PREVALENCE OF CLUSTER B PERSONALITY DISORDERS AND ASSOCIATED FACTORS AMONG PATIENTS WITH MENTAL ILLNESSES ATTENDING PSYCHIATRIC OUTPATIENT TREATMENT AT JIMMA MEDICAL CENTER, JIMMA, SOUTHWEST ETHIOPIA, 2021

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A RESEARCH THESIS TO BE SUBMITTED TO DEPARTMENT OF PSYCHIATRY, INSTITUTE OF HEALTH, JIMMA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR DEGREE OF MASTERS IN INTEGRATED CLINICAL AND COMMUNITY MENTAL HEALTH.

NOVEMBER, 2021

JIMMA, ETHIOPIA

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ABSTRACT

Background: *Diagnosing co-occurring personality disorders, particularly cluster B personality disorders the most comorbid one, in psychiatric patients is clinically important because of their association with the duration, recurrence, and outcome of the comorbid disorders.*

Objective: *To assess the prevalence of cluster B personality disorders and associated factors among patients with mental illnesses attending psychiatric outpatient treatment at JMC,2021.*

Methods: *An institutional-based cross-sectional study was employed among 404 patients with mental illnesses. A systematic random sampling method was utilized to select the patients from Jimma medical center, psychiatry clinic, from July 15 to September 14, 2021. Personality disorder questionnaire four (PDQ-4) was used to assess the prevalence of cluster B personality disorders through a face-to-face interview. Data was entered into Epi Data Version 4.6 and exported to SPSS Version 26 for analysis. Descriptive analysis was done using frequency, percentage, mean and standard deviation. Logistic regression analysis was done and variables with a p-value less than 0.05 with 95% confidence interval in the final fitting model were declared as independent predictors of cluster B personality disorders.*

Result: *Among 401 respondents with response rate of 99.3%, slightly less than one-fourth (23.19%, N=93) were found to have cluster B personality disorders, from which (8.7%, N=35) were borderline, (7.2%, N=29) antisocial, (6.5%, N=26) narcissistic, and (3.2%, N=13) histrionic personality disorder. Diagnosis of depressive (AOR=3.33, 95%CI=1.59–6.97)) and bipolar-I disorders (AOR=2.76, 95%CI=1.16–6.56)), longer duration of illness (AOR=2.22, 95%CI=1.24–3.98)), multiple relapses (AOR=2.21, 95%CI=1.18–4.15)), history of family mental illnesses (AOR=2.33, 95%CI=1.26–4.30)), recent cannabis use (AOR =5.73, 95%CI=2.16–15.24)), starting to use substance at earlier age (AOR=4.77, 95%CI=1.71–13.33),suicidal attempt (AOR=3.17, 95%CI=1.39–7.26), emotional abuse(AOR=2.85, 95%CI=1.44–5.63), and interpersonal functioning impairments (AOR=3.74, 95%CI=1.99–7.02) were the factors significantly associated with cluster B personality disorders.*

Conclusion: *The prevalence of cluster B personality disorders was high among mentally ill outpatients and it is found to be important for mental health professionals working on the outpatient departments to screen for cluster B PD as part of their routine activities. Having diagnosis of mood disorders, longer duration of illness, multiple relapses, history of family mental illnesses, recent cannabis use, starting to use substance at earlier age, suicidal attempt, emotional abuse, and interpersonal functioning impairments were significantly associated with cluster B personality disorders.*

Key words: *Cluster B personality disorders, mental illness, Jimma medical center, outpatient, Jimma, Ethiopia*

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Abbreviations and Acronyms

AOR: Adjusted odds ratio

CBPD: - Cluster B personality disorders

COR: Crude odds ratio

DSM: - Diagnostic and statistical manual of psychiatry.

GAPD: - General assessment of personality disorders.

ICD-10: - International classification of disease tenth edition.

JMC: - Jimma medical center.

MBT: - Metallization-Based Therapy.

NMU: - Non-medical use.

OPD: - Outpatient departement

OR: - Odds ratio.

PAS-I: - Personality assessment schedule one.

PDs: - Personality disorders.

PDQ-4+: - Personality disorders questionnaire four plus.

SCID-II: - structured clinical interview for DSM-IV personality disorder.

UK: - United Kingdom

1. INTRODUCTION

1.1. Background

Mental health is a dynamic state of internal equilibrium that allows people to use their skills harmonic with universal values of society. Basic psychological feature and social skills; ability to acknowledge, specify and modulate one's own emotions, yet as sympathize with others, flexibility and skill to deal with adverse life events and performance in social roles(1). Mental illness is the term that refers collectively to any or all identifiable mental disorders; which are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination) associated with distress and/or impaired functioning(2)., and it affected more than 450 million people worldwide(3).

The DSM-V (2013) defines personality disorders (PDs) as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment". It categorized personality disorders in 3 clusters (A, B, and C), personality changes due to another medical condition, other specified personality disorder and unspecified personality disorder. Cluster B or dramatic cluster consists of 4 subtypes, which are antisocial, borderline, histrionic, and narcissistic PD(4). They are excessively demanding, manipulative, emotionally unstable, and interpersonally inappropriate, and may attempt to create relationships that cross professional boundaries and to place physicians in difficult or compromising positions(5).

Cluster B PDs are the most common personality disorders in clinical settings and characterized by severe functional impairment(6), substantial treatment utilization(7), and a high mortality rate by suicide, which is almost 10% and is 50 times higher than the rate in the general population(8). People with these features present with psychosocial functioning problems, suicidal behaviors, and more psychiatric comorbidities(9). Those patients who have cluster B PDs are highly comorbid with externalizing and substance use disorders and have three or more axis-I disorders than other personality disorders(10). Patients with axis-I and cluster B PDs comorbidity presented an earlier onset and more severity in suicide attempts, hospitalizations, and self-harm behaviors than patients with axis-I disorders only(11) and accounting for more impairment in functioning than axis-I disorder alone(6).

Lastly cluster B PDs are a chronic conditions, and associated with a multitude of medical and social problems(12) and becomes increasingly common in mental health services, the judicial

system, and in prison settings (13). It is also associated with considerable comorbidity, especially with other personality disorders, substance misuse(14) and another axis I condition(15). Therefore, diagnosing a co-occurring personality disorder in psychiatric patients with another disorder is clinically important because of their association with the duration, recurrence, and outcome of axis I disorders(16).

1.2 Statement of the problem

Studies of the frequency and correlates of psychiatric disorders in the general population should be replicated in clinical populations where the disorder rates are higher, comorbidity rates are also expected to be higher since help-seeking is related to comorbidity(17), and to provide the practicing clinicians with information that might have more direct clinical uses(18). Cluster B personality disorders are the most frequent among outpatients(18,19); have the highest prevalence of any co-occurrence with another mental illnesses (83.8%) with a predominance of mood disorders (48.8%)(19).

Globally, the overall prevalence estimate of cluster B personality disorders was 23%(20). The prevalence of cluster B personality disorders among mentally ill outpatients ranges from 9.8%(21) to 66.7%(22), and also through five years working experience on clinical area, we have seen that cluster B PDs are the most co-diagnosed PDs with other mental disorders. Personality factors interfere with the response to treatment of many clinical syndromes and increase personal incapacitation, morbidity, and mortality of these patients, and significantly associated with global, cognition, and social interaction impairments; even when not comorbid with other disorders, due to its chronicity(23,24).

A comorbid personality disorder is associated traditionally with a poor prognosis for associated mental illnesses; substantial evidence suggests that PDs influence the prognosis of other mental disorders, treatment response, and costs(21). Moran and his colleagues reported that co-morbid PD is independently associated with an increased risk of violent behavior in psychosis(25). Moreover, personality disorders are a predisposing factor for many other psychiatric disorders, including substance use disorders, suicide, mood disorders, impulse-control disorders, eating disorders, and anxiety disorders(23).

Despite the aforementioned importance in diagnosing personality disorders including cluster B the most comorbid one, it is underdiagnosed by the clinicians in their studies(6,26) and clinicians are sometimes reluctant to diagnose them(27), especially in developing countries. Finally, since PD is by its nature ego-syntonic(23), most of the patients present for treatment is fail to complain for their clinician; it is underdiagnosed and got very less attention, even

though it has a major effect on the course and treatment outcome of comorbid illnesses and great contribution to social and functional impairment.

Almost all of the studies done on this area are from developed countries and most of them are done on subclinical population. They were also failed to address psychosocial factors like social support, self and interpersonal functioning and the age at which substance use is started among study participants. Up to the best of investigator's knowledge, there is no data on the prevalence of cluster B PDs, even personality disorders as a general in psychiatric outpatients in Ethiopia as a particular and Africa in general.

This study is designed, in part, to address these limitations. Thus, the overall aim of this study was to assess cluster B PDs and associated factors among mentally ill patients attending outpatient's treatment at Jimma medical center (JMC), psychiatric clinic.

1.3 Significance of the study

In contrast to its high prevalence, cluster B personality disorders appear unrecognized, misdiagnosed and left untreated. These can affect the treatment quality, which in turn affect the treatment outcome, increase the risk of chronicity, and is associated with adverse out comes, including more prolonged hospitalization, episodes of illnesses and persistent functional impairments. Also, leads to high direct costs through high utilization of healthcare systems and increased morbidity and mortality.

Thus, detection and treatments of those disorders among psychiatric outpatients is far reaching significances to minimize adverse outcomes and reduce mortality and morbidity associated with it, especially in developing countries, where data on the prevalence of cluster B personality disorders is not available currently in the study area, despite its significant individual and societal burden.

As recognizing the magnitude of the problem is important for designing early and appropriate intervention, this study was assessed the prevalence of cluster B PDs and also identified the factors associated with high prevalence of this disorders. Thus, the finding will be used to reveal health professionals' insight into the prevalence of cluster B PDs and associated factors in psychiatric outpatients, increase awareness on PDs, cluster B in particular, offer knowledge for clinicians working in the field of mental health, that can be used to identify and improve intervention areas during treatment. Also, it will be accommodating in order to come up with possible solutions to understand patients with this problem and improve their quality of life by addressing their problems accordingly.

It will provide base line data for factors contributing to these conditions which will use as an input for policy makers and intervention designer to design intervention strategies regarding patients with cluster B personality disorders. Moreover, it will lay background for further studies and will be add to the limited body of the literature on the prevalence of cluster B PDs from the developing region.

2. LITERATURE REVIEW

2.1. Overview of Cluster B personality disorders

Cluster B PDs have unstable interpersonal relationships, and show behaviors that are overly emotional, impulsive, dramatic and erratic(28). The influence of cluster B PDs on other disorders has pointed to clinical aspects such as an earlier onset of symptoms; longer time to respond to treatment(29–31);higher rates of suicide and suicide attempts, longer-lasting episodes(29,32), as well as a higher frequency of relapse and hospital admissions; poorer social support(32,33) and high divorce and separation rates(29).

2.2. Prevalence of Cluster B personality disorders among psychiatric outpatients

According to world health organization cross-sectional study in a sample of 716 psychiatric patients from 14 centers in 11 countries, including Kenya from African countries by using international personality disorder examination, the prevalence of each cluster B PDs is borderline (14.5%), histrionic (7.1%), antisocial (6.4%), and narcissistic (1.3%), indicating that cluster B PDs occurs in many different countries, languages, and cultures(34).

A cross-sectional study done in Rhode Island hospital among psychiatric outpatients, using the structured interview for DSM-IV personality disorders shows that the prevalence of three clusters personality disorders (PDs) is 31.4% of which 13% is covered by cluster B PDs(18).

A study done in Oxford, to assess psychiatric and personality disorders among deliberate self-harm patients who visited general hospital, by using personality assessment schedule, identified personality disorders in 46% of self-harm patients from which 28.8% is cluster B PDs(35).

According to study conducted in McGill University health center (MUHC), Canada, among patients with alcohol use disorders, using structured interview for DSM-IV personality disorders the prevalence of cluster B PD is 32%(36).

A study done in University of Colorado among remitted bipolar patients by using personality disorder examination(PDE), revealed that 15 (28.8%) had any PDs, of which eight(15.4%) are in cluster B PDs(37).

A study done among psychiatric patients in the Netherlands, using general assessment of personality disorder (GAPD), revealed that the prevalence of cluster B PD is 24.5%(38).

A comparative cross-sectional study done in an Italian outpatient clinic, studied alexithymia in personality disorders: using structured clinical interview for DSM-IV personality disorders (SCID-II), revealed that the frequency of cluster B PD is 25.8%(39).

A study in South London, by using standardized assessment of personality (SAP) shows that the frequency of each cluster B PDs is antisocial (11%)), narcissistic (13%), borderline (11%) and histrionic (6%)(40).

In a study conducted among 73 patients of the Paddington outreach rehabilitation, central London, using the informant-based ICD-10 version of the personality assessment schedule (PAS-I),the prevalence of PDs is 92%, of which 56.5% is cluster B PDs(41).

A comparative study done among outpatients with primary dysthymia and episodic major depression in Greece, using structured diagnostic interview revealed that the prevalence of PDs is 41% among major depression patients from which 11% is cluster B PD yand 70% among dysthymic patients from which 34% is cluster B PD(42).

A study conducted in the medical school of Dicle university, Turkey, among randomly selected adults who met DSM-IV criteria for panic disorder, by using structured clinical interview for DSM-IV personality disorders (SCID-II) shows that the prevalence of cluster B PD is 23.2%(43).

According study done among outpatients randomly sampled from clinical settings in China, the frequency of DSM-IV PDs evaluated by the SCID-II is 31.9 %, from which 9.8% is cluster B PD(21).

A comparative cross-sectional study done in psychiatric and psycho-counseling clinics at Shanghai mental health center , to assess co-morbidity of personality disorder in schizophrenia among psychiatric outpatients, by using SCID-II revealed that the prevalence of cluster B PD is 3.8% and 12.2% among schizophrenic and affective disorder/neurotic patients respectively(44).

2.3. Factors associated with cluster B personality disorders

2.3.1. Sociodemographic characteristics

According to national comorbidity survey replication in USA, age and education are inversely related to cluster B PDs and unemployment is positively related to borderline PD(45).

A comparative cross-sectional study done at Shanghai mental health center, to assess co-morbidity of personality disorder in schizophrenia among psychiatric outpatients in China, cluster B PD is more prevalent among those below 30 years old (29.8%) than above 30 years old (17.8%) and single than married, but no significant difference between gender and educational status%(44).

A study done among patients with major depressive disorder at Shanghai mental health center, reported that the individuals who were raised by their parents were less likely to diagnosed with PDs(22).

According to the study conducted in South London, antisocial PD is about three times more prevalent in males than females, borderline PD is two times in females than males, while there is no difference of histrionic and narcissistic PDs(41).

A study done among inpatients at Mathari psychiatric hospital, Kenya, 18(60%) out of the 30 (20.3%) patients with PDs, from which majority 26(87%) is cluster B PDs, were aged between 25 and 34 years. An antisocial PD is around four times more prevalent in males than females, while twice as many females as males were diagnosed with borderline PD(46).

2.3.2. Clinical factors

According to national comorbidity survey replication in USA cluster B PDs are consistently associated with higher odds of impairment(15).

A study done to assess co-morbidity of personality disorder in schizophrenia among psychiatric outpatients in China, reveal that cluster B PDs are more prevalent among those who have a duration of illness less than six months (29.8%) than those more than six months (22.7%)(44).

According to the study done among patients with eating disorders in Japan, the patients with cluster B, especially borderline PD had significantly lower global assessment of functioning score (GAFS) and greater hospital admissions than those without this disorder(47).

A study conducted in Kenya documented that among those diagnosed with PDs (20.3%) from which 87% is cluster B PDs,13% of them had a family history of mental illnesses which was significantly associated with the positive and negative scores for the PDs(46).

2.*3.3*. Psychiatric diagnosis

According to world health organization world mental health (WMH) Surveys in 13 countries, the odds ratio of having more comorbid axis-I disorders and a personality disorders is higher for cluster B PDs than other personality disorders(10).

A study done among UK primary care attenders indicated that cluster B personality disorders are associated with psychiatric morbidity(48).

A study done in Rhode Island hospital shows that 14.1%of major depression, 12.8% of generalized anxiety disorder, 17.6% of panic disorder, 20.1% of social phobia, 28.3% of post-traumatic stress disorder, and 25.9% of alcohol disorders are comorbid with cluster B PD(18).

According to the study done among deliberate self-harm patients who presented to general hospital in Oxford, 44% of axis- I psychiatric disorders are comorbid with cluster B personality disorders(35).

A study done in New York, reported that borderline personality disorder showed significant longitudinal associations with major depressive disorder and posttraumatic stress disorder(19).

2.*3.4*. Substance use related factors

According to the study done alcoholic patients, in the USA, individuals with cluster B personality disorders seek to modify the environment to cope with internal stress and accompanying anxiety and often do so with self-medication by using alcohol(49).

A study done on randomly sampled inpatients at Mathari psychiatric hospital, Kenya, revealed that there were significant associations between PDs and substance abuse dependence; 66.7%; (mainly alcohol 33%, cannabis 31% and 24% both cannabis and alcohol)(46).

A study conducted at the academic department of psychiatry and behavioral sciences, Mayo hospital, Lahore, showed that multiple substance use is strongly associated with personality disorder (77.8%) as opposed to single substance use disorder (27.3%)(50).

According to the study done among patients with eating disorders in Japan, the patients with cluster B PDs have a higher frequency of alcoholism(47).

2.3.5 Risky behaviors

According to the study done among deliberate self-harm patients who presented to a general hospital in Oxford, cluster B personality disorders are among comorbid conditions that increase the risk for attempted suicide. The relationship between PTSD and suicidal behavior appears to be mediated by the presence of cluster B personality disorder (CBPD) and Suicide attempts are also reported to be more common in depressed patients with comorbid borderline personality disorder (BPD) than in depressed patients without BPD(35).

A study done among patients with eating disorders in Japan, the patients with cluster B PDs have significantly greater numbers of suicidal attempts(47).

