ESTABLISHING THE EPIDEMIOLOGY OF CHILD AND ADOLESCENT MENTAL HEALTH PROBLEMS IN RURAL, URBAN, AND SLUM AREAS IN BANGLADESH

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DEDICATION

To all the Children of my Country

CERTIFICATE

This is to certify that Mohammad Sayadul Islam Mullick has completed thesis work entitled, " Establishing the Epidemiology of Child and Adolescent Metal Health Problems in Rural, Urban, and Slum Areas in Bangladesh" under our supervision for the fulfillment of the degree of Doctorate of Philosophy in Faculty of Postgraduate Medical Science and Research from the University of Dhaka. The work on any part thereof has not been submitted any where for any other degree.

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LIST OF ABBREVIATION

TERM	ABBREVIATION
Acquired Immunodeficiency Syndrome	AIDS
Acute respiratory infection	ARI
American Psychiatric Association	APA
Analysis of variance	ANOVA
And others	et al
Attention Deficit Hyperactivity Disorder	ADHD
Bangladesh Bureau of Statistics	BBS
Bangladesh College of Physicians and Surgeons	BCPS
Bangabandhu Sheikh Mujib Medical University	BSMMU
Body Mass Index	BMI
Centimetre	cm
Child	C
Children's Global Assessment Scale	CGAS
Child and Adolescent Psychiatric assessment	CAPA
Child Assessment Scale	CAS
Child Behaviour Check List	CBCL
Chi-square	x^2
Conduct disorder	CD
Confidence interval	CI
Convention of the Rights of the Children	CRC
Cubic metric ton	cumec
Degree of freedom	df
Development and Well-Being Assessment	DAWBA
Development Finance Institution	DFI
Diagnostic Interview Schedule for Children	DISC
Diagnostic and Statistical Manual	DSM
Doctor of Philosophy	Ph D
Education for all	EFA
Etcetra	etc
Expanded Programme of Immunization	EPI

TERM	ABBREVIATION
Export Processing Zone	EPZ
Follow-up interview for children	FIC
For example	e.g.
Fellow of the College of Physicians and Surgeons	FCPS
Fiscal Year	FY
Gross National Income	GNI
Gross National Product	GDP
Health Population Sector Programme	HPSP
Health Population Sector Strategies	HPSS
Height	Ht
Household Questionnaire	HHQ
Human Immunodeficiency Virus	HIV
Institute of Psychiatry	IOP
International centre for Diarrhoeal Diseases and Research, Bangladesh	ICDDR, B
International Classification of Disease	ICD
Institute of Postgraduate Medicine and Research	IPGM&R
Kilogram	Kg
Kilometer	Km
Limited	Ltd
Master of Philosophy	M Phil
Member of the College of Physicians and Surgeons	MCPS
Mean Sea Level	MSL
National Health Policy	NHP
National Institute of Mental Health	NIMH
Not significant	NS
Non-Government Organization	NGO
Number of observations	N
Obsessive compulsive disorder	OCD
Ontario Child Health Study	OCHS
Parents	P
Pervasive developmental Disorder	PDD

TERM	ABBREVIATION
Percent	%
Probability	p
Post traumatic stress disorder	PTSD
Public-Private Partnership in Health	PPPH
Research Questionnaire for Children	RQC
Revised Behaviour Problem Checklist	RBPC
Self Reported Delinquency	SRED
Self Reporting Questionnaire	SRQ
Sexually Transmitted Disease	STD
Schedule for Affective Disorders and Schizophrenia, Present Episode, Child's version	K-SADS-P
Square	sq
Statististics data analysis Program	STATA
Strenghts and Difficulties Questionnaire	SDQ
That is	i.e.
Taka	Tk
Teacher	S
Teacher's Report Form TRF	
United Nations International Children Emergency Fund	UNICEF
US Dollar	$
Versus	v
Weight	Wt
World Health Organization	WHO
Year	Yr

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ABSTRACT

Introduction

Bangladesh is a developing nation of 124 million people, with 45% under the age of 18 years. Bangladesh has an infant mortality rate of 53 per thousand live births; an adult literacy rate of 54% and 41% for males and females respectively; and a per capital gross national income of US$ 444. Natural calamities only adds to this state of poor health care, lack of universal education, and a vastly agriculture based economy. The country is largely made up of river deltas, with about 75% of the land being less than 3 metres (10 feet) above sea level and almost every year experiences devastating flood. In the above background, psychiatry is one of the most neglected and least appreciated medical disciplines. There are few well trained psychiatrists in Bangladesh and even fewer trained in child and adolescent psychiatry, psychology and behavioural science. Socio-cultural, lingual and religious characteristics preclude use of child psychiatric assessment tools developed in the western countries. Yet, there has been no clinical and public health studies in child and adolescent psychiatry and psychology in Bangladesh. In that context, the study applied and validated a standardised child psychiatric assessment tool to three contrasting community settings: rural, urban, and inner city slum areas.

In the developed world, around 10-20% of children suffer from various psychiatric disorders resulting in serious distress or social impairment. Empirical evidence and preliminary data from other developing nations suggest that the rate could be higher in developing countries. This is not uprising as children in the developing world are exposed to poverty, malnutrition, infectious diseases, violence and social disintegration.

There have been no epidemiological studies of the prevalence of child and adolescent psychiatric disorders in Bangladesh, and indeed there are no validated psychiatric measures in Bangla (Bengali) that could be used for this purpose. This was in part due to lack of suitable measurement tools. The purpose of this study was to test three hypotheses that (1) the prevalence of psychiatric disorders among children and adolescents in Bangladesh is likely to be parallel with other countries, (2) existence of emotional disorder is more than behavioural disorder among children, adolescents in

Bangladesh, and (3) conduct disorder is substantially commoner in poor urban areas than in rural or middle-income urban areas of Bangladesh.

The specific objectives of these studies were (1) to validate psychiatric assessment tools for children and adolescents in Bangla; (2) to generate approximate prevalence estimates as a guide to future research and service planning; (3) to estimate the differences in rates and types of child psychiatric disorders in rural, urban, inner city slum areas of Bangladesh, (4) to explore differences in types and rates of psychopathology between rural, urban and slum areas; and (5) to examine the differences of variables between rural, urban and slum areas as a guide to explore the correlates of child psychopathology, to provide methodological foundations for future larger epidemiological studies in Bangladesh. The focus of this thesis is entirely on prevalence. Data on risk factors and service use was collected in parallel with the prevalence data, and a planned follow-up will add a longitudinal element to the study. Additional elements of the study will be analyzed later to examine various risk factors for child and adolescent psychiatric disorders in Bangladesh.

The organization of this study is divided in three parts namely the preliminary study for screening measures, the pilot study for the validation of measures of psychopathology, reliability of screening measures, and the main study for prevalence estimate.

Preliminary Study (of Suitability of a Standardized Screening Tool)

Introduction: There is no inexpensive and effective method for detecting child psychiatric problems in Bangaldesh. The objective of this study was to examine the potential suitability of the Strengths and Difficulties Questionnaire (SDQ) in Bangladesh.

Methods: SDQs were administered to the parents and teachers of 261 Bangladeshi 4-16 year olds: 99 drawn from a psychiatric clinic and 162 drawn from the community. Self-report SDQs were completed by 11-16 year olds. Children from the clinic sample were assigned psychiatric diagnoses blind to their SDQ scores.

Results: SDQ scores distinguished well between community and clinic samples, and also between children with different psychiatric diagnoses in the clinic sample. The rate

of psychiatric disorders for 4 to 16 years children in the stable urban communities was just 17.9%, but was 13% by parent SDQ, and 10% by teacher SDQ. This predictive prevalence was only 7.5% by self rated SDQ. The combined (multi-informant SDQ) prevalence of 18% was assumed for prevalence for power calculation for the main stage study. A simple algorithm based on SDQ scores was used to predict whether children had hyperkinesis, conduct disorders, emotional disorders or any psychiatric disorder – rates of predicted disorder varied markedly between clinic and community samples.

Conclusions: Predictions based on multi-informant SDQs potentially provide a cheap and easy method for detecting children in the developing world with significant mental health problems. The reliability of the SDQ was tested in the pilot study described below. The potential effectiveness of SDQ needs to be evaluated on a broad range of children, using both international and culture-specific assessments.

Pilot Study (of Validation of Standardized Tools)

Introduction: There is no validated screening tool for diagnosing psychiatric disorder in children and adolescent in Bangladesh. The purpose of this pilot study was to validate diagnostic interview of child psychopathology, the Development and Well-Being Assessment (DAWBA) and to test the reliability of the Strengths and Difficulties Questionnaire (SDQ) in Bangladesh.

Methods: Using a cross-sectional design, with a single-phase sampling and assessment, data were collected from 100 children and adolescents 5-17 years by administering the SDQ, the Household Questionnaire (HHQ), and the Development and Well-Being Assessment (DAWBA). The research diagnostic assessment was repeated an average of 3 weeks later by a different interviewer on a randomly chosen 25 subjects. The instruments were in Bangla.

Results: The validity of the DAWBA diagnoses was assessed by examining their level of agreement with the clinic diagnoses that were completely independently of one another, being based on separate assessments made by different interviewers and then rated by different clinicians. Kappa values of between 0.63 and 0.94 reflect a high level of

agreement between DAWBA diagnoses and clinic diagnoses. Sensitivities ranged from 63-94% and specificities ranged from 81-100%. The clinic sample of 100 children spanned the 5-16 age range of the DAWBA.

Conclusion: Methodologically, this is the first study to validate the Bangla version of the DAWBA. It also validated the Bangla version of the SDQ. The results of the preliminary and pilot studies provided the necessary tools for the main study described below.

The Main Study (of Prevalence)

Introduction: No previous epidemiological studies of child mental health have been conducted in Bangladesh, partly due to lack of suitable measures. The primary purpose of this study was to determine the prevalence of the common child mental health disorders among children, 5-10 years, in Bangladesh. Secondary objectives of the study were (1) to confirm the validation of screening measures; (2) to determine if the prevalence varied among children in a rural, a moderately prosperous urban, and an urban slum settings, (3) to determine possible variables as a guide to search the correlates of child psychiatric disorder, and (4) to establish appropriate ascertainment techniques and foundations for more extensive and representative epidemiological surveys of child mental health in Bangladesh in the future.

Methods: We recruit 922 children, 5-10 years old, through household survey and carried out a two-phase assessment using the SDQ in first phase and DAWBA in second phase.The sample was drawn from three contrasting areas: a rural area; a moderately prosperous urban area; and an urban inner city slum area. The three areas have clear geographical and administrative boundaries, and were chosen after consultation with local representatives. The instruments were validated Bangla version of screening measure of psychopathology, the Strengths and Difficulties Questionnaire (SDQ) validated Bangla version of a standardised child psychiatric interview, and the Development and Well-Being Assessment (DAWBA). The refined Household Questionnaire (HHQ), a socio-economic questionnaire in Bangla, was used to measure socio-demographic factors. Results are presented as prevalence estimates based on ICD-10 psychiatric disorders with 95% confidence intervals. Prevalence data was

adjusted for the two-phase design with weighting. Statistical analyses were performed using the Statistics/Data Analysis Program (STATA 8) survey program, which adjusts appropriately for weighting when calculating test statistics and 95% confidence intervals.

Results: The overall participation rate for families with 5-10 year old children was 75%, ranging from 66% for the inner city slums to 97% for the rural areas. There were small but statistically significant differences in the mean ages of the three community samples (p>.02) but no gender differences were noted. There was substantial agreement between the DAWBA and the independent clinic diagnosis (kappas 0.63-0.94). The proportion of 5-10 year old children who had at least one ICD-10 psychiatric diagnosis according to the DAWBA varied by area: 20% for the slum area, 15% for the rural area, and 10% for the urban area. The overall prevalence in all three areas was 15% (95% confidence interval, 11 to 21%). The prevalence of obsessive compulsive disorders was relatively high. We also noted that hyperkinesis was less common, and depression was rare. Children from all three areas had similar rates of oppositional-defiant disorder. By contrast, children from the slum were substantially more likely to have more serious conduct disorders. Post-traumatic stress disorder was more likely to affect the children from the slum, though this was only marginally statistically significant.

Disscussion: This study generated both methodological and substantive findings of interest. Substantively, the study suggests that around 10-20% of Bangladeshi 5-10 year olds have emotional and behavioural problems that are severe enough to result in substantial distress or social impairment, thereby warranting a psychiatric diagnosis, and necessary treatment. Children from the slum were substantially more likely than children from the other two areas to have serious conduct problems and the same might apply to post-traumatic stress disorder. This fairly compares with DAWBA-based prevalence with two different recent surveys in developed and developing countries. The pattern of psychiatric disorders found in Bangladeshi children 5-10 year old resembles that identified in other parts of the world, with a preponderance of behavioural and anxiety disorders. As discussed in the next section, an apparently distinctive aspect of the pattern of psychiatric disorder in Bangladesh is the high rate of obsessive compulsive disorder.

Three specific features of the pattern of area differences and similarities warrant further comment. Firstly, within the behavioural disorders, the association with area varied strikingly according to the type and severity of behavioural problem. Children from all three areas had similar rates of oppositional-defiant disorder. By contrast, children from the slum were substantially more likely to have more serious conduct disorders. Secondly, post-traumatic stress disorder was more likely to affect the children from the slum, though this was only marginally statistically significant. Thirdly, the prevalence of obsessive compulsive disorder was high across all three areas. Based on the rates of child psychiatric disorders determined for the areas in the present study, estimated number of 5-10 year-olds with psychiatric disorders for Bangladesh is 2.2 million. The differences in types and rates of socioeconomic characteristics among three areas revealed following features. Religious practice, as measured by the child's attendance in worship, was found significantly lower in slum area in comparison to nearly similar religious practice in rural and urban area. Significantly higher level of illiteracy of the both mother and father of the slum children. In contrast, higher education of both parents of the urban children was found highly significant. Rural parents fall between two extremes. The urban area was the most materially advantaged, as judged by the possession of a refrigerator and other rate of advantageous parameters of households was found significantly higher in urban area. All these parameters were indicative of worse living conditions in slum areas that were statistically significant. The position of rural area were also far behind from the urban area but not much worse like slum area.

Annual income of urban family was significantly higher than that of slum and urban areas Annual family income of the slum area was the lowest. Though annual income of the rural families was higher than annual income of slum families, but was significantly lower from urban families. the rural area had the highest rating for neighbourhood helpfulness as measured three variables. That for slum area had lowest. The differences were highly significant. the slum children had poorest physical health as told by their parents and as found in the body mass index calculated by the proportion of weight and height. That was also true for the rural children. The urban children had better physical status. The differences of these variables are highly significant. Mental health status of the slum mothers was significantly poor than that of urban and rural mothers as measured by the SRQ scores. The SRQ scores were found almost similar in the mothers of rural and urban areas.

Conclusion: The present study can be considered the first attempt to investigate the epidemiology of child and adolescent psychiatric disorders in Bangladesh using the current diagnostic criteria and appropriate methodology. These studies have produced quality data that can influence policy makers and guide the service planning and also be used for cross-cultural comparison. Although there is still much to do, the epidemiological studies described in this thesis are a first step towards informing clinicians and policy makers in Bangladesh of the scale of the problems that need to be addressed if all Bangladeshi children with mental health problems are to have access to appropriate help. Future studies can refine the estimate of the present study by estimating other areas, age ranges, and different risk groups. A conservative extrapolation is that around 5 million Bangladeshi children and adolescents have psychiatric disorders. In a country with very few child mental health professionals, there is a vast gap between need and provision is vast.

Key Words: standardized assessment; epidemiology; child and adolescent; mental health problems; psychiatric disorder; Bangladesh.

CHAPTER 1

INTRODUCTION

1.1 Setting the scenario

This thesis proposes to investigate the prevalence of psychiatric disorders as it applies to service planning in 5 to 16 year-olds, in the Central part of Bangladesh. It will also compare the prevalence by three distinct population groups: poor urban, middle-income urban, and mixed rural. An overview of the country including information in brief and region where this investigation took place will be provided in the next paragraphs, so to put into context the methods, findings and discussion that will follow in the next chapters.

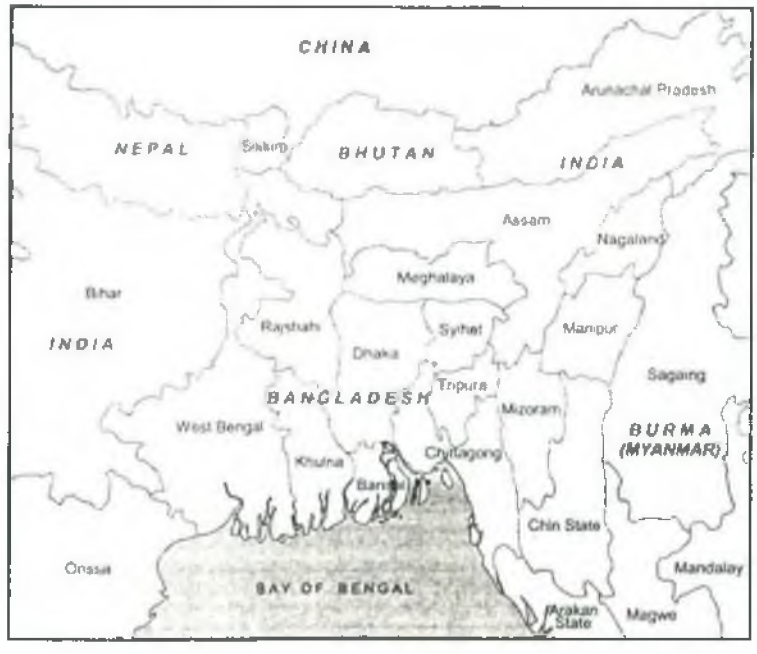


Figure 1.1: Location and Border of Bangladesh

Bangladesh emerged as an independent and sovereign country on 16 December 1971 following a nine-month war of liberation. Official name is People's Republic of Bangladesh. Dhaka (previously spelt Dacca) is its capital. Type of Government Parliamentary form of government, president is head of the State and prime minister is head of government. Geographical location is In South Asia, between 20°34' to 26°38' north latitude and 88°01' to 92°41' east longitude. Maximum extension is about 440 km in E-W direction and 760 km

in NNW-SSE direction. Time is calculated as GMT +6.00 hours. Area and boundaries Area is 147,570 sq km. Bangladesh lies in the north eastern part of South Asia, with a rich fertile area of 147,570 sq.km (56,977 square miles). It is mostly surrounded by Indian territory, except for a small strip in the south east bordered by Myanmer. Boundaries can be West Bengal (India) on the west; West Bengal, Assam and Meghalaya (all the Indian states) on the north; Indian states of Assam, Tripura and Mizoram together with Myanmar on the east; and Bay of Bengal on the south (Figure 1.1). The total length of the land border is about 4,246 km, of which 93.9% is shared with India and the rest 6% with Myanmar. Limit of territorial water is12 nautical miles (22.22 km) and the area of the high seas extending to 200 nautical miles (370.40 km) measured from the baselines constitutes the Exclusive Economic Zone (EEZ). Administrative units are Division 6 (Dhaka, Chittagong,Khulna, Rajshahi, Barisal, Sylhet); zila(district) 64; upazila and thana 507, union 4,533, mouza 59,047 , village 87,928; city corporation 4 (Dhaka, Chittagong, Khulna, Rajshahi); municipality 223 (Figure:1.2).

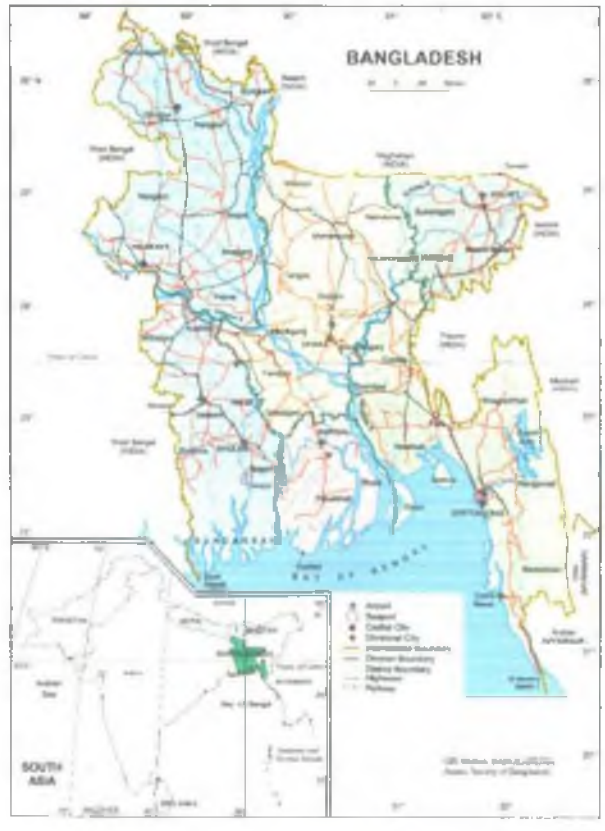


Figure 1.2: Map of Bangladesh

Bangladesh is a revering country which is 8,236 sq. km. Total rivers including tributaries and distributaries are about 700 under three mighty river systems: ganges-Padma river system,Brahmaputra-Jamuna river system,and Surma-Meghna river system. Rivers of the southeastern hilly region are considered as the Chittagong region river system. Principal rivers are:Ganges, Padma, Brahmaputra, Jamuna, Surma, Kushiara, Meghna, Karnafuli, Old Brahmaputra, ArialKhan, Buriganga, Shitalakahya, Tista.Atrai. Gorai, Madhumati, Kobadak, Rupsa Pashur, Feni (Figure 1.3)

Figure 1.3: Map of the main rivers of Bangladesh

Bangladesh is very flood prone area mainly due to excessive rainfall, low land, downward flow of glacier water of through rivers, decreased navigability, barrier in the river flow, unplanned roads, tidal wave. Each year vast area are effected by flood that cause great suffering of the flood victim people and loss of huge amount of wealth of the country. Other natural calamities like tidal wave, tornado, and drought are also happened almost every year **(Asiatic Society of Bangladesh 2003).**

Climate of the country is sub-tropical monsoon. Average maximum and minimum winter temperatures are 29°C and 11°C respectively; average maximum and minimum summer temperatures are 34°C and 21°C respectively. Annual rainfall is 1,194 mm to 3,454 mm. Highest humidity 80% to 100% (August-September), lowest 36% (February-March).

Archaeological sites include Paharpur (5 km west of Jamalganj railway station in Joypurhat district, actually the site includes the Badalgachi upazila of Naogaon district), Mahasthangarah, (about 12 km north of Bogra town, the site includes partly Shibgang and partly Bogra sadar upazilas of Bogra district), Bhasu Vihara, (about 4.8-6.4 km northwest of Mahasthangarh), Mainamati, (8 km west of Comilla town), Halud Vihara, (about 14.5 km west-south-west of Paharpur), Sitakot Vihara, (Nawabganj upazila of Dinajpur district), Wari-Bateshwar (Narsingdi). Recognized tourist spots are Cox's Bazar, Rangamati, Chittagong, Syleht, Kuakata (Patuakhali), Sundarbans (Khulna). The 120-km long Cox's Bazar sea beach is considered to be the longest in the world. Kuakata is a unique beach for viewing sunrise as well as sun-setting **(Asiatic Society of Bangladesh 2003).**

1.1.1 Demographic Data of Bangladesh

Bangladesh is one of the densely populated countries of the world. In 2001 population census, population of Bangladesh is 123.85 million; male 63.89 million, female 59.96; male-female ratio 106:100; density 839 persons per sq km, population growth rate 1.53, urban population 28.60 million, and rural population 95.25 million. Distribution of population according to religion is Muslims 89.7%, Hindus 9.2%, the rest being Buddhists (0.7%), Christian (0.3%) and others (0.2%). Population of 18 years and below is 55.77 million, the population of 16 years and below is 52.2million the population of 14 years and below is 48.72 million and the under 5 population is 18.7million. The population below 18 years constituted 45.03% of the total and below 14 years - 39.34% of the total.

The increase of total population in the last decade was 16.49%. On the other hand, the increase of urban population was 37.04% during the decade comprised to only 11.48% for the rural area. The rate of increase of urban population was more than three times than that of the rural population. It is observed that from 1901 to 1961 the percentage of urban population was very small. The growth of urban population was also steady with some variation in some years. A sharp rise of urban population was noticed after the independence of the country in 1971.Dhaka emerged as the capital of the new country where influx of people occurred more. The other cities also got importance as administrative headquarters of a newly independent country. Thus, the urban population of the country increased at through 1981. After 1981 the urban population has also experienced higher growth due to rural to urban migration for search of better job

opportunity for their livelihood, opportunity for education and business etc. Rapid urbanization of Bangladesh results in an uneven urban growth where a large number of urban people live in the urban slums and squatters where the amenities of life are very scarce. It is interesting to note that increase of female population in the urban area, was higher than that of males. The increase of male population in the urban area was 36,555 compared to 37.62% for the females. It is observed that at the beginning of the century, the population growth rate was below 1.0%.This low growth rate was due to high birth and death rates of the population. The growth rate between 1951 through 1991 was above 2.0% and this higher trend because of the comparatively high fertility and low mortality. The notable decline in population growth occurred during 1991 through 2001. The growth rate during this period is calculated as 1.54%. Life expectancy at birth is 61 years. Population is more or less homogeneously distributed across the country. However, there are variations of population density in different areas of the country. The distribution of density of population per sq km of the country has been shown in Figure 1.4. Historical trend of population density of the country is alarming that the population density was only 196 per sq.km. at the beginning of the current century for the country as a whole and rose to 839 in 2001.the increase over century is 328% **(Bangladesh Bureau of Statistics 2003)**.

Figure 1.4: Map of the density of population 2001

Number of households are 25.3 million at the aggregate level of which 19.4 million are in rural area and only 5.9 million in are in urban area. Average annual growth rate of urban population is 4.6%.The percentage of rural and urban households are 76.9 and 23.1 respectively .In the last 20 years an additional 10.2 million new households are added to the households of the country of which 6.5 million are in the rural area and 3.7 million in the urban area. Such increase of households has created pressure on housing, water supply, fuel, transportation and other utility services both in urban and rural areas. In the rural area, increased numbers of households are settled in the crop lands which have negative impact on the total cultivable land of the country. In the urban area, due to rapid growth of households, a large number of additional households settled in the urban slums and squatters which is one of the major causes of deterioration of urban environment.Average household size is 4.9.It need to be mentioned that the reduction of the household size throughout the country between 1991-2001 is noticable(5.5 to 4.9).The decline in the fertility in the recent years and disintigration of joint family households may be responsible for lowering the household size.In 2001 census,the urban householdsize was found lower than that of rural sizewhich is 4.8 and 4.9 respectively. **(Bangladesh Bureau of Statistics 2003)**.

Sources of drinking water (Dwelling) of the population are Tap (6.0%), Tube-well (79.8%), Deep Tube-well (4.9%), Pond (3.4%) and others (5.9%). About 97% of population use improved drinking water sources. Toilet facilities (Dwelling) include sanitary (36.9%), others 41.5% and none 21.6%. About 48% of population use adequate sanitation facilities (urban 41% and rural 71%). It is praiseworthy that sanitary latrine has improved tremendously over the last decade. It was only 12.46% in 1991 and it increased to 36.87%in 2001.The rate of increase stands at 195% over the last 10 years. Households having no arrangement for discharge of excreta was 34.20% in 1991 now it declined to 21.59% which is encouraging, however, still more than one fifth of the households at the aggregate level and one fourth households of the rural area has no particular place for discharge of human waste in 2001.The percentage of household having no arrangement for toilet is 7.36% for the urban area of the country. These households are mainly slum and squatter households. Household's access of electricity is 31.5%.In 19991 only 14.29% households had access of electricity. The rate of increase in the last decade stands 1205 that is encouraging. The percentage of households having electric connection was only 4.57% for rural areas and 58.06% for urban areas in 1991 it has been increased to 20.13% and 70.94% respectively in 2001.At the national level, ownership of the agricultural land of the dwelling households is 55.25% and 44.8% households do not own any agricultural

land. It has been seen that such ownership is decreasing through out the two decades. Such percentage was 61.30% in 1981 census.

As illustrated in Table 1.1, the cardinal demographic indicators are comparatively better in the last decades **(Bangladesh Bureau of Statistics 2003)**.

Table 1.1 Demographic indicators for Bangladesh

Demographic indicators	Rate
Crude birth rate	29%
Crude death rate	8%
Infant mortality rate (under 1) per 1,000 live births	53
Under-5 mortality rate per 1,000 live births	77
Total fertility rate	3.5%
Antenatal care coverage of women	40%
Maternal mortality rate per 1,000 live births	3.1
Life expectancy at birth	68.3 years

1.1.2 Sociocultural Context of Bangladesh

At the point of ethnicity Bangladeshi people are amalgamation of Dravidian, Proto-Australoaid, Mongoloid, and Arian. Ethnic distributions of the population are fairly homogeneous throughout the country. There is no gross ethnic diversity in the country. Tribal people with a population of just over 1.2 million occupy mainly Khagrachari,Bandarban, Rangamati, Chittagong,Cox's Bazar,Habigang, Sylhet, Sunamganj, Maulavi Bazar, Dinajpur, Joypurhat, Rajshahi, Naogaon, Rangpur, Bogra, Nawabganj, Mymensing, Netrokona, Barguna , and Bhola districts. There are some 45 tribal groups in Bangladesh and among those Chakma, Garo, Hajong, Khasia, Magh, Santals, Rakhain, Manipuri, Muraong are notable**(Asiatic Society of Bangladesh 2003).**

In Bangladesh, people share common culture and language. In terms of language, National Language is Bangla (99.5% speak Bangla and 0.5% other dialects). English is the second most important language. Family structures are usually joint0 in nature,

particularly in rural areas. On the other hand, a nuclear family structure is more common in urban areas. Overall, the trend towards the nuclear family structure is increasing day by day. However, Bangladesh has strong family support inherent in the culture, which is considered as one of the major strengths regarding treatment of psychiatric disorders. Women infrequently work outside the family environment and being a housewife or household worker is widely accepted as an occupation. Bangladeshi mothers usually stay and home and look after their children, and fathers work. Children and adolescents are living as dependants. Parents are conservative, authoritarian and likely to be protective. As most of the families of the country are in low income group they usually do not want to keep their children at school for long period and older children are usually involved with income related activities either working in family agricultural activities or else through paid employment.

Staple diets are rice, wheat, vegetable, pulses, fish and meat. National days are *Shaheed Dibas* (Martyrs' Day) on 21 February now observed as International Mother Language Day; *Swadhinata Dibas* (Independence Day) on 26 March; *Pahela Baishakh* or *Bangla Nababarsa* (Bangla New Year); *Bijoy Dibas* (Victory Day) on 16 December.Common festivals are Navanna, Pahela Baishakh, (Bangla Nababarsha). Religious festivals are: Muslim Eid-Ul Fitr,Eid-Ul Azha, Shab-e-Qadr, Shab-Barat, Eid-e-Miladunnabi,Muharram; Hindu Durga Puja, Kali Puja, Laksmi Puja, Saraswati puja, Doljatra, Holi; Christian Christmas; Buddhist Buddha Purnima. Regarding games, Kabadi is the national game; football, cricket, hockey, tennis, badminton, volleyball, handball, chess and carom are also popular games. However, cricket is the most increasingly popular game of the country after achieving full membership of the International Cricket Committee.

1.1.3 Education in Bangladesh

The educational system in Bangladesh consists of primary, secondary, higher secondary and higher education. There is also provision of further education (e.g. vocational, technical). There are state and private institutions that exist in all of these stages. The usual age of going to primary school is 6 years. The pre-primary or kindergarten school facilities are mostly confined to urban and semi-urban areas. Five year primary education (up to 5th grade) is compulsory and free of charge for the children of both sexes. There is provision of further 3 years (up to 8th grade) free education for girls. Educational institutions (2001) include Public university 17, private university 24, college (general education) 2551, government medical college 13, private medical college 19, dental

college 3, engineering college 4, polytechnic institute 21. There are some 63,255 primary schools, 15,837 secondary schools, 7,279 madrashas (religious schools), 15,000 non-government registered schools and over 30,000 non-formal education centers. In 2001, there are 264502 teachers at primary schools and 187707 teachers at secondary schools. The gross primary enrolment rate has risen from 71.7% in 1990 to 89.0%% in 2002. The gross secondary enrolment rate (1986-92) was 25% for males and 12% for females. Now, Gross rate of secondary school enrolment is 45% for male and 47% for female. Table 1.2 shows education status indicators for Bangladesh **(Bangladesh Bureau of Statistics 2003)**

Table 1.2 Education status indicators for Bangladesh

Education status indicators	Rate
Literacy rate of the population for all ages for both sexes	37.0%
Literacy rate of the population for all ages for male	40.35%
Literacy rate of the population for all ages for female	33.4%
Literacy rate (7 years and over)	45.3%
Literacy rate (7 years and over) for male	49.65%
Literacy rate (7 years and over) for female	40.8%
School attendance (5 to 24 years) rate for both sexes	44.1%
School attendance (5 to 24 years) rate for male	53.8%
School attendance (5 to 24 years) rate for female	46.2%
Net primary school attendance for boys	77%
Net primary school attendance for girls	78%
Rate of primary school entrants reaching grade 5	72%
Gross rate of secondary school enrolment is for male	45%
Gross rate of secondary school enrolment is for female	47%

1.1.4 Resources of Bangladesh

Mineral resources are mainly natural gas, coal, peat, limestone, hardrock, beach sand heavy mineral (zircon, rutile, Ilmenite, Garnet, Magnetite, Monazite, Leucoxene, Kyanite), glass sand, white clay, brick clay and metallic minerals. Considering water resources, Bangladesh is endowed with plenty of surface water and groundwater resources. Surface water inflows of the country vary from a maximum of about 140,000 cumec in August to a minimum of about 7,000 cumec in February. The alluvial aquifer systems of Bangladesh are some of the most productive groundwater reservoirs. Groundwater in Bangladesh occurs at a very shallow depth where the recent river-borne sediments form prolific aquifers in the floodplains. In the higher terraces, the Barind and Madhupur tracts, the Pleistocene Dupi Tila sands act as aquifers. In the hilly areas, the Pliocene Tipam sands serve as aquifers. The groundwater table over most of Bangladesh lies very close to the surface and fluctuates with the annual recharge discharge conditions. Energy sources are Fuel wood, natural gas, liquid petroleum fuels, coal, hydropower, solar power, biogas etc. **(Asiatic Society of Bangladesh 2003).** Forest is total 21403 sq km. Hill forest land 13,617 sq km; Inland forest land 1,220 sq km; Littoral forest 6,566 sq km. Flora consists of 6000 species (5000 flowering plants).Fauna Vertebrates include about 1600 species.

National flower is *Shapla* or water lily (*Nymphaea pubescens*).National fruit is *Kanthal* or jackfruit (*Artocarpus heterophyllus*).National bird is *Doel* or Magpie-Robin or Orien tal Magpie-Robin (*Copsychus saularis*).National fish is Ilish Hilsa (*Tenualosa ilisha*).National animal is *Bagh* or Bengal tiger, well known as Royal Bengal Tiger (*Pathera tigris*).

1.1.5 Economy of Bangladesh

Financial system consists of one central bank (Bangladesh Bank), 45 commercial banks, 5 state-owned specialized banks, also known as development finance institutions (DFIs), 23 non-bank financial institutions, 27 merchant bankers, 556 money changers, the Investment Corporation of Bangladesh (ICB), 2 stock exchanges (the Dhaka Stock Exchange and Chittagong Stock Exchange), 2 state-owned and 39 private sector insurance companies, about 10 leasing companies, Post Office Savings Bank and the Postal Life Insurance schemes. There are 145,000 co-operatives. Bangladesh Samabaya Bank Ltd is the apex institution of the co-operative sector. There are over 1,200 non-governmental and non-profit micro finance institutions. Industries include Jute, tea, textile, garments, paper, newsprint, fertiliser, leather and leather goods, cement, sugar, fish processing,

pharmaceuticals and chemicals. Export Processing Zone (EPZ) Existing includes Chittagong EPZ (1983) and Dhaka EPZ. The government has signed an agreement with the Republic of Korea to establish a Korean EPZ in Chittagong. Exports are Ready made garments, raw jute, jute manufactures, tea, leather and leather products, frozen shrimps and other fish products, newsprint, handicraft. Imports are Wheat, oil seeds, crude petroleum, raw cotton, edible oil, petroleum products, fertilizer, cement, yarn. Foreign trade is Export: 5 billion US$; Import: 7 billion US$ (1999).Currency is Taka (Tk 58.10 = US$1, March 2004) **(Asiatic Society of Bangladesh 2003).**

Total Civilian Labour Fource(1999-2000) is 40.7 million(male 32.2 million, female 8.5 million).Female Labour Force is lower because household work was not included in the calculation. Employed population is 1.6 million whereas unemployed population is 1.8 million. Youth Labour Fource (15-29 years) is 14.5 million (male10.5 million, female 4.1 million. Child Labour Fource(10-14 years) is 6.8 million (male 4.0 million, female 2.8million).Working Child Labour Fource(10-14 years) is 6.3 million (male 3.8 million, female 2.5 million). Population of abroad employment is 2.2 million and earned remittance (in 2000) is Taka 10199.12 Crore **(Bangladesh Bureau of Statistics, 2004).**

Economic activity rate of the population is 37.6% (64.6% for male and 9.3% for female) Principal source of household income are agriculture/forestry/livestock (9.2%),fishing/psiciculture (1.7%), agricultural labour (20.6%), non-agreeculture labour (0.7%), weaving industry/workshop (1.3%), business (14.7%),hawker (0.4%), transport (3.8%), construction (1.6%), religious services (0.2%),salary/wage (10.9%).rent (0.3%),remittance (2.0%) and others(8.5%).Table 1.3 shows the basic economic indicators of Bangladesh.

Table 1.3 Economic indicators for Bangladesh

Economic indicators	Rate
Per Capita Gross Domestic Product (GDP)	US $ 421
Per Capita Gross National Income (GNI)	US $ 444
growth rate of GDP for FY2003	5.6%
Average annual rate of inflation	4.38%
Economic activity rate of the population	37.6%
dependency ratio of the population	75.99%

Sectoral shares of GDP agriculture (21.8%), Industry (26.3%), service (52.0%) and others (0.9%). Average annual rate of inflation is 4.38%.Sectoral share of agricultural sector in GDP is gradually decreasing while the sectoral shares of industry and service sectors are increasing **(Bangladesh Bureau of Statistics 2004).**

1.1.6 Divisions of Bangladesh

Bangladesh is also a country of moderate diversity within its homogeniousity in terms of geographic and economic characteristics. The country is usually divided in 6 administrative Divisions (Figure 1.5), each of which includes several Zilas (Districts), Upazila/thana, Unions/Wards that in turn comprise Bangladesh's local governments.

Figure 1.5: Divisions of Bangladesh

Brief description of the Divisions of the Divisions is given below to compare and contrast in the different parts of Bangladesh within its overall homogeneous character**(Asiatic Society of Bangladesh 2003; Bangladesh Bureau of Statistics 2004; Bangladesh Bureau of Statistics 2004a; Bangladesh Bureau of Statistics 2003).**

Barisal Division is bounded by Dhaka Division on the north, Bay of Bangal on the south, Chittagong Division on the east and Khulna Division on the west. This Division is full of rivers and canals. Divisional headquarter is Barisal city which consists of 30 wards. It has an area of 16.36 sq km. The town has a population of 321460; male 53.28%, female 46.72%. Literacy rate among the town people is 65%. Of the population, male 50.67%, female 49.33%; Muslim 88.06%, Hindu 11.7%, Christian 0.18% and others 0.06%. Literaricy rate male 39.67%, female 30.76%. Main occupations are agriculture 40.96%, fishing 3.4%, agricultural labourer 18%, wage labourer 4.59%, commerce 11.92%, transport 1.73%, construction 1.34%, service 7.39%, others 10.67%.Main crops are paddy, betel leaf, potato, sugarcane, oil seed, onion, garlic, vegetables. Main fruits are Coconut, *amra*, guava, betel nut, and banana.

Chittagong Division, the largest Division by land occupation, is bounded by Dhaka and Sylhet Divisions and Tripura state of India on the north, Bay of Bengal,and Arakan (Myanmar) on the south, Mizoram, Tripura states of India and chin state of Myanmar on the east and Bay of Bengal, Barisal, and Dhaka Divisions on the west. Main islands are Sandwip, Hatya,Kutubdia, Maheshkhali and St. Martins. There are many big hills in Rangamati, Khagrachhari, Bandarban and in eastern part of Chittagong districts. Divisional headquarter is Chittagong metropolitan city which consists of six thanas, 68 wards. It has an area of 209.66 sq km. The town has a population 3385800; male 54.37% and female 45.63%; population density per sq km 15272. The main seaport of Bangladesh is located at the estuary of the Karnafuli River. Chittagong is also called the commercial capital of Bangladesh.Of the population, male 52.32%, female 47.97%; Muslim 79%; Hindu 12.65%; Buddhist 7.08%; Christian 0.84% and others 0.43%. Average literacy is male 39.7% and female 25.3%. Main occupations are agriculture 35.73%, agricultural labourer 16.82%, wage labourer 4.46%, fishing 2.36, industry 2.47%, weaving 0.22%, commerce 11.66%, transport 2.83%, forestry 2.3%, service 12.64% and others 8.51%.Main crops are paddy, betel leaf, potato, cotton, tea, peanut, mustard, *patol* (heap), brinjal, ginger, bean and other vegetables. Main fruits are mango, jackfruit, pineapple guava, coconut, betel nut, litchi, banana, papaya, water melon and lemon.

Dhaka Division, where the preliminary study, pilot study and the main stage study (Dhaka study) of this thesis took place, is the most populated region in Bangladesh. The Division is bounded by Meghalaya state of India on the north, Barisal and Chittagong, Divisions on the south, Sylhet and Chittagong Divisions on the east, Rajshahi, and Khulna Divisions on the west. Madhupur and Bhawal Garhs are located to the northern parts of Dhaka, in Gazipur, southern part of Mymensingh and eastern part of Tangail districts; Garo hills are located in Mymensingh district. Divisional headquarter is in Dhaka metropolitan city with the population of 10712206. Description of Dhaka city is given in chapter 3. Of the population of this Division, male 51.63%, female 48.37%; Muslim 89.51%; Hindu 9.64%, Christian 0.5%, Buddhist 0.03% and others 0.32%. Literacy rate is for 39.8% male and female 26.5%.Main occupations are agriculture 38.63%, agricultural labourer 15.93%, wage labourer 2.75%, weaving 3.75%, industrial labourer 1.93%,

commerce 10.75%, service 7.78%, construction 1.42%, house renting out 2.23%, transport 0.42%, fishing 11.99% and others 2.42%.Main crops are paddy, jute, wheat, potato, ground nut, onion, garlic, chilly, various kinds of pulse, sugarcane and vegetables. Main fruits are mango, jackfruit, papaya, pineapple, guava, watermelon, coconut and banana.

Khulna Division is bounded by Rajshahi Division on the north, Bay of Bengal, on the south, Dhaka and Barisal Divisions on the east, West Bengal on the west. The Sundarbans is located in this Division covering parts of Satkhira, Bagerhat and Khulna districts. Divisional headquarter is Khulna metropolitan city which consists of 38 wards. The area of the town is 20.60 sq km. It has a population of 1340826; male 53.26%, female 46.74%; density of population is 37535 sq km. The literacy rate among the town people is 59.1%.Of the population male is 51.05%, female is 48.95%; Muslim 82.87%, Hindu 16.45% and others 0.68%. Literacy rate for male is 40% and that for female is 25.8%.Main occupations are agriculture 39.43%, fishing 1.98%, agricultural labourer 21.65%, wage labourer 3.85%, weaving 3.58%, commerce 12.66%, transport 2.4%, construction 1.47%, service 7.46%, industry 1.35% and others 4.17%.Main crops are paddy, jute, betel leaf, sugarcane, potato, turmeric, oil seeds mulberry plant, and vegetable. Main fruits are Mango, jackfruit, banana, litchi, black berry, coconut, palm and papaya.

Rajshahi Division is bounded by West Bengal of India on the north, Khulna and Dhaka Divisions on the south, Assam and Meghalaya state of India and Dhaka Division on the east and West Bengal of India on the west. Parts of Naogaon, Rajshahi, Bogra, Joyprhat, Gaibandha, Rangpr and Dinajpur are composed of Barind tracts. Chalan Beel, largest in Bangladesh, is located in this Division. Divisional headquarter is Rajshahi metropolitan city which stands on the bank of the river Padma. The area of the Rajshahi town is 96.69 sq km. It consists of four thanas, and 39 wards. The city has a population of 700140; male 52.91%, female 47.09%. Density of population is 3968 per sq km (Population Census 2001, National Report). Rajshahi was flourished In the seventeenth century. The tomb of Hazrat Shah Makhdum (established in 1634) is located at Dargahpara of the town. Many European traders were attracted to this town because of its being a centre of silk production and location by the side of the river Padma; subsequently the Dutch, the French and the English East India Company established business houses in the town in phases. Because of flourishing silk industry Rajshahi is also called the City of Silk. Male and female distribution of the population is 50.80% and 49.20% respectively. Distributions of religions among population are Muslim 86.84%; Hindu 11.09%, Christian 1.17%, Buddhist 0.23% and others 0.67%.Main occupations are agriculture 40.99%, agricultural labourer 22.9%, wage labourer 3.24%, fishing 1.32%, weaving 2.85%, industry 1.77%, commerce 9.61%, service 4.74%, transport 2.68% and others 9.9%. Main crops Paddy, wheat, jute, sugarcane, oil seed, onion, garlic, potato, betel leaf and mulberry plant. Main fruits are mango, jackfruit, banana, litchi, black berry, coconut and papaya.

Sylhet Division is located to the north-east of Bangladesh and is bounded by Meghalaya State of India on the north, Tripura State on the south, Assam State of India on the east

and Dhaka and Chittagong Divisions on the west. There are many hills, hillocks, *extensive* marsh, accumulated water in depressed lands, swamp and long pools of water in this Division. Divisional headquarter is Sylhet city which consists of 27 wards. The area of the city is 10.49 sq km. The city has a population of 3,20,280; male 54.68%, female 45.32%; density of population is 27198 per sq km. Literacy rate among the town people is 66.9%.Of the population, male 50.47%, female 49.53%; Muslim 81.16%, Hindu 17.80%, Christian 0.06%, Buddhist 0.02% and others 0.96%. Literacy rate for male is 33.7% and female is 21.8%.Main occupations are agriculture 36.93%, fishing 3.07%, agricultural labourer 18.81%, wage labourer 7.49%, commerce 9.24%, transport 1.94%, service 6.43%, industry 1.33%, house renting out 3.1% and others 11.66%.Main crops Paddy, wheat, tea, mustard seed, onion, garlic, betel leaf, vegetables. Main fruits are orange, pineapple, mango, jackfruit, litchi **(Asiatic Society of Bangladesh 2003)**.

There are some variations in terms of socio-economic characteristics among the Divisions which are shown in Figure 1.4

Table 1.4: Socio-economic characteristics per Division (**Bangladesh Bureau of Statistics 2003, 2004**)

Characteristics	Barisal	Chittagong	Dhaka	Khulna	Rajshahi	Sylhet
Area (sq km)	13,297	33,771	31,119	22,274	34,513	12,596
Population	8,153,960	24,119,660	38,987,140	14,604,900	30,088,740	7,896,720
Population 18 years & below	3,816,140	11,873,840	16,985,220	6,113,140	13,170,020	3,811,820
Sex ratio	104.9	104.1	109.5	106.5	106.0	104.8
Population density per sq km	613	714	1253	616	872	627
Urban population	1,160,300	5,724,140	13,386,060	2,920,580	4,437,740	976,380
% of urban population	14.2	23.7	34.3	20.0	14.7	12.4
Percent change of population,1901-2001	-2.00	+3.2	+2.7	-1.34	-1.75	- 0.64
Zila	6	11	17	10	16	04
Upazila/Thana	39	102	140	64	127	35
Union/Ward	553	1,340	1,985	861	1681	468
Village	4,193	1,5,037	25,435	9,284	23,639	10,340
Municipality	22	38	64	28	57	14
Population of municipalities	776,960	3,661,840	8,698,600	1,965,120	3,100,560	687,160
Household	1,644,120	4,424,020	8,178,200	3,095,200	6,586,580	1.379,480
Dwelling households	1,614,220	4,314,540	7,962,340	3,060,460	6,544,340	1,354,380
Average size of dwelling household	5.0	5.5	4.8	4.7	4.6	5.7
Literacy (%)	53.17	46.88	46.22	48.14	40.90	39.57
Primary school	5,908	11,640	16,258	7,666	16,707	5,076
Primary student	1,338,000	3,839,000	4,851,000	1,820,000	4,362,000	1,246,000
Primary teacher	24,970	51,267	69,083	32,862	69,475	16,845
Secondary school	1,404	2,430	3,755	2,189	5,424	635
Secondary student	515,000	1,490,000	2,170,000	919,000	1,876,000	318,000
Secondary teacher	15,761	30,733	53,409	25,414	55,188	7,202
Economically active population (%)	9.4	18.2	31.2	12.5	23.3	5.4

Though the largest Division by area is Chittagong Division, Dhaka is the largest populated Division.The Divisional variation in sex-ratio is not well pronounced. The sex-ratio of is comparatively higher for Dhaka Division. This can be explained by the higher proportion of urban population of Dhaka Division. The sex-ratio of Barisal, Chittagong and Sylehet Division seems almost similar; however sex-ratio of Khulna and Rajshahi are a bit higher than these three Divisions. The urban sex-ratio of Dhaka and Chittagong Division is comparatively higher than the urban sex-ratio of the other four Divisions which are121.9 and 116.1 respectively. Among the rural population, the lowest sex-ratio (100.7) is in Chittagong Division. This may be attributed to male migration from the rural areas of this Division to urban area of this Division and also to other urban areas of the country.

Among the Divisions of the country the highest density is in Dhaka Division (1253 per sq km).Population distribution by Divisions has been changed over the last decade.The percentage change of populationby Divisions from 1991 to 2001 is indicative of this change.The Divisions where population proportions reduced are Barisal,Khulna, Rajshahi, and Sylhet.The Divisions where population proportion increased are Dhaka and Chittagong.The increase of population proportion of these two Divisions may be explained by rapid urbanization of these two Divisions compared to the other four.The maximum increase of population proportion was observed in Chittagong Division whe the percentage of population was 16.45% in 1991 and incresed to 19.47% in 2001.The increase is 3,02 percent points.The increase of population in Chittagong Division may be exolained by two regions namely growth of urban population and migration of people from other Divisions of the country to this Division.Among the loosing Divisions the highest loss of population proportion occured in Barisal Division (2.0%) followed by Rajshahi Division (1.75%). Khulna Division (1.34%) and Sylhet Division ().64%).The loss of population in these Divisions may be explained by out migration of population from these Divisions to Dhaka and Chittagong Division for better job, education and other economic activities. The recession of population of Barisal Division can partly be explained by natural disasters like cyclone, tidal surge and river erosion in this Division over the last decade.

Average size of the dwelling households varies among the Division of the country. is highest in Sylhet Division and lowest in Rajshahi Division. It is interesting to note that average size of households in all census were below 5 for three Divisions namely Dhaka,Khulna and Rajshahi.The average size of other Divisions was 5.0 or more.

Interestingly,literacy rate is highest in Khulna Division and lowest in Sylhet Division.Khulna and dhaka Divisions is second and third position respectively. There exixits wide variation of zilas of the Divisions in respects of literacy.Number of institutions,teachers and students both of primary and secondary level is high in Dhaka Division than that of any other Divisions.

In total, dependency ratio of the population is 75.99 %(urban 58.90%, rural 81.87%). Economically active population is highest in Dhaka Division followed by Rajshahi Division. That is lower in Khulna Division followed by sylhet Division which is the lowest.

Divisions of Bangladesh are basically made for administrative purpose. Despite of some quantitative differences of characteristics are observed that are not so significant. Major demographic characteristics among Divisions are more or less similar. Qualitatively, all Divisions carries the similar socio-cultural characteristics, in terms of language, believe, attitude, behaviour, habits, family system, and social structure. All these make the Bangladsh a traditional homogeneous society.

1.1.7 Children in Bangladesh

According to Banglapaedia, the National Encyclopedia of Bangladesh **(Asiatic Society of Bangladesh 2003)**, children are boys and girls under 14. The UN Convention of the Rights of Children treats every human being below the age 18 years as a child. The convention allows every society to consider its own laws and customs. The ministry of women and children affairs of the government formulated a National Children Policy in December 1994 to adopt an appropriate programme of action for welfare of the children in the interest of the overall development of the country and that it is desirable that everyone should participate in the task of helping every child grow into an able citizen. To promote children's welfare the government enacted a law in 1974 and established the Bangladesh Shishu Academy in 1976. Bangladesh was an early signatory to the UN Charter of Children's Rights and has since been taking steps to implement its provisions. The objectives of the policy are to ensure a child's right to live, it is necessary to provide him security of health, nutrition and person. To ensure his overall mental growth, it is necessary to educate him. Other objectives outlined in the policy are to help develop a child's sense of moral, cultural and social values; to take necessary steps to help develop his family environment; to ensure special support for handicapped children; to adopt policies to ensure maximum protection of children's rights at national, social, family and personal levels; and to ensure legal rights of children in national, social and family activities. To ensure overall welfare of the children, it is necessary to give particular

attention to management at family, group or social levels; to develop institutional management at village level and ensure people's participation in the activities of the government's social welfare institutions; to strengthen management of government institutions to ensure proper rehabilitation of homeless and helpless children; and, when necessary, to create new institutions and enlist support of Non-Government Organizations. The policy describes the way a national children council is to be formed and its agenda. The children policy concludes with the declaration that it was the objective of the policy to ensure that all children of the country, irrespective of their caste, colour, gender, language, religion or belief, social status, wealth, birth or any other status, enjoy all rights and opportunities equally.

The Family system in Bangladesh

The Family system in Bangladesh is mostly patriarchal, except in some ethnic minority groups. The father is responsible under law for taking care of the children. But the children remain close to their mother, whose role in shaping their character is predominant. Generally, boys start getting away from their mothers in their adolescent age, when they are guided by the father or other male guardians. Girls remain close to the mother or female relatives. Parents love children and often give top priority to fulfilling their needs but traditionally, ignore their opinions, arguing that they understand little. In some cases, simple survival demands do not allow poor parents to take much care of their children **(Asiatic Society of Bangladesh 2003)**.

Children in Bangladesh, especially in the rural areas and in conservative families, are often subject to gender discrimination. Many parents think that the male child represents heredity. A boy enjoys more freedom than does a girl. The boy is allowed to go outside of the house more frequently than a girl, who is to remain with her mother or aunts to help in a household work or is to imply stay inside because of Purda and 'security'. From very early age, boys and girls in Bangladesh society wear different dresses. Boys wear pants, shirts, *lungis, pidjamas, panjabis*, etc. and girls wear *salwar-kamijes, urnas, saris*, etc. The girls are to keep long hair from their early age.

Traditionally, only the father or a senior male person in the family is the legal guardian of a family. Only the father's name is put in the school register and elsewhere. Recently, however, the government has issued an administrative order to put the mother's name along with the father's in the school-register book. Child marriage, although officially

banned, continues to take place in many parts of the country. Arranged marriage is still the prevalent feature and the opinion of the girl in question is largely ignored.

In Bangladesh, children have little scope for enjoying their childhood. Most village boys help their fathers in the fields from an early age. The girls are engaged in household work. Slum boys and girls have to earn own livelihood, most of the time, for themselves and often, for their families. A large number of children are born with physical and mental handicaps. Such children are neglected within the family as well as in society. Although some schools and training centers have been established for these children, entry to these institutions is restricted to the privileged few.

Rights of the Child (CRC)

Bangladesh was one of the first countries to sign and ratify the UN Convention of the Rights of the Child (CRC). In addition, the Constitution of Bangladesh ensures children's rights by its various articles. For example, Article 14 of the Constitution prohibits all kinds of exploitations. Article 15(d) ensures the right of social security of people of all age groups. Article 17 provides for adopting effective measures for the purpose of establishing a uniform, mass-oriented and universal system of education for all children. Primary education is now free and compulsory. Girls enjoy special facilities and stipend in studies up to the secondary level. However, not all rights of children or of girls are ensured in practice.

The state of the children in Bangladesh

Every year about two and a half million children are born in Bangladesh. About three-fourths of all children in the country live below the poverty line. Child mortality is very high. In the early 1990s, for every thousand children born alive 12 died within several hours of birth, 8 due to birth trauma and 4 due to prematurity. A further 23 died within a week, 16 due to prematurity and 7 as a result of neonatal tetanus. Poverty, inadequate housingm, malnutrition, shortage of pure drinking water, sanitation, primary health care, immunisation and inadequate knowledge of hygiene, teen-age motherhood, etc are causes of the high infant mortality. The infant mortality rate in rural areas is higher than in urban areas.

Child trafficking has become a regular phenomenon. Children are being smuggled to the Middle East and other countries for various exploitative and abusive purposes. Bangladeshi children are found in large number in brothels at home and abroad. Children are also being used as camel jockeys in the Gulf countries.

Bangladesh officially launched the education for all plan (EFA) in March 1992. But a large number of children still remain beyond coverage of primary education. 76% boys and 64% girls enroll in primary schools. Children of rich families in urban areas attend kindergarten, which are divided into two categories, English medium and Bengali medium. Children of lower classes of urban areas go to conventional primary schools. Rural children go to primary schools and to *ebtedayee madrasahs* (Religious school). Solvent families in rural and urban areas employ private tutors for their children. In urban areas, coaching classes are organised, where children take extra lessons. The children of Muslim families learn the Holy Quran at home and in mosques. Interested guardians in urban areas send children to music schools for lessons in music and dancing. In many towns there are specialised libraries for children to read books. In addition, there are organisations, which develop children's literary and cultural faculties.

Children in Bangladesh do not have access to facilities in games and sports. Not all schools have adequate arrangements. Whatever little provisions are available, are created by communities. They consist of some open space in the village or town for boys to play cricket, football or traditional games. In rural areas, children also play within the house premises. But in urban areas, children do not have the opportunity simply because of the lack of space. Indoor games like table tennis, carom and chess and video games are the privileges of urban children only, but that too only for those having access to medium and large educational establishments. Girls are virtually excluded from the benefit of playing outdoor games. In villages they play with dolls and in urban areas, some of them play indoor games.

Child Labour

Child Labour means children of the age of 5-14 years, employed to work for pay or profit, or without pay, in a family enterprise or organization. Economic hardships of many families force most of their children to get involved in income generating activities, some of which are hazardous. Most of these children grow and live in absolute poverty and deprivation. They do not get opportunities to acquire education and skills to ensure a better life for them.

Children aged 5-14 years are found working in households, fields and factories as paid or unpaid labour. The rights of children are neglected in Bangladesh. Increasing abuse and infringement of children's rights have triggered off a concern over it. A dense population,

limited resources, and frequent natural calamities complicate the poverty situation in Bangladesh and children are the worst victims.

The usual scenario in Bangladesh sees girl children engaged in activities within the inner 'female' spheres, whereas boys work in the outer 'male' spaces. This frequently results in high ratios of school dropout amongst girls. The potential labour power of children is a significant aspect for families as the survival of households depends on their ability to reproduce themselves. The perceived economic value attached to children greatly encourages people to raise large families. Expectations of assistance from children arise from the deep-rooted concept of sharing the burden amongst the adult members of the family. Early participation in income generating activities compels children to experience a first transition through different stages of their childhood; this transition is important in conceptualizing children's productive life cycles.

While children are occupied in both organized and unorganized sectors, the kind of work they do depends largely on where they live. Although children in organized sectors are covered by protective legislation, those working in unorganized sectors are not as fortunate. Working conditions there are far from congenial.

Labour laws prohibit Child labour in Bangladesh. However, analyses of data generated in the 2001 census and of the trends in the subsequent years suggest that approximately 19% of the total child population (5-14 years) of Bangladesh work as child labour. The proportion is much higher in case of boys (22%) than in case of girls (16%). About 83% of the children employed as child labour work in rural areas and the rest work in urban areas and the ratio is almost the same for both boys and girls. About 65% of the child labour work in agriculture and 8.5% of them work in manufacturing. There is little variation in distribution of child labour by girls and boys in these two sectors. But gender distribution of child labour in transport and communication shows that the proportion of boys to total child labour in this sector is 3%, while that of girls to the same is only 0.1%. Average weekly working hours for child labour in Bangladesh is roughly half of those for adult workers. The wages, or monthly income of the working children, however, are about one-third of those for the latter. Slightly more than 20% households of Bangladesh have working children of age 5-14 years. The corresponding figure for urban households is 17% and for rural households, it is 23%. Despite the fact that existing labour laws prohibit child labour, a large number of children are employed in the formal and informal sectors, eg small industries, workshops, restaurants, sweetmeat shops, motor garages, bus and tempos, construction, tea plantations, , agriculture domestic work etc. Their employment however,

is rarely secure. Sometimes they receive only subsistence rations for survival. And these, in many cases, are considered as favours. In some cases children are nearer to what can be called bond labour. Child labourers are often assigned tasks beyond their physical capacity. Many of them work in hazardous conditions among dangerous fumes, gases, asbestos, lead, sodium etc. As a result, they have to suffer from skin diseases, heart diseases, bronchial problems, etc. In domestic service the child, especially a girl child, has every possibility of being abused. A large number of children die from fire, accidents by machinery, toxic substances, injury and violence.

The most vulnerable category of children is known as street children or street urchins commonly known as *tokais*. These children survive by picking things from the street, dustbins and other places. Street children have no parents. Actually, they are born on the street, live on the street and die on it. Some of them have parents but have no contacts with them. Factors forcing children to the street are mainly poverty, broken family, running away from family, and sexual abuse. Nobody takes care of vagrant children. They live at stations, bus terminals, office premises and in parks, street sides etc, or under the open sky **(Asiatic Society of Bangladesh 2003)**.

1.1.8 Health Status in Bangladesh

In Bangladesh, healthcare during the past 40 years did not create an equitable distribution of health services. Health chapter of the Fourth Five-Year Plan (1990-95) began with the theme that access to health is a fundamental right of a person. The Fifth Five-Year Plan (1997-2002) states: 'Providing medical care is the constitutional obligation of the government'. In response to the changing health situation of the country, reforms in the health sector, particularly in the areas of management structure, service delivery mechanisms and utilization of both public and private sector resources are called for urgently

The Government Health Service is the main health service and in general, people do not have to pay for medical treatment. At the primary level, there are health centres in local areas and district hospitals constitute the secondary level. Teaching and specialised hospitals and institutes are the tertiary level. Usually people treated by primary health care physicians at the primary level under primary health care package programmes, can be referred to the next level. But, due to the shortage of money allocation, people have to buy many drugs that the doctors prescribe and the Government health service is inadequate according to the need.

It is also possible to have treatment done privately, for which one has to pay. This sector is mainly urban based and gradually expanding. In addition, there is private health insurance to help the people pay for treatment. There are many voluntary health care agencies throughout the country that treat ill people with only a small charge and sometimes free of cost.

UNICEF in Bangladesh provides water and sanitation goals for children. These have already been achieved and universal salt iodination, baby-friendly hospital initiative, oral rehydration therapy, vitamin A supplementation and immunisation related goals are nearly achieved. Only the malnutrition goal will not be reached, but concentrated efforts have now been launched to make up for lost time will collaboration between the WHO and the Government. Vitamin a supplementation coverage rate (6-59 months) 90%.Households covering iodized salt is 70%. Universal child immunisation achieved the 93% target in 1990 and expanded programme of immunisation coverage is 97%. In addition, other non-government organisations have a significant achievement in health care. Although this sector is increasing but the coverage is still inadequate. Overall, 45% of the population has access to health services. These are enormous traditional healers services particularly in the rural areas and the majority of the rural people still attend mainly due to easy availability and low cost.

The spectrum of health situation has also been changing in Bangladesh with the global scenario changes in health over time. The major contributors to these changes are rapid population growth, increasing urbanisation and major shifts in disease patterns prevailing in the country. Resurgence of malaria, kala-zar and other emerging and reemerging diseases such as dengue, filariasis, tuberculosis, are a few example of these changes, whilst the risks of Sexually Transmitted Diseases (STDs), Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS), and other infectious diseases menacing public health are increasing. Increase in the incidence of cardiovascular disease, renal disorders, mental illness, cancer, and conditions related to substance abuse, smoking, and alcoholism has been noted. Increased arsenic in sub-soil water in many areas also poses a potential danger to public health. It is likely that Bangladesh will continue to experience epidemiological transition and witness the phenomenon of coexistence of both age-old infectious and emerging new diseases. Diseases related to metabolic disorders, malnutrition, tuberculosis, reproductive health, diarrhea, respiratory tract etc continue to influence the health status of the population. Over the 25 years of independence, the health situation of the population has improved quite remarkably. Smallpox, cholera, and malaria have been eradicated or are no longer major killers. Life

expectancy rose from 45 in 1970 to 60.8 in 2000. Total fertility rate was reduced from 6.3 in 1975 to 3.4 in 1995. The crude death rate dropped from 12.0 in 1990 to 9.0 in 1995 and is declining further. Extended Programme of Immunization (EPI) coverage had been over 66 percent in 1995 and infant mortality rate declined to around 78 per thousand live births in 1995. Similarly the under 5 mortality dropped from over 210 in the mid 1970s to 133 per thousand live births in 1995.

The key challenge in health and family planning is to expand access to basic services and improving the quality of services both in the public and private sectors. An immediate recent major achievement has been the preparation of a Health and Population Sector Strategy (HPSS) by the government (under implementation since 1998). The government, after approving it, has started implementing the Health and Population Sector Programme (HPSP 1998-2003) under the Health and Population Sector Strategy (HPSS) from July 1998. There has been another remarkable achievement in the health sector between 1998 and 2000. For the first time in Bangladesh, the country has formulated and approved a national health policy. It is understood that though the HPSP pre-empted the national health policy, the HPSP has been cut according to the new national health policy. It was possible as the formulation of the HPSP and the National Health Policy (NHP) began almost simultaneously.

A recently conducted Health and Demographic Survey indicated that 41 percent of rural people who were sick lost an average of 10 days of work per person. Annual per capita treatment costs were relatively high, at about Tk 900 in urban areas and Tk 600 in rural areas. In both urban and rural areas, this amount is equal to or higher than the regional monthly poverty lines. Fertility has decreased; child immunization has reached more than 70%. From 1981 to 1992 the population to doctor ratio fell by half i.e. 1:5242 and at the end of year 2000 it stands at 1:4719. The population to nurse ratio stands at 1 nurse for 8226 persons. The number of registered doctors in 2000 stands at 27,546 for a population of about 130 millions and the number of registered nurses is 15804. In 2000, the numbers of hospital beds were 40,793 of which 29,402 are in the government hospitals. The number of medical colleges in private sectors is 13 and in the public sector it is also 13. The World Bank report entitled *In Search of Healthy Bangladesh: Expectation in the Twenty-first Century* says that Bangladesh is at the top of the list with regard to malnutrition, and child mortality. Reasons for these, as identified are poverty, illiteracy and largely inadequate health care. In Bangladesh 70% mothers and children suffer from malnutrition. Everyday about 600 children die due to malnutrition and every year about

28,000 mothers die due to pregnancy related diseases and complications. More than 3 million children are born annually out of which about one third are born with lesser than normal birth weight. During childbirth, 5 expecting mothers die out of 1000 births. One out of nine children dies before the age of five. Among the most poor, this rate is one out of six. Pneumonia, diarrhoeal diseases, malnutrition, measles, and Tetanus, at the time of birth, are the main causes of child mortality. Number of below five children is 20 million in the country. Out of this 20 million, 3,80,000 die every year: 1,20,000 die due to pneumonia, 95,000 due to diarrhoea, 19,000 due to tetanus and 15,000 due to measles. Low birth weight of the child is one of the major causes of child mortality in Bangladesh **(Asiatic Society of Bangladesh 2003)**.

Despite sound infrastructure the health care services remain out of reach of the majority people. The primary reason, experts believe, is that government commitment for allocation for the health service sector never got a priority. According to a recent study conducted by the health economic unit of the Ministry of Health and Family Welfare, only 34 percent expenditure in health was financed by the public sector, 64 percent by the household and a mere two percent by NGOs. In 1997-98 government allocation was Tk 1480 crore which was equivalent to 1.3 percent of GDP or Tk 117 per person per year. It is noted that the highest number of problems (22%) in health sector are related to inadequate number of physicians, wrong treatment, negligence towards patients, non-attentiveness, irresponsibility, absence from duty, and unwillingness of doctors to stay at rural areas and small towns. The other problems are related to supplies, equipment, beds etc (21%). Some other major problems often discussed also include lack of ambulance services as well as proper referral services, which are almost non-existent. The problems related to health bureaucrats, employees and nurses are also very significant. These are the state of affairs at the government hospitals.

The district hospitals are generally overcrowded with capacity unequal to demand. But facilities at the lower level are characterized by underutilization and this is mainly due to lack of people's confidence. The new five-year health and population sector programme (HPSP) based on the Health and Population Sector Strategy (HPSS) already under implementation since July 1998 calls for providing an essential service package (ESP) or a community based healthcare scheme to the entire population at four different levels of delivery. The levels are: community out-reaches, health and family welfare centres/rural dispensaries, upazila health complexes as first referral system and district hospital as second referral system. The public-private partnership in health (PPPH) programme is one

of the components of the HPSP which aims to improve the access to the poor of good quality essential services especially to women and children by engaging the private sector. ESP includes child health, reproductive health, adolescent health, family planning, infectious diseases and curative services. These are the priority primary healthcare services for Bangladesh. The purpose of this is to develop a delivery system for primary care services for people of rural Bangladesh who have less access to healthcare services.

The non-government sector has successful stories in implementation of health and population programmes in accessing the poor to good quality essential services, especially the women and children. Today there are about 20,000 NGOs operating in the country. Most of these are, however, small with focused sphere of activity, but there are a few very large and internationally reputed. These have a broad spectrum of activities including some healthcare programmes. By far the most prominent NGO working exclusively in the health sector is an international NGO which was created by the Parliament of Bangladesh in 1979 under the name International Centre for Diarrhoeal Disease Research, Bangladesh. Although it had its early focus on diarrhoeal diseases, the centre has broadened its scope in recent years to include health research in general. Since the very large numbers of NGOs that operate in the country at the present time have their units active in all parts of the country, the NGOs have served an important ancillary function. They have been of value in supplementing government efforts in healthcare areas such as childhood immunisation, and nutritional education and intervention at the community level. Currently the traditional healers (about 80%) are the major healthcare providers in the country. They are the first source of care for rural people with acute as well as chronic illness. These traditional healers need improved knowledge of medical science **(Asiatic Society of Bangladesh 2003)**.

Child Health

According to the *State of the World's Children 2004* published recently by UNICEF out of 189 reported countries, Bangladesh stands 59th from the bottom up in terms of child mortality rates **(UNICEF, 2004)**. Regionally, Bangladesh is reported to be doing better than other countries such as India and Pakistan, which come out 53rd and 44th respectively. Parameters such as immunization coverage access to 'safe' drinking water, sanitation, rate of school enrollment especially of girls and completion of primary education are slowly but definitely showing an upward and positive trend. If the validity of these statistics holds, these are something that Bangladesh has achieved in the last three decades. 2001. A child is highly vulnerable to two categories of acquired ailments; one is a heavy load of

infectious diseases and the other, those diseases that are caused by inadequate nutrition. The profiles of childhood diseases in Bangladesh are generally similar to those of other developing countries in the tropics such as Asia, Africa and South America. There are six childhood diseases for which effective vaccines are now available. These are diphtheria, pertussis (whooping cough), tetanus, polio, measles, and tuberculosis. As a result of use of these vaccines through the WHO sponsored Expanded Programme of Immunization (EPI) throughout countries of the developing world, incidence of these diseases is rapidly declining. Major childhood diseases for which no effective vaccines are available include: diarrhoea caused by bacteria and some viruses, enteric fever such as typhoid, respiratory infections such as viral influenza and bacterial pneumonia and parasitic illnesses such as intestinal helminth diseases and malaria. Among the infectious diseases, diarrhoeal diseases are perhaps the most common illness in children in Bangladesh due largely to unsafe drinking water and poor health and sanitation practices. The next major category of illness involves the respiratory system, the most severe being acute respiratory infection (ARI) of which pneumonia is the prototype. Intestinal parasitic are also common particularly in rural children and children living in urban slums. Many children become victims of nutritional deficiency diseases early in life due largely to poverty-related inadequate food intake and also partly due to lack of knowledge about common and inexpensive food items (vegetables and fruits) that could prevent important vitamin and mineral deficiencies. Vitamin A deficiency that causes night blindness is very common in Bangladeshi children. This deficiency can be easily prevented by dietary manipulation, for instance, eating adequate quantities of coloured vegetables and fruits. Iron deficiency commonly measured as low blood haemoglobin is very common in children which is partly due to inadequate diet and partly due to intestinal parasites. Sporadic cases of zinc deficiency are seen in children with diarrhoea at the International Centre for Diarrhoeal Disease Research, Bangladesh, but its overall incidence is not high. Incidence of malaria and tuberculosis is increasing. For malaria, there is as yet no vaccine available, but for tuberculosis a vaccine is used through the EPI programme. More worrying is the fact that the pathogens causing malaria and tuberculosis are increasingly becoming drug-resistant which makes treatment options limited, a major impediment to both saving lives and to control these diseases. Common genetic diseases or congenital abnormalities occurring among Bangladeshi children include albinism, spino bifida, colour blindness, Down's syndrome, etc.

Health Manpower

Health manpower includes trained personnel that include doctors, medical technologists, nurses and paramedics. In Bangladesh and in many other developing countries, another category of workers is closely associated with delivery of health services to the villages. These comprise field-level health workers who are trained in specific areas, generally non-technical, and are dedicated to offer specific services related to community health, reproductive health and family planning, including awareness creation activities. In addition, there are homeopathic doctors and doctors practicing *Ayurvedic* (Alternative) medicine. Bangladesh has a population of about 130 million. At present, most doctors are based in cities and towns serving a meager 20% of the population. The bulk of the population of Bangladesh lives in rural areas and is thus away from easy access to the service of these trained doctors. The reason for this is poor economic condition of people living in rural areas. The bulk of the nation's health manpower is under government control because provision of health care is government's responsibility. Only in cities and towns there are doctors available in private practice and in recent years, diagnostic services and hospital care have witnessed good growth in the private sector particularly in the capital city of Dhaka and a few other major cities. The bulk of the population living in rural Bangladesh and too poor to afford private medical facilities have to be cared for by government facilities which admittedly are victims of chronic funding and manpower shortage. Most rural hospitals operated by government lack adequate number of doctors and technicians; moreover, the doctors are permitted to engage in private practice which often takes away their time, time that they could otherwise devote to hospital work and medical research **(Asiatic Society of Bangladesh 2003).**

The lone medical university of the country is the Bangabandhu Shiekh Mujib Medical University (BSMMU) established in April 1998 by converting the IPGMR into this full-fledged university. The IPGMR was established during the Pakistan time in 1965 and had served as the sole institute offering post-graduate degrees in medicine under the administrative control of the University of Dhaka, the premier general university of the country. The BSMMU offers post-graduate degrees. It also offers diplomas in many subjects to produce trained medical technologists. The institution responsible for specialist practice of doctors in the country is the Bangladesh College of Physicians and Surgeons (BCPS). The BCPS has in its mandate the promotion of specialist practice in various

branches of medicine through Fellowship (FCPS) and Membership (MCPS) examinations conducted every year.

1.1.9 Mental Health Services in Bangladesh

Existing Mental Health Services in Bangladesh are extremely poor and are provided briefly by the government, though the general health care system. Psychiatry department of the medical university hospital (BSMMU) has the provision of 24 beds. A National Institute of Mental health in the capital, Dhaka, has 50 beds. There is only one mental hospital of 500 beds, and there are psychiatric units in only 13 Government medical college hospitals with a total of 120 beds and also some beds in non-government medical college hospitals, and 4 Drug Addiction Treatment and Rehabilitation Centres with 40 beds each. These centres represent the main inpatient service strength. District hospitals have a provision of 5 beds for mental patients. All of these hospitals have outpatient services.

At the private level there are specialised clinics (number not known) for psychiatric patients which provide roughly 500 beds. There are only 77 qualified psychiatrists. Of them, 2 are child psychiatrists, and psychiatrist- population ration is 1:2 million. Primary health care physicians trained in psychiatry are currently 2,270.The number of psychiatric nurses is 72, nurses trained in psychiatry are20. We have 42 Clinical Psychologists, 1 Occupational therapist and no psychiatric social worker. There are 4,950 health workers trained in mental health at grass root level **(National Institute of Mental Health 2004).**

Cultural attitudes regarding psychiatric disorders are not particularly medically oriented. The concept of 'spirit possession' is highly prevalent in all strata of the Bangladeshi culture and is integrated in the social belief system. This allows mismanagement of specific psychiatric syndromes. Often patients undergo painful hurdles while suffering from treatable psychiatric conditions and frequently the cases become chronic. However, this trend is changing due to direct benefit from existing mental health services, social awareness programmes, health education and increasing health consciousness among the people, which is reflected in the increasing number of patients attending psychiatric units and referral pattern **(Mullick et al. 1994)**.

1.1.10 Child and Adolescent Mental Health Services in Bangladesh

First specified child psychiatric service in Bangladesh is established in the only one postgraduate medical university in 1999.Now the child and adolescent wing of this university has the provision of teaching, training, research and services in this field. The

department of child adolescent and family psychiatry of the National Institute of Mental Health provides child mental health service science 2001.Eventually, child psychiatric service is a part of general psychiatric service of the medical colleges and children with psychiatric disorders are seen by the adult psychiatrists. Only one qualified child psychiatrist is working in this set-up. A Child Guidance Clinic is providing a service in the Children's Hospital of the capital. At national level, a NGO named Child Development Network for the disabled children and they also established few child development centers in different hospitals and institutions.

Welfare Services available for child care are chiefly provided by the government Agencies. The Ministry of Social Welfare has some children's homes for abandoned children in different parts of the country. There is only one school for special education for disabled children at Dhaka city and a National Institute for Correctional Services at Dhaka district, only one Borstal school for juvenile offenders and four specialized schools for children with learning difficulties run by the social welfare department of the Government. At non-government level, Foundation for the developmentally disabled and Bangladesh Association for Intellectually Disabled work for childhood disability and they run special education and training centers in the main cities of the country. Some schools for the autistic children are working in Dhaka city which are poorly organized. However, these services are extremely inadequate to the actual need.

1.2 Epidemiology, an over view of concepts and methodology:

Epidemiology can be defined as "the study of the distribution and determinants of disease frequency" in human populations (**MacMahon B et al. 1970**), and one of the most used measures of disease frequency is prevalence. Point Prevalence (P) quantifies the proportion of individuals in a population who have the disease at a specific instant and provides an estimate of the probability (risk) that an individual will be ill at a point in time (**Hennekens et al. 1987**). Period prevalence is similar except covers a specified period rather than one point in time. The diagnostic criteria in child psychiatry, such as DSM-IV or ICD 10, often include the presence of symptoms for a minimum length of time (e.g. 3 months), therefore sometimes it can be difficult to differentiate between point and period prevalence and most studies refer to it just as prevalence.

$$P = \frac{\text{number of existing cases of a disease at a given point or period in time}}{\text{total population}}$$

Epidemiological studies in Child and Adolescent Psychiatry provide information about the prevalence of psychiatric disorders and associated factors such as risk and protective factors. Findings from these studies highlight the need for child and adolescent mental health services. In addiction, these studies can indicate services priorities and distribution in a given region or country. Epidemiological information will indicate which are the main disorders to be covered in a given locality, what the main risk factors are, and what mix of professional background is likely to be needed by services.

The appropriate planning for mental health services will not just have immediate consequences such as prevention of new cases and avoidance of more severe cases but also long term effect on crime, drug abuse, adult mental illness and inappropriate parenting skills that will impact on future generations. The overall benefits are economic as well as human given that epidemiological information will help to maximise human and financial resources and avoid future expenses on the consequences of non treated psychiatric disorders in children.

A psychiatric disorder is conceptualised as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and is associated with present distress or disability (**American Psychiatric Association, DSM-IV 1994**). In ICD 10 (**World Health Organisation, ICD 10 1994**) the term disorder is used to imply the existence of a clinically recognisable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions. In epidemiological studies there are methodological issues to be considered when measuring psychiatric disorders. The first issue is that the instrument should measure not only signs and symptoms but also their impact, i. e. check whether they are causing distress or disability. The presence of impact is crucial to determine whether there is a psychiatric disorder, given that most of children have at least one symptom and in some studies up to 50 % of children have enough symptoms to fulfil diagnostic criteria **(Bird et al. 1988)**. However, in developed countries, only 5 to 15% of children have child psychiatric symptoms that have significant impact on their lives causing distress and interfering with their functioning (**Meltzer et al. 2000; Simonoff et al. 1997; Shaffer et al. 1996; Rutter et al. 1970**). The second issue is related to whether the questions are well understood by the informant and if they are answered accurately. In psychiatry, often a question aims to identifying feelings or emotions that may have particularities in a given cultural and socio-economic context. A third issue is related to the need in Child Psychiatry not to have only the child, particularly

under 11 years old, as the only informant (in contrast to studies with adult subjects) **(Goodman et al. 2000a)**, which raises the difficulty of combining information about one subject, coming from different sources.

These methodological points, (1) the need for a measure of impact, (2) the uncertainty about the level of understanding of informants and (3) the need for multi-informants can alter prevalence. Prevalence can also vary according to sample characteristics which highlight the importance of a representative sample as regards size, sources of subjects, recruitment of subjects and response rate.

The way in which information is obtained, reported or interpreted and the manner in which subjects are selected into the study can lead to two main types of bias: information bias and selection bias. Bias may be defined as any systematic error in an epidemiological study that results in an incorrect estimate of prevalence and also of the association between risk factors and prevalence.

A one phase study versus a multi phase study design is another point to be mentioned. For economic and strategic reasons, most studies will be designed either as a single phase or as two phases, that will comprise the use of screening (questionnaire) and diagnostic (interview) measures. A complete diagnostic interview may not be needed for all subjects in a large survey, when a good screening questionnaire can select cases and reduce the amount of work and therefore money involved in the second phase (diagnostic). On the other hand, in certain geographic and social conditions, it may be difficult to relocate subjects for the second phase, requiring human resources and time, therefore increasing the budget. The methodological considerations introduced in this chapter will be dealt with in more detail and related to this thesis's methodology in the respective chapters (Chapters 3,4 and 5).

The practice of modern psychiatry in Bangladesh began 50 years ago and child psychiatry is a very recent addition. The prevalence of psychiatric disorders among children in Bangladesh remains uncertain, since there have been no previous community based epidemiological surveys in Bangladesh.

Like in other less developed countries, Bangladeshi children are subject to a large diversity of conditions which may negatively affect their physical and psychological well-being.

These conditions include malnutrition and illiteracy. Conversely, Bangladesh has strong family support and a high degree of cohesiveness within the family, inherent in the culture. These factors can be considered as major protective factors.
Epidemiological surveys will provide information about the distribution of psychiatric disorders in children and the factors that influence this distribution in Bangladesh. Such studies will provide a scientific basis for appropriate planning of child mental health services in Bangladesh.

This research proposal is concerned with an epidemiological study of child and adolescent psychiatric disorders in three distinct communities in Bangladesh. Details of the study will be given in the following chapters.

1.3 Assumption in the preliminary study:

As described earlier, Bangladesh is a least developed country of economic inequality, as in like of the developing world, with the demarcation between the poor and the affluent. This thesis looked at the overall prevalence but also at the prevalence in three distinct populations reflecting the fact that for most of the country, and particularly for the Bangladesh where the population divides into 3 main groups: one group consisting of the population living in stable urban areas, called 'stable urban', the second group consisting of the population living in rural areas, called 'rural' and the third group consisting of the population living in urban slum areas called 'poor urban'. The Division between three groups may be of good enough approximation to be useful for planning purposes.

In Bangladesh, the relative proportion of the 3 groups varies. Planners can apply their knowledge of the relative proportion to estimate overall prevalence. These 3 groups can be defined in terms of affluence, and location.

The prevalence of disorders is potentially important evidence for governments, stressing the importance of allocating funds to services for the respective disorders. In general, epidemiological studies in the field of child psychiatry show that: (1) child mental health problems in children and adolescents are common and alter school achievement and social interaction; (2) mental health problems tend to persist throughout life; (3) the majority of children with mental health problems do not receive proper treatment; (4) if not treated these disorders can lead to severe problems in adult life, such as psychiatric

disorders, involvement with crime, alcohol and drug abuse, unemployment and impaired parenting skills.

Epidemiological studies of child and adolescent psychiatric disorders in the developing world have generated prevalence estimates ranging from 1% to 49% **(Hackett and Hackett 1999)**. However, most of these studies lack one or more of the methodological features required for generating believable prevalence estimates, namely: an adequate sample size; a representative sampling frame; standardized assessment measures that are suitable for generating exact diagnoses (as opposed to use of screening questionnaires alone); explicit and internationally accepted diagnostic criteria; and assessment not just of symptoms but also of resultant distress and social impairment **(Fleitlich-Bilyk and Goodman 2004)**. The studies that do meet these crucial methodological requirements report a range of prevalence ranging from 5 to18% (**Bird et al. 1988, 1990; Canino et al. 2004; Fleitlich-Bilyk and Goodman 2004; Hackett et al. 1999**).

In Bangladesh, the current scarcity of child mental health services mirrors the scarcity of epidemiological studies. The current lack of services and lack of prevalence studies to inform this planning must improve. Fortunately the health policymakers are increasingly interested in child mental health, making it urgent to provide prevalence rates which can form a basis for service planning.

There have been no epidemiological studies of the prevalence of child and adolescent psychiatric disorders in Bangladesh, and indeed there are no validated psychiatric measures in Bangla (Bengali) that could be used for this purpose which has made it substantially harder to plan and develop child mental health services in Bangladesh. From the substantial reports of hospital-based analyses, clinical studies, residential and school-based surveys among the child and adolescent population, it is evident that considerable number of children and adolescents are suffering from psychiatric problems. Analyses of these reports revealed that overall, emotional disorder was more than the behavioural disorder and conduct problems are proportionally more in urban slum area. The researcher's experiences of working in the Child Mental Health Clinic of Bangabandhu Sheikh Mujib Medical University since early 1998 is roughly similar with these analyses which stimulates the researcher's to explore this aspect. The present study translated and validated a standardised child psychiatric assessment and applied it to three contrasting community samples: a rural area, a moderately prosperous urban area, and an urban slum.

1.4 Hypotheses

Through careful evaluation and critical analyses of the above mentioned assumption of the preliminary reports considering the knowledge from the literature as background the following hypotheses were set.

1. Psychiatric disorder among children and adolescents in Bangladesh is likely to be parallel with other countries.
2. Existence of emotional disorder is more than behavioural disorder among children and adolescents in Bangladesh.
3. Conduct disorder is substantially commoner in poor urban area than in rural or middle-income urban areas of Bangladesh.

1.5 Objectives

This thesis is about one attempt to provide epidemiological data relevant to planning child mental health services in Bangladesh. Service planners are interested in all disorders, all ages and the whole of Bangladesh. The thesis is more restricted, covering only the common psychiatric disorders in children in rural, urban and slum areas in three contrasting areas in Bangladesh. These restrictions were made for the following reasons:

a) Common disorders are currently of greatest interest to service planners. The best strategy for measuring their prevalence is a general population survey. This strategy is not a good way to estimate the need for services for rare but severe disorders such as anorexia, psychosis, autism. Estimating their prevalence would have required a different strategy, e.g. identifying possible cases not from a general population survey but via paedtiacians, special schools, and psychiatrists. etc.

b) Children between 5 and 10 are legally obliged to attend school in Bangladesh, and the great majority do. Focusing on this age range makes ascertainment easier, and provides an opportunity to supplement parent with teacher information (which is particularly relevant for the diagnosis of conduct and hyperkinetic disorders). Learning more about the prevalence of disorder in under-5s and over-10s is an important task for the future.

c) The study was conducted in the central part of Bangladesh. The methods developed in the course of the study could be applied in other regions of Bangladesh to see how far the conclusions from this study apply elsewhere. At some future date, this may permit a joint analysis of data from multiple sites to generate a truly national picture of Bangladeshi child mental health

Allowing for these restrictions in scope, the objectives of the study were as follows:

1.5.1 General objective

To generate approximate prevalence estimates as a guide to future research and service planning

1.5.2 Specific objectives

i. To validate psychiatric measures for children and adolescents in Bangla

ii. To estimate the differences in rates and types of child psychiatric disorders in rural, urban and slum areas of Bangladesh.

iii. To examine the differences of variables between rural, urban and slum areas as a guide to explore the correlates of child psychopathology

iv. To provide methodological foundations for more extensive and representative epidemiological studies in Bangladesh in the future.

To generate an overall prevalence estimate for child psychiatric disorders is needed to be sufficiently precise to be of use to service planners. The prior assumption is that the overall prevalence would be in and around 18%. Predicting the planning in Bangladesh, an estimate with a confidence interval of plus or minus 2 to 3% would be adequate.

To generate separate prevalence estimates for the three or four commonest diagnostic groups of child mental health problems, namely anxiety, hyperkinetic and behavioural disorders, has important consequences in terms of the needs for different types of treatment (parent management training, medication, cognitive-behavioural therapy etc.)

To generate separate estimates of prevalence for each of the three contrasting areas, namely rural, urban and poor slum. This has two benefits. Firstly, it will then be possible for planners to adjust for area differences in population mix. Secondly, it will then be possible to plan the location of services more rationally, e.g. deciding to concentrate services in the areas likely to have the highest prevalence.

To validate psychiatric measures for children and adolescents in Bangla is major issues to perform methodologically sound research in this field in Bangladesh. Another benefit is that the screening measures will be useful to predict possible 'caseness' in clinical, educational and other relevant field related to children and adolescent.

