

SEMI-STRUCTURED ASSESSMENT FOR THE
GENETICS OF ALCOHOLISM-II

SSAGA-II
SPECIFICATIONS

updated: 09/09/96

1. INTRODUCTION TO THE SSAGA-II

The Semi-Structured Assessment for the Genetics of Alcoholism-II (SSAGA-II) addresses psychiatric disorders according to several diagnostic classification systems, including DSM-III-R, DSM-IV, ICD-10, Feighner, and RDC. Its diagnostic coverage is most extensive for alcohol abuse and dependence, as its name would suggest. In SSAGA-II, all diagnoses may be made based on both DSM-III-R and DSM-IV classification. The SSAGA-II assesses physical, psychological, and social manifestations of alcohol abuse or dependence and other psychiatric disorders. It capitalizes on prior research in psychiatric epidemiology and relies on items previously validated by other research interviews, including the DIS, CIDI, HELPER, SAM, SADS, and SCID.

The SSAGA-II is formatted with an index in the left margin, questions in the center, and coding space in the right margin. The labels in the left margin are coded to reflect the diagnosis, the diagnostic system, and the criterion covered by the question. The following key lists the diagnoses assessed by the SSAGA-II, the diagnostic systems used, and the abbreviations used in the index labels:

DIAGNOSES:

AA = Alcohol Abuse
AD = Alcohol Dependence
AGP = Agoraphobia
ANR = Anorexia
ASP = Antisocial Personality Disorder
BUL = Bulimia
CD = Conduct Disorder
DA = Drug Abuse
DD = Drug Dependence
DEP = Depression
DS = Dissocial Personality
DYS = Dysthymia
GAD = Generalized Anxiety Disorder
MAN = Mania
ND = Nicotine Dependence
OCD = Obsessive/Compulsive Disorder
PAN = Panic
PTS = Post Traumatic Stress Disorder
SOM = Somatization
SP = Social Phobia

EXAMPLES OF LABELS:

AD3RA4 = Alcohol Dependence, DSM-III-R system, criterion A, item 4.
DA4A2 = Drug Abuse, DSM-IV system, criterion A, item 2.
CDICD18 = Conduct Disorder, ICD-10 system, criterion 18.

DIAGNOSTIC SYSTEMS:

3R = DSM-III-R
4 = DSM-IV
ICD = ICD-10, Criteria for Research
FGN = Feighner Criteria
RDC = Research Diagnostic Criteria

2. GENERAL NOTES ON INTERVIEWING

SSAGA-II interviewers do not need a clinical background, but they must be skilled communicators and listeners. Interviewers need to read questions smoothly and clearly. They must also listen carefully to answers, ensuring that respondents understand the questions and that answers fit the questions appropriately (e.g., a response that doesn't fit is an age of onset of 16 for a question that reads "*Before age 15, did you...?*"). When an interviewer feels an answer is inconsistent with the respondent's previous answers, s/he needs to ask for clarification without expressing judgment, disbelief, or dissatisfaction. Because the SSAGA-II covers a wide range of human experiences, interviewers must also be sensitive, tolerant, and empathetic. At the same time, they need to ask personal and sometimes embarrassing questions in a matter-of-fact way. Interviewers may, at times, be surprised by what they hear, but they should never show this. Interviewers should never lead a respondent or assume they know how a respondent will answer a question (e.g., "*You are in treatment, so in the last week you haven't had a drink.*" It may happen that R relapsed on pass, and, in this case, the interviewer may have made it hard for R to admit this). Interviewers should never ask questions apologetically or comment on what might seem inappropriate for R, for example, "*This probably doesn't apply to you, but...*" or "*You might find this (funny/tough to answer/awkward), but...*". Such comments may influence the respondent's answers if s/he thinks the interviewer is making judgments on what is appropriate for R. Interviewers may want to explain at the start that the interview is in the form of a structured booklet, and that each participant is asked the very same questions. This will help a respondent understand that even though some questions may not be of relevance to him/her, the interviewer still has to read them. (This can be repeated during the interview if R gets annoyed or offended by a question.)

The SSAGA-II's semi-structured design gives interviewers the freedom needed to extract the best information possible, while also maintaining a standardized pattern of interviewing. Whenever possible, questions should be read exactly as written. Skipping phrases may change the content of the question. Long questions may need to be broken into two questions for some respondents. If the respondent looks confused after the question is read, the interviewer should try re-reading the question before rephrasing. Questions should only be rephrased or followed up with additional probes when a response does not seem appropriate for the question, leading the interviewer to suspect that the respondent did not understand. If this is done, interviewers should carefully document the dialogue in the left margin for the editor's reference. Sometimes respondents volunteer information before a question is asked. When this happens, interviewers may ask the question in a confirmatory way, but they should also pay careful attention to the respondent's answer in case the information provided earlier is wrong or does not fit the question as it is worded.

Interviewers should start an interview by introducing himself/herself. Interviewers should be pleasant, but professional. This includes dressing appropriately and addressing respondents with Mr., Mrs., Ms., or Dr., etc.

When obtaining informed consent, interviewers are advised to read the consent form aloud to the respondent to ensure that each item is covered. Respondents should be given COGA telephone numbers, in case s/he has a question at a later time.

Interviewers need to explain that the interview is for research purposes, so the respondent does not confuse it with any kind of treatment. Interviewers must keep in mind that even though many respondents find the interview therapeutic, the interviewer's job is to collect the data -- a job of utmost importance to the whole project.

Interviewers should let R know that s/he may always refuse to answer any question, but that we would appreciate honesty. Interviewers should also stress confidentiality. One way to explain this is to tell R that all answers are assigned a numerical code that is entered into a computer, and that is what makes the research interview different from an interview with a doctor or therapist.

The SSAGA-II needs to be administered in private, where R can respond in utter candor without fear of others finding out about possibly unsavory or unpleasant behaviors. If privacy is not possible in a respondent's home, arrange to interview him/her in the research setting, or in a quiet public setting, such as a study room in a local library. The issue of privacy should be broached at the time of the initial telephone contact. By privacy, we mean that there will be a place where the interviewer can talk to R without others listening to R's responses (that is, it is alright if someone else in the house at the time of the interview, as long as that person is out of earshot). If a person should walk into the room during the interview, the interviewer should stop speaking until the person leaves. Young children may pose a problem, in that R may not be able to give his/her complete attention. The interviewer will have to use his/her judgment in these situations. If the interviewer has any doubts about the situation, s/he should call the site coordinator to get advice as to how to proceed.

The interviewer should make sure that R is interviewable; that is, is in a condition suitable to understanding and responding to questions. The interviewer should note any evidence of substance involvement (alcohol on breath, etc.), impairment of speech, disorientation, etc. If there is reason to believe that R is under the influence of alcohol or drugs, or has any other impairment that interferes with interview comprehension, the interviewer should break off the interview in a diplomatic way and reschedule.

