Psychological Distress and Coping Strategies in Adolescents of Substance Dependent Parents

Mahjareen Binta Gaffar
Registration No: 056/2015-16
Department of Clinical Psychology
University of Dhaka

Psychological Distress and Coping Strategies in Adolescents of Substance Dependent Parents

By

Mahjareen Binta Gaffar

Department of Clinical Psychology

University of Dhaka

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A dissertation

Submitted to the Department of Clinical Psychology, University of Dhaka, in partial fulfillment of the requirements for the degree of Master of Philosophy in Clinical Psychology.

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Dedicated to

My mother

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APPROVAL SHEET

This is to certify that I have read the thesis entitled "Psychological distress and coping strategies in adolescents of substance dependent parents" submitted by Mahjareen Binta Gaffar, in partial fulfillment of the requirements for the degree of Master of Philosophy in Clinical Psychology and this research was carried out by her under my supervision and guidance.

Dated, Dhaka
March, 2018.

Dr. Farah Deeba
Associate Professor
Department of Clinical Psychology
University of Dhaka

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Abstract

‘Parental substance dependency’ a parent-dependent stressor for offspring, has an immense impact especially on adolescents. Being in a critical bio-psycho-socio transitional development phase of life, adolescents with substance dependent parents have to experience several negative life events that potentially can increase vulnerability to grow psychological distress within them. Families with substance dependent parents are usually found to have higher levels of interpersonal conflicts, physical aggression towards partners and children, poor parenting and significantly higher levels of trauma, depression and anxiety in offspring, compared to substance non-dependent parents. Although a number of research works have been done in western world so far on substance dependent parents and their children in various dimensions, yet in our culture research works are still mostly focused on prevalence, causes, relapse factors, etc. which are related to drug dependency problem itself. In present case-control study method was followed. It was attempted to examine the psychological distress and coping strategies among the adolescents of substance dependent parents. All participants (*M*= 13.63; *SD*=1.61) of cases (adolescents with substance dependent parents) and controls (adolescents with substance non-dependent parents) were unmatched. Both groups (139 cases and 278 controls) were drawn from a study population of 650. Both groups of adolescents completed four measures on depression, anxiety, stress reactions and coping strategies. Adolescents from case group scored higher on psychological distress, whereas, adolescents with substance dependent parents were more depressed, anxious and had high elevated risk of developing post-traumatic stress disorder. In coping with the parental substance dependency adolescents from case group used more active coping and negative coping strategies whereas, adolescents with substance non-

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dependent parents used more active and avoidant coping. The strongest predictors of psychological distress among adolescents were parental substance dependency, coping strategies (mostly avoidant and negative coping), socio-economic status, gender, educational status and achievement of adolescents and parental history of chronic relapse. The findings uphold the psychological state of adolescents with parental substance dependency that demand more intensive intervention and prevention program to reduce the vulnerability among these adolescents. we recommend to conduct various research studies on such vulnerable psychological areas of the adolescents so that pathways to create a socio-cultural context that is essentially supportive and helpful for them to recover permanently from existing psychological problems and become resilient to any future vulnerabilities.

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CHAPTER 1:

INTRODUCTION

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1.1 Adolescence

Adolescence is a transitional period with simultaneous dynamic changes with the impact of environment (UNICEF, 2006). It is at-a-time a very crucial and a conflicting period of human development where unique developmental challenges needed to be fulfilled. It is a crucial stage because this encompasses transition to adulthood often with emergence and resolution of psychobiological and psychosocial problems (Ausubel, Montemayor & Svajian, 1977).However, at adolescence both physical and psychosocial developments are at a stage which is not fully grown or completed. At this stage an adolescent has immature limbic system and prefrontal cortex which makes him/her vulnerable to many emotional reactions (Arain, Haque, Johal, Mathur, Nel, Rais, Sandhu & Sharma, 2013). It is found that cortical volume in cerebral cortex which increase in early childhood decreases in thickness throughout the adolescence which also have a greater impact on adolescents judgment, impulsive choices, etc. (Mills, Goddings, Herting, Meuwese, Blakemore, Crone,Dahl, Guroglu, Raznahan, Sowell & Tammes, 2016; Churchwell, Larson & Todd, 2010). Adolescents who went through chronic stresses showed disruption in working memory, problem solving, creativity and other prefrontal cortex related processes (Schraml, 2013). Thus significance of the period is inevitable as impact of this period is far-reaching. It is stressed that adolescence years is susceptible to predisposing risky behaviors, non-communicable disorders, viral infections as total health outcomes is depends on several societal factors like social determinants of health, social role transitions, health related behaviors and states (Sawyer, Afifi, Bearinger, Blakemore, Dick, Ezeh& Patton, 2012). The period (from age 10 to 19) could be characterized as second decade of life, a time of opportunity to regain, restore and recover all the developmental tasks that were not met in earlier years, as well as high-risk stages too (World Health Organization, WHO, 2009).

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The significance of adolescence is also stressed through different developmental theorists who described the crucial development in this period. Spano (2004) explained significant development of adolescent years through different biological, psychological, psychosocial, cognitive, ecological, social cognitive and cultural theories. All these theories shed light on healthy development of adolescents. As through resolving developmental crisis at adolescence one could developed as healthy or unhealthy adult, identity development at adolescence years is often the result of interaction with psychopathological, emotional, academic functioning, interpersonal relationship and adjustment within the family and peers (Klimstra & Doeselaar, 2017), where cultural context is also significant (Zacares & Iborra, 2015). To develop a healthy identity in adulthood positive experiences in childhood and adolescence is necessary (Banyard, Hamby &Grych, 2017; Shiner, Allen &Masten, 2017; Hagan, Bush, Mendes, Arenander, Epel&Puterman, 2017). Adolescents who have earlier experiences of traumatic events or experiences chronic conditions have negative outcome on educational status, resiliency and behavioral issues (Soleimanpour, Geierstanger & Brindis, 2017).Studies shows that adolescents with stressful family life events experiences high cortisol reactivity which eventually exhibits more internalizing and externalizing problems (Steeger, Cook & Connell, 2017).

In resolving stress, adolescents face conflicts which manifested by mood disruption and undertaking risky behaviors often interacting with biological, social and familial interaction factors and different complicated psychological factors (Kalam, 2013). The way adolescents resolve their conflicts bring positive or negative changes in themselves. Unresolved problems within this stage as well as disruptive attachment with parents result in conduct problems, substance abuse disorders, antisocial personality disorder & paranoid personality traits in the adolescents (Rosenstein & Horowitz, 1996). However, relationship with parents is one of the strongest predictor of adolescent well-being and their life

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satisfaction (Lachowska, 2016). Quality of parent-adolescent relationship is crucial and associated with negative mental health outcomes as depression, anxiety and feeling of hopelessness (Kim, Thompson, Walsh &Schepp, 2015).

Concerning these, current trend of adolescent studies is emphasizing on transitional crises and resilience in high-risk circumstances (Nancy & Bonnie, 2010). For enhancing resilience and promoting positive behaviors among adolescents it is needed to identify risks embedded in their environment that is within family, community and culture and to develop effective intervention programs. According to WHO (2012), in developing mental health services and intervention, utmost importance is needed to give on the management of conditions related to stress.

1.1.1 Vulnerability to distress during adolescence

Studies showed that late adolescents (15-19 years) are more vulnerable for psychological distress when coping with chronic or stressful situations (Rainville, Dumont, Simard & Savard, 2012; Bhui, Silva, Harding &Stansfeld, 2017). Commonly, environmental stresses make adolescents vulnerable to several chronic non-communicable diseases (Mollah, 2014). Environmental stressors could be adolescents family structure, substance use problems in family, family violence, sexual abuse in family, prevailing social condition etc which have physiological, emotional and behavioral outcomes like poor emotional health, strain or blockage, anger, anxiety, depression, fear and harmful behavior (Borowsky & Resnick, 1998; Sigfusdottir, Kristjansson, Thorlindsson & Allegrante, 2016). Thus emotional problems experienced during adolescence eventually create long-term impact on the mental health of an adult or an older adult person (Nashida et al, 2016; Taylor, 2010; Mirescu, Peters & Gould,2004; Glaser, Os, Portegijs & Germeys, 2005; Hlavaty, 2011). Most of the time due to the emotional problems (like, anxiety, depression, stress reaction, etc.) youths face difficulties

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in expressing, understanding and accepting emotions as they still have less developed adaptive coping strategies (Mathews, Koehn &Abtahi, 2016).

Literature on this stated that, the most prevalent causes of stress among adolescents are school grades, parental and peer group pressures, relationships with parents or peers, violence, sexuality and sexually transmitted diseases(STD), psychosocial conditions, lifestyle factors and many more (Kempf, 2011; Schraml,2013). Among all of these, one of the most influential causes of stress is nature of parent –adolescent relationship that is continuously being influenced by parental support, parental psychological problems, poor monitoring and inconsistent discipline (Singh & Krishna, 2014; Parpio et al, 2012; Kai-wen, 2014; Kempf, 2011; Schraml, 2013). Amin (2015) found that around 20% of world’s adolescents are going through mental or behavioral problem, and 80% of them hardly seek services where parental role is significant.

Life experiences of adolescents in Bangladesh are no different from their counter parts in other countries. Rather they are to experience some more stresses such as performing gender-specific roles, parent-child conflict, imposing values and attitudes of parental behavior and viewpoints as well as adolescents internalizing or externalizing problems (Hashmi, 2013). Study also shows that, adolescent girls in urban areas are more stressed and have more anger problem than boys and rural girls, due to high expectation for good grades and interpersonal stress, whereas urban areas boys show anger due to more exposure to violence, physical aggression, poor housing and drug use (Dey, Rahman, Bairagi& Roy, 2014). Not with standing to these, adolescents of the new era are experiencing some new very influential social factors, like, media, female empowerment, maladaptive parental disciplinary technique or terrorism (Kalam, 2013), that are obviously changing their development of mental health (Mathers, Canterford Olds, Hesketh Ridley & Wake, 2009;Strasburger, Jordan &Donnerstein, 2010; Pinquart, 2017; Tang, Deng & Wang, 2017;

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Young &Kenardy, 2017; Greca, 2007; Wooding & Raphael, 2004). So it is obvious adolescents of this era are more stressed than earlier.

1.1.2 Psychological distress among adolescents

Psychological distress is an emotional condition that is manifested through depressive, anxious symptoms and stress reactions (Decker, Barnett &Muni, 1995; Lerutla, 2000; Mirowsky & Ross, 2002; Meeske, Ruccione, Globe, & Stuber,2001; Brioness, Heller, Chalfant, Roberts, Aguirre-Hauchbaum & Farr, 1990; Wheaton. 2007; Drapeau, Merchand & Dominic, 2012; Cardoza, Crawford, Eriksson, Zhu, Sabin, Ager & Olff, 2012; Wildt, Umanos, Khanzada, Saleh, Rahman & Zakowski, 2017). Ayub & Iqbal (2012) also stressed that presence of psychological distress among adolescents negatively associated with personal growth initiative. Strine, Dube, Edwards, Prehn, Rasmussen, Wagenfeld, Dhingra& Croft (2012) found that psychological distress mediated significant proportions of alcohol problems associated with childhood emotional abuse, neglect, mental illness in home, emotional neglect etc. Studies on psychological distress primarily includes depression and anxiety, arguing that psychological distress mostly denoted by these two aspects (Cassidy, Connor, Howe & Warden, 2004; Rainville, Dumont, Simard & Savard, 2012; Sheikh et al, 2016; Kumar, Talwar& Raut,2013; Lindqvist, 2015; Marcussen, 2006; Oberoi, 2014; Bales & Pidgeon, 2015;Spinhoven, Hemert, Rooij & Penninx, 2015; McCarthy, McNeil, Drew, Dunt, Kosola, Orme, Sawyer, 2016; Vernon, Eyles, Hulbert, Bretherton, McCarthy, 2016;Duchesne et al, 2016). But studies also showed that stress reactions following traumatic events or chronic stress is strongly associated with psychological distress (Glad, Hafstad, Jensen, & Dyb, 2017; Silove, Tay, Steel, Tam, Soares, Soares, & Rees, 2017). Psychological distress increases with the age among girls but not in boys (Stansfeld, 2004) and it is often related with self-esteem (Duchesne, Dion, Lalande, Begin, Emond, Lalande & McDuff, 2017). At 1980, Leonard Pearlin developed a theory on psychological distress stating that

distress brings continuous change in young people's life and choosing the way often determined by individual characteristics, like one's coping skills, availability of social support network & nature and timing of demands. The theory disagrees with life stage theory considering that people are able to change the life structure at any time that is more motivating and optimistic.

As an integral part of psychological distress, depression is mostly significant as it is one of the most leading causes of death on this era as well as unfortunately for several decades (WHO, 2012). Prevalence of depression among adolescents in U.S is around 12.8%, where females have more prevalence rate than males (SAMHSA, 2016). Whereas, in India the prevalence of depression is about 12.6% (Jha, Singh, Nirala, Kumar, Kumar &Agrawal, 2017). Related with earlier findings, study conducted on school-going adolescents showed prevalence rate of 38% (where, girls scored higher) which increases with age (Goel, Aggarwal, Choudhary & Jain, 2018). Studies conducted on adolescents showed that the far-reaching impact of depression primarily prevalent on psychosocial functioning, relations with family and friends and academic performance (Raising, Creemers, Janssens & Scholtl, 2017). Researchers also showed that adolescents who are depressed have several risk factors present in their living condition like, minimal or less physical activity (McDowell, Mac Donncha & Herring, 2017), ethnic identity, socio-economic condition, sex and age (Tran, 2017), parents with depression or any other mental illness (Diler, Goldstein, Hafeman, Rooks, Sakolsky, Goldstein, Monk, Hickey, Axelson, Iyengar & Birmaher, 2017; Rasing et al, 2017), religion, birth order (Jha et al, 2017). Along with this, parental bonding, parenting and parent-child relationship also associated with depression among adolescents(Ohtaki, Ohiz& Suzuki, 2016).

Prevalence of anxiety among adolescents and children is around 5%, where females are more diagnosed with anxiety disorders than male (Rapee, 2012). Adolescents diagnosed

with anxiety disorders generally cope more with cognitive coping strategies (Legerstee, Garnefski, Verhulst &Utens, 2011).

Stresses in adolescent years have long term impact. Adolescents who lost their parents reported higher post-traumatic stress and grief reaction than other because impacts on adolescents are more detrimental (Hirooka, Fukahori, Ozawa & Akita, 2016). Exposure to traumatic events in adolescent years has long-term on future adult life as these adolescents combat and survive trauma for long time and eventually showed elevated risk of psychiatric disorders (Spinazzola, Ford, Zucker, Van der Kolk, Silva, Smith &Blaustein, 2017).

Emphasizing on various mental disorders or illnesses among adolescents it is found that perceived parental care and control were closely associated with adolescents' mental disorder (Eun, Paksarian, He & Merikanyan, 2017). This finding shed light on "Child affected by parental relationship distress"- is one of the conditions which could give rise to psychiatric problems among children (Bernet, Wamboldt& Narrow, 2016). Related with this condition several studies showed that parental low SES and emotional distress could results in negative parenting (Herbors, Garcia &Obradevic, 2017), maternal secure base have moderating effect on adolescents adjustment (Martin, Sturge-Apple, Davies & Romero, 2017), lower closeness of parent-child relationship leads to more externalizing problems among children (Dieleman, DePauw, Soenens, Mabbe, Campbell &Rinzie, 2018) and maternal coping and depressive symptoms were associated with coping behavior of children (Monti, Winning, Watson, Williams, Gerhardt, Compas &Vannatta, 2017). All these findings strongly emphasized the role of parenting and parent-child relationship in initiation of distress among adolescents.

Study showed that psychological distress differs according to coping strategies, where after trauma negative coping reduces the distress among adolescents and positive coping

reduces distress when used after few time lapses after trauma (Hooberman et al, 2010). Coping is also associated with resilience which is positive adaptation in the context of significant adversity and reduces the likelihood of being distressed (Luthar, Cicchetti& Becker, 2000).

1.2 Coping

Coping is a cognitive and behavioral effort in order to manage internal and external demands of the environments. It is an ongoing dynamic process with changes in response to the changing demands in any stressful event (Compas, Connor-Smith, Saltzman, Thomsen & Wadsworth, 2001).Coping is one of the protective factors against psychological distress while existence of psychological distress often demands coping (Drageset, 2012; Choi, Steward, Miege,Hudes&Gregorich, 2015; MacNicol&Thorsteinsson, 2017; Mclean, Strongman &Neha, 1007; Schroder, Yalch, Dawood, Callahan, Donnellan& Moser, 2017; Siciliano, Santangelo, Trojsi, Somma, Patrone, Femiano, Monsurro, Trojano&Tedeschi, 2017). According to Lazarus &Folkman (1984), there are two types of coping strategies. First one is, emotion-focused or disengagement coping where one tries to cope with emotional responses to stressor as avoidance, distraction, social withdrawal, and wishful thinking. Many studies describe this as avoidant or negative coping, which works as mediator and positively related with internalizing symptoms. Avoidant coping often leads to more psychological distress among adolescents (Hooberman, Rosenfeld, Rasmussen & Keller, 2010). Second coping strategy is problem focused or engagement or active coping where a person use problem solving, information seeking, social support, cognitive restructuring, emotion regulation, etc. to manage stress. The other name of problem-focused coping is approach or positive coping which reduces symptoms like Post traumatic stress disorder (PTSD) (Budge, Rossman& Howard, 2014; Paysnick, 2015). Among all these, primarily, active, avoidant and negative coping are mostly prevalent. Active coping strategies are cognitive restructuring,

problem solving, emotion regulation and social support. Avoidant coping strategies are distraction, social withdrawal, resignation and wishful thinking. Negative coping strategies are self-criticism and blaming others.