To provide methodological foundations, like feasible and appropriate sampling frame, ascertainment technique, sampling strategy is basic need for area research as well as more extensive and representative research in Bangladesh in the future.

The focus of this thesis is entirely on prevalence on sound methodological foundation. Data on the variables indicative of risk factors was collected in parallel with the prevalence data, and a planned follow-up will add a longitudinal element to the study - but these additional elements of the study will be analysed subsequently. It would not have been possible to include all these elements in a single thesis without making the thesis unreasonably long, or treating each theme relatively superficially.

1.6 Rationale

The prevalence of psychiatric disorders among children and adolescents in Bangladesh remain uncertain, since there have been no previous community based epidemiological survey in Bangladesh. These needed to be sufficiently precise to be of use to service planners. Given the a priori assumption that the overall prevalence would be between 10% and 20%, and an estimate with a confidence interval of plus or minus 2 to 3 or minus 2 to 3% would be adequate.

The present study generates separate prevalence estimates for the three or four commonest groups of child mental health problems, namely conduct, hyperkinetic and emotional disorders, potentially splitting emotional disorders into anxiety and depressive disorders. This distinction by diagnostic group has important consequences in terms of the needs for different types of treatment (parent management training, medication, cognitive-behavioural therapy etc.)

This study generates separate estimates of prevalence for each of the three main populations, namely rural, moderately prosperous and urban slum. This has two benefits. Firstly, it will then be possible for planners to adjust for local differences in population mix, i.e. for regions that are more or less rural, or more or less affluent. Secondly, it will then be possible to plan the location of services more rationally, e.g. deciding to concentrate services in the areas likely to have the highest prevalence.

The proposed study will give a basic picture about characteristics of childhood and adolescence psychiatric disorders in Bangladesh. The study will also highlight the variables, indicative of the aetiology and the risk factors in positive direction that will act as a guide to future search of the correlates of disorders. The study will provide a scientific basis for appropriate planning and development of child psychiatric services in Bangladesh by giving relevant information. The findings of the study will provide information for health administrators, clinicians and other health providers in the design of preventive interventions and treatment programmes. The study will develop reliable and valid measures of child psychopathology in a Bangladeshi context which does not exist at present.

The focus of this thesis is entirely on prevalence. Data on risk factors and service use was collected in parallel with the prevalence data, and a planned follow-up will add a longitudinal element to the study - but these additional elements of the study partly analyzed as an indicative of possible risk factors and will be analysed subsequently. It would not have been possible to include all these elements in a single thesis without making the thesis unreasonably long, or treating each theme relatively superficially.

The following chapters review the literature relevant to this study (Chapter 2), describe the preliminary study of measures (Chapter 3), validation of measures in pilot study (Chapter 4) and then describe the design of the main study, as well as its findings, implications and limitations (Chapters 5-7).

CHAPTER 2

REVIEW OF LITERATURES

2.1 Introduction

Child psychiatric epidemiology is a relatively new field of research that has increased in the last three decades. However, major methodological issues remain unresolved, particularly in developing countries. The first issue regards appropriate sampling methods such as the identification of accurate sampling frames for a given country or area. This is particularly relevant for developing countries where health or social benefits registers are often not representative of a total population and census information is not always available or updated. The second issue regards measures, such as the need to use multiple informants (who often disagree) and the applicability in developing countries of questionnaires and structured interviews developed in the first world. This chapter reviews the literature of child psychiatric epidemiology focussing on how the different studies have dealt with these methodological issues. It will also review the substantive findings in prevalence rates and their clinical and policy implications. The review in this chapter is based on a computerised literature search in 'Medline' and Psych Info and will not try to be comprehensive but will include well-known epidemiological studies in child and adolescent psychiatry and also studies with a particular methodological interest.

2.2 Methodological Issues

2.2.1 Sample selection

Descriptive epidemiological studies are concerned with the general characteristics of the distribution of a disorder, in relation to socio-demographic factors, such as age, gender, race, as well as life-style and economic variables. Particularly in child psychiatry, these factors might be risk or protective factors and therefore influence rates of disorders. When a sample is identified, it is expected to represent and reproduce, as closely as possible, the total population and its socio-economic characteristics. The ideal sampling frame aims to identify individuals from a population to become subjects in a sample, which should be as similar as possible to the total population in focus.

In developed countries, epidemiological studies adopt different sampling frames such as household ("door to door") search, birth registers, social benefits records, postcode address files, school records, and health care clinic and hospital records. The identification of subjects through household searches (**Verhulst et al. 1997; Shaffer et al.1996**) is considered an accurate but expensive and time consuming method (**Costello et al. 1996**). In some countries such as the UK and Canada, social benefits records convey a good source of information about children living in a given area (**Meltzer et al. 2000; Breton et al. 1999**) and are less expensive as a source of ascertainment, since this method does not require initial home visits to identify the sample. School records are also used for ascertaining children (**Simonoff et al. 1997; Costello et al. 1996; Fombonne et al. 1994; Kashani et al. 1989; Rutter et al. 1975; Rutter et al. 1970**), but has limitations when substantial numbers of children do not attend school, particularly among minorities and low income populations. Birth registers are also used as a sampling frame (**Fergusson et al. 1993; McGee et al. 1990; Esser et al. 1990; Anderson et al. 1987**) and are particularly useful in cohort studies in developed countries, where birth registers are considered representative. Children can also be sampled from primary health care clinics (**Costello 1989**), but these studies only sample children who are in contact with such clinics, whether for medical treatment or routine surveillance or immunisation. Children not known to such clinics may be unusually healthy or, more probably, from disadvantaged families with less access to health care. In either case, sampling from health clinics may introduce a referral bias.

In developing countries, the most appropriate sampling frame for ascertainment of subjects is still not clear. There are often no social benefits records and birth records (including the registration of births) might not be accurate, particularly in more deprived areas. Household searches may provide the most reliable source of subjects, since this method allows the researcher to map the whole area to be studied (**Hackett et al. 1999a; Kasmini et al. 1993; Bird et al. 1988**). However, it can be a dangerous method in favelas (shanty towns) where the inhabitants might be suspicious of such a procedure. It is a time-consuming and expensive method and can be even more so in favelas, where a family often have to rebuild their house in a different location after a storm has destroyed it. The school registers are often the method adopted (**Shenoy et al. 1996; Sarkar et al. 1995; Wang et al. 1989; Minde 1975**) but such studies incur in the risk of missing children who are working or living in the streets – likely to be high risk populations. Primary care clinics have also been used as sampling frames in developing countries (**Gureje et al. 1994; Giel**

et al. 1981a). However, they may be particularly likely to generate unrepresentative samples because children are often taken to the clinics not for preventative assessments but for treatment of established physical disorders that may put them at higher risk for mental disorders. In Brazil, one study located children via household search (**Almeida-Filho 1984**) and did not describe whether there were street children included in the study. Street children are a mixed group which include children actually living in the streets ("children *of* the streets") and also those who spend their time in the streets but continue to live at home ("children *on* the streets"). Both are probably at greater risk for psychiatric disorders, but the risk is likely to be higher for the former group, and they are also much harder to sample and study. One option for sampling children of the streets is use of the "snow ball technique". This identifies core individuals that will be used as the starting points of the snow ball to identify other individuals living in the streets in a given area (**Lopes et al. 1996**). In the Southeast of Brazil, in one area where the majority of street children were children *on* the streets, a study compared sampling frames. The results showed no significant difference comparing child mental health problems in two groups, either ascertained via household searches or via school registers (**Fleitlich et al. 2001**).Another study in the Southeast Brazil, the subjects were ascertained via school. It was a two phase study, one-phase, cross school survey with stratification by type of school, The two stages were random sampling of pupils from school and that was proved as effective strategy (**Fleitlich et al. 2004**).In Bangladesh, school based ascertained technique was proved to be effective in two school- based studies (**Jahan 1998; Rabbani et al.1999**).

2.2.2 Measures: questionnaires, structured interviews, semi-structured interviews and their suitability in the developing world

Making a diagnosis in child psychiatric epidemiology shares many of the difficulties of diagnosis in clinical child psychiatry, including disagreement among informants, and the difficulty defining the boundaries between normal and abnormal behaviours and between different disorders. Indeed, these problems are often more marked in epidemiological samples and the difficulties are even more pronounced in community surveys in developing countries. Respondent's lack of formal education and cultural background sometimes lead to misunderstanding and misinterpretation of the questions on which the clinical psychiatrist or researcher will base their diagnosis.

Surveys often use translated versions of Western questionnaires but it is uncertain how far linguistic equivalence can be achieved just by the process of translation and back translation. **Bird (1996)** proposes two alternative ways of dealing with cultural issues in cross-cultural research. One involves applying similar methods across two cultural settings but making the research culturally sensitive by fine-tuning research methods and taking social and cultural factors into account in interpreting the results. The alternative approach goes beyond these methodological refinements and proposes to define the same diagnosis differently for each of the cultural groups under investigation in ways that are 'culturally valid' for each group. The extent to which research methods can be just adapted or need to be reconstructed under a different paradigm to be applied in different countries remain a open question; and will probably have different answers according to each country in focus.

Some studies have explored the extent to which culture and ethnicity may need to be considered in relation to assessment and diagnosis. Particularly in the developing world, studies have found differences in perception of problems, for example mental retardation is a common reason for approaching primary health services in India but not in the Sudan (**Giel et al. 1981b**). Other studies have used differences in parents' patterns of response to child behaviour checklists as evidence that cultural values affect how parents judge child behaviour. **Weisz et al. 1987** found that Thai parents rated their children as having significantly more emotional symptoms (shyness, anxiety, and depression) then American children. Another study looked at prevalence of conduct disorder and found significantly less problems rated in the Indian subcontinent **(Malhotra et al. 1984)**, which may reflect not a true reduction in prevalence but rather family and community attitudes that view conduct problems as disciplinary issues to be handled by the family. Having highlighted the importance of cultural aspects for constructing adequate measures in child psychiatry, it is also important to note that there have been clear demonstrations of patterns of child psychopathology in non Western cultures similar to those reported elsewhere **(Minde et al. 1993).**

In a cross-cultural context, more recently, a study aiming to identify mental health profiles in different age bands in an Arab sample, adopted the Strengths and Difficulties Questionnaire, a measure originally developed in a western country (**Thabet et al. 2000**). According to factor analysis and reliability analysis, the SDQ was considered very promising as a screening and rating scale in a non-westernised population. However,

there were differences for instance in parents' perceptions of emotional problems in pre-school children, indicating that not all western diagnostic categories were directly applicable to the Arab population. Although it is clearly necessary to be culturally sensitive, the barriers to translating measures and diagnostic constructs may have been exaggerated at times. Even between very different cultures, such as Britain and India, measures can be remarkably robust (**Bhul et al. 2000**). The Strengths and Difficulties Questionnaire was also applied to patients attending two culturally distinct populations (mental health clinics in Britain and Bangladesh) and found that the level of agreement between SDQ prediction and an independent clinical diagnosis was substantial and highly significant in both samples **(Goodman et al. 2000c)**. The 'strong' universalist position that the same measure can be used in all cultures may be closer to the truth than the 'strong' relativist position that each culture needs its own distinct measures and diagnoses. And if the truth lies closer to the universalist than the relativist pole for cultures as different as the West and the Middle-East or South Asia, the truth may lie even closer to the universalist position when thinking about Bangladesh. It is worth noting here that the applicability of the universalist and relativist positions probably varies not just with cultural distance but with the nature of the disorder under consideration. It is plausible, for example, that autism shows less inter-cultural variation than disruptive behavioural disorders.

The issues that apply to other non-westernised developing countries are also relevant in Bangladesh. Studies adopting questionnaires and interviews in Bangladeshi samples should consider particularly the high rates of illiteracy and the low levels of formal education in some sectors of the population. These factors will interfere with the understanding and interpretation of questions and therefore could potentially alter the rates and risks of disorders. Besides that, Bangladesh may be considered as a research naïve country, which can also alter the response to interviews. In Kerala, South India, also considered a research naïve society, a study looking at the prevalence and associations of psychiatric disorders, described that parents initially denied having any concerns about their children. As the interview went through, mothers endorsed progressively more symptoms **(Hackett et al. 1999a)**.

Few measures for child psychiatry have been applied to the Bangladeshi population. The translated Rutter B2 Scale for completion by teachers to screen the children in a school based study in Dhaka city to estimate the prevalence of different types of psychiatric disorder. The original English scale was translated into Bangla using the back-translation

procedure. The findings suggest that screening for mental health conditions by informant-report questionnaires might be of value for identifying groups of children at risk. However, the measures adopted need further validation and application to larger samples from different types of Bangladeshi populations. The Strengths and Difficulties Questionnaire, a self-completion questionnaire (**Goodman 2001, Goodman 1997**) was translated and adapted to an interviewed questionnaire to be applied in Bangladeshi samples (**Goodman et al. 2000c**). The measures above were adapted from developed countries, and in all cases they were shown to be applicable, keeping similar properties and providing plausible data in the Bangladeshi population.

2.2.3 Use of multiple informants

Particularly in child psychiatry, but also in some areas of adult psychiatry where self report is considered to be of doubtful validity, it is important to collect information from a number of informants, such as parents and teachers, in addition to self-report. There are two main reasons why a comprehensive assessment of child psychopathology depends on information about the child's behaviour both at home and at school. First, certain diagnosis such as hyperkinesis **(Word Health Organisation, 1994)** and attention deficit hyperactivity disorder **(ADHD, American Psychiatric Association, 1994)** need the presence of symptoms in two or more settings, usually home and school. Second, in other behavioural disorders, the symptoms may be situational; e. g. severe conduct problems may be present at school but not at home, or vice versa. Parents can report whether teachers have complained about the child, but information collected directly is preferable.

Children's reliability as informants is questionable because it is dependent on their level of cognition, on their ability to reflect and verbalise their own behaviour and feeling states. Children also find it hard to provide a description of the emotions or behaviours averaged over relatively lengthy periods of time, whether the last month or the last year – their response is strongly influenced by very recent events or feelings. This is probably another reason why test-retest reliabilities are so poor for interviews administered to under-11s. The teenager self-report can provide further information about their behaviours and emotions that parents or teachers had not noticed or that had been hidden from them. This is illustrated in the Ontario Child Health Study (OCHS), where the prevalence of parent-identified conduct disorder in adolescent boys is 4%, whilst the prevalence of youth-identified conduct disorder in the same group is 7.2% **(Offord et al. 1989)**. Also supporting

this position, a study looking at child and parent agreement on symptoms showed that children reported symptoms significantly more frequently then their mothers including worries, anxious or depressed feelings. These finding suggest that there are some areas in which children may be the best and, in some cases, the only source of information about a problem (**Herjanic et al. 1982**). However, this is assuming that when children report more behavioural or emotional problems than their parents, the children are correct. It is also possible that parents are providing a more accurate report and that the children's positive answers are based on misunderstanding the questions or lack of perspective.

Disagreement among Informants

A uniform finding in the literature is the low agreement among informants about children's behaviours. For example, in the OCHS, the prevalence of ADHD in boys between 4 an 11 years of age was 2.15% according to parents account and the rates increased to 7.2% according to teachers. Furthermore, the two respondents, whether parent and teacher for 4 to 11 years-old or parents and the youth themselves for 12-16 years-old, identified the same children as having a particular disorder only in a small minority of cases **(Offord et al. 1989)**. Similarly, in the Netherlands, a prevalence study using the Diagnostic Interview Schedule for Children (DISC) found that, among the cases identified either via parents or child interviews only 4% met criteria for any disorders in both (**Verhulst et al. 1997).** Case ascertainment depends heavily on who provides information for assessment. Prevalence rates of disorders and the patterns of associated features can vary depending on who identifies the child as having disorder. Therefore, the identification of childhood disorders is much influenced by the perception of informants and the contexts in which assessments are done. Traditionally, psychiatric assessment of children has considered data from multiple information, each whom may provide information about different aspects of the child's functioning **(Bird 1996)**. Many experienced clinicians and researchers in child psychiatry believe that information from multiple informants facilitates the best estimate of diagnosis in the individual case **(Young et al 1987)**. This strategy has been adapted in the screen procedure of this study to obtain a comprehensive picture of the children's behaviour.

There is also variability in the way that rates of disorders change longitudinally, according to the type of informant. **Esser at al. (1990)** found that when prevalence estimates were based on parent reports, there was no increase in prevalence observed from preadolescence to puberty; however, when prevalence estimation was based on the youth's reports, rates increased significantly between the two periods.

Given the desirability of multiple sources of information, and given the frequent disagreement between these sources, the clinician or researcher is faced with a difficult problem: how, if at all, to attempt to synthesise the discrepant accounts. Some researchers have chosen not to combine information from different sources, simply reporting prevalence and associations for each class of informant separately, e.g. prevalence of depression according to parents, according to teachers and according to young people themselves. This can result in striking differences in prevalence, e.g. **Breton et al (1999)** reported that the six-month prevalence of ADHD was 3.3% as judged from child informants, 5.0% as judged from parents, and 8.9% as judged from teachers. This same study showed equally striking differences in the associations of disorders judged from different informants, with the patterns of association of demographic variables with anxiety and depressive disorders varying across informants. This lack of convergence between informants is disconcerting and makes it hard to use the resultant epidemiological information for service planning. For example, what is the 'true' rate of ADHD that needs to be catered for by clinics – 3.3% as derived from the child account or 8.9% as derived from the teacher account? In ordinary clinical practice, clinicians need to 'come off the fence' and decide who is right. It is not likely to be an acceptable formulation to say that a given child does and does not have a diagnosis of ADHD, in part because that does not help with the decision as to whether to suggest a trial of medication or whether to alert the teachers to the need to educate the child differently.

So although some researchers are happy describing prevalence rates for each informant separately, there are good reasons for wanting to find a method that generates a 'best estimate' of prevalence by combining the information from all informants. Unfortunately, there is no clear consensus on how to do this. **Bird et al. (1992**) discusses two ways in which discrepant information from multiple informants can be combined. The first way is to use the 'OR' rule and accept a symptom or a criterion as present when it is acknowledge by one *or* more of the informants. Such an approach implies that all sources provide similarly useful diagnostic information, and has the disadvantage that false positives will always be given priority over true negatives. An alternative method is to place greater weight on symptom or criterion information provided by a preferred informant according to the nature of the symptoms. For example, the researcher or clinician could decide that when adolescents and parents disagree about emotional symptoms, the adolescents own views should always be given priority since they should know best about their own feelings. This 'preferred informant' approach also has disadvantages. In some instances,

for example, adolescents may deny depression out of shyness or bravado when their parents can give a clear account of low mood, loss of interest and suicidal talk.

A third alternative to the 'OR' rule or the prioritisation of a preferred informant is allowing experienced clinical raters to judge from detailed transcripts which informant to prioritise on a symptom-by-symptom basis. This is closer to ordinary clinical practice, and such ratings can be made with acceptable reliability and validity (**Goodman et al. 1996**). This same approach was incorporated into the Development and Well-being Assessment (**Goodman et al. 2000a**).

2.2.4 Case definition

The benefits of operationalized diagnosis

The benefits of operationalized diagnosis apply to both clinical and research areas in Psychiatry. The mental health classifications (e.g., DSM IV and ICD 10) facilitate communication among clinicians and researchers and are also helpful for educational purposes. Their greatest importance however, is in the collection of statistical information. An official nomenclature is applicable in a wide diversity of contexts and can be used by professionals of different orientations (e.g., biological, psychodynamic, cognitive, behavioural, as well as researchers). It can be used across settings –inpatient, outpatient, primary care and community populations and it is also a necessary tool for collecting and communicating accurate public health statistics.

A review of research psychiatric diagnostic interviews for children and adolescents points out the controversial view about models (categorical, dimensional or mixed) that best describe psychiatric disorders. For some disorders like schizophrenia, a categorical model could be more appropriate whereas for others like conduct disorders, a dimensional model could fit better. The authors argue that although this is still debatable, there are advantages in the current categorical model, compared to previous practice. It allows both clinicians and researchers to communicate broadly about diagnostic entities with some expectation that the disorders are the same, or at least similar, across settings (**McClellan et al. 2000**).

Adopting a mixed categorical and dimensional model, a study of a representative sample of London children with a clinical diagnosis of hemiplegia looked at the validity and

reliability of rating diagnosis from case histories, using an novel operationalized criteria. The results showed that the operationalized criteria adopted provided a reliable method for using detailed case histories in order to dichotomize children into 'cases' who had a level of symptomatology comparable to psychiatric clinic attenders, and 'non-cases' who had a level of psychiatric symptomatology comparable to community controls (**Goodman et al. 1996**). In accordance with this study, a review of methodology for clinical epidemiological studies in psychiatry stated that psychiatric disorders are likely to behave both dimensionally and categorically, depending upon what property one is examining; and that most major psychiatric epidemiological studies now use both systems (**Pickles 1998**).

In clinical settings such as paediatrics and primary care clinics, operationalized diagnostic systems can contribute to greater consistency of data, thereby allowing more meaningful comparisons to be made across sites. A review of the prevalence of psychiatric disorders in clinical paediatric populations pointed out that only a few studies have systematically examined child psychiatry consultations to paediatric centres and that the examination of psychiatric diagnoses was complicated by the wide range of diagnostic classifications that have been used. In this review, the general adoption of a given diagnostic system would improve the comparability between studies. **(Shugart 1991)**.

Operationalized diagnostic systems not only facilitate communication between professionals within and across settings but also the development of structured interviews. Operationalized criteria reduce one source of variability in diagnosis while structured interviews address variability in the wording of questions or the interpretation of answers. Appropriate structured measures can reduce such variability and therefore improve the reliability of the information collected.

The need for impact as well as diagnosis

According to **Goodman (1999)** the need to measure impact as well as symptoms is indicated by unrealistically high caseness rates in epidemiological studies, based solely on symptoms. Definition of a case involves more than just application of diagnostic criteria to ascertain the presence of specific symptoms. It also involves the severity of the disorder, in terms of either functional impairment or perceived need for mental health services. A review about prevalence of psychopathology among children and adolescents highlighted the concern about severity of symptoms, and whether community or epidemiologic 'cases' are cases in the same sense as cases of children brought to clinical settings (**Roberts et**

al. 1998). For example, **Bird et al. (1988)** estimated that 49.5% of Puerto Rican children aged between 4 an 16 years met criteria for at least one DSM III diagnosis. Later, **Bird et al. (1990)** found that many of these children weren't significantly socially impaired and did not correspond to what clinicians would normally recognise as 'cases'. These findings underline the importance of defining psychiatric disorders not only in terms of symptoms constellations, but also in terms of significant impact. The current classifications DSM IV **(American Psychiatric Association, 1994)** and ICD 10 **(World Health Organisation, 1994)** both require impact in terms of significant distress or social incapacity.

In the studies summarised in Tables 2.1 and 2.2 (developed countries) impairment criteria is not always adopted and also varies in terms of which criteria is considered. The Isle of Wight study defined impairment when the disability impeded the child in his daily life or distressed the family or community. **Esser at al. 1990** adopted a similar criteria that said that symptoms were impairing to the child or disruptive to the environment. Other studies (**Fombonne 1994, Verhuslt et al. 1997**) adopted the Children's Global Assessment Scale (CGAS) (**Shafer et al. 1983**) as impairment criteria. The Virginia Twin Study adopted a psychosocial impairment scale, and the prevalence of DSM-III-R disorders fell from 41.3% to 11.4% when the impairment criteria was applied (**Simonoff et al. 1997).** When comparing the studies in Tables 2.3 and 2.4 (developing countries) with and without impairment criteria described prevalence rates were on average higher in the latter studies.

Attention should be drawn to the fact that prevalence studies in child psychiatry vary not only in terms of impairment criteria, but also in other methodological aspects such as diagnostic systems and measures. In Canada, a study evaluated the implications of choosing different thresholds to classify conduct disorder and attention-deficit hyperactivity disorder for estimating prevalence. The results showed that estimates varied widely depending on the rationale used to set the thresholds, with prevalence rates ranging from 0.1 to 39.2 (**Boyle et al. 1985**). Even when some impairment criteria was adopted such as in Boyle et al. 1985, prevalence rates were still uncertain because checklist items and structured impact questions may not be accurate.

This marked between-study variation in prevalence rates can also be attributed to the variability in demarcating the frontier between the normal and the pathological based on the number and intensity of symptoms as illustrated in a study in Ontario, Canada (Ontario

Child Health Study – OCHS). The study examined the effect of adopting different severity criteria for major depression. The prevalence rates for severe symptoms were 0.6% and 1.8% for pre-adolescents and adolescents respectively. On the other hand, for mild symptomatology, the rates were 17.5% and 43.9% respectively **(Fleming et al 1989)**.

Different methods for classifying disorder can have a strong impact on prevalence rates as illustrated in the Tables 2.2 and 2.4. When the impact of symptoms becomes part of the diagnostic criteria, the variability produced by checklists items and arbitrary thresholds can be reduced. However, even when impact of symptoms is considered, structured interview questions may not reflect the exact symptom content and severity implied in the diagnostic system adopted. Structured questions cannot incorporate clinical judgement about the nature and implications of symptoms.

The need for 'not otherwise specified' diagnosis to catch those children who slip through the 'operationalized net' (needing clinical raters)

Epidemiological studies designed to facilitate service planning should identify children with psychiatric diagnose that require treatment. However, there are children where operationalized diagnostic criteria are not fulfilled but where some sort of professional help is needed. How could those individuals be classified? If it were possible to apply the clinical judgement in such cases, the "not otherwise specified" diagnosis could be selected (e.g. anxiety disorder not otherwise specified), thereby avoiding these cases slipping through the operationalized net.

Combining the results of structured interviews, based on operationalized diagnostic criteria, with clinical judgement is also useful when information needs to be combined across informants for one particular individual. In general, structured interviews provide diagnosis in the basis of each informant, therefore one individual might get different diagnosis according to each informant. A clinical rater (trained child psychiatrist) can gather all information collected from different informants for each individual and provide a final diagnosis. Besides that, a clinical rater can also include descriptive answers obtained from open-ended questions in their judgement.

Most of the measures for child and adolescent psychiatric disorders available generate a diagnosis on the basis of structured questions and can be applied by non-clinical child psychiatrists. A major advantage of this method is that it minimises the costs of data

collection, which would be prohibitive if child psychiatrists had to collect all information from community surveys, particularly in developing countries. By contrast, semi-structured measures require the interviewers to have intensive clinical training, to apply their clinical judgement about the quality, intensity and implications of symptoms. The advantage of the semi-structured measures requiring clinical judgement is that, in a survey, children considered 'cases' according to these
measures will have higher chances of being real 'cases' (children in need of service care) in a clinical setting.

A psychiatric interview combining the main advantages of both structured and semi-structured measures could be cheap enough to be adopted in developing countries and yet accurate enough to provide information for service planning. A nation-wide survey carried out in Great Britain in 1999 (**Meltzer et al. 2000**) adopted a novel package of questionnaires, interviews and rating techniques, The Development and Well-Being Assessment (DAWBA). It was designed to generate ICD-10 and DSM-IV psychiatric diagnosis on 5-16 year-olds, and incorporated some of the best features of structured and semi-structured measures. When definite symptoms are identified by the structured questions, interviewers use open-ended questions and prompt to obtain descriptions of the problems (**Goodman et al. 2000a**). The advantage is that the field data can be collected by 'lay-interviewers' and only afterwards, are experienced clinical raters needed to make diagnosis in the light of a review of all data, including transcripts.

2.2.5 Cross Cultural Issues

Cultural factors are very important to considers in designing epidemiological studies, particularly in the field of child psychiatry, where there are wide variations of measures, cultural differences in judgments of behaviour and unresolved issues on cross-cultural application of standardized assessment procedures (especially validity). There is evidence of Trans-cultural variation in the pattern of child psychiatric disorders and their prevalences, the risk and protective factors and the degree of vulnerabilities **(Bird1996;Yu-Feng et al.1989;Roglar 1989)**. Research can be made culturally sensitive through a continuing repeated and open-ended series of questions and insertion of adaptations designed to mesh the process of inquiry with the cultural characteristic of the group being studied. Examples include pre-testing and planning of research, collection of data and translation instruments, instrumentations of measures and analysis and interpretation of data **(Rogler 1989)**. Moreover, cross-cultural epidemiological

studies are essential for establishing a common methodology that is needed to test the generalibility of findings **(Verhurst and Koot 1992)**.

2.3 Substantive findings

Early epidemiological studies indicated that, during the course of one year, 5% to 15% of children between 9 and 10 years of age presented behavioural or emotional disorders with functional impairment **(Rutter et al. 1970, Costello 1989)**. Illustrating
the difficulty of obtaining accurate epidemiological rates in child psychiatry, a recent review including studies from the last 4 decades, showed a large variation in prevalence estimates (1% to 51%). It also illustrated the diversity in diagnostic criteria adopted, which initially were the Rutter criteria and lately the ICD and DSM criteria **(Roberts et al. 1998)**. The Tables 2.1, 2.2, 2.3 and 2.4 summarise prevalence rates of child and adolescent epidemiological studies that include school-age children and generates overall prevalence.

2.3.1 Developed countries

Tables 2.1 and 2.2 include some of the best known epidemiological studies of child psychiatric disorders in general in community samples of school-age children in the developed world. It is not a comprehensive list – which would be beyond the scope of this theses – but it aims to include the most influential and respected studies, as well as providing an indication of the range of methods and findings. Overall prevalence estimates range from 3% to 41%. In the UK, **Rutter et al. 1970**, found 7% of psychiatric disorders in 10 to 11 year-olds, one of the lowest rates, accompanied by **Shaffer et al. (1996)** study in the USA, with a 3% rate (when a very strict impairment criteria was applied a CGAS score below 50). Nearly all the other studies included in this table found prevalence rates of child and adolescent psychiatric disorders higher than 10%, ranging up to 41%, when no impairment criteria was adopted (**Simonoff et al. 1997**). The most recent study in Tables 2.1 and 2.2 was conducted in Great Britain evaluating 10,500 families, and found 9.5% prevalence rate of child and adolescent psychiatric disorders. This study adopted measures based on ICD-10 and DSM-IV criteria which included impairment criteria in four domains of child's life (daily activities, friendship, school performance and leisure) as well as impact on family life (**Meltzer et al. 2000**).

Table 2.1: Epidemiological studies in Developed Countries (main features)

Study	Date	Setting	Sampling frame	Design	One or two phase	Sample size	Age range	Response	Prevalence
Rutter et al. 1970	1970	UK	school (not private)	1st phase:birth cohorts 2nd phase: screen +	two-phase	2193 286*	10 to 11	88%	7%
Rutter et al. 1975	1975	UK	school	1st stage: birth cohort 2nd stage: screen +/-	two-phase	ILB 1689 / 322* IOW 1279 / 136*	10	ILB=IOW 92%	ILB 25% IOW 12%
Verhuslt 1985	1985	Netherlands	birth register	birth cohort	two-phase	334 / 116*	8 and 11	90%	26%
Anderson 1987	1987	New Zealand	birth register	birth cohort	one-phase	792	11	86%	18%
Offord et al. 1987	1987	Canada	census	stratified, clustered	one-phase	3294	4 to 16	91%	18%
Kashani et al. 1989	1989	USA	school	birth cohorts, stratified	one-phase	210	8, 12, 17	77%	25%
Velez 1989	1989	USA	census	simple	one-phase	776	11 to 18	80%	18%
Esser et al. 1990	1990	Germany	birth register	simple	one-phase	356	8 13	64% 89%	16%
McGee 1990	1990	New Zealand	birth register	birth cohort	one-phase	943	15	92%	22%
Fergusson et al. 1993	1993	New Zealand	birth register	birth cohort	one-phase	961	15	88%	27%
Fombonne 1994	1994	France	school	1st phase: simple 2nd phase: screen +/-	two-phase	2441 347*	8 to 11	88%	12%
Costello et al. 1996	1996	USA	school	stratified, clustered	two-phase	4067 1015*	9, 11, 13	96% 80%*	20%
Shaffer et al. 1996	1996	USA	household	simple	one-phase	1285	9 to 17	84%	19% 3%**
Simonoff et al. 1997	1997	USA	school + volunteers	total sample	one-phase	2762	8 to 16 (twins)	75%	41% 14%**
Verhuslt 1997	1997	Netherlands	household	stratified, clustered	two-phase	2709 780*	13 to 18	82%	22%
Breton et al. 1999	1999	Canada	family benefit register	simple / stratified	one-phase	2400	6 to 14	83%	18%
Meltzer et al. 2000	2000	UK	child benefit register	stratified, clustered	one-phase	10438	5 to 15	83%	9.5%

* 2nd phase

** with impairment criteria

Table 2.2: Epidemiological studies in Developed Countries (diagnostic procedures)

Study	Measure	Diagnostic system	Impairment criteria	Informants
Rutter et al. 1970	Rutter scales[1] Isle of Wight interview[2]	Rutter 1965	disability, distress	P/T/C
Rutter et al. 1975a	Rutter scales[1] Isle of Wight interview[2]	Rutter 1965	disability, distress	P/T
Verhuslt 1985	CBCL; TRF CAS; Psychiatric interview[4]	DSM III	not known	P/T/C
Anderson 1987	DISC Rutter scales[1]	DSM III	not known	P/T/C
Offord et al. 1987	questionnaire (adapted CBCL) clinical interview	DSM III Rutter et al. 1968	Rutter et al. 1968	P/T/C
Kashani et al. 1989	CAS	DSM III	functioning scores	P/C
Velez 1989	DISC	DSM III-R	not known	P/C
Esser et al. 1990	Isle of Wight interview[2] (adapted)	ICD 9	impairing or disruptive	P/C
Mc Gee 1990	DISC; RBPC social competence scales[5]	DSM III	not known	P/C
Fergusson et al. 1993	abbreviated DISC; SRED DISC; RBPC	DSM III-R	not known	P/T/C
Fombonne 1994	Rutter teacher scale[1] CBCL; Interview with parents	ICD 9	CGAS	P/T
Costello et al. 1996	CBCL CAPA	DSM III-R	Children and Adolescent Burden Assessment	P/C
Shaffer et al. 1996	DISC 2.3	DSM III-R	included in DISC 2.3; CGAS; Columbia Impairment Scale[7]	P/C
Simonoff et al. 1997	CAPA	DSM III-R ICD 10	psychosocial impairment scale	P/T/C
Verhuslt 1997	CBCL; DISC 2.3	DSM III-R	CGAS	P/T/C
Breton et al. 1999	DISC 2.25 The Dominic Questionnaire[6]	DSM III-R	included in DISC 2.25	P/T/C
Meltzer et al. 2000	SDQ DAWBA	ICD 10	included in SDQ and DAWBA	P/T/C

Key at the base of Table 2.4

2.3.2 Developing countries

Tables 2.3 and 2.4 include all the studies in the developing world that I have been able to locate that meet the same criteria used in tables 2.1 and 2.2. for the developed world, namely epidemiological studies looking at psychiatric disorders in general (and not just one type of disorder) in school-age children in the community. This list of studies was assembled from previous reviews (**Hackett et al. 1999b**; **Roberts et al. 1998**), from a hand screen of relevant journals and from a computerised search of Medline and Psych Info using the following key-words 'epidemiology', 'child psychiatry'. The overall prevalence estimates in developing countries ranges from 5% in India (**Hackett et al. 1999a**) using impairment criteria, to 49% in Puerto Rico (**Bird et al. 1988**) and 35.6% in India (**Lal et al. 1977**), without impairment criteria.In Brazil, only one study of school-age children has generated an overall prevalence for child psychiatric disorders (**Almeida-Filho 1984**). The estimated rate was 23% for psychiatric disorders for children from 5 to 14 years old. This study can be considered a pioneering work in child psychiatric epidemiology in Brazil, providing the first data in this area, and developing a Brazilian screening measure. There were other more recent epidemiological studies in India (**Sarkar et al. 1995, Shenoy et al. 1996**) that provided rates of psychological symptoms or disturbances rather then diagnosis, and which were not included in the table which focus only on studies that present diagnostic rates.

Another study in southern India investigated the prevalence of mental disorders in school-age children attending a general paediatric department (**Chandra et al. 1993**). This study was also not included in the Tables 2.3 and 2.4 since it did not provide prevalence rates representative of the general populations. The main problems identified were conversion disorder, conduct disorder, nocturnal enuresis and somatoform pain. These findings illustrate the diversity of diagnostic criteria adopted in different epidemiological studies, since nocturnal enuresis is not included as a child psychiatric disorder in most studies, and somatoform and conversion disorders are commonly omitted due to methodological difficulties in ascertainment. Two other studies in developing countries (**Minde 1975, Wang et al. 1989**), investigating mental health problems in school children, were not included in the table since the only measure they both adopted was the Rutter teacher's scale, therefore they could only provide scores above and below threshold, but not rates of disorders. Minde (1975) found 18% above threshold among 577 children assessed in three deliberately chosen schools in Uganda. Wang et al. (1989) assessed a larger and

Table 2.3: Epidemiological studies in Developing Countries (main features)

Study	Date	Setting	Sampling frame	Design	One or two phases	Sample size	Age range	Response	Prevalence
Lal et al. 1977	1977	India	household	clustered	one-phase	272	0 to 12	100%	35.6%
Giel et al. 1981	1981	Colombia India Sudan Philippines	primary care	clustered	two-phase	286 / 117* 151 / 39* 250 / 27* 238 / 68*	5 to 15	> 99%	Colombia 29% India 22% Sudan 10% Philippines 15%
Almeida-Filho 1984	1984	Brazil	household	clustered	two-phase	828 / not known	5 to 14	not known	23%
Bird et al. 1988	1988	Puerto Rico	household	clustered	two-phase	777 / 386*	4 to 16	92%, 88%*	49%; 18%**
Kasmini et al. 1993	1993	Malaysia	household	total sample RCQ ≥ 1 *	two-phase	507 / 77*	1 to 15	not known	5%
Gureje et al. 1994	1994	Nigeria	primary care	total sample screen + / 15% - *	two-phase	990 / 227*	7 to 14		20%
Hackett et al. 1999	1999	India	household	clustered	two-phase	1403 / 426*	8 to 12	100%	9%; 5%**
Fleitlich et al.	2004	Brazil	household	Clustered stratified	One-phase	1,251	7 to 14	83%	13%

* second phase
** with impairment criteria

Table 2.4: Epidemiological studies in Developing Countries (diagnostic procedures)

Study	Measure	Diagnostic system	Impairment criteria	Informants*
Lal et al. 1977	clinical interview	not known	not known	P/C
Giel et al. 1981	Reporting Questionnaire for Children; E12 semi-structured psychiatric interview	Rutter et al. 1975	not known	P/C
Almeida-Filho 1984	Questionario de Morbidade Psiquiatrica Infantil; open psychiatric interview	Rutter et al. 1969	not known	P
Bird et al. 1988	CBCL DISC + clinical judgment	DSM III	CGAS	P/T/C
Kasmini et al. 1993	RQC FIC	Rutter et al. 1975	not known	P/C
Gureje et al. 1994	Rutter's scale[1] K-SADS	DSM III-R	CGAS	P/C
Hackett et al. 1999	Rutter's scales[1] Rutter's interviews[2]	ICD 10	child's performance in tasks; Chedoke-McMaster[3] (adapted)	P/T
Fletitlich et al.	DAWBA	DSM IV	included in DAWBA	P/T/C

* P: parents; C: child; T: teacher

CAPA: Child and Adolescence Psychiatric Assessment (Angold et al. 1995)
CAS: Child Assessment Scale (Hodges et al. 1982)
CBCL: Child Behaviour Check List (Achenbach et al. 1981; Achenbach 1983; Achenbach 1991abc)
CGAS: Children's Global Assessment Scale (Shafer et al. 1983)
Child's version (Chambers et al. 1985)
DAWBA: Development and Well-Being Assessment (Goodman 2000)
DISC: Diagnostic Interview Schedule for Children (Costello et al. 1984; Edelbrock et al. 1985)
FIC: Follow-up interview for children
K-SADS-P: Schedule for Affective Disorders and Schizophrenia, Present Episode,
RBPC: Revised Behavioural Problem Checklist (Quay et al. 1987)
RQC: Research Questionnaire for Children (WHO; Giel et al. 1981)
SDQ: Strengths and Difficulties Questionnaire (Goodman 1997; Goodman 2001)
SRED: Self-report early delinquency (Moffit et al. 1988)
TRF: Teacher's Report Form (Achenbach 1991c)

[1] (Rutter 1967; Rutter et al. 1970)
[2] (Rutter et al. 1968; Graham et al. 1968)
[3] (Boyle et al. 1987)
[4] (Richman et al. 1982)
[5] (Armsden et al. 1987; Elliot et al. 1974)
[6] (Valla et al. 1994)
[7] (Bird et al. 1993)

more representative sample of 2432 children and found a lower percentage of 8% above threshold according to Rutter's teacher scale.

Although not providing overall prevalence rates, interesting cross-cultural finds came out from a study comparing rates of behavioural and emotional problems between North-American and Thai children using the Child Behaviour Checklist (CBCL, **Achenbach 1983**). Although some cross-national differences were identified when North-American and Thai children were compared, more than half the 118 problems showed no significant difference in prevalence. Moreover, only six of the Thai-U.S. differences were significant qualified as 'medium' or 'large' according to variance criteria (**Weisz et al. 1987**).

2.3.3 Comparison between epidemiological studies in developed and developing countries

Not surprisingly, there were significantly fewer studies in developing countries that could be included in the table, i. e. that provided rates of disorders from a representative sample of children, reflecting the shortage of epidemiological information in the field of child psychiatry in these countries. Among the reduced number of studies in tables 2.3 and 2.4, most were held in non-westernised countries (e. g. India, China, Malaysia) which though interesting for cross-cultural comparison, leave Latin America with very little in terms of culturally appropriate data. In Brazil, only one epidemiological study providing overall prevalence rates was found. The methodology adopted in epidemiological studies in developing countries is often dissimilar as detailed below, and often not fully appropriate for comparison with studies in developed countries.

The commonest sampling frame in developing countries was 'household', whereas in developed countries 'birth register' and 'school' were frequently used. The samples were considerably larger in developed countries, several studies included more than 2000 subjects, and the largest study reached almost 10,500 children in the UK. In the developing countries the average sample size was around 400 subjects with two larger samples, one reaching 2,400 and the other 1,403 subjects in the screening stage of the study. Rutter's scales were still the most used in developing countries, whereas in developed countries, particularly in the more recent studies, CBCL and DISC were commonly used. Most of the studies in developed countries adopted the DSM III-R or DSM IV criteria, generally with some impairment criteria associated, whereas most of the developing countries, even the more recent ones, adopted Rutter's criteria, often

appearing to drop the impairment criteria adopted in the Rutter's studies. Participants rates are higher in developing countries despite (or perhaps because of) the fact that the population in these countries is not used take part into surveys, so questionnaires cannot be posted. Prevalence rates varied in both tables with the highest rates mostly in studies that did not include impairment criteria. Overall, although fewer, there are some good epidemiological studies in developing countries, indicating that these are feasible and potentially worthwhile. However future studies in developing countries should try to investigate larger and more representative samples, and when possible, use internationally accepted measures so as to enable further cross-cultural comparisons.

2.3.4 Urban-Rural differences

Both in developed and developing countries, urbanism has been considered as a relevant factor that may influence the prevalence rates of child and adolescent psychiatric problems. A review in this field (**Quinton 1988**) highlights studies with samples from Norway (**Lavik 1977**) and England (**Rutter et al. 1975**) that compared urban and rural areas, showing that inner city rates were markedly higher than rates in rural areas. This difference applied as much to emotional as to conduct problems. In another study in Norway at rural versus small town rates also showed higher prevalence in the urban areas (**Vikan 1985**). Examining the effect of residing in urban areas in Brazil on mental health status of adults, a study compared three areas of residence. Among the three areas examined, the area with the highest proportion of migrants, lowest level of education and lowest family income had the highest prevalence rate (22%) compared to 11% in the area with the lowest proportion of migrants, highest level of education and highest family income. The effect was still significant after controlling for key individual socio-economic variables (**Blue 2000**). A study in Sudan looked at the effects of urbanisation, after 15 years, on child behaviour and health. The urbanisation brought a significant occupational shift away from agriculture toward manufacture and services, resulting in positive changes in quality of life including better housing, nutrition, sanitation, medical care, education and transport. Despite this improvements, significantly more symptoms were reported in 1980 then there had been in 1965. This rise was largely accounted for by hyperactivity, psychosomatic headache and behavioural symptoms. Although the methods and research instruments were the same, mothers might have experienced and reported symptoms differently at the time of the two studies. Depending on social context and expectations, behavioural problems might have different meanings. Hyperactivity, for example, might

have become more of a problem when children were expected to sit still in school, while it might have been less conspicuous in the traditional rural life. On the other hand, psychosomatic headache and stuttering would be considered discomforting in all social settings. Therefore both cultural factors and real changes of behaviour in children seem to have caused the results (**Rahim et al. 1984**). Although it is possible to find evidence in the opposite direction, such as a study in China, where lowest rates were found in urban areas (**Shen et al. 1985**), **Quinton (1988**) concludes that although the urban environment is not necessarily 'toxic', it is often the case that families with multiple psychological problems are concentrated in inner cities rather then suburbs or rural areas. **Quinton (1988**) also urged that further studies should look at the combinations of poor environments, low resources and personal vulnerabilities generating pathogenic family environments.

The large variation in prevalence estimates observed between countries and even within countries can partly be attributed to socio-cultural differences (social norms, urban/rural environments, behavioural responses, expressions of distress). For example, what behaviours are considered to be abnormal by parents and society is very variable, altering prevalence rates of externalising disorders. In this case, one should always interpret and understand rates in the light of the socio-cultural background (which, in any case, should be a constant exercise in clinical practice as well). Nevertheless, this variation can also be related to all the methodological issues discussed earlier in this chapter: sampling strategy, choice of measures, the use of single or multiple informants, and case definition. These methodological issues apply to child psychiatric epidemiological studies in any socio-cultural background. It is only when this methodological 'noise' is taken out of the picture – by applying comparable methods to different cultures – that it is possible to look for substantive differences in prevalence between countries and cultures. Such direct comparisons may not be possible when the cultural 'distance' is too great, but in the case of a westernised developing country such as Brazil, the relativist position that each culture needs its own distinct measures and diagnoses may be supplanted by the need for sound methodological studies with comparable methods to other westernised countries, going along with the universalist position discussed earlier.

2.3.5 Findings of psychiatric disorders among children and adolescent in Bangladesh

The community based prevalence study of psychiatric disorder among children of Bangladesh has not yet been studied. According to the analytical predictions, prevalence would be roughly 10-20% among children and adolescents as like as the prevalence findings of the reports of the developing countries. Tables 2.5 and 2.5 include some of the best known studies of child psychiatric disorders in hospital and clinic patients, samples of special population and school-based samples in Bangladesh. All the studies are carried out in urban area and had several methodological limitations. These studies are mostly clinical and institutional in nature and certainly do not reflect the actual situations of child psychiatric disorder of Bangladesh. However, these studies at least give some indications of pattern and extent of psychiatric disorders among Bangladeshi children and adolescent population.

Hospital based survey reveled significant psychiatric morbitidy among children and adolescents who were brought to the tertiary refferal hospitals for treatment. A study of psychiatric outpatient attendance at the Institute of Mental Health and Research in Dhaka, revealed that 8.6% of cases were children or adolescents **(Islam et al. 1993)**. In a different analysis of psychiatric morbidity among the Institute outpatients, emotional disorder was found to be the largest group with 32.5%, followed by conduct disorder 18.8%; mental retardation comprised 16.2%, psychoses and allied conditions 11.2%, epilepsy with behavioural problems 12.5% and the rest 8.5% comprised of other groups of disorders, according to ICD-9 criteria **(Mullick et al. 1995)**. In a survey among the children in a child guidance clinic at the Bangladesh Institute of Child Health and Dhaka Childrens' Hospital, **Rabbani and Quamaruzzaman (1996)**, assessed psychiatric morbidity by using the Rutter Multiaxial diagnostic system. Their findings revealed that conduct disorder was 8.9%, somatoform disorders 7.1%, attention deficit hyperactivity disorder 6.8%, autism 6%,and other emotional disorder 15.28% of the cases. Specific delays in development was found to be 10% and mental retardation was 17.8% of the cases. Another analysis of the 97 children patients attended in the psychiatric outpatients department of Sir Salimullah Medical College and Mitford Hospital, Dhaka,reported that dissociative disorder was 21,65% followed by mental retardation 15.46%, parvasive developmental disorder 12.37%.conduct disorder 10.31% and hyperkinetic disorder 9.28% according ICD-10 diagnostic criteria **(Rahim et al. 1997)**.These findings are very much indicative of the need for establishment of Child and Adolescent Mental Health Services at least at tertiary level.

Table 2.5: Studies on psychiatric disorder in children and adolescents in Bangladesh (main features)

Study	Setting	Sampling frame	Design	One or two phase	Sample size	Age range	Findings
Islam et al. 1993	Psychiatry OPD attendance of a Psychiatry Institute, Dhaka	Patient register	Total sample of new cases	one-phase	928	2 to 16	8.6% child psychiatric disorder in psychiatric OPD
Mullick et al. 1995	Psychiatry OPD attendance of a Psychiatry Institute, Dhaka	Patient register	Total sample of new cases	one-phase	80	2 to 14	32.5% emotional,18.7% behavioral of the child psychiatric cases in psychiatry OPD
Rabbani & Qamaruzzaman 1996	Attendance at a Child Guidance Clinic of Dhaka Children Hospital	Patient register	Total sample of new cases	one -phase	218	Mean 13.5	19.9%emotional,8.9%conduct,6.7%hyperactivity, 6.04% autism,17.85 MR of the child psychiatric cases in Child Guidance Clinic
Rahim et al. 1997	Psychiatry OPD attendance of Mitford Hospital, Dhaka	Patient register	Total sample of new cases	one-phase	97	3 to 14	21%dissociative(conversion)disorder,15.5%MR, 12.4%PDD,12.4% conduct,9.3% hyperkinetive disorder of the child psychiatric cases in psychiatry OPD
Hoque 1999	Juvenile delinquents of National Institute for Correctional Services, Dhaka	Resident register	Total sample	one-phase	200	10 to18	99.5% psychiatric disorder in Juvenile delinquents of a correction center.86% behavioural,26.4% emotional,44.6% substance misuse
Shaheed 2001	Orphans residing in Sir Salimullah Muslim Orphanage Dhaka	Resident register	Total sample	one-phase	210	5 to 16	25.2% psychiatric disorder among orphan children & adolescents in a residential orphanage 14.3% emotional, 9.6% behavioral
Mullick 2000	Autistic cases attendance in Child Mental Health Clinic BSMMU, Dhaka	Patient register	Consecutive sample	one-phase	56	2 to 13	Associated features with autism:64%hyperkinesis, 48% MR,48% phobia
Mullick 2002	Attendance in Child & adolescent Consultation Center Dhaka	Patient register	Consecutive sample	one-phase	546	5 to 16	20.5% somatoform disorder in child & adolescent consultation
Das 2002	Attendance in Child & adolescent Consultation Center Dhaka	Patient register	Consecutive sample	one-phase	450	5 to 16	11.7% somatoform disorder in children OPD
Mullick 2003	Attendance in Child & adolescent Consultation Center Dhaka	Patient register	Consecutive sample	one-phase	850	5 to 16	6% were school refusers in child & adolescent consultation.
Jahan 1998	Students of 5 schools Underprivileged Children Educational Program, Dhaka	School register	1st phase: random lottery 2nd phase: simple random	one-phase	210	10 to16	22.9% psychiatric disorder among urban slam school children
Rabbani & Hossain 1999	Primary school children of the 11 schools of Dhaka	School register	1st phase: random stratified, clustered 2nd phase: simple random	one-phase	128 8	Not mention ed	13.4% psychiatric disorder among urban school children 3.2% emotional, 8.9% conduct

* 2nd phase

** with impairment criteria

Table 2.6: Studies on psychiatric disorder among children and adolescents in Bangladesh (diagnostic procedures)

Study	Measure	Diagnostic system	Impairment criteria	Informants*
Islam et al. 1977	Semistructured clinical psychiatric interview	ICD 9	not known	P/C
Mullick et al. 1995	Semistructured clinical psychiatric interview	ICD 9	not known	P/C
Rabbani & Qamaruzzaman 1996	Clinical assessment + WISC III R	Rutter Multiaxial, 1969	not known	P/C
Rahim et al, 1997	Semistructured clinical psychiatric interview	ICD 10	not known	P/C
Haque 1999	Semistructured clinical psychiatric interview	ICD 10	not known	C/T
Shaheed 2001	DAWABA	ICD 10	Included in DAWBA	C/T
Mullick 2000	Semistructured clinical psychiatric interview	ICD 10 Multiaxial	Axis Six impairment criteria	P/C
Mullick 2002	Semistructured clinical psychiatric interview	ICD 10 Multiaxial	Axis Six impairment criteria	P/C
Das 2002	Semistructured clinical psychiatric interview	ICD 10 Multiaxial	Axis Six impairment criteria	P/C
Mullick 2003	Semistructured clinical psychiatric interview	ICD 10 Multiaxial	Axis Six impairment criteria	P/C
Jahan 1998	Clinical psychiatric assessment	DSM IV		P/C
Rabbani & Hossain 1999	Rutter B2 Scale	Rutter et 1970	Axis Five impairment criteria	T

* P: parents; C: child; T: teacher

Rutter B2 :Rutter Teacher Scale (Rutter et al. 1970)
WISC III R: Wescler Intellegent Scale for Children Third version revised
DAWBA: Development and Well-Being Assessment (Goodman 2000)

Turning to the point of special group of children population,a primary study was conducted among 200 Juvinile delimquents of 10-18 year olds at National Institute for Correctional Services,Gazipur,Dhaka.The psychiatric disorder was reported 90.5% of the studied population. Of these, conduct disorder was found 74.1%,substunce use disorder was 44.1%, emotional disorder was 26.6% and hyperkinetic disorder was 8.1%.These findings suggest overwhelming psychiatric morbidity among juvinile offenders and warrant recognition of their special need for assessment and integrated treatment approaches both for prevention of delinquency and treatment of psychiaric disorder **(Hoque 1999)**. The first study on psychiatric morbidity among orphan children and adolescents in residential care in Dhaka. Standardized structured interview (DAWABA) was used to assign 1CD-10 diagnoses.and 25.2% orphan children were reported of having psychiatric disorder in contrast to that of 11.7% of controls collected from schools.Emotional disorder was highly prevalent (14.3%) followed coduct disorder and hyperkinetic disorder with 4.8% for the each.Both emotional and behavioural disorder was 1.9%. Coduct disorder and hyperkinetic disorder were found significantly higher in the orphans in residential care than that of the control school children in their home **(Shaheed 2001)**. The findings of this study warrant special attention for these children and adolescents.

The findings of clinical studies on common child psychiatric problems exist among the children who were brought to the tertiary hospital and consultation centers for seeking help are impressive. A study among 56 autistic children attended in the Child Mental Health clinic of the Bangabandhu Sheikh Mujib Medical University a tartiary referal center in Dhaka, explored that autistic disorder was one of the common cause of referral to child mental health services. Hyperkinesis was the the main associated feature (64%) followed by mental retardation (48%).tepertantrums (20%),self-injurious behaviour (18%) and phobia (48%).Seizure was found in 20% cases. Any grade of impaired psychosocial functioning was found in all cases.Ofthese,severe and pervassive social disability was common (45%) and 25% autistic children were unable to function in most areas **(Mullick 2000).** The findings are sugestive of multidisciplinary team in child psychiatric service and provision for adequate organized special education in the community level to help the autistic children and their families. The first study on somatoform disorder in children and adolescents attended in a Child and Adolescent Psychiatric Consultation Center at Dhaka reported that 20.5% of total 546 clinic population fulfilled the ICD-10 clinical diagnostic criteria of any form of somatoform disorders. Pain was the most prevalent symptom. Children showed significantly higher rates of abdominal complaints and adolescents showed higher rates of headaches. All cases reported an average of 14.21 somatic symptoms. Boys and girls reported an average of 13.75 and 14.61 somatic symptoms respectively and this difference between two groups was not significant. Whereas children

reported an average of 12.66 somatic symptoms and adolescents reported an average of 15.94 somatic symptoms. Girls reported higher rates of somatization disorder and persistent somatoform pain disorder than that of boys.Children reported higher rates of undifferentiated somatoform disorder and somatoform autonomic dysfunction. In contrast, adolescents reported higher rates of somatization disorder. Remarkable social impairments particularly, in the domains of academic and peer relationship were found among the cases **(Mullick 2002)**. Another survey on 450 children and adolescents attended in the children outpatients department of a tertiary referral hospital, Dhaka, reported that 11.78% of them had ICD-10 diagnosis of somatoform disorders **(Das 2004)**. Findings of these two studies suggest that somatoform disorders in children and adolescents are frequent in clinical practice. Better understanding of these disorders can promote early diagnoses and timely treatments and improve the quality of life by preventing negative consequences. A pioneer study on school refusal reported that the cases of school refusal were 6% of the total cases of childhood and adolescence disorders attended in a child and adolescent psychiatric consultation center at Dhaka. The cases were assigned ICD-10 clinical diagnoses of multiaxial classification of childhood and adolescent psychiatric disorder. The commonest diagnoses in the decreasing order were found to be separation anxiety disorder(19.61%), specific phobia (17.65%),depressive disorder (15.69%), and somatoform disorder(11.76%). Remarkable social impairments particularly, in the domains of academic and peer relationship were found among the cases **(Mullick 2003)**.The findings of this study support the existing views of school refusal and suggest need for detailed studies on nosology, description, trends, pathogenesis, management, and outcome of this problem in Bangladesh.

Some representative school-based surveys are very much indicative of the pattern and extent of child and adolescence psychiatric disorder in Bangladesh. A school based study reported 22.9% DSM-IV diagnoses among 210 slum children and adolescents of 10-16 year olds in Dhaka city. Of these, emotional disorder and behaviuoral disorder were found 13.3% and 10.5% respectively **(Jahan 1998)**. This study clearly indicates high rates of psychiatric morbidity among slum children that caused adverse effects on overall urban environmental health. Another school based study on 1128 urban primary school children (up to grade IV) screened with Rutter Teacher Scale and reported 13.4% of them had psychiatric disorders.Emotional,conduct,and undifferentiated disoprders were detected in 3.2%, 8.9%.and 1.2% respectively **(Rabbani and Hossain 1999)**. These studies indicate that psychiatric morbidity among children in Bangladesh is likely to be comparable with other countries.

2.4 Correlates of disorders

Various child psychiatric epidemiological research studies have reported many variables that can be said to be aetiologically linked to the child psychiatric disorders either in a favourable or unfavourable direction. Here, some specific correlates have been evaluated along with its proposed possible mediating mechanism on the basis of empirical findings.

2.4.1 Risk factors

Individual Characteristics

Age and Sex

In community surveys, the prevalence of one or more disorders tends to be less in the younger age group than in the older age group, and overall to be more common in boys than girls. In the Isle of Wight survey, psychiatric disorder was, in general, twice as prevalent in boys, although within the category of emotional disorder there was a slight excess of girls **(Rutter et al. 1970)**. In the Ontario Child Health Study **(Offord et al. 1987)** for children 4 to 11 years old, prevalence was higher among boys (19.5%) than girls (13.5%), while the reverse was true among children 12 to 16 years of (18.8% for boys versus 21.8% for girls).

Racial and Ethnic Minorities

There is evidence from several community studies that the rate of emotional and behavioural problems varies by race and ethnic minority. For instance, in a total population survey of 10-year old children in an inner London borough, more behavioural problems were reported among children from West Indian immigrant families compared with children from non-immigrant families **(Rutter et al. 1975; Rutter et al. 1981)**. Conversely, children of Asian origin in Britain appear to have comparable rates or slightly reduced frequencies of psychiatric disorders compared to White children **(Cochrane 1979)**. Difficulty performing satisfactorily in school and growing up in conditions of family adversity appear to be two major factors that place children in certain racial and ethnic groups at increased risk for emotional and behavioural problems **(Offord 1987)**.

Chronic Health Problems

A consistent finding in general population surveys of children is the increased rate of psychiatric problems with chronic health problems, as compared to healthy children **(Rutter et al.1970; Breslau 1985).** Possible aetiological variables include low self-esteem, poor peer relationships and poor school performance **(Cadman et al. 1987)**.

Brain Damage

Children with brain damage are at increased risk for psychiatric disorder. In the Isle of Wight study, the rate of psychiatric disorder was increased five times in youngsters with cerebral palsy, epilepsy or some other disorders above the brain stem **(Rutter et al. 1970)**. Several studies indicate that brain damage puts children at risk for psychiatric disorder in general rather than a specific type of disturbance **(Brown et al. 1991; Rutter 1977,1981,)**. Possible mediating variables include psychosocial disadvantages **(Brown et al. 1991; Rutter 1977)** intellectual and cognitive disability leading to poor school performance **(Rutter et al. 1970,Brown et al. 1991)** and abnormal temperament **(Brown et al. 1991)**.

Temperament

Individual children differ from one another in certain behavioural patterns such as activity level, behavioural inhibition and sociability **(Rutter 1987)**. It has been found that among a general population sample of children at age 7, those who were judged to be temperamentally difficult, compared to those with an easy temperament, had more psychiatric disorders at age 12 **(Maziade et al. 1985)**.

IQ, Learning Disorders

Children who do poorly in school, whether because of low IQ or a specific learning disorder are at increased risk for psychiatric disorders **(Rutter et al. 1970; Costello et al. 1988)**. This is particularly true for conduct disorder **(Rutter et al. 1970)** and hyperactivity **(Minde et al. 1971)**.

Psychosocial Factors

Parental Psychopathology

Parental psychiatric disorder is associated with increased rates of emotional or behavioural problems in offspring **(Rutter et al. 1970; Rutter and Quinton 1984)**. **Weisman and Colleagues (1987)** found that offspring, aged 6 to 23, of depressed parents had significantly higher rates of major depression, substance abuse, mean number of psychiatric diagnoses, psychiatric treatment, poor social functioning and school problems, compared to the offspring of normal parents.

Family Factors

Poor parenting, marital discord and family dysfunction have all been associated with an increased rate of psychiatric disorder. For example, the prevalence of discordant family relationships **(Rutter et al. 1970)**, lack of emotional warmth displayed towards the child

(Rutter et al. 1970) and marital discord **(Rutter 1981)** are all associated with antisocial behaviours in children. Child-identified but not parent-identified anxiety disorders have been reported to be significantly associated with family difficulties **(Costello et al. 1988)**. Large family size (usually four or more children) has been associated with increased rates of conduct disorder and delinquency in boys **(Rutter et al. 1970)**.

Social Class

Rutter et al. (1970) found no significant relationship between social class and psychiatric disorder as determined by parental occupation based on occupational prestige. In contrast, when social class is measured in terms of economic disadvantage, there is a strong and consistent relationship with child psychiatric disorders **(Offord et al. 1987)**.

Urban-Rural Dwelling

A number of studies have reported increased rates of child psychiatric disorder in urban as compared to rural settings **(Rutter et al. 1975, Offord, Boyle and Szatmari et al.1987)**. These elevated rates are especially marked in pre-adolescents rather than adolescents **(Rutter et al. 1981)** and are related particularly to chronic disorders of early onset **(Rutter et al. 1987)**. In a comparison of the rate of child psychiatric disorder in the Isle of Wight (a predominantly rural setting) and inner London borough (an inner city area), it was found that a two-fold increase in the prevalence of psychiatric disorder in the urban setting was accounted for entirely by the increased rates of psychosocial adversity and disadvantaged schools in the inner city area **(Rutter and Quinton 1977)**. Other characteristics of the urban environment, such as the physical design and layout of large housing complexes, which make it difficult to supervise children adequately, and the lack of social support for parents in this setting, may also contribute to the elevated rates of child disturbance **(Quinton 1988)**.

2.4.2 Protective factors

Within the child, several types of protective factors have been identified **(Rutter et al 1970, Rutter 1987, Offord 1989)**. These are female sex, above average IQ, easy temperament and considerable self-understanding. Family protective factors include a high degree of cohesiveness within the family and a good relationship with one parent. The reported protective factors in the wider community include excellent schools and social development and recreational programmes. Mediating mechanisms for protective factors include reducing the impact of risk factors on the individual, lessening a chain of negative events and increasing the self-esteem and self-efficacy of the individual **(Rutter 1987)**.

2.4.3 Correlates of disorders in Bangladesh

Like in other less developed countries, Bangladeshi children are subject to a large deversity of conditions, which may negatively affect their physical and psychological well-being. These conditions include malnutrition and illiteracy. Conversely, Bangladesh has strong family support and a high degree of cohesiveness within the family inherent in the culture. These factors con be considered as major protective factors.

In Bangladesh, analysis of hospital surveys among children with psychiatric disorders revealed some correlates of psychiatric morbidity. For instance, poor socio-economic condition, physical illness, malnutrition and inadequate social amenities were identified as suspected aetiological factors for the development of psychiatric disorders among children **(Mullick et al. 1995)**. Association of conduct disorder with marital discord in parents, parental mental and physical illness, were reported **(Rabbani and Quamaruzzaman 1996)**. Family discord was identified as the most frequent stressor, significantly related with deliberate self-harm among teenagers **(Mullick et al. 1992)**.Significantly higher rate of psychiatric disorder among juvinile offenders was found to be associated with poor physical health, low economic condition,disorganized urban background,and unfavourable family which included single parent family, multiple marriage of father,parental discord,prolong abscence of fatherfrom the family and away of both parents from their children for most of the time of the day **(Hoque 1999)**. Psychiatric disorder among orphan children and adolescents was reported to be associated with loss of parents before four years of age, physical illness,substance misuse,long stay in residential care.inadequeate care in the orphanage and living under unfavourable environment **(Shaheed 2004)**. Family genetic study of childhood autism reveled that significantly higher of social and communicative impaifement, and restrictive and repititive activities and interests were found in the first degree relatives of autistic probands **(Mullick 2001)**. As the samples of these studies are biased, conclusions based on these must be viewed with caution. Abnormal psychosocial situations were found to be associated with predisposition, onset, and course of the somatoform disorders in majority of the cases and most common was parental overprotection. Significant association was reported beteween school refusal and abnormal psychosocial situations and most common was parental overprotection and abnormal qualities of upbringing,abnormal intrafamilial relationship and chronic interpersonal stress associated with school and acute life events were associated with school refusal having psychiatric diagnoses **(Mullick 2003; Das 2004)**. Higher rates of psychiatric disorders among slum children were found to be associated with poor school performence,low economic status,family history of psychiatric disorder,overcrowed living

condition, and poor dwelling condition **(Jahan 1998)**. In a suvey on Dhaka city primary school children,it was reported that all form of psychiatric disorder were more prevelent in boys than in girls **(Rabbani and Hossain 1999)**.The community based epidemiological research will more reliably identify the factors influencing the development of child psychopathology in a favourable or unfavourable direction in Bangladesh.

2.5 Measurements of other veriables

Reliable and valid measures of correlates and associate features are just as important as psychometrically sound measures of disorder if the aim is to describe accurately the strength of the relationship between disorder and correlates. Though there is a good number of reliable and valid measures in this aspect, unresolved issues remain. What is needed are reliable and useful measures of impairment that are independent of the usual informants.

2.6 Policy and clinical implications

Epidemiological data increases the knowledge about the characteristics, the aetiology and risk factors for psychopathology and provide a scientific basis for appropriate mental health planning. Findings from epidemiological studies are necessary for health administrators and also inform clinicians and other health providers in the design of preventive interventions and treatment programmes (**Bird 1996**).

2.6.1 Policy implications

The need for services

Particularly in developing countries, epidemiological evidence that child mental health problems are common and impairing is vital if child psychiatric services are to receive funding in competition with services for life-threatening physical and social problems. In some developing countries like Bangladesh, the physical and social needs are so prominent that they steal the attention of politicians and medical authorities from emotional and behavioural problems. Health authorities would probably not argue against the idea that emotional and behavioural problems in children and adolescents are potentially linked to drug abuse, crime, unemployment in adult life and other expensive social and health problems. But no formal attention has yet been drawn to developing a national plan for

child and adolescent mental health services. Some developing countries don't see behavioural disturbance in children as within the medical domain, either for cultural reasons or for lack of information, which also delays the economic resources allocation.

Prevalence rates will not only help in terms of justifying the need for services but will also provide qualitative information in terms of where and which kind of services should be implemented. General population studies can provide adequate information on the distribution of both mental disorders and patterns of service use across specific population subgroups (e.g. gender, ethinicity, age, socio-economic status, and region). Such information is crucial to mental health care planners and policy makers for the appropriate distribution of service resources (**Lahey et al. 1996**). For example, studies that compare prevalence rates of child psychiatric problems in urban and rural areas generally indicate that public policy should give more emphasis to the urban areas. As well as area of living, other risk factors can guide the allocation of resources to the most needy children, and to the most prevalent disorders. Attention should be drawn to the fact that prevalence rates must be based not only in a list of symptoms but also consider the impairment in family and child's life in order to reflect more accurately the actual need for services in a population.

Prevalence rates of child mental health problems, particularly in developing countries, also indicate the need of offering treatment and preventive interventions in general health settings since specialist clinics are not always available. A recent study systematically reviewed the evidence concerning the effectiveness of interventions for child and adolescent mental health problems in primary care and interventions designed to improve the skills of primary care staff. Most studies concerned specialist treatment in primary care or treatment by community nurses and the interventions tested included behavioural therapy, cognitive-behavioural therapy, non-directive counselling, dynamic therapy, psychiatric evaluation and guidance, parent education and counselling, group work and child education (**Bower et al. 2001**). This review concluded that there is some evidence that these interventions are effective but further investigation is needed.

The need for training health and education professionals and educating the population

In paediatric primary care, epidemiological studies indicate that most emotional and behavioural problems in children are not recognised by paediatricians. An example of that is illustrated in a study carried out in a large health centre in the United States, where paediatricians identified only 5.7% of psychiatric problems in a sample of children that were identified of having 22% of psychiatric problems according to DISC interviews (**Costello 1989**). These findings suggest that there might be a large pool of untreated mental health problems and that these are largely unrecognised even by physicians who see the children regularly.

Bowman et al. (1993) also illustrates that general practitioner recognition of child psychiatric disorders is low when contrasted with research interview caseness. Among 48 cases with psychiatric disorder according to K-SADS (Schedule for Affective Disorders and Schizophrenia in School-Age Children) and DSM-III-R criteria (**APA 1987**), only 10 cases were recognised by general practitioners as having a disorder.

A review on epidemiological studies in child psychiatry across cultures in developing countries stresses the importance of educating paediatricians and primary care doctors in recognising psychiatric disorders, arguing that even if psychological treatments will not be fully available, a psychologically-informed interpretation to parents may help them respond to their child's emotional needs more effectively (**Hackett et al. 1999b**).

2.6.2 Clinical implications

Child psychiatric epidemiology can help to explain the aetiology of mental disorders. Prospective, longitudinal studies assessing the roles of multiple risk factors drawn from both psychosocial and biological domains can contribute to improving the knowledge of each psychiatric disorder. Fuller knowledge of the aetiology of such disorders requires more emphasis on biological and genetic variables in the conceptual models. Epidemiological studies can also improve the understanding of factors affecting duration and recurrence of child disorders (**Roberts et al. 1998**).

An important clinical implication of epidemiological studies regards preventive treatment. Only population-based samples can provide valid information on the relationship of risk

and protective factors to the onset, maintenance and remission of mental disorders. Such information can be used to develop further studies that target malleable risk factors, with the goal of preventing the onset, altering the course, and improving the outcome of mental disorders in children and adolescents (**Lahey et al. 1996**).

Another clinical implication of epidemiological studies arise from the findings about the variation of rates according to the informant, reinforcing the knowledge that clinically, information should be gathered not only from parents or children but also from other informants such as teachers (**Goodman et al. 2000a**). Epidemiological studies also clarify issues about clinical course and comorbidity. Learning about the taxonomy of mental disorders and how they vary in different settings (according to different informants) is useful to improve the quality of diagnosis and also treatment. Clinicians will be more accurate when counselling parents and youths and in developing treatment plans.

2.7 Important unanswered questions in Bangladesh

Thinking about child mental health in Bangladesh today, not only is there a lack of adequate services to meet the needs of different sectors of the population, but also there is an even more basic lack of adequate information the needs that should be met. What are the main behavioural and emotional problems to be treated? How do they vary according to socio-economic factors? Where is it best to concentrate services? What should be the composition and qualifications of team members in primary mental health clinics?

To answer these questions it is certainly possible to import some information from other developing countries, but most of what is available comes from developed cultures. Another option would be to try to estimate our needs based on studies from developed countries. However, it is already known that the population in developing countries such as Bangladesh are probably more exposed to potential risk factors, as well as effective protective factors what would be differ the actual needs of Bangladeshi children as compared to children from developed countries. Furthermore, cultural differences could lead some behaviours to be considered less problematic then in developed countries, decreasing our needs when compared to developed countries. With so much to find out, and with so many methodological and practical limitations, it would be easy to loose heart

and conclude that a single handed researcher in the developing world would never be able to overcome these problems and generate suitably sophisticated models and hypotheses. But this would be unnecessarily defeatist. There is no reason why taking a relatively straightforward approach to epidemiological research in child psychiatry in Bangladesh should not generate useful and interesting findings. Similar approaches have been very productive in various developed and developing countries, and there is no reason why Bangladesh should be an exception, provided methods are adapted to local circumstances.

CHAPTER 3

PRELIMINARY STUDY

This chapter comprises the preliminary study and is divided into six parts: (1) Introduction and objectives; (2) Setting; (3) Method; (4) Analytic strategy; (5) Results; (6) Discussion and interim conclusions. The preliminary study was needed to inform the design to be adopted in the main stage study that will be presented in the following chapters.

3.1 Introduction and objectives

In the absence of sound epidemiological studies in child and adolescent psychiatry in Bangladesh, some core methodological issues remained unclear at the time this study began. As mentioned before (Chapter 2) there is no reported epidemiological studies performed in Bangladesh, and in school and institution based studies, the ascertainment methods were not tested to demonstrate whether the identified subjects were representative of the population they aimed to investigate and the measures adopted were neither previously tested nor validated.

Therefore, one issue to be clarified regarded appropriate ascertainment methods for identifying children that should be included in a representative community survey. In developed countries such as the UK, there are health or social benefits registers that, in general, contain almost all children living in a certain area. In Bangladesh, a similar register could be the vaccination file in each local government clinic. However, there is no guarantee that all children are indeed taken to the clinic, particularly in more deprived areas. An alternative could be the official register of births, but there is no regular governmental procedure to check whether all parents are registering their children and in any case, many families will have moved into and out from any given area since the time their children were born. A third possibility would be the school registers, but no sound information was available about how many children are not attending, and who they are.

Another methodological issue that remained open regarded survey measures to be adopted in the developing world. Given the cultural and social-economic characteristics such as higher rates of illiteracy, lower levels of understanding and local idiomatic

expressions, epidemiological studies in developing countries should not adopt instruments and measures from developed countries straightaway, without looking at their suitability for the developing world.

The Strengths and Difficulties Questionnaire (SDQ) is a behavioural screening questionnaire for the common forms of child and adolescent psychopathology. Originally published in English (**Goodman 1997**), and subsequently translated into over 40 languages, the SDQ is brief and available without charge for non-commercial purposes. In a large British study, multi-informant SDQs detected psychiatric disorders in the community with a specificity of 95% and a sensitivity of 63% (**Goodman et al. 2000a**). Using British norms and a computerized algorithm, the SDQ predicted clinical diagnosis as accurately in child mental health clinics in Bangladesh as in Britain (**Goodman et al. 2000b**), supporting the cross-cultural relevance of the SDQ and raising the possibility that the SDQ might be useful as a screen for psychiatric disorders in community or paediatric clinics in Bangladesh. The preliminary study looks further into this possibility by examining how well the Bangla versions of the SDQ distinguish between community and psychiatric samples. While the complex diagnostic algorithms in use in the developed countries depend on computers, simpler algorithms that do not rely on computers would currently be more useful in Bangladesh

The purpose of doing a preliminary study was to clarify the methodological issues presented in the previous paragraphs with the following objectives:

- To validate the Strengths and Difficulties Questionnaire (SDQ) as screening measures of child psychopathology suitable to the cultural and socio-demographic characteristics of Bangladesh.

- To establish locally derived SDQ cut-offs and simple analytic methods that could potentially identify children in the community with a high likelihood of mental health problems
- To check that ascertainment via school lists with random sampling in Bangladesh as a feasible method for obtaining child and adolescent samples from the community for epidemiological surveys of child mental health in Bangladesh.

- To generate approximate prevalence estimates for power calculation

3.2 Settings

For the investigation of ascertainment methods and approximate prevalence a community sample was necessary, whereas to determine appropriate measures, a combination of community and clinical samples was needed.

3.2.1 Clinical sample: Bangabandhu Sheikh Mujib Medical University Hospital, Dhaka

The clinical sample for the preliminary was obtained from the Child Mental Health Clinic of the Department of Psychiatry, Bangabandhu Sheikh Mujib Medical University (BSMMU) hospital, a tertiary hospital located in the heart of Dhaka city, the largest city in Bangladesh. The Department of Psychiatry of the University has Child and Adolescent Psychiatry Wing, a specialist service in Child and Adolescent Psychiatry which offers both outpatient and inpatient treatments. The Child Mental Health Clinic is a multidiscplinery outpatient clinic of the department of Psychiatry of the University hospital headed by the researcher (a child and adolescent psychiatrist). The hospital is part of the BSMMU, the only postgraduate medical university of Bangladesh and receives referrals from Dhaka as well as from other parts of Bangladesh when of scientific interest. This clinic is the first formal child and adolescent mental health service of Bangladesh. Moreover, there is a provision that any problematic children can be brought in this clinic directly without any formal referral. Therefore, increasing number of child and adolescent are brought to this clinic to receive comprehensive and high quality of service. On an average, 7-10 new cases attended every day during the period of the study. Therefore, a fairly representative sample of the children population of Bangladesh is possible to be obtained from the clinic. A wide range of patients with different child and adolescent mental disorders attend in the clinic. They are developmental disorder like autism and other pervasive developmental disorders, mental retardation, wide varieties of emotional disorder including somatoform disorder, and behavioural disorder mainly hyperkinetic disorder and oppositional defiant disorder and conduct disorder. The cases included in the clinical sample were randomly selected and had a previous clinical assessment and diagnosis by the child psychiatrist at the hospital.

3.2.2 Community sample: Mohammadpur Thana

The community sample was collected from Mohammadpur. Mohammadphur is one thana of the western part of Dhaka city a largely residential area within Dhaka (well described in the setting section of the Main Study, Chapter 5). The area was chosen because the families who lived there were very similar in socio-economic background to the families who made up the clinic sample, i.e. the great majority of families were of medium socio-economic status. Most parents and children were literate and almost all 4-16 year olds attended school.

3.2.3 Ascertainment: determining the appropriate sampling frame

As mentioned in the introduction of this chapter, school registers was tested as a reliable sources of subjects sampling frame to identify children living in a given area in Bangladesh samples. However, the main reason for school based ascertainment was to test the hypothesis that sampling children in Bangladesh via school registers could be missing a substantial number of children who were out of school and at high risk for psychiatric disorders.

3.3 Methods

3.3.1 Design

The preliminary study was an epidemiological cross-sectional study, using two-stage sampling and a one-phase assessment. Parent and teacher SDQs were administered on all subjects (age range 4-16 years) whereas self-report SDQs were only administered to 11-16 year olds.

3.3.2 Sampling strategy

Clinic Sample

The clinic administered the SDQ to parents, teachers and young people at the time of the first assessment. The children referred to this specialist clinic came predominantly from families of medium socio-economic status, being neither affluent nor extremely poor. The questionnaire was read out when the respondents' literacy skills were insufficient for them to complete the questionnaire directly.

Questionnaires were administered to a consecutive series of 146 new patients aged 4-16 years when first seen in the clinic between June and December 1998; 44 were excluded from further analyses because either the parent or the teacher had not filled in a questionnaire; a further 3 were excluded because missing answers to some questions made it impossible to generate all scores. The present sample consists of the remaining 99 new referrals. While parent and teacher SDQs were completed on all these subjects, a complete self-report SDQ was only available on 35 (53%) of the 66 subjects aged between 11 and 16. The mean age of the sample was 12.5 years (SD 3.5 years) and 55% (54/99) were male.

Community Sample

To obtain the community sample children between the ages of 4 and 16 were obtained through a two-stage ascertainment program. In the first stage, a stratified random sample of schools was selected from the list of schools held by the education authority, stratifying for age band (kindergarten, school), source of funding (state or private), and type (boys, girls, coeducational). The chosen schools were two kindergartens (coeducational, private), two boys schools (one state, one private), two girls schools (both private) and one coeducational school (private) – there were no state kindergartens, girls schools or coeducational schools in the area. All the randomly chosen schools agreed to participate. In the second stage, children were randomly selected from class registers. Parents were visited at home and all agreed to take part in the study. Parents, teachers and young people completed SDQs, with the questionnaire being read out when the respondent did not have adequate literacy skills. The children sampled in this way are likely to be a fairly representative sample of this neighbourhood, with the exception that the area contained some small pockets of slum housing where many children did not attend school – children from these very poor families will have been systematically under-sampled by our school-based ascertainment strategy.

Two hundred 4-16 year old subjects were assessed between March and July 1999; 38 of these subjects were excluded from the analyses reported here either because it was not possible to get teacher as well as parent SDQs, or because missing answers to some questions made it impossible to generate all scores. The community sample consists of the remaining 162 subjects (81% participation rate). While parent and teacher SDQs were completed on all of these 162 subjects, a complete self-report SDQ was only available on 94 (89%) of the 106 subjects aged between 11 and 16. The mean age of the sample was 12.0 years (SD 2.9 years), and 52% (85/162) were male. The community and clinic

samples were well matched for gender (continuity-adjusted chi-square=0.04, 1df, NS) and for age (t=1.1, 179 df, NS).

3.3.3 Questionnaires

The Strengths and Difficulties Questionnaire (SDQ)

The SDQ asks about 25 attributes, some positive and some negative. The items, which were selected on the basis of contemporary diagnostic criteria as well as factor analyses, are divided between five scales of five items each, generating scores for Emotional Symptoms, Conduct Problems, Hyperactivity, Peer Problems, and Prosocial Behaviours. All items contributing to the first four subscales are summed to generate a Total Difficulties Score. The same questionnaire can be completed in about five minutes by parents or teachers of children aged 4 to 16. There is also a self-report version (**Goodman et al. 1998**) for those aged 11 and above. An extended version assesses the impact of any psychiatric symptoms in terms of resultant distress, social impairment or burden for others (**Goodman. 1999**). The SDQ has been shown to be of acceptable reliability and validity, performing at least as well as the lengthier and longer-established Rutter questionnaires and Child Behavior Checklist (**Goodman 1997; Goodman & Scott 1999**). The web site at www.sdqinfo.com provides more information on the SDQ plus downloadable versions of the questionnaires in many languages.

Translation of SDQ

The various versions of the SDQ were translated into Bangla by the researcher, after clarifying possible ambiguities in the English with the original author (Robert Goodman), who wrote the original version. Three psychiatrists, a psychologist, a general practitioner, a journalist and a teacher made independent back-translations. There were few differences between the original and the seven back-translations – discrepancies were resolved by panel discussion. Great care was taken to ensure that the translation was culturally sensitive, using only those words and idioms that would readily be understood by all Bangla-speakers irrespective of their social or educational backgrounds. The versions of the SDQ used in the study were the informant and self-report versions including impact supplements, all being scored in the standard manner (**Goodman 1997; Goodman et al. 1998, Goodman 1999**

3.3.4 Clinical diagnosis

Children from the psychiatric clinic were assigned clinical diagnoses based on the operationalised criteria of ICD-10 (**World Health Organization 1994**). These clinical diagnoses were made at the time of the initial assessment by the researcher, who was the child and adolescent psychiatrirst involved in the assessment. All diagnoses were phenomenologically based, drawing on the extensive information on symptoms and resultant impairments gathered from multiple informants. These diagnoses were made blind to the children's SDQ scores. Diagnoses were collapsed into three broad categories to provide cell sizes that would be sufficient for meaningful analysis. These categories were hyperkinesis, conduct disorder (including oppositional disorder) and emotional disorder (including anxiety, depressive and obsessive compulsive disorders). Overall, 47 patients had an emotional disorder, 18 had a conduct disorder, and 11 had a hyperkinetic disorder (with 5 patients met criteria for more than one of these three broad categories). The remaining 28 patients without an emotional, conduct or hyperkinetic disorder all had some other psychiatric diagnosis, e.g. psychosis or autism.

3.4 Analytic strategy

The ability of different SDQ scales to distinguish between community and clinic subjects was examined using Receiver Operating Characteristic (ROC) curves, employing the area under the curve (AUC) as the index of discriminant ability. As a guide to interpretation, the area under a ROC curve is 1.0 for a measure that discriminates perfectly, and 0.5 for a measure that discriminated with no better than chance accuracy. With the number of subjects in this study, the difference between an AUC of around 0.6 and 0.5 is statistically significant, i.e. an AUC of 0.6 is statistically reliable in the sense that that the level of prediction is significantly better than chance. Clinically, however, this level of prediction seems unlikely to be useful. A substantially higher benchmark of 0.8 was adopted to highlight measures might generate clinically useful predictions.

To generate ROC curves for each SDQ scale, the community sample was compared with the most relevant clinical group. For four of the SDQ scales - the total difficulties scale, the total impact scale, the peer problems scale and the prosocial behaviour scale – the comparison was between all community subjects and all clinic cases. The remaining three scales – covering emotional, conduct and hyperactivity symptoms – were judged by comparing the entire community sample with those clinic cases who had the

corresponding disorder. For example, the discriminant power of the SDQ *emotional* scale was judged by comparing all community subjects with those clinic cases who had been diagnosed as having an *emotional* disorder.

3.5 Results

Table 3.1 summarizes the ability of different SDQ scales and informants to distinguish between community and clinic subjects, as gauged by the area under a receiver operating characteristic curve (AUC). Using an AUC of 0.8 or more to identify scales that might generate clinically useful predictions, four SDQ scales seem potentially useful for predictive purposes: total impact, emotional symptoms, conduct problems and hyperactivity. In each case, the AUC was significantly greater than 0.5 ($p<0.001$). By contrast, total difficulties, peer relationship problems and prosocial behaviour did not distinguish well between the clinic and community samples.

Table 3.1 Ability of different SDQ scores to distinguish between community and clinic samples

SDQ score	*Area under curve (SE) comparing community and clinic[1] samples*		
	Parent rated	Teacher rated	Self rated
Total impact[2,3]	0.87 (0.02)	0.89 (0.02)	0.89 (0.03)
Total difficulties[2,3]	0.64 (0.03)	0.65 (0.03)	0.54 (0.06)
Emotional symptoms[2,4]	0.78 (0.03)	0.88 (0.03)	0.87 (0.04)
Conduct problems[2,5]	0.93 (0.03)	0.83 (0.05)	0.72 (0.08)
Hyperactivity[2,6]	0.92 (0.03)	0.95 (0.02)	0.92 (0.03)
Peer problems[2,3]	0.49 (0.04)	0.45 (0.04)	0.46 (0.06)
Prosocial behaviour[2,3]	0.67 (0.03)	0.64 (0.04)	0.39 (0.06)

[1] The clinic sample includes all clinic cases for total impact and difficulties, peer problems and prosocial behaviour. For the remaining scores, only clinic cases with the corresponding diagnosis are included, e.g. the AUC for emotional symptoms is for all community subjects compared with just those clinic cases who have an emotional disorder.

[2] For the community sample, N=162 for parent and teacher ratings, N=94 for self-ratings.

[3] For the clinic sample, N=99 for parent and teacher ratings, N=35 for self-ratings.

[4] For the clinic sample, N=47 for parent and teacher ratings, N=21 for self-ratings.

[5] For the clinic sample, N=16 for parent and teacher ratings, N=6 for self-ratings.

[6] For the clinic sample, N=11 for parent and teacher ratings, N=2 for self-ratings.

Did the emotional, conduct and hyperactivity scores discriminate *within the clinic sample* between patients with different sorts of disorders? This was also examined using the area under ROC curves (Table 3.2). For example, the SDQ emotional score discriminated well between patients with emotional disorders and psychiatric controls, i.e. clinic patients without an emotional disorder but with other diagnoses instead. Similarly, conduct and hyperactivity scores all discriminated satisfactorily between clinic cases with and without the corresponding type of disorders. All AUCs represented a level of prediction substantially better than chance ($p<0.001$).

Table 3.2 Ability of different SDQ scores to distinguish between disorders within the clinic sample

SDQ score	Comparing clinic cases with and without:	*Area under curve (SE)*		
		Parent rated	Teacher rated	Self rated
Emotional symptoms[1]	Emotional Disorder	0.84 (0.04)	0.86 (0.04)	0.89 (0.05)
Conduct problems[2]	Conduct Disorder	0.94 (0.03)	0.84 (0.05)	0.81 (0.07)
Hyperactivity[3]	Hyperactivity Disorder	0.87 (0.05)	0.91 (0.03)	0.89 (0.05)

[1] *For parent and teacher ratings, N=52 for clinic subjects without an emotional disorder and N=47 for clinic subjects with an emotional disorder; the corresponding totals for self ratings were N=14 and N=21.*

[2] *For parent and teacher ratings, N=81 for clinic subjects without a conduct disorder and N=18 for clinic subjects with a conduct disorder; the corresponding totals for self ratings were N=29 and N=6.*

[3] *For parent and teacher ratings, N=88 for clinic subjects without a hyperactivity disorder and N=11 for clinic subjects with a hyperactivity disorder; the corresponding totals for self ratings were N=33 and N=2.*

Since the results reported so far showed that the most discriminating SDQ scores in a Bangladeshi sample were those covering impact, emotional symptoms, conduct problems and hyperactivity, these were the only SDQ scores included in the Bangladeshi predictive algorithm. Current diagnostic criteria (**World Health Organization 1994**) and previous experience with the SDQ (**Goodman 1999; Goodman et al. 2000b**) suggest that child

psychiatric disorders are best diagnosed from the combination of symptom and impact scores. Consequently, families of ROC curves generated by combining SDQ impact and symptom scores were reviewed in order to establish which symptom-impact combinations provided a suitable basis for 'suspecting' psychiatric disorder. Multi-informant predictions were devised to combine SDQ information from all available informants. A hyperkinetic disorder was only 'suspected' when criteria were met according to at least two informants – reflecting the emphasis on pervasiveness in contemporary diagnostic criteria for hyperkinesis (**World Health Organization 1994**). By contrast, emotional and conduct disorders were suspected when the criteria were met for any one informant. The SDQ criteria for suspecting psychiatric disorders in a Bangladeshi sample are summarized in Table 3.3.