2.3.6 Psychosocial factors

According to the study done to assess role of childhood traumatic experience in personality disorders in China, early childhood traumatic experiences are strongly related to the development of PDs, particularly have the most significant impact on cluster B PD(21).

2.4. Conceptual framework

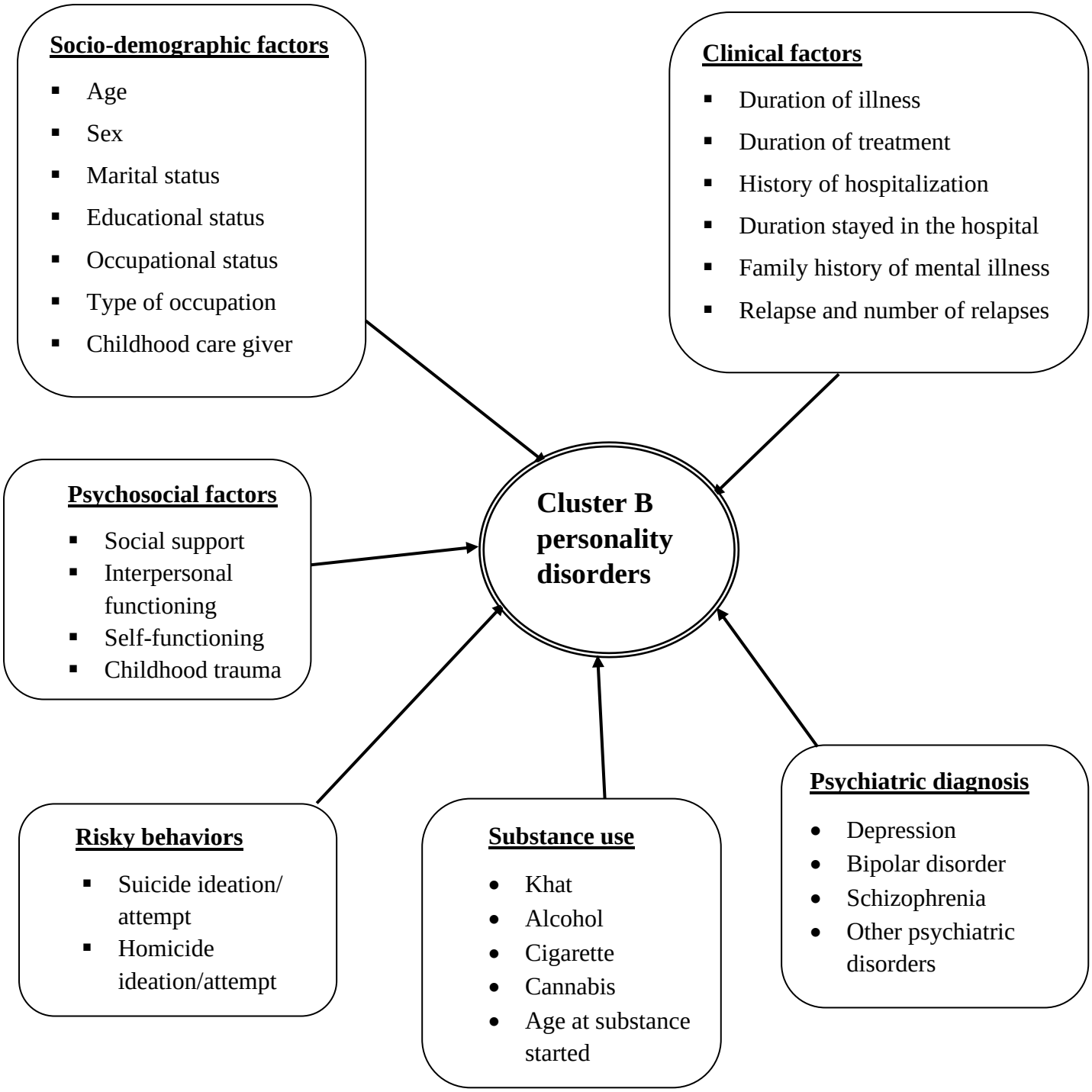

Figure 1: conceptual framework of cluster B personality disorders and its associated factors developed after extensive literature review(46,51)

3. OBJECTIVES

3.1 General objective

To assess the prevalence of cluster B personality disorders and associated factors among patients with mental illnesses attending psychiatric outpatient treatment at JMC, 2021.

3.2 Specific objectives

To determine the prevalence of cluster B personality disorders among patients with mental illnesses attending psychiatric outpatient treatment at JMC, 2021.

To identify factors associated with cluster B personality disorders among patients with mental illnesses attending psychiatric outpatient treatment at JMC, 2021.

4. METHODS AND MATERIALS

4.1 Study area and period

The study was conducted in Jimma medical center (JMC), a psychiatric clinic from July 15 to September 14, 2021. Jimma medical center (JMC) is found in Jimma town, Oromia regional state, which is 352 km far from Addis Ababa (capital city of Ethiopia) to the south-west. JMC is one of the oldest governmental hospitals, which was established in 1937 G.C during Italian occupation for the service of their soldiers.

After the withdrawal of the colonial conquerors, it has been running as a public hospital under the ministry of health by different names at different times and currently named as "Jimma medical center" and gave service including inpatient and outpatients for about 15 million population in southwest Ethiopia. The psychiatric clinic of JMC was established in 1996 G.C next to Amanuel mental health specialized hospital. Currently, there are more than 1000 patients who are attending follow-up treatments at OPD monthly, and on average, around 70 patients are visiting daily. Officially the psychiatric clinic has 60 beds for inpatient services and 4 OPD.

4.2 Study design

An institution-based cross-sectional study design was employed**.**

4.3 Population

4.3.1 Source population

All patients with mental illnesses attending outpatient treatment at JMC, psychiatric clinic, 2021.

4.3.2 Study population

All patients with mental illnesses attending outpatient treatment during the data collection period at JMC, psychiatric clinic, 2021.

4.4 Eligibility criteria

4.4.1 Inclusion criteria

Patients with mental illnesses who were age18 year and above.

4.4.2 Exclusion criteria

Patients who were acutely disturbed and unable to communicate well.

4.5 Sample size and sampling techniques

4.5.1 Sample size determination

To get sufficient sample size, it was determined by using the single population proportion formula, using the following assumptions:

Where n = minimum required sample size

Zα/2= Z value at (α = 0.05) = 1.96, 95% confidence interval

P= 50% proportion is taken since data in this area is not available locally

$$n = \frac{\left(\frac{z\alpha}{2}\right)^2 pq}{d^2}$$

n= $(1.96)^2$ x0.5 x $0.5/0.05^2$ = 0.9604/0.0025=384

By adding a 5% non-response rate, the final sample size was **n=404**

4.5.2. Sampling techniques

The average number of patients who visit the outpatient department per two months period were 2000 patients. The final sample size required for this study was 404 patients. Systematic random sampling was used to select the representative sample. The sampling interval was done by dividing the total number of patients visiting the outpatients with in two months to the final sample size. K=2000/404=5. The first patient to be included in the sample was chosen by lottery method. Thus, the sample was selected every five intervals by using registration book. In case when ineligible patients were encountered, the next patient was selected.

4.6. Data collection instruments and procedure

4.6.1. Data collection Instruments

The prevalence of cluster B personality disorders was measured using the personality diagnostic questionnaire (PDQ-4+) cluster B part. It is a self-report, assessing four specific cluster B PDs. It has 34 items, true-false format; literally reflect a single DSM diagnostic criterion. Besides, a brief structured interview, the clinical significance scale, follows the self-report and either confirms or does not confirm the diagnosis for each PD scoring at/over threshold. This interview directly reflects the principal DSM-IV/V general criteria for PDs assessing whether: (a) the trait is enduring (criterion D for DSM); (b) it is present in the absence

of a psychopathological state, the effects of a substance or any medical condition (criteria E and F); and (c) it leads to distress or impairment (criterion C)(52).

Like its previous versions (PDQ and PDQ-R), the PDQ-4+ has proven to have suitable psychometric properties both in its original version(52) and in its adaptation to other languages and cultures, and in clinical and non-clinical samples(21,53–58). Its sensitivity ranges from 0.5 (histrionic PD) to 1 (antisocial PD) and specificity from 0.90 (borderline PD) to 0.98 (histrionic & narcissistic)(59)) and diagnostic agreement (kappa) between PDQ-4+ and SCID-II was moderate (0.43)(53). The reliability test in this study was 0.93.

Substance use was assessed using, adopted alcohol, smoking, and substance involvement screening test. The ASSIST (Version 3.0) consists of items measuring lifetime and recent (past three months) use of substances, including tobacco, alcohol, cannabis, cocaine, and other drugs(60). Psychosocial factors such as social support, self and interpersonal functioning and childhood trauma was measured by the social support scale (Oslo-3), level of personality functioning scale-brief form 2.0(LPFS-BF 2.0) and childhood traumatic questionnaire short form (CTQ-SF) respectively. Social support scale (Oslo-3) used to collect data regarding the strength of social support. The sum score categorized into three broad categories of social support;3–8 poor social support, 9–11 moderate social support, and 12–14 strong social support(61). The Cronbach's alpha in this study was 0.83. The LPFS-BF 2.0 is a brief self-report questionnaire, which consists of 12 items, clustered into two higher order domains: self-functioning and interpersonal functioning(62). Its Cronbach's alpha in this study was 0.90. Childhood traumatic questionnaire (CHTQ) assess five types of childhood trauma which are emotional abuse, physical abuse, sexual abuse, emotional neglect and physical neglect retrospectively(63). Its reliability test in this study was found 0.89. The questionnaire was also covered a range of topics including socio-demographic factors, clinical factors, and risky behaviors. Other mental illnesses diagnosis was obtained from the charts of the patients.

4.6.2. Data collection procedure

The data was collected by face-to-face interview by using semi-structured and pre-tested interviewer-administered questionnaires. Four data collectors (BSc psychiatric professionals) were employed for two months of data collection periods and was supervised by one mental health professional specialist. Study participants were identified by data collectors by reviewing the patient registration book. Then, data was collected from selected study participants.

4.7. Study variables

4.7.1. Dependent variable

Cluster B personality disorders

4.7.2. Independent variables

Socio-demographic factors

- ✓ Age
- ✓ Marital status
- ✓ Sex
- ✓ Educational status
- ✓ Occupational status
- ✓ Type of occupation
- ✓ Childhood care giver

Clinical factors

- ✓ Duration of illnesses
- ✓ Duration of treatment
- ✓ History of relapse and number of relapses
- ✓ History of hospitalization
- ✓ Duration stayed in the hospital
- ✓ Family history of mental illnesses

Psychiatric diagnosis

- ✓ Depression
- ✓ Bipolar disorder
- ✓ Schizophrenia
- ✓ Other psychiatric disorders

Psychosocial factors

- ✓ Social support
- ✓ Interpersonal functioning
- ✓ Self-functioning
- ✓ Childhood traumas

Substance use

- ✓ Khat
- ✓ Alcohol
- ✓ Tobacco
- ✓ Cannabis and others
- ✓ Age at substance using started

Risky behaviors

- ✓ Suicide idea/attempt
- ✓ Homicide idea/attempt

4.8. Operational definitions

Personality disorder: - If an individual fulfilled diagnostic DSM-V threshold for specific PD through PDQ-4 measurement and confirmed by its clinical significance scale, the individual has a personality disorder.

Cluster B PD: - If individual was positive for at least one of four (borderline, antisocial, histrionic and narcissistic) PDs

Substance use: -ever and current use of any psychoactive substance**.**

Social support :-(3-8) poor, (9-11) moderate, and (12-14) strong social support on OSLO 3 score.

Self and interpersonal functioning: - was measured by LPFS-BF which contains two high domains (total of 12 items) if individual respond at least one positive score on each subdomain he/she has impairment on that domain.

Childhood trauma: - each five types of traumas was measured by childhood traumatic questionnaire short form and if total score is 10 and above for emotional abuse, ≥8 for physical and sexual abuse, ≥15 for emotional neglect, and ≥8 for physical neglect the individual has that specific trauma.

4.9 Data quality control

The questionnaire was prepared first in English and translated into Afaan Oromo and Amharic language with back translation to English to check the consistency. Training was given for data collectors and a supervisor for two days. A pre-test was conducted (5% of the sample size, n=21) at Shenen Gibe general hospital to identify potential problems in data collection tools and modification of the questionnaire. Regular supervision and support were made for data collectors by the supervisor and principal investigator. Data was checked for completeness and

consistency by the supervisor and principal investigator on daily basis during data collection time.

4.10 Data processing and analysis

Data was entered into Epi Data Version 4.6 and analyzed using SPSS version 26. Descriptive analysis was done using frequency, percentage, mean and standard deviation. The prevalence of self-reported PDQ-4+ scales was analyzed using the DSM-V thresholds. The clinical significance scale interview was confirming the diagnosis for screened-positive disorders, leading to dichotomous present/absent outcomes.

All variables were entered into a bivariate logistic regression to identify associated factors of cluster B PDs among people with a psychiatric disorder, and variables with *p-value* < 0.25 were considered candidates for multivariable logistic regression analysis. In multivariable logistic regression analysis, variables with a p-value < 0.05 was considered statistically significant. Hosmer and lemeshow model goodness fitness test was checked for the final model and it was fitted the data.

4.11 Ethical consideration

Ethical approval for the study was obtained from the Inistitutional Review Board (IRB) of Jimma University with Ref.No IHRPGm\337\21. The aims of the study were clearly explained for study participants. A written consent sheet was prepared and attached to the questionnaire on a separate page and data was collected after obtaining written consent from each participant. Assurance of the maintenance of confidentiality and anonymity was also given. Appropriate measurements for Covid-19 prevention were taken during the data collection period to secure data collectors and participants.

4.12 Dissemination plan

The results of the study will be submitted to Jimma university, Institute of health, faculty of medicine and after getting approved hard copies of the findings will be disseminated to JMC and other concerned bodies as well. The research paper will be presented in health professional organizations, annual meetings, professional conferences and training. Finally, attempts will be made to publish the work in a scientific journal to make it accessible to all individuals and organization who may want to use it.

5. RESULT

5.1 Sociodemographic characteristic of respondents

Among 404 patients approached for interview a total of 401 have participated in this study with a response rate of 99.3%. Of the total respondent's nearly two-third (63.8%, N=256) of them were males and the mean age was of 34.69 (SD=± 10.94) years. The majority of respondents were Muslims (80.3%, N= 322) followed by Protestant (10.2%, N=41). Regarding educational status around half (46.6%, N=189) of them reported that they attended college and above, and almost half of them were single (49.1%, N=197) by marital status. More than half of the respondents (55.1%, n=221) have no occupation and among those who have occupation majority of them were farmers (46.1%, N=83). Almost three-fourth (74.6%, N=299) were raised by their mothers alone during their childhood (Table1).

Table 1: Sociodemographic characteristics of study participants with mental illnesses attending psychiatric outpatient treatment at Jimma medical center, Jimma, southwest Ethiopia, 2021(N=401)

Variable	Categories	Frequency	Percent
Sex	Male	256	63.8
	Female	145	36.2
Age	≥ 34.69	205	51.1
	< 34.69	196	48.9
Religion	Muslim	322	80.3
	Orthodox	38	9.5
	Protestant	41	10.2
Marital status	Single	197	49.1
	Married	143	35.7
	Divorced	49	12.2
	Widowed	12	3.0
Educational status	College and above	189	46.6
	9-12th grade	143	35.7
	not able to read and write	59	14.7
	1-8th grade	12	3.0
Occupational Status	No	221	55.1
	Yes	180	44.9
Type of occupation	gov't employee	37	20.6
	Merchant	20	11.1
	Farmer	83	46.1
	Private worker	25	13.9
	Daily labor	15	8.3
Childhood care giver	Mother only	299	74.6
	father and mother	58	14.5
	Others*	44	10.9

*****: - those who are out of father and mother

5.2. Clinical related characteristics of respondents

Majority of the study participants (40.1%, N=161) had diagnosis of major depressive disorder followed by schizophrenia (32.4%, N=130). The mean duration of illnesses was 101.29(SD=±73.4) months and the mean age onset of illnesses was 26.53 (SD=± 8.28) years. The mean duration of treatment was 86.92 (SD=±75.4) months and the mean number of admissions was 1.39 (SD=± 0.49) times. The mean duration stayed in the hospital for those who were admitted was 1.25 (SD=± 0.44) months and the mean number of relapses was 1.54 (SD=± 0.49) times. More than one-third (35.4%, N=142) of the respondents have history of family mental illness (Table 2).

Table 2: Clinical related characteristic of study participants with mental illnesses attending psychiatric outpatient treatment at Jimma medical center, Jimma, southwest Ethiopia, 2021(N=401)

Variable	Categories	Frequency	Percent
Psychiatric diagnosis	Major depression disorder	161	40.2
	Schizophrenia	130	32.4
	Bipolar-I disorder	99	24.7
	Other psychotic disorder*	11	2.7
Mean duration of illness (SD=±73.4)	≥ 101.29 months	185	46.1
	< 101.29 months	216	53.9
Mean age of onset of illnesses (SD=±8.28)	≥ 26.53 years	178	44.4
	< 26.53 years	223	55.6
Mean duration of treatment (SD=±75.4)	≥ 86.92 months	154	38.4
	< 86.92 months	247	61.6
Admission (yes/no)	No	243	60.6
	Yes	158	39.4
Mean number of admissions (SD=± 0.49)	≥ 1.39 times	158	39.4
	< 1.39 times	243	60.6
Mean duration stayed in hospital (SD=± 0.44)	≥ 1.25 months	102	25.4
	< 1.25 months	299	74.6
Relapse (yes/no)	No	184	45.9
	Yes	217	54.1
Mean number of relapses (SD=± 0.49)	≥ 1.54 times	217	54.1
	< 1.54 times	184	45.9
History of family mental illnesses (yes/no)	No	259	64.6
	Yes	142	35.4

Note: - Other psychotic disorder* (Brief Psychotic disorder and Schizophreniform)

5.3. Substance use related characteristic of Respondents

The life time prevalence of alcohol, Khat, tobacco, and cannabis use among respondents was (16.2%, N=65), (52.1%, N=209), (16.5%, N=66), and (6.2%, N=25) respectively. About (8%, N=32), (32%, N=131), (8.5%, N=34), and (9%, N=36) of respondents were current users of alcohol, Khat, tobacco, and cannabis respectively, and more than half (57.9%, N=71) of them started to use substance before age 17(Table 3).

