
Je, ulikuwa ukiongea au kutembea pole pole zaidi kuliko kawaida yako, au ulikuwa na hali ya kuhangaika, kutotulia, au kuwa na tatizo la kukaa kwa utulivu karibu kila siku?	HAPANA	NDIYO	5
Did you feel tired or without energy, almost every day?	NO	YES	6
Je, ulijisikia mchovu au kutokuwa na nguvu karibu kila siku?	HAPANA	NDIYO	6
Did you feel worthless or guilty, almost every day?	NO	YES	7
Je, ulihisi kuwa huna thamani, au kuwa na hali ya kujiona kuwa na makosa karibu kila siku?	HAPANA	NDIYO	7
Did you have difficulty concentrating or making decisions, almost every day?	NO	YES	8
Je, ulikuwa na matatizo ya kuwa makini au kufanya maamuzi karibu kila siku?	HAPANA	NDIYO	8

➔ MEANS GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, **CIRCLE NO** IN ALL OF THEM AND **MOVE** TO THE NEXT MODULE

g Did you repeatedly consider hurting yourself, feel suicidal, or wish that you were dead? — NO YES 9

Je, mara kwa mara ulifikiria kuhusu kujiumiza, au kutaka kujiua, au bora ufe? — HAPANA NDIYO 9

ARE 3 OR MORE **A3** ANSWERS CODED **YES** ?
(OR **4 A3** ANSWERS IF **A1** OR **A2** ARE CODED **NO**)
JE, VIPENGELE 3 AU ZAIDI VYA **A3** VIMEJIBIWA **NDIYO**?
(AU MAJIBU **4 YA A3** IKIWA **A1** AU **A2** VIMEJIBIWA **HAPANA**)

NO	**YES**
HAPANA	**NDIYO**

MAJOR DEPRESSIVE EPISODE CURRENT
TUKIO LA SONONA KWA SASA

IF PATIENT MEETS CRITERIA FOR MAJOR DEPRESSIVE EPISODE CURRENT :
IKIWA MGONJWA ATAFIKIA VIGEZO VYA TUKIO LA SONONA KWA SASA:

a During your lifetime, did you have other periods of two weeks or more when you felt depressed or uninterested in most things, and had most of the problems we just talked about? — ➔ NO YES 10

Katika maisha yako, uliwahi kuwa na kipindi kingine cha wiki mbili au zaidi ambapo ulikosa raha au kukosa ari katika mambo mengi na kwamba umekuwa na shida kama zile tulizokwishazizungumzia? — ➔ HAPANA NDIYO 10

b Was there an interval of at least 2 months without depression and/or lost of interest between your current episode and your last episode of depression? — NO YES 11

Je, kulikuwa na kipindi cha angalau miezi 2 bila hali ya kukosa raha na /au kupoteza ari kati ya wakati huu na ulipokuwa na hali hii siku za nyuma? — HAPANA HAPANA 11

IS **A5b** CODED **YES**?
JE, KIPENGELE **A5b** KIMEJIBIWA **NDIYO**?

NO	**YES**
HAPANA	**NDIYO**

MAJOR DEPRESSIVE EPISODE PAST

TUKIO LA SONONA WAKATI ULIOPITA

A'. MAJOR DEPRESSIVE EPISODE WITH MELANCHOLIC FEATURES (optional)

A. TUKIO LA SONONA LILILOAMBATANA NA UZITO WA MOYO (HIARI)

IF THE PATIENT CODES POSITIVE FOR A MAJOR DEPRESSIVE EPISODE (**A4 = YES**), EXPLORE THE FOLLOWING :

KAMA MGONJWA ATADHIHIRISHA KUWA NA SONONA KWA SASA (**A4 = NDIYO**), CHUNGUZA YAFUATAYO:

A6 a	IS **A2** CODED **YES** ? JE KIPENGELE **A2** KIMEJIBIWA NDIYO?	NO HAPANA	YES NDIYO	12 12
b	During the most severe period of the current depressive episode, did you lose your ability to respond to things that previously gave you pleasure, or cheered you up?	NO	YES	13
	Wakati wa hali mbaya zaidi ya sonona ya sasa, uliwahi kupoteza uwezo wa kufanya vitu ambavyo mwanzoni vilikuwa vikikupa furaha au kukuchangamsha?	HAPANA	NDIYO	13
	IF NO: When something good happens does it fail to make you feel better, even temporarily? **KAMA JIBU NI HAPANA:** Wakati jambo zuri linatokea, je, jambo			
	IS EITHER **A6a** OR **A6b** CODED **YES** ?	➔ NO	YES	
	JE, KIPENGELE **A6a** AU **A6b** KIMEJIBIWA NDIYO?	➔ HAPANA	NDIYO	

Over the past two weeks period, when you felt depressed and uninterested :

Katika kipindi cha wiki mbili zilizopita, ulipojisikia kukosa raha au kukosa ari:

A7 a	Did you feel depressed in a way that is different from the kind of feeling you experience when someone close to you dies ?	NO	YES	14
	Je, ulikosa raha tofauti na vile unavyojisikia wakati unapofiwa na mtu wako wa karibu?	HAPANA	NDIYO	14
b	Did you feel regularly worse in the morning, almost every day? Je, ulijisikia kuwa na hali mbaya zaidi kwa kila asubuhi karibu kila siku?	NO HAPANA	YES NDIYO	15 15
c	Did you wake up at least 2 hours before the usual time of awakening and have difficulty getting back to sleep, almost every day?	NO	YES	16
	Je, ulikuwa ukiamka angalau masaa mawili kabla ya muda wako wa kawaida wa kuamka na kupata tabu ya kulala tena karibu kila siku?	HAPANA	NDIYO	16
e	IS **A3c** CODED **YES**? JE, KIPENGELE **A3c** KIMEJIBIWA NDIYO?	NO HAPANA	YES NDIYO	17 17
d	IS **A3a** CODED **YES** (ANOREXIA OR WEIGHT LOSS ONLY)? JE, KIPENGELE **A3a** KIMEJIBIWA NDIYO (KUKOSA HAMU YA CHAKULA AU KUPUNGUA MWILI)?	NO HAPANA	YES NDIYO	18 18
f	Did you feel excessive guilt or out of proportion to the reality of the situation?	NO	YES	19
	Je, ulijihisi mwenye makosa zaidi ama kuwa katika hali isiyo ya kawaida. JE, **A3e** IMEJIBIWA NDIYO (KUJILAUMU KUPITA KIASI, AU	HAPANA	NDIYO	19

KUJILAUMU KUSIVYOSTAHILI)?

A8 ARE 3 OR MORE **A7** ANSWERS CODED **YES?**
JE, VIPENGELE **VITATU** AU ZAIDI VYA **A7** VIMEJIBIWA **NDIYO**?

NO	**YES**
HAPANA	**NDIYO**

MAJOR DEPRESSIVE EPISODE
With Melancholic Features CURRENT

TUKIO LA SONONA lililoambatana na uzito wa moyo KWA SASA

→ MEANS : **GO** TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, **CIRCLE NO** IN ALL OF THEM AND **MOVE** TO THE NEXT MODULE

B. DYSTHYMIA

DISTHIMIA

IF PATIENT'S SYMPTOMS CURRENTLY MEET CRITERIA FOR MAJOR DEPRESSIVE EPISODE, DO NOT EXPLORE THIS MODULE
KAMA DALILI ZA MGONJWA KWA SASA ZINAFIKIA KIGEZO CHA TUKIO LA SONONA , USICHUNGUZE KIHUNZI HURU HIKI

B1	Have you felt sad, low or depressed most of the time for the last two years ?	→ NO	YES	20
	Je, ulijisikia huzuni, mnyonge au kukosa raha muda mwingi kwa kipindi cha miaka miwili iliyopita?	→ HAPANA	NDIYO	20
B2	Was this period interrupted by your feeling OK for two months or more ?	NO	→ YES	21
	Je, kipindi hiki kilikatizwa na hali ya kujisikia safi kwa muda wa miezi miwili au zaidi?	HAPANA	→ NDIYO	21
B3	**During this period of feeling depressed most of the time :** **Wakati wa kipindi hiki cha kujisikia kukosa raha muda mwingi:**			
a	Did your appetite change significantly ?	NO	YES	22
	Je, hamu yako ya kula ilibadilika kwa kiasi kikubwa?	HAPANA	NDIYO	22
b	Did you have trouble sleeping or sleep excessively ?	NO	YES	23
	Je, ulipata tabu ya kupata usingizi au kulala mno?	HAPANA	NDIYO	23
c	Did you feel tired or without energy ?	NO	YES	24
	Je, ulijisikia kuchoka au kukosa nguvu?	HAPANA	NDIYO	24
d	Did you lose your self-confidence ?	NO	YES	25
	Je, ulipoteza uwezo wa kujiamini?	HAPANA	NDIYO	25
e	Did you have trouble concentrating or making decisions ?	NO	YES	26
	Je, ulikuwa na tabu ya kuwa makini au ya kutoa maamuzi?	HAPANA	NDIYO	26
f	Did you feel hopeless ?	NO	YES	27
	Je, ulijisikia kukosa matumaini?	HAPANA	NDIYO	27
	ARE 2 OR MORE **B3** ANSWERS CODED **YES** ?	→ NO	YES	
	JE, VIPENGELE 2 AU ZAIDI VYA **B3** VIMEJIBIWA NDIYO?	→ HAPANA	NDIYO	
B4	Did the symptoms of depression cause you significant distress or impair your ability to function at work, socially, or in some other important way ?	→ NO	YES	28
	Je, dalili za kukosa raha zilikupa shida nyingi au kudhoofisha ufanisi wako kazini, kijamii, au katika njia nyingine muhimu?	→ HAPANA	NDIYO	28

5 IS **B4** CODED **YES** ?
JE KIPENGELE **B4** KIMEJIBIWA **NDIYO**?

NO	**YES**
HAPANA	**NDIYO**

DYSTHYMIA CURRENT
***DISTHIMIA** KWA SASA*

C. SUICIDALITY

HALI YA KUTAKA KUJIUA

In the past month did you :
Katika mwezi uliopita, je:

C1	Think that you would be better off dead or wish you were dead ? Ulifikiria kwamba ni bora ungekufa?	NO HAPANA	YES NDIYO	1 1
C2	Want to harm yourself ? Ulitaka kujidhuru?	NO HAPANA	YES NDIYO	2 2
C3	Think about suicide ? Ulifikiria juu ya kutaka kujiua?	NO HAPANA	YES NDIYO	3 3
C4	Have a suicide plan ? Ulikuwa na mipango ya kujiua?	NO HAPANA	YES NDIYO	4 4
C5	Attempt suicide ? Ulijaribu kujiua?	NO HAPANA	YES NDIYO	5 5

In your lifetime
Katika maisha yako

C6	Did you ever make a suicide attempt ? Ulishawahi, wakati wowote, kujaribu kujiua?	NO HAPANA	YES NDIYO	6 6

IS AT LEAST **1** OF THE ABOVE CODED **YES** ?
JE, ANGALAU KIPENGELE **KIMOJA** KATI YA VYA HAPO JUU, KIMEJIBIWA **NDIYO**?

IF YES, SPECIFY THE LEVEL OF SUICIDE RISK AS FOLLOWS :
KAMA NDIYO, **ELEZA** KIWANGO CHA HATARI YA KUJIUA KAMA IFUATAVYO:

C1 or C2 or C6 = YES : LOW
C1 au C2 au C3 = NDIYO : HATARI NDOGO

C3 or (C2 +C6) = YES : MODERATE
C3 au (C2 +C6) = NDIYO : HATARI YA KATI

C4 or C5 or (C3 + C6) = YES : HIGH
C4 au C5 au (C3 + C6) = NDIYO : HATARI KUBWA

NO **HAPANA**	**YES** **NDIYO**
SUICIDE RISK CURRENT ***HATARI YA KUJIUA*** *KWA SASA*	
LOW	☐
HATARI NDOGO	☐
MODERATE	☐
HATARI YA KATI	☐
HIGH	☐
HATARI KUBWA	☐

D. (HYPO) MANIC EPISODE

TUKIO LA MANIA (MANIA NDOGO)

D1 a	Have you **ever** had a period of time when you were feeling "up" or "high" or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol) IF PATIENT IS PUZZLED OR UNCLEAR ABOUT WHAT YOU MEAN BY "UP" OR "HIGH", CLARIFY AS FOLLOW : By "up" or "high" I mean : having elated mood, increased energy, needing less sleep, having rapid thoughts, being full of ideas, having an increase in productivity, creativity, motivation or impulsive behavior.	NO	YES	1
	Je, ulishawahi kwa kipindi Fulani kujisikia una hali ya juu, au umejawa na nguvu au umesongwa kiasi cha kupatashida, au kwamba watu kukudhania kuwa sio mtu wa kawaida? (usichukulie muda ambao ulikuwa umedhurika kwa madawa au pombe) KAMA MGONJWA ANAONEKANA KUTOELEWA MAANA YA "HALI YA JUU", FAFANUA KAMA IFUATAVYO : Hali ya juu ina maana ya kuwa na hali ya furaha; kuhitaji usingizi mchache;kuwa na fikra za haraka; kusongwa na mawazo; kuongezeka katika tija, ubunifu, motisha au tabia ya kuamua ghafla	HAPANA	NDIYO	1
	IF YES : KAMA JIBU NI NDIYO :			
b	Are you currently feeling "up" or "high" or full of energy ?	NO	YES	2
	Je, sasa hivi unajisikia kuwa na hali ya juu au kujawa na nguvu?	HAPANA	NDIYO	2
D2a	Have you ever been persistently irritable, for several days, so that you had arguments or verbal or physical fights, or shouted at people outside your family ? Have you or others noticed that you have been more irritable or over reacted, compared to other people, even in situations that you felt were justified ? (Do not consider times when you were intoxicated on drugs or alcohol)	NO	YES	3
	Je, umeshawahi kuwa mwenye kuudhika upesi kwa muda mrefu, kwa siku nyingi, kiasi kwamba ukawa na mabishano, au mapigano kwa maneno au vitendo, au kuwapigia kelele watu wasiokuwa wa familia yako?			
	IF YES : KAMA JIBU NI NDIYO :			
b	Are you currently feeling persistently irritable ?	NO	YES	4
	Je, kwa sasa unajisikia kuwa mwepesi wa kuudhika kwa muda mrefu?	HAPANA	NDIYO	4
	ARE **D1a** OR **D2a** CODED **YES** ?	➔ NO	YES	
	JE, KIPENGELE **D1a** AU **D2a** KIMEJIBIWA **NDIYO?**	➔ HAPANA	NDIYO	

IF D1b OR D2b = YES : EXPLORE ONLY **CURRENT** EPISODE
IF D1b AND D2b = NO : EXPLORE **THE MOST SYMPTOMATIC** PAST EPISODE
KAMA D1B AU D2B = NDIYO: CHUNGUZA TUKIO **LA SASA** TU
KAMAD1B NA D2B = HAPANA: CHUNGUZA TUKIO LILILOPITA AMBALO LILIKUWA NA **DALILI NYINGI ZAIDI**

During the time(s) when you felt "high", full of energy and/or irritable did you :
Kwa muda ambao ulijisikia hali ya juu, kujawa na nguvu, au mwenyekuudhika upesi, je :

Feel that you could do things others couldn't do, or that you were an especially important person ?	NO	YES	5
Ulijisikiakuweza kufanya vitu ambavyo wengine hawawezi au kujiona kuwa mtu pekee muhimu	HAPANA	NDIYO	5
Need less sleep (e.g., feel rested after only a few hours sleep) ?	NO	YES	6
Ulihitaji usingizi mchache (kwa mfano, kujisikisa mapumziko baada ya muda mdogo tu wa kulala) ?	HAPANA	NDIYO	6
Talk too much without stopping, or so fast that people had difficulty understanding ?	NO	YES	7
Uliongea sana bila kunyamaza, au kwa haraka zaidi kiasi kwamba watu wakapata tabu ya kukuelewa?	HAPANA	NDIYO	7
Have thoughts racing?	NO	YES	8
Umekuwa na mawazo ya harakaharaka	HAPANA	NDIYO	8
Become easily distracted so that any little interruption could distract you ?	NO	YES	9
Ulikuwa mwepesi wa kuvurugwa kiasi kwamba hata kukatizwa kidogo kunakuvuruga?	HAPANA	NDIYO	9
Become so active or physically restless that others were worried about you ?	NO	YES	10
Ulikuwa mashuhuri au kutotulia kiasi kwamba watu wengine wakapata wasiwasi juu yako?	HAPANA	NDIYO	10
Want so much to engage in pleasurable activities that you ignored the risks or consequences (e.g., spending sprees, reckless driving, or sexual indiscretions) ?	NO	YES	11
Ulitaka sana kujiingiza katika shughuli za starehe na kutojali hatari zake au matokeo yake(mfano, kufanya shamrashamra , udereva wa kizembe, au ngono bila kujihadhari)?	HAPANA	NDIYO	11
ARE 3 OR MORE **D3** ANSWERS CODED **YES** OR 4 IF **D1a = NO** (PAST EPISODE) OR **D1b = NO** (CURRENT EPISODE) ?	➔ NO	YES	
JE, VIPENGELE **3** AU ZAIDI VYA **D3** VIMEJIBIWA **NDIYO** AU VIPENGELE **4**, IKIWA **D1a** = **HAPANA** (TUKIO LILILOPITA) AU **D1b** = **HAPANA** (TUKIO LA SASA)	➔ HAPANA	NDIYO	
Did these symptoms last at least a week **and** cause significant problems at home, at work, or at school, or were you hospitalized for these problems?	NO	YES	12
Je, dalili hizi zilidumu kwa muda wa angalau wiki moja na kusababisha			

MEANS GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

natatizo makubwa nyumbani, kazini, kijamii, au shuleni, au alilazwa ospitalini kwa ajili ya matatizo haya? HAPANA NDIYO 12

: YES TO EITHER, CODE YES
AMA JIBU NI NDIYO KWA LOLOTE, JAZA NDIYO

S D4 CODED **NO** ?
E, KIPENGELE **D4** KIMEJIBIWA **HAPANA**?

: YES, SPECIFY IF THE EPISODE EXPLORED IS CURRENT OR PAST
AMA NDIYO, ELEZA NI TUKIO LA SASA AU LILILOPITA

NO **HAPANA**	**YES** **NDIYO**
HYPOMANIC EPISODE ***TUKIO LA MANIA NDOGO***	
CURRENT	☐
KWA SASA	☐
PAST	☐
LILILOPITA	☐

S D4 CODED **YES** ?
E, KIPENGELE **D4** KIMEJIBIWA **NDIYO**?