Table 3.3 Criteria for suspecting psychiatric disorder on the basis of individual SDQ scores

Predicting from:	Predicting to:			
	Emotional Disorder	Conduct Disorder	Hyperkinesis	Any Psychiatric Disorder
Parent SDQ only	PI ≥ 2 & PE ≥7	PI ≥2 & PC ≥6	PI ≥ 2 & PH ≥ 8	Meets any of the criteria to the left
Teacher SDQ only	TI ≥ 2 & TE ≥6	TI ≥ 2 & TC ≥ 6	TI ≥ 2 & TH ≥ 8	Meets any of the criteria to the left
Self-rated SDQ only	SI ≥2 & SE ≥8	SI ≥ 2 & SC ≥ 6	SI ≥ 2 & SH ≥ 7	Meets any of the criteria to the left
Multi-informant SDQ	≥1 of the above	≥1 of the above	≥ 2 of the above	Meets any of the criteria to the left

Designation of SDQ scores:
First letter: P = parent, T = teacher, S= self-report;
Second letter: I = Impact score, E = emotional symptoms score, C = conduct problems score, H = hyperactivity score.

The summarized SDQ criteria for suspecting psychiatric disorders in a Bangladeshi sample form the basis for the simple paper-and-pencil algorithm that is presented in Figure 3.1.

Figure 3.1 Algorithm for converting multi-informant Strengths and Difficulties Questionnaire (SDQ) into diagnostic predictions

PARENT SDQ ---------->	Emotional Conduct Hyperactivity Impact	0 1 2 3 4 5 6‖ 7 8 9 10 0 1 2 3 4 5‖ 6 7 8 9 10 0 1 2 3 4 5 6 7‖ 8 9 10 0 1‖ 2 3 4 5 6 7 8 9 10	If Emotional ≥ 7 AND Impact ≥ 2 Then tick here ☐	If Conduct ≥ 6 AND Impact ≥ 2 Then tick here ☐	If Hyperactivity ≥ 8 AND Impact ≥ 2 Then tick here ☐
TEACHER SDQ ---------->	Emotional Conduct Hyperactivity Impact	0 1 2 3 4 5‖ 6 7 8 9 10 0 1 2 3 4 5‖ 6 7 8 9 10 0 1 2 3 4 5 6 7‖ 8 9 10 0 1‖ 2 3 4 5 6 7 8 9 10	If Emotional ≥ 6 AND Impact ≥ 2 Then tick here ☐	If Conduct ≥ 6 AND Impact ≥ 2 Then tick here ☐	If Hyperactivity ≥ 8 AND Impact ≥ 2 Then tick here ☐
SELF SDQ ---------->	Emotional Conduct Hyperactivity Impact	0 1 2 3 4 5 6 7‖ 8 9 10 0 1 2 3 4 5‖ 6 7 8 9 10 0 1 2 3 4 5 6‖ 7 8 9 10 0 1‖ 2 3 4 5 6 7 8 9 10	If Emotional ≥ 8 AND Impact ≥ 2 Then tick here ☐	If Conduct ≥ 6 AND Impact ≥ 2 Then tick here ☐	If Hyperactivity ≥ 7 AND Impact ≥ 2 Then tick here ☐
			If ≥ 1 of the above are ticked then: SUSPECT EMOTIONAL DISORDER Tick here ☐	If ≥ 1 of the above are ticked then: SUSPECT CONDUCT DISORDER Tick here ☐	If ≥ 1 of the above are ticked then: SUSPECT HYPERACTIVITY DISORDER Tick here ☐
			If any of these specific disorder are ticked then SUSPECT PSYCHIATRIC DISODER Tick here ☐		

For each category of rater, and also for the combined multi-informant prediction, it was possible to examine how many community and clinic subjects met the relevant 'suspicion' criteria. As shown in Tables 3.4a to 4d, the proportion of subjects meeting these criteria was substantially higher for clinic cases with the relevant diagnosis than for community or psychiatric controls (all differences significant on chi-square testing, with the exception of non-significant differences in the rates of conduct disorder judged solely from self-report SDQs). Predicting hyperkinesis by combining SDQ information from all informants, the proportion meeting 'suspicion' criteria was 3% for the community sample and 82% for the clinic cases – representing an odds ratio of 141 (relative risk=27). The corresponding odds rations (relative risks) were 60 (14) for conduct disorders, 29 (8) for emotional disorders and 16 (4) for any disorder.

Table 3.4 Predicting disorder from cut-offs on SDQ scores

a) Predicting **hyperkinesis** from:	Proportion meeting SDQ "suspicion" criteria		
	Community sample	Clinic cases without hyperkinesis	Clinic cases with hyperkinesis
Parent SDQ only	6.2% (10/162)	23.9% (21/88)	72.7% (8/11)
Teacher SDQ only	3.7% (6/162)	18.2% (16/88)	90.9% (10/11)
Self-rated SDQ only	4.3% (4/94)	12.1% (4/33)	100% (2/2)
Multi-informant SDQ	3.1% (5/162)	13.6% (12/88)	81.8% (9/11)

b) Predicting **conduct disorder** from:	Proportion meeting SDQ "suspicion" criteria		
	Community sample	Clinic cases without a conduct disorder	Clinic cases with a conduct disorder
Parent SDQ only	3.1% (5/162)	6.2% (5/81)	77.8% (14/18)
Teacher SDQ only	2.5% (4/162)	7.4% (6/81)	38.9% (7/18)
Self-rated SDQ only	1.0% (1/94)	3.5% (1/29)	16.7% (1/6)
Multi-informant SDQ	5.6% (9/162)	12.4% (10/81)	77.8% (14/18)

c) Predicting **emotional disorder** from:	Proportion meeting SDQ "suspicion" criteria		
	Community sample	Clinic cases without an emotional disorder	Clinic cases with an emotional disorder
Parent SDQ only	8.6% (14/162)	13.5% (7/52)	51.1% (24/47)
Teacher SDQ only	6.2% (10162)	15.4% (8/52)	74.5% (35/47)
Self-rated SDQ only	4.3% (4/94)	14.3% (2/14)	57.1% (12/21)
Multi-informant SDQ	10.5% (17/162)	19.2% (10/52)	83.0% (39/47)

d) Predicting **any psychiatric disorder** from:	Proportion meeting SDQ "suspicion" criteria	
	Community sample	All clinic cases
Parent SDQ only	13.0% (21/162)	59.6% (59/99)
Teacher SDQ only	9.9% (16/162)	67.7% (67/99)
Self-rated SDQ only	7.5% (7/94)	48.6% (17/35)
Multi-informant SDQ	17.9% (29/162)	77.8% (77/99)

3.5.1 Prevalence for power calculation

As judged by the predictive algorithm based on multi-informant SDQs, the rate of psychiatric disorders for 4 to 16 years children in the stable urban communities was just 17.9%, but was 13% by parent SDQ, and 10% by teacher SDQ. This predictive prevalence rate was only 7.5% by self rated SDQ (Table 3.5). The combined (multi-informant SDQ) prevalence of 18% was assumed for power calculation for the main stage study.

Table 3.5: Prevalence by the basis of prediction on

Basis of prediction	prevalence N=162 (%)
Multi-informant SDQ predicts 'caseness'	17.9
Parent SDQ predicts 'caseness'	13.0
Teacher SDQ predicts 'caseness'	9.9
Self SDQ predicts 'caseness'	7.5

3.6 Discussion

The principal purpose of this preliminary study was to establish whether a main stage study was feasible and how best that could be carried out. For that, four main aims were investigated: (1) Strengths and Difficulties Questionnaire (SDQ) as a valid screening measure for mental health problems in Bangladeshi children; (2) establish locally derived SDQ cut-offs and simple analytic methods; and (3) prevalence for power calculations; (4) ascertainment methods

3.6.1 Strengths and Difficulties Questionnaire (SDQ) as a valid screening measure for mental health problems in Bangladeshi children

a) It was possible to discriminate between community subjects and clinic patients on the basis of the SDQ scales covering total impact, emotional symptoms, conduct problems and hyperactivity. By contrast, peer problems, prosocial behaviour and total difficulties did not discriminate well between community and clinic samples. The impact score was generally high for all clinic patients, whatever type of psychiatric disorder they had. By contrast, the emotional, conduct and hyperactivity scores were more specific to the type of psychiatric disorder. This specificity could potentially be useful if SDQs are obtained prior to the initial clinical assessment. For example, children whose parent and teacher SDQ scores suggest that they are at a particularly high risk of a hyperkinetic disorder could be allocated to a hyperkinesis clinic or to a professional with particular expertise in this domain.

b) Particularly in a developing country with very limited access to child mental health professionals, there is a pressing need to develop simple screening mechanisms to help ensure that referrals to child mental health services are appropriate. It would be unrealistic to develop screening mechanisms that depended on complex or expensive measures that have to be administered by highly trained staff. A brief questionnaire such as the SDQ

represents a relatively cheap and easy screening mechanism, though two provisos deserve mention. The first proviso is that the questionnaire needs to be read out to respondents who are not literate. The second proviso is that predictions based on multi-informant SDQs – particularly the combination of parent and teacher SDQs – miss fewer disorders than do SDQs obtained from just one category of rater. Both these provisos increase the amount of work required to screen with adequate sensitivity and specificity.

3.6.2 Establish locally derived SDQ cut-offs and simple analytic methods

In the developed world, the results of SDQ questionnaires can be turned into diagnostic predictions by complex scoring algorithms that required computers (Goodman et al., 2000b). This need for computer-assisted scoring is acceptable in countries where primary health care teams and child mental health teams routinely have access to computers. In less economically developed countries, by contrast, dependence on computer-assisted scoring would seriously limit the value of a screening programme. Like the measure itself, the system for generating scores and predictions needs to be cheap, simple and portable. The diagnostic algorithms presented in this paper were developed with this need in mind. Simple transparent overlays are available to facilitate the scoring of individual SDQs. There is also a simple paper-and-pencil scheme for converting these scores into diagnostic predictions.

3.6.3 Power Calculations

Extrapolating from SDQ results obtained in this preliminary study, the likely rate of psychiatric disorders was around 18%. This rate was applied to the power calculations for the main stage study. Consultation with expert service planners established that a confidence interval (CI) of ± 2.5% around an estimated prevalence of 18% would be precise enough for service planning. The required sample size was then calculated as follows:

CI of ± 2.5% → SE of 2.5%/1.96 = 1.27%

SE of a population = $\sqrt{p(1-p)/n}$

$0.0127=\sqrt{0.18 \times 0.82/n}$

$0.000161=0.18 \times 0.82/n$

$n=917$

The researcher chose, on this basis, to aim for a sample of 917 children in the main study.

3.6.4 Ascertainment methods

From this preliminary study it was evident that School based ascertainment was good enough for the gathering community sample of children population for the epidemiological study. It was important to note that this was true for children living in a middle income urban area, because of school attendance. This will certainly be true in high income urban area. However, in the poor urban slum area, many children who could not be approached via school lists because of school non-attendance and thus were out of this preliminary study. It can be assumed that this noninclusion will also be happened in rural area. Therefore, the household search in the community was needed for proper recruitment from different contrasting areas. So recruitment via house hold is turned out to be the only way to identify a sample in Bangladesh and therefore, is a comprehensive method for obtaining child and adolescent samples from three contrasting areas (urban, rural, slum) for epidemiological surveys of child mental health. Overall, household based ascertainment is the proved trusted method and was the method adopted in the main stage study of this research.

3.6.5 Limitations

Several limitations of the current study deserve mention. Firstly, the children from both the clinic and community sample were predominantly drawn from families of medium socio-economic status – poor by the standards of the developed world, but not generally subject to the extreme poverty, illiteracy and marginalization experienced by many severely disadvantaged families in Bangladesh. It is to need to be mentioned here, this point was successfully examined in the main study that how well the SDQ worked when applied to children at the greatest social and economic disadvantage. A second limitation is that the children from the community sample were not subsequently assessed in more detail, using standardised interviews and "blind" raters to generate psychiatric diagnoses. This point was addressed in the pilot study. Here, it it should be pointed out that SDQ predictions have been shown to agree well with independent psychiatric diagnoses in a large British community sample (**Goodman et al 2000a**), but it remains to be seen if the same is true for Bangladeshi community samples. A final limitation is that using a translated English questionnaire to screen for problems in Bangladesh can only be valid to the extent that the chosen indicators of psychopathology transcend differences in language and culture

(**Patel & Winston 1994**). The fact that the SDQ is as predictive of psychiatric diagnosis in Dhaka as in London supports the cross-cultural robustness of the SDQ (**Goodman et al. 2000b**). It is also encouraging that conceptually similar screening questionnaires for adult mental health problems are culturally robust (**Beusenberg & Orley 1994; Furukawa & Goldberg 1999; Bhui et al. 2000**). Nevertheless pilot study and main study of this thesis examined the accuracy of predictions based on the SDQ and identified those Bangladeshi children who were considered to have emotional or behavioural problems.

3.6.6 Conclusion

The preliminary study provides evidence that the Bangla version of the SDQ predicts psychiatric diagnosis accurately enough to be of value in screening and assessment. Based on the preliminary study, the pilot study was deigned to generate a valid measure on structured diagnostic interview. The potential effectiveness of the translated Strengths and Difficulties Questionnaire (SDQ) in screening phase was further evaluated with the internationally accepted structured assessment to carry out a two-phase assessment in the main study. The pilot study also aimed to test and modify measures of risk factors for child psychiatric disorders that they could be used in Bangladesh. The details of the pilot study have been described in the next chapter.

CHAPTER 4

PILOT STUDY

This chapter comprises the pilot study and is divided into six parts: (1) Introduction and objectives; (2) Setting; (3) Method; (4) Analytic strategy; (5) Results; (6) Discussion and interim conclusions. The preliminary study was needed to inform the design to be adopted in the main stage study that will be presented in the following chapters.

4.1 Introduction and objectives

In the absence of sound epidemiological studies in child and adolescent psychiatry in Bangladesh, some core methodological issues remained unclear at the time this study began. As mentioned before (Chapter 2) there is no reported epidemiological studies performed in Bangladesh and the measures adopted were neither previously tested nor validated.

Another methodological issue that remained open regarded survey measures to be adopted in the developing world. Given the cultural and social-economic characteristics such as higher rates of illiteracy, lower levels of understanding and local idiomatic expressions, epidemiological studies in developing countries should not adopt instruments and measures from developed countries straightaway, without looking at their suitability for the developing world.

The purpose of doing a pilot study was to clarify the methodological issues presented in the previous paragraphs with the following objectives:

- To develop measures of child psychopathology suitable to the cultural and socio-demographic characteristics of Bangladesh.
- To generate preliminary validity data on diagnostic interview
- To test and modify measures of risk factors for child psychiatric disorders that they could be used in Bangladesh.

4.2 Settings

For the investigation of ascertainment methods and approximate prevalence a community sample was necessary, whereas to determine appropriate measures, a combination of community and clinical samples was needed.

4.2.1 Clinical sample: Bangabandhu Sheikh Mujib Medical University Hospital,Dhaka

The clinical sample for the piloting was obtained from the Child Mental Health Clinic of the Department of Psychiatry, Bangabandhu Sheikh Mujib Medical University (BSMMU) hospital, a tertiary hospital located in the heart of Dhaka city. The Department of Psychiatry of the University has Child and Adolescent Psychiatry Wing, a specialist service in Child and Adolescent Psychiatry which offers both outpatient and inpatient treatments. The Child Mental Health Clinic is a multidiscplinery outpatient clinic of the department of Psychiatry of the University hospital headed by the researcher (a child and adolescent psychiatrist). The hospital is part of the BSMMU, the only postgraduate medical university of Bangladesh and receives referrals from Dhaka as well as from other parts of Bangladesh when of scientific interest. This clinic is the first formal child and adolescent mental health service of Bangladesh. Moreover, there is a provision that any problematic children can be brought in this clinic directly without any formal referral. Therefore, increasing number of child and adolescent are brought to this clinic to receive comprehensive and high quality of service. On an average, 7-10 new cases attended every day during the period of the study. Therefore, a fairly representative sample of the children population of Bangladesh is possible to be obtained from the clinic. A wide range of patients with different child and adolescent mental disorders attend in the clinic. They are developmental disorder like autism and other pervasive developmental disorders, mental retardation, wide varieties of emotional disorder including somatoform disorder, and behavioural disorder mainly hyperkinetic disorder and oppositional defiant disorder and conduct disorder

4.3 Methods

4.3.1 Design

This was a cross-sectional study using a one-phase sampling and one-phase assessment.

4.3.2 Ethical approval and consent procedures

The study was approved by the ethical committees at the Bangabandhu Sheikh Mujib Medical University, Dhaka. A consent form (**Appendix 5 and 10**) was used for this study.

4.3.3 Ascertainment: sampling frame

Patients register of the Child Mental health Clinic was the sampling frame.

4.3.4 Sampling strategy

A clinical sample of one hundred 5-17 year olds was obtained by approaching the families of consecutive new referrals to the clinic. A total of 116 families were approached in order to obtain a total of 100 participating families. The research team administered both screening and detailed measures of psychopathology for all 100 subjects, who were also independently assigned a diagnosis by the clinic blind to the research assessment. Parents and teachers provided information on all 100 children. Of the 49 children who were aged 11 or more, 45 (92%) provided information about themselves. The research diagnostic assessment was repeated an average of 3 weeks later by a different interviewer on a randomly chosen 25 subjects.

4.3.5 Measures

The two main measures of psychopathology were the Strengths and Difficulties Questionnaire (SDQ) **(Goodman 2001; Goodman et al. 2000b; Goodman 1997)** and a suite of psychiatric interview, the Development and Well-Being Assessment for Children and Adolescents (DAWBA) **(Goodman et al. 2000a)**. These were translated, back-translated and adapted over the course of preliminary study and piloting and were then used in the main stage study in three contrasting areas. The battery of measures also

included a socio-economic questionnaire – Household Questionnaire, which is not the focus of this thesis. The measures are available in full in the Appendix of this thesis in both languages English and Bangla.

Strengths and Difficulties Questionnaire (SDQ)

As described in Chapter 3, the screening measure of psychopathology was the Bangla translation of the Strengths and Difficulties Questionnaire (**Appendix 1 and 6**). The Strengths and Difficulties Questionnaire (SDQ) asks about 25 attributes, some positive and some negative. The items cover emotional symptoms, conduct problems, hyperactivity, peer problems, and prosocial behaviours. A brief impact supplement asks whether the respondent thinks that the child has a problem, and if so, inquires further about overall distress, social impairment, burden and chronicity (**Goodman 1999**). The informant version of the SDQ can be completed in about five minutes by parents or teachers of children aged 4 to 16 (**Goodman 1997**). The SDQ has been shown to be of acceptable reliability and validity, performing at least as well as lengthier and longer-established alternatives (**Goodman 2001**). The web site at www.sdqinfo.com provides more information on the SDQ plus downloadable versions of the questionnaires in many languages. The versions of the SDQ used in this study were the informant versions including impact supplements (**Goodman 1997; Goodman 1999**). The Bangla translation of the SDQ has been validated for Bangladeshi children in the preliminary study.

Development and Well-Being Assessment (DAWBA)

The research assessment of psychiatric disorder was carried out using the Bangla translation of Development and Well-Being Assessment (**DAWBA; Goodman et al., 2000a**) **(Appendix 2 and 7)**. The DAWBA is a 34-page structured psychiatric interview with additional open-ended questions **(Goodman et al. 2000a)**. It was designed to combine some of the best features of structured and semi-structured measures for a British nation-wide epidemiological survey of common emotional and behavioural disorders in children and adolescents (**Meltzer et al. 2000**). The semi-structured measures are often too expensive for epidemiological surveys, requiring a great number of clinically trained interviewers. On the other hand, the fully structured interviews can provide less convincing results with rare symptoms over-reported because the respondents may have

not understood the questions. The DAWBA overcomes this problem adopting a structured interview with open-ended questions when parents can describe the problems with their own words. Further more, open-ended questions in survey instruments give parents an opportunity to mention worries not covered by a structured measure. This will help to identify the culture-specific concerns of parents that lie outside the measures initially developed in developed countries (**Hackett 1999b**).

DAWBA uses a mixture of closed and open questions about child psychiatric symptoms and their *impact* (i.e. resultant distress and social impairment). It is administered as an interview to parents and as an abbreviated questionnaire to teachers. The interviews are administered by lay interviewers who also record verbatim accounts of any reported problems, but do not rate them. Experienced clinicians subsequently review both the verbatim accounts and the answers to structured questions before assigning Axis 1 diagnoses according to ICD-10 criteria (**World Health Organization 1993**). Previous studies have provided evidence for the validity of the DAWBA in English (**Goodman et al. 2000a, Ford et al. 2003**) and Bangla (**Fleitlich-Bilyk and Goodman 2004**).

Translation of DAWBA

The various versions of DAWBA were translated into Bangla by the researcher of the study. The back-translation was carried out by a panel of seven expert persons with excellent proficiency in English and Bangla having Bangladeshi cultural and linguistic background who made independent back translations. The results of these back translations were compared. All the back translations were similar or very close to the original. There were few discrepancies between the original and back translations. These discrepancies were resolved by panel discussion. Few problematic words and items were identified and minimized by replacing words with more suitable and culturally accessible alternatives and restructuring such items with widely accessible meanings that would readily be understood by all Bangla-speakers irrespective of their social or educational backgrounds. A series of analyses and evaluations were made to reach the final form of translation. Then all the versions of DAWBA was experimentally administered to the 15 families of the Child Mental health Clinic of the Bangabandhu Sheikh Mujib Medical University (BSMMU) hospital, Dhaka, carefully selecting those cases with mixed socoidemographic and cultural backgrounds to evaluate the applicability of DAWBA and level of understanding of DAWBA among the respondents, considering that similar type of people would be the possible respondents for DAWBA in Bangladeshi population. The

comments of the respondents about the DAWBA and interviewers experience and comments were recorded by the interviewer. These were evaluated and a series of analyses were made to reach the final form of translation. It was found that the respondents could able to understand what was being asked irrespective of the level of literacy and other socio-economic and cultural background. In this experimental application, again some words were identified to be hard to understand equally by the respondents which permitted the final adjustments to the wording of the questions so as to ensure the understanding of Bangladeshi people in general. Feedback from the respondents and interviewers guided the final adjustments in wording to maximise comprehensibility and cultural appropriateness. The ultimate culturally sensitive translation of DAWBA in Bangla was obtained for each version through this translation exercise.

The Household Questionnaire (HHQ)

The Household Questionnaire (HHQ), a socio-economic questionnaire was developed in Bangla and administered, covering sociodemographic factors including social class, social capital, and a range of other risk factors included parents' attitude and behaviour towards their children, parents' believe about punishment, supervision and reward, measures of physical health and mental age of the child. The measure was applied to all subjects, tested and finalized. The HHQ are available in full text in the Appendix of this thesis **(Appendix 3 and 8)**.

4.3.6 Procedure

Sampling

The aim was to recruit 100 subjects. For this purpose, a consecutive series of 110 new referred patients aged 5-16 years were required to select during the period between July and December, 2002. The nature of the study and the entirely voluntary nature of participation were explained orally and through clearly written information and fully informed consent were obtained for all cases to participate themselves, children and teachers. Great emphasis was placed on the fact that their assessment and treatment will not be affected in anyway if they choose to participate or not to participate in the study. All these families were agreed to take part in the study and gave their consent. The information was collected from all these cases. Of these, 16 cases were excluded because of failure to get teacher and parent SDQ or considerably incomplete filled up SDQs, or

nonavilability of the cases for DAWBA interview. The recruitment process was continued until a total 100 families with an indexed child had been recruited for the study. Therefore, present sample consists of 100 cases. Participation rates were assessed along with reasons for nonparticipation when found was recorded.

The screening measures (SDQ) and HHQ were administered to all the cases by the one set of members of the research team when they seen first. The questionnaires were read out when the respondents' literacy skills were insufficient for them to complete the questionnaires directly. The teacher's questionnaires were distributed to the parents with an approach of participating latter addressing the teacher and were collected from them after completion.

Then a detailed measure of psychopathology (DAWBA) assessment was carried out for all the 100 cases by another set of members of the research team. The assessment of SDQs and DAWBAs were made independently (blindly) by the members of the research team. Participating parents were interviewed for DAWBA in a separate room of the department of psychiatry of the University (BSMMU).The 11 to 16 years olds were interviewed in an interview room of the department separately.

The clinical assessment and psychiatric diagnoses were made for all cases from the time of the initial assessment in the child mental health outpatient services of the department of psychiatry of the University hospital by the researcher who was the senior child psychiatrist and in charge of that child mental health outpatient clinic. Psychiatric diagnoses were assigned clinical diagnoses based on both the operational criteria of ICD-10 **(World Health Organization 1993)** and DSM-IV **(American Psychiatric Association 1994)** independently and recorded in the separate sheet. The clinical diagnosis was rated at the time of the initial assessment and subsequent series of assessment whenever required on the basis of the Clinic's standard diagnostic protocol which consisted of semistructured case assessment sheet for detailed clinical case history, mental status examination, and diagnostic formulation. All diagnoses were phenomenologically based, drawing on the extensive information on symptoms and resultant impairments gathered from multiple informants. Clinic diagnoses were made according to the operational criteria of ICD-10 and were allocated blind to the DAWBA assessment and diagnosis. These diagnoses were made blind to the children's SDQ scores or DAWBA assessment.

Subsequently, 25 subjects were readministered the SDQs and DAWBAs after an interval of 3 weeks for test-retest reliability by different members of the team.

All data were coded and entered onto a computer, cross-checked followed by double checked by separate set of data entry personnes. HHQ (including SRQ score) data entered into a created Microsoft Excel spreadsheet and were imported for statistical analysis. SDQ and DAWBA data entered into a specially prepared data entry program with the facilities of analysis and diagnostic coding and clinical rating. The data on clinical diagnosis of the subjects were entered separately into a 'diagnostic profile' Excel spread sheet.

Rating

All open-ended comments were translated from Bangla into English, and DAWBA diagnoses were assigned by Professor Robert Goodman, who is an experienced child psychiatrist who has previously carried out or supervised over 20,000 clinical ratings using the DAWBA. The research diagnoses made by the Professor Robert Goodman were assigned blind to the diagnoses assigned by the clinic (and were not discussed with the researcher since he had generated the clinic diagnoses). To avoid small cell sizes for subsequent analyses, diagnoses were grouped into emotional disorders (including anxiety, depressive and obsessive compulsive disorders), hyperkinesis, and behavioural disorders (including oppositional-defiant and other conduct disorders).

4.3.7 Data Collection team

The data collection was performed by a team composed by 3 non clinical, trained interviewer, and 3 medical graduates. The researcher recruited, trained and supervised the team, including interviewers and data processors. The researcher himself continuously supervised by two supervisors.

4.4 Analytic Strategy

4.4.1 Participation rates

To examine participation rates based on subjects ascertained via patients register.

4.4.2 Sample characteristics

To examine the sociodemographic characteristics of the sample.

4.4.3 Validity of Bangla DAWBA

Though the DAWBA has been validated in English **(Goodman et al. 2000a)**, it was not necessary to carry out an extensive validation exercise as if the measure were entirely novel. The validity of the translated version was primarily tested by examining the correspondence between research and clinical diagnosis in the clinic sample (external validity).

4.4.4 Reliability of Bangla DAWBA

The reliability was evaluated through a small number of interviews (25) that were performed twice for each subject (parent, teacher and self version when applicable) within an interval of 3 weeks on an average.

4.4.5 Reliability of Bangla SDQ

To investigate inter-rater reliability, comparing means of SDQ total scores subscale score for the three different informants (parent, Teacher, Self) obtained from a small sample of 25 subjects, in two occasions (Time1 and Time 2) with an aimed interval of three weeks, performing a kappa chance correlations .

4.5 Results

4.5.1 Participation rate

A total of 116 families were approached in order to obtain a total of 100 participating families. The participation rate 86 % (100 of 1160).

4.5.2 Sample characteristics

Of the total 100 cases, 71 cases were between 5 to 10 year of age and the rest 29 cases were 11 to 16 year of age. The mean age of the clinic sample was 11.3 years (SD 3.3 years). Of the total cases, 59 were male (Table 4.1 and Table 4.2)

Table 4.1: Distribution by age group

Age group	Number
5-10	71
11-16	29
Total	100

Table 4.2: Gender distribution

	Number
Male	59
Female	41
Total	100

4.5.3 Validity of Bangla DAWBA

Of the 100 clinic patients, 93 were assigned a DSM-IV diagnosis by the clinic. Emotional, hyperkinetic and behavioural disorders were diagnosed by the clinic in 55, 32 and 21 children respectively, with some children being assigned diagnoses from more than one group. The validity of the DAWBA diagnoses was assessed by examining their level of agreement with the clinic diagnoses – the DAWBA and clinic diagnoses were completely independently of one another, being based on separate assessments made by different interviewers and then rated by different clinicians. The results are shown in Table 4.3. For example, the second row of data shows the level of agreement for getting an ICD-10 emotional disorder: 55 children had an emotional disorder according to the clinic, of whom 53 were also diagnosed as having an emotional disorder by the DAWBA (sensitivity 96%); conversely, 45 children did not have an emotional disorder according to the clinic, of whom only 1 child had an emotional disorder according to the DAWBA (specificity 98%). Kappa

values of between 0.63 and 0.94 (fourth column of table) reflect a high level of agreement between DAWBA diagnoses and clinic diagnoses. Sensitivities ranged from 63-94% (third column of table) and specificities ranged from 81-100% (100% minus second column of table). The DAWBA was more likely to diagnose behavioural disorders than the clinic, whereas the reverse was true for hyperkinesis.

Table 4.3 Comparison between DAWBA diagnosis and clinic-assigned diagnosis for the clinic sample (N=100)

ICD-10 Diagnosis	Proportion assigned that diagnosis by DAWBA		Kappa (SE)	Significance (continuity-corrected)
	For those **not** given that diagnosis by clinic	For those given that diagnosis by clinic		
Any	0% (0/7)	97% (90/93)	.81 (.11)	X^2=57.4, 1df, p<.001
Emotional	2% (1/45)	96% (53/55)	.94 (.03)	X^2=84.6, 1df, p<.001
Hyperkinesis	4% (3/68)	63% (20/32)	.63 (.09)	X^2=38.2, 1df, p<.001
Behavioural	19% (15/79)	100% (21/21)	.64 (.08)	X^2=43.8, 1df, p<.001

4.5.4 Test -retest Reliability of Bangla DAWBA

Table 4.4 presents test-retest agreement for DAWBA diagnoses when the assessment was repeated an average of 3 weeks later by different interviewers. Kappa values of between 0.50 and 0.91 reflect a moderately high level of agreement, though it is important to note that the standard errors are large because the repeated assessments were carried out on a random sample of only 25 children. With only 12 children aged 5-10 in the test-retest sample, it was not appropriate to generate kappa values for this age range separately.

Table 4.4 Test-retest agreement on diagnosis for clinical sample(N=25) administered the DAWBA initially and 3 weeks later

ICD-10 Diagnosis	Proportion assigned that DAWBA diagnosis on retest		Kappa (SE)	Significance (Fisher exact, 2-sided)
	For those not given that DAWBA diagnosis initially	For those given that DAWBA diagnosis initially		
Any	50% (1/2)	100% (23/23)	.65 (.32)	.08
Emotional	0% (0/8)	94% (16/17)	.91 (.09)	<.001
Hyperkinesis	15% (3/20)	100% (5/5)	.69 (.16)	.001
Behavioural	10% (2/20)	80% (3/5)	.50 (.22)	.04

4.5.5 Test -retest Reliability of Bangla SDQ

From the total 100 clinic cases, the repeated assessments were carried out on a random sample of only 25 children with only 12 children aged 10-16 in the test-retest sample. Table 4.5 presents test-retest agreement for SDQ diagnoses when the assessment was repeated an average of 3 weeks later by different interviewers. Kappa values of between 0.52 and 0.90 reflect a moderately high level of agreement.

Table 4.5 Test-Retest agreement of SDQ scales for clinical sample (N=25) administered the SDQ initially and 3 weeks later

SDQ scale	Time1*Time2 correlations		
	Parent (N=25)	Teacher (N=25)	Youth (N=13)
Total difficulties	.78	.72	.73
Emotional symptoms	.70	.67	.76
Conduct problems	.77	.64	.70
Hyperactivity-inattention	.78	.71	.69
Peer problems	.59	.59	.52
Prosocial behaviour	.66	.57	.67
Impact	.90	.88	.74

*All correlations significant, p<0.01

4.5.6 SDQ prediction

As presented in Table 4.6, overall prediction (N=100) of SDQ for the psychiatric disorder were found from the repeated assessment indicate good test-retest correlations and kappa values.

Table 4.6 SDQ prediction from Test-Retest agreement of SDQ scales for clinical sample (N=25) administered the SDQ initially and 3 weeks later

SDQ scale	Time1*Time2 correlations		
	Kappa	SE	P
Any disorder (unlikely, possible, probable)	0.53	0.07	0.000
Emotional disorder (unlikely, possible, probable)	.70	.67	.76
Conduct disorder (unlikely, possible, probable)	.77	.64	.70
ADHD disorder (unlikely, possible, probable)	.78	.71	.69

4.5.7 Finalizing the variables of HHQ

The variables of the HHQ were clustered and analysed. These were sociodemographic factors including social class(affluent score), social capital, and a range of other risk factors included parents' attitude and behaviour towards their children, parents' believe about punishment, supervision and reward, measures of physical health, and mental age. The result of analysis caused several changes in the questions. The HHQ had minor adaptations and some entirely new items that emerged from the field work and findings in the pilot study. The finalized version of HHQ obtained after the pilot study was used in the main study. The analysis of these factors will not be the focus of this thesis.

4.6 Discussion

4.6.1 Measures

The pilot study generated both methodological and substantive findings of interest. Methodologically, the study provided the first evidence for the validity of the Bangla version of the Development and Well-Being Assessment (DAWBA)

Psychometric properties of the Bangla translation of the DAWBA

Within the clinic sample, there was substantial agreement between the DAWBA diagnosis and the independent diagnosis made by clinicians. The DAWBA generated more diagnoses of behavioural disorders while the clinicians generated more diagnoses of hyperkinesis – in the absence of a true 'gold standard', we currently have no way of telling whether the DAWBA or the clinic was more accurate in this respect. It was not possible to compare the DAWBA diagnoses with diagnoses generated with previously validated measures since no such measures exist in Bangla. In the longer term, it will be important to establish how well DAWBA diagnoses predict prognosis and response to treatment since this sort of predictive validity is of great practical relevance to clinicians. Test-retest reliability was satisfactory. On the basis of the available evidence from this study and from previous studies of the DAWBA in developed and developing countries (**Goodman et al. 2000a; Fleitlich-Bilyk and Goodman 2004**), the DAWBA would appear to be a suitable assessment tool for both clinical and research purposes in Bangladesh.

Psychometric properties of the Bangla translation of the SDQ

The first validation study of the SDQ in Bangla demonstrated in a *clinic* sample that there was substantial agreement between the SDQ 'caseness' predictions and an independent psychiatric diagnosis (**Goodman et al. 2000b**). The preliminary study was the second validation study of the SDQ that established demonstrated in a *clinic* sample that there was substantial agreement between the SDQ 'caseness' predictions and an independent psychiatric diagnosis. The pilot study confirms that the screening properties of SDQ in a sample are good enough to warrant use of the SDQ as the first phase of a two-phase design. The main stage study confirmed these validation studies by demonstrating that SDQ 'caseness' prediction in diverse community samples by independent psychiatric assessment that was presented in the next chapter.

For all of these reasons the researcher decided that a classical two-phase study, starting with a questionnaire screening phase would be most appropriate in Bangladesh. A two-phase study **(Newman et al. 1990)** is only more economical then a one-phase study that administers the definitive measure to everyone, if the screening measure is quick, cheap and discriminating, or if the disorder in question is rare. All of these apply to a study in Bangladesh of common child mental health problems using the SDQ in Bangla.

4.6.2 Conclusion

Based on the pilot study, the main study was designed to carrying out a two-phase assessment using the validated Bangla version of SDQ and DAWBA.

CHAPTER 5

MAIN STUDY: METHODOLOGY

This chapter describes the methodology of the main study which was based on the findings from the preliminary study and pilot study. After obtaining the valid measures of child psychopathology including final version of Household Questionnaire from piloting with necessary modifications of the measures, the main study was conducted in the same community areas where pilot study had been carried out. The data were collected during the period between January and April, 2004. Ethical procedure was similar to that of pilot study.

5.1 Introduction and objectives

In chapters 2 and 3 the current absence of sound epidemiological studies in child and adolescent mental health in Bangladesh was discussed. The preliminary study and pilot study presented in chapter 3 was designed to establish sampling strategy, measures and prevalence for power calculations.

As regards sampling strategy, the preliminary study showed that school-based search was good enough to get a fairly representative community sample of children identified by school lists. However, this method failed to include those children who did not attend school though they were relatively smaller in size. To avoid under- sample of children from very poor families who do not attend school the best way of ascertained technique should be household search which was adopted in the main study. As regards measures, the screening questionnaire (SDQ) was less discriminating and more time consuming than it is in developed countries. Extrapolating from SDQ results obtained in Mohammadpur, Dhaka, and the likely rate of psychiatric disorders was around 18%. Predictions based on multi-informant SDQs potentially provide a cheap and easy method for detecting children in the developing world with significant mental health problems. The potential effectiveness of any such screening program was further evaluated in the pilot study. It was also detected that the structured interview (DAWBA) worked well as judged by its agreement with independent clinical diagnosis.

The Main study aimed:

- To confirm the validation of screening measures
- To generate prevalence estimates of the common child mental health disorders among 5-10 year old in Bangladesh

- To determine how prevalence varies with population group (e.g. rural, moderately prosperous urban, urban slum)
- To identify possible variables as a guide to search the correlates of child psychiatric disorder in future
- To establish appropriate ascertainment technique for epidemiological surveys of child mental health in Bangladesh

Based on the preliminary and pilot study findings, the main study was designed to recruit 917 children through household survey and carrying out a two-phase assessment using the SDQ in first phase and DAWBA in second phase.

5.2 Settings

The main stage study was set in three contrasting areas located in the Dhaka district and Dhaka City.

5.2.1 Dhaka District

Dhaka District is one of the main district of Dhaka division with an area of 1463.60 sq km, is bounded by Gazipur and Tangail districts on the north, Munshiganj and Rajbai districts on the south, Narayanganj district on the east, manikganj district on the west (Figure 5.1). Annual average temperature maximum 34.5°C, minimum 11.5°C; total rainfall 1931mm. Dhaka district was established in 1772. The district consists of 5 upazilas, 21 thanas, 3 municipalities, 77 unions, and 863 villages. The upazilas are Dhamrai, Dohar, Keraniganj, Nawabganj and Savar.

Figure 5.1: Map of the Dhaka District

Total households are 1,788,520.Average size of household is 4.82 (rural 4.92, urban 4.92).Type of households are 92.71 % dwelling units (30.55% owned, 57.80% rented, 4.97% rent free), 1.45% institutions and 5.85% others. Population is 8,618,700; male 4,795,300(55.15%), female 3, 823,400(44.85%); sex ratio is 125.4. Among the zilas of the country, the highest density is in Dhaka zila. Population density per sq. km is 5887; Muslim 92.72%; Hindu 6.50% and others 0.78%.Pouplation 18 years or below is 3,193,660.Urban population is 7901700 (91.7% of the total population. Literacy rate of 7+ years is 64.26%; male 69.27%, female 57.86%.Urban literacy rate is 65.98%(male 70.80%),female 59.56%) and rural literacy rate is 44.56%(male 47.905, female 41.40%) **(Bangladesh Bureau of Statistics 2003).**

5.2.2 Dhaka City

Dhaka, the megacity and the capital of Bangladesh is within the administrative area of Dhaka district stands on the bank of the river Buriganga. It consists of seven principal electoral and administrative areas known as thanas and 14 auxiliary.Each Thana is again divided into smaller electoral units called Wards **(Bangladesh Bureau of Statistics 2003)**.Dhaka city has 130 wards. It has an area of 304 sq km. The size of population of Dhaka megacity is 10,712,206; male 56.62%, female 43.38%. Population density of Dhaka per sq km is 17691.

Figure 5.2: Maps of the Dhaka City

The population growth of Dhaka stands at 56.5% in the last decade which is very high. During the last decade an additional population of 3,868,077 was added to the city. This additional people has created pressure on the utility services such as water, sewerage,

electricity, gas, housing, transport, education and other amenities of life. This resulted in an adverse effect on the urban environment where a large number of people settled in slums and squatters. Scarcity situation of water, gas electricity, housing etc. has further deteriorated over the last decade **(Bangladesh Bureau of Statistics 2003).**

Dhaka municipality was established in 1864 and was turned into a Town Committee in 1960. The name of the Town Committee was changed to Dhaka Municipality in 1972. It was turned into a Municipal Corporation in 1983. Finally it was elevated to City Corporation in 1991. Dhaka is the capital city of Bangladesh. Average literacy is 65.98%; male 70.87% and female 59.56 %.**(Bangladesh Bureau of Statistics, 2003**). Main occupations are service 31.49%, commerce 23.08%, transport 8.53%, agriculture 7.62%, agricultural labourer 4.41%, wage labourer 2.71%, industrial labourer 1.87%, , construction 2.76%, house renting out 2.23%, and others 15.3%**(Asiatic Society of Bangladesh, 2003).**

Historical events: Once upon a time Dhaka was ruled by the Hindu Kings. The Pala and the Sena dynasties ruled Dhaka for many years. It was not until early fourteenth century when the Muslim rulers began to come to Bengal. This city was built in the seventeenth century and bears a long tradition through Pathan, Mughal and British period. Dhaka was made the capital of Bengal in 1608 and Islam Khan renamed Dhaka as Jahangirnagar after the name of Emperor Jahangir. In the eighteenth century Dhaka lost political importance when Murshid Quli Khan transferred the capital of Bengal from Dhaka to Murshidabad. But Dhaka never lost its commercial importance. It became capital of East Bengal & Assam Province during period of divided Bengal from 1905 to 1912 during British rule. It was a provincial city during Pakistani control. After the independence in 1971 it became increasingly important, rapidly modernised with constant increase of its area and population and became the largest metropolitan city of Bangladesh.

Dhaka is very closely related with the politics of the post 1947 political history. Mentions may be made of language movement of 1952, six-point programme of 1966, mass upsurge in 1969, historic speech of Bangabandhu Sheikh Mujibur Rahman on 7 March 1971, signing the document of surrender of Pakistan army on 16 December 1971, etc.

5.3 Study area

The main study was carried out in three contrasting areas of Bangladesh: a representative rural area (Boxnagar Union of Nawabganj Upazilla of Dhaka District), a mixed but stable middle-income urban area (Mohammadpur Thana of Dhaka city) and a very deprived urban area (slums of Mohammadppur Thana of Dhaka city).The photos of the study area is viewed in the the anneure **(Annexure 11).**

The site for the main study needed to include all three of the groups that make up Bangladesh: Urban poorer, Urban mixed but middle-income and Rural mixed but poor. As mentioned in chapter 1, this is because in most of the country, the population divides into these 3 main groups. At this point a representative and deliberate contrasting sample is needed to encompass all three populations. The reasercher wanted to make sure that the measures and ascertainment methods worked for all 3 groups. The site also needed to be small enough to facilitate contact with local authorities. Overall, the areas were chosen after informal local consultation as representative exemplars of that sort of area (rural, urban, slum).

5.3.1 Rural study area

Nawabganj Upazila (Figure 5.3) where the rural sample was obtained from Boxnagar Union. Nawabganj Upazilla is one of the Upazilla of Dhaka District, with an area of 244.81 sq km. It is bounded by Singair upazila on the north, Dohar upazila on the south, Keraniganj, Sirajdikhan and Sreenagar upazilas on the east, Harirampur and Manikganj Sadar upazilas on the west. Main rivers are Dhaleshwari, Ichamati and Kaliganga **(Asiatic Society of Bangladesh 2003).**

.Nawabganj town, the administrative centre of the Upazilla is located 30 km from Dhaka city. The communication between Dhaka city and Nawabganj Upazila by road is not straight forward. There is ferry to cross the river between two places. The availability of ferry causes variation of time to reach Nawabganj from Dhaka or to come Dhaka from Nawabganj. On an average, it takes 3-4 hours for one way journey by public transport and 2-3 hours by car.

Nawabganj upazila was established in 1974. The upazila consists of 14 unions, 327 villages and 57,760 households. According to the population census 2001,population of

the Upazilla is 2,93,740; male142940 (49.31%), female 1,50,800 (50.69%); Muslim 77.19%, Hindu 20.74%, Christian 2.04%, Buddhist 0.01% and others 0.02%. The population of 18 years or below is 124,680(42.45%) and the population between 5-10 years is 32,312 (11%) **(Bangladesh Bureau of Statistics 2003).**

Figure 5.3: Rural Study Area- Nawabganj Thana

Average literacy rate is 34.5%; male 38.5% and female 30.6%. Literacy rate 7+ years is 54.08% Educational institutions include college 7, high school 24, junior high school 6, madrasa 9, government primary school 90, non-government primary school 19. Main occupations are agriculture 22.1%, agricultural labourer 13.27%, wage labourer 4.5%, fishing 2.9%, weaving 4.37%, industry 1.3%, commerce 12.2%, service 18.54%, construction 2.98%, house renting out 3.45%, and others 14.39%.Total cultivable land 18208.01 hectares, fallow land 6272.76 hectares; single crop 47.5%, double crop 37.8% and treble crop land 14.7%. Among the peasants 29% are landless, 30% small, 32% intermediate and 9% rich peasants; cultivable land per head is 0.07 hectare.

Reasons for selection

Boxnagar Union of Nawabganj Upazilla was selected for this study because of its relatively more rural character than other Unions of Nawabganj. This union is 3.4 km from Nawabganj town and 35 km from Dhaka city, with an area of 8.43 sq km. Boxnagar Union consists of 16 villages with 2743 households. Population of the Union is 14,797; male 7123, female 7674.Population of 5-10 year children is 1,628 (11%).Its inhabitants are mainly farmers and therefore relatively impoverished. In contrast some were businessmen

and comparatively rich. Most of the families in this area have already been there for some generations. This union was purposively selected for the sample because villages of this union are more representative of rural population in terms of mixed economic, sociodemographic cultural, geographic nature and degree of urban influence of rural areas of Bagladesh in general. Moreover, manageable sample size could be ensured from this area with the help of the support of the local peoples

5.3.2 Urban study area

Mohammadpur Thana (**Figure 5.4**), where the stable urban sample was obtained Mohammadphur is one thana of the western part of Dhaka city bounded by Mirpur and Kafrul thanas on the north, Hzaribagh thana on the south, Tejgaon and Dhanmondi thanas on the east, Savar upazila on the west. It has an area of 12.14 sq. Km. According to the Population Census 2001,population of Mohammadpur Thana is 456,300; male 244,800(53.65%), female211,500 (46.35%); Muslim 92.87%, Hindu 6.73%, others 0.4%; population density per sq km is 27346.The population of 18 years or below is 165,540 (36.28%).The population of 5-10 year old is 16,554 (10 %). The total number of households is 97240. The area is divided into 11 Wards, of almost equal area and population **(Bangladesh Bureau of Statistics, 2003).** Area authorities have good records of households and population chiefly for the purpose of elections.

Average literacy is 52.7%; male 56.1% and female 48.7%. Literacy of the 7+years is 63.54%. Educational institutions are college 7, medical college 2, government high school 3, non-government high school 10, government primary school 4, non-government primary school 10, English medium school 10. Main occupations are service 32.91%,commerce 22.11%, transport 16.29%, wage labourer 2.95%, industry 1.95%, construction 3.67%, renting out 2.85% and others 17.27%.Manufactories include Garments industry, glass factory, oil mill, brick factory, ice factory, shoe factory, etc. Cottage industries are approximately 100 including goldsmith, tailoring, and handicrafts. Main exports are Ready made garments and handicrafts. Health centres include Government hospital 6, private hospital and clinic 7, considerable number of NGO operated hospitals **(Asiatic Society of Bangladesh 2003).**

Mohammadphur is rather a modern prosperous area compared to the older part of Dhaka city, and was formed about fifty years ago. The area is residential in nature. Inhabitants of this Thana are considered as national gathering, having people from all over the country. They are mainly service holders, small businessmen, professionals of middle economic

class. Houses of the main residential area were mostly of 300 sq. metres on an average, with one or two-storied structure. However, the trend for multi-storied building is rapidly increasing. All of these houses have electricity, gas and water supplies. The area is under the coverage of Government health Service and the people have access to the wide range of health care facilities of the capital. Education facilities are fairly adequate and children's school enrolment is almost hundred percent. Almost all children are under cover of immunisation.

Reasons for selection

Moammadphur is chosen for this study because is a residential area by nature. This area represents the place of residence of the permanent inhabitants. People from almost all parts of the country live in this area. Therefore the population is fairly representative of the distribution of general population though the area is not representative of Bangladesh in general because of its urban nature. The urban characteristics of this area in terms of socio-economic status, type of economic activities, housing pattern, living conditions and educational facilities compare well with the urban areas throughout the country and therefore are fairly representative of urban areas for the purpose of this study.

The majority of the population in this area are literate and almost all school-age children attend schools. Therefore, it would be easier to apply the measures of the survey. The distribution of households is more homogenous compared to other parts of the city. The area has comprehensive and updated electoral list of population records which was proved to be helpful in identifying households for the selection of sample.

After the critical analysis of the experience of several field visits along with gathered information from reliable sources, we selected a mixed but stable middle income urban area (Ward 41) for the urban sample of this study. The population of this Ward is 38,124. The population of 5-10 year old is 3,812 (considering 10 % of the population).

Figure 5.4: Mohammadpur Thana-The Urban Study Area

5.3.3 Slum study area

Ring Road- Beribandh Slum of Mohammadpur (**Figure 5.5**), where the poorer urban slum sample was obtained, is a relatively recent but stable urban slum area. This slum is located in the administrative area of Mohammadpur thana. It is situated in the outskirt of the main residential area of Mohammadpur. The slum is largely populated. Its population is 36,048 (7.90% of the total population of Mohammadpur Thana); male 58.30%, female 42.70 %(**Asiatic Society of Bangladesh 2003**).There is no reliable data on other information on this slum. From the source of data of Mohammadpur, the calculated population of 18 years or below is 13,078 (considering 36.28%).The population of 5-10 year old is 3,605 (considering 10 %).The children population of slum will certainly be higher as calculated. The density of the population is more and population of 18 years and below are assumed to be much higher proportion than that of the main residential area of Mohammadpur and the literacy rate is certainly lower. Its population is composed mostly by working class families, therefore poor, very poor. They are mainly floating population came from different areas of the country who were landless, lost their houses by flood, lost their work and came to the Capital with the hope of changing their fortunes. Like many slum areas, Ring Road-Beribandh slum is built on illegally occupied land both side and in

between Ring Road (Road surrounded the main Mohammadpur Residential Area) and Beribandh (City flood protection Dam). Its houses are built of precarious materials, usually, bamboo, wood, tin, cement fibre, partial break wall or, in poorest areas, jute stalk, sack, straw, cardboard, plastic, bamboo and hay. Some houses may have some sort of improvised flooring. Whole families will typically occupy one or two rooms inside the house. Most of them have to give money for their dwelling either in form of rent to the legal owner of the land or in form forceful subscription to the local gang leaders. Sewage run in hand cut open gutters on the land. Electricity and water are illegally drawn from the public networks. Regarding occupation, males are mainly rickshaw puller, day labour, worker of the small industry, petty shop keeper, mechanics, vender and self employed. Some are low paid service holder. Besides housewives, considerable numbers of women of the slum are also working. Their main occupations are made servant, garment worker, petty business, and cottage industry worker. Like other slums, the slum of Mohammadpur are also the heaven of business of drugs of abuse and crimes and slum people are used in drug trafficking and related purpose. They are also prey of local gang leaders and live in very insecure and uncertain life. The area is deprived of the urban facilities in all aspect.

The numbers of Children of the slum go to school are not reliably recorded. It has been observed that trend of school attendance are increasing. The schools of the slum are mainly run by Non-government organisations working in this area for the purpose of their socio-economic activities. Some schools are well organized. However, other schools are partially organized with inadequate teachers, lack of school building, irregular learning program. Children of the slum are also working as house servant, day labour, garment worker, and worker of small industry. They are supposed to be used for criminal purpose.

Reasons for selection

Ring Road-Bari Bandh slum of Mohammadpur are selected because it is relatively stable slum area of Dhaka city having typical characteristics of slum. In Bangladeshi context it is difficult to get secured access in the slum to conduct research activities. This slum was accessible for the research team due to availability of adequate local support. As a very recognized slum, majority of the adult population are included in the electoral list. They are enlisted in the updated electoral register because of the political interest.

All the areas of the slum are basically under the administrative area of the Wards of the Mohammadpur Thana and divided accordingly. We selected those areas of the slum fall into the ward 42,44,46, 47 because these parts of the slum are very much representative

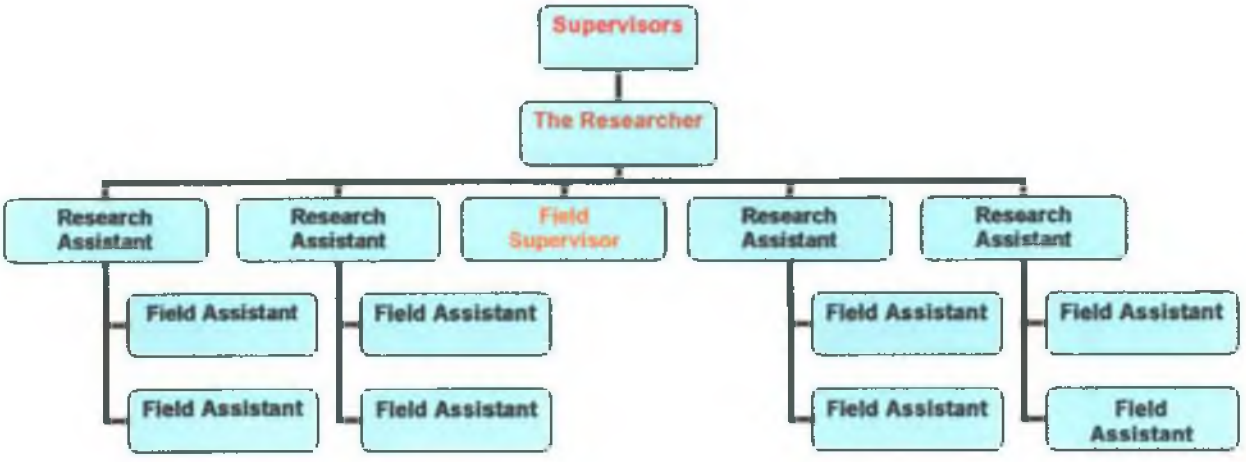
of slum character and adult population are included in the updated electoral register that was necessary to find the householdes to select the sample of the very deprived urban area.

Figure 5.5: Ring Road-Beribandh Slum of Mohammadpur

5.4 The research team

The interviewers who took part in the preliminary study remained in the team (three medical graduates and three non-clinical trained interviewers).Further thirteen non-clinical interviewer and five part-time medical graduates joined the team. The medical graduates and non-clinical interviewers were designated as 'research assistant' and 'field assistant' respectively. The data entry was done twice by two different members of the team. It was possible to keep up with the data collection schedule, but it demanded a great deal of continuous prompting and motivational strategies. The researcher was intensively supervised by two experienced senior professors of psychiatry .The researcher himself trained and closely supervised the team, including weekly meetings, case-discussions and management of data entry. As illustrated in Figure 5.2, the organogram of the research team functioned with two-way communication and network system.

Figure 5.6: Organization of the Research team



The team was assisted by senior teachers of the department of psychiatry having experience in child psychiatry. Other staffs of the department also involved the management and implementation of the research and gave logistic supports.

The team was extended by taking support of the author of the DAWBA (Professor Goodman). The researcher was also received intensive training on clinical rating of computer based DAWBA diagnoses by the concerned trainer headed by the author of DAWBA, at the Institute of Psychiatry, London. He also performed clinical rating of computer based DAWBA diagnosis, discussing with the researcher. Consultation with experience researcher at home and abroad was taken when felt. Experienced statisticians ware also involved for data analyses.

The organized activates of the research team is reflected in the photos **(Annexure 11)**.

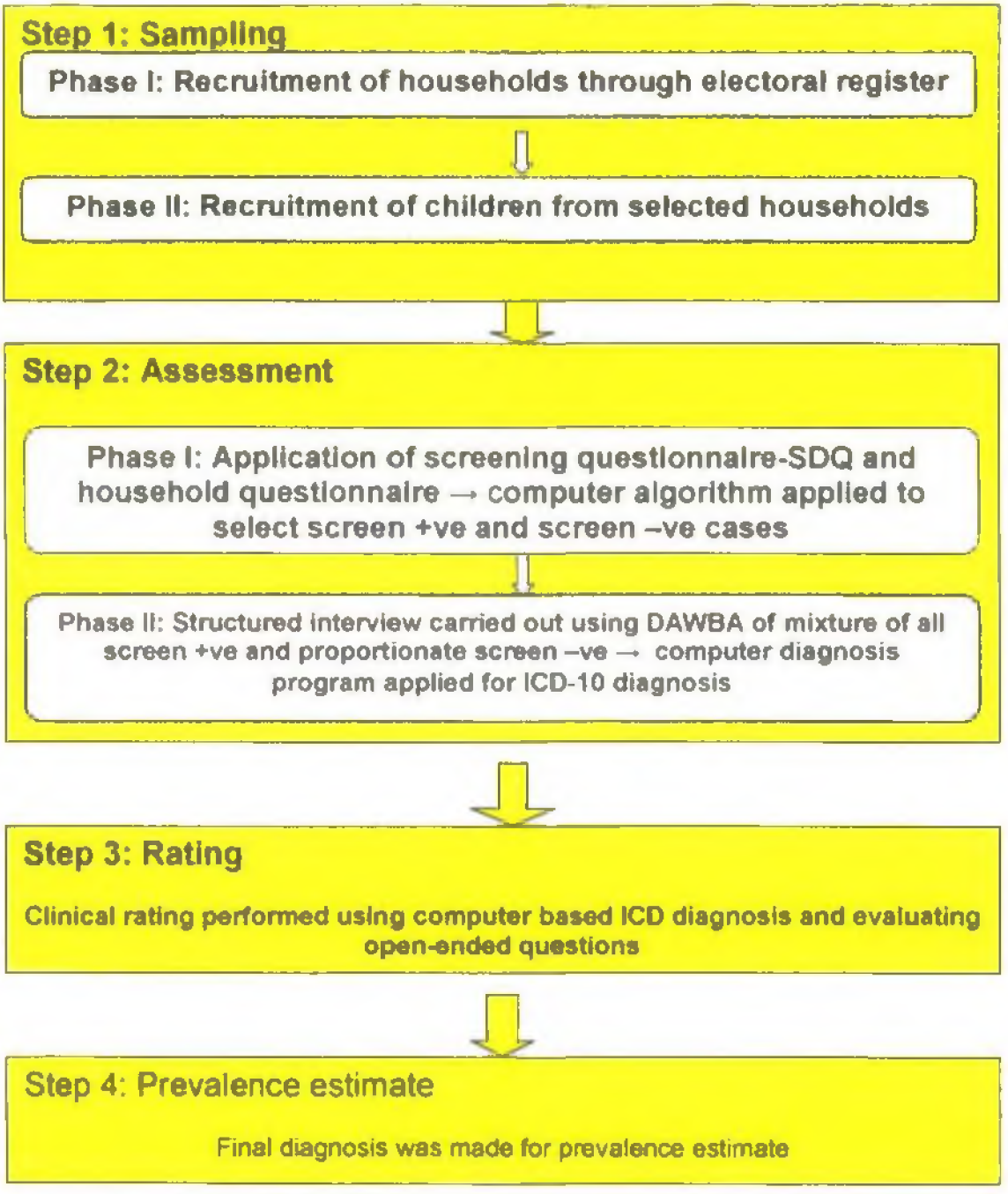
5.5 Design and sampling strategy

5.5.1 Design

A quantitative cross-sectional design was applied in this study, with two-stage sampling and two-phase assessment.

5.5.2 Methodological steps

As shown in Figure 5.7 the key methodological steps were based on the study design.



5.5.3 Total sample size

Likely prevalence was judged from multi-informant SDQs, using a predictive algorithm that has previously proved relatively accurate in the developed and developing world (**Goodman et al 2000b and c**).

The sample consists of 922 children aged between 5 and 10 years old. The sample size was based on power calculations that assumed that the overall prevalence of psychiatric disorder would be around 18% (as judged from the preliminary study, Chapter 3) and that a 95% confidence interval (CI) of ± 2.5% would be precise enough for service planning expectation from health authorities. This implies a standard error (SE) of 1.27%. The sample size was calculated as follows **(Altman 1991)**.

CI of ± 2.5% → SE of (2.6% /1.96) = 1.33%

$SE=\sqrt{p(1-p)/n}$
$0.0133=\sqrt{0.18 \times 0.82/n}$
$0.000177=0.18 \times 0.82/n$
$n=834$

Defining sub-sample sizes:
In the study areas, 5-10 old children population is around 11% of the total population in rural area, and around 10% in urban area. The percentage of 5-10 year old children population is assumed to be much higher in slum area. Therefore, it was decided to oversample from all the areas and more oversampled in slum area in order to have enough statistical power to compare areas.

The preliminary study in Mohammadpur found that the prevalence rate was around 18%. The researcher wanted to ensure that enough children were included in each area to have sufficient power to detect a difference in prevalence in areas, i.e. rural, urban, and slum. Power calculations in STATA version 6.0 (**StatCorp. 1997**) were run to estimate the sample sizes for three-sample comparison of proportions. For 82% power, the estimated sample size was 223 subjects in each of the three groups. According to these estimates, the researcher decided to aim for a sample size of 250 for rural and urban area and remaining 350 for the slum area (Table 5.1).

Table 5.1 Sub-sample sizes

Area	estimated total 5-10 yr. old population	Planned sample size	Planned sampling percentage	Actual sample size	Actual sampling percentage
Rural	1,628	250	15.36	293	18.00
Urban	3,812	250	6.56	280	7.34
Slum	3,605	350	9.71	349	9.68
Total	9,045	850	9.40	922	10.20

5.5.4 Sampling Strategy

The sampling strategy included random selection of households in first stage followed by random selection of one child from each household. The updated final electoral register was used for the selection of the households. This register is a unified and reliable record that includes the households of the study areas--- urban, rural and slum area. Household based sampling was adopted. This ascertainment technique was taken to obtain a representative sample of children and minimizing the possibilities of missing of children who were not attending school. Further, door to door family visit strategy was taken to ensure the desired data collection in Bangladeshi context as postal or any other correspondence is not workable because reply from the respondents by post is less likely expected for this type of study. Moreover, there were incomplete postal addresses recorded in the register of the many households in slum area and also in rural area. Families were randomly selected from the electoral list. The families were visited to see if they included any children aged between 5 and 16 years. Written letter and oral information about the study to participate in the study were provided to the parents by the members of the research team through home visit before being asked whether they were willing to participate in the research and whether they gave their permission for their child and child's teacher to take part in the research procedure. The request letter to participate in the study along with information about the study was also provided to the teachers. The nature of the study were explained to all the families and the children's teachers and oral information were well clarified, particularly for families who could not read or could not read well. The voluntary nature of participation was also explained. Participation rates were assessed along with reasons for nonparticipation when given were recorded. Every third family was taken. If for any reason, the third family was not available, the next was taken then again the third was taken. The families who agreed to participate in the study and gave their consent, one child of either sex within the age range of 5-16 years was randomly (lottery method) selected from each households. To minimize the possibilities of

undersampled children from large families, a 50% probability of inclusion of the child from small families, with just one child in the age range was ensured by deciding randomly.

5.5.5 Two phase assessment

The assessment was carried out in a two-phase. In the preliminary study it was proved that the parent and teacher versions of the screening measure (SDQ) did discriminate well between clinical and community samples, which also contributed for the decision of adopt a two-phase design for this study. Adopting a two-phase design, this study was likely to achieve a proved representative ness and less exhaustive, less time consuming and importantly cost effective rate and fewer cases with missing data.

5.6 Ethical approval and consent procedures

The study was approved by the ethical committees at the Bangabandhu Sheikh Mujib Medical University, Dhaka. A consent form was designed which was accompanied of a letter of introduction that contained motivational and mentioning ethical matters **(Appendix 5 and 10)**; both were read and explained to the parent when they were illiterate.

5.7 Inclusion / exclusion criteria

All children of households recognized through the electoral register aged 5 to 10 years old and who were living in study areas were eligible for inclusion in the study. Active parental consent was required before a child could be considered for inclusion in the study. Even after giving their consent, there were a few parents who could not subsequently be interviewed – since the parent interview is a crucial part of the diagnostic assessment, and since parents provided practically all the information about relevant risk factors, we only included children in the sample when parents not only consented but also completed their interviews.

There were no exclusion criteria.

5.8 Sampling

Two-stage sampling was carried out in the main study. In the first stage households were sampled randomly in each area and in the second stage, when a participating family included more than one 5-10 year old, just one of these children was chosen at random. Although we were generally aiming for about one child in three, we approached slightly more families to balance the proportion of children whose families could not be located and did not consent. This ascertainment technique was taken to obtain a representative sample of children and minimizing the possibilities of missing of children who were not attending school. Further, door to door family visit strategy was taken to ensure the desired data collection in Bangladeshi context as postal or any other correspondence is not workable because reply from the respondents by post is less likely expected for this type of study. Moreover, there were incomplete postal addresses recorded in the register of the many households in slum area and also in rural area.

5.8.1 The sampling frame

The sampling frame elected for this study was electoral register. This decision was based on the finding from the preliminary study that considerable children did not attend school and the household search in the community was needed for representative recruitment from different contrasting areas in Bangladesh. In developed countries such as the UK, there are health or social benefits registers that, in general, contain almost all children living in a certain area. In Bangladesh, a similar register could be the vaccination file in each local government clinic. However, there is no guarantee that all children are indeed taken to the clinic, particularly in more deprived areas. An alternative could be the official register of births, but there is no regular governmental procedure to check whether all parents are registering their children and in any case, many families will have moved into and out from any given area since the time their children were born. Another possibility would be the electoral register. As mentioned in chapter 1, Government system of Bangladesh is parliamentary democracy. National election happens in every five years. Election for local governments and municipal authorities happen round the year. Bangladeshi people are very concern about election and to exercise their voting rights. They usually keen to include their name in the electoral register. Election commission maintains good record of voters. Therefore, the best ascertainment method for identifying

children that should be included in a representative community survey is selecting families from electoral register. For this study, the updated final electoral register was used for the selection of the households. This register is a unified and reliable record that includes the households of the study areas--- urban, rural and slums area. Household based sampling was adopted.

5.8.2 Recruitment of the subjects and procedure

The selected families were visited to see if they included any children aged between 5 and 16 years. Written letter and oral information about the study to participate in the study were provided to the parents by the members of the research team through home visit before being asked whether they were willing to participate in the research and whether they gave their permission for their child and child's teacher to take part in the research procedure. The request letter to participate in the study along with information about the study was also provided to the teachers. The nature of the study were explained to all the families and the children's teachers and oral information were well clarified, particularly for families who could not read or could not read well. The voluntary nature of participation was also explained. Participation rates were assessed along with reasons for nonparticipation when given were recorded (This will be described in Chapter 6). Every third family was taken. If for any reason, the third family was not available, the next was taken then again the third was taken. The families who agreed to participate in the study and gave their consent, one child of either sex within the age range of 5-16 years was randomly (lottery method) selected from each households. To minimize the possibilities of undersampled children from large families, a 50% probability of inclusion of the child from small families, with just one child in the age range was ensured by deciding randomly.

In stage one, all the 950 children selected randomly screened by parent and teacher version of SDQ. Parents completed the questionnaire at home and teacher completed the questionnaire at school. Where it appeared that school teacher was not in a position of giving adequate information (new teacher, new school, new class session, irregular or infrequent school attendance, poorly organized school with very few teachers and irregular school days and little learning activities, where home teacher knew the child best as there is exiting trained of engaging the child with home tutor), home teacher filled up the questionnaire at there own places. The HHQ (along with SRQ) was also completed for each subject by the parents at this stage. All data were entered onto a computer were

verified initially by cross checking and double checking. The HHQ data were entered into a Microsoft Excel spreadsheet. The SDQ data entered into an entry program for SDQ with the facilities of analyses of the possible cases, using the multi-informant SDQ computer algorithm. Thus the positive cases and a random sample of the negative cases were selected for further study. This selection of cases was done by an expert independently (who was not involved with clinical diagnoses) to avoid any possibility of biasness.
In the first phase of the study, screening questionnaires and sociodemographic measures were obtained on all subjects. Parents provided SDQs and sociodemographic information on all subjects, but teacher SDQs were only obtained on 88% of rural children, 98% of urban children, and 65% of slum children (chi-square=132.4, 2df, $p<0.001$), partly reflecting differences in school attendance.

In the second stage, detailed psychiatric assessment for the cases selected by computer based predictive algorithm by using DAWBA was carried out between March and April, 2004.For this purpose, two groups of children were included on the basis of mixture of positive cases and randomly children population for rest of the sample. In total, DAWBA assessments were carried out for 208 subjects (70 subjects from rural area, 60 subjects from urban area, and 78 subjects from slum area) by well trained different group of members of the team from the stage one who were blind to the SDQ scores. Parents were interviewed at home. Teacher version of DAWBA were distributed to the teachers and collected from them by the interviewers. Parents of the children with suspected psychiatric problems were informed about the problem and those children were referred to the appropriate child mental health services for clinical help and support. That was done for the interest of those children and their families as part of the ethical components.

It should be mentioned here that we had limited resources. This meant that it was only possible to carry out DAWBA assessments on one in five subjects; the families invited to take part in the second phase were all those whose children were screen positive in the first phase, plus a random sample of those who were screen negative (adjusting the sampling fraction for the screen negative so as to achieve an overall sampling fraction of around 20% in each of the three areas). All families invited to take part in the second phase agreed to do so. Table 1 shows how many screen-positive and screen-negative subjects from each area were assessed in the second phase. The DAWBA assessment involved a parent interview in all cases, but teacher DAWBAs were only obtained on 94%

of rural children, 97% of urban children, and 69% of slum children (chi-square=27.2, 2df, p<.001).

All the DAWBA data were entered onto a computer with crossed and double checking and further verified independently. Special data entry programs were used for computer based diagnostic coding and clinical rating.

Subjects

The data were collected between January and April, 2004. A total of 1575 families were selected from the electoral register of the community areas: 550 families from urban area, 425 families from rural area, and 600 families from slum area. In total, 233 families (81 urban, 5 rural, and 147 slum) were not found as they moved to different places. Therefore, 1342 families (469 urban, 420 rural, and 453 slum) could be located. The families were visited to see if the households included any children aged between 5 and 10 years. Of these, 338 families (143 urban, 123 rural, 72 slum) had not at least one child of 5-10 year old. Therefore, 1004 families (326 urban, 297 rural, 381 slum) found to have at least one child between 5 and 10 year old. Of these families, 57 families (33 urban, 0 rural and 24 slum) did not agree to participate in the study. From the remaining 947 families, 947children (293 urban, 297 rural, and 357 slum) from 5-10 years age of either sex were included by random selection of one child for each family. The method of selection was similar to that of community sampling of the pilot study. Information for these children was collected. Further, 25 subjects, (13 urban, 4 rural, and 8 slum) were excluded because it was not possible to get sufficient information on the questionnaires (either due to failure to get SDQs or incomplete filled up HHQ and/or SDQ that were insufficient for analyses).Finally, 922 children (280 urban, 293 rural, and 349 slum) were included for analyses. The main reason for nonparticipation was because a considerable number of families were not found in their addresses as recorded in the electoral register due to relocation mainly from rented houses. The participatory rate of the slum area was largely influenced by their higher relocation rate. Further, some addresses of the family were difficult to locate according to the record of the electoral register. The main reason of nonagreement to take part in the study were fear of any possible bad occurrences (rubbery, claim for money by terrorists or outlaws) that caused avoidance (told by the not agreed urban families), inability to give time (told by both not agreed urban and slum families). Other reasons were that such type of study is useless expressed by the not

agreed urban families; feelings of being neglected by the society and finding no benefit, and fear of any possible botheration expressed by the not agreed slum families.

5.9 Measures

The principal measures of psychopathology were again the Strengths and Difficulties Questionnaire (SDQ) **(Appendix 1 and 6)** and the Development and Well-Being Assessment (DAWBA) **(Appendix 2 and 7)** which were tested and validated in the preliminary study and pilot study. The battery of measures also included a Household Questionnaire (HHQ) **(Appendix 3 and 8)** which consisted of socio-economic variables and the Self Reporting Questionnaire (SRQ) **(Appendix 4 and 9)** as a measure of mental health of the adult with primary responsibility for looking after the child. The measures are available in full in the Appendix of this thesis in both languages English and Bangla.

Strengths and Difficulties Questionnaire (SDQ)

As described in Chapter 3, the SDQ is brief behavioural screening questionnaire. There are three versions for different respondents: parent (or main carer), teacher and a self-completion version for youth over 11 years old. It covers four groups of symptoms: emotional, hyperactivity, social and conduct; and a fifth group of pro-social behaviours. It also enquires whether the informant thinks that there is a problem in any of theses areas and if so, what distress and social impairment is caused. The SDQ was originally published in English, but it is currently available in over 40 languages, which will allow the results of this thesis to be compared with studies in other developing and developed countries. The web site at www.sdqinfo.com provides more information on the SDQ plus downloadable versions of the questionnaires in Bangla.

Development and Well-Being Assessment for Children and Adolescents (DAWBA)

The DAWBA is a 34-page structured psychiatric interview with additional open-ended questions **(Goodman et al. 2000a)**, also described in Chapter 3. It was designed to combine some of the best features of structured and semi-structured measures for a British nation-wide epidemiological survey of common emotional and behavioural disorders in children and adolescents (**Meltzer et al. 2000**). The semi-structured measures are often too expensive for epidemiological surveys, requiring a great number of clinically trained interviewers. On the other hand, the fully structured interviews can provide less

convincing results with rare symptoms over-reported because the respondents may have not understood the questions. The DAWBA overcomes this problem adopting a structured interview with open-ended questions when parents can describe the problems with their own words. Further more, open-ended questions in survey instruments give parents an opportunity to mention worries not covered by a structured measure. This will help to identify the culture-specific concerns of parents that lie outside the measures initially developed in developed countries (**Hackett 1999b**).Improvements that emerged from the pilot study were incorporated into the DAWBA. It had only minor changes in the separation anxiety section, social phobia section, and generalized anxiety section to facilitate to proceed on other questions on this section. Two questions on religious obsession was incorporated in the obsession and compulsion section.

The DAWBA (which starts with the SDQ) and the QSE were applied to all subjects included in the sample and generated computer diagnoses for each subject. After the computer diagnosis, the programme allows a clinical rating that may or may not confirm the computer diagnosis. In order to perform this rating, , the researcher underwent through a specific training on the DAWBA rating procedures. The researcher studied the DAWBA Rating Manual, and accompanied the ratings for the British 99 Survey (**Meltzer et al. 2000**). Also, the researcher's ratings were supervised by Professor Robert Goodman, the author of the DAWBA interview. The rating consisted on reviewing information from the structured and open-end questions and re-evaluating the computer diagnoses to provide final clinical diagnoses based on DSM IV and ICD 10 diagnostic criteria for each subject. Further information on the DAWBA is available from www.dawba.com – including downloadable versions of the measures in English and Bangla as well as on-line demonstrations of the clinical rating process.

The design of the DAWBA was influenced by several related considerations already discussed in chapter 4: (1) the need to measure impact as well as symptoms; (2) the need for multiple informants; (3) the simplicity and economy of respondent-based measures and (4) the desirability of clinical review to reduce false positives and make "not otherwise specified" diagnosis.

The Household Questionnaire (HHQ)

As described in chapter 5, the Household Questionnaire (HHQ),is a socio-demographic questionnaire developed for this study in Bangla. The HHQ covers sociodemographic factors including social class(affluent score), social capital, and a range of other risk factors included parents' attitude and behaviour towards their children, parents' believe about punishment, supervision and reward, measures of physical health, and mental age. The affluence measure was obtained from a standardised Brazilian questionnaire Criterio de Classificacao Economica Brasil (**Associacao Nacional de Empresas de Pesquisa - ANEP 2000**). The HHQ had minor adaptations and some entirely new items that emerged from the field work and findings in the pilot study. The finalized version of HHQ obtained after the pilot study was used in the main study.

The Self Reporting Questionnaire (SRQ)

The Self Reporting Questionnaire (SRQ) has been developed by World Health Organization (WHO) as an instrument designed to screen for psychiatric disturbance, especially in the developing countries. The SRQ consists of 20 questions related to neurotic symptoms with simple yes/no responses. It may be used as a self administered or as an interviewer administered questionnaire. Additional 4 questions have been used with SRQ-20, to screen psychotic disorder (**Harding et al. 1980**).The SRQ is an instrument with proven reliability and validity. In addition to English, it has been translated and validated in many languages and has been used in research studies throughout the globe. The SRQ has also been translated and validated in Bangla (**Islam et al. 2000**).The validated Bangla version of SRQ-24 was used in the main study as a measure of mental health of the adult with primary responsibility for looking after the child (normally the mother).

5.10 Definition of Variables

The concepts and definitions of following variables except income group, are adopted from the concepts and definition used in the Bangladesh population census 1991 **(Bangladesh Bureau of Statistics 1994)**.

Household: Persons having relations or not, living together and taking food from the same kitchen is considered as a household. Households are divided into three categories namely, dwelling, intuitional and other.

Dwelling household: Households which are mainly used for residential purposes.

Institutional household: Hostels, hospitals, clinics, jails, barrack or orphanages where a person or group of persons spent.

Other Household: Household other than dwelling and institutional household. Mess or people livening in offices fall into this category.

Literate: A person who is able to write a letter in any language has been considered as literate.

Employed: Persons who are either (a) working one or more hours for pay and profit, or working 20 hours or more without pay in a family farm or enterprise; (b) not working but who have a job or business from which he is absent temporarily.

Unemployed: Persons who are involuntarily out of gainful employment.

Inactive: Persons who are unable to work and are out of gainful employment, such as disabled, retired, too old, students, remittance recipients, beggars etc.,

Self-Employed: A person who operates an enterprise on business on his own account or operates it jointly with others in the form of partnership. A self-employed person may or may not hire workers to assist him in his enterprises.

Geographical Area and Community level Area

Division: Largest administrative unit of Bangladesh. Divisions are made according to the geographical areas of Bangladesh.

Zila (District): Largest administration unit of Division which is comprised of Upazilas and thanas.

Upazila: administrative unit of Zila which is comprised of unions.

Thana: Administrative unit of urban area which is comprised of wards. The urban areas include magacity, statistical metropolitan area, Paurashava(municipality),district town.

Union: Smallest electoral unit of rural area which is comprised of villages.

Village: Smallest geographic area in rural areas which is known to the people as village. A village is always populated.

Ward: Smallest electoral unit of paurashavas (municipalities) and other urban areas which is known to the inhabitants as Ward.

Urban Area: Developed areas around (i) an identifiable central place where (ii) amenities like metalled roads, communication facilities, electricity, gas, water supply, sewerage, sanitation etc., usually exist, (iii) which are densely populated and a majority of the population are non-agricultural and (iv) where community sense is well-developed.

5.11 Analyses

In the main study, all open-ended comments were translated from Bangla into English, and DAWBA diagnoses were assigned by Professor Robert Goodman, who is an experienced child psychiatrist who has previously carried out or supervised over 20,000 clinical ratings using the DAWBA. The research diagnoses made by Robert Goodman(author of the DAWABA) were subsequently discussed with the researcher to ensure that cultural context had been adequately allowed for, and that diagnoses were not being assigned to culturally sanctioned variations within the normal range – a process particularly relevant to obsessive compulsive disorder, post-traumatic stress disorder and behavioural disorders.

5.11.1 Analytic Strategy

Validity of the Bangla SDQ

Within the community sample, to investigate whether a division into low and high risk on the basis of SDQ scores lead to different rates of psychiatric disorders as determined by the DAWBA.

Prevalence rates and associate risk factors

To avoid small cell sizes for subsequent analyses, diagnoses were grouped into emotional disorders (including anxiety, depressive and obsessive compulsive disorders), hyperkinesis, and behavioural disorders (including oppositional-defiant and other conduct disorders). Although children in developing countries may be referred to psychiatric clinics because they have learning difficulties or physical disorders such as epilepsy, the DAWBA diagnoses only extend to Axis 1 psychiatric disorders. Parents' open-ended comments made it clear that some of the children included in the study did have physical or learning disabilities (their presence was not an exclusion criterion), but in the absence of any standardised measure of these additional disabilities, their rate cannot usefully be reported.

Having defined the relevant areas and respective weights, the prevalence of child and adolescent psychiatric disorders were calculated. They were grouped by the main types of disorders (emotional, hyperkinetic disorders, behavioural, autism spectrum) and by individual diagnoses.

5.11.2 Statistical Analysis

Whereas the first phase was a simple random sample and did not require weighting, the second phase did require weighting to adjust for the disproportionate sampling of screen positive children. Statistical analyses were performed using the Statistics/Data Analysis Program (STATA 8) survey program, which adjusts appropriately for weighting when calculating test statistics and 95% confidence intervals.

5.12 Summary

This is a two-stage, random sample study design of 922 children and adolescents, from the general population of a three contrasting areas: a rural,a moderately prosperous urban area, and an urban slum. The sampling frame was electoral register. The family randomly selected from electoral register. The children of 5 to 10 year-olds, obtained from randomly selected families those included a 5-10 year- old from rural, urban and slum areas. The measures, a package containing questionnaire and interview, that provides computerised and clinically review psychiatric diagnosis, were translated, back-translated and adopted for the use in Bangladesh. Besides area of residence, other risk factors were investigated as part of a broader epidemiological study, but are not the focus of this thesis.

CHAPTER 6
MAIN STUDY: RESULTS

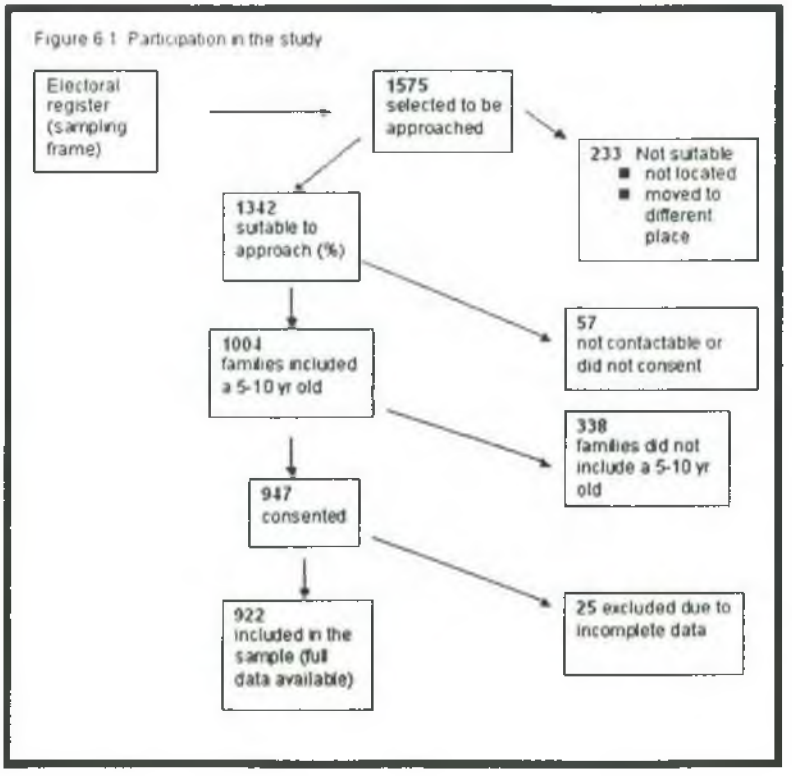
The results presented in this chapter focus on the main objectives of the present study which were estimating prevalence of the common child mental health disorders in Bangladesh with sufficient precision to be useful for service planning and establishing how prevalence varied with areas in order to help policy makers decide where to site or concentrate services. The area model adopted in this study is comprised of 3 contrasting areas. These three areas are---**'Rural':** children in rural area, **'Urban':** children in moderately prosperous urban areas and **'Slum':** children in urban areas

6.1 Participation in the main study

6.1.1 Overall participation

Having adopted electoral list as the sampling frame, a total of 1575 families were selected to be approached. Of these, 233 (14.8%) families did not located and 338 (21.5%) did not have a 5-10 year olds children. From the rest, 57 (3.6%) did not give consent and 947 (60.1%) subjects were initially included in the sample. However, the final sample included 922(58.5%) subjects, with 25 (1.6%) subjects being excluded due to incomplete data. Thus, for the analysis reported here, only 922 (58%) subjects with full data are considered as participants (Figure 6.1)

Figure 6.1 Participation in the study

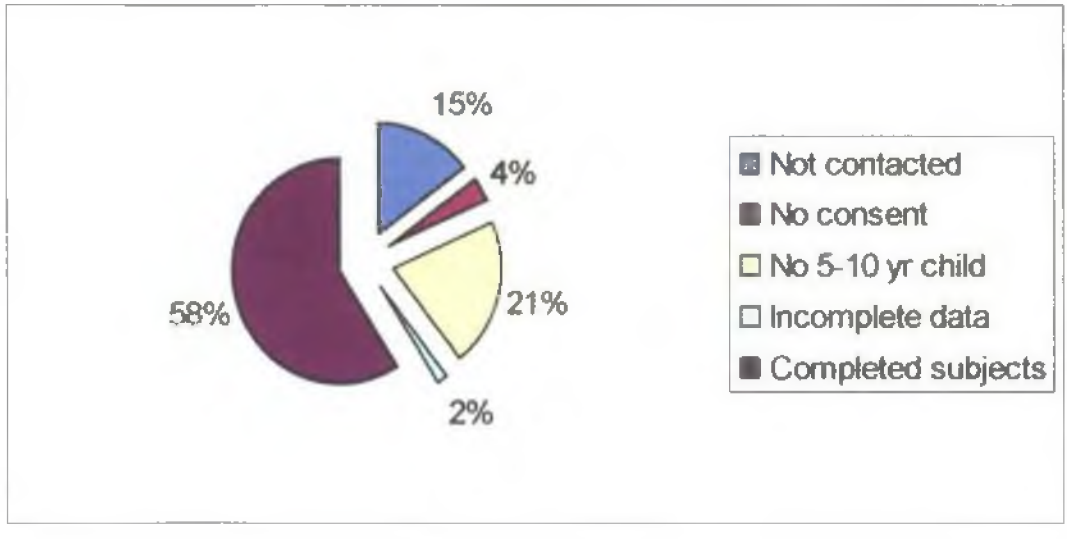


6.1.2 Characteristics of the non-included

The decision to approach 25% more than the target number of subjects (917) was based on participation rates obtained from the preliminary study. As shown in Figure 6.2, 25% of the subjects initially approached could not be included in the initial (922), but in fact, only 5.7% did not consent.

Figure 6.2 shows that subjects included with complete data were 922 (59.5%).Amongst the non-included, 233 (14.8%) corresponded to families were not located (from where the sampling frame was obtained), 338 (21.5%) families did not have 5-10 year olds, 57 (3.6%) families did not give consent, and 25 cases (2.6%) were excluded due to incomplete data.

Figure 6.2 Inclusion and reasons for non-inclusion



6.1.3 Participation in both phases of the main study

The overall participation rate for families with 5-10 year old children was 75%, ranging from 66% for the slum to 97% for the rural area (Table 6.1). Parents provided SDQs and sociodemographic information on all subjects, but teacher SDQs were only obtained on 88% of rural children, 98% of urban children, and 65% of slum children (chi-square=132.4, 2df, $p<0.001$), partly reflecting differences in school attendance.

Limited resources meant that it was only possible to carry out DAWBA assessments on one in five subjects; the families invited to take part in the second phase were all those whose children were screen positive in the first phase, plus a random sample of those who were screen negative (adjusting the sampling fraction for the screen negative so as to achieve an overall sampling fraction of around 20% in each of the three areas). All families invited to take part in the second phase agreed to do so. Table 6.1 shows how many screen-positive and screen-negative subjects from each area were assessed in the second phase. The DAWBA assessment involved a parent interview in all cases, but teacher DAWBAs were only obtained on 94% of rural children, 97% of urban children, and 69% of slum children (chi-square=27.2, 2df, p<.001)

Table 6.1 Recruitment into the first and second phase of the main survey

		Rural	Urban	Slum	Total
a	Family randomly selected from electoral register	425	550	600	1575
b	Family located by interviewers	420	469	453	1342
c	Family includes a 5-10 year old	297	326	381	1004
d	Family does not include a 5-10 year old =b-c	123	143	72	338
e	Family with a 5-10 year old agrees to participate	297	293	357	947
f	Full information obtained in first stage	293	280	349	922
g	Participation rate for first stage* =f/(a-d)	97%	69%	66%	75%
h	Screen positive (all to second stage)	12	12	35	59
i	Proportion screen positive =h/f	4.1%	4.3%	10.0%**	6.4%
j	Screen negative randomly selected for second stage	58	48	43	149
k	Total participants in second stage	70	60	78	208
l	Proportion of first stage participants who were assessed in second phase =(j+k)/f	24%	21%	22%	23%

* The participation rate in the first stage was defined as the proportion of families with 5-10 year olds where full information was obtained. Families who definitely did not have a 5-10 year old were excluded from this calculation. The participation rate was calculated on the 'worst case' assumption that the families who could not be located all had at least one 5-10 year old child.

