THE EFFECT OF FAMILY ISSUES ON MENTAL HEALTH IN KOHAT, PAKISTAN

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FINAL APPROVAL OF THESIS

This is to certify that we have read the thesis submitted by Mr. Hamza Safi, it is our judgment that this thesis is of sufficient standard to warrant its acceptance by the Quaid-i-Azam University, Islamabad for the award of the Degree of "MSC in Sociology ".

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Hamza Safi

Abstract:

My topic of thesis is "Effect of family issues on the mental health" and my thesis is totally qualitative it means that all the problems that are created in the family then what is the real effect on the mental health of the family members by these problems. The real mean of my topic is that (Looking after a family member with a mental illness can be an extremely stressful time and coping with the stress may rouse various reactions such as somatic problems (migraines, loss of appetite, fatigue, insomnia), cognitive and emotional problems (anxiety, depression, guilt, fear, anger, confusion) and behavioral). The main objectives that I have taken for my research are (To provide the systematic and descriptive overview with the help of specific reference to intervention format and characteristic, what is the real condition of the mental health of the parents by the problems that are in their family, analyzing all the data that I got by studying the research of family problems on the mental health of family members.

In this research methodology was qualitative methodology, Qualitative research is the process of collecting and analyzing random type of data. It can be used to find patterns and averages, make predictions, test causal relationships, and generalize results to wider populations. So I use qualitative method for my research. In my research my targeted population was all over KPK province and the main place was KOHAT. The main result after analyzing all the data of my research was that the mental health problems are more common in young people therefore Adolescence is therefore likely to be an important phase for early intervention with primary care identified as the target setting in the World Health Organization strategy for mental health. Research suggests that most people do not recognize the symptoms of depression and are suspicious about effective treatments. Doctor related barriers to detection and management of mental health symptoms include insufficient time for assessments, a lack of confidence in managing and treating mental health symptoms, and a lack of systematic approaches to identify and provide evidence-based interventions for psychological disorders. So everyone should not hide their illness and should have contact with their family if they have any type of mental problem.

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CHAPTER 1

INTRODUCTION

The interest in family structure and its effects on children's mental health gained momentum in the 1960s and 1970s when there was a spike in divorce rates and single-parent families. The focus was on separation and divorce and their impact on the well-being of children. Over the years, there has been a change in the family structure reflected in the increased proportion of children living in a single-parent home which changed from 12% in 1960 to 28% in 2003. These studies were also able to document some of the long-term effects of stress because of separation on children. According to 2001–2007, Centers for Disease Control (CDC) estimates about half of children live with their biological parents. This does vary across race and falls to almost 24% when dealing with African American children.

Reviewing the literature, it also becomes clear that single parenthood becomes a clear risk factor for mental health problems for both children and adults, leading to greater psychological distress and depression, and puts women at a socioeconomic disadvantage further increasing the level of stress. Several studies have also documented the link between separation and depressive disorders most likely because of both social and economic reasons. Weisman et al. 1987 found that single Caucasian women were almost twice as likely to suffer from depression compared to married women.

Over the years, there has been a consensus that single-parent families are at a greater disadvantage compared to more traditional homes. The factors associated with worse outcome in single-parent families maybe more complicated than first evident. Single-parent families are also suggested to have less resilience when confronting stress. Single parenthood raises further economic challenges compounding the level of stress, possibly causing more difficulties in parent–child relationships. The prevalence of poverty in single-parent family has been estimated to be as high as 50% compared to around 5% in two-parent intact families. This economic disadvantage can further lead to higher rates of emotional and behavioral problems in children. Factors which increase the likelihood that children will show disturbance over time include marital conflict, being raised in poverty, teen and single parenthood, parental depression, and hostile/angry parenting. Dysfunctional family backgrounds and socioeconomic adversity have also been attributed to suicide in young people. Childhood adversity including divorce and impaired parenting seems to cause both short- and long-term problems, various childhood disorders, and subsequently depression in adulthood.

Single mothers have been found twice as likely to come from families where a parent had a mental health problem. Studies have also reported as high as a threefold risk of depression, and substance use in single mothers compared to married mothers. Children from single family were more than twice likely to report internalizing problems and more than three times likely to report externalizing problems compared to children from two-parent families. More and more research studies have underscored the importance of early life experience in defining life trajectories. Silver et al. also suggested in their study that children who lived their mother and an unrelated partner had the poorest adjustment and highest levels of conduct problems compared to children who just lived their mothers. Studies have also suggested that adjustment problems in children with mother-only families are comparable to mother and an unrelated partner or a stepfather. The risk slightly decreases with another adult like grandparent being in the family.

1.1 Statement of the problem:

The aim of this study is to find out what are the basic reason of family disturbance or issues. This study will be aimed to explore main causes of family issues like women domestic violence, child abuse. This study will explore weather household economic condition play role in creation of family issues. Disruption in family structure can lead to several adverse events impacting both the mental health of children and their parents. Not all disruptions have equal effects. More emotional and behavioral problems occur in families disrupted by divorce than compared to other types of disruptions, for example, death of a parent. Certain characteristics have been identified in caregivers as well as the children themselves that serve as risk factors for abuse. Young age, depression, substance abuse, poverty, and history of mothers being separated from their own mothers during childhood serve as risk factors. Similar risk factors are also seen in male caregivers with unrelated male partner present at home acting as an additional risk factor. Some 30% children are expected to be living with unrelated surrogate father. Studies have also found that the presence of a stepparent increases the risk of being abused by a staggering factor of 20–40 times in contrast to living with single mothers where the risk was about 14 times compared to living in a biologically intact family. Some risk factors have also been identified within the children themselves such as low birth weight, physical, mental disabilities, aggression, and hyperactivity. Parents exposed to abuse in their childhood or domestic violence were also more prone to act aggressively toward their own children. However, studies have not been able to

decipher and document in the detail the different forms of abuse experienced by children who come from various types of disturbed family structures.

History of parental psychopathology predisposes children to increased rates of depression and other psychopathology when compared to children of parents who do not have any affective illness. Further, studies have also indicated that the course of depression in these children may be more chronic with increased rates of relapse. It also appears that mother's affective state has a more profound effect on the child than father's illness and the difference being statistically significant. As mentioned previously, parental marital impairments also affect child's risk for psychopathology and probably intertwine with parental psychopathology further leading to marital discord.

Athlete mental health (MH) is receiving increased attention in the sports medicine community. While participation in athletics has many benefits, the very nature of competition can provoke, augment or expose psychological issues in athletes. Certain personality traits can aid in athletic success, yet these same traits can also be associated with MH disorders. Importantly, the athletic culture may have an impact on performance and psychological health through its effect on existing personality traits and MH disorders. Consensus or position statements have been published by a number of organizations with each society bringing its own focus and perspective. Sports medicine physicians are trained through their primary disciplines and sports medicine fellowships to provide comprehensive medical care to athletes, including the management of MH disorders. The team physician is often the coordinator of the athlete's overall healthcare and may oversee MH screening and treatment, the prescribing of psychiatric medication and consultation with members of the MH care network.

The American Medical Society for Sports Medicine (AMSSM) convened a panel of experts to provide an evidence-based, best practices document to assist sports medicine physicians and other members of the athletic care network with the detection, treatment and prevention of MH issues in competitive athletes. This position statement focuses on the competitive athlete, from the youth and collegiate athlete to the Olympian and professional athlete and how team physicians, athletic trainers and MH care providers can assist with the detection and treatment of psychological issues in athletes. The unique signs and symptoms in athletes, prevalence of MH disorders in the athlete

population and utilization of available screening tools will be reviewed. Specific Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnostic criteria and the pathophysiology of MH disorders will not be discussed. The discussion of management may include psychosocial approaches and pharmacological treatments, emphasizing the selection of the most effective treatments with the fewest side effects of relevance for athletic performance. Last, this paper will present recommendations for prevention, including the identification and possible elimination of risk factors within the athlete environment.

This document provides an Executive Summary of key evidence-based findings. The full position statement provides a comprehensive review and is accessible as an online supplementary file. While this statement is directed towards sports medicine physicians, it also may assist other physicians and healthcare professionals in the care of competitive athletes with psychological issues and MH disorders.

1.2 Research Objective:

To provide a systematic and descriptive overview of all the evidence for community-based interventions for improving QoL in children and adolescents of parents with SMI, with specific reference to intervention format and content, participant characteristics, study validity and QoL outcomes measured

to examine the clinical effectiveness of community-based interventions in terms of their impact on a range of pre-determined outcomes, particularly those likely to be associated with QoL for children and adolescents of parents with SMI

to examine, when possible, potential associations between intervention effect and delivery including intervention format and content, prioritization of child outcomes, child age group, parental mental health condition, family structure and residency.

Significant of the study:

Although numerous studies reveal differences in mental health by the structure of one's family of origin, there remains debate regarding the processes generating these patterns. Using a sample of young adults (19–21 years) in Miami-Dade County in Florida, this study examines the explanatory significance of three presumed correlates of family type: socioeconomic status, family processes, and level of social stress. Consistent with prior research, our results reveal higher levels of depressive symptoms among those

from stepfamilies, single parent families, and single parent families with other relatives' present, compared with mother-father families. All three presumed correlates make significant independent contributions to the prediction of depressive symptomatology. Substantial mediating effects also are observed for all three explanatory dimensions. Collectively, they completely or largely explain observed family type variations in mental health risk.

This study is a follow-up of 39 working class couples who were interviewed after suffering economic stress or unemployment and again six years later. Repeated measures related to economics, stress, family functioning, anxiety, and depression were collected and analyzed for couples and for husbands and wives separately. A model of long-term coping was suggested for future testing. Initially stressed families appeared to grow stronger. Mental health correlated negatively to family problems. Depressed wives seemed to maintain their depression over time if they perceived family life as stressful. Irrespective of marital problems, husbands were less likely to stay depressed.