Interviewer attitude and demeanor are very important since these can influence the data collection tremendously. If R is trying to please the interviewer, s/he may not be honest; if s/he is trying to impress the interviewer, s/he could exaggerate. The interviewer's attitude should be very professional and serious. This means not laughing, regardless of what is said; one can instead smile politely. Interviewers should not make comments, get into discussions, or share personal information with R. If R has questions or asks for advice or help, the interviewer should refer him/her to his/her doctor or therapist. Interviewers must follow the structure of the interview in a friendly, but professional and distant manner. Even touchy situations (i.e.,

description of a suicide attempt, crying) should be approached with a serious, professional manner. The interviewer may

show compassion by handing a tissue, offering a glass of water, or a similar gesture, but s/he should not make any comments because sometimes these comments may be uninformative, misleading, or misunderstood as patronizing or condescending.

Many different interviewers will administer the SSAGA. The interview should be conducted in such a way that it makes no difference which interviewer is collecting the data. Ideally, an interview would be coded in the same manner by all interviewers.

Because everyone's history is unique, each interview is going to be different. It is impossible to structure and specify questions for all possibilities and variations of the problems people might have. There will be situations when the interviewer is uncertain about how to code or how to interpret. In such cases, interviewers should record all the information in the margins and discuss it later with an editor.

Interviewers should follow these safety precautions when interviewing:

- Don't sit anywhere that would make it difficult to leave in a hurry, like behind a desk or where you have to pass R to get to the door. If possible, arrange the interviewing rooms so that the interviewer's back is to the door.
- Don't let R sit behind a desk with an unlocked drawer that might contain sharp objects like scissors.
- Don't sit too close to R both for safety and to ensure that R cannot see the interview questions or what you are writing down.
- When in the field, make sure your supervisor knows where and when you will be interviewing a subject (name, address, and phone number of subject). Always call your supervisor, after the interview is completed so the project staff know the interview has concluded and that you are on your way back.
- Emergency Procedures: If, during the interview, an emergency situation develops (e.g., overt suicidal gesture, current or suicidal thoughts, actual requests for help, or any situation that you feel uncomfortable about letting R leave once the interview is completed), immediately contact one of the project clinicians. (Immediately means right after the interview; R should not be allowed to leave). When calling a clinician, identify yourself as a staff member of the research project, explain the situation, and ask the clinician what his/her recommendation would be.

After the interview, interviewers should only discuss relevant details of the interview with the appropriate project personnel, and outside of earshot of non-study personnel. A basic rule to follow is this: Treat the information you have heard with the same respect that you would want a researcher to treat your personal information. That means, not swapping "horror" stories at the

lunch table with other interviewers for entertainment purposes. Interviewers also must never share interview information, including family history information, with other family members. Some participants may not want their family members to even know that they participated, so it is most prudent to not even share the names of who has participated.

3. INTERVIEW CONVENTIONS

Questions and Instructions: The questions that are to be read aloud are printed in upper and lower case letters, and interviewer instructions are printed in upper case letters. Interviewer instructions are not read to the respondent. They can be located in the center column above or under questions, in interviewer boxes, or in parentheses next to coding options. Interviewer instructions direct the interviewer how to code and/or where to proceed.

EXAMPLE: E10 Have you 3 or more times wanted to stop NO (SKIP TO B) 1
or cut down on drinking? YES 5

DO NOT COUNT DIETING OR PREGNANCY.

[In this example, the interviewer does not tell the respondent to not count dieting or pregnancy. If a respondent volunteers that she only stopped drinking when she was pregnant, the interviewer circles the code for "NO" and skips to the subquestion B.]

Optional Phrases: Some questions contain optional phrases in parentheses that allow the interviewer to tailor the question based on previous information.

EXAMPLE: E7 (Since (AGE OF REGULAR DRINKING IN _____ MONTHS
E5)), what is the longest time you have gone
without drinking?

[In this example, the interviewer would not read the optional phrase if the respondent had never been a regular drinker.]

Word Substitutions: The SSAGA-II uses upper case letters in parentheses for generic words that should be substituted with the appropriate word.

EXAMPLE: G3 Have you ever stayed high from (DRUG) for NO COC STIM SED OP OTH 1 1 1 1 1
a whole day or more? YES 5 5 5 5 5

[In this example, the interviewer reads the question for each drug as needed, "Have you ever stayed high from cocaine for a whole day or more?", "Have you ever stayed high from sedatives for a whole day or more?"]

Another convention used for word substitution is parentheses containing slashes. In these questions, the interviewer selects the appropriate word based on the respondent's previous answers.

EXAMPLE:	K34 Have you ever switched back and forth quickly between feeling (hyper/elated/irritable) and feeling depressed?	NO . . . (SKIP TO L1, p. 106) ... 1 YES 5
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Timeline and Tally Sheet Items: Responses that require the interviewer to mark the timeline or a tally sheet are labeled in the far right margin next to the code. The character used for the tally sheet label varies, but it is typically an uppercase letter, usually A, B, or C when there are more than one tally sheet. The timeline items are marked with "t". For tally sheet items, the Tobacco section uses an asterisk; the Alcohol, Marijuana, Drug, and Antisocial Personality sections use letters (directing the interviewer to the appropriate tally sheet or part of a tally sheet); and the Depression section uses a plus sign.

EXAMPLE:	F9 Did you ever need larger amounts of marijuana to get an effect, or did you ever find that you could no longer get high on the amount you used to use?	NO 1 YES 5	A,B, C
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[If the respondent answers "YES," the interviewer marks Marijuana tally sheets A, B, and C.]

The tally sheets should be coded in tandem with the diagnostic section, not completed at the end of the section.

Abbreviations: The interview and the specifications manual use the following abbreviations:

- DK = don't know
- IVR = the interviewer
- ONS = onset, the first occurrence
- R = the respondent
- REC = recency, the last occurrence
- RF = refused to answer
- SX = symptom or symptoms
- 3+ = three or more
- 5+ = five or more

4. READING QUESTIONS AND RECORDING ANSWERS

Questions are located in the center column and answers are usually coded in the right margin. Most questions require a precoded answer to be circled, but some require the information to be written on a blank line. Interviewers should record additional notes and comments in the left margin or on lines provided.

