Journal of Emerging Trends in Educational Research and Policy Studies (JETERAPS) 3(6): 933-940
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jeteraps.scholarlinkresearch.org

Late Childhood and Adolescent Externalizing and Internalizing Psychopathology in Rural Public Secondary and Primary Schools in Western Kenya

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Abstract

This paper addresses the level of externalizing and internalizing behavior problems in students and pupils between ages 11 and 18 years in rural public Secondary and Primary schools. The study design was cross-sectional; using stratified random sampling among students and pupils in the study area. Close and open ended questionnaires were administered to 176 students and pupils in schools. Externalizing and internalizing behavior problems were assessed by ASEBA Youth Self Report 11-18 years. Descriptive and inferential statistics were used to analyze data. Data analysis was computed using SPSS statistical software and to systematically classify data into the syndromes an ADM (Assessment Data Manager) was used. Presentation of the study results was in tables. Study findings showed that there are prevalence of subclinical (27%) and clinical (30.1%) internalizing problems among pupils/students in public primary and secondary school than subclinical (15.6%) and clinical (13.7%) externalizing problems. The study established a higher relationship between internalizing problems and gender. Gilts had higher internalizing problems than boys, while boys had higher externalizing problems than girls. In additional there was high association between internalizing problems with age groups. Age group 15 – 18 years had high internalizing problems. The study is of great benefit to psychologists and Kenyan government in coming up with mental health policies. The study recommended that government, NGOs and other stakeholders should enhance mental health treatment services in rural areas. More counseling should be emphasized in public primary and secondary schools. .

Keywords: psychopathology, externalize, Internalize, late childhood, adolescence, clinical.

INTRODUCTION

Psychopathology is an essential component of maladjustment in later life (Guttmannova et al, 2007). As cited in Previous studies have found long-term associations that exist between childhood externalizing behavior problems and substance abuse (King, Iacono, & McGue, 2004), smoking (Helstrom, Bryan, Hutchison, Riggs, & Blechman, 2004), antisocial out- comes (Lynam, 1996; Moffitt, 1993), underachievement (Hinshaw, 1992), and lower graduation rates from high school (McLeod & Kaiser, 2004). According to Reinherz et al (1993) Childhood internalizing behavior problems are linked to major depression in adolescence, initiation of illegal substance use in early adolescence, and elevated risks of high school dropout (McLeod & Kaiser, 2004). Garvey (2007) has found that children with multiple problems have problems that cluster in at least three general groups namely: -

a) Internalizing behaviors (anxious/depressed, withdrawn/depressed and somatic complaints),
b) Externalizing behaviors, (rule- breaking and aggressive behavior)
c) Low incidence behaviors such as Schizophrenia, a rare disorder in children, although experts agree that the earlier the onset the more severe the disturbance (Newcomer, 1993).

Psychopathology therefore, as referred to in this study, is a description of aggregates of abnormal behavior, experiences, and cognitions that are observed and reported by individuals or proxies. It has been established that childhood and adolescence can ordinarily be turbulent periods. The adolescents in particular have uniquely characteristic challenges. Puberty, for example, is an extremely tough period when significant body changes take place, sexual desires develop and quest for independence strengthens. Peer influence begins to take effect and the adolescents start fighting to fit in with peers. Besides, most adolescents begin to grapple with issues of body weight, get tempted to experiment with drugs and the possibility of teen pregnancy becomes even more real. But getting along with parents is an issue that affects both children and adolescents, although it is usually more difficult during adolescence (Sourander, 2000).

The World Health Organization (WHO) defines ‘adolescents’ as people aged 10-19; ‘youth’ as those aged between 15-24; and ‘young people’ as those aged between 10 and 24 years old (WHO 1989 cited

in Central Bureau Statistics Indonesia 2008). Adolescence is sometimes viewed as a transitional state during which youths begin to become independent from parents, but still lack a clearly defined role in society. It is generally regarded as an emotionally intense and often stressful period. It is therefore a period of physical and psychological development from the onset of puberty to maturity or a transitional period of development between youth and maturity (Steinberg, 1996). While changes are to be biologically, cognitively, emotionally and socially expected during adolescence, certain inappropriate changes in personality, physical appearance, or abnormal sexual development may require psychological support. Such signals may assume many forms such as irregular weight changes, excessive dieting, sleep disturbance and change in social interests among others (Abad, Forns, & Gomez, 2002).