YES, SPECIFY IF THE EPISODE EXPLORED IS CURRENT OR PAST
AMA NDIYO, ELEZA NI TUKIO LA SASA AU LILILOPITA

NO **HAPANA**	**YES** **NDIYO**
MANIC EPISODE ***TUKIO LA MANIA***	
CURRENT	☐
KWA SASA	☐
PAST	☐
LILILOPITA	☐

→ MEANS : GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

E. PANIC DISORDER

UGONJWA WA HOFU KUBWA

E1	Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way ? Did the spells peak within 10 minutes ?	NO	YES	1
	Je, kwa mara zaidi ya moja, umekuwa na vipindi vya kujisikia au kupatwa na wasiwasi wa ghafla, hofu, kutotulia au mashaka, hata katika mazingira ambayo watu wengi hawajisikii hivyo? Je, mshituko huo uliisha ndani ya dakika kumi?	HAPANA	NDIYO	1
	CODE YES ONLY IF THE SPELLS PEAK WITHIN 10 MINUTES JAZA NDIYO IKIWA TU MSHITUKO HUO ULIISHA NDANI YA DAKIKA KUMI			

IF **E1 = NO**, CIRCLE NO IN E5 AND SKIP TO F1

KAMA **E1 = HAPANA**, JAZA HAPANA KATIKA **E5** NA NENDA KIPENGELE **F1**

E2	At any time in the past, did any of those spells or attacks come on unexpectedly or spontaneously, or occur in an unpredictable or unprovoked manner ?	NO	YES	2
	Katika wakati wowote uliopita, je, vipindi hivi au mishituko hiyo ilikuja bila kutegemea au kutokea katika namna isiyobashirika au kuchochewa?	HAPANA	NDIYO	2

IF **E2 = NO**, CIRCLE NO IN E5 AND SKIP TO F1

KAMA **E2 = HAPANA**, JAZA HAPANA KATIKA **E5** NA NENDA KIPENGELE **F1**

E3	Have you ever had one such attack followed by a month or more of persistent fear of having another attack, or worries about the consequences of the attack ?	NO	YES	3
	Je, ulishawahi kupata tukio moja kama hilo lililofuatiwa na kipindi cha mwezi mmoja au zaidi cha kujisikia hofu ya tukio jingine au woga wa madhara ya tukio hilo?	HAPANA	NDIYO	3

IF **E3 = NO**, CIRCLE NO IN E5 AND SKIP TO F1

KAMA **E3 = HAPANA**, ZUNGUSHIA HAPANA NA NENDA KIPENGELE **F1**

E4 During the worst spell that you can remember :
Katika kipindi kibaya zaidi ambacho unakumbuka :

a	Did you have skipping, racing or pounding of your heart ?	NO	YES	4
	Je, moyo wako ulidundadunda, kwenda mbio, au kupiga kwa kasi?	HAPANA	NDIYO	4
b	Did you have sweating or clammy hands ?	NO	YES	5
	Je, ulitokwa na majasho au mikono kuwa ya baridi?	HAPANA	NDIYO	5
c	Were you trembling or shaking ?	NO	YES	6
	Je, ulitetemeka au kutikisika?	HAPANA	NDIYO	6
d	Did you have shortness of breath or difficulty breathing ?	NO	YES	7
	Je, ulipata kutapia hewa au tabu ya kupumua?	HAPANA	NDIYO	7
e	Did you have a choking sensation or a lump in your throat ?	NO	YES	8

→ MEANS **GO** TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, **CIRCLE NO** IN ALL OF THEM AND **MOVE** TO THE NEXT MODULE

	Question			
	Je, ulihisi kupaliwa au donge kifuani kwako?	HAPANA	NDIYO	8
f	Did you have chest pain, pressure or discomfort ?	NO	YES	9
	Je, ulipata maumivu ya kifua, shinikizo au usumbufu?	HAPANA	NDIYO	9
g	Did you have nausea, stomach problems or sudden diarrhea ?	NO	YES	10
	Je, ulipata kichefuchefu, matatizo ya tumbo au kuharisha kwa ghafla ?	HAPANA	NDIYO	10
h	Did you feel dizzy, unsteady, lightheaded or faint ?	NO	YES	11
	Je, ulijisikia kizunguzungu, kutetereka, kichwa chepesi, au kuzirai ?	HAPANA	NDIYO	11
i	Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from part or all of your body ?	NO	YES	12
	Je, vitu vilivyokuzunguka uliviona ni vya ajabu, sio halisi, upweke au vya kigeni, au je, ulijisikia upo kando ya, au kujitenga kutoka katika sehemu au mwili wako wote ?	HAPANA	NDIYO	12
j	Did you fear that you were losing control or going crazy ?	NO	YES	13
	Je, ulihofia kwamba umeshindwa kujizuia au umepata wazimu ?	HAPANA	NDIYO	13
k	Did you fear that you were dying ?	NO	YES	14
	Je, ulihofia kwamba unakufa ?	HAPANA	NDIYO	14
l	Did you have tingling or numbness in parts of your body ?	NO	YES	15
	Je, ulipatwa na msisimko au ganzi katika sehemu za mwili wako ?	HAPANA	NDIYO	15
m	Did you have hot flashes or chills ?	NO	YES	16
	Je, ulipatwa na wekundu usoni(kuiva uso) u mzizimo wa baridi ?	HAPANA	NDIYO	16

E5 ARE 4 OR MORE **E4** ANSWERS CODED **YES** ?
JE, VIPENGELE 4 AU ZAIDI VYA **E4** VIMEJIBIWA **NDIYO** ?

NO / HAPANA YES / NDIYO

Panic Disorder Life time
Hofu kubwa Maisha yote

IF **E5 = NO**, SKIP TO E7

KAMA **E5 = HAPANA**, NENDA KIPENGELE E7

E6 In the past month, did you have such attacks repeatedly (2 or more) followed by persistant fear of having another attack ? NO YES 17

Katika mwezi mmoja uliopita, ulipatwa na matukio hayo kwa kujirudiarudia (mara 2 au zaidi) kufuatiwa na hofu ya kupata tukio jingine ? HAPANA NDIYO 17

Panic Disorder Current
Hofu kubwa kwa sasa

IF **E6 = YES**, SKIP TO F1

KAMA **E6 = NDIYO**, NENDA **F1**

E7 ARE **1, 2** OR **3 E4** ANSWERS CODED **YES** ? NO YES 18

Limited Symptom Attacks Lifetime

→ MEANS GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, CIRCLE NO IN ALL OF THEM AND MOVE TO THE NEXT MODULE

F. AGORAPHOBIA

WOGA WA NAFASI ZA WAZI

F1 Do you feel anxious or particularly uneasy in places or situations from which escape might be difficult, and where help might not be available in case of panic attack, like being in a crowd, standing in a line (queue), when you are alone away from home or alone at home, or when crossing a bridge, traveling in a bus, train or car ?	NO YES	19
Je, unajisikia wasiwasi au mashaka katika sehemu au mazingira ambapo unaweza kupata mshituko wa hofu kubwa au dalili zinazofanana na hofu kubwa tulizozizungumza hivi punde, na ambapo msaada unaweza usiwepo, au ambapo kukwepa kunaweza kuwa kugumu: kama kuwa kwenye kundi la watu wengi, kusimama kwenye foleni, ukiwa peke yako mbali na nyumbani, au upo nyumbani peke yako, au ukiwa unavuka daraja, kusafiri ndani ya basi, treni, au gari ?	HAPANA NDIYO	19

IF **F1 = NO**, CIRCLE NO IN F2
KAMA **F1 = HAPANA**, ZUNGUSHIA HAPANA KATIKA F2

F2 Do you fear these situations so much that you avoid them, or suffer through them, or need a companion to face them ?	NO YES
Je, unahofia sana mazingira haya kiasi cha kujitenga nayo, au kuteseka kwa ajili ya mazingira hayo auunahitaji mwenzi kukabiliana nayo ?	HAPANA NDIYO ***Agoraphobia Current*** ***Woga wa nafasi za wazi kwa sasa***

IS **F2** (CURRENT AGORAPHOBIA) CODED **NO** and IS **E6** (CURRENT PANIC DISORDER) CODED **YES** ? JE **F2** (WOGA WA NAFASI ZA WAZI KWA SASA)	**NO** **YES** ***PANIC DISORDER without Agoraphobia CURRENT***
IS **F2** (CURRENT AGORAPHOBIA) CODED **YES** and IS **E6** (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 without history of Panic Disorder***

CURRENT

→ MEANS **GO** TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, **CIRCLE NO** IN ALL OF THEM AND **MOVE** TO THE NEXT MODULE

G. SOCIAL PHOBIA
G. WOGA WA MKUSANYIKO WA WATU

G1	In the past month, were you fearful or embarrassed being watched, being the focus of attention, or fearful of being humiliated ? This includes situations like speaking in public, eating in public or with others, writing while someone watches, or being in social situations.	→ NO	YES	1
G1	Katika mwezi uliopita, je ulipata hofu au shida ukiwa uanaangaliwa, ukiwa mlengwa, au hofu ya kufedheheshwa? Hii ni pamoja na mambo kama kuongea hadharani; kula hadharani au kula na watu, kuandika wakati mtu anakuangalia au kuwa katika mikusanyiko ya watu.			
G2	Is this fear excessive or unreasonable ?	→ NO	YES	2
G2	Je hofu hii ni kubwa mno au yenye kuzidi?			
G3	Do you fear these situations so much that you avoid them or suffer through them ?	→ NO	YES	3
G3	Je unahofia sana mazingira haya kiasi cha kujitenga nayo au kuteseka kwa ajili ya mazingira hayo.			
G4	Does this fear disrupt your normal work or social functioning or cause you significant distress ?	NO	YES	4
G4	Je hofu hizi zinavuruga shughuli zako za kawaida au shughuli za kijamii au zinakusababishia shida kubwa.			

IS G4 CODED **YES** ?
Je kipengele G4 kimejibiwa ndiyo?

NO	**YES**
SOCIAL PHOBIA CURRENT	

H. OBSESSIVE-COMPULSIVE DISORDER
H. SHAUKU LAZIMISHO

H1 In the past month, have you been bothered by recurrent thoughts, impulses or images that were unwanted, distasteful, inappropriate, intrusive or distressing ? (e.g., the idea that you were dirty, contaminated or had germs, **or** fear of contaminating others, **or** fear of harming someone even though you didn't want to, **or** fearing you would act on some impulse, **or** fear or superstitions that you would be responsible for things going wrong, **or** obsessions with sexual thoughts, images or impulses, **or** hoarding, collecting, **or** religious obsessions.) — NO YES 1

DO NOT INCLUDE SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PROBLEMS.
DO NOT INCLUDE OBSESSIONS DIRECTLY RELATED TO EATING DISORDERS, SEXUAL DEVIATIONS, PATHOLOGICAL GAMBLING, OR ALCOHOL OR DRUG ABUSE BECAUSE THE PATIENT MAY DERIVE PLEASURE FROM THE ACTIVITY AND MAY WANT TO RESIST IT ONLY BECAUSE OF ITS NEGATIVE CONSEQUENCES.

H1 Katika mwezi ulioputa, je ulishawahi kukerwa na mawazo yenye kujirudiarudia, misukumo, au fikra ambazo hazihitajiki, za maudhi, zisizostahili, zenye kuingilia, au zenye kuleta shida? (mf: mawazo ya kwamba umchafu, umechafuliwa na vijidudu, au hofu ya kuwachafua wengine, au hofu ya kumdhuru mtu hata kama hukutaka kufanya hivyo, au kuhofia kutenda kwa msukumo, au hofu au imani za kichawi kwamba ungewajibika kwa mambo mabaya, au shauku yenye mawazo ya ngono, fikra au misukumo,au shauku ya kuhodhi, kukusanya au ya kidini).

(Usichanganye na wasiwasi juu ya matatizo halisi ya maisha, usichanganye na shauku zinazoendana moja kwa moja na magonjwa ya kula chakula, tabia za uasherati, kamari, au pombe au madawa ya kulevya kwa sababu, mgonjwa anaweza kupata starehe kutokana na tendo hilo na kutaka kujizuia kwa sababu tu ya matokeo hasi ya jambo hilo.

IF H1 = NO, SKIP TO H4

H2 Did they keep coming back into your mind even when you tried to ignore or get rid of them ? — NO YES 2
IF H2 = NO, SKIP TO H4

H2 JE, yanaendelea kukurudia ndani ya mawazo yako hata wakati unapojaribu kuyadharau au kujaondoa?

H3 Do you think that these obsessions are the product of your own mind and that they are not imposed from the outside ? — NO YES 3

Je, unadhani kwamba shauku hizi zinatokana na mawazo yako mwenyewe na kwamba hazijalazimishwa kutoka nje?

H4 In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, arranging things, or other superstitious rituals ? — NO YES 4

Katika mwezi uliopita, je ulifanya kitu kwa kurudiarudia bila kuwa na

uwezo wa kujizuia kufanya hivyo, kama vile kuosha au kusafisha sana, kuhesabu, kukagua vitu mara kwa mara, au kurudia, kukusanya, kupanga vitu, au matambiko mangine ya kishirikina.

ARE **H3** OR **H4** CODED **YES** ? ➔ NO YES
JE KIPENDELE **H3** AU **H4** KIMEJIBIWA **NDIYO?**

H5 Did you recognize that either these obsessive thoughts and / or these compulsive behaviors you can not resist doing them, were excessive or unreasonable ? ➔ NO YES 5
H5 Je ulitambua kwamba kujiwa na mawazo haya au hizi tabia zisizodhibitika zimekuwa ni nyingi mno au zimezidi?

H6 Did these obsessive thoughts and / or compulsive behaviors significantly interfere with your normal routine, occupational functioning, usual social activities, or relationships, or did they take more than one hour a day ? NO YES 6
H6 Je kujawa na mawazo haya na/au tabia zisizodhibitika kwa kiasi kikubwa kunaingilia zako za kawaida, shughuli za kikazi, kazi za kawaida za kijamii, au mahusiano, au yamechukua zaidi ya saa nzima kwa siku?

H7 IS **H6** CODED **YES** ?

NO	**YES**
OBSESSIVE-COMPULSIVE DISORDER CURRENT	

I. POSTTRAUMATIC STRESS DISORDER (optional)
I. UGONGWA WA MSONGO BAADA YA MATUKIO MABAYA (Hiari)

I1	Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else?	➔ NO	YES	1
I1	Je, umewahi kupata au kushuhudia au kushughulika na matukio mabaya ikiwepo kifo au tishio la kifo au ajali mbaya kwako au mtu mwingine?			
	EX OF TRAUMATIC EVENTS: SERIOUS ACCIDENT, SEXUAL OR PHYSICAL ASSAULT, A TERRORIST ATTACK, BEING HELD HOSTAGE, KIDNAPPING, HOLD-UP, FIRE, DISCOVERNG A BODY, UNEXPECTED DEATH, WAR, NATURAL DISASTER...			
I2	During the past month, have you re-experienced the event in a distressing way (i.e., dreams, intense recollections, flashbacks or physical reactions)?	➔ NO	YES	2
I2	Kwa mwezi uliopita je umewahi kupata tena tukio hilo katika namna ya mashaka (Kama vile, ndoto, mkusanyiko mkali, kumbukumbu za ghafla, au kujibu kwa matendo)?			
I3	**In the past month :**			
I3	**Katika mwezi uliopita:**			
a	Have you avoided thinking about the event, or have you avoided things that remind you of the event?	NO	YES	3
a	Je, umewahi kujizuia kufikiria juu ya tukio hilo, au kujiepusha na vitu vinavyokukumbusha tukio hilo?			
b	Have you had trouble recalling some important part of what happened?	NO	YES	4
b	Je, umepata tabu ya kukumbuka baadhi ya sehemu muhimu juu ya kilichotokea?			
c	Have you become less interested in hobbies or social activities?	NO	YES	5
c	Je umekuwa na ulegevu katika kufanya mambo uyapendayo au kazi za kijamii?			
d	Have you felt detached or estranged from others?	NO	YES	6
d	Je, ulijisikia umejitenga au kutenganisha na wengine?			
e	Have you noticed that your feelings are numbed?	NO	YES	7
e	Je, ulitambua kwamba hisia zako hazipo tena?			
f	Have you felt that your life would be shortened because of this trauma?	NO	YES	8
f	Je, ulijisikia kwamba maisha yako yangekuwa mafupi kutokana na tukio hili?			
	ARE 3 OR MORE I3 ANSWERS CODED **YES**? JE, VIPENGELE **VITATU** AU ZAIDI VYA I3 VIMEJIBIWA NDIYO?	➔ NO	YES	
I4	**In the past month :**			
I4	**Katika mwezi uliopita:**			
a	Have you had difficulty sleeping?	NO	YES	9

→ MEANS GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, **CIRCLE NO** IN ALL OF THEM AND **MOVE** TO THE NEXT MODULE

a	Je ulipata tabu ya usingizi?			
b	Were you especially irritable or did you have outbursts of anger?	NO	YES	10
b	Je ulikuwa mwenye kuudhika upesi, au ulipatwa na milipuko ya hasira?			
c	Have you had difficulty concentrating?	NO	YES	11
c	Je, umepata taabu ya kuwa makini?			
d	Were you nervous or constantly on your guard?	NO	YES	12
d	Je, ulikuwa na wahaka/wasiwasi au katika hali ya taharuki hivi kwamba ulitaka kujilinda wakati wote?			
e	Were you easily startled?	NO	YES	13
e	Je, ulikuwa mwepesi wa kushtushwa?			
	ARE 2 OR MORE **I4** ANSWERS CODED **YES**? JE VIPENGELE 2 AU ZAIDI YA **I4** VIMEJIBIWA **NDIYO**?	→ NO	YES	
5)	During the past month, have these problems significantly interfered with your work or social activities, or caused significant distress?	NO	YES	14
5)	Katika mwezi uliopita, je matatizo haya kwa kiasi kikubwa yalivuruga utendaji wa kazi yako au shughuli za kijamii au kusababisha mashaka makubwa?			

