M A N U A L

F O R

C - S S A G A

CHILDREN'S SEMI-STRUCTURED ASSESSMENT

FOR THE GENETICS OF ALCOHOLISM

NOV. 1994

B A C K G R O U N D

The child version of the SSAGA is based on the Diagnostic Interview for Children and Adolescents (DICA) first developed by Dr. Barbara Herjanic at Washington University in St. Louis in the late 1960's and early 70's. The DICA was based on the Diagnostic Interview Schedule (DIS) written by Drs. Lee Robins and John Helzer, under contract from the NIMH for the Epidemiological Catchment Area studies. Like the DIS, the DICA was originally designed as a fully structured interview. That is, the questions and probes were designed to be read exactly as written, and the respondent's answer to the question was recorded. For example, one of the questions in the original depression section reads as follows:

"Have you ever felt really down in the dumps, sad, or felt like crying a whole lot more than usual?"

The child's answer to that question was recorded "yes" or "no" without any further probing or explanation on the part of the interviewer.

Testing on the early versions of the DICA showed quite good results. A 1975 study by Herjanic and colleagues compared interviews on 50 children ages 6-16 with interviews administered to their mothers about the children. The agreement between parent and child was highest on questions relating to factual information (84%) and the agreement was lowest in the section dealing with mental status (69%). Girls were more reliable informants than boys.

Another study of this version of the DICA was conducted by Drs. Barbara Herjanic and Wendy Reich. In this second study diagnoses and symptoms were compared from 307 mother-child interviews. This time the comparisons were made using the kappa statistic which corrects for agreement made by chance. The kappa statistic gives a more accurate picture of the amount of agreement on positive symptoms than does percent agreement.

Analysis of these data showed that children and parents agreed moderately on the presence or absence of diagnoses, with the agreements being for antisocial personality, conduct disorder, enuresis, mixed behavior-neurotic disorder and possible depression. Comparison of agreement on 168 individual symptoms showed that highest agreement was found on questions concerning symptoms that were concrete, observable, severe and unambiguous. The data also showed that mothers tended to report significantly more behavioral symptoms (e.g. attention deficit-hyperactivity disorder), while the children reported significantly more subjective ones (e.g., depression and anxiety).

These data suggest that parents and children can be considered as different and important

sources of information on the children of interest, and they point to the need to interview both parents and children in order to obtain a complete picture of the range of psychopathology in any given child.

While some of the parent/child disagreement in this study was due to the fact that parents and children reported different kinds of information, the authors hypothesized that another source of disagreement might lie with the interview's ambiguously worded questions which did not always clearly highlight the symptoms they were trying to elicit. Additionally, since the study had shown that parent-child concordance was highest on concrete, observable, and severe questions, (as well as those which were the least ambiguous), the authors also hypothesized that a rewriting of the interview which would emphasize phrasing the questions in a concrete and unambiguous fashion and keying the questions to precise DSM-III criteria would remove sources of disagreement that were due to parents or children simply misunderstanding the questions.

With these goals in mind, the interview was rewritten by Drs. Herjanic and Reich, and reliability and validity tests were conducted on it (Welner, Reich et. al. 1987). Parent/child agreement improved considerably from the previous version. Inter-rater and test-retest reliability were good as was the results of a study comparing the results of the interview and a diagnosis by a psychiatrist.

The DICA was revised once again in 1987 by Drs. Reich and Welner to meet the criteria of the newly published DSM-III-R.

This version, known as the DICA-R, is less structured than previous versions of the DICA. It includes more probes and gives the interviewers some latitude to rephrase questions if they need to clarify them for a child or parent Dr. Reich, along with the computer firm Multi-Health Systems in Toronto, Canada, has developed a computerized version of the DICA-R. The computerized DICA-R is available through Multi-Health Systems.

The COGA version of the DICA, the CHILD-SSAGA (C-SSAGA), represents the latest version of the DICA and includes revisions from the child assessment experts at each of the COGA sites.

The C-SSAGA also contains selected questions from the Home Environment Interview for Children (HEIC), an interview schedule for children 6-17 and their parents, developed by Drs. Wendy Reich and Felton Earls. The HEIC was based on the Home Environment Interview designed by Dr. Lee Robins to be given to adults retrospectively about their childhood environment. The questions from the HEIC that have been integrated into the C-SSAGA include items about how the child gets along with his parents and with his friends, how he behaves at school, what his grades are like, and whether or not he is involved in sports or other extra- curricular activities. Questions also probe for information about life events and the child's home life, for example, whether or not there is much quarreling or fighting in the family, whether the parents are abrasive or neglectful, and whether they provide good role models for their children.

A special section of the HEIC was developed and used in two other alcohol studies at Washington University. This section, known as the Structured Assessment Record of Alcoholic Homes (SARAH), asks questions about the child's exposure to parental alcoholism and behavior resulting from that alcoholism. In the two previous studies, scales derived from this section discriminated very well between sick and well children of alcoholic parents (Reich et. al. 1988).

The format of the C-SSAGA has been changed to that of a semi-structured schedule to match the interviewing style of the adult SSAGA.

As with the SSAGA, questions and probes are provided, but the interviewers must be trained so that they will be able to clarify particular questions and assess symptoms accurately. Some of the C-SSAGA questions have the DSM-III-R criteria listed below them in order to remind the interviewer of the exact nature of the symptom and assist the editor as a reference.

SPECIFICATIONS

OVERVIEW

The Children's version of the Semi-Structured Assessment Instrument for the Genetics of Alcoholism (C-SSAGA) is an interview designed to assess psychiatric problems and the home and social environments of children ages 6-17. The C-SSAGA is a semi-structured instrument based on the Diagnostic Interview for Children and Adolescents (DICA) and the Home Environment Interview for Children (HEIC).

The interview is designed to make a lifetime assessment of the following diagnoses based on DSM-III-R criteria.

Attention Deficit-Hyperactivity Disorder
Oppositional Defiant Disorder
Conduct Disorder
Alcohol Abuse and Dependence
Tobacco Use
Marijuana Abuse and Dependence
Drug Abuse and Dependence
Major Affective Disorder
Separation Anxiety
Overanxious Disorder
Obsessive Compulsive Disorder
Anorexia Nervosa
Bulimia
Somatization
Presence of Psychotic Symptoms
Suicidal Behavior*

In addition to the above diagnoses, the C-SSAGA provides current information on the following aspects of the child's home and social environments.

Extended Family
Parent's Time Spent With Child
Discipline
Adults as Role Models
Family Rules
Peer Relations
Sibling Network
School and Other Activities Outside the Home

*This section is based on DSM-III-R symptomatology and used to detail any suicidal ideation reported in the depression section or screen for any suicidal behavior in those who skipped out of the section on depression.

The interview also contains a special section called the Structured Assessment Record of Alcoholic Homes (SARAH). The SARAH inquires in detail about the child's relationships with alcoholic (and drug abusing) parents, and the child's perception of the possible impact of parental alcoholism or drug abuse on the child.

INTERVIEW FORMAT

Labels

At the left hand margin are labels denoting which DSM-II-R criterion the question represents. From left to right is the abbreviation for the disorder (ADHD), the diagnostic system (3R), and the DSM-III-R criterion number (A1).

Criterion

Beneath the questions that identify criteria of DSM-III-R diagnoses the literal criterion is printed in bold italicized uppercase letters enclosed in brackets.

Questions

Questions are numbered, lettered, and placed in the center of the page.

Coding Spaces

Responses are coded in the right hand margin.

Examples

Written examples are given for some questions. These examples are clearly labeled as such and contained in parentheses.

Skip Instructions

Some skip instructions are written in parentheses next to the coding variables where needed.

READ THESE INSTRUCTIONS CAREFULLY to avoid skipping questions that should have been asked. This will guard against losing important data or having to recoup missing data due to interviewer error. In addition, careful attention to these instructions minimizes the time it takes to administer the interview, ensuring that unnecessary questions are not asked. Even after you become familiar with the interview, remain attentive to the skip instruction; they will assure that you make "the right move".

Some skips are designed to allow interviewers to move out of a section if the answer to the first question (or couple of questions) is "NO". This assumes that the rest of the questions would be answered "NO", if they were asked. The rationale is that the initial questions reflect the more commonly manifested symptoms, and if they are answered "NO" it is highly unlikely that a significant number of responses to the subsequent questions would be positive.

"OTHERS" refers to any answer or combination of answers different from the exception given in the previous line of the instruction. For example, in D10C "OTHERS refer to answers coded 5, or 9.

Interviewer Instructions

READ THESE CAREFULLY. Special instructions for the interviewer are located throughout the interview. They are enclosed in boxes with shading and in all uppercase lettering.

These instructions must be read and followed completely before going on to the next step in the interview. Some contain special coding information, review information, or in some instances, an alert to ask the respondent a question in a special way. As a general rule the information in these instruction boxes is not to be read to the respondent. Only in directed situations will the interviewer repeat aloud what is written in these boxes.

PROBES

Probes are additional information that should help the respondent understand the question better and thereby give an answer that the interviewer can clearly code. There are two types of probes found in the interview; standard probes and individual probes.

STANDARD PROBES

These are located in a box at the beginning of the Attention Deficit-Hyperactivity Disorder, Oppositional Disorder, and Major Affective Disorder sections. They are designed to be used with any question in that section that gets a positive or "YES" response.

These probes help confirm as well as establish the severity of the symptom. Remember, only use these standard probes if the respondent's initial answer to a question is "YES". If their answer is "NO" simply go on to the next question without probing.

INDIVIDUAL PROBES

These are contained in parentheses following many of the questions in the interview. These individual probes are printed in all (UPPERCASE LETTERS). They are designed to be used only for clarifying the question which it follows and is read by the interviewer to the respondent. They give common examples or suggestions as to what the question is asking about. There could be plenty of other circumstances that apply specifically to the respondent that are not mentioned. It might be helpful to let them know that you are giving them ideas about the kind of situation the question is asking about.

CODING

Coding options are located at the far righthand margin. The numerical values are written opposite the acceptable verbal responses.

NO=1 and YES=5. These are the standard codes used for most of the instrument. However, there are groups of variables where a "1" or "5" may mean something else. Interviewers should pay careful attention throughout the interview to circle the numerical value that corresponds to the given response. In the Obsessive Compulsive, Anorexia, Bulimia, Somatization, Psychotic Symptoms, and Suicidal Behavior sections a 2, 3, or 4 code is available to reflect behavior that is below criteria or influenced by drugs, alcohol, illness, or injury. There are also some special coding values available for use in special circumstances (see Onset Questions p.12 and Special Codes p.14)

The interviewer should put forth every effort to get a definitive response from the respondent. Try and differentiate between an answer of "I don't know" meaning they really don't have any knowledge of the information and using "I don't know" as a convention to get through the interview without giving any real thought to the answer. When a respondent consistently replies "sometimes" find out if the symptom is indeed happening some of the time as opposed to only once or twice or conversely more often than not.

Be mindful not to bully the respondent into giving a "yes" or "no" response. Nor do you want to create the impression that you don't believe them. Reassure them that everyone gets asked the same questions, that their contribution to the project is extremely important, and everyone is encouraged to answer as truthfully as possible.

HOW TO CODE RESPONSES

To the right of each question is a space for coding the answer the respondent gives.
In questions where a quantitative value is sought that particular number is coded.

e.g.

I: How old are you? _ /_ YEARS

R: "I'm thirteen."

Code: 1 / 3

If there are more coding spaces provided than there are digits in the answer given the number should be coded as follows.

e.g.

six = 0 6 or 16 = 0 1 6

Independent Coding Variables

Some questions have independent coding options. This list of options is found directly beneath the question. Each variable has its own corresponding coding value. The respondent may choose a response from this list of variables and the interviewer will then code the corresponding value.

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Onset/Recency Questions

For questions that ask the age of onset for a symptom, if the respondent can't decide between two ages even after probing code the youngest age given.

e.g.

I: How old were you the first time you skipped school?

R: "Eleven or twelve"

Code: 1 /1

If the respondent says that they have "always" had a symptom or "for as long as they can remember" the interviewer should code 0 3. This is indicated where applicable in the interview.

For questions that ask the recency of a symptom that happened over a year ago, if the respondent can't decide between two ages even after probing code the oldest age.

e.g.

I: How old were you the last time you skipped school?

R: "Fifteen or sixteen."

Code: 1 / 6 YEARS

For both onset and recency questions, if the subject gives a range of ages, even after probing, choose a middle value.

e.g.

I: How old were you the last time you skipped school?

R: Somewhere between twelve and fourteen.