Table 3: - Substance use characteristic of study participants with mental illnesses attending psychiatric outpatient treatment at Jimma medical center, Jimma, southwest Ethiopia, 2021 (N=401)

Variables	Categories	Frequency	Percent
Alcohol(E)*(yes/no)	No	336	83.8
	Yes	65	16.2
Khat(E) (yes/no)	No	192	47.9
	Yes	209	52.1
Tobacco product(E) (yes/no)	No	335	83.5
	Yes	66	16.5
Cannabis(E) (yes/no)	No	376	93.8
	Yes	25	6.2
Alcohol(R)(yes/no)	No	369	92.0
	Yes	32	8.0
Khat(R)* (yes/no)	No	270	67.3
	Yes	131	32.7
Tobacco product(R) (yes/no)	No	367	91.5
	Yes	34	8.5
Cannabis(R) (yes/no)	No	365	91.0
	Yes	36	9.0
Mean age at using substance started (SD=±9.46)	<17.79 years	98	57.9
	≥17.79 years	71	42.1

Note: E*- ever use of substance in the life time, R*- recent (with in past 3 months) use of substance

5.4. Risky behaviors related characteristics of respondents

Among study participants (47.1%, N=189) had a history of passive suicidal thought, (33.9%, N=136) active suicidal thought, (16%, N=64) suicidal attempt, (19.2%, N=77), homicidal thought, and (12.5%, N=50) had a history of homicidal attempt in their life (Figure 2).

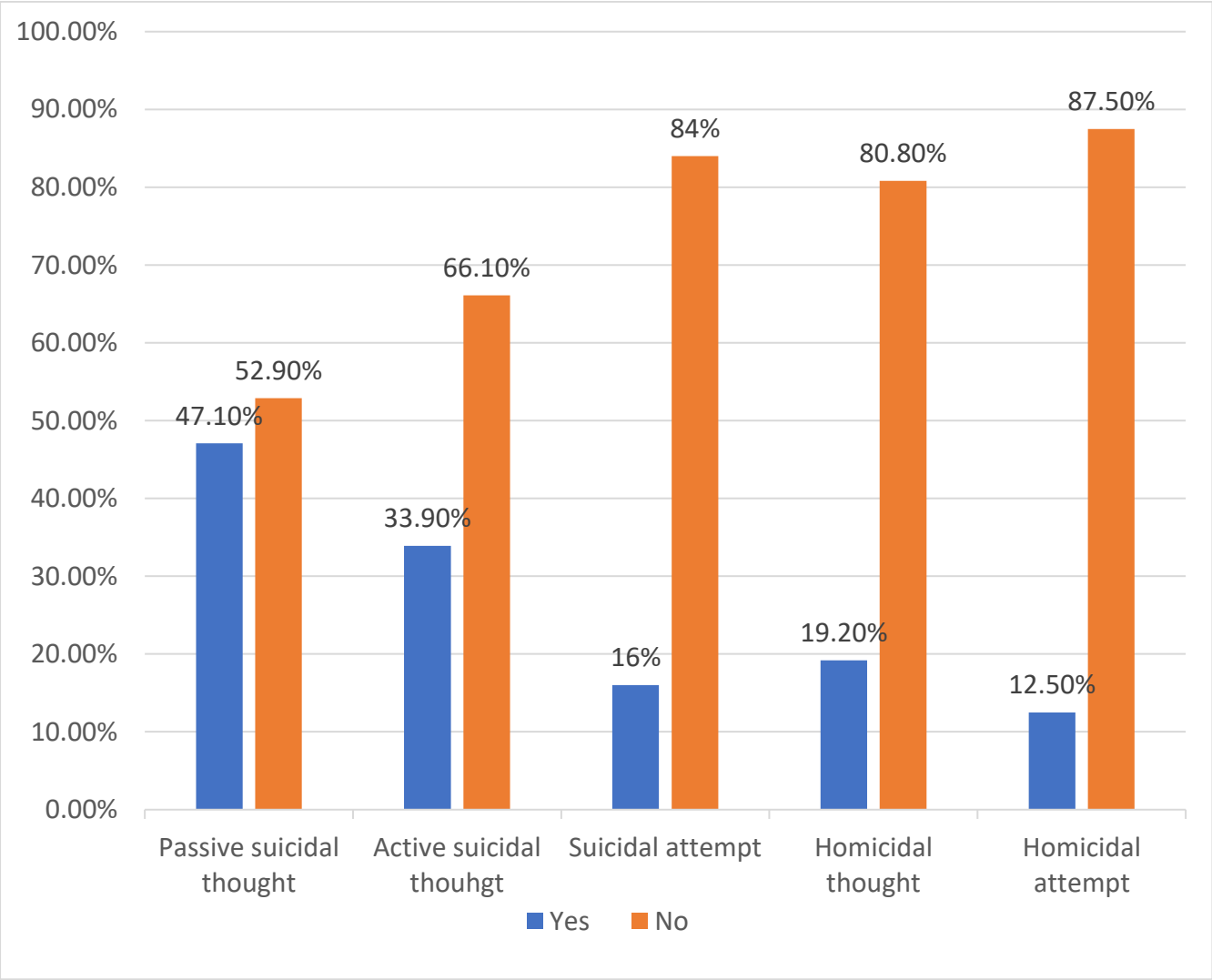

Figure 2: Risky behaviors related characteristic of study participants with mental illnesses attending psychiatric outpatient treatment at Jimma medical center, Jimma, southwest Ethiopia, 2021(N=401).

5.5. Psychosocial factors related characteristics of respondents

Regarding the social support status of respondents about (44.6%, N=179) reported as they have poor social support according to the Oslo-3 social support scale measurement. About (18.7%, N=75), (25.7%, N=103), (20.9%, N=84) (9.7%, N=39), (31.2%, N=125,) of the respondents had emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect respectively as measured by childhood traumatic questionnaire. Around (38.9%, N=156) of respondents have a self-functioning impairment and more than half (54.4%, N=218) have interpersonal functioning impairment according to the level of personality functioning scale measurement (Table 4).

Table 4: Psychosocial factors related characteristic of study participants with mental illnesses attending psychiatric outpatient treatment at Jimma medical center, Jimma, southwest Ethiopia,2021(N=401)

Variable	Categories	Frequency	Percent
Social support	Poor	179	44.6
	Moderate	147	36.7
	Strong	75	18.7
Emotional abuse	No	326	81.3
	Yes	75	18.7
Physical abuse	No	298	74.3
	Yes	103	25.7
Sexual abuse	No	317	79.1
	Yes	84	20.9
Emotional neglect	No	362	90.3
	Yes	39	9.7
Physical neglect	No	276	68.8
	Yes	125	31.2
Self-functioning impairment	No	245	61.1
	Yes	156	38.9
Interpersonal functioning impairment	No	183	45.6
	Yes	218	54.4

5.6. Prevalence of cluster B personality disorder

From all repondents, about 93(23.19%, 95%CI=19 – 27) of them have cluster B personality disorder as measured by the Personality disorder questionnaire (PDQ-4+) with its significance scale. The frequency of each cluster B personality disorders was 35(8.7%, 95%CI= 6-12), 29(7.2%, 95%CI= 5-10), 26(6.5%, 95%CI= 4-9), and 13(3.2%, 95%CI=2-5) for borderline, antisocial, narcissistic and histrionic personality disorder respectively (figure 3).

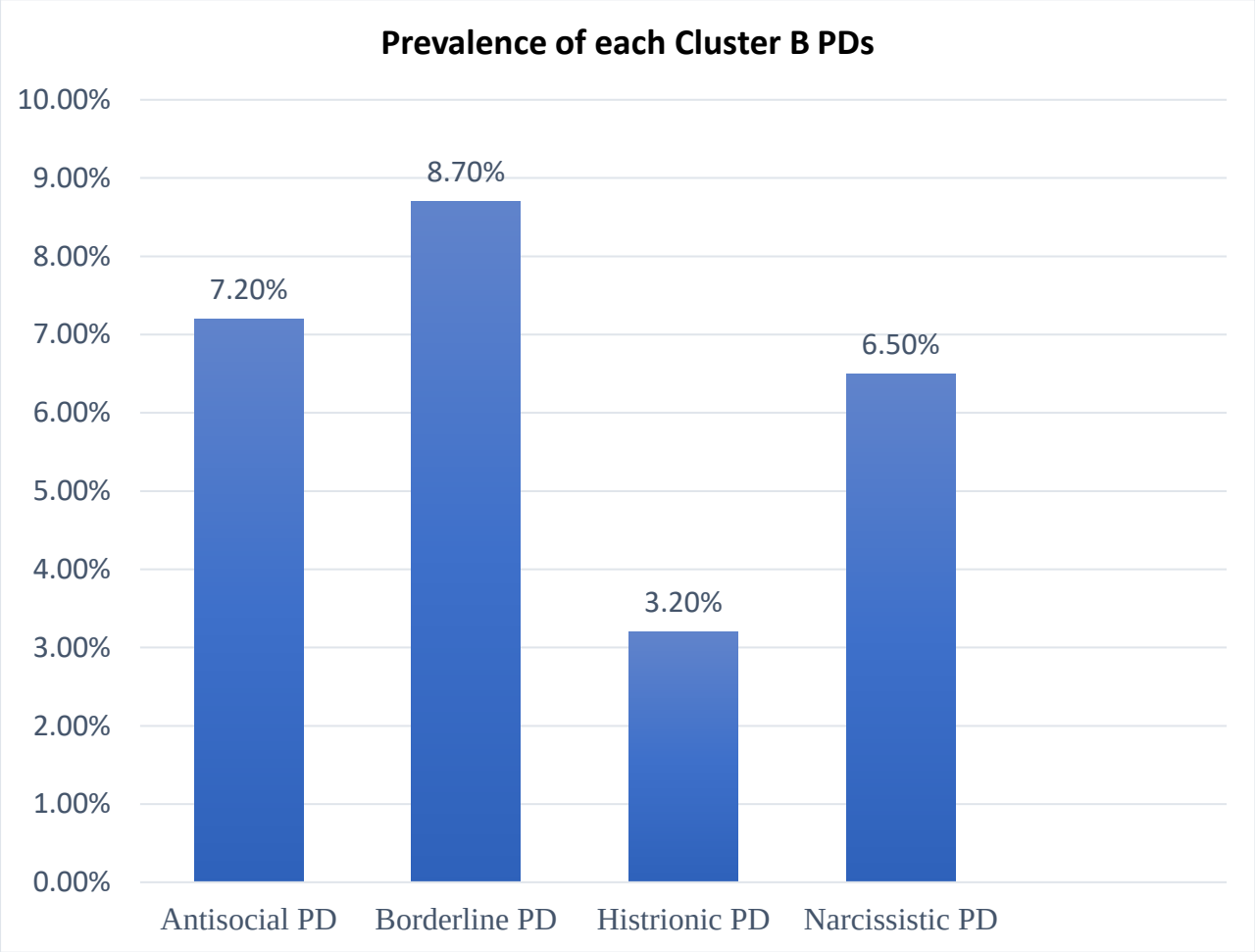

Figure 3: Prevalence of each cluster B personality disorder of study participants with mental illnesses attending psychiatric outpatient treatment at Jimma medical center, Jimma, southwest Ethiopia,2021(N=401)

5.7. Factors associated with cluster B personality disorders

Bivariate logistic regression analysis was done to identify factors associated with cluster B personality disorders at p-value of less than 0.25 with 95% confidence interval. Accordingly educational status, unemployment, psychiatric diagnosis, duration of illness, duration of treatment, duration stayed in the hospital during admission, history of relapse, number of relapses, history of family mental illness, active suicidal thought, suicidal attempt, homicidal attempt, ever use of alcohol, and cannabis, current use of alcohol and cannabis, age at using substance started, having poor social support, emotional abuse, physical abuse, emotional neglect, physical neglect, self, and interpersonal functioning impairment were found to be associated with cluster B personality disorders and entered to multivariate analysis(Table 5).

All candidate variables for multivariable logistic regression analysis were first checked for multicollinearity and all the candidates for the final model had Variance Inflation Factor (VIF) less than 1.5 and tolerance of above 0.67.

After confounding variables were controlled, multivariable logistic regression analysis revealed that being unable to read and write,having diagnosis of major depressive disorder and bipolar-I disorder, having a longer duration of illness and multiple relapses, family history of mental illness, suicidal attempt, recent cannabis use, having earlier age at substance-using started, emotional abuse and interpersonal functioning impairment were significantly associated with cluster B personality disorders with p value less than 0.05 at 95% confidence interval. Participants who can't able to read and write were 3 times more likely to have cluster B personality disorder than those who have the educational status of college and above AOR= 3.12 (1.36- 7.15). Major depressive and bipolar-I disorder patients were 3.3 and 2.8 times more likely to have cluster B personality disorders than schizophrenia patients AOR = 3.33 (1.59 - 6.97) & AOR = 2.76(1.16 - 6.56) respectively. Likewise, those patients who have a longer duration of illness (above the mean) and many relapses (above the mean) were more than two times more likely to have cluster B PDs than their counterpart AOR = 2.22(1.24 - 3.98) & AOR = 2.21(1.18 - 4.15) respectively. Those patients who have a family history of mental illnesses were 2.3 times more likely to have cluster B PD than those who have not AOR= 2.33(1.26 - 4.30) and also cluster B PD was 3 times more likely to present among those who have a history of suicidal attempt AOR =3.17(1.39 - 7.26). Cluster B personality disorder was nearly 6 times more likely to present among respondents who are using cannabis currently AOR =5.73(2.16 - 15.24) and around 5 times more likely to present among those who started to use substance earlier (before age 17) AOR= 4.77(1.71- 13.33). Participants who were abused emotionally

during their childhood were almost 3 times more likely to have cluster B PD AOR= 2.85(1.44 – 5.63) than those who had no. Finally, cluster B PD was found to present nearly 4 times more likely among those who have interpersonal functioning impairment than those who have not 3.74(1.99 – 7.02). (Table 5)

Table 5: -Bivariate and multivariable analysis of factors associated with cluster B personality disorders among repondents with mental illnesses attending psychiatric outpatient treatment at Jimma medical center, Jimma, southwest Ethiopia,2021(N=401)

Variables	Categories	Cluster B personality disorders		COR & 95%CI	P-value	AOR & 95%CI	P-value
		No N (%)	Yes N (%)				
Educational status	College & above	151(80.7)	36(19.3)	1	1	1	1
	9-12th grade	108(75.5)	35(24.5)	1.35(0.80-2.30)	0.25	1.17 (0.62 -2.20)	.625
	1-8th grade	9(75)	3(25)	1.39(0.36-5.42)	0.63	1.36 (0.27-6.79)	.706
	Not able to read & write	40(67.8)	19(32.2)	1.99(1.03-3.84)	0.04*	3.12 (1.36-7.15)	.007**
Occupational status	Yes	153(85.5)	26(14.5)	1	1	1	1
	No	155(69.8)	67(30.2)	2.54(1.54-4.21)	0.001*	1.87(0.89-5.76)	0.27
Psychiatric diagnosis	Schizophrenia	109(83.8)	21(16.2)	1	1	1	1
	Others psychotic d/o	9(74.7)	2(25.3)	1.15(0.23-5.72)	0.86	3.19 (0.56-18.2)	.190
	Bipolar-I disorders	74(74.7)	25(25.3)	1.75(0.96-3.36)	0.09*	2.76 (1.16-6.56)	.021**
	Major depression	116(72)	45(28)	2.01(1.13-3.59)	0.02*	3.33 (1.59 -6.97)	.001**
Mean duration of illness (SD=±73.4)	≥ 101.29 months	177(81.9)	39(18.1)	1	1	1	1
	< 101.29 months	131(70.8)	54(29.2)	1.87(1.17-2.99)	0.01*	2.22(1.24 - 3.98)	.007**
	≥ 86.92 months	195(78.9)	52(21.1)	1	1	1	1