Research in the sociology of mental health is concerned primarily with understanding how individuals' social locations have consequences for their mental health. These investigations typically attempt to identify social and psychosocial processes that connect individuals' positions in the social structure with various measures of psychiatric disorder or psychological distress. However, as previous chapters in this handbook have demonstrated, mental illness also has important social consequences for individuals in terms of their experiences in help seeking, in accessing treatment, and in terms of the social stigma that they may experience. In this context, sociologists of mental health have made important contributions to our understanding of the social sequelae of mental illness.

CHAPTER 2

REVIEW OF LITERATURE

To find any association between family structure and rates of hospitalization as an indicator for behavior problems in children. Methods: Retrospective chart review of 154 patients who were admitted to the preadolescent unit at Lincoln Prairie Behavioral Health Center between July and December 2012. Results: We found that only 11% of children came from intact families living with biological parents while 89% had disruption in their family structure. Two-third of the children in the study population had been exposed to trauma with physical abuse seen in 36% of cases. Seventy-one percent had reported either a parent or a sibling with a psychiatric disorder. "I don't feel so alone now," one woman commented. "It's a huge help being able to talk to people who really understand." Others are grateful for the discussions about ways to deal with the issues they bring up.

The mental illness often becomes the family's primary focus

Family members have different perceptions of the problem and have conflicts about the solutions

Feelings of helplessness, frustration, loss, guilt, and compassion fatigue

Children coming from biologically family were less likely to have been exposed to trauma. Children coming from single/divorced families were less likely to have been exposed to sexual abuse but more likely to have a diagnosis of attention deficit hyperactivity disorder (ADHD) compared to other types of families. Strong association was found between exposure to trauma and certain diagnoses in respect to hospitalization. ADHD predicted a 4 times likelihood of having more than one previous hospitalization, with mood disorder, oppositional defiant disorder, and physical abuse increasing the risk by more than twice. Conclusions: Significant differences in family structure were demonstrated in our study of children being admitted to inpatient psychiatric hospitalization. The presence of trauma and family psychiatric history predicted higher rates of readmission. Our study highlighted the role of psychosocial factors, namely, family structure and its adverse effects on the mental well-being of children.

Social change, intensified by industrialization and globalization, has not only changed people's work lives but also their personal lives, especially in developing countries

2.1 General Overview about literature:

Mental illness has far-reaching effects on other family members, as individuals and as members of a social system. While the study of the family impact of mental illness has been reported in the specialized mental health literature, it has not received much attention from sociologists. This article applies an illness behavior perspective to the study of family burden, reviews knowledge, and invites research by defining several issues, substantive and methodological, that need to be addressed. These include the definition and measurement of burden, diagnosis and course of illness, residence and kinship, social class, context, and coping, and the evaluation of social interventions designed to reduce burden and strengthen family supports. The article concludes with a discussion of family burden in terms of normative forces operating at the macro level.

Schizophrenia is a severe mental illness, which is stressful not only for patients, but also for family members. Numerous studies have demonstrated that family caregivers of persons with a severe mental illness suffer from significant stresses, experience moderately high levels of burden, and often receive inadequate assistance from mental health professionals. Effective family functioning in families with schizophrenia may be influenced by a variety of psychosocial factors. The purpose of this article was to present a review of the social science literature related to families living with schizophrenia that has been published during the last three decades. There is general agreement in the literature that a multitude of variables affect families with a severe mental illness, such as schizophrenia. Therefore, this literature review examined the most frequently investigated variables (coping, psychological distress and caregiver burden, social support, caregiver resiliency and depression, and client behavioral problems) as they are related to families and schizophrenia.

2.2 lack of Health facilities and family issues:

It is known that the health of populations is shaped by the socioeconomic context, welfare systems, labor markets, public policies, and demographic characteristics of countries. There are strong reasons to believe that changes in these key determinants may be reflected in the mental wellbeing of populations. Therefore, mental health should be a health area regarded as possibly vulnerable during a recession, especially if mental disorders were already highly prevalent even before the crisis began. Nonetheless, some authors have argued that associations between contracting

economies and levels of well-being may show mixed patterns of both positive and negative impacts. However, this current recession is likely to aggravate and boost mental health problems through growing socioeconomic risk factors such as unemployment, financial strain, debts, and job-related problems. People facing these major life changes are more prone to mental ill-health. It has also been theorized that economic pressure and unemployment have a devastating impact on families, children, since the family is the most important context for their healthy development.

2.3 Poverty and weak mentality:

This paper intends to cover the main sources and types of recent evidence on populations' mental health outcomes in times of economic recession. Specifically, to summarize the mental health outcomes and the socioeconomic determinants most frequently addressed by the literature on economic recessions, which groups of people seem to be the most vulnerable, and to determine possible research needs.

We organized the main results by mental health outcomes and the socioeconomic determinants most frequently addressed by the literature, based on the quality of study design (cohort, case–control, cross-sectional and ecological). The mental health outcomes were clustered into four main groups psychological wellbeing (measured by continuous variables of mental health distress, self-rated health, and wellbeing or quality of life variables); common mental disorders (assessed by baseness for depression, anxiety, and somatoform disorders); problems related to substance-related disorders (reports on smoking, patterns of alcohol consumption, drug use, and substance-related harms), and reports on suicidal behaviors (suicide mortality, Para suicidal behavior, suicidal ideation, and attempts). The socioeconomic determinants retrieved were clustered into

A recent review of interventions for families affected by parental mental illness identifies a heterogeneous mix of interventions targeting children, parents, and/or the parent–child dyad. The format and content of these interventions varies. Direct interventions, by definition, establish the child as the major change agent and seek to improve child health or resiliency through either therapeutic or strength-based models of care. By virtue of their need for active child participation, these interventions typically target school-aged children or adolescents, with specific content and an overview of a research- informed family resilience framework developed as a

conceptual map to guide clinical intervention and prevention efforts with vulnerable families is presented. Building on studies of individual and family resilience and developments in strength- based approaches to family therapy, this practice approach is distinguished by its focus on strengthening family functioning in the context of adversity. Key processes that foster resilience are questions remain concerning the `effects of parenting on behavioral/emotional problems in children. This annotation discusses recent findings concerning the parenting `effects' literature and identifies areas in need of further research. The review begins by examining theories and definitions of parenting, and then considers research findings on the predictors of parent–child relationships and their effects on behavioral/emotional adjustment in children. Evidence for causal processes are then examined in light of findings emphasizing the need to consider the impact of larger systems on child's well- being, bi- directional processes in parent–child interactions, and alternative hypotheses suggested by behavioral genetics. Different kinds of evidence suggest strong links between parent–child relationship quality and children's well- being, but difficulties remain for drawing causal connections. The need for greater integration among research traditions and the need for theory development are highlighted. In addition, although a substantial and robust research base exists on parent–child relationships, the applicability of these findings to clinical settings is uncertain. Substantial progress has been made in our understanding of the nature of parent–child relationships and their developmental effects, but several basic conceptual and methodological and clinical questions continue to need rigorous study. outlined, as are several innovative family systems training and service applications.

There is widespread agreement that over 11% of our nation's children need mental health treatment, but most of these children receive inadequate or inappropriate treatment. This gap between what we know should be provided and what is provided is the result of a poorly structured health care financing system and a poorly coordinated treatment system. The treatment system fails to recognize that children's mental health problems are interactions between intraindividual difficulties and environmental conditions. A wealth of models of prevention and treatment have been developed, and a substantial scientific basis for children's mental health interventions now exists, but there is a shortage of community-based services and a lack of coordination across services. Public policy toward children with mental health problems must encourage

application of knowledge about effective treatment systems and encourage care in the least restrictive and most cost-effective settings.

In 1992, the National Institute if Mental Health and 6 teams of investigation began

a multisite clinical trial, the Multimodal Treatment of Attention-Deficit Hyperactivity Disorder(MTA) study. Five hundred seventy-nine children were randomly assigned to either routine community care (CC) or one of three study-delivered treatments, all lasting 14 months. The three MTA treatments-monthly medication management (usually methylphenidate) following weekly titration (Midge), intensive behavioral treatment (Bah), and the combination (Comb)-were designed to reflect known best practices within each treatment approach. Children were assessed at four time points in multiple outcomes. Results indicated that Comb and Midge interventions were substantially superior to Bah and CC interventions for attention-deficit hyperactivity disorder symptoms. For other functioning domains (social skills, academics, parent-child relations, oppositional behavior, anxiety/depression), results suggested slight advantages of Comb over single treatments (Midge, Bah) and community care. High quality medication treatment characterized by careful yet adequate dosing, three times daily methylphenidate administration, monthly follow-up visits, and communication with schools conveyed substantial benefits to those children that received it. In contrast to the overall findings that showed the largest benefits for high quality modification management (regardless of whether given in the Midge or Comb group), secondary analysis revealed that Comb had a significant incremental effect over Midge (with a small effect size for this comparison) when categorical indicators of excellent response and when composite outcome measures were used. In addition, children with parent-defined comorbid anxiety disorders, particularly those with overlapping disruptive disorder comorbites, showed preferential benefits to the Bath and Comb interventions. Parental attitudes and disciplinary practices appeared to mediate improved response to the Bath and Comb interventions.

To address problems in access, several family-based service models have been developed with the common goal of supporting families' engagement with or knowledge about mental health services. For example, developed a theory-based "parent empowerment" intervention designed to increase parents' self-efficacy in advocating for their children's mental health care needs. While this intervention

constitutes the sole controlled study to date testing empowerment methods in the area of children's mental health, other types of family support models have been developed to address specific types of mental health issues. These include education and psychological support for families of youth with bipolar disorder; support interventions addressing parent stress and other familial barriers to service use among families of children with disruptive behavior disorders; strategies to address problems of clinician engagement and retention of families in services. parent support interventions to promote flexible service planning using wrap-around service and peer-led interventions to facilitate parent connections with service.