Code: 1 / 3

Don't Know / N/A

If a respondent truly does not know an answer to a question code 9, -9, -09, etc. for the corresponding number of spaces. If a question is not applicable to a person or given situation. use the same codes and write N/A in he margin. Nines will also be used for missing data.

Questionable Responses

In situations where the interviewer believes a response is incorrect (i.e. the child states that he is not living with his biological father because his parents are divorced; however, the interviewer knows that the child' parents were never married) the interviewer should not override subject reports with information obtained from previous knowledge. An exception is made in the case of recording the respondent's birthdate since some diagnoses are dependent on the age of onset.

Clustering

WHAT IS A CLUSTER?
Although DSM-III-R is very specific in the number of symptoms needed over a given period of time to make a diagnosis, it is not specific in its definition of clustering. The assumption is that each of the reported symptoms occurred simultaneously over the defined time period. However, for the C-SSAGA clustering is defined in the following way: "A cluster is any group of symptoms that occur over a designated time period but not necessarily concurrently." So for example, if a respondent reported several positive symptoms over a given period of time all of

the symptoms need not occur on a given day or even in a given week. It is more likely that they will start out with one or two symptoms and continue to develop others over a period of time. This is considered clustering. If in fact the respondent describes having only a few symptoms at isolated times then they will not have clustered.

Duration

Duration in most instances is more clearly stated in DSM-III-R. However, the children may not be as good at reporting this component of the diagnosis. Therefore somewhat flexible rules may be applied in instances where the child's recollection of the period of duration is a few months shy of the DSM-III-R standard.

Special Codes

There are some special codes that are applicable in places throughout the interview. Careful note should be made of these particular circumstances. These codes refer to quantitative values and are found in boxes following the question.

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This means that if the respondent's answer is 98 days or more the proper code is "98".

Refusal to Answer

Respondents have every right to refuse to answer a question. If this happens do not leave the coding space blank. Write in "RF". This will indicate that the information is not missing due to interviewer error.

Unsure

Anytime the interviewer is not sure of what to code s/he should write clear and detailed notes written in the left hand margin. The editor will then be able to make a decision about proper coding for those blank spaces.

HEIC Sections

The Home Environment sections of the C-SSAGA uses the 1, 5, 9 coding sequence. However, in this part of the C-SSAGA there are three coding spaces to reflect the mother's, father's, and a significant other's interaction with the child. One, two, or all three of these spaces could be coded with either the same response or a mixture of possible coding options. For example, Mother might spend more time with the child as most parents (code 1), dad might spend the same amount of time with the child as most parents (code 2), while aunt Jenny (other) spends

less time with the child than most parents do (code 3). Or, mom, dad, and aunt Jenny might all spend about the same amount of time as most parents with the child (code 2 for all three).

INTERVIEWING CHILDREN AND ADOLESCENTS

As with the administration of any instrument it is important to develop a comfortable rapport between the respondent and the interviewer. The level of ease and trust with which the respondent feels s/he can communicate personal information is paramount to a successful interview. Children and adolescents are no different than adults in that respect. Accept their reports without being judgmental. Do not reprimand behaviors even if they are clearly unacceptable based on societal norms. Likewise, do not go overboard with praise for positive behaviors thinking it will make them trust you more. They may in fact at times try to please you by withholding negative information. Focus on getting a response that clearly either does or does not meet the criterion. Be sensitive to their youth and not afraid of it. As an interviewer, it is ok to be firm in communicating your needs for responsiveness and cooperation. Use language and examples that they can relate to and understand. Remember that their sphere of activity primarily consists of home and school and that behaviors and feelings will probably be reflected in one or both areas. Use a moderate tone of voice that is respectful of their age, intelligence, and circumstance. Avoid the sing -song approach at all cost. Projecting a balanced sense of empathy is an extremely important interviewing tool.

A: DEMOGRAPHICS

If time is of concern, this section can be done over the phone before the actual interview date. If this option is exercised, the introductory statement should be read again at the personal interview to remind the respondent of what is about to happen and to ensure them of confidentiality.

During the interview, if the child (the younger children especially) is having difficulty in answering any of the demographic questions, don't spend too much time on them. Continue on, and the parent's report can be used to fill in the needed information.

A2. If the information is being asked over the phone ask, "What racial or ethnic group do you belong to?" This may also be asked during a personal interview if there is a question in the interviewers mind about the race/ethnicity of the child. Otherwise, record the information as observed.

A4. Quickly check the age given (A3) against the birth date given and the current date. Make sure the child's current age is recorded and the age he will be on his next birthday.

A5A: If the respondent is not currently attending school because of illness or the school is closed for some reason (i.e. natural disaster, vacation, etc.) s/he is still enrolled in school and this item should be coded "YES".

A5B: If at the end of a school year a respondent states that they are planning to drop out (not go back next school year) this question should be coded "NO" since the intent has no yet been carried out.

A6-7. Include the respondent as a household member (i.e. "self" or "respondent").
In some households it is difficult to figure out exactly who is living there and who isn't. Try to figure out who has been living in the house on a permanent basis during the past year. This includes friends, relatives, boarders, etc. Don't count relatives who come to visit, or friends of the parents who move in and out. If there are people who come and go, like visiting cousins or grandmother who is recuperating from an illness, note this in the margin. Siblings who are away at college should be recorded in A8. Record ages if the child can give them easily. Ages of children less than one year of age should be coded as -1. Some children won't know how old their parents are, so don't press them. Remember we will also get this information from the parent interview.

In cases of joint custody note the primary household, or note that there are two households, if the custody really is "joint" or equal.

A8. Include all biological siblings. Also include all step and half siblings with whom the child has lived for a year or longer. Even if the child visits these siblings regularly but has never actually lived with them on and on going basis for at least a year they should not be included here. Also record here any siblings who are away at college.

A9A&A11A. Use information provided in A7. We don't want to confront the children about whether the father that they have named is their natural father but rather confirm it in a non threatening way. Presumably the parents will give us accurate information if there is any discrepancy.

A9B&A11B. If the child does not know why his/her parent is not living with them code "OTHER" and record DK.

A10B&A12B: If the child's frequency of visitation with the parent has changed within the past year, code the most usual occurrence over the past few years.
A10B&A11B. If a child sees their parent only during the summer or school holidays, code "HOLIDAYS ONLY" and record the number of days s/he sees them.

A13. Include things like head trauma, seizure, acute asthma, broken bones, and surgery. Exclude measles, ear infections, tonsillitis, flu, and other common childhood illnesses unless they are of a serious or chronic nature (i.e. child has many ear infections, recurrent bout of tonsillitis, etc.). Having problems with ones eyes should go beyond simply needing glasses. Needing eye surgery or having to wear patches for an astigmatism or crossed eyes count as having eye problems. Some clinical judgement may be used here to determine whether some common illnesses are serious enough to warrant a yes code.

A14. Be sure to ask and note the name of the hospital at which treatment was given.

A15A. Code only prescribed medicines. Do not count over-the-counter medication. If the child knows why the medication was taken record that, too. Don't spend too much time on these questions, because we will be getting a medical history from the parents. The information here will be mostly for the interviewer to find out some things about the child that may be useful during the interview. For example, one could ask: "Did that happen about the time you were in the hospital with your asthma attack?" Or, "Did that trouble breathing happen only when you were having one of your asthma attacks?"

Don't forget, however, that kids do report illnesses and medicine taken that their parents may have forgotten. So, the kids are also a real source of information.

A16: When the respondent's problems are intrusive enough, help may be sought by the respondent, parents, or the school. The emotional help that the respondent receives should be of a professional nature and not just with a friend or family member. Advisors to the respondent include people like school counselors, clergy, social workers, psychiatrists, psychologists, teachers, and coaches.

B: SCHOOL AND OTHER ACTIVITIES OUTSIDE THE HOME

This section gives a broad picture of the child's academic record along with an indication of how involved they are with things outside of school. These can act as very accurate indicators of significant changes that might have occurred in their life.

B1: Be sure to read the answer options to the respondent. Since letter grading has different standards in different schools the question asks only for a comparison of work accomplishment in relation to the rest of the class. Don't assume that if the response is, "I get all A's" or "I'm in a gifted class", that his/her grades are better than most of the class. You should then follow up by asking, "Is that better than most of the class or the same....." Any specific information that might lend some insight into special academic circumstances should be noted in the margins. If the respondent has dropped out of school, ask about what grades were like in the last year of school attendance.

B2-B4: This group of questions seeks more detailed information about any changes in academic performance. Do not count one exceptionally good or bad mark on a report card. It is the overall achievement that is important here. Note both positive and negative influences.

B3&B4: Grades could conceivably be both highest and lowest in the same grade under the circumstance of being held back. If more than one grade of equally high marks is coded, they may be recorded in either ascending or descending order.

B4. If a child was held back a grade and his/her grades were equally lowest for both years, code that grade twice.

B5A: Code "NO" and record the reason that the child was held back if the reason was other than poor academic performance. Sometimes when children are transferred to a different school they will be held back a grade because of varying standards in the schools. Or their birthday may fall late in the year causing them to be held back because of their age. Also physical illness may be a factor in their being held back. If a child is held back a grade for any reason other than poor academic performance do not count as failing the grade.

B7: High academic achievement programs come under many different titles. The interviewer is free to use any reference that might be more meaningful in their locale. Do not code positively in the event that s/he is anticipating being placed in a special program in the future.

B8A: Any athletic participation (leisure or competitive) is acceptable for this question.

B: Count organized team sports only. We are interested in finding out if organized activities such as sports act as protective factors. If the child has played on the team of an out-of-season sport that year, credit should be given for being "on a team now".

D: The number if hours should reflect those spent on organized team sports during the

current academic year only.

B9A: All other types of organized after school activities should be recorded here. They do not have to be school affiliated. Organized community programs are also acceptable. Also inquire about time spent on performances and practices. If the only time spent is in the classroom, like for band, then code "NO".

B10: The work done should be work for pay. This does not include allowance earned for doing household chores. That is unless of course work is done above and beyond what is expected as regular chores and done on a regular basis for pay.

B11: Any wholesome kind of hobby or personal interest of the child should be recorded here. This includes things like stamp collecting, playing electronic games, Dungeons and Dragons (D&D), and reading.(even if only magazines or comics) Many young people enjoy going to the mall and hanging out with their friends. This too may be considered a wholesome activity. However, a response of "watching TV" only, is not sufficient for use of spare time and therefore is coded "1".

B13: Only code "YES" when the respondent is shifted into an unfamiliar situation or is with a person seen only in this circumstance or is placed into a makeshift environment. For example, some one other than a parents is given the responsibility for care of the child or the child leaves home to be cared for. If, for example, the child was being cared for in their own home by a relative who normally lives there the question should be coded "NO". If mom has a designated routine arrangement (paid or otherwise) with grandmother code the question "YES".

B14A: Any achievement, other than winning games of chance, for which the child may have received some recognition should be coded for here. It could be anything from a perfect attendance certificate to a national merit scholarship. We are also interested in how they perceive their accomplishment.

C: ATTENTION DEFICIT - HYPERACTIVITY DISORDER

DSM III-R delineates the changes in behavior expected in a child with ADHD as he ages. In younger children, the most prominent features are generally signs of gross motor overactivity, such as excessive running or climbing. Inattention and impulsiveness are likely to be shown by frequent shifting from one activity to another. In older children and adolescents, the most prominent features tend to be excessive fighting and restlessness rather than gross motor overactivity. Inattention and impulsiveness may hinder finishing tasks or following instructions, or may contribute to the production of careless or sloppy work. In adolescents, impulsiveness is often displayed in social activities, such as doing something fun on the spur of the moment instead of fulfilling a previous obligation (joy riding instead of doing homework).

These characteristics often make it difficult to establish and maintain friendships and other relationships. Teachers who see many children across equal age levels are often good sources of input into the severity of the problem. While the child may not have adequate insight, concrete examples are given that include questions about behaviors that other people (teachers, parents, adults) may have complained about.

Low stimulation environments, like classrooms, tend to be the most problematic for ADHD children, However, children with behavioral disorders may act very differently in novel situations, or in one-to-one interviews. In fact it may be easier for a child with ADHD to cooperate in a one on one interview because all of the attention is directed at them and there is one person to help keep them focused. By the same token, a child can sit perfectly still and remain attentive during an interview and still be very much attention deficit. This is referred to as "situation specificity". Be sure to note behaviors that seem relevant during the interview, especially if they differ from information the child is giving. The questions have been written to ask about the lifetime of the child because they may currently be on Ritalin or some other medication and not having any symptoms, or they might be outgrowing them.