Active coping strategies like emotion regulation and problem solving are influenced by parent-child attachment relationship (Modecki, Zimmer-Gembeck, & Guerra, 2017; Zimmer-Gembeck, Webb, Pepping, Swan, Merlo, Skinner, & Dunbar,2017). Among these, adolescents while coping with social support mostly valued emotional social support (Camara, Bacigalupe& Padilla, 2014). Study showed that in more stressful events, lack of social support (from family, friends and teachers) leads to higher depression whereas, social support from family is more beneficial than others (Posse, Burton, Cauley, Sawyer, Spence & Sheffield, 2017). Coping with social support is also negatively correlated with post-traumatic growth (Rzeszutek, Oniszezenko & Firlag-Burkacka, 2017) and play a protective role against suicide (Roy & Chakma, 2015). Also people who use social support as coping are less prone to use substances and get less distressed (Perreault, Toure, Perreault& Caron, 2017). Another active coping strategy – problem solving is used when the condition is controllable (Sarfan, Gooch & Clerkin, 2017) and more use of it lower distresses among adolescents (viola, Taggi-pinto, Sahler, Alderfer& Devine, 2018). Coping through emotion regulation has broad implication in mental health (Liu & Thompson, 2017) which is often depends on contextual factors like, SES-where people in lower SES regulate more effectively (Troy, Ford, McRae, Zarolia&Mauss, 2017). Emotion regulation is significant predictors of adolescent resilience (Mestre, Nunez-Lozano, Gomez-Moeibero, Zayas&Guil, 2017). Adolescents who adopt emotion regulation as coping have reported lower anxiety and mood disorders problems (Klemanski, Curtiss, McLaughlin & Nolen-Hoeksema, 2017) whereas, maladaptive emotion regulation predict more PTSD symptoms (Short, Boffa, Norman & Schmidt, 2018). In

absence of emotion regulation, adolescents have greater risks of getting dependent on substances (Wang, Burton & Pachankis, 2017).

Avoidant coping is associated with depression (Cherenack, Sikkema, Watt, Hansen, & Wilson, 2018) and negative mental health outcome (Adams, Mosher, Cohee, Stump, Monahan, Sledge, & Champion, 2017). Research conducted on workers showed that use of avoidant coping, like, distraction is associated with low stress and better performance (Shimazu & Schaufeli, 2007). On the contrary, findings from another study showed that coping through distraction has a stress-buffering effect (Janson & Rohleder, 2017), which also effect children's distress (Camisasca, Miragoli, Blasio & Grych, 2017). Distraction coping is also associated with PTSD symptomatology (Skeffington, Rees & Mazzucchelli, 2016). Another avoidant coping strategies, wishful thinking and resignation has more detrimental effect because both were mostly used by depressed individuals who results in increase of symptom severity (Thimm, Wang, Waterloo, Eisemann & Halvorsen, 2018; Holubova & Prasko, 2017).

Negative coping like, self-criticism and blaming others have also impact on distress where low level of both coping decreases distress and vice versa (Campos, Holden, Cacador, Fragata & Baleizao, 2017).

Adopting coping strategies often depends on physical, psychological and environmental resources (Zhou, Peng, Wang, Kou, Chen, Ye, Deng, Yan & Liao, 2017). Emotion focused or negative coping showed strong positive association with distress whereas positive or problem-focused coping was negatively related to distress (Shaheen & Alam, 2010). Studies also shows that, negative coping associated with mental health and adolescent boys are more vulnerable when placed in stressful situation but modeling from parental coping works more successful where age is also a determinant (Undheim & Sund, 2017).

1.2.1 Coping of adolescents with stress

Coping is important in adolescent years as it is closely associated with externalizing behavioral problems and emotion regulation and decision making skills which often fed brain development and development of psychopathology (Modecki, Zimmer-Gembeck& Guerra, 2017). In adopting coping strategies among adolescents age, gender, parents education, family income play a determining role (Ahmad, Ishtiaq& Mustafa, 2016). Kim et al (2012) found that when adolescents use adaptive stress-coping strategies by means of engagement in meaningful activities, social support, positive emotion, it results in a sense of happiness and psychological well-being. Therefore, use of such positive coping strategies protects adolescents' mental health and well-being. However, many also try negative coping strategies (like, substance abuse, self-harm/suicide, isolation, etc.) when face life stresses to manage distresses. Adolescents use coping strategies like avoidance, increased food consumption (Paul &Leudicke, 2012), distraction, seeking social support, rumination(Thorsteinsson, Ryan, &Sveinbjornsdottir, 2013), problem solving, information seeking, helplessness, escape, self-reliance, support seeking, delegation, social isolation, accommodation, negotiation, submission (Zimmer & Skinner, 2008). All these negative or avoidant coping strategies used increase the internalizing (like, depression and anxiety) and externalizing problems (for instance, traumatic stress reactions) and thus also affects overall mental health and normal development (Arslan, 2016).

It is found that adolescents who are depressed and anxious use more negative coping strategies, like, self-blame, rumination, where girls mostly uses negative or avoidance coping (Maji, Bhattacharya &Ghosh, 2016). As a result adolescent who are unable to develop and implement adaptive coping strategies are more psychologically distressed (Dhillon& Hafiz, 2007). As socio-economic status is also related with coping, study on low-income urban adolescents show that positive coping moderates' violence in community and exert

externalizing problems due to their disadvantaged environment (Carothers, Arizaga, Carter, Taylor & Grant, 2016). In which way one will cope is depends on multiple factors like severity and nature of stressors, personality pattern (Blaxton&Bergeman,2017), cultural differences (Tsai, Nguyen, Weiss, Ngo & Lau, 2017), gender (Malooly, Flannery & Ohannessian, 2017) etc.

Stressors in adolescent years which demands adopting coping strategies is associated with parenting style adopted by parents. If parents are stressed and instable the effects is also visible among children and adolescents mental health (McLoyd, Jayaratne, Ceballo& Borquez,1994; Williamson, Creswell, Fearon, Hiller, Walker &Halligan, 2017).Inconsistent, authoritative parenting generates negative coping and avoidant coping behavior among offspring which in turn affect the mental health (Eisenberg, Zhou, Spinrad, Valiente, Fabes, &Liew, 2005;On contrary of this, positive parenting generates active coping which results in lesser mental health problems and more positive qualities among the adolescents (Berg, Butner, Wiebe, Lansing, Osborn, King, & Butler, 2017; Campbell, DiLorenzo, Atkinson & Riddell, 2017)

1.3. Importance of parent-child relationship among adolescence

Parent-child relationship is extremely important for either healthy or unhealthy development of an individual (Chow, Hart, Ellis & Tan, 2017; Dilmer, Natsuaki, Hastings, Waxler&Dougan, 2016; Msdams, Rijsdijk, Narusyte, Ganiban, Reiss, Spotts, Neiderhiser, Lichenstein&Elay, 2016). In this very sensitive and delicate development phase of adolescence, this parent-child relationship becomes extremely important to assist healthy growth of an adolescent to an adult (Bradford, Burningham, Sandberg & Johnson, 2017; Perez, 2017; Soenens, Desi&Vansteenkiste, 2017). At this stage, the relationship between parent and adolescents rely mainly on attachment, monitoring, communication and involvement (Ramirez, 2016). Studies also showed that parental monitoring and effective

communication play a role in substance related issues like time of initiation, refusal,etc (Simmons & Robertson, 2008). Relationship with parents not only plays a crucial role to predict depression but also adolescents' personal development and self-esteem (Hu & Ai, 2016). Although both parents' relationship with an adolescent is very important, relationship with a father has been found very much influential for healthy development of adolescents (Tam, Lai, Lo, Low, Yeung& Li, 2017;Harewood, Vallotton&Brophy-Herb, 2017).Study also stated that father's behavior directly affect adolescents' satisfaction on family which emphasize the crucial role of the fathers (Lachowska, 2016).Adolescents in dysfunctional families perceive their family as more conflicting than adolescents in normal families and this style of perception enhances the widening of the distance in parent-adolescent relationship (Rothenberg, Hussong & Chassin, 2016). In many cases parental mental health conditions are the reasons for family dysfunctions and deterioration of mental health of the adolescents.

In most studies done with young people who are children of parents with mental health conditions mainly emphasized on depression, anxiety and traumatic stress reactions within them. This is because that in most studies it is found that adolescents of parents with mental illness showed various mental health problems (Jaaskelainen, Holmila, Notkola & Raitasalo, 2016) and most prevalent among them is anxiety (Kelly, Bravo, Hamrick, Braitman, White & Jenkins, 2017) and significant level of traumatic reactions (Parolin, 2016; Vanderzee, John, Edge, Pemberton & Kramer, 2017; Schafer et al, 2017; Wiig, Halsa&Haugland, 2016). Also, adolescents experience depression when they are in need to cope with stresses (Loon, Ven, Doesum, Hosman&Witteman, 2015; Anyan&Hjemdal, 2016; Mazurka,Wynne-Edwards, Harkness, 2015;Nasreen, Alam&Edhborg, 2016).

1.4 Parental mental illness

Mental illness within family is a great factor for development of stresses on anyone been adult or a child (Roos, Boer & Bot, 2016; Foster, Hills & Foster, 2017; Chang, Yen, Jang, Su & Lin, 2017; Jeyagurunathan, Sagayadevan, Abdin, Zhang, Chang, Shafie, Rahman,Vainganker, Chong &Subramaniam, 2017; Mulud&Mccarthy, 2016). When there is a parent with mental health illness there are increased sufferings and possibilities to develop various mental health issues in the life of a child (Uher&Zwicker, 2017; Gluschkoff, Keltikangas-Järvinen, Pulkki-Råback, Jokela, Viikari, Raitakari, &Hintsanen, 2017). Children of such parents are not only biologically but also psychologically vulnerable to become psychologicallyunhealthy at any time later in their life (Christl, Haller, Otto, Barkman, Grefe, Holling, Markwort, Sieberer&Klasen, 2017).Studies on parents with mental illness emphasized that children of such families have emotional as well as behavioral problems as they are deprived of emotional support and security demanding multidisciplinary help through school and other agency (Tabak&Zawadzka, 2016). Another study shows that, children with mentally ill parents face tremendous uncertainty, disconnectedness, over burdened with responsibility and jumble while balancing (Foster, 2010). In context of any mental illness, how the child perceives parental mental illness is often depends on his/her day-to-day life, way of coping and their knowledge of mental illness (Gladstone, 2011). Compared to younger children, adolescents become more affected with parental mental illness as the condition appeared to them as chronic stress affecting well-being, cognitive capacities, education and peer relationships (Suris, Michaud &Viner, 2017; Roos, Boer & Bot, 2016).

The type of the parental mental illness is another aspect that contributes on the sufferings of the adolescents. For instance, parents with depression (Eckshtain, Marchette, Schleider& Weis, 2017; Propper, Cumby, Patterson, Drobinin, Glover, Mackenzie &Hajek,

2017), parents with anxiety (Leijdesdorff, Doesum, Popma, Klassen&Amelsvoart, 2017), parents with personality disorder (Macfie, Kurdziel, Mahan &Kors, 2017; Pearson, Campbell, Howard & Bornstein, 2017), psychosis (Campbell, Hanlon, Galletly, Harvey, Stain, Cohen, Ravenzwaaij& Brown, 2017) etc. Unfortunately, parental substance dependency problem creates a deep dearth in children's lives in various ways and lead to grave difficulties, as the dependency problem in an individual may consists of various psychological problems like depression, personality disorder, and anxiety (Jaaskelainen, Holmila, Notkola&Raitasalo, 2016;Kelley, Bravo&Hamrick, 2017; Parolin, Simonelli, Mapelli, Sacco &Cristofalo, 2016; Vanderzee, John, Edge, Pemberton & Kramer, 2017; Schäfer, Pawils, Driessen, Härter, Hillemacher& Klein, 2017; Wiig, Halsa&Haugland, 2016).

1.5 Parental substance dependency-a mental disorder

In U.S.A 8.3 million children (U.S Department of Health & Human Services, 2009) and in UK 2.5 million children (Carbonneau, Vitaro& Tremblay, 2017) are currently living with one substance dependent parents. People who are dependent on any kind of substance, face difficulties and impairments in their familylives, manifested in various ways, such as, stressful marital interactions, poor communication with spouse or family member(s), lack of problem solving capacities, frequent argument on trivial family matter(s), financial stress, nagging and so on (Gruber & Taylor, 2006). A substance dependent person generally go through several problems simultaneously, like, loss of behavioral control, psychophysical withdrawal, co-morbid mental disorders, disturbances in physical health, domestic violence, trauma, poverty, crime, and homelessness (Feidler, Mooney, Nakashian, Sanclimenti, Shuman &Tacy, 2009). In another report on substance abuse and conjugal violence it is found that the higher the consumption of alcohol in men the severe the physical injury they throw to their spouse, and have less social stability and on the other hand female alcoholics and victims of conjugal violence experience high rate of Post-Traumatic Stress Disorder

(PTSD)(Collins, Spencer, Snodgrass & Wheeless, 1999). These marital problems and violence due to substance dependency make children of alcoholics vulnerable to the risk for maladaptive behaviors (Johnson &Leff, 1999). It also significantly impairs parent-child attachment through conflict and violence and decreasing cohesion of parenting, by making children feel abandoned, unloved, fear of parental death, unmet basic demands, poor school attendance, and unavailability of parents for emotional support which could results in long term distress (Suikkanen & Virtala, 2010). Most alarming and crucial effects of parental substance dependency is acute financial instability, food and housing insecurity, chaotic family environment, domestic violence, social stigma or social isolation, absent parent, ineffective control of children's behavior, poor discipline skills, use of coercive control, harsh discipline etc (Smith & Wilson, 2016).

Parental substance dependency pose as chronic stress for adolescent children whom negative outcome is expected and coping is also demanded. Low-income urban adolescents with substance dependent fathers are most likely to experience more physical and psychosocial stressors than others (Dixit &Gulati, 2016). Coping of such adolescents whose fathers are substance dependent could be negative or avoidant as they are also deprived of proper parenting which in turn is detrimental for their mental health (Suikkanen&Virtala, 2010; Wlodarczyk, Schwarze, Rumpf, Metzner&Pawils, 2016).

Parental substance dependency is a parent dependent stressor for an adolescent which often results in psychological distress as a product of disorganized attachment with parent, faulty communications, less or no monitoring, parental positive or liberal attitude towards substances, less or no space for expressiveness. Though studies show that parent dependent stressor has less effect on children's anxiety in compared to control children (Allen, Sandberg, Chhoa, Fearn & Rapee, 2017). Nevertheless, older adolescents are in polygenic risk of developing substance dependency due to significant interactions of gene-environment

like parental substance dependency and reluctance in parenting, peer substance use etc (Bountress, Chassin & Chalfant, 2016).

An important and less mentioned protective factor for positive mental health among adolescents of substance dependent parents is father- child relationship (Wlodarczyk, Schwarze, Rumpf, Metzner & Pawils, 2016). Along with this, negative interaction with father figure is more predictive of early initiation of substances use which increases the vulnerability among adolescents (Moreno, Janssen, Cox, Colley & Jackson, 2017). Adolescents from such stress laden family or family's vulnerability could also be lessen by connected communication, appropriate parental monitoring, direct and clear talk about substances and substance dependency (Choi, Miller-Day, Shin, Hecht, Pettigrew, Krieger, & Graham,2017; Kingston, Rose, Serrins & Knight, 2017; Carver, Elliott, Kennedy & Hanley, 2016).

1.6 Impact of parental substance dependency on adolescents

As mentioned before children from substance dependent families are more vulnerable to develop different psychological problems than children of parents with no dependency (Gruber & Taylor, 2006; Staton-Tindall, Sprang, &Straussner, 2016; Smith & Wilson, 2016). Adolescents of substance dependent parent generally went through the various difficulties from childhood, where behavioral deterioration could be at extreme during adolescents. The most common problems that are found to develop in adolescents of drug dependent parents are alcohol or drug addictions (Kumpher, 1999), poorer academic achievement, externalizing problems and maladaptive behaviors (Jessica et al, 2012;Paya, Giustti, Saccani, Mastandrea&Figlie, 2015). Browning, Kumpher, Kruse, Sack, Schaunig-Busch, Ruths, Moesgen, Pflug, Klein &Thomasius(2012) showed that, children and adolescent of substance dependent parents show higher rates of having antisocial problems, emotional problems, attention deficits, social isolation, earlier drunkenness experiences, increased binge drinking

problems and elevated risk of developing substance abuse disorder at quite young age. Stewart and Kelly (2004) found in their study that families in which fathers are substance dependents are marked by high levels of interpersonal conflict, physical aggression between parents, poor parenting and children shows significantly higher levels of both depression and anxiety.

Children of substance dependent parent often experiences, inconsistency in parenting, lack of healthy routines, abuse and neglect, high risks of acquired infectious diseases, easily get involved in selling substances etc (Smith& Watson, 2016). The findings also show that, children from substance affected families are at high risks of anxiety disorder, Attention deficit hyperactivity disorder, truancy, trauma & stress related disorders which results in disruption of effective coping. Konijnenburg,Lee, Teeuw, Lindeboom, Brilleslijper-Kater, Sieswerda-Hoogendoorn, &Lindauer, (2017) studied the children whose parents went for emergency help due to substance use and found that these children reported post traumatic stress disorder though not significantly higher than other non effected community children. Henry & Augustyn (2016) also showed that there is an intergenerational continuity in initiation of cannabis use, where they showed that father's early initiation of cannabis use is associated with children's. A qualitative study on substance dependent fathers adolescents reported that, they found themselves trapped (helpless, seized) in the situation, struggling with parental practice of substances, felt blocked physically and emotionally, realizing the trauma and then take initiatives for themselves (Park & Schepp, 2017). According to social learning theory, parents and peers both serves as role model for adolescents which influences adolescent's substance initiation and refusing behavior (Petraitis, Flay & Miller, 1995).