16)	IS **I5** CODED **YES**? JE I5 IMEJIBIWA NDIYO?	**NO** **YES** ***POSTTRAUMATIC STRESS DISORDER CURRENT***

J. ALCOHOL ABUSE AND DEPENDENCE
J. MATUMIZI MABAYA NA KUTAWALIWA NA POMBE

		→ NO	YES	
J(1)	In the past 12 months, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions?	NO	YES	1
J(1)	Katika miezi 12 iliyopita, ulishawahi kuwa na vinywaji vitatu au zaidi vya pombe ndani ya kipindi cha masaa matatu katika matukio m atatu au zaidi/			
J(2)	**In the past 12 months :**			
	Did you need to drink more in order to get the same effect that you did when you first started drinking?	NO	YES	2
J(2)	**Katika miezi 12 iliyopita:**			
a	Je, ulihitaji kunywa zaidi ili upate matokeo sawa nay ale uliyokunywa mara ya kwanza?			
b	When you cut down on drinking did your hands shake, did you sweat, or feel agitated ? Or, did you drink to avoid these symptoms or to avoid being hangover, e.g., "the shakes", sweating or agitation ?	NO	YES	3
b	Je, wakati ulipoacha kunywa mikono yako ilitetemeka ulitokwa na majasho, au kujisikia wasiwasi? Je, ulikunywa ili kuondoa dalili hizi au kuepuka kuwa mchovu, mfano mtetemeko, kutokwa majasho au wasiwasi? IF YES TO EITHER, CODE YES KAMA NI NDIYO KWA CHOCHOTE, JIBU NDIYO			
c	During the times when you drank alcohol, did you end up drinking more than you planned when you started ?	NO	YES	4
c	Wakati ambapo umelewa pombe, je uliishia kunywa zaidi kuliko ulivyopanga mwanzoni?			
d	Have you tried to reduce or stop drinking alcohol but failed ?	NO	YES	5
d	Je ulijaribu kupunguza au kuacha ulevi ikashindikana?			
e	On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovering from the effects of alcohol ?	NO	YES	6
e	Katika siku ambazo umelewa, je ulipoteza muda mwingi kupata pombe, kunywa au kupata nafuu kutoka katika athari za pombe?			
f	Did you spend less time working, enjoying hobbies, or being with others because of your drinking ?	NO	YES	7
f	Je ulitumia muda mchache kufanya kazi kufurahia uvipendavyo au kuwa na wenzako kwa sababu ya ulevi wako?			

g Have you continued to drink even though you knew that the drinking caused you health or mental problems ? NO YES 8

g Je uliendelea kulewa japo kuwa ulifahamu kuwa ulevi ulikusababishia matatizo ya kiafya na kiakili?

H ARE 3 OR MORE **J2** ANSWERS CODED **YES**?
JE VIPENGELE **VITATU** AU ZAIDI VYA **J2** VIMEJIBIWA NDIYO?

NO	**YES**
ALCOHOL DEPENDENCE CURRENT	

I DOES THE PATIENT CODES POSITIVES FOR ALCOHOL DEPENDENCE? NO YES →

(3) In the past 12 months :
(3) Katika miezi 12 iliyopita:

a Have you been intoxicated, high, or hangover more than once when you had other responsibilities at school, at work, or at home? Did this cause any problems? NO YES 9

a Je, umewahi kurukwa akili, kuwa na hali ya juu, au kuwa na uchovu wa pombe zaidi ya mara moja wakati ambapo ulikuwa na majukumu mengine shuleni, kazini au nyumbani? Je hili litaleta matatizo yeyote?

CODE YES ONLY IF THIS CAUSED PROBLEMS
(JIBU NDIYO IKIWA TU HILI LILILETA MATATIZO)

b Were you intoxicated in any situation where you were physically at risk, e.g., driving a car, riding a motor bike, using machinery, boating, etc. ? NO YES 10

b Je, ulirukwa akili katika mazingira yeyote ambapo ulikuwa hatarini mf. Kuendesha gari, kuendesha pikipiki, kutumia mashine, kusafiri kwa mashua, etc.

c	Did you have any legal problems because of your drinking, e.g., an arrest or disorderly conduct ?	NO	YES	11
c	Je ulipata matatizo yeyote ya kisheria kwa sababu ya ulevi wakomfa. Kutiwa mbaroni au kufanya vurugu?			
d	Did you continue to drink even though your drinking caused problems with your family or other people ?	NO	YES	12
d	Je, uliendelea kulewa japokuwa ulevi wako ulisababisha matatizo kwa familia yako au watu wengine?			

ARE **1** OR MORE **J3** ANSWERS CODED **YES** ?

JE KIPENGELE **KIMOJA** AU ZAIDI CHA **J3** KIMEJIBIWA NDIYO?

NO **YES**

ALCOHOL ABUSE CURRENT

CARD OF SUBSTANCES

AMPHETAMINE	GASOLINE	MORPHINE
CANNABIS	GLUE	OPIUM
COCAINE	GRASS	PALFIUM
CODEINE	HASHISH	PCP
CRACK	HEROIN	RITALIN
DICONAL	LSD	TEMGESIC
ECSTASY	MARIJUANA	THC
ETHER	MESCALINE	TOLUENE
FREEBASE	METHADONE	TRICHLORETHYLENE

K NON-ALCOHOL PSYCHOACTIVE SUBSTANCE USE DISORDERS
UGONJWA WA MATUMIZI YA MADAWA YA KULEVYA AMBAYO SI POMBE

K1 a Now, I am going to show you (SHOW THE CARD OF SUBSTANCES) / to read to you, a list (READ THE LIST BELOW) of street drugs or medicines. In the past 12 months, did you take any of these drugs, more than once, to get high, to feel better or to change your mood?
Sasa ninakuonyesha (ONYESHA KADI YA MADAWA) / ninakusomea orodha ya madawa ya mitaani. Katika miezi 12 iliyopita, je ulitumia dawa yeyote katika hizi zaidi ya mara moja, ili uwe na hali ya juu, kujisikia mbora zaidi, au kubadilisha hali yako? ➔ NO YES

CIRCLE EACH DRUG TAKEN :

Stimulants: amphetamines, « speed », crystal meth, « rush », Dexedrine, Ritalin, diet pills.
Cocaine: snorting, IV, freebase, crack, « speedball ».
Narcotics: heroin, morphine, dilaudid, opium, demerol, methadone, codeine, percodan, darvon.
Hallucinogens: LSD (« acid »), mescaline, peyote, PCP (« angel dust », « peace pill »), psilocybin, STP, « mushrooms », ecstasy, MDA, or MDMA.
Inhalants: « glue », ethyl chloride, 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.
Miscellaneous: steroids, nonprescription sleep or diet pills. Any others ?

SPECIFY MOST USED DRUG(S) : ____________________

ZUNGUSHIA KILA DAWA ULIYOTUMIA:
Vichangamsho:Amphetamini
Cokein:
Nakotiks:
Hallucinogens:
Inhalants:

Marijuana:
Tranquilizers:
Nyinginezo:

ELEZA DAWA / MADAWA UTUMIAYO ZAIDI:______________________

SPECIFY WHICH WILL BE EXPLORED IN CRITERIA BELOW :

- IF CONCURRENT OR SEQUENTIAL POLYSUBSTANCE USE :
  - EACH DRUG (OR DRUG CLASS) USED INDIVIDUALLY ☐
  - MOST USED DRUG (OR DRUG CLASS) ONLY ☐
- IF ONE DRUG (OR DRUG CLASS) USED : ☐
  - SINGLE DRUG (OR DRUG CLASS) ONLY

ELEZA NI DAWA IPI IPO NDANI YA VIGEZO HAPA CHINI:
KAMA NI MATUMIZI YA PAMOJA AU YENYE KUFUATANA YA DAWA ZAIDI YA MOJA:

- KILA KUNDI LA DAWA KUTUMIKA PEKE YAKE ☐
- KUNDI LA DAWA LINALOTUMIKA ZAIDI TU ☐
- NI DAWA MOJA TU / KUNDI LA DAWA IMETUMIKA ☐

J2) **Considering your use of [NAME THE SELECTED DRUG / DRUG CLASS] in the past 12 months :**
Fikiria matumizi yako ya madawa (TAJA JINA LA DAWA / KUNDI LA DAWA LILILOCHAGULIWA), katika miezi 12 iliyopita:

a Have you found that you needed to use more of [NAME OF SELECTED DRUG / DRUG CLASS] to get the same effect that you did when you first started taking it ? NO YES 1
Je, uliona kwamba unahitaji kutumia zaidi (Jina la dawa au kundi la dawa lililochaguliwa) ili kupata athari sawa na ile ulipotumia mara ya kwanza?

c When you reduced or stopped using [NAME OF SELECTED DRUG / DRUG CLASS] did you have withdrawal symptoms (aches, shaking, fever, weakness, diarrhea, nausea, sweating, heart pounding, difficulty sleeping, or feeling agitated, anxious, irritable or depressed) ?
Or did you use any drug(s) to keep yourself from getting sick (WITHDRAWAL SYMPTOMS) or so that you would feel better ?
IF **YES** TO EITHER, CODE **YES** NO YES 2

Wakati ulipopunguza au kutotumia (JINA LA DAWA / KUNDI LA DAWA LILILOCHAGULIWA) Je, ulipatwa na dalili zinazotokana na kuacha madawa? (Maumivu, kutetemeka, homa, udhaifu, kuharisha, kichefuchefu, kutokwa jacho, moyo kudunda, tabu ya usingizi, kujisikia wasiwasi, dukuduku, mwenye kuudhika upesi, au mwenye huzuni). Je ulitumia dawa/madawa yeyote ili kukufanya usiumwe (dalili za kuacha dawa) au

kukufanya ujisikie vizuri zaidi?
IKIWA JIBU NI **NDIYO** KWA SWALI LOLOTE, JAZA **NDIYO**

c	Have you often found that when you used [NAME OF SELECTED DRUG / DRUG CLASS], you ended up taking more than you thought you would? Je, mara kwa mara ulijiona kwamba wakati unatumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), uliishia kutumia nyingi zaidi kuliko uwezo wako?	NO	YES	3
d	Have you tried to reduce or stop taking [NAME OF SELECTED DRUG / DRUG CLASS] but failed? Je, ulijaribu kupunguza/kuacha kutumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA) lakini ukashindwa?	NO	YES	4
e	On the days that you used [NAME OF SELECTED DRUG / DRUG CLASS], did you spend substantial time (>2 hours), obtaining, using or recovering from the effects, or thinking about it ? Katika siku ambazo ulitumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA)Je, ulipoteza muda mwingi (> masaa 2) kupata, kutumia au kupata nafuu kutoka katika madawa au kufikiria juu ya madawa?	NO	YES	5
f	Did you spend less time working, enjoying hobbies, or being with family or friends, because of your drug use ? Je, ulitumia muda mchache kufanya kazi, kufurahia uvipendavyo, au kuwa na familia yako au marafiki kwa sababu ya kutumia kwako madawa?	NO	YES	6
g	Have you continued to use [NAME OF SELECTED DRUG / DRUG CLASS] even though it caused you health or mental problems? Je, uliendelea kutumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), japokuwa ilikusababishia matatizo ya kiafya na kiakili?	NO	YES	7

ARE **3** OR MORE **K2** ANSWERS CODED **YES**?

SPECIFY DRUG(S) : ____________________

JE VIPENGELE **3** AU ZAIDI VYA **K2** VIMEJIBIWA **NDIYO?**

TAJA DAWA / MADAWA: ____________________

NO	**YES**
	DRUG(S) DEPENDENCE CURRENT

DOES PATIENT CODES POSITIVE FOR DRUG DEPENDENCE? NO → YES

In the past 12 months :
Fikiria matumizi yako ya madawa (Jina la kundi la dawa lililochaguliwa)
Katika kipindi cha miezi 12 iliyopita:
Have you been intoxicated, high, or hangover from [NAME OF SELECTED DRUG / DRUG CLASS], more than once when you had other responsibilities at

	Question			
	school, at work, or at home? Did this cause any problem? (CODE YES ONLY IF THIS CAUSED PROBLEMS) Je, umewahi kurukwa akili, kuwa na hali ya juu, au kuwa na uchovu wa dawa (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), zaidi ya mara moja, wakati ambapo ulikuwa na majukumu mengine shuleni, kazini au nyumbani? Je hili lilileta matatizo yeyote? (JAZA NDIYO IKIWA TU HILI LILILETA MATATIZO)	NO	YES	8
b	Have you been high or intoxicated from [NAME OF SELECTED DRUG / DRUG CLASS] in any situation where you were physically at risk (e.g., driving a car, or a motorbike, using machinery, boating, etc.)? Je, umewahi kujisikia na hali ya juu au kurukwa akili kutokana na (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA) katika mazingira yeyote ambapo ulikuwa hatarini (mfano, kuendesha gari, kuendesha pikipiki, kutumia machine, kusafiri kwa mashua, nk).	NO	YES	9
	Did you have any legal problems because of your [NAME OF SELECTED DRUG / DRUG CLASS] use, e.g., an arrest or disorderly conduct ? Je, ulipata matatizo yeyote ya kisheria kwa sababu ya matumizi ya madawa mf. Kutiwa mbaroni au kufanya vurugu.	NO	YES	10
d	Did you continue to use [NAME OF SELECTED DRUG / DRUG CLASS] even though it caused problems with your family or other people ? Je uliendelea kutumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), japokuwa ilisababisha matatizo kwa familia yako au watu wengine	NO	YES	11

K4

ARE 1 OR MORE **K3** ANSWERS CODED **YES** ?

SPECIFY DRUG(S) : ____________________

JE, KIPENGELE **KIMOJA** AU ZAIDI CHA **K3** KIMEJIBIWA **NDIYO?**

TAJA DAWA/MADAWA : ____________________

NO	**YES**
DRUG(S) ABUSE CURRENT	
NDIYO	**HAPANA**
MATUMIZI YA MADAWA KWA SASA	

L. PSYCHOTIC DISORDERS
L. MAGONJWA YA SAIKOSIS

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 RATED BIZARRE IF : A VOICE COMMENTS ON THE PERSON'S THOUGHTS OR BEHAVIOR, OR WHEN TWO OR MORE VOICES ARE CONVERSING WITH EACH OTHER.

OMBA MFANO KWA KILA SWALI LINAJIBIWA NDIYO. JAZA NDIO IWAPO TU MIFANO INAONYESHA WAZI MABADILIKO YA MAWAZO AU UTAMBUZI AU KAMA HAIHUSIANI NA MILA NA DESTURI
KABLA YA KUJAZA CHUNGUZA IWAPO IMANI ZA UWONGO ZINA SIFA ZA KUWA SI ZA KAWAIDA.
IMANI POTOFU AMBAZO "SI ZA KAWAIDA" KAMA: ISIYOWEZEKANA KUWA KWELI, UPUUZI, ISIYOELEWEKA, NA ISIYOTOKANA NA MAISHA YA KAWAIDA.
HISIA POTOFU AMBAZO "SI ZA KAWAIDA" NI KAMA: SAUTI KUELEZEA JUU YA MAWAZO YA MTU AU TABIA, AU WAKATI SAUTI 2 AU ZAIDI ZINAZUNGUMZA ZENYEWE.

Now I'm going to ask you about unusual experiences that some individuals may experience.
Sasa ninakuuliza kuhusu matukio yasiyo ya kawaida ambayo watu wanapata.

			BIZARRE	
a Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you ? Je, umewahi kuamini kwamba watu wanakupeleleza, au kwamba mtu anapanga njama juu yako, au kujaribu kukudhuru? KUMBUKA: Ulizia mifano ili kupata uhalisia.	NO	YES	YES	1
b IF YES : Do you currently believe these things ?	NO	YES	YES	2

KAMA NDIYO: Je kwa sasa unaamini mambo haya? → L6a

L(2) a Have you ever believed that someone was reading your mind or could hear your thoughts or that you could actually read or hear what another person was thinking ? — NO YES 3
Je, umewahi kuamini kwamba mtu alikuwa anasoma mawazo yako au kuweza kusikia mawazo yako, au kwamba wewe kuweza kusoma mawazo ya mtumwingine au kusikia kile anachowaza mtu mwingine?

b **IF YES** : Do you currently believe these things ? — NO YES 4
KAMA NDIYO: Je kwa sasa unaamini mambo haya? → L6a

L(3) a Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self ? Have you ever felt that you were possessed? — NO YES 5
Je , umewahi kuamini kwamba mtu au nguvu Fulani kutoka nje zimeweka mawazo ndani yako na kwamba umekuwa siyo wewe mwenyewe, au imekufanya utende matendo ambapo haikuwa kawaida yako?
Je, umewahi kujisikia kama kwamba umemilikiwa?
TABIBU: ULIZIA MIFANO NA UONDOE YEYOTE ISIYOHUSIANA NA KURUKWA AKILI

b **IF YES** : Do you currently believe these things ? — NO YES 6
KAMA NDIYO: Je, kwa sasa unaamini mambo haya? → L6a

L4) a **Have you ever believed that you were being sent special messages through the TV, radio or newspaper, or that a person you did not personally know was particularly interested in you ?** — NO YES YES 7
Je, umewahi kuamini kwamba umekuwa ukipokea ujumbe maalum kupitia TV, redio, au magazeti, au kwamba mtu usiyemjua akawa amevutiwa na wewe?

b **IF YES** : Do you currently believe these things ? — NO YES YES 8
KAMA NDIYO: Je, kwa sasa unaamini mambo haya? → L6a

L5) a Have your relatives or friends ever considered any of your beliefs strange or out of reality ? — NO YES YES 9
ANY DELUSIONAL IDEAS NOT EXPLORED IN QUESTIONS L1 TO L4, E.G., OF GRANDIOSITY, RUIN, GUILT, HYPOCONDRIASIS,...
Je, ndugu zako au marafiki walishawahi kuona kwamba imani zako ni za ajabu au si za kawaida? Tafadhali, naomba mifano.
MSAILI: Jaza ndiyo ikiwa tu mifano inaonyesha wazi kuwa ni imani za uwongo ambazo hazikuelezwa katika maswali L1 mpaka L4, mfano, za kujifaharisha, za unyong'onyevu, za maangamizi, kuwa na hatia, n.k.

b **IF YES**: Do they currently consider your beliefs strange ? — NO YES YES 10
KAMA NDIYO: Je, kwa sasa wanaona imani zako ni za ajabu?

L6) a Have you ever heard things other people couldn't hear, such as voices ? — NO YES YES 11
HALLUCINATIONS ARE CODED « BIZARRE » ONLY IF PATIENT ANSWERS YES TO THE FOLLOWING :
Did you hear a voice commenting on your thoughts or behavior, or did you hear two or more voices talking to each other ?