This section can be difficult to ask for a number of reasons. Many children have difficulty with insight into their own behavior. Hyperactive children may underreport their disruptive behaviors. Conversely, normal range children who are trying very hard to do a good job on the interview, will search their memories for an instance when they were misbehaving. In order to deal with both problems, the interviewer must be sure to emphasize words like "often' and "a lot" when asking the questions. The examples and proper probing must be used to find out whether or not the behavior is really a "symptom".

Because the section can be difficult, the clinical skills of the interviewer will be depended upon to a large extent. Every effort should be put forth to decide whether or not the child's behavior reaches criteria levels

HOW TO ASK ADHD QUESTIONS

When asking this section first read the question asking about any occurrence of the symptom in the child's lifetime. If the child answers "NO", code "1" and move on to the next question. If the child firmly answers "YES", use the standard probe, "Did/Does this happen a lot?" If the response is still yes, code "5" in the lifetime column and ask, "Is it still happening now?" The current behavior is not queried with the standard probe. It does not have to happen

a lot. This answer is coded in the Now column.

Examples following the questions may be used in circumstances when the respondent needs more clarification to help them answer.

C1: The interviewer can demonstrate fidgeting and squirming.

C2: In order for this symptom to be present, the child should indicate an inability to stay seated. Examples might be that s/he gets up and walks around the classroom, or that it is difficult for the child to stay seated while eating or watching television. The difference between this question and item C1 is that in item C1 the child is in her/his seat but restless and moving around, while here s/he is in and out of the seat.

C3: Everyone gets distracted at times. This item requires that the child is EASILY and ALWAYS distracted and by ANY LITTLE THING. The criterion states "extraneous" stimuli e.g. routine movement or discussion in the classroom as opposed to truly startling noises that would momentarily distract anyone.

C4: Children with this symptom typically have difficulty waiting in line, but they also have trouble waiting their turn when playing games, sports, or any group activity where turns are taken.

C5: While young children may interrupt conversations, this item requires that the child often blurts out or generally BURSTS in before questions are finished. (If this behavior occurs frequently during the interview it is worth noting.) Notice how similar item C11 is, which asks if the child often interrupts or intrudes on others.

C6: This item is meant to determine whether the child has difficulty following through on instructions. It does not apply if the child lacks comprehension of instructions or refuses to follow directions due to oppositional behavior. Rather, this is a child who fails to follow through on assignments simply because he lacks the attention or concentration required. He literally "forgets" key elements of instruction. For example, when told to pick up his clothes in the bathroom and bedroom to put in the hamper, he only does the clothes in the bathroom because his short attention span doesn't allow him to take it all in.

C7: A) This part of the item asks about daydreaming or difficulty holding attention while doing tasks, such as schoolwork or homework. If the child describes being distracted easily, this should be coded in item C3. Item C7 is similar, but in this case attention is frequently lost without apparent extraneous stimuli interfering.

B) This part of the item asks about attentional difficulty in play activities. Simply shifting from one uncompleted activity to another is a separate criterion.

C8: Many people do not finish things. This item is looking for a consistent behavior pattern of shifting from one uncompleted activity to another. Often a child will start a game or puzzle

then leave it unfinished (and undoubtedly lying around the room) and begin coloring a picture, which is shortly thereafter abandoned for Legos, etc. Keep in mind that the previous question refers to a short attention span while here the focus is on leaving things unfinished.

C9: Many children are noisy at times, especially when playing with other children. But children with this symptom have a real problem doing anything quietly, and if they are quiet it is not likely to be that way for very long. If the child is able to play quietly without too much difficulty or if they are usually active but have things they enjoy doing quietly then they do not have the symptom. A useful probe might be: "If a grown-up tells you to quiet down, do you, or can you?"

C10: Many children will say that their parents called them chatterboxes when they were little. The child described here is one that talked so much that others found it annoying. Its best to stress key words such as, "Did people tell you that you talked **ALL THE TIME** or that you **NEVER** stopped talking?", to determine that talking was excessive.

C11: Notice the similarity between this item and item C5. Item C5 asks if the child will often blurt out an answer to question before it is finished. This item asks if the child often interrupts or intrudes on others. In a situation where a group of children might be playing together this child would charge over and barge in on the activities even when it is clear that he isn't wanted. The child may also repeatedly intrude on the conversations of other people. These interruptions should occur frequently and be inappropriate and often aggravating to others.

C12: Parents or especially teachers may comment to validate that the child often does not seem to listen.

C13: This item asks if the child often loses things necessary for tasks or activities at school or home. Common examples of this behavior include losing homework and losing important letters from the school to give to the parents.

C14: This item asks if the child would frequently and impulsively engage in dangerous activities. Deliberate thrill seeking does not qualify. The intent of this item is that the child acts and puts him/herself into dangerous situations without any thought as to the possible consequences of such actions.

C15: Try to work with the child to determine the age of onset for the items identified as positive. DSM-III-R criteria requires an age onset before age seven. For this reason it is good to ask if any of the problems were occurring in early elementary school, specifically kindergarten or first grade. Another method is to ask if the child can remember which teachers commented on behaviors and determine the grade from this information. If an older age of onset is given, it is possible or likely that the child is having problems, but should not be diagnosed as having ADHD. One suggested way of probing is to ask if the behavior occurred before the 2nd grade, and then to ask if it occurred before the age of 7 years.

C15D-E: DSM-III-R also requires a duration of at least six months during which at least eight symptoms were present. This clustering may be difficult for younger children to understand. If it is clear from the onset and recency codes and/or any discussion that has already taken place, the interviewer may code these questions without asking. Otherwise, you will need to work with the child to establish clustering and duration. Don't worry about getting ALL the symptoms to cluster simultaneously. DSM-III-R specifies that the eight symptoms occur within the same six month period. It is conceivable, particularly with adolescents, that some symptoms will happen one year and then stop and then different ones will start up particularly if they are really symptoms of a depressed episode, hypo-manic episode, or some other disorder. Usually ADHD symptoms will cluster in small children. Get a ball park idea. Each of the reported positive symptoms do not have to occur at the same time over the course of six months. The symptoms might manifest themselves sequentially over the course of the six months, and it is unlikely that they won't cluster or that they will cluster in different groups.

If the child gives the onset as kindergarten, is in the 2nd grade, and reports the behaviors as happening currently, then you can assume that the symptoms have lasted for six months or longer.

C16-17: While this information will be asked also of a parent, it is good to ask the child about any treatment or medication that he may have received for these problems. Specific information on any drugs prescribed and when they were taken can be useful when later considering drug side effects and symptom overlap with disorders.

D: OPPOSITIONAL DISORDER

The essential feature of this disorder is negative, hostile, and defiant behavior without the more serious violations of the basic rights of others that are seen in Conduct Disorder. Children with this disorder commonly are angry, resentful, easily annoyed by others, argumentative, and defiant. They deliberately annoy other people and often blame others for their own mistakes. Most ODD children are not aware that they are oppositional or defiant, but justify their behavior as an appropriate response to unreasonable circumstances.

Oppositional defiant disorder is only to be diagnosed if the behaviors occur considerably more frequently than for other people of the same mental age. Symptoms should also be pervasive enough to impair functioning at home and school and with other adults and peers.

Any adolescent worth his or her salt is somewhat oppositional. Therefore, it can be very easy to over diagnose in this section. Always being annoyed with only a brother or sister may indicate a strong sense of irritability, but is not a strong case for being oppositional. Sibling rivalry is looked upon as normal conflict and therefore not considered symptomatic of the disorder. So if the respondent is just having problems with a brother or sister they should not be credited with the symptom. However, if everyone else is getting on his nerves all of the time then candidacy for being truly oppositional becomes substantiated.

HOW TO ASK OPPOSITIONAL DISORDER QUESTIONS

If the answer to the question is No, code "1" and move on the next question.

If after asking the initial question the respondent is not sure how to answer the question use the examples given. This should help clarify the intent of the question.

When asking ODD questions, if a YES response is given, generally the interviewer will probe for more than one person with whom the behavior is happening in order to get a sense of the pervasiveness of the problem. If there really is only one person that they exhibit the oppositional behavior with, then "1" should be coded. If the behavior is being acted out with more than one person, then the standard probe should be asked.

If the yes response is still confirmed after the standard probe then "5" should be coded.

D1: Oppositional children sometimes start out losing their tempers with their parents and then move on to teachers and others. Even if it is only their parents that they often lose their temper with, still code a "5".

D2: The oppositional children also often start out <u>arguing</u> with parents and then move on to other adults. Ask with whom they argue the most. If it is "parents" or "Mom" Or "Dad" etc. code it "YES" or "5". The question asks "Do you get into a lot of arguments with your <u>parents, teachers, or other adults</u>?" It is still possible , however, that the respondents will tell you that they argue with their siblings. Siblings don't count, even if it is an adult sibling living at

home. The words "a lot" should be emphasized.

D3A: This item asks about actively refusing adult requests and rules. For example, if the child has a curfew of 12 midnight, he comes in at 1 A.M., and doesn't offer an explanation and says that he thinks midnight is simply too early for him. We would consider him oppositional.This is opposed to the child who comes home at 12:15 saying "I'm sorry Mom, I just lost track of the time.

The problem here occurs when a child is continually staying out after curfew (an hour or more) but makes up some lame excuse such as "Well, all the other kids were allowed to stay that late". This kind of excuse should be coded "5". Even if the child doesn't quite "actively" defy - it comes awfully close and does have that passive aggressive quality that is supposed to characterize oppositional children.

Other Potential Problems. There may be agreed upon tasks that the child doesn't like to do, so the parents just don't ask the child to do them. For example, a particular child may not like going grocery shopping with his mother so his mother doesn't ask him. It is possible that this child would say that he won't go grocery shopping with Mom. However, in order to be coded "5" Mom has to ask the child to come grocery shopping and the child should refuse. It should be an issue between the mother and the child.

All children put off cleaning their rooms. To be coded a "5" the parent must insist that the child clean up his room and the child should actively refuse.

Be sure to record the example in detail so the editor can get a sense of the quality of the refusing.

In situations where the respondent is refusing to do things that are of a harmful or abusive nature, code the question "NO" and make appropriate notations.

D4: This item refers to the act of deliberately annoying others. This means intentionally bothering others when they clearly don't want to be bothered. Included are things like Playing practical jokes, teasing, making burping noises, staring, or making fun of someone. In the case where the interviewer has a strong suspicion that the child does have this symptom, but he does not admit it, a bit more non- offensive probing might be useful.

D5: This symptom counts as a positive only if the answer is "others to blame" or "2".

D6: The spirit of this symptom lies in the notion that anyone and everyone is a potential annoyance to the oppositional child. And while these feelings tend to be directed at more than one person often it starts with a parent and spirals outward. Any one person, except a sibling, is acceptable, but do probe for any others who may have the same affect.

D7: The intent of this question is also that, in general, the child is often angry or resentful with just about anyone. It should be approached along the same course as the pervious question (D6).

D8: It is very common for children to think that things are "not fair". The intent of this item is that the child often responds to these instances by behaving in a spiteful or vindictive manner. Some spiteful ways to get back at someone might include damaging their property, ripping up their homework, or "telling" on them for some past deed.

D9: A lot of children, even very young ones, swear among themselves, taking a certain delight in the wickedness of it all. This is not really oppositional behavior. In order to be oppositional, the child should be aggravating some one. Also, if the child swears in front of grownups, or if he swears a lot more than other kids his age consider it oppositional. If the child swears in front of his parents but volunteers that his parents don't mind then ask if he swears in front of other adults and more than other kids his age. In other words, if swearing is acceptable in the child's milieu, then the behavior cannot be considered oppositional. The term "cuss" is also an acceptable alternative to swear or curse.

D10D-E: DSM-III-R requires a duration of at least six months during which at least five of the symptoms were present. If necessary, help the child to recall when the problems occurred and how long they lasted. It may be useful to refer to certain grades in school, teachers, etc. Otherwise, if the clustering and duration are clear, code without asking.

D11: In an attempt to clearly establish the pervasiveness of the child's behavior, this final question presents an opportunity to reaffirm the symptoms indicated previously. Ironically, if the child is oppositional, he may say "No" to this question. You might need to probe a bit. You could ask about most of the kids in their class. Some of the behaviors may make the child unpopular with other kids. You could also ask if behaving this way gets the child into trouble with parents or teachers. This is a good time to utilize semi-structured interviewing privileges.
*While there are two questions asked in this item, a yes to either is acceptable.

E: CONDUCT DISORDER

The essential feature of this disorder is a persistent pattern of conduct in which the basic rights of others and societal rules and norms are violated. These conduct problems are more serious than those seen in Oppositional Defiant Disorder. Common Conduct Disorder symptoms include physical aggression with both humans and animals, destruction of other people's property, lying, stealing and truancy. Symptoms often become more severe as the child ages.