Mean duration of treatment (SD=±75.4)	< 86.92 months	113(73.4)	41(26.6)	1.36(0.85-2.17)	0.19*	1.45(0.88-7.32)	0.32
Mean duration stayed in hospital (SD=± 0.44)	<1.25 months	237(79.3)	62(20.7)	1	1	1	1
	≥1.25months	71(69.6)	31(30.4)	1.67(1.01-2.77)	0.05*	0.69(.33-1.48)	0.35
Relapse (yes/no)	No	156(84.8)	28(15.2)	1	1	1	1
	Yes	152(70.0)	65(30.0)	2.38(1.45-3.91)	<0.001*	0.59(0.07-4.98)	0.63
Mean number of relapses (SD=± 0.49)	<1.54 times	157(85.3)	27(14.7)	1	1	1	1
	≥1.54 times	151(69.6)	66(30.4)	2.91(1.74-4.83)	<0.001*	2.21(1.18 - 4.15)	.014**
History of family mental illness	No	212(81.9)	47(18.1)	1	1	1	1
	Yes	96(67.6)	46(32.4)	2.16(1.35-3.47)	0.001*	2.33(1.26 - 4.30)	.007**
Active suicidal thought	No	212(80.0)	53(20.0)	1	1	1	1
	Yes	96(70.6)	40(29.4)	1.67(1.04-2.68)	0.04*	0.82(0.32-2.09)	0.68
Suicidal attempt	No	265(78.6)	72(21.4)	1	1	1	1
	Yes	43(67.2)	21(32.8)	1.79(1.00-3.22)	0.05*	3.17(1.39 - 7.26)	.006**
Homicidal attempt	No	275(78.3)	76(21.7)	1	1	1	1
	Yes	33(66.0)	17(34.0)	1.86(0.96-3.53)	0.06*	1.00(0.39-2.62)	0.99
Alcohol(E)*	No	266(79.2)	70(20.8)	1	1	1	1
	Yes	42(64.6)	23(35.4)	2.08(1.17-3.69)	0.01*	1.85(0.64-5.36)	0.26
Cannabis(E) *	No	293(77.9)	83(22.1)	1	1	1	1
	Yes	15(60.0)	10(40.0)	2.35(1.02-5.43)	0.05*	1.28(0.32-5.13)	0.73
Alcohol(R)*	No	288(78.0)	81(22.0)	1	1	1	1
	Yes	20(62.5)	12(37.5)	2.13(1.00-4.54)	0.05*	1.93(.87-4.28)	0.10
Cannabis(R) *	No	285(78.1)	80(21.9)	1	1	1	1
	Yes	23(63.9)	13(36.1)	2.4(0.96-4.15)	0.06*	5.73(2.16-15.24)	0.001**
Mean age at substance using started (SD=±9.46)	≥17.79 years	68(88.3)	9(11.7)	1	1	1	1
	<17.79 years	240(74.1)	84(25.9)	0.38(0.18-0.79)	0.01*	4.77(1.71-13.33)	.003**
Social support	Strong	62(82.7)	13(17.3)	1	1	1	1

	Moderate	121(82.3)	26(17.7)	1.03(0.49-2.17)	0.95	1.01(0.62-4.64)	0.23
	Poor	125(69.8)	54(30.2)	2.06(1.05-4.05)	0.04*	1.53(1.02-10.91)	0.08
Emotional abuse	No	257(78.8)	69(21.2)	1	1	1	1
	Yes	51(68.0)	24(32.0)	1.75(1.08-3.05)	0.05*	2.85(1.44 –5.63)	.003**
Physical abuse	No	237(79.5)	61(20.5)	1	1	1	1
	Yes	71(68.9)	32(31.1)	1.75(1.06-2.89)	0.03*	1.63(0.84-3.18)	0.15
Emotional neglect	No	281(77.6)	81(22.4)	1	1	1	1
	Yes	27(69.2)	12(30.8)	1.5(0.75-3.18)	0.24*	0.68(0.24-1.91)	0.46
Physical neglect	No	222(80.4)	54(19.6)	1	1	1	1
	Yes	86(68.8)	39(31.2)	1.86(1.15-3.02)	0.01*	1.48(0.77-2.86)	0.24
Self-functioning impairment	No	197(80.4)	48(19.6)	1	1	1	1
	Yes	111(71.2)	45(28.8)	1.66(1.04-2.66)	0.03*	1.44(0.68-3.03)	0.34
Interpersonal functioning impairment	No	151(82.5)	32(17.5)	1	1	1	1
	Yes	157(72.0)	61(28.0)	1.83(1.13-2.97)	0.01	3.74(1.99– 7.02)	.0001**

*: - variable is significant at p-value less than 0.25

**: - variables which are significant at p-value less than 0.05

1= reference category

E*- ever use of substance in the life time

R*- recent (with in past 3 months) use of substance

6. DISCUSSION

In this study out of the total respondents, the prevalence of cluster B PD was found to be 93(23.19%, 95%CI=19-27). The finding is in agreement with a study conducted in Turkey, Netherland, and Italy which reported the prevalence of cluster B PD was 23.2%, 24.5%, and 25.8% respectively(38,39,43).

The figure is higher than the studies conducted in Kenya, Rhode, Island and China which revealed that the prevalence of cluster B PD was 17.6%, 13%, and 9.8% respectively(18,46,51). The difference might be due to the difference of instrument used in which structured clinical interview is used in those studies, a tool that was known with its low-frequency report compared to self-report screening tools like ours (PDQ-4+). The other issue that might explain the disparity is the study population, in which the study was conducted among admitted patients in Kenya and different setting of studies, from psychiatric and psycho counseling clinics, was used in China in contrast to ours which was only from psychiatric outpatient department.

The frequency of our study was found to be lower than the study conducted in Canada and Oxford which reported the prevalence of cluster B PDs was 32% and 28.8% respectively(35,36). The difference in prevalence is likely to be due to differences in participants of the study in which only alcohol use disorder patients in Canada study and deliberate self-harm patients in Oxford study have participated. It might be also due to the difference in tool used, which structured interview for DSM-IV PDs in Canada and personality assessment schedule in Oxford was used.

In this study, the prevalence of each PD under cluster B was 8.7% for borderline, 7.2% for antisocial, 6.5% for narcissistic, and 3.2% for histrionic personality disorder. In this study borderline PD was found to be most prevalent than others, which is in agreement with studies documented that borderline was most prevalent among clinical population(18,43,64). Additionally, in this study majority of respondents had diagnosis mood disorders (64.9%) which tend to have more comorbid borderline PD could be also explain the reason.

Borderline PD was found to be two times more prevalent among females and antisocial was three times more prevalent among males, while there was no significant difference of histrionic and narcissistic PDs in terms of sex. This is in agreement with a study conducted in Kenya among admitted patients(46). Among the respondents 4(1%) of them have borderline and antisocial, 2(0.5%) borderline and histrionic, and 2(0.5%) borderline and narcissistic

personality disorders. This indicated borderline PD was found to be comorbid with all other disorders within the cluster, which is supported by different studies conducted in different countries which documented that borderline PD was the most comorbid disorder with other PDs(65,66).

Regarding associated factors of cluster B PD, from educational status, those respondents who can't read and write were three(AOR=3.12, 95%CI=1.36-7.15) times more likely to have the disorder than those who have the educational level of college and above. The finding is in line with a study from the USA which reported that educational status is inversely related to CBPDs(45). Refusal of going to school, early drop out, and low educational attainment among those with cluster B PD could be another explanation. In this study cluster B PD was more than three (AOR=3.33, 95%CI=1.59 -6.97) and near three (AOR=2.76, 95%CI=1.16-6.56) times more likely to present among major depressive and bipolar-I disorder patients respectively than schizophrenia patients. The finding is supported by a study from Kenya which stated that mood disorder was the most comorbid with PD(46%)(46) and a study conducted in China which revealed that cluster B PD was more common among patients with affective disorders(12.2%) than schizophrenia patients(3.8%)(44). Those respondents who have a longer duration of illness (101.3 months and above) were more than two times (AOR=2.22, 95%CI=1.24 - 3.98) more likely to have the disorder than their counterparts. The earlier onset of symptoms, obstacles to treatment like non-adherence due to interpersonal functioning impairment, and poorer response to treatment among those who have comorbid PD could explain the reason(29,30,43,67).

In this study, the disorder was more than two (AOR=2.21, 95%CI=1.18 - 4.15) times more likely to present among the respondents who have multiple relapses. The finding is in agreement with the studies from France and Dutch which revealed that those patients who have comorbid PDs were experienced more relapses than those who do not have(31,33). The respondents who have a history of family mental illness were more than two (AOR=2.33, 95%CI=1.26 - 4.30) times more likely to have cluster B PD than those who have not. This is similar to the study from Kenya that explained the family history of mental illness was significantly associated with positive and negative scores of PD(46). The reason might be almost all psychiatric illnesses including personality disorders are genetically influenced and run around the family(23).

The disorder was more than three (AOR=3.17, 95%CI=1.39 - 7.26) times more likely to present among participants who have a history of suicidal attempts than the counterpart. The finding is supported by the study conducted in Japan which reported a greater number of suicidal attempts among cluster B PD(47) and study from Oxford that explained suicidal attempts to be more common among depressed patients with comorbid borderline PD than depressive patients without comorbidity(35). It is also supported by the multisite collaborative longitudinal study which reported 12.5% of respondents who have the disorder attempted suicide within three years follow-up and study conducted in Turkey which documented that history of suicide attempt was significantly common in patients comorbid with any cluster B personality disorders(43,68).

Regarding the substance-related factors, the disorder was nearly six (AOR=5.73, 95%CI=2.16-15.24) times more likely to be found among those participants who are currently using cannabis. The finding is supported by a study from Kenya which reported that there was a significant association between CBPDs and cannabis use (31%)(46), a study conducted in Connecticut southeastern USA, reported the highest rate of recent cannabis use among individuals with PDs(69) and study from Turkey which revealed the frequency of cannabis among the participants with the disorder is 67%(70). Additionally, our finding indicated that those participants who started to use substances at an earlier age (before age 17) are almost five (AOR=4.77, 95%CI=1.71-13.33) times more likely to have the disorder than those who started later. The reason might be due to common etiologic processes with early expression of impaired impulse control and affective dysregulation(71). The age of onset of the personality disorders which is in adolescence/early adulthood the time at independence from family/caregiver and trying new events like substance use despite its consequences are exercised, the type of defense mechanism used by this group that is most of the time acting out and their inability to conform to the social norms might be the other reasons(23).

In the current study, it's found that those respondents who were emotionally abused during their childhood were three (AOR=2.85, 95%CI=1.44–5.63) times more likely to have the disorder than those who didn't abused emotionally. The finding is supported with the study conducted in Mc Gilli university Canada which stated that emotional abuse was common (76.8%) among individuals who have the disorder(72) and the study conducted in China which reported that cluster B PD was positively associated with each childhood traumatic factor except physical neglect(21). This might be due to common environmental factors (e.g., stressful family environments, the impact of parental reactions on the trauma-exposed child)

and/or shared genetic factors that predispose to both(73). Also, it could be due to individuals with PDs compared to those without PDs may experience childhood trauma because of greater negative emotionality and impulsivity.

Lastly, cluster B PD was almost four (AOR=3.7495%CI=1.99–7.02) times more likely to present among those who have interpersonal functioning impairment than those who have not. It is in agreement with the study conducted in Germany which reported considerable deficits in interpersonal functioning among individuals who scored high in any PD dimensions except for schizoid PD(74). It is additionally supported by a study from a national comorbidity survey replication in the USA which stated that individuals with cluster B personality disorder have high odds of impairment in social role functioning(15).

6.1. Strength and limitation of the study

Up to the best knowledge of the investigator, this is the first study conducted on cluster B PD among psychiatric outpatients in Ethiopia as well as in Africa. The study also addressed factors like social support, childhood trauma, age at which substance using is started, self and interpersonal functioning which were not included in many studies conducted previously if it was, very rare. Additionally, we used PDQ4+ with a clinical significance scale that reduces false-positive responses which was the main drawback of self-report tools.

Despite this, it is also important to note that there are several methodological limitations in this study. Firstly, some patients might have the wrong diagnosis on the main disorder for which they are after the treatment that may limit to see the difference of CBPD among different disorders. Some tools like childhood traumatic questionnaire and some semi-structured questions were assessed retrospectively several years backward in which there might be recall bias. To check the longitudinal relationship of PD and above-stated variables, as well as to minimize the influence of misdiagnosis, prospective follow-up studies are in need. Finally, the sample of this study was selected from psychiatric outpatients' clinics in one hospital in Southwest Ethiopia. Hence, the results might not be generalized to a broader population.

7. CONCLUSION AND RECOMMENDATION

7.1. Conclusion

This study revealed that the prevalence of cluster B personality disorders was high among mentally ill outpatients.

The presence of the diagnosis of mood disorders, longer duration of illness, multiple relapses, family history of mental illness, history of suicidal attempt, recent use of cannabis, early age at substance use started, emotional abuse, and interpersonal functioning impairment were significantly associated with cluster B PDs.

7.2. Recommendation

For mental health professionals: it is important to give more emphasis in assessing comorbid cluster B PDs as daily routine activities especially those who have associated factors like mood disorders, history of many relapses, family mental illness, substance use particularly cannabis, suicidal attempt, childhood emotional abuse, and interpersonal functioning impairment. This helps to improve the course and treatment of the other disorder that patients typically identify as their chief complaint, the effectiveness and efficacy of the care provided at mental health service and in order to give PD oriented psychotherapy.

For the psychiatry department: it is better to make continuous supervision and evaluation to ensure patients who follow outpatient treatment are screened for cluster B PD and accordingly adequate intervention is given for those found to have comorbid PD.

For researchers: even though this study tried to address many associated factors of cluster B personality disorder, it is important to include factors like personality traits, mindfulness, adherence to medication/treatment, and also other personality disorders in future researches. Additionally, it is better to include new outpatients who were not included in this study and to use a better study design to see the cause and effect between personality disorder and its associated factors.

References

1. Galderisi S, , Andreas Heinz , Marianne Kastrup, Julian Beezhold NS. Toward a new definition of mental health. World psychiatry. 2015;14(2):231–3.

2. Ronald C. Kessler, Ph.D., Olga Demler, M.A., M.S., Richard G. Frank, Ph.D., Mark Olfson, M.D., Harold Alan Pincus, M.D., Ellen E. Walters MS, Philip Wang, M.D., Dr.P.H., Kenneth B. Wells, M.D., and Alan M. Zaslavsky P. Prevalence and treatment of mental disorders, 1990 to 2003. N Engl J med. 2005;325(24):2515–23.

3. Jong-wook L. Investing in mental health. WHO Libr Cat data world. 2003;30:4–8.

4. Arlington, VA, Jeffrey Akaka MD, Carol A. Bernstein, M.D. BrL·^^ Crowley, M.D. Anita S. Everett MD, Jeffrey Geller, M.D. MP. Diagnostic and statistical manual of mental disorders, fifth edition. 5th editio. 2013. 645 p.

5. Randy K. Ward M. Assessment and management of personality disorders. Am Fam Physician. 2004;70(8):1505–12.

6. Gunderson JG, Mcglashan TH, Dyck IR, Stout RL, Ph D, Bender DS, et al. Functional impairment in patients with schizotypal, borderline, avoidant, or obsessive-compulsive personality disorder. Am J Psychiatry. 2002;159:276–83.

7. Bender DS, Ph D, Dolan RT, Ph D, Skodol AE, Sanislow CA, et al. Treatment utilization by patients with personality disorders. Am J psychiatry. 2001;158(2):295–302.

8. Oldham JM, Gabbard GO, Soloff P, Spiegel D, Stone M, Phillips KA, et al. Treatment of Patients With borderline personality disorder. APA Pract Guidel. 2005;107:1–82.

9. Health N collaborating centre for mental, Royal College of Psychiatrists' Research and Training Unit. Borderline personality disorder : The nice guideline on treatment and management. 2009. 433–44 p.

10. Huang Y, Kotov R, Girolamo G De, Preti A, Angermeyer M, Karam N, et al. DSM – IV personality disorders in the WHO world mental health surveys. Br J psychiatry. 2009;195:46–53.

11. Gagliesi, Sergio Apfelbaum PRLHJTP. Comorbidity between bipolar disorder and cluster B personality disorders as indicator of affective dysregulation and clinical severity. Actas esp Psiquiatr. 2013;41(5):269–78.

12. Moran P. The epidemiology of personality disorder. Soc psychiatry psychiatry epidemiol. 1999;34:231–42.

13. Maureen O'Brien, Linda Mortimer NS and HML. Psychiatric morbidity among women prisoners in England and Wales. International review of psychiatry. 2003. 1–156 p.

14. Deborah S. Hasin, PhD; Frederick S. Stinson, PhD; Elizabeth Ogburn, MS; Bridget F. Grant P. Prevalence, correlates, disability, and comorbidity of DSM-IV alcohol abuse and dependence in the United States. Arch gen psychiatry. 2007;64(7):830–42.

15. Mark F. Lenzenweger, Michael C. Lane, Armand W. Loranger RCK. DSM-IV personality disorders in the national comorbidity survey replication. Biol Psychiatry. 2008;62(6):553–64.

16. Alnaes R TS. Personality and personality disorders predict development and relapses of major depression. Acta Psychintr Scand. 1997;95:336–42.

17. Berkson J. Limitations of the application of fourfold table analysis to hospital data . Int J Epidemiol. 2014;43(2):511–5.

18. Zimmerman M, Rothschild L, Ph D. The prevalence of DSM-IV personality disorders in psychiatric outpatients. Am J psychiatry. 2005;162(10):1911–8.

19. Shea MT, Pagano ME, Morey LC, Stout RL. Associations in the course of personality disorders and axis I disorders over time. J Abnorm Psychol. 2004;113(4):499–508.

20. Bezerra-filho S, Galva A, Studart P, Rocha M V. Personality disorders in euthymic bipolar patients : a systematic review. Rev Bras Psiquiatr. 2015;37:162–7.

21. Zhang T, Chow A, Wang L, Dai Y, Xiao Z. Role of childhood traumatic experience in personality disorders in China. Compr Psychiatry [Internet]. 2012;53(6):829–36. Available from: http://dx.doi.org/10.1016/j.comppsych.2011.10.004

22. Zheng Y, Severino F, Hui L, Wu H, Wang J, Zhang T. Co-morbidity of DSM-IV dersonality disorder in major depressive disorder among psychiatric outpatients in China. Front psychiatry. 2019;10:1–9.

23. Benjamin James Sadock, M.D, Virginia Alcott Sadock, M.D, Pedro Ruiz MD. Kaplan & Sadock's behavioral sciences/clinical Psychiatry, eleventh edition. 2015. 1594 p.

24. Santana GL, Coelho BM, Wang Y, Porto D, Filho C, Viana MC, et al. The epidemiology of personality disorders in the Sao Paulo megacity general population. PLos/one [Internet]. 2018;13(4):1–20. Available from: http://dx.doi.org/10.1371/journal.pone.0195581

25. Moran P, Walsh E, Yrer, Peter T, Burns T om. Impact of comorbid personality disorder on violence in psychosis - Report from the UK700 trial. Br J Psychiatry. 2003;182:129–34.