6a1 The voices you heard talking about you in 6a above, do you know the

people
Je umewahi kusikia mambo ambayo wengine hawasikii, kama vile sauti?
A₁ The voices you heard talking about you in 6a above, do you know the people

HISIA POTOFU ZINAKUWA "SI ZA KAWAIDA" IKIWA TU MGONJWA ANAJIBU NDIYO KATIKA SWALI LIFUATALO:
Je ulisikia sauti ikielezea mawazo yako au tabia au kusikia sauti mbili au zaidi zikizungumza zenyewe?

b	**IF YES** : Have you heard these things in the past month ? **KAMA NDIYO:** Je, umesikia vitu hivi ndani ya mwezi 1 uliopita?	NO	YES	YES → L8b	12
L7) a	Have you ever had visions when you were awake or have you ever seen things other people couldn't see ? CODE YES ONLY IF THE VISIONS ARE CULTURALLY INAPPROPRIATE. Je, umewahi kuwa na ndoto wakati yu macho au kuona vitu ambapo watu wengine hawavioni? **TABIBU:** chunguza ili kujua kama havihusiani na mambo ya kimila na desturi?	NO	YES		13
B	**IF YES** : Have you seen these things in the past month? : INTERVIEWER'S JUDGMENT : **KAMA NDIYO:** Je umeviona vitu hivi katika mwezi mmoja uliopita? UAMUZI WA TABIBU	NO	YES		14
L8) b	IS THE PATIENT CURRENTLY EXHIBITING INCOHERENCE, DISORGANIZED SPEECH, OR MARKED LOOSENING OF ASSOCIATIONS ? JE MGONJWA KWA SASA ANAONYESHA MAMBO YASIYOELEWEKA, MANENO YASIYO NA MPANGILIO, AU MAMBO YASIYOUNGANIKA.	NO	YES		115
L9) b	IS THE PATIENT CURRENTLY EXHIBITING DISORGANIZED OR CATATONIC BEHAVIOR ? JE KWA SASA MGONJWA ANAONYESHA TABIA ISIYOELEWEKA AU KUZUBAA?	NO	YES		16
10b	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? JE, DALILI HASI ZA SKIZOFRENIA, MFANO KUTODHIHIRISHA HISIA, UPUNGUFU WA MANENO YA KUSEMA (KUTOSEMA) AU KUTOWEZA KUANZISHA AU KUDUMU KATIKA SHUGHULI MAALUM, ZINAONEKANA WAKATI WA USAILI?	NO	YES		17

FROM **L1 TO L10** :
- ARE **1 OR MORE** « **b** » QUESTIONS CODED **YES BIZARRE** ?

OR

- ARE **2** OR MORE « **b** » QUESTIONS CODED **YES** (RATHER THAN YES BIZARRE) ?
- JE KIPENDELE **KIMOJA** AU ZAIDI VYA MASWALI **(b)**

NO	YES
PSYCHOTIC SYNDROME CURRENT	

KIMEJIBIWA **NDIYO SI YA KAWAIDA**?

AU

- JE, VIPENGELE **2** AU ZAIDI VYA MASWALI **(b)** VIMEJIBIWA **NDIYO** (BADALA YA NDIYO SI YA KAWAIDA).

L12 FROM **L1 TO L7** :

- ARE **1** OR MORE « **a** » QUESTIONS CODED **YES BIZARRE** ?

OR

- ARE **2** OR MORE « **a** » QUESTIONS CODED **YES** (RATHER THAN YES BIZARRE) ?

(CHECK THAT THE 2 SYMPTOMS OCCURRED DURING THE SAME TIME PERIOD)

OR

- IS **L11** CODED **YES** ?

NO **YES**

PSYCHOTIC SYNDROME LIFETIME

L12
- JE, KIPENGELE 1 AU ZAIDI YA MASWALI **(a)** VIMEPITIWA **NDIYO SI YA KAWAIDA**?

AU

- JE, VIPENGELE **2** AU ZAIDI VYA MASWALI **(a)** VIMEJIBIWA **NDIYO** (BADALA YA NDIYO SI YA KAWAIDA)

UAMUZI WA TABIBU

CHUNGUZA KAMA DALILI 2 ZILITOKEA WA KATI MMOJA

AU

- JE, KIPENGELE **L11** KIMEJIBIWA **NDIYO**?

L13a IF L12 IS CODED YES OR AT LEAST ONE YES FROM L1 TO L7 :

DOES THE PATIENT CODE POSITIVE FOR EITHER
MAJOR DEPRESSIVE EPISODE (CURRENT OR PAST)
OR MANIC EPISODE (CURRENT OR PAST) ?

→
NO YES

L13a KAMA L12 IMEJIBIWA NDIYO NA ANGALAU NDIYO MOJA KUTOKA L1 MPAKA L7:

JE DALILI HIZO ZIMEJIBIWA NDIYO KWA AIDHA
TUKIO LA SONONA. (KWA SASA)
AU TUKIO LA MANIA, (KWA SASA AU MUDA ULIOPITA)?

NO YES 18

b You told me earlier that you had period(s) when you felt depressed/ high/ persistently irritable.
Were the beliefs and experiences you just described (SYMPTOMS CODED YES FROM L1 TO L7) restricted exclusively to times when you were feeling depressed / high / irritable ?

Kama L13 imejibiwa ndiyo:
Uliniambia mwanzoni kwamba kulikuwa na vipindi ambavyo ulijisikia (huzuni/hali ya juu/mwepesi wa kuudhika mara zote).
Je, imani na matukio uliyoyaeleza hivi punde (dalili zimejibiwa ndiyo kutoka L1 mpaka L7).vimekuwepo pale tu ulipojisikia huzuni/hali ya

juu/mwenyekuudhika?.

L14 IS **L13b** CODED **YES** ?
JE, **L13b** IMEJIBIWA **NDIYO**?

NO	**YES**
MOOD DISORDER WITH PSYCHOTIC FEATURES CURRENT	

M. ANOREXIA NERVOSA
M. UGONJWA WA TAFSIRI YA MAUMBILE BINAFSI UNAOHUSIANA NA KUTOKULA

M1 a How tall are you ? |__|__|__| Ft ☐ Ins ☐ Cm ☐

a Una urefu kiasi gani?

b What was your lowest weight in the past 3 months ? |__|__|__| Lbs. ☐ Kg ☐

b Ni uzito upi mdogo kuliko wote katika miezi mitatu iliyopita.

c IS PATIENT'S WEIGHT LOWER THAN THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT ? SEE TABLE BELOW — → NO YES 1

c JE, UZITO WA MGONJWA NI MDOGO KULIKO KIWANGO KINACHOLINGANA NA UREFU WAKE? (ANGALIA JEDWALI CHINI)

In the past 3 months :
Katika miezi 3 iliyopita:

M2 In spite of this low weight, have you tried not to gain weight ? → NO YES 2

M2 Pamoja na uzito huu mdogo, je ulijaribu kutoongeza uzito?

M3 Have you feared gaining weight or becoming fat, even though you were underweight ? → NO YES 3

M3 Je, ulihofia kuongezeka uzito au kuwa mnene hata kama ulikuwa na uzito mdogo?

M4a Have you considered yourself fat or that part of your body was too fat ? NO YES 4

a Je ulijiona wewe mwenyewe mnene, au sehemu ya mwili wako nene sana?

b Has your body weight or shape greatly influenced how you felt about yourself ? NO YES 5

b Je, uzito wa mwili wako au umbile umeathiri kwa kiasi kikubwa jinsi unavyojiona?

c Have you thought that your current low body weight was normal or excessive ? NO YES 6

c Je, ulifikiria kwamba uzito wako mdogo wa sasa ni kawaida au umezidi?

ARE 1 OR MORE **M4** ANSWERS CODED **YES** ? → NO YES

JE, KIPENGELE **KIMOJA** AU ZAIDI VYA **M4** VIMEJIBIWA **NDIYO?**

M5 FOR WOMEN ONLY : During the last 3 months, did you miss all your menstrual periods when they were expected to occur (when you were not pregnant) ? → NO YES 7

M5 Kwa wanawake tu: Katika miezi mitatu iliyopita, Je ulikosa siku zako zote

→ MEANS **GO** TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, **CIRCLE NO** IN ALL OF THEM AND **MOVE** TO THE NEXT MODULE

za hedhi pale ambapo ulizitarajia kutokea (wakati hukuwa mjamzito)?

M7

FOR WOMEN : ARE **M5** AND **M6** CODED **YES** ?
FOR MEN : IS **M5** CODED **YES** ?
KWA WANAWAKE: JE, **M5** NA **M6** VIMEJIBIWA **NDIYO**?
KWA WANAUME: JE, **M5** IMEJIBIWA **NDIYO**?

NO	YES
ANOREXIA NERVOSA CURRENT	

TABLE HEIGHT / WEIGHT THRESHOLD (HEIGHT-WITHOUT SHOES ; WEIGHT-WITHOUT CLOTHING)

HEIGHT(cm) UREFU (sm)		140	145	150	155	160	165	170	175	180	185	190
WEIGHT (kg) UZITO (kilo)	Females Wanawake	37	38	39	41	43	45	47	50	52	54	57
	Males Wanaume	41	43	45	47	49	51	52	54	56	58	61

WEIGHT THRESHOLDS ABOVE ARE CALCULATED AS A 15% REDUCTION BELOW THE NORMAL RANGE FOR THE PATIENT`S HEIGHT AND GENDER AS REQUIRED BY DSM-IV

N. BULIMIA NERVOSA
N. UGONJWA WA TAFSIRI YA MAUMBILE BINAFSI UNAOHUSIANA NA KULA MNO

N1	In the past three months, did you have eating binges or times when you ate a very large amount of food within a 2-hour period ?	→ NO	YES	8
N1	Katika miezi mitatu iliyopita, je uliwahi kula kupita kiasi au wakati ambapo umekula chakula kingi sana ndani ya masaa mawili?			
N2	In the last three months, did you have eating binges as often as twice a week ?	→ NO	YES	9
N2	Katika miezi 3 iliyopita, je umewahi kula kupita kiasi kila mara, mara 2 kwa wiki?			
N3	During these binges, did you feel that your eating was out of control ?	→ NO	YES	10
N3	Katika milo hii, ulijisikia kwamba kula kwako ni kwa kushindwa kujitawala?			
N4	Did you do anything to compensate for, or to prevent a weight gain from these binges, like vomiting, fasting, exercising or taking laxatives, enemas, diuretics (fluid pills), or other medications ?	→ NO	YES	11
N4	Je ulifanya kitu chochote kufidia, au kuzuia kuongezeka uzito kutokana na milo hii, kama vile kutapika, kushinda na njaa, kufanya mazoezi, kumeza dawa za kuharisha, enema, kuongeza mkojo au dawa nyinginezo?			
N5	Does your body weight or shape greatly influence how you feel about yourself ?	→ NO	YES	12
N5	Je uzito wako au umbile lako linaathiri kwa kiasi kikubwa jinsi unavyojiona?			
N6	DOES THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA ? IF N6 = NO, SKIP TO N8	NO	YES	13
	Do these binges occur only when you are under ______ kg/lbs.* ? • TAKE THE THRESHOLD WEIGHT FOR THIS PATIENT'S HEIGHT FROM THE HEIGHT / WEIGHT TABLE IN THE ANOREXIA NERVOSA MODULE	NO	YES	14
	Je, milo hii ya kupita kiasi hutokea pale tu una uzito chini ya kilo ______ ? • ANDIKA KIWANGO CHA UZITO KINACHOLINGANA NA UREFU WA MGONJWA KUTOKA KATIKA JEDWALILILILOPO KWENYE KIHUNZI CHA UGONJWA WA KUTOKULA			

N8 IS **N5** CODED **YES** AND **N7** CODED **NO** (OR SKIPPED) ?
JE, **N5** IMEJIBIWA NDIYO **N7** IMEJIBIWA HAPANA (AU IMERUKWA KWA SABABU DALILI ZA MGONJWA HAZIFIKII VIGEZO VYA UGONJWA WA KUTOKULA)?

NO **YES**

BULIMIA NERVOSA
CURRENT

N9 IS **N7** CODED **YES** ?
JE, **N7** IMEJIBIWA **NDIYO**?

NO **YES**

ANOREXIA NERVOSA
Binge-Eating/Purging Type
CURRENT

O. GENERALIZED ANXIETY DISORDER
O. UGONJWA WA WASIWASI MKUBWA

O(1) a Have you worried excessively or been anxious about several things of day to day life, at work, at home, in your close circle over the past 6 months ? → NO YES 1

DO NOT CODE YES IF THE FOCUS OF THE ANXIETY IS CONFINED TO ANOTHER DISORDER EXPLORED PRIOR TO THIS POINT SUCH AS HAVING A PANIC ATTACK (PANIC DISORDER), BEING EMBARRASSED IN PUBLIC (SOCIAL PHOBIA), BEING CONTAMINATED (OCD), GAINING WEIGHT (ANOREXIA NERVOSA)...

Are these worries present most days ? → NO YES 2

O(1) a Je, ulikuwa na woga sana au kupata wasiwasi juu ya mambo mawili au zaidi(mf. Pesa, afya ya watoto, msiba) kwa kipindi cha miezi 6 iliyopita? Zaidi ya watu wengi webgine wanavyokuwa?

Je, woga huu unakuwepo karibu siku zote?

O2) Do you find it difficult to control the worries or do they interfere with your ability to focus on what you are doing ? → NO YES 3

O2) Je unapata tabu kujizuia na woga, au je inavuruga uwezo wako wa kuwa makini kwa unachokifanya?

FROM O3a TO O3f, CODE NO THE SYMPTOMS CONFINED TO FEATURES OF ANY DISORDER EXPLORED PRIOR TO THIS POINT

O3 **When you were anxious over the past 6 months, did you, almost every day :**

O3 **Waakati ulipokuwa na wasiwasi katika miezi 6 iliyopita, je, muda mwingi:**

a Feel restless, keyed up or on edge ? NO YES 4

a Ulijisikia kutotulia, kuamshwa, au mwenye kiherehere?

b Feel tense ? NO YES 5

b Ulijisikia kukakamaa?

→ MEANS GO TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, **CIRCLE NO** IN ALL OF THEM AND **MOVE** TO THE NEXT MODULE

c	Feel tired, weak or exhausted easily ?	NO	YES	6
c	Ulijisikia kuchoka, mdhaifu, au kuchoka mapema?			
d	Have difficulty concentrating or find your mind going blank ?	NO	YES	7
d	Ulipata tabu ya kuwa makini, au kuona unapoteza kumbukumbu?			
e	Feel irritable ?	NO	YES	8
e	Ulijisikia mwenye kuudhika upesi?			
f	Have difficulty sleeping (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively) ?	NO	YES	9
f	Ulipata tabu ya usingizi (tabu ya kupata usingizi, kuamka katikati ya usiku, kuamka mapema asubuhi, au kulala mno)?			

ARE **3** OR MORE **O3** ANSWERS CODED **YES** ?

JE VIPENGELE **3** AU ZAIDI VYA **O3** VIMEJIBIWA **NDIYO**?

NO **YES**

GENERALIZED ANXIETY DISORDER CURRENT

P. ANTISOCIAL PERSONALITY DISORDER (optional)

P. UGONJWA WA MAKUZI YA HULKA NA TABIA ZINAZOPINGANA NA JAMII (hiari)

Before you were 15 years old, did you :
Kabla hujawa na umri wa miaka 15, je:

Repeatedly skip school or run away from home overnight ? Ulikuwa ukitoroka shule mara kwa mara au kuondoka nyumbani usiku?	NO	YES	1
Repeatedly lie, cheat, « con » others, or steal? Ulikuwa ukidanganya mara kwa mara, ukilaghai, kutapeli wengine, au kuiba?	NO	YES	2
Start fights or bully, threaten, or intimidate others? Ulianzisha ugomvi au kudhulumu, kutishia au kutisha wengine?	NO	YES	3
Deliberately destroy things or start fires? Kwa makusudi uliharibu vitu au kuwasha moto?	NO	YES	4
Deliberately hurt animals or people? Kwa makusudi kuwadhuru wanyama au watu?	NO	YES	5
Force someone to have sex with you? Kumlazimisha mtu kufanya mapenzi na wewe?	NO	YES	6

ARE 2 OR MORE **P1** ANSWERS CODED **YES**? — NO YES
JE, VIPENGELE **2** AU ZAIDI VYA **P1** VIMEJIBIWA **NDIYO**?

DO NOT CODE YES THE BEHAVIORS BELOW IF THEY ARE EXCLUSIVELY POLITICALLY OR RELIGIOUSLY MOTIVATED
USIJIBU NDIYO KWA TABIA ZILIZO HAPA CHINI IKIWA ZIMESABABISHWA NA MAMBO YA KISIASA AU KIDINI

**Since you were 15 years old, have you: **
Tangu umri wa miaka 15, je:

Repeatedly behaved in a way that others would consider irresponsible, like failing to pay for things you owed, deliberately being impulsive or deliberately not working to support yourself? Mara kwa mara ulikuwa na tabia ambayo watu wengine wangeona kama ni kutowajibika, kama vile kushindwa kulipa madeni, kwa makusudi kuwa jazba au kwa makusudi kutofanya kazi ili kujitegemea?	NO	YES	7
Done things that are illegal even if you didn't get caught (i.e., destroying property, shoplifting, stealing, selling drugs, or committing a felony) ? Hufanya mambo kinyume cha sheria hata kama hukutiwa mbaroni (kama vile, kuharibu mali, kuiba vitu dukani, wizi, kuuza madawa ya kulevya, au kufanya kosa la jinai)?	NO	YES	8
Been in physical fights repeatedly (including physical fights with your spouse or children) ?	NO	YES	9

Ulikuwa ukipigana mara kwa mara (ikiwemo kupigana na mke / mume wako au watoto)

d Often lied or « conned » other people to get money or pleasure, or lied just for fun? NO YES
Mara kwa mara kudanganya au "kutapeli" watu wengine ili kupata pesa au starehe, au kudanganya kwa kuchekesha watu tu?

e Exposed others to danger without caring? NO YES
Kuwaweka wengine katika hatari bila ya kujali?

f Felt no guilt after hurting, mistreating, lying to, or stealing from others, or after damaging property? NO YES
Kujiona huna hatia baada ya kuleta madhara, kufanya maovu, kudanganya, au kuwaibia watu, au baada ya kuharibu mali?

ARE 3 OR MORE ITEMS FROM **P2** CODED **YES** ?
JE, VIPENGELE **3** AU ZAIDI VYA **P2** VIMEJIBIWA **NDIYO**?

NO	**YES**
ANTISOCIAL PERSONALITY DISORDE LIFETIME	

EFERENCES

bier Y, Sheehan D, Weiller E, Amorim P, Bonora I, Sheehan K, Janavs J, Dunbar G. The Mini International Neuropsychiatric Interview (M.I.N.I.), a short diagnostic interview : Reliability and validity according to the CIDI. *European Psychiatry*, 1997 ; **12** : 224-231.

n DV, Lecrubier Y, Harnett Sheehan K, Janavs J, Weiller E, Bonora LI, Keskiner A, Schinka J, Knapp E, Sheehan MF, Dunbar GC. bility and validity of the Mini International Neuropsychiatric Interview (M I N I.) according to the SCID-P. *European Psychiatry*, 1997 ; **12** 32-241.

n DV, Lecrubier Y, Harnett Sheehan K, Amorim P, Janavs J, Weiller E, Hergueta T., Baker R, Dunbar G. The Mini International psychiatric Interview (M I N I), : The development and validation of a structured diagnostic psychiatric interview. In press. *Journal of cal Psychiatry*, 1998

m P. Lecrubier Y, Weiller E, Hergueta T, Sheehan D. DSM-III-R Psychotic disorders : procedural validity of the Mini International psychiatric Interview (M I N I). Concordance and causes for discordance with the CIDI. *European Psychiatry*, 1998 ; **13** : 26-34.