This section is generally easier to give than ADHD or ODD as the behaviors are more concrete and objective. As with the entire interview, if conflicting information is given, it is fine to ask for clarification. This can be done by stating that you do not understand how new information doesn't seem to match earlier information. This should be done nicely with the assumption that perhaps the interviewer has missed something, or a question was not clear, or perhaps the respondent has simply mis-remembered or forgotten an event. If there is reason to suspect the child is truly trying to conceal things, it is O.K. to <u>appropriately</u> challenge her/him. For example, if a child states that s/he never gets into fights, you may point out that he has already told you that s/he has been suspended for fighting. On the other hand don't be judgmental. These kids have heard it all before. They know adults do not approve of things like skipping school and fighting.

In general, behavior occurring only between siblings is not considered conduct disorder. However, in extreme cases where the actions of a sibling are malicious and executed with out conscious the behavior may be attributed to the disorder.

For each positive behavior the respondent is asked how many times he has done a thing. A concrete number is preferable. However, if the child maintains that s/he doesn't know or can't remember go on and read the series of variables from which they can choose an appropriate response. The interview then proceeds to the next question.

There is also a tally sheet (TALLY SHEET E) for this section to record the symptoms needed for diagnosis, clustering, and duration. This should make reviewing information simpler for the interviewer as well as the respondent.

E1A: Suspended means being told not to attend school for a day or more. In-school suspensions (i.e. being at school in a designated place but not allowed to attend regular classes) are also included here. While this is not a DSM-III-R criterion, this item can provide useful information if examples are obtained in part D. Note that detentions (being kept after school) are not suspensions. If the child volunteers information about detentions that you think might be relevant, then note it in the margin.

E2: This item about expulsions is not a DSM-III-R criterion, but can obtain useful information, with examples in part D.

E3: This item asks about stealing without confrontation of a victim and includes any kind of stealing or "permanent borrowing". A child might confess to having stolen a total of three pieces of bubble gum in his lifetime. Objects may be big or small. School supplies count just

as much as a watch. If the child takes money from the mother's purse without her knowing and without her permission, it counts as stealing even if the mother never says anything about it.

E3E: DSM-III-R really refers to forgery in the context of stealing and not just signing someone else's name to things. Therefore, signing a check or credit card would qualify, but signing absence slips from home would not be considered for this item. If they do tell you that they've done this you can ask them about it later under "skipping school" or "lying".

E4: Running away must have occurred overnight or longer without the child notifying the parents of his/her whereabouts. There should be a definite intent to run away as opposed to staying out all night or coming home really late. This act must have occurred at least twice. If the child ran away only one time and never returned home it would also count as a positive symptom. Running away to another parent's house or relative's house counts as a symptom if the first parent is not notified. This applies to staying at a friend's house as well. In this item if the only reason for running away is for fear of physical or sexual abuse, then code the question "NO".

E5: This item asks about telling lies or making up stories. If the main reason is to avoid physical or sexual abuse the lying does not qualify. If the child does respond that the main reason for lying is to avoid being hurt physically, probe to make sure that the child doesn't mean the parents might get mad at him or spank him. Ask for an example and record it.

E6: The DSM-III-R criteria of deliberately setting fires focuses on intent. Lighting small fires or burning paper even a controlled situation count if done repeatedly and on purpose. If a younger child is deliberately playing with matches (that is lighting the matches) and sets something on fire then this counts as a positive. On the other hand if, an adolescent is barbecuing and the flames shoot up and catch something on fire, this is accidental. Be sure to get specific examples of each incident reported, as one example can be ambiguous. If the child has been involved in a number of fires some of which were accidental and some of which were deliberate, then code the accidental/deliberate option.

E7: This item assesses truancy, but is only considering whole days that are skipped, not just individual classes. If a child says that his/her parent gave their permission not to go to school, then code "NO". If it turns out to be a case that is questionable because of the frequency with which the parent "gave permission" or the child tricked the parent it should be coded "YES".

E8: This item assesses truancy by asking about cutting on several occasions on different days. Cutting classes is defined as being in school for some portion of the day but not attending all classes.

E7&E8: Even if the respondent proclaims that they were never punished by the school for either form of truancy the question is still be coded "YES".

E9: This item asks if the child has broken into a house, building, or car. In the case of an abandoned building that is not locked or barred entering it would be a matter of trespassing and not breaking in. If a child walks into an abandoned house and wrecks or steals something this gets coded under "wrecking or destroying" and stealing. If a group of kids walk into an abandoned building and spend some time smoking cigarettes or marijuana then this behavior will get recorded under substance abuse. In the unlikely event that a child enters an abandoned building that is not barred in any way, and stays for a while and then leaves, then no deviant behavior is recorded. Trespassing may be illegal, but it is not a DSM-III-R criterion for Conduct Disorder. Remember that playing in an abandoned building or going to the beach or park after dark (when they are technically closed) are common and socially acceptable behaviors for many urban children.

E10: This item asks about deliberate destruction of other's property, but does not including fire-setting. It is advisable to obtain examples of what the child did and to stress "on purpose" when reading the question. Things like egging cars would count as destructive because it destroys the finish on a car and is expensive to repair. On the other hand, T.P.ing (toilet papering) would not count because even though it is aggravating, nothing is actually wrecked or destroyed. Egging houses/cars, soaping windows, and the like would not count if only done as a prank on Halloween. Write what was destroyed in the margin.

E11: Count any kind of inappropriate physical aggression towards animals. Be sure to obtain examples to determine whether the child was deliberately cruel to animals. It should not be considered a hunting activity. For example, in some rural areas kids will shoot squirrels or birds with B.B. guns. This is sanctioned by their parents and other adults in the community and therefore does not meet criteria for the symptom. Hitting a dog on the nose with a newspaper while training would be appropriate, while kicking it as you pass it on the street is not. Other cruel and deliberate examples would be animal torturing activities that children may find funny like pulling a dog's tail and ears; putting animals in stoves, refrigerators, and microwaves; "tipping cows", etc.

E12: This item asks if the child has ever forced someone into sexual activities. By sexual activity, we mean sexual intercourse (heterosexual or homosexual), oral sex, molestation, or unwanted touching. Heavy petting does not qualify. If young children are innocently playing "doctor" or discovering private parts of each other's bodies, so long as no one is forced or threatened, it is ok. Clearly, this is a DSM-III-R criterion, and we <u>have</u> to ask it. The interviewer should ask it in a natural and non-judgmental manner. <u>DO NOT</u> preface it by saying "Now this question may not apply to you", or anything like that. If the respondent replies "YES", simply ask what happened and record whatever information is volunteered.

E13A: This item asks about starting physical fights, not just verbal arguments. The person who started the fight is the person who first made aggressive physical contact. It could be a push or a shove as well as an indirect hit. If fighting only occurred with siblings it does not qualify. The symptom requires that the subject not simply be a fighter but that s/he "often initiates physical fights".

E13B: This is positive if the answer is either "2"-self or "3"-some of both.

E14: It may seem awkward to ask about using a weapon if the child has stated that s/he never fights, but it is possible that this may remind the child of incidents s/he had forgotten. Further they may have been a position of self-defense and not considered it a fight. Using a weapon, even in self-defense, will count as a positive symptom. Rocks and sticks should be considered weapons in addition to guns and knives. When an object is used as a weapon that is unlikely to be thought of as a weapon, if the intent is to hurt someone, then code a positive response.

E15: This item asks about stealing <u>with</u> confrontation of a victim. While the child may have used a weapon to do so, this is not required. Snatching a purse, or doing things in a group, (e.g. rolling a drunk), would qualify.

E16: In this item make sure the harming is cruel, and intentional. If siblings are roughhousing, mad at one another, or get into a scuffle in which someone gets hurt this does not count. One might feel that if a child starts a physical fight he intends to hurt them. This is recorded under fighting. Here, it is deliberate harming in a non-fighting context that meets the criterion. Consider the kinds of acts of aggression that are associated with children (tripping just to watch some one fall or kicking) as well as more adult like behavior. In sporting events if the unsportsman like conduct is intended to temporarily knock an opponent out of commission, even if it hurts badly, code "NO".

E17A: This a non-diagnostic question, but it may provide important information. For example, if the child has been picked up for possession of marijuana, you will want to remember that for another section. It is possible that the child will admit to have been picked up by the police for shoplifting but did not give a yes response to stealing. In this case you will want to return to the stealing question and indicate the discrepancy in a non-accusatory way.

If this does happen, do not assume that the child is lying, or that nothing s/he reports on the interview is going to be valid. Evidence from the adult interviews show that people forget the most incredible kinds of information about themselves. The child may have forgotten about the shoplifting incident, but when you mention the police, this might jog the child's memory. It could even jog it to the point where the child remembers shoplifting a couple times. For this question being in trouble means that they were either arrested, taken in for questioning, or the child's parents were called. In some neighborhoods police harassment is a real issue. If it is clear that child has been taken (perhaps repeatedly) to the station as the result of a police initiated confrontation, do not count these instances. If illegal acts were committed but the charges were dropped for some reason still code "YES".

E17C: Do not count multiple appearances in court for the same incident, appearances as a witness, or appearances as a result of custody proceedings. Do count repeated problems with the police for the same type of offense.

E18: Throughout the Conduct Disorder section, onset and recency questions are asked for each symptom. This should give a clear indication as to whether or not any of the symptoms clustered. If clustering is not clearly evident, work with the child to construct a clear picture

of the behaviors.

F: ALCOHOL

Be sure to read the introductory statement in which the respondent is reminded that everything they tell the interviewer is confidential. Don't exacerbate the issue. It is important that they feel as comfortable as possible to answer these questions truthfully. A matter of fact tone of voice will do.

There is also a tally sheet (TALLY SHEET F) to be used with this section to assist the interviewer with summarization of symptoms for onset, recency, clustering, and duration questions.

F1: Do not count infrequent sips given by parents on special occasions. However, if every time the parent has a beer they give the child a few sips, consider this drinking. Also, if it is reported that the child has had one entire drink only, code "5" and then proceed with the questioning in F4D (at which point there will be a skipout). If the child volunteers that s/he takes a drink of alcohol for religious reasons, probe to make sure that s/he doesn't drink on other occasions as well. Code "NO" or "1", if appropriate. While most religious rituals that include the drinking of wine may use a small amount other ceremonies may include drinking more significant amounts. These respondents are to be asked questions F1 through F5B only and then skipped out of the section.

F2: This is a second chance question before skipping out of the section. It is not meant as a challenge of disbelief to their previous response.

F4A: This item refers to the time while the child is drinking - not the next day.

F4C-D: If a concrete number cannot be given in (F4C), then a range of options is provided (F4D). In either case , the threshold for continuing the alcohol section is 7 or more times.

F6: This item wants to know if the child has a regular drinking pattern of once or twice a week. It is conceivable that someone will drink only on Wednesdays. This should be coded as "5". If it turns out the child has gone from a few drinks to drinking everyday and has never gone through a once or twice a week drinking period code "1".

F7B: Read the question as is, but if a question arises code the lowest common denominator for the week. For example, if the respondent drank 7, 10, 12, 8, 15 drinks on different days during the week, the number to be coded is seven. If more than one period of drinking most every day for two weeks or more is reported, code the period in which the most alcohol was consumed.

F8B: This set of questions identifies the child's drinking pattern during the past week. There are two components to the questioning: the kind of alcohol consumed and the amount of time it took to consume. Both are to be recorded in the appropriate columns for each day of the past week.

e.g. I: How many drinks of beer or lite beer
did you have on Sunday?"
R: "Two".

Code 2 in the number of drinks column for beer/lite beer on Sunday.

Then ask:

I: "How long did it take you to drink the beer you had on Sunday?

R: "About fifteen minutes."

Code 15 in the time column for beer/lite beer on Sunday.

Continue in the same manner with the remaining categories of alcohol for Sunday. Then go on to the next day in the week to be coded (Saturday) and ask about each category as before. Do the same until the entire week is finished. All cocktails or mixed drinks should be coded in the "other" column. They may have a high sugar content that may interact with alcohol. Probe for how many shots are in the drink because some drinks contain more than one shot of alcohol. Each shot used in a mixed drink is equivalent to one drink.

F9B: In this set of questions the child's overall typical weekly drinking pattern is identified.

F10A: This is a classic sign of early alcohol abuse and should give an indication if the child is starting to drink more than his/her peers. Comments that peers might make should reflect a serious observation on more than one occasion and not a joking remark in passing.