Increasingly in service interventions such as these, parents are viewed not as recipients of services but as agents of change. In a recent review of the empirical literature on family-based services since 1990, 41 rigorous studies of specific program models of family processes were identified. This review identified no core set of constructs, definitions, or theoretical foundations upon which to base the thin set of studies. The purpose of this manuscript is to describe the development of a Parent Empowerment Program (PEP) in New York State. Using a community-based participatory research approach, a parent empowerment program (PEP) that integrates grassroots-driven Principles of Parent Support and a research-based Unified Theory of Behavior Change was developed in an iterative process to support parents as change agents in the engagement of effective services for their children and family.

The process of parent empowerment has been conceptualized as a "process of recognizing, promoting and enhancing [parents'] abilities to meet their own needs, solve their own problems, and mobilize the necessary resources in order to feel in control of their own lives". According to , parent empowerment involves a dynamic process, encompassing four key components:

(1) understanding and acceptance of a child's diagnosis.

(2) critical reflection of themselves and their situation by taking stock of their strengths, capabilities and resources.

(3) taking charge of there.

2.4 Assumptions:

A broken family can negatively affect all domains of your child's development. The effects of a broken family on a child's development depend on numerous factors, including the age of the child at the time of parents' separation, and on the personality and family relationships. Although infants and young children may experience few negative developmental effects, older children and teenagers may experience some problems in their social, emotional and educational functioning. After a divorce, children from pre-school through late adolescence can experience deficits in emotional development. Children of all ages may seem tearful or depressed, which is a state that can last for several years after a child's parents' have separated, explains psychologist Lori Rappaport. Additionally, some older children may show very little emotional reaction to their parents' divorce. According to Lori Rappaport, this may not be developmentally beneficial. Some children who show little emotional response are actually bottling up their negative feelings. This emotional suppression makes it difficult for parents, teachers and therapists to help the child process her feelings in developmentally appropriate ways. Slowed academic development is another common way that separation of the parents affects children. The emotional stress of a divorce alone can be enough to stunt your child's academic progress, but the lifestyle changes and instability of a broken family can contribute to poor educational outcomes. This poor academic progress can stem from a number of factors, including instability in the home environment, inadequate financial resources and inconsistent routines. By its very nature, divorce, changes not only the structure of the family but also its dynamics. Even if you and your spouse have an amicable divorce, simply creating two new households permanently alters family interactions and roles. Based on the new living arrangements, your children may need to perform more chores and assume additional roles in the new household's basic functioning. Additionally, in some broken families, older children may take on a parental-type role when interacting with younger siblings because of their parents' work schedules or inability to be present in the way that the parents were before the divorce.

CHAPTER 3

THEORETICAL FRAMEWORK

3.1 The Theory

Family theories can be as stressful as families themselves, however, theory can serve as a reference point to assist the health provider. Although a dysfunctional family can be detrimental to a person's well-being, having a family as an ally can be a valuable component for helping the patient. A family does not have to be perfect but if the good outweighs the bad, a PMHNP should use that to his or her advantage. The hassle of managing a psychiatric patient can be tough work, let alone trying to fix a family. Therefore, this is a basic overview of family theories and information. Just to be clear, if you have a family that's willing to work with you then therapy may be helpful, but if not -then it can be litigious and I would limit my interactions and keep it simple with the usual standards. Family therapy is usually employed by a therapist. Therefore, this page is a formal understanding and hopefully one day, PMHNP's will be able to provide therapy more often. In the meantime, psych NP's can at least offer an abbreviated form of assistance with client families.

3.2 Lack of Economic resources and family issues:

Economic recessions have been estimated to significantly affect the population's health and wellbeing, which applies, in particular, to vulnerable groups of people. In countries that have been hardest hit by the latest recession, which started in 2007, the living and working conditions have substantially worsened. Work became more precarious and unemployment rates increased as a result of the slowdown in global growth and consequent deterioration of the labor markets. For instance, almost half of the citizens of Europe reported knowing someone who had lost his/her job as a direct result of the crisis. Rates of involuntary part-time employment have also been rising since the beginning of the recession. Overall, people are more fearful about losing their employment since competition for jobs is rising and finding work quickly is perceived as unlikely. It is estimated that labor markets will take time to improve even though there are prospects for economic recovery. Levels of poverty and social exclusion have worsened, mainly in groups that were already at risk. During this recession, more people have been reporting being at risk of being unable to cope with unexpected expenses and even facing difficulties with paying ordinary bills or buying food over the coming year.

3.2 Application:

Children in child welfare are especially likely to have unmet mental health needs. The role of family factors in children's use of mental health services was examined in a longitudinal sample of 1075 maltreated or at-risk children. Vulnerable family environment (poor family functioning, low social support, and caregiver psychological distress) is an important predictor of children's mental health needs. It also predicts them not having these needs met. In the terms of mental health, strong relationships are one of the biggest predictors of happiness. Research shows that the benefits of healthy relationships are profound and affect our lives in a myriad of ways. Healthy relationships can help buttress us from the stresses of life.

However, these relationships can be negatively impacted when a loved one suffers from mental health challenges or substance misuse. This not only affects the individual but also impacts their closest relationships. Unfortunately, there is a great deal of shame and stigma associated with these conditions, making it challenging to talk about with loved ones, let alone reach out for help. In fact, many wait too long to get help because they do not want to be a burden or they feel they should be able to get better on their own.

It's often difficult for a person whose loved one is struggling to know when and how to help. Dealing with a loved one's crises and ongoing struggles can sometimes lead to an over-involvement and focus on the person who is suffering, leaving other areas and other relationships in one's life neglected. PCH Treatment Center is very aware of this risk and is in a unique position to address the family dynamics surrounding a person with mental health issues.

PCH understands that when someone we love suffers, it impacts us profoundly. While mental health issues need targeted, professional assessment and treatment, PCH believes that mental health does not stop there. In order to optimize outcomes, we invite the client's primary support system into the treatment process.

Each month we offer a family intensive weekend, a program designed specifically for our clients and their families. Throughout the weekend, we provide in-depth psycho-education along with practical tools and individualized therapeutic support. Clients and family members benefit from interactive learning, group work and individualized family therapy sessions with their own assigned family therapist.

3.3 Proposition Hypothesis:

Parental separation has been reported in the literature as being associated with a wide range of adverse effects on children's wellbeing, both as a short-term consequence of the transition and in the form of more enduring effects that persist into adulthood. Effects reported include adverse impacts on cognitive capacity (Fergusson, Lynskey and Horwood 1994), schooling (Evans et al. 2001), physical health (Dawson 1991), mental and emotional health (Chase-Lansdale et al. 1995), social conduct and behavior (Morrison and Coiro 1999), peer relations (Demo and Acock 1988), criminal offending (Hanson 1999), cigarette smoking (Ermisch and Francesconi 2001), substance use (Fergusson, Horwood and Lynskey 1994), early departure from home (Mitchell et al. 1989), early-onset sexual behavior (Ellis et al. 2003) and teenage pregnancy (Woodward et al. 2001).

A further range of impacts in early adulthood and beyond include higher rates of early childbearing (Manahan and Bumpass 1994), early marriage (Keith and Finlay 1988), marital dissolution (Amato and DeBoer 2001), lone parenthood (Manahan and Booth 1989), low occupational status (Biblarz and Gottainer 2000), economic hardship (Manahan and Booth 1989), poor-quality relationships with parents (Aquilino 1994), unhappiness (Biblarz and Gottainer 2000), discontentment with life (Furstenberg and Teitler 1994), mistrust in others (Ross and Mirowsky 1999), and reduced longevity (Tucker et al. 1997).

On the face of it, this seems like a long and forlorn listing, which suggests that parental separation bears down heavily on children and blights their lives to a significant degree across all domains of functioning. Yet the picture is not as bleak as this litany of problems might suggest. In most cases the size of the reported effects is small; a minority of children are negatively affected, generally only in the presence of other exacerbating factors; and in many cases the existence of a causal connection is contested and other competing explanations for these associations have been put forward. In other words, it is important to be cautious in interpreting the meaning of these patterns of association.

Many scholars who have identified associations between family structure and family change and child outcomes have drawn attention to the relatively small size of the effects. Joshi et al. (1999) describe the effect sizes they measured as "modest", while

Burns et al. (1997) refer to effects that were "very weak". Allison and Furstenberg (1989) report that the proportion of variation in outcome measures that could be attributed to marital dissolution was generally small, never amounting to more than 3%.

The modest nature of the associations between separation and children's outcomes means that knowing that a child comes from a separated family, and knowing nothing else about the child, has little predictive power in terms of the child's wellbeing. There is a wide diversity of outcomes among both groups of children from divorced and intact families, and the adjustment of children following divorce depends on a wide range of other factors.

Demo and Adcock (1996) note that "the differences in adolescent well-being within family types are greater than the differences across family types, suggesting that family processes are more important than family composition". Indeed, O'Connor et al. (2001) showed that differences in adjustment between children within the same family are as great as, and even slightly greater than, differences between children in different families. Demo and Adcock (1996) note further that measures of family relations explained the largest proportion of variance in adolescent wellbeing.

The majority of children whose parents have divorced function within normal or average limits in the years after divorce (Kelly 1993). As a group, they cannot be characterized as "disturbed". Furthermore, there is a considerable range of functioning within both groups of children from divorced and intact families. Among children whose parents have divorced are many who are functioning quite well, while among children from intact families are many with major adjustment problems. In short, there is no one-to-one relationship between divorce and psychological adjustment problems in children.

In fact, not only do some children do well despite the divorce of their parents, but some children actually benefit from the divorce. Demo and Adcock 1988 note that adolescents living in single-parent families can "acquire certain strengths, notably a sense of responsibility, as a consequence of altered family routines". It is likely, however, that such benefits will accrue only where the altered routines are structured and predictable. Changes that involve the emergence of more chaotic patterns of family life are unlikely to be beneficial for children, even if some strive to furnish a sense of order where their parents fail to do so. Butler et al. (2002) note that the children in their

study demonstrated "an active role helping their parents cope with divorce, even in circumstances where parents did not seem able to contain their more negative emotions and impulses".