Parental substance dependency is one of the most alarming risk factors for adolescents substance dependency (Negussie, 2012; Hamdulay& Mash, 2011; Birhanu, Bisetegn

&Woldeyohannes, 2014). Anda,Whitfield, Felitti, Chapman, Edwards, Dube& Williamson (2002) stated that, the prevalence of alcoholism was higher among adolescent persons who reported parental alcohol abuse. According to the theory of intergenerational transmission of addiction, people who get dependent on substance are intrinsically susceptible due to heredity (Capuzzi& Stauffer, 2012). It is also stressed that, adolescent children of substance dependent adults are four to seven fold increased risk of developing substance dependency (Merrich et al, 2007). Children of substance dependent parents are genetically predisposed to substance dependency (Elam, Wang, Bountress, Chassin, Pandika&Chalfant, 2016; Kendler, Ohlsson, Sandquist & Sandquist, 2016; Reilly, Noronha, Goldman &Koob, 2017). Studies conducted on causes of substance dependency showed that, 13% of adult substance abusers had bitter family relationships and among them, 12.9% took drugs to forget family conflicts and 6.5% of substance abusers took substance due to parental disharmony (Riya, Rahman, Sadeque, Kabir & omar, 2013). In social learning theory, adolescent children initiate to take substance when they model the behavior of parents or substance using peers (Walden, Iocono&McGue, 2007). Susceptibility to substance use of adolescents often vary from culture to culture as, parental absence is more highlighted in one culture to another (Dieck, 2013). Research found that parental attitudes, communication, addictive behavior directly related with adolescents alcohol dependency (Mares, Vorst, Engels & Aschoff, 2011).Onesmoker parent has two times higher influence as well as smoker father had 3 times higher influence on son (Flora, Taylor, Rahman & Aktar, 2007).Alcoholic parents children's have risks of adolescent psychiatric disorders in both gender (Zynskey, Fergusson &Horwood, 2006).Childhood disorder, eating disorder, anxiety, depression, pathological gambling, sociopath are psychiatric consequences of parental addiction (Green & Smith, 2010).

All the above mentioned literature reviews are indicators of the presence of psychological distresses among the adolescents of substance dependent parents that could be

defined as combination of symptoms ranging from depression and general anxiety symptoms to personality traits, functional disabilities and behavioral problems (Drapeau, Merchand& Dominic, 2012). In other studies it is showed that people who play the part of caregiver roles in families are at risk of mental illness in the form of emotional stress, depressive symptom, which is also true for the mental health of adolescent children of substance dependent parent, since in many occasions they are to take care of the families (Dieck, 2013). In such conditions, early identification of problems, effective care support, health promotion, monitoring high-risk behaviors and appropriate interventions would be helpful (Shah, Wadoo & Latoo, 2010).

1.7 Drug dependency and parents in Bangladesh

Taleb (2014) stated that, the exact numbers of substance dependent people in Bangladesh are not investigated though it is estimated that approximately fifty lakh people are involved in drug addiction. The report also mentioned that around 80% of the drug users are youth and 78.42% are illiterate, less educated as well as more than 50% drug abusers are living in Dhaka city. A study on smokers shows that 45% of smokers' parents are also smoker (Khan, Afrin, Huq, Zaman & Rahman, 2014). Shazzad, Abdal, Majumder, Sohel& Ahmed (2013) found that, among the drug addicts 93.9% are male and 20.6% are female (only in Dhaka), where 64.8% are unmarried people. Shazzadet al, argued that there are physical, psychological, familial, social, economic and national effects of drug abuse. Another study of Khatun& Anwar (2013) reported that educated people are well-informed about the impacts of drug addiction than illiterate people in Bangladesh. Study conducted by Ahad, Chowdhury, Kundu, Tanny & Rahman (2017) showed that people with substance dependency faces social, financial, physical and psychological problems.

Different studies in our country showed that among the drug addicts (e.g. male, 93.2% and female, 20.6% only in Dhaka city) 6.71%-7.69% people are above 45 years and 33.65%-

35.2% are married people (Hossain& Mamun,2006; Maruf, Khan &Jahan, 2016),who might had children too. Though substance dependency problem has rodent effect on our society for many years, we do not have the exact number of parents who are currently practicing substances. Many of these people are in the vicious cycle of relapse and resilience of drug dependency and make their young children highly vulnerable to develop some psychological or mental health issues at any point of their lives.

Though earlier mentioned studies are clearly indicating that more youth and adolescents are getting dependent on drugs the number of effected adolescents due to parental substance dependency is still unknown. It is known from study that initiation of substance in adolescent years has more deteriorating effect than later age (Jordan & Andersen, 2016). Theories of planned behavior, social learning theory, social control theory, social development theory have been used to comprehend the underlying mechanisms of addiction related human behavior and a continuum has been proposed. The continuum highlighted that parental or caregiver engagement, relationship between parents, family history of substance dependency, biological factors, level of susceptibility to peer pressure, childhood adversities & academic engagement with some cultural influences directed an adolescent to substance dependency, which again proved the significance of parental role in substance dependency (Miller & Cook, 2017).

1.8 Rationale

The prevalence of mental disorder of children and adolescent is varied from 13.4% to 22.9% in Bangladesh (Hossain, Ahmed, Chowdhury, Niessen&Alam, 2014). Another study stated that, behavioral problems among rural children are 14.6% (Khan, Ferdous, Islam, Sultana, Durkin & McConachie, 2009) whereas, prevalence of depression among disadvantaged adolescents is 14% (Nasreen, Alam & Edhborg, 2016) . In clinical setting the numbers of child cases are almost equivalent with adult cases. These gives us an essence that

children and adolescents are in need of psychological services specially who are at high risk like adolescents whom parent are substance dependent.

Substance dependency is one of the pernicious and over-burdened concerns for our country. As we have been in rodent effects of substance dependency for several decades, our exponential estimation can tell that if appropriate management methods cannot be implemented, then contemporary substance dependent youth would gradually turn to a large number of older substance dependent within a short time. In due course, they will become parents with children soon and make offspring vulnerable to above mentioned difficulties as the result of the vicious cycle of drug dependency. But from earlier mentioned research it is also evident that little concern has been given to the off-spring of substance dependent person. The effects of parental addictive behavior and how their adolescents cope with the family environment is also needed attention from the community.

Consistent with the literature of western cultures, a vast number of adolescents in our country are currently living with at least one substance dependent parent. Though many substance related studies have been done to date focused only on substance dependent individuals, unfortunately no initiative was taken to investigate the effects of parental substance dependency on children and adolescents till date.

The rationale of the present study is that, as adolescence is a sophisticated developmental period, the distress due to parental addiction and faulty coping strategies could be results in vulnerable adult thus causal attention and specific intervention needed to be studied. From the present study we could come to know in what extent one or both substance dependent parents play a vital role in adolescent's psychological distress. It is evident from current research trend that the emphasis is on young substance dependent individual as large numbers of young are getting into it. But a large number of adult populations are also suffering from the problems that are forgotten intentionally or unintentionally. The impact of

those forgotten people could have greater effect on our nations' upcoming generation as those people do belong from families, societies and nation. From the present study we could come to know about their rodent impact, partially or wholly.

Earlier studies covering substance dependency mainly focused on psycho-social factors related with relapse, role of family and society in treating substance dependency causes of substance dependency, prevalence of substance dependency, and psycho-social factors of female drug dependency. The research trend followed in our country is varied widely with other countries. In western world the trend of research in substance dependency is mainly evidence-based where they emphasized on genetic predisposition of substance dependency, effect of parents and peers in adolescent years, assessing risk of substance dependency among pregnant women & women in reproductive ages, effect of substance dependency on development, neurological disorder as a result of substance dependency etc. This bunches of studies plays a crucial role in preventive work. It is demand of time to conduct studies those have much concerned with preventive work.

In current study the initiative was taken to compare these extremely vulnerable adolescents with other adolescents by using case-control method. The study will not only provide picture of older substance dependent and vulnerable adolescents, it will also create awareness in community.

1.9 Objectives

The main objective of the current study was to investigate the level of psychological distress among adolescents whose parent(s) had substance dependency problems and nature of their coping strategies. . Along with this, some other specific objectives were also tried to find out, that are as follows,

a) To explore the demographic features of substance dependent parents of adolescents.

b) To explore the prevalence of psychological distress among adolescents of substance dependent and non-dependent parents in Bangladesh.

c) To explore the factors play significant roles in predicting psychological distress among the adolescents.

d) To explore the predominant coping strategies used by the adolescents.

CHAPTER 2

METHODS

2.1 Participants

The sample of present study was constituted with case group and control group with adolescents of 12-17 years. A sample of 417 adolescents (*M*= 13.63, *SD*= 1.61) were collected through drug rehabilitation and detoxification centers and schools. The case group was consisted of 139 adolescents who were offspring of parents currently admitted to a drug addiction rehabilitation centre for treatment of their dependency problem. The control group was consisted of 278 adolescents of parents without any substance dependency. We excluded those adolescent offspring of substance dependent parents who were already substance dependents themselves sand/or had diagnosed with developmental disorders (like, autism spectrum disorders and intellectual disabilities)and/or any psychotic disorders (like, delusional disorder, schizophreniform disorder, schizophrenia, schizoaffective disorder, catatonia and attenuated psychosis syndrome and shared psychotic disorders), adolescents who were not aware of their parents' substance dependency and when the other parent and/or guardian of the adolescent were not willing to allow him/her to participate in the research. Family with more than two adolescent children was also excluded so that each adolescent have been representing only one family in both groups, since this is suggested in improving convenient sampling methods .By controlling the above mentioned factors a robust strategy was adopted to draw a reliable and valid conclusion. For all of the demographic information two independent sources of data (child and parent) were used. Permission for data collection from female drug rehabilitation centers were not given thus in case group only substance dependent fathers were included. However, the patterns of substance dependency among treatment receiving fathers were addressed through current study. All demographic information regarding adolescents and their parents are given in the Table 1.

Table 1.

Pattern of substance dependency among substance dependent parent

Factors	Number (N=139)	Percentage(%)
Age of the substance dependent parents (Father)		
35-45 years	57	41%
46-55years	57	41%
above 55 years	25	18%
Educational qualification		
Illiterate	12	8.6%
Class 1-H.S.C	92	66.2%
Graduate	22	15.8%
Postgraduate	13	9.4%
Professions		
Service holder	17	12.2%
Business	46	33.1%
Other(self-employed etc)	55	39.6%
Unemployed	21	15.1%
Main drug intake		
Alcohol	32	23%
Amphetamine	50	36%
Heroine	47	33.8%
Injecting substances or others	10	7.2%
Total duration of substance dependency		
One year to five years	12	8.6%
More than five years	127	91.4%
Earlier treated by drug addiction treatment center		
Yes	88	63.3%
No	51	36.7%

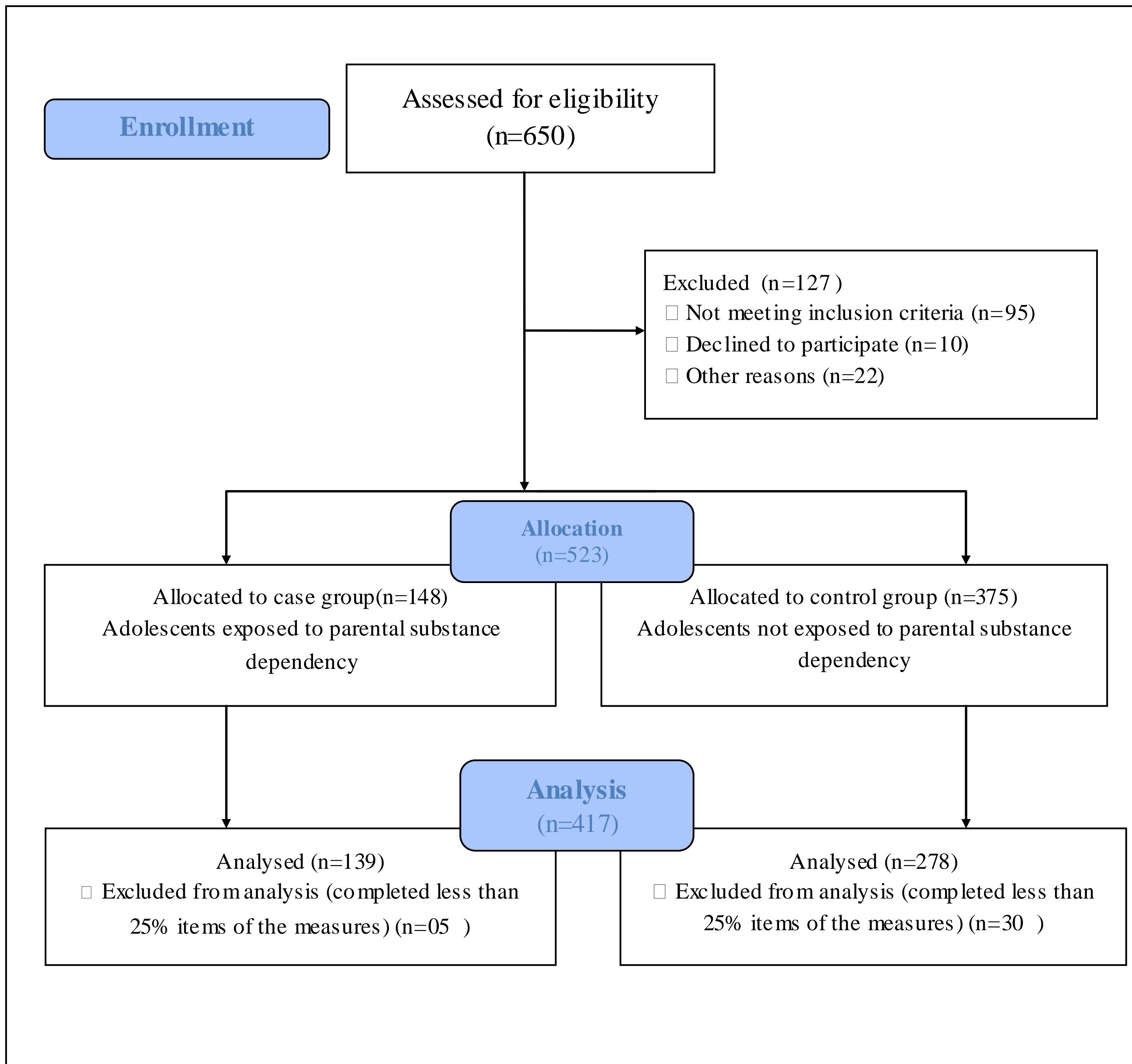
2.2 Sampling procedure

Present study was of a case-control study. Case-control study is an observational retrospective study as it begins with outcome and backwardly leads to exposure of some condition (Alexander, Lopes, Ricchetti-Masterson &Yeatts, 2015). It proceeds from effect to cause (Schlesselman, 1982). Sampling of case-control study is determined by taking the equal, double or more number of the participants for the control group than case group, which could be matched or unmatched (Mandrekar &Madrekar, 2008). For the current study, unmatched sampling was followed by taking two sub-samples of two groups.

The sample size calculation was conducted using methods of Kelsey, Fleiss and Fleiss with continuity correction (Kelsey, Whittemore, Evans & Thompson, 1996; Fleiss, 1981). Sample was estimated considering minimum odds ratio of 2, 20% of adolescents were exposed among controls, power was 90%, number of controls per case was 2 and the alpha risk was 5. With this target sample, size we had approached 625 adolescents and their parents. Among them 127 adolescents were excluded as they didn't fit to the inclusion criteria. Since we, targeted 139 sample for case group so we stopped collecting for case group. In control group 300 control data were found with no missing data. Since, we were following 1:2 case and control participants so random numbers (1-22) were used for excluding data. The procedure of sampling is shown in Figure 1.

Figure 1.

Procedural flowchart of participants in case-control study



2.3 Measures

Psychological distress of the adolescents was measured by measuring depression, anxiety and stress reactions. In current study, three separate measures for depression, anxiety and stress reactions were used. They are described in the following paragraphs. Permissions were taken from the authors of the all scales. Demographic and substance related background information was collected from both parents of each adolescent.

2.3.1 Measure for assessing depression. Depression was measured by Short Mood and Feelings Questionnaire-SMFQ (Angold, Costello, Messer, Pickles, Winder & Silver, 1995). We had used the Bengali version of the measure (Deeba & Rapee, 2014).SMFQ was developed to identify DSM-IV-based signs and symptoms of depressive disorders in children and adolescents aged 6–17 years. The scale is scored on a 3-point Likert-type response scale 0 (Never); 1 (Sometimes true) and 2 (Always true). The total score is the sum of all items providing possible scores ranging from 0 to 26 with higher scores reflecting lower mood and risk of clinical level depression. The SMFQ has been shown to comprise a single factor and has good criterion-related validity and discriminant validity to identify clinical levels of depression in children and adolescents (Angold et al., 1995; Thapar& McGuffin, 1998). Cronbach's alpha for the SMFQ has been reported ranging from .87 to .90 (Angold et al., 1995). For the Bangladeshi children and adolescents, Cronbach's alpha was strong at .80 and convergent validity was (r=.44, p<.001) (Deeba, Rapee&Prvan, 2014).Reliability for present sample was .79Cronbach's alpha.

2.3.2 Measure for anxiety in adolescents. Symptoms of anxiety in the adolescent participants were measured with the Spence Children's Anxiety Scale-20 (Deeba, &Rapee,2014). The SCAS-20 is a short form of the more commonly used 38-item scale of Spence Children Anxiety Scale(Spence, 1998; Spence, Barrett & Turner, 2003). The

responses on items arerated on a 4-point Likert-type scale as 0 (never), 1 (sometimes), 2 (often) and 3 (always) and summed to obtain a total score where higher scores indicate higher levels of anxiety. Items for the short version were selected from factor analyses of the full version. All subscales of the scale are related through a single higher order factor.

The psychometric properties of the SCAS-20 among Bangladeshi children and adolescents showed good internal consistency (Cronbach's alpha .84) and satisfactory construct validity (convergent validity, r=.60, p<.001) for the scale (Deeba, Rapee&Prvan, 2014) which is also conform to the original scale. The reliability for the present sample is .85 Cronbach's alpha, which indicates the scale's functionality intact.

2.3.3 Measure to assess stress reactions. To measure the stress reactions, Children's Revised Impact of Events Scale-13 (CRIES-13) was used. CRIES-13 is derived from the original 33-item Impact of Events Scale (Horowitz, Wilner& Alvarez, 1979). It has two version-CRIES-13 & CRIES-8. Internal consistency ranges from .75 to .87 for CRIES-13 and .75 to .84 for CRIES-8.The validity for both the version proved satisfactory. The items on the scale are scored on a four-point scale, 0(not at all); 1 (rarely); 3(sometimes); 5(often). There are mainly three subscales: intrusion, voidance and arousal. Test retest reliability up to 7-day is .76-.85 for CRIES-13 and .75 for CRIES-8.

Bengali version of CRIES-13 (Deeba, Rapee & Prvan, 2014) was used in current study. The Internal consistency of the Bengali-version CRIES-13 range from .75 to .87. In scoring CRIES-13, scores from 0 to 65 indicates greater PTSD symptoms, whereas, a cut-off score of 30 balance between sensitivity and specificity. The reliabilityof the Bengali version CRIES-13 with our current sample and it was found .87Cronbach's alpha.

