

need of mental health support. The PHQ-9 and GAD-7 were previously culturally adapted, translated into isiXhosa, and administered to 302 adolescents (10-19 years old, 56.9% female), and three culturally adapted items were asked to assess functional impairment regarding problems that 1) interfere with activities/relationships at home, 2) interfere with activities at school/work, and 3) cause any issues with peers. FX items were dichotomized into at least some impairment (“sometimes” and “often”) and no impairment (“rarely” and “never”). The Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS) was administered by trained clinicians as the gold standard measures for MDD, GAD, and FX. To assess criterion validity against a clinician’s diagnosis, we used total PHQ-9 and GAD-7 scores as well as combined FX and PHQ-9 and GAD-7 scores to construct receiver operating characteristic curves, and calculated the area under the curve (AUC) for each test as well as other psychometric properties.

Results: In the sample, 32.1% and 17.9% of adolescents screened positive for moderate to severe MDD and GAD respectively with the culturally adapted PHQ-9 and GAD-7. Among adolescents, 39.7%, 37.1%, and 29.1% reported at least some impairment at home, school, and among peers respectively. Spearman correlations between the three items (Cronbach’s Alpha = 0.69) ranged from 0.35-0.53, and kappa statistics ranged from 0.18-0.47. For the culturally adapted PHQ-9, the AUC was 0.86 for the full sample. A score of ≥ 10 had 97% sensitivity and 75% specificity for detecting MDD. For the culturally adapted GAD-7, the area under the curve was 0.69, and cutoff scores with an optimal sensitivity-specificity balance were low (≥ 6) and had 76% sensitivity and 69% specificity for detecting GAD. For the combination of the culturally adapted PHQ-9 with the FX questions, the AUC was 0.80 for the sample, and a score of ≥ 10 had 77% sensitivity and 83% specificity for detecting adolescents with MDD. For the combination of the culturally adapted GAD-7 with the FX questions, the AUC was 0.68, and a score ≥ 6 had 70% sensitivity and 76% specificity for detecting adolescents with GAD.

Conclusions: While the culturally adapted FX questions didn’t enhance the assessment of MDD and GAD among adolescents in South Africa, these items still provide an opportunity to measure FX in different settings.

Disclosure of Interest: None Declared

O0014

Psychometric Evaluation of the Computerized Battery for Neuropsychological Evaluation of Children (BENCI) among School Aged Children in the Context of HIV in an Urban Kenyan Setting

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Introduction: Culturally validated neurocognitive measures for children in Low- and Middle-income Countries are important in the timely and correct identification of neurocognitive impairments. Such measures can inform development of interventions for children exposed to additional vulnerabilities like HIV infection. The Battery for Neuropsychological Evaluation of Children (BENCI) is an openly available, computerized neuropsychological battery specifically developed to evaluate neurocognitive impairment.

Objectives: This study adapted the BENCI and evaluated its reliability and validity in Kenya.

Methods: The BENCI was adapted using translation and back-translation from Spanish to English language. The psychometric properties were evaluated in a case-control study of 328 children (aged 6 – 14 years) living with HIV and 260 children not living with HIV in Kenya. We assessed reliability, factor structure, and measurement invariance with respect to HIV. Additionally, we examined convergent validity of the BENCI using tests from the Kilifi Toolkit.

Results: Internal consistencies ($0.49 < \alpha < 0.97$) and test-retest reliabilities ($-.34$ to $.81$) were sufficient-to-good for most of the subtests. Convergent validity was supported by significant correlations between the BENCI’s Verbal memory and Kilifi’s Verbal List Learning ($r = .41$), the BENCI’s Visual memory and Kilifi’s Verbal List Learning ($r = .32$) and the BENCI’s Planning total time test and Kilifi’s Tower Test ($r = -.21$) and the BENCI’s Abstract Reasoning test and Kilifi’s Raven’s Progressive Matrix ($r = .21$). The BENCI subtests highlighted meaningful differences between children living with HIV and those not living with HIV. After some minor adaptations, a confirmatory four-factor model consisting off flexibility, fluency, reasoning and working memory fitted well ($\chi^2 = 135.57$, $DF = 51$, $N = 604$, $p < .001$, $RMSEA = .052$, $CFI = .944$, $TLI = .914$) and was partially scalar invariant between HIV positive and negative groups.

Conclusions: The English version of the BENCI formally translated for use in Kenya can be further adapted and integrated in clinical and research settings as a valid and reliable cognitive test battery.

Disclosure of Interest: None Declared

O0015

Disentangling the multigenerational transmissions of socioeconomic disadvantages and mental health problems by gender and across lineages: Findings from the Stockholm Birth Cohort Multigenerational Study

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Introduction: There is a paucity of research examining the patterning of socioeconomic disadvantages and mental health problems across multiple generations. The significance of research on multigenerational processes is based on a concern with if and how (dis)advantages are generated and sustained across generations, and how socioeconomic, mental health, and gender inequalities evolve over a longer period of time.