<p>EXAMPLE: A13 (Other than when you separated just before a divorce,) have you and your partner(s) ever separated for 3 days or longer because of not getting along?</p> <p>A. How many times did you separate? COUNT ALL MARRIAGE AND LIVE-IN SITUATIONS.</p>	<p>NO . . . (SKIP TO A14)... 1 YES 5</p> <p>___ __ TIMES</p>
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When a number is to be recorded (as in the above example), all spaces should be filled. That means that leading zeros may need to be added (e.g., if R had separated three times, it would be coded "03"), or a maximum number recorded if there are too few spaces (e.g., if R reported one hundred separations, "99" would be coded). Generally, a separate line is available for each digit. The only exception is found in the drug section, where page space is limited. For example, in G1A, even though only one line is available for number of times a drug was used, interviewer can code up to 9999 times.

Some questions begin with a stem that is repeated for the list of questions that follow. The stem generally should be repeated after every third question, but some respondents may need it repeated more often.

<p>EXAMPLE: S2 Did you feel this way about:</p> <ol style="list-style-type: none"> 1. going outside of the house alone?..... 1 2. being in a crowd or standing in a line?..... 1 3. being on a bridge or in a tunnel? 1 4. travelling in a bus, train, or car? 1 5. being in an elevator?..... 1 	<p><u>NO</u> <u>YES</u></p> <p>5 5 5 5 5</p>
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When recording answers, interviewers should be careful to circle codes clearly and print legibly. Any changes in coding should be crossed out with a single slash, with the correct code clearly circled or printed above it. That is, interviewers should not erase answers. Interviewers are encouraged to document the reason for the change (e.g., R changed his mind, IVR error). Changes made by editors will be made in colored ink.

If an interviewer is uncertain about how to code a response, s/he should record information in the left margin so the editor can make an informed decision. If a respondent refuses to answer a

question, document this with "RF." The editor will fill in a "-9" code for refusals. If a respondent says s/he does not know a particular answer, the interviewer should ask "*Could you give me your best guess?*" If the respondent cannot guess, and simply does not know the answer, document with "DK", and the editor will record the appropriate code. The Antisocial Personality section has an additional probe if the respondent does not know at what age the experience first happened. If the respondent cannot guess the age, the interviewer follows up with a standard probe: "*Do you think it was before your 13th birthday or was it later than that?*" In this section, there are specific codes for BEFORE 13, 13-14, 15-17, and 18 OR OLDER.

Ranges of Values: Many times, when respondents are asked for a number, like the age when something took place or how many times something happened, they give a range rather than an exact number (e.g., "Oh, I was 19 or 20 when that happened" or "That happened 4 or 5 times"). The convention for recording two consecutive ages is to record the younger age for an age onset and the older age for an age recency. For recording other consecutive numbers, the interviewer codes the more pathological number. For example, if R said she had 4 or 5 blackouts, code 5. If she said she was abstinent for 1 to 2 months, code 1 month. However, if a broader range is given (e.g., "I was between 20 and 24"), the midpoint should be recorded, so 22 is recorded for the range 20-24. Another example of this: if R said she had 4 to 5 blackouts per year for 4 years, the interviewer would code the midpoint of 16 to 20 times, which is 18.

5. PROBING

The SSAGA-II uses two types of standard probes: A/D probing (1/3/5/6) and probing.

A/D Probing: The SSAGA-II uses a standard Alcohol/Drug probe in the Antisocial Personality and Post Traumatic Stress Disorder sections. This probe allows the interviewer to assess the relationship between the experience endorsed and substance use. For all questions with 1/3/5/6 coding options, start by asking the stem question as written. If the respondent answers "NO,"

code 1. If the respondent answers "YES" to the stem question, then start the A/D probe:

IVR: *Did this ever happen when you were under the influence of alcohol (or drugs)?*

If the answer to ever under the influence is "NO," **code 5.** (YES, CLEAN)

If the answer is "YES," ask:

Did this only happen when you were under the influence of alcohol (or drugs)?

If YES, only when under the influence, **code 3.** (ONLY A/D)

If NO, sometimes when under the influence/sometimes not, **code 6.** (BOTH)

Probing: This type of probing attempts to determine the cause and clinical significance of a symptom. Clinical significance is defined by either seeing a health professional about the problem or endorsing a lot of interference with life and/or activities. Clinically significant symptoms are assigned a 3, 4, or 5 code, depending on the etiology. A 2 code indicates that a symptom was below the threshold for clinical significance, regardless of etiology. In summary, SSAGA-II probes are defined as:

5 = Yes, the symptom is present and possibly PSYCHIATRIC IN ORIGIN. Causes may include:

- a diagnosed psychiatric disorder (e.g., depression, schizophrenia),
- a vague emotional complaint (e.g., stress, nerves),
- a vague complaint that a health professional could not completely explain (e.g., found nothing abnormal on examination, x-ray, or lab tests).

The symptom may, at times (but not always), have also been caused by a physical illness, alcohol, or drugs. The respondent has seen a health professional about the symptom (interference assumed) or acknowledges symptom interfered a lot with life or activities.

4 = Yes, the symptom is present, but always due to PHYSICAL ILLNESS, INJURY, OR CONDITION, and the respondent either saw a health professional about it or acknowledges the symptom interfered a lot with life or activities.

3 = Yes, the symptom is present, but either always due to (a) taking MEDICATION, DRUGS, OR ALCOHOL, or (b) sometimes due to taking medication, drugs or alcohol and sometimes due to a physical illness, injury or condition. R must have either seen a health professional (interference assumed) or acknowledge a lot of interference with life or activities.

- 2 = Yes, the symptom is present, but it does not interfere with life or activities a lot. Symptoms that are not clinically significant are coded 2, regardless of cause(s). If R saw a doctor or another health professional about the symptom, then clinical significance is assumed and a 2 code is not possible.
- 1 = No, never had the symptom.

In standard probing, interviewers probe all possible etiologies of each symptom, regardless of whether the individual saw a health professional or not. If the respondent never saw a health professional about the symptom, the interference probe is asked.

Doctor or Other Health Professional: The "doctor" category includes psychiatrists, other medical doctors, physician assistants, osteopaths, and students in training to be medical doctors or osteopaths. "Other health professional" includes psychologists, counselors, dentists, nurses, social workers, and chiropractors. If the individual contacted is a relative, it must be established that s/he was contacted for help-seeking reasons (e.g., Uncle Jim was called not because he was the favorite uncle, but because he was a psychologist). This information would be recorded in the WHOM SAW line.

The following flow chart is used every time for this type of probing.

An example using the probing flow chart:

EXAMPLE: C4.4 Have you ever been bothered a lot by excessive gas or bloating of your stomach or abdomen?

CODE: 1 2 3 4 5

WHOM SAW: _____ WHAT TOLD: _____

IVR: "Have you ever been bothered a lot by excessive gas or bloating of your stomach or abdomen?"

IF NO, **code 1** and go to the next question.

IF YES, ASK: "Did you tell your doctor or another health professional about the excessive gas?"