It is known that adolescents face many mental and social problems irrespective of their social setting, but those from well off backgrounds, particularly in urban areas, may not be able to easily access remedies. The contrary applies to their counterparts from poor rural settings, as the guardians may not even recognize or appreciate the enormity of the disorders among adolescents. Research in adolescents' psychopathology has been limited mostly to developed countries where researchers have identified risks and protecting factors. Little has been done to assess adolescent psychopathology in developing countries such as those in Sub Sahara Africa and their rural setting in particular. The future of a country depends on the mental health and strength of young people. However many children and adolescents have mental health problems that interfere with normal development and functioning (Scholte, Janssens & De Bruyn, 2006).

Most of the studies have assessed internalizing and externalizing syndromes of the adolescents from the teachers' perspective. In addition, Laukkanen et al (2002) studied internalizing and externalizing problems without their treatments. However, this paper presents a different approach to the assessment of internalizing and externalizing psychopathology problems by taking a narrowed perspective of the problem from the adolescents' perspective while applying treatments at 3-levels (normal, sub-clinical and clinical). Patterns of psychopathology and their determinants are not known in rural public secondary and primary schools. This research therefore was set to assess and determine adolescent externalizing and internalizing psychopathology in public schools in Bungoma County –Western Kenya.

There were three specific objectives in this study, these are;

a. To identify the prevalence and pattern of psychiatric syndromes in the study population.
b. To find the relationship between psychiatric syndromes and gender.
c. To find the relationship between psychiatric syndromes and age

This study worked from the premise that Child and Adolescent Mental Health (CAMH) is the capacity to achieve and maintain optimal psychological function and well being (World Health Organization, 2005). In this context it is viewed as a resource essential to subjective well being and to the ability to perceive, comprehend and interpret surroundings, adapt or change the surrounding where necessary, to communicate and have successful social interactions (Lehtinen, et al,. 2005). Child and Adolescent Mental ill-health is about inability of the child to optimize competence.

Mental health research in Low and Middle Income Countries (LAMIC) contributes barely 3-6 percent of published mental health research in the world (Patel, et al,. 2001), and research on Coalition Against Major Diseases (CAMD) represents only a small fraction. In these studies, it was established that the evidence base on the burden of child and adolescent mental disorders in LAMIC is relatively small. This very small evidence is due to a number of factors - insufficient skilled human resources, low awareness and low priority.

A Kenyan study showed that, of the 441 students referred to a psychological assessment clinic by primary schools for poor academic performance, learning disabilities and emotional problems were the commonest causes (Dhadphale, et al,. 1984). After the post election violence in Kenya, a study on behavioral and emotional problems among youth from an informal settlement in Nairobi, Kenya, used YSR. The results indicated that girls had significantly higher internalizing (anxious/depressed, withdrawn, and somatic) problem scores than boys. When stratified by sex and compared to multicultural samples from high-scoring societies, Kenyan girls scored significantly higher on all internalizing and social problems while boys scored significantly higher on somatic complaints (Ndetei, Othieno & Kathuku, 1997; Barasa, 2011).

A study on bulling in secondary schools in Nairobi, Kenya, reported that between 63.2% (640) and 81.8% (828) of students reported various types of bullying, both direct and indirect, with significant variations found for sex, age, class and year of study, whether in day or boarding school, and the place where bullied. Being bullied was significantly associated with becoming a bully, in turn. (Ndetei, et al,. 1997).

METHODOLOGY

Study Design

The study adopted cross-sectional design. The study area was Bungoma County - Western Kenya. The study targeted boys and girls aged 11-18 years in rural public secondary and primary schools in the study area. The study used Cochran's sample size formula that addresses both continuous and categorical statistical variables which are the outcome measures in this study. This formula applies key risk factors that the researcher is willing to accept but at 95% confident interval. The study tended to produce quantitative data and qualitative data using a large sample size.