** Comparison of the three areas, chi-square=12.4, 2df, p=0.002

6.1.4 Participation rate per area

The participation rate was very similar in urban and slum area but varied in rural area. (Table 5.4).Higher rate of relocation was the common reason of low participation both in urban and slum areas though it was more in slum. Nonavailability of parents at home, failure to locate the house were the additional cause in slum area. Other causes of lower participation in urban area were mainly due to suspiciousness about the interviewers as strangers and fear of possible bad occurrence (rubbery, claim for money by terrorists or outlaws), and botheration. That for slum area was due to, inability to give time as mothers were working. A small proportion of not agreed slum families expressed their feelings of being neglected by the society and finds no benefit to participate.

Table 6.2: Participation rate

Area type	Total number of 5-10 year old pupils	Planned sample	Number approached	Achieved sample	Participation rate
Rural	1,628	250	297	293	97%
Urban	3,812	250	326	280	69%
Slum	3,605	350	381	349	66%
Total	9,045	850	1,004	922	75%

6.2 Characteristics of the three community samples

6.2.1 Age distribution

The 922 subjects were obtained from a random sampling procedure. As illustrated in Table 6.3, the sample mean age was 8 years old. However, looking at each area separately, there were small but statistically significant differences in the mean ages of the three community samples. In the urban sample the mean age (7.8 years-old) was slightly but significantly lower than in the rural (8.1 years-old) and slum sample (10.6 years-old).The gender distribution of the total sample was 53% and 57% for male and female, but no differences in the gender balance of the sample in each area.

Table 6.3 Sample age distributions as a whole and for each area separately

Characteristics	Total N=922	Rural N=293	Urban N=280	Slum N=349	p*
Mean age (SD)	8.0 (1.7)	8.1 (1.8)	7.8 (1.6)	8.2 (1.7)	.02

* Significance of area differences, calculated using one-way ANOVA for age

6.2.2 Gender distribution

In the total sample, 53% were male, which is not significantly different from the proportion of males (49%) and females in the total population of Bangladesh, in this age band (Table 6.5).

Table 6.4 : Observed/Expected community sample

Number of 5 to 10 years-old	Males	Females	Total
Observed	481	441	922
Expected	470	452	922

$$\text{Continuity-corrected chi-square} = \sum \frac{(\text{observed} - \text{expected} - \frac{1}{2})^2}{\text{expected}}$$

chi-square = 0.531; 1df → p>0.2

6.2.3 Gender distribution across area

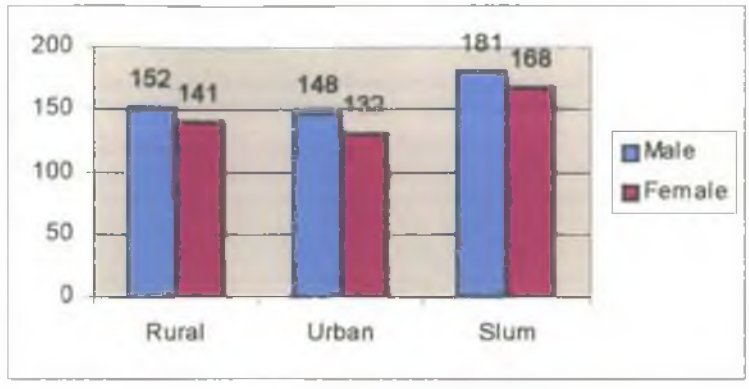
Comparing the proportion of males and females across area (Table 6.5 and Figure 6.3), the proportion of males did not vary between areas. The proportion of males was highest in the rural area. The difference was not significant (chi-square=0.09, 1df, p=0.956).

Table 6.5: Gender distribution by area

Gender	Rural	Urban	Slum	Total	p*
Male	152 (52%)	148 (53%)	181 (52%)	481 (52%)	NS
Female	141 (48%)	132 (47%)	168 (48%)	441 (48%)	NS
Total	293	280	349	922	

* Significance of area differences, calculated using chi-square for dichotomous variables.

Figure 6.3 Gender distributions by area



6.2.4 Distribution of religion across area

The expected distributions of the Muslim as a religion are 77%, 93%, and 93% in the rural, urban and slum area. Observed distribution of religion is similar to the expected distribution of religion in these areas.

In comparing the religion in three areas, Muslim is the largest religious group in all areas. This rate is highest in the slum children and lowest in rural children. That difference was statically significant (Table 6.6).

Table 6.6: Distribution of religion by area

Religion	Rural	Urban	Slum	Total	p*
Muslim	199 (68%)	269 (96%)	345 (99%)	481 (52%)	<.001
Others	94 (38%)	11 (04%)	04 (01%)	441 (48%)	
Total	293	280		922	

* Significance of area differences, calculated using chi-square for dichotomous variables.

6.3 Predictive validity of screening in the community samples

All 922 children in the community samples were assessed with the SDQ in the first phase of the study, but practical constraints only permitted about 20% of these to be assessed using the DAWBA in the second phase. All 59 children who were screen positive in the first phase were assessed with the DAWBA, of whom 90% (53) were assigned at least one ICD-10 diagnosis; 149 randomly selected children who were screen negative were also

assessed with the DAWBA, of whom 10% (15) were assigned at least one ICD-10 diagnosis (chi-square=122.2, 1df, p<.001). If the SDQ screen-negative children were subdivided into those predicted to be 'possible' and 'unlikely' cases by the predictive algorithm (Goodman et al., 2000b), then at least one ICD-10 diagnosis was made for 16% (12/76) of the possible cases and 4% (3/73) of the unlikely cases. Examining all three community samples separately, there were highly significant differences between the rates of psychiatric diagnoses for screen positive and negative children in each area: 92% v 12% for rural children (chi-square=33.0, 1df, p<.001); 92% v 6% for urban children (chi-square=39.2, 1df, p<.001); 89% v 12% for slum children (chi-square=46.0, 1df, p<.001).

6.4 Prevalence of child psychiatric disorders according to ICD 10 criteria

Adequate weight was applied to each area, in order to adjust the results for the oversampling procedure to obtain statistical power (Chapter 5). Weighted prevalence rates were then applied to reconstruct the prevalence of child psychiatric disorders in three areas. All data presented in this chapter refers to weighted rates. These estimates probably applicable to the whole of Bangladesh, but are applicable to the Dhaka district, and in and around Dhaka city, which resembles these three study areas in terms of socio-economic and geographic characteristics. Estimates for the Dhaka, and for the whole of Bangladesh will also be presented later in this chapter.

6.4.1 Overall prevalence rate

Of the 922 subjects in the study, overall prevalence of 5 to 10 years-old children was 15.2% (95% CI 10,9 – 20,80) with confidence intervals and test statistics adjusted for the two-phase design with weighting (Table 6.7)

Table 6.7: Overall prevalence rate

	Overall prevalence rate (95% CI)
Weighted	15.2% (10.9 – 20.8)

6.4.2 Prevalence rates per area

Comparison of prevalence of psychiatric disorder in the three areas was made after adjusting for weighting with 95% confidence interval. As illustrated in Table 6.9, the highest prevalence rate of 19.5 (95% CI 11,7 – 30,3) was identified among slum children, serving children from families with low and very low income (Slum area); followed by 15.4% (95% CI 8,7– 25,7) in rural sample, also serving middle and poor families (Rural area) and a lower rate of 10.0% (95% CI 4,8-19,4) among children from middle class families living in stable urban areas (Urban area). Chi-square showed no significant differences in prevalence rates across the three population groups (chi-square 2.99; 2df; p=0.22). Partitioning with protected significance levels (**Brunden 1972**) indicated that the significant chi-squared value was based on the difference between 'Slum' sample and the other two (Table 6.8). Although there was lower prevalence in the urban rather than the rural sample but the difference was not significant.

Table 6.8: Prevalence of any psychiatric disorder (ICD-10)

Area	Prevalence% (95% CI) any psychiatric disorder
Overall rate (weighted)	15.2 (10.9-20.80)
Rural	15.4(8.7-25.7)
Urban	10.0 (4.8-19.4)
Slum	19.5 (10.9-20.8)

6.4.3 Prevalence rates for groups of disorders

The groups analysed were 'anxiety' including separation anxiety, specific phobia, social phobia, PTSD, OCD, generalized anxiety and other anxiety disorder, which were also examined separately; 'hyperkinesis' including all hyperkinetic disorders; 'behavoural', including oppositional defiant disorder and conduct disorders and 'pervasive developmental disorder' including childhood autism and other pervasive developmental disorder(PDD). In Table 6.9 prevalence rates for groups are illustrated. The rates were highest for behavioural disorders (8.9%), closely followed by anxiety disorders (8.1%). The group of hyperkinetic disorders was present in 2.0%.Pervasive developmental disorder was found only 0.2%.

Table 6.9: Weighted prevalence for groups of ICD 10 diagnosis

Groups of disorders	Weighted Prevalence %	(95% CI)
Overall rate	15.2	(10.9-20.8)
Any anxiety	8.1	(5.1-12.7)
Any hyperkinesis	2.0	(1.0-4.1)
Any behavioural	8.9	(5.6-13.6)
Pervasive developmental	0.2	(0.0-0.9)

6.4.4 Prevalence rates for each ICD 10 diagnosis

Prevalence rate of individual disorder is illustrated in Table 6.10. Conduct disorder includes socialised, unsocialised and other conduct disorder, but excludes oppositional defiant disorder. Oppositional defiant disorder were the commonest followed by conduct disorder. Among the anxiety disorder, other anxiety disorder was most prevalent. Next common two disorders were and obsessive compulsive disorder and hyperkinetic disorder. There were no cases of depression, panic attacks or agoraphobia.

Table 6.10: Weighted prevalence for ICD 10 diagnosis

ICD 10 Diagnosis	Weighted Prevalence % (95% CI)
Separation Anxiety disorder	1.5 (0.6-3.6)
Specific Phobia	1.0 (0.3-3.1)
Social Phobia	0.1 (0. 0 – 0.8)
Panic Disorder	No cases detected
Agoraphobia	No cases detected
Post traumatic stress disorder	1.3 (0.4 – 4.5)
Obsessive compulsive disorder	2.0(0.7 – 5.9)
Generalised anxiety disorder	0.8 (0.4 – 1.6)
Other anxiety disorder	2.5 (1.0 – 5.9)
Depressive disorder	No cases detected
Hyperkinetic disorder	2.0 (1.0 – 4.1)
Oppositional defiant disorder	5.9 (3.4 – 10.0)

Conduct disorder	2.9 (1.3 – 6.4)
Pervasive developmental disorder	0.2 (0.0 - 0.9)

6.4.5 Prevalence of psychiatric disorder in the three community samples

Table 6.11 summarises the prevalence estimates for ICD-10 psychiatric disorders in the three areas, with confidence intervals and test statistics adjusted for the two-phase design with weighting.

Differences are most striking between slum area and the other two areas, with higher rates of almost all types of disorders and highly significant rate of prevalence of conduct disorder in the slum area. Among rural children the commonest group was anxiety disorders, whereas for urban children, oppositional defiant disorder was the commonest.

Table 6.11: Psychiatric disorder by area

ICD-10 Diagnosis	Weighted prevalence (95% confidence interval)			
	Rural	Urban	Slum	Total
Any disorder	15.4% (8.7-25.7%)	10.0% (4.8-19.4%)	19.5% (11.7-30.3%)	15.2% (10.9-20.8%)
Any anxiety	9.3% (4.5-18.3%)	3.8% (1.2-11.1%)	10.6% (5.2-20.3%)	8.1% (5.1-12.7%)
Separation anxiety	0.7% (0.2-2.8%)	2.7% (0.6-11.4%)	1.1% (0.4-3.1%)	1.5% (0.6-3.6%)
Specific phobia	2.0% (0.4-10.0%)	0%	0.9% (0.3-2.7%)	1.0% (0.3%-3.1%)
Social phobia	0%	0%	0.3% (0-2.1%)	0.1% (0-0.8%)
PTSD	0.3% (0-2.5%)	0%	3.2%⊥ (0.9-11.5%)	1.3% (0.4-4.5%)
OCD	1.7% (0.2-11.0%)	2.0% (0.3-13.0%)	2.4% (0.4-12.6%)	2.0% (0.7-5.9%)
Generalised anxiety	1.0% (0.3-3.2%)	0.4% (0-2.6%)	0.9% (0.3-2.7%)	0.8% (0.4-1.6%)
Other anxiety	4.0% (1.2-12.2%)	0.7% (0.2-2.9%)	2.7% (0.8-12.0)	2.5% (1.0-5.9%)
Hyperkinesis	1.0% (0.3-3.2%)	3.1% (0.8-11.1%)	2.0% (0.9-4.4%)	2.0% (1.0-4.1%)
Any behavioural	6.7% (2.8-15.2%)	7.1% (2.7-17.4%)	12.0% (6.4-21.6%)	8.9% (5.6-13.6%)
Oppositional defiant	6.0% (2.3-14.8%)	6.7% (2.4-17.3%)	5.2% (2.2-12.1%)	5.9% (3.4-10.0%)
Conduct disorder	0.7% (0.2-2.8%)	0.4% (0-2.6%)	6.8%*** (2.7-15.7%)	2.9% (1.3-6.4%)
Pervasive developmental	0.3% (0-2.5%)	0.4% (0-2.6%)	0%	0.2% (0-0.9%)

OCD=Obsessive compulsive disorder. PTSD=Post-traumatic stress disorder.
Comparison of the three areas after adjusting for weighting: ⊥ p=0.1, *** p<0.001

Three specific features of the pattern of area differences and similarities warrant further comment.

Firstly, within the behavioural disorders, the association with area varied strikingly according to the type and severity of behavioural problem. Children from all three areas had similar rates of oppositional-defiant disorder, involving behaviours such as temper outbursts, arguing with adults, refusing to follow rules, annoying others on purpose, and irritability. By contrast, children from the slum were substantially more likely to have more serious conduct disorders, involving behaviours such as stealing, use of weapons, deliberate cruelty to people or animals, and repeatedly staying out late without permission.

Secondly, post-traumatic stress disorder was more likely to affect the children from the slum, though this was only marginally statistically significant. The relevant traumatic events for the six affected children (five from the slum, one from the rural area) were witnessing and/or victim of gang violence, fall in road traffic accident, witnessing group violence to family, victim deliberate fire setting of family home while all was asleep, physically abused.

Thirdly, the prevalence of obsessive compulsive disorder was high across all three areas. The obsessions and compulsions of the five effected children can be summarised as engagement in excessive cleaning and washing, repetitive walking and counting, repeatedly checking of school bag and school work. In other cases, repetitive obscene thoughts, associated with fear of punishment by God; repetitive praying a lot for forgiveness. Other features were constantly intrusive worries that siblings and mother would die that linked with fear of God caused repeatedly crossed herself to avoid punishment. Overconcern about dirt and washing hands, body and clothes was found to be linked with fear of improperly clean for prayers and that God might be angry and begging pardon repetitively.

6.5 Estimates for the study area as a whole, Dhaka District, for the Dhaka Division and for the whole of Bangladesh

Estimates for the Dhaka District, for the Dhaka Division, and for Bangladesh a whole were based on the rates of child psychiatric disorders determined for whole study area in the present study which are presented in Table 6.12. These rates were multiplies by the relevant numbers of 5-10 year olds population; based on data obtained from **Bangladesh Bureau of Statistics (2003).**

Table 6.12: Estimated number and percentage of 5-10 year-olds with psychiatric disorders

	Whole study areas		Dhaka District		Dhaka Division		Bangladesh	
Total population	9,045		37,343		5,458,190		17,339,156	
	N	%	N	%	N	%	N	%
Any disorder	1,131	12.5	4,668	12.5	682,274	12.5	2,167,394	12.5
Any Anxiety disorders	732.6	8.1	3,025	8.1	442,113	8.1	1,404472	8.1
Hyperkinetic disorders	181	2.0	747	2.0	109,164	2.0	346,783	2.0
Any behavioural disorder	805	8.9	3,323	8.9	485,779	8.9	1,543,185	8.9
Pervasive developmental disorder	18	0.2	75	0.2	1,092	0.2	34,678	0.2

6.6 Differences of characteristics of the community samples

Differences of characteristics of the community samples as a whole and for each area are presented below. The differences in types and rates of these characteristics could be a guide to explore psychopathology of child psychiatric disorder between rural, urban and slum areas in future studies.

6.6.1 Religious practice

Religious practice was measured by the child's attendance in worship. As shown in Table 6.13, religious practice was found significantly lower in slum area in comparison to nearly similar religious practice in rural and urban area.

Table 6.13 Religious practice of the subjects

Characteristics	Total N=922	Rural N=293	Urban N=280	Slum N=349	p*
Child attend worship weekly or more3	286(31%)	295(32%)	111(38%)	67(24%)	<.001

* Significance of area differences, calculated using chi-square for dichotomous variables.

6.6.2 Parental literacy

Table 6.14 shows significantly higher level of illiteracy of the both mother and father of the slum children. In contrast, higher education of both parents of the urban children was found highly significant. Rural parents fall between two extremes.

Table 6.14 Literacy of the parents of the subjects

Characteristics	Total N=922	Rural N=293	Urban N=280	Slum N=349	p*
Mother is illiterate	30%	23%	4%	58%	<.001
Mother completed higher education	8%	0%	28%	0%	<.001
Father is illiterate	23%	22%	0%	43%	<.001
Father completed higher education	18%	2%	58%	0%	<.001

* Significance of area differences, calculated using chi-square for dichotomous variables.

6.6.3 Living and economic conditions

As shown in Table 6.15, the urban area was the most materially advantaged, as judged by the possession of a refrigerator. Other rate of advantageous parameters of households was found significantly higher in urban area. All these parameters were indicative of worse

living conditions in slum areas that were statistically significant. The position of rural area were also far behind from the urban area but not much worse like slum area.

Annual income of urban family was significantly higher than that of slum and urban areas Annual family income of the slum area was the lowest. Though annual income of the rural families was higher than annual income of slum families, but was significantly lower from urban families.

Table 6.15 living and economic conditions of the subjects

Characteristics	Total N=922	Rural N=293	Urban N=280	Slum N=349	p*
House built of bricks	45%	37%	100%	10%	<.001
Household employs servants	27%	23%	66%	1%	<.001
Household has television	59%	52%	97%	35%	<.001
Household has phone	23%	6%	66%	1%	<.001
Household has refrigerator	32%	15%	86%	2%	<.001
Annual family income (thousands)	101 (128)	74 (69)	208 (177)	39 (31)	<.001

* Significance of area differences, calculated using one-way ANOVA for continuous variables and using chi-square for dichotomous variables.

6.6.4 Social capital

Table 6.16 shows that the rural area had the highest rating for neighbourhood helpfulness as measured three variables. That for slum area had lowest. The differences were highly significant.

Table 6.16 Social capital of the family of the subjects

Characteristics	Total N=922	Rural N=293	Urban N=280	Slum N=349	p*
Mother says area is very dangerous to live in	12%	1%	11%	23%	<.001
Mother says people in the area help one another a lot	46%	71%	33%	35%	<.001

Mother says she can count a lot on family and friends for childcare help	33%	42%	30%	27%	<.001

* Significance of area differences, calculated using chi-square for dichotomous variables.

6.6.5 Physical health status

As illustrated in Table 6.17, the slum children had poorest physical health as told by their parents and as found in the body mass index calculated by the proportion of weight and height. That was also true for the rural children. The urban children had better physical status. The differences of these variables are highly significant.

Table 6.17 Physical health status of the subjects

Characteristics	Total N=922	Rural N=293	Urban N=280	Slum N=349	p*
Physical health good	29%	25%	42%	22%	<.001
Body mass index	15.9 (3.8)	15.2 (3.3)	16.8 (4.3)	15.7 (3.5)	<.001

* Significance of area differences, calculated using one-way ANOVA for continuous variables and using chi-square for dichotomous variables.

6.6.6 Mental health status of the mothers

As illustrated in Table 6.18, mental health status of the slum mothers was significantly poor than that of urban and rural mothers as measured by the SRQ scores. The SRQ scores were found almost similar in the mothers of rural and urban areas.

Table 6.18 Mental health status of the mothers of the subjects

Characteristics	Total N=922	Rural N=293	Urban N=280	Slum N=349	p*
Maternal SRQ total	7.5 (4.4)	7.2 (4.6)	6.3 (3.8)	8.8 (4.4)	<.001

SRQ=Self-reporting questionnaire, a measure of psychological distress
* Significance of area differences, calculated using one-way ANOVA

CHAPTER 7

MAIN STUDY: DISCUSSION

The present study generated both methodological and substantive findings of interest. Methodologically, the study provided the first evidence for the validity of the Bangla version of the Development and Well-Being Assessment (DAWBA), as well as confirming and extending previous validation studies of the Bangla version of the Strengths and Difficulties Questionnaire (SDQ; Goodman et al., 2000b; Mullick and Goodman, 2001). Substantively, the study suggests that around 10-20% of Bangladeshi 5-10 year olds have emotional and behavioural problems that are severe enough to result in substantial distress or social impairment, thereby warranting a psychiatric diagnosis, and probably warranting treatment too. Children from the slum were substantially more likely than children from the other two areas to have serious conduct problems and the same might apply to post-traumatic stress disorder.

The epidemiological study in three contrasting area in Bangladesh was able to accomplish its main objectives. It established that the overall prevalence of child psychiatric disorders was 15.2%. The prevalence for the three main population groups was: 15.4% for children from rural families, 10.0% for children from urban families and 19.5% for children from slum families. The preliminary study and pilot study parts of the present study also validated the methodology adopted in the main study part, including ascertainment methods and measures.

Prevalence rates per type of disorder were also obtained. The group of behavioural disorders (according to the ICD 10) was the most prevalent with estimates around 8.9%, followed by emotional disorders (mainly anxiety disorders) with estimates around 8.1%. In Bangladesh, based on these rates, 2.2 million 5 – 10 year olds have one or more psychiatric disorders, including 1.5 million with behavioural disorders and 1.4 million with anxiety disorders.

Epidemiological data increases the knowledge about the characteristics, the aetiology and risk factors of psychopathology and provide scientific basis for appropriate mental health planning. Findings such as those from the present study are necessary for health administrators and also to inform clinicians and other health providers when they are designing preventive interventions and treatment programs. Without epidemiological studies it would be difficult to justify the need to establish child psychiatric services in developing countries like Bangladesh, given the long list of life-threatening physical and social conditions that are also competing for scarce funds. The implications for service planning and socio-economic impact of the present findings are discussed in this chapter. Before considering the implication of these findings, however, it is important to review the methodological constraints.

7.1 Methodological constraints

The sampling frame chosen was based on electoral register. A considerable number of families could not be located through the electoral list due to families who had recently migrated &/or relocated and that was not excluded in the list of that area. This was highly evident for slum children followed by urban children. The sample obtained in present study could then be biased towards under-representing particular sub-samples of children that were possibly at higher risk for psychiatric disorders. Further, exhaustive 'door to door' visits were made to attain the targeted sample size. On the other hand it was not possible to include many families who were found in the study areas but not listed in the electoral register. Thus, a selection bias could exist in both directions since some children at higher risk (low socio-economic status) may have been excluded as well as some children at lower risk (affluent families). This is one crucial issue of the sampling frame that will need to be addressed to use this frame in future studies.

Another selection bias could be related to families that refused to take part or were excluded because of incomplete data. In some cases, parents of children with psychiatric disorders may be uninterested or unwilling to respond. However it is also possible that such parents may be especially interested in a study related to their child's condition. Thus, good explanations exist for potential biases in opposite directions in the estimation of population prevalence of disorders. Based on the findings from the present study, one

could argue that the majority of parents who refused to participate came from middle-class families and the selection of compliant middle-class parents may have contributed to the low rate of disorder in middle class children. It is important to note that the preceding considerations relate more to studies with low to moderate non-response rates, which is not the case in the present study. Furthermore, the participation rates in present study were high across all groups.

Observer bias was reduced by the use of structured interviews and by training the interviewers. The fact that information was collected from two different sources of informants was a further strength. However, the possibility of recall bias can not be excluded since the informants' apprehension of a child's emotions and behaviours may vary according to their own emotional states.

Although structured interviews can be overinclusive, this effect was reduced by the format of the interview (DAWBA) adopted in the present study. The fact that the DAWBA contains open-ended questions and allows a trained child psychiatrist to perform the final diagnosis for each subject reduces the overinclusiveness of fully-structured interviews.

Cross-sectional studies are not appropriate for estimating the prevalence of less common disorders. For instance Turret's disorder, anorexia nervosa were not diagnosed in our sample. Only an extremely large general population sample (10,000 or more) could begin to generate prevalence rates for these rare disorders, and this would be prohibitively expensive for Bangladesh. Furthermore, the measure chosen for the study was designed for common child psychiatric disorders and was therefore not very appropriate for rarer disorders such as anorexia nervosa or autism though the measures broadly provided diagnosis of autistic spectrum disorders. To study rarer disorders there are alternative designs, for example locating possible cases of autism through clinics or special schools, but these designs would not have been appropriate for the main objective of the study, namely establish prevalence rates of common disorders for service planning.

The interview (DAWBA) did not include somatoform disorders. According to the anecdotal experience of paediatricians and psychiatrists in hospital/clinics in Bangladesh, conversion disorders seem to be as common as in other developing countries such as India. Therefore, in the current study, somatoform disorders were not diagnosed and therefore not estimated. In particular, somatoform disorder is needed to be diagnosed not just on the

basis of physical symptoms or pain, but on the basis that these are not medically explainable or are out of proportion to any medical cause. It is hard to establish this even in physically healthy and highly doctored societies, and even harder in an epidemiological study in a tropical country where there are many paediatric disorders, and where many of these are never adequately investigated.

7.2 Psychometric properties of the Bangla translation of the SDQ

The first validation study of the SDQ in Bangla demonstrated in a *clinic* sample that there was substantial agreement between the SDQ 'caseness' predictions and an independent psychiatric diagnosis **(Goodman et al. 2000b)**. The preliminary study was second validation study demonstrated that mean SDQ scores differed markedly between clinic and community samples. This main stage study extends the previous validation studies by demonstrating that SDQ 'caseness' predictions in diverse *community* samples are substantially confirmed by independent psychiatric assessments.

This study demonstrated that mean SDQ scores differed markedly between clinic and community samples. This study extends the previous validation studies by demonstrating that SDQ 'caseness' predictions in diverse *community* samples are substantially confirmed by independent psychiatric assessments. Overall, the likelihood of being assigned a psychiatric diagnosis was 90% for children predicted to be 'probable' cases by the SDQ, as compared to 16% for children predicted to be 'possible' cases, and 4% for children predicted to be 'unlikely cases. The caseness predictions worked well in all three communities studied. These findings suggest that the multi-informant SDQ might have a useful role in community screening. In particular, since 90% of children with 'probable' caseness have a psychiatric disorder, referring these children for specialist evaluation would not waste a substantial amount of scarce clinical resources on the evaluation of false positives. In a society where child mental health resources are very scarce, it is appropriate to use a screening test with a high threshold. The fact that a high threshold will also increase the proportion of false negatives is probably a cost worth paying since the children missed by the screening process would almost certainly never have been referred to services in any case.

Rates of disorders were highest in slum area and lowest in moderately prosperous urban areas. Conduct disorders were the most prevalent among children from slum area. These

finding and other prevalence rates will be further discussed in comparison with findings from other developing countries and with findings from the British 99 Survey (**Meltzer et al. 2000**).

7.3 Common mental health problems in children in three contrasting areas

7.3.1 Substantive findings

Participation rates were higher than the researcher expected in all three areas. In the slum area (low socio-economic status) the researcher suspected that their lack of experience in participating in surveys would inhibit them and make them reluctant to agree to answer questions which they would fear were too difficult for them. Considering this possibility, larger number of children was targeted in the slum area. In fact, the participation rate in this slum area was almost equal that in urban area (middle socio-economic status) which 69% and 66% respectively. The participation rate of urban families was less than the researcher's expectation. The researcher assumed that higher educational and awareness level of these middle class families will encourage them to participate more in the study. The urban families were found suspicious of interviewers who visited at home and apprehensive of any possible bad occurrences. This was an important reason of nonparticipation in urban areas. In the rural area, the rate achieved (97%) was as the expectation. This rate was significantly higher then other two areas. Highest participation rate in the rural area reflects that people of Bangladesh is cooperative, interested to participate in studies if they feel secured.

7.3.2 Characteristics of the three community samples

The urban area was the most educationally and materially advantaged, as judged by literacy levels and the possession of a refrigerator. By contrast, the rural area had the highest rating for neighbourhood helpfulness and the lowest rating for neighbourhood danger. The slum did worst in all respects.

7.3.3 Overall prevalence of psychiatric disorder

The proportion of 5-10 year old children who had at least one ICD-10 psychiatric diagnosis according to the DAWBA was 15% for the rural area, 10% for the relatively prosperous

urban area and 20% for the slum. Combining all three samples, the 95% confidence interval for prevalence was 11-21%. This compares with DAWBA-based prevalences of 8% for British 5-10 year olds (**Meltzer et al 2000**); 7% and 13% for two different surveys of Brazilian 7-14 year olds (**Fleitlich-Bilyk and Goodman 2004; Goodman et al. 2005a**); and 15% for Russian 7-14 year olds (**Goodman et al. 2005b**).

7.3.4 Comparison with other developing countries

Prevalence of child psychiatric disorders in developing countries (according to the studies reviewed in Chapter 2) ranged from 5% to 49%. Countries with the closest rates to the Bangladesh rates (15.2%) were the Philippines (15%), Brazil (12.5%), Sudan (10%), Malaysia (6%) and India (5%). However, the study in Sudan and the Philippines did not adopt impairment criteria – had it done so, the rate would probably have been lower. The Present study went, assessing a representative sample, 922 children, with a full set of validated measures and appropriate statistical methods, generating psychiatric diagnoses according to ICD 10 including impairment criteria. Most other studies of overall prevalence had smaller samples and adopted old diagnostic criteria without impairment criteria. All studies which adopted the ICD 8 and ICD 9 diagnostic criteria included mental retardation. For example, among the 35.6% prevalence rate found in the **Lal et al. (1977)** study, 60% had mental retardation as one of the psychiatric diagnosis. In **Giel et al. (1981)** multicentric study, only 5 of the 10 symptoms listed in their screening measure are part of the current classifications for child mental health disorders, comprising 2 symptoms of conduct disorders, 2 symptoms of emotional disorders and 1 symptom of peer relationship problems. The other half of the symptoms was related to mental retardation. The current classifications (ICD 10 and DSM IV) do not consider mental retardation as an axis 1 psychiatric disorder, so from this perspective the prevalence rates from older studies are overinclusive.

The rates of most prevalence studies in the developing world are likely to have been overestimates until impairment criteria started to de adopted. In developing countries, the first study to adopt impairment criteria was held in Puerto Rico (**Bird et al. 1988**), followed by the **Hackett et al. (1999a)** study in India and this study in Bangladesh. Looking at prevalence per type of disorder, studies adopting ICD 8 and ICD 9 and no impairment criteria did not have conduct disorders as one of the most prevalent, but this changed once studies were based on ICD10 and included impairment criteria. For example, in the **Giel et**

al. (1981) study, conduct symptoms were the least prevalent and in the **Lal et al. (1977)** study only 9% of 35.6% children with a psychiatric diagnosis had conduct disorders symptoms, as opposed to the present study findings that identified conduct disorders as the most prevalent in poorer areas.

Findings from the **Lal et al. (1977)** and **Giel et al. (1981)** study in relation to Behavioural Disorder go in opposite directions as compared to findings in this study and other more recent studies in Puerto Rico and India. The **Bird et al. (1988)** study in Puerto Rico adopted DSM III criteria and CGAS as the impairment criteria and found a very similar rate of conduct type of disorders (5%).The **Fleitlich-Bilyk and Goodman (2004)** adapted DSM IV criteria and DAWABA and found 7% of oppositional-conduct disorder to what was found in the present study in Bangladesh (9%). **Hackett et al. (1999)** in India found a slightly lower rate of conduct type of disorders, though they still corresponded to 57% of all diagnoses.

Thus recent findings from studies that adopted similar diagnostic criteria and impairment criteria go along with the finding of this study in Bangladesh that behavioural disorders should be one of the major concerns in developing countries. This could be a real change in the pattern of child mental health disorders over the years or could simply reflect the way that epidemiological studies in child psychiatry have been improving their methodology. Thus, further investigation is needed in order to be able to compare findings across countries adopting comparable measures and methods and taking into account important risk factors such as socio-economic status.

7.3.5 Applicability of the prevalence estimate

Since a variety of rural, urban and slum areas were not sampled in the present study, let alone obtain a representative sample of the country as a whole, using figures of the present study as the basis for a precise estimate for Bangladesh as a whole need to be considered provisional. Nevertheless, allowing for the relative proportion of Bangladeshis living in rural, urban and slum areas, it seems unlikely that the prevalence of psychiatric disorders among Bangladeshi children is lower than 10%, and it is probably closer to 15%. The prevalence is probably higher still in adolescents (**Ford et al. 2003**). On the conservative assumption that 10% of Bangladeshi children and adolescents have a psychiatric diagnosis, this represents over 5 million individuals who are experiencing

substantial distress and social impairment; their disorders will also be affecting family members, classmates and teachers. These childhood problems will have substantial long-term costs, including higher rates of adult psychiatric disorders, criminality, substance abuse and under-employment. There are currently only a handful of child mental health professionals with specialist training in Bangladesh. Bridging the vast gap between need and provision will probably need to involve three strands: increasing the number of child mental health professionals; disseminating assessment and treatment techniques to other professionals, including teachers, family doctors and paediatricians; and preventing disorders where possible by tackling identifiable risk factors. Approaches to meeting mental health needs in developing countries are discussed by **Rahman et al. (2000) and Patel (2003)**.

7.3.6 The pattern of psychiatric disorders

The pattern of psychiatric disorders found in Bangladeshi 5-10 year olds resembles that identified in other parts of the world, with a preponderance of behavioural and anxiety disorders (e.g. **Ford et al. 2003; Fleitlich-Bilyk and Goodman 2004**); hyperkinesis is less common, and depression in this age range is rare. As discussed in the next section, an apparently distinctive aspect of the pattern of psychiatric disorder in Bangladesh is the high rate of obsessive compulsive disorder.

Obsessive compulsive disorder

The prevalence of obsessive compulsive disorder (OCD) among this sample of Bangladeshi 5-10 year olds was 2.0% (95% confidence interval 0.7% to 5.9%). This compares with prevalence rates of 0.1% (95% CI 0-0.2%) for British 5-10 year olds **(Ford et al. 2003; Meltzer et al. 2000)** and 0.1% (95% CI 0-0.2%) for Brazilian 7-14 year olds **(Fleitlich-Bilyk and Goodman 2004)**. This twenty-fold difference occurred despite the DAWBA being used for the psychiatric assessment in all three countries, and despite clinical ratings being made or supervised by the experienced child psychiatrist (author of the DAWBA) in all three countries.

Since the high Bangladeshi prevalence was based on just five cases, it would be a mistake to make too much of the finding. Nevertheless, it does warrant some comment. The two commonest themes (each occurring in four of the five children) were obsessional concerns of having offended God and compulsions related to cleanliness. Bangladesh is a

religious country; about 90% of the population are Muslim, and there are also significant numbers of Hindus, Buddhists and Christians. In a religious society, it is unsurprising that religious concerns are more common; the occurrence of an OCD-like 'scrupulosity' has been noted for many centuries among practicing Christians (**Seuss and Halpern 1989**). Islam particularly emphasises the importance of cleanliness in preparation for prayer; the themes of cleanliness and religion were explicitly linked by one of the children with OCD in this study, and may implicitly have been linked by some of the others. Furthermore, since Bangladesh is a country with a high mortality from diarrhoeal diseases spread by poor hygiene, and since health promotion in Bangladesh emphasises this link, heightened concerns about the dangers of poor hygiene are understandable. In this context, is it possible that we assigned diagnoses of obsessive compulsive disorder to what should have been regarded as culturally sanctioned variations within the normal range? It is certainly possible, but three factors lead the researcher to believe that diagnoses were culturally appropriate. Firstly, the diagnoses were agreed by both the researcher and the rater. Secondly, the families of the five affected children reported that the obsessions and compulsions led to marked distress or social impairment. Finally, in the clinical experience of the researcher, children and adolescents with similar symptoms, including religious obsessions, are brought to mental health professionals by parents who are themselves religious leaders or pious lay people.

The researcher's favoured interpretation, therefore, is that children with a constitutional tendency to obsessions and compulsions are more likely to present with frank obsessive compulsive disorder in societies such as Bangladesh that emphasise and link cleanliness and piety. If this interpretation is correct, then religious authorities in Bangladesh may potentially be well placed to reassure overanxious believers of any age who have taken things too far.

7.3.7 Area differences in psychiatric disorders

In the first screening phase of the study, 10% of the children from the slum were screen positive, as compared with just 4% in both the rural and urban samples – a highly significant difference (Table 6.1). For comparison, a study using the same screening measure in Brazil found that 22% of 7-14 year old children from a favela (shanty town) were screen positive, as compared to 13% in a rural area and 12% in a mixed urban area (**Fleitlich and Goodman 2001**). The absolute percentages were higher in the Brazilian

study than in the present study, though much of this may be attributable to differences in the screening properties of the SDQ in the two countries. Thus whereas 90% of screen positive children in Bangladesh in the present study had a psychiatric diagnosis when assessed with the DAWBA, the corresponding figure was only 56% in Brazil (**Fleitlich and Goodman 2001**), suggesting that the threshold for becoming screen positive is lower in Brazil than in Bangladesh. The fact that the Brazilian sample was older may also have been relevant, since the prevalence of psychiatric disorder rises in adolescence (**Ford et al. 2003**). Setting aside the national differences in absolute percentages, the similarity in pattern is very striking. Thus, in each country, children from rural and urban areas had similar rates of probable psychiatric disorders, whereas the rates for children from the slum/favela were roughly twice as high. The present study suggests that one possible explanation is that the slum families are generally poorer in all respects. Although families in the rural area were less affluent and less well educated than families from the relatively prosperous urban area, rural life had compensatory advantages, as judged by high ratings for neighbourhood helpfulness and low ratings for neighbourhood danger. By contrast, the slum families were poorer in all ways – experiencing even more financial and educational disadvantage than the rural families, but without compensatory neighbourhood benefits to offset this. The urban poor in developing countries may experience the worst of all worlds (**Harpham and Molyneux 2001**), missing out on the potential benefits of both rural and urban life, while experiencing a heightened sense of relative poverty as a result of daily reminders of how much less privileged they are then wealthy city dwellers. Rural to urban migration may have an adverse impact on the mental health of rural as well as urban children and adolescents. This is reported to be the case in Swaziland where children are left in the care of over-burdened grandparents in depopulated rural areas while parents migrate to cities to work (**Guinness 1992**). Whether this effect is relevant in some rural areas of Bangladesh remains to be established.

The first phase of this study applied the screening measures to almost a thousand children, giving the study reasonable statistical power to detect area differences. By contrast, the second phase applied detailed psychiatric assessments to only a fifth of these children, with more limited statistical power. Despite this, two interesting differences emerged from the second phase. Whereas the rates of non-compliant and irritable behaviours warranting a diagnosis of oppositional-defiant disorder were similar in all three areas, the children from the slum had significantly higher rate of serious behavioural

problems warranting a diagnosis of conduct disorder (6.8% as compared with 0.7% and 0.4% for rural and urban children respectively). There are several plausible reasons for children from a slum being more likely to have serious behavioural problems. For example, stealing may sometimes be an economic necessity; the use of weapons and being cruel to others may be linked to high levels of ambient violence; and repeatedly staying out late without permission may reflect stressed parents who are too busy or depressed to provide adequate supervision or discipline. The higher rate of serious conduct problems in our slum sample is in keeping with the adverse impact of rapid urbanisation on child behaviour in Sudan (**Rahim and Cederblad 1984**) and the marked excess of conduct disorder among the urban poor in Brazil (**Fleitlich-Bilyk and Goodman 2004**). In Swaziland, rural to urban migration may have had an adverse impact on the mental health of children and adolescents growing up in the increasingly depopulated rural areas (**Guinness 1992**); whether this applies in some rural areas of Bangladesh remains to be established.

A second area difference that only reached marginal statistical significance was the excess of post-traumatic stress disorder among the slum children (3.2% as compared with 0.3% and 0% for rural and urban children respectively). This difference is plausibly attributable to the slum children being more frequently exposed to some sorts of trauma, e.g. gang warfare, attacks by neighbours.

Demonstrating area differences and then teasing out the proximal mediators of those differences are mostly tasks for the future, but this preliminary study suggests that undertaking these tasks will be worthwhile. For example, a future study that involved many randomly selected areas, could investigate how area rates of child mental health problems correlate with the area averages for material, educational and social wealth.

7.3.8 Possible variables as a guide to search the correlates of child psychiatric disorder in future

Differences of socioeconomic characteristics of the community samples for each area revealed some important variables that can be considered as possible correlates of child psychiatric disorders.

The rates and types of different social and demographic factors related to the subjects of three areas of the study, it was found that, the urban area was the most educationally and

materially advantaged, as judged by literacy levels and the possession of a refrigerator. By contrast, the rural area had the highest rating for neighbourhood helpfulness and the lowest rating for neighbourhood danger. The slum did worst in all respects. The slum children had lowest religious practice was. Their school attendance was the lowest. The slum had higher rate of children with large family size having lowest social capital. The physical health status of the slum children was also poor.

To identify definite risk and protective factors was not the focus of this thesis. The significant differences in types and rates of those characteristics found in the present study could be a guide to explore correlates of psychiatric disorder of child psychiatric disorder in favourable and unfavourable direction between rural, urban and slum areas in future studies.

7.4 Limitations

Although the three communities that the researcher studied were chosen after informal local consultation as representative exemplars of rural, urban and slum areas, it cannot be ruled out the possibility that they may nevertheless be unrepresentative. Thus present findings of the main study are necessarily provisional, awaiting confirmation by larger studies sampling from a greater number of randomly chosen areas. Although present study has validated screening and detailed measures that can be used in future studies, and has generated approximate prevalence estimates that can be employed in the power calculations for such studies, the definitive studies have yet to be done. Researchers and policy makers should view the findings of this study as provisional and approximate.

7.5 Qualitative conclusions

The conclusions, the researcher would like to present in this section are not based in quantitative analysis, but nonetheless, the researcher considered them very helpful for further studies that will be developed in Brazil and other developing countries. The first qualitative conclusion regards measures. When the preliminary study and the pilot study of the thesis work started, one of the main questions still unanswered in the literature regarded the use of measures. There was no child epidemiological study in Bangladesh

with sound measures that could indicate whether a psychiatric questionnaire or interview initially developed for a first world country would be applicable to developing countries. Initially developed to be applied in the British population, the measures used in this study worked well in Bangladesh, illustrating that the same measure can be used in different cultures – providing more support for the universalist position then for the relativist position discussed in Chapter 2. From now on, epidemiological studies in Bangladesh can be more confident in adopting measures already developed and tested in other countries rather then having to start from scratch with new and untested measures, which in the end will not provide data that are comparable with other developing and developed countries.

The second qualitative conclusion regards Governmental initiatives and human resources that were relevant to facilitate the implementation of an epidemiological study that depended on electoral register as the sampling frame. The Election Commission were ready to prepare updated electoral register by including new voters soon as officially reported by the potential voters as part of their routine activities. It was found that people in the study area were willing to participate, which resulted in excellent participation rates. However, a considerable number of families could not found as the left from the areas. Again many families in the areas were willing to participate in the study but not included because their names were not listed in the electoral register. The participation rate would be higher if there was effective initiation, communication and collaboration between people and the electoral authority. Therefore, continuous updating of the electoral register as part political system of the Bangladesh need to be facilitated that will work well as sampling frame of the similar studies.

The third qualitative conclusion regards the prejudice around mental health issues. Having had personal experience through contact with the peoples of the study areas and getting information from individual report of the members of the research team, the researcher was left with the strong impression that 'mental health' issues are not well understood by the people all levels irrespective of educational, social and economical background. In fact, the prejudice around mental health issues was felt not only in rural and slum areas but also in the more educated urban area. Mental health problems were understood as severe mental retardation, learning disability or psychosis at the best, and a typical reaction in families was to say that they did not have those kinds of problems. To minimise the prejudice around mental health issues the strategies which worked well were to use the motivational activities by the team members to introduce the idea that the study was

intended to assess the strengths as well as the difficulties of the child's behaviour and emotion. It was explained that mental health problems included behavioural and emotional difficulties which any child could present and that the study would be helpful by generating information that could improve services.

The lack of information about what the scope of mental health is became clear throughout the study. The old view that mental health problems in children include mostly mental retardation and other developmental delays is still held by most of the professional the researcher met during the study. That was true for all three study areas both among educational and health professionals. Educational campaigns are urgent and should focus on basic information about the common child and adolescent mental health problems, how to recognise them and where to refer the children.

7.6 Implications for service planning

Our findings indicated that services should be concentrated in poorer areas. The findings also indicated that the commonest disorders were behavioural (oppositional-conduct) disorders and anxiety disorders, with hyperkinetic disorder and PDD being less common but important because of their severity and treatability. In terms of service planning this information suggests three main aims. One is that providing parent training and specific advice to teachers on behavioural management should be a high priority to meet the needs of children with oppositional-conduct disorders and their parents. Secondly, clinics should also be able to offer adequate treatment for anxiety and depressive disorders, including cognitive behavioural therapy, medication and advice to schools for conditions such as school phobia. The third focus should be on hyperkinetic disorder, aiming to offer medication and behavioural management in clinics and advice in schools on education and behavioural management of children with hyperkinetic disorder. The forth focus of attention should be on PDD, aiming to offer assessment in clinics and advice in school placement and behavioural management of children with PDD.

In poorer areas where behavioural disorders are the commonest, the very first priority might be developing cost-effective programs for managing conduct disorders. This sort of decision would have a major impact on choice of skill mix. For example, rather than investing most of the budget in relatively expensive doctors and psychologists to deliver

cognitive behavioural programs and medication, the primary focus could be on training larger numbers of lower paid community workers to deliver parent management courses. Conversely, clinics serving areas with a relative little behavioural disorders and a predominance of emotional disorders and hyperkinetic disorder may choose to devote a higher proportion of their budget to employing doctors and psychologists. The researcher will now try to describe current health and child mental services available in Bangladesh, hoping to provide the reader with a general idea about what tools are currently available and what must be tackled to help to implement and develop mental health services, in the light of the real needs of Bangladeshi children and adolescents.

The government-funded health system in Bangladesh is inadequate in many ways. There is not enough funding and infra-structure. Most of the hospitals do not have enough equipment and personel. Well-trained doctors tend to remain in large cities which also have better infra-structure in hospitals and health clinics. Thus the best services are highly concentrated in the large cities. Outside of these, particularly in the countryside, doctors tend to be worse trained and working conditions are even worse than that in the metropolitan areas. The private system offers much lower infra-structure. The private hospitals are not in a position to offer treatment comparable to the developed world. Further, the costs are also high and are therefore only accessible to middle and upper-class families.

In terms of child and adolescent psychiatric services, there are severe deficiencies in both government-funded and private health systems. In the government-funded system, there is neither a national plan nor specific policies for the country. There are only a few isolated programmes which might be doing some good, but no evaluation data is available. In the private system, general psychiatrists are concentrated in the largest cities and the costs are very high particularly when a multi-disciplinary treatment is needed. In fact, true multi-disciplinary service does not exist in the country due to lack of trained personnel of the concerned disciplines.

As it is probably typical of most developing countries, services in Sao Paulo focus on severe and rare child mental health disorders rather then on commoner disorders. The best services are based in university hospitals rather community clinics. The same pattern is evident in other areas of Medicine such as cardiology or gastroenterology, with a few excellent services based in university hospitals on the one hand, and neglected community

health clinics on the other hand. For example, heart surgery and liver transplants are fields in which the government offers high quality treatment. Their specialist doctors are often funded to train abroad, and research funds are also much more freely available than for work in the community health system. It is worth highlighting that there are already some sectors of community health that have been the focus of government and nongovernmental organizations such as AIDS and other infectious diseases.

The so called non-communicable diseases seem still to be considered less relevant then infectious diseases in Bangladesh. This can be understood at different levels such as historical, cultural and practical. Historically, Psychiatry has had a secondary place among the different fields in Medicine. Child Psychiatry 'has been seen to be coterminous with child psychoanalysis' which has led to some marginalization of the routine services such as multidisciplinary teams, the practicalities of educational psychology in schools and medication approaches (e.g. the use of antidepressants for significant depressive illness) **(Neve et al. 2002)**. For example, antibiotics were released in the 1920s and research in this area has made very good progress since then. Conversely, drug treatments in psychiatry, such as the tricyclic antidepressants and monoamine oxidase inhibitors, only were discovered in the 1950s, and there have not been major advances (**Nestlera et al. 1998**). Until the nineties, there was little emphasis on scientific approaches to mental health problems. Scientific research on aetiology, risk factors and sound methodological treatment trials in psychiatry are recent, whereas infectious diseases have been the focus of attention for many centuries. Culturally, psychiatry has also been neglected since in most societies mental health conditions were and still are hidden, being considered a reason for shame and sorrow. In the present study for example, it is probably appropriate to characterise the barriers the researcher encountered when dealing with education authorities, teachers and parents as a mixture of ignorance about what child mental health problems are and where they come from, and prejudice which reinforces the ignorance and perpetuates the vicious cycle. At a practical level, it is understandable that infectious diseases receive more attention then mental health, since the immediate effects are more visible and measurable and therefore socio-economic consequences are more measurable too. The researcher believe that such initiatives as in this study will not only facilitate service planing as the researcher will discuss in the next paragraphs, but will also help liberate child psychiatry from some of the misunderstandings and prejudices that have held up progress in this area.

In the whole of Bangladesh, there are a few child psychiatrists, though they have had a satisfactory training by western standards. Child psychiatry is very recent introduction in psychiatric service which itself is being neglected and suffers from scarcity of general psychiatrists.Considering that estimate for the whole of Bangladesh is around 2.2 million children aged between 5 and 10 with a psychiatric disorder, it is clearly impossible to meet the national needs by relying only on child psychiatrists. It becomes very clear that other health professionals also need to be prepared to recognise and treat the commoner child and adolescent psychiatric problems, turning to more specialised services only for the more complicated cases. As has been comprehensively discussed in a recent review paper, general practice plays an important role in the identification and management of child psychiatric disorders and in the promotion of child and adolescent mental health. This review pointed out models of psychiatric treatment in primary care such as local outpatient clinics and consultation-liaison. In outpatient clinics, for example, short interventions, guided by problem-specific protocols have been adopted. Liaison consultation was found to be helpful to guide practitioners in the identification and management of psychiatric morbidity and in the definition of the best time for specialist referral (**Garralda 2001**). In particular, the model that offers problem-specific intervention seems to suit very well the need of 1.5 million children with behavioural disorders in Brazil, as estimated from the present study. In this case, parent-training protocols offered by trained health professionals in general health clinics should be one of the first strategies implemented.

The second most important focus of intervention suggested by the present study was anxiety disorders. These interventions should include cognitive behavioural therapy, medication and advice to schools for conditions such as school phobia. Emotional disorders or the so called internalising disorders might be harder to recognise and less obviously in need of treatment than behavioural problems and therefore children's emotional needs may be left aside. In this case a more complex strategy is needed. It would include training paediatricians and psychologists from local health clinics to recognise these problems and how to treat ordinary cases. Primary care physicians could also be trained for this purpose to work in excellent national health infrastructure. The liaison with schools to provide advice to teachers could be done by the health clinics, but there is no tradition of this sort of interaction in Bangladesh. Another option could be to develop a continuous educational programme run jointly by education and health authorities that would progressively prepare teachers and schools to receive and implement advice provided by health professionals.

The third focus of intervention that the researcher suggested is Hyperkinesis, offering medication and behavioural management in clinics and advice in schools on education and behavioural management of children with Hyperkinetic disorder. By contrast with internalising disorders, children with Hyperkinetic disorder in general present with difficult behaviour and therefore teachers and schools will probably be more receptive and motivated to get advice. In developed countries educational packs have been developed such as brochures, videos, books, websites and have been very useful to instruct but also to demystify mental health issues. In Bangladesh, videos, books and websites might not have such a good penetration in poorer areas, but short and simple brochures would certainly be appropriate. This has been happening successfully in other areas such as immunization, women's health, drug abuse, and AIDS campaigns.

7.7 Future directions

The present study can be considered the first attempt to investigate the epidemiology of child and adolescent psychiatric disorders in Bangladesh using the current diagnostic criteria and appropriate methodology. These studies have produced quality data that can influence policy makers and guide the service planning and also be used for cross-cultural comparison. However, in this section the researcher will to discuss several topics that remain unanswered.

7.7.1 Aetiology

Child psychiatric epidemiology investigates not only the distribution of child psychiatric disorders but also the factors that influence that distribution and therefore helps increase understanding about the aetiology of disorders. The present study was a cross-sectional study and investigated, along with the main measures of prevalence, several variables to indicate possible risk factors. The study also raised new hypotheses in relation to other risk and protective factors such as social capital, which will require further investigation. A follow-up study of the present study, targeting the original sample three years later will provide stronger data to address the outcome of disorders, predictors or prognostic variables and risk factors.

7.7.2 Mental Retardation

It was also not possible to assign mental retardation with these measures and the present study was not aimed for this assessment. Mental retardation is an important risk factor for child mental health problems and will certainly need further investigation in Bangladeshi children. At present, both the health and educational systems are poorly prepared to identify and meet the needs of learning disabled children.

7.7.3 Rarer disorders and others not included in the psychiatric measures adopted

Neither the design of the present study nor the psychiatric measures adopted (SDQ and DAWBA) were appropriate to address rarer disorders such as, psychosis and eating disorders. Along with these rarer disorders, a few commoner disorders such as somatoform disorders were also not included in the present study. The considerable prevalence of somatoform disorders is expectable as Bangladeshi children have the tendency of somatization. The reports on somatoform disorders in children and adolescents in Bangladesh also support this assumption (**Mullick 2002, Das 2004**). Questions about their prevalence and correlation with socio-economic and geographic characteristics of Bangladesh remain open.

7.7.4 Extending the age range

The age range targeted (5 to 10) was the lower to middle age. Therefore, the prevalence rates obtained might be slightly altered when the age range targeted is extended to the lower and upper ends, in future studies.

7.7.5 Financial costs

There have been growing interests in the child psychiatric literature about the impact of child mental health problems in adult life and financial costs of these problems. For example, **Scott et al. 2001** investigated the cumulative costs of public services used through to adulthood by individuals with three levels of antisocial behaviour in childhood. This study concluded that antisocial behaviour is a major predictor of how much an individual will cost society. Along with emotional disorder, behavioural disorders should indeed be a major concern according to the findings of the present study in Bangladesh

and require studies on financial costs adjusted to the economy of Bangladesh. This field is currently unexplored in Bangladesh and will be of major importance in terms of helping policy makers and health authorities to recognise the need for funding prevention and treatment.

Now that the present study has demonstrated the scale of the need, it will be vital to develop treatments and modes of service delivery appropriate to Bangladesh. Having done so, they should be clinically and economically evaluated in order to determine their clinical and cost effectiveness (**Bower et al. 2001**).

7.7.6 Investigations elsewhere in Bangladesh

The results from the present study are probably adequately extendable to the whole of the Bangladesh. As there is no major socio-economic and geographic diversity of Bangladesh, nationwide community based survey using the same methodology of the present study is fairly plausible to look at the prevalence of child psychiatric disorders in Bangladeshi population.

7.8 Final Conclusion

Hypotheses status

It was found from the present studies that the prevalence rate of child psychiatric disorder in Bangladesh is likely parallel with other countries that proved the first hypothesis perfectly well by comparing the findings of the similar studies in developed and developing countries. The second hypothesis of this study was that existence of emotional disorder is more than behavioural disorder among children and adolescents in Bangladesh. The prevalence of emotional disorder and behavioural disorder were found almost equal in the present study. Therefore, no conclusion can be drawn either in favour or against of the hypothesis. Further studies with more representative sample only can clarify it. The last hypothesis was that the conduct disorder is substantially commoner in poor urban area than in rural or middle-income urban areas of Bangladesh. In the present study, most striking difference between slum area and the other two areas in term of types of disorders was significantly higher rate of prevalence of conduct disorder in slum area than that in other two areas. Therefore it can be concluded that children from the slum were substantially more likely than children from the other two areas to have serious conduct problems.

Objective status

This epidemiological study in three contrasting area in Bangladesh was able to accomplish its main objectives. It established that the overall prevalence of child psychiatric disorders was 15.2%. The prevalence for the three main population groups was: 15.4% for children from rural families, 10.0% for children from urban families and 19.5% for children from slum families. The group of behavioural disorders (according to the ICD 10) was the most prevalent with estimates around 8.9%, followed by emotional disorders (mainly anxiety disorders) with estimates around 8.1%. Prevalence rates per type of disorder were also obtained. Differences in types of disorders in the present study are most striking between slum area and the other two areas, with highly significant rate of prevalence of conduct disorder (6.8%).The rate of conduct disorder was lower in other two areas (0.7% in rural and 0.7% in urban)The preliminary study and pilot study of the present thesis also validated the methodology adopted in the main stage study, including ascertainment methods and measures that established strong methodological foundations for more epidemiological studies in future. The possible variables for searching correlates of child

psychiatric disorder were identified for future search. However, findings of the present study need to be viewed as provisional and approximate. The definitive broad based studies with larger sample from lower to upper age limit have yet to be done to confirm the report of the present study. Researchers and policy makers should view

Ultimate need

Although there is still much to do, the epidemiological studies described in this thesis are a first step towards informing clinicians and policy makers in Bangladesh of the scale of the problems that need to be addressed if all Bangladeshi children with mental health problems are to have access to appropriate help. Future studies can refine the estimate of the present study by estimating other areas, age ranges, and different risk groups. A conservative extrapolation is that around 5 million Bangladeshi children and adolescents have psychiatric disorders. In a country with very few child mental health professionals, there is a vast gap between need and provision that must be fulfilled. Meeting this need will be costly, but not doing so will probably be considerably more costly, both in human and economic terms.

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ANNEXURES

ANNEXURE 1

English version of the Strengths and Difficulties Questionnaire

Strengths and Difficulties Questionnaire

P4-16

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

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

Date of Birth .....

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

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

• How long have these difficulties been present?

Less than a month	1-5 months	5-12 months	Over a year
☐	☐	☐	☐

• Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

• Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

• Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

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

Mother/Father/Other (please specify:)

Thank you very much for your help

Strengths and Difficulties Questionnaire

T4-16

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

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

Date of Birth .....

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

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that this child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

• How long have these difficulties been present?

Less than a month	1-5 months	5-12 months	Over a year
☐	☐	☐	☐

• Do the difficulties upset or distress the child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

• Do the difficulties interfere with the child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
PEER RELATIONSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐

• Do the difficulties put a burden on you or the class as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

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

Class Teacher/Head of Year/Other (please specify:)

Thank you very much for your help

Strengths and Difficulties Questionnaire

S[11-16]

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

Your Name ..... Male/Female

Date of Birth .....

	Not True	Somewhat True	Certainly True
I am considerate of other people's feelings	☐	☐	☐
I am restless, I cannot stay still for long	☐	☐	☐
I get a lot of headaches, stomach-aches or sickness	☐	☐	☐
I usually share with others (food, games, pens etc.)	☐	☐	☐
I get very angry and often lose my temper	☐	☐	☐
I am rather solitary. I usually play alone or keep to myself	☐	☐	☐
I usually do as I am told	☐	☐	☐
I worry a lot	☐	☐	☐
I am helpful if someone is hurt, upset or feeling ill	☐	☐	☐
I am constantly fidgeting or squirming	☐	☐	☐
I have at least one good friend	☐	☐	☐
I fight a lot. I can make other people do what I want	☐	☐	☐
I am often unhappy, down-hearted or tearful	☐	☐	☐
Other people my age generally like me	☐	☐	☐
I am easily distracted, I find it difficult to concentrate	☐	☐	☐
I am nervous in new situations. I easily lose confidence	☐	☐	☐
I am kind to younger children	☐	☐	☐
I am often accused of lying or cheating	☐	☐	☐
Other children or young people pick on me or bully me	☐	☐	☐
I often volunteer to help others (parents, teachers, children)	☐	☐	☐
I think things out before acting	☐	☐	☐
I take things that are not mine from home, school or elsewhere	☐	☐	☐
I get on better with adults than with people my own age	☐	☐	☐
I have many fears, I am easily scared	☐	☐	☐
I see tasks through to the end. My attention is good	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that you have difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

• How long have these difficulties been present?

Less than a month	1-5 months	5-12 months	Over a year
☐	☐	☐	☐

• Do the difficulties upset or distress you?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

• Do the difficulties interfere with your everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

• Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Your Signature .....

Today's Date .....

Thank you very much for your help

ANNEXURE 2

English version of the Development and Well-Being Assessment (DAWBA)

The Development and Well-Being Assessment

Parent Interview

Child's Surname:

Child's First Names:

Age:

Date of Birth:

Male / Female

Clinic/Study Number:

Date of Interview:

Person Interviewed:

Interviewer:

The first step is to administer the P4-16 Strengths and Difficulties Questionnaire (SDQ) and then use the transparency to score the front page, ringing the scores below.

SDQ Emotion Score	0	1	2	3 ||	4	5	6	7	8	9	10
SDQ Hyperactivity Score	0	1	2	3	4	5 ||	6	7	8	9	10
SDQ Conduct Score	0	1	2 ||	3	4	5	6	7	8	9	10

Section A Separation Anxiety

Most children are particularly attached to a few key adults, looking to them for security and comfort, and turning to them when upset or hurt.

		No	Yes
A1	Is [Name] specially attached to the following adults?		
a)	Mother (biological or adoptive)	0	1
b)	Father (biological or adoptive)	0	1
c)	Another mother figure (stepmother, foster mother, father's partner)	0	1
d)	Another father figure (stepfather, foster father, mother's partner)	0	1
e)	One or more grandparents	0	1
f)	One or more other adult relatives (e.g. aunt, uncle, grown-up brother or sister)	0	1
g)	Childminder, nanny, au pair	0	1
h)	One or more teachers	0	1
i)	One or more other adult non-relatives (e.g. a family friend or neighbour)	0	1
j)	Not specially attached to any adult	0	1

Only ask the following questions if the answer to A1j was 'Yes', i.e. the child is not specially attached to any adult.

		No	Yes
	Is (Child) specially attached to the following children or young people?		
k)	One or more brothers, sisters or other young relatives	0	1
l)	One or more friends	0	1
m)	Not specially attached to anyone	0	1

if A1m is 'Yes', then skip to section B. Otherwise continue.

You've just told me who [Name] is specially attached to: *If you want, you can list all from A1a to A1l (or from A1k to A1l) that were answered 'Yes'.* From now on, I am going refer to these people as his/her 'attachment figures'

What I'd like to know next is how much [Name] worries about being separated from his/her attachment figures. Most children have some worries of this sort, but I'd like to know how [Name] compares with other children of his/her age. I am interested in how s/he is usually - not on the occasional 'off day'.

		No	Yes
A2	Overall, in the **last 4 weeks**, has s/he been particularly worried about being separated from his/her attachment figures?	0	1

If A2 = Yes or if SDQ emotion score is ≥ 4 then continue. If neither, then skip to section B.

A3	Over the **last 4 weeks**, and compared with other children of the same age...	No more than others (or Not applicable)	A little more than others	A lot more than others
a)	has s/he worried either about something unpleasant happening to his/her attachment figures, or about losing them?	0	1	2
b)	has s/he worried unrealistically that s/he might be taken away from his/her attachment figures, e.g. by being kidnapped, taken to hospital or killed?	0	1	2
c)	Has s/he not wanted to go to school in case something nasty happened to his/her attachment figures while s/he was away at school? *(Do not include reluctance to go to school for other reasons e.g. fear of bullying or exams)*	0	1	2
d)	has s/he worried about sleeping alone?	0	1	2
e)	has s/he come out of his/her bedroom at night to check on, or to sleep near, his/her attachment figures?	0	1	2
f)	has s/he worried about sleeping in a strange place?	0	1	2
g)	*(Only ask if aged under 11)* has s/he been afraid of being alone in a room at home without his/her attachment figures even if they are close by?	0	1	2
h)	*(Only ask if aged 11 or more)* has s/he been afraid of being alone at home if his/her attachment figures pop out for a moment?	0	1	2
i)	has s/he had repeated nightmares or bad dreams about being separated from his/her attachment figures?	0	1	2
j)	has s/he had headaches, stomach aches or felt sick when s/he had to leave his/her attachment figures or when s/he knew it was about to happen?	0	1	2
k)	has being apart from his/her attachment figures, or the thought of being apart from them led to worry, crying, tantrums, clinginess or misery?	0	1	2

If any of the items in A3 have been answered "A lot more than others" then tick Separation Anxiety on the check list in M1 (p.34) and continue with A4. If not, skip to section B.

A4 Have [Name's] worries about separation been there for at least **4 weeks**?

No	Yes
0	1

A5 How old was s/he when his/her worries about separation began?

(if since birth, enter 0)

[ ] years old

A6 How much have these worries upset or distressed him/her?

Not at all	A little	A medium amount	A great deal
0	1	2	3

A7 Have these worries interfered with ...

		Not at all	A little	A medium amount	A great deal
a)	how well s/he gets on with you and the rest of the family?	0	1	2	3
b)	making and keeping friends?	0	1	2	3
c)	learning or class work?	0	1	2	3
d)	playing, hobbies, sports or other leisure activities?	0	1	2	3

A8 Have these worries put a burden on you or the family as a whole?

Not at all	A little	A medium amount	A great deal
0	1	2	3

Section B Fears of specific things or situations

This section of the interview is about some things or situations that children are often scared of, even though they aren't really a danger to them. I'd like to know what [Name] is afraid of. I am interested in how s/he is usually - not on the occasional 'off day'. Not all fears are covered in this section – some are covered in other sections, e.g. fears of social situations, dirt, separation, crowds.

B1	Is [Name] scared of any of the things or situations on this list?	No	A little	A lot
a)	Animals: Dogs, spiders, bees and wasps, mice and rats, snakes, or any other animal, bird or insect	0	1	2
b)	Some aspect of the natural environment, e.g. storms, thunder, heights, water	0	1	2
c)	The dark	0	1	2
d)	Loud noises, e.g. fire alarms, fireworks	0	1	2
e)	Blood - injection - injury: Set off by the sight of blood or injury, or by an injection, or by other medical procedures	0	1	2
f)	Dentists or doctors	0	1	2
g)	Vomiting, choking or getting particular diseases, e.g. cancer or AIDS	0	1	2
h)	Using particular types of transport, e.g. cars, buses, boats, planes, ordinary trains, underground trains, bridges	0	1	2
i)	Small enclosed spaces, e.g. lifts, tunnels	0	1	2
j)	Using the toilet, e.g. at school or in someone else's house	0	1	2
k)	Specific types of people, e.g. clowns, people with beards, with crash-helmets, in fancy dress, dressed as Santa Claus	0	1	2
l)	Imaginary or supernatural beings, e.g. monsters, ghosts, aliens, witches	0	1	2
m)	Any other specific fear *(Describe)*	0	1	2

If any of the items in B1 have been answered "a lot", then continue with B2. Otherwise, go to section C.

B2	Are these fears a real nuisance to him/her, to you, or to anyone else?	No	Perhaps	Definitely
		0	1	2

If B2 = "Definitely" or if SDQ emotion score is ≥ 4 then continue. If neither, then skip to section C.

B3 How long has this fear or the most severe of these fears been present?

Less than 1 month	1 - 5 months	6 months or more
0	1	2

B4 When [Name] comes up against the things s/he is afraid of, or when s/he thinks s/he is about to come up against them, does s/he become anxious or upset?

No	A little	A lot
0	1	2
	B7	↓ B5

B5 Does s/he become anxious or upset every time, or almost every time, s/he comes up against the things s/he is afraid of?

No	Yes
0	1

B6 How often do his/her fears result in his/her becoming upset like this?

N.B. if [Name] is afraid of something that is only there for part of the year (e.g. wasps), this question is about that particular season.

Every now and then	Most weeks	Most days	Many times a day
0	1	2	3

B7 Do [Name's] fears lead to him/her avoiding the things s/he is afraid of?

No	A little	A lot
0	1	2
	B9	↓ B8

B8 Does this avoidance interfere with his/her daily life?

No	A little	A lot
0	1	2

	No	Perhaps	Definitely
B9 Do <u>you</u> think that his/her fears are over the top or unreasonable?	0	1	2
B10 And what about him/her? Does <u>s/he</u> think that his/her fears are over the top or unreasonable?	0	1	2

If B2 = "Definitely" or B4 = "A lot" or B7 = "A lot", then tick Specific Phobia on check list in M1(p.34).

B11 Have [Name's] fears put a burden on you or the family as a whole?

Not at all	A little	A medium amount	A great deal
0	1	2	3

Section C Fear of social situations

I am interested in whether (Child) is particularly afraid of social situations. This is as compared with other children of his/her age, and is not counting the occasional 'off day' or ordinary shyness.

C1	Overall, does [Name] particularly fear or avoid social situations that involve a lot of people, meeting new people, or doing things in front of people?	No	Yes
		0	1

If C1 = "Yes" or if SDQ emotion score is ≥ 4, then continue. If neither, then skip to section D.

C2	Has [Name] been particularly afraid of any of the following social situations over the **last 4 weeks**?	No	A little	A lot
a)	Meeting new people?	0	1	2
b)	Meeting a lot of people, such as at a party?	0	1	2
c)	Eating in front of others?	0	1	2
d)	Speaking in class?	0	1	2
e)	Reading out loud in front of others?	0	1	2
f)	Writing in front of others?	0	1	2

If none of the items in C2 have been answered "A lot", then skip to section D.

C3 Most children are attached to a few key adults, feeling more secure when they are around. Some children are only afraid of social situations if they don't have one of these key adults around.

Other children are afraid of social situations even when they are with one of these key adults.

Which is true for [Name]?	Mostly fine in social situations as long as key adults are around	Social fears are marked even when key adults are around
	0	1

C4 Is [Name] just afraid with adults, or is s/he also afraid in situations that involve a lot of children, or meeting new children?

Just with adults	Just with children	With both adults and children
0	1	2

C5 Outside of these social situations, is [Name] able to get on well enough with the adults and children s/he knows best?

No	Yes
0	1

C6 Do you think his/her dislike of social situations is because s/he is afraid s/he will act in a way that will be embarrassing or show him/her up?

No	Perhaps	Definitely
0	1	2

C7 *(Only ask if C2d = Yes, or C2e = Yes, or C2f = Yes)*

Is his/her dislike of social situations related to specific problems with speech, reading or writing?

No	Perhaps	Definitely
0	1	2

C8 How long has his/her fear of social situations been present?

Less than 1 month	1 - 5 months	6 months or more
0	1	2

C9 How old was s/he when this fear of social situations began?

(if since birth, enter 0) ____ years old

C10 When [Name] is in one of the social situations s/he fears, or when s/he thinks s/he is about to come up against one of these situations, does s/he become anxious or upset?

No	A little	A lot
0	1	2
		↓
C12		C11

C11 How often does his/her fear of social situations result in him/her becoming upset like this?

Every now and then	most weeks	most days	many times a day
0	1	2	3

C12 Does his/her fear lead to [Name] avoiding social situations?

No	A little	A lot
0	1	2
		↓
C14		C13

C13 Does this avoidance interfere with his/her daily life?

No	A little	A lot
0	1	2

	No	Perhaps	Definitely
C14 Does s/he think that this fear of social situations is over the top or unreasonable?	0	1	2
C15 Is s/he upset about having this fear?	0	1	2

If C10 = "A lot" or C12 = "A lot", then tick Social Phobia on check list in M1(p.34).

C16 Has [Name's] fear of social situations put a burden on you or the family as a whole?

Not at all	A little	A medium amount	A great deal
0	1	2	3

Section D Panic Attacks and Agoraphobia

Many children have times when they get very anxious or worked up about silly little things, but some children get severe panics that come out of the blue - they just don't seem to have any trigger at all.

		No	Yes
D1	In the **last 4 weeks**, has [Name] had a panic attack when s/he suddenly became very panicky for no reason at all, without even a little thing to set him/her off?	0	1

If D1 = "Yes" then tick the box for Panic/Agoraphobia on the check list in M1 (p.34).

		No or Not Applicable	Yes
D2	Over the **last 4 weeks**, has [Name] been very afraid of, or tried to avoid, the following situations?		
a)	Crowds	0	1
b)	Public Places	0	1
c)	Travelling alone (If s/he ever does so)	0	1
d)	Being far from home	0	1

If any of the items in D2 have been answered "Yes", then continue with D3. Otherwise skip to section E.

		No	Yes
D3	Do you think this fear or avoidance of (Situation) is because s/he is afraid that if s/he had a panic attack, or something like that, s/he would find it difficult or embarrassing to get away, or wouldn't be able to get the help s/he needs?	0	1

If D3 = "Yes", then tick the box for Panic/Agoraphobia on the check list in M1 (p.34).

Section E Post Traumatic Stress

The next section is about events or situations that are exceptionally stressful, and that would really upset almost anyone. For example being caught in a burning house, being abused, being in a serious car crash or seeing you being mugged at gunpoint.

		No	Yes
E1	During [Name's] lifetime has anything like this happened to him/her?	0	1

		No	Yes
E2	*(If E1 = 'No' then start question with* 'Just to check...') Has [Name] ever experienced any of the following? (use card)		
	<u>Child involved in a disaster</u>		
a)	A serious and frightening accident, e.g. being run over by a car, being in a bad car or train crash, etc.	0	1
b)	A bad fire, e.g. trapped in a burning building	0	1
c)	Other disasters, e.g. kidnapping, earthquake, war	0	1
	<u>Violence to child</u>		
d)	A severe attack or threat, e.g. by a mugger or a gang	0	1
e)	Severe physical abuse that s/he still remembers	0	1
	<u>Sexual assault of child</u>		
f)	Sexual abuse	0	1
g)	Rape	0	1
	<u>Child witnessed something very upsetting</u>		
h)	Witnessed severe domestic violence, e.g. saw mother being badly beaten up at home	0	1
i)	Saw a family member or a friend severely attacked or threatened, e.g. by a mugger or a gang	0	1
j)	Witnessed a sudden death, a suicide, an overdose, a serious accident, a heart attack etc.	0	1
	<u>Other severe trauma</u>		
k)	Some other severe trauma (Describe)	0	1

If any of the items in E2 have been answered "Yes", then continue with E3. Otherwise, go to section F.

E3	At the time, was [Name] very distressed or did his/her behaviour change dramatically?	No: 0	Yes: 1
E3A	At present, is it affecting [Name's] behaviour, feelings or concentration?	No: 0 → Section F	Yes: 1 → E4

		No	A little	A lot
E4	Over the **last 4 weeks**, has [Name]...			
a)	"relived" the event with vivid memories (flashbacks) of it?	0	1	2
b)	had repeated distressing dreams of the event?	0	1	2
c)	got upset if anything happened that reminded him/her of it?	0	1	2
d)	tried to avoid thinking or talking about anything to do with the event?	0	1	2
e)	tried to avoid activities, places or people that remind him/her of the event?	0	1	2
f)	blocked out important details of the event from his/her memory?	0	1	2
g)	shown much less interest in activities s/he used to enjoy?	0	1	2
h)	felt cut off or distant from others?	0	1	2
i)	expressed a smaller range of feelings than in the past, e.g. no longer able to express loving feelings?	0	1	2
j)	felt less confidence in the future?	0	1	2
k)	had problems sleeping?	0	1	2
l)	felt irritable or angry?	0	1	2
m)	had difficulty concentrating?	0	1	2
n)	always been on the alert for possible dangers?	0	1	2
o)	jumped at little noises or been easily startled in other ways?	0	1	2

If any part of E4 is answered "A lot", then tick the box for Post Traumatic Stress on the check list in M1 (p.34) and continue with E5. Otherwise, skip to section F.

E5 You have told me about (Definite Symptom/s). How long after the stressful event(s) did these other problems begin?

Within 6 months	More than 6 months after event
0	1

E6 How long has s/he been having these problems?

Less than 1 month	1 or 2 months	3 months or more
0	1	2

E7 How upset or distressed is s/he by the problems that the stressful event(s) triggered off?

Not at all	A little	A medium amount	A great deal
0	1	2	3

E8 Have these problems interfered with ...

		Not at all	A little	A medium amount	A great deal
a)	how well s/he gets on with you and the rest of the family?	0	1	2	3
b)	making and keeping friends?	0	1	2	3
c)	learning or class work?	0	1	2	3
d)	playing, hobbies, sports or other leisure activities?	0	1	2	3

E9 Have these problems put a burden on you or the family as a whole?

Not at all	A little	A medium amount	A great deal
0	1	2	3

Section F Compulsions and Obsessions

Many children have some rituals or superstitions, e.g. not stepping on the cracks in the pavement, having to go through a special goodnight ritual, having to wear lucky clothes for exams, or needing a lucky mascot for school sports matches. It is also common for children to go through phases when they seem obsessed by one particular subject or activity, e.g. cars, a pop group, a football team. But what I want to know is whether [Name] has any rituals or obsessions that go beyond this.

F1 Does [Name] have rituals or obsessions that upset him/her, waste a lot of his/her time, or interfere with his/her ability to get on with everyday life?

No	Yes
0	1

If F1 = Yes, or SDQ Emotion score is ≥4 then continue. If neither, then skip to section G.

F2 Over the **last 4 weeks**, has s/he had any of the following rituals (doing any of the following things over and over again even, though s/he has already done them or doesn't need to do them at all)?

		No	A little	A lot
a)	Excessive cleaning: hand washing, baths, showers, toothbrushing etc.	0	1	2
b)	Other special measures to avoid dirt, germs or poisons	0	1	2
c)	Excessive checking: electric switches, gas taps, locks, doors, the oven	0	1	2
d)	Repeating the same simple activity many times in a row for no reason, e.g. repeatedly standing up or sitting down or going backwards and forwards through a doorway	0	1	2
e)	Touching things or people in particular ways	0	1	2
f)	Arranging things so they are just so, or exactly symmetrical	0	1	2
g)	Counting to particular lucky numbers or avoiding unlucky numbers	0	1	2

F3 Over the **last 4 weeks**, has [Name] been obsessively worrying about dirt, germs or poisons – not being able to get thoughts about them out of his/her mind?

No	A little	A lot
0	1	2

F3a Over the **last 4 weeks**, has [Name] been obsessively worrying about religion or having done things that have offended God?

No	A little	A lot
0	1	2

If any of the items in F2 or F3 or F3a have been answered "A lot", then tick Obsessions and Compulsions on the check list in M1 (p.34).

F4 Over the **last 4 weeks**, has [Name] been obsessed by the worry that something terrible will happen to him/her or to others, e.g. illnesses, accidents, fires?

No	A little	A lot
0	1	2
	F7	↓ F6

F6 Is this obsession about something terrible happening to him/her or to others just one part of a general concern about being separated from his/her key attachment figures, or is it a problem in its own right?

Part of separation anxiety	A problem in its own right
0	1

If F6 = "A problem in its own right" then tick Obsessions and Compulsions on the check list in M1 (p.34).

If the Obsessions and Compulsions box is ticked in M1, then continue. Otherwise skip to section G

F7 Have [Name's] rituals or obsessions been present on most days for a period of at **least 2 weeks**?

No	Yes
0	1

F8 Does s/he think that his/her rituals or obsessions are over the top or unreasonable?

No	Perhaps	Definitely
0	1	2

F9 Does s/he resist the rituals or obsessions?

No	Perhaps	Definitely
0	1	2

F10 Do the rituals or obsessions upset him/her?

No, s/he enjoys them	Neutral, s/he neither enjoys them nor becomes upset	They upset him/her a little	They upset him/her a lot
0	1	2	3

F11 Do the rituals or obsessions use up at least an hour a day on average?

No	Yes
0	1

F12 Have the rituals or obsessions interfered with...

		Not at all	A little	A medium amount	A great deal
a)	how well s/he gets on with you and the rest of the family?	0	1	2	3
b)	making and keeping friends?	0	1	2	3
c)	learning or class work?	0	1	2	3
d)	playing, hobbies, sports or other leisure activities?	0	1	2	3

F13 Have the rituals or obsessions put a burden on you or the family as a whole?

Not at all	A little	A medium amount	A great deal
0	1	2	3

Section G Generalized Anxiety

This section is about worrying

G2 Does [Name] ever worry?

No	Yes
0	1
↓	↓
Section H	Continue

Some children worry about just a few things, sometimes related to specific fears, obsessions or separation anxieties. Other children worry about many different aspects of their lives. They may have specific fears, obsessions or separation anxieties, but they also have a wide range of worries about many things.

G2A Is [Name] a worrier in general?

No, s/he just has a few specific worries	Yes, s/he worries in general
0	1
↓	↓
Only continue if SDQ emotion score ≥ 4	*Continue*

G3 Over the **last 6 months**, has [Name] worried so much about so many things that it has really upset him/her or interfered with his/her life?

No	Perhaps	Definitely
0	1	2

If G3 = "Perhaps" or G3 = "Definitely" or SDQ emotion score is ≥ 4, then continue. If neither, then skip to section H.

		No more than others	A little more than others	A lot more than others
G4	Over the **last 6 months**, and by comparison with other children of the same age, has [Name] worried about…			
a)	Past behaviour: Did I do that wrong? Have I upset someone? Have they forgiven me?	0	1	2
b)	School work, homework or examinations	0	1	2
c)	Disasters: Burglaries, muggings, fires, bombs etc.	0	1	2
d)	His/her own health	0	1	2
e)	Bad things happening to others: family, friends, pets, the world (e.g. wars).	0	1	2
f)	The future: e.g. changing school, moving house, getting a job, getting a boy/girlfriend	0	1	2
g)	Making and keeping friends	0	1	2
h)	Death and dying	0	1	2
i)	Being bullied or teased	0	1	2
j)	His/Her appearance or weight	0	1	2
k)	Other specific worry (Describe)	0	1	2

If 2 or more of these worries were answered 'a lot more than others' then continue, else skip to section H

		No	Yes
G6	Over the **last 6 months** has s/he worried excessively on more days than not?	0 ↓	1 ↓

		No	Yes
G7	Does s/he find it difficult to control the worry?	0	1

If G6 = "Yes" or G7 = "Yes" then tick Generalized Anxiety on the check list in M1 (p.34) and continue. If neither is "Yes" then, skip to section H.

G8 *If any of the following questions are answered "Yes", ask* "Has this been true for more days than not in the **last 6 months**?" *and record answer in second column.*

		In general			*More days than not in last 6 months*	
		No	Yes		No	Yes
a)	Does worrying lead to him/her feeling restless, keyed up, on edge, or unable to relax?	0	1	→	0	1
b)	Does worrying lead to him/her feeling tired or worn out more easily?	0	1	→	0	1
c)	Does worrying lead to difficulties in concentrating or his/her mind going blank?	0	1	→	0	1
d)	Does worrying lead to irritability?	0	1	→	0	1
e)	Does worrying lead to muscle tension?	0	1	→	0	1
f)	Does worrying interfere with his/her sleep, e.g. difficulty in falling or staying asleep, or restless, unsatisfying sleep?	0	1	→	0	1

G9 How upset or distressed is [Name] as a result of all his/her various worries?

Not at all	A little	A medium amount	A great deal
0	1	2	3

G10 Have his/her worries interfered with...

		Not at all	A little	A medium amount	A great deal
a)	how well s/he gets on with you and the rest of the family?	0	1	2	3
b)	making and keeping friends?	0	1	2	3
c)	learning or class work?	0	1	2	3
d)	playing, hobbies, sports or other leisure activities?	0	1	2	3

G11 Have these worries put a burden on you or the family as a whole?

Not at all	A little	A medium amount	A great deal
0	1	2	3

Section H Depression

This section of the interview is about [Name's] mood.

H1 In the **last 4 weeks**, have there been times when [Name] has been very sad, miserable, unhappy or tearful?

No	Yes
0	1
↓	↓
H7	H2

H2 Over the **last 4 weeks**, has there been a period when s/he has been really miserable nearly every day?

No	Yes
0	1

H3 During the time when s/he has been miserable, has s/he been really miserable for most of the day? (i.e. for more hours than not)

No	Yes
0	1

H4 When s/he has been miserable, could s/he be cheered up?

Easily	With difficulty/ only briefly	Not at all
0	1	2

H5 Over the **last 4 weeks**, the period of being really miserable has lasted:

Less than 2 weeks	2 weeks or more
0	1

If H1 = "Yes" and H2 = "Yes" and H3 = "Yes", then tick Depression on check list in M1 (p.34).

H7 In the **last 4 weeks**, have there been times when [Name] has been grumpy or irritable in a way that has been out of character for him/her?

No	Yes
0	1
↓	↓
H13	H8

H8 Over the **last 4 weeks**, has there been a period when s/he has been really grumpy or irritable nearly <u>every</u> day?

No	Yes
0	1

H9 During the period when s/he has been grumpy or irritable, has s/he been like that for <u>most</u> of the day? (i.e. for more hours than not)

No	Yes
0	1

H10 Has the irritability been improved by particular activities, by friends coming round, or by anything else?

Easily	With difficulty/ only briefly	Not at all
0	1	2

H11 Over the **last 4 weeks**, the period of being really irritable has lasted:

Less than 2 weeks	2 weeks or more
0	1

If H7 = "Yes" <u>and</u> H8 = "Yes" <u>and</u> H9 = "Yes", then tick Irritability on check list in M1 (p.34).

H13 In the **last 4 weeks**, have there been times when [Name] has lost interest in everything, or nearly everything, that s/he normally enjoys doing?

No	Yes
0	1
↓ H18	↓ H14

H14 Over the **last 4 weeks**, has there been a period when this lack of interest has been present nearly every day?

No	Yes
0	1

H15 During these days when s/he has lost interest in things, has s/he been like this for most of each day? (i.e. for more hours than not)

No	Yes
0	1

H16 Over the **last 4 weeks**, this loss of interest has lasted:

Less than 2 weeks	2 weeks or more
0	1

H17 *If Depression or Irritability box has been checked, ask:*

Has this loss of interest been present during the same period when s/he has been really miserable or irritable for most of the time?

No	Yes
0	1

If H13 = "Yes" and H14 = "Yes", then tick Loss of Interest on check list in M1 (p.34).

If Depression or Irritability or Loss of Interest box has been ticked on the check list M1 (p.34), then continue. Otherwise skip to H22.

		No	Yes
H18	During the period when [Name] was sad, irritable or lacking in interest…		
a)	did s/he lack energy and seem tired all the time?	0	1
b)	was s/he eating much more or much less than normal?	0	1
c)	did s/he either lose or gain a lot of weight?	0	1
d)	did s/he find it hard to get to sleep or to stay asleep?	0	1
e)	did s/he sleep too much?	0	1
f)	was s/he agitated or restless for much of the time?	0	1
g)	did s/he feel worthless or unnecessarily guilty for much of the time?	0	1
h)	did s/he find it unusually hard to concentrate or to think things out?	0	1
i)	did s/he think about death a lot?	0	1
j)	did s/he talk about harming himself/herself or killing himself/herself?	0	1
k)	did s/he try to harm himself/herself or kill himself/herself?	0	1

		No	Yes
H18L	Over the whole of his/her lifetime, has s/he ever tried to harm himself/herself or kill himself/herself?	0	1

		Not at all	A little	A medium amount	A great deal
H19	How much has [Name's] sadness, irritability or loss of interest upset or distressed him/her?	0	1	2	3

		Not at all	A little	A medium amount	A great deal
H20	Has his/her sadness, irritability or loss of interest interfered with...				
a)	how well s/he gets on with you and the rest of the family?	0	1	2	3
b)	making and keeping friends?	0	1	2	3
c)	learning or class work?	0	1	2	3
d)	playing, hobbies, sports or other leisure activities?	0	1	2	3

		Not at all	A little	A medium amount	A great deal
H21	Has his/her sadness, irritability or loss of interest put a burden on you or the family as a whole?	0	1	2	3

*Now go to section J. **Do not ask** H22 to H24 if you have already asked H18 i to l.*

Deliberate Self-Harm

		No	Yes
H22	Over the **last 4 weeks**, has s/he talked about deliberately harming or hurting himself/herself?	0	1
H23	Over the **last 4 weeks**, has s/he tried to harm or hurt himself/herself?	0	1
H24	Over the whole of his/her lifetime, has s/he ever tried to harm or hurt himself/herself?	0	1

If H22="Yes" or H23="Yes" or H24="Yes", then tick Deliberate Self-Harm on check list in M1 (p.34).

Section J Attention and Activity

This section of the interview is about [Name's] level of activity and concentration over the **last 6 months**. Nearly all children are overactive or lose concentration at times, but what I would like to know is how [Name] compares with other children of his/her own age. I am interested in how s/he is usually - not on the occasional 'off day'.

J1 Allowing for his/her age, do you think that [Name] definitely has some problems with overactivity or poor concentration?

No	Yes
0	1

If J1 = "Yes" or if SDQ hyperactivity score is ≥ 6, then continue. If neither, then skip to section K.

J2 I would now like to go through some more detailed questions about how [Name] has usually been over the **last 6 months**. I will start with questions about how active s/he has been.