IF NO PROFESSIONAL SEEN: record "NONE" on WHOM SAW line, and continue probing according to flow chart.

IF YES, ASK: "What did the doctor say was causing the excessive gas?" IVR records type of professional on WHOM SAW line and diagnosis on WHAT TOLD.

PSYCH DX/STRESS: **Code 5**

ALC/DRUG/MEDS: Ask: "Was (SX) always the result of taking alcohol, drugs, or medications?"

IF YES: **Code 3**

IF NO: Ask "When (SX) was not due to alcohol, drugs, or medication, was it always due to a physical illness or injury?"

IF YES: **Code 3** (see hierarchy of codes below)

IF NO: **Code 5**

PHYSICAL ILLNESS/CONDITION: Ask: "Was (SX) always the result of a physical illness or injury?"

IF YES: **Code 4**

IF NO: Ask: "When (SX) was not due to a physical illness or injury was it always due to taking medications, drugs, or alcohol?"

IF YES: **Code 3** (see hierarchy of codes below)

IF NO: **Code 5**

Hierarchy of Codes: Following the flow chart should result with the highest priority code. However, sometimes a particular symptom will have more than one cause. For example, headaches will sometimes be caused by eye strain (code 4), sometimes be caused by taking speed (code 3), and sometimes be caused by tension over problems at work (code 5). The SSAGA-II's hierarchy gives psychiatrically-relevant symptoms top priority (code 5) followed by symptoms which are related to use of medication, drugs, and/or alcohol (code 3). That means:

CODE 5 TAKES PRECEDENCE OVER CODES 3 AND 4

(e.g., headaches sometimes due to eye strain, sometimes to drinking, and sometimes due to

nothing at all; no diagnosis by the doctor; nothing unusual found with tests/X-rays; code 5)

CODE 3 TAKES PRECEDENCE OVER CODE 4

(e.g., headaches sometimes caused by eye strain and sometimes by drinking/drugs will be coded 3, provided R saw a doctor or other health professional or R endorses interference).

WHOM SAW and WHAT TOLD Lines: On the WHOM SAW line, the interviewer records whether the respondent had seen (or talked to) a health professional about the problem, and if so, the type of professional. The interviewer records the doctor's explanation on the WHAT TOLD line. If no help was sought for the problem, the interviewer records WHOM SAW as "none" or with a slash (/) and records R's explanation for the problem on the WHAT TOLD line.

The only exception to this pattern is when a respondent has previously stated that a doctor has diagnosed him/her with a psychiatric disorder, such as Schizophrenia, or that s/he has been hospitalized for a specific psychiatric diagnosis, but claims non-interference. In these cases, a 5 may be coded; that is, R's response may be overridden. The fact that R felt that this did not interfere with life or activities a lot should be noted on the WHAT TOLD line. These unusual situations should be well-documented in the margins.

In the general spirit of the SSAGA, the interviewer will have to probe, remember as much as possible, and use good judgment in case of any inconsistencies. Interviewers should follow the coding system, but to do so, they may need to adapt the probing pattern. Sometimes interviewers will need to ask more questions and sometimes fewer.

For example, if the respondent reports: *"Yes, I've had pains in the joints, but only when I hurt my toe hitting the chair barefoot. The pain was gone in two days. I never spoke to anyone about it, because I knew it wasn't broken. It did interfere with my life a lot because I couldn't walk properly for about a week because the pains would come back."* The interviewer should confirm that the SX was always due to illness/injury, and if so, code 4, record "NONE" on the WHOM SAW line and record something like "TOE, HIT CHAIR BAREFOOT" on the WHAT TOLD line.

Onset and Recency Codes: Many questions ask for the first time (onset) and/or the last time (recency) that an experience happened. The age of onset is coded in the spaces next to AGE ONS and the age of recency next to AGE REC. In the case of episodic illness, such as dysthymia or major depression, the end of the most recent episode gets coded as recency. AGE ONS and AGE REC allow the interviewer to code the age at which something happened and ONS and REC allow the interviewer to code when it happened in relation to the time of interview.

ONS and REC codes:

- 1 = within the last two weeks
- 2 = two weeks to just under one month ago
- 3 = one month to just under six months ago
- 4 = six months to a year ago
- 5 = more than a year ago

If the experience clearly happened more than a year ago (e.g., when the 43-year-old respondent was 25 years old) the interviewer can code 5 without probing. However if the time was not clearly over a year ago (e.g., when the 43-year-old respondent was 42 years old), the interviewer must probe for ONS and REC codes. ONS and REC probing should start with the lowest code, such as "Was that within the last two weeks?" If YES, code 1, but if NO, ask "Was that within the last month?" and continue as needed to determine the ONS or REC code. (See example below.)

EXAMPLE: A. How old were you the (first/last) time this happened?	AGE ONS:								
	ONS:	1	2	3	4	5			
	AGE REC:								
	REC:	1	2	3	4	5			

IVR: "How old were you the first time this happened?"

R(who just turned 43 years old): "When I was 40 or 41."

[IVR codes AGE ONS=40, and because it is clearly more than a year ago codes ONS=5.]

IVR: "How old were you the last time this happened?"

R: "When I was 42."

[IVR codes AGE REC=42]

IVR: "Was that within the last two weeks?"

R: "No."

IVR: "Was that within the last month?"

R: "No."

IVR: "Was that within the last 6 months?"

R: "Yes."

[IVR codes REC=3.]

6. CLUSTERING -- SYNDROMES

The Tobacco, Alcohol, Marijuana, Drug, Depression, and Antisocial Personality sections ask if symptoms ever occurred around the same time, or in other words: "clustered." These co-occurring symptoms establish a syndrome of a psychiatric disorder. When asking these clustering questions, interviewers use tally sheets to list all the symptoms that occurred.

The time frame for clustering questions varies according to the disorder and the criteria system used. For example, DSM-III-R clustering in the substance sections requires symptoms to occur together within a one-month period. The duration of clustering can last from one month to many years. Symptoms that have occurred sporadically throughout the respondent's life (e.g., one problem when R was 18, another when 25, another when 30) are not considered to have clustered. Similarly, we would not consider it clustering if multiple symptoms occurred as a result of an isolated incident (e.g., when R had been involved in hazing for a fraternity). For clustering to occur, symptoms do not have to occur at the same time or even on the same day. Rather, they must co-occur as part of a pattern in which R is experiencing several problems repeatedly within a given time span.

The time frame for clustering in Depression and Antisocial Personality (ASP) is different from that in the substance sections. In Depression, we ask if symptoms from different groups co-occurred within the span of a week (see I25), and in ASP, we ask if symptoms co-occurred over a period lasting 6 months (see M22).

All clustering questions in the SSAGA-II require the interviewer to record on the tally sheet which symptoms clustered by circling the symptoms.