26. Oldham JM, Skodol AE. Personality disorders in the public sector. Psychiatr Serv. 1991;42(5):481–7.

27. Hillman JL, Stricker G, Zweig RA. Clinical psychologists' judgments of older adult patients with character pathology. Prof Psychol Res Pract. 1997;28(2):179–83.

28. Preti E, Pierro R Di, Fanti E, Madeddu F, Calati R. Personality disorders in time of pandemic. Curr Psychiatry Rep. 2020;22:80.

29. Roger T. Mulder, M.B., Ch.B., Ph.D. . Reviews and overviews personality pathology and treatment Outcome in major depression. Am J Psychiatry. 2002;159(3):359–71.

30. Newton-howes G, Tyrer P. Personality disorder and the outcome of depression : meta-analysis of published studies. Br J psychiatry. 2006;188:13–6.

31. Quilty LC, Fruyt F De, Rolland J, Kennedy SH. Dimensional personality traits and treatment outcome in patients with major depressive disorder. J Affect Disord. 2008;108:241–50.

32. Adam Moser, Kevin Range and DMY. NIH Public Access. Bone [Internet]. 2008;23(1):1–7. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3624763/pdf/nihms412728.pdf

33. Jan Spijker, M.D., Ph.D., Ron de Graaf, Ph.D., Albertine J. Oldehinkel, Ph.D., Willem A. Nolen, M.D., Ph.D., and Johan Ormel PD. Are the vulnerability effects of personality and psychosocial functioning on depression accounted for by subthreshild symptoms ? Depress Anxiety. 2007;24:(11):472–8.

34. Sartorius N, Buchheim P, Dahl AA, Diekstra RFW. The international personality disorder examination . The World Health Organization / alcohol , drug abuse , and mental health administration international pilot study of personality disorder. Arch

Gen Psychiatry. 1994;51:215–24.

35. Haw C, Ton KHAW, Houston K, Townsend E. Psychiatric and personality disorders in deliberate self-harm patients. Br J psychiatry. 2001;178:48–54.

36. Eugenia Zikos, MD, Frcpc; Kathryn J Gill, PhD; Dara A Charney, MDCM F. Personality disorders among alcoholic outpatients: Prevalence and course in treatment. Can J Psychiatry. 2010;55(2):65–73.

37. El G, Dj M, Ja R, Tl S, The T Do, George EL, et al. The comorbidity of bipolar disorder and axis II personality disorders : prevalence and clinical correlates. Bipolar Disord. 2003;5:115–22.

38. Berghuis H, Kamphuis JH. Core feature of personality diaorder : Differentiating general personality dysfunctioning from persoality traits. J Personal Disord. 2012;26(28):1–13.

39. Nicolò G, Semerari A, Lysaker PH, Dimaggio G, Conti L. Alexithymia in personality disorders : Correlations with symptoms and interpersonal functioning. Psychiatry Res [Internet]. 2011;1016:1–7. Available from: http://dx.doi.org/10.1016/j.psychres.2010.07.046

40. Keown P, Holloway F, Kuipers E. The prevalence of personality disorders , psychotic disorders and affective disorders amongst the patients seen by a community mental health team in London. Soc psychiatry psychiatr epidemiol. 2002;37:225–9.

41. Huen A met, Ah D, Ter RUT, Ao BR, Yrer P etert. Prevalence of personality disorder in the case-load of an inner-city assertive outreach team. Psychiatr Bull. 2004;28:441–3.

42. Garyfallos G, Adamopoulou A, Karastcrgiou A, Voikli M, Sotiropoulou A, Donias S, Giouzepas J PA. Personality disorders in dysthymia and major depression. Acta psychiar scand. 1999;99(11):332–40.

43. Mustafa Ozkan AA. Comorbidity of personality disorders in subjects with panic disorder: which personality disorders increase clinical severity. Dicle tıp Derg. 2003;30:102–11.

44. Wei Y, Zhang T, Chow A, Tang Y, Xu L, Dai Y, et al. Co-morbidity of personality disorder in schizophrenia among psychiatric outpatients in China. BMC Psychiatry.

2016;16:224.

45. Lane, Michael C, Mark F. Lenzenweger, PhD, Armand W. Loranger, PhD, And Ronald C. Kessler P. DSM-IV personality disorders in the national comorbidity survey replication. Biol Psychiatry. 2007;62(6):553–64.

46. Thuo J, Ndetei DM, Maru H, Kuria M. The prevalence of personality disorders in a Keniyan inpatient sample. J Pers Disord. 2008;22(2):217–20.

47. Matsunaga H, Kiriike N, Nagata T, Yamagami S. Personality disorders in patients with eating disorders in Japan. Int J eat disord. 1998;23(1):399–408.

48. Moran P, Jenkins R, Tylee, A. R. Blizard AM. The prevalence of personality disorder among U.K. primary care attenders. Acta psychiatr scand. 2000;102(4):52–7.

49. Colder CR. Life stress, physiological and subjective indexes of negative emotionality, and coping reasons for drinking. Psychol Addict Behav. 2001;15(3):237.

50. Shakoor A. Co-morbidity of personality disorders and other psychiatric disorders. Proceeding SZPGMI. 2005;19(1):37–45.

51. Tianhong Zhang, Lanlan Wang, Mary-Jo D. Good, Byron J. Good, Annabelle Chow, Yunfei Dai1, Junhan Yu, Haiyin Zhang and ZX. Prevalence of personality disorders using two diagnostic systems in psychiatric outpatients in Shanghai, China. Soc psychiatry psychiatr epidemiol. 2012;47(9):1409–17.

52. Hyler D. Personality Questionnaire Developed Pdq -4+. www.pdq4.com. 1994;8(212):1–12.

53. Abdin E, Subramaniam M. Validity of the personality diagnostic questionnarrie — 4 (PDQ-4 +) among mentally ill prison inmates in Singapore. J Pers Disord. 2011;25(6):834–41.

54. Calvo N, Gutiérrez F, Casas M. Diagnostic agreement between the personality diagnostic questionnaire-4 + (PDQ-4 +) and its clinical significance scale. Psicothema. 2013;25(4):427–32.

55. Fossati A, Porro FV, Maffei C, Borroni S. Are the DSM-IV personality disorders related to mindfulness ? An Italian study on clinical participants. J ofclinical Psychol. 2012;68(6):672–83.

56. Christopher J. Hopwood, M. Brent Dinnellan, Robert A. Ackerman, Katherine M. Thomas, Leslie C. Morey and AES. The validity of the personality diagnostic questionnaire-4 narcissistic personality disorder scale for assessing pathological grandiosity. J Pers Assess. 2013;95(3):274–83.

57. Bottesi G, Novara C, Ghisi M, Lang M, Sanavio E. The M illon clinical multiaxial inventory – III (MCMI - III) and the personality diagnostic questionnaire - 4 + (PDQ - 4 +) in mixed Italian psychiatric sample. 2008. 1–29 p.

58. T. Wilberg, T. Dammen and SF, A. Comparing personality diagnostic questionnaire-4+ with longitudinal, expert, all data (LEAD) standard diagnoses in a sample with a high prevalence of axis I and axis II disorders. Compr Psychiatry. 2000;41(4):295–302.

59. Calvo N, Gutiérrez F, Andión Ó, Caseras X, Torrubia R, Casas M. Psychometric properties of the Spanish version of the self-report personality diagnostic questionnaire-4 + (PDQ-4 +) in psychiatric outpatients. Psicothema. 2012;24(1):156–60.

60. WHO ASSIST working group. The alcohol, smoking and substance involvement screening test (ASSIST): development, reliability and feasibility. …. 2010;97:1–74.

61. Kocalevent RD, Berg L, Beutel ME, Hinz A, Zenger M, Härter M, et al. Social support in the general population: Standardization of the Oslo social support scale (OSSS-3). BMC Psychol. 2018;6(31):1–8.

62. Weekers LC, Hutsebaut J, Kamphuis JH. The Level of personality functioning scale-brief Form 2.0: update of a brief instrument for assessing level of personality functioning. Personal Ment Health. 2018;13(1):1–12.

63. Walker EA, Gelfand A, Katon WJ, Koss MP, Von Korff M, Bernstein D, et al. Adult health status of women with histories of childhood abuse and neglect. Am J Med. 1999;107(4):332–9.

64. Tianhong Zhang, Lanlan Wang, Mary-Jo D. Good, Byron J. Good, Annabelle Chow, Yunfei Dai, Junhan Yu, Haiyin Zhang and ZX. Prevalence of personality disorders using two diagnostic systems in psychiatric outpatients in Shanghai, China. Soc Psychiatry Psychiatr epidemiol. 2012;47(9):1409–17.

65. Th M, Cm G, Ae S, Jg G, Mt S. The collaborative longitudinal personality disorders study : baseline axis I / II and II / II diagnostic co-occurrence. Acta Psychiatr Scand. 2000;102(2).

66. Lanlan Wang, MD, Colin A. Ross, MD, Tianhong Zhang, MD, Yunfei Dai, MD, Haiyin Zhang, MD, PhD, Mingyi Tao, MD, Jianying Qin, MD, PhD, Jue Chen, MD, PhD, Yanling He, MD, Mingyuan Zhang, MD, and Zeping Xiao, MD P. Frequency of borderline personality disorder among paychiatric outpatients in Shanghai. J Pers disord 2012. 2012;26(3):393–401.

67. Gerhardstein KR, Griffin PT, Hormes JM, Diagnostic T, Disorders M, Edition F, et al. Personality disorders lead to risky behavior, treatment obstacles. HIV Clin. 2015;23(2):6–7.

68. Pagano ME, Shea MT, Grilo CM, Gunderson JG. Recent life events preceding suicide attempts in a personality disorder Sample: Findings from the collaborative longitudinal personality disorders study. J Consult Clin Psychol. 2012;73(1):99–105.

69. Mueser KT, Crocker AG, Frisman LB, Drake RE, Covell NH, Essock SM. Conduct disorder and antisocial personality disorder in persons with severe psychiatric and substance use disorders. Schizophr Bull. 2006;32(4):626–36.

70. Tümer Ö, Blazer D. Substance use disorders in men with Antisocial personality disorder : A Study in Turkish sample. Subst Use Misuse. 2006;41:1167–74.

71. Sher KJ, Trull TJ. Substance use disorder and personality disorder. Curr Psychiatry Rep. 2002;4:25–9.

72. Laporte L, Paris J, Guttman H, Russell J. Psychopathology, childhood trauma , and personality traits in patients with borderline personality disorder and their sisters. 2011;25(4):448–62.

73. Kounou KB, Bui E, Dassa KS, Hinton D, Fischer L, Djassoa G, et al. Childhood trauma, personality disorders symptoms and current major depressive disorder in Togo. Soc Psychiatry Psychiatr Epidemiol. 2012;48(7):1095–103.

74. Hengartner MP, Mu M, Rodgers S, Ro W, Ajdacic-gross V. Interpersonal functioning deficits in association with DSM-IV personality disorder dimensions. Soc Psychiatry Psychiatr Epidemiol. 2014;49:317–25.

Appendices

Annex I: English version questioner
Jimma University, Inistitute of health

Information sheet

Title of the research project – prevalence of cluster B personality disorders and associated factors among patients with mental illness attending psychiatric outpatient treatment at JMC, 2021.

Name of the principal investigator – Muzeyen Jemal

Name of the organization and sponsor - Jimma University

The objective of the research project: To assess prevalence of cluster B personality disorders and associated factors among patients with mental illnesses attending psychiatric outpatient treatment at JMC, 2021.

Procedure: We invite you to participate in this study. If you are willing to participate in this study, you need to understand and sign the agreement form. Then after, you will be interviewed by the data collectors. You do not need to tell your name or to give your telephone number to the data collector and all your responses and the results obtained will be kept confidentially by using coding system whereby no one will have access to your response.

Harm - No harm will be inflicted because of their participation in this study.

Benefit - If you participate in this research project, there may not be direct benefit to you but your participation is likely help us to meet the research objective. Ultimately, this will help us to improve quality of services provided to patients.

Incentives- You will not be provided any incentives or payment to take part in this project.

Voluntary participation and withdrawal - Your decision to participate in this study is complete voluntary. If you decide to not participate in this study, it will not affect the care, services, or benefits to which you are entitled. If you decide to participate in this study, you may withdraw from your participation at any time without penalty.

Contact person - This research project will be reviewed and approved by the ethical committee of Jimma University. If you have any question or doubt regarding this study, you can contact the following individual through:

Phone number: +251934080055 Email: muzeyenje55@gmail.com

+251912806976 Email: liyew2003@gmail.com
+ 251911740105 Email:fitsumbeselot@gmail.com

Your consent - I voluntarily agree to participate in this research program

Yes No

I understand that I will be given a copy of this signed consent form.

Signature of participant _____ Date _____

Name and signature of supervisor: _____ Date_____

Name and signature of data collector: _____ Date_____

Part l: Questions related to the socio demographic characteristics of the patient

S. N	Questions	Responses
SD1.	Age	_____
SD2.	Sex	1. Male 2. Female
SD3.	Marital status	1. Single 2. Married 3. Divorced 4. Widowed
SD4.	Religion	1. Muslim 2. Orthodox 3. Protestant 4. Catholic 4. Other specify _____
SD5.	Educational status	1. Not able to read and write 2. Able to read and write 3. 1 - 8th grade 4. 9-12thgrade 5. College and above
SD6.	Have you occupation?	0. No 1. Yes
SD7	If yes for SD6 what type of occupation?	1. Farmer 2. Merchant 3. Gov't employee 4. Private 5. Daily laborer 6. Other specify____
SD8.	Who was raised you while you are child?	1. Mother only 2. Father only 3. Both 1&2 3. Others_____

Part II: Clinical Related Factors

S. N	Questions	Responses
CR1.	What is the diagnosis of the patient? (Chart review)	
CR2.	How long the total duration of the illness?	
CR3	Age at onset of illness	
CR4.	Total duration of treatment	
CR5.	Have you ever admitted to the hospital?	0. No 1. Yes
CR6.	If your response to question CR3 is "yes "for how many times have you been admitted?	_____
CR7.	Average duration stayed in the hospital	
CR8.	Have you experienced relapse? (if illness returns after at least 2 months of symptoms free)	0. No 1. Yes
CR9.	If yes for CR9 how many times	
CR10.	Is there history of mental illness in your family?	0. No 1. Yes

Part-III: Questions to assess Risk behaviors

S. N	Questions	No	Yes
RB1	Do you have thoughts of wanting to die?	0	1
RB2	Do you have thoughts of wanting to take your own life?	0	1
RB3	Have you tried to take your own life?	0	1
RB4	Do you have thoughts of killing others?	0	1
RB5	Have you tried to take life of others?	0	1

Part-IV Personality disorder questionaries (PDQ-4+) cluster B part

Instructions: The purpose of this questionnaire is for you to describe the kind of person you are. When answering the questions, think about how you have tended to feel, think, and act over the past several years. Please answer either **T**rue or **F**alse to each item.

Where: T (True) means that the statement is generally true for you.

F(False) means that the statement is generally false for you.

Borderline	
Br1. I'll go to extremes to prevent those who I love from ever leaving me.	0.F 1.T
Br2. I either love someone or hate them, with nothing in between.	0 1
Br3. I often wonder who I really am.	0 1
Br4. I have tried to hurt or kill myself.	0 1
Br5. I am a very moody person.	0 1
Br6. I feel that my life is dull and meaningless.	0 1
Br7. I have difficulty controlling my anger, or temper.	0 1
Br8. When stressed, things happen Like I get paranoid or just "black out."	0 1
Br9. I have done things on impulse (such as those below) that could have gotten me into *Check all that apply to you:* a. Spending more money than I have b. Having sex with people I hardly know c. Drinking too much. d. Taking drugs e. Eating binges f. Reckless driving	
Antisocial	
An1. I've been in trouble with the law several times (or would have been if I had been caught).	0. T 1. F
An2. I get into a lot of physical fights.	0 1
An3. I have difficulty paying bills because I don't stay at any one job for very long.	0 1
An4. I do a lot of things without considering the consequences	0 1
An5. Lying comes easily to me and I often do it.	0 1
An6. I enjoy doing risky things.	0 1
An7. I don't care if others get hurt so long as I get what I want.	0 1

An8. When I was a kid (before age 15), I was somewhat of a juvenile delinquent, doing some of the things below. 0 1 *Check° all that apply to you:* (a) I was considered a bully (b) I used to start fights with other kids. (c) I used a weapon in fights that I had (d) I robbed or mugged other people (e) I was physically cruel to other people (f) I was physically cruel to animals (g) I forced someone to have sex with me. (h) I lied a lot. (i) I stole things from others. (j) I stayed out at night without my parents' permission. (k) I set fires (l) I broke windows or destroyed property. (m) I ran away from home overnight more than once. (n) I began skipping school, a lot, before age 13 (o) I broke into someone's house, building or car	
Histrionic	
Hs1. I need to be the center of attention.	0. T 1. F
Hs2. I am "sexier" than most people.	0 1
Hs3. I show my emotions easily	0 1
Hs4. I use my "looks" to get the attention that I need.	0 1
Hs5. Even though I talk a lot, people say that I have trouble getting to the point.	0 1
Hs6. I have a flair for the dramatic.	0 1
Hs7. I am easily influenced by others.	0 1
Hs8. I take relationships more seriously than do those who I'm involved with.	0 1
Narcissistic	
Nr1. I have accomplished far more than others give me credit for.	0.T 1. F
Nr2. I often find myself thinking about how great a person I am, or will be	0 1
Nr3. Only certain special people can really appreciate and understand me.	0 1
Nr4. I very much need other people to take notice of me or compliment me.	0 1
Nr5. I expect other people to do favors for me even though I do not usually do favors for them.	0 1
Nr6. Some people think that I take advantage of others.	0 1
Nr7. People have often complained that I did not realize that they were upset.	0 1
Nr8. Some people are jealous of me.	0 1
Nr9. Others consider me to be stuck up.	0 1

PDQ-4 Clinical Significance Scale

Interview guide: *If the patient has scored at or above threshold on any disorder evaluated, the clinician should use this interview format to assess the clinical significance of the disorder.*

You have reported that the following related items are true for you:

(Read the pathological items for each disorder, one at a time, to the patient)

A. How long have these items been part of your personality? 1. Less than one year 2. One to five years 3. Most of your life, or since before age 18
B. Have these items been part of your personality only when you have been depressed, anxious, using alcohol/drugs or physically ill or have they been there most of the time regardless of your mood, level of anxiety, use of alcohol/drugs or general state of health? 1. Only when depressed 2. Only when anxious 3. Only when using alcohol/drugs 4. Only when physically ill 5. Not related to any of the above
C. In what areas have these items created difficulties for you?
1. At home 2. At work 3. In relationships 4. Other (specify)_____ **OR**
D. Are you bothered about yourself because of the above? 1. Yes 2. No

Part-V Questionaries to assess substance use related factors

Instruction: this question is about substance use. Please choose the option represents the participants and write appropriate answer for participants experience about his/her use of substances.