F10B: Alcohol has the specific effect of making some people angry. It is very common for people who have been drinking to lash out at others verbally or to attack them physically.
If the respondent hits someone back when drinking this counts, because if the child had not been drinking they might have walked away and not hit back.

F10D: High school students who drink "socially" (i.e. a little beer on select weekends), can often be interestingly judgmental about their peers who drink "too much" and will exclude them from the group. It is very typical of adolescent abusers to have been dropped by some of their friends, even those who will take a drink from time to time.

F10F: The intent of this item is to determine whether, or not the respondent realizes that the social problems they've experienced are connected with their drinking.

F10H: Continued use despite recurrent problems is being defined as engaging in a behavior that yields certain consequences three or more times. The symptoms from item F10A-F (social problems) that meet this criterion should also be indicated on tally sheet F.

F12: This question is asking the respondent to give a self evaluation of drinking behavior. It refers to drinking in general and not the amount consumed on a particular occasion.

F13E: The psychological problems from item F13A-C that meet this criterion should also be marked on tally sheet F. These experiences do not have to occur at the actual moment of taking a drink, but during a time period when drinking was going on.

F14C: Even if the respondent believes that mixing alcohol with marijuana or some other substance that is not dangerous to mix with alcohol, code this "NO". Essentially sedatives are the only substances that will fall into the "dangerous to mix with alcohol" category.

F17A: In this question the person is asked whether they ever drink constantly for a couple of days or longer. During this binge the individual is usually drinking whenever they are not actually asleep (or passed out).

F19A: Sometimes adolescents will be drinking "abusively" but will not have been drinking long enough to have built up tolerance to alcohol e.g. the need to drink four beers to get the effect or "high"' that two used to give them. Also, if they haven't experienced it, they may not understand what tolerance means. A 50% increased tolerance is, however, one of the criteria for the diagnosis of alcohol dependence, so a good effort should be put forth to explain it if the child is having trouble answering. There is no minimum for tolerance in this question so consequently if the child goes from drinking even 1 drink to 2 drinks, this item will be coded positively.

F20A: The respondent must have <u>often</u> wanted to decrease the quantity of usual alcohol consumption to reflect a persistent desire.

F20B: The respondent needs only once to have made an attempt to drink less alcohol and failed.

F21A & F22A: These questions refer to a phenomenon known as "loss of control", which involves some an inability to stop drinking. People with this symptom will go on drinking even after they feel the effects. They will accept a drink every time it is offered. They will "kill the bottle".

F24: This question lists some common symptoms of alcohol withdrawal.

F26A: In this question the respondent engages in activities where drinking increases the risk of being injured.

F27A: This question is concerned with <u>serious accidental</u> injuries that occurred when the respondent was drinking.

F28: This item is subjective and will be coded "YES" as long as the respondent believes s/he spends a lot of time on procuring, using, and recovering from alcohol. (This applies to H20 and I11 as well.)

F32A: Attending an AA program is considered treatment.

F32B: Include AA programs under variable item 2.

G: CIGARETTE SMOKING

This section is non-diagnostic. It asks whether the child has ever used tobacco products, when they used them, and if use lasted a month or more. It is important to get the age of onset to highlight the temporal relationship between tobacco use and other substance use.

H: MARIJUANA

Many children/adolescents experiment with marijuana a few times or even more than a few times and then stop with no apparent ill effects. Do not assume that just because they try it, they are on the road to "reefer madness". On the other hand, "nice" children from "good" homes can get into terrible trouble with marijuana. Do not assume anything.

Note that "cannabis", according to DSM-III-R criteria, also includes hashish and THC.

Marijuana tolerance may be manifested by the respondent using marijuana more frequently rather than in larger amounts.

The questions in this section parallel those in the Alcohol and Street Drugs sections.

There is also a tally sheet (TALLY SHEET J) used to record the positive diagnostic symptoms throughout the section. This will assist in the summary of these symptoms for the onset, recency, clustering, and duration questions.

I: STREET DRUGS

Because of the coding structure for the questions in this section, only one child can be recorded on the parent interview form. For each additional child in the family a SUPPLEMENT 1 must be used to record the parent's responses.

There is also a tally sheet (TALLY SHEET I) to record the positive diagnostic symptoms throughout the section. This will assist in the summary of these symptoms for the onset, recency, clustering, and duration questions.

All questions are drug specific. Only those drugs that have been used seven or more (7+) times should be referred to in the question. The response to each symptom is then coded under the appropriate drug category. Be careful to follow the drug categories columns correctly.

The questions in this section parallel those in the Alcohol and Marijuana sections.

J: MAJOR AFFECTIVE DISORDER

Why Ask About The Past Two Weeks?

It is much easier for children to talk about the present than to review their whole lifetime. If they are currently depressed,this can be more easily assessed by specifically inquiring about the past two weeks. Even if the child has had a depressed episode in the past, it will be easier for him/her to understand if the symptoms are described in the present first, and then asked about the symptoms occurrence at some other time in their life.

The Standard Probe

Even though many of the symptom questions ask if a feeling has been occurring more than usual, the standard probe should be used with each positive reply to make sure that the feeling was different from usual. The respondent should clearly understand that the questions are asking about feelings that are very different from their routine emotions.

Symptom Duration

The questions about the past two weeks are designed to pick up current episodes of depression. It is possible that the episode will have just started and may not have gone on for two weeks. In that case the child is likely to answer "no" to the questions about "everyday or nearly everyday for the past two weeks".

If the child says "yes" to ever having the symptom but "no" to having it everyday or nearly everyday, the interviewer should try to establish how many days the symptom lasted.

It is also possible that the episode is ending, which means the child would have felt this way for the first couple of days of the two week period and then started to feel better. If this is the case, an episode like that can be coded under a "past episode".

What happens most frequently is that the child will have a slight mood disturbance that will be subclinical, occur on one or two days only, and/or not last for most of the day.

Occasionally you will find a child who is in the midst of a severe depression.

How Old Were You Then?

Children have a lot of difficulty remembering how old they were when "depressed" symptoms occurred. It may be useful to help establish the duration by associating feelings and behaviors to time markers. Use the probes such as WHAT GRADE WERE YOU IN?, DID IT LAST UNTIL THANKSGIVING BREAK, WAS THAT BEFORE SCHOOL STARTED IN THE FALL?, ETC. Probe to get some indication of the child's age rather than "I don't know".

The Depressed Adolescent

In depressed adolescents, negativistic or antisocial behavior is common as well as the use of alcohol or illicit drugs. Depressed adolescents tend to feel isolated, unappreciated or

misunderstood, and may display their unhappiness as grouchiness, sulkiness, or aggression. They are likely to be experiencing significant problems with school and family. This description may seem to describe most adolescents, but again their behavior should represent a real change in their emotional and behavioral state.

Coding Episodes of Depression

There are two coding columns for depressed episodes in this section. One column is for a current episode, and the other is for the most severe episode. Episodes of depression have may be "clean" or "dirty". A "clean" episode of depression is one where there has been no use of alcohol or drugs during that period. A "dirty" episode of depression, is therefore, one where alcohol or drugs were also being used. The following shows the hierarchy in coding clean/dirty current and most severe past episodes of depression.

	Column To Code In	
	Current	Most Severe
If there is a clean current episode but no past episode		**X**
If there is a dirty current episode but no past episode		**X**
If there is no current episode but a clean past episode		**X**
If there is no current episode and only a dirty past episode		**X**
If there is a clean current episode and a different clean most severe past episode, record each in its respective column.	**X**	**X**
If there is a clean current and a dirty most severe past episode, record the current episode in the most severe column. Remember to count dirty past episode when probing about other dirty past episodes.		**X(current)**
If there is a dirty current episode and a clean most severe past episode, record each in its respective column.	**X**	**X**
If there is a dirty current episode and only a dirty most severe past episode, record each in its respective column.	**X**	**X**

J1: This is not a DSM-III-R symptom. The purpose of the question is to get the child thinking about "down" moods.

J2A-E: Any of these questions can count towards the symptom of dysphoria for the current episode of depression. As with all of the symptoms of depression, the child should describe an experience that is markedly different and unusual from the way s/he normally feels.

J2B: Feeling tearful can mean feeling sad enough to cry or feeling the tears come into ones eyes but not actually crying. Ask, "Did you ever feel your eyes fill up with tears, but they never actually came onto your cheeks?" That is a very concrete feeling and the children seem to remember it.

C: The child does not derive any pleasure from the things that s/he usually enjoys. This does not mean that s/he no longer feels that playing Ninja Turtles is fun because s/he has outgrown playing it. The question refers to an active loss of pleasure.

D: The child does not have any interest in the things that s/he usually enjoys. For example, if friends tried to get him/her to go to a movie, s/he just couldn't get very interested in the idea, (versus not feeling like going one particular night).

E: This question is very important because sometimes children and adolescents can be depressed without exhibiting either a dysphoric or anhedonic mood. For adolescents especially, the mood can be one of irritability.

J3A: The DSM-III-R criteria state that the mood should exist most of the day, nearly everyday. Nearly every day should be interpreted as at least four days out of the week.

B: Either sad feelings, tearfulness, or irritability can count towards the dysphoria symptom.

C: Either loss of interest or lack of enjoyment can count towards the anhedonia symptom.

J4: These questions should be asked only if the respondent reported ever using drugs or alcohol. If the respondent has had 2 drinks or less the week prior to the reported depression the episode is considered clean. If they drank at least 3 drinks the week prior to the reported depression the episode is dirty.

J4A: These questions refer to drinking during the feelings of depression.

J4F-H: Marijuana should be coded under the "Other" column.

J5: This question is very important because sometimes children and adolescents can be depressed without exhibiting either a sadness or lack of interest. For adolescents especially, the dysphoric mood might be manifested as irritability.

J6A-E: This group of questions attempts to identify a past episode of depression.

J7A: This question refers to the severity of the reported "most severe episode" of depression and should be interpreted as at least four days out of a week.

B: Either sad feelings, tearfulness, or irritability can count towards the mood symptom.

C: Either loss of interest or lack of enjoyment can count towards the anhedonia symptom.

J8: Age of onset for most severe episode of depression.

J9: DSM-III-R requires a minimum duration of two weeks for an episode of depression. However, less than two weeks is acceptable for continuing through the section in order to identify other and perhaps more prominent symptoms for the children.

J10: See J4.

J10A: See J4A.

J10F-H: See J4F-H.

J11: This question is not used to confirm whether the reported episode is clean or dirty. The information given here only gives a point of reference and more details as to what was going on at the time.

J12A-B: The purpose of this group of questions is to identify a clean most severe episode of depression in the event that the episode reported in J8 is dirty (i.e.influenced by drugs or alcohol). Although there has been ample discussion about the various components of a depressed episode being sought (i.e. mood, anhedonia, severity, and use of substances), some additional time may be needed to make sure that this other episode actually meets the requirements.

J13: Age of onset for the second-chance clean most severe episode of depression.

J19B & J20B: Even if the child has a severe appetite disturbance s/he may not be able to tell you if s/he has lost weight. The interviewer can probe by asking, "So you think you've lost (or gained) weight? Do your clothes fit like they usually do?" Don't spend too much time on this.

J21A-C: Some children and adolescents always have trouble getting to sleep. Be sure that the child is expressing difficulties that are different from their usual sleep patterns. You may also want to establish whether something or someone was interfering with their sleeping.

J22A: Children with this symptom can often be quite agitated. They will pace up and down and wring their hands.

J23A: Children with this symptom move slowly and talk slowly. They sometimes feel that their thinking is slowed down. Others talking with them may notice that their thinking doesn't seem clear or that they appear to be having trouble expressing their ideas.

J24A: Notice that fatigue and psychomotor retardation are not the same. With psychomotor retardation the child does everything very slowly. If fatigue is one of their symptoms, they feel will feel tired or exhausted most of the time. If the child has both symptoms, it may be difficult to distinguish them. Emphasize feeling tired and exhausted for this question.

J25A & 26A: Worthlessness or excessive guilt are all one symptom, so a positive for either item J14A or item J15A means the symptom is present. The interview divides the symptom into two questions so that the feelings can be distinguished by the child. It is possible that the child feels that everything s/he does is wrong, but might not actually feel guilty. Be sure to stress the specific nature of the two kinds of feelings.

J27A & 28A: These two questions also comprise one symptom, but the interview splits them in order to detail these feelings to the child. Indecisiveness is difficult to explain to a child. Try to make sure s/he understands that this is a period of time when s/he has A LOT MORE trouble than usual making decisions - that is s/he can't seem to decide anything.

J27B&J28B: Difficulty in concentrating and feeling indecisive do not always have to be subjectively reported. Other people's comments, based on their own observation, is also acceptable.