These risk factors include: the error margin which the researcher accepted as an acceptable risk that is within a true margin error, type1 error also called Alpha, a value usually estimated at 0.05 (5%); relative risk called power, a value estimated at 0.8 (80%) which is defined as a statistical measure to detect a statistical significant difference between the test groups, that is the likelihood that the study will detect deviation from the null hypothesis given that there exists a difference between the study groups. Sample size for the study therefore was determined by the Cochran's sample size formula:

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

Where: Z is the standard normal distribution set at 1.96 which corresponds to 95% confidence level, P is the proportion in the population with characteristics (prevalence) under investigation set at 6.1% (Mulatu,1999) and d is the degree of accuracy desired or the error margin set at 5% (0.05). The youth under investigation were seen in rural area in Kenya, where by 6.1% presented with psychopathologies that require interventions. Therefore N will be:

$$\frac{(1.96)^2\ 0.061(1-0.061)}{0.05^2} = 88$$

N=88 (minimum sample per school)

Minimum sample size expected was 176 participants from 2 schools. However, in a given school of one stream per class total population was recruited. In addition, only one stream per class were sampled in Schools with more than one stream. With an assumption that in any given class in Kenya, the expected number of students per class is 40. Therefore, considering the number of students in form 1 to form 4 or in standard 5 to 8, the average number of students per school was 160, giving a total of 320 students who were recruited in the study.

Sampling

A stratified random sampling was used to categorize schools in public primary and public secondary, after which purposive sampling was used to select one day public mixed secondary school and one day public mixed primary school. One stream from standard five to form four was selected, In a school with more than one stream per class, simple random sampling was used to select the stream to be interviewed (yes-no or secret ballot).

Data Collection Tool

The Youth Self Report (YSR) is part of the Achenbach (1991) System of Empirically Based Assessments (ASEBA). It is, empirically-derived, quantitative, and sensitive to sex-differences in self-reported psychopathology. Although first developed and tested among United States (US) populations, the YSR has been translated into over 60 languages with published studies of self-reported youth psychopathology from over 40 societies. Multicultural comparisons of YSR samples from over 20 societies have shown that the factor structure (Ivanova, Achenbach, Rescorla, et al,. 2007) and epidemiology of psychopathology (Rescorla, Achenbach, Ivanova, et al,. 2007) are remarkably consistent across diverse societies from both developed and developing countries.

The ASEBA Youth Self Report (YSR) contains 112 items that assess children's self report of behavioral and emotional problems and positive qualities too. Children are asked to report on their behaviors and feelings over the past six months. Two broad internalizing and externalizing factors are obtained as well as eight more specific subscales. All subscales have been shown to have moderate to good internal consistency as well as high test retest reliability (Achenbach, 1991). The YSR syndrome scales are: Anxious/Depressed, Withdrawn/Depressed, Somatic Complains, Social Problems, Thought Problems, Attention Problems, Rule- Breaking Behavior, Aggressive Behavior and Other Problems

On the appointed day and time, assent form sets were distributed first, the researcher then explained the assent requirements and asked them to sign it. Next questionnaire sets were distributed by the researcher and once every child had a copy, the researcher read out loud the questions one by one as they filled in. Assent sets were written in English except the YSR which were in both English and Kiswahili. The two sets consisted of;

a. Assent explanation form,
b. ASEBA Youth Self Report (11-18 years) questionnaire

Data Analysis Techniques

Data was double entered by two separate people and then compared for inconsistencies and corrected before the final cleaned database was analyzed. Data exploration and statistical analyses was completed using SPSS statistical software and to systematically classify data into the syndromes an ADM (Assessment Data Manager) was used DESC.

Descriptive statistics such, means, frequencies and percentage and inferential statistics such as Chi-Square and Pearson correlation were used to analyze data. The analyzed data was presented using frequency tables.

CONCLUSION AND RECOMMENDATIONS

Data collected was quantitative. Quantitative data was analyzed using descriptive statistics such as mean, mode, median and inferential statistics such as Chi – square (X^2) and Pearson correlation (r). Data is also presented using tables

Response Rate

A total of 320 questionnaires were issued to targeted students out of which 302 were returned giving a response rate of 94%. According to Mugenda and Mugenda (1999) a 50% response rate is adequate, 60% good and above 70% rated very good. This implies that basing on this assertion; the response rate in this case of 94 % is very good. Majority (167) 55% of the respondents were girls, while the rest (135)45% of the respondents were boys. This implies that there was normality in gender distribution between boys and girls in the study.

Table 4.1.1 indicates the response rate by age; from the findings the response rate had a mean of 15.77 with a standard deviation of .717. Majority (57)19% of the respondents were within 15 years of age, followed closely by 16 % of the respondents with age 17. Age 13,16 and 17 were represented by (37)12% each. However, there was normality age distribution among the respondents. The study of analysis reported that there were a significantly higher number of respondents in primary school (132) 60% than in secondary school (88) 40%.