M.I.N.I. was developed simultaneously into French and English The French and English original versions of the M I N I for DSM-IV were translated and can ted to the authors (see page 3) An ICD-10 version is also available into French, English, Danish and Indonesian

nges	**M.I.N.I. 4.4 and previous versions**	**M.I.N.I. 5.0.0 +**
		R Emsley, N Kevter
		O. Osman, E Al-Radi
		In preparation
		H. Banerjee, A Banerjee
	P Amorim	P Amorim
		L G Hranov
		In preparation
	P Zvolsky	P Zvolsky
		In preparation
nish	P Bech	P Bech, G Bech-Andersen, T Schutze
	E. Griez, K Schruers, T Overbeek, K Demyttenaere	I. van Vliet, H Leroy, H van Megen
(Arabic)		R Haddad, W Naja, C Baddoura, A Okasha
		J Shlik, A Aluoja, E Kihl

→ MEANS : **GO** TO THE DIAGNOSTIC BOX(ES) OF THIS MODULE, **CIRCLE NO** IN ALL OF THEM AND **MOVE** TO THE NEXT MODULE

Ulikuwa ukipigana mara kwa mara (ikiwemo kupigana na mke / mume wako au watoto)

d Often lied or « conned » other people to get money or pleasure, or lied just for fun? — NO YES 10
Mara kwa mara kudanganya au "kutapeli" watu wengine ili kupata pesa au starehe, au kudanganya kwa kuchekesha watu tu?

e Exposed others to danger without caring? — NO YES 11
Kuwaweka wengine katika hatari bila ya kujali?

f Felt no guilt after hurting, mistreating, lying to, or stealing from others, or after damaging property? — NO YES 12
Kujiona huna hatia baada ya kuleta madhara, kufanya maovu, kudanganya, au kuwaibia watu, au baada ya kuharibu mali?

ARE **3** OR MORE ITEMS FROM **P2** CODED **YES** ?
JE, VIPENGELE **3** AU ZAIDI VYA **P2** VIMEJIBIWA **NDIYO**?

NO **YES**

ANTISOCIAL PERSONALITY DISORDER LIFETIME

EFERENCES

crubier Y, Sheehan D, Weiller E, Amorim P, Bonora I, Sheehan K, Janavs J, Dunbar G. The Mini International Neuropsychiatric Interview (M.I.N.I.), a short diagnostic interview : Reliability and validity according to the CIDI. *European Psychiatry*, 1997 ; **12** 224-231

eehan DV, Lecrubier Y, Harnett Sheehan K, Janavs J, Weiller E, Bonora LI, Keskiner A, Schinka J, Knapp E, Sheehan MF, Dunbar GC. ability and validity of the Mini International Neuropsychiatric Interview (M.I.N.I.) according to the SCID-P. *European Psychiatry*, 1997 ; **12** 32-241

eehan DV, Lecrubier Y, Harnett Sheehan K, Amorim P, Janavs J, Weiller E, Hergueta T., Baker R, Dunbar G. The Mini International europsychiatric Interview (M.I.N.I.), : The development and validation of a structured diagnostic psychiatric interview. In press. *Journal of inical Psychiatry*, 1998.

m P, Lecrubier Y, Weiller E, Hergueta T, Sheehan D. DSM-III-R Psychotic disorders : procedural validity of the Mini International psychiatric Interview (M.I.N.I.). Concordance and causes for discordance with the CIDI. *European Psychiatry*, 1998 ; **13** 26-34

he M.I.N.I. was developed simultaneously into French and English. The French and English original versions of the M.I.N.I. for DSM-IV were translated and can sked to the authors (see page 3). An ICD-10 version is also available into French, English, Danish and Indonesian

	M.I.N.I. 4.4 and previous versions	**M.I.N.I. 5.0.0 +**
		R. Emsley, N. Keyter
		O. Osman, E. Al-Radi
		In preparation
		H. Banerjee, A. Banerjee
	P. Amorim	P. Amorim
		L.G. Hranov
		In preparation
	P. Zvolsky	P. Zvolsky
		In preparation
	P. Bech	P. Bech, G. Bech-Andersen, T. Schutze
Flemish	E. Griez, K. Schruers, T. Overbeek, K. Demyttenaere	I. van Vliet, H. Leroy, H. van Megen
(Arabic)		R. Haddad, W. Naja, C. Baddoura, A. Okasha
		J. Shlik, A. Aluoja, E. Kihl

…/Persian		K Khooshabi, A Zomorodi
…nish	M Heikkinen, M Lijeström, O. Tuominen	M Heikkinen
…rman	L van Denffer, M Ackenheil, R Dietz-Bauer	M Ackenheil, G. Stotz, R Dietz-Bauer, A Vossen
…jarati		M Patel, B Patel
Greek	S Beratis	T Calligas, S Beratis
…brew	J Zohar, Y Sasson	R Barda, I Levinson
…ndi		K Batra, S Gambir
…garian	I Bitter, J Balazs	I Bitter, J Balazs
…landic		J Stefanson
…onesian		A Maramis et al
…lian	P Donda, E Weiller, I Bonora	L Conti, P Donda, A Rossi, M Piccinelli, M Tansella, G Cassano
…anese		T Otsobo, H Watanabe, H Miyaoka, K Kamijima, J Shinoda, K Tanaka, Y Okajima
Korean		H Y Jung et al
…vian	V Janavs, J Janavs, I Nagobads	V Janavs, J Janavs
…anese (Arabic)		R Haddad, W Naja, C Baddoura
…uanian		V Danilevicute
…		Adapted from A Maramis
…aysian (Chinese)		L.Caroll, J-d-Juang, Ong Choong Moi
…occan (Arabic)		N Kadri, M Agoub, S El Gnaou
…wegian	G Pedersen, S Blomhoff	K Leiknes, S Leganger, E. Malt, U Malt
…lish	M Masiak, E Jasiak	M Masiak, J. Przychoda
…uguese	P Amorim	T. Guterres, P Levy, P Amorim
…jabi		A Gahunia, S Gambhir
…manian	O Driga	M.D Gheorghe
…ssian		A Bystitsky, E. Selivra, M Bystitsky
…bian	I Timotijevic	I Timotijevic
…swana		K Ketlogetswe
…vak		L. Vavrušova, J Pečeňak, L. Forgačova
…venian	M Kocmur	M Kocmur
…nish	L. Ferrando, J Bobes-Garcia, J Gibert-Rahola	L Ferrando, L Franco-Alfonso, M Soto, J Bobes, O Soto, L Franco, J Gibert Adaptation for Central and South America: G. Heinze
…edish	M. Waern, S. Andersch, M Humble	C Allgulander, M Waern, M. Humble, S. Andersch, H Ågren
…ai		P. Kittirattanapaiboon, S. Mahatnirunkul, P Udomrat, P. Silpakit, M Khamwongpin, S. Srikosai
…alog (Filipino)		B L Conde, A Lao
…wanese (Chinese)		L. Caroll, K-d Juang
…kish	T. Örnek, A Keskiner, I Vahip	Y. Yazgan

…idation studies on the M I N I. were made possible, in part, by grants from SmithKline Beecham, the Caisse Nationale d'Assurance Maladie (701061) and the …pean Union. The authors are grateful to Dr Pauline

Appendix 2c: M.I.N.I.SCREEN and MINI PLUS FOR ADULTS

Participants Name: ________________ Date of Birth: ____________________ *(AGE IN YEARS-------) TEL--------------; ALTERNATIVE TEL.............................. DISTRICT AT CURRENT ADDRESS------------*

ID|__|__|__|__|__|__|

MINI PLUS SCREEN ADULTS

A_1 ___ A_2 ___ B ___ C ___ D_1 ___ D_2 ___ E ___ F ___ G ___ H_1 ___ H_2 ___ I_1 ___ I_2 ___ I_3 ___ J ___ K (Name the street name of drug and amount taken-------------,-------------------,-------------------,-------------=------------,----------:(Name the Chemical of drug and amount taken-------------,-----------------,-------------------,------------=------------,---------))L_1 ___ L_2 ___ M ___ N_1 ___ N_2 ___ O ___ P ___

MAIN QUESTIONNAIRE

A. MAJOR DEPRESSIVE EPISODE

A1: ___ A2a: ___ A2b ___ A3: a ___ b ___ c ___ d ___ e ___ f ___ g ___

A4 ___ A5 a___ A5b ___ A5c ___ A6 a ___ b ___ c ___ A7: a ___ b ___ c ___ d ___ e ___ f ___ A8: ___

B. DYSTHYMIA

B1 ___ B2 ___ B3: a ___ b ___ c ___ d ___ e ___ f ___ B4 ___ B5 ___

C. SUICIDALITY

C1 ___ C2 ___ C3 ___ C4 ___ C5 ___ C6 ___ C7 ___

D. (HYPO) MANIC EPISODE

D1: a ___ b ___ D2: a ___ b ___ D3: a ___ b ___ c ___ d ___ e ___ f ___ g ___ h ___
D4 ___ D5 ___ D6 ___

E. PANIC DISORDER

E1: ___ E2 ___ E3 ___ E4: a ___ b ___ c ___ d ___ e ___ f ___ g ___ h ___ I ___ j ___
k ___ l ___ m ___ E5: ___ E6 ___ E7 ___

F. AGORAPHOBIA

F1 ____ F2 ____ F3 ____ F4 ____ F5 ____

G. SOCIAL PHOBIA *(Social Anxiety Disorder)*

G1 ____ G2 ____ G3 ___ G4 ___ G5 ___

H. OBSESSIVE-COMPULSIVE DISORDER

H1 ___ H2 ___ H3 ___ H4____ H5 ___ H6 ___ H7 ___

I. POST TRAUMATIC STRESS DISORDER

I1 ___ I2 ___ I3 a ___ b ___ c ___ d ___ e ___ f ___ g ___ I4 a ___ b ___ c ___ d ___
e ___ f ___ I5____ I6 ___

J. ALCOHOL ABUSE AND DEPENDENCE

Give the street name for each type of alcohol taken and specify amount in the space below before moving on to J-------

J1 ___ J2 a ___ b ___ c ___ d ___ e ___ f ___ g ___ h ___ i ___ J3 a ___ b ___ c ___ d ___ e ___

K. NON-ALCOHOLPSYCHOACTIVE SUBSTANCE USE DISORDERS

K1-CIRCLE EACH DRUG TAKEN:

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

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

Narcotics: heroin, morphine, Dilaudid, opium, Demerol, methadone, codeine, Percodan, Darvon, 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, nonprescription sleep or diet pills. Any others?

Specify MOST USED Drug, GIVE BOTH STREET NAMES AND CHEMICAL NAMES AND SPECIFY AMOUNT TAKEN FOR EACH DRUG(s): ____________

CHECK ONE BOX

ONLY ONE DRUG / DRUG CLASS HAS BEEN USED ☐

ONLY THE MOST USED DRUG CLASS IS INVESTIGATED. ☐

EACH DRUG CLASS USED IS EXAMINED SEPARATELY (PHOTOCOPY L2 AND L3 AS NEEDED) ☐

b SPECIFY WHICH DRUG/DRUG CLASS WILL BE EXPLORED IN THE INTERVIEW BELOW IF THERE IS

CONCURRENT OR SEQUENTIAL POLYSUBSTANCE USE:____________________

K2$_1$: a ___ b ___ c ___ d ___ e ___ f ___ g ___ h ___ i ___ (Give The street names and specify amount taken ___________,___________, ___________, ___________).

K2$_2$: a ___ b ___ c ___ d ___ e ___ f ___ g ___ h ___ i ___ (2 specify the chemical name of the drugs ___________,___________, ___________, ___________).

K3$_1$: a ___ b ___ c ___ d ___ e ___ (give street name of the drug ___________,___________, ___________).

K3$_2$: a ___ b ___ c ___ d ___ e ___ (give chemical name of the drug ___________,___________, ___________).

K4 ___

L. PSYCHOTIC DISORDERS

L1A: a ___ b ___ L2A: a ___ b ___ L3A: a ___ b ___ L4A: a ___ b ___ L5A: a ___ b ___ L6A: a ___ a$_1$_____ b ___ L7A: a ___ b ___ L8b b ___ L9 b ___ L10b ___ L11 ___ L12 ___ L13 a ___ b ___ L14 ___

M. ANOREXIA NERVOSA

M1: a ___ b ___ c___ M2 ___ M3 ___ M4: a ___ b ___ c ___ M5 ___ M6 ___ M7 ___

TABLE HEIGHT / WEIGHT THRESHOLD (HEIGHT-WITHOUT SHOES ; WEIGHT-WITHOUT CLOTHING)

HEIGHT(cm) UREFU (sm)	140	145	150	155	160	165	170	175	180	185	190
Females Wanawake WEIGHT (kg) UZITO (kilo)	37	38	39	41	43	45	47	50	52	54	57
Males Wanaume	41	43	45	47	49	51	52	54	56	58	61

THE WEIGHT THRESHOLDS ABOVE ARE CALCULATED AS A 15% REDUCTION BELOW THE NORMAL RANGE FOR THE PATIENT'S HEIGHT AND GENDER AS REQUIRED BY DSM-IV.

N. BULIMIA NERVOSA

N1 __ N2 ___ N3 ___ N4 ___ N5 ___ N6 ___ N7 ___ N8 ___ N9 _______

O. GENERALIZED ANXIETY DISORDER

O1: __ O2 ___ O3: a ___ b ___ c ___ d ___ e ___ f ___ g ___

P. ANTISOCIAL PERSONALITY DISORDER (optional)

P1: a ___ b ___ c ___ d ___ e ___ f ___ P2: a ___ b ___ c ___ d ___ e ___ f ___ g

Appendix 2d: MINI-MENTAL STATE EXAMINATION (MMSE) QUESTIONNAIRE

Orientation (maximum marks = 10, 1 for each)

Name this hospital ____________

What city are you in now? ____________

What year is it? ____________

What month is it? ____________

What is the date today? ____________

What province/district are you in? ____________

What country is this? ____________

What ward are you in? ____________

What day of the week is it? ____________

What season (dry, wet) of the year is it? ____________

Registration (Three marks, are for a, b, c, each)

I am going to give you names of three objects, you will required to say and remember them. I will ask you for the objects after some time. Repeat after me: hen, tree, cup.

Name the three objectives and have the patient repeat them. Score number repeated by the patient. Name the three objects several more times it needed for the patient to repeat correctly (record trials ___).

The scores (a) hen ___ (number of trials before it is correctly recalled) _____

(b) tree ___ (number of trials before it is correctly recalled) _____

(c) cup ___ (number of trials before it is correctly recalled) _____

Attention and calculation (maximum score = 5 are for each correct answer (a – e)

ubtract 7 from 100 in serial fashion to 65.

Maximum score = 5 or say the days of the week forward then backwards _____

Recall (Three marks one for each)

What are the three object repeated above/Do you recall the three objects named before? (a) hen ___ (b) tree ___ (c) up ___

Language tests (8 marks)

a) Confrontation naming: A pencil/pen and a watch/key are shown to the patient and he/she asked to name them -(i) watch (1 mark) ____

(ii) pen (1 mark) ____

b) Repetition: "No its, ands, or buts" (1 mark) ___

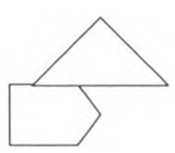
c) Comprehension: (i) Pick up the paper in your right hand, (ii) fold it in half, and (ii) set it on the floor or (i) Take a pen (ii) remove the cover and (iii) put it on the bed (3 marks for correctly carried out instructions) ____

Read and perform the command "close your eyes" (1 mark) ___

Write any sentence (subject, object, verb) (1 mark)

Construction (maximum 1 mark)

Copy the design below (1 mark)



Draw a clock face

Total MMSE questionnaire score (maximum = 30) _______

Other mental state examinations areas to be assessed

Behaviour and appearance ____

Mood ______________________________

Speech(quality & quantity) ______________________________

____

Thought process ______________________________

____

____

Thought content ______________________________

____

Perception process ______________________________

____

Diagnosis

____

____

____

____

Treatment

Investigations ______________________________

____

Biological treatment (s)

____

____

iii) Psychosocial/Spiritual

APPENDIX 2E: MY MEMORIES OF UPBRINGING-(EMBU) QUESTIONNAIRE

EMBU Questionnaire

It can sometimes be difficult to remember in what way one's parents were alike and in what way they differed. Do therefore try, for each question, first to consider how your father behaved and then how your mother behaved towards you.

Here is an example to illustrate how you should fill out the questionnaire.

=No Never 2= Yes Occasionally 3= Yes Often 4= Yes Always

= Father M= Mother

Did your parents use to beat you? F ...2..... M ...3........

your parents use to be kind to you? F ...4..... M ......4.....

ned with both parents up to the age of.................

father is still living................. (died when I was ....years old)

mother is still living .... (died when I was .... years old)

parents separated when I was ....years old.

ave lived with................. since I was ....years old.

ave ....brothers and sisters.

ve.................brothers and sisters older than me.

our father working/employed? 1 = Yes 2 = No

es specify type of work/employment ....

mother working/employed? 1 = Yes 2 = No

yes specify type of work/employment ……………………………………………………………………

Did you feel that your parents interfered with everything you did? F ………. M ……….

Did your parents show with words and gestures that they liked you? F ………. M ……….

Were you spoilt by your parents in comparison with your sister(s) and/ or brother(s)? F ………. M ……….

Did you feel that your parents liked you? F ………. M ……….

Did your parents usually refuse to speak to you for a long time if you had done anything silly? F ….. M…..

Did it happen that your parents punished you even for small offences? F ………. M ……….

Did your parents try to influence you to become something "posh" F ………. M ……….

Did it happen that you were disappointed with your parents because you didn't get something you wanted?

Do you think that either of your parents wished you had been any different in way? F ………. M ……….

Did your parents let you have things your sister(s) and/or brother(s) were not allowed to have? F ……M …

Did you think your parents punished you justly? F ………. M ……….

Do you think that either of your parents was severe with you? F ………. M ……….

If you had done something foolish, could you then go to your parents and make everything right again by asking their forgiveness? F ………. M ……….

Did your parents always want to decide how you should be dressed or how you should look? F …..M ….

Did your parents usually lie to you? F ………. M ……….

Did you feel that your parents liked your brother(s) and/or sister(s) more than they liked you? F …. M …..

Did your parents treat you unjustly (badly) in comparison with how they treated your sister(s) and/or brother(s)? F ………. M ……….