2.3.4 Measure for assessing coping strategies. Kidcope-Child Form (Spirito, Stark &Williams, 1988) was used to measure the coping strategies of adolescents. It is a brief- self-reportform. The scale was validated for children and adolescents from community as well as those with different chronic diseases and diversified condition (Thabet, 2017; Cosma&Baban, 2017; Pereda, Forns, Kirchner & Munoz, 2009, Miller, Sabin, Goldman, Clemente, Sadowski, Taylor & Lee, 2000). It has two versions, one for younger (7-12 years) and other for older adolescents(13-18 years). Version for younger group has 15 items and version for older grouphas 11 items consisted of 10 general cognitive and behavioral coping strategies. The scores of 11 items give results on two aspects- frequency of coping strategies (that is-how often did one use one coping strategies?) and efficacy of coping strategies (that is-how much did the coping strategy helped?). For the present study version for older adolescent was used. Scores on items of Kidcope indicates three dimensions: 1). Active coping (cognitive restructuring, problem solving, emotional regulation, and social support), 2) Avoidant coping (distraction, social withdrawal, resignation, and wishful thinking), and 3) Negative coping (self-criticism and blaming others). Participants in case group were asked whether they found their parent's substance dependency problems stressful and adolescents in control group were asked to identify any stressful situation at present and rate how much they found the situation stressful. Both group of adolescents were asked to rate (frequency)whether they use each strategy on a 4-point Likert scale from 0(*Not at all*) to 3 (*almost all the time*) and to rate how much they found each strategy effective (efficacy) on a 5-point Likert scale from 0(*Not at all*) to 4(*very much*).

As Bangla version was not available, after the author's permission following formal method the scale was translated and administered. For current study only the older version on adolescents were used. The Kidcope was reported moderate (0.41) to fairly high (0.83) test-

retest reliability. The item reliability for less than 1 week is .41 -.83 and stability over 10 weeks is .15-.43. Item correlation with other coping scales ranges from .33-.77.

Other studies on factor analysis of Kidcope showed that mostly one to three-factor structures is explored invariant across age and gender (Vigna, Hernandez, Kelley & Gresham, 2009; Tak-Cheng & Chan, 2010; Spirito, 1996). As original author suggested conducting factor-analysis for own sample, most of the studies which used Kidcope explored psychometric properties separately for their own sample. Like, Bedel, Isik and Hamarta (2014) conducted both EFA (Exploratory factor analysis) and CFA (confirmatory factor analysis) for their own sample where, internal consistency score of subscales were α=.72 for active coping, α=.70 for avoidant coping and α=.65 for negative coping. In scoring Kidcope, studies mostly analyzed the individual score of frequency and efficacy of each coping strategies (Thabet, 2017; Cosma & Baban, 2017; Pereda, Forns, Kirchner & Munoz, 2009; Rathner & Zangerie, 1996; Marsac, Donlon, Winston &Kassam-Adams, 2011). Study showed that adolescents mostly used cognitive restructuring and resignation coping strategies and problem solving, emotion regulation and cognitive restructuring were found most effective (Smith, Russell, Kelley, Mulcahey, Betz & Vogel, 2013). Comparative studies on Kidcope showed that adolescents who were at-risk and who were healthy, both mostly used positive coping (Gold, Mahrer, Treadwell, Weissman & Vichinsky, 2008). But for current study each frequency score and efficacy score were multiplied and use as a total score for each item and then sum all items which was suggested by the original author through personal communication (A. Spirito, Personal communication, May 4, 2016). The higher score denotes higher usage and effectiveness of the coping strategies and lower scores denotes less usage and efficacy. Cronbach's alpha for the current study was found for .77 indicating a good internal consistency for the scale.

2.4 Procedure

Using a case-control study design in total 417 adolescents was enrolled between March 2017 and September 2017. Ethical approval to conduct the study was granted from the Faculty of Biological Science, University of Dhaka(Number-27, See Attachment No. 4)and Department of Clinical Psychology in University of Dhaka (Project number: MP161001, See Attachment No. 5). After the ethical clearance, applications for the data collection were submitted to 63 drug rehabilitation and detoxification centers in Dhaka, seven drug rehabilitation and treatment centers at Chittagong and five centers at Bogra (sample of application to organizations in the Attachment No. 1).The lists of drug treatment and rehabilitation centers were taken from the Directory of Drug Treatment and Rehabilitation Centers which is published by Department of Narcotics control, Home Ministry, Government of People's Republic, Bangladesh, (2017). Primarily 19 centers gave permission and 14 centers refused to give permission for data collections the research work as it directly involves personal issues of the clients and their families. In addition to 19 centers, 20 more centers gave permission but after approaching the parents (both drug dependent and drug non-dependent parents) they denied to give consent for their children. During the first visit to the centers, the rationale and implication were shared with the authority of the centers'. After taking permissions from agreed organizations a list was made concerning the age of the child those were admitted in their center. Rehabilitation centers were contacted with the non-dependent and dependent parent for consent. After the consent of both parents, the adolescent was invited on a fixed date. For some cases where parents disagreed to visit the rehabilitation center with adolescent but were interested to give information in another setting home visit was done. During this time, questions concerning the research was encouraged and answered by the researcher. The whole process was completed in individual setting.

In context of adolescents from control group, written permission (See sample of letter in the Attachment No. 2) was sought from every school where the study was conducted. Informed consent from parents and primary caregivers were obtained before the administration of all the measures. Invitation letters (See sample of letter in the Attachment No. 8) were sent to the guardians of the adolescents from the school. Adolescent's participation was purely voluntary, those who was not interested to participate were excluded. Adolescents were completed the assessment task within the class time in class setting. Assessment sessions were conducted in groups of 25-30 with verbal instructions.

2.5 Data Analysis

Mantel-Haenszel and logistic regression are mostly used (Speer, Gefeller, Groneck, Laufkötter, Roll, Hanssler&Windeler, 1995) as statistical analyses in case-control study. It is found that according to the types of questions or objectives answered by any case-control study generally, chi-square and Fisher's exact test are used for association (Golshiri, Akbari&Zarei, 2017).

Descriptive statistics, correlation, chi-square, ANOVA, independent sample t-test and stepwise linear regression was computed in present study. Odd ratio and relative risk was also computed to explore the association along with the differences (Schechtman, 2002). Odd ratio is the measure of association between the exposure and outcome, which is mostly prevalent in case-control study (Szumilas, 2010). On the other hand, relative risk is the ratio of risks (Stare & Maucort-Boulch, 2016).Linear regression is generally used to identify whether the assumed predictors could predict outcome variable through description, estimation and prognostication (Schneider, Hommel & Blettner, 2010). The mentioned analysis were also suggested by various studies to compare the means between case and control group (Kuypers, Legrand, Ramaekers, Verstraete, 2012; Betancourt et al, 2014; Golpour, 2012).

CHAPTER 3:

RESULTS

3.1 Descriptive statistics

Among the adolescents of substance dependent parents 173 (before allocation) adolescents were approached and 148 adolescents were finally participated during the period of seven months. Among the total approached eight adolescents were found who are also undergone the drug addiction treatment for their own substance dependency. Three hundred and fifty adolescents were participated from three schools. Those who completed less than 25% items of the measures were excluded (N=52) from the analysis for both groups. Throughout the sample 1.85% adolescents were currently living with substance dependent father, where 64% were relapsed cases and 91% of fathers were practicing substances for more than five years. Sample only consists of adolescents of substance dependent fathers due to the inaccessibility of substance dependent mothers. Findings of the present study showed that 33% of adolescents of the sample were currently living with substance dependent fathers. Descriptive statistics findings showed that there are there were differences in demographic variables between adolescents of substance dependent parents and adolescents of substance non-dependent parents (shown in Table 2). The two groups differed significantly on various social-demographic variables apart from age and gender (please see, Table 2).

3.2 Bivariate correlations

Pearson's correlation coefficients were computed to explore the strength of relationship between parental substance dependency and psychological distress and coping strategies of adolescents (see Table 3). The results showed that psychological distress were correlated with parental substance dependency (r (417) =.57, $p<.05$). There was also significant correlation between psychological distress and coping strategies (r (417) =.45,$p<.05$).

Table 2.

Differences between adolescents of substance dependent and substance non-dependent parents.

Variables	Substance dependent father's adolescents (N=139)	Substance non-dependent adolescents (N=278)	Statistics
Age (*N,% of total group*)			
12-14 years	*95, 68.4%*	190,31.6%	χ^2(5, N=417)=2.59, *p*<.762
15-17 years	*44, 68.4%*	88, 31.6%	
Sex(*N, % of total group*)			
Boys	80, 57.6%	59, 60.4%	χ^2(1, N=417)=.318, *p*<.323
Girls	168, 42.4%	110, 39.6%	
Education status(*N,% of group total*)			
Drop out of school/college	10, 92.8%	0, 100%	
On study	129, 7.2%	278, 0%	χ^2(3, N=417)=38.53, *p*<.001
Educational achievement (*N, % of group total)*			
Failed on recent examination	45, 32.4%	94, 3.6%	
Passed on recent examination	10, 67.6%	268, 96.4%	χ^2(2, N=417)=67.16, *p*<.001

Variables	Substance dependent father's adolescents (N=139)	Substance non-dependent adolescents (N=278)	Statistics
Spent time with friends(*N,% of group total)*	11, 4%	267, 77.7%	χ^2(3, N=417)=69.52, p<.001
No not spent time with friends (*N% of group total)*	31, 22.3%	108, 96.1%	
Involved in recreational activity out of school/college (*N,% of group total)*	48, 64.7%	230, 82.7%	χ^2(2, N=417)=35.70, p<.001
Do not involved in recreational activity out of school/college(*N% of group total)*	51, 35.3%	88, 17.3%	
Intake substances (*N,% of group total)*	20, 14.4%	75, 27%	χ^2(1, N=417)=8.35, p<.002
Do not intake substances(*% of group total)*	119, 85.6%	203, 73%	
Monthly income (*N*, *% of group total*)			
Low socio-economic status	48, 34.5%	28, 10.1%	χ^2(1, N=417)=40.31, p<.001
High socio-economic status	15, 10.8%	37, 13.3%	

Table 3.

Bivariate correlations and descriptive statistics between dependent and independent variables.

Measures	1	2	3	4	5	6	7	8	9	10	11	12
1.Parental substance dependency	1											
2. Psychological distress	.575**	1										
3. Distraction	.127**	.321**	1									
4. Social withdrawal	.187**	.304**	.355**	1								
5. Cognitive restructuring	-.135**	.109*	.345**	.323**	1							
6. Self-criticism	-.076	.211**	.017	.126*	.274**	1						
7. Blaming others	.471**	.395**	.092	.124*	.103*	.197**	1					

Measures	1	2	3	4	5	6	7	8	9	10	11	12
8. Problem solving	.249**	.255**	.167**	.149**	.048	.233**	.330**	1				
9. Emotion regulation	.413**	.341**	.261**	.304**	.100*	.045	.144**	126**	1			
10. Wishful thinking	-.023	.194**	.406**	.252**	.126**	.010	.136**	.217**	.217**	1		
11. Social support	-.094	.026	,224**	.064	.132**	.016	.074	.166**	.175**	.217**	1	
12. Resignation	-.182**	.012	.177**	.101	.048	.377	.587**	.551**	.454**	.166**	.175**	1

*p<.05.**p<.01.

3.3 Difference in psychological distress.

Standardized scores on SMFQ-13, SCAS-20 and CRIES-13 were summed and converted into a single variable named distress. Adolescents of both substance dependent and non-substance dependent parents were compared on their scores on distress (Table 4). The adolescents of case group scored high on all three measures and on single variable. A one-way ANOVA was conducted to compare the effect of parental substance dependency on psychological distress. There was significant effect of parental substance dependency on psychological distress at the $p<.01$ level [$F(1, 415)=27.62, p=.001$]. Age and gender wise two-way ANOVA was conducted (see, Table 4). There were significant differences between in depression of age and gender for both groups [$F(7, 417)=10.84, p=.001$]. Significant differences were also found in analyzing anxiety [$F(7,417)=14.44, p=.001$] and stress reactions [$F(7, 417)=44.86, p=.001$] for both age and gender .

Table 4.

Means and SDs of depression, anxiety and stress reactions between substance dependent parent's adolescents and substance non-dependent parent's adolescents.

	Adolescents of Substance dependent parent's *Mean (SDs)*	Adolescents of substancenon-dependent parent's *Mean (SDs)*	Statistics
Depression	9.98(5.22)	6.10(4.44)	$t(415)=2.54, p<.001, d=.36$
Anxiety	21.60(12.27)	12.80(8.49)	$t(415)=40.20, p<.001, d=.39$
Stress reactions	35.22(13.32)	14.77(10.42)	$t(415)=20.74, p<.001, d=.64$

Table 5.

Two-way ANOVA for age and gender differences in psychological distress among both groups.

Variables	Gender	Adolescents with substance dependent parents		Adolescents with substance non-dependent parents	
		Younger (M, SD)	Older (M,SD)	Younger (M, SD)	Older (M,SD)
Depression	Boys	9.73(5.25)	10.37(5.86)	5.07 (4.35)	6.62 (4.29)
	Girls	9.93 (4.93)	10.23(5.41)	6.37 (4.25)	8.17 (4.75)
Anxiety	Boys	23.28 (13.95)	17.11 (11.00)	10.24(7.86)	13.83 (7.71)
	Girls	20.02 (9.85)	24.94 (12.77)	14 (8.69)	17.0 (9.15)
Stress reactions	Boys	33.56 (14.31)	33.89 (13.06)	12.94 (9.88)	15 (10.04)
	Girls	35.50 (12.87)	41.82 (10.17)	15.78 (10. 51)	18.37(11.92)

3.4 Frequency and efficacy of coping strategies.

Frequency and efficacy score of KidCOPE were multiplied and a total score for each item was sought which was summed up to get a single variable score (A. Spirito, Personal communication, May 4, 2016). An independent sample *t*-test (see Table 5) was conducted to compare the each coping strategies in both groups of adolescents. There was significant difference in the scores for adolescents with substance dependent parents (M=25.49, SD=11.20) and adolescents with substance non-dependent parents (M=18.22, SD=16.94), $t(414) = 4.58$, $p= .001$. F test was conducted to get an overall differences between groups [$F(1,414)$=20.99, p=.001, d=.81]. Adolescents of substance dependent parent used all three types (Active, avoidant and negative)

of coping strategies. Whereas, adolescents of substance non-dependent parent mostly used active coping strategies in resolving their day to day life stresses.

3.5 Odds ratio of psychological distress

Odds ratio was conducted to predict the psychological distress among the adolescents of substance dependent parents. Here, the reference category was 1. For depression, scores more than 11 were considered depressed, for anxiety, scores more than 23 were considered as anxious and for stress reactions, scores more than 30 were considered as more stressed. The findings of odds ratio shows that the cases (adolescents of substance dependent parent) have a 3.39 lower odds (through the reverse way) to develop depression, 4.57 lower odds to develop anxiety and 31.25 lower odds to develop PTSD of the event than the controls (Table 6).It showed that the exposure to parental substance dependency is negatively related and associated to psychological distress.

Table 6.

Independent sample t-test for coping strategies among adolescents of substance dependent parent and substance non-dependent parent.

Coping strategies	Adolescents of substance dependent parent (*N*=139)		Adolescents of substance non-dependent parents (*N*=278)		Statistics	
	M	*SD*	*M*	*SD*	*t*	*P*
Active coping						
Cognitive restructuring	1.65	2.90	2.58	3.39	-2.771	.006
Problem solving	3.45	3.62	1.72	2.92	4.883	.001
Emotion regulation	5.30	3.85	1.94	3.32	8.77	.001
Social support	1.46	2.69	2.09	3.39	1.928	.005
Avoidant coping						
Distraction	2.59	2.99	1.78	3.05	2.606	.009
Social withdrawal	2.25	3.05	1.17	2.47	3.616	.001
Resignation	.78	2.08	1.89	3.15	-4.295	.001
Wishful thinking	1.87	2.95	2.02	3.03	-.460	.646
Negative coping						
Self-criticism	1.22	2.50	1.64	2.71	-1.544	.123
Blaming others	4.91	4.06	1.31	2.62	9.469	.001

Table 7.

Odds ratios to predict depression, anxiety and stress reactions among adolescents of substance dependent parents.

Predictor variables	Depression		Anxiety		Stress reactions	
	Odds ratio	CI	Odds ratio	CI	Odds ratio	CI
Parental substance dependency						
Yes	.29	.18-.47	.21	.13-.36	.03	.01-.06
No	1		1		1	

Note. OR= Odds Ratio, CI= Confidence Intervals.

3.6 Predictors of psychological distress.

The standardized score of SMFQ-13, SCAS-20 and CRIES-13 was summed and created a single estimate for psychological distress. Stepwise linear regression was conducted to find out the predictors of psychological distress. Parental substance dependency, current class of studying, time spent with friends, recreational activities out of school/college, both positive and negative coping strategies were entered as predictors along with result of last examination, gender and age of the adolescents. Overall the predictors accounted for 55% of the variance in psychological distress, where parental substance dependency have 33% of variances for psychological distress among adolescents (F (12,415) =40.68, p<.001). Parental substance dependency, B= 1.22, t(417)= 14.29, p<.001;self-criticism B=.09,t(417)= 6.64p<.001, distraction (avoidant or negative coping)B=.08,t(417)= .24p<.001, socio-economic status B=.16,t(417)= 4.16p<.001, educational status B=.39,t(417)= 4.16p<.001, blaming others B=.03,t(417)= 3.15 p<.001, gender of adolescents B=.20,t(417)= 2.84p<.001, wishful thinking B=.03,t(417)= 2.75 p<.001, intake of substance by adolescents

B=.25,t(417)= 2.97p<.001, social withdrawal B=.03,t(417)= 2.19 p<.008, result of last examination B=-.12 ,t(417)= -2.15 p<.032, chronically relapsed parent B=.23 ,t(417)= 1.99 p<.001were found to be the predictors of adolescents psychological distress. Total duration of parental substance dependency, B=-.15,t(417)= -.69p<.493, age of the adolescents B=.05,t(417)= 1.34p<.181, time spent with friends B=.01,t(417)= -.35p<.724, recreational activities outside the school/ college B=.05,t(417)= .-1.31p<.191, cognitive restructuring B=.01,t(417)= .38p<.704, problem solving B=.07,t(417)= 1.96p<.050, emotion regulation B=.07,t(417)= 1.67p<.095, social support B=.02,t(417)= .68 p<.494, resignation B=.05,t(417)= 1.40p<.161 are excluded from the model.