Su1.	In your lifetime, have you ever used any substances?	0. No 1. Yes
Su2.	If your answer is Yes for Q-1, which substance do you used? (More than one answer is possible)	a. Alcohol (beer, wine, arake, teji, tella) b. Khat c. Tobacco productd. Others (specify)
Su3.	In the past 3 months, have you used any of the substances?	0. No 1. Yes
Su4.	If your answer is Yes, which substance do you use? (More than one answer is possible)	a. Alcohol b. Kat c. Tobacco product d. Others (specify)
Su5.	Age at using the substance started	

PART VI: question to assess social support (Oslo Social Support Questionnaires (Oslo-3)

No	Oslo social support questions	Response
OS1.	How many people are so close to you that you can count on them if you have serious personal problems? (Choose one option)	4. More than 5 3. 3-5 2. 1 or 2 1. None
OS2.	How much concern do people show in what you are doing? (Choose one option)	5.A lot of concern and interest 4. Some concern and interest 3.Uncertain 2.Little concern and interest 1.No concern and interest
OS3.	How easy is it to get practical help from family or relatives if you should need it?	5. Very easy 4. Easy 3. possible 2. Difficult 1. Very difficult

Part: VII Questions to assess self and interpersonal functioning (Level of Personality Functioning Scale - Brief Form 2.0)

S. N	Questions	Very false	sometimes false	sometimes true	very true
LP1	I often do not know who I really am	1	2	3	4
LP2	I often think very negatively about myself				
LP3	My emotions change without me having a grip on them				
LP4	I have no sense of where I want to go in my life				
LP5	I often do not understand my own thoughts and feelings				
LP6	I often make unrealistic demands on myself				
LP7	I often have difficulty understanding the thoughts and feelings of others				
LP8	I often find it hard to stand it when others have a different opinion				

LP9	I often do not fully understand why my behavior has a certain effect on others				
LP10	My relationships and friendships never last long				
LP 11	I often feel very vulnerable when relations become more personal				
LP 12	I often do not succeed in cooperating with others in a mutually satisfactory way				

Part VIII: Childhood Trauma Questionnaire-Short Form (CTQ-SF)

Instruction: The following questions are related to list of events that happened to you before Age 18.

Code	Item category	Item (When I was growing up)	Never true	Rarely true	Sometimes true	Often true	Very often true
Ea1	Emotional abuse	people in my family called me things like “stupid”, “lazy” or “ugly”	1	2	3	4	5
Ea2		I thought my parents wished I had never been born	1	2	3	4	5
Ea3		people in my family said hurtful or insulting things to me	1	2	3	4	5
Ea4		I felt that someone in my family hated me	1	2	3	4	5
Ea5		I believed that I was emotionally abused	1	2	3	4	5
Pa1	Physical Abuse	I got hit so hard by someone in my family that I had to see a doctor or go to hospital	1	2	3	4	5
Pa2		people in my family hit me so hard that it left me with bruises or marks	1	2	3	4	5
Pa3		I was punished with a belt, a board or a cord or some other hard object	1	2	3	4	5
Pa4		I believe that I was physically abused	1	2	3	4	5
Pa5		I got hit or beaten so badly that it was noticed by someone like a teacher, neighbor or doctor	1	2	3	4	5

Sa1	Sexual Abuse	Someone tried to touch me in a sexual way or make me touch them	1	2	3	4	5
Sa2		Someone threatened me to hurt me or tell lies about me unless I did something sexual with them	1	2	3	4	5
Sa3		someone tried to make me do sexual things or watch sexual things	1	2	3	4	5
Sa4		someone molested me	1	2	3	4	5
Sa5		I believe that I was sexually abused	1	2	3	4	5
En1	Emotional neglect	There was someone in my family who helped me feel that I was important or special (R)	1	2	3	4	5
En2		I felt loved (R)	1	2	3	4	5
En3		People in my family looked out for each other(R)	1	2	3	4	5
En4		People in my family felt close to each other(R)	1	2	3	4	5
En5		My family was a source of strength and support(R)	1	2	3	4	5
Pn1	Physical neglect	I didn't have enough to eat	1	2	3	4	5
Pn2		I knew that there was someone to take care of me and protect me(R)	1	2	3	4	5
Pn3		My parents were too high or drunk to take care of the family	1	2	3	4	5
Pn4		I had to wear dirty clothes	1	2	3	4	5
Pn5		There was someone to take me to doctor if I needed(R)	1	2	3	4	5
Md1	Minimization/ denial	There was nothing I wanted to change about my life	1	2	3	4	5
Md2		I had a perfect childhood	1	2	3	4	5
Md3		I had the best family in the world	1	2	3	4	5

Annex II: Afan Oromo version questionaries

Gucaa I: Gaaffilee afaan oromoo

Yuunivarsiitii Jimmaatti instituyuuti yaalaa fayyaa

Kutaa yaala sammuu

Oddeeffannoo

Mata-duree– Prevalence of Cluster B personality disorders and associated factors among patients with mental illness attending psychiatric outpatient treatment at JMC, 2021.

Maqaa qoraataa – Muzayyan Jamaal

Maqaa dhaabbataa fi ispoonsara qorannichaa - yuunivarsiiti Jimmaa

Xiyyeeffannoo qorannoo - To assess the prevalence of cluster B personality disorders and associated factors among patients with mental illness attending psychiatric outpatient treatment at JMC, 2021.

Haalaa qorannoo: akka qorannoo kana irratti hirmaattaniif affeeramtanii jirtu. Qorannoo kana keessatti hirmaachuu yoo barbaaddan haala qorannoo hubachuu fi walii galtee mallatteessuu barbaachisa. Maqaa keessanii fi lakkoofsa bilbilaa nama odeeffannoo isinirraa funaanuuf kennuun hin barbaachisu. Iccitiin odeeffannoo isinirraa argamuu guutuun guututti eegamaadha.

Rakkoo – qorannoo kanaa irrattii hirmaachuu/dhabuu keessaniif rakkoon kamiyyu isin hin qunnamu.

Iccitii eeguu – oddeeffannoon isin keennitan kamiyyuu xiyyeeffannoo qorannootin alaa wan biraatiif hin oolu.

Hirmaachu fi hirmaachuu dhabuu – qorannoo kana irrattii hirmaachu fi hirmaachu dhabuun fedhii keessaan irrattii kan hundaa'e, tajaajilaa kanaan duraa hospitalaa kana irraa argacha turtan irrattii dhiibbaa hin qabu. Ergaa qorannoo kana irrattii hirmaachuu egaltan booddeelle addaan kutuu ni dandeessu.

Nama wal qunaamtan –qorannoon kun boordii qorannoo Yuunivarsiitii Jimmaatin kan sakatta'amee fi mirkaana'ee dha. Qorannoo kana irrattii yoo gaaffii qabaattan namoota armaan gadii qunnamuu ni dandeessu.

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+251911740105 imeeli: fitsumbeselot@gmail.com

Walii galtee - qorannoo kan irraattii hirmaachuf fedhii kiyya nan agarsiisa. Eeyyen miti.

Mallaattoo hirmaattoota _____ guyyaa _____

Maqaa fi mallatto too'ataa: _____ guyyaa _____

Kutaa 1: Gaaffiilee haala hawaasummaa dhukkuubsataan wal qabatan.

Lakk	Halaa hawaasummaa dhukubasataa	Deebii
SD1.	Umrii	_____
SD2.	saala	1.Dhiiraa 2. Dubartii
SD3.	Haala gaa'elaa	1. kan hin fuune 2. Kan fuudhe/heerumte 3. Kan adda ba'ee/baate 4. kan jalaa du'ee/duutee
SD4.	Amantaa	1. Muslima 2. Ortodoksii 3. protestaanti 4.kan biroo ____
SD5.	Sadarkaa barumsaa	1. dubbisuu kan hin dandeenye 2. Dubbisuu kan danda'u 3. sadarkaa 1ffaa 3. Sadarkaa 2ffaa 4. kolleejji fi isaa ol
SD6.	Hojii qabdaa?	0. Lakki 1. Eeyyee
SD7.	Gaaffii SD6 eeyyee yoo ta'e gosa hojii eeri	1.Qote-bulaa 2. Daldalaa 3 hojii mootummaa 4. Hojii dhuunfaa 5. Hojii guyyaa 6.kan biraa_____
SD8.	Yeroo ijoollummaa keetti eenyutu si guddise?	1.Haadha 2. Abbaa 3. Haadhafi abbaa 4. Kan biro

Kutaa 2ffaa: gaaffilee fayyaa dhukkubsataa waliin wal-qabatan.

Lakk	Gaaffilee	Deebii
CR1.	Gosa dhukkubaa (chaartii irraa)	
CR2.	Dhukkubni kee yeroo hangam sirra ture?	
CR3.	Umrii dhukkubni itti jalqabe	
CR4.	Waliigala yeroo yaali/waldhaansa irra turame	
CR5.	Hospitaala keessaa ciistee yaalaamte beekta?	0. Lakki 1. Eeyyee

CR6.	Gaafii 4 eeyyee yoo ta’e yeroo meeqaa ciiste?	
CR7.	Gidugalaan yeroo hammamiif hospitaala ciise/te	
CR8.	Dhukkubni kee deebi’ee sitti cimee beekaa?	0. Lakki 1. Eeyyee
CR9.	Gaafii eeyyee yoo ta’e marsaa meeqaaf?	
CR10.	Maatii/fira dhihoo keessa namni dhukkuba sammuu qabu jiraa?	0. Lakki 1. Eeyyee

Kutaa-3ffaa Gaaffiwwan waa’ee amaloota miidha qaban qoratan

RB1.Yaada du’a hawwuu qabdaa?	0. Lakki	1.Eeyee
RB2.Yaada lubbuu kee baasu qabdaa?	0	1
RB3. Lubbuu kee baasuuf yaaltee beektaa?	0	1
RB4. Namoota biroo miidhuuf/ajjeessuuf yaaddee beektaa?	0	1
RB5. Lubbuu namoota biroo baasuuf yaaltee beektaa?	0	1

Kutaa 4ffaa: Gaafiwwan haala namoomaa wajjiin wal qabatan

Hubachiisa: -Kaayyoon gaaffiwwan kanneeni ati nama akami akka taatee hubachuuf. Tokko tokkoo gaaffiwwan kanneeniitiif deebii yeroo kennitu baroota darban hedduuf maaltu akka sitti dhagahamaa turee, amala akkamii akka qabaataa turtee fi maal akka hojjetaa turte yaadadhuu deebisi. Tokko tokkoo gaafiitiif eeyyee yookiin lakki jechuun deebisi.

Borderline
Br1. Namootni jaaladhu akka narraa adda hin baane tiksuuf hanga dhumaatti gatii baarbachisu hunda ni kanfala. 0 1
Br2. Sababa gahaa tokkoon maletti namoota takkaa guutuun guututti jaaladha takkaa guutuun guututti jibba. 0 1
Br3. Yeroo hedduu ani nama akkamii akka ta’en of yaada. 0 1
Br4. Of miidhuuf takkaa of ajjeesuuf yaalii godhee beeka. 0 1
Br5. Ani nama akkaan tapha jaalatuudha. 0 1
Br6. Jireenyi kiyya kan hin gammachiisnee fi hiika hin qabne natti fakkaata. 0 1
Br7. Lola ykn dallansuu kiyya too’achuun natti ulfaata 0 1.

Br8 Yeroo dhiphadhu waan, shakka akkasumas wanta uumames ni irraanfadha. 0 1
Br9. Wantoota akka armaan gadii kan rakkoo keessa na galchan miira of too'achuu dadhabuutiin raawwadhee beeka. a. Humnaa ol mallaqa qisaasessu 0 1 b. Namoota sirritti hin beekne waliin wal qunnamti saalaa raawwachuu 0 1 c. Baay'isee dhuguu 0 1 d. Araada fayyadamu 0 1 e. Humnaa ol baay'isee nyaachu 0 1 f. Of eeggannoo malee konkolachisuu 0 1
Antisocial
An1. Yeroo heddu rakkoo seeraan adabsiisu keessa gala. 0 1
An2. Yeroo hedduu namooti waliin lola qaamaa keessa gala. 0 1
An3. Yeroo dheeraaf hojii irra turu waan hin dandeenyeef kanfaltii narraa eegamu raawwachuun natti ulfaata. 0 1
An4. Wantoota hedduu miidhaa isa hordofee dhufu osoo hin xiinxalin raawwadha. 0 1
An5. Soba sobuun salphaati naaf dhufa, anis soba ni baay'isa. 0 1
An6. Wantoota miidhaa qaban hojjechuun na gammachiisa/natti tola. 0 1
An7. Waan ofii kooti barbaadu argannaan miidhaan namoota biro irra gahu na hin yaachisu. 0 1
An8. Yeroo ijoollumaa kootii (umrii 15n duratti) wantoota armaan gadii fi Kkf raawwachaa ture.0 1
a. Humnatti amana ture. 0 1 b. Ijoolle biroo wajjiin waltumuu baay'isa ture 0 1 c.Yeroo namaan wallolu meeshaa waraana fayyadama ture 0 1 d. Namoota biroo saamaa/hataan ture. 0 1 e. Namoota birootti garaa jabaadha. 0 1 f. Bineeldota irratti gara jabinaan miidhaa raawwadha. 0 1 g. walqunnamtii saalaa akka na waliin raawwatuuf nama dirqisiisee beeka. 0 1 h. Hedduu soba ture 0 1 i. Ibiddaan waa gubee beeka. 0 1 j. Eeyyama maatiin malee halkan alatti/bakkeetti barfadha. 0 1 k. Foddaa cabsee/ qabeenya barbadeessee beeka. 0 1 l. Yeroo tokko oliif halkan manaa bade beeka. 0 1 m. Umrii 13 duratti mana barumsaarra hafuu fi barfachuu baay'isaa ture. 0 1 n. mana, gamoo fi konkolaataa namaa cabsee seenee beeka. 0 1
Histrionic
Hs1. Xiyyeeffannoo namoota gara kootti hawwatuu barbaada. 0 1
Hs2. Ani namoota hundaa ol nama hawwadha. 0 1
Hs3. Miirri koo saphaatti narraa muldhata 0 1
Hs4. Namoota hawwatuudhaaf bareedinna qama kootti fayyadama. 0 1

Hs5. Nama haasawa baay'isu ta'us namoonni wanti ani dubbadhu akka isaaniif hin galle natti himu. 0 1
Hs6. Waa fakkeessuu irratti kennaa addaa qaba. 0 1
Hs7. salphaadhumatti dhiibbaa namoota jalatti kufuu danda'a. 0 1
Hs8. Walitti dhufeenyaa namoota waliin qabu haala adda ta'een xiyyeeffannoo itti kenna. 0 1
Narcissistic
Nr1. Tilmaama namootni naaf kennaniin olitti wantoota hedduu raawwadheera, milkeesseeras. 0 1
Nr2. Yeroo hedduu ani nama guddaa akami akka ta'ee fi ta'u (fuulduratti) yaada. 0 1
Nr3. Namoota dandeettii addaa qaban muraasa qofatu na hubachuu danda'a. 0 1
Nr4. Namootni akka baay'ee na faarsan/guddisan barbaada. 0 1
Nr5. Namootatti tola ooluu baadhus, akka isaan tola natti oolan garuu ni barbaada. 0 1
Nr6. Namoonni tokko tokko akka ani faaydaa namoota biroo akka ofiif fudhadhu yaadu. 0 1
Nr7. Namootni akka ani miira dallansuu isaanii hin hubanne himatu 0 1
Nr8. Namootni tokko tokko natti inaafu. 0 1
Nr9. Namootni biroo akka ani nama ejjennoo hin jijjiirramne qabu ta'e yaadu 0 1

PDQ-4 Clinical Significance Scale

Dhukkubsataan gosa dhukkubaa qoratame kamirrattuu ulaagaa barbaachisu yookiin isaa ol guute barbaachisummaa kilinikaala dhukkubichaa madaaluuf gaaffilee armaan gadii gaafatamuu qaba.

Mallattooleen armaan gadii akka dhugaa ta'e gabaastanii jirtu (tokko tokkoolee mallattoo

SSa.Mallattooleen kunneen yeroo hammamiif isin wajjiin turan. 1. wagga 1gadi. 2.waggaa 1-5 3. Baroota hedduuf umrii 18 duraa jalqabee
SSb.Mallattooleen kunneen qaama jiruuf jireenya keetii kan ta'an yeroo kam kam? 1.Yeroo mukaahu qofa. 2. Yeroo dhiphadhu qofa 3. Alcooli/araada yeroo fayyadamu qofa. 4.Yeroo dhukkuba qama keessa dhukkubsadhu qofa. 5.Yeroo hundumaa.
SSc.Mallattooleen kunneen iddoo kam kamitti rakkoo/dhiibba sirra geessan? 1. Mana keessatti. 2. Iddoo hojiitti 3. walitti dhufeenya irratti. 4.Kan biro_____ Ykn
SSd. Sababa mallattoolee kanneeniin dhiphattanii beektuu. 0. Lakki 1. Eeyyee

Kutaa 5ffaa: Gaaffiille haala fayyadaama araadaa gadhee waliin kan wal-qabatan.