Table 4.1.1 Respondents Age

Age	Frequency	Percentage	Mean	Standard deviation
11	3	1		
12	34	11		
13	37	12		
14	49	16	15.77	2.07
15	57	19		
16	37	12		
17	48	16		
18	37	12		
	302	100		

The Prevalence and Pattern of Psychiatric Syndromes

The current study investigated the percentage and frequencies of internalizing syndromes (Anxious/depressed, Withdraw/Depressed and Somatic/ Problem and among the students and pupils in Bungoma county. Each syndrome was matched with the three treatments levels (Normal, Subclinical and Clinical).

Table 4.1.2 Prevalence of ASEBA internalizing syndromes

Psychopathology	**Normal**		**Subclinical**		**Clinical**		**Total**	
	Freq.	**%**	**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**
Anxious/depressed	135	44.7	78	25.8	89	29.5	302	100
Withdraw/Depressed	145	48.0	64	21.2	93	30.8	302	100
Somatic/ Problems	117	38.7	85	28.1	100	33.1	302	100
Mean	137	45.4	81	27	57	30.1		
Standard deviation	16.11		3.11		20.1	4.11		

Freq. = frequency

The study of analysis indicated that the mean percentage of respondents with clinical ASEB internalizing syndromes was 30.1% with standard deviation 4.11. Further on the research it was revealed that in clinical internalizing problems (100)33.1% of the respondents had somatic/problems, (89)29.5% of them with anxious/depression and (93)30.8% of them with withdraw/ depression.

The mean percentage for those with subclinical internalizing problems that is on (anxious/depression (78)25.8%, withdraw/depression (64)21.2% and somatic/problems. As shown by table 4.1.2 above. To summarize, majority of the students had internalizing problems in the clinical stage.

Table 4.1.3 Prevalence of ASEBA externalizing syndromes

Psychopathology	**Normal**		**Subclinical**		**Clinical**		**Total**	
	Freq.	**%**	**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**
Rule-Breaking Behavior	211	69.9	51	16.9	40	13.2	302	100%
Aggressive behavior	217	71.9	43	14.2	43	14.2	302	100%
Mean	211.4	70.0	47.1	15.6	41.31	13.7		
Standard Deviation	0.891		0.911		1.71			

From Table 4.1.3 it is revealed that on ASEBA externalizing syndromes the mean percentage of respondents with clinical externalizing syndrome was 13.2%. Findings showed that in subclinical and clinical region there was 14.2 % of the pupils with aggressive behaviors each, while (51)16.9% and 40 (13.2%) had rule – breaking behavior respectively. Respondents with subclinical externalizing syndrome had mean percentage of 15.6%. In general results indicated that there was bigger percentage of pupils and students with subclinical and clinical externalizing syndromes

Relationship between Gender (Boys/Girls) and Psychopathology

Table 4.1.4 Relationship between gender (boys/girls) and psychopathology

	Gender	Normal		Subclinical		Clinical		Total	
		Freq.	%	Freq.	%	Freq.	%	No	χ^2 and r
Anxious/ depressed	Boys	89	53.29	35	20.96	43	25.75	167	χ^2 = 7.23*
	Girls	72	53.3	40	29.6	23	17.0	135	r = 0.565*
Withdraw/ Depressed	Boys	83	49.70	21	12.57	63	37.72	167	χ^2 = 32.478*
	Girls	74	54.8	27	20.0	34	25.2	135	r = 0.232*
Somatic/ Problems	Boys	74	44.31	32	19.16	61	36.53	167	χ^2 = 27.091*
	Girls	21	15.6	57	42.2	57	42.2	135	r = 0.210*
Social Problems	Boys	68	40.72	51	30.54	48	28.74	167	χ^2 = 21.331
	Girls	61	39	35	61	39	35	135	r= 0.412*
Thought Problems	Boys	123	73.65	21	12.57	23	13.77	167	χ^2 = 42.10
	Girls	111	82.2	14	10.4	7.4	10.0	135	r = 0.001
Attention Problems	Boys	114	68.26	24	14.37	29	17.37	167	χ^2 =11.88*
	Girls	99	73.3	17	12.6	19	14.1	135	r = 0.339*
Rule–Breaking Behavior	Boys	120	71.86	19	11.38	28	16.77	167	χ^2 = 16.64*
	Girls	114	84.4	12	8.9	9	6.7	135	r = 0.235*
Aggressive behavior	Boys	134	80.24	18	10.78	15	8.98	167	χ^2 = 0.693
	Girls	113	83.7	11	8.1	11	8.1	135	r = 0.007