Suicidal Ideation

The DSM-III-R description of the symptom "suicidal ideation" reads: "recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan or a suicide attempt or a specific plan for committing suicide".

J29A: This is not a symptom of suicidal ideation, but a question to bring up the subject's hopeless feelings.

J29B: It is very important to make sure the child is not just afraid of dying. Many of children and adolescents are afraid of dying and it is easy to get a false positive for this question. It is a morbid preoccupation that is of concern. Further probing may be warranted along the lines of, "were you really thinking a lot about death or dying or were you simply feeling very sad about X having died?" Or, "were you really worried that some day you might die?"

J30A: Name only those symptoms reported by the child.

J32: This question is not used to confirm whether the reported episode is clean or dirty. The information given here only gives a point of reference and more details as to what was going on at the time both mood and other symptoms were present. It should re-affirm the information given in J11, but additional information might also be revealed.

J34C: The number of days recorded here should also include the days in between regular MD visits. For example, if the respondent saw the doctor once a week for a year. code 365 days, not 52 days.

J35: This group of questions serves as a general accounting of any other "dirty" episodes of depression that the respondent may have had in their lifetime.

J36: This group of questions serves as a general accounting of any other "clean" episodes of depression that the respondent may have had in their lifetime.

J35E &
J36E: These items are inclusive of all dirty and clean episodes of depression. The current and past most severe episodes are to be included as well.

K: SEPARATION ANXIETY

Separation Anxiety Disorder deals with the excessive concern of being parted from one's parents or some other major attachment figure. Most young children go through a period of panic or anxiety when a parent leaves them. Some parents spend a great deal of time away from the family which can be emotionally upsetting for children of all ages. Starting kindergarten can be a very traumatic experience for many six year olds. Expression of anxiety to some degree would, of course, be normal. When the anxiety continues beyond the appropriate developmental level it reflects a deeper problem.

Affected children have an anxiety that is persistent and unrealistic. For no real reason (e.g. illness or threat of harm) they often fear that some terrible event will befall their parents or themselves and thereby cause separation. They might also try to keep from going to school by complaining of physical ailments, throwing tantrums, and issuing an out and out refusal. Staying overnight, even with a relative or close friend, would probably be out of the question. Having their parents stay next to them until they fall asleep can be a necessary comforting experience. There may even be recurrent nightmares centered around the theme of being separated. Such experiences would not be isolated events, but repeated incidents of acting out behavior due to separation anxiety.

DSM-III-R dictates that the age of onset must occur before the age of eighteen and persist at least two weeks.

Note the coding change for this section at the top of the page (i.e. 1-3-5). For any 'Yes' response the interviewer should probe for alcohol or drug use being the cause of the symptom.

K1: Usually the child with separation anxiety anticipates some extreme or morbid occurrence coming between themselves and their attachment figure. Younger children may not have a concrete notion of what kind of harm the major attachment figure is destined for, whereas adolescents tend to identify a more specific array of things that might separate them. In any case, consideration should be given to not only the realistic nature of the anxiety, but the frequency, duration, and pervasiveness of the symptom. While these things are addressed specifically in later questions, some preliminary probing might prove very useful in decision making at this point. Be sure to ask for examples of the respondent's anxiety.

K2: Sometimes the child's anxiety will stem from a fear of something bad happening to them. S/He may fear being lost in a store, kidnapped, or even killed. Be sure to ask for examples of the respondent's anxiety over being separated from and attachment figure. Again, understanding not only the realistic nature of the response but the frequency, duration and pervasiveness of the anxiety is important.

K6: Because children are not usually left totally alone in the house, the question refers to some other room in the house where a parent is not present. Places that are typically scary like the basement or attic, are not relevant.

K7: Children are not always given a choice about where they want to be (e.g. a situation where they are away from home and can not return at will). Children with this symptom are very miserable and emotional distressed.

K8: A "yes" to either part A or B counts as a positive for this symptom.

K9: The child should have had more than just one or two nightmares.

K11: Make sure that the child does not want the parent to leave because s/he is afraid that something bad might happen, not because s/he just doesn't want her/his parents to leave.

K12: The interviewer may have to help the respondents (particularly the younger ones) determine how long the symptoms lasted. Use the probe and help the child determine if these feelings lasted two weeks. For example: "When did these feelings happen? Was it at Christmas time? Did it happen all through Christmas vacation? Did it happen on the weekend and did it happen again the next week and then maybe again the next weekend?"

Another approach might be: "Did those feelings happen a lot? How many times? Did they go on for one week or two weeks?

If the child has a number of symptoms severe enough to be coded "5", it is unlikely that they all happened in less than a two week period. You may need to demonstrate the logic of this to a young child.

If K12 does not get a clear response try to determine the duration of the symptoms from K13. If it is clear from K12A-C that the duration lasted two weeks or longer, code "5" in K13.

L: OVERANXIOUS DISORDER

The essential feature of overanxious disorder is excessive or unrealistic anxiety or worry for six months or longer. Overanxious children tend to be extremely self-conscious. They worry about a number of different things including peer relations, expectations of parents and teachers, past behavior, and future events (e.g. doctors appointments or tests). They may have physical complaints such as headaches, stomachaches, shortness of breath, and sleeplessness. Overanxious children need to be constantly reassured about their performance and behavior. Even receiving such reassurance might not relieve their anxiety and tension.

Remember when asking the questions in this section that all adolescents have a heightened (and one could argue, unreasonable) sensitivity to peer relations. Be sure when you are interviewing an adolescent or a parent of an adolescent that the peer-sensitive behavior is excessive in his or her peer group.

Note the coding change for this section at the top of the page (i.e. 1-3-5). For any 'Yes' response the interviewer should probe for alcohol or drug use being the cause of the symptom.

L1: Emphasize "more than most kids your age." This question is not a DSM-III-R symptom, but it is intended to get the children thinking about worrying.

L2: The symptom is "excessive or unrealistic worry about future events." These examples are typical of the kinds of things that children with overanxious disorder worry about. The interviewer may use other examples, particularly if they seem especially appropriate for an individual child.

L3: Adolescent girls often appear to worry like this. Make sure the worrying is "excessive or unrealistic". Most adolescents will know whether or not they worry more than their peers. Be sure to get an example.

L4: Once again, this is not just normal worrying. The child with this kind of emotional problem is quite the perfectionist. Things must be performed at the correct level. Anything less is very upsetting and causes significant worry. The worry can be tied to their own feelings of competency or what they think other people feel. It is excessive, unrealistic, or "more than most of their friends."

L6: Most adolescents, male and female, worry about this to a certain extent. Use the probe to find out if they are worrying more than their peers.

L10A & B: These are clustering and duration questions. Check with the child to ensure that the symptoms did not all occur at separate times.

M: SUICIDAL BEHAVIOR

The Suicidal Behavior section is not diagnostic. It details any suicidal behavior related to or independent of depression. In the cases where suicidal ideation has been reported in the depression section, the introductory statement should be read with the words in parentheses.

Note the coding change for this section at the top of the page (i.e. 1-3-5). For any 'Yes' response the interviewer should probe for alcohol or drug use being the cause of the symptom.

M1A: Emphasis should be placed on the words 'a lot' in order to establish the degree of severity of the thoughts of death. Most everyone has contemplated death or dying, whether it be their own or someone else's. However, these thoughts should represent more than that; they should represent an morbid pre-occupation or rumination on the part of the respondent as opposed to a reasonable sadness over the loss of a loved one. (also see J29B)

E: Record as much information as possible surrounding the respondent's thoughts of death or dying.

M2E: At least one plan for suicide should be recorded. However, if the respondent has made more than one plan for suicide, record as much information as possible.

M3F: If there was more than one suicide attempt made, ask the respondent to describe the one s/he deems the most serious attempt. Adults and children alike will make very sincere attempts at ending their lives but by very ineffective means. Young adolescent girls commonly attempt to overdose on Tylenol.

M4: The lethality of the suicide attempt is coded by the interviewer based on the physical consequences of the respondent's actions. Psychiatric treatment is not considered.

M5: The interviewer codes the intent of the respondent based on the account of the suicide attempt reported in question M3F.

N: OBSESSIONS

The main feature of this disorder is recurrent obsessions or compulsions which are severe enough to cause marked distress, be time consuming, or significantly interfere with any aspect of a person's life. Usually the obsessions have a bizarre senseless quality about them and these will probably be one of the ones described.

Obsessions are defined in DSM-III-R as follows:

"Obsessions are persistent ideas, thoughts, impulses, or images that are experienced at least initially, as intrusive and senseless - for example, a parent having repeated impulses to kill a loved child, or a religious person having recurrent blasphemous thoughts"....."The most common obsessions are repetitive thoughts of violence (e.g. killing one's child), contamination (e.g. becoming infected by shaking hands), and doubt (e.g. repeatedly wondering whether one has performed some act, such as having hurt someone in a traffic accident)."

Sometimes the child will give an answer that suggests a different kind of problem. For example, a particular child may say that s/he worries a lot about dying. This could be a symptom of depression or even PTSD. In order for the symptom to indicate an obsession, it has to be intrusive, i.e. that means the thought has to stay on the child's mind and be bothersome. This is fairly easy to distinguish from a phobia in which the child is alright unless confronted with something that reminds him of death. It may be more difficult to distinguish an obsession from depressive brooding about death, but by that time the interviewer will know whether or not the child has any depressed symptoms or suicidal thoughts. The child can be asked if the only time they had the intrusive thoughts was when they were sad. If the child reports thoughts of dying under Obsessions, but probing reveals that the obsessions occurred only when the child was depressed, do not make the judgement that the child has depression and not obsessions. Write down the child's answer, i.e. "dying", note that the child has reported suicidal ideation, and continue on. Also write down any other relevant information that will assist in editing.

A classic way of describing obsessions is to compare them to music playing in your mind that you can't stop. Used as a probe, that example works well with many children.

Note the coding change for this section at the top of the page (i.e. 1-3-5). For any 'Yes' response, the interviewer should probe for alcohol or drug use being the cause of the symptom.

N1: This general question about obsessive behavior is difficult because it can be easily confused with worries. Adolescents might worry a great deal about something they have said to their friends, whether or not a boy/girl likes them, or whether or not they are getting fat. These are associated with the pangs of growing up rather than obsessive behavior. A younger children might find themselves thinking a lot about something that their parents may have told them. For example, if parents told a child that there was an old man in the bathroom who

would get them if they were bad, and the child subsequently reported thinking about this a lot, it would not be an obsession on the part of the child but a fear instilled by the parent. If a 'yes' response is given, ask for an example. If needed, try and explain that the thoughts are not what they would think about on their own. The thoughts being asked about just seem to come out of nowhere and persist for no good reason. The person often realizes that the thoughts are strange or unrealistic and will find thinking this way upsetting.

N2: A child worrying about germs or dirty hands because of constant instruction from an adult reflects concern about getting into trouble and not an obsession.

N5: The worry should be about doing something that is truly inappropriate and not just silly or embarrassing.

N6: Even if the child tries to not think about the obsessions s/he can't. It invades the child's thinking. Focusing on other things or even doing something to preoccupy the mind will not work.

N7: This question is meant to distinguish an obsession from a psychotic symptom. If the child believes that such ideas are really put into their head by someone else - as in hearing voices, the behavior might possibly be attributed to schizophrenia. A person who is obsessive can often be helped to recognize that the ideas bear no truth and are coming from their own mind.

N8A & B: The persistence of the obsessive behavior can be measured by the effect it has on the child's daily routine or by the amount of time the thoughts and ideas take out of a day.

O:COMPULSIONS

Compulsions are repetitive and intentional behaviors that are performed in response to an obsession, according to certain rules or in a stereotyped fashion. Usually the behavior is thought of as neutralizing an obsession but it can occur independently. However, the activity is not connected in a realistic way with the event that it is trying to neutralize, or it is clearly excessive. Acting out compulsions is not pleasurable but does provide a release of tension. Some common compulsions are hand washing, counting, checking, or touching.

Everyone has habits or behaviors that they repeatedly exhibit, but compulsions are excessive disruptive behaviors that make the person feel uncomfortable.

Note the coding change for this section at the top of the page (i.e. 1-3-5). For any 'Yes' response the interviewer should probe for alcohol or drug use being the cause of the symptom.

O1: The most common acts of compulsion are washing, checking, counting and touching. However, a compulsion can be manifested in many other ways. Adolescents, especially, may show compulsive behavior by spending an excessive amount of time rereading school assignments to the point of not being able to complete the work.