Over the **last 6 months**, and compared with other children of his/her age...	No more than others	A little more than others	A lot more than others
a) Does s/he often fidget?	0	1	2
b) Is it hard for him/her to stay sitting down for long?	0	1	2
c) Does s/he run or climb about when s/he shouldn't?	0	1	2
d) Does s/he find it hard to play or take part in other leisure activities without making a lot of noise?	0	1	2
e) If s/he is rushing about, does s/he find it hard to calm down when someone asks him/her to?	0	1	2

J3 The next few questions are about impulsiveness.

Over the **last 6 months**, and compared with other children of his/her own age...	No more than others	A little more than others	A lot more than others
a) Does s/he often blurt out an answer before s/he had heard the question properly?	0	1	2
b) Is it hard for him/her to wait his/her turn?	0	1	2
c) Does s/he often butt in on other people's conversations or games?	0	1	2
d) Does s/he often go on talking even if s/he has been asked to stop, or if no one is listening?	0	1	2

J4 The next set of questions are about attention.

	Over the **last 6 months**, and compared with other children his/her age...	No more than others	A little more than others	A lot more than others
a)	Does s/he often make careless mistakes or fail to pay attention to what s/he is supposed to be doing?	0	1	2
b)	Does s/he often seem to lose interest in what s/he is doing?	0	1	2
c)	Does s/he often not listen to what people are saying to him/her?	0	1	2
d)	Does s/he often not finish a job properly?	0	1	2
e)	Is it often hard for him/her to get himself/ herself organized to do something?	0	1	2
f)	Does s/he often try to get out of things s/he would have to think about, such as homework?	0	1	2
g)	Does s/he often lose things s/he needs for school or games?	0	1	2
h)	Is s/he easily distracted?	0	1	2
i)	Is s/he often forgetful?	0	1	2

J5 Have [Name's] teachers complained over the **last 6 months** of problems with...

		No	A little	A lot
a)	fidgetiness, restlessness or overactivity?	0	1	2
b)	poor concentration or being easily distracted?	0	1	2
c)	acting without thinking about what s/he is doing, frequently butting in, or not waiting his/her turn?	0	1	2

If two or more of the items in J2, J3, or J4 have been answered "A lot more than others," then tick the box for Hyperactivity on the check list in M1 (p.34) and continue to J6. If not, skip to section K.

J6 Have [Name's] difficulties with activity or concentration been there for at least **6 months**?

No	Yes
0	1

J7 How old was s/he when his/her difficulties with activity or concentration began?
(if since birth, enter 0)

[ ] years old

J8 How much have [Name's] difficulties with activity or concentration upset or distressed him/her?

Not at all	A little	A medium amount	A great deal
0	1	2	3

J9 Have [Name's] difficulties with activity or concentration interfered with...

		Not at all	A little	A medium amount	A great deal
a)	how well s/he gets on with you and the rest of the family?	0	1	2	3
b)	making and keeping friends?	0	1	2	3
c)	learning or class work?	0	1	2	3
d)	playing, hobbies, sports or other leisure activities?	0	1	2	3

J10 Have these difficulties with activity or concentration put a burden on you or the family as a whole?

Not at all	A little	A medium amount	A great deal
0	1	2	3

Section K Awkward and Troublesome Behaviour

This next section of the interview is about behaviour. Nearly all children are awkward and difficult at times – not doing what they are told, being irritable or annoying, having temper outbursts, and so on. What I would like to know is how [Name] compares with other children of the same age. I am interested in how s/he is usually, and not just on occasional 'off days'.

K1	Thinking about the **last 6 months**, how does [Name's] behaviour compare with other children of his/her age?	Less awkward or troublesome than average	About average	More awkward or troublesome than average
		0	1	2

If K1 = "More awkward or troublesome than average," or if SDQ conduct problems score is ≥ 3, then continue. If neither, then skip to section L.

Some children are awkward or annoying with just one person - perhaps with yourself or just one brother or sister. Other children are troublesome with a range of adults or children. The following questions are about how [Name] is in general, and not just with one person.

K2	Over the **last 6 months**, and as compared with other children of the same age, has s/he often...	No more than others	A little more than others	A lot more than others
a)	had temper outbursts?	0	1	2
b)	argued with grown-ups?	0	1	2
c)	taken no notice of rules, or refused to do as s/he is told?	0	1	2
d)	seemed to do things to annoy other people on purpose?	0	1	2
e)	blamed others for his/her own mistakes or bad behaviour?	0	1	2
f)	been touchy or easily annoyed?	0	1	2
g)	been angry and resentful?	0	1	2
h)	been spiteful?	0	1	2
i)	tried to get his/her own back on people?	0	1	2

If any of the items in K2 have been answered "A lot more than others", then tick Awkward Behaviour on the check list M1 (p.34) and continue with K3. If not, skip to K8.

K3 Have [Name's] teachers complained over the **last 6 months** of problems with this kind of awkward behaviour or disruptiveness in class?

No	A little	A lot
0	1	2

K4 Has [Name's] awkward behaviour been there for at least **6 months**?

No	Yes
0	1

K5 How old was s/he when this sort of awkward behaviour began?

(if since birth, enter 0)

[ ] years old

K6 Has [Name's] awkward behaviour interfered with...

		Not at all	A little	A medium amount	A great deal
a)	how well s/he gets on with you and the rest of the family?	0	1	2	3
b)	making and keeping friends?	0	1	2	3
c)	learning or class work?	0	1	2	3
d)	playing, hobbies, sports or other leisure activities?	0	1	2	3

K7 Has his/her awkward behaviour put a burden on you or the family as a whole?

Not at all	A little	A medium amount	A great deal
0	1	2	3

Continue with K8.

Behaviour that sometimes gets children into trouble.

I'm now going to ask about behaviour that sometimes gets children into trouble, including dangerous, aggressive or antisocial behaviour. Please answer according to how s/he has been over the last year - I'm switching to the **last 12 months** for this next set of questions.

K8 *If any of the following questions are answered* "Definitely" *ask* "Has this been going on for the **last 6 months**?" *and record answer in second column.,*

As far as you know, over the **last 12 months**...	*Over the last 12 months*				*Last 6 months*	
	No	Perhaps	Definitely		No	Yes
a) has s/he often told lies in order to get things or favours from others, or to get out of having to do things s/he is supposed to do?	0	1	2	→	0	1
b) has s/he often started fights? (*Other than with brothers and sisters*)	0	1	2	→	0	1
c) has s/he often bullied or threatened people?	0	1	2	→	0	1
d) has s/he often stayed out after dark much later than s/he was supposed to?	0	1	2	→	0	1
e) has s/he stolen from the house, or from other people's houses, or from shops or school? *(This doesn't include very minor thefts, e.g. stealing his/her brother's pencil or food from the fridge)*	0	1	2	→	0	1
f) has s/he run away from home more than once, or ever stayed away all night without your permission?	0	1	2	→	0	1
g) has s/he often played truant (bunked off) from school?	0	1	2	→	0	1

(If 13 or older and definitely playing truant in the past year, ask this question. Otherwise skip to K10)

K9 Did s/he start playing truant (bunking off) from school before s/he was 13?

No	Yes
0	1

If any of the items in K8 have been answered "Definitely", then tick Troublesome Behaviour on the check list in M1 (p.34).

Only continue if check list M1 (p.34) has been ticked for Awkward Behaviour or Troublesome Behaviour. Otherwise skip to section L.

K10

May I now ask you about a list of less common but potentially more serious behaviours. I have to ask all people all questions even when they are not likely to apply.

If any of the following questions are answered "Yes" then ask "Has this happened in the **last 6 months**?" *and record answer in second column*

	As far as you know, have any of the following happened even once in the **last 12 months**?	*Over the last 12 months*			*Last 6 months*	
		No	Yes		No	Yes
a)	Has s/he used a weapon or anything that could seriously hurt someone? *(e.g. a bat, brick, broken bottle, knife, gun)*	0	1	→	0	1
b)	Has s/he really hurt someone or been physically cruel to them? *(e.g. has tied up, cut or burned someone).*	0	1	→	0	1
c)	Has s/he been really cruel on purpose to animals and birds?	0	1	→	0	1
d)	Has s/he deliberately started a fire? *(This is only if s/he intended to cause severe damage. This question is not about lighting campfires, or burning individual matches or pieces of paper)*	0	1	→	0	1
e)	Has s/he deliberately destroyed someone else's property? *(This question is not about fire setting or very minor acts, e.g. destroying sister's drawing. It does include behaviour such as smashing car windows or school vandalism)*	0	1	→	0	1
f)	Has s/he been involved in stealing on the streets, e.g. snatching a handbag or mugging?	0	1	→	0	1
g)	Has s/he tried to force someone to have sexual activity against their will?	0	1	→	0	1
h)	Has s/he broken into a house, any other building or a car?	0	1	→	0	1

If any of the items in K10 have been answered "Yes", then tick Troublesome Behaviour on the check list in M1 (p.34).

K11 Have [Name's] teachers complained of troublesome behaviour over the **last 6 months**?

No	Yes
0	1

K11AA Has his/her troublesome behaviour been present for at **least 6 months?**

No	Yes
0	1

K11A Has [Name] ever been in trouble with the police? *(Describe)*

.....

.....

No	Yes
0	1

If K11A= "Yes" then tick Trouble With The Police on the check list in M1 (p.34).

If the check list in M1 (p.34) has been ticked for Troublesome Behaviour then continue. Otherwise skip to section L.

K12	Has [Name's] troublesome behaviour interfered with...	Not at all	A little	A medium amount	A great deal
a)	how well s/he gets on with you and the rest of the family?	0	1	2	3
b)	making and keeping friends?	0	1	2	3
c)	learning or class work?	0	1	2	3
d)	playing, hobbies, sports or other leisure activities?	0	1	2	3

K13 Has his/her troublesome behaviour put a burden on you or the family as a whole?

Not at all	A little	A medium amount	A great deal
0	1	2	3

Section L Less common problems

This next section is about a variety of different aspects of [Name's] behaviour and development.

		No	Yes
L1	In his/her first 3 years of life, was there anything that seriously worried you about...		
a)	the way his/her speech developed?	0	1
b)	how s/he got on with other people?	0	1
c)	any odd rituals or unusual habits that were very hard to interrupt?	0	1

(Only ask if L1a, L1b or L1c = Yes)

		Completely cleared up	Some continuing problems
L2	Have all these early delays or difficulties now cleared up completely?	0	1

		No	Yes
L3	Does s/he have any tics or twitches that s/he can't seem to control?	0	1
L4	Have you been concerned about him/her being too thin or dieting too much?	0	1
L5	Apart from the things you have already told me about, are there any other aspects of [Name's] psychological development that really concern <u>you</u>?	0	1
L6	Apart from the things you have already told me about, are there any other aspects of [Name's] psychological development that really concern <u>his/her teachers</u>?	0	1

If L2 = "Some continuing problems", or L3 = "Yes" or L4 = "Yes" or L5 = "Yes" or L6 = "Yes" then tick Less Common Difficulties on the check list in M1 (p.34).

Section M Areas of Difficulty

M1 Check list of difficulties

A ☐ Separation anxiety = fear of being separated from *(list main attachment figures from A1)*

.....

B ☐ Specific phobia = fear of *(list main fears from B1)*.....

.....

C ☐ Social phobia = fear of *(list main fears from C1)*.....

.....

D ☐ Panic/agoraphobia = panic attacks and avoidance of crowds, being out alone etc. *(delete as appropriate).*

E ☐ Post traumatic stress = distress triggered by his/her experience of *(from E1)*.....

.....

F ☐ Obsessions and compulsions = rituals or obsessions involving *(from F2, F 3 and F4)*.....

.....

G ☐ Generalized anxiety = excessive worrying about *(from G4)*.....

.....

H ☐ Depression
☐ Irritability
☐ Loss of interest
☐ Deliberate self-harm

J ☐ Hyperactivity = difficulties with activities and attention such as *(list up to one each from J2, J3 and J4)*

.....

K ☐ Awkward behaviour = awkward behaviours such as *(list up to three from K2)*

.....

☐ Troublesome behaviour = troublesome behaviour such as *(list from K8 and K10)*

.....

☐ Trouble with the Police

L ☐ Less common difficulties = difficulties with *(list from L2, L3 L4 L5 and L6)* .....

M2 Getting a description of the child's difficulties in the parent's own words

If none of the boxes in M1 are ticked, skip to section N.

Whenever you have checked a box for one of the sections in M1, you should make sure that you get answers to the corresponding open-ended questions about that section. These open-ended questions are listed below as suggestions, but you can use your initiative to add extra questions or explain the existing questions more clearly.

You have a choice – you can ask the open-ended questions as you go along, or you can ask them after you have finished sections A to L. For example, if you tick the box for section A, then you could ask the extra questions before going on to section B, or you could wait until you have finished all the sections from A to L. If you are asking all the open-ended questions at the end, then it is often a good idea to let the parents choose which order to take the different topics in, starting with the area that concerns them most.

Whichever you decide to do, it is usually a good idea to note down the parents' spontaneous comments when they make them. That way, you will have less need to ask them to repeat themselves in this section. But do check before the end of the interview to make sure all questions have been covered for each area of difficulty.

When parents provide a vague or generalized answer, then ask them for specific examples. For example, if they say, "he worries about everything," then ask "What sorts of worries?" Or if they say, "he never does what he is told," then ask "Can you tell me about a recent occasion when he caused problems by not doing what he was told?"

Don't feel that you need to keep your answers short just because there's only a small space on this form – write small and use extra paper if necessary!

Introducing the open-ended questions:
You have already told me about [Name]'s difficulties. I'd now like to hear a bit more about these in your own words.

M2A: Separation anxiety

If M1A is ticked for separation anxiety, ask

M2A1) Please describe [Name]'s current worries about separation. How do these worries show themselves?

M2A2) How often does this worrying lead to difficulties?

M2A3) How severe are the difficulties at their worst?

M2A4) How long has he or she had these worries about separation?

M2A5) Are these worries interfering with his or her quality of life? If so, how?

M2A6) What do you think the worries are due to?

M2A7) Have you tried to do anything about these worries? If so, please describe what you've tried to do, any help that you have had, and whether this has made a difference.

M2B: Specific phobia

If M1B is ticked for specific phobia, ask

M2B1) Please describe any fears that are a real nuisance, that seriously upset him or her, or that lead to him or her not doing things that he or she would otherwise want to do.

M2B2) How often are his or her fears a nuisance or upsetting for him or her?

M2B3) How severe are the fears at their worst?

M2B4) Are his or her fears interfering with his or her quality of life? If so, how?

M2B5) Have you tried to do anything about these fears? If so, please describe what you've tried to do, any help that you have had, and whether this has made a difference.

M2C: Social phobia

If M2C is ticked for social phobia, ask

M2C1) Please describe any social fears that are a real nuisance, that seriously upset him or her, or that lead to him or her not doing things that he or she would otherwise want to do.

M2C2) How often do his or her social fears cause difficulties or upset him or her?

M2C3) How severe are these social fears at their worst?

M2C4) Are his or her social fears interfering with his or her quality of life? If so, how?

M2C5) Have you tried to do anything about these social fears? If so, please describe what you've tried to do, any help that you have had, and whether this has made a difference.

M2D: Panic/agoraphobia

If M1D is ticked for panic/agoraphobia, ask one or both of the following (according to whether the child has panic attacks or avoidance, or both)

M2D1) Please describe as fully as possible what these panic attacks are like, how often they occur, when they started, and what effect they have on [Name]'s life.

M2D2) We'd like to hear more about [Name]'s fear or avoidance of crowds, public places, travelling alone, or being far from home. Please describe this as fully as possible. Please also tell us how often this occurs, when it started, and what effect it has on his or her life.

M2E: Post traumatic stress

If M1E is ticked for post traumatic stress, ask

M2E1) What was the extremely stressful event? We're very sorry if asking about this is upsetting for you too. You only need to tell us enough details for us to make sense of [Name]'s current symptoms.

M2E2) Please describe the symptoms that [Name] still has as a result of his or her very stressful experience.

M2E3) How often do these symptoms cause difficulties or upset him or her?

M2E4) How severe are the symptoms at their worst?

M2E5) Are the symptoms interfering with his or her quality of life? If so, how?

M2E6) Have you tried to do anything about these symptoms? If so, please describe what you've tried to do, any help that you have had, and whether this has made a difference.

M2F: Obsessions and compulsions

If M1F is ticked for obsessions and compulsions, ask

M2F1) Please describe all of [Name]'s rituals or obsessions.

M2F2) How often do these rituals or obsessions cause difficulties or upset him or her?

M2F3) How severe are the rituals or obsessions at their worst?

M2F4) How long have they been present?

M2F5) Are they interfering with his or her quality of life? If so, how?

M2F6) Have you tried to do anything about these rituals or obsessions? If so, please describe what you've tried to do, any help that you have had, and whether this has made a difference.

M2G: Generalized anxiety

If M1G is ticked for generalized anxiety, ask

M2G1) Please describe what it is that [Name] worries about?

M2G2) How often does this worrying lead to difficulties?

M2G3) How severe are the worries at their worst?

M2G4) How long has he or she worried a lot about things?

M2G5) Are his or her worries interfering with his or her quality of life? If so, how?

M2G6) Have you tried to do anything about these worries? If so, please describe what you've tried to do, any help that you have had, and whether this has made a difference.

M2H: Depression

If M1H is ticked for depression, irritability or loss of interest, ask

M2H1) Please describe [Name]'s mood (sadness, irritability) and his or her level of interest in things.

M2H2) What else has changed at the same time as his or her mood and level of interest? If relevant, tell us about energy, appetite, sleep, self-confidence, blaming him or herself, hopelessness about the future, thoughts of death, self-harm etc.

M2H3) Over the **last 4 weeks**, how much of the time has he or she been like this?

M2H4) Over the **last 4 weeks**, how severe have the difficulties been at their worst?

M2H5) When did this episode of low mood, irritability or loss of interest begin?

M2H6) What do you think triggered this episode off?

M2H7) Has he or she had similar episodes in the past? If so, please describe.

M2H8) Has he or she had episodes in the past when he or she has gone 'high' instead of 'low'? If so, please describe.

M2H9) Is his or her mood or loss of interest interfering with his or her quality of life? If so, how?

M2H10) Have you tried to do anything about his or her mood or loss of interest? If so, please describe what you've tried to do, any help that you have had, and whether this has made a difference.

M2H2: Deliberate self-harm

If M1H is ticked for deliberate self-harm, ask

M2H11) It would help us to hear more about [Name]'s harming or hurting him or herself, or at least talking about doing so.

M2J: Hyperactivity

If M1J is ticked for hyperactivity, ask

M2J1) Please describe difficulties that [Name] has with overactivity, lack of attention or impulsiveness.

M2J2) How often does his or her level of activity or his or her lack of attention lead to difficulties?

M2J3) How severe are the difficulties at their worst?

M2J4) How long has he or she been like this?

M2J5) Is his or her level of activity or his or her lack of attention interfering with his or her quality of life? If so, how?

M2J6) Have you tried to do anything about his or her overactivity, lack of attention or impulsiveness? If so, please describe what you've tried to do, any help that you have had, and whether this has made a difference.

M2K: Awkward and troublesome behaviour

If M1K is ticked for awkward or troublesome behaviour, ask

M2K1) Please describe [Name]'s awkward and troublesome behaviour.

M2K2) How often does this behaviour lead to difficulties?

M2K3) How severe are the difficulties at their worst?

M2K4) How long has he or she been like this?

M2K5) Is his or her awkward and troublesome behaviour interfering with his or her quality of life? If so, how?

M2K6) Have you tried to do anything about his or her behaviour? If so, please describe what you've tried to do, any help that you have had, and whether this has made a difference.

M2L: Less common difficulties

If M1L is ticked for less common difficulties, ask whichever of the following apply:

M2L1) We would like to hear more about the sorts of difficulties that [Name] has with language, getting on with people, odd habits or unusual rituals.

M2L2) We would like to hear more about his or her tics or twitches.

M2L3) We would like to hear more about your concerns about his or her weight or dieting.

M2L4) We would like to hear more about the other things that you are concerned about.

M2L5) We would like to hear more about his or her teachers' concerns.

M2X: The interview in general:

M2X1) Finally, this is your opportunity as an interviewer to comment on the interview in general, e.g. to describe the level of motivation or understanding of the respondent, or to record your observations about the child's activity level while you were interviewing the child's parent.

Section N Strengths

I have been asking you a lot of questions about difficulties and problems. I now want to ask you about (Child's) good points or strengths.

N1

In terms of what sort of a person s/he is, what would you say are the best things about him/her?

Spontaneously says "Nothing" ☐

a)

b)

c)

d)

e)

N2

Can you tell me some things which s/he does that really please you?

Spontaneously says "Nothing" ☐

a)

b)

c)

d)

e)

Development and Well-being Assessment (Teacher Version)

Student's Name ..... Male / Female

Date of Birth ..... Form or Class .....

Teacher (form, year, subject etc.) .....

Signature ..... Today's Date .....

For each item, please mark the box. It would help us if you answered all items as best you can even if you are not absolutely certain or the item doesn't seem very relevant to this student. Please give your answers on the basis of the student's behaviour over the last six months or this school year.

Emotions

	Not True	Partly True	Certainly True
A1 Excessive worries	☐	☐	☐
A2 Marked tension or inability to relax	☐	☐	☐
A3 Excessive concern about his/her own abilities, (e.g. academic, sporting or social)	☐	☐	☐
A4 Particularly anxious about speaking to class or reading aloud	☐	☐	☐
A5 Reluctant to separate from family to come to school	☐	☐	☐
A6 Unhappy, sad or depressed	☐	☐	☐
A7 Has lost interest in carrying out usual activities	☐	☐	☐
A8 Feels worthless or inferior	☐	☐	☐
A9 Concentration affected by worries or misery	☐	☐	☐
A10 Other emotional difficulties (e.g. marked fears, panic attacks, obsessions or compulsions)	☐	☐	☐ *

*** A11 Please describe briefly:**

If you have ticked "Certainly True" to any of the questions A1 to A10, please complete the rest of this page. If not, go to the next page.

Do these difficulties	Not at all	A little	A medium amount	A great deal
A12 upset or distress him/her?	☐	☐	☐	☐
A13 interfere with his/her peer relationships?	☐	☐	☐	☐
A14 interfere with his/her classroom learning?	☐	☐	☐	☐
A15 put a burden on you or the class as a whole?	☐	☐	☐	☐

Attention, Activity and Impulsiveness

B1 When s/he is doing something in class that s/he enjoys and is good at, whether reading or drawing or making a model or whatever, how long does s/he typically stay on that task?

Less than 2 minutes	2-4 minutes	5-9 minutes	10-19 minutes	20 minutes or more
☐	☐	☐	☐	☐

	Not True	Partly True	Certainly True
B2 Makes careless mistakes	☐	☐	☐
B3 Fails to pay attention	☐	☐	☐
B4 Loses interest in what s/he is doing	☐	☐	☐
B5 Doesn't seem to listen	☐	☐	☐
B6 Fails to finish things s/he starts	☐	☐	☐
B7 Disorganised	☐	☐	☐
B8 Tries to avoid tasks that require thought	☐	☐	☐
B9 Loses things	☐	☐	☐
B10 Easily distracted	☐	☐	☐
B11 Forgetful	☐	☐	☐
B12 Fidgets	☐	☐	☐
B13 Can't stay seated when required to do so	☐	☐	☐
B14 Runs or climbs about when s/he shouldn't	☐	☐	☐
B15 Has difficulty playing quietly	☐	☐	☐
B16 Finds it hard to calm down when asked to do so	☐	☐	☐
B17 Blurts out answers before questions are finished	☐	☐	☐
B18 Hard for him/her to wait their turn	☐	☐	☐
B19 Interrupts, butts in on conversations or activities	☐	☐	☐
B20 Goes on talking if asked to stop	☐	☐	☐

If you have ticked "Certainly True" to <u>any</u> of the questions B2 to B20, please complete the rest of this page. If not, go to the next page.

Do these difficulties	Not at all	A little	A medium amount	A great deal
B21 upset or distress him/her?	☐	☐	☐	☐
B22 interfere with his/her peer relationships?	☐	☐	☐	☐
B23 interfere with his/her classroom learning?	☐	☐	☐	☐
B24 put a burden on you or the class as a whole?	☐	☐	☐	☐

Awkward and Troublesome Behaviour

	Not True	Partly True	Certainly True

C1 Temper tantrums or hot tempers	☐	☐	☐
C2 Argues a lot with adults	☐	☐	☐
C3 Disobedient at school	☐	☐	☐
C4 Deliberately does things to annoy others	☐	☐	☐
C5 Blames others for his/her own mistakes	☐	☐	☐
C6 Easily annoyed by others	☐	☐	☐
C7 Angry and resentful	☐	☐	☐
C8 Spiteful	☐	☐	☐
C9 Tries to get his/her own back	☐	☐	☐
C10 Seriously lies or cheats	☐	☐	☐
C11 Starts fights	☐	☐	☐
C12 Bullies others	☐	☐	☐
C13 Plays truant	☐	☐	☐
C14 Uses weapons when fighting	☐	☐	☐
C15 Has been physically cruel, has really hurt someone	☐	☐	☐
C16 Deliberately cruel to animals	☐	☐	☐
C17 Sets fires deliberately	☐	☐	☐
C18 Steals things	☐	☐	☐ *
C19 Vandalises property, or destroys things belonging to others	☐	☐	☐ *
C20 Shows unwanted sexualized behaviour towards others	☐	☐	☐ *
C21 Has been in trouble with the law	☐	☐	☐ *

*** C22 Please describe briefly:**

If you have ticked "Certainly True" to <u>any</u> of the questions C1 to C21, please complete the rest of this page. If not, go to the next page.

Do these behaviours	Not at all	A little	A medium amount	A great deal
C23 upset or distress him/her?	☐	☐	☐	☐
C24 interfere with his/her peer relationships?	☐	☐	☐	☐
C25 interfere with his/her classroom learning?	☐	☐	☐	☐
C26 put a burden on you or the class as a whole?	☐	☐	☐	☐

Other concerns

	Not True	Partly True	Certainly True
D1 Tics, twitches, involuntary grunts or noises	☐	☐	☐ *
D2 Diets to excess	☐	☐	☐ *

	No	Yes
D3 Do you have any other concerns about the child's psychological development?	☐	☐ *

* **D4 Please describe:**

D5 The rest of this page is for any additional comments about this child

Thank you very much for your help

The Development and Well-Being Assessment

Interview with 11-16 year olds

Surname:

First Names:

Age:

Date of Birth:

Male / Female

Clinic/Study Number:

Date of Interview:

Interviewer:

The first step is to administer the S11-16 Strengths and Difficulties Questionnaire (SDQ) and then use the transparency to score the front page, ringing the scores below.

SDQ Emotion Score	0	1	2	3	4	5 | |	6	7	8	9	10
SDQ Conduct Score	0	1	2	3 | |	4	5	6	7	8	9	10

Section A Separation Anxiety

Most young people are particularly attached to a few key adults, looking to them for security and comfort, and turning to them when upset or hurt.

		No	Yes
A1	Are you specially attached to the following adults?		
a)	Your mother (biological or adoptive)	0	1
b)	Your father (biological or adoptive)	0	1
c)	Another mother figure (stepmother, foster mother, father's partner)	0	1
d)	Another father figure (stepfather, foster father, mother's partner)	0	1
e)	One or more grandparents	0	1
f)	One or more other adult relatives (e.g. aunt, uncle, grown-up brother or sister)	0	1
g)	Childminder, nanny, au pair	0	1
h)	One or more teachers	0	1
i)	One or more other adult non-relatives (e.g. a family friend or neighbour)	0	1
j)	Not specially attached to any adult	0	1

Only ask the following questions if the answer to A1j was 'Yes', i.e. the child is not specially attached to any adult.

		No	Yes
	Are you specially attached to the following children or young people?		
k)	One or more brothers, sisters or other young relatives	0	1
l)	One or more friends	0	1
m)	Not specially attached to anyone	0	1

if A1m is 'Yes', then skip to section B. Otherwise continue:

You've just told me who you are specially attached to: *If you want, you can list all from A1a to A1i (or from A1k to A1l) that were answered 'Yes'.* From now on, I am going refer to these people as your 'attachment figures'

What I'd like to know next is how much you worry about being separated from your attachment figures. Most young people have some worries of this sort, but I'd like to know how you compare with others of your own age. I am interested in how you are usually - not on the occasional 'off day'.

		No	Yes
A2	Overall, in the **last 4 weeks**, have you been particularly worried about being separated from your attachment figures?	0	1

If A2 = Yes or if SDQ emotion score is ≥6 then continue. If neither, then skip to section B.

A3	Over the **last 4 weeks**, and comparing yourself with other people of the same age...	No more than others (or Not applicable)	A little more than others	A lot more than others
a)	have you worried either about something unpleasant happening to your attachment figures, or about losing them?	0	1	2
b)	have you worried unrealistically that you might be taken away from your attachment figures, e.g. by being kidnapped, taken to hospital or killed?	0	1	2
c)	have you not wanted to go to school in case something nasty happened to your attachment figures while you were at school? *(Do not include reluctance to go to school for other reasons e.g. fear of bullying or exams)*	0	1	2
d)	have you worried about sleeping alone?	0	1	2
e)	have you come out of your bedroom at night to check on, or to sleep near, your attachment figures?	0	1	2
f)	have you worried about sleeping in a strange place?	0	1	2
g)	have you been afraid of being alone at home if your attachment figures pop out for a moment?	0	1	2
h)	have you had repeated nightmares or bad dreams about being separated from your attachment figures?	0	1	2
i)	have you had headaches, stomach aches or felt sick when you had to leave your attachment figures or when you knew it was about to happen?	0	1	2
j)	has being apart from your attachment figures or the thought of being apart from your attachment figures led to worry, crying, angry outbursts or misery?	0	1	2

If any of the items in A3 have been answered "A lot more than others" then tick Separation Anxiety on the check list in M1 (p.3) and continue with A4. If not, skip to section B.

A4 Have your worries about separation been there for at least **4 weeks**?

No	Yes
0	1

A5 How old were you when your worries about separation began?

(if since birth, enter 0)

[ ] years old

A6 How much have these worries upset or distressed you?

Not at all	A little	A medium amount	A great deal
0	1	2	3

A7 Have these worries interfered with...

		Not at all	A little	A medium amount	A great deal
a)	how well you get on with the rest of the family?	0	1	2	3
b)	making and keeping friends?	0	1	2	3
c)	learning or class work?	0	1	2	3
d)	playing, hobbies, sports or other leisure activities?	0	1	2	3

A8 Have these worries made it harder for those around you (family, friends, teachers etc.)?

Not at all	A little	A medium amount	A great deal
0	1	2	3

Section B Fears of specific things or situations

This section of the interview is about some things or situations that young people are often scared of, even though they aren't really a danger to them. I'd like to know what you are scared of. I am interested in how you are usually - not on the occasional 'off day'. Not all fears are covered in this section – some are covered in other sections, e.g. fear of social situations, dirt, separation, crowds.

B1	Are you scared of any of the things or situations on this list?	No	A little	A lot
a)	Animals: Dogs, spiders, bees and wasps, mice and rats, snakes, or any other animal, bird or insect	0	1	2
b)	Some aspect of the natural environment, e.g. storms, thunder, heights or water	0	1	2
c)	The dark	0	1	2
d)	Loud noises, e.g. fire alarms, fireworks	0	1	2
e)	Blood - injection - injury: Set off by the sight of blood or injury, or by an injection, or by other medical procedures	0	1	2
f)	Dentists or doctors	0	1	2
g)	Vomiting, choking or getting particular diseases, e.g. cancer or AIDS	0	1	2
h)	Using particular types of transport, e.g. cars, buses, boats, planes, ordinary trains, underground trains, bridges	0	1	2
i)	Small enclosed spaces, e.g. lifts, tunnels	0	1	2
j)	Using the toilet, e.g. at school or in someone else's house	0	1	2
k)	Specific types of people, e.g clowns, people with beards, with crash-helmets, in fancy dress, dressed as Santa Claus	0	1	2
l)	Imaginary or supernatural beings, e.g. monsters, ghosts, aliens, witches	0	1	2
m)	Any other specific fear *(Describe)*	0	1	2

If any of the items in B1 have been answered "a lot", then continue with B2. Otherwise, go to section C.

B2	Are these fears a real nuisance to you, or to anyone else?	No	Perhaps	Definitely
		0	1	2

If B2 = "Definitely" or if SDQ emotion score is ≥ 6 then continue. If neither, then skip to section C.

B3 How long has this fear or the most severe of these fears been present?

Less than 1 month	1 - 5 months	6 months or more
0	1	2

B4 When you come up against the things you are afraid of, or when you think you are about to come up against them, do you become anxious or upset?

No	A little	A lot
0	1	2
	→ B7	↓ B5

B5 Do you become anxious or upset every time, or almost every time, you come up against the things you are afraid of?

No	Yes
0	1

B6 How often do your fears result in you becoming upset like this?
N.B. if you are afraid of something that is only there for part of the year (e.g. wasps), this question is about that particular season.

Every now and then	Most weeks	Most days	Many times a day
0	1	2	3

B7 Do your fears lead to you avoiding the things you are afraid of?

No	A little	A lot
0	1	2
	→ B9	↓ B8

B8 Does this avoidance interfere with your daily life?

No	A little	A lot
0	1	2

		No	Perhaps	Definitely
B9	Do <u>other people</u> think that your fears are over the top or unreasonable?	0	1	2
B10	And what about you? Do <u>you</u> think that your fears are over the top or unreasonable?	0	1	2

If B2 = "Definitely" or B4 = "A lot" or B7 = "A lot", then tick Specific Phobia on check list in M1(p.31).

B11 Have your fears made it harder for those around you (family, friends, teachers, etc.)?

Not at all	A little	A medium amount	A great deal
0	1	2	3

Section C Fear of social situations

I am interested in whether you are particularly afraid of social situations. This is as compared with other people of your own age, and is not counting the occasional 'off day' or ordinary shyness.

C1 Overall, do you particularly fear or avoid social situations that involve a lot of people, meeting new people, or doing things in front of other people?

No	Yes
0	1

If C1 = "Yes" or if SDQ emotion score is ≥ 6, then continue. If neither, then skip to section D.

C2 Have you been particularly afraid of any of the following social situations over the **last 4 weeks**?

		No	A little	A lot
a)	Meeting new people?	0	1	2
b)	Meeting a lot of people, such as at a party?	0	1	2
c)	Eating in front of others?	0	1	2
d)	Speaking in class?	0	1	2
e)	Reading out loud in front of others?	0	1	2
f)	Writing in front of others?	0	1	2

If none of the items in C2 have been answered "A lot", then skip to section D.

C3 Most young people are attached to a few key adults, feeling more secure when they are around. Some young people are only afraid of social situations if they don't have one of these key adults around.

Other young people are afraid of social situations even when they are with one of these key adults.

Which is true for you?

Mostly fine in social situations as long as key adults are around	Social fears are marked even when key adults are around
0	1

C4 Are you just afraid with adults, or are you also afraid in situations that involve a lot of young people, or meeting new people of your own age?

Just with adults	Just with young people	With both adults and young people
0	1	2

C5 Outside of these social situations, are you able to get on well enough with the adults and young people you know best?

No	Yes
0	1

C6 Is the main reason you dislike social situations because you are afraid you will act in a way that will be embarrassing or show you up?

No	Perhaps	Definitely
0	1	2

C7 *(Only ask if C2d = Yes, or C2e = Yes, or C2f = Yes)*

Do you dislike social situations because of specific problems with speaking, reading or writing?

No	Perhaps	Definitely
0	1	2

C8 How long has this fear of social situations been present?

Less than 1 month	1 - 5 months	6 months or more
0	1	2

C9 How old were you when this fear of social situations began?

(if since birth, enter 0) _____ years old

C10 When you are in one of the social situations you are afraid of, do you normally...

		No	Yes
a)	blush (go red) or shake (tremble)?	0	1
b)	feel afraid that you are going to be sick (throw up)?	0	1
c)	need to rush off to the toilet or worry that you might be caught short?	0	1

C11 When you are in one of the social situations you are afraid of, or when you think you are about to come up against one of these situations, do you become anxious or upset?

No	A little	A lot
0	1	2
	C13	C12

C12 How often does your fear of social situations result in you becoming upset like this?

Every now and then	Most weeks	Most days	Many times a day
0	1	2	3

C13 Does your fear lead to you avoiding social situations?

No	A little	A lot
0	1	2
	C15	C14

C14 Does this avoidance interfere with your daily life?

No	A little	A lot
0	1	2

	No	Perhaps	Definitely
C15 Do you think that your fear of social situations is over the top or unreasonable?	0	1	2
C16 Are you upset about having this fear?	0	1	2

If C11 = "A lot" or C13 = "A lot", then tick Social Phobia on check list in M1(p.31).

C17 Has your fear of social situations made it harder for those around you (family, friends, teachers etc.)?

Not at all	A little	A medium amount	A great deal
0	1	2	3

Section D Panic attacks and agoraphobia

Many young people have times when they get very anxious or worked up about silly little things, but some get severe panics that come out of the blue - they just don't seem to have any trigger at all.

		No	Yes
D1	In the **last 4 weeks** have you had a panic attack when you suddenly became very panicky for no reason at all, without even a little thing to set you off?	0	1

If D1 = "Yes", then tick the box for Panic/Agoraphobia on the check list in M1 (p.31) and continue with D2. Otherwise skip to D4.

D2		No	Yes
a)	Do your panics start very suddenly?	0	1
b)	Do they reach a peak within a few minutes (up to 10)?	0	1
c)	Do they last at least a few minutes?	0	1

D3	When you are feeling panicky, do you also feel…	No	Yes
a)	your heart racing, fluttering or pounding away?	0	1
b)	sweaty?	0	1
c)	trembly or shaky?	0	1
d)	that your mouth is very dry?	0	1
e)	that it is hard to get your breath or that you are suffocating?	0	1
f)	that you are choking?	0	1
g)	pain or an uncomfortable feeling in your chest?	0	1
h)	that you want to be sick (throw up) or that you stomach is turning over?	0	1
i)	dizzy, unsteady, faint or light-headed?	0	1
j)	as though things around you were unreal or you were not really there?	0	1
k)	afraid that you might lose control, go crazy or pass out?	0	1
l)	afraid you might die?	0	1
m)	hot or cold all over?	0	1
n)	numbness or tingling feelings in your body?	0	1

		No or Not applicable	Yes
D4	Over the **last 4 weeks** have you been very afraid of, or tried to avoid, the following situations?		
a)	Crowds	0	1
b)	Public Places	0	1
c)	Travelling alone (if you ever do so)	0	1
d)	Being far from home	0	1

D5 *(Only ask if any of the items in D4 have been answered "Yes")*

Is this fear or avoidance of (Situation mentioned in D4) mostly because you are afraid that if you had a panic attack, or something like that (such as dizziness or diarrhoea), you would find it difficult or embarrassing to get away, or wouldn't be able to get the help you need?	No	Yes
	0	1

If D5 = "Yes" then tick the box for Panic/Agoraphobia on the check list in M1 (p.31).

D6 *If the check list in M1 (p.31) has been ticked for Panic/Agoraphobia then continue. Otherwise skip to section E.*

How much have panic attacks and/or avoidance of specific situations upset or distressed you?	Not at all	A little	A medium amount	A great deal
	0	1	2	3

	Have these panic attacks and/or avoidance of specific situations interfered with...	Not at all	A little	A medium amount	A great deal
a)	how well you get on with the rest of the family?	0	1	2	3
b)	making and keeping friends?	0	1	2	3
c)	learning or class work?	0	1	2	3
d)	playing, hobbies, sports or other leisure activities?	0	1	2	3

D8 Have panic attacks and/or avoidance of specific situations made it harder for those around you (family, friends, teachers etc.)?	Not at all	A little	A medium amount	A great deal
	0	1	2	3

Section E Post-traumatic stress

The next section is about events or situations that are exceptionally stressful, and that would really upset almost anyone. For example being caught in a burning house, being abused, being in a serious car crash or seeing family or friends being mugged at gunpoint.

		No	Yes
E1	During your lifetime has anything like this happened to you?	0	1

		No	Yes
E2	*(If E1 = 'No' then start question with* 'Just to check…') Have you ever experienced any of the following? (use card)		
	Involved in a disaster		
a)	A serious and frightening accident, e.g. being run over by a car, being in a bad car or train crash, etc.	0	1
b)	A bad fire, e.g. trapped in a burning building	0	1
c)	Other disasters, e.g. kidnapping, earthquake, war	0	1
	Victim of violence		
d)	A severe attack or threat, e.g. by a mugger or a gang	0	1
e)	Severe physical abuse that you still remember	0	1
	Victim of sexual assault		
f)	Sexual abuse	0	1
g)	Rape	0	1
	You witnessed something very upsetting		
h)	You witnessed severe domestic violence, e.g. saw your mother being badly beaten up at home	0	1
i)	You saw a family member or a friend severely attacked or threatened, e.g. by a mugger or a gang	0	1
j)	You witnessed a sudden death, a suicide, an overdose, a serious accident, a heart attack etc.	0	1
	Other severe trauma		
k)	Some other severe trauma (Describe)	0	1

If any of the items in E2 have been answered "Yes", then continue with E3. Otherwise, go to section F.

		No	Yes
E3	At the time, were you very upset or badly affected by it in some way?	0	1

		No	Yes
E3A	At present, is it affecting you behaviour, feelings or concentration?	0 ↓ Section F	1 ↓ E4

		No	A little	A lot
E4	Over the **last 4 weeks**, have you...			
a)	"relived" the event with vivid memories (flashbacks) of it?	0	1	2
b)	had a lot of upsetting dreams of the event?	0	1	2
c)	got upset if anything happened that reminded you of it?	0	1	2
d)	tried to avoid thinking or talking about anything to do with the event?	0	1	2
e)	tried to avoid activities, places or people that remind you of the event?	0	1	2
f)	blocked out important details of the event from your memory?	0	1	2
g)	shown much less interest in activities you used to enjoy?	0	1	2
h)	felt cut off or distant from others?	0	1	2
i)	expressed a smaller range of feelings than in the past, e.g. no longer able to express loving feelings?	0	1	2
j)	felt less confidence in the future?	0	1	2
k)	had problems sleeping?	0	1	2
l)	felt irritable or angry?	0	1	2
m)	had difficulty concentrating?	0	1	2
n)	always been on the alert for possible dangers?	0	1	2
o)	jumped at little noises or been easily startled in other ways?	0	1	2

If any part of E4 is answered "A lot", then tick the box for Post Traumatic Stress on the check list in M1 (p.31) and continue with E5. Otherwise, skip to section F.

E5 You have told me about (Definite Symptom/s). How long after the stressful event did these other problems begin?

Within 6 months	More than 6 months after event
0	1

E6 How long have you been having these problems?

Less than 1 month	1 or 2 months	3 months or more
0	1	2

E7 How upset or distressed are you by the problems that the stressful event(s) triggered off?

Not at all	A little	A medium amount	A great deal
0	1	2	3

E8 Have these problems interfered with...

		Not at all	A little	A medium amount	A great deal
a)	how well you get on with the rest of the family?	0	1	2	3
b)	making and keeping friends?	0	1	2	3
c)	learning or class work?	0	1	2	3
d)	playing, hobbies, sports or other leisure activities?	0	1	2	3

E9 Have these problems made it harder for those around you (family, friends, teachers etc.)?

Not at all	A little	A medium amount	A great deal
0	1	2	3

Section F Compulsions and Obsessions

Many young people have some rituals or superstitions, e.g. not stepping on the cracks in the pavement, having to go through a special goodnight ritual, having to wear lucky clothes for exams, or needing a lucky mascot for school sports matches. It is also common for young people to go through phases when they seem obsessed by one particular subject or activity, e.g. cars, a pop group, a football team. But what I want to know is whether you have any rituals or obsessions that go beyond this.

F1 Do you have rituals or obsessions that upset you, waste a lot of your time, or interfere with your ability to get on with everyday life?

No	Yes
0	1

If F1 = Yes, or SDQ Emotion score is ≥ 6 then continue. If neither, then skip to section G.

F2 Over the **last 4 weeks** have you had any of the following rituals (doing any of the following things over and over again even, though you have already done them or don't need to do them at all)?

		No	A little	A lot
a)	Excessive cleaning: hand washing, baths, showers, toothbrushing etc?	0	1	2
b)	Other special measures to avoid dirt, germs or poisons?	0	1	2
c)	Excessive checking: electric switches, gas taps, locks, doors, the oven?	0	1	2
d)	Repeating the same simple activity many times in a row for no reason, e.g. repeatedly standing up or sitting down or going backwards and forwards through a doorway?	0	1	2
e)	Touching things or people in particular ways?	0	1	2
f)	Arranging things so they are just so, or exactly symmetrical?	0	1	2
g)	Counting to particular lucky numbers or avoiding unlucky numbers?	0	1	2

F3 Over the **last 4 weeks** have you been obsessively worrying about dirt, germs or poisons – not being able to get thoughts about them out of your mind?

No	A little	A lot
0	1	2

F3a Over the **last 4 weeks** have you been obsessively worrying about religion or having done things that have been offended God?

No	A little	A lot
0	1	2

If any of the items in F2 or F3 or F3a have been answered "A lot", then tick Obsessions and Compulsions on the check list in M1 (p.31).

F4 Over the **last 4 weeks** have you been obsessed by the worry that something terrible will happen to yourself or to others - illnesses, accidents, fires etc.

No	A little	A lot
0	1	2
	F7	↓ F6

F6 Is this obsession about something terrible happening to yourself or to others just one part of a general concern about being separated from your key attachment figures, or is it a problem in its own right?

Part of separation anxiety	A problem in its own right
0	1

If F6 = "A problem in its own right" then tick Obsessions and Compulsions on the check list in M1 (p.31).

F7 *If the Obsessions and Compulsions box is ticked in M1, then continue. Otherwise skip to section G*

Have your rituals or obsessions been present on most days for a period of at **least 2 weeks**?

No	Yes
0	1

F8 Do you think that your rituals or obsessions are over the top or unreasonable?

No	Perhaps	Definitely
0	1	2

F9 Do you resist the rituals or obsessions?

No	Perhaps	Definitely
0	1	2

F10 Do the rituals or obsessions upset you?

No, I enjoy them	Neutral, I neither enjoy them nor become upset	They upset me a little	They upset me a lot
0	1	2	3

F11 Do the rituals or obsessions use up at least an hour a day on average?

No	Yes
0	1

F12 Have the rituals or obsessions interfered with...

		Not at all	A little	A medium amount	A great deal
a)	how well you get on with the rest of the family?	0	1	2	3
b)	making and keeping friends?	0	1	2	3
c)	learning or class work?	0	1	2	3
d)	playing, hobbies, sports or other leisure activities?	0	1	2	3

F13 Have the rituals or obsessions made it harder for those around you (family, friends, teachers etc.)?

Not at all	A little	A medium amount	A great deal
0	1	2	3

Section G Generalized Anxiety

This section is about worrying

G2 Do you ever worry?

No	Yes
0	1
↓	↓
Section H	Continue

Some young people worry about just a few things, sometimes related to specific fears, obsessions or separation anxieties. Other young people worry about many different aspects of their lives. They may have specific fears, obsessions or separation anxieties, but they also have a wide range of worries about many things.

G2A Are you a worrier in general?

No, I just have a few specific worries	Yes, I worry in general
0	1
↓	↓
Only continue if SDQ emotion score ≥ 6	*Continue*

G3 Over the **last 6 months**, have you worried so much about so many things that it has really upset you or interfered with your life?

No	Perhaps	Definitely
0	1	2

If G3 = "Perhaps" or G3 = "Definitely" or SDQ emotion score is ≥ 6, then continue. If neither, then skip to section H.

		No more than others	A little more than others	A lot more than others
G4	Thinking about the **last 6 months**, and comparing yourself with other people of your age, have you worried about...			
a)	Past behaviour: Did I do that wrong? Have I upset someone? Have they forgiven me?	0	1	2
b)	School work, homework or examinations	0	1	2
c)	Disasters: Burglaries, muggings, fires, bombs etc.	0	1	2
d)	Your own health	0	1	2
e)	Bad things happening to others: family, friends, pets, the world (e.g. wars).	0	1	2
f)	The future: e.g. changing school, moving house, getting a job, getting a boy/girlfriend	0	1	2
g)	Making and keeping friends	0	1	2
h)	Death and dying	0	1	2
i)	Being bullied or teased	0	1	2
j)	Your appearance or weight	0	1	2
k)	Other specific worry (Describe)	0	1	2

If 2 or more of these worries were answered 'A lot more than others' then continue, else skip to section H

G6	Over the **last 6 months** have you worried excessively on more days than not?	No	Yes
		0 ↓	1 ↓

G7	Do you find it difficult to control the worry?	No	Yes
		0	1

If G6 = "Yes" or G7 = "Yes", then tick Generalized Anxiety on the check list in M1 (p.31) and continue. If neither is "Yes" then skip to section H.

G8 *If any of the following questions are answered "Yes", ask* "Has this been true for more days than not in the **last 6 months**?" *and record answer in second column.*

		In general			*More days than not*	
		No	Yes		No	Yes
a)	Does worrying lead to you feeling restless, keyed up, on edge, or unable to relax?	0	1	→	0	1
b)	Does worrying lead to you feeling tired or "worn out" more easily?	0	1	→	0	1
c)	Does worrying lead to difficulties in concentrating or to your mind going blank?	0	1	→	0	1
d)	Does worrying lead to irritability?	0	1	→	0	1
e)	Does worrying lead to you feeling tense in your whole body?	0	1	→	0	1
f)	Does worrying interfere with your sleep, e.g. difficulty in falling or staying asleep, or restless, unsatisfying sleep?	0	1	→	0	1

G9 How upset or distressed are you as a result of all your worries?

Not at all	A little	A medium amount	A great deal
0	1	2	3

G10 Have your worries interfered with…

		Not at all	A little	A medium amount	A great deal
a)	how well you get on with the rest of the family?	0	1	2	3
b)	making and keeping friends?	0	1	2	3
c)	learning or class work?	0	1	2	3
d)	playing, hobbies, sports or other leisure activities?	0	1	2	3

G11 Have these worries made it harder for those around you (family, friends, teachers etc.)?

Not at all	A little	A medium amount	A great deal
0	1	2	3

Section H Depression

This section of the interview is about your mood.

H1 In the **last 4 weeks**, have there been times when you have been very sad, miserable, unhappy or tearful?

No	Yes
0	1
↓	↓
H7	H2

H2 Over the **last 4 weeks**, has there been a period when you have been really miserable nearly every day?

No	Yes
0	1

H3 During the time when you have been miserable, have you been really miserable for most of the day? (i.e. for more hours than not).

No	Yes
0	1

H4 When you have been miserable, could you be cheered up?

Easily	With difficulty/ only briefly	Not at all
0	1	2

H5 Over the **last 4 weeks**, the period of being really miserable has lasted:

Less than 2 weeks	2 weeks or more
0	1

If H1 = "Yes" and H2 = "Yes" and H3 = "Yes", then tick Depression on check list in M1 (p.31).

H7 In the **last 4 weeks**, have there been times when you have been grumpy or irritable in a way that was out of character for you?

No	Yes
0	1
↓	↓
H13	H8

H8 Over the **last 4 weeks**, has there been a period when you have been really irritable nearly every day?

No	Yes
0	1

H9 During the period when you have been grumpy or irritable, have you been like that for most of the day? (i.e. more hours than not)

No	Yes
0	1

H10 Has the irritability been improved by particular activities, by friends coming round or by anything else?

Easily	With difficulty/ only briefly	Not at all
0	1	2

H11 Over the **last 4 weeks**, the period of being really irritable has lasted:

Less than 2 weeks	2 weeks or more
0	1

If H7 = "Yes" and H8 = "Yes" and H9 = "Yes", then tick Irritability on check list in M1 (p.31).

H13 In the **last 4 weeks**, have there been times when you have lost interest in everything, or nearly everything, that you normally enjoy doing?

No	Yes
0	1
↓	↓
H18	H14

H14 Over the **last 4 weeks**, has there been a period when this lack of interest has been present nearly every day?

No	Yes
0	1

H15 During these days when you have lost interest in things, have you been like this for most of each day? (i.e. more hours than not).

No	Yes
0	1

H16 Over the **last 4 weeks**, this loss of interest has lasted:

Less than 2 weeks	2 weeks or more
0	1

H17 *If Depression or Irritability box has been checked, ask:*

Has this loss of interest been present during the same period when you have been really miserable or irritable for most of the time?

No	Yes
0	1

If H13 = "Yes" and H14 = "Yes", then tick Loss of Interest on check list in M1 (p.31).

If Depression or Irritability or Loss of Interest box has been ticked on the check list M1 (p.31), then continue. Otherwise skip to H22.

		No	Yes
H18	During the period when you were sad, irritable or lacking in interest...		
a)	did you lack energy and feel tired all the time?	0	1
b)	were you eating much more or much less than normal?	0	1
c)	did you either lose or gain a lot of weight?	0	1
d)	did you find it hard to get to sleep or to stay asleep?	0	1
e)	did you sleep too much?	0	1
f)	were you agitated or restless for much of the time?	0	1
g)	did you feel worthless or unnecessarily guilty for much of the time?	0	1
h)	did you find it unusually hard to concentrate or to think things out?	0	1
i)	did you think about death a lot?	0	1
j)	did you think about harming yourself or killing yourself?	0	1
k)	did you try to harm yourself or kill yourself?	0	1

		No	Yes
H18L	Over the whole of your lifetime have you ever tried to harm yourself or kill yourself?		
		0	1

		Not at all	A little	A medium amount	A great deal
H19	How much has your sadness, irritability or loss of interest upset or distressed you?				
		0	1	2	3

		Not at all	A little	A medium amount	A great deal
H20	Has your sadness, irritability or loss of interest interfered with...				
a)	how well you get on with the rest of the family?	0	1	2	3
b)	making and keeping friends?	0	1	2	3
c)	learning or class work?	0	1	2	3
d)	playing, hobbies, sports or other leisure activities?	0	1	2	3

		Not at all	A little	A medium amount	A great deal
H21	Has your sadness, irritability or loss of interest made it harder for those around you (family, friends, teachers, etc.)?	0	1	2	3

Now go to section J. ***Do not ask*** *H22 to H24 if you have already asked H18 i to l.*

Deliberate Self-Harm

		No	Yes
H22	Over the **last 4 weeks**, have you thought about deliberately harming or hurting yourself?	0	1
H23	Over the **last 4 weeks**, have you tried to harm or hurt yourself?	0	1
H24	Over the whole of your lifetime, have you ever tried to harm or hurt yourself?	0	1

If H22= "Yes" or H23= "Yes" or H24= "Yes", then tick Deliberate Self-Harm on check list in M1 (p.31).

Section J Attention and Activity

This section of the interview is about attention and activity.

		No	A little	A lot
J1	Do your teachers complain about you having problems with overactivity or poor concentration?	0	1	2
J2	Do your family complain about you having problems with overactivity or poor concentration?	0	1	2
J3	And what do you think? Do you think you have real problems with overactivity or poor concentration?	0	1	2

Section K Behaviour that sometimes gets people into trouble

This next section is about behaviour that sometimes gets young people into trouble with parents, teachers, or other adults.

		No	A little	A lot
K1	Do your teachers complain about you being awkward or troublesome?	0	1	2
K2	Do your family complain about you being awkward or troublesome?	0	1	2
K3	And what do you think? Do you think you are awkward or troublesome?	0	1	2

I'm now going to ask about things you may have done over the **last 12 months**.

K4 *If any of the following questions are answered* "Definitely" *ask* "Has this been going on for the **last 6 months**?" *and record answer in second column.*

	Over the **last 12 months**...	*Over last 12 months*				*Last 6 months*	
		No	Perhaps	Definitely		No	Yes
a)	have you often told lies in order to get things or favours from others, or to get out of having to do things you are supposed to do?	0	1	2	→	0	1
b)	have you often started fights? (*Other than with brothers or sisters*)	0	1	2	→	0	1
c)	have you often bullied or threatened people?	0	1	2	→	0	1
d)	have you often stayed out after dark much later than you were supposed to?	0	1	2	→	0	1
e)	have you stolen from the house, or from other people's houses, or from shops or school? *(This doesn't include very minor thefts, e.g. stealing your brother's pencil or food from the fridge)*	0	1	2	→	0	1
f)	have you run away from home more than once, or ever stayed away all night without permission	0	1	2	→	0	1
g)	have you often played truant (bunked off) from school?	0	1	2	→	0	1

K5 *(If 13 or older and definitely playing truant in the past year, ask this question. Otherwise skip to K6)*

Did you start playing truant (bunking off) from school before you were 13?	No	Yes
	0	1

If any of the items in K4 have been answered "Definitely", then tick Troublesome Behaviour on the check list in M1 (p.31).

Only continue if you have just ticked the check list M1 (p.31) for Troublesome Behaviour, or if SDQ conduct score ≥4. Otherwise skip to section L.

K6

I am now going to ask about some more behaviours that sometimes get people into trouble. I have to ask all people all questions even when they are not likely to apply.

If any of the following questions are answered "Yes" then ask "Has this happened in the **last 6 months**?" *and record answer in second column*

	Have any of the following happened even once in the **last 12 months**?	*Over the last 12 months* No	Yes		*Last 6 months* No	Yes
a)	Have you used a weapon or anything that could seriously hurt someone? *(e.g. a bat, brick, broken bottle, knife, gun)*	0	1	→	0	1
b)	Have you really hurt someone or been physically cruel to them? *(e.g. have tied up, cut or burned someone).*	0	1	→	0	1
c)	Have you been really cruel on purpose to animals and birds?	0	1	→	0	1
d)	Have you deliberately started a fire? *(This is only if you intended to cause severe damage. This question is not about lighting campfires, or burning individual matches or pieces of paper)*	0	1	→	0	1
e)	Have you deliberately destroyed someone else's property? *(This question is not about fire setting or very minor acts, e.g. destroying sister's drawing. It does include behaviour such as smashing car windows or school vandalism)*	0	1	→	0	1
f)	Have you ever been involved in stealing on the streets, e.g. snatching a handbag or mugging?	0	1	→	0	1
g)	Have you tried to force someone into sexual activity against their will?	0	1	→	0	1
h)	Have you broken into a house, any other building or a car?	0	1	→	0	1

If any of the items in K6 have been answered "Yes", then tick Troublesome Behaviour on the check list in M1 (p.31).

K7A Have the behaviours that have got you into trouble been present for at **least 6 months**?

No	Yes
0	1

K7 Have you ever been in trouble with the police? *(Describe)*

.....

.....

No	Yes
0	1

If K7= "Yes" then tick Trouble With The Police on the check list in M1 (p.31).

If the check list in M1 (p.31) has been ticked for Troublesome Behaviour or Trouble With The Police then continue. Otherwise skip to section L.

K8 Have the behaviours that have got you into trouble interfered with ...

		Not at all	A little	A medium amount	A great deal
a)	how well you get on with the rest of the family?	0	1	2	3
b)	making and keeping friends?	0	1	2	3
c)	learning or class work?	0	1	2	3
d)	playing, hobbies, sports or other leisure activities?	0	1	2	3

K9 Have the behaviours that have got you into trouble made it harder for those around you (family, friends, teachers etc.)?

Not at all	A little	A medium amount	A great deal
0	1	2	3

Section L Less common problems

L1 Do you have any tics or twitches that you can't seem to control?

No	Yes
0	1

L2 Have other people been concerned that you have been dieting too much?

No	Yes
0	1

L3 Have you had any out-of-the-ordinary experiences, such as seeing or hearing things, or having unusual ideas - that have worried you?

No	Yes
0	1

L4 Apart from the things you have already told me about, is there anything else about your feelings or behaviour that really concerns you or anyone else?

No	Yes
0	1

If L1 = "Yes" or L2 = "Yes" or L3 = "Yes" or L4 = "Yes" then tick Less Common Difficulties on the check list in M1 (p.31).

Section M Areas of Difficulty

M1 Check list of difficulties

A ☐ Separation anxiety = fear of being separated from *(list main attachment figures from A1)*

.....

B ☐ Specific phobia = fear of *(list main fears from B1)*.....

.....

C ☐ Social phobia = fear of *(list main fears from C1)*.....

.....

D ☐ Panic/agoraphobia = panic attacks and avoidance of crowds, being out alone etc. *(delete as appropriate)*.

E ☐ Post traumatic stress = distress triggered by experiencing *(from E1)*.....

.....

F ☐ Obsessions and compulsions = rituals or obsessions involving *(from F2, F 3 and F4)*.....

.....

G ☐ Generalized anxiety = excessive worrying about *(from G4)*.....

.....

H ☐ Depression
☐ Irritability
☐ Loss of interest
☐ Deliberate self-harm

K ☐ Troublesome behaviour = behaviours that can get people into trouble such as *(list from K4 and K6)*

.....

☐ Trouble with the Police

L ☐ Less common difficulties = difficulties with *(list from L1, L2 and L3)*

.....

M2 Getting a description of the child's difficulties in their own words

If none of the boxes in M1 are ticked, skip to section N.

Whenever you have checked a box for one of the sections in M1, you should make sure that you get answers to the corresponding open-ended questions about that section. These open-ended questions are listed below as suggestions, but you can use your initiative to add extra questions or explain the existing questions more clearly.

You have a choice – you can ask the open-ended questions as you go along, or you can ask them after you have finished sections A to L. For example, if you tick the box for section A, then you could ask the extra questions before going on to section B, or you could wait until you have finished all the sections from A to L. If you are asking all the open-ended questions at the end, then it is often a good idea to let the child choose which order to take the different topics in, starting with the area that concerns him/her most.

Whichever you decide to do, it is usually a good idea to note down the child's spontaneous comments when s/he makes them. That way, you will have less need to ask him/her to repeat him/herself in this section. But do check before the end of the interview to make sure all questions have been covered for each area of difficulty.

When the child provides a vague or generalized answer, then ask them for specific examples. For example, if s/he says, "I worry about everything," then ask "What sorts of worries?" Or if s/he says, "I'm always getting into trouble," then ask "Can you tell me about a recent occasion when you got into trouble?"

Don't feel that you need to keep your answers short just because there's only a small space on this form – write small and use extra paper if necessary!

Introducing the open-ended questions:
You have already told me about your difficulties. I'd now like to hear a bit more about these in your own words.

M2A: Separation anxiety

If M1A is ticked for separation anxiety, ask

M2A1) Please describe your current worries about separation. How do these worries show themselves?

M2A2) How often does this worrying lead to difficulties?

M2A3) How severe are the difficulties at their worst?

M2A4) How long have you had these worries about separation?

M2A5) Are these worries interfering with your quality of life? If so, how?

M2A6) What do you think the worries are due to?

M2A7) Have you tried to do anything about these worries? If so, please describe what you've tried to do, any help that you have had, and whether this has made a difference.

M2B: Specific phobia

If M1B is ticked for specific phobia, ask

M2B1) Please describe any fears that are a real nuisance, that seriously upset you, or that lead to you not doing things that you would otherwise want to do.

M2B2) How often are your fears a nuisance or upsetting for you?

M2B3) How severe are the fears at their worst?

M2B4) Are your fears interfering with your quality of life? If so, how?

M2B5) Have you tried to do anything about these fears? If so, please describe what you've tried to do, any help that you have had, and whether this has made a difference.

M2C: Social phobia

If M2C is ticked for social phobia, ask

M2C1) Please describe any social fears that are a real nuisance, that seriously upset you, or that lead to you not doing things that you would otherwise want to do.

M2C2) How often do your social fears cause difficulties or upset you?

M2C3) How severe are these social fears at their worst?

M2C4) Are your social fears interfering with your quality of life? If so, how?

M2C5) Have you tried to do anything about these social fears? If so, please describe what you've tried to do, any help that you have had, and whether this has made a difference.

M2D: Panic/agoraphobia

If M1D is ticked for panic/agoraphobia, ask some or all of the following (according to whether the child has panic attacks or avoidance, or both)

M2D1) Please describe as fully as possible what your panic attacks are like.

M2D2) How often do these panic attacks occur?

M2D3) When did these attacks first start?

M2D4) Please describe your fear or avoidance of crowds, public places, travelling alone, or being far from home.

M2D5) How often does this fear or avoidance occur?

M2D6) When did this fear or avoidance first start?

M2D7) Are panic attacks or avoidance of specific situations interfering with your quality of life? If so, how?

M2D8) Have you tried to do anything about the panics or avoidance? If so, please describe what you've tried to do, any help that you have had, and whether this has made a difference.

M2E: Post traumatic stress

If M1E is ticked for post traumatic stress, ask

M2E1) What was the extremely stressful event? We're very sorry if asking about this is upsetting for you. You only need to tell us enough details for us to make sense of your current symptoms.

M2E2) Please describe the symptoms that you still have as a result of your very stressful experience.

M2E3) How often do these symptoms cause difficulties or upset you?

M2E4) How severe are the symptoms at their worst?

M2E5) Are the symptoms interfering with your quality of life? If so, how?

M2E6) Have you tried to do anything about these symptoms? If so, please describe what you've tried to do, any help that you have had, and whether this has made a difference.

M2F: Obsessions and compulsions

If M1F is ticked for obsessions and compulsions, ask

M2F1) Please describe all of your rituals or obsessions.

M2F2) How often do these rituals or obsessions cause difficulties or upset you?

M2F3) How severe are the rituals or obsessions at their worst?

M2F4) How long have they been present?

M2F5) Are they interfering with your quality of life? If so, how?

M2F6) Have you tried to do anything about these rituals or obsessions? If so, please describe what you've tried to do, any help that you have had, and whether this has made a difference.

M2G: Generalized anxiety

If M1G is ticked for generalized anxiety, ask

M2G1) Please describe what it is that you worry about?

M2G2) How often does this worrying lead to difficulties?

M2G3) How severe are the worries at their worst?

M2G4) How long have you worried a lot about things?

M2G5) Are your worries interfering with your quality of life? If so, how?

M2G6) Have you tried to do anything about these worries? If so, please describe what you've tried to do, any help that you have had, and whether this has made a difference.

M2H: Depression

If M1H is ticked for depression, irritability or loss of interest, ask

M2H1) Please describe your mood (sadness, irritability) and your level of interest in things.

M2H2) What else has changed at the same time as your mood and level of interest? If relevant, tell us about energy, appetite, sleep, self-confidence, blaming yourself, hopelessness about the future, thoughts of death, self-harm etc.

M2H3) Over the **last 4 weeks**, how much of the time have you been like this?

M2H4) Over the **last 4 weeks**, how severe have the difficulties been at their worst?

M2H5) When did this episode of low mood, irritability or loss of interest begin?

M2H6) What do you think triggered this episode off?

M2H7) Have you had similar episodes in the past? If so, please describe.

M2H8) Have you had episodes in the past when you have gone 'high' instead of 'low'? If so, please describe.

M2H9) Is your mood or loss of interest interfering with your quality of life? If so, how?

M2H10) Have you tried to do anything about your mood or loss of interest? If so, please describe what you've tried to do, any help that you have had, and whether this has made a difference.

M2H2: Deliberate self-harm

If M1H is ticked for deliberate self-harm, ask

M2H11) It would help us to hear more about your harming or hurting yourself, or at least talking about doing so.

M2J: Hyperactivity

If M1J is ticked for hyperactivity, ask

M2J1) It would help us to hear more about these concerns about overactivity or poor concentration.

M2K: Awkward and troublesome behaviour

If M1K is ticked for awkward or troublesome behaviour, ask

M2K1) Please describe the behaviours that get you into trouble.

M2K2) How often does this behaviour lead to difficulties?

M2K3) How severe are the difficulties at their worst?

M2K4) How long have you been like this?

M2K5) Are the behaviours that get you into trouble interfering with your quality of life? If so, how?

M2K6) Have you tried to do anything about your behaviour? If so, please describe what you've tried to do, any help that you have had, and whether this has made a difference.

M2L: Less common difficulties

If M1L is ticked for less common difficulties, ask whichever of the following apply:

M2L1) We would like to hear more about your tics or twitches.

M2L2) Who has been concerned about your dieting? Why have they been concerned? Do you agree with them?

M2L3) We would like to hear more about these out-of-the-ordinary experiences.

M2L4) We would like to hear more about the other things you are concerned about.

M2X: The interview in general:

M2X1) Finally, this is your opportunity as an interviewer to comment on the interview in general, e.g. to describe the young person's level of motivation, concentration or understanding, or to record your observations about his or her activity level during the course of the interview.

Section N Strengths

I have been asking you a lot of questions about possible difficulties and problems. I now want to ask you about your good points or strengths.

N1

In terms of what sort of a person you are, what would you say are the best things about you?

Spontaneously says "Nothing" ☐

a)

b)

c)

d)

e)

N2

Can you tell me some things you have done that you are really proud of? They could be related to school, or sport, or music, or friends, or charity, or anything.

Spontaneously says "Nothing" ☐

a)

b)

c)

d)

e)

ANNEXURE 3

English version of the Household Questionnaire (HHQ)

Household Questionnaire

Child's ID:_____

1. Sociodemographic factors

1.1 Personal Details:

Name of child : _____
Sex of child : _____ Boy = 1 Girl = 2
Date of birth : _____
Age of child : _____
Place of birth : _____
Name of father : _____
Name of mother: _____
Address : _____
_____

Address of relatives who live permanently : _____
_____

1.2 Family Information (Household Information):

Type of family : _____ Nuclear = 1 Joint = 2
Who is in the household?

Mother	No = 0	Yes = 1	
Father	No = 0	Yes = 1	
Brothers	No = 0	Yes =	(actual number)
Sisters	No = 0	Yes =	(actual number)
Grandparents	No = 0	Yes =	(actual number)
Other relatives	No = 0	Yes =	(actual number)
Non-relatives	No = 0	Yes =	(actual number)

Number of children in the family including any children who are no longer living at home (include cousins if they are part of the same household) :_____

Position of child among siblings : _____
Religion : _____ Islam = 1 Hinduism = 2 Buddhism = 3 Christianity = 4 Other = 5

Religious practice of child : _____ More than once a week = 1 Once a week = 2 Less than once a week = 3
During religious festivals only = 4 Not practicing = 5

1.3 School Details:

Name of school : _____
Class : _____
Name of class teacher : _____
Nature of school attendance : _____ Regular = 1 Irregular = 2 sporadic = 3 Not attending = 4
If not going to school,reason:— Works =1 Truants =2 Financial difficulties =3 Illness =4 Expelled =5 Other =6
If the child engaged in work,
Type of work :_____ Agriculture = 1 Industrial = 2 House servant = 3 Self employed = 4 Other = 5
Status of work : _____ Paid = 1 Unpaid = 2
Has the child ever had to repeat a year ? _____ No = 1 Yes = 2
Has the child ever had to a special education ? _____ No = 1 Yes = 2

1.4 Information about whoever takes primary responsibility for looking after the child (usually mother) :

Who is the Person: _____
Mother = 1 Aunt = 2 Grand mother = 3 Another relative = 4 Any non- relative = 5
Name: _____
Level of education: _____ Illiterate = 1 Literate / incomplete primary = 2
Complete primary/incomplete secondary = 3 Complete secondary/incomplete higher secondary = 4
Complete higher secondary/incomplete further education = 5 Complete further education = 6

Mental health condition (score on SRQ) : _____

1.5 More information on father :

Alive = 1/Dead =2 : _____ Age : _____
Level of education : _____
Occupation:_____ Service = 1 Cultivator = 2 Business = 3 Self-employed = 4 Other = 5 Unemployed = 6
If unemployed, how long for : _____
How long living in current area : _____

1.6 More information on mother :

Alive = 1/Dead =2 : _____ Age : _____
Level of education : _____
Occupation: _____ 1 – 6 = as above Housewife / household worker = 7
If unemployed, how long for : _____
How long living in current area : _____

1.7 Living and socio-economic conditions :

House made of brick: No=0 Yes=1
Servants: No=0 Yes=1
TV: No=0 Yes=1
Refrigerator: No=0 Yes=1
Telephone : No=0 Yes=1

Family income (per year) : _____

2. Social capital:

a) In general, do the people who live in this area help one another? No=0 / a little=1 / a lot=2

b) Is this an area that is dangerous for the people who live in it? No=0 / a little=1 / a lot=2

c) When you need help in order to look after your children, can you count on family or friends?
No=0 / a little=1 / a lot=2

3. Parents' attitude and behaviour towards their children:

a) Do you usually prevent or restrict the child from engaging in normal sporting activities because of supposed risks involved? Yes=0 / partly yes=1 / No=2
b) Do you usually go to bed with the child to allay his/her anxieties or provide comfort even when it is not norm? Yes=0 / partly yes=1 / No=2
c) Do you frequently go to doctors or seek treatment for the child's minor physical complainants and taking much care? Yes=0 / partly yes=1 / No=2
d) Do you manage to know what your child is doing or going when s/he is out of home? Yes=0 / partly yes=1 / No=2
e) Do you impose rules strongly for the child and do not allow him/her to deviate from it in anyway? Yes=0 / partly yes=1 / No=2

4. Miscellaneous supplementary questions for parents

a) Sometimes children behave themselves very badly so that adults lose patience with them. Tell me how you deal with (Child's name) when s/he behaves very badly (Can tick more than one option):
   I. we talk it over (Yes=1 /No =0.)
   II. withdrawal of privileges (explain what this means) (Yes=1 /No =0.)
   III. shouting or swearing (Yes=1 /No =0.)
   IV. hitting him or her just with my hand (Yes=1 /No =0.)
   V. hitting him or her with a stick or other object (Yes=1 /No =0.)
   VI. other (Yes=1 /No =0.) Please describe: _____

b) When the adults in the house get into arguments with one another, the children may see or hear what is going on. Has your child witnessed one of these arguments? (Yes=1 /No =0.)
If yes, were the arguments between the adults : (Can tick more than one option)
   I. without verbal or physical aggression (Yes=1 /No =0.)
   II. with verbal aggression (Yes=1 /No =0.)
   III. with physical aggression (Yes=1 /No =0.)

c) Has your child used one of the following (0=Never used / 1=once or twice per year / 2=less than once a month / 3=1-2 times per month / 4=1-2 times a week / 5=once a day / 6=several times a day (ask about the child of 11-16 years),):
   I. Cigarettes,
   II. Phensidyl (codein),
   III. cannabis,
   IV. sedative-hypnotics,
   V. alcoholic drinks.

d) In the last year, has your child received any help for emotional problems or behavioural problems?
0=NO, 1=Yes Government services, 2= Yes Private services, 3= Both Government & Private services.

d.i) If Yes, ask who provided the service –
1=a paediatrician (check this was not for physical problems), 2=psychologist, 3=speech therapist, 4= occupational therapist, 5=social services, 6=other.

d.ii) Frequency of contact.
_____

d.iii) What was the cause of the consultation?
_____

d.iv) Was your child prescribed any medicine for this problem? Yes=1 / No=0

d.v) Was your child admitted into hospital for that problem? Yes=1 / No=0

5. Questions on parents' beliefs about punishment, supervision and reward

(For parents of 5-10 year olds)

a) Mariam thinks that children need to be smacked (physically punished) from time to time if they are to behave themselves well. Amena thinks that children don't need to be smacked, and that it is sufficient to talk with them and withdraw privileges, e.g. punish them by not letting them go out with their friends. Who do you agree with, Mariam or Amena? (You can read out Mariam and Amena's views repeatedly if necessary). (1=Agreeing with Mariam / 2=agreeing with Amena / 3=not agreeing with either / 4=not knowing how to answer.)

b) Zarina thinks it is important to praise children when they are behaving themselves well. Aleya thinks that it isn't necessary to praise children for them to behave well. Who do you agree with Zarina or Aleya? (1=Agreeing with Zarina / 2=agreeing with Aleya / 3=not agreeing with either / 4=not knowing how to answer.)

c) Kulsum thinks that when children are playing, it is important to keep an eye on what they are doing. Jahanara thinks that when children are playing, it isn't necessary to pay attention to what they are up to. Who do you agree with, Kulsum or Jahanara? (1=Agreeing with Kulsum / 2=agreeing with Jahanara / 3=not agreeing with either / 4=not knowing how to answer.)

For parents of 11-16 year olds

d) Mariom thinks that young people need to be smacked (physically punished) from time to time if they are to behave themselves well. Amena thinks that young people don't need to be smacked, and that it is sufficient to talk with them and withdraw privileges, eg. punish them by not letting them go out with their friends. Who do you agree with, Mariom or Amena? (1=Agreeing with Mariam / 2=agreeing with Amena / 3=not agreeing with either / not knowing how to answer.)

e) Zarina thinks it is important to praise young people when they are behaving themselves well. Aleya thinks that it isn't necessary to praise young people for them to behave well. Who do you agree with Zarina or Aleya? (1=Agreeing with Zarina / 2=agreeing with Aleya / 3=not agreeing with either / 4=not knowing how to answer.)

f) Kulsum thinks that when young people are out of the house, it is important to know what they are doing, or to keep an eye on them from a distance. Jahanara thinks that when young people are out of the house, it's not necessary to know what they are doing, or to keep an eye on them from a distance. Who do agree with, Kulsum or Jahanara? (1=Agreeing with Kulsum / 2=agreeing with Jahanara / 3=not agreeing with either / 4=not knowing how to answer.)

6. Measures of physical health

a) One question for parents : How is your child's health in general ?
(1=Very good / 2=Good / 3=Fair / 4=Bad / 5=Very bad)

b) Child's Height (cm) : _____ c) Child's Weight (kg) : _____

7. Mental age

7.1 Thinking about [Name]'s school work and about his/her ability to reason things out, is s/he about average, ahead of his/her age, or behind his/her age?

Ahead	Average	Behind
0	1	2

Finish → 7.2

7.2 At present, roughly what sort of age level is s/he at in his/her school work and ability to reason things out? For example like an average [*insert an age 2 years younger than the child's chronological age]* year old?

If under 12 month level, code as '0' [ ] years old

ANNEXURE 4

English version of the Self Reporting Questionnaire (SRQ)

Self Reporting Questionnaire (SRQ)

In the last month:

'Non-psychotic'

1.	Do you often have headaches?	Yes / No
2.	Is your appetite poor?	Yes / No
3.	Do you sleep badly?	Yes / No
4.	Are you easily frightened?	Yes / No
5.	Do you hands shake?	Yes / No
6.	Do you feel nervous, tense or worried?	Yes / No
7.	Is your digestion poor?	Yes / No
8.	Do you have trouble thinking clearly?	Yes / No
9.	Do you feel unhappy?	Yes / No
10.	Do you cry more than usual?	Yes / No
11.	Do you find it difficult to enjoy your daily activities?	Yes / No
12.	Do you find it difficult to make decision?	Yes / No
13.	Is your daily work suffering?	Yes / No
14.	Are you unable to pay a useful part in life?	Yes / No
15.	Have you lost interest in things?	Yes / No
16.	Do you feel that you are a worthless person?	Yes / No
17.	Has the thought of ending your life been on your mind?	Yes / No
18.	Do you feel tired all the time?	Yes / No
19.	Do you have uncomfortable feelings in your stomach?	Yes / No
20.	Are you easily tired?	Yes / No

'Psychotic'

1.	Do you feel that somebody has been trying to harm you in some way?	Yes / No
2.	Are you a much more important person than most people think?	Yes / No
3.	Have you noticed any interference or anything else unusual with your thinking?	Yes / No
4.	Do you ever hear voices without knowing where they come from or which other people cannot hear?	Yes / No

ANNEXURE 5

Letter of introduction and consent form in English

APPENDIX -5
Letter of introduction to the parents and teachers

Office of Project Director
"Establishing the Epidemiology of Child and Adolescent Mental Health Problems in Bangladesh" Project
Department of Psychiatry,
Bangabandhu Shiekh Mujib Medical University (BSMMU)
Shahabag, Dhaka-1000

No. BSMMU/Psych/RP/2002/8 Date: .....

Request letter

Respected parents/guardian/teacher

.....

.....

.....

Mr/Mrs,

The assessment of emotion, behavior, social and physical aspect of children of 5-10 years old is going to be carried out by the Department of Psychiatry, of this University Hospital (Former PG Hospital). Along with, the information of socio-economic status of the families will be collected.

For this reason you can play a vital role to provide this important information regarding the children during the survey. You are earnestly requested to permit and assist our field workers in collecting the information during survey period. We like to assure that the confidentiality of the information given by you will be strictly maintained.

Children are future of nation. The out come of this survey will help the development and promotion for the child health service of Bangladesh. To build up a healthy nation, your active participation in this survey is earnestly needed.

Thank you.

Your siencerly

.....

Dr. M S I Mullick
Project Director
Department of psychiatry.
Bangabandhu Shiekh Mujib Medical University (BSMMU)

Questionnaire for informed consent

1.	Have you get full information about type, objectives and methods of the research work?	Yes/No
2.	Have you assured that you/your children will not face any physical, mental or social problems for this research?	Yes/No
3.	Have you informed that you/your children will receive no pain or distress physically and mentally, for this research?	Yes/No
4.	Do you firmly realize about the result of this research and its possible future benefits?	Yes/No
5.	Do you take the decision of participation, assistance or abstaining from taking part in this research work independently?	Yes/No
6.	Do you think that the participation in this research work will hamper the basic human right of you/your children?	Yes/No
7.	Do you know that confidentiality of your information and obscurity will be maintained?	Yes/No
8.	Do you know that any kind financial benefit will not be offered for this research work?	Yes/No

Consent letter

After receiving full idea on objective, procedure and necessity of this research, I agree to the ethical points of the research work. I have not been influenced by any person and group or my basic human rights have not been hindered for my participation of this research work.

Therefore, after the proper review, I agree to sign in this consent letter on my free-will.

Signature:.....

Full Name:.....

Address:.....

.....

ANNEXURE 6

Bangla version of the Strengths and Difficulties Questionnaire (SDQ)

Strengths and Difficulties Questionnaire
সবলতা বা অসুবিধা নির্ণয়ক প্রশ্নমালা

P4-16

প্রত্যেকটি প্রশ্নের জন্য সত্য নয়, কিছুটা সত্য বা নিশ্চিতভাবে সত্য ঘরে টিক চিহ্ন দিন। সবকটি প্রশ্নের উত্তর দিলে আমাদের যাচাই করতে সুবিধে হবে। দয়া করে বিগত ছয় মাসে অথবা চলতি শিক্ষা বছরে শিশুর আচরণের ওপর ভিত্তি করে উত্তর দিন।

শিশুর নাম ..... ছেলে/মেয়ে

জন্ম তারিখ .....

	সত্য নয়	কিছুটা সত্য	নিশ্চিতভাবে সত্য
অন্যদের অনুভূতিকে মূল্য দেয়	☐	☐	☐
অস্থির, ছটফটে, বেশীক্ষণ চুপ করে থাকতে পারে না	☐	☐	☐
প্রায়ই মাথাধরা, পেটব্যথা বা বমি বমি ভাবের কথা বলে	☐	☐	☐
অন্য ছেলে মেয়েদের সাথে খাবার,খেলনা,পেন্সিল ইত্যাদি সহজেই ভাগাভাগি করে নেয়	☐	☐	☐
প্রায়ই রাগী আচরণ বা গরম মেজাজ করে	☐	☐	☐
অনেকটা একা থাকে, একা একা খেলতে ভালবাসে	☐	☐	☐
বেশ বাধ্য, সাধারণতঃ বড়দের কথা শোনে	☐	☐	☐
অনেক চিন্তা করে, প্রায়ই চিন্তিত দেখায়	☐	☐	☐
কেউ ব্যথা পেলে, মন খারাপ করলে বা অসুস্থবোধ করলে সাহায্য করে	☐	☐	☐
সারাক্ষণ উসখুস করে বা গা-হাত মোড়ামুড়ি করে	☐	☐	☐
অন্ততঃ একজন ভাল বন্ধু আছে	☐	☐	☐
প্রায়ই অন্য ছেলেমেয়েদের সাথে মারামারি করে বা গায়ের জোর দেখায়	☐	☐	☐
প্রায়ই বিষন্ন, মনমরা ও কাঁদো কাঁদো থাকে	☐	☐	☐
সাধারনভাবে অন্য ছেলে মেয়েরা তাকে পছন্দ করে	☐	☐	☐
সহজেই অন্যমনস্ক হয়ে পড়ে, মনোযোগ ধরে রাখতে পারে না	☐	☐	☐
অচেনা পরিবেশে ঘাবড়ে যায় বা আড়ষ্ট থাকে, সহজেই সাহস হারায়	☐	☐	☐
ছোটদের প্রতি মায়া মমতা আছে	☐	☐	☐
প্রায়ই মিথ্যে বলে বা ধাপ্পা দেয়	☐	☐	☐
অন্য ছেলে মেয়েরা তার পেছনে লাগে বা তার ওপর গায়ের জোর দেখায়	☐	☐	☐
অপরকে সাহায্য করতে প্রায়ই এগিয়ে যায় (বাবা-মা, শিক্ষক, অন্য ছেলেমেয়েদের)	☐	☐	☐
ভেবে চিন্তে কাজ করে	☐	☐	☐
বাড়ি, স্কুল বা অন্য জায়গা থেকে চুরি করে	☐	☐	☐
ছোটদের চেয়ে বড়দের সাথে ভালো মিশতে পারে	☐	☐	☐
অনেক ভয়, একটুতেই চমকে যায়	☐	☐	☐
কাজ ধরলে শেষ করে, মনোযোগের পরিমান ভালো	☐	☐	☐

আপনার অন্য কোন মন্তব্য বা বলার বিষয় আছে কি ?

দয়া করে পাতা উল্টান, অপর পিঠে আরো কিছু প্রশ্ন আছে

সব মিলিয়ে আপনি কি মনে করেন যে, নিচের এক বা একাধিক ক্ষেত্রে আপনার ছেলে/মেয়ের অসুবিধে আছেঃ আবেগ, মনোযোগ, আচরণ বা অন্যদের সাথে মেলামেশায় ?

না	হ্যাঁ, সামান্য অসুবিধে আছে	হ্যাঁ, বেশ অসুবিধে আছে	হ্যাঁ, গুরুতর অসুবিধে আছে
☐	☐	☐	☐

যদি আপনার উত্তর "হ্যাঁ" হয়, তা হলে এসব অসুবিধে সম্পর্কে নিচের প্রশ্নগুলির উত্তর দিন ঃ

✪ কত দিন থেকে এসব অসুবিধে আছে ?

এক মাসের কম	১-৫ মাস	৫-১২ মাস	এক বছরের বেশী
☐	☐	☐	☐

✪ এসব অসুবিধে কি তাকে এলোমেলো করে ফেলে বা কষ্ট দেয় ?

মোটেই নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
☐	☐	☐	☐

✪ এসব অসুবিধে কি তার দৈনন্দিন জীবনের নিচের দেয়া ক্ষেত্রগুলিতে ব্যাঘাত ঘটায় ?

	মোটেই নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
ঘরোয়া জীবনে	☐	☐	☐	☐
বন্ধুত্ব স্থাপন করতে	☐	☐	☐	☐
ক্লাসের লেখাপড়ায়	☐	☐	☐	☐
অবসর বিনোদনে	☐	☐	☐	☐

✪ এসব অসুবিধে কি আপনার কিংবা সামগ্রিকভাবে পরিবারের ওপর একটা বোঝা ?

মোটেই নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
☐	☐	☐	☐

স্বাক্ষর ..... তারিখ .....

মা/বাবা/অন্য কেউ (উল্লেখ করুন)

আপনার সাহায্যের জন্য অনেক ধন্যবাদ

Strengths and Difficulties Questionnaire
সবলতা বা অসুবিধা নির্ণয়ক প্রশ্নমালা

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প্রত্যেকটি প্রশ্নের জন্য সত্য নয়, কিছুটা সত্য বা নিশ্চিতভাবে সত্য ঘরে টিক চিহ্ন দিন। সবকটি প্রশ্নের উত্তর দিলে আমাদের বাচাই করতে সুবিধে হবে। দয়া করে বিগত ছয় মাসে অথবা চলতি শিক্ষা বছরে শিশুর আচরণের ওপর ভিত্তি করে উত্তর দিন।

শিশুর নাম ..... ছেলে/মেয়ে

জন্ম তারিখ .....

	সত্য নয়	কিছুটা সত্য	নিশ্চিতভাবে সত্য
অন্যদের অনুভূতিকে মূল্য দেয়	☐	☐	☐
অস্থির, ছটফটে, বেশীক্ষণ চুপ করে থাকতে পারে না	☐	☐	☐
প্রায়ই মাথাধরা, পেটব্যথা বা বমি বমি ভাবের কথা বলে	☐	☐	☐
অন্য ছেলে মেয়েদের সাথে খাবার,খেলনা,পেন্সিল ইত্যাদি সহজেই ভাগাভাগি করে নেয়	☐	☐	☐
প্রায়ই রাগী আচরণ বা গরম মেজাজ করে	☐	☐	☐
অনেকটা একা থাকে, একা একা খেলতে ভালবাসে	☐	☐	☐
বেশ বাধ্য, সাধারনতঃ বড়দের কথা শোনে	☐	☐	☐
অনেক চিন্তা করে, প্রায়ই চিন্তিত দেখায়	☐	☐	☐
কেউ ব্যথা পেলে, মন খারাপ করলে বা অসুস্থবোধ করলে সাহায্য করে	☐	☐	☐
সারাক্ষণ উসখুস করে বা গা-হাত নেড়াচাড়ি করে	☐	☐	☐
অন্ততঃ একজন ভাল বন্ধু আছে	☐	☐	☐
প্রায়ই অন্য ছেলেমেয়েদের সাথে মারামারি করে বা গায়ের জোর দেখায়	☐	☐	☐
প্রায়ই বিষন্ন, মনমরা বা কাঁদো কাঁদো থাকে	☐	☐	☐
সাধারনতঃ অন্য ছেলে মেয়েরা তাকে পছন্দ করে	☐	☐	☐
সহজেই অন্যমনস্ক হয়ে পড়ে, মনোযোগ ধরে রাখতে পারে না	☐	☐	☐
অচেনা পরিবেশে ঘাবড়ে যায় বা আড়ষ্ট থাকে, সহজেই সাহস হারায়	☐	☐	☐
ছোটদের প্রতি মায়া মমতা আছে	☐	☐	☐
প্রায়ই মিথ্যে বলে বা ধাপ্পা দেয়	☐	☐	☐
অন্য ছেলে মেয়েরা তার পেছনে লাগে বা তার ওপর গায়ের জোর দেখায়	☐	☐	☐
অপরকে সাহায্য করতে প্রায়ই এগিয়ে যায় (বাবা-মা, শিক্ষক, অন্য ছেলেমেয়েদের)	☐	☐	☐
ভেবে চিন্তে কাজ করে	☐	☐	☐
বাড়ি, স্কুল বা অন্য জায়গা থেকে চুরি করে	☐	☐	☐
ছোটদের চেয়ে বড়দের সাথে ভালো মিশতে পারে	☐	☐	☐
অনেক ভয়, একটুতেই চমকে যায়	☐	☐	☐
কাজ ধরলে শেষ করে, মনোযোগের পরিমান ভালো	☐	☐	☐

আপনার অন্য কোন মন্তব্য বা বলার বিষয় আছে কি ?