d.f = 2,
* significant at the 0.05 level

Results obtained from table 4.1.4 indicate most girls (29.6%) had subclinical depression than boys (20.9%), contrary to most boys (25.75) with clinical depression/anxious than girls (17.0). spearman correlations showed that anxious/ depression had positive relationship of 56.5% with gender. There was statistical percentage difference between boys and girls with anxious/depression as evident of chi – square values of 7.23 significant at 0.05 level of significance. Further, clinical withdraw/depressed was found to me more into boys (36.72%) than girls (25.2%), the percentage difference was supported by χ^2 = 32.478 significant at 0.05). there was significant positive correlation between withdraw/depressed and gender (r = 0.232). most girls had subclinical and clinical social problems (35%) than boys (30.54%), the percentage difference between the two groups was not significant, however, social problems was related to gender (r = 0.21). Further analysis reported that thought problems was less found among the students/pupils as only 13.77% and 10% boys and girls respectively had clinical thought problems. More study findings revealed that subclinical and clinical attention problems was more observed in boys (24% and 29%) and than girls (17 and 19%) respectively, the percentage statistical difference was significant (χ^2 =11.88 significant at 0.05). attention problems was reported to have positive relationship (r = 0.339). on the study of analysis rule-breaking behavior was correlated to gender (r = 0.235), while aggressive behaviors was not. Moreover, a higher percentage of boys (11.38% and 16.77%) had subclinical and clinical rule – breaking behaviors respectively than girls (8.9% and 6.7%). Findings indicated that there was few cases of clinical aggressive behaviors among boys (8.98%) and girls (8.1%) .

Table 4.1.5 Relationship between age groups and psychopathology

		Normal		Subclinical		Clinical		Total	X2
	Age Group	Freq.	%	Freq.	%	Freq.	%	No	
Anxious/ depressed	11 – 14yrs	88	64.2	28	20.4	21	15.3	137	χ^2 =0.231
	15 – 18yrs	83	60.6	30	21.9	23	17.5	165	r = 0.026
Withdraw/ Depressed	11 – 14yrs	83	60.6	30	21.9	23	17.5	137	χ^2 = 2.901
	15 – 18yrs	119	72.12	24	14.55	22	13.33	165	r = 0.110
Somatic/ Problems	11 – 14yrs	77	56.2	40	29.2	20	14.6	137	χ^2 = 12.1*
	15 – 18yrs	80	48.48	67	40.61	18	10.91	165	r = 0.22*
Social Problems	11 – 14yrs	58	42.3	61	44.5	18	13.1	137	χ^2 = 1.23
	15 – 18yrs	91	55.15	40	24.24	34	20.61	165	p = 0.958*
Thought Problems	11 – 14yrs	93	67.9	55	40.1	17	12.4	137	χ^2 = 17.3*
	15 – 18yrs	111	67.27	20	12.12	34	20.61	165	r = 0.319*
Attention Problems	11 – 14yrs	103	75.2	17	12.4	17	12.4	137	χ^2 = 24.3*
	15 – 18yrs	81	49.09	61	36.97	23	13.94	165	r = 0.126
Rule–Breaking Behavior	11 – 14yrs	93	67.9	23	16.8	21	15.3	137	χ^2 = 33.3*
	15 – 18yrs	87	52.73	53	32.12	25	15.15	165	r = 0.349
Aggressive behavior	11 – 14yrs	67	48.9	42	30.7	28	20.4	137	χ^2 = 26.4*
	15 – 18yrs	69	41.82	37	22.42	59	35.76	165	r= 0.285