Su1.	Jiruu kee keessatti araadota addaa addaa fayyadamtee beektaa?	0. Miti 1. Eeyye
Su2.	Yoo deebiin gaaffii 1 “eeyyen” ta’e araada gosa kam fayyadamtee beekta?	1.alkoolii (biiraa, waynii, araqee, daadhii, farsoo) 2. Jimaa 3. Tamboo 4.kan biro_____
Su3.	Ji’oota sadan darban keessattii araada fayyadamtee beektaa?	0. Miti 1. Eeyyee
Su4.	Yoo deebiin gaaffii 3ffa “eeyyeen” ta’e maal fayyadaamte?	1. alkoolii 2. Jimaa 3. tamboo 4. kan biro
Su5.	Umrii araada fayyadamuun itti jalqabame	

Kutaa 6ffaa: gaaffiileen armaan gadii gargaarsa hawaasummaan waliin kan wal qabataniidha

Lakk	Gaffiilee	Deebii
OS1	Yoo rakkoon cimaan si qunname namoota hagamtu si waliin ta’uu danda’aa? (Tokkoo qofa filadhu)	4/ 5 oli 3/ 3-5
		2/ 1ykn 2 1/ hin jiru
OS2	Hojii hojjattu irratti hangam namootnii xiyeyeffannoo siif kennu? (Tokkoo qofa filaadhu)	5.xiyyeeffanno fi fedhii baay’ee guddaa ta’e.
		4.xiyyeeffannoo fi fedhii guddaa qabu
		3. hin beekamu
		2. xiyyeeffanno fi fedhii xiqoo
		1. Xiyyeeffanno fi fedhii hin qaban.
OS3	Gargaarsa barbaadde maatii ykn firaa kee irraa argachuun hangam sitti salphata? (tokkoo qofa filaadhu)	5. baay’ee salphaadha 4. Salphaadha
		3.giddu galeessa 2. Ulfaataadha
		1.baay’ee ulfaata

Kutaa 7ffaa: - Level of personality functioning scale brief 2.0(LPFS.BF)

LP1. Yeroo hedduu ani nama akami akka ta’e of hin beeku	1.Baay’ee soba	2.Soba	3.dhugaadha	4.Baay’ee dhugaadha
LP2. Yeroo hedduu waa’ee kooti haala hin taaneen yaada.	1	2	3	4
LP3. Miirri koo too’annoo koo malee jijjiirama	1	2	3	4

LP4.Jireenya koo keessatti garam akka deemuu qabu hin beeku.	1	2	3	4
LP5.Yeroo hedduu yaada fi miira koo hubachuu hin danda'u	1	2	3	4
LP6. Yeroo hedduu waan dhugaa irraa fagaate of gaafadha/hawwa.	1	2	3	4
LP7. Yaadaa fi miira namoota biroo hubachuun natti ulfaata.	1	2	3	4
LP8.Namoonni yaada narraa adda ta'e yoo qabaatan walii galuun natti ulfaata.	1	2	3	4
LP9. Amalli koo maaliif namoota irratti dhiibba/miidhaa akka qabaatan hin beeku.	1	2	3	4
LP10. Walitti dhufeenyaa fi hiriyyumaan namoota wajjiin qabu walitti fufiinsa hin qabu.	1	2	3	4
LP11. Yeroo hedduu walitti dhufeenyi namoota waliin qabu dhuunfaan yoo ta'e miirri saaxilamummaa natti dhagahama.	1	2	3	4
LP12.Namoota waliin haala hunduu fayyadamaa ta'een walgaaruun natti ulfaata.	1	2	3	4

Gaaffiilee miidhama ijoollummaa / (Childhood Trauma Questionaires- Short Form)

Gaaffiileen armaan gadii mudannoowwan umuriin keessan waggaa kudha saddeet osoo hin gahiin dura isin quunnaman ilaallata. Hamma dhugummaa taateewwan isin mudatanii hubachuun lakkoofsa tokkoo hanga shanii jiran keessaa guutaa.

Koodii	Gosa miidhaa	Miidhamawwan (Utuu umuriin koo 18 hin guutiin)	Gonkumaa	Xiqqoo	Darbee	Yeroo baayee	Yeroo mara
Ea1	Cunqursaa/miidh	Namoonni maatiikoo keessaa jechoota hin taane kanneen akka dhibooftuu /dhiba'a, fokkisa/stu, doofaa jechuun na waamu turan	1	2	3	4	5

Ea2	aa miiraa	Maatiin koo otuu isa/ishee argachuu baannee jedhanii hawwu turan jedheen yaadeen ture	1	2	3	4	5
Ea3		Namoonni maatii koo keessaa jecha nama miidhuu fi arrabsoo natti dubbatu turan	1	2	3	4	5
Ea4		Maatiikoo keessa namni ta'e na jibba jedheen yaada ture	1	2	3	4	5
Ea5		Miidhamni miiraa narra gaheera jedheen amana ture	1	2	3	4	5
Pa1	Cunqursaa/miidhama/ qaamaa	Maatii koo keessaa namni ta'e akka hamaatti na rukutee gara hospitaalaa geeffameen ture	1	2	3	4	5
Pa2		Namoonni maatii koo keessaa akka hamaatti na rukutanii madaa ykn godaannisa natti uumee ture	1	2	3	4	5
Pa3		Ani watoota akka qabattoo, garaftuu fi qacceetiin adabameen ture	1	2	3	4	5
Pa4		Cunqursaan qaamaa narra gahee ture jedheen amana	1	2	3	4	5
Pa5		Ani akka hamaatti rukutamee namoonni akka barsiisaa, ollaa fi ogessi fayyaa narratti baranii turan	1	2	3	4	5
Sa1	Sexual Abuse	Namoonni bifa saalquunnamtiin na tuquuf yaalanii turan ykn akkan isaan tuqu na taasisanii turan	1	2	3	4	5
Sa2		Namoonni yoon ani waan saal quunnamtii wal qabatu isaan waliin gochuu baadhe na miidhuuf ykn waa'ee koo sobachuun na doorsisanii turan	1	2	3	4	5
Sa3		Namni ta'e wayii waan saalquunnamtiin walqabatu akkan godhu yookiin ilaalu na taasisee ture.	1	2	3	4	5
Sa4		Namni ta'e wayii gidiraa saalaa narraan gahee ture	1	2	3	4	5
Sa5		Cunqursaan saalquunnamtii narra gahee ture jedheen amana	1	2	3	4	5
En1	Miiraan dagatamuu/emotional neglect	Maatiikoo keessa namni ani akkan faayida qabeessa ta'e yaaduuf na gargaare jira ture (R)	1	2	3	4	5
En2		Jaalatamaa akkan ta'e natti dhagahama ture(R)	1	2	3	4	5
En3		Namoonni maatii koo keessaa wal kunuunsu turan(R)	1	2	3	4	5
En4		Namoonni maatii koo keessaa hariiroo gaarii qabu turan (R)	1	2	3	4	5
En5		Maatiin koo madda ciminaa fi gargaarsaa turan.	1	2	3	4	5

Pn1	Qaamaan dagatamuu/physical neglect/	Nyaata gahaa hin argadhun ture	1	2	3	4	5
Pn2		namni na kunuunsu ykn na eegu akkan jiru nan amanan ture(R)	1	2	3	4	5
Pn3		Abbaa fi haatikoo baay'ee dhuganii waan machaa'aa turaniif maatii kunuunsuu hin danda'an turan	1	2	3	4	5
Pn4		wayaa xuraawaa uffachuun qaba ture	1	2	3	4	5
Pn5		Yeroo barbaachisetti namni gara ogeessa yaalaa na geessu jira ture(R)	1	2	3	4	5
Md1	Xiqqeessa/diddaa/Minimization/ denial	Waa'ee jireenya kootii wantin jijjiiruuf hawwu tokkollee hin jiru ture	1	2	3	4	5
Md2		Ijoollummaa milkaa'aan qaba ture	1	2	3	4	5
Md3		Akka addunyaatti maatii bbay'ee gaariin qaba ture.	1	2	3	4	5

Maqaa nama daataa funaanee_____

Mallattoo_____

Annex III: Amharic version questionaries

በጅማ ዩኒቨርስሲቲ የጤና ሳይንስ እንስቲቱት

የአዕምሮ ህክምና ትምህርት ክፍል

መጠይቅ ለመሳተፍ የፍቃደኝነት ቃል መቀበያ ቅፅእና መጠይቆች።

<u>የምርምሩ ርዕስ</u>፡- Prevalence of Cluster B personality disorders and associated factors among patients with mental illness attending psychiatric outpatient treatment at JMC, 2021.

<u>የምርምሩ አጥኚ</u> ፡- *ሙዘየን ጀማል*

<u>የምርምር ፕሮጀክቱ ስፖንሰር</u> ፡- ጅማ ዩኒቨርሲቲ

ይህ ጥናት በጅማ ዩኒቨርሲቲ ሜዲካል ሴንተር ውስጥ ያጠናል፡፡እርሶ በዚህ ጥናት ተሳታፊ እንዲሆኑ ተጋብዘዋል፡፡

<u>የምርምሩ ሒደት</u>፡- ይህ የጥናት ሂደት ቀላል ሲሆን የተወሰኑ ጥያቄዎችን የሚጠየቁ ይሆናል፡፡ በዚህ ጥናት ተሳታፊ መሆንዎ ምንም የሚያስከትለው ጉዳት የለም ይልቁንም ከርስዎ የምናገኘው መረጃ ተገቢውን ህክምና ለመስጠት ይረዳል፡፡

<u>የምርምሩ ሚስጥራዊነት ሁኔታ</u>፡- በዚህ ጥናት ውስጥየሚሰጡት መረጃ ጥናቱን ከሚያካሂዱት አካላት ውጪ አይወጣም፤ በጥናቱ ተሳታፊ ለመሆን ካልፈለጉ ለመሳተፍ አይገደዱም፤ ከተጀመረም በኋላ በማንኛውም ጊዜ የማቋረጥ መብቶት የተጠበቀ ይሆናል፡፡

ይህ ምርምር ፕሮጀክት በጅማ ዩኒቨርሲቲ የጥናትና ምርምር ስነምግባር ኮሚቴ ይገመገማል፡፡ ይህንን ጥናት በተመለከተ ጥያቄ ወይም ጥርጥር ካሎት ከታች በተጠቀሰው አድረሻ የሚመለከተውን ሰው ማግኘት ይችላሉ፡፡

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<u>ስምምነት፡-</u> በዚህ የምርምር ፕሮጀክት ውስጥ ለመሳተፍ እስማማለው። አዎ_____ አይደለም__

የተሳታፊ ፊርማ_____ ቀን_____

ቁጥር	የህመምተኛው/የታካሚው ሁኔታ	
SD1	ዕድሜ	----------
SD2	ፆታ	1. ሴት 2. ወንድ
SD3	የጋብቻ ሁኔታ	1. ያላገባ/ች 2. የተፋታ/ች 3. ያገባ/ች 4. የሞተበት/ ባት
SD4	ሀይመኖት	1. ሙስሊም 2. ኦርቶዶክስ 3. ፕሮቴስታንት 4. ሌሎች፡ይጥቀሱ_____
SD5	የትምህርት ደረጃ	1. ማንበብ መፃፍ የማይችል 2. ማንበብና መፃፍ የሚችል 3. 1-8ኛ ክፍል 4. 9-12ኛክፍል 5. ኮሌጅና ከዛ በላይ
SD6	ስራ አሎት	0። አይደለም 1። አዎ
SD7	የስራ ሁኔታ	1. ግብርና 2. ነጋዴ 3. የመንግስት ሰራተኛ 4. የግል መ/ቤት ሰራተኛ 5. ተማሪ 7. የቀን ሰራተኛ 6. ሌሎች፡ይጥቀሱ----------
SD8	በ ልጅነቶ ያሳደጎት ማነዉ?	1።እናት ብቻ 2። አባት ብቻ 3። ሁላቱም 4። ሌላ

ክፍል-1: - የህመምተኛው/የታካሚውን የሰነ-ህዝብ እና ማህበራዊ ጉዳዮች መጠይቅ።

ክፍል -2: - ከክሊኒካዊ ነገሮች ጋር የተያያዙ ነገሮች

ተ.ቁ	**ጥያቄ**	**መልስ**
CR1.	የ ህመም አይነት(ከ ቻርት ላይ)	
CR2.	በሽታዉ ለምን ያህል ጊዜ ቆየ?	
CR3.	በሽታዉ የ ጀመረበት እድሜ	
CR4.	ለምን ያህል ጊዜ ህክምና ላይ ቆዩ?	
CR5.	ሆስፒታል ተኝተዉ ታክመዉ ያዉቃሉ?	0. የለም 1. አዎ
CR6.	ለጥያቄ CR6 መልሱ አዎ ከሆነ ስንት ዙር ተኙ?	
CR7.	ለምን ያህል ጊዜ ሆስፒታል ዉስጥ ቆዩ?	
CR8.	በሽታዉ እንደገና አገርሽቶቦት ያዉቃል?	0. የለም 1. አዎ
CR9.	ለጥያቄ CR9 መልሱ አዎ ከሆነ ለስንት ዙር?	
CR10.	በ ቤተሰቦ/ቅርብ ዘመዶ ዉስጥ የ አእምሮ ህመምተኛ አለ?	0. የለም 1. አዎ

ክፍል -3:- የአደጋ ባህሪያት ምጠይቅዎች

RB1. መሞት የመፈለግ ሀሳቦች አሉዎት?	0. አይደለም	1. አዎ
RB2. የራስዎን ሕይወት ለማጥፋት የመፈለግ ሀሳቦች አሉዎት?	0. አይደለም	1. አዎ
RB3. የራስዎን ሕይወት ለማጥፋት ሞክሮ ያዉቃሉ?	0. አይደለም	1. አዎ
RB4. ሌሎችን ለመግደል ሀሳቦች አሉዎት?	0. አይደለም	1. አዎ
RB5. የሌሎችን ሕይወት ለማጥፋት ሞክሮ ያዉቃሉ?	0. አይደለም	1. አዎ

ክፍል -4: -የስብእና መጠይቅ

መመሪያዎች

የዚህ መጠይቅ አላማ እርስዎ ምን ዓይነት ሰው እንደሆኑ ለመግለፅ ነው። ለእያንዳንዱ ጥያቄዎች ምላሽ ሲሰጡ ባለፉት በርካታ ዓመታት ምን እንደሚሰማዎት እና ምን ያደርጉ እንደነበር ያስታውሱ።

እባክዎ ለእያንዳንዱ ጥያቄ **አዎ** ወይም **አይደለም** በማለት ይመልሱ።

አዎ(እውነት) ማለት በአጠቃላይ መግለጫው ለእርስዎ እውነት ነው ማለትነው.

አይደለም (ውሸት) ማለት በአጠቃላይ መግለጫው ሐሰት ነው፤ እባክዎትን ምንም እንኳን ሙሉለሙሉ እርግጠኛ ባይሆኑም ለእያንዳንዱ ጥያቄ **አዎ** ወይም **አይደለም** ብለው ያሳዩ።

Borderline	
Br1. የምወዳቸው ሰዎች ከእኔ መቼም እንዳይርቁ ለመከላከል እስከ ጽንፍ ድረስ እሄዳለሁ::	0. አይደለም 1. አዎ
Br2. ያለ ምንም በቂ ምክንያት ሰዎችን ወይ ሙሉ ለሙሉ እወዳቸዋለሁ ወይንም ሙሉ ለሙሉ እጠላቸዋለሁ::	0 1
Br3. አብዛኛውን ጊዜ እኔ ማን እንደሆንኩ አሰላስላለሁ::	0 1
Br4. እራሴን ለመጉዳት ወይም ለማጥፋት ሞክሬ አውቃለሁ::	0 1
Br5. እኔ በጣም ተጫዋች ሰው ነኝ::	0 1
Br6. ሕይወቴ የማያዝናና እና ትርጉም የሌለው ይመስለኛል::	0 1
Br7. ቁጣዬን ወይም ንዴቴን መቆጣጠር ይከብደኛል::	0 1
Br8. ውጥረት ሲፈጠርብኝ ነገሮችን መጠራጠር እና "የተፈጠረውን እስከማለማወቅ" ይሆናሉ::	0 1
Br9. ከታች ያሉት ነገሮች በ ስሜታዊ መንፈስ አድርጌ ችግር ውስጥ ገብቼ አዉቃለዉ::	0 1
ሀ. ካለኝ በላይ ብዙ ገንዘብ አባክናለሁ፣ 0 1	ለ. ማላዉቃቸዉ ሰዉ ጋር ግብረ ስጋ ግንኙነት ማድረግ :: 0 1
ሐ. ብዙ አልኮል መጠጣት:: 0 1	መ. አደንዛዥ ዕፅ መውሰድ:: 0 1
ሠ. ያለ መጠን መመገብ:: 0 1	ሰ. ያለ ጥንቃቄ ማሽከርከር:: 0 1
Antisocial	
An1. በተደጋጋሚ ጊዜ ከህግ ጋር የተያያዘ ችግር ውስጥ እገባለሁ (ወይም ተይዜ ቢሆን ኖሮ ችግር ውስጥ ልገባ ይችል ነበር) ::	0 1
An2. በጣም ብዙ አካላዊ ጸብ ውስጥ እገባለሁ::	0 1
An3. ያሉብኝን ክፍያዎችን ለመክፈል እቸገራለሁ፤ ምክንያቱም በአንድ ስራ ላይ ለረጅም ጊዜ አልቆይም::	0 1
An4. ነገሮች የሚያስከትሉትን ውጤቶቹ ብዙ ሳላገናዝብ ብዙ ነገሮችን እፈጽማለሁ::	0 1
An5. መዋሸት በቀላሉ ይመጣልኛል እና እኔም ብዙውን ጊዜ አደርገዋለው::	0 1.