দয়া করে পাতা উল্টান, অপর পিঠে আরো কিছু প্রশ্ন আছে

সব মিলিয়ে আপনি কি মনে করেন যে, নিচের এক বা একাধিক ক্ষেত্রে এই ছেলে/মেয়ের অসুবিধে আছেঃ আবেগ, মনোযোগ, আচরণ বা অন্যদের সাথে মেলামেশায় ?

না	হ্যাঁ, সামান্য অসুবিধে আছে	হ্যাঁ, বেশ অসুবিধে আছে	হ্যাঁ, গুরুতর অসুবিধে আছে
☐	☐	☐	☐

যদি আপনার উত্তর "হ্যাঁ" হয়, তা হলে এসব অসুবিধে সম্পর্কে নিচের প্রশ্নগুলির উত্তর দিন ঃ

✪ কত দিন থেকে এসব অসুবিধে আছে ?

এক মাসের কম	১-৫ মাস	৫-১২ মাস	এক বছরের বেশী
☐	☐	☐	☐

✪ এসব অসুবিধে কি তাকে এলোমেলো করে ফেলে বা কষ্ট দেয় ?

মোটেই নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
☐	☐	☐	☐

✪ এসব অসুবিধে কি তার দৈনন্দিন জীবনের নিচের দেয়া ক্ষেত্রগুলিতে ব্যাঘাত ঘটায় ?

	মোটেই নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
সহপাঠীদের সাথে সম্পর্কের বেলায়	☐	☐	☐	☐
ক্লাসের লেখাপড়ায়	☐	☐	☐	☐

✪ এসব অসুবিধে কি আপনার কিংবা সামগ্রিকভাবে ক্লাসের ওপর একটা বোঝা ?

মোটেই নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
☐	☐	☐	☐

স্বাক্ষর ..... তারিখ .....

শ্রেণী শিক্ষক/বর্ষ প্রধান/অন্য কেউ (উল্লেখ করুন)

আপনার সাহায্যের জন্য অনেক ধন্যবাদ

Strengths and Difficulties Questionnaire
সবলতা বা অসুবিধা নির্ণয়ক প্রশ্নমালা

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প্রত্যেকটি প্রশ্নের জন্য সত্য নয়, কিছুটা সত্য বা নিশ্চিতভাবে সত্য ঘরে টিক চিহ্ন দাও। সবকটি প্রশ্নের উত্তর দিলে আমাদের যাচাই করতে সুবিধে হবে। গত ছয় মাসে অথবা স্কুলের এই বছরে প্রশ্নগুলি তোমার উপর যেভাবে খাটে সেই ভিত্তিতে উত্তর দাও।

শিশুর নাম ..... ছেলে/মেয়ে

জন্ম তারিখ .....

	সত্য নয়	কিছুটা সত্য	নিশ্চিতভাবে সত্য
আমি অন্যদের অনুভূতিকে মূল্য দিই	☐	☐	☐
আমি অস্থির বোধ করি, বেশীক্ষণ চুপ করে থাকতে পারি না	☐	☐	☐
আমার প্রায়ই মাথা ধরা, পেট ব্যথা বা কমি বমি ভাব হয়	☐	☐	☐
সাধারণতঃ অন্য ছেলেমেয়েদের সাথে খাবার, খেলনা, কলম ইত্যাদি ভাগাভাগি করে নিই	☐	☐	☐
আমি খুব রাগ হয়ে যাই, প্রায়ই মেজাজ খারাপ করি	☐	☐	☐
আমি বেশ একা, সাধারনতঃ একা একা খেলি, বা নিজের মধ্যে থাকি	☐	☐	☐
বড়রা আমাকে যা করতে বলে, সাধারনতঃ তা করি	☐	☐	☐
আমি অনেক দুশ্চিন্তা করি	☐	☐	☐
কেউ ব্যথা পেলে, মন খারাপ করলে বা অসুস্থবোধ করলে সাহায্য করি	☐	☐	☐
আমি সারাক্ষণ উসখুস করি বা পা-হাত মোড়ামুড়ি করি	☐	☐	☐
আমার অন্ততঃ একজন ভাল বন্ধু আছে	☐	☐	☐
আমি খুব মারামারি করি। আমি যা চাই অন্যদেরকে দিয়ে তা করিয়ে নিতে পারি	☐	☐	☐
আমি প্রায়ই বিষন্ন, মনমরা বা কাঁদোকাঁদো থাকি	☐	☐	☐
আমার বয়সী ছেলেমেয়েরা সাধারণতঃ আমাকে পছন্দ করে	☐	☐	☐
আমি সহজেই অন্যমনস্ক হয়ে পড়ি, মনোযোগ ধরে রাখতে আমার কষ্ট হয়	☐	☐	☐
আচেনা পরিবেশে আমি ঘাবড়ে যাই, সহজেই সাহস হারাই	☐	☐	☐
ছোটদের প্রতি আমার মায়া মমতা আছে	☐	☐	☐
আমি প্রায়ই মিথ্যা বলা বা ধাপ্পা দেবার দায়ে অভিযুক্ত হই	☐	☐	☐
অন্য ছেলেমেয়েরা আমার পেছনে লাগে ও আমার ওপর গায়ের জোর দেখায়	☐	☐	☐
আমি অপরকে সাহায্য করতে প্রায়ই এগিয়ে যাই(বাবা-মা,শিক্ষক,অন্য ছেলেমেয়েদের)	☐	☐	☐
আমি ভেবেচিন্তে কাজ করি	☐	☐	☐
বাড়ি, স্কুল বা অন্য জায়গা থেকে আমি না বলে অন্যের জিনিষ নিয়ে থাকি	☐	☐	☐
আমার বয়েসী ছেলেমেয়েদের চাইতে বড়দের সাথে ভালো মিশতে পারি	☐	☐	☐
আমি অনেক ভয় পাই, একটুতেই চমকে যাই	☐	☐	☐
আমি কোন কাজ ধরলে শেষ করি, আমার মনোযোগ ভালো	☐	☐	☐

তোমার অন্য কোন মন্তব্য বা বলার বিষয় আছে কি ?

দয়া করে পাতা উল্টাও, অপর পিঠে আরো কিছু প্রশ্ন আছে

সব মিলিয়ে তুমি কি মনে কর যে, নিচের এক বা একাধিক ক্ষেত্রে তোমার অসুবিধে আছেঃ আবেগ, মনোযোগ, আচরণ বা অন্যদের সাথে মেলামেশায় ?

না	হ্যাঁ, সামান্য অসুবিধে আছে	হ্যাঁ, বেশ অসুবিধে আছে	হ্যাঁ, ভীষণ অসুবিধে আছে
☐	☐	☐	☐

যদি তোমার উত্তর হ্যাঁ হয়, তা হলে এসব অসুবিধে সম্পর্কে নিচের প্রশ্নগুলির উত্তর দাও ঃ

✪ কত দিন থেকে এসব অসুবিধে আছে ?

এক মাসের কম	১-৫ মাস	৫-১২ মাস	এক বছরের বেশী
☐	☐	☐	☐

✪ এসব অসুবিধে কি তোমাকে এলোমেলো করে ফেলে বা কষ্ট দেয় ?

মোটেই নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
☐	☐	☐	☐

✪ এসব অসুবিধে কি তোমার দৈনন্দিন জীবনের নিচের দেয়া ক্ষেত্রগুলিতে ব্যাঘাত সৃষ্টি করে ?

	মোটেই নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
ঘরোয়া জীবনে	☐	☐	☐	☐
বন্ধুত্ব স্থাপন করতে	☐	☐	☐	☐
ক্লাসের লেখাপড়ায়	☐	☐	☐	☐
অবসর বিনোদনে	☐	☐	☐	☐

✪ এসব অসুবিধে কি তোমার চারপাশের সবার (পরিবারের লোকজন, বন্ধু, শিক্ষক বা আর কারোর) কষ্টের বা বিরক্তির কারণ ?

মোটেই নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
☐	☐	☐	☐

তোমার স্বাক্ষর .....

আজকের তারিখ .....

তোমার সাহায্যের জন্য অনেক ধন্যবাদ

ANNEXURE 7

Bangla version of the Development and Well-Being Assessment (DAWBA)

The Development and Well-Being Assessment

Parent Interview

বিকাশ এবং কুশল নির্ণয়

পিতামাতার সাক্ষাৎকার

শিশুর শেষের নাম	ঃ
শিশুর প্রথম নামসমূহ	ঃ
বয়স	ঃ
জন্ম তারিখ	ঃ
ছেলে/মেয়ে	ঃ
ক্লিনিক/গবেষণা সংখ্যামান	ঃ
সাক্ষাৎকারের তারিখ	ঃ
যার সাক্ষাৎকার নেয়া হয়েছে	ঃ
সাক্ষাৎকার গ্রহণকারী	ঃ

প্রথম ধাপ হলো পিডি-১৬ সফলতা ও অসুবিধা নির্ণয়ক প্রশ্নমালা (এসডিকিউ) পূরণ করা ও প্রদত্ত ছক ব্যবহার করে প্রশ্নমালার প্রথম পৃষ্ঠার হিসেব নিচের সংখ্যামানে প্রকাশ করা।

এসডিকিউ আবেগ মান	০	১	২	৩	৪	৫	৬	৭	৮	৯	১০
এসডিকিউ চঞ্চলতা মান	০	১	২	৩	৪	৫	৬	৭	৮	৯	১০
এসডিকিউ আচরণ মান	০	১	২	৩	৪	৫	৬	৭	৮	৯	১০

অংশ ক বিচ্ছিন্নতা সংশ্লিষ্ট উদ্বেগাধিক্য (Separation Anxiety)

বেশিরভাগ শিশু একজন বা অল্প কয়েকজন বয়স্কের প্রতি বিশেষভাবে আসক্ত থাকে। শিশু এদের কাছে নিরাপত্তা ও স্বস্তি চায় এবং কষ্ট বা আঘাত পেলে তাদের কাছে ছুটে যায়।

ক১	নিচের বয়স্কজনদের সাথে কি শিশু (নাম) বিশেষভাবে আসক্ত?	না	হ্যাঁ
১)	মা (জন্মদাত্রী বা দত্তক মা)	০	১
২)	বাবা (জন্মদাতা বা দত্তক বাবা)	০	১
৩)	মা'য়ের মত আর কেউ (সৎ মা, পালক মা, বাবার সঙ্গিনী)	০	১
৪)	বাবার মত আর কেউ (সৎ বাবা, পালক বাবা, মা'য়ের সঙ্গী)	০	১
৫)	এক বা একাধিক দাদা-দাদী, নানা-নানী)	০	১
৬)	এক বা একাধিক অন্যান্য বয়স্ক আত্মীয় (চাচা-চাচী, মামা-মামী, খালা-খালু, বড় ভাই বা বড় বোন ইত্যাদি)	০	১
৭)	আয়া, দাইমা, বয়স্ক পরিচারিকা	০	১
৮)	এক বা একাধিক শিক্ষক-শিক্ষিকা	০	১
৯)	এক বা একাধিক অন্য কোনো বয়স্ক অনাত্মীয় (পারিবারিক বন্ধু বা প্রতিবেশী ইত্যাদি)	০	১
১০)	কোনো বয়স্কের সাথেই বিশেষভাবে আসক্ত নয়	০	১

*যদি **ক১ (১০)** এর উত্তর "হ্যাঁ" হয়, অর্থাৎ শিশু কোনো বয়স্কের সাথেই বিশেষভাবে আসক্ত নয়, কেবলমাত্র তখন নিচের প্রশ্নগুলো জিজ্ঞাসা করুন।*

সে কি নিচের শিশুদের বা কিশোর-কিশোরীদের প্রতি বিশেষভাবে আসক্ত?		না	হ্যাঁ
১১)	এক বা একাধিক ভাই, বোন বা অন্য কোনো আত্মীয় ছেলেমেয়ে	০	১
১২)	এক বা একাধিক বন্ধু	০	১
১৩)	কারোর সাথেই বিশেষভাবে আসক্ত নয়	০	১

*যদি **ক১ (১৩)** এর উত্তর "হ্যাঁ" হয়, তাহলে সরাসরি **অংশ খ** তে চলে যান। অন্যথায় পরবর্তী প্রশ্নগুলোতে এগিয়ে যান।*

আপনি আমাকে এইমাত্র শিশুর (নাম) সাথে কে বিশেষভাবে আসক্ত তা বলেছেনঃ *আপনি চাইলে **ক১(১)** থেকে **ক১ (৯)** কিংবা **ক১ (১১)** থেকে **ক১ (১২)** এর মধ্যে যে গুলোতে "হ্যাঁ" উত্তর দেয়া হয়েছে তার সবগুলোর তালিকা করতে পারেন।* এখন থেকে আমি এই সব ব্যক্তিদের তার "আসক্তজন" বলে উল্লেখ করবো।

শিশু (নাম) তার "আসক্তজনদের" কাছ থেকে আলাদা হবার বিষয়ে কতোটা উদ্বেগে ভোগে এখন সে সম্পর্কে জানতে চাই। অধিকাংশ শিশু এ জাতীয় কিছু উদ্বেগে ভুগে থাকে, তবে আমি জানতে চাচ্ছি তার সমবয়সী অন্যান্য শিশুদের তুলনায় তার এই উদ্বেগ প্রকাশ কতোটা তীব্র। এক্ষেত্রে সে সচরাচর যে আচরণ দেখায় তার বর্ণনা দিন ---- মাঝে মধ্যে বিশেষ কোনো দিন বা ছুটির দিনের আচরণ নয়।

ক২	মোটামুটিভাবে **গত ৪ সপ্তাহে** সে কি তার আসক্তজন থেকে আলাদা হবার বিষয়ে উদ্বেগ প্রকাশ করেছে?	না	হ্যাঁ
		০	১

*যদি **ক২** এর উত্তর "হ্যাঁ" অথবা এসডিকিউ আবেগ মান ≥ 4 হয়, তাহলে পরবর্তী প্রশ্নগুলোতে এগিয়ে যান। যদি উত্তর "না" হয়, তাহলে সরাসরি **অংশ খ** তে চলে যান।*

ক৩	গত ৪ সপ্তাহে এবং শিশুর সমবয়সীদের সাথে তুলনা করলে ...	অন্যদের তুলনায় বেশি নয় (বা প্রযোজ্য নয়)	অন্যদের তুলনায় সামান্য বেশি	অন্যদের তুলনায় অনেক বেশি
১)	সে কি তার আসক্তজনদের খারাপ কিছু একটা ঘটতে যাচ্ছে অথবা তাদেরকে হারাতে যাচ্ছে ভেবে উদ্বিগ্ন হয়েছে?	০	১	২
২)	আসক্তজনদের কাছ থেকে নানাভাবে তাকে সরিয়ে নিয়ে যাওয়া হতে পারে ভেবে সে কি উদ্বিগ্ন থাকে, যেমন - ধরে নিয়ে যাওয়া, হাসপাতালে নেয়া, এমনকি মেরে ফেলা?	০	১	২
৩)	যখন সে স্কুলে থাকবে তখন আসক্তজনদের কিছু ঘটে যেতে পারে এই ভয়ে সে কি প্রায়ই স্কুলে যেতে চায় না? *(শিশু যদি অন্য কোনো কারণ যেমন - অন্যদের গায়ের জোর দেখানো বা মারামারির কারণে স্কুলে যেতে অনীহা দেখায় তা এখানে সংশ্লিষ্ট করবেন না)*	০	১	২
৪)	একা ঘুমাতে হবে ভেবে সে কি উদ্বিগ্ন হয়ে থাকে?	০	১	২
৫)	সে কি রাতে নিজ শোবার ঘর থেকে বের হয়ে এসে দেখে নেয়, তার আসক্তজনেরা ঘরে আছেন কিনা অথবা তাদের কাছাকাছি ঘুমাতে চায়?	০	১	২
৬)	অপরিচিত কোনো জায়গায় ঘুমানোর ব্যাপারে সে কি উদ্বিগ্ন হয়ে থাকে?	০	১	২
৭)	*(শিশুর বয়স যদি ১১ বছরের কম হয় কেবলমাত্র তখন জিজ্ঞাসা করুন)* আসক্তজনেরা ঘরের কোথাও থাকা সত্ত্বেও সে কি একা হতে ভয় পায়?	০	১	২
৮)	*(শিশুর বয়স যদি ১১ বছর বা তার বেশি হয় কেবলমাত্র তখন জিজ্ঞাসা করুন)* আসক্তজনেরা হঠাৎ এক মুহূর্তের জন্য বাইরে গেলে ঘরে একা থাকতে হবে ভেবে সে কি উদ্বিগ্ন হয়ে থাকে?	০	১	২
৯)	আসক্তজনদের কাছ থেকে আলাদা হওয়া নিয়ে সে কি প্রায়ই ভয়ের স্বপ্ন বা দুঃস্বপ্ন দেখে থাকে?	০	১	২
১০)	আসক্তজনদের কাছ থেকে আলাদা হলে বা আলাদা হতে যাচ্ছে জেনে তার কি মাথাব্যথা, পেটব্যথা, বমি বমি ভাব ইত্যাদি উপসর্গ হয়ে থাকে?	০	১	২
১১)	আসক্তজনদের কাছ থেকে আলাদা হবার সময় বা আলাদা হবার চিন্তায় সে কি উদ্বিগ্ন হয়, কাঁদতে থাকে, জেদ করে আসক্তজনদের জড়িয়ে থাকে অথবা মর্মপীড়া দেখায়?	০	১	২

যদি ক৩ এর প্রশ্নমালার যে কোনো একটিতে "অন্যদের তুলনায় অনেক বেশি" ঘরে টিক চিহ্ন দেয়া হয় তাহলে ঠ১ (৩৪ পৃষ্ঠা) চেকলিস্টের "বিচ্ছিন্নতা সংশ্লিষ্ট উদ্বেগাধিক্য" এর ঘরে টিক চিহ্ন দিন এবং ক৪ এ এগিয়ে যান। অন্যথায় সরাসরি অংশ খ তে চলে যান।

ক৪ আসক্তজনদের কাছ থেকে শিশুর (নাম) আলাদা হবার উদ্বেগ কি কমপক্ষে **৪ সপ্তাহ** ধরে আছে?

না	হ্যাঁ
০	১

ক৫ আসক্তজনদের কাছ থেকে তার আলাদা হবার উদ্বেগ যখন শুরু হয়েছিল তখন তার বয়স কতো ছিল?
(যদি জন্ম থেকেই হয়, ০ বসান)

[ ] বছর বয়স

ক৬ এসব উদ্বেগ তাকে কতোটা এলোমেলো করেছে বা কষ্ট দিয়েছে?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

ক৭ এসব উদ্বেগ কি ব্যাঘাত ঘটিয়েছে ...

	মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
১) আপনার ও পরিবারের অন্যান্যদের সাথে তার স্বাচ্ছন্দে?	০	১	২	৩
২) বন্ধু তৈরি করা ও ধরে রাখতে পারায়?	০	১	২	৩
৩) লেখাপড়া বা শ্রেণীর কাজে?	০	১	২	৩
৪) খেলাধুলা, শখ বা অন্যান্য অবসর বিনোদনমূলক কাজে?	০	১	২	৩

ক৮ এসব উদ্বেগ কি আপনার বা সামগ্রিকভাবে পরিবারের ওপর একটা বোঝা হয়ে দাঁড়িয়েছে?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

অংশ খ বিশেষ বিষয় বা পরিস্থিতি ভীতি (Fears of specific things or situations)

এ অংশটিতে শিশুদের কোনো বিশেষ বিষয় বা পরিস্থিতি যা তাদের জন্য সত্যিকারভাবে বিপজ্জনক না হওয়া সত্ত্বেও ভয় পায় তা জানা যায়। আমি জানতে চাই শিশু (নাম) কিসে ভয় পায়। সে সচরাচর যে আচরণ দেখায় তা জানতে আমি আগ্রহী, মাঝেমধ্যে বিশেষ দিনের এ ধরনের কোনো আচরণ নয়। এই অংশে সব ধরনের ভীতি সম্পর্কে জানা যাবে না ; কতোগুলো ভীতি, যেমন - সামাজিক পরিস্থিতি, নোংরা, বিচ্ছিন্নতা সংশ্লিষ্ট, লোকজনের ভিড়জনিত ভীতি অন্যান্য অংশে জানা যাবে।

খ১	শিশু (নাম) কি নিচের তালিকার বিষয় বা পরিস্থিতিতে ভয় পায়?	না	কিছুটা	অনেকটা
১)	প্রাণীঃ কুকুর, মাকড়সা, মৌমাছি এবং বোলতা, নেংটি ইঁদুর বা ধেড়ে ইঁদুর, সাপ, বা অন্য কোনো প্রাণী, পাখি অথবা পোকা	০	১	২
২)	প্রাকৃতিক পরিবেশের কিছু বিষয়ঃ ঝড়, বজ্রগর্জন, উচ্চতা, পানি	০	১	২
৩)	অন্ধকার	০	১	২
৪)	তীব্র শব্দঃ দমকলের ঘন্টি, বাজিপটকা	০	১	২
৫)	রক্ত-ইনজেকশন-আঘাতঃ রক্ত বা আঘাত, ইনজেকশন, বা অন্যান্য ডাক্তারি পদ্ধতি দেখে ভয় শুরু হওয়া	০	১	২
৬)	দন্তচিকিৎসক বা চিকিৎসক	০	১	২
৭)	বমি, শ্বাসকষ্ট বা নির্দিষ্ট কোনো রোগ হওয়া, যেমন - ক্যান্সার বা এইডস্	০	১	২
৮)	বিশেষ যানবাহনে চড়াঃ যেমন - মোটরগাড়ি, বাস, নৌকা, উড়োজাহাজ, রেলগাড়ি, ভূতল ট্রেন, সেতু	০	১	২
৯)	ছোট আবদ্ধ জায়গাঃ যেমন - লিফ্‌ট, সুরঙ্গপথ	০	১	২
১০)	টয়লেট ব্যবহার করাঃ যেমন - স্কুলে বা অন্য কারো বাড়িতে	০	১	২
১১)	বিশেষ ধরণের লোকজনঃ যেমন - ভাঁড়, দাড়িওয়ালা লোক, মাথায় আঘাত নিরোধক হেলমেটধারী, কিম্ভুত সাজপোষাকধারী, বুড়ো সাজা লোক	০	১	২
১২)	কাল্পনিক বা অতিপ্রাকৃতিক সত্তাঃ যেমন - দৈত্যদানো, ভূতপ্রেত, জ্বীন, ডাইনী	০	১	২
১৩)	অন্য কোনো বিশেষ ভয়ঃ *(বর্ণনা করুন)*	০	১	২

যদি খ১ এর তালিকায় কোনো একটিতে "অনেকটা" উত্তর দেয়া হয়, তাহলে খ২ প্রশ্নে এগিয়ে যান। অন্যথায় সরাসরি অংশ গ তে চলে যান।

খ২	এসব ভয় কি তার, আপনার বা আর কারোর জন্য সত্যিকার বিড়ম্বনার ব্যাপার হয়ে দাঁড়ায়?	না	হয়তোবা	নিশ্চিতভাবে
		০	১	২

যদি খ২ এর উত্তর "নিশ্চিতভাবে" অথবা এসডিকিউ আবেগ মান ≥৪ হয়, তাহলে পরবর্তী প্রশ্নে এগিয়ে যান। অন্যথায় সরাসরি অংশ গ তে চলে যান।

খ৩ কতোদিন ধরে এই ভয় বা ভয়গুলোর মধ্যে সবচেয়ে বেশি ভয় বর্তমান?

১ মাসের কম	১ - ৫ মাস	৬ মাস বা তার বেশি
০	১	২

খ৪ যখন শিশু (নাম) ভীতি উদ্রেককারী জিনিসের মুখোমুখি হয় বা হবার চিন্তা করে তখন সে কি উদ্বিগ্ন হয় বা এলোমেলো হয়ে পড়ে?

না	কিছুটা	অনেকটা
০	১	২

→ খ৭ (০) / ↓ খ৫ (২)

খ৫ ভীতি উদ্রেককারী জিনিসের মুখোমুখি হলে সে কি প্রতিবারই বা প্রায় প্রতিবারই উদ্বিগ্ন হয় বা এলোমেলো হয়ে পড়ে?

না	হ্যাঁ
০	১

খ৬ এই ভয় তাকে কতোবার এলোমেলো করে ফেলে?

দ্রষ্টব্য : যদি সে কোনো কিছুতে ভয় পায় যা কেবলমাত্র বছরের কোনো এক সময়ে হয়ে থাকে (যেমন - বাদলা পোকা, শুঁয়োপোকা) তাহলে এই প্রশ্ন সেই বিশেষ ঋতু সম্পর্কে হবে।

মাঝেমধ্যে	বেশিরভাগ সপ্তাহ	বেশিরভাগ দিন	দিনের মধ্যে অনেকবার
০	১	২	৩

খ৭ এসব ভয়ের কারণে কি সে ভীতি উদ্রেককারী জিনিসগুলো এড়িয়ে চলে?

না	কিছুটা	অনেকটা
০	১	২

→ খ৯ (০) / ↓ খ৮ (২)

খ৮ এরূপ এড়িয়ে চলা কি তার দৈনন্দিন জীবনে ব্যাঘাত ঘটায়?

না	কিছুটা	অনেকটা
০	১	২

	না	হয়তোবা	নিশ্চিতভাবে
খ৯ আপনি কি মনে করেন যে তার ভয়গুলো মাত্রাতিরিক্ত বা অহেতুক?	০	১	২
খ১০ তার ধারণা কি? সে কি মনে করে যে এসব ভয় মাত্রাতিরিক্ত বা অহেতুক?	০	১	২

যদি খ২ এর উত্তর "নিশ্চিতভাবে" অথবা খ৪ বা খ৭ এর উত্তর "অনেকটা" হয়, তাহলে ঠ১ (৩৪ পৃষ্ঠা) চেকলিস্টের "বিশেষ অহেতুক ভীতি" ঘরে টিক চিহ্ন দিন।

খ১১ তার এসব ভয় কি আপনার বা সামগ্রিকভাবে পরিবারের ওপর একটা বোঝা হয়ে দাঁড়িয়েছে?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

অংশ গ সামাজিক পরিস্থিতি ভীতি (Fear of social situations)

শিশু (নাম) বিভিন্ন সামাজিক পরিস্থিতিতে বিশেষভাবে ভয় পায় কিনা তা জানতে চাই। এটি সমবয়সী শিশুদের সাথে তুলনা করে বলতে হবে এবং মাঝে মধ্যে বিশেষ দিনের ভীতি বা সাধারণ লাজুকভাব নয়।

গ১ সামগ্রিকভাবে শিশু (নাম) কি অনেক লোকজনের মধ্যে থাকা, অপরিচিত কারো সাথে কথাবার্তা বলা, অন্যের সামনে কিছু করতে যাওয়ার মত সামাজিক পরিস্থিতিতে ভয় পায় বা এড়িয়ে চলে?

না	হ্যাঁ
০	১

*যদি গ১ এর উত্তর "হ্যাঁ" অথবা এসডিকিউ আবেগ মান >৪ হয়, তাহলে এগিয়ে যান। যদি এগুলোর কোনোটাই "না" হয়, তাহলে পরের অংশ বাদ দিয়ে সরাসরি **অংশ ঘ** তে চলে যান।*

গ২ সে গত ৪ সপ্তাহে নিচের দেয়া সামাজিক পরিস্থিতিগুলোতে বিশেষভাবে ভয় পেয়েছে কি?

		না	কিছুটা	অনেকটা
১)	অপরিচিত কারো সাথে কথাবার্তা বলতে?	০	১	২
২)	অনেক লোকজনের মধ্যে থাকতে, যেমন কোনো ভোজসভায়?	০	১	২
৩)	অন্যদের সামনে যেতে?	০	১	২
৪)	ক্লাসে কথা বলতে?	০	১	২
৫)	অন্যদের সামনে শব্দ করে পড়তে?	০	১	২
৬)	অন্যদের সামনে লিখতে?	০	১	২

*যদি গ২ এর তালিকার কোনো একটিতেও "অনেকটা" উত্তর পাওয়া না যায়, তাহলে পরবর্তী অংশ বাদ দিয়ে সরাসরি **অংশ ঘ** তে চলে যান।*

গ৩ বেশির ভাগ শিশু কয়েকজন প্রধান বয়স্কের সাথে বিশেষভাবে আসক্ত থাকে, তারা কাছাকাছি থাকলে বেশি নিরাপদ বোধ করে। কতোক শিশু কেবলমাত্র সামাজিক পরিস্থিতিতে ভয় পায় যদি তাদের কাছাকাছি বিশেষভাবে আসক্ত প্রধান বয়স্কদের একজনও না থাকে।

অন্য শিশুরা বিশেষভাবে আসক্ত প্রধান বয়স্কদের কেউ সাথে থাকলেও বিভিন্ন সামাজিক পরিবেশে ভয় পায়।

শিশুর (নাম) জন্য কোনটা সত্য?

সামাজিক পরিস্থিতিতে বেশিরভাগ সময় ভালো থাকে যতক্ষণ প্রধান বয়স্করা তার কাছাকাছি থাকে	এমনকি প্রধান বয়স্করা কাছাকাছি থাকলেও সামাজিক ভীতি সুস্পষ্ট
০	১

গ৪ শিশু (নাম) কি কেবল বড়দের ভয় পায়, নাকি সে অনেক শিশুর মধ্যে বা অপরিচিত শিশুদের মুখোমুখি হতেও ভয় পায়?

কেবল বড়দের	কেবল শিশুদের	বড় ও শিশু উভয়দের
০	১	২

গ৫ এসব সামাজিক পরিস্থিতি ছাড়া সে কি তার সবচেয়ে পরিচিত বড়দের এবং শিশুদের সাথে স্বাচ্ছন্দ্যে থাকে?

না	হ্যাঁ
০	১

গ৬ আপনি কি মনে করেন যে, সে এসব সামাজিক পরিস্থিতি অপছন্দ করে কারণ সে যা কিছু করে তা বিব্রতকর অথবা সবাই তাকে লক্ষ করবে?

না	হয়তোবা	নিশ্চিতভাবে
০	১	২

গ৭ *(যদি গ২ এর ৪ বা ৫ বা ৬ প্রশ্নের উত্তর "হ্যাঁ" হয়, কেবলমাত্র তখন জিজ্ঞাসা করুন)*

সে কি কথা বলতে, পড়তে বা লিখতে হবে এ ধরনের সামাজিক পরিস্থিতিগুলোকে অপছন্দ করে থাকে?

না	হয়তোবা	নিশ্চিতভাবে
০	১	২

গ৮ এসব সামাজিক পরিস্থিতিতে তার ভয় কতোদিন ধরে আছে?

১ মাসের কম	১ - ৫ মাস	৬ মাস বা তারও বেশি
০	১	২

গ৯ যখন তার সামাজিক পরিস্থিতি ভীতি শুরু হয়েছিল তখন তার বয়স কতো ছিল?

(যদি জন্ম থেকেই হয়, ০ বসান)

[ ] বছর বয়স

গ১০ শিশু (নাম) যেসব সামাজিক পরিস্থিতির মুখোমুখি হলে বা হবার কথা ভাবলে ভয় পায় তার কোনো একটির মুখোমুখি হলে বা হবার কথা ভাবলে সে কি উদ্বিগ্ন হয় বা এলোমেলো হয়ে পড়ে?

না	কিছুটা	অনেকটা
০	১	২
		↓
গ১২		গ১১

গ১১ তার সামাজিক পরিস্থিতি ভীতি তাকে এরকম কতোবার এলোমেলো করে দেয়?

মাঝেমধ্যে	বেশিরভাগ সপ্তাহ	বেশিরভাগ দিন	দিনের মধ্যে অনেক বার
০	১	২	৩

গ১২ এই ভয়ের কারণে কি শিশু (নাম) সামাজিক পরিস্থিতি এড়িয়ে চলে?

না	কিছুটা	অনেকটা
০	১	২
		↓
গ১৪		গ১৩

গ১৩ এরূপ এড়িয়ে চলা কি তার দৈনন্দিন জীবনে ব্যাঘাত সৃষ্টি করে?

না	কিছুটা	অনেকটা
০	১	২

না	হয়তোবা	নিশ্চিতভাবে
০	১	২

গ১৪ সে কি মনে করে যে এই সামাজিক পরিস্থিতি ভীতি মাত্রাতিরিক্ত বা অহেতুক?

গ১৫ তার এই ভয় আছে বলে সে কি বিপর্যস্ত?

০	১	২

যদি গ১০ বা গ১২ এর উত্তর "অনেকটা" হয়, তাহলে ঠ১ (৩৪ পৃষ্ঠা) চেকলিস্টের "সামাজিক অহেতুক ভীতি" ঘরে টিক চিহ্ন দিন।

গ১৬ শিশুর (নাম) সামাজিক পরিস্থিতি ভীতি কি আপনার বা সামগ্রিকভাবে পরিবারের ওপর একটা বোঝা হয়ে দাঁড়িয়েছে?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

অংশ ঘ আতঙ্কগ্রস্ততা এবং বহির্গমনের ভীতি (Panic Attacks and Agoraphobia)

অনেক শিশুই কখনো কখনো তুচ্ছ সামান্য বিষয়ে অনেক বেশি উদ্বিগ্ন বা আতঙ্কিত হয়। কিছু শিশু কোনো কারণ ছাড়াই হঠাৎ করে প্রচন্ড মাত্রায় আতঙ্কিত হয়ে পড়ে। এই আতঙ্কের জন্য কোনো বিষয় বা পরিস্থিতির দরকার হয় না।

ঘ১ **গত ৪ সপ্তাহে** কি শিশু (নাম) একবার আতঙ্কগ্রস্ততা দেখিয়েছিল যার কোনো কারণ ছিল না এমনকি আতঙ্ক শুরু হবার মত একটি সামান্য বিষয় ছাড়াই?

না	হ্যাঁ
০	১

*যদি **ঘ১** এর উত্তর "হ্যাঁ" হয়, তাহলে **ঠ১** (৩৪ পৃষ্ঠা) চেকলিস্টের "আতঙ্কগ্রস্ততা/বহির্গমনের অহেতুক ভীতি" ঘরে টিক চিহ্ন দিন।*

ঘ২ **গত ৪ সপ্তাহ** ধরে শিশু (নাম) কি নিচের পরিস্থিতিগুলোতে ভয় পেয়েছে অথবা এগুলো এড়িয়ে চলার চেষ্টা করেছে?

		না বা প্রযোজ্য নয়	হ্যাঁ
১)	মানুষের ভিড়	০	১
২)	জনসাধারণের জন্য বিভিন্ন স্থান	০	১
৩)	একা ভ্রমন করা (যদি সে কখনো এরূপ করে থাকে)	০	১
৪)	বাড়ির অনেক দূরে যাওয়া	০	১

*যদি **ঘ২** এর কোনো একটির উত্তর "হ্যাঁ" হয়, তাহলে **ঘ৩** এ যান। অন্যথায় বাদ দিয়ে সরাসরি **অংশ ঙ** তে চলে যান।*

ঘ৩ আপনি কি মনে করেন যে, তার আতঙ্কগ্রস্ততা বা এ জাতীয় কিছু ঘটবে বা ভয়ের পরিস্থিতি থেকে বেরিয়ে আসাটা কঠিন বা বিব্রতকর হবে বা সে দরকারি সহায়তা পাবে না - এসব কি এই ভয় বা ভয়ের পরিস্থিতি এড়িয়ে চলার কারণ?

না	হ্যাঁ
০	১

*যদি **ঘ৩** এর উত্তর "হ্যাঁ" হয়, তাহলে **ঠ১** (৩৪ পৃষ্ঠা) চেকলিস্টের "আতঙ্কগ্রস্ততা/বহির্গমনের অহেতুক ভীতি" ঘরে টিক চিহ্ন দিন।*

অংশ ঙ মানসিক আঘাতোত্তর মানসিক চাপ (Post Traumatic Stress)

এ অংশটা এমন সব ঘটনা অথবা পরিস্থিতি সংশ্লিষ্ট যেগুলো আসলেই ব্যতিক্রমধর্মী মানসিক চাপসম্পন্ন এবং এতে আক্রান্ত প্রায় সবাই সত্যিকারভাবে বিপর্যস্ত হতে পারে। যেমন - আগুন লেগেছে এমন কোনো বাড়িতে আটকে পড়া, নির্যাতিত হওয়া, কোনো মারাত্মক ধরণের যান দুর্ঘটনার শিকার হওয়া, অস্ত্রের মুখে নিজেকে ছিনতাই হতে দেখা।

		না	হ্যাঁ
ঙ১	শিশুর (নাম) জীবনে কি এ ধরণের কোনো ঘটনা ঘটেছিল?	০	১

		না	হ্যাঁ
ঙ২	*(যদি ঙ১ এর উত্তর "হ্যাঁ" হয়, তাহলে "যাচাই করার জন্য ....." বলে প্রশ্ন শুরু করুন)* শিশু (নাম) কি কখনো নিচের কোনো একটির মুখোমুখি হয়েছিল?		
	শিশুর দুর্বিপাকের মধ্যে পড়া		
১)	মারাত্মক এবং ভয়াবহ দুর্ঘটনা, যেমন - গাড়ি চাপা পড়া, ভয়ানক গাড়ি বা ট্রেনের সংঘর্ষ হওয়া, ইত্যাদি	০	১
২)	অগ্নিকান্ড, যেমন - জ্বলন্ত বাড়ির মধ্যে আটকে পড়া	০	১
৩)	অন্যান্য দুর্বিপাক, যেমন - অপহরণ, বন্যা, জলোচ্ছ্বাস, ভূমিকম্প, যুদ্ধ	০	১
	শিশুর প্রতি সহিংসতা		
৪)	গুরুতর আক্রমন বা হুমকি, যেমন - ছিনতাইকারী বা ডাকাতদলের কাছ থেকে	০	১
৫)	গুরুতর শারীরিক নির্যাতন যা তার এখনো মনে পড়ে	০	১
	শিশুর প্রতি যৌন নিপীড়ন		
৬)	যৌন নির্যাতন	০	১
৭)	ধর্ষণ	০	১
	দারুণ বিপর্যস্ত হবার মত কিছু শিশুর প্রত্যক্ষ করা		
৮)	মারাত্মক গৃহবিবাদ হতে দেখা, যেমন - মা'কে প্রচন্ড মার খেতে দেখা	০	১
৯)	পরিবারের কোনো সদস্য বা কোনো বন্ধুকে আক্রান্ত বা হুমকির শিকার হতে দেখা	০	১
১০)	আকস্মিক মৃত্যু, আত্মহত্যা, আত্মহত্যার চেষ্টা, মারাত্মক দুর্ঘটনা বা হৃদরোগে আক্রান্ত হতে দেখা	০	১
	অন্যান্য মারাত্মক বৈকল্য		
১১)	অন্য কোনো মারাত্মক পীড়াদায়ক ঘটনা *(বর্ণনা করুন)*..	০	১

*যদি ঙ২ এর কোনো একটির উত্তর "হ্যাঁ" হয়, তাহলে এগিয়ে যান। অন্যথায় **অংশ চ** তে চলে যান।*

৪৩ ঐ সময়ে শিশু (নাম) কি অতিরিক্ত মাত্রায় মর্মবেদনায় ছিল অথবা তার আচরণে আকস্মিক পরিবর্তন দেখা দিয়েছিল?

না	হ্যাঁ
০	১

৪৩ক এখন, তা কি শিশুর (নাম) আচরণ, অনুভূতি বা মনোযোগের ওপর প্রভাব ফেলছে?

না	হ্যাঁ
০	১
↓	↓
অংশ চ	৪৪

৪৪	**গত ৪ সপ্তাহ** ধরে শিশুর (নাম) আছে ...	না	কিছুটা	অনেকটা
১)	ঘটনার স্মৃতিগুলো প্রাণবন্ত ছবির মত ভাসে?	০	১	২
২)	ঘটনাটি দুঃস্বপ্ন হয়ে বার বার আসে?	০	১	২
৩)	সেই ঘটনা স্মরণ করিয়ে দেয় এমন কিছু ঘটলে সে কি এলোমেলো হয়ে পড়ে?	০	১	২
৪)	ঘটনা সম্পর্কে চিন্তা করা, এমনকি কোনো কিছু বলা পর্যন্ত এড়িয়ে চলার চেষ্টা করে থাকে?	০	১	২
৫)	সেই ঘটনা মনে করিয়ে দেয় এমন কাজকর্ম, স্থান বা লোকজন এড়িয়ে চলার চেষ্টা করে থাকে?	০	১	২
৬)	ঘটনার কোনো একটা গুরুত্বপূর্ণ অংশ সে মনে করতে পারে না?	০	১	২
৭)	আগে উপভোগ করতো এমন কর্মকান্ডগুলোতে অনেক কম আগ্রহ দেখায়?	০	১	২
৮)	অন্যদের কাছ থেকে বিচ্ছিন্ন হয়ে গেছে বা দূরে সরে গেছে এরূপ অনুভব করে?	০	১	২
৯)	আগের তুলনায় অনুভূতি প্রকাশের ক্ষমতা সংকীর্ণ হয়ে পড়েছে, যেমন ভালোলাগার অনুভূতি প্রকাশ করতে পারে না?	০	১	২
১০)	ভবিষ্যৎ নিয়ে কম আত্মবিশ্বাসে ভোগে?	০	১	২
১১)	ঘুমের সমস্যা হয়?	০	১	২
১২)	খিটখিটে বা রগচটা হয়ে গেছে?	০	১	২
১৩)	কোনো কিছুতে মনোযোগ দিতে অসুবিধে হয়?	০	১	২
১৪)	বিপদ ঘটে যেতে পারে এমন আশঙ্কায় সর্বদাই সন্ত্রস্ত থাকে?	০	১	২
১৫)	অল্প শব্দ হলেই বা অন্য কোনো কিছুতে সহজেই চমকে ওঠে?	০	১	২

*যদি ৪৪ এর কোনো একটির উত্তর "অনেকটা" হয়, তাহলে ঠ১ (৩৪ পৃষ্ঠা) চেকলিস্টের "মানসিক আঘাতোত্তর মানসিক চাপ" ঘরে টিক চিহ্ন দিন ও ৪৫ এ এগিয়ে যান। অন্যথায় পরবর্তী অংশ বাদ দিয়ে সরাসরি **অংশ চ** তে চলে যান।*

৬৫ আপনি শিশুর এসব সুস্পষ্ট উপসর্গ সম্পর্কে বলেছেন। ঘটনার কতো পরে এসব সমস্যা শুরু হয়েছিল?

৬ মাসের মধ্যে	ঘটনার ৬ মাস পরে
০	১

৬৬ শিশু কতোদিন ধরে এসব সমস্যায় ভুগছে?

১ মাসের কম	১ - ৩ মাস	৩ মাস বা তারও বেশি
০	১	২

৬৭ মানসিক চাপজনিত ঘটনা বা ঘটনাগুলো থেকে উদ্ভুত সমস্যাগুলোর কারণে সে কতোটা বেদনার্ত বা বিপর্যস্ত?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

৬৮ এসব সমস্যা কি ব্যঘাত ঘটিয়েছে ....

		মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
১)	আপনার ও পরিবারের অন্যান্যদের সাথে তার স্বাচ্ছন্দ্যে?	০	১	২	৩
২)	বন্ধু তৈরি করা ও ধরে রাখতে পারায়?	০	১	২	৩
৩)	লেখাপড়া বা শ্রেণীর কাজে?	০	১	২	৩
৪)	খেলাধুলা, শখ বা অন্যান্য অবসর বিনোদনমূলক কাজে?	০	১	২	৩

৬৯ শিশুর এসব সমস্যা কি আপনার বা সামগ্রিকভাবে পরিবারের ওপর একটা বোঝা হয়ে দাঁড়িয়েছে?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

অংশ চ বাধ্যতাধর্মী আচরণ ও চিন্তাবাতিক (Compulsions and Obsessions)

অনেক শিশুর মাঝে কতক অভ্যাস আর সংস্কার দেখা যায়, যেমন - মেঝের ফাটলে পা না দেয়া, রাতে ঘুমানোর আগে কোনো বিশেষ আচরণ করা, সামনের পরীক্ষা বা ফুটবল ম্যাচের জন্য কোনো পয়মন্ত পোষাক পরা বা চিহ্ন ধারণ করা ইত্যাদি। বিকাশের বিভিন্ন স্তরে শিশুদের মধ্যে কোনো সুনির্দিষ্ট বিষয় বা কার্যক্রম সম্পর্কে চিন্তাবাতিক থাকা স্বাভাবিক। শিশুর (নাম) যে সব আচরণ বা চিন্তাবাতিক এই স্বাভাবিক মাত্রার চাইতে বেশি সে সম্পর্কে আমি জানতে চাই।

চ১ সামগ্রিকভাবে শিশুর (নাম) এমন সব আচরণ বা চিন্তাবাতিক আছে কি যেসব তাকে এলোমেলো করে, অনেক সময় নষ্ট করে দেয় বা দৈনন্দিন জীবনযাত্রায় বিঘ্ন ঘটিয়ে থাকে?

না	হ্যাঁ
০	১

*যদি চ১ এর উত্তর "হ্যাঁ" অথবা এসডিকিউ আবেগ মান ≥৪ হয়, তাহলে নিচের প্রশ্নগুলোতে এগোন। অন্যথায় বাদ দিয়ে সরাসরি **অংশ ছ** তে চলে যান।*

চ২ **গত ৪ সপ্তাহ** ধরে, সে কি নিচের আচরণগুলোর অন্তত একটি বারবার করছে বা করেছে, যদিও শিশু একবার তা করেছে বা এগুলো করায় আদৌ কোনো দরকার ছিল না?

		না	কিছুটা	অনেকটা
১)	মাত্রাতিরিক্ত পরিচ্ছন্নতাঃ হাত ধোয়া, গোসল করা, ধারাস্নান করা, দাঁত মাজা ইত্যাদি	০	১	২
২)	ধুলোবালি, ময়লা বা জীবাণু থেকে রক্ষা পাওয়ার জন্য কোনো বিশেষ পদ্ধতি অবলম্বন করা	০	১	২
৩)	বার বার পরখ করে দেখাঃ দরজা, তালা, চুলো, গ্যাসের নির্গমন, বৈদ্যুতিক সুইচ	০	১	২
৪)	অকারণে একই সাধারণ কাজ শ্রেণীবদ্ধভাবে বারংবার করাঃ যেমন - উঠে দাঁড়ানো বা বসে পড়া, দরজাপথ দিয়ে সামনে বা পিছনে যাওয়া	০	১	২
৫)	কোনো বস্তু বা ব্যক্তিকে বিশেষ নিয়মে স্পর্শ করা	০	১	২
৬)	জিনিসগুলোকে এমনভাবে সাজানো যেনো এভাবে সাজাতে হয় বা সাদৃশ্যতা প্রকাশ পায়	০	১	২
৭)	কোনো বিশেষ শুভ সংখ্যা গণনা করা বা অশুভ সংখ্যা পরিহার করা	০	১	২

চ৩ **গত ৪ সপ্তাহ** ধরে, শিশুকে (নাম) ধুলোময়লা, জীবাণু বা বিষাক্ত জিনিস সম্পর্কে বাধ্যতাধর্মীভাবে উদ্বিগ্ন হতে দেখা গেছে কি - যা সে তার মন থেকে সরাতে পারছে না?

না	কিছুটা	অনেকটা
০	১	২

চ৩ক **গত ৪ সপ্তাহ** ধরে, শিশুকে (নাম) কি ধর্ম সম্পর্কে বা স্রষ্টা নারাজ হতে পারে বলে বাধ্যতাধর্মীভাবে উদ্বিগ্ন হতে দেখা গেছে?

না	কিছুটা	অনেকটা
০	১	২

যদি চ২ বা চ৩ বা চ৩ক এর উত্তর "অনেকটা" হয়, তাহলে ঠ১ (৩৪পৃষ্ঠা) চেকলিস্টের "চিন্তাবাতিক ও বাধ্যতাধর্মী আচরণ" ঘরে টিক চিহ্ন দিন।

চ৪ **গত ৪ সপ্তাহ** ধরে, শিশু (নাম) কি তার নিজের অথবা অন্য কারোর অসুস্থতা, দুর্ঘটনা, আগুন লাগা বা এ ধরনের মারাত্মক কিছু ঘটবে এমন চিন্তায় বার বার উদ্বিগ্ন হয়েছে?

না	কিছুটা	অনেকটা
০	১	২

↓ চ৭ / চ৬

চ৬ তার বা অন্যের মারাত্মক কিছু একটা ঘটতে যাচ্ছে এমন বাধ্যতাধর্মী চিন্তা কি তার প্রধান আসক্তজনদের কাছ থেকে বিচ্ছিন্ন হবার সাধারণ উদ্বেগের অংশ অথবা এগুলো সম্পূর্ণ স্বতন্ত্র সমস্যা?

বিচ্ছিন্নতা সংশ্লিষ্ট উদ্বেগাধিক্যের অংশ	সম্পূর্ণ স্বতন্ত্র একটা সমস্যা
০	১

যদি চ৬ এর উত্তর "সম্পূর্ণ স্বতন্ত্র একটা সমস্যা" হয়, তাহলে ঠ১ (৩৪পৃষ্ঠা) চেকলিস্টের "চিন্তাবাতিক ও বাধ্যতাধর্মী আচরণ" ঘরে টিক চিহ্ন দিন।

*ঠ১ চেকলিস্টের চিন্তাবাতিক ও বাধ্যতাধর্মী আচরণে টিক চিহ্ন দেয়া হলে পরবর্তী প্রশ্নগুলোতে এগিয়ে যান। অন্যথায় তা বাদ দিয়ে সরাসরি **অংশ ছ** তে চলে যান।*

চ৭ শিশুর (নাম) বাধ্যতাধর্মী আচরণ বা চিন্তাগুলো কি **কমপক্ষে ২ সপ্তাহ** ধরে প্রায় সবসময় দিনে বর্তমান?

না	হ্যাঁ
০	১

চ৮ সে কি মনে করে যে তার বাধ্যতাধর্মী আচরণ বা চিন্তাগুলো মাত্রাতিরিক্ত বা অহেতুক?

না	হয়তোবা	নিশ্চিতভাবে
০	১	২

চ৯ সে কি বাধ্যতাধর্মী আচরণ বা চিন্তাগুলো না করার চেষ্টা করে থাকে?

না	হয়তোবা	নিশ্চিতভাবে
০	১	২

চ১০ এসব বাধ্যতাধর্মী আচরণ বা চিন্তা কি তাকে এলোমেলো করে ফেলে?

না, সে ওইগুলো উপভোগ করে থাকে	প্রতিক্রিয়াহীন, সে উপভোগও করেনা বা এলোমেলো হয়েও পড়েনা	ওইগুলো তাকে কিছুটা এলোমেলো করে ফেলে	ওইগুলো তাকে অনেকটা এলোমেলো করে ফেলে
০	১	২	৩

চ১১ এসব বাধ্যতাধর্মী আচরণ বা চিন্তাতে কি পড়ে প্রতিদিন অন্তত এক ঘন্টা সময় অতিবাহিত হয়ে যায়?

না	হ্যাঁ
০	১

চ১২ এসব বাধ্যতাধর্মী আচরণ বা চিন্তা কি ব্যাঘাত ঘটিয়েছে ...

	মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
১) আপনার ও পরিবারের অন্যান্যদের সাথে তার স্বাচ্ছন্দ্যে?	০	১	২	৩
২) বন্ধু তৈরি করা ও ধরে রাখতে পারায়?	০	১	২	৩
৩) লেখাপড়া বা শ্রেণীর কাজে?	০	১	২	৩
৪) খেলাধুলা, শখ বা অন্যান্য অবসর বিনোদনমূলক কাজে?	০	১	২	৩

চ১৩ এসব বাধ্যতাধর্মী আচরণ বা চিন্তা কি আপনার বা সামগ্রিকভাবে পরিবারের ওপর একটা বোঝা হয়ে দাঁড়িয়েছে?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

অংশ ছ অনির্দিষ্ট উদ্বেগাধিক্য (Generalized Anxiety)

এই অংশ উদ্বিগ্নতা সম্পর্কিত।

ছ২ শিশু (নাম) কি কখনো উদ্বিগ্ন হয়েছে?

না	হ্যাঁ
০	১
↓	↓
অংশ জ	এগিয়ে যান

কিছু শিশু অল্প কয়েকটা বিষয়ে উদ্বিগ্ন থাকে যা কখনো বিশেষ ভীতি, বাধ্যতাধর্মী চিন্তাবাতিক বা আসক্তজন হতে বিচ্ছিন্নতা সংশ্লিষ্ট উদ্বেগের সাথে সম্পর্কিত। অন্য শিশুরা জীবন যাপনের নানান দিক সম্পর্কে উদ্বিগ্ন হয়ে থাকে। তাদের বিশেষ ভীতি, বাধ্যতাধর্মী চিন্তাবাতিক বা আসক্তজন হতে বিচ্ছিন্নতা সংশ্লিষ্ট উদ্বেগ থাকলেও বিভিন্ন বিষয়ে একটা ব্যাপক উদ্বেগ থাকে।

ছ২ক শিশু (নাম) কি সাধারণভাবে উদ্বেগসম্পন্ন?

না, তার শুধু ক'য়েকটা নির্দিষ্ট উদ্বেগ আছে	হ্যাঁ, সে সাধারণভাবে উদ্বিগ্ন হয়ে থাকে
০	১
↓	↓
কেবলমাত্র এসডিকিউ আবেগ মান ≥৪ হলে এগিয়ে যান	*এগিয়ে যান*

ছ৩ **গত ৬ মাস** ধরে, শিশু (নাম) কি অনেক কিছু নিয়ে এতটা বেশি উদ্বিগ্ন আছে যা শিশুকে এলোমেলো করে ফেলেছে বা দৈনন্দিন জীবন যাত্রায় বিঘ্ন ঘটিয়েছে?

না	হয়তোবা	নিশ্চিতভাবে
০	১	২

*যদি **ছ৩** এর উত্তর "হয়তোবা" অথবা "নিশ্চিতভাবে" অথবা এসডিকিউ আবেগ মান ≥৪ হয়, তাহলে নিচের প্রশ্নগুলোতে এগোন। অন্যথায় বাদ দিয়ে সরাসরি **অংশ জ** তে চলে যান।*

ছ৪ **গত ৬ মাস** ধরে এবং সমবয়সী অন্যদের তুলনায় নিচের বিষয়গুলোতে শিশুর (নাম) উদ্বেগ আছে কি ...

		অন্যদের তুলনায় বেশি নয়	অন্যদের তুলনায় সামান্য বেশি	অন্যদের তুলনায় অনেক বেশি
১)	অতীত আচরণঃ আমি কি ভুল করেছি? আমি কি কাউকে কষ্ট দিয়েছি? তারা কি আমাকে ক্ষমা করেছে?	০	১	২
২)	স্কুলের কাজ, বাড়ির কাজ বা পরীক্ষা সম্পর্কিত উদ্বেগ	০	১	২
৩)	দুর্বিপাকঃ চুরি, ছিনতাই, আগুন লাগা, বোমা বিস্ফোরিত হওয়া ইত্যাদি বিষয়	০	১	২
৪)	তার নিজ স্বাস্থ্য সম্পর্কে	০	১	২
৫)	অন্যদের খারাপ কিছু ঘটতে যাচ্ছে এমন উদ্বেগঃ পরিবারের, বন্ধুদের, পোষা প্রাণীদের, পৃথিবীর (যেমন - যুদ্ধবিগ্রহ)	০	১	২
৬)	ভবিষ্যৎ নিয়ে উদ্বেগঃ যেমন - স্কুল বদল, বাড়ি বদল, চাকরি পাওয়া, বন্ধু-বান্ধবী পাওয়া	০	১	২
৭)	বন্ধু তৈরি করা ও ধরে রাখা	০	১	২
৮)	মৃত্যু ও মরণ বিষয়ক	০	১	২
৯)	লাঞ্ছনা বা বিদ্রুপের শিকার হওয়া	০	১	২
১০)	তার চেহারা বা ওজন	০	১	২
১১)	অন্য নির্দিষ্ট উদ্বেগ *(বর্ণনা করুন)*	০	১	২

যদি এসব উদ্বেগের ২ বা ততোধিক বিষয়ে "অন্যদের তুলনায় অনেক বেশি" উত্তর দেয়া হয় তাহলে এগিয়ে যান, অন্যথায় বাদ দিয়ে অংশ জ তে চলে যান।

ছ৬ **গত ৬ মাস** ধরে অধিকাংশ দিনই শিশু কি মাত্রাতিরিক্ত উদ্বিগ্ন ছিল?

না	হ্যাঁ
০	১

ছ৭ এ উদ্বেগ নিয়ন্ত্রণ করাটা কি শিশুর জন্য কষ্টকর হয়ে দাঁড়ায়?

না	হ্যাঁ
০	১

ছ৮ *যদি নিচের প্রশ্নগুলোর কোনো একটি উত্তর "হ্যাঁ" হয়, জিজ্ঞাসা করুন* **"গত ৬ মাসের** অধিকাংশ দিনের জন্য তা কি সত্য?" *এবং উত্তর দ্বিতীয় কলামে লিখুন।*

		সাধারণভাবে			*৬ মাসের অধিকাংশ দিন*	
		না	হ্যাঁ		না	হ্যাঁ
১)	উদ্বেগের কারণে সে কি অস্থির, উৎকণ্ঠিত, টানটান অবস্থায় থাকতো বা সহজ হতে পারতো না?	০	১	→	০	১
২)	উদ্বেগের কারণে তার অবসন্নতা বা সহজেই হাঁপিয়ে ওঠার অবস্থা হতো কি?	০	১	→	০	১
৩)	উদ্বেগের কারণে তার কি কোনো কিছুতে মনোযোগ দেয়াতে বিঘ্ন ঘটতো অথবা মাথা ফাঁকা হয়ে যাচ্ছে এমন মনে হতো?	০	১	→	০	১
৪)	উদ্বেগের কারণে সে কি খিটখিটে হয়ে যেতো?	০	১	→	০	১
৫)	উদ্বেগের কারণে তার মাংসপেশীতে কি ব্যথা হতো?	০	১	→	০	১
৬)	উদ্বেগের কারণে তার ঘুমের সমস্যা, যেমন - ঘুম আসতে বা ঘুমিয়ে থাকতে অসুবিধে হতো বা অস্থির বা অতৃপ্তির ঘুম হতো?	০	১	→	০	১

ছ৯ সামগ্রিকভাবে শিশু (নাম) তার নানান উদ্বেগের কারণে কতোটা এলোমেলো হয়ে পড়ে বা কষ্ট পায়?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

ছ১০ এসব উদ্বেগ কি ব্যাঘাত ঘটিয়েছে .....

		মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
১)	আপনার ও পরিবারের অন্যান্যদের সাথে তার স্বাচ্ছন্দ্যে?	০	১	২	৩
২)	বন্ধু তৈরি করা ও ধরে রাখতে পারায়?	০	১	২	৩
৩)	লেখাপড়া বা শ্রেণীর কাজে?	০	১	২	৩
৪)	খেলাধুলা, শখ বা অন্যান্য অবসর বিনোদনমূলক কাজে?	০	১	২	৩

ছ১১ শিশুর এসব উদ্বেগ কি আপনার বা সামগ্রিকভাবে পরিবারের ওপর একটা বোঝা হয়ে দাঁড়িয়েছে?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

অংশ জ বিষণ্নতা (Depression)

সাক্ষাৎকারের এ অংশটি শিশুর মেজাজ সম্পর্কিত।

জ১ **গত ৪ সপ্তাহে** এমন সময় কি গিয়েছে যখন শিশু খুব বেশি মাত্রায় বিষণ্ন, বিমর্ষ, অসুখী বা কাঁদো কাঁদো থাকতো?

না	হ্যাঁ
০	১
↓	↓
জ৭	জ২

জ২ **গত ৪ সপ্তাহে** ধরে এমন সময় কি ছিল যখন সে প্রায় প্রতিদিনই সত্যিকারভাবে বিমর্ষ থাকতো?

না	হ্যাঁ
০	১

জ৩ ওই বিমর্ষকালীন সময়ে সে কি দিনের বেশিরভাগ সময়েই সত্যিকারভাবে বিমর্ষ থাকতো?
(অর্থাৎ কয়েক ঘন্টার কম নয়)

না	হ্যাঁ
০	১

জ৪ বিমর্ষকালীন সময়ে সে কি উৎফুল্ল হয়ে উঠতে পারতো?

সহজেই	কষ্টের সাথে / তাও ক্ষণিকের জন্য	মোটেই না
০	১	২

জ৫ **গত ৪ সপ্তাহ** ধরে সত্যিকার বিমর্ষ থাকার সময়কাল ছিলঃ

২ সপ্তাহের কম	২ সপ্তাহ বা তারও বেশি
০	১

যদি জ১ এবং জ২ এবং জ৩ এর উত্তর "হ্যাঁ" হয়, তাহলে ঠ১ (৩৪ পৃষ্ঠা) চেকলিস্টের "বিষণ্নতা" ঘরে টিক চিহ্ন দিন।

জ৭ গত ৪ সপ্তাহে শিশুকে বদমেজাজী বা খিটখিটে মেজাজের হতে দেখা গেছে কি যা তার সহজাত আচরণ নয়?

না	হ্যাঁ
০	১
↓ জ১৩	↓ জ৮

জ৮ গত ৪ সপ্তাহ ধরে এমন সময় গেছে কি যখন প্রায় প্রতিদিনই সে বদমেজাজী বা খিটখিটে মেজাজের ছিল?

না	হ্যাঁ
০	১

জ৯ ওই সময়ে সে কি দিনের বেশিরভাগ সময়েই বদমেজাজী বা খিটখিটে মেজাজের থাকতো? (অর্থাৎ কয়েক ঘন্টার কম নয়)

না	হ্যাঁ
০	১

জ১০ বিশেষ কোনো কার্যকলাপে, বন্ধু-বান্ধবদের সাথে দেখা সাক্ষাতে বা অন্য কোনোভাবে কি তার খিটখিটে মেজাজ কমতো?

সহজেই	কষ্টের সাথে / তাও ক্ষণিকের জন্য	মোটেই না
০	১	২

জ১১ গত ৪ সপ্তাহ ধরে সত্যিকারভাবে খিটখিটে মেজাজ থাকার সময়কাল ছিলঃ

২ সপ্তাহের কম	২ সপ্তাহ বা তারও বেশি
০	১

যদি জ৭ এবং জ৮ এবং জ৯ এর উত্তর "হ্যাঁ" হয়, তাহলে ঠ১ (৩৪ পৃষ্ঠা) চেকলিস্টের "বিরক্তিবোধ" ঘরে টিক চিহ্ন দিন।

জ১৩ গত ৪ **সপ্তাহে** এমন সময় গেছে কি যখন শিশু (নাম) সাধারণভাবে উপভোগ করতো এধরনের সবকিছুতেই বা প্রায় সবকিছুতেই আগ্রহ হারিয়ে ফেলেছিল?

না	হ্যাঁ
০	১
↓	↓
জ১৮	**জ১৪**

জ১৪ গত ৪ **সপ্তাহ** ধরে সে কি প্রায় প্রতিদিনই আগ্রহ হারিয়ে ফেলতো?

না	হ্যাঁ
০	১

জ১৫ এই দিনগুলিতে সে কি প্রতিটি দিনের বেশিরভাগ সময়েই আগ্রহ হারিয়ে ফেলতো?
(অর্থাৎ কয়েক ঘন্টার কম নয়)

না	হ্যাঁ
০	১

জ১৬ গত ৪ **সপ্তাহ** ধরে এই আগ্রহ হারিয়ে ফেলার সময়কাল হতো:

২ সপ্তাহের কম	২ সপ্তাহ বা তারও বেশি
০	১

জ১৭ *যদি "বিষণ্ণতা অথবা বিরক্তিবোধ" ঘরে টিক চিহ্ন দেয়া হয়ে থাকে, তাহলে জিজ্ঞাসা করুন:*

যখন শিশু সত্যিকারভাবে বেশিরভাগ সময় বিমর্ষ বা বিরক্ত থাকতো তখন তার সাথে কি অনাগ্রহ বিষয়টিও বেশিরভাগ সময় থাকতো?

না	হ্যাঁ
০	১

যদি জ১৩ এবং জ১৪ এর উত্তর "হ্যাঁ" হয়, তাহলে ঠ১ (৩৪ পৃষ্ঠা) চেকলিস্টের "আগ্রহ হারানো" ঘরে টিক চিহ্ন দিন।

যদি ঠ১ (৩৪ পৃষ্ঠা) চেকলিস্টের "বিষণ্ণতা বা বিরক্তিবোধ বা আগ্রহ হারানো" ঘরে টিক চিহ্ন দেয়া হয়ে থাকে তাহলে এগিয়ে যান। অন্যথায় বাদ দিয়ে সরাসরি জ২২ এ চলে যান।

জ১৮	যে সময়ে শিশু (নাম) বিমর্ষ, বিরক্ত বা অনাগ্রহী ছিল,	না	হ্যাঁ
১)	সে কি সবসময় শক্তিহীনতা বা ক্লান্তি বোধ করতো?	০	১
২)	সে কি স্বাভাবিক অবস্থার তুলনায় অনেক বেশি বা কম পরিমাণ খেতো?	০	১
৩)	তার ওজন কি অনেকটা কমতো বা বেড়ে যেতো?	০	১
৪)	ঘুমাতে পারা কি তার জন্য কষ্টকর হতো?	০	১
৫)	সে কি বেশি পরিমাণে ঘুমিয়ে থাকতো?	০	১
৬)	সে কি বেশিরভাগ সময় কষ্টে ছটফট করতো বা অস্থির থাকতো?	০	১
৭)	সে কি বেশিরভাগ সময় নিজেকে মূল্যহীন বা অহেতুক অপরাধী ভাবতো?	০	১
৮)	কোনো কিছুতে মনোযোগ দেয়া বা চিন্তা করা তার জন্য কি খুব বেশি কঠিন হয়ে দাঁড়াতো?	০	১
৯)	সে কি অনেক বেশি মৃত্যু চিন্তা করতো?	০	১
১০)	সে কি নিজের ক্ষতি করা বা আত্মহননের কথা বলতো?	০	১
১১)	সে কি নিজের ক্ষতি করা বা আত্মহননের চেষ্টা করেছিল?	০	১

জ১৮(১২)

জীবনে কোনোদিন সে কি নিজের ক্ষতি করা বা আত্মহননের চেষ্টা করেছে?	না	হ্যাঁ
	০	১

জ১৯	শিশুর (নাম) বিমর্ষতা, বিরক্তিবোধ বা অনাগ্রহ তাকে কতোটা এলোমেলো করে ফেলে বা কষ্ট দেয়?	মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
		০	১	২	৩

		মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
জ২০	তার বিমর্ষতা, বিরক্তিবোধ বা অনাগ্রহ কি ব্যাঘাত ঘটিয়েছে				
১)	আপনার ও পরিবারের অন্যান্যদের সাথে তার স্বাচ্ছন্দ্যে?	০	১	২	৩
২)	বন্ধু তৈরি করা ও ধরে রাখতে পারায়?	০	১	২	৩
৩)	লেখাপড়া বা শ্রেণীর কাজে?	০	১	২	৩
৪)	খেলাধুলা, শখ বা অন্যান্য অবসর বিনোদনমূলক কাজে?	০	১	২	৩

		মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
জ২১	তার বিমর্ষতা, বিরক্তিবোধ বা অনাগ্রহ কি আপনার বা সামগ্রিকভাবে পরিবারের ওপর একটা বোঝা হয়ে দাঁড়িয়েছে?	০	১	২	৩

*এবার **অংশ ঝ** তে চলে যান। যদি আপনি ইতিমধ্যেই **জ১৮ (৯ থেকে ১২)** জিজ্ঞাসা করে থাকেন তাহলে **জ২২ থেকে জ২৪ আর জিজ্ঞাসা করার দরকার নেই।***

স্বেচ্ছাপ্রণোদিতভাবে নিজের ক্ষতি করা (Deliberate Self-Harm)

		না	হ্যাঁ
জ২২	**গত ৪ সপ্তাহ** ধরে, সে কি স্বেচ্ছাপ্রণোদিতভাবে নিজের ক্ষতি বা আঘাত করার কথা বলেছে?	০	১
জ২৩	**গত ৪ সপ্তাহ** ধরে, সে কি স্বেচ্ছাপ্রণোদিতভাবে নিজের ক্ষতি বা আঘাত করার চেষ্টা করেছে?	০	১
জ২৪	তার জীবনে সে কি স্বেচ্ছাপ্রণোদিতভাবে নিজের ক্ষতি বা আঘাত করার চেষ্টা করেছে?	০	১

*যদি **জ২২** বা **জ২৩** বা **জ২৪** এর উত্তর "হ্যাঁ" হয়, তাহলে **ঠ১** (৩৪ পৃষ্ঠা) চেকলিস্টের "স্বেচ্ছাপ্রণোদিতভাবে নিজের ক্ষতি করা" ঘরে টিক চিহ্ন দিন।*

অংশ ঝ মনোযোগ ও কর্মকান্ড (Attention and Activity)

সাক্ষাৎকারের এই অংশটি **গত ৬ মাসকালে** শিশুর (নাম) চঞ্চলতা ও মনোযোগ দেয়ার ক্ষমতা সম্পর্কিত। প্রায় সব শিশুই চঞ্চল প্রকৃতির হয় ও সচরাচর মনোযোগ হারিয়ে ফেলে। এক্ষেত্রে বিবেচ্য হলো সমবয়সীদের তুলনায় শিশুর (নাম) চঞ্চলতা ও মনোযোগ দেবার ক্ষমতা কেমন। শিশু সচরাচর যে আচরণ দেখায় সে সম্পর্কে জানতে আমি আগ্রহী, মাঝে মধ্যে বিশেষ দিনের এ ধরনের কোনো আচরণ নয়।

ঝ১ বয়স বিবেচনায় আপনি কি মনে করেন শিশুর (নাম) নিশ্চিতভাবে অতিরিক্ত চঞ্চলতা ও কম মনোযোগের সমস্যা রয়েছে?

না	হ্যাঁ
০	১

*যদি **ঝ১** এর উত্তর "হ্যাঁ" অথবা এসডিকিউ চঞ্চলতা মান $\geq$ ৬ হয়, তাহলে এগিয়ে যান। নতুবা বাদ দিয়ে সরাসরি **অংশ ঞ** তে চলে যান।*

ঝ২ **গত ৬ মাসে** শিশুর (নাম) আচরণ সাধারণভাবে কেমন ছিল এসম্পর্কে আরো সবিস্তারে জানতে চাই। প্রথমে সে কতোটা চঞ্চল ছিল সে বিষয়ে প্রশ্ন করবো।

	গত ৬ মাস সময়কালে ও তার সমবয়সীদের সাথে তুলনা করলে ...	অন্যদের তুলনায় বেশি নয়	অন্যদের তুলনায় সামান্য বেশি	অন্যদের তুলনায় অনেক বেশি
১)	সে কি প্রায়ই উসখুস করে?	০	১	২
২)	বেশিক্ষণ স্থির হয়ে বসে থাকা তার পক্ষে কি কষ্টকর হয়ে দাঁড়ায়?	০	১	২
৩)	সে কি অনাবশ্যক হওয়া সত্ত্বেও লাফঝাঁপ দেয়?	০	১	২
৪)	গোলমাল না করে খেলায় বা বিনোদনমূলক কোনো কাজে অংশ নেয়াটা তার পক্ষে কি কঠিন হয়ে দাঁড়ায়?	০	১	২
৫)	তাড়াহুড়া করে খাওয়ার সময় কেউ তাকে শান্ত হতে বললে তা করা তার পক্ষে কি কঠিন হয়ে দাঁড়ায়?	০	১	২

ঝ৩ নিচের কয়েকটা প্রশ্ন হঠাৎ কিছু করে ফেলার প্রবণতা সম্পর্কিত।

	গত ৬ মাস সময়কালে ও তার সমবয়সীদের সাথে তুলনা করলে ...	অন্যদের তুলনায় বেশি নয়	অন্যদের তুলনায় সামান্য বেশি	অন্যদের তুলনায় অনেক বেশি
১)	প্রায়ই কি সে প্রশ্ন ভালোভাবে শোনার আগেই চিন্তাভাবনা না করে একটা কিছু উত্তর দেয়?	০	১	২
২)	খেলাধুলাতে তার পালা আসা পর্যন্ত অপেক্ষা করা কি তার জন্য কঠিন হয়ে দাঁড়ায়?	০	১	২
৩)	অন্যদের কথাবার্তা বা খেলাধুলার মধ্যে সে কি প্রায়ই ব্যাঘাত ঘটায়?	০	১	২
৪)	তাকে থামতে বলা হলেও বা কেউ না শুনলেও সে কি প্রায়ই কথা বলতেই থাকে?	০	১	২

ঋ৪ নিচের প্রশ্নমালা মনোযোগ সংশ্লিষ্ট।

	গত ৬ মাস সময়কালে ও তার সমবয়সীদের সাথে তুলনা করলে ...	অন্যদের তুলনায় বেশি নয়	অন্যদের তুলনায় সামান্য বেশি	অন্যদের তুলনায় অনেক বেশি
১)	সে কি প্রায়ই অসতর্কভাবে অনেক ভুল করে বসে অথবা প্রয়োজনের সময় মনোযোগ দিতে ব্যর্থ হয়?	০	১	২
২)	সে কি প্রায়ই যা করছে তাতে উৎসাহ হারিয়ে ফেলে?	০	১	২
৩)	সে কি প্রায়ই লোকজন তাকে কি বলছে তা শোনে না?	০	১	২
৪)	সে কি প্রায়ই কোনো কাজ যথার্থভাবে শেষ করতে পারে না?	০	১	২
৫)	কোনো কিছু করতে নিজেকে গুছিয়ে তোলা তার পক্ষে কি প্রায়ই কঠিন হয়ে দাঁড়ায়?	০	১	২
৬)	সে কি প্রায়ই তার করণীয় কাজগুলো থেকে রেহাই পেতে চায়, যেমন - বাড়ির কাজ করা?	০	১	২
৭)	সে কি প্রায়ই স্কুলের অথবা খেলাধুলার জন্য দরকারি জিনিসপত্র হারিয়ে ফেলে?	০	১	২
৮)	সে কি সহজেই অন্যমনস্ক হয়ে যায়?	০	১	২
৯)	সে কি প্রায়ই ভুলে যায়?	০	১	২

ঋ৫	**গত ৬ মাসে** শিশুর (নাম) শিক্ষক/শিক্ষিকা কি নিচের সমস্যাগুলো তার আছে বলে কি অভিযোগ জানিয়েছিল	না	কিছুটা	অনেকটা
১)	উসখুস করা, অতিরিক্ত চঞ্চলতা বা ছটফটে আচরণ?	০	১	২
২)	মনোযোগের অভাব, সহজেই অন্যমনস্ক হয়ে যাওয়া?	০	১	২
৩)	চিন্তা ভাবনা না করে হঠাৎ কোন কাজ করে বসা, অন্যের কাজে ব্যাঘাত ঘটানো বা খেলাধুলায় নিজের পালা আসা অবধি অপেক্ষা না করতে পারা?	০	১	২

*যদি **ঋ২, ঋ৩** বা **ঋ৪** এর দুই বা ততোধিক বিষয়ের উত্তর "অন্যদের তুলনায় অনেক বেশি" হয়, তাহলে **ঠ১** (৩৪ পৃষ্ঠা) চেকলিস্টের "অতিচঞ্চলতা" ঘরে টিক চিহ্ন দিন এবং **ঋ৬** এ এগিয়ে যান। অন্যথায় বাদ দিয়ে সরাসরি **অংশ এ** তে চলে যান।*

ঝ৬ শিশুর (নাম) কর্মকান্ড বা মনোযোগের সমস্যা কি অন্তত ৬ মাস ধরে রয়েছে?

না	হ্যাঁ
০	১

ঝ৭ তার কর্মকান্ড বা মনোযোগের সমস্যা কত বছর বয়সে শুরু হয়েছিল?

(যদি জন্ম থেকে হয়, ০ বসান) বছর বয়স

ঝ৮ শিশুর (নাম) কর্মকান্ড বা মনোযোগ সংশ্লিষ্ট সমস্যাগুলো তাকে কতোটা এলোমেলো করে ফেলেছে বা কষ্ট দিয়েছে?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

ঝ৯ শিশুর (নাম) কর্মকান্ড বা মনোযোগ সংশ্লিষ্ট সমস্যাগুলো কি ব্যাঘাত ঘটিয়েছে .....

		মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
১)	আপনার ও পরিবারের অন্যান্যদের সাথে তার স্বাচ্ছন্দ্যে?	০	১	২	৩
২)	বন্ধু তৈরি করা ও ধরে রাখতে পারায়?	০	১	২	৩
৩)	লেখাপড়া বা শ্রেণীর কাজে?	০	১	২	৩
৪)	খেলাধুলা, শখ বা অন্যান্য অবসর বিনোদনমূলক কাজে?	০	১	২	৩

ঝ১০ তার কর্মকান্ড বা মনোযোগ সংশ্লিষ্ট সমস্যাগুলো কি আপনার বা সামগ্রিকভাবে পরিবারের ওপর একটা বোঝা হয়ে দাঁড়িয়েছে?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

অংশ এ বিব্রতকর ও পীড়াদায়ক আচরণ (Awkward and Troublesome Behaviour)

সাক্ষাৎকারের এই অংশটি আচরণ সম্পর্কিত। প্রায় সব শিশু মাঝেমধ্যে কমবেশি বিব্রতকর ও পীড়াদায়ক আচরণ করতে পারে, যেমন - যা করতে বলা হয় তা না করা, বিরক্ত বা উৎপাত করা, হঠাৎ হঠাৎ রাগী আচরণ করা ইত্যাদি। সমবয়সীদের তুলনায় শিশুর (নাম) এসব আচরণ কি মাত্রায় আছে সে সম্পর্কে জানতে চাই। শিশু সচরাচর যে আচরণ দেখায় সে সম্পর্কে আমি জানতে আগ্রহী, মাঝেমধ্যে বা বিশেষ দিনের এধরনের কোনো আচরণ নয়।

এ১ **গত ৬ মাসের** কথা ভাবলে, সমবয়সীদের তুলনায় শিশুর (নাম) আচরণ কেমন ছিল?

গড়পরতা মানের চেয়ে কম বিব্রতকর বা পীড়াদায়ক	গড়পরতা মানের মতো বিব্রতকর বা পীড়াদায়ক	গড়পরতা মানের চেয়ে অনেক বেশি বিব্রতকর বা পীড়াদায়ক
০	১	২

*যদি এ১ এর উত্তর " গড়পরতা মানের চেয়ে অনেক বেশি বিব্রতকর বা পীড়াদায়ক" অথবা এসডিকিউ স্কোর ≥৩ হয়, তাহলে এগিয়ে যান। অন্যথায় বাদ দিয়ে সরাসরি **অংশ ট** তে চলে যান।*

কিছু শিশু পরিবারের কেবলমাত্র একজনের সাথে বিব্রতকর বা বিরক্তিকর আচরণ দেখিয়ে থাকে, হয়তোবা আপনার সাথে অথবা কোনো ভাইবোনের সাথে। অন্যান্য শিশুরা অনেক প্রাপ্তবয়স্ক বা শিশুদের সাথে এরকম আচরণ দেখিয়ে থাকে। নিচের প্রশ্নগুলোতে সবার সাথে শিশুর (নাম) আচরণ সম্পর্কে জানতে চাওয়া হয়েছে, কেবলমাত্র কোনো একজনের সাথে নয়।

এ২ **গত ৬ মাস** ধরে ও সমবয়সীদের তুলনায় সে কি প্রায়ই ...

		অন্যদের তুলনায় বেশি নয়	অন্যদের তুলনায় সামান্য বেশি	অন্যদের তুলনায় অনেক বেশি
১)	অতিরিক্ত মাত্রায় গরম মেজাজ করে?	০	১	২
২)	বড়দের সাথে তর্কাতর্কি করে?	০	১	২
৩)	নিয়মের কোনো ধার ধারে না বা যেভাবে বলা হয় সেভাবে করতে অস্বীকার করে থাকে?	০	১	২
৪)	ইচ্ছাকৃতভাবে আশপাশের লোকজনের জন্য বিরক্তিকর এমনসব কাজ করে থাকে?	০	১	২
৫)	নিজের ভুলভ্রান্তি বা মন্দ আচরণের জন্য প্রায়ই অন্যদের দোষারোপ করে থাকে?	০	১	২
৬)	চটে ওঠে বা বিরক্ত হয়ে থাকে?	০	১	২
৭)	ক্রুদ্ধ ও ক্ষুব্ধ হয়?	০	১	২
৮)	আক্রোশপূর্ণ থাকে?	০	১	২
৯)	প্রতিশোধ নিতে চেষ্টা করে?	০	১	২

যদি এ২ এর যে কোনো একটি বিষয়ে "অন্যদের তুলনায় অনেক বেশি" ঘরে টিক চিহ্ন দেয়া হয়ে থাকে, তাহলে ঠ১ (৩৪পৃষ্ঠা) চেকলিস্টের "বিব্রতকর আচরণ" ঘরে টিক চিহ্ন দিন এবং এ৩ এ চলে যান। অন্যথায় নিচের অংশ বাদ দিয়ে সরাসরি এ৮ এ চলে যান।

এ৩ গত ৬ মাস সমকালে শিশুর (নাম) শিক্ষক/শিক্ষিকা ক্লাসে তার এরকম বিব্রতকর আচরণ বা বিশৃংখলা নিয়ে কি অভিযোগ জানিয়েছিল?

না	কিছুটা	অনেকটা
০	১	২

এ৪ শিশুর (নাম) বিব্রতকর আচরণ কি অন্তত ৬ মাস ধরে ছিল?

না	হ্যাঁ
০	১

এ৫ যখন তার বিব্রতকর আচরণ শুরু হয়েছিল তখন তার বয়স কতো ছিল?

(যদি জন্ম থেকে হয়, ০ বসান)

[ ] বছর বয়স

এ৫ শিশুর (নাম) বিব্রতকর আচরণ কি ব্যঘাত ঘটিয়েছে .....

	মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
১) আপনার ও পরিবারের অন্যান্যদের সাথে তার স্বাচ্ছন্দ্যে?	০	১	২	৩
২) বন্ধু তৈরি করা ও ধরে রাখতে পারায়?	০	১	২	৩
৩) লেখাপড়া বা শ্রেণীর কাজে?	০	১	২	৩
৪) খেলাধুলা, শখ বা অন্যান্য অবসর বিনোদনমূলক কাজে?	০	১	২	৩

এ৬ তার বিব্রতকর আচরণ কি আপনার বা সামগ্রিকভাবে পরিবারের ওপর একটা বোঝা হয়ে দাঁড়িয়েছে?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

এরপর এ৮ এ এগিয়ে যান।

এমন আচরণ যা শিশুদের কখনো কখনো ঝামেলায় ফেলে (Behaviour that sometimes gets children into trouble)

এখন আমি এমন আচরণ সম্পর্কে জানতে চাই যা শিশুদের কখনো কখনো ঝামেলায় ফেলে, কতকক্ষেত্রে তা ঝুঁকিপ্রদ, আগ্রাসী অথবা অসামাজিক আচরণ। গত বছরে সে কি রকম ছিল তার ভিত্তিতে উত্তর দিন - পরবর্তী প্রশ্নমালার জন্য **গত ১২ মাসের** আচরণই বিবেচ্য।

এ৪৮ *যদি নিচের প্রশ্নগুলোর কোনো একটিতে "নিশ্চিতভাবে" উত্তর দেয়া হয়ে থাকে তাহলে* **"গত ৬ মাসে** *সে কি এমন আচরণ দেখিয়েছে?" প্রশ্ন করুন ও উত্তর দ্বিতীয় কলামে রেকর্ড করুন।*

শিশু সম্পর্কে আপনি যতদুর জানেন তাতে **গত ১২ মাস** সময়কালে ...	*গত ১২ মাস সময়কালে*				*গত ৬ মাসে*	
	না	হয়তোবা	নিশ্চিতভাবে		না	হ্যাঁ
১) কোন কিছু পাবার জন্য বা অন্যদের কাছ থেকে সুবিধা আদায়ের জন্য, বা তার ওপরে অর্পিত কোনো দায়িত্ব থেকে মুক্তি পাওয়ার জন্য সে কি প্রায়ই মিথ্যে কথা বলে থাকে?	০	১	২	→	০	১
২) সে কি নিজের থেকেই প্রথমে মারামারি শুরু করে থাকে? *(নিজের ভাইবোনদের সাথে মারামারি ছাড়া)*	০	১	২	→	০	১
৩) সে কি প্রায়ই গায়ের জোর দেখায় বা অন্যদের ভয়-ভীতি দেখিয়ে থাকে?	০	১	২	→	০	১
৪) সন্ধ্যা হবার পরেও সে কি প্রায়ই অনেক সময়কাল ঘরের বাইরে থাকে?	০	১	২	→	০	১
৫) সে কি নিজের ঘর, অন্যজনের ঘর, দোকান বা স্কুল থেকে জিনিসপত্র চুরি করে থাকে? *(অতি নগণ্য চুরিকে এর সাথে যুক্ত করবেন না, যেমন - ভাইয়ের পেন্সিল বা ঘরের খাবার চুরি করা)*	০	১	২	→	০	১
৬) সে কি কাউকে না জানিয়ে একাধিকবার বাড়ি থেকে পালিয়ে গেছে কিংবা আপনার অনুমতি ছাড়াই বাইরে রাত কাটিয়েছে?	০	১	২	→	০	১
৭) সে কি প্রাই স্কুল ফাঁকি দেয় বা স্কুল থেকে পালায়?	০	১	২	→	০	১

(যদি শিশু ১৩ বছর বা তার চেয়ে বেশি বয়সের হয় এবং নিশ্চিতভাবে গত বছরে স্কুল পালিয়ে থাকে, তাহলে নিচের প্রশ্ন জিজ্ঞাসা করুন। অন্যথায় এ১০ এ চলে যান)

এ৪৯ শিশু কি ১৩ বছর হবার আগে না জানিয়ে স্কুল কামাই করতে বা স্কুল পালাতে শুরু করেছিল?

না	হ্যাঁ
০	১

যদি এ৪৮ এর যেকোনো একটির উত্তর "নিশ্চিতভাবে" দেয়া হয়ে থাকে, তাহলে ঠ১ (৩৪ পৃষ্ঠা) চেকলিস্টের "পীড়াদায়ক আচরণ" ঘরে টিক চিহ্ন দিন।

যদি ঠ১ (৩৪ পৃষ্ঠা) এর চেকলিস্টে বিব্রতকর আচরণ অথবা পীড়াদায়ক আচরণের জন্য টিক চিহ্ন দেয়া হয়ে থাকে তাহলে এগিয়ে যান। অন্যথায় বাদ দিয়ে অংশ ট তে চলে যান।

ক্ষ১০

এখন আপনাকে এমন কতক প্রসঙ্গ নিয়ে প্রশ্ন করছি যেগুলো সচরাচর কম দেখা যায়, কিন্তু বেশ গুরুতর আচরণ। এ বিষয়ে যতগুলো প্রশ্ন হতে পারে সবকটা করছি, এমন কি প্রযোজ্য না হলেও।

*যদি নিচের প্রশ্নগুলোর কোন একটিতে "হ্যাঁ" উত্তর দেয়া হয়ে থাকে তাহলে "সে কি **গত ৬ মাসে** এমন আচরণ দেখিয়েছে" প্রশ্ন করুন এবং উত্তর দ্বিতীয় কলামে রেকর্ড করুন।*

আপনি যতদূর জানেন তাতে **গত ১২ মাস** সময়কালে নিচের কোন একটি কি ঘটেছে?	*গত ১২ মাস সময়কালে*			*গত ৬ মাসে*	
	না	হ্যাঁ		না	হ্যাঁ
১) সে কি অস্ত্র বা এমন কিছু ব্যবহার করেছে যা কাউকে মারাত্মক ভাবে জখম করতে পারতো? *(যেমন - খেলার ব্যাট, ইঁট, ভাঙা বোতল, ছুরি, বন্দুক ইত্যাদি)*	০	১	→	০	১
২) সে কি সত্যিসত্যি কাউকে জখম করেছে বা শারীরিক নির্যাতন চালিয়েছে? *(যেমন - কাউকে বেঁধে ফেলা, কাটাছেঁড়া করা, বা পোড়ানো ইত্যাদি)*	০	১	→	০	১
৩) সে কি প্রাণী ও পাখিদের প্রতি ইচ্ছাকৃতভাবে নিষ্ঠুর আচরণ দেখিয়েছে?	০	১	→	০	১
৪) সে কি ইচ্ছাকৃতভাবে কোথাও আগুন লাগিয়ে দিয়েছে? *(এর পেছনে অবশ্যই মারাত্মক ক্ষতিসাধনের দুরভিসন্ধি থাকতে হবে। ক্যাম্পফায়ার বা দেশলাইয়ের কাঠি জ্বালানো বা কাগজ পোড়ানোর মত বিষয়ে এই প্রশ্ন নয়)*	০	১	→	০	১
৫) সে কি ইচ্ছাকৃতভাবে কারো সম্পত্তি ধ্বংস করেছে? *(আগুন লাগিয়ে দেয়া অথবা হাল্কা মাত্রার কোনো ঘটনা, যেমন - বোনের আঁকা ছবি নষ্ট করে ফেলা ইত্যাদির জন্য এই প্রশ্ন নয়। গাড়ির জানালা চূর্ণবিচূর্ণ করা বা স্কুলে ভাংচুর ইত্যাদি আচরণ এতে গণ্য হবে)*	০	১	→	০	১
৬) সে কি রাস্তাঘাটে কারো কাছ থেকে কিছু চুরি করার সাথে জড়িত ছিল? *(যেমন - হাতব্যাগ ছিনতাই করা বা লুণ্ঠন)*	০	১	→	০	১
৭) সে কি কাউকে ইচ্ছার বিরুদ্ধে জোর করে যৌনকর্মে বাধ্য করেছে?	০	১	→	০	১
৮) সে কি কারো বাড়িতে, অন্য কোনো ভবনে বা গাড়িতে ভেঙে ঢুকেছে?	০	১	→	০	১

যদি ক্ষ১০ এর যেকোনো একটি বিষয়ের উত্তর "হ্যাঁ" হয়, তাহলে ঠ১ (৩৪ পৃষ্ঠা) চেকলিস্টের "পীড়াদায়ক আচরণ" ঘরে টিক চিহ্ন দিন।

ঞ১১	গত ৬ মাস সময়কালে শিশুর (নাম) শিক্ষক/শিক্ষিকা কি তার পীড়াদায়ক আচরণের জন্য অভিযোগ জানিয়েছে?	না	হ্যাঁ
		০	১

ঞ১১কক	তার পীড়াদায়ক আচরণ কি **অন্তত ৬ মাস** ধরে আছে?	না	হ্যাঁ
		০	১

ঞ১১ক	তাকে কি কখনো পুলিশের সাথে ঝামেলায় পড়তে হয়েছে? *(বর্ণনা করুন)*	না	হ্যাঁ
	.....	০	১
	.....		