Children also benefit where a parental separation provides release from an aversive family situation; for example, where the parental relationship is highly conflicted and the children are drawn into the conflict (Booth and Amato 2001, Jekielek 1998) or where the child's relationship with a parent figure is of poor quality (Videon 2002). Videon (2002) notes that:

The prophylactic effects of parental separation are amplified as adolescents' satisfaction with the parent–adolescent relationship decreases. When adolescents are residentially separated from an unsatisfying same-sex parent relationship ... their level of delinquent behaviour is lower than adolescents who continue to reside with a same-sex parent with whom they have a poor relationship.

A further circumstance where children may benefit from a parental separation is where a parent exhibits antisocial behaviour. Jaffee et al. (2003) found that the less time fathers lived with their children, the more conduct problems the children had, but only if the fathers exhibit low levels of antisocial behaviour. In contrast, when fathers exhibit high levels of antisocial behaviour, the longer they lived with their children the more conduct problems the children exhibited. In such cases, children are likely to be receiving a double whammy of genetic and environmental factors that heighten the risk of conduct problems.

Nevertheless, despite all these caveats and qualifications, it remains true that children whose parents separate do less well, on average, across a range of measures of wellbeing. A pressing question that follows from this is why these associations arise. Before examining this question, I will consider briefly whether remarriage changes the outlook for children who have experienced a parental separation, what impact multiple family transitions have on child wellbeing and whether the effects of parental separation are primarily short-term or whether it also has more persistent and enduring consequences for children's wellbeing.

Remarriage does not generally improve outcomes for children, despite the potential gains from both improved economic circumstances and the presence of an additional adult to help with parenting tasks. Indeed, some studies have shown children to be

worse off after a parent's remarriage. Elliott and Richards (1991) found that having a stepfather1 had a deleterious effect on children's behavior scores. Fergusson et al. (1986) found that, among children who had experienced a parental separation, those whose parents reconciled or whose mother remarried exhibited more behavioral difficulties than children who remained in a single-parent family. Baydar (1988) found that, although divorce was not negatively related to mothers' reports of children's behavioral and emotional problems, remarriage was.

It appears, then, that there is something about the complexity of family life in stepfamilies that hinders them from benefiting from the additional resources that are available when a lone mother remarries. Relationships within stepfamilies are complex and need time and goodwill on all sides to work well. Unlike the relationship between mother and stepfather, that between stepfather and stepchild is not a relationship of choice, which means that goodwill may sometimes be in short supply, at least in the early stages of establishing a stepfamily. Children are often suspicious of their mothers' new partners and slow to open up to the benefits the new relationship might confer on them, while stepfathers are often uncertain about how to respond to the children of their new partner (Amato 1987). Typically, this uncertainty results in lower levels of involvement: as Fine et al. (1993) note, stepfathers appear to actively refrain from becoming involved with their stepchildren, engaging in both fewer positive and fewer negative behaviors. Perhaps as a result, cohesion remains lower among stepfamilies than among intact families (Pryor & Rodgers 2001). Even so, improvements in stepfamily functioning are evident over time (Amato 1987), which suggests that many families manage to master the challenges they face.

Several studies have found that multiple family transitions are especially damaging for children. Dunn et al. (1998) reported that the number of transitions impacted both on children's adjustment problems and on levels of prosocial behavior. Kurdek et al. (1994) found that, although the effects of the number of parenting transitions were significant, these accounted for a relatively small percentage of the variation of adjustment, ranging between 5% and 8% across three separate samples.

Aquilino (1996) reported that the experience of multiple transitions and multiple family types, among a sample of children not born into an intact biological family, was associated with lower educational attainment and greatly increased the likelihood that

children would try to establish an independent household and enter the labour force at an early age.

One possible explanation is that having multiple transitions presents children with a succession of caregivers ... and this experience may weaken children's attachment to any particular caregiver, making early autonomy seem more attractive.

The evidence on this, however, is not entirely consistent. A range of other studies failed to turn up any evidence that multiple transitions are more damaging to children's wellbeing (Booth and Amato 2001, Carlson and Corcoran 2001, Teachman 2002). It may be that the impact of multiple transitions depends to some extent on the circumstances associated with transitions. Where transitions are well managed and conducted with goodwill, they may do little damage, while transitions that are chaotic, unpredictable and infused with rancor and disputation may have malign effects on children's wellbeing.

CHAPTER NO:4

CONCEPTUALIZATION AND OPERATIONALIZATION

4.1 Conceptualization:

The concept of social support is used increasingly to understand families and their functioning. While conceptualization of the support process is regrettably absent for much research on families, earlier models developed for examining social support of individuals can enlighten research on families. The history of the social support concept is presented along with an overview of current typologies of social support and models of how it impacts physical and mental health. Research on the social support of families with children with special needs is reviewed relative to these issues. Greater recognition of a comprehensive model of support is advocated. Recommendations are made for longitudinal research on temporal patterns of utilization and satisfaction with support, and for consideration of cultural contexts in interpreting social supports. There is much debate in the addiction literature about the extent to which excessive drinking affects nondrinking family members. The issue is considered in this review by examining and evaluating research relating to the effects of drinking on children, family systems, and partners of drinkers. The latter group have, historically, been blamed and pathologies for their partner's drinking, although more recent theories have adopted a stress and coping paradigm, thus normalizing individuals and their behaviors. Conceptualizations of spouses over the last five decades are described and evaluated in the second part of the review. Finally, the review considers the impact of the recent stress and coping paradigm on clinical interventions for excessive drinkers and their families, and suggestions are made for future research.

Systematic theorizing about work—family balance has not kept pace with interest, which undermines organizations' abilities to effectively monitor work—family balance and to use work—family balance strategically. The goal of this article is to develop a better conceptual understanding of work—family balance. Work—family balance is defined as accomplishment of role-related expectations that are negotiated and shared between an individual and his or her role-related partners in the work and family domains. This article elaborates on how this definition of work—family balance addresses limitations of previous conceptualizations and describes areas for human resource development research and implications for using work—family balance strategically in management practice.

Using person- environment fit theory, this article formulates a conceptual model that links work, family, and boundary- spanning demands and resources to work and family role performance and quality. Linking mechanisms include 2 dimensions of perceived work- family fit (work demands–family resources fit and family demands–work resources fit) and a global assessment of perceived work- family balance. Work, family, and boundary- spanning demands and resources are associated with the 2 dimensions of fit, which combine with boundary- spanning strategies to influence work- family balance, which in turn affects role performance and quality. The model provides a framework for clarifying and integrating previous conceptualizations, measures, and empirical research regarding perceived work- family fit and balance as linkages between the work- family interface and outcomes. The article closes with suggestions for further work.

Research on family health communication is based in part on the assumption that families actually communicate about a wide variety of topics pertaining to their health and wellness. However, whether they do communicate about health and wellness, and exactly what they communicate about concerning health and wellness as well as how often, remains undocumented. To begin to address this problem of documenting the extent to which families talk about health and wellness, this study adapted Warren and Neer's (1986) Family Sex Communication Quotient to create and report the preliminary validation of a new measurement instrument called the Family Health Communication Quotient. The new measurement assesses an individual's reported levels of comfort, perception, and value regarding health and wellness communication within their family. To assess the new measurement's convergent validity, the Revised Family Communication Patterns Instrument (Ritchie & Fitzpatrick, 1990) as well as a new Family Health Evaluation questionnaire were used. Results confirm the concurrent validity of the FHCQ instrument and found that families with high FHCQ scores were also high in conversation-orientation, more likely to talk about health and wellness topics, have a working relationship with a physician, a positive outlook on diet, and exercise regularly. Keywords: family communication, health and wellness, well-being, positive communication. Across the lifespan, the family is recognized as the primary and proximal influence on the collective as well as the individual members' health. For better or worse, interactions within the family circle shape behavior, lifestyle, relationships, perceptions, and ultimately, health capacities and health decisions (e.g.,

see Turner & West, 2015). Likewise, "The family occupies a central position in the lives of individuals and is also humanity's most enduring and most fundamental social institution". More specifically, the parent-child dyad is an influential relationship in which the parental interaction with their children may directly affect the child's choices and behaviors (Socha & Yingling, 2010). Reciprocity describes how children can also influence their parent's choices and behaviors (Socha & Stamp, 1995). Reciprocal interactions occur within conversations between the parent-child dyad directly influencing one another through elicited and regulated responses. The same theories and propositions that apply to families in general can also apply to health and wellness communication within the family, in particular because parents are central to these efforts and play a key role in the health choices of their children. Considerable research exists from various disciplines regarding family communication and the physician-patient relationship as it pertains to the education, prevention, and intervention of unhealthy behaviors including family studies. Public health, medicine, psychology, and so on. However, limited research exists that has examined how families talk about health in the home as well as 2 the effects these conversations may have on the behavioral outcomes of individuals. Rebecca Cline (2003, p. 285), for example, states that health communication "focuses on the relationships between communication and health, health attitudes and beliefs, and health behavior."

4.2 Operationalization:

Research studies investigating the impact of childhood cumulative adversity on adult mental health have proliferated in recent years. In general, little attention has been paid to the operationalization of cumulative adversity, with most studies operationalizing this as the simple sum of the number of occurrences of distinct events experienced. In addition, the possibility that the mathematical relationship of cumulative childhood adversity to some mental health dimensions may be more complex than a basic linear association has not often been considered. This study explores these issues with 2 waves of data drawn from an economically and racially diverse sample transitioning to adulthood in Boston, Massachusetts, USA. A diverse set of childhood adversities were reported in high school and 3 mental health outcomes—depressed mood, drug use, and antisocial behavior—were reported 2 years later during the transition to adulthood.