O2: Compulsive behavior can also present itself through the establishment of rules. These rules have a ritualistic status that does not allow for the slightest deviation. It is the ritual that is more important than the actual result of doing things according to the rules. Compulsive ritualistic behavior and habit should clearly be distinguished. The compulsive person is greatly disturbed if they are not able to perform a task in a specific sequence. Their anguish over this 'mistake' causes them to start over from the beginning until the procedure is to their satisfaction. The non-compulsive person, for example, who has a very strict habit about washing the glassware, dishes, silverware, and then pots and pans could, though reluctantly, wash the silverware first and complete the job to go on to something else.

O3: The compulsion to count is sometimes misunderstood. Is not a challenge to count all of the squares in a tile floor. It is a very serious need. Counting compulsions are usually directed at objects (e.g. cars going by, red specks in the carpet). Thinking that you've always made a mistake when adding up the numbers in a math problem is not a compulsion to count, although it might qualify for another kind of compulsive behavior. Counting like The Count on Sesame Street definitely does not count.

O4: True compulsions will disturb the normal functioning of a person's day to day routine either by virtue of the amount of time it takes or the emotional stress that comes from unrelieved tension.

P: ANOREXIA

People with Anorexia have distorted body images and as a result control their weight or diet down to a point where they are dangerously thin. People with this disorder say that they "feel fat" or that parts of their body are "fat" even when they are very slender or even grossly underweight. They are afraid of gaining weight and refuse to maintain a body weight normal for their height. To achieve this end, people with Anorexia often drastically diet and exercise, and may self-induce vomiting after a meal to avoid weight gain. (In such cases Bulimia Nervosa may also be present.)

According to DSM-III-R, to be anorexic, a person must weigh less than 85% of their expected weight. Accordingly a teenage girl who unrealistically views herself as "fat" but who actually maintains an average (or slender normal) frame, is not considered to be suffering from anorexia. By the same token an extremely thin child who is not concerned with weight or body image, does not receive a diagnosis of Anorexia. Keep in mind, however, that most people suffering from Anorexia will deny it.

Note the coding change for this section at the top of the page (i.e. 1-3-5). For any 'Yes' response the interviewer should probe for alcohol or drug use being the cause of the symptom.

P1: Most children will skip out after this question as they will not have lost weight intentionally. However, some children will have successfully lost weight (without being anorectic) and will respond positively to this question but skip out on a later question.

P2: The anorexic truly believes themself to be overweight in spite of reassurance from others that they are in fact very thin and maybe too thin.

P3A-C: These items are used to calculate maintenance of body weight. An anorectic will maintain a body weight of at least 15% below what is normally expected for their age and height. This is a difficult symptom to satisfy as DSM-III-R does not indicate the minimal normal weight for a child of a given age and height. When asking about lowest weight be sure to focus on the least amount weighed during the period of intentionally losing weight. Use the height and weight chart to make the proper coding.

P4: Anorexics are never satisfied with their appearance. Their goal is not to reach a given number of pounds but an image. Unfortunately, the image that they perceive is dangerously distorted and never attainable. One word of caution - anorectics become annoyed with being told that they are not really overweight and that their ideas about their appearance are pretty foolish.

P5: The worry that an anorexic possesses over weight gain is actually a preoccupying fear.

P6: Many mothers feel that their dieting daughters really do not need to loose weight. Mothers of anorexics, however, really are worried about the child's weight loss. Probe for the parent who is actually worried.

Q: BULIMIA

"The essential feature of this disorder are: recurrent episodes of binge eating (eating a large amount of food in a short period of time), a feeling of lack of control during the eating binges, the use of one or many tactics to avoid weight gain from the binges (self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise), and persistent overconcern with body weight. In order to qualify for the diagnosis, the person must have had, on average, a minimum of two binge eating episodes a week for at least three months."

Note the coding change for this section at the top of the page (i.e. 1-3-5). For any 'Yes' response the interviewer should probe for alcohol or drug use being the cause of the symptom.

Q1: One difficulty with this section is establishing the presence of an eating binge and what isn't. A "binge" is quickly eating much more than a person would normally eat even when they are extremely hungry. Many children will say that they've eaten a very large amount of food all at one time, but this may not be enough to be considered a binge. For example, they might say that they ate a whole big bag of potato chips. For this reason we ask for an example to determine whether or not the amount eaten was clearly a binge. The child's answer should be recorded even it turns out not to be a binge.

Q2B: Bulimics are very secretive about their behavior. This a second chance for the respondent to admit to binging at least twice in <u>one</u> week.

Q4B: Weighing themselves on a scale several times a day is common practice for a bulimic.

Q5: Some bulimics will down hundreds of laxatives until they are no longer effective. The phrase "taking medicine to make yourself go to the bathroom" is an alternative to the word laxatives. If they have been taking laxatives they probably know the word. Use the word "laxatives" and explain its meaning if you think the child does not understand it. Self-induced vomiting is also a typical manipulation to keep from gaining weight. The child may stick fingers down the throat or use other foreign objects as well.

Q6: If a positive response is given, make sure the child is exercising to keep his/her weight down and not just playing sports.

Q7: The bulimic is not in control of the binge. What usually stops the continuous eating is physical pain, finally running out of food to consume, or being caught.

R: SOMATIZATION

This is a really difficult section to give because it is hard to decide the actual source of the symptom, i.e. was it really the result of a medical condition or is it, in fact, a somatization symptom.

DSM-III-R criteria (p.263) specify that the symptom should not be the result of a physical disorder or the effects of injury, medication, drugs, or alcohol. So each question that receives a positive response must be probed to establish if it is truly a somatizing symptom.

In fact it is often difficult for a physician who is examining the patient to decide whether or not a specific symptom is really a somatizing symptom. In light of that, this group of questions should probably be considered a good screening for possible somatization. On the other hand, it does take 14 symptoms to get a diagnosis of somatization. This means 14 physical symptoms that can't be obviously explained by a medical illness (e.g. seizures because the patient is epileptic rather than unexplained seizures or seizures that are the result of withdrawal from alcohol). In addition, finding children with that many symptoms will not happen often.

While it may be difficult to judge whether or not a specific symptom should be coded a "5", you will rarely be in the position of having enough symptoms to warrant a diagnosis of somatization. However it does happen.

In addition, the interviewer should be aware of both multiple direct and indirect causes of any given symptom. SEE EXAMPLES.

It is best to ask these questions in a relaxed and conversational semi-structured manner. The coding chart preceding the questions shows the coding options and the paths by which the conclusions can be made.

If a symptom is ONLY present when a subject is using alcohol or drugs of some kind, Code 3.

If a symptom is ONLY present when a subject is suffering from a physical illness or physical condition, code 4.

If a symptom is EVER unexplained and
1) The subject has seen a doctor about it, or
2) The subject has taken over-the-counter medication other than pain medication for the problem, or
3) The symptom interferes with a subject's life or activities a lot, code 5.

If a symptom is either explained or unexplained but
1) The subject has never seen a doctor about it, and
2) The subject has never taken over-the counter- medications other than pain medication for the problem, and
3) The symptom does not interfere with a subject's life or activities a lot, code 2.

If a symptom is NEVER unexplained, but is sometimes due to alcohol or drugs and is sometimes due to physical illness or condition, code 3.

So, in summary, coding is as follows:
1 = Symptom not present.
2 = Symptom present but not clinically relevant.
3 = Symptom present, clinically relevant, but due to drug or alcohol use.
4 = Symptom present, clinically relevant, but due to physical illness or condition.
5 = Symptom present, clinically relevant, and not fully explained, hence a somatizing symptom.

We have phrased the questions in such a way as to find out if the child suffers from the symptom "a lot" or "much more than his friends or other people his age". This is to satisfy the DSM-III-R requirements that "the essential features of this disorder are recurrent and multiple somatic complaints of several years duration, for which medical attention has been sought, but that are not due to any physical disorder....Complaints are often presented in a dramatic manner." For the very young children some of the symptoms may need to be explained in tactful everyday terms that are more familiar to them.

SAMPLE PROBING SEQUENCES
Example A:
Interviewer: Have you had a lot of problems with back pain?

Respondent: Yes.

I: Did you see a doctor about your back pain?

R: Yeah, I did. I saw my doctor.

I: And what did the doctor say was the reason for the back pain?

R: She said I'd pulled some muscles playing soccer.

I: Did you have back pain another time, for instance, when you hadn't been playing sports?

R: No, that was it.

CODE 4.

Example B (Multiple direct causes)

I: Has your child had a lot of trouble with his heart pounding or beating too fast?

R: Yes.

I: Did you take him to see a doctor about his heart pounding?

R: No.

I: Did he take over-the-counter medicines for his heart pounding?

R: Oh, no. No medicines at all.

I: Did this heart pounding interfere with his life or activities a lot?

R: Hmm. Well, he didn't like to go out with his friends, because he got scared that his heart would start beating too fast. Is that what you mean?

I: Yes. When did he have this heart pounding?

R: Well, he was using cocaine pretty heavily. I think when he was high he suffered the most.

I: Was there any other time that he had these heart problems?

R: Oh, sure. My son weighs almost 200 pounds - he's very over weight. He complains that his heart starts beating too quickly when he's just walking up the stairs.

I: Does your son ever have these heart problems for no reason at all? For instance, when he hasn't used cocaine or isn't walking around?

R: No.

CODE 3, to indicate that her son's cocaine use is the cause of the heart palpitations. Because of the hierarchy of coding, use of drugs or alcohol take precedence over physical reasons for a symptom.

<u>Example C: (Chained causes)</u>

I: Do you have trouble with getting out of breath at times when you're not exercising?

R: I hurt my back in a car accident, and every time I have a big swim meet at school I get so worried that I'll hurt it again that I start to breathe really fast and hard.

I: Did you see a doctor about it?

R: Oh, yeah. The coach made me go see the team doctor. He just told me to try and relax, focus on what I was doing and stop worrying so much. I'm not doing such a great job on the team this year either.

CODE 5. The back injury caused him to worry which caused his shortness of breath. So, it was the worry that caused the actual symptom (shortness of breath).

Example D

I: Have you ever lost your voice?

R: Yeah, one time I went to a football game and screamed so loud that I couldn't talk the whole next day!

I: Was the that the only time that you lost your voice?

R: No. Once, after my parents got separated, I lost my voice for three whole days.

I: Did you see a doctor about it?

R: No.

I: Did you take any medicine for it.

R: No.

I: Did losing your voice interfere with your life activities a lot?

R: Well, I guess. My mom kept me home from school for it. But that was what I wanted, so I was happy.

CODE 5. Even though their respondent was happy to be taken out of school the loss of his voice interfered with his performing a major obligation - being a student. The symptom is also unexplained, hence, code 5.

Example E

I: Has he had very bad pain in his arms and legs?

R: Sometimes he complains that his legs hurt so badly that he can't do his chores.

I: Did you take him to see a doctor about the pain in his legs?

R: No.

I: Did he take a lot of over-the-counter medicine for the leg pain?

R: No.

I: Did the pain interfere with his life activities a lot?

R: Well, he would complain that it hurt so bad that he couldn't clean up his toys, but if his friends wanted him to come outside to play he'd be perfectly fine. I think that its just a way to get out of doing his jobs around the house.

CODE 2.

R1: Stress the words 'a lot' and 'more'. You may also want to ask about the kinds of things they get sick with in order to get a better sense of what their idea of being sick a lot is. Record the information given.

R2: This is a second chance question for the same symptom in R1.

R3: This question is concerned with vomiting that occurs outside of pregnancy.

R4A: This question refers to feelings of nausea and not vomiting. Nausea from any type of motion sickness does not count.

B: This symptom might also be described to younger children as an uncomfortable feeling in your stomach that sometimes makes you feel like you have to go to the bathroom.

C. The word 'diarrhea' may not be familiar to some children. Even the phrase 'bowel movement' might not work. If needed, try phrases like BM, poop, or number 2.

D: This does not refer to overeating. Nor does it necessarily mean that problems resulted from eating new foods.

E: The pain referred to here is any kind of pain other than pain when menstruating for girls nine years and older.

R5: Hurting from spankings does not count. However, if the spanking results in some degree of physical injury, 4 should be coded.

R6: If necessary the word 'pee' can tactfully be substituted with the word 'urination'.

R8: Dizziness can also be described as "like your head is spinning around and around and you feel like you might fall over".

R11A: The voice should be totally inaudible and not simply strained or hoarse.

B: There should be a total loss of hearing.

E: This question refers to total blindness as opposed to badly blurred vision.

G: Seizures can be described as "when your body jumps and shakes all over by itself and you didn't even know it was happening".

I: This question refers to muscle weakness or paralysis.

R3: Self induced vomiting is coded "5".