An6. አደጋ ሊያስከትሉ የሚችሉ ነገሮችን ማድረግ ያዝናኑኛል፡፡	0 1
An7. እኔ የፈለኩትን እስካገኘሁ ድረስ የሌሎች መጎዳት አያሳስበኝም ፡፡	0 1
An8. በልጅነቴ (ከ 15 አመቴ በፊት) የሚከተሉ ወጣ ያሉ ባሕሪያት ታይተውብኛል፡፡	
(ሀ) እንደ ጉልበተኛ ተደርጌ እቆጠር ነበር፡፡ 0 1	(ለ) ከሌሎች ልጆች ጋር እደባደብ ነበር፡፡ 0 1
(ሐ) ስደባደብ መሣሪያ እጠቀም ነበር፡፡ 0 1	(መ) ሌሎች ሰዎችን እዘረፍ ወይም እነጥቅ ነበር፡፡ 0 1
(ሠ) በሌሎች ሰዎች ላ ይጨካኝ ነበርኩ፡፡ 0 1	(ረ) በእንስሳት ላይ ጭካኔ የተሞላ ነገር አደርግ ነበር፡፡ 0 1
(ሰ) አንድ ሰው ከእኔ ጋር ግብረ ስጋ ግንኙነት እንዲፈጽም አስገደድኜ አውቃለሁ፡፡ 0 1 (ሸ) ብዙ ጊዜ እዋሽ ነበር፡፡	0 1
(ቀ) ያለ ወላጆቼ ፈቃድ ከቤት ውጭ አመሽ ነበር፡፡ 0 1 (ተ) ነገሮችን ጉዳት በሚያደርስ መልኩ በእሳት አንድጄ አውቃለሁ፡፡	0 1
(ቸ) መስኮቶችን ሰብሬ ወይም ንብረት አወድሜ አውቃለሁ፡፡	0 1
(ኘ) ከ 13 አመት በፊት ብዙ ጌዜ ከትምህርት ቤት መጥፋት (መፎረፍ)ጀምሬ ነበር፡፡	0 1
(ወ) የሰዎች ቤት፣ሕንፃ ወይም መኪና ሰብሬ ገብቼ አውቃለሁ፡፡	0 1
Histrionic	
Hs1. የሰዎች አትኩሮት ማእከል መሆን እፈልጋለዉ፡፡	0 1
Hs2. እኔ ከብዙ ሰዎች ይልቅ "አማላይ" ነኝ፡፡	0 1
Hs3. ስሜቴን በቀላሉ አሳያለሁ፡፡	0 1
Hs4. ገጽታዬን እኔ የሚያስፈልገኝን የሌሎችነ ትኩረት ለመሳብ እጠቀምበታለሁ፡፡	0 1
Hs5. ብዙ ጊዜ መናገር (ማውራት)የማበዛ ሰው ብሆንም ሰዎች ፍሬ ሀሳቤ ግልጽ አነደማይሆንላቸው ይነግሩኛል፡፡	0 1
Hs6. የመተወን (ነገሮችን የማስመሰል) ልዩ ተሰጥኦ አለኝ፡፡	0 1
Hs7. በሌሎች ሰዎች ተጽእኖ ስር በቀላሉ እወድቃለሁ፡፡	0 1
Hs8. እኔ ከሌሎች ጋር ያለኝን ግንኙነት ከነሱ በተለየ ትኩረት እሰጠዋለሁ፡፡	0 1
Narcissistic	
Nr1. ሌሎች ሰዎች ለእኔ ከሚሰጡኝ ግምት በላይ ብዙ ነገሮችን አከናውኛለሁ፣አሳከቻለሁ፡፡	0 1
Nr2. ብዙውን ጊዜ ራሴን እኔ ምን ያህል ታላቅ ሰው እንደሆንኩኝ ፣ወይምወደፊት አንደምሆን፡እያሰብኩ አገኛለሁ፡፡	0 1
Nr3. በጣም የተወሰኑ እና የተመረጡ ሰዎች ብቻ ናቸው አኔን የሚረዱኝ እና የሚገነዘቡኝ፡፡	0 1
Nr4. ሌሎች ሰዎች እኔን በጣም እንዲያስተውሉኝ ወይም እንዲያሞጋግሱኝ እፈልጋለሁ፡፡	0 1
Nr5. ምንም እንኮን በአብዛኛው እኔ ለሌሎች ሰዎች ውለታ ውዬላቸው ባላውቅም እነርሱ ግን ውለታ እንዲውሉልኝ እጠብቃለሁ፡፡	0 1
Nr6. አንዳንድ ሰዎች እኔ በሌሎች ሰዎች ያለ አግባብ የምጠቀም ሰው እንደሆንኩ ያስባሉ፡፡	0 1
Nr7. ሰዎች ብዙ ጊዜ ብስጭታቸውን እንደማላስተዉል ቅሬታ ያቀርባሉ፡፡	0 1
Nr8. አንዳንድ ሰዎች በእኔ ላይ የምቀኝነት ቅናት አለባቸው፡፡	0 1
Nr9. ሌሎች ሰዎች አንድ ቦታ ቆሜ የምቀር (የማልቀየር)አድርገው ያስቡኛል፡፡	0 1

PDQ-4 Clinical Significance Scale

በሽተኛው በተገመገመ ማንኛውም ዓይነት መታወክ ላይ ወይም ከዚያ በላይ ነጥብ ካስመዘገበ ሐኪሙ የበሽታውን ክሊኒካዊ ጠቀሜታ ለመገምገም ይህንን የቃለ መጠይቅ ቅርጸት መጠቀም አለበት።

የሚከተሉት ተዛማጅ ነገሮች ለእርስዎ እውነት እንደሆኑ ዘግበዋል- (ምልክቶቹን ላንድ ብ አንድ ያንብቡ) ።

SSa. እነዚህ ምልክቶች ለምን ያህል ግዜ ነው የእርስዎ ስብዕና አካል የሆኑት?
1. ከአንድ ዓመት በታች ፣ 2. ከአንድ እስከ አምስት ዓመት ፤ 3. አብዛኛው ሕይወትዎ ከ 18 ዓመት በፊት ጀምሮ
SSb።እነዚህ ነገሮች የባህሪዎ አካል ሆነው የቆዩት መቼ መቼ ነዉ?   1. በ ድብርት ጊዜ ብቻ 2. ሲጨነቅ ብቻ 3. አልኮል / አደንዛዥ ዕፅ ሲጠቀሙ ብቻ   4. በአካል ሲታመሙ ብቻ 5. ከላይ ካሉት ማናቸውም ጋር የማይዛመድ (አብዛኛዉ ግዜ)
SSc. እነዚህ ነገሮች በየትኞቹ አካባቢዎች ለእርስዎ ችግር ፈጥረዋል?   1. ቤት ውስጥ 2. በሥራ ላይ 3. በግንኙነቶች ውስጥ 3. ሌላ (ይግለጹ) _____ ወይም
SSd. ከላይ በተጠቀሰው ምክንያት ስለራስዎ ይጨነቃሉ? 0 አይ 1 አዎ

ክፍል-5: የእጽ ተጠቃሚነት መጠይቅ

	የእጽ አይነት መጠይቅ	መልስ
Su1.	በህይወት ዘመንዎ ከዚህ በታች ከተዘረዘሩት ንጥረ ነገሮች ውስጥ ተጠቅመዋል?	0.አይ 1. አዎ
Su2.	ለ ጥ.ቁ.1 አዎ ከሆነ ፣ ምን አይነት ንጥረ ነገሮች? (አንድ እና ከዚያ በላይ ማከበብ ይቻላል)	1.አልኮሆል 2. ጫት 3. ትንባሆ 4. ሌላ____
Su3.	በአሁኑ ጊዜ እና ላለፉት ሶስት ወሮች ማንኛውንም ንጥረ ነገር ተጠቅመዋል?	0.አይ 1.አዎ
Su4.	ለ እጥ.ቁ.3 አዎን ከሆነ ምን አይነት ንጥረ ነገሮችን ይጠቀማሉ?	1.አልኮሆል 2. ጫት 3. ትንባሆ 4.ሌላ____
Su5.	እጽን ምጠቀም የጀመሩበት እድሜ	

ክፍል-6: የማህበራዊ ግንኙነት እና የግል ተሞክሮዎን ይመከታል።

ተ. ቁ	የማህበራዊ ግንኙነት እና የግሌ ተሞክሮዎን ይመለከታል	አማራጭ መልሶች
OS1.	ምን ያህል ሠው አደጋ (ችግር) በሚያጋጥሞት ጊዜ በቅርብ የችግርዎ ተካፊይ ሉሆኑሌዎት ይችላል?	4. ከ 5 በላይ 3. 3-5 2. 1 ወይም 2 1. ምንም
OS2.	ሰዎች እርሰዉ ለሚሰሩ ስራ ምን ያህል ትከረት ይሰጣሉ?	5. ብዙ 4. ጥቂት 3. እርግጠኛ አይደለሁም 2. በጣም ትንሽ ነ. ምንም
OS3.	ከቅርብ ጎረቤትዎ በተጨባጭ እርዲታ የማግኘት እዴለዎ ምን ያህል ነው?	5.በጣም ቀላል 4. ቀላል 3. መጠነኛ 2. ከባድ 1. በጣም ከባድ

ክፍል-7: Level of personality functioning scale form(LPFS.BF)

LP1. ብዙውን ጊዜ እኔ ማን እንደሆንኩ አላውቅም።	1. በጣም ዉሸት	2.ዉሸት	3.እዉነት	4. በጣም እዉነት
LP2. ብዙውን ጊዜ ስለ ራሴ በጣም አሉታዊ አስባለሁ።	1	2	3	4
LP3. ስሜቶቼ ያለ እኔ በእነሱ ላይ መያዝ(ፍላጎት) ይለወጣሉ።	1	2	3	4
LP4.በሕይወቴ ውስጥ የት መሄድ እንደምፈልግ ስሜት የለኝም።	1	2	3	4
LP5 ብዙ ጊዜ የራሴ ሀሳቦች እና ስሜቶች አይገቡኝም።	1	2	3	4
LP6 ብዙውን ጊዜ በራሴ ላይ ከእውነታው የራቁ ጥያቄዎችን አቀርባለሁ።	1	2	3	4
LP7 ብዙ ጊዜ የሌሎችን ሀሳቦች እና ስሜቶች ለመረዳት ይቸግረኛል።	1	2	3	4
LP8 ብዙውን ጊዜ ሌሎች የተለየ አስተያየት ስኖራቸው እሱን መቋቋም በጣም ይከብደኛል።	1	2	3	4
LP9 የእኔ ባህሪ በሌሎች ላይ የተወሰነ ተጽኖ ለምን እንዳለዉ ብዙውን ጊዜ ሙሉ በሙሉ አይገባኝም።	1	2	3	4
LP10. ግንኙነቶቼ እና ጓደኝነቶቼ በጭራሽ ረጅም ዕድሜ የለውም።	1	2	3	4
LP11. ብዙ ጊዜ ግንኙነቶች የበለጠ የግል ስሁኑ ተጋላጭነት ይሰማኛል።	1	2	3	4
LP12. ከሌሎች ጋር እርስ በእርስ አጥጋቢ በሆነ መንገድ መተባበር ብዙ ጊዜ አይሳካልኝም።	1	2	3	4

ክፍል-8: የልጅነት በደል መጠይቆች (Childhood Trauma Questionaire-Short Form (CTQ-SF)

መመሪያ: ከዚህ በታች ያሉት እድሜዎት 18 ዓመት ሳይሞላ ልደርስቦት የሚችሉት ክስተቶች(በደሎች) ዝርዝር ናቸው:: እባክዎን ያጋጠሞትን ክስተት እና ምን ያህል እንደደረሰቦት ይሙሉ::

ኮድ	ለልጅነት በደል/ጉዳት አይነት	ክስተቶት (እድሜዬ 18 አመት ከመሙላቱ በፊት)	በጭራሽ እውነት አይደለም	አልፎ አልፎ	አንዳንድ ጊዜ	ብዙ ጊዜ	በተደጋጋሚ
Ea1	ስሜታዊ በደል	በቤተሰቤ ውስጥ ያሉ ሰዎች እንደ “ሞኝ” ፣ “ሰነፍ” ወይም “አስቀያሚ” በሚባሉ ነገሮች ይጠሩኝ ነበር	1	2	3	4	5
Ea2		ወላጆቼ በጭራሽ ባልወለድ ይመኙ ነበር ብዬ አስብ ነበር	1	2	3	4	5
Ea3		በቤተሰቤ ውስጥ ያሉ ሰዎች መጥፎ ነገር ወይም ስድብ ይናገሩኝ ነበር	1	2	3	4	5
Ea4		በቤተሰቤ ውስጥ የሆነ ሰው እንደሚጠላኝ ይሰማኝ ነበር	1	2	3	4	5
Ea5		ስሜታዊ በደል እንደ ተፈጸመብኝ አምን ነበር	1	2	3	4	5
Pa1	አካላዊ በደል	በቤተሰቤ ውስጥ አንድ ሰው በጣም መቶኝ ዶክተር ማየት ወይም ወደ ሆስፒታል እስከመሄድ ጉዳት ደርሶብኝ ነበር	1	2	3	4	5
Pa2		በቤተሰቤ ውስጥ ያሉ ሰዎች በጣም በጥፊ ይመቱኝ ነበር እናም በእብጠት ወይም ምልክቶች ይታዩብኝ ነበር	1	2	3	4	5
Pa3		እኔ በቀበቶ ፣ ቦርድ ወይም ገመድ ወይም በሌላ ከባድ ነገር ተቀጥቼ ነበር	1	2	3	4	5
Pa4		አካላዊ ጉዳት እንደደረሰብኝ አምን ነበር	1	2	3	4	5
Pa5		እጅግ በጣም በጥፊ ተመትቼ ወይም ተደብድቤ ፣መምህር ፣ ጎረቤት ወይም ዶክተር አይቶኝ ነበር	1	2	3	4	5
Sa1	ወሲባዊ በደል	የሆነ ሰው ወሲባዊ በሆነ መንገድ ሊነካኝ ወይም እኔ እንዲነካው ለማድረግ ሞክሯል	1	2	3	4	5
Sa2		አንድ ሰው ከእነሱ ጋር ፆታዊ ግንኙነት ካልፈፀምኩ ሊጎዳኝ ወይም ስለ እኔ ውሸት እንደሚናገር አስፈራርቶኝ ነበር	1	2	3	4	5
Sa3		የሆነ ሰው ወሲባዊ ነገሮችን እንድሠራ ወይም እንድመለከት ሊያደርገኝ ሞክሮ ነበር	1	2	3	4	5
Sa4		የሆነ ሰው ፆታዊ ጥቃት አድርሶብኛል	1	2	3	4	5
Sa5		ወሲባዊ ጥቃት እንደተፈጸመብኝ አምናለሁ	1	2	3	4	5
En1	ስሜታዊ ቸልተኝነት	እኔ አስፈላጊ ወይም ልዩ እንደሆንኩ እንዲሰማኝ የሚያደርግ በቤተሰቤ ውስጥ የሆነ ሰው ነበር (R)	1	2	3	4	5

En2	(Emotional neglect)	እንደተወደድኩ ይሰማኝ ነበር(R)	1	2	3	4	5
En3		በቤተሰቤ ውስጥ ያሉ ሰዎች ለእርስ በርሳቸዉ ይጠናቀቁ ነበር (R)	1	2	3	4	5
En4		በቤተሰቤ ውስጥ ያሉ ሰዎች እርስ በርስ ይቀራረቡ ነበር (R)	1	2	3	4	5
En5		ቤተሰቦቼ የብርታትና የድጋፍ ምንጭ ነበሩ	1	2	3	4	5
Pn1	አካላዊ ቸልተኝነት	ለመብላት በቂ ምግብ አልነበረኝም	1	2	3	4	5
Pn2		የሚንከባከበኝ እና የሚጠብቀኝ ሰው እንዳለ አውቅ ነበር (R)	1	2	3	4	5
Pn3		ወላጆቼ ቤተሰባችንን እንዳይንከባከቡ በጣም ይሰክሩ ነበር	1	2	3	4	5
Pn4		የቆሸሹ ልብሶችን መልበስ ነበረብኝ	1	2	3	4	5
Pn5		በሚያስፈልግበት ጊዜ ወደ ሐኪም የሚወስደኝ የሆነ ሰው ነበረ (R)	1	2	3	4	5
Md1	የመቀነስ / ውድቅ ማድረግ (Minimization/ denial)	በሕይወቴ ውስጥ ለመቀየር የፈለግኩት ምንም ነገር አልነበረም	1	2	3	4	5
Md2		ፍጹም እና ደስ የሚል ልጅነት ነበረኝ	1	2	3	4	5
Md3		በዓለም ላይ ምርጥ ቤተሰብ ነበረኝ	1	2	3	4	5

መረጃ የ ሰባሰባ ሰዉ ስም_____ ፣ ፍርማ_____

DECLARATION

I, the undersigned, declare that this thesis is my original work, where my work is indebted to the work of others, it has not been accepted or presented for a degree in this or any other university, and that all sources of materials used for the thesis have been fully acknowledged.

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APPROVAL SHEET

The undersigned examining committee certify that the thesis presented by Muzeyen Jemal entitled PREVALENCE OF CLUSTER B PERSONALITY DISORDER AND ASSOCIATED FACTORS AMONG PATIENTS WITH MENTAL ILLNESSES ATTENDING PSYCHIATRIC OUTPATIENT TREATMENT AT JIMMA MEDICAL CENTER, JIMMA, SOUTHWEST ETHIOPIA, 2021,submitted to Jimma University Institute of Health department of Psychiatry in partial fulfilment of the requirement for master degree in integrated clinical and community mental health, compiles with the regulation of university and meet the accepted standards with respect to originality and quality.

Place of submission: Department of Psychiatry Institute of health

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