CHAPTER 4:

DISCUSSIONS

The main objective of the current study was to explore the psychological distress among adolescents of substance dependent parents in comparison with adolescents of substance non-dependent parents. The further objectives were to explore the nature and differences of coping strategies among the two different groups of adolescents. We also wanted to see the factors that can predict the distress among the adolescents. Results showed that adolescents of substance dependent parents are more psychologically distressed than adolescents of substance non-dependent parents which also found in other studies conducted in other countries (Merikangas, Dierker& Szatmari,1998; Zimić, &Jukić, 2012; Morton & Wells, 2017; Lander, Howsare, & Byrne, 2013).Adolescents of substance dependent parents scored high on all three parameters (depression, anxiety and stress reactions) that were summed to represent psychological distress compared to the other group of adolescents. The findings also suggest that, differences of scores in stress reactions were more than two times higher among adolescents of substance dependent parents, which is very alarming. These elevated stress reactions among adolescents of substance dependent parents increase their vulnerability to being mentally ill (Middelton-Moz &Dwinell, 2010; Smith & Watson, 2016).

Our study showed that there are gender and age differences in psychological distress and coping strategies in the two groups. It was found that both older adolescents girls of both groups were depressed than younger adolescent girls. Whereas, younger boys and older girls of substance dependent parents were more anxious. Though, among adolescents of substance non-dependent parents older boys were more anxious. In analyzing stress reactions, our findings suggested that both younger and older adolescents and girls were highly stressed. For both groups females in late adolescence years were more psychologically distressed than male in early adolescent years. Adolescent girls of both groups scored comparatively higher on psychological distress than boys which was also evident in early studies (Fagg, Curtic, Stansfield&Congdon, 2016; Kleppang, Thurston, Hartz&Hagquist, 2017).

Significant differences were found across groups for coping strategies (see, Table 6), where adolescents of substance dependent parents mostly used active and avoidant coping. Among active coping strategies, emotion regulation, problem solving, among avoidant coping strategies, distraction, social withdrawal and among negative coping strategies blaming others were most frequently used and also found effective. Whereas, adolescents of substance non-dependent parents mostly used active coping strategies, though avoidant coping strategies were also used at minimal level. Among active coping strategies these adolescents mostly used cognitive restructuring, social support, emotion regulation, as well as among avoidant coping strategies, wishful thinking and resignation were found mostly used and effective. From this, we could assumed that, though both groups of adolescents were coping to deal with distresses, significant differences were found between the coping strategies, which can predict their distress.

Moreover, in analyzing distress among adolescents of substance dependent parents it could be assumed that as adolescents had to go through adverse childhood experiences, they also had to cope for long time. Probably these adolescents were trying to cope with life stresses using positive coping strategies which made them more resilient which was also found by the study of Morris (2017). Studies on resilience showed that, both active and avoidant coping strategies were associated with resilience (Booth & Neil, 2017; Lee, Seo, Lee, Park, Lee, & Lee, 2017).

Though earlier findings showed heightened risk of developing psychiatric disorders or deteriorating mental health among adolescents of substance dependent parent (Elam et al., 2016; Kendler, Ohlsson, Sandquist&Sandquist, 2016; Reilly, Noronha, Goldman &Koob, 2017) numerous studies had also indicated resilience among these at-risk adolescents (Liebschutz, Crooks, Rose-Jacobs, Cabral, Heeren, Gerteis& Frank, 2015; Parsai, Voisine, Marsiglia, Kulis&Nieri, 2009; Godsall, Jurkovic, Emshoff, Anderson &Stanwyck,

2004;Skinner, Haggerty, Fleming & Catalano, 2009).Related with this, another study showed that when dealing with chronic stresses like, chronic illness and situations which demanded gradual deterioration, adolescents reported low level of depression, anxiety and used more adaptive or positive coping (Undheim & Sund, 2017), which is also found in current result.

The findings of current study showed significant positive association between parental substance dependency with psychological distress and coping strategies, socio-economic status and substance intake by adolescents, gender of adolescents and psychological distress, psychological distress and coping strategies. All these associations indicated the significance of parental substance dependency on adolescents' psychological states of well-being.

In predicting psychological distress it is found that adolescents who are currently living with substance dependent parents, who are female, used substances at least once in their life time, studying at higher grades, belongs to high socio-economic class, having good grades in examinations, parents having the history of chronic relapses and used negative(self-criticism and blaming others) and avoidant(distraction, social withdrawal and wishful thinking) coping strategies are more at risk for psychologically distressed. From these findings it could be assumed that parental substance dependency and avoidant and negative coping strategies are the most significant predictors of psychological distress on the model predicting distress (Neil, 2007; Shaheen&Alam, 2010; Fatima &Tahir, 2013).

Earlier studies on adolescents of substance dependent parents showed that these adolescents are at high risk of early initiation of substance abuse (Negussie, 2012; Hamdulay, Mash, 2011; Birhanu, Bisetegn &Woldeyohannes, 2014; Milligan, Meixner, & Usher, 2017) that is also found in the findings of present study. Remarkably, present study explored that rate of substance intake is also prevalent on adolescents of substance non-dependent parents along with adolescents of substance dependent parent. This finding conforms with the social stress model (Rhodes & Jason, 1990) of substance abuse among adolescents where protective

factors strongly contribute to resiliency of adolescents of substance dependent parents in the face of stress. Evidence from prior findings also suggested that initiation of substance use and dependence of adolescents partly depends on types of substances used by parents, one or both parents' dependency, cultural contexts, personality factors of adolescents, parenting behaviors and co-morbidity of other mental disorders among parents (Williams &McGillicuddy-De, 1999; Anda et al, 2000; Li, Pentz& Chou, 2002; Kiral, Yetin, Ozge&Aydin, 2015; Monteiro, Balogun&Oratilo, 2014; Wlodarczyk, Schwarze, Rumpf, Metzner&Pawils; 2017; Marmorstein, Iacono&McGue, 2009; Arria, Mericle, Meyers & Winters, 2011; Nunes, Weissman, Goldstein, McAvay, Seracini, Verdeli &Wickramaratne, 1998). These factors could also have worked as protective factors for adolescents of substance dependent parents. While coping with stress many adolescents intake substances, results of current findings showed that coping strategies used by adolescents were negatively associated with substance intake which proved the importance of adaptive or positive coping(Cao, Qi, Cai& Han, 2018' Thompson, Fiorillo, Rothbaum, Ressler&Michopoulos, 2018).

Current results suggested that parental substance dependency could create considerable impact on adolescents' life conditions. For instance, adolescents of substance dependent parents showed higher rates of school dropouts, failure on last examination, poverty, dependent parents unemployment and other parents imposed employment, less involvement in recreational activities and friends than community adolescents which confirmed the findings of earlier studies on plight of substance dependent parents' families (Suris, Michaud & Viner, 2017; Roos, Boes& Bot, 2016; Gruber & Taylor, 2006; Dieck, 2013; Thomas, 2011; Feidler, Mooney, Nakashian, Shuman &Tacy, 2009; Suikkanen&Virtala, 2010; Jessica et al, 2012; Paya et al, 2015; Rainville, Dumont, Simar&Savard, 2012; Carbonneau, Vitaro& Tremblay, 2015; Savard, 2012). However,

adolescents of substance non-dependent parents also scored moderate on psychological distress which could poses threat to these adolescents for psychiatric disorders or mental health in no time (Caron, Fleury, Perreault, Crocker, Tremblay, Tousignant& Daniel, 2012; Horwitz, 2007; Payton, 2009; Phillips, 2009). Studies on prevalence of adolescents mental disorder supported the result by explaining that today's adolescents are more distressed than ever before in both western and eastern cultures(Sweeting, West & Young, 2010; Collishaw, Maughan&Natarajan, 2010; Twenge, Gentile &DeWall, 2010; Deeba&Rapee, 2015; Billah& Khan, 2014). The finding of current study also shed lights on the fact that community children are also psychologically distressed.

Taken together, all results from the current study indicated that parental substance dependency is one of the significant factors of psychological distress among adolescents, where coping strategies used by adolescents of substance dependent parents are also played a determining role for their distress. Hence it can be assumed that the adolescents with substance dependent parents are at greater risks for development of, depression, anxiety and post-traumatic stress disorder since there is ambivalent nature of coping strategies. These findings have significant implications. First, it is apparent that all adolescents of substance dependent parents reportedly fall within the range of vulnerable group. Interestingly, adolescents of substance non-dependent parents were also at minimal risks of psychological distress. These emphasize the importance of parenting; as in various findings mentioned earlier have found substance dependency of a parent has greater impact on parenting (Mares, Warren & Newman, 2011; Mayes & Truman, 2002). However, the current findings showed that apart from basic parenting behaviors or techniques some other skills, additional quality or features are needed to ensure sound mental health of offspring (Trivette&Dunst, 2014; Annan, Sim, Puffer, Salhi& Betancourt, 2017;Prinz&Neger, 2017; Morris, Robinson, Hays-Grudo, Claussen, Hartwig& Treat, 2017).

In addition, the results also indicate that adolescents with substance dependent parents need psychological intervention on individual or group settings. Along with them, adolescents with substance non-dependent parents are also in need of psycho-social support in school as well as community settings for creating awareness. Importantly, both group of adolescents are coping somewhat with positive coping strategies and also found positive coping effective in comparison to negative and avoidant coping which is one of the mentionable findings of current study.

Future studies need to investigate the reason or mechanisms behind the resilience and resistance among the adolescents of substance dependent fathers. One possibility could be as our culture is more restricted and absence of parent figure (due to illness or death) is often reminded repeatedly by society which works as resistant factor. In addition, positive coping often leads to resiliency which is evident among the adolescents of substance dependent parent (Leipold & Greve,2009; Campbell-sills, Cohan & Stein, 2006; Crane &Boga, 2017, Velleman&Tempton, 2016) . Reason behind lower report of substance intake among adolescents of substance dependent fathers could be underscore in reporting due to societal stigma.

Although the findings of present study extend the current literature, longitudinal study could better explain the relationship between adolescents' psychopathology and parental substance dependency in more exclusive way. However, the findings somewhat uphold why some adolescents adjusted more than other and why the prevalence rate of mental illness is increasing in our country.

4.1. Conceptual utility of the findings

As per diathesis-stress model, the adolescents of substance dependent parents are going through an ambivalent condition with continuous coping (both adaptive and maladaptive) for long time. This imbalance use of strategies may be indicate their

vulnerability to distress as it seems they effortfully using active strategies to cope but high use of negative strategies may be the reason for vulnerability to develop any psychopathology under some unpredictable stressful situation.

Individual whether he/she is an adult, children or adolescent when face stresses in their lives intrinsically take initiatives to cope. In the context of our current study, before enter into adolescence a child went through the family condition affected by parental substance dependency. Thus the child went through few family crises that creates stress and in long run results in psychological distress. In current study the manifestation of psychological distress were examined at adolescence. Here, parental substance dependency pose as family as well as parental stress, which results in distress and demanded coping (Reed-Knight et al, 2017) among adolescents. The findings showed that adolescents with substance dependent parents went through plight with an impact on their mental health. According to the objective of current study, the psychological distress and coping strategies used by the adolescents of substance dependent parents were sought. The graphical presentation of the study is shown in Figure 2.

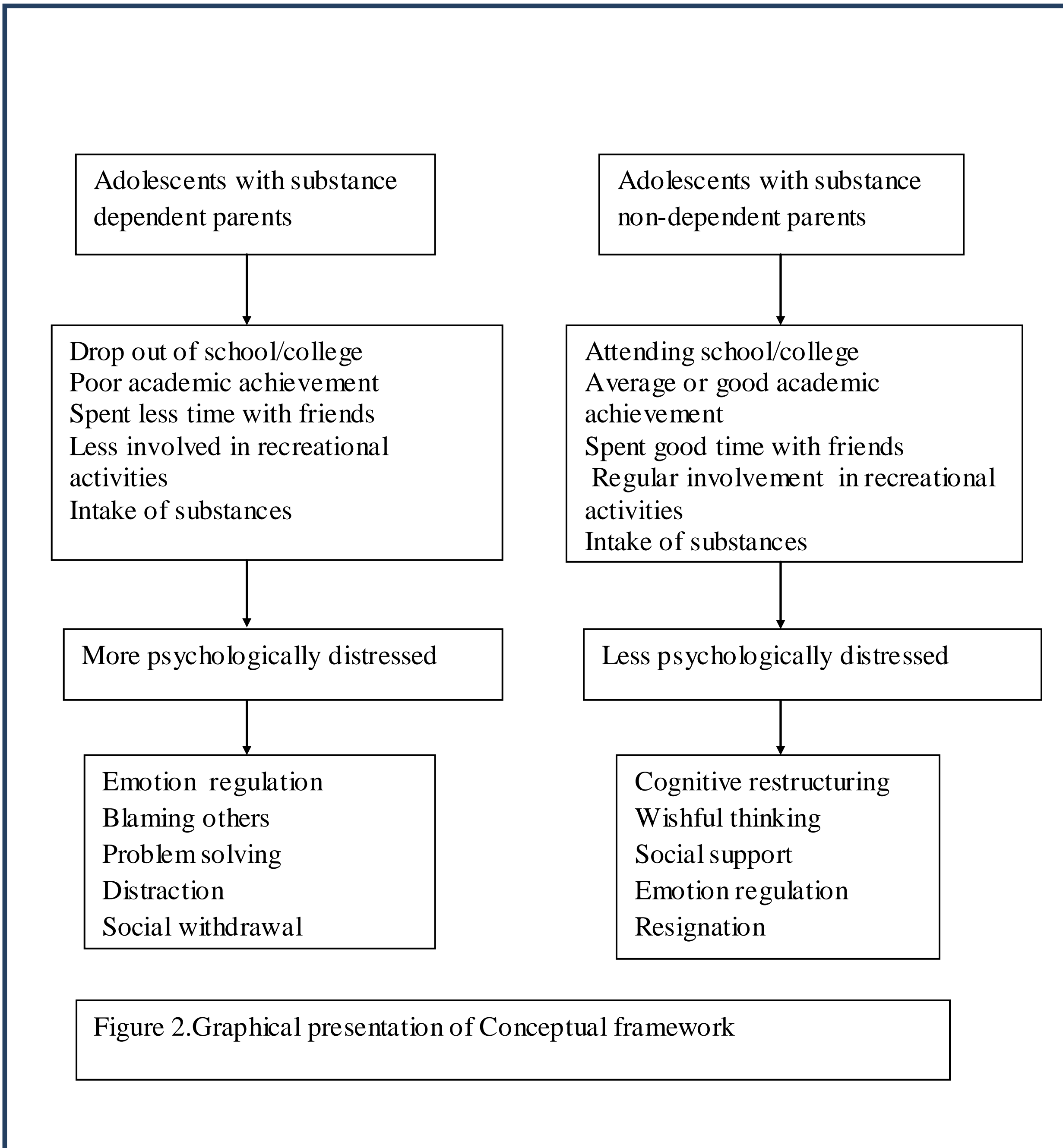


Figure 2.Graphical presentation of Conceptual framework

4.3 Limitations

There were several limitations to this study. First of all, not all socio-economic classes were included in our sample for adolescents of substance dependent parents due to social stigma regarding the substance dependency problem and treatment. There are possibilities that, adolescents of substance dependent parents often under-score on their self-report measures due to stigma or resistance to acknowledgement. Moreover, substance dependent mothers were not included in the study that would make the result more valid by giving the complete picture. Though initiatives were taken to negotiate with the authorities.

Despite these limitations, the study could have made some significant contributions to the literature of drug dependency field by examining the effect of parental substance dependency among adolescents through the manifestation of psychological distress and prevailing coping strategies. The findings highlight the need to adopt an evidence-based treatment and prevention programs not only for the individuals but also their family members and children (Griffin &Botvin, 2010; Aktan, Kumpfer & Turner, 2009). Preventive measures and early intervention strategies could be managed to identify mental health problems of such vulnerable young people who are the future of any community or a country.

4.3. Recommendations

The results of the current study indicate statistically significant elevated rates of psychological distress among the adolescents of substance dependent parents. To ensure these adolescents' healthy mental health more research works are needed to do with larger samples and including participants from all social classes or races. Future works should emphasize on various important topics, for instance, family or genetic or neurobiological contributions to psychopathological risks among these vulnerable group of adolescents. Future works also should focus on protective factors related to initiation of substance abuse and the early warning signs leading to psychopathology.

The findings of current study suggested that adolescents of substance dependent parents are in need of intensive treatments, both medical and psychotherapeutic. Among those, several initiatives could be taken for adolescents with intensive focus on the whole family by emphasizing improving family communication, reducing family conflict and promoting parenting skills. Behavioral couple therapies, couple-based psycho-educational attention control treatment (PACT) as well as integrated treatment programs could also mark significant behavioral and cognitive changes upon the whole family along with the children (Calhoun, Conner, Miller &Messin, 2015).

In addition to individual intervention works, informative and interactive techniques focus on collective preventative attempts that could be used with 'normative education curriculum' for adolescents in both community and school settings. Effective problem solving or management techniques, focused on interpersonal skills, such as, drug refusal skills, sticking to anti-drug norm, personal self-management skills, general social skills, enhancing social, emotional, behavioral, cognitive and more competencies, building self-efficacy, involving adolescents as leadership role and improving social relationships (Velasco, Griffin, Botvin, Celata & Lombardia, 2017; Beckman, Svensson, Geidne& Eriksson, 2017; Sanchez, Valente, Sanudo, Pereira, Cruz, Schneider & Andreoni, 2017). Eventually, we therefore, recommend to conduct various research studies so that pathways to create a social and cultural context that is essentially supportive and helpful for these people to recover permanently from existing psychological problems and become resilient to any future vulnerabilities. For instance, in the perspective, we could plan prevention steps through assessing the adolescents of substance dependent parent when the parent is getting admitted, if found proper measures and initiatives should be taken for him or her. Educational settings like school, college, university-based workshops and training could be imparted to raise awareness and enhance social influence on substance dependency.