7. TIMELINE

The SSAGA-II uses a timeline for every respondent. Interviewers record personal information (such as marriages, divorces, children's birthdates, graduation years, and any other markers a respondent may use to date an event), substance use (noting onset, recency, and abstinent periods lasting 3 months or longer), onset and recency of clustering, and episodes of psychiatric disorders. Substance use is recorded as a thin line and heavy use is recorded as a thick line. Clustering is marked by X's. Abstinence is labeled with a "∅".

A: DEMOGRAPHICS

General:

This is a non-diagnostic section that elicits basic demographic information useful for later analysis.

Question by question specifications:

- A1 If R is a transsexual, record sex s/he was born with.
- A2 Round height up to nearest whole number.
- A3A Do not include weight gain during pregnancy.
- A6 This question implies any legal adoption. Adoption by a family member should be noted in the margin.
- A7 If the subject had a twin or other multiple who died at birth or when s/he was very young, this should be noted, but still coded as yes (5).
- A8A Record code from card A1. In cases where R is unsure of his/her race, ask him/her to choose the group that s/he most closely identifies with. If R refuses to answer, record apparent race in the margin. Depending on the situation, it may be reasonable for the editor to code race as it appeared and to leave ethnicity as a refusal.
- A8B Record code from card A2. This determines the country of origin of R's biological grandparents. Spaces for 8 ethnic codes are provided in cases where R is aware that his/her grandparent is a mixture of two ethnicities. In general, code to reflect a mixture, even if mixture is not 50%-50%. If R is unable to provide any more information than my Mother's Mother was English, use the code for English in both columns. If R states that his/her background is American, check to see whether his/her background is Native American. If not, use code 67 (American, N.O.S.). The Unknown code should be used only as a last resort. When R knows origins but not from which side of the family, code the specifics randomly.
- A8C If R says that s/he is an Atheist or an Agnostic, make note of this. If R then volunteers s/he has attended religious services in the past 12 months, determine what services these were. Code current preference regardless of what R was raised as.

- A8C.1 This question looks at the influence of religion on alcohol use. Many religions do not condone alcohol consumption but do not pointedly forbid it. Code yes (5) only when any alcohol use is explicitly forbidden. Religions such as Fundamentalist Baptist, Mormon, Moslem are examples of sects where alcohol use is forbidden.
- A8D In the case of an alternative religion with no organized services, record 000. Organized meetings for alternative religions should be included. Television church , or watching services on the television (particularly when this is done as a regular part of religious exposure) counts. Listening to a religious service on the radio also counts, but make sure that R specifies having listened to a service. Do not count simply listening to a religious station. Make a note of this in the margin. If R attends several services in one day code only as 1 time.
- A9 "Married" refers to **legal** marriages only, not live-in relationships that would, in some states, qualify as common-law marriages. Marriages between members of the same sex and marriages that were legally annulled do not count because they are not **legal** marriages. In the case of annulment, code legal annulment as never married and religious annulment as divorced. If R has married the same person twice, code as two separate marriages.
- A9 If R says that s/he is widowed, obtain the year his/her spouse died, and code in the space provided. Separated includes both legal and informal separations from a legal spouse -- it would not include separation from a live-in partner. Even if R has been separated from his/her spouse for a number of years, count this as a separation (rather than a divorce).
- A10 This question refers to live-in relationships as though you were married and **not** to marriages or roommate situations. Emphasis should be placed on duration of at least a year. This also includes homosexual live-in relationships.
- A11 If R has been married more than four times, code his/her four most recent marriages in the space provided and code all other marriages in the margins. This also holds true for divorces in A12.
- A12 Information from A9 is used to phrase A12. If A9 is coded as 5, A12 would begin So, you've never been divorced . In any other case How many times have you been divorced should be read. Marital instability may be of psychiatric relevance.

- A13 The phrase "Other than when separated just before a divorce" should only be read if A12 is coded 01 or more. This separation refers to any marriage/s or live-in situation/s. Separations due to job, school, or military necessity do not qualify. The intent is that the couple was not getting along. R should thus be reminded that this number should be the **total** of all separations in all such relationships. The last time R separated should not include the final separation just before (and leading up to) a divorce.
- A14 Include: pregnancies terminated by abortion or miscarriage, and pregnancies ending with a stillborn. Tubal pregnancies count.
- A14B Count termination of tubal pregnancies here. If R loses twins or other multiples through miscarriage, code as 1.
- A14C Count all biological children -- including those given up for adoption, those produced out of wedlock, and/or those who R never took care of. If R cannot remember the month of birth, try to at least get the year. Because the SSAGA-II is designed to be a self-report instrument, it is inappropriate to use pedigree information to fill in birth dates on the SSAGA. If R does not know dates of birth, then R may be called later for that information. There are spaces for 8 children; others should be noted in the margin. Do not include step children (those who are not biological children of R).
- A15 In general, 12 depicts a high school education, 16 depicts a Bachelor's degree and 17 depicts any post-graduate degree earned. Completion of a technical school is coded 13, even if it took more than 1 year to complete. If R did not complete a degree, code the highest grade actually completed. With college, code the year equivalent and not the time it took R to complete it. For example, if it takes R 3 years of attending college part-time to complete the equivalent of 1 year's credits, code as 13. If it took R 5 years to complete a Bachelor's degree, code this as 16. Some Bachelor's degrees do take 5 full-time years to complete and do have the equivalent of an additional year or two of credits, but they should still be coded as 16. If R has 2 Bachelor's degrees, code as 16. Unusual situations, such as assisted living teaching programs, should be reviewed case-by-case. Information such as the age at completion of the program and the depth of the program may help editors decide what grade-level best estimates R's education. Do not, however, code A15A "Yes" if R did not receive a high school diploma.
- A15A,B Asked only if R reports 12 or fewer years of education.
- A15C If R is currently enrolled in school, code no (1). Count only high school and above (eighth grade school graduation does not count). If R gets a GED but never goes further, code as no (1).