Did it happen that either of your parents forbade you to do things other youths were allowed to do

because they were afraid that something might happen to you? F .... M ....

19. Did it happen that as a youth you were beaten or scolded in the presence of others? F .... M ....

20. Did your parents usually care about what you did in the evenings? F .... M ....

21. If things' went badly for you, did you then feel that your parents tried to comfort and encourage you?

F .... M ....

22. Did your parents usually worry about your health unnecessarily? F .... M ....

23. Did it happen that your parents gave you more corporal punishment than you deserved? F ....M.......

24. Would your parents become angry if you didn't help at home with what you were asked to do? F .... M ...

25. Would your parents look sad or in any other way show that you had behaved badly so that you got real

Feelings of guilt? F .... M ....

26. Did your parents let you have things which your friends got, to the extent they could afford them? F ... M...

27. Did you feel that it was difficult to approach your parents? F .... M ....

28. Did it happen that your parents narrated something you had said or done in front of others so that you

felt ashamed? F .... M ....

29. Did you feel that your parents liked you more than they liked your sister(s) and/or brother(s) F ..... M ....

30. Did your parents begrudge things you needed? F .... M ....

31. Did your parents usually show that they were interested in your getting good marks? F .... M ....

32. If you had a difficult task in front of you, did you then feel support from your parents? F .... M ......

33. Were you treated as the "black sheep" or "scapegoat" of the family? F .... M ....

34. Did it happen that your parents wished you had been like somebody else? F .... M ....

35. Would your parents say: You who are so big or you, who are a boy/girl shouldn't act like that, should you?

F .... M ....

36. Did your parents usually criticize the friends you like to frequent? F .... M ....

37. Did you feel your parents thought it was your fault when they were unhappy? F .... M ....

38. Did your parents try to spur you to become the best? F .... M ....

39. Would your parents demonstrate that they were fond of you? F .... M ....

40. Did you feel that your parents trusted you so that you were allowed to do things on your own? F ..... M ...

41. Do you think that your parents respected your opinions? F .... M ....

42. If you had little secrets, did either of your parents want you to tell them about them? F ...... M ....

43. Did you feel that your parents anted to be together with you? F .... M ....

44. Do you think your parents were mean and grudging towards your? F .... M ....

45. Did your parents use expressions like: "If you do that you will make me sad"? F .... M ....

46. When you came home, did you then always have to account for what you had been doing to your parents?

47. Do you think that your parents tried to make your adolescence stimulating, interesting and instructive (for instance by giving you good books, arranging for you to go on camps, taking you to clubs)? F ...... M ......

48. Did your parents usually praise you? F .... M ....

49. Would your parents use expressions like: "Is this the thanks we get for having done so much for you and for having sacrificed so much for your sake"? F .... M ....

50. Did it happen that your parents wouldn't let you have things you needed, based on the principle that you shouldn't become spoilt? F .... M ....

51. Did it happen that you got a bad conscience towards your parents because you behaved in a way they did not desire? F .... M ....

52. Do you think that your parents put high demands on you when it came to school marks, sport performances or similar things? F .... M ....

53. Did your parents usually ignore it if you behaved carelessly or in a similar way? F .... M ....

54. Could you seek comfort from your parents if you were sad? F .... M ....

55. Did it happen that you were punished by your parents without having do anything? F .... M ....

56. Did your parents allow to do the same things as your friends did? F .... M ....

57. Did your parents often say that they did not approve of your behavior at home? F .... M ....

58. Did it happen that your parents tried to press more food upon you than you could manage? F ....M ......

59. Did your parents usually criticise you and tell you how lazy and useless you were in front of others? F ... M ....

60. Did your parents usually take an interest in what kind of friends you frequented? F .... M ....

61. Were you the one or your sister(s) and/or brother(s), whom our parents blamed if anything had happened?

F .... M ....

62. Did your parents accept you as you were? F .... M ....

63. Were your parents usually abrupt towards you? F .... M ....

64. Would your parents punish you hard, even for trifles? F .... M ....

65. Did it happen that your parents beat you for no reason? F .... M ....

66. Did it happen that you wished your parents would worry less about what you were doing? F ...... M ......

67. Did your parents usually engage themselves in your interests and hobbies? F .... M ....

68. Did you usually get beaten by your parents? F .... M ....

69. Were you usually allowed to go where you liked without your parents caring too much? F .... M ......

70. Did your parents put decisive limits for what you were and were not allowed to do - to which they then adhered vigorously? F .... M ....

71. Did your parents treat you in such a way that you felt ashamed? F .... M ....

72. Did your parents let your sister(s) and/or brother(s) have things which you were not allowed to get? F ... M...

73. Do you think that your parents' anxiety that something might happen to you was exaggerated? F ... M ......

74. Did you feel that warmth and tenderness existed between you and your parents? F .... M ....

75. Did your parents respect the fact that you had other opinions than they had? F .... M ....

. Did it happen that your parents were sour or angry with you without letting you know the cause? F … M…

7. Did it happen that your parents let you go to bed without food? F ………. M ……….

. Did you feel that your parents were proud when you succeeded in something you had undertaken? F…..M …

9. Did your parents usually favour you in relation to your sister(s) and/or brother(s)? F ………. M ……….

). Did your parents take your part against your sister(s) and/or brother(s) even if you were the guilty one?

F ………. M ……….

1. Did your parents usually hug you? F ………. M ……….

2. I am of the opinion that my parents, with regards to my upbringing, have been: (Tick one)

(a) Extremely consistent with almost unswerving principles!

(b) Consistent most of the time!

(c) Fairly inconsistent!

(d) Extremely inconsistent, could change principles from time to time

13. I am of the opinion that my parents, with regard to my upbringing, have been: (Tick one) •

(a) Very severe, I was close to being terrorized!

(b) Severe on the whole!

(c) Not particularly severe!

(d) Not at all severe, I was allowed to do as I pleased!

Does your mother have any medical/psychological [mental] problem?

Yes [] No [].

If yes, specify which problem. ……………………………………………………………..

Does your father have any medical/psychological [mental] problem?

Yes [] No []

specify which problem ……………………………………………………………..

APPENDIX 3: FAMILY- COGNITIVE-BEHAVIOURAL THERAPY (F-CBT) MODEL

Introduction: Extensive research has demonstrated the effectiveness of this program in helping youth and their parents successfully adapt. Short-term effectiveness and setting generalization from the clinic to the home have been demonstrated for both parent and youth behaviours as well as parents' perceptions of their youths. Youth compliance and inappropriate behaviour have been shown to improve to within the "normal" range by the end of training. The model aims to communicate fundamental Cognitive Behaviour Therapy principles and key clinical treatments in a clear language. It is important to recognize that it is not a new F-CBT approach; rather, it is a new way of communicating the existing evidence-based CBT approach for use in a non-psychotherapy setting. The CBT mode of assessment and treatment in this model offer the psychosocial treatment across the range of psychiatric disorders. The fundamental principle of CBT is that what people think, affects how they feel emotionally and physically and also alters what they do. In depression and anxiety for example, characteristic changes have been shown to occur in thinking and behaviour. Thinking becomes extreme and unhelpful – focusing on themes in which individuals see themselves as worthless, incompetent, failures, bad or vulnerable. Behaviour alters, with reduced or avoided activity, and/or the commencement of unhelpful behaviours (e.g. excessive drinking, self-cutting and reassurance-seeking) that worsen the problems.

A major goal in applying F-CBT is to improve family communication and supportiveness while decreasing the intense negativity so often a characteristic of these families. Other goals of this therapy include helping family members identify what they desire from each other and possible solutions to family problems; and develop powerful behaviour change which in turn changes the way each family member feels and thinks. Although originally designed to treat middle class families with delinquent and "pre-delinquent" youth, the program has recently included poor, multi-ethnic, multi-cultural populations, with very serious problems such as mood disorders, conduct disorder, adolescent drug abuse, and violence/psychosis (schizophrenia).

The model can be conducted by family therapists working with each individual family in a clinical setting, which is standard for most family therapy programs. The model includes five phases: (1) an introduction/ Impression Phase; (2) a Motivation (Therapy) Phase; (3) a Behaviour Change Phase; and (4) a Generalization (more multi-system focused) Phase and 4) Termination phase. Each phase includes assessment, specific techniques of treatment that used both strong cognitive and behaviour methods, and therapist goals. Cognitive methods are integrated as a systemic skill-training in family communication, parenting skills, and conflict management skills. The cognitive methods include motivational interviewing, guided discovery, examining the evidence, examining the advantages and disadvantages, identifying cognitive errors, thought change records, generating rational alternatives, imagery, role plays and rehearsal. While behavioural methods used are social skill building that involve activity and pleasant event scheduling during family therapy sessions to plan graded task assignments, exposure and response prevention, relaxation training, calming down (breathing control exercises), coping skills and rehearsal.

This model of psychosocial treatment is fully compatible with biological treatment when used together with medication. Studies on depression have confirmed that when F-CBT is used together with antidepressant medication it is more effective than either treatment alone.[101] F-CBT has been shown to lead to a reduction in future relapse.[102] This therapy has been used in majority of psychiatric disorders because of its effectiveness as a psychosocial treatment that is able to provide: a focus on current relevant problems of the family; a clear underlying model, structure or plan to the treatment being offered; and delivery that is built on an effective relationship with the practitioner. F-CBT is easy to follow because the principles of CBT are used in formulation of the psycho-education format in the treatment. The main purposes in giving psycho-education in this therapy was to educate the dysfunctional families (youth and their parents) to learn new skills of self-management which form the pillar in each session as the participants put into practice for everyday living. In

this study, the F-CBT adopted a collaborative stance which encouraged individual family members (youth, their father and mother) to work on changes they felt put into practice what they had learned.

Behvaioural methods used in this therapyinclude: imagery action reaction based on imagined adaptive behaviour, role play, rehearsal exercises, and homework assignments to put modified cognitions into action. However the most common behavioural approach that was used in CBT is activity and pleasant event scheduling that can help persons with psychiatric disorders to reverse their low energy and anhedonia feelings. These techniques involve obtaining a baseline of activities during a day or week, rating activities on the degree of mastery and/or pleasure, and then collaboratively designing changes that will reactivate the patient, stimulate a greater sense of enjoyment in life, or change patterns of social isolation or procrastination. Another behaviour technique used is the graded task assignments, in which problems are broken down into pieces and a stepwise management plan is developed. This assists patients in coping with situations that seem especially challenging or overwhelming. Other most useful behavioural methods for treating psychiatric disorders are basic coping mechanisms that include relaxation training and breathing control exercises. In anxiety disorders, hierarchical exposures to feared stimuli are recorded at the beginning of therapy before exposure to these feared situations. Progressive relaxation and breathing exercises are used in CBT to reduce levels of autonomic arousal and support the exposure protocol. These techniques may also be used alone to help manage panic attacks or other symptoms of anxiety disorders that come about when emotion expressions are over expressed in a family setting. This is an important component of coping with a stressful situation for any family member who has a psychiatric disorder since over expression of emotions worsens the symptoms of the disorder. One particular useful way to encourage the patient to use behavioural skills learned in therapy sessions is to develop a schedule to do homeworks and in case the client is aroused any time in their home situation, try to coping by applying these basic stress inoculation coping mechanisms.

The most important and frequently used cognitive technique is the use of questions that encourage the patient to break through their rigid patterns of dysfunctional thinking. This conscious approach assists families to see new perspectives and therefore solve their ambivalence relationships. The two terms most often used to describe this form of inquiry are: (1) motivational interviewing, where open ended questions that guide the patient are asked thereby making clients actively involved in finding their own answers; and (2) guided discovery or reflections (both simple and complex), this is a structured sequence of giving care to patients so that they can explore and change their maladaptive cognitive processes by examining the evidence of the advantages and disadvantages of holding what they believe belief in, referred to core beliefs. This is the most useful area in cognitive treatment that changes the maladaptive thoughts by analyzing the evidence held by the patient. In the beginning phase of cognitive methods of therapy, patients are introduced to thought recording by asking them to make a note of automatic thoughts that occur in stressful situations and identify emotions and behaviour associated with these thoughts, called cognitive triad. As the patient gains knowledge and experience with CBT, a full five-column thought change record is used in which the patients identify cognitive errors in automatic thoughts, generates rational alternatives, and chart the outcome of making changes in their belief system.

Structure of the F-CBT (Model)

Sessions were typically conducted with individual families as a group. Parents and adolescent participated in 14 sessions on average every fortnight for 40-60 minute. The model consisted of a series of parenting skills designed to help the parent break out of their coercive cycle of interaction with the youth by increasing positive attention for appropriate youth behaviour, ignoring minor inappropriate behaviours, providing clear instructions to the youth, and providing appropriate consequences for compliance (positive attention) and noncompliance (time out). Skills were taught using extensive demonstration, role plays, and direct practice

with the youth at the youth centre and at home. Progression from one skill to the next was based upon demonstrated proficiency reviewed at every appointment before starting a new schedule therapy process.

Treatment process (figure 4)

First two sessions of the study were used to recruit and assess participants.

Third session

a) Family members were first allocated into either experiment or control , contracted into treatment plans; F-CBT plus standard psychiatric treatment approaches or standard psychiatric treatment approaches only before initiating psycho-education. Thus, the participants were first re-assessed using the MMSE; those who scored below 25 points were (excluded) and referred for follow-up at the youth centre or patient support centre. Those who scored 25 or above were allocated to different groups; youth who had odd number on the researcher's list were allocated to Experimental group and even numbered youth to the control . Parents in the experimental group were started on biological treatment according to the DSM-IV multi-axial diagnoses while those in the control were referred to the patient support centre for appropriate biological treatment. Emphases on need for follow-up in the next 12 months were explained.

b) Psycho-eduction: the multiple disorders found among youth, fathers and mothers were explained by discussing each symptom that meets specific DSM-IV axis 1 disorder. Also psycho-education was given on positive clinical findings specifically DSM-IV axis 4 psychosocial/environmental stressors in each family setting, global functioning (axis 5 assessment of each respondent), any biological disorders (axis 3 disorders) and any personality disorders (axis 2 disorders). In this session, family members in the experimental group were trained on psychological basic coping skills (behavioural approaches): (1) stress inoculation therapy where each family member was trained on: calming down process, physical exercise, and progressive muscular relaxation; (2) time management- scheduling activities for each day. At the end of session, family members were given home, practice coping

skills twice per day until next session and schedule daily activities each evening for next day activities. Control participants were requested to continue with the standard psychiatric methods offered at KNH; youth schedule their visits at youth centre and adults referred to patient support centre, to be reassessed at mid and final (3 months and 6 months respectively). The experiment group participants were engaged into every fortnight sessions, fourth session to 14th sessions.

Fourth session

The inter-family relationships were discussed, emphases laid on perceived abnormal parenting behaviour (rejecting, un-protectiveness and no emotional attachment by parents). Psychiatric disorders of parents and youth, relationship to the perceived parenting behaviour are discussed in the session. Review of the homework was undertaken and harmonization of previous sessions is discussed by focusing on the psycho-education of both parent's and youth's mental disorder in each family setting in relationship to: perceived parenting behaviour, mental disorder, feelings, thoughts and behaviour of each member of the family in session. Participants were then trained on feeling safe in reference to their family setting, thus participants belong to their specific families and this setting gives them safety. Last participants were trained on how to identify their feelings and record the feelings three times a day; on working up, after lunch and before retiring to bed, but must continue with basic coping skills until next session.

Session five, homework for each family member was discussed such that the members understand their association feelings. Then the key elements in the CBT model were introduced, the cognitive triad, what people think affects how they feel emotionally and physically and also alters what they do, this was to explain the cognitive triad. Homework for each member was re-examined, picking out the maladaptive patterns in the members feelings, behaviour and thoughts. For the diagnosed mental disorder for each member, characteristic changes which occur in thinking and behaviour are explained and discussed in the therapy setting. Thinking among people with mental disorder usually become extreme and unhelpful most of the time, the mentally sick person focuses on themes in which individuals see themselves as worthless,

incompetent, failures, bad or vulnerable. Behaviour alters, with reduced or avoided activity, and/or the commencement of unhelpful behaviours (e.g. excessive drinking and reassurance-seeking) that worsen the problems. These two areas, thinking (cognition) and behaviour, form the focus for CBT assessment and treatment, therefore formulated the process to be changed cognitively by each individual with mental disorder. The Unhelpful thinking styles often start by thinking about things in extreme and unhelpful ways. Unhelpful thinking styles are important because they tend to reflect habitual, repetitive and consistent thought patterns that occur during times of anxiety or depression - the common co morbid disorders among patients with any mental disorder. As a result, many of everyday situations are misinterpreted; problems are focused on and blown out of proportion, and the person's strengths and ability to cope are overlooked or downplayed, becoming increasingly distressed. To a far extent, these unhelpful thinking styles are a normal part of everyday life among persons with psychiatric disorders. At one time or another, most of us can recognize experiencing at least some of these thinking styles. Usually, when people are not feeling low or are only mildly distressed, they can modify and balance this type of thinking fairly easily. However, during times of greater anxiety or depression these unhelpful thinking styles become more frequent, last longer, more intense, more intrusive, more repetitive and more believable.[155] As a result, more helpful (balanced) thoughts are crowded out. Helping the patient to notice these unhelpful thinking patterns is an important first step in the process of change and this was the focus of therapy in this treatment.[156]

Such thinking styles are so unhelpful because of the effect that believing them has on how people feel and on what they do. Consider the links between the different situations, thoughts, feelings and behaviour. From time to time these fears and negative predictions are correct: sometimes we won't enjoy a party, a medication will be ineffective and someone may well not like us. However, during times of depression or anxiety people become overly prone to misinterpret almost everything in such ways – nothing will be enjoyed, nothing will make any difference and no one at all likes them. Extreme and unhelpful thinking can become part of the

problem by worsening how people feel emotionally and physically and causing them to act in ways that add to their problems.

In the session 6, the B (behaviour) component of CBT; reduced activity or avoidance (altered behaviour) formed the focus point in the family therapy. When people feel depressed or anxious, it is normal for them to experience difficulty doing things. In depression, this reduced activity may be because of: low energy and tiredness; negative thinking and reduced enthusiasm for doing things; low mood and little sense of enjoyment or achievement when things are done; and a feeling of guilt and belief that they do not deserve any pleasure. Anxiety may also cause people to reduce what they do. In this case they tend to avoid doing certain things or going to particular places – for example speaking out loud when others are around, going into a large shop or on a bus, or meeting other people in the community. In clients with alcohol or substance use/abuse, they use/abuse these substances as a source of pleasure; avoid feelings of depression. This vicious circle may result, where the reduced or avoided activity exacerbates the feelings of depression and anxiety. In CBT, vicious circles are seen as the main mechanism by which current illness is maintained, and the goal of CBT is to identify and break any that are part of the present problem. Inherent in this approach is the belief that all elements of the vicious circle represent symptoms that maintain the problem.