CHAPTER 5:

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CHAPTER 6

APPENDICES

Date :

To
The Director
Drug Addiction Treatment Center

Subject: **Permission for data collection.**

Dear Sir,

I am currently enrolled in the M.Phil degree program of Department of Clinical Psychology, University of Dhaka. As part of my degree works requirement, I am conducting a research entitled **" Psychological distress and coping strategies among the adolescents of substance dependent parents "** under the supervision of Dr. Farah Deeba , Associate Professor, Department of Clinical Psychology, University of Dhaka. The study will help us to know the role of parental dependency on substance for predisposing children's distress which could be results in vulnerable adults.

Since your organization gets in contact with relevant groups of adolescents as their parents seek intervention for their substance dependency, I would be highly grateful to you if you allow me to assess such adolescents and their parents for my research. Confidentiality and all other research ethical issues will be followed during data collection. Please note that I have received ethical clearance for conducting the study from Ethical committee of Department of Clinical Psychology, University of Dhaka.
I therefore, request you to give me an approval of working with your staff and clients for collecting data for my research.

Sincerely Yours

Mahjareen Binta Gaffer
Registration no. 056/2015-16
Department of Clinical Psychology
University of Dhaka
Contact no. +8801676095159

Date :

To
The Principal
University Laboratory School & College
1000, Nilkhet Road
Dhaka-1000.

Subject: **Permission for data collection.**

Dear Sir,

I am currently enrolled in the M.Phil degree program of Department of Clinical Psychology, University of Dhaka. As part of my degree works requirement, I am conducting a research entitled **" Psychological distress and coping strategies among the adolescents of substance dependent parents "** under the supervision of Dr. Farah Deeba , Associate Professor, Department of Clinical Psychology, University of Dhaka. As part of research I need some information from your school's adolescents student whose none of the parents are currently dependent on substance.

Since your organization always help and encourage research activities, I would be highly grateful to you if you allow me to assess such adolescents and their parents for my research. Confidentiality and all other research ethical issues will be followed during data collection. Please note that I have received ethical clearance for conducting the study from Ethical committee of Department of Clinical Psychology, University of Dhaka.

I therefore, request you to give me an approval of working with your students and teachers for collecting data for my research.

Sincerely Yours

Mahjareen Binta Gaffer
Registration no. 056/2015-16
Department of Clinical Psychology
University of Dhaka
Contact no. +8801676095159

Name of the study: Psychological distress and coping strategies in adolescents of substance dependent parents

Instructions: adolescent boys and girls face various types of problems in their life and they try to solve such problems in different ways. A situation is given below- your task would be to describe the situation by answering the to the questions:

Situation: one guardian (father/mother) is dependent on drug.

1. Did this situation make you puzzled or anxious?	Not at all	Very little	To some extent	To a large extent	Very much
2. Did this situation make you sad or depressed?	Not at all	Very little	To some extent	To a large extent	Very much
3. In general, was the situation such that it could be changed or something could be done?	Yes			No	
4. In general, was the situation such that it must be accepted or one has to adjust with it?	Yes			No	
5. Did the circumstance make you angry or aggressive?	Not at all	Very little	To some extent	To a large extent	Very much

Please go to the next page and to manage this situation, if you had to adopt any of the following means, then put a mark (√) on it.

	How many times you have done it?				To what extent this has helped you?				
	Not even a single time	Sometimes	Quite often	Almost all the time	Not at all	Very rarely	To some extent	To a large extent	Very much
1. I thought about something else, wanted to forget the matter; and/or I did something else to take it out from my mind, for example, to watch television or to take part in any sports (games).	0	1 2	3		0	1	2 3	4	
2. I step back from myself from other people; kept my feelings within myself; and I managed the situation in my own way.	0	1 2	3		0	1	2 3	4	
3. I wanted to see some good things around myself, and/or wanted to think what good outcome can come out of this situation.	0	1 2	3		0	1	2 3	4	
4. I could understand that the problem had arisen because of me and I was blaming myself as I was the cause of it.	0	1 2	3		0	1	2 3	4	
5. I could understand that the problem had arisen because of others and I was blaming others as I had to go through such problem.	0	1 2	3		0	1	2 3	4	
6. I thought about how to solve this problem, discussed with others to get more information and data; and/or have tried really to solve the problem.	0	1 2	3		0	1	2 3	4	
7. (a) I used to talk about my feeling, used to shout, or used to hit with something.	0	1 2	3		0	1	2 3	4	
(b) to keep myself relaxed- I talked with myself, I prayed, I walked, or I took rest exclusively.	0	1 2	3		0	1	2 3	4	
8. I used to think and hoped that whatever has happened if that didn't happen, or if I could change that.	0	1 2	3		0	1	2 3	4	
9. I asked for help to my family, friends or other adults, so that they could help me to feel good.	0	1 2	3		0	1	2 3	4	
10. I only accepted the problem, as I knew that nothing I could do about it.	0	1 2	3		0	1	2 3	4	

বিচারকের প্রতি নিদের্শনা

সম্মানিত বিচারক,

আমি মেহজারীন বিনতে গাফফার, চিকিৎসা মনোবিজ্ঞান বিভাগের এম.ফিল পর্যায়ে অধ্যায়নরত গবেষক। এম.ফিল ডিগ্রীর অংশ হিসেবে আমি বর্তমান গবেষণাটি করছি। আমার গবেষণার বিষয়, "Psychological distress & coping strategies in adolescents of substance dependent parents"| গবেষণাটি বিভাগের সহযোগী অধ্যাপক, ড. ফারাহ দীবা-র তত্ত্বাবধায়নে পরিচালিত হচ্ছে। গবেষণার বিভিন্ন চলকে পরিমাপের জন্য বিভিন্ন নির্ভরযোগ্য ও যথার্থ মানক ব্যবহার করা হবে। তাদের মধ্যে মাদকনির্ভর পিতা-মাতার কিশোর-কিশোরী সন্তানরা মানসিক কষ্ট মোকাবিলার জন্য কি ধরনের কৌশল অবলম্বন (Coping Strategies) কওে তা পরিমাপের জন্য ১৫-পদ সম্বলিত Kidcope (Spirito, Stark & Williams, 1988) মানকটি ব্যবহার করা হবে। মানকটির নির্ভরযোগ্যতা (Test-Retest Reliability) .১৫ থেকে .৮৩ এবং যথার্থতা (Concurrent Validity) .০৮ থেকে .৭৭ (Spirito et al., 1988; Cheng & Chan.,2003; Vigna et al., 2010)। মানকটি আমরা (আমি ও আমার তত্ত্বাবধায়ক) অনুবাদ করার পর, একজন মনোবিজ্ঞানীর মতামত সাপেক্ষে বর্তমানরূপে তৈরী করা হয়েছে। Kidcope মানকটি বিভিন্ন গবেষণায়, যেমন, হাসপাতাল পরিবেশে, ক্যান্সার আক্রান্ত, অটিজম আক্রান্ত ব্যক্তিদের ক্ষেত্রে ব্যবহার করা হয়েছে (Edgar & Skinner., 2003; Stallard, Nelleman, Langsford& Baldwing.,2001; Laslo., 1989; Sharma.,2014; Pretzlik& Sylva., 1999)।

বর্তমান গবেষণায় Kidcope মানকটি ব্যবহারের জন্য পদসমূহের অনুবাদ ও বিষয়বস্তু (Item Content)-এর বিষয়ে আপনার সুচিন্তিত মতামত প্রত্যাশা করছি। এক্ষেত্রে উল্লেখ্য যে, প্রতিটি পদ সমস্যা মোকাবিলার কৌশল হিসেবে শব্দার্থগত ওধারণাগতভাবে আপনার মতে যথাযথভাবে অনুবাদিত হয়েছে কিনা তা জানতে চাওয়া হয়েছে।প্রতিটি বিবৃতির পাশে আপনার মতামতের জন্য কয়েকটি ঘর রয়েছে। আপনার মতামত অনুযায়ী নির্দিষ্ট ঘরেটিক (√) চিহ্নদিন।

এ বিবৃতিগুলোর বিষয়ে আপনার মূল্যবান মতামত গবেষণাটির ক্ষেত্রে সহায়ক হবে। আপনার মূল্যবান সময় ও বিজ্ঞ মতামত দিয়ে সহযোগিতার জন্য আন্তরিক ধন্যবাদ।

সাপেক্ষে

মেহজারীন বিনতে গাফফার

এম.ফিল

চিকিৎসা মনোবিজ্ঞান বিভাগ

ঢাকা বিশ্ববিদ্যালয়

Spirito, A., Stark, L.J., & Williams, C., (1988). Development of a brief coping checklist for use with pediatric populations. *Journal of Pediatric Psychology*, Vol. 13, No. 4, 1988, pp. 555-574.

Kidcope ((Spirito, Stark & Williams, 1988)

<table>
<tr><th colspan="2">Instructions</th></tr>
<tr><th>নিদের্শনা</th><th>নিদের্শনা</th></tr>
<tr><td>Instructions: we are trying to find out how people deal with different problems. Think about a situation that has bothered you during the last month. Please pick a situation not related to being sick or being in hospital. Please describe the situation below:
এখানে উল্লেখ্য যে মূল মানকটি তে যে কোন একটি পরিস্থিতির কথা বলা হয়েছে কিন্তু পরবর্তীতে আরও যে সব গবেষণায় এই মানকটি ব্যবহার করা হয়েছে সেখানে গবেষণার বিষয় অনুযায়ী পরিস্থিতিটি ও নির্দেশনাটি পরিবর্তন করা হয়েছে।</td><td>নির্দেশনাঃ কিশোর-কিশোরীরা দৈনন্দিন জীবনে বিভিন ধরনের সমস্যার সম্মুখীন হয়ে থাকে এবং বিভিন্ন উপায়ে সমাধানের চেষ্টা করে থাকে। নিম্মে একটি পরিস্থিতি দেয়া আছে। তোমার কাজ হবে নিম্নে উল্লেখিত পরিস্থিতি প্রশ্নের উত্তর দ্বারা বর্ননা করা।

পরিস্থিতি ঃ একজন অভিভাবক (পিতা/মাতা) মাদকের উপর নির্ভরশীল।</td></tr>
</table>

<table>
<tr><td colspan="5">1. Did this situation make you nervous or anxious?</td><td colspan="5">১. এ পরিস্থিতি-টি কি তোমাকে অস্থির অথবা উদ্বিগ্ন করে তুলেছিল?</td></tr>
<tr><td>Not at all</td><td>a little</td><td>somewhat</td><td>Pretty much</td><td>very much</td><td>একদমইনা</td><td>কিছুটা</td><td>খুবইঅল্প</td><td>অনেকটা</td><td>অনেক বেশী</td></tr>
<tr><td colspan="5">2. Did this situation make you sad or depressed?</td><td colspan="5">২. এ পরিস্থিতিটি কি তোমাকে দুঃখিত অথবা বিষন্ন করে তুলেছিল?</td></tr>
<tr><td>Not at all</td><td>a little</td><td>somewhat</td><td>Pretty much</td><td>very much</td><td>একদমইনা</td><td>কিছুটা</td><td>খুবইঅল্প</td><td>অনেকটা</td><td>অনেক বেশী</td></tr>
<tr><td colspan="5">3. In general, is this situation one that could change or do something about?</td><td colspan="5">৩। তুমি কি মনে কর এই পরিস্থিতি পরিবর্তন করা যায় বা তোমার কিছু করার আছে?</td></tr>
<tr><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="3">হ্যাঁ</td><td colspan="2">না</td></tr>
</table>

Spirito, A., Stark, L.J., & Williams, C., (1988). Development of a brief coping checklist for use with pediatric populations. *Journal of Pediatric Psychology*, Vol. 13, No. 4, 1988, pp. 555-574.

<table>
<tr><td colspan="5">4. In general, is this situation one that must be accepted or gotten used to?</td><td colspan="5">৪। তুমি কি মনে কর এই পরিস্থিতি অবশ্যই মেনে নিতে হবে বা এর সাথে খাপখাওয়াতে হবে?</td></tr>
<tr><td colspan="3">Yes</td><td colspan="2">No</td><td colspan="3">হ্যাঁ</td><td colspan="2">না</td></tr>
<tr><td colspan="5">5. Did this situation make you angry or mad?</td><td colspan="5">৫। এই পরিস্থিতি কি তোমাকে রাগিয়ে তুলেছিল বা তোমাকে দিশেহারা করে ফেলেছিল?</td></tr>
<tr><td>Not at all</td><td>a little</td><td>somewhat</td><td>Pretty much</td><td>very much</td><td>একদমইনা</td><td>কিছুটা</td><td>খুবইঅল্প</td><td>অনেকটা</td><td>অনেক বেশী</td></tr>
<tr><td colspan="5">Now, please turn over this sheet and circle whether you used any of the following ways to help deal with this problem.</td><td colspan="5">দয়া করে পরবর্তী পৃষ্ঠায় যাও এবং এই পরিস্থিতিকে সামাল দিতে যদি নিচের যেকোন একটি উপায় ব্যবহার করে থাক তাহলে তাতে (√)চিহ্ন দাও।</td></tr>
</table>

Spirito, A., Stark, L.J., & Williams, C., (1988). Development of a brief coping checklist for use with pediatric populations. *Journal of Pediatric Psychology*, Vol. 13, No. 4, 1988, pp. 555-574.

বিবৃতিসমূহ		শব্দার্থগত মূল্যায়ন (Translation)	ধারনাগত মূল্যায়ন (Content)	মতামত
মূলবিবৃতি	অনুবাদকৃত বিবৃতি			
1. I thought about something else; tried to forget it; and/or went and did something like watch TV or play a game to get it off my mind.	১.আমি অন্য কিছু চিন্তা করেছি; ভুলে যেতে চেষ্টা করেছি; , এবং/অথবা আমার মন থেকে ওটা বের কওে দিতে অন্য কিছু করতে গিয়েছি, যেমন টেলিভিশন দেখা বা কোন খেলায় অংশগ্রহণ করা			
2. I stayed away from people; kept my feelings to myself; and just handled the situation on my own.	২। আমি অন্য মানুষ থেকে দুরে থেকে ছিলাম; আমার অনুভূতিগুলি আমার কাছেই রেখেছিলাম; এবং পরিস্থিতিটা কেবল আমার মত করে সামলে নিয়েছিলাম			
3. I tried to see the good side of things and/or concentrated on something good that could come out of the situation.	৩। আমি পরিস্থিতির ভালো দিকটা দেখার চেষ্টা করছিলাম অথবা এ পরিস্থিতি থেকে ভালো কি আসতে পারে সেখানে মনোযোগ দেওয়ার চেষ্টা করছিলাম।			
4. I realized I brought the problem on myself and blamed myself for causing it.	৪। আমি বুঝতে পারছিলাম যে, আমার দ্বারাই সমস্যাটা দেখা দিয়েছিল এবং নিজেকে এর কারণ হিসেবে দায়ী করছিলাম।			
5. I realized that someone else caused the problem and blamed them for making me go through this.	৫। আমি বুঝতে পারছিলাম যে, অন্য কারো দ্বারা সমস্যাটা তৈরী হয়েছিল এবং তাদেরকে দায়ী করছিলাম আমাকে এ সমস্যার মধ্যে দিয়ে যেতে হচ্ছে তাই			
6. I thought of ways to solve the problem; talked to others to get more facts and information about the problem and/or tried to actually solve the problem.	৬। আমি সমস্যা সমাধানের উপায় নিয়ে চিন্তা করছিলাম, সমস্যাটি সম্পর্কে আরও তথ্য পেতে অন্যদের কথা বলতাম এবং আসলেই সমস্যা সমাধানের চেষ্টা করছিলাম			
7a. I talked about how I was feeling; yelled, screamed, or hit something.	৭। (ক) আমি আমার অনূভূতি সম্পর্কে কথা বলতাম, চিৎকার–চেচামেচি করতাম অথবা কোন কিছু দিয়ে আঘাত করতাম।			

Spirito, A., Stark, L.J., & Williams, C., (1988). Development of a brief coping checklist for use with pediatric populations. *Journal of Pediatric Psychology,* Vol. 13, No. 4, 1988, pp. 555-574.

b. Tried to calm myself by talking to myself, praying, taking a walk, or just trying to relax	(খ) নিজের সাথে কথা বলা, প্রার্থনা করা, হাটাহাটি করা, অথবা আরাম করার মাধ্যমে নিজেকে শান্তরাখার চেষ্টা করেছিলাম।			
8. I kept thinking and wishing this had never happened; and/or that I could change what had happened.	৮। আমি চিন্তা ও আশা করতে থাকতাম যেন যা হয়েছে তা যদি না হত অথবা আমি যদি তা পরিবর্তন করতে পারতাম।			
9. Turned to my family, friends, or other adults to help me feel better.	৯। আমার পরিবার, বন্ধু অথবা অন্যান্য প্রাপ্তবয়স্কদের নিকট সাহায্য চাইতাম যেন তারা আমাকে সাহায্য করতে পারে			
10. I just accepted the problem because I knew I couldn't do anything about it.	১০। আমি কেবল সমস্যাটি মেনে নিয়েছিলাম কারণ আমি জানতাম যে এই ব্যাপারে আমার কিছুই করার নেই।			

বর্তমান পরিমাপকটি সম্পর্কে আপনার মতামত :

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Spirito, A., Stark, L.J., & Williams, C., (1988). Development of a brief coping checklist for use with pediatric populations. *Journal of Pediatric Psychology,* Vol. 13, No. 4, 1988, pp. 555-574.

ডিন অফিস
জীববিজ্ঞান অনুষদ
ঢাকা বিশ্ববিদ্যালয়, ঢাকা-১০০০, বাংলাদেশ

Tel : 8613243
PABX : 9661900-59/4355, 7489
Fax : 880-2-865583
E-mail : deanbio@univdhaka.edu
mimdadul07@yahoo.com

নং - --27------/ জীবঃ অনুঃ/২০১৬-২০১৭

তারিখ: ১৬/০৫/২০১৭

Dr. Farah Deeba
Associate Professor
Department of Clinical Psychology
University of Dhaka
Dhaka-1000.

Sub: Ethical Clearance of Research Proposal entitled "Psychological distress and coping strategies among the adolescents of substance dependent parents".