- A15D Ask for the dates of all graduations that apply to R. If R has multiple college and/or graduate degrees, code the most recent graduation of each. If R has both a Masters and a Ph.D., code the date the Ph.D. was awarded. Make note of the other graduation dates in the margin. A.S.N. and B.S.N. nursing degrees should be included under the college category. Other School is to be used for technical schools, such as auto mechanic, secretarial, LPN, CNA, QMA, and other special degrees including registered nursing (R.N.) degrees awarded based on additional training following a college degree. This **does not include** 6-month training programs, such as cable line school.
- A15E This is asked of everyone, to help assess whether R did not complete his/her education because s/he is still in school or working toward a degree. Failure to complete education has been implicated as a risk factor for psychiatric disorders. Night courses towards GED count as being enrolled in school.
- A16 This question asks about work for pay only. If R has been hospitalized and his/her employer is holding the job until R can return or R is receiving worker's compensation for an injury, count this as employed. Also include situations like sabbaticals and paid leave-of-absences (such as maternity leave) after which time R would be expected to return to work. If R is a teacher and works only 9 months out of the year (generally with the summer months off), code this as 12 months of employment.
- A17 If R volunteers that s/he is self-employed (which might include free-lance writing, farming, contracting, consulting, selling) count as full-time even if R went without a job for several weeks or even months. Work in federal job corps programs counts and situations that count as being employed in A16 also count in A17.
- A17A Full-time work status is 37.5 hours per week or longer.
- A17B R is given card A3 and asked to list the code of the income category that best fits his/her current situation. Current **household** gross income is the combined pre-tax income of R and spouse (or spouse equivalent), and would include other members of the household that would be contributing money for maintenance and payment of general expenses. Do not combine income of roommates who are not significant others. If R is in a live-in relationship with a lover and shares bills and responsibilities with his/her live-in partner, then the two incomes should be combined. Also included are payments of child support, alimony, social security, disability, welfare, and food stamps. Students with part-time jobs should include this income with parents' income. Married couples that live with parents, who pay rent but do not combine incomes with the parents, should not include the parents' income. People such as farmers who have large outlays of money for equipment and supplies should use their taxable income as reported to the IRS.

The sale of property does not count as income. Student loans do not count as income. Prorate income if it changes during the year. For example, if R has been retired for less than a full year and reports 02 for current retirement income and 07 before retirement, the interviewer should prorate R's income as if R had been retired for a full year -- thus code 02 as his/her current income.

A18 If R states s/he has been in the military Reserves do not count **unless** s/he has been called up for active duty.

A18A If R does not know the type of discharge s/he was given, read the choices to him/her.

A18B Highest rank ever achieved in **any** branch of the military should be recorded as a formal rank (e.g., Sergeant) as well as a letter-number combination pay grade (e.g., E4).

B: MEDICAL HISTORY

General:

The first six items in the medical history section, written in structured format, assess R's lifetime history of physical illness/injury, types and duration of non-psychiatric or non-substance use related hospitalizations, number of outpatient surgeries, doctor and emergency room visits, and lifetime/current use of medications. The latter portion of this section (B7-B9) deals with R's psychiatric/emotional history and contains information about treatment and hospitalizations. Question B7 is open-ended and unstructured, designed to both develop rapport with the subject and to determine whether s/he ever had psychiatrically relevant problems. It differs in form and content from the rest of SSAGA. Data obtained in B7 can be checked against information obtained in later diagnostic sections or used as a memory prompt for later responses.

Question by question specifications:

- B1 The intent of this question is to get a general rating of health, not a "day of interview" rating.
- B2 The state of R's health, coded in B1, is inserted here. Record the explanation if his/her health has not always been this way. If R is customarily in excellent health but has a temporary condition, such as a broken collarbone, code as "excellent" since the broken collarbone is temporary.
- B3 This is a list of medical illnesses of neurophysiological relevance. If R says "*Oh, I have high blood pressure*", or "*I get headaches all the time*", or "*I know that I have heart disease because my father, uncle, grandfather and brother all had heart disease*", you must again follow-up with "*Did a doctor ever tell you had...*". The year that R was diagnosed by the doctor is to be coded for each YES. Illnesses must have been diagnosed by a doctor, not a physician assistant.

Definitions and descriptions:

1. **Abnormal blood pressure**-The following findings are considered abnormal: systolic pressure persistently above 100; pulse pressure constantly greater than 50. Blood pressure varies with age, sex, muscular development, and states of worry and fatigue. Usually, it is lower in women than in men, low in childhood, and higher in elderly individuals.
2. **Migraine headaches**-Paroxysmal (convulsive or spasmodic) attacks of headaches, frequently unilateral, usually accompanied by disordered vision and gastrointestinal disturbances. They are thought to be the result of vasodilation of extracerebral cranial arteries.

3. Brain injury or concussion - Blunt trauma to the cranial vault will have differing consequences and final outcomes depending on whether the injury was penetrating or non-penetrating. Non-penetrating injuries can result in fractures of bones that directly affect adjacent brain tissue. Bleeding (hemorrhage) from head injuries may occur at various sites, depending on the site of the injury, which have different prognostic implications. In an epidural hemorrhage, the blood is in a layer between the skull and a sheath-like covering of the brain (the dura). Sometimes the blood accumulates slowly with neurological symptoms proceeding to coma within hours to days. In a subdural hematoma the hemorrhage is located between the brain and the dura or sheath-like covering of the brain. The neurological consequences are obvious almost immediately. A chronic version of the acute subdural hematoma caused by a minor blow to an elderly person may result in a slow period of mental decline over weeks. Keep in mind that a "head injury" is some type of trauma to the brain; it does not include scalp lacerations. **Concussion**-An injury to the head resulting from impact with an object or violent shaking and agitation of the brain. The effects include loss of consciousness (usually), loss of reflexes, brief cessation of breathing, slowing of the heart, and changes in blood pressure. Amnesia and confusion may last only briefly or several days.

4. **Unconscious**- Not conscious or responsive to environmental stimuli.

5. **Epilepsy/Seizure**-A recurrent paroxysmal disorder of cerebral function characterized by sudden, brief attacks of altered consciousness, motor activity, or sensory phenomena. Epilepsy is the sudden disorderly electrical discharge of cerebral brain cells with disturbance in sensation, loss of consciousness, impaired mental functioning, convulsive movements. Convulsive seizures are the most common form of attacks, but any recurrent seizure pattern is considered epilepsy. **Do not count seizures which are a result of alcohol withdrawal.**

6. **Meningitis**-An infection of the layers covering the brain caused by viruses (aseptic meningitis) or bacteria infections such as Hemophilus influenza, Neisseria meningitides or streptococcus pneumonia, resulting in inflammation of the membrane of the spinal cord or brain. **Encephalitis**-Infection and inflammation of the brain itself is called encephalitis. Its symptoms include convulsions, delirium, confusion, stupor, mutism, hemiparesis (weakness on one side of the body) etc. associated with an aseptic meningitis.

7. **Stroke**-The sudden, non-convulsive focal neurologic deficit, also known as a cerebrovascular accident (CVA). A malfunction of the cerebral vessels has many causes including Atherosclerosis (hardening of the vessels). There is sudden loss of consciousness followed by paralysis caused by hemorrhage into the brain.

8. **Heart Disease**-Diseases that affect the heart can be congenital or intrinsic (such as an abnormal valve, malformed heart or arrhythmias, the irregular beating of the heart) or acquired (such as endocarditis; ischemic due to atherosclerosis of the vessels flowing to the heart or secondary to external problems such as heart failure due to hypertension). Occasionally, heart disease may need to be determined on a case-by-case basis but would also include such things as angina, heart murmurs, and CAD.