7th Session: midline assessment was undertaken

For experimental group, the SFF-CBT focused on Five Areas in the model that has structured information that is different from the standard psychiatric model of assessment. This Five Areas model is described as an assessment model, and the purpose of this assessment is to inform treatment. There were two main reasons for working with the family to identify problems in each of the five areas. First, this is helpful for us as practitioners. It aids understanding of the impact of depression or other disorders on the patient's subjective experience. It also enables one to identify clear target areas for treatment: making changes in any one of these areas leads to change in other areas as well (this is a direct implication of the vicious circle model). Second, it is helpful for our patients. This Five Areas assessment is easily understood by patients and it helps

hem to develop an understanding of the effect that psychiatric disorder has on them. The process of writing lown their symptoms as they respond to either MINI kid or MINI plus questionnaire was helpful in that it nabled patients to look at their symptoms more objectively. This provided a degree of emotional distance rom their experiences. Encouraging patients to consider the psychiatric disorders and perceived maladaptive arenting behaviour as a set of interrelated problems that affect various areas of their lives can lead to very mportant insight as they recognize that hitherto seemingly unconnected and diverse symptoms are in fact all lifferent aspects of anxiety or depression.

Sessions 8-14: Explaining maintenance of the disorders

The time spend in formal sessions with patients is only a very small part of their week. It is consequently urged that the patients must put into practice in their everyday life what they have learned during sessions, hence the reason why they must do homework after every session. Perhaps the same principle can be helpfully applied to our own learning of CBT skills. It is therefore important to encourage patients under this therapy to apply elements of CBT during the 14 sessions of therapy. This allows them to find out how useful (or not) the model might be for them and other psychiatric team members.

There were two main reasons for working with the family: to identify problems in their feeling, thinking and behaviour in order to aid understanding of the impact of DSM-IV disorders on the patient's subjective experience. It also enabled participants to identify clear target areas for treatment. Making changes in any one of these areas lead to change in other areas as well (this is a direct implication of the vicious circle model). Second, the assessment was easily understood by participants and it helped them to develop an understanding of the effect the DSM-IV disorders had on them. The process of each participant in the experimental group of writing down their symptoms in each sessions was helpful and enabled them to look at the symptoms more objectively (participants become mindful of their symptoms and identified their feeling). Encouraging participants to consider co-existence of disorders as a set of interrelated problems that

affect various areas of their lives lead to very important insight as they recognized the seemingly unconnected and diverse issues.

Explaining maintenance of the disorders: Regardless of the original cause of any disorder, the clinically significant psychiatric symptoms are usually intensified by the unhelpful thinking styles and altered behaviour which provoke maladaptive feelings and therefore worsen the psychiatric disorder. By giving summary in each session using motivation interviewing caring skills,the assessment in this study gave participants insight in areas of difficulties currently experienced by each participant by looking at their life events, hereditary factors, changes in brain neurochemistry, and vicarious learning from and modeling on significant others such as family members and friends.

The most important cognitive techniques (methods) used in sessions 7-14 was the use of questions that encourage the patient to break through their rigid patterns of dysfunctional thinking. This conscious approach assists families to see new perspectives and therefore solve their ambivalence relationships. The two terms most often used to describe this form of inquiry are: (1) motivational interviewing, where open ended questions that guide the patient are asked thereby making clients actively involved in finding their own answers; and (2) guided discovery or reflections (both simple and complex), is a series of giving care to clients that help the patient explore and change maladaptive cognitive processes by examining the evidence of the advantages and disadvantages of holding their beliefs. This is the most useful area in cognitive treatment that changes the thought record by analyzing the evidence held by the patient. In the beginning phase of any therapy session (7-14th), patients were introduced to thought recording by asking them to make note of automatic thoughts that occur in stressful situations and identify emotions associated with these thoughts. As the patient gains knowledge and experience with CBT, patients identify cognitive errors in automatic thoughts and records them in their diaries, generates rational alternatives, and chart the outcome of making changes in their belief system.[124] Other behavioural techniques applied include imagery, role play, rehearsal exercises, and homework assignments to put modified cognitions into action.

APPENDIX 4: TRAUMA FOCUSED CBT FOR PTSD IN ADOLESCENTS

This treatment protocol was adapted from TF-CBT treatment manual; Treating Trauma and Traumatic Grief in Children and Adolescents.[307] It is important for the therapists to spend some time in the initial treatment session orienting the adolescent to the TF-CBT model. This consists of explaining to the adolescents the reason that they are coming for treatment and what treatment may consist of. The following should be addressed:

- Someone very important was traumatized or the adolescent was traumatized.
- The nature of the event(s) was traumatic.
- The nature (if human conflict) of the trauma was intentional (i.e., groups planned and purposely carried out acts meant to hurt/injure or kill many innocent people).
- When such a terrible thing happens, people usually have strong feelings and the natural tendency is to not want to talk about it.
- Through working with many adolescents who have had such experiences we have learned that talking about these feelings is the best thing to do.
- Sometimes it is especially helpful to talk with a group of others who have had the same kinds of experiences. In this case, everyone in this group has been traumatized and a few have lost someone in similar circumstances.

Following introductions the therapists may introduce the nature of CBT-TB treatment in this manner: "We know how hard it is to talk about painful things, especially to people, that you don't know all that well. Let's begin by talking about why you are here. It would really help me to know, at least a little bit, about what has happened to you and your family". The therapist may then confirm or explain the purpose of treatment as follows: "During therapy, we are going to have a lot of time to talk about the dead body you

APPENDIX 4: TRAUMA FOCUSED CBT FOR PTSD IN ADOLESCENTS

This treatment protocol was adapted from TF-CBT treatment manual; Treating Trauma and Traumatic Grief in Children and Adolescents.[307] It is important for the therapists to spend some time in the initial treatment session orienting the adolescent to the TF-CBT model. This consists of explaining to the adolescents the reason that they are coming for treatment and what treatment may consist of. The following should be addressed:

- Someone very important was traumatized or the adolescent was traumatized.
- The nature of the event(s) was traumatic.
- The nature (if human conflict) of the trauma was intentional (i.e., groups planned and purposely carried out acts meant to hurt/injure or kill many innocent people).
- When such a terrible thing happens, people usually have strong feelings and the natural tendency is to not want to talk about it.
- Through working with many adolescents who have had such experiences we have learned that talking about these feelings is the best thing to do.
- Sometimes it is especially helpful to talk with a group of others who have had the same kinds of experiences. In this case, everyone in this group has been traumatized and a few have lost someone in similar circumstances.

Following introductions the therapists may introduce the nature of CBT-TB treatment in this manner: "We know how hard it is to talk about painful things, especially to people, that you don't know all that well. Let's begin by talking about why you are here. It would really help me to know, at least a little bit, about what has happened to you and your family". The therapist may then confirm or explain the purpose of treatment as follows: "During therapy, we are going to have a lot of time to talk about the dead body you

saw, the person who was hurt or the houses which were burned and the feelings you are having about what happened. I'm sure that you are having a lot of strong feelings. After working with lots of adolescents who have witnessed severe and terrifying events, we have learned that the more adolescents talk about this stuff, the better they feel and the easier it is to talk. Sometimes it is easiest to begin by just talking about feelings, any kind of feelings at all." At this point, the therapist typically proceeds to introduce feeling identification (described below under Stress Inoculation Therapy).

The TF-CBT manual is therefore an empirically supported treatment model which has been designed to help youths, adolescents and their parents or caregivers who have experienced a traumatic event.

TF-CBT consists of components that build on each other progressively although they are presented as distinct components. TF-CBT is indicated to help individuals with PTSD and its comorbidities especially if these comorbidities are not the primary problems.

TF-CBT VALUES: The core values of TF-CBT model can be summarized by the acronym **CRAFT:**

a) **Components-based - although** each component is presented as distinct from each other, the skills build on each other in a sequence and they are interrelated. Each of these components should be provided in a manner that best suits each of the individuals and their families.

b) **Respectful of cultural values** - each individual and family they belong to operates under different cultural backgrounds (social, religious, community or societal norms). Culture, a lot of the time, determines the presentation of symptoms, how the treatment will progress and the eventual outcome. The therapist therefore must work with the youth/adolescent in the context of the larger cultural community.

c) **Adaptable and flexible - clinical** judgment is crucial in ensuring implementation of the components. The therapist needs to be flexible and creative in using the components of the TF-CBT model and especially when dealing with individuals at different developmental levels.

d) **Family focused - parents** and indeed caregivers are an integral part of TF-CBT treatments. The involvement of parents/caregivers helps in the course of treatment and the eventual treatment outcome. The social environment where the youth/adolescent comes from is predictive of the treatment outcome and how soon good treatment outcome is achieved. Sometimes, it may be necessary to also involve siblings in the treatment to improve communication and closeness among family members.

e) **Therapeutic relationship is central - all** counseling skills and techniques apply during the treatment program. The therapist needs to be warm, empathic, understanding and accepting to the client. These help to build rapport and how treatment progresses will depend upon them.

f) **Self-efficacy is emphasized - TF-**CBT is designed to impact life-long skills to the individual and family to assist them cope with current and future traumatic events. The ultimate long-term goal of TF-CBT model is to improve self-esteem as well as to enhance strengths of individual members of the family in order that they may develop mechanisms to cope with life events even after treatment has ended.

Session 1-3: Stress Inoculation Therapy (SIT)

Stress inoculation process: Stress Inoculation Therapy refers to a variety of treatments which protect youths from the negative effects of stress, and encourage the use of optimal coping skills. The SIT techniques used in CBT-TB include feeling identification, relaxation (deep breathing and progressive muscle relaxation), thought stopping, cognitive coping, and enhancement of sense of safety. We typically start CBT-TB treatment by introducing SIT techniques because many youths benefit from mastering these skills prior to embarking on the gradual exposure and cognitive processing components of CBT.

Feeling identification involves assisting youths in accurately identifying their feelings. For adolescents exposed to violent attacks or terrifying traumatic events, the fact that someone intentionally set out to injure, burn or kill the adolescent's loved one may lead to intense feelings of anger, fear, hatred or wanting to get

even (revenge). This involves practicing the skill of feeling identification. The therapists should begin by asking each adolescent to name any feeling they can think of.

Relaxation techniques are helpful in reducing the physiologic manifestation of stress and PTSD, such as increased adrenergic tone (higher resting heartbeat and faster heart rate in response to stress), increased startle response, hyper vigilance, agitation, difficulty sleeping, restlessness and irritability, and anger/rage reactions. These manifestations may be especially problematic when youths experience traumatic reminders, and may occur during gradual exposure (GE) exercises. For this reason, we teach and practice relaxation techniques prior to starting the GE sessions in this protocol, and utilize these techniques in the middle of GE if hyper arousal symptoms become problematic.

Deep breathing: "Belly breathing" is a technique borrowed from meditation/yoga, which has been found to decrease a number of stress-related symptoms in adults (Kabat-Zinn, 1990). The therapists instruct the youths to close their eyes, and to breathe in deeply so that the lower abdomen protrudes during inhalation, and recedes during exhalation. (This is the opposite of chest breathing, where the chest expands and the abdomen is pulled in during inhalation.) Younger youths may be assisted in mastering this by lying on the floor and putting a small book or stuffed animal on their lower abdomen; when they can make this object rise during inhaling, they are doing belly breathing correctly. Once the youths have mastered this, the therapist instructs them to slowly count to 5 while breathing in through the nose, and then to slowly exhale through the mouth during another 5 count period. (Many youths will breathe in slowly but exhale quickly unless specifically instructed in this manner).

Progressive muscle relaxation: This SIT technique can be particularly helpful to youths who have difficulty falling asleep, or who are having many somatic symptoms. With younger youths we use the analogies of a piece of spaghetti before it is cooked (stiff) versus after it is cooked (wiggly), or a tin soldier stiff and tense) versus Raggedy Ann (loose and floppy). The therapists should explain that when people's

muscles are not relaxed, we feel tight and tense and sore, but when we relax those muscles, it helps us to feel easy and loose. Some youths can relax their muscles simply by trying to "be like a piece of wet spaghetti" or "sit like Raggedy Ann." However, others will need specific instructions on how to progressively relax different muscle groups. This is best practiced in a lying down position although this may not be practical. Nevertheless, the youths should be instructed in the technique itself, while sitting comfortably. The youths should be told to first tense (in order to accurately feel where these muscles are), and then to relax, one set of muscles at a time, starting with the toes, then the foot, then the ankle, etc., all the way up to the head, until every body part has been progressively relaxed. Through practice, youths can learn to fall asleep or to relax specific aching body parts using this technique. However, even when nothing hurts and it is not bedtime, progressive relaxation may be helpful to youths with TB, because the selective attention given to relaxing typically precludes focusing on thoughts about the trauma or death at those particular times. In fact, instructing youths to use these techniques when they have intrusive recollections of the trauma/death at home may help to reverse the physiologic hyper-arousal symptoms that typically accompany such thoughts, because tension and relaxation are incompatible.

The relaxation effect is thought to come at least in part from "quieting" one's thoughts and consistently refocusing on breathing rather than being distracted either by external objects/events or internal thoughts or feelings. By directing one's attention to the act of breathing alone, one simultaneously experiences profound relaxation (loss of tension) and focused awareness. The therapists should instruct adolescents to be aware of any distracting thoughts they are having during the breathing exercise, and as soon as they are aware of such a thought, to redirect their attention back to the moving in and out of air through the body. The goal is not to judge, reject or focus on the thought, but to learn to simply redirect one's focus to the act of breathing. Some youths are not able to do this, but if instructed to just pay attention to counting to five during each inhalation and exhalation, they will derive similar benefits from the deep breathing exercises. Let the youths know they can use deep breathing at times when they feel themselves being overwhelmed with physical or

emotional stress, as long as it is not a situation where they have to be paying attention to something external (for example, during an exam attention needs to be focused on the task, rather than inwardly).

Thought stopping: This is a SIT technique which can short circuit the vicious cycle which typically occurs in TB (where a reminder of the loved one leads to thoughts of the traumatic nature of the death, which leads to cognitive distortions, which leads to more upsetting thoughts and more cognitive distortions, etc.). It is also a very powerful tool in preparing the youths for cognitive processing (CP) treatments, because it teaches them that they can have control over their thoughts. Thought stopping basically works through interruption, that is, it is a method of interrupting a youth's attention on the traumatic thought, and refocusing attention on a non-traumatic replacement thought. In some ways, thought stopping is the opposite of GE (where we try to focus a youth's attention on rather than away from the trauma/death itself). It may therefore seem contradictory to use both of these treatments in the same treatment model. However, youths are instructed to use thought stopping at times when they need to be focused on things going on around them, such as at school, when playing sports or interacting with friends. They use GE techniques in therapy. This teaches youths first and foremost, that they have control over their own thoughts – not just which thoughts they choose to focus on, but also when they focus on which thoughts. For youths initially overwhelmed by intrusive reminders of trauma and loss, as well as distorted thoughts of their own responsibility or thoughts which exaggerate or catastrophizes the reality of the situation (for example, "I will never be happy again"), simply learning this principle can be enormously helpful.

For adolescents having intrusive thoughts about revenge or rescue fantasies related to the traumatic events, it may be helpful to replace these thoughts with more constructive thoughts of how to take "corrective action" or how to stay safe in the future. These more helpful thoughts will be identified during the upcoming CP exercises; once these "correction action" thoughts have been specified in therapy, the therapists may encourage the youths to use these thoughts as replacement thoughts rather than using "perfect moment" thoughts during future thought stopping procedures.

Cognitive coping skills are closely related but not identical to cognitive processing (CP) treatments. While CP requires the youth to logically dismantle inaccurate or unhelpful thoughts as discussed below, cognitive coping refers to what has been termed "learned optimism". Simply put, this consists of practicing the skill of focusing on the **positive instead of the negative aspects of any given situation.** One could easily argue that there is nothing positive to be found about a traumatic event that has caused a youth to lose a parent or other loved one. However, many youths have come through the traumatic loss of a loved one to find themselves stronger, more compassionate toward others, more thankful for the remaining family members they have, more aware of the generosity of strangers and more appreciative of the outpouring of sympathy and assistance that they experienced. Youths may benefit from recognizing (and focusing attention on) the fact that, despite great adversity, they are coping, and are often coping quite well. Cognitive coping treatments consist of helping youths recognize the ways in which they are coping well, and to remind the youths to verbalize these, particularly when they are feeling discouraged. This is also called "positive self-talk." Examples of cognitive coping statements are as follows:

- I can get through this.
- Things are hard now, but they will get better.
- I still have a family and they will help me.
- Lots of people care about me and my family.

Some things have changed, but lots of things are the same as they were before this happened (ex: I still do well in school, I still have friends, I'm still good at math).

Although some youths are more optimistic in their outlook than others, optimism can be learned and practiced so that it becomes more a part of the youth's life. A group activity, such as making "encouragement banners" may prompt the youths to practice positive self-statements and may increase their ability to cope with adverse life events long after therapy has ended.

Enhancing Sense of Safety

Some youths may be in a single parent living arrangement for the first time, or may have lost a sibling, grandparent, or other relative who was an integral part of the youth's family. Others may have been in a single parent environment and have lost their only known parent. Furthermore, some youths may have lost both parents and are now living with a relative, or in another caretaking environment. In all of these situations, youths may be feeling a loss of safety and may be experiencing a decreased sense of trust. It is important to help youths express these emotions as well as to recognize the supports in the environment that can enhance a youth's sense of safety right now.

There are special considerations related to youths's losses following the traumatic event which the therapists must keep in mind. Some of the youths may have lost a loved one who was one of the rescue workers, or have an injured loved one/there home or livelihood was burned. What kinds of messages are the youths hearing about deceased as well as surviving injured person?

After assessing the nature of the social supports for the youths, the therapists may begin addressing safety in this manner: Sometimes, when bad things happen around us, to people that we love, we start to worry that bad things are going to keep on happening. Sometimes it just seems like the world isn't a safe place. Have any of you been having these kinds of worries or feelings? (If any of the youths respond affirmatively, continue.) When you are feeling this way, what can you do or say to yourself that might help you to feel safe? Let's make a list. What do you count on to keep you safe? Who can kids count on to keep them safe when their parents aren't around, like at school or when they are outside playing (grandparents, teachers, police officers, etc.)?

Psycho-education may be introduced at this point in therapy if the youth expresses clear misinformation or distortions regarding safety. For example, it may be helpful to point out to the youth who doubts the ability of rescue workers to provide safety that these workers rescued / helped save thousands of people who escaped from the traumatic event, even though others could not be saved. Youths in this situation should be

encouraged to identify people in this extended support network who are available to comfort them and keep them safe. As noted in the parent treatment section, parents who take steps to enhance their own sense of security and safety will most likely be able to enhance this sense of safety in their own youths.