Dear Dr. Deeba,

I am happy to inform you that your proposal entitled **"Psychological distress and coping strategies among the adolescents of substance dependent parents"** was placed in the Ethical Clearance Certificate for Human Participants Committee meeting held on 16.05.2017 and has been approved for conducting your research project.

I wish for the success of your research project.

Professor Dr. M. Imdadul Hoque
Dean, Faculty of Biological Sciences
University of Dhaka
Dhaka-1000.

চিকিৎসা মনোবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়
কলা ভবন (৫ম তলা)
ঢাকা-১০০০, বাংলাদেশ

DEPARTMENT OF CLINICAL PSYCHOLOGY
UNIVERSITY OF DHAKA
Arts Building (4th floor)
Dhaka-1000, Bangladesh

Tel: 9661900-73, Ext. 7801, Fax: 880-2-8615583, E-mail: clinpsy@du.ac.bd

Certificate of Ethical Approval

Project Number : **MP161001**

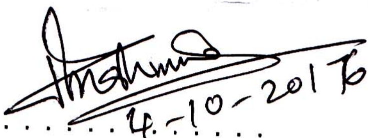
Project Title : **Psychological distress and coping strategies in adolescents of substance dependent parents**

Investigators : **Mahjareen Binta Gaffar** and **Farah Deeba**

Approval Period : **1 November 2016** to **31 October 2018**

Terms of Approval

1. Any changes made to the details submitted for ethical approval should be notified and sought approval by the investigator(s) to the Department of Clinical Psychology Ethics Committee before incorporating the change.
2. The investigator(s) should inform the committee immediately in case of occurrence of any adverse unexpected events that hampers wellbeing of the participants or affect the ethical acceptability of the research.
3. The research project is subject to monitoring or audit by the Department of Clinical Psychology Ethics Committee.
4. The committee can cancel approval if ethical conduction of the research is found to be compromised.
5. If the research cannot be completed within the approved period, the investigator must submit application for an extension.
6. The investigator must submit a research completion report.



Chairperson
Ethics Committee
Department of Clinical Psychology
University of Dhaka

গবেষণা কার্যক্রমে অংশগ্রহনের অনুমতিপত্র (অভিভাবক)

সম্মানিত মহোদয়,

আমি ঢাকা বিশ্ববিদ্যালয়ের চিকিৎসা মনোবিজ্ঞান বিভাগের এম.ফিল পর্যায়ে অধ্যয়নরত একজন শিক্ষার্থী। আমার গবেষণার বিষয়- "Psychological distress and coping strategies in adolescents of substance dependent parents"। এই গবেষণার দ্বারা মাদক নির্ভর পিতা-মাতার কিশোর বয়সী সন্তানদের মানসিক কষ্ট ও তা মোকাবিলার জন্য তারা কি ধরনের কৌশল অবলম্বন করছে তা নির্ণয় করা হবে। আমরা জানি যে, মাদক নির্ভরতার সমস্যা একটি সামাজিক ও পারিবারিক সমস্যা যা শুধু ব্যক্তিই নয় বরং তার পারিপার্শ্বিকতাকেও ভীষণভাবে প্রভাবিত করে। এক্ষেত্রে বর্তমান গবেষণাটি পিতা-মাতার মাদক নির্ভরশীলতা সন্তানদের মানসিক স্বাস্থ্যকে কিভাবে প্রভাবিত করছে এবং যদি তারা মানসিক কষ্টে ভুগে তবে তা কি ধরনের সে সম্পর্কে আমাদের ধারনা দিবে। এছাড়াও পরবর্তীতে যদি তারা কোন প্রকার মানসিক স্বাস্থ্য সেবা নিতে চায় সেক্ষেত্রে যথাযথ নির্দেশনা প্রদান করবে। এই গবেষণার দ্বারা আমরা বাংলাদেশের বিভিন্ন পরিবারের অভিভাবকের মাদক নির্ভরশীলতার কারণে আমাদের সম্ভাবনাময় আগামী প্রজন্মের মানসিক স্বাস্থ্য সম্পর্কে সকলে অবগত হতে পারবো এবং তাদের জন্য প্রয়োজনীয় সামাজিক ও মানসিক সহায়তা সম্পর্কে সকলকে অবহিত করতে পারবো। এক্ষেত্রে উল্লেখ্য যে, আপনার নাম, পরিচয় ও প্রদত্ত তথ্যাদি কেবলমাত্র গবেষণার কাজে ব্যবহার করা হবে। এছাড়াও বর্তমান গবেষণাটির সকল কার্যাবলী সম্পর্কে বিশ্ববিদ্যালয়ের নৈতিক বিধিমালা সম্পর্কিত কমিটি (Ethical committee) অবগত আছেন।

আপনার সন্তানকে এই গবেষণায় অংশগ্রহনে আপনার কোন আপত্তি না থাকলে অনুগ্রহ করে নিম্নে স্বাক্ষর করুন ।

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অভিভাবকের নাম ও স্বাক্ষর

গবেষকের স্বাক্ষর

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মেহজারীন বিনতে গাফফার
এম.ফিল
চিকিৎসা মনোবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়
তারিখঃ

গবেষণা সম্পর্কে কোন বিষয় আপনি পরবর্তীতে জানতে চাইলে নিম্নোক্ত নম্বরে যোগাযোগ করুনঃ
+৮৮০১৬৭৬০৯৫১৫৯

গবেষণা কার্যক্রমে অংশগ্রহনের সম্মতিপত্র

সম্মানিত অংশগ্রহণকারী,

আমি ঢাকা বিশ্ববিদ্যালয়ের চিকিৎসা মনোবিজ্ঞান বিভাগের এম.ফিল পর্যায়ে অধ্যয়নরত একজন শিক্ষার্থী। আমার গবেষণার বিষয়- " Psychological distress and coping strategies in adolescents of substance dependent parents"। এই গবেষণার দ্বারা মাদক নির্ভর পিতা-মাতার কিশোর বয়সী সন্তানদের মানসিক কষ্ট ও তা মোকাবিলার জন্য তারা কি ধরনের কৌশল অবলম্বন করছে তা নির্ণয় করা হবে।

আমাদের দৈনিন্দিন জীবনে আমরা নান ধরনের পরিস্থিতির সম্মুখীন হই যা আমাদের মধ্যে মানসিক চাপের সৃষ্টি করে, যেমন, সমবয়সীদের সাথে মনোমালিন্য, পড়ালেখায় অমনোযোগিতা, শিক্ষকদের অতিরিক্ত শাসন, মা-বাবার সাথে মতের অমিল ইত্যাদি। বাবা-মার নিজস্ব সমস্যাও অনেক সময় আমাদের জীবনে সমস্যার কারণ হয়ে দাঁড়ায়। যেমন, বাবা/মা অথবা উভয় অভিভাবকই যদি মাদকের উপর নির্ভরশীল হয় তবে তা সন্তানের মানসিক কষ্টের কারণ হতে পারে। সন্তানদের মধ্যে ভয়, বিষণ্নতা, দুঃশ্চিন্তা এমন সব সমস্যা তৈরি হতে পারে। কখনও কখনও এ পরিস্থিতি সামলে নেয়াটা সন্তানের জন্য খুব কঠিন হয়ে যায়। আমাদের বর্তমান গবেষণার মধ্যে দিয়ে আমরা এসব বিষয় সম্পর্কে জানতে পারবো এবং কিশোরবয়সীদের এ ধরনের মানসিক কষ্টের জন্য কি করা যায় তা বের করার পথ পাব। আমাদের এ কাজে তথ্য দিয়ে তুমি আমাদের সাথে সমাজের অন্যান্য কিশোর কিশোরীদের সমস্যা সমাধানে সহায়ক ভূমিকা পালন করতে পারো।

তোমার বর্তমান সমস্যা ও তা মোকাবিলার কৌশল সম্পর্কিত কিছু প্রশ্নমালা দেয়া হবে। তোমার নাম ও পরিচয় কেবলমাত্র গবেষণার কাজে ব্যবহার করা হবে। তোমার অংশগ্রহনের সম্মতি সম্পূর্ণ তোমার। সম্মতি দেয়ার পরে যদি কোন কারণে তুমি অংশগ্রহন করতে সমর্থ না হও তবে যে কোন সময়ে তুমি জানাতে পারো। উপরোক্ত বিষয় সম্পর্কে কোন প্রশ্ন না থাকলে ও অংশগ্রহনে সম্মত হলে নিম্নে স্বাক্ষর করঃ

গবেষকের নাম ও স্বাক্ষর

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তারিখঃ.............................. ....

অংশগ্রহণকারীর নাম ও স্বাক্ষর

অথবা,

শিশু/ কিশোরের পক্ষে সই করেছেন

শিশুর বাবা/মা ....।

গবেষণা কার্যক্রমে অংশগ্রহনের অনুমতিপত্র (অভিভাবক)

মহোদয়,

আমি ঢাকা বিশ্ববিদ্যালয়ের চিকিৎসা মনোবিজ্ঞান বিভাগের একজন এম.ফিল গবেষক। আমার গবেষণার বিষয়- "Psychological distress and coping strategies in adolescents of substance dependent parents"।এই গবেষণায় মাদক নির্ভর পিতা-মাতার কিশোর বয়সী সন্তানদের মানসিক স্বাস্থ্য অবস্থা কেমন ও মানসিক চাপ মোকাবিলার জন্য তারা কি ধরনের কৌশল অবলম্বন করছে তা বোঝার চেষ্টা করছি। আমরা সবাই জানি যে, মাদক নির্ভরতার সমস্যা একটি সামাজিক ও পারিবারিক সমস্যা যা শুধু ব্যক্তিই নয় বরং তার আশেপাশের মানুষদেরকেও ভীষণভাবে প্রভাবিত করে। এক্ষেত্রে বর্তমান গবেষণাটি পিতা-মাতার মাদক নির্ভরশীলতা সন্তানদের মানসিক স্বাস্থ্যকে কিভাবে প্রভাবিত করছে এবং যদি তারা মানসিক কষ্টে ভুগে তবে তা কি ধরনের সে সম্পর্কে আমাদের ধারনা দিবে। এছাড়াও পরবর্তীতে যদি তারা কোন প্রকার মানসিক স্বাস্থ্য সেবা নিতে চায় সেক্ষেত্রে যথাযথ নির্দেশনা প্রদান করবে।

গবেষণার অংশ হিসেবে আমি দুই ধরনের কিশোর-কিশোরীদের (১২-১৭) থেকে কিছু তথ্য সংগ্রহ করছি। এক, যাদের পিতা/ মাতা মাদকের ওপর নির্ভরশীল এবং দুই, যাদের পিতা/মাতা মাদকের ওপর নির্ভরশীল নয়। প্রথম অংশের জন্য আমি বিভিন্ন প্রতিষ্ঠানের সাথে কাজ করছি যেখানে মাদক নির্ভর অভিভাবক আছে এবং দ্বিতীয় অংশের জন্য আমি বিভিন্ন বিদ্যালয়ের উক্ত বয়সী কিশোর-কিশোরীদের থেকে তথ্য নিচ্ছি।

একজন উচ্চ শিক্ষিত ও সচেতন নাগরিক হিসেবে আপনি নিশ্চয়ই ওয়াকিবহাল যে, ক্রমাগত বিভিন্ন ধরনের জটিল পারিবারিক সমস্যার সম্মুখীন হলে কিশোর-কিশোরীরা কখনই শিক্ষাগত ও সামাজিক কার্যক্রমে ভালো করতে পারে না এবং তার একটি বহিঃপ্রকাশ তাদের আচরণের মাধ্যমে পরিলক্ষিত হয়। বর্তমান প্রেক্ষাপটে দেখা গেছে, মাদক নির্ভর মানুষদের মধ্যে ২০-৩০% মানুষ কিশোরবয়সী সন্তানের অভিভাবক। যেহেতু, কিশোর বয়স বা বয়ঃসন্ধিকাল মানব জীবনের একটি অত্যন্ত গুরুত্বপূর্ণ ও সংবেদনশীল সময় এধরনের চাপমূলক পরিস্থিতি নিশ্চিতভাবেই তাদের স্বাভাবিক শারীরিক, সামাজিক ও মানসিক বিকাশ ব্যাহত করে। ইতিমধ্যে আমরা আরও জেনেছি যে, সমাজের অনেক গুরুতর অপরাধ ও এধরনের কিশোরবয়সী সন্তানদের দ্বারা সংগঠিত হচ্ছে। আর তাই সংগত কারনেই মাদক নির্ভর পিতা/মাতার সন্তান এবং মাদক নির্ভর নয় এমন পিতা/মাতার সন্তানদের মধ্যকার মানসিক অবস্থা ও চাপ মোকাবেলার কৌশল সম্পর্কে জানা জরুরী।

অতএব, নিম্নে স্বাক্ষর প্রদান করে আপনার সন্তানকে এই গবেষণায় অংশগ্রহনে অনুমতি আশা করছি। এছাড়াও, পরবর্তী পাতায় উল্লেখিত তথ্যগুলোর যথাযথ উত্তর প্রদান করবেন। এক্ষেত্রে উল্লেখ্য যে, আপনার নাম, পরিচয় ও প্রদত্ত তথ্যাদি কেবলমাত্র গবেষণার কাজে ব্যবহার করা হবে। এছাড়াও বর্তমান গবেষণাটির সকল কার্যাবলী সম্পর্কে বিশ্ববিদ্যালয়ের নৈতিক বিধিমালা সম্পর্কিত কমিটি (Ethical committee) অবগত আছেন।

আপনার সন্তানকে এই গবেষণায় অংশগ্রহনে আপনার কোন আপত্তি না থাকলে অনুগ্রহ করে নিম্নে স্বাক্ষর করুন।

....

অভিভাবকের নাম ও স্বাক্ষর

গবেষকের স্বাক্ষর

....

মেহজারীন বিনতে গাফফার
এম.ফিল গবেষক
চিকিৎসা মনোবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়

আপনি যদি কোন মাদক নির্ভর (যে অভিভাবক কোন ধরনের মাদক যেমন গাঁজা, হেরোইন, ইয়াবা, মদ, ফেন্সিডিল ইত্যাদিতে আসক্ত বা নিয়মিত সেবন করেন) পিতা/মাতার সন্তান সম্পর্কে জানেন তবে নিম্নের নম্বরে যোগাযোগ করুনঃ

০১৬৭৬০৯৫১৫৯

আপনার সহযোগিতা আমাদের ভবিষ্যৎ প্রজন্মকে মাদকের করাল গ্রাস থেকে মুক্ত করে একটি সুস্থ সমাজ গঠনে অশেষ ভূমিকা রাখবে।

ব্যক্তিগত তথ্য (অভিভাবক)

উপযুক্ত স্থানে টিক (√) চিহ্ন দিনঃ

পিতার বয়সঃ

শিক্ষাগত যোগ্যতাঃ

পেশাঃ ক) কর্মহীন খ) ব্যবসা

গ) চাকুরী ঘ) অন্যান্য

পারিবারিক আয়ঃ ক) ৫০০০- ১০,০০০ খ) ১০,০০০-২০,০০০

গ) ৩০,০০০-৪০,০০০ ঘ) ৫০,০০০ বা তার বেশী

পরিবারের ধরনঃ ক) একক খ) যৌথ

পরিবারের সদস্য সংখ্যাঃ

মোট সন্তানঃ

মায়ের বয়সঃ

শিক্ষাগত যোগ্যতাঃ

পেশাঃ ক) কর্মহীন খ) ব্যবসা গ) চাকুরী ঘ) অন্যান্য

গবেষণা কার্যক্রমে অংশগ্রহনের সম্মতিপত্র

অংশগ্রহণকারী,

আমি ঢাকা বিশ্ববিদ্যালয়ের চিকিৎসা মনোবিজ্ঞান বিভাগের একজন এম্‌ফিল গবেষক। আমার গবেষণার বিষয়- ‘‘ “Psychological distress and coping strategies in adolescents of substance dependent parents”।এই গবেষণার দ্বারা মাদক নির্ভর পিতা-মাতার কিশোর বয়সী সন্তান ও মাদক নির্ভর নয় এমন পিতা/মাতার সন্তানদেরদের মানসিক স্বাস্থ্য অবস্থা ও চাপ মোকাবিলার জন্য তারা কি ধরনের কৌশল অবলম্বন করছে তা নির্ণয়ের চেষ্টা করছি।

আমাদের দৈনিন্দিন জীবনে আমরা নান ধরনের পরিস্থিতির সম্মুখীন হই যা আমাদের মধ্যে মানসিক চাপের সৃষ্টি করে, যেমন, সমবয়সীদের সাথে মনোমালিন্য, পরালেখায় অমনোযোগিতা, শিক্ষকদের অতিরিক্ত শাসন, মা-বাবার সাথে মতের অমিল ইত্যাদি। বাবা-মার নিজস্ব সমস্যাও অনেক সময় আমাদের জীবনে সমস্যার কারণ হয়ে দাঁড়ায়।

তোমাকে বর্তমান সমস্যা ও তা মোকাবিলার কৌশল সম্পর্কিত কিছু প্রশ্নমালা দেয়া হবে । প্রদত্ত তথ্যাদি কেবলমাত্র গবেষণার কাজে ব্যবহার করা হবে। তুমি যদিঅংশগ্রহনে সম্মত হলে নিম্নে স্বাক্ষর করঃ

....

অংশগ্রহণকারীর নাম ও স্বাক্ষর

গবেষকের স্বাক্ষর

....