9. **Liver disease**-Alcohol's effect on the liver initially causes fat accumulation but eventually causes a small hard fibrotic liver that is ineffective in metabolizing body products. This is called cirrhosis. Gall stones in the gall bladder near the liver can have a negative effect on the liver. Also, the liver may become infected (hepatitis), develop cancer, be the site of a cancer originating in another part of the body, or become filled with abnormal substances due to a genetic enzymatic disorder - Gaucher's disease.

10. **Thyroid disease**-The thyroid controls the rate of metabolic activity in the body and the rate of activity of other cells in the body. Hyperthyroid is the result of too much thyroid hormone of which Grave's disease is one kind. Thyrotoxicosis is a hyper-metabolic state due to elevation of thyroid hormone that can cause heart failure. The opposite is the clinical state of hypothyroidism in which weight gain, skin thickening, lethargy and mental dullness are observed. Cancer of the thyroid is common in individuals who received radiation treatment near the neck for an unrelated condition. If a subject reveals that s/he is taking "Synthroid" but is uncertain as to whether s/he has thyroid disease, code "5" since s/he will probably need to take it for life.

11. **Asthma** - A respiratory disorder characterized by recurrent episodes of difficulty in breathing, wheezing, cough, and thick mucous production, usually caused by a spasm or inflammation of the bronchial airways. Attacks are precipitated by exposure to an allergen (e.g., pollen, dust, food), strenuous exercise, stress or infection. Asthma is most common in childhood (occurring more often in boys) and has a strong hereditary factor. Treatment involves the use of bronchodilators.

12. **Diabetes** - A metabolic disorder characterized by extreme thirst and the passing of very large amounts of urine; it is caused by failure of the pituitary gland to produce or secrete sufficient amounts of antidiuretic hormone (ADH). Treatment depends on the severity of the disease; mild forms may be managed with diet alone, but other cases require the use of drugs to lower blood sugar levels or injections of insulin.

13. **Cancer** - An abnormal, malignant growth of cells that invades nearby tissues

and often spreads to other sites in the body, interfering with the normal function of the affected sites. We obtain the type of cancer. (breast, lung, etc.)

14. **HIV/AIDS - AIDS:** First identified in 1981, AIDS is a serious and often fatal condition in which the immune system breaks down and does not respond normally to infection. **HIV:** A test has been developed to detect the presence in a person's blood of antibodies that specifically recognize HIV and that serve as a marker for viral infection. The virus can be isolated from most persons who test positive for the presence of these antibodies. Anyone who has antibodies to the virus must be assumed to be infected. A person infected with HIV may not show any clinical symptoms for months or even years but apparently never becomes free of the virus.

15. **A sexually transmitted disease** - Refers to communicable diseases transmitted by sexual intercourse or genital contact. This may include gonorrhea, syphilis, hepatitis A & B, genital herpes, etc.

16 & 17. Two additional illnesses can be recorded in B3.16 & 17. If the subject has more than two additional illnesses, code the more serious illnesses: if you are not sure, check with a clinician). If they are equally serious, code the more recent ones.

B4A As stated, begin with the most recent hospitalization. Include hospitalizations for normal pregnancies. If R was a student, and "hospitalized" in the college infirmary, this counts. Information will be used to obtain medical records. Therefore, it is essential that the list of non-psychiatric, non-substance abuse related hospitalizations be **as complete as possible**. If the hospital name cannot be recalled, then the location (e.g., city and state) should be obtained. Total number of hospitalizations, even if the stay was just overnight, must be recorded. If R has had numerous hospitalizations, the information can be recorded in the margins. If R was admitted to a hospital (not a psychiatric ward) for medical problems associated with anorexia or a suicide attempt, this should be coded here (under B4A), instead of B9 or B4C.

B4B Common procedures done on an outpatient basis include arthroscopy, liposuction, augmentation mammoplasty, d&c, some forms of cosmetic and reconstructive surgery, and oral surgery (regardless of anesthesia use). Do not count a simple tooth extraction, but do count surgery to remove wisdom teeth. If R volunteers that she had an abortion, code it here as outpatient surgery.

B4C Count all Emergency room visits that were for accidents or injuries or acute conditions such as food poisoning. Include ER visits that led directly to in-patient hospitalization.

- B5 Count any check-ups or routine visits to doctors, D.O.s (Doctors of Osteopathy), eye doctors, as well as visits due to illness/injury, or for emergency care. Do not count visits to chiropractors and physical therapists (but do make a margin note). Also, recent hospitalizations are not included here.
- B6A This question is used to screen for prescription medications R has taken for at least 2 weeks anytime in his/her life. Do not count over-the-counter (OTC) medication. For every "YES" response, the interviewer should elicit the name of the medication, to be coded later by the editor. Medication taken to have more energy can include items such as diet pills and other caffeine-containing products. Vitamins do not count, even when given as shots, nor do immunization shots. This does not include any illegal drugs R was using (for example, taking cocaine for more energy). However, it does count if R was taking others' (e.g., friends') prescription drugs. When R responds that an unknown medication was taken to feel less nervous, do not code anxiolytics. Instead, code -09 (unknown.) Items should be coded according to R's understanding of what the medication was to be used for. For example, if a subject went to a GP complaining of depression and was given medication to help sleep ("if you get a few nights sleep you won't be depressed anymore") then this would be coded under B6A.3 (to feel less depressed), even if the medication was a sleeping pill.
- B6B.8 Ask every respondent for any other prescription medication that s/he has been taking for at least 2 weeks and has used sometime within the past 30 days. If R volunteers that s/he was just prescribed a medication that s/he will take for 2 weeks or longer, code it here.
- B7 Designed to facilitate rapport with R, keep response under 10 minutes. This would include any period in R's life that has been upsetting, including work and social difficulties such as loss of a job or breakup of a love relationship. Record what R says in as much detail as possible, including dates or ages when troublesome events took place. Also record whether R sought professional help, took medication, or was hospitalized. This question is useful as reference when completing other sections of SSAGA. Before moving on to question B8, always ask R whether s/he has any other examples of troubling times that stand out as particularly upsetting.
- R should be allowed to speak freely; however, some structuring of information may be necessary to elicit psychiatrically relevant information. For example, if R elaborates about the details of the death of his grandmother, but gives no information about how this death affected him, the interviewer should ask R about what **he** was experiencing at this time.

If R initially answers "NO" to B7, the interviewer should probe gently by stating, "*So, there has **never** been a time in your life that stands out as troubling or upsetting?*" Likewise, if R responds positively to B7, but then provides few details, the interviewer should probe for more information and relevant details.