*যদি **ঞ১১ক** এর উত্তর "হ্যাঁ" হয়, তাহলে **ঠ১** (৩৪ পৃষ্ঠা) চেকলিস্টের " পুলিশের সাথে ঝামেলা" ঘরে টিক চিহ্ন দিন।*

*যদি **ঠ১** (৩৪ পৃষ্ঠা) চেকলিস্টে পীড়াদায়ক আচরণের জন্য টিক চিহ্ন দেয়া হয়ে থাকে তাহলে এগিয়ে যান। অন্যথায় বাদ দিয়ে সরাসরি **অংশ ট** তে চলে যান।*

ঞ১২	শিশুর (নাম) পীড়াদায়ক আচরণ কি ব্যাঘাত ঘটিয়েছে	মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
১)	আপনার ও পরিবারের অন্যান্যদের সাথে তার স্বাচ্ছন্দ্যে?	০	১	২	৩
২)	বন্ধু তৈরি করা ও ধরে রাখতে পারায়?	০	১	২	৩
৩)	লেখাপড়া বা শ্রেণীর কাজে?	০	১	২	৩
৪)	খেলাধুলা, শখ বা অন্যান্য অবসর বিনোদনমূলক কাজে?	০	১	২	৩

ঞ১৩	তার পীড়াদায়ক আচরণ কি আপনার বা সামগ্রিকভাবে পরিবারের ওপর একটা বোঝা হয়ে দাঁড়িয়েছে?	মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
		০	১	২	৩

অংশ ট কম দেখা যায় এমন সমস্যা (Less common problems)

এই অংশটি শিশুর (নাম) আচরণ ও বিকাশের নানান ধরণের দিক সম্পর্কিত।

		না	হ্যাঁ
ট১	তার জীবনের প্রথম ৩ বছরে এমন কিছু কি ঘটেছিল যা আপনাকে মারাত্মকভাবে উদ্বিগ্ন করে তুলেছিল ...		
১)	তার বাচনক্ষমতা বিকাশের ক্ষেত্রে?	০	১
২)	তার অন্যদের সাথে মেলামেশার ক্ষেত্রে?	০	১
৩)	তার কোনো অদ্ভুত আচার বা অস্বাভাবিক অভ্যাস যেগুলো পাল্টানো খুব কঠিন ছিল?	০	১

(যদি ট১ এর (১), (২) বা (৩) এর উত্তর "হ্যাঁ" হয়, কেবলমাত্র তখন জিজ্ঞাসা করুন)

		সম্পূর্ণভাবে কেটে গেছে	কিছু কিছু সমস্যা রয়ে গেছে
ট২	তার গোড়ার দিককার এসব পিছিয়ে পড়া বা সমস্যা কি বর্তমানে সম্পূর্ণভাবে কেটে গেছে?	০	১

		না	হ্যাঁ
ট৩	তার কি মাংসপেশীর এমন কোনো অস্বাভাবিক সঞ্চালন বা কম্পন সমস্যা আছে যা সে নিয়ন্ত্রণ করতে পারে না?	০	১
ট৪	সে অতিশয় রোগাপাতলা বা অতিরিক্ত কম খাবার অভ্যাস করছে বলে কি আপনি উদ্বিগ্ন?	০	১
ট৫	এ পর্যন্ত যা বলেছেন সেগুলো ছাড়া শিশুর (নাম) মানসিক বিকাশের আর কোনো দিক আছে কি যা আপনাকে সত্যিকারভাবে উদ্বিগ্ন করে?	০	১
ট৬	এ পর্যন্ত যা বলেছেন সেগুলো ছাড়া শিশুর (নাম) মানসিক বিকাশের আর কোনো দিক আছে কি যা তার শিক্ষকদের সত্যিকারভাবে উদ্বিগ্ন করে?	০	১

যদি ট২ এর উত্তর "কিছু কিছু সমস্যা রয়ে গেছে" অথবা ট৩ বা ট৪ বা ট৫ এর উত্তর "হ্যাঁ" হয়, তাহলে ঠ১ (৩৪ পৃষ্ঠা) চেকলিস্টের "কম দেখা যায় এমন সমস্যা" ঘরে টিক চিহ্ন দিন।

অংশ ঠ অসুবিধের ক্ষেত্রগুলো (Areas of Difficulty)

ঠ১ বিভিন্ন অসুবিধের তালিকা (Check list of difficulties)

ক ❑ বিচ্ছিন্নতা সংশ্লিষ্ট উদ্বেগাধিক্য (Separation anxiety) = আসক্তজন হতে আলাদা হবার ভয় *(ক১ হতে শিশুর আসক্তজনদের তালিকা দিন)* .....

.....

খ ❑ বিশেষ অহেতুক ভীতি (Specific phobia) = শিশু ভয় পায় এমনসব মুখ্য বিষয় *(খ১ হতে উল্লেখ করুন)* .....

.....

গ ❑ সামাজিক অহেতুক ভীতি (Social phobia) = শিশু ভয় পায় এমনসব মুখ্য বিষয় *(গ১ হতে উল্লেখ করুন)* .....

.....

ঘ ❑ আতঙ্কগ্রস্ততা/বহির্গমনের অহেতুক ভীতি (Panic/agoraphobia) = আতঙ্কগ্রস্ত হওয়া এবং জনসমাগমের ভিড়, কোথাও একা যাওয়া ইত্যাদি পরিহার করা *(অপ্রয়োজনীয় অংশটুকু কেটে দিন)*

ঙ ❑ মানসিক আঘাতোত্তর মানসিক চাপ (Post traumatic stress) = মানসিক আঘাত পেয়েছে এমন ঘটনা*(ঙ১ হতে উল্লেখ করুন)*

.....

চ ❑ চিন্তাব্যাতিক ও বাধ্যতাধর্মী আচরণ (Obsessions and compulsions) = বাধ্যতাধর্মী আচরণ বা চিন্তাগুলোর বিষয়বস্তু ..... *(চ২, চ৩ ও চ৪ হতে উল্লেখ করুন)* .....

.....

ছ ❑ অনির্দিষ্ট উদ্বেগাধিক্য (Generalized anxiety) = অতিরিক্তমাত্রায় উদ্বেগ দেখিয়ে থাকে এমনসব বিষয়*(ছ৪ হতে উল্লেখ করুন)*

.....

জ ❑ বিষণ্নতা (Depression)
❑ বিরক্তিবোধ (Irritability)
❑ আগ্রহ হারানো (Loss of interest)
❑ স্বেচ্ছাপ্রণোদিতভাবে নিজের ক্ষতি করা (Deliberate self-harm)

ঝ ❑ অতি চঞ্চলতা (Hyperactivity) = কর্মকান্ড ও মনোযোগে অসুবিধে ঘটায় এমন সব বিষয় *(ঝ২, ঝ৩ ও ঝ৪ হতে উল্লেখ করুন)*

.....

ঞ ❑ বিব্রতকর আচরণ (Awkward behaviour) = নানান বিব্রতকর আচরণ, যেমন *(ঞ২ হতে কমপক্ষে তিনটি উল্লেখ করুন)*

.....

❑ পীড়াদায়ক আচরণ (Troublesome behaviour) = নানান পীড়াদায়ক আচরণ, যেমন *(ঞ৮ ও ঞ১০ হতে উল্লেখ করুন)*

.....

❑ পুলিশের সাথে ঝামেলা (Trouble with the Police)

ট ❑ কম দেখা যায় এমন সমস্যা (Less common difficulties) = সমস্যাগুলো *(ট২, ট৩, ট৪, ট৫ ও ট৬ হতে উল্লেখ করুন)*

.....

ঠ২ শিশুর অসুবিধে সম্পর্কে পিতামাতার নিজের ভাষায় দেয়া বক্তব্য
(Getting a description of the child's difficulties in the parent's own words)

যদি ঠ১ তালিকায় বর্ণিত কোনো ঘরে টিক চিহ্ন দেয়া না হয়, বাদ দিয়ে সরাসরি ***অংশ ড*** *তে চলে যান।*

যখনই আপনি ঠ১ এর অংশগুলোর কোনো একটি ঘর যাচাই করবেন, নিশ্চিত হোন যে আপনি ঐ অংশের জন্য সংশ্লিষ্ট খোলামেলা প্রশ্নগুলোর উত্তর পেয়েছেন। এসব খোলামেলা প্রশ্নের একটা তালিকা সুবিধের জন্য নিচে দেয়া হলো, তবে আপনি নিজ উদ্যোগে অতিরিক্ত প্রশ্ন যোগ করতে বা প্রদত্ত প্রশ্নগুলোকে আরো পরিষ্কারভাবে ব্যাখ্যা করতে পারেন।

আপনার পছন্দমত আপনি খোলামেলা প্রশ্নগুলো সংশ্লিষ্ট অংশের সাক্ষাৎকারের সাথে করতে পারেন, অথবা ***ক*** *থেকে* ***ট*** *পর্যন্ত অংশগুলো শেষ করার পর করতে পারেন। উদাহরণ স্বরূপ, যদি* ***অংশ ক*** *এর জন্য নির্দেশিত ঘরে টিক চিহ্ন দিয়ে থাকেন তাহলে* ***অংশ খ*** *তে যাবার আগেই অতিরিক্ত প্রশ্নগুলো করতে পারেন, অথবা* ***ক*** *থেকে* ***ট*** *পর্যন্ত অংশগুলো শেষ না হওয়া পর্যন্ত অপেক্ষা করতে পারেন। যদি আপনি ঠিক করেন যে, সবশেষেই খোলামেলা প্রশ্নগুলো করবেন তাহলে কোন্ বিষয়ে প্রশ্ন করা হবে তা পিতামাতাকে বাছাই করতে বললে ভাল হয়। এরূপ বাছাই শিশুর যে দিকটি পিতামাতাকে সবচেয়ে বেশি চিন্তিত করে তা দিয়ে শুরু করে ক্রমানুসারে বিভিন্ন বিষয়ে হবে।*

যেভাবেই প্রশ্নগুলো করুন না কেন পিতামাতার স্বতঃস্ফূর্ত মন্তব্যগুলো করার সাথে সাথে নোট করে রাখা ভালো। এতে করে এই অংশে তাদেরকে পুনরায় অনেক কিছু জিজ্ঞাসা করার প্রয়োজন কমে যাবে। তবে সাক্ষাৎকার শেষ হবার আগে অসুবিধের প্রতিটি ক্ষেত্রের জন্য সকল প্রশ্নের জবাব দেয়া হয়েছে কিনা তা নিশ্চিত হবার জন্য যাচাই করে নিন।

যখন পিতামাতা অস্পষ্ট বা অনির্দিষ্ট উত্তর দেন, তখন সুনির্দিষ্ট উদাহরণ জানতে চান, যেমন - যদি তারা বলেন, "সে সবকিছুতেই উদ্বিগ্ন হয়," তাহলে "উদ্বেগগুলো কি ধরণের?" জিজ্ঞাসা করুন কিংবা যদি তারা বলেন, "যা বলা হয় তা সে কখনো করে না," তাহলে জিজ্ঞাসা করুন, "আপনি কি সাম্প্রতিক একটা ঘটনার কথা বলতে পারেন যখন তাকে যা করতে বলা হয়েছিল সে তা না করে সমস্যা সৃষ্টি করেছিল?"

এই ফরমে অল্প জায়গা আছে বলে আপনাকে যে উত্তর ছোট করে লিখতে হবে এমন ভাববেন না। ছোট অক্ষরে লিখুন এবং প্রয়োজনে অতিরিক্ত কাগজ ব্যবহার করুন।

খোলামেলা প্রশ্নগুলো শুরু করার জন্য:

আপনি ইতিমধ্যেই শিশুর (নাম) সমস্যাগুলো বলেছেন। এসব বিষয়ে আপনার নিজের ভাষায় আরো কিছুটা জানতে চাই।

ঠ২ক: বিচ্ছিন্নতা সংশ্লিষ্ট উদ্বেগাধিক্য (Separation anxiety)

যদি বিচ্ছিন্নতা সংশ্লিষ্ট উদ্বেগাধিক্য এর জন্য ঠ১ক তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

ঠ২ক১) আসক্তজন হতে আলাদা হবার বিষয়ে শিশুর (নাম) বর্তমান উদ্বেগগুলো বর্ণনা করুন। কিভাবে এসব উদ্বেগ প্রকাশিত হয়?

ঠ২ক২) এসব উদ্বেগ কতোবার সমস্যা সৃষ্টি করে?

ঠ২ক৩) সবচেয়ে খারাপ অবস্থায় উদ্বেগগুলো কতোটা প্রকট?

ঠ২ক৪) কতোদিন ধরে তার বিচ্ছিন্নতা সংশ্লিষ্ট উদ্বেগ আছে?

ঠ২ক৫) এসব উদ্বেগ কি তার জীবনযাত্রার মান ব্যাহত করছে? যদি করে, কিভাবে?

ঠ২ক৬) উদ্বেগগুলো কি জন্য হয় বলে আপনি মনে করেন?

ঠ২ক৭) এসব উদ্বেগ দূর করার জন্য আপনি কি কিছু করেছেন? যদি করে থাকেন, আপনার পক্ষে সম্ভব এমন কি চেষ্টা করেছেন বিবরণ দিন, এবং এসব কি তার অবস্থার কোনো পরিবর্তন করতে পেরেছে?

ঠ২খঃ বিশেষ অহেতুক ভীতি (Specific phobia)

যদি বিশেষ অহেতুক ভীতি এর জন্য ঠ১খ তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

ঠ২খ১) শিশুর এমন কোনো ভয়ের বিবরণ দিন যা সত্যিকার বিড়ম্বনার, যা তাকে দারুণভাবে এলোমেলো করে, বা যেসব জিনিষ সে করতে চায় তা করা থেকে তাকে বিরত করে।

ঠ২খ২) তার এসব ভয় কতোবার তাকে পীড়া দেয় বা এলোমেলো করে ফেলে?

ঠ২খ৩) সবচেয়ে খারাপ অবস্থায় ভয়গুলো কতোটা প্রকট?

ঠ২খ৪) তার এসব ভয় কি তার জীবনযাত্রার মান ব্যাহত করছে? যদি করে, কিভাবে?

ঠ২খ৫) এসব ভয় দূর করার জন্য আপনি কি কিছু করেছেন? যদি করে থাকেন, আপনার পক্ষে সম্ভব এমন কি চেষ্টা করেছেন বিবরণ দিন, এবং এসব কি তার অবস্থার কোনো পরিবর্তন করতে পেরেছে?

ঠ২গঃ সামাজিক অহেতুক ভীতি (Social phobia)

যদি সামাজিক অহেতুক ভীতি এর জন্য ঠ১গ তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

ঠ২গ১) শিশুর কি কি সামাজিক অহেতুক ভীতি আছে বর্ণনা করুন যা সত্যিকার বিড়ম্বনার, যা তাকে দারুণভাবে এলোমেলো করে, বা যেসব জিনিষ সে করতে চায় তা করা থেকে তাকে বিরত করে।

ঠ২গ২) তার এসব সামাজিক ভীতি কতোবার তাকে বিপর্যস্ত বা এলোমেলো করে ফেলে?

ঠ২গ৩) সবচেয়ে খারাপ অবস্থায় এসব সামাজিক ভীতি কতোটা প্রকট?

ঠ২গ৪) তার এসব সামাজিক ভীতি কি তার জীবনযাত্রার মান ব্যাহত করছে? যদি করে, কিভাবে?

ঠ২গ৫) এসব সামাজিক ভীতি দুর করার জন্য আপনি কি কিছু করেছেন? যদি করে থাকেন, আপনার পক্ষে সম্ভব এমন কি চেষ্টা করেছেন বিবরণ দিন, এবং এসব কি তার অবস্থার কোনো পরিবর্তন করতে পেরেছে?

ঠ২ঘঃ আতঙ্কগ্রস্ততা/বহির্গমনের অহেতুক ভীতি (Panic/agoraphobia)

যদি আতঙ্কগ্রস্ততা/বহির্গমনের অহেতুক ভীতি এর জন্য ঠ১ঘ তে টিক চিহ্ন দেয়া হয়, নিচের কোনো একটি বা দু'টি প্রশ্ন জিজ্ঞাসা করুন (শিশুর আতঙ্কগ্রস্ততা/বহির্গমনের অহেতুক ভীতি, অথবা দু'টোই থাকলে সেভাবে প্রশ্ন করুন)

ঠ২ঘ১) এসব আতঙ্কগ্রস্ততা কিরকম, কতোবার হয়, কখন শুরু হয় এবং শিশুর (নাম) জীবনে এগুলো কি প্রভাব ফেলে তা যতদূর সম্ভব বিস্তারিত ভাবে বর্ণনা করুন।

ঠ২ঘ২) মানুষের ভিড়, জনসাধারণের জন্য বিভিন্ন স্থান, একা ভ্রমন বা বাড়ির অনেক দূরে যাওয়া ইত্যাদি বিষয়ে শিশুর (নাম) ভয় বা এড়িয়ে চলা সম্পর্কে আরো কিছু জানতে চাই। অনুগ্রহ করে যতদূর সম্ভব সবিস্তারে বর্ণনা করুন। এসব কতোবার হয়, কখন শুরু হয় এবং তার জীবনে কি প্রভাব ফেলে তাও বলুন।

ঠ২৪ঃ মানসিক আঘাতোত্তর মানসিক চাপ (Post traumatic stress)

যদি মানসিক আঘাতোত্তর মানসিক চাপ এর জন্য ঠ১৪ তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

ঠ২৪১) চরম মানসিক আঘাতোত্তর মানসিক চাপের ঘটনাটি কি ছিল? আপনার জন্য পীড়াদায়ক হতে পারে জেনেও এবিষয়ে প্রশ্ন করার জন্য দুঃখিত। শিশুর (নাম) বর্তমান উপসর্গগুলো অর্থবহ করার জন্য যথেষ্ট বিবরণ দিলেই চলবে।

ঠ২৪২) প্রচন্ড মানসিক চাপের কারণে তার এখনও যেসব উপসর্গ হয় তা বর্ণনা করুন।

ঠ২৪৩) এসব উপসর্গ তাকে কতোবার বিপর্যস্ত বা এলোমেলো করে ফেলে?

ঠ২৪৪) সবচেয়ে খারাপ অবস্থায় উপসর্গগুলো কতোটা প্রকট?

ঠ২৪৫) উপসর্গগুলো কি তার জীবনযাত্রার মান ব্যাহত করছে? যদি করে, কিভাবে?

ঠ২৪৬) এসব উপসর্গ দূর করার জন্য আপনি কি কিছু করেছেন? যদি করে থাকেন, আপনার পক্ষে সম্ভব এমন কি চেষ্টা করেছেন বিবরণ দিন, এবং এসব কি তার অবস্থার কোনো পরিবর্তন করতে পেরেছে?

ঠ২৫ঃ চিন্তাবাতিক ও বাধ্যতাধর্মী আচরণ (Obsessions and compulsions)

যদি চিন্তাবাতিক ও বাধ্যতাধর্মী আচরণ এর জন্য এর জন্য ঠ১৮ তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

ঠ২৫১) শিশুর (নাম) সব ধরণের বাধ্যতাধর্মী আচরণ ও চিন্তাবাতিকের বিবরণ দিন।

৯২৮২) এসব বাধ্যতাধর্মী আচরণ ও চিন্তাবাতিক তাকে কতোবার বিপর্যস্ত বা এলোমেলো করে ফেলে?

৯২৮৩) সবচেয়ে খারাপ অবস্থায় এসব বাধ্যতাধর্মী আচরণ ও চিন্তাবাতিক কতোটা প্রকট?

৯২৮৪) কতোদিন ধরে এসব বর্তমান?

৯২৮৫) এগুলো কি তার জীবনযাত্রার মান ব্যাহত করছে? যদি করে, কিভাবে?

৯২৮৬) এসব বাধ্যতাধর্মী আচরণ ও চিন্তাবাতিক দূর করার জন্য আপনি কি কিছু করেছেন? যদি করে থাকেন, আপনার পক্ষে সম্ভব এমন কি চেষ্টা করেছেন বিবরণ দিন, এবং এসব কি তার অবস্থার কোনো পরিবর্তন করতে পেরেছে?

৯২৮৯: অনির্দিষ্ট উদ্বেগাধিক্য (Generalized anxiety)

যদি অনির্দিষ্ট উদ্বেগাধিক্য এর জন্য এর জন্য ৯১৮ তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

৯২৮১) কি বিষয়ে শিশু (নাম) উদ্বিগ্ন হয় বর্ণনা করুন।

৯২৮২) এসব উদ্বেগ কতোবার সমস্যা সৃষ্টি করে?

৯২৮৩) সবচেয়ে খারাপ অবস্থায় উদ্বেগগুলো কতোটা প্রকট?

৯২৮৪) কতোদিন ধরে সে বিভিন্ন বিষয়ে বেশ উদ্বিগ্ন?

৯২৮৫) উদ্বেগগুলো কি তার জীবনযাত্রার মান ব্যাহত করছে? যদি করে, কিভাবে?

৯২জ৬) এসব উদ্বেগ দূর করার জন্য আপনি কি কিছু করেছেন? যদি করে থাকেন, আপনার পক্ষে সম্ভব এমন কি চেষ্টা করেছেন বিবরণ দিন, এবং এসব কি তার অবস্থার কোনো পরিবর্তন করতে পেরেছে?

৯২জঃ বিষণ্নতা (Depression)

যদি বিষণ্নতা, বিরক্তিবোধ বা আগ্রহ হারানো এর জন্য ৯১জ তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

৯২জ১) শিশুর (নাম) মেজাজের (বিষণ্নতা, বিরক্তিবোধ) এবং বিভিন্ন বিষয়ে তার আগ্রহের পরিমাণ বর্ণনা করুন।

৯২জ২) তার মেজাজ ও আগ্রহের পরিমান পরিবর্তনের সাথে আর কি পরিবর্তন হয়ে থাকে? প্রাসঙ্গিক হলে - তার বলশক্তি, খিদে, ঘুম, নিজের প্রতি আস্থা, নিজেকে অপরাধী ভাবা, ভবিষ্যৎ সম্পর্কে আশাহীনতা, মৃত্যুচিন্তা, নিজের ক্ষতি করা ইত্যাদি সম্পর্কে বলুন।

৯২জ৩) গত ৪ সপ্তাহ ধরে, কতোটা সময়কাল সে এরকম আছে?

৯২জ৪) গত ৪ সপ্তাহ ধরে, সবচেয়ে খারাপ অবস্থায় এসব সমস্যা কতোটা প্রকট?

৯২জ৫) কখন এই বিষণ্নতা, বিরক্তিবোধ বা আগ্রহ হারানোর ঘটনা শুরু হয়েছিল?

৯২জ৬) আপনি কি মনে করেন কোনোকিছুতে এই সমস্যা কমে যেতো?

৯২জ৭) আগেও কি তার এরকম সমস্যা হয়েছিল? যদি হয়ে থাকে, বর্ণনা করুন।

৯২জ৮) "বিষণ্নতার" পরিবর্তে অস্বাভাবিক "উৎফুল্ল" হবার ঘটনা কি অতীতে তার কখনো হয়েছিল? যদি হয়ে থাকে, বর্ণনা করুন।

ঠ২জ৯) তার মেজাজ বা আগ্রহ হারানো কি তার জীবনযাত্রার মান ব্যাহত করছে? যদি করে, কিভাবে?

ঠ২জ১০) তার মেজাজ বা আগ্রহ হারানো দূর করার জন্য আপনি কি কিছু করেছেন? যদি করে থাকেন, আপনার পক্ষের সম্ভব এমন কি চেষ্টা করেছেন বিবরণ দিন, এবং এসব কি তার অবস্থার কোনো পরিবর্তন করতে পেরেছে?

ঠ২জ২ঃ স্বেচ্ছাপ্রণোদিতভাবে নিজের ক্ষতি করা **(Deliberate self-harm)**

যদি স্বেচ্ছাপ্রণোদিতভাবে নিজের ক্ষতি করা এর জন্য এর জন্য ঠ১জ তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

ঠ২জ১১) শিশুর (নাম) স্বেচ্ছাপ্রণোদিতভাবে নিজের ক্ষতি বা আঘাত করা, কিংবা কখনো এরূপ করার কথা বলা সম্পর্কে আরো কিছু জানালে ভালো হয়।

ঠ২ঝঃ অতিচঞ্চলতা **(Hyperactivity)**

যদি অতিচঞ্চলতা এর জন্য ঠ১ঝ তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

ঠ২ঝ১) শিশুর (নাম) অতিরিক্ত চঞ্চলতা, মনোযোগের অভাব বা হঠাৎ কিছু করে ফেলার প্রবণতা সম্পর্কিত সমস্যাগুলো বর্ণনা করুন।

ঠ২ঝ২) চঞ্চলতার মাত্রা বা মনোযোগের অভাব কতোবার সমস্যা সৃষ্টি করে?

ঠ২ঝ৩) সবচেয়ে খারাপ অবস্থায় সমস্যাগুলো কতোটা প্রকট?

ঠ২ঝ৪) কতোদিন ধরে সে এরকম?

ঠ২ঝ৫) তার চঞ্চলতার মাত্রা বা মনোযোগের অভাব কি তার জীবনযাত্রার মান ব্যাহত করছে? যদি করে, কিভাবে?

ঠ২ক৬) তার চঞ্চলতার মাত্রা, মনোযোগের অভাব বা হঠাৎ কিছু করার প্রবণতা দূর করার জন্য আপনি কি কিছু করেছেন? যদি করে থাকেন, আপনার পক্ষে সম্ভব এমন কি চেষ্টা করেছেন বিবরণ দিন, এবং এসব কি তার অবস্থার কোনো পরিবর্তন করতে পেরেছে?

ঠ২এঃ বিব্রতকর ও পীড়াদায়ক আচরণ (Awkward and troublesome behaviour)

যদি বিব্রতকর বা পীড়াদায়ক আচরণ এর জন্য ঠ১এ তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

ঠ২এ১) শিশুর (নাম) বিব্রতকর ও পীড়াদায়ক আচরণ বর্ণনা করুন।

ঠ২এ২) এই আচরণ কতোখানি সমস্যা সৃষ্টি করে?

ঠ২এ৩) সবচেয়ে খারাপ অবস্থায় এই সমস্যা কতোটা প্রকট?

ঠ২এ৪) কতোদিন ধরে সে এরকম?

ঠ২এ৫) তার বিব্রতকর ও পীড়াদায়ক আচরণ কি তার জীবনযাত্রার মান ব্যাহত করছে? যদি করে, কিভাবে?

ঠ২এ৬) তার এই আচরণ দূর করার জন্য আপনি কি কিছু করেছেন? যদি করে থাকেন, আপনার পক্ষে সম্ভব এমন কি চেষ্টা করেছেন বিবরণ দিন, এবং এসব কি তার অবস্থার কোনো পরিবর্তন করতে পেরেছে?

ঠ২টঃ কম দেখা যায় এমন সমস্যা (Less common difficulties)

যদি কম দেখা যায় এমন সমস্যা এর জন্য ঠ১ট তে টিক চিহ্ন দেয়া হয়, তাহলে নিচের প্রশ্নগুলোর যেটি খাটে জিজ্ঞাসা করুন

ঠ২ট১) শিশুর (নাম) বাচনক্ষমতা, অন্যদের সাথে মেলামেশা, অদ্ভুত আচার বা অস্বাভাবিক অভ্যাস বিষয়ক সমস্যা সম্পর্কে আরো কিছু বলুন।

ঠ২ট২) তার মাংসপেশীর অস্বাভাবিক সঞ্চালন বা কম্পন সমস্যা সম্পর্কে আরো কিছু বলুন।

ঠ২ট৩) তার ওজন বা অতিরিক্ত কম খাবার প্রবণতার কারণে আপনার উদ্বেগ সম্পর্কে আরো কিছু বলুন।

ঠ২ট৪) তার আর কোনো বিষয়ে আপনার উদ্বেগ সম্পর্কে আরো কিছু বলুন।

ঠ২ট৫) কোনো বিষয়ে তার শিক্ষকদের উদ্বেগ সম্পর্কে আরো কিছু বলুন।

ঠ২অঃ সার্বিকভাবে সাক্ষাৎকার সম্পর্কে (The interview in general):

ঠ২অ১) সবশেষে, একজন সাক্ষাৎকার গ্রহণকারী হিসেবে এখানে আপনার সার্বিক মন্তব্য লেখার সুযোগ রয়েছে, যেমন - যার সাক্ষাৎকার নেয়া হলো তার উৎসাহ বা বোধগম্যতার বর্ণনা, কিংবা শিশুর পিতামাতার সাক্ষাৎকার নেবার সময় শিশুর কর্মকান্ডের মাত্রা সম্পর্কে আপনার পর্যবেক্ষণ রেকর্ড করা ইত্যাদি।

অংশ ড সবলতা (Strengths)

এতক্ষণ বিভিন্ন অসুবিধে ও সমস্যা সম্পর্কে আমি আপনাকে অনেক প্রশ্ন জিজ্ঞাসা করেছি। এবার শিশুর (নাম) কিছু ভালো বা সবল দিক সম্পর্কে জানতে চাই।

ড১

তার সম্পর্কে সবচেয়ে ভালো মন্তব্য করতে বলা হলে আপনি কি বলবেন?

যদি স্বতঃস্ফূর্তভাবে "কিছুই না" বলে ☐

১)

২)

৩)

৪)

৫)

ড২

তার এমন কিছু দিক সম্পর্কে বলবেন কি যা সত্যিকারভাবে আপনাকে আনন্দিত করে?

যদি স্বতঃস্ফূর্তভাবে "কিছুই না" বলে ☐

১)

২)

৩)

৪)

৫)

Development and Well-being Assessment (Teacher Version)
বিকাশ এবং কুশল নির্ণয় (শিক্ষকের জন্য)

ছাত্রের নাম ..... ছেলে/মেয়ে

জন্ম তারিখ ..... শ্রেণী .....

শিক্ষক (শ্রেণী, বর্ষ, বিষয় ইত্যাদি) .....

স্বাক্ষর ..... আজকের তারিখ .....

প্রত্যেকটি প্রশ্নের জন্য নির্দিষ্ট ঘরে টিক চিহ্ন দিন। আপনি যতোটা সবচেয়ে ভালোভাবে পারেন সেভাবে সবকটি প্রশ্নের উত্তর দিলে আমাদের যাচাই করতে সুবিধে হবে। এমনকি আপনি যদি পুরোপুরি নিশ্চিত নাও হন কিংবা প্রশ্নটি এই ছাত্রের জন্য তেমন প্রাসঙ্গিক মনে নাও হয় তাও উত্তর দিন। দয়া করে বিগত ছয় মাসে অথবা চলতি শিক্ষা বছরে ছাত্রের আচরণের ওপর ভিত্তি করে উত্তর দিন।

আবেগ (Emotions)

		সত্য নয়	কিছুটা সত্য	নিশ্চিতভাবে সত্য
ক১	অনেক দুশ্চিন্তা করে	☐	☐	☐
ক২	সুস্পষ্ট উদ্বেগ আছে বা হাল্কা হতে পারে না	☐	☐	☐
ক৩	নিজের সামর্থ সম্পর্কে অত্যাধিক চিন্তা করে (যেমন - পড়াশোনা, খেলাধুলা, সামাজিক)	☐	☐	☐
ক৪	বিশেষ করে শ্রেণীকক্ষে কথা বলতে বা জোরে জোরে পড়তে পারা নিয়ে উদ্বিগ্ন থাকে	☐	☐	☐
ক৫	পরিবার পরিজন থেকে বিচ্ছিন্ন হতে হবে বলে স্কুলে আসতে অনীহা দেখায়	☐	☐	☐
ক৬	অসুখী, বিমর্ষ অথবা বিষণ্ন দেখায়	☐	☐	☐
ক৭	দৈনন্দিন কাজকর্মে উৎসাহ হারিয়ে ফেলেছে	☐	☐	☐
ক৮	নিজেকে মূল্যহীন বা হীন মনে করে	☐	☐	☐
ক৯	উদ্বেগ বা মর্মপীড়ার কারণে মনোযোগ ব্যাহত হয়	☐	☐	☐
ক১০	আবেগজনিত অন্যান্য অসুবিধে আছে (যেমন - অতিরিক্ত ভয়, আতঙ্কগ্রস্ততা, চিন্তাবাতিক বা বাধ্যতাধর্মী আচরণ)	☐	☐	☐*

* ক১১ অনুগ্রহ করে সংক্ষিপ্তভাবে বর্ণনা করুন ঃ

যদি আপনি ক১ হতে ক১০ পর্যন্ত প্রশ্নগুলোর কোনো একটিতে "নিশ্চিতভাবে সত্য" ঘরে টিক চিহ্ন দিয়ে থাকেন, তাহলে অনুগ্রহ করে এ পৃষ্ঠার বাকি অংশ সমাপ্ত করুন। যদি "নিশ্চিতভাবে সত্য" ঘরে টিক চিহ্ন না দিয়ে থাকেন, তাহলে পরের পৃষ্ঠায় চলে যান।

এসব অসুবিধে কি		মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
ক১২	তাকে এলোমেলো করে ফেলে বা কষ্ট দেয়?	☐	☐	☐	☐
ক১৩	তার সহপাঠীদের সাথে সম্পর্কে বিঘ্ন ঘটায়?	☐	☐	☐	☐
ক১৪	তার ক্লাসের লেখাপড়ায় ব্যাঘাত ঘটায়?	☐	☐	☐	☐
ক১৫	আপনার বা সামগ্রিকভাবে ক্লাসের ওপর একটা বোঝা হয়ে দাঁড়ায়?	☐	☐	☐	☐

মনোযোগ, কর্মকাণ্ড ও হঠাৎ কিছু করে ফেলার প্রবণতা (Attention, Activity and Impulsiveness)

খ১ শ্রেণীকক্ষে পছন্দ করে থাকে ও করে এমন কাজে আসলে সে কতক্ষণ নিমগ্ন থাকে (যেমন - পড়া, ছবি আঁকা, অংক করা, কোনো কিছু বানানো বা এ জাতীয় কাজ)?

২ মিনিটের কম	২-৪ মিনিট	৫-৯ মিনিট	১০-১৯ মিনিট	২০ মিনিট বা তারও বেশি
☐	☐	☐	☐	☐

		সত্য নয়	কিছুটা সত্য	নিশ্চিতভাবে সত্য
খ২	অসতর্কভাবে অনেক ভুল করে বসে	☐	☐	☐
খ৩	কোনো বিষয়ে মনোযোগ দিতে ব্যর্থ হয়	☐	☐	☐
খ৪	যা করছে তাতে উৎসাহ হারিয়ে ফেলে	☐	☐	☐
খ৫	মনোযোগ দিয়ে শোনে বলে মনে হয় না	☐	☐	☐
খ৬	যা শুরু করে তা শেষ করতে পারে না	☐	☐	☐
খ৭	অগোছালো কাজ করে	☐	☐	☐
খ৮	চিন্তা করে করতে হবে এমন কাজ এড়িয়ে যেতে চায়	☐	☐	☐
খ৯	জিনিসপত্র হারিয়ে ফেলে	☐	☐	☐
খ১০	সহজেই অন্যমনস্ক হয়ে পড়ে	☐	☐	☐
খ১১	ভুলে যায়	☐	☐	☐
খ১২	উসখুস করে বা গা-হাত মোড়ামুড়ি করে	☐	☐	☐
খ১৩	প্রয়োজনীয় সময়ে স্থির হয়ে বসে থাকতে পারে না	☐	☐	☐
খ১৪	বিপদজনকভাবে দৌড়ায় বা লাফঝাঁপ দেয়	☐	☐	☐
খ১৫	ধীরস্থিরভাবে খেলতে পারে না	☐	☐	☐
খ১৬	শান্ত হতে বলা হলে তা পারে না	☐	☐	☐
খ১৭	কথার মাঝে ব্যাঘাত ঘটায়, প্রশ্ন শেষ না হতেই চিন্তাভাবনা না করে হঠাৎ একটা কিছু উত্তর দেয়	☐	☐	☐
খ১৮	কোনকিছুতে তার পালা আসা পর্যন্ত অপেক্ষা করতে পারে না	☐	☐	☐
খ১৯	অন্যদের কথাবার্তা ও কাজের মধ্যে ব্যাঘাত ঘটায়	☐	☐	☐
খ২০	কথা বলতে মানা করলেও শোনে না	☐	☐	☐

যদি আপনি খ২ হতে খ২০ পর্যন্ত প্রশ্নগুলোর কোনো একটিতে "নিশ্চিতভাবে সত্য" ঘরে টিক চিহ্ন দিয়ে থাকেন, তাহলে অনুগ্রহ করে এ পৃষ্ঠার বাকি অংশ সমাপ্ত করুন। যদি "নিশ্চিতভাবে সত্য" ঘরে টিক চিহ্ন না দিয়ে থাকেন, তাহলে পরের পৃষ্ঠায় চলে যান।

এসব অসুবিধে কি		মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
খ২১	তাকে এলোমেলো করে ফেলে বা কষ্ট দেয়?	☐	☐	☐	☐
খ২২	তার সহপাঠীদের সাথে সম্পর্কে বিঘ্ন ঘটায়?	☐	☐	☐	☐
খ২৩	তার ক্লাসের লেখাপড়ায় ব্যাঘাত ঘটায়?	☐	☐	☐	☐
খ২৪	আপনার বা সামগ্রিকভাবে ক্লাসের ওপর একটা বোঝা হয়ে দাঁড়ায়?	☐	☐	☐	☐

বিব্রতকর ও পীড়াদায়ক আচরণ (Awkward and Troublesome Behaviour)

		সত্য নয়	কিছুটা সত্য	নিশ্চিতভাবে সত্য
গ১	জেদী আচরণ বা গরম মেজাজ করে	☐	☐	☐
গ২	বড়দের সাথে বেশ তর্কাতর্কি করে	☐	☐	☐
গ৩	স্কুলে অবাধ্য আচরণ করে	☐	☐	☐
গ৪	ইচ্ছাকৃতভাবে এমন কাজ করে যা অন্যদের বিরক্তির উদ্রেগ করে	☐	☐	☐
গ৫	নিজে ভুল করে অন্যদের ওপর দোষ চাপায়	☐	☐	☐
গ৬	সহজেই অন্যদের দ্বারা বিরক্ত হয়ে পড়ে	☐	☐	☐
গ৭	ক্রুদ্ধ ও ক্ষুব্ধ থাকে	☐	☐	☐
গ৮	অন্যদের উত্যক্ত করে	☐	☐	☐
গ৯	প্রতিশোধ নিতে চেষ্টা করে	☐	☐	☐
গ১০	আসলেই মিথ্যা বলে বা ধাপ্পা দেয়	☐	☐	☐
গ১১	নিজের থেকেই মারামারি আরম্ভ করে	☐	☐	☐
গ১২	অন্যদের ওপর গায়ের জোর দেখায়	☐	☐	☐
গ১৩	স্কুল পালিয়ে ফাঁকি দেয়	☐	☐	☐
গ১৪	মারামারিতে অস্ত্র ব্যবহার করে থাকে	☐	☐	☐
গ১৫	নিষ্ঠুর প্রকৃতির, সত্যিসত্যিই অন্য কাউকে আঘাত করেছে	☐	☐	☐
গ১৬	প্রাণীদের প্রতি ইচ্ছাকৃতভাবে নিষ্ঠুরতা দেখায়	☐	☐	☐
গ১৭	ইচ্ছাকৃতভাবে আগুন ধরিয়ে দেয়	☐	☐	☐
গ১৮	জিনিষপত্র চুরি করে থাকে	☐	☐	☐*
গ১৯	ইচ্ছে করে অন্যের সম্পদ ধ্বংস করে বা অন্যের জিনিস নষ্ট করে থাকে	☐	☐	☐*
গ২০	অন্যদের প্রতি অশোভন যৌন আচরণ দেখিয়ে থাকে	☐	☐	☐*
গ২১	তাকে আইনগত ঝামেলায় পড়তে হয়েছে	☐	☐	☐*

* গ২২ অনুগ্রহ করে সংক্ষিপ্তভাবে বর্ণনা করুনঃ

যদি আপনি গ১ হতে গ২১ পর্যন্ত প্রশ্নগুলোর কোনো একটিতে "নিশ্চিতভাবে সত্য" ঘরে টিক চিহ্ন দিয়ে থাকেন, তাহলে অনুগ্রহ করে এ পৃষ্ঠার বাকি অংশ সমাপ্ত করুন। যদি "নিশ্চিতভাবে সত্য" ঘরে টিক চিহ্ন না দিয়ে থাকেন, তাহলে পরের পৃষ্ঠায় চলে যান।

এসব অসুবিধে কি		মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
গ২৩	তাকে এলোমেলো করে ফেলে বা কষ্ট দেয়?	☐	☐	☐	☐
গ২৪	তার সহপাঠীদের সাথে সম্পর্কে বিঘ্ন ঘটায়?	☐	☐	☐	☐
গ২৫	তার ক্লাসের লেখাপড়ায় ব্যাঘাত ঘটায়?	☐	☐	☐	☐
গ২৬	আপনার বা সামগ্রিকভাবে ক্লাসের ওপর একটা বোঝা হয়ে দাঁড়ায়?	☐	☐	☐	☐

অন্যান্য উদ্বেগের বিষয় (Other concerns)

		সত্য নয়	কিছুটা সত্য	নিশ্চিতভাবে সত্য
ঘ১	পেশীর অস্বাভাবিক সঞ্চালন, আকস্মিক সংকোচন, অনিয়ন্ত্রিত ঘোঁত ঘোঁত বা অস্বাভাবিক শব্দ করে	☐	☐	☐*
ঘ২	মাত্রারিক্ত খাদ্য নিয়ন্ত্রণ করে	☐	☐	☐*

		না	হ্যাঁ
ঘ৩	শিশুর মানসিক বিকাশের অন্য কোনো দিক আছে কি যা আপনাকে উদ্বিগ্ন করে?	☐	☐*

*** ঘ৪ অনুগ্রহ করে বর্ণনা করুন ঃ**

ঘ৫ এই পাতার বাকি অংশ শিশু সম্পর্কে আর কোন মন্তব্যের জন্য

আপনার সাহায্যের জন্য অনেক ধন্যবাদ

The Development and Well-Being Assessment

Interview with 11–16 year olds

বিকাশ এবং কুশল নির্ণয়

১১-১৬ বছরের ছেলেমেয়ের সাক্ষাৎকার

শেষের নাম	:
প্রথম নামসমূহ	:
বয়স	:
জন্ম তারিখ	:
ছেলে/মেয়ে	:
ক্লিনিক/গবেষণা সংখ্যামান	:
সাক্ষাৎকারের তারিখ	:
যার সাক্ষাৎকার নেয়া হয়েছে	:
সাক্ষাৎকার গ্রহণকারী	:

প্রথম ধাপ হলো এস৪-১৬ সবলতা ও অসুবিধা নির্ণয়ক প্রশ্নমালা (এসডিকিউ) পূরণ করা ও প্রদত্ত ছক ব্যবহার করে প্রশ্নমালার প্রথম পৃষ্ঠার হিসেব নিচের সংখ্যামানে প্রকাশ করা।

এসডিকিউ আবেগ মান	০	১	২	৩	৪	৫	৬	৭	৮	৯	১০
এসডিকিউ আচরণ মান	০	১	২	৩	৪	৫	৬	৭	৮	৯	১০

অংশ ক বিচ্ছিন্নতা সংশ্লিষ্ট উদ্বেগাধিক্য (Separation Anxiety)

বেশিরভাগ কিশোর-কিশোরী একজন বা অল্প কয়েকজন বয়স্কের প্রতি বিশেষভাবে আসক্ত থাকে। কিশোর-কিশোরী এদের কাছে নিরাপত্তা ও স্বস্তি চায় এবং কষ্ট বা আঘাত পেলে তাদের কাছে ছুটে যায়।

ক১	নিচের বয়স্কজনদের সাথে তুমি কি বিশেষভাবে আসক্ত?	না	হ্যাঁ
১)	তোমার মা (জন্মদাত্রী বা দত্তক মা)	০	১
২)	তোমার বাবা (জন্মদাতা বা দত্তক বাবা)	০	১
৩)	মা'য়ের মত আর কেউ (সৎ মা, পালক মা, বাবার সঙ্গিনী)	০	১
৪)	বাবার মত আর কেউ (সৎ বাবা, পালক বাবা, মা'য়ের সঙ্গী)	০	১
৫)	এক বা একাধিক দাদা-দাদী, নানা-নানী)	০	১
৬)	এক বা একাধিক অন্যান্য বয়স্ক আত্মীয় (চাচা-চাচী, মামা-মামী, খালা-খালু, বড় ভাই বা বড় বোন ইত্যাদি)	০	১
৭)	আয়া, দাইমা, বয়স্ক পরিচারিকা	০	১
৮)	এক বা একাধিক শিক্ষক-শিক্ষিকা	০	১
৯)	এক বা একাধিক অন্য কোনো বয়স্ক অনাত্মীয় (পারিবারিক বন্ধু বা প্রতিবেশী ইত্যাদি)	০	১
১০)	কোনো বয়স্কের সাথেই বিশেষভাবে আসক্ত নয়	০	১

যদি **ক১** *(১০) এর উত্তর "হ্যাঁ" হয়, অর্থাৎ সে কোনো বয়স্কের সাথেই বিশেষভাবে আসক্ত নয়, কেবলমাত্র তখন নিচের প্রশ্নগুলো জিজ্ঞাসা করুন।*

তুমি কি নিচের শিশুদের বা কিশোর-কিশোরীদের প্রতি বিশেষভাবে আসক্ত?		না	হ্যাঁ
১১)	এক বা একাধিক ভাই, বোন বা অন্য কোনো আত্মীয় ছেলেমেয়ে	০	১
১২)	এক বা একাধিক বন্ধু	০	১
১৩)	কারোর সাথেই বিশেষভাবে আসক্ত নয়	০	১

যদি **ক১** *(১৩) এর উত্তর "হ্যাঁ" হয়, তাহলে সরাসরি* ***অংশ খ*** *তে চলে যান। অন্যথায় পরবর্তী প্রশ্নগুলোতে এগিয়ে যান।*

তুমি আমাকে এইমাত্র তোমার সাথে কে বিশেষভাবে আসক্ত তা বলেছোঃ *আপনি চাইলে* **ক১(১)** *থেকে* **ক১** *(৯) কিংবা* **ক১** *(১১) থেকে* **ক১** *(১২) এর মধ্যে যে গুলোতে "হ্যাঁ" উত্তর দেয়া হয়েছে তার সবগুলোর তালিকা করতে পারেন।* এখন থেকে আমি এই সব ব্যক্তিদের তোমার "আসক্তজন" বলে উল্লেখ করবো।

"আসক্তজনদের" কাছ থেকে আলাদা হবার বিষয়ে তুমি কতোটা উদ্বেগে ভোগো এখন সে সম্পর্কে জানতে চাই। অধিকাংশ কিশোর-কিশোরী এ জাতীয় কিছু উদ্বেগে ভুগে থাকে, তবে আমি জানতে চাচ্ছি সমবয়সী অন্যান্য কিশোর-কিশোরীদের তুলনায় তোমার এই উদ্বেগ প্রকাশ কতোটা তীব্র। এক্ষেত্রে সে সচরাচর যে আচরণ দেখায় তার বর্ণনা দাও - মাঝে মধ্যে বিশেষ কোনো দিন বা ছুটির দিনের আচরণ নয়।

ক২ মোটামুটিভাবে **গত ৪ সপ্তাহে** তুমি কি তোমার আসক্তজন থেকে আলাদা হবার বিষয়ে উদ্বেগ প্রকাশ করেছো?	না	হ্যাঁ
	০	১

যদি **ক২** *এর উত্তর "হ্যাঁ" অথবা এসডিকিউ আবেগ মান* ≥ 6 *হয়, তাহলে পরবর্তী প্রশ্নগুলোতে এগিয়ে যান। যদি উত্তর "না" হয়, তাহলে সরাসরি* ***অংশ খ*** *তে চলে যান।*

ক৩	গত ৪ সপ্তাহে এবং তোমার সমবয়সীদের সাথে তুলনা করলে ...	অন্যদের তুলনায় বেশি নয় (বা প্রযোজ্য নয়)	অন্যদের তুলনায় সামান্য বেশি	অন্যদের তুলনায় অনেক বেশি
১)	তুমি কি তোমার আসক্তজনদের খারাপ কিছু একটা ঘটতে যাচ্ছে অথবা তাদেরকে হারাতে যাচ্ছো ভেবে উদ্বিগ্ন হয়েছো?	০	১	২
২)	আসক্তজনদের কাছ থেকে নানাভাবে তোমাকে সরিয়ে নিয়ে যাওয়া হতে পারে ভেবে তুমি কি উদ্বিগ্ন থাকো, যেমন - ধরে নিয়ে যাওয়া, হাসপাতালে নেয়া, এমনকি মেরে ফেলা?	০	১	২
৩)	যখন তুমি স্কুলে থাকবে তখন আসক্তজনদের কিছু ঘটে যেতে পারে এই ভয়ে তুমি কি প্রায়ই স্কুলে যেতে চাও না? *(যদি অন্য কোনো কারণ যেমন - অন্যদের গায়ের জোর দেখানো বা মারামারির কারণে স্কুলে যেতে অনীহা দেখায় তা এখানে সংশ্লিষ্ট করবেন না)*	০	১	২
৪)	একা ঘুমাতে হবে ভেবে তুমি কি উদ্বিগ্ন হয়ে থাকো?	০	১	২
৫)	তুমি কি রাতে নিজ শোবার ঘর থেকে বের হয়ে এসে দেখে নাও, তোমার আসক্তজনেরা ঘরে আছেন কিনা অথবা তাদের কাছাকাছি ঘুমাতে চাও?	০	১	২
৬)	অপরিচিত কোনো জায়গায় ঘুমানোর ব্যাপারে তুমি কি উদ্বিগ্ন হয়ে থাকো?	০	১	২
৭)	আসক্তজনেরা হঠাৎ এক মুহূর্তের জন্য বাইরে গেলে ঘরে একা থাকতে হবে ভেবে তুমি কি উদ্বিগ্ন হয়ে থাকো?	০	১	২
৮)	আসক্তজনদের কাছ থেকে আলাদা হওয়া নিয়ে তুমি কি প্রায়ই ভয়ের স্বপ্ন বা দুঃস্বপ্ন দেখে থাকো?	০	১	২
৯)	আসক্তজনদের কাছ থেকে আলাদা হলে বা আলাদা হতে যাচ্ছো জেনে তোমার কি মাথাব্যথা, পেটব্যথা, বমি বমি ভাব ইত্যাদি উপসর্গ হয়ে থাকে?	০	১	২
১০)	আসক্তজনদের কাছ থেকে আলাদা হবার সময় বা আলাদা হবার চিন্তায় তুমি কি উদ্বিগ্ন হও, কাঁদতে থাকো, রাগে ফেটে পড়ো অথবা মর্মপীড়া দেখাও?	০	১	২

যদি ক৩ এর প্রশ্নমালার যে কোনো একটিতে "অন্যদের তুলনায় অনেক বেশি" ঘরে টিক চিহ্ন দেয়া হয় তাহলে ঠ১ (৩১ পৃষ্ঠা) চেকলিস্টের "বিচ্ছিন্নতা সংশ্লিষ্ট উদ্বেগাধিক্য" এর ঘরে টিক চিহ্ন দিন এবং ক৪ এ এগিয়ে যান। অন্যথায় সরাসরি অংশ খ তে চলে যান।

ক৪ আসক্তজনদের কাছ থেকে তোমার আলাদা হবার উদ্বেগ কি অন্তত ৪ সপ্তাহ ধরে আছে?

না	হ্যাঁ
০	১

ক৫ আসক্তজনদের কাছ থেকে তোমার আলাদা হবার উদ্বেগ যখন শুরু হয়েছিল তখন তোমার বয়স কতো ছিল?
(যদি জন্ম থেকেই হয়, ০ বসান)

[ ] বছর বয়স

ক৬ এসব উদ্বেগ তোমাকে কতোটা এলোমেলো করেছে বা কষ্ট দিয়েছে?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

ক৭ এসব উদ্বেগ কি ব্যাঘাত ঘটিয়েছে ...

	মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
১) পরিবারের অন্যান্যদের সাথে তোমার স্বাচ্ছন্দে?	০	১	২	৩
২) বন্ধু তৈরি করা ও ধরে রাখতে পারায়?	০	১	২	৩
৩) লেখাপড়া বা শ্রেণীর কাজে?	০	১	২	৩
৪) খেলাধুলা, শখ বা অন্যান্য অবসর বিনোদনমূলক কাজে?	০	১	২	৩

ক৮ এসব উদ্বেগ কি তোমার চারপাশের সবার (পরিবারের লোকজন, বন্ধুবান্ধব, শিক্ষকদের বা আর কারোর) কষ্টের বা বিরক্তির কারণ হয়ে দাঁড়িয়েছে?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

অংশ খ বিশেষ বিষয় বা পরিস্থিতি ভীতি (Fears of specific things or situations)

এ অংশটিতে কিশোর-কিশোরীরা কোনো বিশেষ বিষয় বা পরিস্থিতি যা তাদের জন্য সত্যিকারভাবে বিপজ্জনক না হওয়া সত্ত্বেও ভয় পায় তা জানা যায়। আমি জানতে চাই তুমি কিসে ভয় পাও। তুমি সচরাচর যে আচরণ দেখাও তা জানতে আমি আগ্রহী, মাঝেমধ্যে বিশেষ দিনের এ ধরনের বেদনো আচরণ নয়। এই অংশে সব ধরনের ভীতি সম্পর্কে জানা যাবে না ; কতোগুলো ভীতি, যেমন - সামাজিক পরিস্থিতি, নোংরা, বিচ্ছিন্নতা সংশ্লিষ্ট, লোকজনের ভিড়জনিত ভীতি অন্যান্য অংশে জানা যাবে।

খ১	তুমি কি নিচের তালিকার বিষয় বা পরিস্থিতিতে ভয় পাও?	না	কিছুটা	অনেকটা
১)	প্রাণীঃ কুকুর, মাকড়সা, মৌমাছি এবং মোলতা, নেংটি ইঁদুর বা ধেড়ে ইঁদুর, সাপ, বা অন্য কোনো প্রাণী, পাখি অথবা পোকা	০	১	২
২)	প্রাকৃতিক পরিবেশের কিছু বিষয়ঃ ঝড়, বজ্রগর্জন, উচ্চতা, পানি	০	১	২
৩)	অন্ধকার	০	১	২
৪)	তীব্র শব্দঃ দমকলের ঘন্টি, বাজিপটকা	০	১	২
৫)	রক্ত-ইনজেকশন-আঘাতঃ রক্ত বা আঘাত, ইনজেকশন, বা অন্যান্য ডাক্তারি পদ্ধতি দেখে ভয় শুরু হওয়া	০	১	২
৬)	দন্তচিকিৎসক বা চিকিৎসক	০	১	২
৭)	বমি, শ্বাসকষ্ট বা নির্দিষ্ট কোনো রোগ হওয়া, যেমন - ক্যান্সার বা এইডস্	০	১	২
৮)	বিশেষ যানবাহনে চড়াঃ যেমন - মোটরগাড়ি, বাস, নৌকা, উড়োজাহাজ, রেলগাড়ি, ভূতল ট্রেন, সেতু	০	১	২
৯)	ছোট আবদ্ধ জায়গাঃ যেমন - লিফট, সুরঙ্গপথ	০	১	২
১০)	টয়লেট ব্যবহার করাঃ যেমন - স্কুলে বা অন্য কারো বাড়িতে	০	১	২
১১)	বিশেষ ধরণের লোকজনঃ যেমন - ভাঁড়, দাড়িওয়ালা লোক, মাথায় আঘাত নিরোধক হেলমেটধারী, কিম্ভুত সাজপোষাকধারী, বুড়ো সাজা লোক	০	১	২
১২)	কাল্পনিক বা অতিপ্রাকৃতিক সত্তাঃ যেমন - দৈত্যদানো, ভূতপ্রেত, জ্বীন, ডাইনী	০	১	২
১৩)	অন্য কোনো বিশেষ ভয়ঃ *(বর্ণনা করো)*	০	১	২

*যদি খ১ এর তালিকার কোনো একটিতে "অনেকটা" উত্তর দেয়া হয়, তাহলে খ২ প্রশ্নে এগিয়ে যান। অন্যথায় সরাসরি **অংশ গ** তে চলে যান।*

খ২	এসব ভয় কি তোমার বা আর কারোর জন্য সত্যিকার বিড়ম্বনার ব্যাপার হয়ে দাঁড়ায়?	না	হয়তোবা	নিশ্চিতভাবে
		০	১	২

*যদি খ২ এর উত্তর "নিশ্চিতভাবে" অথবা এসডিকিউ আবেগ মান ≥৬ হয়, তাহলে পরবর্তী প্রশ্নে এগিয়ে যান। অন্যথায় সরাসরি **অংশ গ** তে চলে যান।*

খ৩ কতোদিন ধরে এই ভয় বা ভয়গুলোর মধ্যে সবচেয়ে বেশি ভয় বর্তমান?

১ মাসের কম	১ - ৫ মাস	৬ মাস বা তার বেশি
০	১	২

খ৪ যখন তুমি ভীতি উদ্রেককারী জিনিসের মুখোমুখি হও বা হবার চিন্তা করো তখন তুমি কি উদ্বিগ্ন হও বা এলোমেলো হয়ে পড়ো?

না	কিছুটা	অনেকটা
০	১	২

↓ খ৭ / খ৫

খ৫ ভীতি উদ্রেককারী জিনিসের মুখোমুখি হলে তুমি কি প্রতিবারই বা প্রায় প্রতিবারই উদ্বিগ্ন হও বা এলোমেলো হয়ে পড়ো?

না	হ্যাঁ
০	১

খ৬ এই ভয় তোমাকে কতোবার এলোমেলো করে ফেলে?

দ্রষ্টব্য : যদি তুমি কোনো কিছুতে ভয় পাও যা কেবলমাত্র বছরের যেকোনো এক সময়ে হয়ে থাকে (যেমন - বাদলা পোকা, ভঁয়োপোকা) তাহলে এই প্রশ্ন সেই বিশেষ ঋতু সম্পর্কে হবে।

মাঝেমধ্যে	বেশিরভাগ সপ্তাহ	বেশিরভাগ দিন	দিনের মধ্যে অনেকবার
০	১	২	৩

খ৭ এসব ভয়ের কারণে কি তুমি ভীতি উদ্রেককারী জিনিসগুলো এড়িয়ে চলো?

না	কিছুটা	অনেকটা
০	১	২

↓ খ৯ / খ৮

খ৮ এরূপ এড়িয়ে চলা কি তোমার দৈনন্দিন জীবনে ব্যাঘাত ঘটায়?

না	কিছুটা	অনেকটা
০	১	২

না	হয়তোবা	নিশ্চিতভাবে
০	১	২
০	১	২

খ৯ অন্যেরা কি মনে করে যে তোমার ভয়গুলো মাত্রাতিরিক্ত বা অহেতুক?

খ১০ তোমার ধারণা কি? তুমি কি মনে করো যে এসব ভয় মাত্রাতিরিক্ত বা অহেতুক?

যদি খ২ এর উত্তর "নিশ্চিতভাবে" অথবা খ৪ বা খ৭ এর উত্তর "অনেকটা" হয়, তাহলে ঠ১ (৩১ পৃষ্ঠা) চেকলিস্টের "বিশেষ অহেতুক ভীতি" ঘরে টিক চিহ্ন দিন।

খ১১ তোমার এসব ভয় কি তোমার চারপাশের সবার (পরিবারের লোকজন, বন্ধুবান্ধব, শিক্ষকদের বা আর কারোর) কষ্টের বা বিরক্তির কারণ হয়ে দাঁড়িয়েছে?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

অংশ গ সামাজিক পরিস্থিতি ভীতি (Fear of social situations)

তুমি বিভিন্ন সামাজিক পরিস্থিতিতে বিশেষভাবে যে ভয় পেয়ে থাকো তা জানতে আমি আগ্রহী। তোমার এই ভয় সমবয়সীদের সাথে তুলনা করে বলতে হবে এবং এটি মাঝেমধ্যে বিশেষ দিনের ভীতি বা সাধারণ লাজুকভাব নয়।

গ১ সামগ্রিকভাবে তুমি কি অনেক লোকজনের মধ্যে থাকা, অপরিচিত কারো সাথে কথাবার্তা বলা, অন্যের সামনে কিছু করতে যাওয়ার মত সামাজিক পরিস্থিতিতে ভয় পাও বা এড়িয়ে চলো?

না	হ্যাঁ
০	১

*যদি গ১ এর উত্তর "হ্যাঁ" অথবা এসাডিকিউ আবেগ মান ≥৬ হয়, তাহলে এগিয়ে যান। যদি এগুলোর কোনোটাই "না" হয়, তাহলে পরের অংশ বাদ দিয়ে সরাসরি **অংশ ঘ** তে চলে যান।*

গ২ তুমি গত ৪ সপ্তাহে নিচের দেয়া সামাজিক পরিস্থিতিগুলোতে বিশেষভাবে ভয় পেয়েছো কি?

		না	কিছুটা	অনেকটা
১)	অপরিচিত কারো সাথে কথাবার্তা বলতে?	০	১	২
২)	অনেক লোকজনের মধ্যে থাকতে, যেমন কোনো ভোজসভায়?	০	১	২
৩)	অন্যদের সামনে খেতে?	০	১	২
৪)	ক্লাসে কথা বলতে?	০	১	২
৫)	অন্যদের সামনে শব্দ করে পড়তে?	০	১	২
৬)	অন্যদের সামনে লিখতে?	০	১	২

*যদি গ২ এর তালিকার কোনো একটিতেও "অনেকটা" উত্তর পাওয়া না যায়, তাহলে পরবর্তী অংশ বাদ দিয়ে সরাসরি **অংশ ঘ** তে চলে যান।*

গ৩ বেশির ভাগ কিশোর-কিশোরী কয়েকজন প্রধান বয়স্কের সাথে বিশেষভাবে আসক্ত থাকে, তারা কাছাকাছি থাকলে বেশি নিরাপদ বোধ করে। কতোক কিশোর-কিশোরী কেবলমাত্র সামাজিক পরিস্থিতিতে ভয় পায় যদি তাদের কাছাকাছি বিশেষভাবে আসক্ত প্রধান বয়স্কদের একজনও না থাকে।

অন্য কিশোর-কিশোরীরা বিশেষভাবে আসক্ত প্রধান বয়স্কদের কেউ সাথে থাকলেও বিভিন্ন সামাজিক পরিবেশে ভয় পায়।

তোমার জন্য কোনটা সত্য?

সামাজিক পরিস্থিতিতে বেশিরভাগ সময় ভালো থাকি যতক্ষণ প্রধান বয়স্করা কাছাকাছি থাকে	এমনকি প্রধান বয়স্করা কাছাকাছি থাকলেও সামাজিক ভীতি সুস্পষ্ট
০	১

গ৪ তুমি কি কেবল বড়দের ভয় পাও, নাকি অনেক কিশোর-কিশোরীদের মধ্যে বা সমবয়সী অপরিচিতদের মুখোমুখি হতেও ভয় পাও?

কেবল বড়দের	কেবল শিশুদের	বড় ও শিশু উভয়দের
০	১	২

গ৫ এসব সামাজিক পরিস্থিতি ছাড়া তুমি কি তোমার সবচেয়ে পরিচিত বড়দের এবং কিশোর-কিশোরীদের সাথে স্বাচ্ছন্দ্যে থাকো?

না	হ্যাঁ
০	১

গ৬ তুমি কি মনে করো যে, তুমি এসব সামাজিক পরিস্থিতি অপছন্দ করো, কারণ তুমি এমন কিছু করে বসবে যা বিব্রতকর অথবা সবাই তোমাকে লক্ষ করবে?

না	হয়তোবা	নিশ্চিতভাবে
০	১	২

গ৭ *(যদি গ২ এর ৪ বা ৫ বা ৬ প্রশ্নের উত্তর "হ্যাঁ" হয়, কেবলমাত্র তখন জিজ্ঞাসা করুন)*

তুমি কি কথা বলতে, পড়তে বা লিখতে হবে এ ধরনের সামাজিক পরিস্থিতিগুলোকে অপছন্দ করে থাকো?

না	হয়তোবা	নিশ্চিতভাবে
০	১	২

গ৮ এসব সামাজিক পরিস্থিতিতে তোমার ভয় কতোদিন ধরে আছে?

১ মাসের কম	১ - ৫ মাস	৬ মাস বা তারও বেশি
০	১	২

গ৯ যখন তোমার সামাজিক পরিস্থিতি ভীতি শুরু হয়েছিল তখন তোমার বয়স কতো ছিল?

(যদি জন্ম থেকেই হয়, ০ বসান)

[ ] বছর বয়স

গ১০ তুমি যেসব সামাজিক পরিস্থিতি ভয় পেয়ে থাকো সেগুলোর মুখোমুখি হলে সাধারণত তুমি কি ...

	না	হ্যাঁ
১) লজ্জায় লাল হয়ে যাও বা কাঁপতে থাকো?	০	১
২) অসুস্থ হয়ে পড়বে এমন ভয় পাও?	০	১
৩) তাড়াতাড়ি বাথরুমের দিকে দৌড়াও বা পেশাব হয়ে যাবে এবং কাপড় ভিজে যাবে বা কাপড় খারাপ হয়ে যাবে ভেবে উদ্বিগ্ন থাকো?	০	১

গ১১ তুমি যেসব সামাজিক পরিস্থিতির মুখোমুখি হলে বা হবার কথা ভাবলে ভয় পাও তার কোনো একটির মুখোমুখি হলে বা হবার কথা ভাবলে তুমি কি উদ্বিগ্ন হও বা এলোমেলো হয়ে পড়ো?

না	কিছুটা	অনেকটা
০	১	২

↓ গ১৩ / গ১২

গ১২ তোমার সামাজিক পরিস্থিতি ভীতি তোমাকে এরকম কতোবার এলোমেলো করে দেয়?

মাঝেমধ্যে	বেশিরভাগ সপ্তাহ	বেশিরভাগ দিন	দিনের মধ্যে অনেক বার
০	১	২	৩

গ১৩ এই ভয়ের কারণে কি তুমি সামাজিক পরিস্থিতি এড়িয়ে চলো?

না	কিছুটা	অনেকটা
০	১	২

↓ গ১৫ / গ১৪

গ১৪ এরূপ এড়িয়ে চলা কি তোমার দৈনন্দিন জীবনে ব্যাঘাত সৃষ্টি করে?

না	কিছুটা	অনেকটা
০	১	২

না	হয়তোবা	নিশ্চিতভাবে
০	১	২

গ১৫ তুমি কি মনে করো যে তোমার সামাজিক পরিস্থিতি ভীতি মাত্রাতিরিক্ত বা অহেতুক?

গ১৬ তোমার এই ভয় আছে বলে তুমি কি বিপর্যস্ত?

০	১	২

*যদি **গ১১** বা **গ১৩** এর উত্তর "অনেকটা" হয়, তাহলে **ঐ১** (৩১ পৃষ্ঠা) চেকলিস্টের "সামাজিক অহেতুক ভীতি" ঘরে টিক চিহ্ন দিন।*

গ১৭ তোমার সামাজিক পরিস্থিতি ভীতি কি তোমার চারপাশের সবার (পরিবারের লোকজন, বন্ধুবান্ধব, শিক্ষকদের বা আর কারোর) কষ্টের বা বিরক্তির কারণ হয়ে দাঁড়িয়েছে?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

অংশ ঘ আতঙ্কগ্রস্ততা এবং বহির্গমনের ভীতি (Panic Attacks and Agoraphobia)

অনেক কিশোর-কিশোরীই কখনো কখনো তুচ্ছ সামান্য বিষয়ে অনেক বেশি উদ্বিগ্ন বা আতঙ্কিত হয়। কেউ কেউ কোনো কারণ ছাড়াই হঠাৎ করে প্রচন্ড মাত্রায় আতঙ্কিত হয়ে পড়ে। এই আতঙ্কের জন্য কোনো বিষয় বা পরিস্থিতির দরকার হয় না।

		না	হ্যাঁ
ঘ১	গত ৪ সপ্তাহে কি তুমি একবার আতঙ্কগ্রস্ততা দেখিয়েছিলে যার কোনো কারণ ছিল না এমনকি আতঙ্ক শুরু হবার মত একটি সামান্য বিষয় ছাড়াই?	০	১

যদি ঘ১ এর উত্তর "হ্যাঁ" হয়, তাহলে ঠ১ (৩১ পৃষ্ঠা) চেকলিস্টের "আতঙ্কগ্রস্ততা/বহির্গমনের অহেতুক ভীতি" ঘরে টিক চিহ্ন দিন।

ঘ২		না	হ্যাঁ
১)	তোমার এসব আতঙ্কগ্রস্ততা কি হঠাৎ শুরু হয়ে যায়?	০	১
২)	এসব কি কয়েক মিনিটের মধ্যেই প্রকট হয়ে যায় (বড়জোর ১০ মিনিট)?	০	১
৩)	এসব কি কমপক্ষে কয়েক মিনিটকাল থাকে?	০	১

ঘ৩	যখন তোমার এই আতঙ্কগ্রস্ততা বোধ হয়, তখন কি তুমি এর সাথে অনুভব কর...	না	হ্যাঁ
১)	দ্রুত হৃদস্পন্দন হয়, বুক কাঁপে বা ধড়ফড় করে?	০	১
২)	শরীর ঘামতে থাকে?	০	১
৩)	শরীর কাঁপতে বা থরথর করতে থাকে?	০	১
৪)	মুখ শুকিয়ে যায়?	০	১
৫)	শ্বাস নিতে কষ্টবোধ হয় বা দম বন্ধ হয়ে আসে?	০	১
৬)	গলায় কিছু আটকে যাচ্ছে এমন মনে হয়?	০	১
৭)	বুকে ব্যথা বা অস্বস্তিবোধ হয়?	০	১
৮)	তুমি বমি করতে চাও বা পেটের ভিতরের সবকিছু বের হয়ে আসতে চাচ্ছে এমন লাগে?	০	১
৯)	মাথা ঝিমঝিম বা টলমল করে বা খালি খালি লাগে?	০	১
১০)	চারপাশের সবকিছু অবাস্তব বা তুমি বাস্তবে সেখানে নেই এমন মনে হয়?	০	১
১১)	তুমি তোমার নিয়ন্ত্রণ হারিয়ে ফেলবে, পাগল হয়ে যাবে বা হুঁশ হারিয়ে ফেলবে এমন ভয় হয়?	০	১
১২)	তুমি মরে যেতে পারো এমন ভয় হয়?	০	১
১৩)	সারা শরীর ঠান্ডা বা গরম হয়ে আসে?	০	১
১৪)	শরীরে অবশ বা শিরশির বোধ হয়?	০	১

ঘ৪	গত ৪ সপ্তাহ ধরে তুমি কি নিচের পরিস্থিতিগুলোতে ভয় পেয়েছো অথবা এগুলো এড়িয়ে চলার চেষ্টা করেছো?	না বা প্রযোজ্য নয়	হ্যাঁ
১)	মানুষের ভিড়	০	১
২)	জনসাধারণের জন্য বিভিন্ন স্থান	০	১
৩)	একা ভ্রমন করা (যদি তুমি কখনো এরূপ করে থাকো)	০	১
৪)	বাড়ির অনেক দূরে যাওয়া	০	১

ঘ৫ *(যদি ঘ৪ এর কোনো একটির উত্তর "হ্যাঁ" হয়, কেবলমাত্র তখন জিজ্ঞাসা করুন)*

এই ভয় বা এড়িয়ে চলা (ঘ৪ এ উল্লেখিত পরিস্থিতিতে) কি এ কারণে যে, তোমার আতঙ্কগ্রস্ততা বা এ জাতীয় কিছু ঘটবে (যেমন - মাথা ঝিমঝিম করা বা পাতলা পায়খানা), ভয়ের পরিস্থিতি থেকে বেরিয়ে আসাটা কঠিন বা বিব্রতকর হবে বা তোমার দরকারি সহায়তা পাবে না?	না	হ্যাঁ
	০	১

যদি ঘ৫ এর উত্তর "হ্যাঁ" হয়, তাহলে ঠ১ (৩১পৃষ্ঠা) চেকলিস্টের আতঙ্কগ্রস্ততা/বহির্গমনের ভীতি ঘরে টিক চিহ্ন দিন)

যদি ঠ১ (৩১পৃষ্ঠা) চেকলিস্টে আতঙ্কগ্রস্ততা/বহির্গমনের ভীতির জন্য টিক চিহ্ন দেয়া হয়ে থাকে তাহলে এগিয়ে যান। অন্যথায় সরাসরি অংশ ঙ তে চলে যান।

ঘ৬	এসব আতঙ্কগ্রস্ততা ও/বা বিশেষ পরিস্থিতিগুলো এড়িয়ে চলা তোমাকে কতোটা এলোমেলো করেছে বা কষ্ট দিয়েছে?	মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
		০	১	২	৩

ঘ৭	এসব আতঙ্কগ্রস্ততা ও/বা বিশেষ পরিস্থিতিগুলো এড়িয়ে চলা কি ব্যাঘাত ঘটিয়েছে ...	মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
১)	পরিবারের অন্যান্যদের সাথে তোমার স্বাচ্ছন্দে?	০	১	২	৩
২)	বন্ধু তৈরি করা ও ধরে রাখতে পারায়?	০	১	২	৩
৩)	লেখাপড়া বা শ্রেণীর কাজে?	০	১	২	৩
৪)	খেলাধুলা, শখ বা অন্যান্য অবসর বিনোদনমূলক কাজে?	০	১	২	৩

ঘ৮	এসব আতঙ্কগ্রস্ততা ও/বা বিশেষ পরিস্থিতিগুলো এড়িয়ে চলা কি তোমার চারপাশের সবার (পরিবারের লোকজন, বন্ধুবান্ধব, শিক্ষকদের বা আর কারোর) কষ্টের বা বিরক্তির কারণ হয়ে দাঁড়িয়েছে?	মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
		০	১	২	৩

অংশ ঙ মানসিক আঘাতোত্তর মানসিক চাপ (Post Traumatic Stress)

এ অংশটা এমন সব ঘটনা অথবা পরিস্থিতি সংশ্লিষ্ট যেগুলো আসলেই ব্যতিক্রমধর্মী মানসিক চাপসম্পন্ন এবং এতে আক্রান্ত প্রায় সবাই সত্যিকারভাবে বিপর্যস্ত হতে পারে। যেমন - আগুন লেগেছে এমন কোনো বাড়িতে আটকে পড়া, নির্যাতিত হওয়া, কোনো মারাত্মক ধরণের যান দুর্ঘটনার শিকার হওয়া, অস্ত্রের মুখে নিজেকে ছিনতাই হতে দেখা।

		না	হ্যাঁ
ঙ১	তোমার জীবনে কি এ ধরনের কোনো ঘটনা ঘটেছিল?	০	১

		না	হ্যাঁ
ঙ২	*(যদি ঙ১ এর উত্তর "হ্যাঁ" হয়, তাহলে "যাচাই করার জন্য ....." বলে প্রশ্ন শুরু করুন)* তুমি কি কখনো নিচের কোনো একটির মুখোমুখি হয়েছিলে?		
	দুর্বিপাকের মধ্যে পড়া		
১)	মারাত্মক এবং ভয়াবহ দুর্ঘটনা, যেমন - গাড়ি চাপা পড়া, ভয়ানক গাড়ি বা ট্রেনের সংঘর্ষ হওয়া, ইত্যাদি	০	১
২)	অগ্নিকান্ড, যেমন - জ্বলন্ত বাড়ির মধ্যে আটকে পড়া	০	১
৩)	অন্যান্য দুর্বিপাক, যেমন - অপহরণ, বন্যা, জলোচ্ছাস, ভূমিকম্প, যুদ্ধ	০	১
	সহিংসতার শিকার		
৪)	গুরুতর আক্রমন বা হুমকি, যেমন - ছিনতাইকারী বা ডাকাতদলের কাছ থেকে	০	১
৫)	গুরুতর শারীরিক নির্যাতন যা তোমার এখনো মনে পড়ে	০	১
	যৌন নিপীড়নের শিকার		
৬)	যৌন নির্যাতন	০	১
৭)	ধর্ষণ	০	১
	দারুণ বিপর্যস্ত হবার মত কিছু প্রত্যক্ষ করা		
৮)	মারাত্মক গৃহবিবাদ হতে দেখা, যেমন - মা'কে প্রচন্ড মার খেতে দেখা	০	১
৯)	পরিবারের কোনো সদস্য বা কোনো বন্ধুকে আক্রান্ত বা হুমকির শিকার হতে দেখা	০	১
১০)	আকস্মিক মৃত্যু, আত্মহত্যা, আত্মহত্যার চেষ্টা, মারাত্মক দুর্ঘটনা বা হৃদরোগে আক্রান্ত হতে দেখা	০	১
	অন্যান্য মারাত্মক বৈকল্য		
১১)	অন্য কোনো মারাত্মক পীড়াদায়ক ঘটনা *(বর্ণনা করো)*	০	১
	.....		

যদি ঙ২ এর কোনো একটির উত্তর "হ্যাঁ" হয়, তাহলে এগিয়ে যান। অন্যথায় অংশ চ তে চলে যান।

৪৩ ঐ সময়ে তুমি কি খুব এলোমেলো অথবা মারাত্মকভাবে বিপর্যস্ত হয়ে পড়েছিলে?

না	হ্যাঁ
০	১

৪৩ক এখন, তা কি তোমার আচরণ, অনুভূতি বা মনোযোগের ওপর প্রভাব ফেলছে?

না	হ্যাঁ
০	১
↓	↓
অংশ চ	৪৪

৪৪ গত ৪ সপ্তাহ ধরে তোমার আছে ...

		না	কিছুটা	অনেকটা
১)	ঘটনার স্মৃতিগুলো প্রাণবন্ত ছবির মত ভাসে?	০	১	২
২)	ঘটনাটি দুঃস্বপ্ন হয়ে বার বার আসে?	০	১	২
৩)	সেই ঘটনা স্মরণ করিয়ে দেয় এমন কিছু ঘটলে তুমি কি এলোমেলো হয়ে পড়ো?	০	১	২
৪)	ঘটনা সম্পর্কে চিন্তা করা, এমনকি কোনো কিছু বলা পর্যন্ত এড়িয়ে চলার চেষ্টা করে থাকো?	০	১	২
৫)	সেই ঘটনা মনে করিয়ে দেয় এমন কাজকর্ম, স্থান বা লোকজন এড়িয়ে চলার চেষ্টা করে থাকো?	০	১	২
৬)	ঘটনার কোনো একটা গুরুত্বপূর্ণ অংশ তুমি মনে করতে পারো না?	০	১	২
৭)	আগে উপভোগ করতে এমন কর্মকান্ডগুলোতে অনেক কম আগ্রহ দেখাও?	০	১	২
৮)	অন্যদের কাছ থেকে বিচ্ছিন্ন হয়ে গেছো বা দূরে সরে গেছো এরূপ অনুভব করো?	০	১	২
৯)	আগের তুলনায় অনুভূতি প্রকাশের ক্ষমতা সংকীর্ণ হয়ে পড়েছে, যেমন ভালোলাগার অনুভূতি প্রকাশ করতে পারো না?	০	১	২
১০)	ভবিষ্যৎ নিয়ে কম আত্মবিশ্বাসে ভোগো?	০	১	২
১১)	ঘুমের সমস্যা হয়?	০	১	২
১২)	খিটখিটে বা রগচটা হয়ে গেছো?	০	১	২
১৩)	কোনো কিছুতে মনোযোগ দিতে অসুবিধে হয়?	০	১	২
১৪)	বিপদ ঘটে যেতে পারে এমন আশঙ্কায় সর্বদাই সন্ত্রস্ত থাকো?	০	১	২
১৫)	অল্প শব্দ হলেই বা অন্য কোনো কিছুতে সহজেই চমকে ওঠো?	০	১	২

যদি ৪৪ এর কোনো একটির উত্তর "অনেকটা" হয়, তাহলে ঠ১ (৩১ পৃষ্ঠা) চেকলিস্টের "মানসিক আঘাতোত্তর মানসিক চাপ" ঘরে টিক চিহ্ন দিন ও ৪৫ এ এগিয়ে যান। অন্যথায় পরবর্তী অংশ বাদ দিয়ে সরাসরি অংশ চ তে চলে যান।

৪৫ তুমি এসব সুস্পষ্ট উপসর্গ সম্পর্কে বলেছো।
ঘটনার কতো পরে এসব সমস্যা শুরু হয়েছিল?

৬ মাসের মধ্যে	ঘটনার ৬ মাস পরে
০	১

৪৬ তুমি কতোদিন ধরে এসব সমস্যায় ভুগছো?

১ মাসের কম	১ - ৩ মাস	৩ মাস বা তারও বেশি
০	১	২

৪৭ মানসিক চাপজনিত ঘটনা বা ঘটনাগুলো থেকে উদ্ভূত সমস্যাগুলোর কারণে তুমি কতোটা বেদনার্ত বা বিপর্যস্ত?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

৪৮ এসব সমস্যা কি ব্যাঘাত ঘটিয়েছে ....

		মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
১)	পরিবারের অন্যান্যদের সাথে তোমার স্বাচ্ছন্দ্যে?	০	১	২	৩
২)	বন্ধু তৈরি করা ও ধরে রাখতে পারায়?	০	১	২	৩
৩)	লেখাপড়া বা শ্রেণীর কাজে?	০	১	২	৩
৪)	খেলাধুলা, শখ বা অন্যান্য অবসর বিনোদনমূলক কাজে?	০	১	২	৩

৪৯ তোমার এসব সমস্যা কি তোমার চারপাশের সবার (পরিবারের লোকজন, বন্ধুবান্ধব, শিক্ষকদের বা আর কারোর) কষ্টের বা বিরক্তির কারণ হয়ে দাঁড়িয়েছে?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

অংশ চ বাধ্যতাধর্মী আচরণ ও চিন্তাবাতিক (Compulsions and Obsessions)

অনেক কিশোর-কিশোরীর মাঝে কতক অভ্যাস আর সংস্কার দেখা যায়, যেমন - মেঝের ফাটলে পা না দেয়া, রাতে ঘুমানোর আগে কোনো বিশেষ আচরণ করা, সামনের পরীক্ষা বা ফুটবল ম্যাচের জন্য কোনো নয়মন্ত পোষাক পরা বা চিহ্ন ধারণ করা ইত্যাদি। বিকাশের বিভিন্ন স্তরে কিশোর-কিশোরীদের মধ্যে কোনো সুনির্দিষ্ট বিষয় বা কার্যক্রম সম্পর্কে চিন্তাবাতিক থাকা স্বাভাবিক। তোমার যে সব আচরণ বা চিন্তাবাতিক এই স্বাভাবিক মাত্রার চাইতে বেশি সে সম্পর্কে আমি জানতে চাই।

চ১ সামগ্রিকভাবে তোমার এমন সব আচরণ বা চিন্তাবাতিক আছে কি যেসব তোমাকে এলোমেলো করে, অনেক সময় নষ্ট করে দেয় বা দৈনন্দিন জীবনযাত্রায় বিঘ্ন ঘটিয়ে থাকে?

না	হ্যাঁ
০	১

যদি চ১ এর উত্তর "হ্যাঁ" অথবা এসডিকিউ আবেগ মান ≥৬ হয়, তাহলে নিচের প্রশ্নগুলোতে এগোন। অন্যথায় বাদ দিয়ে সরাসরি অংশ ছ তে চলে যান।

চ২ **গত ৪ সপ্তাহ** ধরে, তুমি কি নিচের আচরণগুলোর অন্তত একটি বারবার করছো বা করেছো, যদিও তুমি একবার তা করেছো বা এগুলো করার আদৌ কোনো দরকার ছিল না?

		না	কিছুটা	অনেকটা
১)	মাত্রাতিরিক্ত পরিচ্ছন্নতাঃ হাত ধোয়া, গোসল করা, ধারাস্নান করা, দাঁত মাজা ইত্যাদি	০	১	২
২)	ধুলোবালি, ময়লা বা জীবাণু থেকে রক্ষা পাওয়ার জন্য কোনো বিশেষ পদ্ধতি অবলম্বন করা	০	১	২
৩)	বার বার পরখ করে দেখাঃ দরজা, তালা, চুলো, গ্যাসের নির্গমন, বৈদ্যুতিক সুইচ	০	১	২
৪)	অকারণে একই সাধারণ কাজ শ্রেণীবদ্ধভাবে বারংবার করাঃ যেমন - উঠে দাঁড়ানো বা বসে পড়া, দরজাপথ দিয়ে সামনে বা পিছনে যাওয়া	০	১	২
৫)	কোনো বস্তু বা ব্যক্তিকে বিশেষ নিয়মে স্পর্শ করা	০	১	২
৬)	জিনিসগুলোকে এমনভাবে সাজানো যেনো এভাবে সাজাতে হয় বা সাদৃশ্যতা প্রকাশ পায়	০	১	২
৭)	কোনো বিশেষ শুভ সংখ্যা গণনা করা বা অশুভ সংখ্যা পরিহার করা	০	১	২

চ৩ **গত ৪ সপ্তাহ** ধরে, তুমি ধুলোময়লা, জীবাণু বা বিষাক্ত জিনিস সম্পর্কে বাধ্যতাধর্মীভাবে উদ্বিগ্ন হয়েছো - যা তুমি মন থেকে সরাতে পারছো না?

না	কিছুটা	অনেকটা
০	১	২

চ৩ক **গত ৪ সপ্তাহ** ধরে, তুমি কি ধর্ম সম্পর্কে বা স্রষ্টা নারাজ হতে পারে এমন কিছু করেছো বলে বাধ্যতাধর্মীভাবে উদ্বিগ্ন হয়েছো?

না	কিছুটা	অনেকটা
০	১	২

যদি চ২ বা চ৩ বা চ৩ক এর উত্তর "অনেকটা" হয়, তাহলে ঠ১ (৩১পৃষ্ঠা) চেকলিস্টের "চিন্তাবাতিক ও বাধ্যতাধর্মী আচরণ" ঘরে টিক চিহ্ন দিন।

চ৪ **গত ৪ সপ্তাহ** ধরে, তুমি কি তোমার নিজের অথবা অন্য কারোর অসুস্থতা, দুর্ঘটনা, আগুন লাগা বা এ ধরনের মারাত্মক কিছু ঘটবে এমন চিন্তায় বার বার উদ্বিগ্ন হয়েছো?

না	কিছুটা	অনেকটা
০	১	২

চ৭ চ৬

চ৬ তোমার বা অন্যের মারাত্মক কিছু একটা ঘটতে যাচ্ছে এমন বাধ্যতাধর্মী চিন্তা কি তোমার প্রধান আসক্তজনদের কাছ থেকে বিচ্ছিন্ন হবার সাধারণ উদ্বেগের অংশ অথবা এগুলো সম্পূর্ণ স্বতন্ত্র সমস্যা?

বিচ্ছিন্নতা সংশ্লিষ্ট উদ্বেগাধিক্যের অংশ	সম্পূর্ণ স্বতন্ত্র একটা সমস্যা
০	১

যদি চ৬ এর উত্তর "সম্পূর্ণ স্বতন্ত্র একটা সমস্যা" হয়, তাহলে ঠ১ (৩১পৃষ্ঠা) চেকলিস্টের "চিন্তাবাতিক ও বাধ্যতাধর্মী আচরণ" ঘরে টিক চিহ্ন দিন।

*ঠ১ চেকলিস্টের চিন্তাবাতিক ও বাধ্যতাধর্মী আচরণে টিক চিহ্ন দেয়া হলে পরবর্তী প্রশ্নগুলোতে এগিয়ে যান। অন্যথায় তা বাদ দিয়ে সরাসরি **অংশ ছ** তে চলে যান।*

চ৭ তোমার বাধ্যতাধর্মী আচরণ বা চিন্তাগুলো কি **কমপক্ষে ২ সপ্তাহ** ধরে প্রায় সবক্ষটা দিনে বর্তমান?