মেহজারীন বিনতে গাফফার
এম.ফিল গবেষক
চিকিৎসা মনোবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়
তারিখঃ

ব্যক্তিগত তথ্য

উপযুক্ত স্থানে টিক (✓) চিহ্ন দিনঃ

নামঃ

বয়সঃ

লিঙ্গঃ ক) পুরুষ খ) মহিলা

শিক্ষাগত যোগ্যতাঃ

পেশাঃ ক) কর্মহীন খ) ব্যবসা
গ) চাকুরী ঘ) অন্যান্য

পারিবারিক আয়ঃ ক) ৫০০০ - ১০,০০০ খ) ১০,০০০-২০,০০০
গ) ২০,০০০-৩০,০০০ ঘ) ৪০,০০০ বা তার বেশী

পরিবারের ধরনঃ ক) একক খ) যৌথ

পরিবারের সদস্য সংখ্যাঃ

মোট সন্তানঃ

আপনার সন্তান কি কখনও মানসিক রোগ আছে বলে চিকিৎসক দ্বারা নির্ণীত হয়েছেঃ

ক) হ্যাঁ , বর্ণনা করুনঃ

খ) না

আপনার সাথে আপনার স্বামী/স্ত্রীর সম্পর্ক কেমনঃ

ব্যক্তিগত তথ্য

উপযুক্ত স্থানে টিক (✓) চিহ্ন দিনঃ

নামঃ

বয়সঃ

লিঙ্গঃ ক) পুরুষ খ) মহিলা

শিক্ষাগত যোগ্যতাঃ

পেশাঃ ক) কর্মহীন খ) ব্যবসা

গ) চাকুরী ঘ) অন্যান্য

প্রধান মাদকসমূহঃ ক) প্রধান মাদকঃ

খ) অন্যান্য মাদকঃ

মাদক সেবনের সময়ঃ ক) ৬ মাস খ) ৬ মাস থেকে ১ বছর

গ) ১ বছর থেকে ৫ বছর ঘ) ৫ বছরের বেশী

আপনি কি কখনও অন্য কোন মানসিক রোগ আছে বলে চিকিৎসক দ্বারা নির্ণীত হয়েছেনঃ

ক) না খ) হ্যাঁ, বর্ণনা করুনঃ

কার কাছে চিকিৎসা চিকিৎসা করিয়েছেনঃ

ক) চিকিৎসক খ) মনঃচিকিৎসক গ) মনোবিজ্ঞানী

আপনি কি পূর্বেও বর্তমান সমস্যার জন্য চিকিৎসা করিয়েছেনঃ

ক) হ্যাঁ খ) না

আপনার সাথে আপনার স্বামী/স্ত্রীর সম্পর্ক কেমনঃ

ব্যক্তিগত তথ্য

উপযুক্ত স্থানে টিক (✓) চিহ্ন দিনঃ

বয়সঃ

লিঙ্গঃ

বর্তমানে যে শ্রেণীতে পড়ছঃ

সর্বশেষ পরীক্ষার ফলাফলঃ

তোমার বন্ধুদের সাথে প্রতিদিন তুমি কতটা সময় কাটাও (ঘণ্টায়) -

স্কুল/ কলেজের বাইরে তুমি অন্য কোন পছন্দের কাজ কর কি (যেমন- গান শোনা, নাচ শেখা, কবিতা আবৃত্তি করা, ছবি আঁকা, সাঁতার কাটা, ফুটবল বা ক্রিকেট খেলা ইত্যাদি)

ক) হ্যাঁ , বর্ণনা কর-

খ)না

তুমি কি কখনও মাদক গ্রহন করেছঃ

ক) না খ) হ্যাঁ, বর্ণনা কর-

তুমি কি কখনও মানসিক চাপ মোকাবিলার জন্য মাদক গ্রহন করেছঃ

ক) না খ) হ্যাঁ, বর্ণনা কর-

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Kidcope (Spirito, Stark & Williams, 1988)

নিদের্শনা

নির্দেশনাঃ কিশোর-কিশোরীরা দৈনন্দিন জীবনে বিভিন্ন ধরনের সমস্যার সম্মুখীন হয়ে থাকে এবং বিভিন্ন উপায়ে সমাধানের চেষ্টা করে থাকে। নিম্মে একটি পরিস্থিতি দেয়া আছে। তোমার কাজ হবে নিম্নে উল্লেখিত পরিস্থিতি প্রশ্নের উত্তর দ্বারা বর্ননা করা।

পরিস্থিতি ঃ একজন অভিভাবক (পিতা/মাতা) মাদকের উপর নির্ভরশীল।

<table>
<tr><td colspan="5">১। এ পরিস্থিতি-টি কি তোমাকে বিচলিত অথবা উদ্বিগ্ন করে তুলেছিল?</td></tr>
<tr><td>একদমইনা</td><td>খুবই
সামান্য</td><td>কিছুটা</td><td>বেশ খানিকটা</td><td>অনেক বেশী</td></tr>
<tr><td colspan="5">২। এ পরিস্থিতিটি কি তোমাকে দুঃখিত অথবা বিষন্ন করে তুলেছিল?</td></tr>
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<tr><td colspan="5">৩। সাধারনভাবে, পরিস্থিতি-টি কি এমন যা পরিবর্তন করার বা কোন কিছু করার ছিল?</td></tr>
<tr><td colspan="2">হ্যাঁ</td><td colspan="3">না</td></tr>
<tr><td colspan="5">৪। সাধারনভাবে, পরিস্থিতি-টি কি এমন যা অবশ্যই মেনে নিতে হবে বা এর সাথে খাপ খাওয়াতে হবে?</td></tr>
<tr><td colspan="2">হ্যাঁ</td><td colspan="3">না</td></tr>
<tr><td colspan="5">৫। এই পরিস্থিতি-টি কি তোমাকে রাগিয়ে তুলেছিল বা ক্রুদ্ধ করে ফেলেছিল ?</td></tr>
<tr><td>একদমইনা</td><td>খুবই
সামান্য</td><td>কিছুটা</td><td>বেশ খানিকটা</td><td>অনেক বেশী</td></tr>
<tr><td colspan="5">দয়া করে পরবর্তী পৃষ্ঠায় যাও এবং এই পরিস্থিতিকে সামাল দিতে যদি নিচের যেকোন একটি উপায় ব্যবহার করে থাক তাহলে তাতে (√)চিহ্ন দাও।</td></tr>
</table>

Translation: Mahjareen Binta Gaffar & Farah Deeba (Department of Clinical Psychology, University of Dhaka)
Original:Spirito, A., Stark, L.J., & Williams, C., (1988). Development of a brief coping checklist for use with pediatric populations. *Journal of Pediatric Psychology,* Vol. 13, No. 4, 1988, pp. 555-574.

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দয়া করে প্রতিটি বিবৃতি পড় এবং যে উপায়টি ব্যবহার করেছ সেটি চিহ্নিত কর (যদি করে থাকো)। ত রপর ডান দিকের দুটি প্রশ্নের উত্তর নিচের সঠিক উত্তর গুলো থেকে চিহ্নিত কর।	তুমি কতবার এটা করেছ?				কি পরিমানে এটি তোমাকে সাহায্য করেছে ?				
	একবারও না	মাঝে মাঝে	বেশ অনেক বার	প্রায় সবসময়ই	একটুও না	খুবই সামান্য	কিছুটা	বেশ খানিকটা	অনেক বেশী
১. আমি অন্য কিছু চিন্তা করেছিলাম, ব্যাপারটা ভুলে যেতে চেষ্টা করেছিলাম এবং এবং আমার মন থেকে ওটা বের করে দিতে অন্য কিছু করতে গিয়েছিলাম, যেমন টেলিভিশন দেখা বা কোন খেলায় অংশগ্রহণ করা	০	১	২	৩	০	১	২	৩	৪
২। আমি অন্যান্য মানুষ থেকে দুরে সরে ছিলাম; নিজের অনুভূতিগুলি নিজের ভেতরেই রেখেছিলাম; এবং পরিস্থিতিটা কেবল আমার মত করে সামলে নিয়েছিলাম	০	১	২	৩	০	১	২	৩	৪
৩। আমি চারপাশের কোন ভালো দিক আছে কিনা তা দেখার চেষ্টা করছিলাম এবং অথবা এ পরিস্থিতি থেকে ভালো কি আসতে পারে তা ভাবার চেষ্টা করছিলাম।	০	১	২	৩	০	১	২	৩	৪
৪। আমি বুঝতে পারছিলাম যে, আমার জন্যই সমস্যাটা দেখা দিয়েছিল এবং নিজেকে এর কারণ হিসেবে দায়ী করছিলাম।	০	১	২	৩	০	১	২	৩	৪
৫। আমি বুঝতে পারছিলাম যে, অন্যদের কারণে সমস্যাটি তৈরী হয়েছিল এবং এ সমস্যার ভেতর দিয়ে যাওয়ার কারণে আমি তাদেরকে দায়ী করছিলাম।	০	১	২	৩	০	১	২	৩	৪
৬। আমি সমস্যা সমাধানের উপায় নিয়ে ভেবেছিলাম, সমস্যা সম্পর্কে আরও বেশী তথ্য ও উপাত্ত পাতে অন্যদের সাথে আলোচনা করেছি এবং /অথবা সত্যিকার অর্থেই সমস্যা সমাধানের চেষ্টা করেছিলাম।	০	১	২	৩	০	১	২	৩	৪
৭। (ক) আমি আমার অনূভূতি সম্পর্কে কথা বলতাম, চিৎকার–চেচামেচি করতাম অথবা কোন কিছু দিয়ে আঘাত করতাম।	০	১	২	৩	০	১	২	৩	৪
(খ) নিজেকে শান্ত রাখতে নিজের সাথে কথা বলেছি, প্রার্থনা করেছি, হাঁটাহাঁটি করেছি, অথবা শুধুই বিশ্রাম করেছি।	০	১	২	৩	০	১	২	৩	৪
৮। আমি কেবল চিন্তা করতাম আর আশা করতাম যে যা হয়েছে তা যদি না হত অথবা আমি যদি তা পরিবর্তন করতে পারতাম।	০	১	২	৩	০	১	২	৩	৪
৯। আমার পরিবার, বন্ধু অথবা অন্যান্য প্রাপ্তবয়স্কদের নিকট সাহায্য চাইতাম যেন তারা আমাকে ভালো বোধ করতে সাহায্য করতে পারে।	০	১	২	৩	০	১	২	৩	৪
১০। আমি কেবল সমস্যাটি মেনে নিয়েছিলাম কারণ আমি জানতাম যে এই ব্যাপারে আমার কিছুই করার নেই।	০	১	২	৩	০	১	২	৩	৪

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Short Mood and Feelings Questionnaire (SMFQ)

নির্দেশনাঃ এই ফর্মটি তুমি গত ২ সপ্তাহ যাবত কেমন অনুভব করছো আর তার জন্য কি করছো তা বোঝার জন্য। প্রতিটি প্রশ্নের ক্ষেত্রে তোমার জন্য কোনটি কতখানি প্রযোজ্য তা পাশের ১টি সংখ্যাকে বৃত্ত এঁকে চিহ্নিত করো। যদি একটি বাক্য তোমার জন্য বেশীরভাগ সময় সত্য হয় তাহলে সত্য চিহ্নিত করো। যদি বাক্যটি তোমার জন্য সবসময় সত্য না নয় কিন্তু কখনও কখনও সত্য হয়, তাহলে মাঝে মাঝে চিহ্নিত করো এবং যদি বাক্যটি তোমার জন্য কখনও সত্য না হয়, তাহলে কখনও নয় চিহ্নিত করো।

		কখনও নয়	মাঝে মাঝে	সত্য
1.	আমি দুঃখিত বা অসুখীবোধ করছিলাম	০	১	২
2.	আমি কোনকিছু উপভোগ করছিলাম না....................................	০	১	২
3.	আমি এত ক্লান্ত বোধ করছিলাম যে শুধু বসে থেকেছি এবং কিছু করিনি	০	১	২
4.	আমি খুব অস্থির ছিলাম	০	১	২
5.	আমার মনে হচ্ছিল যে আমি আর ভালো করার মতো নেই..........................	০	১	২
6.	আমি অনেক কেঁদেছি	০	১	২
7.	আমার সঠিকভাবে চিন্তা করা আর মনোযোগ দেয়া কঠিন ছিল	০	১	২
8.	আমি নিজেকে ঘৃনা করছিলাম	০	১	২
9.	আমি একজন খারাপ মানুষ	০	১	২
10.	আমি একাকীত্বে ভুগছিলাম	০	১	২
11.	আমি ভাবছিলাম কেউ আসলে আমাকে ভালোবাসে না..	০	১	২
12.	আমি ভাবছিলাম আমি কখনও অন্য শিশুদের মত ভালো হতে পারবো না	০	১	২
13.	আমি সবকিছু ভুল করেছি।	০	১	২

@Angold et al., (1995)

Translated by Farah Deeba (2010)

SHORT FORM SPENCE CHILDREN'S ANXIETY SCALE

		অনুগ্রহ করে বাঁ-পাশের বিষয়টি তোমার ক্ষেত্রে যতবার হয় তা ডান পাশের যে শব্দটি দিয়ে সঠিকভাবে প্রকাশ করে সেটিকে বৃত্ত এঁকে চিহ্নিত করো। এখানে সঠিক বা ভুল উত্তর বলে কিছু নেই।			
১	আমার কেবল দু:শ্চিন্তা হয়	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়
৩	আমার কোন সমস্যা হলে আমার পেটে কেমন অদ্ভুত অনুভূতি হয়	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়
৬	পরীক্ষা দিতে হলে আমার ভয় লাগে	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়
৯	আমি অন্যদের সামনে নিজেকে বোকা বানাবো ভেবে ভয় পাই	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়
১০	আমি আমার স্কুলের কাজে খুব খারাপ করবো ভেবে দু:শ্চিন্তায় থাকি	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়
১২	আমার পরিবারের কারো সাথে খারাপ কোনকিছু ঘটবে ভেবে আমি দু:শ্চিন্তায় থাকি	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়
১৩	কোন কারণ ছাড়াই হঠাৎ আমার শ্বাস নিতে পারছি না বলে মনে হয়	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়
১৫	আমাকে একা ঘুমাতে হলে আমি ভয় পাই	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়
১৬	নার্ভাস বা ভয় লাগার কারণে সকালে স্কুলে যাবার সময় আমার সমস্যা হয়	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়
১৯	আমি মাথা থেকে বাজে আর তুচ্ছ চিন্তাগুলো সরাতে পারি না	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়
২২	আমার সাথে খারাপ কিছু ঘটবে বলে দু:শ্চিন্ত্র হয়	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়
২৪	যখন আমার কোন সমস্যা হয় তখন আমি বিচলিত বোধ করি	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়
২৭	খারাপ কিছু ঘটা থামাতে আমাকে বিশেষ ধরনের চিন্তা মনে আনতে হয় (যেমন: সংখ্যা বা শব্দ)	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়
২৯	অন্যরা আমাকে নিয়ে কি ভাবছে তা নিয়ে আমি দু:শ্চিন্তায় থাকি	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়
৩২	কোন কারন ছাড়াই হঠাৎ আমি সত্যি ভীতবোধ করি	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়
৩৬	কোন কারণ ছাড়াই হঠাৎ আমার হৃদস্পন্দন খুব দ্রুত হতে থাকে	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়
৩৭	ভয় পাবার মত কিছু না থাকলেও আমি হঠাৎ সন্ত্রস্তবোধ করতে পারি বলে আমার দু:শ্চিন্তা হয়	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়
৪১	আমার মনে আসা বাজে অথবা তুচ্ছ চিন্তা/ ছবিগুলো আমাকে খুব বিরক্ত করে	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়
৪২	খারাপ কিছু ঘটা থামাতে আমাকে কিছু কাজ নির্দিষ্ট নিয়মে করতে হয়	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়
৪৪	রাতে বাড়ীর বাইরে থাকতে হলে আমার ভয় লাগে	কখনই হয় না	মাঝে মাঝে হয়	প্রায়ই হয়	সবসময় হয়

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(Deeba, Rapee, & Prvan, 2014)
Deeba, F., Rapee, R. M., & Prvan, T. (2014). Psychometric properties of the Children's Revised Impact of Events Scale (CRIES) with Bangladeshi children and adolescents. PeerJ, 2, e536. doi: 10.7717/peerj.536

Children's Revised Impact of Event Scale -13-Bangla (CRIES-13 –Bangla)

জীবনে খুব দু:খজনক ঘটনা ঘটে থাকলে অনেকসময় নীচের তালিকার কথাগুলো মানুষের মনে আসে । অনুগ্রহ করে তোমার নিজের ক্ষেত্রে এই কথাগুলো গত সাতদিনের জন্য কতখানি সত্য মনে হয় তা ডান পাশের ঘরে টিক (√) চিহ্ন দিয়ে নির্দেশ করো । যদি এগুলো গত সাতদিনে তোমার মনে না এসে থাকে তাহলে "একদম না" ঘরে টিক (√) দাও ।

		একদম না	খুব কম	মাঝে মাঝে	প্রায়ই
১	তুমি যখন চাও না তখনও কি তোমার ঘটনাটি মনে পড়ে?	[ ]	[ ]	[ ]	[ ]
২	তুমি কি তোমার স্মৃতি থেকে ঘটনাটি মুছে ফেলার চেষ্টা করো?	[ ]	[ ]	[ ]	[ ]
৩	তোমার কি মনোযোগ দিতে বা মনোযোগ ধরে রাখতে সমস্যা হয়?	[ ]	[ ]	[ ]	[ ]
৪	তোমার কি থেকে থেকে ঘটনাটি নিয়ে খুব কষ্ট হয়?	[ ]	[ ]	[ ]	[ ]
৫	তুমি কি ঘটনাটি ঘটার আগের চাইতে এখন খুব সহজে চমকে ওঠো বা নার্ভাস বোধ করো ?	[ ]	[ ]	[ ]	[ ]
৬	তুমি কি ঘটনাটি মনে করিয়ে দেয় এমন বিষয়গুলো (যেমন- কোন জায়গা বা পরিস্থিতি) এড়িয়ে চলো?	[ ]	[ ]	[ ]	[ ]
৭	তুমি কি ঘটনাটি নিয়ে কথা না বলার চেষ্টা করো?	[ ]	[ ]	[ ]	[ ]
৮	তোমার মনে কি হঠাৎ ঐ ঘটনাটির ছবি ভেসে ওঠে?	[ ]	[ ]	[ ]	[ ]
৯	অন্যান্য সবকিছু কি তোমাকে ঐ ঘটনাটি নিয়ে ভাবিয়ে তোলে?	[ ]	[ ]	[ ]	[ ]
১০	তুমি কি সেটা না ভাবার চেষ্টা করো?	[ ]	[ ]	[ ]	[ ]
১১	তুমি কি সহজেই বিরক্ত হয়ে ওঠো?	[ ]	[ ]	[ ]	[ ]
১২	যখন কোন স্পষ্ট কারণ নেই তখনও কি তুমি সতর্ক আর পাহাড়ারত থাকো?	[ ]	[ ]	[ ]	[ ]
১৩	তোমার কি ঘুমের সমস্যা আছে?	[ ]	[ ]	[ ]	[ ]

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