R: PSYCHOTIC SYMPTOMS

This section is not diagnostic. It only gives some indication as to whether any psychotic symptoms are present which may or may not have some influence on disorders diagnosed in other sections of the interview. There are questions about visual, auditory, and olfactory hallucinations, paranoid delusions, thought broadcasting, thought insertion, and telepathy.

This can be a very tricky section for children, especially young children. Active imaginations produce a wide variety of visual "experiences", and it may be hard for children to distinguish between fantasy and reality. However, if described with an acute sensitivity to this, the questioning should go much smoother. Interviewers must rely on their own sense of the situation, taking into account the child's level of development. And, as always, it is better to write down more than less, so record whatever the child reports. Another potentially difficult determination of whether or not a true psychotic symptom is present is in the case of experiences that are attributed to religious doctrine. It is important to be able to distinguish between true subcultural identification and psychotic behavior.

Note that this section also has a 1-2-3-4-5 coding sequence for probing positive responses.

S1A: The child who has a visual hallucination actually sees the image in he same way that one experiences their real surroundings. It is not just a thought imagined in the mind. It is also a common experience to see things like dead relatives when falling asleep or waking up, and this is not considered hallucinatory.

Everyone has vivid images in their mind (in their mind's eye). People who hallucinate differ from the general population in that they actually believe that they see these images as part of the outside world. You might ask a child who describes a visualized scene, "Did you see it just like you're seeing me know?" or Did you really see it, or did your mind just make it up?" Those who see hallucinations believe very much that they actually see the vision.

Illusions, on the other hand, are not hallucinations. An illusion is seeing something (like a lamp post out of the corner of your eye) and thinking, for and instant, that it is something else (like a tall man). Illusions only last for a few seconds, and are followed by a realization of what is really being seen. They are not psychotic symptoms.

S2: When a child experiences auditory hallucinations they believe that they actually hear a person or persons talking when in fact there are no voices. Sometimes a child will say that they heard some one calling their name. However, if it is just an isolated incident or two, psychosis should not be considered. Another common experience is hearing the voice of a relative who recently died. Again, if this is not a repetitive experience it should be considered a part of the grieving process. It is best to get as much information as possible about the circumstances surrounding the experience and record it on the interview. Children will often say that they can hear people talking in other parts of the house when actually they are simply hearing a conversation between their parents for example - obviously not a psychotic symptom. Some very religious people believe that they can hear God's voice. If the respondent reports hearing God's voice, ask if he can hear God's voice out loud, just as he can

hear your voice. If he says "no",code 1. If he says "yes" code 5 and again write down any related information.

S3: Some auditory hallucinations involve sounds other than human voices. The common complaint of ringing in the ears does not count.

S4: This question is looking for olfactory hallucinations. Some people simply have an acute sense of smell and not psychotic experiences. Those with olfactory hallucinations smell things that are simply not present. Olfactory illusions (mistaking one smell for another) do not count but should be noted.

S5&6: These questions are aimed at identifying paranoid delusions. Both situations might sound very commonplace to younger children and adolescents alike. Most adolescents at one time or another feel as if their parents search through their room or try to know everything that they do outside of the house. And the power of peer pressure often make kids worry about what other kids are saying about them. In fact, there are probably friends who are really talking about them. But the quest for independence and immature gossiping are not contributors to this symptom. The true feelings of paranoid delusion or delusion of persecution have no real basis in reality. They are very real to the person but totally unfounded. These delusions are also experienced as extremely threatening.

S7&8: A relatively common bizarre delusion is one where the person believes that people on the radio or television are speaking directly to them or about them. This may include saying things directly to them, saying things in code that contain a message specifically for them, or talking about them. A young person with this belief might think that a cartoon character is personally telling them to do something or sending them a personal secret message.

Young people who have very strong religious influences in their lives may feel that a TV evangelist, for example, is talking directly to them with a message from God. This should not be related to psychotic belief as long as the respondent can appreciate that others watching the same program can receive the same significant kind of message.

S10: This bizarre delusion involves thought control or the idea that others can control your mind and make you do things against your will. Certainly children who suggest that their parents use guilt or spankings to control them are talking about discipline and not thought control. People who experience thought control must be unable to resist the whims of the controller. Those who believe that they are being controlled to this extent often say that they are told to hurt others, and can be forced to think and do practically anything.

S11&12: These questions probe for evidence of beliefs of telepathy. This delusion leads a person to believe that others can read their minds or that they, in fact, are capable of reading other people's minds. Some will report that a close relative or friend seems to always know what they are thinking. In this case the interviewer should have the respondent distinguish between mind reading and long term familiarity with some one. For example, the interviewer might ask, "Do you really think your Mom can read your mind, or is it because she knows you

very well?" If the respondent is a twin, determine if the co-twin is the only person with whom telepathic communication supposedly occurs. Twins sometimes claim such communication.

S14: The interview does not thoroughly attempt to identify commorbidity between depression and possible psychosis. This question is meant only as an indicator of a possible relationship between the two. If there are depressed episodes that have psychotic features, record as much information as possible for further evaluation.

T: EXTENDED FAMILY

This begins the portion of the C-SSAGA that examines the current psycho-social influences in the child's life. It looks at the child's social experience at school, with friends, and in their immediate family setting.

The children will answer questions based on their own perceptions and feelings about what is going on in the family. Parents, however, will be giving self reports for some of the questions rather than giving answers that they feel reflect their child's perception of the adult members of the family.

It is first necessary to establish who the adults are who have meaningful relationships with the child.

T1&T2: The interviewer should be able to fill in this information based on the previous demographic information given. If the child has had no relationship with their biological mother and father within the past year, the NO response will be coded in those spaces. Having never lived with the parent or the parent left the child's life for more than a year(via death, divorce, or other separation) would constitute "No Relationship". **ONLY BIOLOGICAL PARENTS CAN BE CODED IN MOTHER AND FATHER BLANKS.** Live-in companions can only be coded as OTHER and not as a step-parent.

The next most significant ongoing relationship with an adult the child is likely to have is with a step-parent. **IF LIVING WITH A STEP-PARENT, THEY WILL ALWAYS BE CODED IN THE OTHER BLANK.** If there is both a step-mother and a step-father who play a relatively equal part in the child's life, code for the step mother only, in the OTHER blank. This applies to adoptive parents as well.

Depending on who the OTHER is, some questions may not be applicable. In these instances coding for NA is preferable over coding the least desirable variable

T3: In addition to biological parents and step-parents the child is asked to identify another adult to whom they feel a special attachment. The OTHER should be the adult who fulfills a parenting like role to the child. They do not have to live with the child, but it should be someone who they like a lot and spend a considerable amount of time with. Remember to ask about that person when there is a space provided for "OTHER".

U:PARENT'S TIME SPENT WITH CHILD

In this section interest is directed at the amount of time as well as the quality of time spent between parents and children. Parents who engage in cooperative efforts, mutual discussion, celebrations, in addition to expression of affection, praise, or criticism, contribute significantly to a child's emotional development.

U1A: If the respondent says "no" to the question, probe more by asking if there is anything that the parent and child does together. Even if their child feels that the time spent with the adult is not enough worth mentioning, make a note and record the response.

U2: The aim of this question is to find out about exchanges between parents and children other than the expected discussions about school and family matters. Discussions could be about topics of personal interest, books, etc.

U5: If the child says "yes" to having his feelings hurts when being teased but offers an excuse for the adult by saying that they didn't mean it, the interviewer still codes a 5. Even if an encounter starts off in a joking manner but ends up hurtful to the child, a 5 is coded.

U8B: If the respondent states that s/he does not know, then read the coding choices. If more than one response is given then code the following hierarchy of 1 taking precedent over 2 and 3, and 2 taking precedent over 3 and 4, and so on.

V: DISCIPLINE

The discipline section gives insight into a certain amount of strife and conflict that may be happening in the family. The more conflict a child experiences the more likely it is that it will lead to behavior problems. The extent of the need for discipline can act as a very important marker for indications of psychopathology.

V1: The question refers to verbal reprimand only.

V2: Most every child has had privileges taken away. The respondent is being asked to compare their frequency of punishment to that of most other children.

V3: This question is not aimed at any specific type of discipline but rather how much the child seems to be in some kind of trouble with his parents.

W: ADULTS AS ROLE MODELS

Young children literally imitate the adults in their lives. And even as they grow older and evolve into their own person they still provide a clear reflection of those adult influences. In looking at the parent's social involvement, involvement with their children's activities, personal interests, and emotional and physical temperament, a picture is presented as to how they have contributed to the child's development. The role models that parents set make a big impact as to how a child sees himself in terms of either wanting to be like mom or dad or not wanting to be like them.

W4: This question is looking to find out if the parent displays a sense of involvement in the children and their various activities. It could be school related like for PTA meetings, open house, or a play. Or, it could be community related, like a volleyball game, religious ceremony, or awards banquet.

W5: IF a "no" response if given, probe with an open ended question by asking if there is anything the parent likes to do besides work outside the home or take care of the family. A hobby should involve some active pursuit of a special interest by the person. Following athletic event/teams, soap operas, and cooking can be hobbies if they fit this definition. Passively watching TV, occasionally going to the movies, AA meetings, and therapy are not hobbies. Also, parents getting together with friends is coded in W2 and should not be coded here.

W8: This question refers to fighting and arguing at times other than when drinking or using drugs. The intent of this item is to code whether or not the child hears a lot of arguing when they are home. The arguments can include those with other adults, not just the other parent, and it can be over the phone.

W9: This question refers to irritable behavior other than when drinking or using drugs.

W10: This question refers to physical exhaustion at times other than when drinking or using drugs.

X: FAMILY RULES

Although children often view rules and regulations set forth by their parents as a hardship and injustice, it really expresses a depth of care, concern, and protection for the children. Doing things like setting up a network for the children to visit back and forth with their peers, making them accountable for their whereabouts, and setting concrete limits on behaviors at home can act as powerful positive influences. The child who knows no boundaries is often left to engage in things that could potentially lead to serious behavioral difficulty.

X4A: In situations where no TV watching is allowed in the household, a 9 code for not applicable will be used.

Y: PEER RELATIONS

Parents are not the only people who impact on a child's emotional development. At times, peer relationships seem to have as much if not more impact on young people. Their ability to make and keep friends, handling coed relationships, along with parental concerns about who the children are involved with, are all asked about in this sections.

Z:SIBLING NETWORK

This section examines the relationship between the children of a family. The relationship between most brothers and sisters often resembles a battle ground of never ending opposing forces at one stage or another is not a particularly unusual situation. In spite of what seems to be very tumultuous times, children often gain a sense of family linkage and responsibility through their siblings. The intent here is to code for the best case scenario in order to find out if close sibling relationships protect against aversive family environments. If a child has more than one sibling and has a positive relationship with at least one of them, code the items with reference to this positive relationship. Note any particularly negative relationships in the margin and/or narrative. But whatever the influence the interaction between siblings can be a significant indicator of a child's psychosocial environment.

There are some extenuating circumstances that may affect how this section is coded. In the case where the only siblings of the child being interviewed are infants, toddlers, or have had no contact for some reason, most if not all of the questions will not be applicable. In the case where the only siblings of the child being interviewed are older and living away from the rest of the family, ask about the times when they were living in the same house and code for that time period.

Z1: In the case where there is only an older sibling who lives away from the family and they used to get along very badly but now get along really well (or vice versa), code for the most positive behavior. The interviewer would then ask, "so, now do you think that you and your brothers and sisters fight more.....?"

Z3A: If the response is "nothing", probe further by offering examples of other things that brothers and sisters might do (go to the movies, play video games, ball games, etc.).

STRUCTURED ASSESSMENT RECORD OF ALCOHOLIC HOMES (SARAH)

The purpose of the SARAH is to document the family's drinking and/or drug use and along with behaviors resulting from their use. Responses are based on the child's perceptions and feelings about what is going on in the household. They should not be asked to corroborate previously obtain information about the parent's drinking or drug use. If the parents' drinking occurred before the child was born or very early on in the child's life do not score the section.

Many of the questions in this section have independent coding options. For questions with this set of coding options:

NO.....1
DRINKING.....2
DRUGS.....3
BOTH.....4
CAN'T DISTINGUISH...5

NO =the behavior has not occurred in relationship to drinking or drugs
DRINKING =the behavior has occurred only in relationship to drinking
DRUGS =the behavior has occurred only in relation to drug use
BOTH =the behavior has occurred in relation to both drinking and drug use
CAN'T DISTINGUISH =the behavior is present but not sure if it is because of drinking or drugs.

These independent coding variables supersede those found at the top of each page just as in the rest of the interview.