THE COGNITIVE TRIANGLE

Many youths and parents do not realize that they can choose and change their own thoughts, and that doing so can change their feelings and behaviours. This idea is the basis of the "cognitive triangle," depicted in Figure 1.

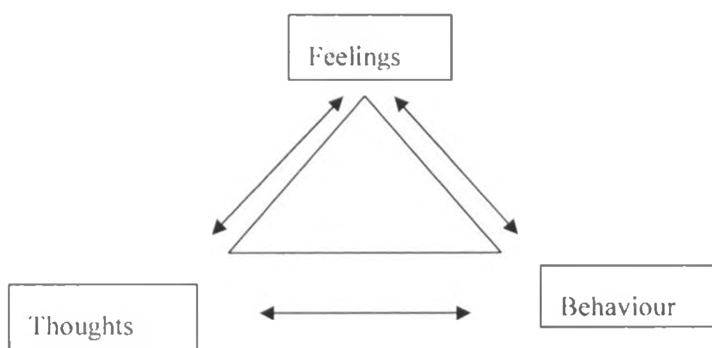


Figure 5: The Cognitive Triangle

Educating youths about the connections between thoughts, feelings, and behaviours is an essential element of cognitive processing (CP) and the adolescents must be taught how to distinguish between thoughts and feelings, the therapists should explain the following: "Most people assume that thoughts come from inside of us, of their own accord, and we have no control over what feelings we have or when we feel them. However, this isn't really accurate. Most of the time, we have feelings in response to the thoughts we are thinking at that time. Sometimes we get used to having certain thoughts so often that we aren't even aware we are having them. These are called 'automatic thoughts' because we have them automatically out of habit.

and just assume that everyone else would have the same thoughts like us at those times. But we often have thoughts that are inaccurate, or not helpful, and this leads to feelings that hurt us rather than help us. Let us give you some examples." The therapists can then give examples, such as the following (these should be tailored so that the youths may easily relate to them): "Say there's a girl in your class, and she never talks to you. When you walk by her, she looks down or looks the other way. If your thought in this situation is, 'that girl hates me,' it might make you feel sad or angry. But let's suppose that, instead of thinking 'she hates me,' your thought is, 'gee, she must be really shy.' How would that make you feel?" (Then allow the youths to answer. Typical responses might be, "I wouldn't feel so sad," "I would feel sorry for her," etc.)

Session 4-6: GRADUAL EXPOSURE (GE)

To begin the GE component, the therapists may again inquire directly about the bereavement customs of the families, their religious congregation, and/or cultural group, and how the adolescents have responded to these thus far (for example, how has the death been explained, was a funeral or memorial service held, did any of the youths attend, how did they react to this, how have relatives and friends responded to the trauma/loss, how has it affected the composition and functioning of the family units, how has the greater community responded, has there been supportive or non-supportive media coverage, etc.). These questions are in fact a form of gradual exposure for the parents, in that without asking specifically about the traumatic event, the therapists are encouraging the parents to discuss some aspects of the trauma/death.

The therapists should then **directly explain the GE procedure** and the parents may wish to discuss concerns about this procedure, and the therapists should encourage such discussion. It may be helpful to predict that the youths may not enjoy this part of therapy, may resist attending, and may even transiently show more symptoms during this phase of treatment. The therapists should ask the parents to tell them if this happens, so that therapy can be adjusted to the youths's comfort level, if appropriate. It is our experience that almost all youths can tolerate GE if it is correctly calibrated and they are given appropriate support from the therapists and parent. The parent should be reassured in this regard, and also told that the

GE treatment will not start until the youths have gained some comfort with the therapists and the therapeutic process.

Finally, the therapists should explain that in addition to resolving the youths's PTSD symptoms and enabling the youths to adequately grieve, another goal of GE is to allow them to become more comfortable in discussing their thoughts and feelings with the parents, even when they are upsetting. The therapists should explain that this is important, because the parents should be the ones the youths can come to with any problems or worries, whether about the trauma/death or anything else. The parents' ability to respond to their youths in a supportive and helpful manner will show the youths that their parents are able to tolerate discussing even the most upsetting subjects (trauma/death). It will encourage the youths to talk to the parent about any problems that arise in the future. Most parents are eager to accomplish this goal, and support the GE procedures when they are explained in this manner.

Once the youths embark on the GE component, it is usually helpful to share with the parent the kinds of information the youths are writing in their GE books. (Parents will be told that the youths's GE books will be shared more privately during parent-youth joint sessions). The therapists should make the parents aware of how important it is for the youths to know that their parents can tolerate hearing of their upset thoughts and feelings and that the parents want to understand what the youths are going through.

To prepare the parents for hearing and seeing the youths's GE books, the therapists should ask the parents to **describe their own experiences of the trauma/death**, in whatever manner they are able. The therapists may begin by asking the parents to share with each other how they heard about what happened – where were they, who told each of them the news, what was his or her first reaction, how did their youths find out about what happened, how did their youths respond, etc. Having the parents talk through the sequence of events, their thoughts and feelings, etc., may be very difficult, and adequate time should be available during these sessions to allow the parents to share their stories. It is important that the parents also have adequate time to regain composure before the end of this session, as it is usually not helpful for them to return to their youths

in tears (many youths will believe that parental distress is related, in some manner, to something they did or said in therapy).

The parents should be reminded that their youths are also describing their experience in therapy, in the form of a book, which they will share with the parent. It is important for the therapists to **praise the youths's ability to put these painful experiences into writing** to the parent. Therapists should overtly **praise the parents** for encouraging the youths to attend therapy and share memories, thoughts and feelings about the trauma/death, even though it may be painful.

As the youths continue in the GE sessions, the parallel parent group sessions should be devoted largely to the therapists reading the portions of the youths's books, and discussing the parents' reactions to this. (Particularly with adolescents, this should only be done after the youth therapists discuss with the youth whether this is acceptable. Some youths may object on the grounds that they do not want to upset the parents with reminders of the trauma/death. It is important that the youth therapists assure these youths that their parents can tolerate this). As with the youths, at each subsequent GE session, the therapists should share portions of the youths's completed GE activities out loud to the parents. This provides ongoing GE for the parent, with the goal of desensitizing the parent to hearing about the trauma/death, and improving the parent's ability to tolerate hearing the youth's description of this. Parents will typically provide a great deal of support to each other in this group activity, which will enhance social supports available to each parent and decrease feelings of isolation, etc. Therapists should actively encourage this peer support as it is expressed in the group.

Some parents may have an urge to "correct" a youth's book (for example, noting that a youth described events out of sequence or had some other details wrong). The therapists should explain that unless these details are directly relevant to a youth's functioning or otherwise have a clear negative impact, parents should not "correct" the book. The point is not to describe the exact objective reality of the trauma, but to get the youths to describe and become desensitized to their most upsetting, intrusive memories and images of

the trauma. Occasionally, a youth will present a misinterpretation or incorrect detail in the book (such as denying the permanency of death) that, if left uncorrected, may be harmful. In this situation, an informational parent-youth joint session may be helpful.

SESSION 7-8: COGNITIVE PROCESSING (CP)

Similar to the youths's sessions, during the GE sessions the therapists may have identified cognitive errors (inaccurate or unhelpful thoughts) that one or more of the parents may have regarding the traumatic event and/or death of a loved one. Some parents may also have developed cognitive distortions about their youth's or their own response to the trauma/death. Common parental errors in this regard include the following:

- My youth will never be happy again
- Our family is destroyed
- My youth's youthhood is ruined
- I can't handle anything anymore

The therapists should encourage the parents to examine their thoughts for both accuracy and helpfulness. For example, with regard to the thought, "My youth will never be happy again," most youths will have moments of ordinary mood or happiness, even when suffering from PTSD or grieving the loss of a loved one. One of the therapists may have personally witnessed a moment or two when the youth was smiling, cheerful, or interacting normally with others. The therapist can point this out to the parent, and ask whether there have been any other moments, however fleeting, in which the youth has seemed less sad. Once the parent is able to acknowledge that his or her youth has experienced such moments, the therapist can point out that this has occurred even early in the bereavement process, when nearly all youths are sad. The therapist can next point out that "never" is a long time, the youths have already made a lot of progress, and they will continue to improve over time.

For many parents, the belief that a youth can never again be happy is connected to concerns about not having two parents ("a boy needs a father"). Therapists should share that, while it is true that these youths will miss

their deceased parent deeply, research has shown that if youths have at least one person with whom they have a positive attachment, they do well. Emphasizing the benefits of having one loving parent, rather than focusing on the loss, is a helpful reframe for the parents.

The parent should then be asked to come up with other examples of how he or she has been thinking about the traumatic event and/or the death of the loved one, and to use the cognitive triangle to understand the impact of those thoughts on their feelings and behaviors. The therapists can model using CP techniques to have parents challenge their own inaccurate or unhelpful thoughts, and have the parents practice this.

The therapists should help the parents recognize that modifying inaccurate thoughts to a more realistic assessment will help them to feel more hopeful, (for example, "My youth is often sad now but this is normal; even now I see moments of happiness and as time passes my youth will continue to get better"). Modifying their own thoughts may also help parents to be more capable of offering encouragement to their youths when the youths are making similar distorted comments.

The therapists should then ask the parents if they are aware of, or can imagine some distorted thoughts that their youths might have, and how CP techniques might be used to replace their youths's distortions with more accurate and helpful thoughts. Finally, therapists may give the parent some examples of things the youth might say in the future, which represent cognitive distortions, and have the parent practice how to effectively challenge the youth's cognitive distortions and help the youth generate more accurate and helpful cognitions in this regard.

MOURNING THE LOSS SESSION 11-14

Session 11: INTRODUCTION TO BEREAVEMENT

Let the adolescent share out what they think happens when someone dies. If this was written during the narrative session, let the youth share out the information on what happened when the relative died. While some misconceptions about death may have been addressed in the trauma focused treatments above, some

youths may still have many confusing ideas about death. The therapists should correct these misconceptions in a general manner, with the understanding that individual families may have varying cultural and religious beliefs.

The adolescent should then make a list of different feelings that they might have when a person they love dies by asking them about their beliefs about what happens after death, and listing feelings that people may have following the death of a loved one

Mourning the loss of their deceased relative will follow by making a list of

(a) Memories of the fun and comforting loving aspects of that relationship, and the loss of things that might have been in the future, but now will never be

(b) Identify and name the things the deceased and the youth did with and for each other, which will no longer occur

These may include everything from basic care giving (tasks which theoretically could be performed by a variety of other caretakers) to the most unique aspects of the relationship. Even mundane tasks such as cooking or cleaning, may have been special to a youth because of the unique way that the deceased involved the youth (for example, mother may have had the youths each perform special tasks in baking cookies–one measured, one poured, one stirred–which made baking cookies more than a mere food preparation task). The therapists should encourage the adolescent to describe the special aspects of their relationships which are now lost.

Let the adolescent write a separate bereavement book (different from the GE book). All of the artwork, writings, crafts, etc. that are created during group, along with other memorabilia, may be placed into this book, or another "special place" that the youth created, such as a memory box. The activities that follow are expected to prompt sadness, which is part of the normal grieving process. Throughout these activities, the therapists will be educating the group regarding the fact that almost everyone feels this great sadness when

they have lost a loved one, and that it is a natural result of having loved the deceased so much. It may be helpful for some youths to know that other family members are also sad and missing the things they used to share with the deceased; however, youths who feel overly protective of remaining family members may not benefit from hearing about their grieving.

SESSION 12: RESOLVING AMBIVALENT FEELINGS ABOUT THE DECEASED

This is the last respect given to the dead relative. Any bitter relationships is resolved between the dead person and the living relatives. In these situations, the youth has to deal with the stigma associated with the activities that led to the loved one's death. Almost all youths have had occasional conflicts with their siblings or parents, and these may have been unresolved at the time of the death, they might be blaming their deceased relative to have caused their own death. youths might have gone through weeks or months of thoughtless, rude or rebellious interactions with the loved one, and not have resolved these conflicts prior to the death. This typically leads to guilt feelings in the surviving youth. It may also leave youths with unresolved resentments or anger that remains unspoken due to family or social expectations to "not speak ill of the dead," etc. The therapists should normalize these issues by pointing out that all youths have these conflicting interactions and feelings with their parents/siblings at times, but typically they are discussed and worked out over time.

Activity 1: Discuss unresolved issues and feelings. (In African settings; there is always opportunity for the members to mourn and discuss unresolved issues with their deceased relative- find out how this was done)

Activity 2: Have the youths write a letter to the deceased, saying all the things the youth wishes he or she could have said before the person died , the youths who can't write, let them verbalize the thoughts and feelings towards the deceased at the therapist and write down.

Activity 3: The youths will then be prompted to imagine anddescribe how the deceased would have responded, as in reverse role play (activity 2 above).

Activity 4: If possible adress the unresolved issues in the youth with their parent(s)

At the end of the session, each youth to brings a photograph or some form of memorabilia to the next last session.

SESSIONS 13 - 14: PRESERVING POSITIVE MEMORIES OF THE DECEASED

Once the youths have begun the process of mourning the deceased and what has been lost from the future, and have addressed unfinished business with the deceased, they should begin to focus on positive aspects of the relationship shared with the loved one. Recording and preserving these positive memories in a concrete manner is bound to produce some sad and painful feelings, but in many cases it also allows youths to re-experience the joy and happiness they shared with the loved one. It is very important for youths to realize that they still have the capacity – and permission – to be happy.

Activity 1: Each youth produces a photograph or some form of memorabilia at the beginning of the session

Activity 2: The youths are then encouraged to share this item with the group, talking about why this particular item is important to them.

Activity 3: Following this sharing time, the youths are encouraged to preserve their memories (write), beginning with the item that they brought to group. The youths will then be asked to preserve these memories in their hero's journal or their "special place," as a separate memory book or memory box, which consists of pictures, keepsakes (tickets to movies or sporting events, etc..), photographs, poems, or other writings about the loved one.

The therapists should assist the youths in identifying others who may be helpful. Younger youths will typically have more difficulty recalling positive memories due to developmental considerations. Such youths may benefit from looking at photographs of themselves with the deceased, writing stories about these photographs, drawing pictures of themselves with the deceased, and asking the surviving parent, older siblings, grandparents, etc. to assist in recalling happy times together with the deceased.

Here are some ideas that youths have written, drawn, or included photographs

about in their memory books with regard to the deceased:

- His favorite clothes
- Funniest habit
- Hobbies
- The best time we ever had together
- Favorite things that he gave me
- The nicest thing she ever did for me
- His favorite expressions/jokes

Activity 4: youths will be encouraged to share this book with the other group members once the task is complete. They are further encouraged to share the book with their parents/caretakers, and other family members outside the group. It is also suggested that the youths continue adding to the book after therapy is over.

Activity 5: Finally, many youths will hold a group memorial service for the deceased, even if there has already been a formal service. This allows them to orchestrate their own special tribute to the deceased. As a group activity, each youth is assigned a special task (e.g., writing an "announcement"). Furthermore, each youth will create his or her own tribute to the deceased, be it a poem, letter, picture, craft, etc. The nature of the memorial service itself will be up to the youths involved. Some groups may choose to invite the parent into thegroup.

FINAL SESSIONS: TREATMENT REVIEW AND CLOSURE

As the end of therapy approaches (around session 10 or 15), the therapists should assess how the adolescents and parents are progressing in sessions. If each parent youth dyad appears to be tolerating this phase of

treatment adequately, the therapists can suggest the possibility of having other joint sessions toward the end of treatment. This should be presented as an opportunity to share the adolescent book and to acknowledge the gains both the youth and parent have made in treatment. It is important that these be planned ahead of time in order to have time for another joint session so that the final treatment session can still be utilized for group wrap-up.

Preparation for the bereavement joint sessions should parallel that of the GE joint session, i.e., the 15 minute individual youth and parent sessions preceding the joint sessions should consist of reading the youth's book and preparing questions for the youth and parent to ask each other. The parent should also practice appropriate responses. The joint sessions should consist of the youth reading the book, the parent praising the youth's ability to do this, and the youth and parent asking each other questions and discussing each others' responses. Additional issues to be addressed in joint sessions might include discussion of how the roles in the family have changed since the death of the loved one; how to assign new tasks or agree on new rules in response to these changes; having the youth conduct the memorial service for the deceased in the joint session (if this is the youth's preference); and openly discussing how the parent, youth, and other families are coping with their own and each other's grief. The 3 Ps (predict, plan, give permission) discussed in the youth's bereavement sessions, should also be addressed together with the parent and youth prior to treatment termination. Finally, the parent should praise the youth for all of the effort and commitment put into therapy, and for all of the progress the youth has made. The therapists should praise the youth and parent in this regard during the joint session.

The final group session (session 10 or 15) should be spent in part discussing the joint session experiences, including thoughts and feelings the parents experienced during these interactions. Additionally, the parents should share their view of their own progress in therapy. The opportunity should be available for other group members to comment on individual's view of their personal progress as it is not uncommon for individuals to underestimate their own progress when others see much more. Similarly, progress should be

UNIVERSITY OF NAIROBI
MEDICAL LIBRARY

reviewed and acknowledged by the therapists, with appropriate praise given to each member. If the therapists believes that any individual needs ongoing therapy, this should be discussed privately, with appropriate referrals and arrangements made prior to treatment termination.

Thought stopping is accomplished by interrupting an unwanted thought, either verbally (saying "go away" or "snap out of it" to the thought) and/or physically (by wearing a rubber band around one's wrist and snapping it when one wants to stop a thought). The next step is to replace that unwanted thought with a welcomed one. Some youths prepare for thought stopping by having a positive thought or mental image ready – such as thinking about a special happy event, place or experience (birthday, Christmas, amusement park, etc.). This may be complicated for youths with TB, as many of their pleasant memories may involve the deceased loved one and thinking these thoughts may re-trigger traumatic/loss thoughts. It may be more helpful for such youths to simply visualize a "perfect moment" (for example, hitting a game-winning home run; being elected class prefect) to use for thought replacement. This mental picture can be drawn and taken home as a prompt to use in thought stopping at home. Also, the more detailed description a youth can give of this image (example: sights, sounds, smells, tastes about this "perfect moment"), the more this image can distract from the intrusive thought. Teaching youths thought stopping techniques helps to prepare them for the likelihood that they will experience ongoing reminders or negative intrusive thoughts about the trauma/ death, both during the course of therapy and after therapy has ended. It is also helpful for youths to have mastered these techniques before starting gradual exposure (GE), so the youths feel confident that if they start to feel overwhelmed while directly talking about the trauma/death, they will be able to stop or control these thoughts.