Our results suggest that both operationalization and statistical modeling are important and interrelated and, as such, they have the potential to influence substantive interpretation of the effect of cumulative childhood adversity on adult mental health. In our data, total cumulative childhood adversity was related to depressive symptoms, drug use, and antisocial behavior in a positive curvilinear manner with incremental impact increasing as adversities accumulate, but further analysis revealed that this curvilinear effect was an artifact of the confounding of high cumulative adversity scores with the experience of more severe events. Thus, respondents with higher cumulative adversity had disproportionately poorer mental health because of the severity of the adversities they were exposed to, not the cumulative number of different types of adversities experienced. These results indicate that public health efforts targeting prevention of childhood adversities would best be aimed at the most severe adversities in order to have greatest benefit to mental health in young adulthood.

CHAPTER 5

RESEARCH METHADOLOGY

When a parent becomes mentally unwell, it can be difficult for them to explain to their child what is happening and for the child to make sense of their parent's behavior.

Parents and children or young people often feel isolated and unsupported when the parent is unwell, which can increase distress and anxiety across the family. It is important that mental health and social services support both the parent and their child. Large numbers of children grow up with a parent who has a mental health problem. Many of these parents will have a mild or short-lived problem. Many children live with a parent who has a long-term alcohol problem or drug dependency, sometimes combined with a mental health problem. Some parents have a severe and enduring mental illness. These long-term illnesses include schizophrenia, personality disorders and bi-polar disorder. Estimates suggest that between 50% and 66% of parents with a severe and enduring mental illness live with one or more children under 18. That amounts to about 17,000 children and young people in the UK. Many parents feel under pressure to balance their parenting role with their other roles as partners or workers. Parents with mental health problems may find this particularly difficult. Parents with mental health problems may also struggle to manage their parenting role. In addition, if a parent has to be admitted to hospital, this may disrupt the stability of their children's lives and change the balance of their relationship with their children. Putting their children's needs first can mean parents avoid hospital stays or stop taking medication that makes them tired or unable to think clearly.

Although many children experience negative effects from their parents' mental ill health, many others do not. Certain factors can protect children's mental health when their parents are unwell for a long time. These include:

being supported by agencies who take a 'whole family' approach to supporting the child, their parent and other family members

getting support from their relatives, teachers, other adults and their friends

having another caregiver who does not have mental health problems

being parented in a consistent way.

cultural factors, such as the support of faith communities, which may vary between different communities.

These factors all go to building and maintaining a child's resilience to difficulties. Social support can help children and young people to cope with their parents' ill health. Young carers' groups can be an important source of support, offering them a chance to meet up with other young carers , talk to people who understand what they are coping with, and enjoy trips and activities that they can't usually join because of their caring responsibilities.

5.1 Research Design:

Overview of Presentation

• Family relationship influences on children's mental health/outcomes o A brief review of theory and research

• Focus on the inter-parental and parent-child relationships

• Addressing caveats of past research • Examining the role of family relationships on child mental health/outcomes –

What is the evidence?

Example Study 1: Inter-parental conflict and children's sleep problems, or vice versa?

Example Study 2: The role of parenting underlying inter-parental conflict and child conduct problems?

Example Study 3: Examining prenatal and postnatal stress and children's conduct problems: The advantages of multiple complementary research designs

• Implications for practice and policy o Summary and recommendations of Implications for policy (and practice) Family Factors and Child Mental Health

• How are children affected by family factors Internalizing Problems Externalizing Problem Social Competence Academic Attainment Physical health

• Medical/social care/production Depression – WHO 2020 o Conduct disorder - £22 billion Education, employability

• What family factors affect children o Family stress (econ. press/poverty) o Parent mental health Parenting behavior/practices Inter-parental conflict, DV Parental separation-divorce.

5.2 Sample:

• 561 sets of adopted children, adoptive parents, and birth parent's o Sample retention: Adoptive family = 90% Birth parent = 92% Families assessed at child age 9-, 18-, 27-months of age; ongoing assessments at 4.5 years, 6 years, 7 years, 8 years, 9 years' Present sample included 341 linked families assessed at 27 months, 4.5 years, and 6 years.

• Nationally-representative sample of families who made domestic infant adoption placements in the United States between 2003-2009 Method.

• Videotaped Observation – adoptive families Child temperament, parent-child interactions, marital interactions video recorded in the home during 3-hour home visits at each wave. Coding for these tasks is on-going.

• Questionnaire – adoptive parent's o Couple relationship, parent-child relationship, symptoms of depression and anxiety, family economic conditions, styles of family interaction, parenting style, children's emotional and behavioral well-being, child sleep problems.

• Questionnaire – birth parent's o Couple relationship, diagnosis and symptoms of psychopathology, drug use, economic conditions, life stress, temperament.

5.3 Universe:

Caribbean and Filipino immigrant families in Canada have much in common: the women have often immigrated as domestic workers, first-generation children may be separated from their parents for long periods, and they must deal with negative stereotypes of their ethnic group. This transcultural study looks at the associations between family relations and adolescents' perceptions of both their own group and the host society, and analyzes how these affect their mental health. The results suggest that family cohesion plays a key role in shaping adolescents' perceptions of racism in the host country and in promoting a positive appraisal of their own community, thus highlighting the need for a systemic understanding of family and intergroup relations.

The word stress has many connotations. There are two quite distinct areas of ambiguity surrounding this term. One has to do with the stage of the stress process at which stress occurs. Some use stress to refer to the problems people face (the stimulus), others to

refer to the generalized response to these problems (as in "psychological stress"), and still others to refer to a mediating state of the organism in response to threat that may or may not generalize (the black box between stimulus and generalized response). It may be helpful, therefore, to distinguish at the outset among Stressors, stress, and distress—the stimulus problem, the processing state of the organism that remains unmapped in the psychosocial approach, and the generalized behavioral response. The term strain is also sometimes used to refer to Stressors, but I use it, following its original meaning, to refer to the response side of the model.

Over the last ten years the basic knowledge of brain structure and function has vastly expanded, and its incorporation into the developmental sciences is now allowing for more complex and heuristic models of human infancy. In a continuation of this effort, in this two- part work I integrate current interdisciplinary data from attachment studies on dyadic affective communications, neuroscience on the early developing right brain, psychophysiology on stress systems, and psychiatry on psychopath genesis to provide a deeper understanding of the psych neurobiological mechanisms that underlie infant mental health. In this article I detail the neurobiology of a secure attachment, an exemplar of adaptive infant mental health, and focus upon the primary caregiver's psychobiological regulation of the infant's maturing limbic system, the brain areas specialized for adapting to a rapidly changing environment. The infant's early developing right hemisphere has deep connections into the limbic and autonomic nervous systems and is dominant for the human stress response, and in this manner the attachment relationship facilitates the expansion of the child's coping capacities. This model suggests that adaptive infant mental health can be fundamentally defined as the earliest expression of flexible strategies for coping with the novelty and stress that is inherent in human interactions. This efficient right brain function is a resilience factor for optimal development over the later stages of the life cycle. This paper studies how in utero exposure to maternal stress from family ruptures affects later mental health. We find that prenatal exposure to the death of a maternal relative increases take-up of ADHD medications during childhood and anti-anxiety and depression medications in adulthood. Further, family ruptures during pregnancy depress birth outcomes and raise the risk of perinatal complications necessitating hospitalization. Our results suggest large welfare gains from preventing fetal stress from family ruptures and possibly from economically

induced stressors such as unemployment. They further suggest that greater stress exposure among the poor may partially explain the intergenerational persistence of poverty. Despite its relative infancy, child abuse research has provided a substantial literature on the psychological sequelae of sexual molestation. These findings have been helpful in informing social policy and guiding mental health practice. Because of the regency of interest in this area, however, as well as the costs and time investment associated with more rigorous longitudinal research, many of these studies have used correlational designs and retrospective reports of abuse. The implications of this methodology are outlined, and remedies are suggested where possible.

Inks between chronic illness and family relationships have led to psychosocial interventions targeted at the patient's closest family member or both patient and family member. The authors conducted a meta-analytic review of randomized studies comparing these interventions with usual medical care (k=70), focusing on patient outcomes (depression, anxiety, relationship satisfaction, disability, and mortality) and family member outcomes (depression, anxiety, relationship satisfaction, and caregiving burden). Among patients, interventions had positive effects on depression when the spouse was included and, in some cases, on mortality. Among family members, positive effects were found for caregiving burden, depression, and anxiety; these effects were strongest for no dementing illnesses and for interventions that targeted only the family member and that addressed relationship issues. Although statistically significant aggregate effects were found, they were generally small in magnitude. These findings provide guidance in developing future interventions in this area.

Unprecedented numbers of children experience parental incarceration worldwide. Families and children of prisoners can experience multiple difficulties after parental incarceration, including traumatic separation, loneliness, stigma, confused explanations to children, unstable childcare arrangements, strained parenting, reduced income, and home, school, and neighborhood moves. Children of incarcerated parents often have multiple, stressful life events before parental incarceration. Theoretically, children with incarcerated parents may be at risk for a range of adverse behavioral outcomes. A systematic review was conducted to synthesize empirical evidence on associations between parental incarceration and children's later antisocial behavior, mental health problems, drug use, and educational performance. Results from 40 studies (including 7,374 children with incarcerated parents and 37,325 comparison children in 50 samples)

were pooled in a meta-analysis. The most rigorous studies showed that parental incarceration is associated with higher risk for children's antisocial behavior, but not for mental health problems, drug use, or poor educational performance. Studies that controlled for parental criminality or children's antisocial behavior before parental incarceration had a pooled effect size of OR = 1.4 ($p < .01$), corresponding to about 10% increased risk for antisocial behavior among children with incarcerated parents, compared with peers. Effect sizes did not decrease with number of covariates controlled. However, the methodological quality of many studies was poor. More rigorous tests of the causal effects of parental incarceration are needed, using randomized designs and prospective longitudinal studies. Criminal justice reforms and national support systems might be needed to prevent harmful consequences of parental incarceration for children.