d.f = 2,
* Significant at the 0.05 level

On relationship between age groups, correlation was determined between age groups (11-14yrs) and (15-18 yrs) in all ASEBA total problems through spearman rank correlation. Study findings indicated that age group 15 – 18 years (21.9%) had more subclinical anxious/depression than age group11 – 14 years (20.4%) similar to clinical anxious/depressed which was seen to be higher in age group 15 – 18 years (17.5%) than 11 – 14 years (15.3%), anxious/depressed was not correlated to age group. Subclinical and clinical withdraw/depressed syndromes were higher in age group 11 – 14 years (21.9% and 14.55% respectively) than age group 15 – 18 years (17.5% and 13.33% respectively). However, the relations between withdraw/depressed was not significant. Somatic/problems, social problems and thought problems were associated with age groups as evidence of r values of 0.22, 0.958 and 0.319 respectively).subclinical somatic problems were very high in age group 15 – 18 years (40.61%), while clinical somatic problems was high in age group 11 – 14 years (14.6%), the percentage difference was significant (χ^2 = 12.1 significant 0.05),

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DISCUSSION OF THE FINDINGS

Prevalence of Internalizing and Externalizing Problems

The study findings showed that there was high subclinical (27%) and clinical (30.1%) internalizing problems among the pupil/students, somatic problems was the highest, followed by withdraw/depressed then anxious/depressed. This is supported by association of childhood and adolescent mental study in which John, et al,. (2008) revealed that Anxious/depression syndrome showed the largest mean percentage and TRF (3% ES for ages 6 – 15), and YRS (3% ES for ages 11 – 16). Prevalence of internalizing syndromes among the students was higher among the students than subclinical (15.6%) and clinical (13.7%) externalizing problems in the pupils/students. This result coincides with association of childhood and adolescent mental study in which Weisz (2008) posits that the ESs for difference among societies on the internalizing scale exceeded those of externalizing syndrome. This results varies more with Ndetei, (1997) that scale for Depression and Anxiety, 49.3% had positive scores for moderate to severe anxiety with or without depression. The SCARED-R yielded high levels (50–100%) for the different syndromes, with obsessive-compulsive disorder at 99.3%, just below separation anxiety and school phobia at 100%.

The study results reported Rule–Breaking Behavior, Anxious/depressed, Withdraw/ Depressed, Somatic/ Problems, Social Problems and Attention Problems were associated with gender. Clinical anxious/depressed, withdraw/depressed and rule breaking behavior was high in boys than girls, while somatic/problems and social problems were high in girls than boys was have significantly higher percentage in internalizing problems than boys. Further in the findings, it is revealed that boys needed more attention in rule – breaking behavior where they reported more than girls.

The above findings corresponds with (Rescorla, Achenbach, Ivanova, et al,. 2007) that Girls scored significantly higher than boys on internalizing problems, whereas boys scored significantly higher than girls on Externalizing problems. Gender effects were more consistent across cultures for internalizing than for externalizing.

Somatic/problems, social problems and thought problems had positive correlation with age groups. This implies that students with 11 – 14yrs will increase thought problems after moving to the next age group. Social problems had the highest correlation with age grouped of 95%, this implies high chances of age group 15 – 18 years having high

subclinical and clinical problem. From the results only somatic/problems and Withdraw/ Depressed were high in age group 11 – 14 years than age group 15 – 18 years. In additional, Social Problems, Thought Problems, Attention Problems, Rule–Breaking Behavior and Aggressive behavior were high in age group 15 – 18 years.

CONCLUSION

The study has focused on prevalence and relationship of psychopathology with gender, school level and age group of the study population. From the findings the study concludes that there is a mental health problem in rural public secondary and primary schools in Bungoma County in Western Kenya. Girls had more clinical internalizing ASEBA problems indicating a mental health problem among girls in public secondary and primary schools. Although not as same as girls, prevalence of clinical and subclinical internalizing syndromes was also reported in boys hence concluding that as much attention given to girls, boys should also be considered. From the discussion above it is reported that there an increasingly high number of students with clinical ASEBA total problems, as such, the study recommends mental treatment services and counseling in rural public secondary and primary schools. In addition, girls need more mental treatment services in internalizing ASEBA syndromes, while the alarming statistics in boy's clinical externalizing syndrome especially rule breaking behaviors calls for special attention.

The result above revealed that boys had a high percentage in clinical somatic problems. Therefore the study recommends mental health treatment on the latter. The findings from the study recommend more use of the relationship age groups and psychopathology results by ministry of health in addressing mental health problems in rural areas. More psychologists are needed in primary school where many students are within 11-14 years. To prevent increase of ASEBA total problems as the students grow. Regular check in student's mental health should be enhanced by schools.

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