না	হ্যাঁ
০	১

চ৮ তুমি কি মনে করো যে তোমার বাধ্যতাধর্মী আচরণ বা চিন্তাগুলো মাত্রাতিরিক্ত বা অহেতুক?

না	হয়তোবা	নিশ্চিতভাবে
০	১	২

চ৯ তুমি কি বাধ্যতাধর্মী আচরণ বা চিন্তাগুলো না করার চেষ্টা করে থাকো?

না	হয়তোবা	নিশ্চিতভাবে
০	১	২

৮১০ এসব বাধ্যতাধর্মী আচরণ বা চিন্তা কি তোমাকে এলোমেলো করে ফেলে?

না, আমি ওইগুলো উপভোগ করে থাকি	প্রতিক্রিয়াহীন, আমি উপভোগও করিনা বা এলোমেলো হয়েও পড়িনা	ওইগুলো আমাকে কিছুটা এলোমেলো করে ফেলে	ওইগুলো আমাকে অনেকটা এলোমেলো করে ফেলে
০	১	২	৩

৮১১ এসব বাধ্যতাধর্মী আচরণ বা চিন্তাতে কি গড়ে প্রতিদিন অন্তত এক ঘন্টা সময় অতিবাহিত হয়ে যায়?

না	হ্যাঁ
০	১

৮১২ এসব বাধ্যতাধর্মী আচরণ বা চিন্তা কি ব্যাঘাত ঘটিয়েছে ...

	মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
১) পরিবারের অন্যান্যদের সাথে তোমার স্বাচ্ছন্দ্যে?	০	১	২	৩
২) বন্ধু তৈরি করা ও ধরে রাখতে পারায়?	০	১	২	৩
৩) লেখাপড়া বা শ্রেণীর কাজে?	০	১	২	৩
৪) খেলাধুলা, শখ বা অন্যান্য অবসর বিনোদনমূলক কাজে?	০	১	২	৩

৮১৩ তোমার বাধ্যতাধর্মী আচরণ ও চিন্তাগুলো কি তোমার চারপাশের সবার (পরিবারের লোকজন, বন্ধুবান্ধব, শিক্ষকদের বা আর কারোর) কষ্টের বা বিরক্তির কারণ হয়ে দাঁড়িয়েছে?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

অংশ ছ অনির্দিষ্ট উদ্বেগাধিক্য (Generalized Anxiety)

এই অংশ উদ্বিগ্নতা সম্পর্কিত।

ছ২ তুমি কি কখনো উদ্বিগ্ন হয়েছো?

না	হ্যাঁ
০	১
↓	↓
অংশ জ	এগিয়ে যান

কিছু কিশোর-কিশোরী অল্প কয়েকটা বিষয়ে উদ্বিগ্ন থাকে যা কখনো বিশেষ ভীতি, বাধ্যতাধর্মী চিন্তাবাতিক বা আসক্তজন হতে বিচ্ছিন্নতা সংশ্লিষ্ট উদ্বেগের সাথে সম্পর্কিত। অন্য কিশোর-কিশোরীরা জীবন যাপনের নানান দিক সম্পর্কে উদ্বিগ্ন হয়ে থাকে। তাদের বিশেষ ভীতি, বাধ্যতাধর্মী চিন্তাবাতিক বা আসক্তজন হতে বিচ্ছিন্নতা সংশ্লিষ্ট উদ্বেগ থাকলেও বিভিন্ন বিষয়ে একটা ব্যাপক উদ্বেগ থাকে।

ছ২ক তুমি কি সাধারণভাবে উদ্বেগসম্পন্ন?

না, আমার শুধু ক'য়েকটা নির্দিষ্ট উদ্বেগ আছে	হ্যাঁ, আমি সাধারণভাবে উদ্বিগ্ন হয়ে থাকি
০	১
↓	↓
কেবলমাত্র এসডিকিউ আবেগ মান >৬ হলে এগিয়ে যান	*এগিয়ে যান*

ছ৩ **গত ৬ মাস** ধরে, তুমি কি অনেক কিছু নিয়ে এতটা বেশি উদ্বিগ্ন আছো যা তোমাকে এলোমেলো করে ফেলেছে বা দৈনন্দিন জীবন যাত্রায় বিঘ্ন ঘটিয়েছে?

না	হয়তোবা	নিশ্চিতভাবে
০	১	২

যদি ***ছ৩*** *এর উত্তর "হয়তোবা" অথবা "নিশ্চিতভাবে" অথবা এসডিকিউ আবেগ মান >৬ হয়, তাহলে নিচের প্রশ্নগুলোতে এগোন। অন্যথায় বাদ দিয়ে সরাসরি* ***অংশ জ*** *তে চলে যান।*

ছ৪	গত ৬ মাস ধরে এবং সমবয়সী অন্যদের তুলনায় নিচের বিষয়গুলোতে তোমার উদ্বেগ আছে কি ...	অন্যদের তুলনায় বেশি নয়	অন্যদের তুলনায় সামান্য বেশি	অন্যদের তুলনায় অনেক বেশি
১)	অতীত আচরণঃ আমি কি ভুল করেছি? আমি কি কাউকে কষ্ট দিয়েছি? তারা কি আমাকে ক্ষমা করেছে?	০	১	২
২)	স্কুলের কাজ, বাড়ির কাজ বা পরীক্ষা সম্পর্কিত উদ্বেগ	০	১	২
৩)	দুর্বিপাকঃ চুরি, ছিনতাই, আগুন লাগা, বোমা বিস্ফোরিত হওয়া ইত্যাদি বিষয়	০	১	২
৪)	তোমার নিজ স্বাস্থ্য সম্পর্কে	০	১	২
৫)	অন্যদের খারাপ কিছু ঘটতে যাচ্ছে এমন উদ্বেগঃ পরিবারের, বন্ধুদের, পোষা প্রাণীদের, পৃথিবীর (যেমন - যুদ্ধবিগ্রহ)	০	১	২
৬)	ভবিষ্যৎ নিয়ে উদ্বেগঃ যেমন - স্কুল বদল, বাড়ি বদল, চাকরি পাওয়া, বন্ধু-বান্ধবী পাওয়া	০	১	২
৭)	বন্ধু তৈরি করা ও ধরে রাখা	০	১	২
৮)	মৃত্যু ও মরণ বিষয়ক	০	১	২
৯)	লাঞ্ছনা বা বিদ্রুপের শিকার হওয়া	০	১	২
১০)	তোমার চেহারা বা ওজন	০	১	২
১১)	অন্য নির্দিষ্ট উদ্বেগ *(বর্ণনা করো)*	০	১	২

*যদি এসব উদ্বেগের ২ বা ততোধিক বিষয়ে "অন্যদের তুলনায় অনেক বেশি" উত্তর দেয়া হয় তাহলে এগিয়ে যান, অন্যথায় বাদ দিয়ে **অংশ জ** তে চলে যান।*

ছ৬	গত ৬ মাস ধরে অধিকাংশ দিনই তুমি কি মাত্রাতিরিক্ত উদ্বিগ্ন ছিলে?	না	হ্যাঁ
		০	১

ছ৭	এই উদ্বেগ নিয়ন্ত্রণ করাটা কি তোমার জন্য কষ্টকর হয়ে দাঁড়ায়?	না	হ্যাঁ
		০	১

*যদি **ছ৬ বা ছ৭** এর উত্তর "হ্যাঁ" হয়, তাহলে **ঠ১** (৩৪পৃষ্ঠা) চেকলিস্টের " অনির্দিষ্ট উদ্বেগাধিক্য" ঘরে টিক চিহ্ন দিন ও এগিয়ে যান। অন্যথায় বাদ দিয়ে **অংশ জ** তে চলে যান।*

ছ৮ *যদি নিচের প্রশ্নগুলোর কোনো একটি উত্তর "হ্যাঁ" হয়, জিজ্ঞাসা করুন "গত ৬ মাসের অধিকাংশ দিনের জন্য তা কি সত্য?" এবং উত্তর দ্বিতীয় কলামে লিখুন।*

	সাধারণভাবে			*৬ মাসের অধিকাংশ দিন*	
	না	হ্যাঁ		না	হ্যাঁ
১) উদ্বেগের কারণে তুমি কি অস্থির, উৎকণ্ঠিত, টানটান অবস্থায় থাকতে বা সহজ হতে পারতে না?	০	১	→	০	১
২) উদ্বেগের কারণে তোমার অবসন্নতা বা সহজেই হাঁপিয়ে ওঠার অবস্থা হতো কি?	০	১	→	০	১
৩) উদ্বেগের কারণে তোমার কি কোনো কিছুতে মনোযোগ দেয়াতে বিঘ্ন ঘটতো অথবা মাথা ফাঁকা হয়ে যাচ্ছে এমন মনে হতো?	০	১	→	০	১
৪) উদ্বেগের কারণে তুমি কি খিটখিটে হয়ে যেতে?	০	১	→	০	১
৫) উদ্বেগের কারণে তোমার মাংসপেশীতে কি ব্যথা হতো?	০	১	→	০	১
৬) উদ্বেগের কারণে তোমার ঘুমের সমস্যা, যেমন - ঘুম আসতে বা ঘুমিয়ে থাকতে অসুবিধে হতো বা অস্থির বা অতৃপ্তির ঘুম হতো?	০	১	→	০	১

ছ৯ সামগ্রিকভাবে তোমার নানান উদ্বেগের কারণে তুমি কতোটা এলোমেলো হয়ে পড়ো বা কষ্ট পাও?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

ছ১০ এসব উদ্বেগ কি ব্যঘাত ঘটিয়েছে .....

	মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
১) পরিবারের অন্যান্যদের সাথে তোমার স্বাচ্ছন্দ্যে?	০	১	২	৩
২) বন্ধু তৈরি করা ও ধরে রাখতে পারায়?	০	১	২	৩
৩) লেখাপড়া বা শ্রেণীর কাজে?	০	১	২	৩
৪) খেলাধুলা, শখ বা অন্যান্য অবসর বিনোদনমূলক কাজে?	০	১	২	৩

ছ১১ এসব উদ্বেগ কি তোমার চারপাশের সবার (পরিবারের লোকজন, বন্ধুবান্ধব, শিক্ষকদের বা আর কারোর) কষ্টের বা বিরক্তির কারণ হয়ে দাঁড়িয়েছে?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

অংশ জ বিষণ্নতা (Depression)

সাক্ষাৎকারের এ অংশটি তোমার মেজাজ সম্পর্কিত।

জ১ **গত ৪ সপ্তাহে** এমন সময় কি গিয়েছে যখন তুমি খুব বেশি মাত্রায় বিষণ্ন, বিমর্ষ, অসুখী বা কাঁদো কাঁদো থাকতে?

না	হ্যাঁ
০	১
↓ জ৭	↓ জ২

জ২ **গত ৪ সপ্তাহে** ধরে এমন সময় কি ছিল যখন তুমি প্রায় প্রতিদিনই সত্যিকারভাবে বিমর্ষ থাকতে?

না	হ্যাঁ
০	১

জ৩ ওই বিমর্ষকালীন সময়ে তুমি কি দিনের বেশিরভাগ সময়েই সত্যিকারভাবে বিমর্ষ থাকতে?
(অর্থাৎ কয়েক ঘন্টার কম নয়)

না	হ্যাঁ
০	১

জ৪ বিমর্ষকালীন সময়ে তুমি কি উৎফুল্ল হয়ে উঠতে পারতে?

সহজেই	কষ্টের সাথে / তাও ক্ষণিকের জন্য	মোটেই না
০	১	২

জ৫ **গত ৪ সপ্তাহ** ধরে সত্যিকার বিমর্ষ থাকার সময়কাল ছিলঃ

২ সপ্তাহের কম	২ সপ্তাহ বা তারও বেশি
০	১

যদি জ১ এবং জ২ এবং জ৩ এর উত্তর "হ্যাঁ" হয়, তাহলে ঠ১ (৩১ পৃষ্ঠা) চেকলিস্টের "বিষণ্নতা" ঘরে টিক চিহ্ন দিন।

জ৭ **গত ৪ সপ্তাহে** তোমাকে বদমেজাজী বা খিটখিটে মেজাজের হতে দেখা গেছে কি যা তোমার সহজাত আচরণ নয়?

না	হ্যাঁ
০	১
↓ জ১৩	↓ জ৮

জ৮ **গত ৪ সপ্তাহ** ধরে এমন সময় গেছে কি যখন প্রায় প্রতিদিনই তুমি বদমেজাজী বা খিটখিটে মেজাজের ছিলে?

না	হ্যাঁ
০	১

জ৯ ওই সময়ে তুমি কি দিনের বেশিরভাগ সময়েই বদমেজাজী বা খিটখিটে মেজাজের থাকতে?
(অর্থাৎ কয়েক ঘন্টার কম নয়)

না	হ্যাঁ
০	১

জ১০ বিশেষ কোনো কার্যকলাপে, বন্ধু-বান্ধবদের সাথে দেখা সাক্ষাতে বা অন্য কোনোভাবে কি তোমার খিটখিটে মেজাজ কমতো?

সহজেই	কষ্টের সাথে / তাও ক্ষণিকের জন্য	মোটেই না
০	১	২

জ১১ **গত ৪ সপ্তাহ** ধরে সত্যিকারভাবে খিটখিটে মেজাজ থাকার সময়কাল ছিলঃ

২ সপ্তাহের কম	২ সপ্তাহ বা তারও বেশি
০	১

যদি জ৭ এবং জ৮ এবং জ৯ এর উত্তর "হ্যাঁ" হয়, তাহলে ঠ১ (৩১ পৃষ্ঠা) চেকলিস্টের "বিরক্তিবোধ" ঘরে টিক চিহ্ন দিন।

জ১৩ **গত ৪ সপ্তাহে** এমন সময় গেছে কি যখন তুমি সাধারণভাবে উপভোগ করতে এধরনের সবকিছুতেই বা প্রায় সবকিছুতেই আগ্রহ হারিয়ে ফেলেছিলে?

না	হ্যাঁ
০	১
↓	↓
জ১৮	জ১৪

জ১৪ **গত ৪ সপ্তাহ** ধরে তুমি কি প্রায় প্রতিদিনই আগ্রহ হারিয়ে ফেলতে?

না	হ্যাঁ
০	১

জ১৫ এই দিনগুলিতে তুমি কি প্রতিটি দিনের বেশিরভাগ সময়েই আগ্রহ হারিয়ে ফেলতে?
(অর্থাৎ কয়েক ঘন্টার কম নয়)

না	হ্যাঁ
০	১

জ১৬ **গত ৪ সপ্তাহ** ধরে এই আগ্রহ হারিয়ে ফেলার সময়কাল হতোঃ

২ সপ্তাহের কম	২ সপ্তাহ বা তারও বেশি
০	১

জ১৭ *যদি "বিষণ্নতা অথবা বিরক্তিবোধ" ঘরে টিক চিহ্ন দেয়া হয়ে থাকে, তাহলে জিজ্ঞাসা করুনঃ*

যখন তুমি সত্যিকারভাবে বেশিরভাগ সময় বিমর্ষ বা বিরক্ত থাকতে তখন তোমার সাথে কি অনাগ্রহ বিষয়টিও বেশিরভাগ সময় থাকতো?

না	হ্যাঁ
০	১

*যদি **জ১৩** এবং **জ১৪** এর উত্তর "হ্যাঁ" হয়, তাহলে **ঠ১** (৩১ পৃষ্ঠা) চেকলিস্টের "আগ্রহ হারানো" ঘরে টিক চিহ্ন দিন।*

যদি ঠ১ (৩১ পৃষ্ঠা) চেকলিস্টের "বিষণ্ণতা বা বিরক্তিবোধ বা আগ্রহ হারানো" ঘরে টিক চিহ্ন দেয়া হয়ে থাকে তাহলে এগিয়ে যান। অন্যথায় বাদ দিয়ে সরাসরি জ২২ এ চলে যান।

জ১৮	যে সময়ে তুমি বিমর্ষ, বিরক্ত বা অনাগ্রহী ছিলে,	না	হ্যাঁ
১)	তুমি কি সবসময় শক্তিহীনতা বা ক্লান্তি বোধ করতে?	০	১
২)	তুমি কি স্বাভাবিক অবস্থার তুলনায় অনেক বেশি বা কম পরিমাণ খেতে?	০	১
৩)	তোমার ওজন কি অনেকটা কমতো বা বেড়ে যেতো?	০	১
৪)	ঘুমাতে পারা কি তোমার জন্য কষ্টকর হতো?	০	১
৫)	তুমি কি বেশি পরিমাণে ঘুমিয়ে থাকতে?	০	১
৬)	তুমি কি বেশিরভাগ সময় কষ্টে ছটফট করতে বা অস্থির থাকতে?	০	১
৭)	তুমি কি বেশিরভাগ সময় নিজেকে মূল্যহীন বা অহেতুক অপরাধী ভাবতে?	০	১
৮)	কোনো কিছুতে মনোযোগ দেয়া বা চিন্তা করা তোমার জন্য কি খুব বেশি কঠিন হয়ে দাঁড়াতো?	০	১
৯)	তুমি কি অনেক বেশি মৃত্যু চিন্তা করতে?	০	১
১০)	তুমি কি নিজের ক্ষতি করা বা আত্মহননের কথা বলতে?	০	১
১১)	তুমি কি নিজের ক্ষতি করা বা আত্মহননের চেষ্টা করেছিলে?	০	১

জ১৮(১২)

জীবনে কোনোদিন তুমি কি নিজের ক্ষতি করা বা আত্মহননের চেষ্টা করেছো?

না	হ্যাঁ
০	১

জ১৯ তোমার বিমর্ষতা, বিরক্তিবোধ বা অনাগ্রহ তোমাকে কতোটা এলোমেলো করে ফেলে বা কষ্ট দেয়?

মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
০	১	২	৩

		মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
জ২০	তোমার বিমর্ষতা, বিরক্তিবোধ বা অনাগ্রহ কি ব্যাঘাত ঘটিয়েছে				
১)	পরিবারের অন্যান্যদের সাথে তোমার স্বাচ্ছন্দ্যে?	০	১	২	৩
২)	বন্ধু তৈরি করা ও ধরে রাখতে পারায়?	০	১	২	৩
৩)	লেখাপড়া বা শ্রেণীর কাজে?	০	১	২	৩
৪)	খেলাধুলা, শখ বা অন্যান্য অবসর বিনোদনমূলক কাজে?	০	১	২	৩

		মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
জ২১	তোমার বিমর্ষতা, বিরক্তিবোধ বা অনাগ্রহ কি তোমার চারপাশের সবার (পরিবারের লোকজন, বন্ধুবান্ধব, শিক্ষকদের বা আর কারোর) কষ্টের বা বিরক্তির কারণ হয়ে দাঁড়িয়েছে?	০	১	২	৩

*এবার **অংশ ঝ** তে চলে যান। যদি আপনি ইতিমধ্যেই **জ১৮ (৯ থেকে ১২)** জিজ্ঞাসা করে থাকেন তাহলে **জ২২ থেকে জ২৪ আর জিজ্ঞাসা করার দরকার নেই।***

স্বেচ্ছাপ্রণোদিতভাবে নিজের ক্ষতি করা (Deliberate Self-Harm)

		না	হ্যাঁ
জ২২	গত ৪ **সপ্তাহ** ধরে, তুমি কি স্বেচ্ছাপ্রণোদিতভাবে নিজের ক্ষতি বা আঘাত করার কথা বলেছো?	০	১
জ২৩	গত ৪ **সপ্তাহ** ধরে, তুমি কি স্বেচ্ছাপ্রণোদিতভাবে নিজের ক্ষতি বা আঘাত করার চেষ্টা করেছো?	০	১
জ২৪	তোমার জীবনে তুমি কি স্বেচ্ছাপ্রণোদিতভাবে নিজের ক্ষতি বা আঘাত করার চেষ্টা করেছো?	০	১

*যদি **জ২২** বা **জ২৩** বা **জ২৪** এর উত্তর "হ্যাঁ" হয়, তাহলে **ঠ১** (৩১ পৃষ্ঠা) চেকলিস্টের "স্বেচ্ছাপ্রণোদিতভাবে নিজের ক্ষতি করা" ঘরে টিক চিহ্ন দিন।*

অংশ ঝ মনোযোগ ও কর্মকান্ড (Attention and Activity)

সাক্ষাৎকারের এই অংশটি মনোযোগ ও কর্মকান্ড সংশ্লিষ্ট।

		না	কিছুটা	অনেকটা
ঝ১	তোমার শিক্ষকরা কি অভিযোগ করে থাকে যে, তোমার অতিচঞ্চলতা ও কম মনোযোগের সমস্যা রয়েছে?	০	১	২
ঝ২	তোমার পরিবার কি অভিযোগ করে থাকে যে, তোমার অতিচঞ্চলতা ও কম মনোযোগের সমস্যা রয়েছে?	০	১	২
ঝ৩	তোমার কি ধারণা? তুমি কি মনে করো যে, তোমার অতিচঞ্চলতা ও কম মনোযোগের সমস্যা রয়েছে?	০	১	২

অংশ ঞ এমন আচরণ যা কখনো কখনো লোকজনদের ঝামেলায় ফেলে
(Behaviour that sometimes gets people into trouble)

সাক্ষাৎকারের এই অংশটি কিশোর-কিশোরীদের এমন সব আচরণ সংশ্লিষ্ট যেগুলো পিতামাতা, শিক্ষক বা অন্যান্য বয়স্কদের পীড়া দিয়ে থাকে।

		না	কিছুটা	অনেকটা
ঞ১	তোমার শিক্ষকরা কি তোমার বিব্রতকর বা পীড়াদায়ক আচরণের ব্যাপারে অভিযোগ করে?	০	১	২
ঞ২	তোমার পরিবার কি তোমার বিব্রতকর বা পীড়াদায়ক আচরণের ব্যাপারে অভিযোগ করে?	০	১	২
ঞ৩	তোমার কি ধারণা? তুমি মনে করো তোমার বিব্রতকর বা পীড়াদায়ক আচরণের সমস্যা আছে?	০	১	২

গত ১২ মাসে তুমি করে থাকতে পারো এমন কিছু আচরণ সম্পর্কে এখন জানতে চাই।

ঞ৪ *যদি নিচের প্রশ্নগুলোর কোনো একটিতে "নিশ্চিতভাবে" উত্তর দেয়া হয়ে থাকে তাহলে "এটি কি **গত ৬ মাস** ধরে হচ্ছে?" প্রশ্ন করুন ও উত্তর দ্বিতীয় কলামে রেকর্ড করুন।*

গত ১২ মাস সময়কালে ...	*গত ১২ মাস সময়কালে*				*গত ৬ মাসে*	
	না	হয়তোবা	নিশ্চিতভাবে		না	হ্যাঁ
১) কোন কিছু পাবার জন্য বা অন্যদের কাছ থেকে সুবিধা আদায়ের জন্য, বা তোমার ওপরে অর্পিত কোনো দায়িত্ব থেকে মুক্তি পাওয়ার জন্য তুমি কি প্রায়ই মিথ্যে কথা বলে থাকো?	০	১	২	→	০	১
২) তুমি কি নিজের থেকেই প্রথমে মারামারি শুরু করে থাকো? *(নিজের ভাইবোনদের সাথে মারামারি ছাড়া)*	০	১	২	→	০	১
৩) তুমি কি প্রায়ই গায়ের জোর দেখাও বা অন্যদের ভয়-ভীতি দেখিয়ে থাকো?	০	১	২	→	০	১
৪) সন্ধ্যা হবার পরেও তুমি কি প্রায়ই অনেক সময়কাল ঘরের বাইরে থাকো?	০	১	২	→	০	১
৫) তুমি কি নিজের ঘর, অন্যজনের ঘর, দোকান বা স্কুল থেকে জিনিসপত্র চুরি করে থাকো? *(ভাইয়ের পেন্সিল বা ঘরের খাবার চুরি করার মতো নগণ্য বিষয় এতে অন্তর্ভুক্ত হবে না)*	০	১	২	→	০	১
৬) তুমি কি কাউকে না জানিয়ে একাধিকবার বাড়ি থেকে পালিয়ে গেছো কিংবা আপনার অনুমতি ছাড়াই বাইরে রাত কাটিয়েছো?	০	১	২	→	০	১
৭) তুমি কি প্রাই স্কুল ফাঁকি দাও বা স্কুল থেকে পালাও?	০	১	২	→	০	১

*(যদি সে ১৩ বছর বা তারচেয়ে বেশি বয়সের হয় এবং নিশ্চিতভাবে গত বছরে স্কুল পালিয়ে থাকে, তাহলে নিচের প্রশ্ন জিজ্ঞাসা করুন। অন্যথায় **ঞ১০** এ চলে যান)*

ঞ৫ তুমি কি ১৩ বছর হবার আগে না জানিয়ে স্কুল কামাই করতে বা স্কুল পালাতে শুরু করেছিলে?

না	হ্যাঁ
০	১

যদি এ৪৪ এর যেকোনো একটির উত্তর "নিশ্চিতভাবে" দেয়া হয়ে থাকে, তাহলে ঠ১ (৩১ পৃষ্ঠা) চেকলিস্টের "পীড়াদায়ক আচরণ" ঘরে টিক চিহ্ন দিন।

*যদি ঠ১ (৩১ পৃষ্ঠা) এর চেকলিস্টে বিরক্তকর আচরণ অথবা পীড়াদায়ক আচরণের জন্য টিক চিহ্ন দেয়া হয়ে থাকে তাহলে এগিয়ে যান। অন্যথায় বাদ দিয়ে **অংশ ট** তে চলে যান।*

এ৯৬

এখন তোমাকে এমন কতক প্রসঙ্গ নিয়ে প্রশ্ন করবো যেগুলো সচরাচর কম দেখা যায়, কিন্তু বেশ গুরুতর আচরণ। এ বিষয়ে যতগুলো প্রশ্ন হতে পারে সবকটা করছি, এমন কি প্রযোজ্য না হলেও।

যদি নিচের প্রশ্নগুলোর কোন একটিতে "হ্যাঁ" উত্তর দেয়া হয়ে থাকে তাহলে "গত ৬ মাসে এমন আচরণ ঘটেছে কি" প্রশ্ন করুন এবং উত্তর দ্বিতীয় কলামে রেকর্ড করুন।

গত ১২ মাস সময়কালে নিচের কোনো একটি কি ঘটেছে?	*গত ১২ মাস সময়কালে*			*গত ৬ মাসে*	
	না	হ্যাঁ		না	হ্যাঁ
১) তুমি কি অস্ত্র বা এমন কিছু ব্যবহার করেছো যা কাউকে মারাত্মক ভাবে জখম করতে পারতো? *(যেমন - খেলার ব্যাট, ইঁট, ভাঙা বোতল, ছুরি, বন্দুক ইত্যাদি)*	০	১	→	০	১
২) তুমি কি সত্যিসত্যি কাউকে জখম করেছো বা শারীরিক নির্যাতন চালিয়েছো? *(যেমন - কাউকে বেঁধে ফেলা, কাটাছেঁড়া করা, বা পোড়ানো ইত্যাদি)*	০	১	→	০	১
৩) তুমি কি প্রাণী ও পাখিদের প্রতি ইচ্ছাকৃতভাবে নিষ্ঠুর আচরণ দেখিয়েছো?	০	১	→	০	১
৪) তুমি কি ইচ্ছাকৃতভাবে কোথাও আগুন লাগিয়ে দিয়েছো? *(এর পেছনে অবশ্যই মারাত্মক ক্ষতিসাধনের দুরভিসন্ধি থাকতে হবে। ক্যাম্পফায়ার বা দেশলাইয়ের কাঠি জ্বালানো বা কাগজ পোড়ানোর মত বিষয়ে এই প্রশ্ন নয়)*	০	১	→	০	১
৫) তুমি কি ইচ্ছাকৃতভাবে কারো সম্পত্তি ধ্বংস করেছো? *(আগুন লাগিয়ে দেয়া অথবা হাল্কা মাত্রার কোনো ঘটনা, যেমন - বোনের আঁকা ছবি নষ্ট করে ফেলা ইত্যাদির জন্য এই প্রশ্ন নয়। গাড়ির জানালা চূর্ণবিচূর্ণ করা বা স্কুলে ভাংচুর ইত্যাদি আচরণ এতে গণ্য হবে)*	০	১	→	০	১
৬) তুমি কি রাস্তাঘাটে কারো কাছ থেকে কিছু চুরি করার সাথে জড়িত ছিলে? *(যেমন - হাতব্যাগ ছিনতাই করা বা লুণ্ঠন)*	০	১	→	০	১
৭) তুমি কি কাউকে ইচ্ছার বিরুদ্ধে জোর করে যৌনকর্মে বাধ্য করেছো?	০	১	→	০	১
৮) তুমি কি কারো বাড়িতে, অন্য কোনো ভবনে বা গাড়িতে ভেঙে ঢুকেছো?	০	১	→	০	১

যদি এ৬ এর যেকোনো একটি বিষয়ের উত্তর "হ্যাঁ" হয়, তাহলে ঠ১ (৩১ পৃষ্ঠা) চেকলিস্টের "পীড়াদায়ক আচরণ" ঘরে টিক চিহ্ন দিন।

এ৭ক তোমাকে ঝামেলায় পড়তে হয়েছে এমনসব আচরণ কি **অন্তত ৬ মাস** ধরে আছে?

না	হ্যাঁ
০	১

এ৭ তুমি কি কখনো পুলিশের সাথে ঝামেলায় পড়েছো? *(বর্ণনা করো)*

না	হ্যাঁ
০	১

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যদি এ৭ এর উত্তর "হ্যাঁ" হয়, তাহলে ঠ১ (৩১ পৃষ্ঠা) চেকলিস্টের " পুলিশের সাথে ঝামেলা" ঘরে টিক চিহ্ন দিন।

*যদি ঠ১ (৩১ পৃষ্ঠা) চেকলিস্টে পীড়াদায়ক আচরণ বা পুলিশের সাথে ঝামেলার জন্য টিক চিহ্ন দেয়া হয়ে থাকে তাহলে এগিয়ে যান। অন্যথায় বাদ দিয়ে সরাসরি **অংশ ট** তে চলে যান।*

এ৮ তোমাকে ঝামেলায় ফেলে এমন সব আচরণ কি ব্যঘাত ঘটিয়েছে	মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
১) পরিবারের অন্যান্যদের সাথে তোমার স্বাচ্ছন্দ্যে?	০	১	২	৩
২) বন্ধু তৈরি করা ও ধরে রাখতে পারায়?	০	১	২	৩
৩) লেখাপড়া বা শ্রেণীর কাজে?	০	১	২	৩
৪) খেলাধুলা, শখ বা অন্যান্য অবসর বিনোদনমূলক কাজে?	০	১	২	৩

এ৯ তোমাকে ঝামেলায় ফেলে এমনসব আচরণ কি তোমার চারপাশের সবার (পরিবারের লোকজন, বন্ধুবান্ধব, শিক্ষকদের বা আর কারোর) কষ্টের বা বিরক্তির কারণ হয়ে দাঁড়িয়েছে?	মোটেও নয়	খুব সামান্য	বেশ অনেকটা	বড় রকমের
	০	১	২	৩

অংশ ট কম দেখা যায় এমন সমস্যা (Less common problems)

ট১	তোমার এমন কোনো মাংসপেশীর অস্বাভাবিক সঞ্চালন বা কম্পন সমস্যা আছে কি যা তুমি নিয়ন্ত্রণ করতে পারো না?	না	হ্যাঁ
		০	১
ট২	তুমি অতিরিক্ত কম খাবার অভ্যাস করছো বলে কি অন্যরা উদ্বিগ্ন?	না	হ্যাঁ
		০	১
ট৩	স্বাভাবিকতার অতীত এমন কোনো অভিজ্ঞতা তোমার হয়েছে কি, যেমন - কোনোকিছু দেখা বা শোনা, কিংবা অদ্ভুত ধারণা থাকা - যা তোমাকে উদ্বিগ্ন করে?	না	হ্যাঁ
		০	১
ট৪	তুমি ইতিমধ্যেই যেসব বিষয়ে বলেছো সেগুলো ছাড়া তোমার অনুভূতি বা আচরণের এমন কোনোকিছু আছে কি যা তোমাকে বা আর কাউকে সত্যিকারভাবে উদ্বিগ্ন করে?	না	হ্যাঁ
		০	১

যদি ট১ বা ট২ বা ট৩ এর উত্তর "হ্যাঁ" হয়, তাহলে ঠ১ (৩১ পৃষ্ঠা) চেকলিস্টের "কম দেখা যায় এমন সমস্যা" ঘরে টিক চিহ্ন দিন।

অংশ ঠ অসুবিধের ক্ষেত্রগুলো (Areas of Difficulty)

ঠ১ বিভিন্ন অসুবিধের তালিকা (Check list of difficulties)

ক ❑ বিচ্ছিন্নতা সংশ্লিষ্ট উদ্বেগাধিক্য (Separation anxiety) = আসক্তজন হতে আলাদা হবার ভয় *(ক১ হতে তার আসক্তজনদের তালিকা দিন)* .....

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খ ❑ বিশেষ অহেতুক ভীতি (Specific phobia) = সে ভয় পায় এমনসব মুখ্য বিষয় *(খ১ হতে উল্লেখ করুন)* .....

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গ ❑ সামাজিক অহেতুক ভীতি (Social phobia) = সে ভয় পায় এমনসব মুখ্য বিষয় *(গ১ হতে উল্লেখ করুন)* .....

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ঘ ❑ আতঙ্কগ্রস্ততা/বহির্গমনের অহেতুক ভীতি (Panic/agoraphobia) = আতঙ্কগ্রস্ত হওয়া এবং জনসমাগমের ভিড়, কোথাও একা যাওয়া ইত্যাদি পরিহার করা *(অপ্রয়োজনীয় অংশটুকু কেটে দিন)*

ঙ ❑ মানসিক আঘাতোত্তর মানসিক চাপ (Post traumatic stress) = মানসিক আঘাত পেয়েছে এমন ঘটনা*(ঙ১ হতে উল্লেখ করুন)*

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চ ❑ চিন্তাবাতিক ও বাধ্যতাধর্মী আচরণ (Obsessions and compulsions) = বাধ্যতাধর্মী আচরণ বা চিন্তাগুলোর বিষয়বস্তু ..... *(চ২, চ৩ ও চ৪ হতে উল্লেখ করুন)* .....

.....

ছ ❑ অনির্দিষ্ট উদ্বেগাধিক্য (Generalized anxiety) = অতিরিক্তমাত্রায় উদ্বেগ দেখিয়ে থাকে এমনসব বিষয় *(ছ১ হতে উল্লেখ করুন)*

.....

জ ❑ বিষণ্ণতা (Depression)
❑ বিরক্তিবোধ (Irritability)
❑ আগ্রহ হারানো (Loss of interest)
❑ স্বেচ্ছাপ্রণোদিতভাবে নিজের ক্ষতি করা (Deliberate self-harm)

ঝ ❑ অতি চঞ্চলতা (Hyperactivity)

ঞ ❑ পীড়াদায়ক আচরণ (Troublesome behaviour) = নানান পীড়াদায়ক আচরণ, যেমন *(ঞ১ ও ঞ৬ হতে উল্লেখ করুন)*

.....

❑ পুলিশের সাথে ঝামেলা (Trouble with the Police)

ট ❑ কম দেখা যায় এমন সমস্যা (Less common difficulties) = সমস্যাগুলো *(ট১, ট২ ও ট৩ হতে উল্লেখ করুন)*

.....

ঠ২ কিশোর-কিশোরীর অসুবিধে সম্পর্কে তাদের নিজেদের ভাষায় দেয়া বক্তব্য
(Getting a description of the young people's difficulties in their own words)

*যদি ঠ১ তালিকায় বর্ণিত কোনো ঘরে টিক চিহ্ন দেয়া না হয়, বাদ দিয়ে সরাসরি **অংশ ঙ** তে চলে যান।*

যখনই আপনি ঠ১ এর অংশগুলোর কোনো একটি ঘর যাচাই করবেন, নিশ্চিত হোন যে আপনি ঐ অংশের জন্য সংশ্লিষ্ট খোলামেলা প্রশ্নগুলোর উত্তর পেয়েছেন। এসব খোলামেলা প্রশ্নের একটা তালিকা সুবিধের জন্য নিচে দেয়া হলো, তবে আপনি নিজ উদ্যোগে অতিরিক্ত প্রশ্ন যোগ করতে বা প্রদত্ত প্রশ্নগুলোকে আরো পরিষ্কারভাবে ব্যাখ্যা করতে পারেন।

*আপনার পছন্দমত আপনি খোলামেলা প্রশ্নগুলো সংশ্লিষ্ট অংশের সাক্ষাৎকারের সাথে করতে পারেন, অথবা **ক** থেকে **ট** পর্যন্ত অংশগুলো শেষ করার পর করতে পারেন। উদাহরণ স্বরূপ, যদি **অংশ ক** এর জন্য নির্দেশিত ঘরে টিক চিহ্ন দিয়ে থাকেন তাহলে **অংশ খ** তে যাবার আগেই অতিরিক্ত প্রশ্নগুলো করতে পারেন, অথবা **ক** থেকে **ট** পর্যন্ত অংশগুলো শেষ না হওয়া পর্যন্ত অপেক্ষা করতে পারেন। যদি আপনি ঠিক করেন যে, সবশেষেই খোলামেলা প্রশ্নগুলো করবেন তাহলে কোন্ বিষয়ে প্রশ্ন করা হবে তা কিশোর/কিশোরীকে বাছাই করতে বললে ভাল হয়। এরূপ বাছাই কিশোর/কিশোরীর যে দিকটি তাকে সবচেয়ে বেশি চিন্তিত করে তা দিয়ে শুরু করে ক্রমানুসারে বিভিন্ন বিষয়ে হবে।*

যেভাবেই প্রশ্নগুলো করুন না কেন কিশোর/কিশোরীর স্বতঃস্ফূর্ত মন্তব্যগুলো করার সাথে সাথে নোট করে রাখা ভালো। এতে করে এই অংশে তাকে পুনরায় অনেক কিছু জিজ্ঞাসা করার প্রয়োজন কমে যাবে। তবে সাক্ষাৎকার শেষ হবার আগে অসুবিধের প্রতিটি ক্ষেত্রের জন্য সকল প্রশ্নের জবাব দেয়া হয়েছে কিনা তা নিশ্চিত হবার জন্য যাচাই করে নিন।

যখন কিশোর/কিশোরী অস্পষ্ট বা অনির্দিষ্ট উত্তর দেয়, তখন সুনির্দিষ্ট উদাহরণ জানতে চান, যেমন - যদি সে বলে, "আমি সবকিছুতেই উদ্বিগ্ন হই," তাহলে "উদ্বেগগুলো কি ধরণের?" জিজ্ঞাসা করুন কিংবা যদি সে বলে, "আমি সবসময় ঝামেলায় জড়িয়ে পড়ি," তাহলে জিজ্ঞাসা করুন, "তুমি কি সাম্প্রতিক একটা ঘটনার কথা বলতে পারো যাতে তুমি ঝামেলায় জড়িয়ে পড়েছিলে?"

এই ফরমে অল্প জায়গা আছে বলে আপনাকে যে উত্তর ছোট করে লিখতে হবে এমন ভাববেন না। ছোট অক্ষরে লিখুন এবং প্রয়োজনে অতিরিক্ত কাগজ ব্যবহার করুন।

খোলামেলা প্রশ্নগুলো শুরু করার জন্যঃ

তুমি ইতিমধ্যেই তোমার সমস্যাগুলো বলেছো। এসব বিষয়ে তোমার নিজের ভাষায় আরো কিছুটা জানতে চাই।

ঠ২কঃ বিচ্ছিন্নতা সংশ্লিষ্ট উদ্বেগাধিক্য (Separation anxiety)

যদি বিচ্ছিন্নতা সংশ্লিষ্ট উদ্বেগাধিক্য এর জন্য ঠ১ক তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

ঠ২ক১) আসক্তজন হতে আলাদা হবার বিষয়ে তোমার বর্তমান উদ্বেগগুলো বর্ণনা করো। কিভাবে এসব উদ্বেগ প্রকাশিত হয়?

ঠ২ক২) এসব উদ্বেগ কতোবার সমস্যা সৃষ্টি করে?

ঠ২ক৩) সবচেয়ে খারাপ অবস্থায় উদ্বেগগুলো কতোটা প্রকট?

ঠ২ক৪) কতোদিন ধরে তোমার বিচ্ছিন্নতা সংশ্লিষ্ট উদ্বেগ আছে?

ঠ২ক৫) এসব উদ্বেগ কি তোমার জীবনযাত্রার মান ব্যাহত করছে? যদি করে, কিভাবে?

ঠ২ক৬) উদ্বেগগুলো কি জন্য হয় বলে তুমি মনে করো?

ঠ২ক৭) এসব উদ্বেগ দূর করার জন্য তুমি কি কিছু করেছো? যদি করে থাকো, তোমার পক্ষে সম্ভব এমন কি চেষ্টা করেছো বিবরণ দাও, এবং এসব কি তোমার অবস্থার কোনো পরিবর্তন করতে পেরেছে?

ঠ২খঃ বিশেষ অহেতুক ভীতি (Specific phobia)

যদি বিশেষ অহেতুক ভীতি এর জন্য ঠ১খ তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

ঠ২খ১) তোমার এমন কোনো ভয়ের বিবরণ দাও যা সত্যিকার বিড়ম্বনার, যা তোমাকে দারুণভাবে এলোমেলো করে, বা যেসব জিনিষ তুমি করতে চাও তা করা থেকে তোমাকে বিরত করে।

ঠ২খ২) তোমার এসব ভয় কতোবার তোমাকে পীড়া দেয় বা এলোমেলো করে ফেলে?

ঠ২খ৩) সবচেয়ে খারাপ অবস্থায় ভয়গুলো কতোটা প্রকট?

ঠ২খ৪) এসব ভয় কি তোমার জীবনযাত্রার মান ব্যাহত করছে? যদি করে, কিভাবে?

ঠ২খ৫) এসব ভয় দূর করার জন্য তুমি কি কিছু করেছো? যদি করে থাকো, তোমার পক্ষে সম্ভব এমন কি চেষ্টা করেছো বিবরণ দাও, এবং এসব কি তোমার অবস্থার কোনো পরিবর্তন করতে পেরেছে?

ঠ২গঃ সামাজিক অহেতুক ভীতি (Social phobia)

যদি সামাজিক অহেতুক ভীতি এর জন্য ঠ১গ তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

ঠ২গ১) তোমার কোনো সামাজিক অহেতুক ভীতির বিবরণ দাও যা সত্যিকার বিড়ম্বনায়, যা তোমাকে দারুণভাবে এলোমেলো করে, বা যেসব জিনিষ তুমি করতে চাও তা করা থেকে তোমাকে বিরত করে।

ঠ২গ২) তোমার এসব সামাজিক ভীতি কতোবার তোমাকে বিপর্যস্ত বা এলোমেলো করে ফেলে?

ঠ২গ৩) সবচেয়ে খারাপ অবস্থায় এসব সামাজিক ভীতি কতোটা প্রকট?

ঠ২গ৪) এসব সামাজিক ভীতি কি তোমার জীবনযাত্রার মান ব্যাহত করছে? যদি করে, কিভাবে?

ঠ২গ৫) এসব সামাজিক ভীতি দূর করার জন্য তুমি কি কিছু করেছো? যদি করে থাকো, তোমার পক্ষে সম্ভব এমন কি চেষ্টা করেছো বিবরণ দাও, এবং এসব কি তোমার অবস্থার কোনো পরিবর্তন করতে পেরেছে?

ঠ২ঘঃ আতঙ্কগ্রস্ততা/বহির্গমনের অহেতুক ভীতি (Panic/agoraphobia)

যদি আতঙ্কগ্রস্ততা/বহির্গমনের অহেতুক ভীতি এর জন্য ঠ১ঘ তে টিক চিহ্ন দেয়া হয়, নিচের ক'য়েকটি বা সবগুলো প্রশ্ন জিজ্ঞাসা করুন (কিশোর/কিশোরীর আতঙ্কগ্রস্ততা/বহির্গমনের অহেতুক ভীতি, অথবা দু'টোই থাকলে সেভাবে প্রশ্ন করুন)

ঠ২ঘ১) এসব আতঙ্কগ্রস্ততা কিরকম তা যতদূর সম্ভব সবিস্তারে বর্ণনা করো।

ঠ২ঘ২) কতোবার এসব আতঙ্কগ্রস্ততা হয়?

ঠ২ঘ৩) কখন এসব আতঙ্কগ্রস্ততা শুরু হয়েছিল?

ঠ২ঘ৪) মানুষের ভিড়, জনসাধারণের জন্য বিভিন্ন স্থান, একা ভ্রমন বা বাড়ির অনেক দূরে যাওয়া ইত্যাদি বিষয়ে তোমার ভয় বা এড়িয়ে চলার বিবরণ দাও।

ঠ২৮৫) কতোবার এই ভয় বা এড়িয়ে চলার ঘটনা ঘটে?

ঠ২৮৬) কখন এই ভয় বা এড়িয়ে চলার ঘটনা শুরু হয়েছিল?

ঠ২৮৭) আতঙ্কগ্রস্ততা বা নির্দিষ্ট পরিস্থিতিসমূহ এড়িয়ে চলার ঘটনা কি তোমার জীবনযাত্রার মান ব্যাহত করছে? যদি করে, কিভাবে?

ঠ২৮৮) এসব আতঙ্কগ্রস্ততা বা নির্দিষ্ট পরিস্থিতিসমূহ এড়িয়ে চলার ঘটনা দূর করার জন্য তুমি কি কিছু করেছো? যদি করে থাকো, তোমার পক্ষে সম্ভব এমন কি চেষ্টা করেছো বিবরণ দাও, এবং এসব কি তোমার অবস্থার কোনো পরিবর্তন করতে পেরেছে?

ঠ২৮৯: মানসিক আঘাতোত্তর মানসিক চাপ (Post traumatic stress)

যদি মানসিক আঘাতোত্তর মানসিক চাপ এর জন্য ঠ১৩ তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

ঠ২৯১) চরম মানসিক আঘাতোত্তর মানসিক চাপের ঘটনাটি কি ছিল? তোমার জন্য পীড়াদায়ক হতে পারে জেনেও এবিষয়ে প্রশ্ন করার জন্য দুঃখিত। তোমার বর্তমান উপসর্গগুলো অর্থবহ করার জন্য যথেষ্ট বিবরণ দিলেই চলবে।

ঠ২৯২) প্রচন্ড মানসিক চাপের কারণে তোমার এখনও যেসব উপসর্গ হয় তা বর্ণনা করো।

ঠ২৯৩) এসব উপসর্গ তোমাকে কতোবার বিপর্যস্ত বা এলোমেলো করে ফেলে?

ঠ২৮৪) সবচেয়ে খারাপ অবস্থায় উপসর্গগুলো কতোটা প্রকট?

ঠ২৮৫) উপসর্গগুলো কি তোমার জীবনযাত্রার মান ব্যাহত করছে? যদি করে, কিভাবে?

ঠ২৮৬) এসব উপসর্গ দূর করার জন্য তুমি কি কিছু করেছো? যদি করে থাকো, তোমার পক্ষে সম্ভব এমন কি চেষ্টা করেছো বিবরণ দাও, এবং এসব কি তোমার অবস্থার কোনো পরিবর্তন করতে পেরেছে?

ঠ২৮ঃ চিন্তাবাতিক ও বাধ্যতাধর্মী আচরণ (Obsessions and compulsions)

যদি চিন্তাবাতিক ও বাধ্যতাধর্মী আচরণ এর জন্য এর জন্য ঠ১৮ তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

ঠ২৮১) তোমার সব ধরণের বাধ্যতাধর্মী আচরণ ও চিন্তাবাতিকের বিবরণ দাও।

ঠ২৮২) এসব বাধ্যতাধর্মী আচরণ ও চিন্তাবাতিক তোমাকে কতোবার বিপর্যস্ত বা এলোমেলো করে ফেলে?

ঠ২৮৩) সবচেয়ে খারাপ অবস্থায় এসব বাধ্যতাধর্মী আচরণ ও চিন্তাবাতিক কতোটা প্রকট?

ঠ২৮৪) কতোদিন ধরে এসব বর্তমান?

ঠ২৮৫) এগুলো কি তোমার জীবনযাত্রার মান ব্যাহত করছে? যদি করে, কিভাবে?

ঠ২৮৬) এসব বাধ্যতাধর্মী আচরণ ও চিন্তাবাতিক দূর করার জন্য তুমি কি কিছু করেছো? যদি করে থাকো, তোমার পক্ষে সম্ভব এমন কি চেষ্টা করেছো বিবরণ দাও, এবং এসব কি তার অবস্থার কোনো পরিবর্তন করতে পেরেছে?

ঠ২ছঃ অনির্দিষ্ট উদ্বেগাধিক্য (Generalized anxietv)

যদি অনির্দিষ্ট উদ্বেগাধিক্য এর জন্য এর জন্য ঠ১হ তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

ঠ২ছ১) কি কি বিষয়ে তুমি উদ্বিগ্ন হও বর্ণনা করো।

ঠ২ছ২) এসব উদ্বেগ কতোবার সমস্যা সৃষ্টি করে?

ঠ২ছ৩) সবচেয়ে খারাপ অবস্থায় উদ্বেগগুলো কতোটা প্রকট?

ঠ২ছ৪) কতোদিন ধরে তুমি বিভিন্ন বিষয়ে বেশ উদ্বিগ্ন?

ঠ২ছ৫) উদ্বেগগুলো কি তোমার জীবনযাত্রার মান ব্যাহত করছে? যদি করে, কিভাবে?

ঠ২ছ৬) এসব উদ্বেগ দূর করার জন্য তুমি কি কিছু করেছো? যদি করে থাকো, তোমার পক্ষে সম্ভব এমন কি চেষ্টা করেছো বিবরণ দাও, এবং এসব কি তোমার অবস্থার কোনো পরিবর্তন করতে পেরেছে?

ঠ২জঃ বিষণ্নতা (Depression)

যদি বিষণ্নতা, বিরক্তিবোধ বা আগ্রহ হারানো এর জন্য ঠ১জ তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

ঠ২জ১) তোমার মেজাজের (বিষণ্নতা, বিরক্তিবোধ) এবং বিভিন্ন বিষয়ে তোমার আগ্রহের পরিমাণ বর্ণনা করো।

ঠ২জ২) তোমার মেজাজ ও আগ্রহের পরিমান পরিবর্তনের সাথে আর কি পরিবর্তন হয়ে থাকে? প্রাসঙ্গিক হলে - তোমার বলশক্তি, খিদে, ঘুম, নিজের প্রতি আস্থা, নিজেকে অপরাধী ভাবা, ভবিষ্যৎ সম্পর্কে আশাহীনতা, মৃত্যুচিন্তা, নিজের ক্ষতি করা ইত্যাদি সম্পর্কে বলো।

ঠ২জ৩) গত ৪ সপ্তাহ ধরে, কতোটা সময়কাল তুমি এরকম আছো?

ঠ২জ৪) গত ৪ সপ্তাহ ধরে, সবচেয়ে খারাপ অবস্থায় এসব সমস্যা কতোটা প্রকট?

ঠ২জ৫) কখন এই বিষণ্ণতা, বিরক্তিবোধ বা আগ্রহ হারানোর ঘটনা শুরু হয়েছিল?

ঠ২জ৬) তুমি কি মনে করো কোনোকিছুতে এই সমস্যা কমে যেতো?

ঠ২জ৭) আগেও কি তোমার এরকম সমস্যা হয়েছিল? যদি হয়ে থাকে, বর্ণনা করো।

ঠ২জ৮) "বিষণ্ণতার" পরিবর্তে অস্বাভাবিক "উৎফুল্ল" হবার ঘটনা কি অতীতে তোমার কখনো হয়েছিল? যদি হয়ে থাকে, বর্ণনা করো।

ঠ২জ৯) তোমার মেজাজ বা আগ্রহ হারানো কি তোমার জীবনযাত্রার মান ব্যাহত করছে? যদি করে, কিভাবে?

ঠ২জ১০) তোমার মেজাজ বা আগ্রহ হারানো দূর করার জন্য তুমি কি কিছু করেছো? যদি করে থাকো, তোমার পক্ষের সম্ভব এমন কি চেষ্টা করেছো বিবরণ দাও, এবং এসব কি তোমার অবস্থার কোনো পরিবর্তন করতে পেরেছে?

ঠ২জ২: স্বেচ্ছাপ্রণোদিতভাবে নিজের ক্ষতি করা (Deliberate self-harm)

যদি স্বেচ্ছাপ্রণোদিতভাবে নিজের ক্ষতি করা এর জন্য এর জন্য ঠ১জ তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

ঠ২জ১১) তোমার স্বেচ্ছাপ্রণোদিতভাবে নিজের ক্ষতি বা আঘাত করা, কিংবা কখনো এরূপ করার কথা বলা সম্পর্কে আরো কিছু জানালে ভালো হয়।

ঠ২ঝঃ অতিচঞ্চলতা (Hyperactivity)

যদি অতিচঞ্চলতা এর জন্য ঠ১ঝ তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

ঠ২ঝ১) তোমার অতিরিক্ত চঞ্চলতা বা মনোযোগের অভাবের কারণে তোমার উদ্বেগ সম্পর্কে আরো কিছু বললে ভালো হয়।

ঠ২ঞঃ বিব্রতকর ও পীড়াদায়ক আচরণ (Awkward and troublesome behaviour)

যদি বিব্রতকর বা পীড়াদায়ক আচরণ এর জন্য ঠ১ঞ তে টিক চিহ্ন দেয়া হয়, জিজ্ঞাসা করুন

ঠ২ঞ১) তোমার বিব্রতকর ও পীড়াদায়ক আচরণ বর্ণনা করো।

ঠ২ঞ২) এই আচরণ কতোবার সমস্যা সৃষ্টি করে?

ঠ২ঞ৩) সবচেয়ে খারাপ অবস্থায় এই সমস্যা কতোটা প্রকট?

ঠ২ঞ৪) কতোদিন ধরে তুমি এরকম আচরণ করছো?

ঠ২ঞ৫) তোমার বিব্রতকর ও পীড়াদায়ক আচরণ কি তোমার জীবনযাত্রার মান ব্যাহত করছে? যদি করে, কিভাবে?

ঠ২ঞ৬) তোমার এই আচরণ দূর করার জন্য তুমি কি কিছু করেছো? যদি করে থাকো, তোমার পক্ষে সম্ভব এমন কি চেষ্টা করেছো বিবরণ দাও, এবং এসব কি তোমার অবস্থার কোনো পরিবর্তন করতে পেরেছে?

ঠ২টঃ কম দেখা যায় এমন সমস্যা (Less common difficulties)

যদি কম দেখা যায় এমন সমস্যা এর জন্য ঠ১টঁ তে টিক চিহ্ন দেয়া হয়, তাহলে নিচের প্রশ্নগুলোর যেটি খাটে জিজ্ঞাসা করুন

ঠ২ট১) তোমার মাংসপেশীর অস্বাভাবিক সঞ্চালন বা কম্পন সমস্যা সম্পর্কে আরো কিছু বলো।

ঠ২ট২) তোমার অতিরিক্ত কম খাবার প্রবণতার কারণে কারা উদ্বিগ্ন থাকে? কেন তারা উদ্বিগ্ন থাকে? তুমি কি তাদের উদ্বেগের সাথে একমত?

ঠ২ট৩) স্বাভাবিকতার অতীত তোমার এমন কোনো অভিজ্ঞতা সম্পর্কে আরো কিছু জানতে চাই।

ঠ২ট৪) আর কোনো বিষয়ে তোমার উদ্বেগ সম্পর্কে আরো কিছু জানতে চাই।

ঠ২অঃ) সার্বিকভাবে সাক্ষাৎকার সম্পর্কে (The interview in general):

ঠ২অ১) সবশেষে, একজন সাক্ষাৎকার গ্রহণকারী হিসেবে এখানে আপনার সার্বিক মন্তব্য লেখার সুযোগ রয়েছে, যেমন - সাক্ষাৎকার প্রদানকারী কিশোর/কিশোরীর উৎসাহ বা বোধগম্যতার বর্ণনা, কিংবা সাক্ষাৎকার নেয়ার সময় তার কর্মকান্ডের মাত্রা সম্পর্কে আপনার পর্যবেক্ষণ রেকর্ড করা ইত্যাদি।

অংশ ড সবলতা (Strengths)

এতক্ষণ সম্ভব্য বিভিন্ন অসুবিধে ও সমস্যা সম্পর্কে আমি তোমাকে অনেক প্রশ্ন জিজ্ঞাসা করেছি। এবার তোমার কিছু ভালো বা সবল দিক সম্পর্কে জানতে চাই।

ড১

তোমার সম্পর্কে সবচেয়ে ভালো মন্তব্য করতে বলা হলে তুমি কি বলবে?

যদি স্বতঃস্ফূর্তভাবে "কিছুই না" বলে ☐

১)

২)

৩)

৪)

৫)

ড২

তুমি করেছো এমনসব বিষয় সম্পর্কে কিছু বলবে কি যা সত্যিকারভাবে তোমাকে গর্বিত করে? এসব বিষয় স্কুল, খেলাধুলা, গানবাজনা, বন্ধুবান্ধব, জনসেবা বা যেকোনো কিছু সম্পর্কে হতে পারে।

যদি স্বতঃস্ফূর্তভাবে "কিছুই না" বলে ☐

১)

২)

৩)

৪)

৫)

ANNEXURE 8

Bangla version of the Household Questionnaire (HHQ)

পরিবার সংক্রান্ত প্রশ্নমালা

শিশুর পরিচিতি নম্বর ঃ _____

১ জনসামাজিক তথ্যসমূহ

১.১ *ব্যক্তিগত তথ্যাদি ঃ*

শিশুর নাম ঃ _____ লিঙ্গঃ ছেলে=১ মেয়ে=২

জন্ম তারিখ ঃ _____ বয়সঃ _____

জন্মস্থান ঃ _____

পিতার নাম ঃ _____

মাতার নাম ঃ _____

ঠিকানা ঃ _____

স্থায়ী বাস করে এমন কোনো আত্মীয়ের ঠিকানা ঃ _____

_____

১.২ *পারিবারিক তথ্য (পরিবার সংক্রান্ত তথ্য) ঃ*

পরিবারের ধরণ ঃ _____ একক = ১ যৌথ = ২

বাড়িতে কে কে আছে?

মা	না = ০	হ্যাঁ = ১	দাদা-দাদী, নানা-নানী	না = ০	হ্যাঁ =	(প্রকৃত সংখ্যা)
বাবা	না = ০	হ্যাঁ = ১	অন্যান্য আত্মীয়	না = ০	হ্যাঁ =	(প্রকৃত সংখ্যা)
ভাই	না = ০	হ্যাঁ = (প্রকৃত সংখ্যা)	অনাত্মীয় সদস্য	না = ০	হ্যাঁ =	(প্রকৃত সংখ্যা)
বোন	না = ০	হ্যাঁ = (প্রকৃত সংখ্যা)				

পরিবারের শিশুর সংখ্যা*(যারা বাড়িতে থাকেনা বা বাস করেনা তাদেরও অন্তর্ভুক্ত করুন কোনো আত্মীয় শিশু পরিবারের সদস্য হলে তার নামও যোগ করুন)*ঃ _____

ভাইবোনের মধ্যে শিশুর অবস্থানঃ _____

ধর্ম _____ ইসলাম = ১ হিন্দু = ২ বৌদ্ধ = ৩ খ্রীষ্টান = ৪ অন্যান্য = ৫

শিশুর ধর্মীয় অভ্যাস ঃ _____ সপ্তাহে একবারের বেশি = ১ সপ্তাহে একবার = ২ সপ্তাহে একবারের কম = ৩

কেবলমাত্র ধর্মীয় উৎসবগুলোতে = ৪ অভ্যাস নেই = ৫

১.৩ স্কুল বিষয়ক প্রশ্নঃ

স্কুলের নামঃ _____

শ্রেণী ঃ _____

শ্রেণী শিক্ষকের নাম ঃ _____

স্কুলে হাজিরার প্রকৃতিঃ _____ নিয়মিত = ১ অনিয়মিত = ২ মাঝেমধ্যে = ৩ স্কুলে যায়না = ৪

শিশুকে কি কখনো একই শ্রেণীতে দুইবার বা তার বেশি থাকতে হয়েছে ? না = ১ হ্যাঁ = ২

শিশুকে কখনো কি বিশেষ শিক্ষা নিতে হয়েছে? _____ না = ১ হ্যাঁ = ২

যদি স্কুলে না যায় তবে তার কারণঃ কাজ = ১ স্কুল পালানো = ২ আর্থিক অনগ্রতি = ৩ অসুস্থতা = ৪ বহিষ্কৃত = ৫ অন্যান্য = ৬

যদি শিশু কাজে নিয়োজিত থাকে তবে কাজের প্রকৃতিঃ _____ কৃষি = ১ শিল্প-কারখানা = ২ ঘরের কাজের ছেলে/মেয়ে = ৩ আত্ম-কর্মসংস্থান = ৪ অন্যান্য = ৫

কাজের মাধ্যমে উপার্জনঃ _____ বেতন পায় = ১ বেতন পায়না = ২

১.৪ শিশুর মুখ্য লালনকারীর বিষয়ে তথ্য (সচরাচর মা)ঃ

মুখ্য লালনকারী কেঃ মা = ১ খালা/ফুপু/চাচী = ২ নানী/দাদী = ৩ অন্য আত্মীয় = ৪ কোনো অনাত্মীয় = ৫

নাম ঃ _____

শিক্ষার পর্যায় ঃ _____ অশিক্ষিত =১ শিক্ষিত কিন্তু প্রাথমিক পর্যায় শেষ করেননি =২ প্রাথমিক পর্যায় শেষ করেছেন কিন্তু মাধ্যমিক পর্যায় শেষ করেননি = ৩ মাধ্যমিক পর্যায় শেষ করেছেন কিন্তু উচ্চ মাধ্যমিক পর্যায় শেষ করেননি = ৪ উচ্চ মাধ্যমিক পর্যায় শেষ করেছেন কিন্তু পরবর্তী পর্যায়ের শিক্ষা শেষ করেননি = ৫ পরবর্তী পর্যায়ের শিক্ষা শেষ করেছেন = ৬

মানসিক স্বাস্থ্যের অবস্থা (এসআরকিউ এর স্কোর) _____

১.৫ বাবার বিষয়ে আরো তথ্য ঃ

জীবিত = ১ মৃত = ২ বয়সঃ _____

শিক্ষার পর্যায়ঃ অশিক্ষিত=১ শিক্ষিত কিন্তু প্রাথমিক পর্যায় শেষ করেননি=২ প্রাথমিক পর্যায় শেষ করেছেন কিন্তু মাধ্যমিক পর্যায় শেষ করেননি=৩ মাধ্যমিক পর্যায় শেষ করেছেন কিন্তু উচ্চ মাধ্যমিক পর্যায় শেষ করেননি = ৪ উচ্চ মাধ্যমিক পর্যায় শেষ করেছেন কিন্তু পরবর্তী পর্যায়ের শিক্ষা শেষ করেননি = ৫ পরবর্তী পর্যায়ের শিক্ষা শেষ করেছেন = ৬

পেশাঃ চাকুরী = ১ কৃষি = ২ ব্যাবসা = ৩ স্ব -কর্মসংস্থান = ৪ অন্যান্য = ৫ বেকার = ৬

যদি বেকার হয়ে থাকেন তবে কতদিন ধরে বেকার আছেন? _____

বর্তমান এলাকায় কতদিন ধরে বাস করছেন? _____

১.৬ মায়ের বিষয়ে আরো তথ্যঃ

জীবিত = ১ মৃত = ২ বয়সঃ _____

শিক্ষার পর্যায়ঃ _____ অশিক্ষিত =১ শিক্ষিত কিন্তু প্রাথমিক পর্যায় শেষ করেননি = ২ প্রাথমিক পর্যায় শেষ করেছেন কিন্তু মাধ্যমিক পর্যায় শেষ করেননি=৩ মাধ্যমিক পর্যায় শেষ করেছেন কিন্তু উচ্চ মাধ্যমিক পর্যায় শেষ করেননি = ৪ উচ্চ মাধ্যমিক পর্যায় শেষ করেছেন কিন্তু পরবর্তী পর্যায়ের শিক্ষা শেষ করেননি = ৫ পরবর্তী পর্যায়ের শিক্ষা শেষ করেছেন = ৬

পেশাঃ _____ চাকুরী = ১ কৃষি = ২ ব্যাবসা = ৩ স্ব-কর্মসংস্থান = ৪ অন্যান্য = ৫ বেকার = ৬ গৃহিণী = ৭

যদি বেকার হয়ে থাকেন তবে কতদিন ধরে বেকার আছেন? _____

বর্তমান এলাকায় কতদিন ধরে বাস করছেন? _____

১.৭ বসবাস এবং আর্থ-সামাজিক অবস্থাঃ

ইটের বাড়ি ঃ না = ০ হ্যাঁ = ১ ত্রিজ ঃ না = ০ হ্যাঁ = ১

কাজের লোক ঃ না = ০ হ্যাঁ = ১

টেলিভিশন ঃ না = ০ হ্যাঁ = ১ টেলিফোন ঃ না = ০ হ্যাঁ = ১

পারিবারিক আয় (বাৎসরিক) _____

২ সামাজিক পুঁজি

ক) সাধারণভাবে এই এলাকার মানুষ কি একে অপরকে সাহায্য করে? না = ০ কিছুটা = ১ অনেকটা = ২

খ) এই এলাকা কি বসবাসকারীদের জন্য বিপদজনক? না = ০ কিছুটা = ১ অনেকটা = ২

গ) যখন আপনার শিশুর যত্নের জন্য সাহায্যের প্রয়োজন পড়ে তখন আপনি কি পরিবারের বা বন্ধুদের উপর নির্ভর করতে পারেন?
না = ০ কিছুটা = ১ অনেকটা = ২

৩ শিশুর প্রতি পিতামাতার মনোভাব ও আচরণ

ক) সম্ভব্য বিপদের আশঙ্কায় আপনি কি সচরাচর আপনার শিশুকে সাধারণ খেলাধুলা থেকে বিরত রাখেন?
হ্যাঁ =০ আংশিক হ্যাঁ =১ না = ২

খ) আপনি কি সচরাচর আপনার শিশুর উদ্বেগ কমানোর জন্য বা তাকে স্বস্তি দেয়ার জন্য একই বিছানায় ঘুমান, এমনকি যদিও তা সাধারণ পিতামাতার আচরণের সাথে বেমানান? হ্যাঁ =০ আংশিক হ্যাঁ =১ না = ২

গ) আপনি কি শিশুর ছোটোখাটো শারীরিক সমস্যার জন্য প্রায়ই ডাক্তারের কাছে যান ও চিকিৎসা চান এবং তার যথেষ্ট যত্ন নেন?
হ্যাঁ =০ আংশিক হ্যাঁ =১ না = ২

ঘ) যখন আপনার শিশু বাড়ির বাইরে থাকে তখন সে কোথায় যাচ্ছে বা কি করছে তা জানা আপনার পক্ষে কি সম্ভব হয়?
হ্যাঁ =০ আংশিক হ্যাঁ =১ না = ২

ঙ) আপনি কি শিশুর জন্য নিয়ম-কানুন শক্ত ভাবে আরোপ করেন এবং তাকে এর থেকে কোন ভাবেই বিচ্যুত হতে দেন না?
হ্যাঁ =০ আংশিক হ্যাঁ =১ না = ২

৪ বাবামায়ের জন্য অন্যান্য সম্পূরক প্রশ্নাবলী

ক) মাঝে মাঝে শিশুরা এতটাই খারাপ ব্যবহার করে যে, বড়রা তাদের উপর ধৈর্য হারিয়ে ফেলে। যখন সে (শিশুর নাম) খারাপ ব্যবহার করে তখন আপনি কিভাবে তা নিয়ন্ত্রণ করেন? *(একের অধিক উত্তরে টিক দিতে পারেন)*

১. আমরা এ বিষয়ে কথা বলি ঃ হ্যাঁ = ১ না = ০
২. সুযোগ বঞ্চিত করি *(এর মানে কি বুঝিয়ে বলুন)*ঃ হ্যাঁ = ১ না = ০
৩. চিৎকার করি বা ধমক দিই ঃ হ্যাঁ = ১ না = ০
৪. চড়-চাপড় দেই ঃ হ্যাঁ = ১ না = ০
৫. অন্য কিছু দিয়ে মারি ঃ হ্যাঁ = ১ না = ০
৬. অন্যান্য ঃ হ্যাঁ = ১ না = ০

(বর্ণনা করুন) ----------

) যখন বাড়িতে বড়রা পরস্পর ঝগড়া করেন, শিশু কি ঘটছে তা দেখতে বা শুনতে পারে। আপনার শিশু এরকম কোনো ঝগড়া দেখে কিনা?

হ্যাঁ = ১ না = ০

যদি হ্যাঁ হয়, বড়দের মধ্যকার ঝগড়া কিরকমের হতো ? *(একের অধিক উত্তরে টিক দিতে পারেন)*

১. গালাগালি বা শারীরিক আঘাত ছাড়া ঃ হ্যাঁ = ১ না = ০

২. গালাগালি সহ ঃ হ্যাঁ = ১ না = ০

৩.শারীরিক আঘাত সহ ঃ হ্যাঁ = ১ না = ০

।) আপনার শিশু কি নিচের যে কোনো একটি ব্যবহার করেছে? কখনোই ব্যবহার করেনি = ০ বছরে এক বা দুইবার = ১ মাসে একবারেরও কম=২ মাসে এক দুই বার=৩ সপ্তাহে এক-দুই বার=৪ দিনে একবার=৫ দিনে বহুবার=৬

প্রতিটি আইটেমের পাশের শূন্যস্থানে উত্তরগুলো লিখুন। *(১১ থেকে ১৬ বছরের শিশুর পিতামাতাকে জিজ্ঞাসা করুন)*

(১)সিগারেট্ ..... (২)ফেন্সিডিল্ .....(৩) হেরোইন (৪)গাঁজা ..... (৫)ঘুমের ঔষধ .....(৬)মদ .....

।) ১. গত বছরে কোনো আবেগজনিত সমস্যা, আচরণগত সমস্যার জন্য আপনার শিশু কি কোনোরকমের সহায়তা পেয়েছে ?

না = ০ হ্যাঁ, সরকারী প্রতিষ্ঠান থেকে = ১ হ্যাঁ, বেসরকারী প্রতিষ্ঠান থেকে হ্যাঁ = ২ সরকারী ও বেসরকারী উভয় প্রতিষ্ঠান থেকে = ৩

২. যদি হ্যাঁ হয়, তবে জিজ্ঞাসা করুন কে সেবা দিয়েছেন ?

একজন শিশু ডাক্তার (শারীরিক কারণে নয়) = ১ মনোবিজ্ঞানী = ২ ভাষা চিকিৎসক (স্পিচ থেরাপিষ্ট) = ৩ কারিগরী চিকিৎসক (অকুপেশনাল থেরাপিষ্ট) =৪, সমাজকর্মী = ৫ অন্যান্য = ৬

৩. কতবার সাহায্য নেয়া হয়েছে ? .....

৪. পরামর্শ নেবার কারণ কি ছিল? .....

৫.এ সমস্যার কারণে কি আপনার শিশুকে কোনো ওষুধ দেয়া হয়েছিল? হ্যাঁ = ০ না = ১

৬.এ সমস্যার কারণে কি আপনার শিশুকে হাসপাতালে ভর্তি করা হয়েছিল? হ্যাঁ = ০ না = ১

২ শাস্তি, তত্ত্বাবধান এবং পুরস্কার সম্পর্কে পিতামাতার বিশ্বাস বিষয়ক প্রশ্নমালা

৫- ১০ বছর বয়সীদের বাবামায়ের জন্য

ক) মরিয়ম বেগম মনে করেন যে, শিশুদেরকে মাঝেমধ্যে চড়-চাপড় (শারীরিক শাস্তি) দিলে তারা ভাল আচরণ করে। আমেনা বেগম মনে করেন, শিশুদেরকে চড়-চাপড় (শারীরিক শাস্তি) দেয়ার দরকার নেই। বরং তাদের সাথে কথা বলা এবং সুযোগসুবিধা থেকে বঞ্চিত করা, যেমন- বন্ধুদের সাথে খেলতে বা বেড়াতে না দেয়ার মাধ্যমে তাদের শাস্তি দেয়াই যথেষ্ট। আপনি কার সাথে একমত, মরিয়ম না আমেনা? *(প্রয়োজনে মরিয়ম এবং আমেনার দৃষ্টিভঙ্গি আবার পড়ে শোনান)* মরিয়মের সাথে একমত =১/ আমেনার সাথে একমত =২/ কারো সাথেই একমত নই =৩/ কি বলবো জানিনা =৪

খ) জরিনা বেগম মনে করেন যে, শিশুরা যখন ভালো আচরণ করে তখন তাদের প্রশংসা করা জরুরী। আলেয়া বেগম মনে করেন, ভালো আচরণের জন্য শিশুদের প্রশংসা করার প্রয়োজন নেই। আপনি জরিনা বা আলেয়া কার সথে একমত? জরিনার সাথে একমত =১/ আলেয়ার সাথে একমত =২/ কারো সাথেই একমত নই =৩/ কি বলবো জানিনা =৪

গ) কুলসুম বেগম মনে করেন যে, যখন শিশুরা খেলে তখন তারা কি করছে তার ওপর নজরদারি করা জরুরী। জাহানারা বেগম মনে করেন, যখন শিশুরা খেলে তখন তারা কি করছে না করছে তার ওপর মনোযোগ দেয়ার দরকার নেই। আপনি কার সাথে একমত? কুলসুম না জাহানারা? কুলসুমের সাথে একমত =১/ জাহানারার সাথে একমত =২/ দুইজনের কারো সাথেই একমত নই =৩/ কি বলবো জানিনা =৪

১১-১৬ বছর বয়সীদের পিতামাতার জন্য

ঘ) মরিয়ম বেগম মনে করেন যে, কিশোর-কিশোরীদেরকে মাঝেমধ্যে চড়-চাপড় (শারীরিক শাস্তি) দিলে তারা ভাল আচরণ করে। আমেনা বেগম মনে করেন, কিশোর-কিশোরীদেরকে চড়-চাপড় (শারীরিক শাস্তি) দেয়ার দরকার নেই। বরং তাদের সাথে কথা বলা এবং সুযোগসুবিধা থেকে বঞ্চিত করা, যেমন- বন্ধুদের সাথে খেলতে বা বেড়াতে না দেয়ার মাধ্যমে তাদের শাস্তি দেয়াই যথেষ্ট। আপনি কার সাথে একমত, মরিয়ম না আমেনা? *(প্রয়োজনে মরিয়ম এবং আমেনার দৃষ্টিভঙ্গি আবার পড়ে শোনান)* মরিয়মের সাথে একমত =১/ আমেনার সাথে একমত =২/ দুইজনের কারো সাথেই একমত নই =৩/ কি বলবো জানিনা =৪

ঙ) জরিনা বেগম মনে করেন যে, অল্পবয়সীরা যখন ভালো আচরণ করে তখন তাদের প্রশংসা করা জরুরী। আলেয়া বেগম মনে করেন, ভালো আচরণের জন্য অল্পবয়সীদের প্রশংসা করার প্রয়োজন নেই। আপনি জরিনা বা আলেয়া কার সাথে একমত? জরিনার সাথে একমত =১/ আলেয়ার সাথে একমত =২/ দুইজনের কারো সাথেই একমত নই =৩/ কি বলবো জানিনা =৪

চ) কুলসুম বেগম মনে করেন যে, যখন অল্পবয়সীরা বাড়ির বাইরে থাকে তখন তারা কি করছে তা জানাটা জরুরী, অথবা দূর থেকে তাদের উপর নজরদারি করা প্রয়োজন। জাহানারা বেগম মনে করেন, যখন অল্পবয়সীরা বাড়ির বাইরে থাকে তারা কি করছে না করছে তা জানার দরকার নেই বা দূর থেকে তাদের উপর নজরদারী করারও প্রয়োজন নেই। আপনি কার সাথে একমত, কুলসুম না জাহানারা? কুলসুমের সাথে একমত =১/ জাহানারার সাথে একমত =২/ দুইজনের কারো সাথেই একমত নই =৩/ কি বলবো জানিনা =৪

৬. শারীরিক স্বাস্থ্যের পরিমাপ

ক) পিতা-মাতার জন্য আরেকটি প্রশ্নঃ সাধারণভাবে আপনার শিশুর স্বাস্থ্য কেমন?

খুব ভালো = ১ ভালো = ২ চলনসই = ৩ খারাপ = ৪ খুব খারাপ = ৫

খ) শিশুর উচ্চতা (সেন্টিমিটার) _____ (গ) শিশুর ওজন (কিলোগ্রাম) _____

৭. মানসিক বয়স

৭.১ শিশুর (নাম) লেখাপড়া এবং বুদ্ধি বিবেচনা করার ক্ষমতার ক্ষেত্রে তার বয়েস অনুযায়ী সে কি গড়পড়তা মানের,এগিয়ে অথবা পিছিয়ে আছে?

এগিয়ে	গড়পড়তা	পিছিয়ে
০	১	২

শেষ ৭.২

৭.২ তার লেখাপড়া ও বুদ্ধি বিবেচনা বর্তমানে মোটামুটিভাবে কোন বয়েসের মত?(শিশুর শারীরিক বয়সের তুলনায় উহার ২ বছরের কম হলে বয়স লিখুন) [ ] বছর বয়স

যদি ১২ মাসের সমান হয় "০" বসেবে।

ANNEXURE 9

Bangla version of the Self Reporting Questionnaire (SRQ)

Self Reporting Questionnaire (SRQ)
স্ব বর্ণন প্রশ্নমালা

নিচের প্রশ্নগুলোতে কিছু কষ্ট ও সমস্যার কথা আছে যা আপনার থাকতে পারে। প্রত্যেকটি প্রশ্নের জন্য *হ্যাঁ* বা *না* ঘরে টিক (✓) চিহ্ন দিন। দয়া করে বিগত *৩০ দিন* সময়ের উপর ভিত্তি করে উত্তর দিন। প্রশ্নগুলোর উত্তর দেয়ার সময় দয়া করে কারো সাথে আলোচনা করবেন না। কোন প্রশ্নের উত্তর কিভাবে দেয়া যায় তা যদি আপনি নিশ্চিত না হতে পারেন তবে অনুগ্রহ করে আপনি যা বোঝেন সেভাবে উত্তর দিন। আপনার দেয়া উত্তরগুলো গোপনীয় থাকবে তা আপনি নিশ্চিত হতে পারেন।

প্রথম অংশ

		হ্যাঁ	না
১.	আপনার কি প্রায়ই মাথাব্যথা করে?	☐	☐
২.	আপনার কি খিদে কম?	☐	☐
৩.	আপনার কি ঘুমের সমস্যা হয়?	☐	☐
৪.	আপনি কি সহজেই ভয় পান?	☐	☐
৫.	আপনার কি হাত কাঁপে?	☐	☐
৬.	আপনি কি ঘাবড়ে যান, উদ্বিগ্ন বা দুশ্চিন্তা বোধ করেন?	☐	☐
৭.	আপনার কি হজমশক্তি কম?	☐	☐
৮.	কোনো বিষয়ে ঠিকমত চিন্তা করতে কি আপনার সমস্যা হয়?	☐	☐
৯.	আপনি কি অসুখী বোধ করেন?	☐	☐
১০.	আপনার কি অল্পতেই কান্না পায়?	☐	☐
১১.	আপনার দৈনন্দিন কাজকর্মে আনন্দ পেতে আপনি কি অসুবিধে বোধ করেন?	☐	☐
১২.	কোনো বিষয়ে সিদ্ধান্ত নেয়া কি আপনার কাছে কঠিন মনে হয়?	☐	☐
১৩.	আপনার দৈনন্দিন কাজ কি ব্যাহত হচ্ছে?	☐	☐
১৪.	জীবনে কার্যকর ভূমিকা রাখতে আপনি কি অক্ষম?	☐	☐
১৫.	আপনি কি অনেক কিছুতে আগ্রহ হারিয়ে ফেলেছেন?	☐	☐
১৬.	আপনি কি নিজেকে একজন মূল্যহীন মানুষ মনে করেন?	☐	☐
১৭.	নিজের জীবনকে শেষ করে দেয়ার চিন্তা আপনার মনে কি কখনো এসেছে?	☐	☐
১৮.	আপনি কি সব সময় ক্লান্তি বোধ করেন?	☐	☐
১৯.	আপনার পেটে কি অস্বস্তিকর অনুভূতি হয়?	☐	☐
২০.	আপনি কি সহজেই ক্লান্ত হয়ে পড়েন?	☐	☐

দ্বিতীয় অংশ

		হ্যাঁ	না
১.	আপনার কি মনে হয় যে কেউ কোনভাবে আপনার ক্ষতি করার চেষ্টা করছে?	☐	☐
২.	বেশির ভাগ লোক যতটুকু মনে করে আপনি কি তার চেয়েও অনেক গুরুত্বপূর্ণ ব্যক্তি?	☐	☐
৩.	আপনার চিন্তার ক্ষেত্রে কোনরকমের বাধা বা অস্বাভাবিক কোনকিছু কি খেয়াল করেছেন?	☐	☐
৪.	আপনি কি কখনো গায়েবী আওয়াজ শুনেছেন যা অন্য লোকেরা শুনতে পায়না?	☐	☐

ANNEXURE 10

Letter of introduction and consent form in Bangla

APPENDIX-10

Letter of introduction to the parents and teachers in Bangla

প্রকল্প পরিচালকের কার্যালয়
"বাংলাদেশের শিশু-কিশোরদের মানসিক স্বাস্থ্য সংক্রান্ত জরিপ"
মনোরোগ বিদ্যা বিভাগ
বঙ্গবন্ধু শেখ মুজিব মেডিকেল বিশ্ববিদ্যালয়
শাহবাগ, ঢাকা-১০০০

নং বিএসএমএমইউ/সাইক/ গঃ প্রঃ / ২০০২/৮ তারিখ .....

অনুরোধ পত্র

সম্মানিত পিতামাতা / অভিভাবক/ শিক্ষক
.....
.....
....

জনাব/ জনাবা

বঙ্গবন্ধু শেখ মুজিব মেডিকেল বিশ্ববিদ্যালয় (পূর্বতন পি জি হাসপাতাল) এর মনোরোগ বিদ্যা বিভাগ কর্তৃক বাংলাদেশের ৫-১৬ বছরের শিশুদের আবেগ, আচরণ, সামাজিক এবং শারীরিক দিক যাচাই করা হবে। সেই সাথে পরিবারের আর্থসামাজিক তথ্য নেয়া হবে।

শিশুর প্রাথমিক ও প্রধান জগত হচ্ছে তার পরিবার ও স্কুল। সে জন্য তার সম্পর্কে আপনারাই হচ্ছেন এই জরিপ কাজের সবচেয়ে গুরুত্বপূর্ণ তথ্যপ্রদানকারী। অনুগ্রহ করে আমাদের জরিপরত মাঠ কর্মীদের তথ্য সংগ্রহে সম্মতিদান ও সক্রিয় সহযোগিতার জন্য আন্তরিকভাবে অনুরোধ জানাচ্ছি। আপনাদের দেয়া সকল তথ্যের গোপনীয়তা নিশ্চিতভাবে বজায় থাকবে।

শিশুরাই জাতির ভবিষ্যত। এই জরিপের ফলাফল দেশের শিশু স্বাস্থ্য সেবার উন্নয়ন ও সম্প্রসারনে সাহায্য করবে। একটি স্বাস্থ্যবান জাতি গঠনের লক্ষ্যে এই জরিপ কাজে আপনাদের অংশগ্রহন একান্ত কাম্য।

অশেষ ধন্যবাদান্তে --

.....
ডাঃ এম এস আই মল্লিক
প্রকল্প পরিচালক
মনোরোগ বিদ্যা বিভাগ
বঙ্গবন্ধু শেখ মুজিব মেডিকেল বিশ্ববিদ্যালয়

Questionnaire for Informed Consent in Bangla

অবহিত করার মাধ্যমে সম্মতিপ্রদানের প্রশ্নমালা

১। এই গবেষনা কর্মের ধরন, উদ্দেশ্য এবং পদ্ধতি সম্পর্কে সম্পূর্ণ জানতে পেরেছেন কি ? হ্যাঁ না

২। এই গবেষনার জন্য যে, আপনাকে/আপনার সন্তানকে শারীরিক, মানসিক এবং সামাজিক কোন ঝুঁকির সম্মুখীন হতে হবেনা, এ বিষয়ে কি নিশ্চিত হয়েছেন? হ্যাঁ না

৩। এই গবেষনার ফলে আপনার/ আপনার সন্তানের শরীর বা মনে যে কোন ক্ষত বা আঘাত সৃষ্টি হবে না, এ বিষয়ে কি অবহিত হয়েছেন? হ্যাঁ না

৪। এই গবেষনার ফলাফল এবং সম্ভাব্য কল্যাণের বিষয়ে আপনার ধারনাটি স্পষ্ট হয়েছে কি? হ্যাঁ না

৫। এই গবেষনা কর্মে অংশগ্রহণ, সহযোগিতা দান অথবা বিরত থাকার সিদ্ধান্ত কি আপনি স্বাধীনভাবে গ্রহন করতে পারছেন ? হ্যাঁ না

৬। এই গবেষনা কর্মে অংশ গ্রহনের ফলে আপনার/ আপনার সন্তানের মৌলিক মানবাধিকার কি ক্ষুন্ন হচ্ছে? হ্যাঁ না

৭। আপনি কি জানেন আপনার তথ্যাবলির গোপনীয়তা বজায় রাখা হবে ? হ্যাঁ না

৮। এই গবেষনা কর্মে অংশ গ্রহণের জন্য আপনাকে কোন পারিশ্রমিক অথবা ভ্রমণভাতা দেয়া হবেনা, এ বিষয়ে কি অবগত হয়েছেন ? হ্যাঁ না

সম্মতি পত্র

এই গবেষনা কর্মের উদ্দেশ্য, পদ্ধতি ও উপযোগিতা সম্পর্কে পূর্ণ ধারনা পেয়ে এর নীতিগত বৈশিষ্ঠসমূহের প্রতি আমার সম্মতি প্রকাশ করছি। গবেষনা কর্মে অংশ গ্রহনের জন্য আমি কোন ব্যক্তি বা গোষ্ঠি দ্বারা প্রভাবিত হইনি অথবা আমার মৌলিক মানবাধিকার ক্ষুন্ন হয়নি।

অতএব, যথাযথ পর্যালোচনা সাপেক্ষে আমি স্ব-প্রনোদিত হয়ে এই অনুমতি পত্রে স্বাক্ষর করছি।

স্বাক্ষর ঃ.....
পূর্ণ নাম ঃ .....
ঠিকানাঃ.....
.....

ANNEXURE 11

The study in pictures

ANNEXURE – 11: THE STUDY IN PICTURES

Bangabandhu Sheikh Mujib Medical University (BSMMU), Dhaka: The study center

Department of Psychiatry, BSMMU: The clinic study place

Photograph of the Study area

Crossing the ferry towards Nawabganj

Nawabganj: The rural study area

Mohammadpur: The urban study area

View of Mohammadpur from the top

Ring Road- Beribandh of Mohammadpur: The slum study area

View of unhealthy environment of the slum study area

The Research Team

Inaugural session of the field work at the premises of the Dept of Psychiatry, BSMMU

Prof. M A Sobhan, Chairman of the Dept. formally opens field work

A view of Research Team meeting at field office

An impromptu sit-down of the Team

A Group of the Team sits together

A group is busy in work analysis

Team in Action

A group of Field Assistants in a close moment at the rural study area

Field Assistants move for data collection at the rural study area

Field Assistants stand together in urban study area

A Research Assistant stands with Field Assistants during 2nd stage data collection

The Researcher along with Field Coordinator visits slum study area

A joyful moment during data collection in slum study area

Data Collection

A Field Assistant is engaged in interviewing mother in a rural house

A field Assistant measures height of a girl in rural study area

A field Assistant sits with a mother at living room of an urban house

Field Assistants collect demographic data of an urban household

A Field Assistant sits on bed to take Interview of a mother in the slum area

A Field Assistant collects data in the slum household

The Researcher in child assessment and training on DAWBA rating

The Researcher assesses a child in the Child Mental Health Clinic of BSMMU

The Researcher engages in clinical assessment of a boy in rural study area

The Researcher sits-down at the Institute of Psychiatry (IOP), London during research training

The Researcher and Professor Robert Goodman the author of the research measures engage in clinical rating at IOP

The Researcher and Tamsin Ford, Clinical training fellow, are pictured during research training at IOP

The researcher sits with Helen Simmons, Clinical Psychologist, during training on on clinical rating at IOP

Seminars on the study

First Seminar held on 21 December, 200 at the Milton Hall, BSMMU

The Researcher presents piloting data in the seminar

A section of panel of experts in the in the seminar

The Participants in active listening

A section of audience in the seminar

Professor Hidayetul Islam, former Director of NIMH participates in discussion. Professor M A Sobhan chairs the seminar

Professor AKMN Chowdhury, former Head of the Dept. of Psychiatry, the than IPGMR comments in his Chief Guest's speech

Seminars on the study

Second Seminar held on 25 May, 2005 at Milton Hall, BSMMU

The Researcher presents the thesis in front of the distinguished audience

The panel of experts and participants in the seminar

Professor A A Munib, former Head of the Dept. of Psychiatry, the than IPGMR, concentrates on the speech

A section of the audience in the seminar

Another section of the learned audience in the seminar

Professor AKMN Chowdhury, Chief Guest, congratulates the Researcher