With prison populations growing rapidly in many countries worldwide, effects of incarceration on prisoners' well-being, health, and behavior have become urgent social concerns. Equally important are possible far-reaching effects of incarceration beyond prison walls, on recidivism, employment opportunities for ex-prisoners, and on families and communities. Children with incarcerated parents have been referred to as the "forgotten victims" of crime, the "orphans of justice" and the "unseen victims of the prison boom". They can experience multiple emotional and social difficulties during their parent's incarceration, which may develop into a range of adjustment problems in the long term. This article describes key aspects of children's experiences during parental incarceration and reports results from a systematic review and meta-analysis on the associations between parental incarceration and children's later antisocial behavior, mental health problems, drug use, and low educational performance.

5.4 Sampling Design:

To examine the association between the frequency of family dinners and positive and negative dimensions of mental health in adolescents and to determine whether this association is explained by the quality of communication between adolescents and parents.

A community sample of 26,069 adolescents (aged 11 to 15 years) participated in the 2010 Canadian Health Behavior of School-aged Children study. Adolescents gave self-report data on the weekly frequency of family dinners, ease of parent–adolescent

communication, and five dimensions of mental health (internalizing and externalizing problems, emotional well-being pro-social behavior, and life satisfaction). Regression analyses tested relations between family dinners, parent–adolescent communication, and mental health.

The frequency of family dinners negatively related to internalizing and externalizing symptoms and positively related to emotional well-being, prosocial behavior, and life satisfaction. These associations did not interact with differences in gender, grade level, or family affluence. However, hierarchical regression analyses found that these associations were partially mediated by differences in parent–adolescent communication, which explained 13% to 30% of the effect of family dinners on mental health, depending on the outcome.

These findings, though correlational, revealed a dose–response association between the frequency of family dinners and positive and negative dimensions of adolescent mental health. The ease of communication between parents and adolescents accounted for some of this association.

5.5 Sampling Technique:

Few studies have examined the effects of individual and organizational characteristics on the use of evidence-based practices in mental health care. Improved understanding of these factors could guide future implementation efforts to ensure effective adoption, implementation, and sustainment of evidence-based practices.

To estimate the relative contribution of individual and organizational factors on therapist self-reported use of cognitive-behavioral, family, and psychodynamic therapy techniques within the context of a large-scale effort to increase use of evidence-based practices in an urban public mental health system serving youth and families.

In this observational, cross-sectional study of 23 organizations, data were collected from March 1 through July 25, 2013. We used purposive sampling to recruit the 29 largest child-serving agencies, which together serve approximately 80% of youth receiving publically funded mental health care. The final sample included 19 agencies with 23 sites, 130 therapists, 36 supervisors, and 22 executive administrators.

Therapist self-reported use of cognitive-behavioral, family, and psychodynamic therapy techniques, as measured by the Therapist Procedures Checklist–Family Revised.

Individual factors accounted for the following percentages of the overall variation: cognitive-behavioral therapy techniques, 16%; family therapy techniques, 7%; and psychodynamic therapy techniques, 20%. Organizational factors accounted for the following percentages of the overall variation: cognitive-behavioral therapy techniques, 23%; family therapy techniques, 19%; and psychodynamic therapy techniques, 7%. Older therapists and therapists with more open attitudes were more likely to endorse use of cognitive-behavioral therapy techniques, as were those in organizations that had spent fewer years participating in evidence-based practice initiatives, had more resistant cultures, and had more functional climates. Women were more likely to endorse use of family therapy techniques, as were those in organizations employing more fee-for-service staff and with more stressful climates. Therapists with more divergent attitudes and less knowledge about evidence-based practices were more likely to use psychodynamic therapy techniques.

This study suggests that individual and organizational factors are important in explaining therapist behavior and use of evidence-based practices, but the relative importance varies by therapeutic technique.

Implementation science frameworks posit that individual (e.g., knowledge and attitudes) and organizational (e.g., culture and climate) characteristics affect the provision of evidence-based practices (EBPs) in general health and mental health care. Little is known about the relative contributions of these 2 sets of characteristics. This study estimates the relative contribution of individual and organizational factors on therapists' use of cognitive-behavioral therapy (CBT), family therapy, and psychodynamic therapy techniques within the context of a large-scale effort to increase the use of CBT in an urban public mental health system.

Literature supports the role of individual and organizational factors in the provision of children's mental health services. For example, individual factors, such as attitudes toward EBPs, predict the extent to which therapists deliver EBPs as designed. Similarly, organizational factors, such as organizational culture (i.e., shared employee perceptions around expectations and norms) and organizational climate (i.e., psychological effect

of the work environment on individual well-being), have been linked to quality of services and youth mental health outcomes. Previous research has largely focused on individual or organizational factors. Both sets of studies find evidence of the predictive validity of their constructs of interest. Individual and organizational factors are correlated, making it difficult to disentangle the contributions of each set. Furthermore, different outcomes have been examined in these 2 sets of studies, making it challenging to compare results.

5.6 Sampling Size:

Self-identified lesbian, gay male, and bisexual (LGB) individuals were recruited via convenience sampling, and they in turn recruited their siblings (79% heterosexual, 19% LGB). The resulting sample of 533 heterosexuals, 558 lesbian or gay male, and 163 bisexual participants was compared on mental health variables and their use of mental health services. Multilevel modeling analyses revealed that sexual orientation predicted suicidal ideation, suicide attempts, self-injurious behavior, use of psychotherapy, and use of psychiatric medications over and above the effects of family adjustment. Sexual orientation was unrelated to current psychological distress, psychiatric hospitalizations, and self-esteem. This is the 1st study to model family effects on the mental health of LGB participants and their siblings. (PsycINFO Database Record (c) 2016 APA, all rights reserved).

Describes research issues related to design, methodology, and implementation of studies on service use and effectiveness of services for children and adolescents with mental disorders. This article provides an overview for methodological issues common across multiple service systems (i.e., schools, primary health care settings, the juvenile justice system) and issues that are affected differentially by the unique service sector in which the research is embedded. This article also serves as an introduction to a special section of articles related to research challenges for researchers of child mental health services in non-mental health settings.

This meta-analysis addresses the association between attachment security and each of three maternal mental health correlates. The meta-analysis is based on 35 studies, 39 samples, and 2,064 mother–child pairs. Social–marital support ($r = .14$; based on 16 studies involving 17 samples and 902 dyads), stress ($r = .19$; 13 studies, 14 samples, and 768 dyads), and depression ($r = .18$; 15 studies, 19 samples, and 953 dyads) each

proved significantly related to attachment security. All constructs showed substantial variance in effect size. Ecological factors and approach to measuring support may explain the heterogeneity of effect sizes within the social–marital support literature. Effect sizes for stress varied according to the time between assessment of stress and assessment of attachment security. Among studies of depression, clinical samples yielded significantly larger effect sizes than community samples. We discuss these results in terms of measurement issues (specifically, overreliance on self-report inventories) and in terms of the need to study the correlates of change in attachment security, rather than just the correlates of attachment security.

5.7 Tools for data collection:

The tools that are basically used for data collection are to first

Get Information

Group discussion

Results

Survey questions

Conclusion

5.8 Techniques of Data Collection:

Observation allows researchers to experience a specific aspect of social life and get a firsthand look at a trend, institution, or behavior. Participant observation involves the researcher joining a sample of individuals without interfering with that group's normal activities in order to document their routine behavior or observe them in a natural context. Often researchers in observational studies will try to blend in seamlessly with the sample group to avoid compromising the results of their observations.

Observational research is a type of descriptive research that differs from most other forms of data gathering in that the researcher's goal is not to manipulate the variables being observed. While participants may or may not be aware of the researchers' presence, the researchers do not try to control variables (as in an experiment), or ask participants to respond to direct questions (as in an interview or survey based study). Instead, the participants are simply observed in a natural setting, defined as a place in

which behavior ordinarily occurs, rather than a place that has been arranged specifically for the purpose of observing the behavior. Unlike correlational and experimental research which use quantitative data, observational studies tend to use qualitative data.

For example, social psychologists Roger Barker and Herbert Wright studied how a sample of children interacted with their daily environments. They observed the children go to school, play with friends, and complete daily chores, and learned a great deal about how children interact with their environments and how their environments shape their character. Similarly, anthropologist Jane Goodall studied the behavior of chimpanzees, taking careful notes on their tool making, family relationships, hunting, and social behavior. Her early work served as the basis for future research on chimpanzees and animal behavior in general.

By observing events as they naturally occur, patterns in behavior will emerge and general questions will become more specific. The hypotheses that result from these observations will guide the researcher in shaping data into results.

One advantage of this type of research is the ability to make on-the-fly adjustments to the initial purpose of a study. These observations also capture behavior that is more natural than behavior occurring in the artificial setting of a lab and that is relatively free of some of the bias seen in survey responses. However, the researcher must be careful not to apply his or her own biases to the interpretation. Researchers may also use this type of data to verify external validity, allowing them to examine whether study findings generalize to real world scenarios.

There are some areas of study where observational studies are more advantageous than others. This type of research allows for the study of phenomena that may be unethical to control for in a lab, such as verbal abuse between romantic partners. Observation is also particularly advantageous as a cross-cultural reference. By observing people from different cultures in the same setting, it is possible to gain information on cultural differences.

While observational studies can generate rich qualitative data, they do not produce quantitative data, and thus mathematical analysis is limited. Researchers also cannot infer causal statements about the situations they observe, meaning that cause and effect cannot be determined. Behavior seen in these studies can only be described, not explained.

There are also ethical concerns related to observing individuals without their consent. One way to avoid this problem is to debrief participants after observing them and to ask for their consent at that time. Overt observation, where the participants are aware of the researcher's presence, is another option to overcome this problem. However, this tactic does have its drawbacks. When subjects know they are being watched, they may alter their behavior in an attempt to make themselves look more admirable.

This type of research can also be very time consuming. Some studies require dozens of observation sessions lasting for several hours and sometimes involving several researchers. Without the use of multiple researchers, the chances of observer bias increase; because behavior is perceived so subjectively, it is possible that two observers will notice different things or draw different conclusions from the same behavior.

The most common techniques used to collect data for case studies are:

Personal interviews

Direct observation

Psychometric tests

Archival records

5.9 Pre-Testing:

The current study evaluated connections between marital distress, harsh parenting, and child externalizing behaviors in line with predictions from the Family Stress Model (FSM). Prospective, longitudinal data came from 273 mothers, fathers, and children participating when the child was 2, between 3 to 5, and 6 to 10 years old. Assessments included observational and self-report measures. Information regarding economic hardship and economic pressure were assessed during toddlerhood, and parental emotional distress, couple conflict, and harsh parenting were collected during early childhood. Child externalizing behavior was assessed during both toddlerhood and middle childhood. Results were consistent with predictions from the FSM in that economic hardship led to economic pressure which was associated with parental emotional distress and couple conflict. This conflict was associated with harsh parenting and child problem behavior. This pathway remained statistically significant controlling for externalizing behavior in toddlerhood.

Data are drawn from the Family Transitions Project (FTP), a longitudinal study of 559 target youth and their families. The FTP represents an extension of two earlier studies: The Iowa Youth and Families Project (IYFP) and the Iowa Single Parent Project (ISPP). In the IYFP, data from the family of origin (N=451) were collected annually from 1989 through 1992. Participants included the target adolescent, their parents, and a sibling within 4 years of age of the target adolescent (217 females, 234 males). These 451 families were originally recruited for a study of family economic stress in the rural Midwest. When interviewed in 1989, the target adolescent was in seventh grade (M age = 12.7 years; 236 females, 215 males). Families were recruited from schools in eight rural Iowa counties. Due to the rural nature of the sample there were few minority families (approximately 1% of the population); therefore, all participants were Caucasian. Seventy-eight percent of eligible families agreed to participate in the study. Families were primarily lower middle- or middle-class with thirty-four percent residing on farms, 12% living in nonfarm rural areas, and 54% living in towns with fewer than 6,500 residents. In 1989, parents averaged 13 years of schooling and had a median family income of $33,700. Fathers' average age was 40 years, while mothers' average age was 38.

The ISPP began in 1991 when the target adolescent was in 9th grade (M age = 14.8 years), the same year of school for the IYFP target youth. Participants included the target adolescents, their single-parent mothers, and a sibling within 4 years of age of the target adolescent (N=108). Families were headed by a mother who had experienced divorce within two years prior to the start of the study. All but three eligible families agreed to participate. The participants were Caucasian, primarily lower middle- or middle-class, one-parent families that lived in the same general geographic area as the IYFP families. Measures and procedures for the IYFP and ISPP studies were identical.

5.10 Study Ethical concerns:

Research about child abuse and neglect is very complex methodologically and ethically. There are not yet uniform research definitions of the problem and the lack of prospective population-based research limits the ability to make progress. To date researchers have been reluctant to ask children directly about their maltreatment experiences because of perceptions of ethical and legal responsibilities. This article begins with a brief review of existing research about the scope and consequences of

child abuse and neglect. We address methodological considerations that are especially pertinent to research about child maltreatment, including the definition of the problem, study design, and issues of causality and bias. We conclude with a discussion of ethical and legal issues that arise in the course of carrying out such research, including issues related to subject recruitment, informed consent, confidentiality, and reporting.

Ethically challenging situations routinely arise in the course of illness and healthcare. However, very few studies have surveyed patients and family members about their experiences with ethically challenging situations. To address this gap in the literature, we surveyed patients and family members at three hospitals. We conducted a content analysis of their responses to open-ended questions about their most memorable experience with an ethical concern for them or their family member. Participants (N = 196) described 219 unique ethical experiences that spanned many of the prevailing themes of bioethics, including the patient-physician relationship, end-of-life care, decision-making capacity, healthcare costs, and genetic testing. Participants focused on relational issues in the course of experiencing illness and receiving medical care and concerns regarding the patient-physician encounters. Many concerns arose outside of a healthcare setting. These data indicate areas for improvement for healthcare providers but some concerns may be better addressed outside of the traditional healthcare setting.

In the clinical domain, ethical analyses involve examination of complex individual responses, psychological processes, and social context. Psychological aspects of stroke adaptation include the risk for depression and anxiety, changes in identity and personality processes, and potential for social isolation. Depression and anxiety are heterogeneous constructs and can affect individuals' emotional functioning and cognitive abilities. Executive function, self-agency, and volition may be affected. Alterations in identity and personality may also result from the interaction of fluctuating emotional, cognitive, and physical abilities as well as from changes in social context and family dynamics. Social isolation, or lack of access to social contact or resources, can be a consequence of difficulties in cognitive and emotional function that influence interpersonal relationships, changes in social roles, communication difficulties, and challenges in transportation and employment. Social stigma and marginalization also contribute to isolation. The authors describe these psychological phenomena in the context of brain damage and recovery and raise ethical concerns including impact on decision-making capacity, pre- and post-injury selves and interests, and the social

milieu in which strokes are experienced. Child maltreatment has been linked to negative adult health outcomes; however, much past research includes only clinical samples of women, focuses exclusively on sexual abuse and/or fails to control for family background and childhood characteristics, both potential confounders. Further research is needed to obtain accurate, generalizable estimates and to educate clinicians who are generally unaware of the link between childhood abuse and adult health. The purpose of this project is to examine how childhood physical abuse by parents' impacts mid-life mental and physical health, and to explore the attenuating effect of family background and childhood adversities.

Parental physical abuse was reported by 11.4% of respondents (10.6% of males and 12.1% of females). In multivariate models controlling for age, sex, childhood adversities, and family background, we found that childhood physical abuse predicted a graded increase in depression, anxiety, anger, physical symptoms, and medical diagnoses. Childhood physical abuse also predicted severe ill health and an array of specific medical diagnoses and physical symptoms. Family background and childhood adversities attenuated but did not eliminate the childhood abuse/adult health relationship.

CHAPTER 6

RESULTS

Results of bootstrap analyses confirm the mediating role of mental health promoting behaviors on well-being and quality of life. The study supports the application of the PRECEDE model in understanding mental health promoting behaviors and demonstrates its relationships with well-being and quality of life. Primary prevention in refugee mental health requires information from clinical, health, and cross-cultural psychology. Primary prevention's roots are in public health, which is distinguished by a communitywide perspective for addressing mental health concerns. This article summarizes research suggesting that refugees are an at-risk population, making them especially suitable for public health interventions. Research on stress and acculturation is highlighted, given its importance to prevention in refugee mental health. The opportunities for primary prevention programs and policies at 3 levels (i.e., local community, national, and international) are illustrated with case examples from both the US and Canada. Prevention at the international level is highlighted by a World Health Organization Mental Health Mission to camps on the Thai-Cambodian border. This article provides the theoretical rationale and overview of a neurodevelopment ally-informed approach to therapeutic work with maltreated and traumatized children and youth. Rather than focusing on any specific therapeutic technique, the Neurosequential Model of Therapeutics (NMT) allows identification of the key systems and areas in the brain which have been impacted by adverse developmental experiences and helps target the selection and sequence of therapeutic, enrichment, and educational activities. In the preliminary applications of this approach in a variety of clinical settings, the outcomes have been positive. More in depth evaluation of this approach is warranted, and is underway. The emerging field of 'predictive analytics in mental health' has recently generated tremendous interest with the bold promise to revolutionize clinical practice in psychiatry paralleling similar developments in personalized and precision medicine. Here, we provide an overview of the key questions and challenges in the field, aiming to

(1) Propose general guidelines for predictive analytics projects in psychiatry.

(2) Provide a conceptual introduction to core aspects of predictive modeling technology.

(3) Foster a broad and informed discussion involving all stakeholders including researchers, clinicians, patients, funding bodies and policymakers.

Over 75% of mental health problems begin in adolescence and primary care has been identified as the target setting for mental health intervention by the World Health Organization. The mobile type program is a mental health assessment and management mobile phone application which monitors mood, stress, coping strategies, activities, eating, sleeping, exercise patterns, and alcohol and cannabis use at least daily, and transmits this information to general practitioners (GPs) via a secure website in summary format for medical review.

Mental health problems are common in young people with 75% of disorders beginning in adolescence and adolescent onset posing a considerable risk factor for long term psychological problems. Adolescence is therefore likely to be an important phase for early intervention with primary care identified as the target setting in the World Health Organization strategy for mental health. General Practitioners (GPs) are often the providers of first step interventions for mental health (i.e. screening, monitoring, and psychoeducation), initially managing mental health concerns within their own clinical practice, then becoming conduits or gatekeepers to second step and further mental health care services (i.e. psychotherapy, medication, hospitalization) when necessary. Nevertheless, detection and management of mental health problems in primary care remains a challenge particularly with young people; it is estimated that GPs detect at best 50% of mental health disorders. Furthermore, 5.7% of adolescents are diagnosed with major depressive disorder and up to 30% of young people experience mild depressive symptoms. New methods are needed that focus on the early stages of mental health problems before clinically diagnosable mental health disorders are identified.

Poor recognition of symptoms by young people creates a significant barrier to communicating, detecting, and receiving help for mental health problems. Research suggests that most people do not recognize the symptoms of depression and are suspicious about effective treatments. Doctor related barriers to detection and management of mental health symptoms include insufficient time for assessments, a lack of confidence in managing and treating mental health symptoms, and a lack of systematic approaches to identify and provide evidence-based interventions for psychological disorders. Detection rates of psychological problems are not necessarily associated with GP level of training in mental health or adolescent health, suggesting that further GP training in recognizing mental health disorders may not be the most effective avenue for increasing detection rates.

There is some evidence that computerized screening, via portable computers such as Personal Digital Assistants or hand held touch pads (e.g. iPad) are both acceptable to patients and physicians, and can increase detection rates of health risk behaviors such as poor nutrition or exercise. Short duration self-monitoring programs involving the completion of homework diaries have had some success at reducing depressive symptoms and can be run on mobile phones. Mobile phones provide a unique avenue for early intervention of mental health problems as they are a ubiquitous accessory, with 100% market penetration in Australia and Britain, and 67% worldwide. Involving technology, such as computers, the internet or mobile phones in mental health programs can engage and foster young people's involvement. Daily monitoring of mental health symptoms across time (i.e. between appointments) via mobile phones may assist young people in reducing their symptoms of mental health problems before reaching clinically diagnosable disorders. Further, daily monitoring data in addition to clinical assessment may allow for greater matching of services to patient needs and enhance pathways to care when second step care is indicated. From the patient's perspective, there is evidence that self-monitoring, on its own, is a therapeutic activity via increasing self-awareness, particularly of one's emotions, and leading to positive behavior change, and therefore in the context of first step mental health care in primary care settings may lead to therapeutic outcomes.

As the integration of "e-health" reforms into primary care are considered a top priority, we have developed a novel mobile phone mental health assessment and management tool, the Mobile Tracking Young People's Experiences program, designed for use in primary care and other clinical settings. The mobile type program monitors a young person's mood, stress, coping strategies and daily activities a number of times per day, and their eating, sleeping, exercise patterns, and alcohol and cannabis use once per day. This information is then uploaded to GPs, via a secure website and displayed in summary reports for review. Our pilot study suggests that young people will monitor their mental health symptoms for the purpose of reviewing this data with their doctor and that both doctor and young person find this a beneficial way of communicating information about mental health and that the mobile type program assisted the doctor to understand their patient better.

The overall aim of this study was to investigate, via a randomized controlled trial, a number of suggested benefits found in our pilot studies of the program. This RCT was

conducted as an effectiveness trial, in which we were interested the utility of the mobile type program in the real world primary care setting. This paper reports on the primary outcomes of the RCT, namely, the mental health outcomes. We hypothesized that the mental health outcomes of participants who complete the mobile type program and review the data with their GP will be lower at post-test and 6 weeks' post-test compared with those in the attention comparison group.

6.2 Hypothesis testing:

This study examined the effects of social support components and providers on mental health and sexual orientation (SO) milestones of lesbian, gay, and bisexual (LGB) youths. Data were collected on 461 self- identified LGB adolescents and young adults. Family acceptance and support yielded the strongest positive effect on self- acceptance of SO, whereas friends' support and acceptance yielded the strongest positive effect on disclosure of SO. Family support had the strongest negative effect on youth's mental distress, whereas friends' and family support had the strongest positive effect on well-being. These findings highlight the importance of the daily perceptions of LGB youth within social and familial settings, indicating that both positive and negative aspects of support affect youths' mental health and identity development.

Used questionnaire and interview data from 200 elementary and high school teachers (primarily 21–55 years old) to examine the relationship between family roles and work-role expectations and stress and strain. Results are consistent with role theory's prediction that multiple roles can lead to stressors (work overload and interrole conflict) and to symptoms of strain. Family roles were related to strain by interaction with work-role expectations so that the relation between those expectations and work overload is progressively greater for single teachers, those who were married, and those who have children. In addition, family roles were directly and negatively associated with physical strain when their relation to interrole conflict was controlled, and they were indirectly related to strain through their relation to interrole conflict. Family-role expectations seemed to reduce the amount of physical strain individuals experienced.

CHAPTER NO:7

DISCUSSION AND CONCLUSION

The positive association between poverty and mental health problems is one of the most well established in all of psychiatric epidemiology. Research has documented consistently that low income and low socioeconomic status are associated with high rates of mental disorder. With the prevalence of poverty itself now on the rise in our country, particularly among women, children and those from minority groups, increased attention must be paid to the mental health risks that accompany poverty.

Early epidemiological research on family status and mental health produced three "social facts":

1: Marriage is beneficial to mental health.

2: Marriage benefits the mental health of men more than women.

3: Parenthood causes psychological distress, especially for women.

In 2012, about 38% of Canadians had at least one family member with a mental health problem; of those, about 35% reported that these problems had affected their time, energy, emotions, finances or daily activities. People who were affected by a family member's mental health experienced stress and symptoms of mental health problems themselves; and about 62% reported that their family member's problem had caused them to become worried, anxious or depressed. Since mental health problems are so diverse, future research would benefit from an examination of the impact of specific types of mental health conditions on family members and their caregivers.

One of the aims of our study was an evaluation of mental health self-care support for CYP. Clearly, in carrying out such an evaluation, we were interested in finding out 'what works?' in terms of self-care support, but in asking this question some significant tensions have emerged. These tensions arise because the answer to the question depends on two inter-related factors: how the question is interpreted (whether 'works' means effective, enjoyable or satisfying, for example) and who is being asked the question (the researcher, parent, clinician or child/young person).

However, two further questions arise here: one concerns the sustainability of these effects, and the other relates to our earlier point about whose perspective – researcher's, parent's, clinician's, or child or young person's – is the more important when the value of (small to medium) intervention effects on mental health symptomatology is being considered. Childhood adversity including divorce and impaired parenting seems to

cause both short- and long-term problems, various childhood disorders, and subsequently depression in adulthood. Single mothers have been found twice as likely to come from families where a parent had a mental health problem. Studies have also reported as high as a threefold risk of depression, and substance use in single mothers compared to married mothers. Children from single family were more than twice likely to report internalizing problems and more than three times likely to report externalizing problems compared to children from two-parent families. More and more research studies have underscored the importance of early life experience in defining life trajectories. Silver et al. also suggested in their study that children who lived their mother and an unrelated partner had the poorest adjustment and highest levels of conduct problems compared to children who just lived their mothers. Studies have also suggested that adjustment problems in children with mother-only families are comparable to mother and an unrelated partner or a stepfather. The risk slightly decreases with another adult like grandparent being in the family.

REFERENCES

Australian Bureau of Statistics (2004). Disability, ageing and carers, Australia: Summary of findings, 2003 (Cat. No. 4430.0). Canberra: Author.

Andrews, G., Henderson, S., & Hall, W. (2001). Prevalence, comorbidity, disability and service utilization: Overview of the Australian National Mental Health Survey. British Journal of Psychiatry, 178, 145-153.

Lim, D., Sanderson, K., & Andrews, G. (2000). Lost productivity among full-time workers with mental disorders. Journal of Mental Health Policy and Economics, 3, 139-146.

Mayberry, D., Reupert, A., Patrick, K., Goodyear, M., & Crase, L. (2005). VicHealth Research Report on children at risk in families affected by parental mental illness. Melbourne: Victorian Health Promotion Foundation.

Murray, C. J. L., & Lopez, A. D. (1997). Alternative projections of mortality and disability by cause 1990-2020: Global Burden of Disease Study. The Lancet, 349, 1498-1504.

Mental Health Commission of Canada. 2012. Changing Directions, Changing Lives: The Mental Health Strategy for Canada. Calgary: Alberta. http://strategy.mentalhealthcommission.ca/download/

Pearson C, T. Janz, and Ali J. 2013. "Mental and substance use disorders in Canada." Health at a Glance. September. Statistics Canada Catalogue no. 82-624-X. http://www.statcan.gc.ca/pub/82-624-x/2013001/article/11855-eng.htm

Symptoms consistent with at least one of the following disorders: major depressive episode, generalized anxiety, bipolar disorder, alcohol, cannabis or other drug abuse or dependence.

Mental Health Commission of Canada. 2009. Toward Recovery & Well-being: A Framework for a Mental Health Strategy for Canada. Calgary: Alberta. http://www.mentalhealthcommission.ca/English/document/241/toward-recovery-and-well-being

Pirkis, J., P. Burgess, J. Hardy, M. Harris, T. Slade and A. Johnston. 2010. "Who cares? A profile of people who care for relatives with a mental disorder." Australian and New Zealand Journal of Psychiatry. Vol. 44, p. 929-937.j

Ennis, E. and B.P. Bunting. 2013, "Family burden, family health and personal mental health." BMC Public Health. Vol. 13.

Moller, T., C.B. Gudde, G.E. Folden and O.M Linaker. 2009. "The experience of caring in relatives to patients with serious mental illness: gender differences, health and functioning." Scand J Caring Sci. Vol. 23,

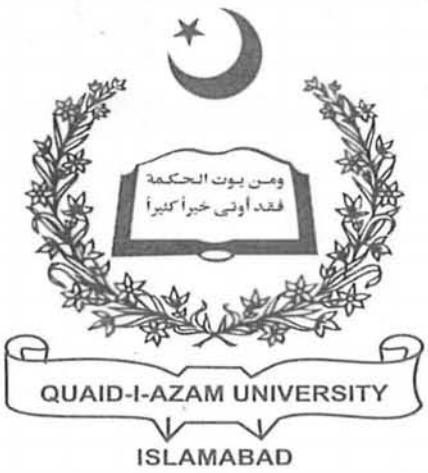
A family member's problems related to: autism, Alzheimer's or other neurological disorders and developmental disabilities, were not measured in the survey.

Sinha, M. 2013. "Portrait of caregivers, 2012: Spotlight on Canadians: Results from the General Social Survey." Statistics Canada Catalogue no. 89-652-X. http://www.statcan.gc.ca/pub/89-652-x/89-652-x2013001-eng.htm

ANNEXURE

Semi-Structured Interview Guide (For In-Depth Interviews)

Effect of family issues on mental health in Kohat, Pakistan



By

Hamza safe

Research student, department of sociology, Quaid-I-Azam University.

Islamabad

I am Hamza safe conducting research on the Effect of family issues on mental health in Kohath, Pakistan. My respondents are the local peoples of Kohat.All the information that you will provide us will be kept in close confidence and only use for academic purposes. Kindly forward the interview through voice messages. Thank you for participation.

Q1: Are there any issues in your family?

Q2: Is it is a routine or not?

Q3: Any basic reason due to which issues are caused?

Q4: Are the issues are greatly affected?

Q5: Do you try anything to get rid of your family issues?

Q6: What do you try to get rid from your family issues?