- B8 Even if R reported no troubling time, s/he is asked if s/he ever spoke with a professional (including a general medical doctor) about emotional or psychiatric problems. Probation officers are not considered mental health professionals and should not be coded here.
- B9 Record the number of times R was a patient in a psychiatric hospital or ward, including a chemical dependency unit. The specifics of the hospitalizations are required for obtaining medical records.
- B10 Outpatient treatment may include a recovery residence for alcoholics or other treatment programs. Do not count school or career counseling, but do count other counseling or therapy visits to a psychiatrist, psychologist, or counselor (e.g. marital or family counseling).
- BOX B11A Count either inpatient or outpatient treatment.

C: SOMATIZATION

General:

Somatization is defined as the conversion of mental experiences or states into bodily functions. The cardinal feature of Somatization Disorder is a pattern of repeated, multiple, somatic complaints that result in medical treatment or cause significant impairment in social, occupational, or other key areas of functioning. If the symptoms occur in the presence of a medical condition, the physical complaints or impairment must be greater than what would be expected from the history or physical findings. Unexplained symptoms in Somatization Disorder cannot be intentionally feigned or produced (as in Factitious Disorder or Malingering). Although most people have various aches and pains and other physical complaints not explained by a known medical illness, they rarely mention them to a doctor or professional, and rarely do these interfere with a person's life. This distinguishes individuals with Somatization Disorder from those experiencing everyday aches and pains.

Generally, persons with this disorder have vague and complicated medical histories that begin before the age of 30. Often the person believes that s/he has been "sickly" for much or most of his/her life, with repeated visits to clinics, the use of multiple medications prescribed by different physicians, and frequent hospitalizations and operations. Complaints almost always involve gastrointestinal problems, female reproductive difficulties, sexual problems, cardiopulmonary symptoms, and conversion (pseudo-neurological/grand hysterical) symptoms. The latter are unexplained complaints suggestive of neurologic disease (e.g., amnesia, paralysis, "spells", difficulty walking, anesthesia, blindness).

Somatization is a fully diagnostic section that ascertains DSM-IV and DSM-III-R criteria. In addition, the 11 questions under C1 differ in format from other SSAGA-II sections. They have been organized so that only if 4 or more body pains are present will the individual continue with severity coding. There are skip-outs throughout the Somatization section, so that if R has continued through the body pain questions s/he may still skip out if no gastrointestinal problems are present. To continue through Somatization the following must be coded 3,4, or 5: Body pains, 4+; gastrointestinal problems, 1+; neurological problems, 1+; general problems, 1+. The coding structure (1,2,3,4,5) is a method of determining both severity and etiology of the problem. See General Specifications Section for details.

Determining Symptom Cause:

If there are multiple diagnoses, the interviewer must decide whether they are all direct or are parts of casual chains. In the latter case, only the most proximal cause is considered in deciding on a code:

1) Multiple direct causes (no causal chain).

R: *Sometimes the pain is caused by my ulcer. Other times it is from stress. It does*

interfere with my life because I have to take time off from work.

In this example there are two direct causes and no chain of causes. Since the pain sometimes results from stress, which is psychiatrically relevant, and following from our hierarchy of coding precedence (see Probing/Coding beginning on page 5), this would be coded 5.

2) Chained causes

R: *I only get the pain when stress makes my ulcer act up.*
(stress - - -ulcer- - -pain)

In this example, stress makes the ulcer worse but the proximal cause of the pain is the ulcer, not the stress. Code 4 (assuming interference)

3) R: *I have an ulcer that I'm afraid may perforate. When I worry a lot about the ulcer, I get headaches. These headaches make me really sick and I have to take time from work, which interferes with my life.*
(ulcer - - -worry - - - -headaches)

In this example, it is the worry about the ulcer, not the ulcer directly, which causes headaches and interference in R's life. Code 5.

When certain questions are coded "5", it is necessary to ask a sub-question such as "Did this occur only during a panic attack". The panic disorder section is placed later in the interview, but it is necessary to ask these questions because symptoms that occur only within the context of panic attacks are not counted in DSM-IV toward the diagnosis of Somatization.

Alcohol and drug explanations ("3" code) take precedence over physical illness explanations ("4" code). Other medications would not take precedence over a "4" code.

Record all specific information told to R by any health professional (including chiropractors) on the "WHAT TOLD" line, and list the care-giver on the "WHOM SAW" line. If R neither saw nor spoke to a Dr./other health professional, record a slash (/) through the "WHOM SAW" line and R's comments on the "WHAT TOLD" line. If R did see a Doctor/other health professional, a 2 code is not possible.

Question by question specifications:

General: Always stress a lot of problems with each individual symptom. If R asks what is meant by "a lot of problems" respond that "a lot of problems" means whatever R considers it to be. When a doctor attributes physical symptoms either to fatigue or to growing pains, code as a 5.

C1.5 Sometimes R will answer, when s/he has been asked about pains in the joints, that s/he has pains in the leg or arm. Tell R that these will be asked about later (C1.6). The leg/arm pain should be noted in C1.6, and then C1.5 should be re-asked, with an emphasis on "in the joints".

- C1.11 Some respondents will mention pains that are not listed, such as a "painful, burning sensation on the forehead". All pains not listed should be recorded under the "other pains" line. (e.g., hand or foot pain gets coded under C1.11)
- C2.10 Code painful menstrual periods that MD said were 'normal' as 5.
- C4.2 Nausea-not vomiting, feeling sick to stomach but not actually vomiting
- C4.5 "3 or more foods making you sick" This refers to 3 or more **different** types of food, not 3 of the same type of food (e.g., ice cream, cheese, whipped cream are all milk products and thus the same type of food).
- C6 Symptoms occurring as part of a recuperative process should be recorded and probed in the typical pattern.
- C6.3 Hearing must be lost completely.
- C6.4 Inability to move a part of the body, and not just numbness.
- C6.8 Feeling loss must be for a few minutes or more.
- C6.9 Losing feeling must be for a few minutes or more.
- C8.1 "Exerting yourself" would include exercising, sports, physical labor or other heavy or strenuous physical activity. Hyperventilation is synonymous with shortness of breath.
- C8.3 "Fainting spells": R must actually pass out. If R does not pass out, and simply gets dizzy spells, this would be coded in C8.5.
- C8.4 "Heart beating so hard" must not be due to vigorous exercise, or watching scary or erotic movies. The symptom must occur spontaneously.
- C8.5 A period of dizziness where R does not pass out. This includes vertigo or a period of lightheadedness.
- C8.6 "Sickly" is left for R to define, but refers to someone who either gets sick easily or is in generally poor health.
- C8.7 "Not well enough to carry on" describes an inability to perform normal daily activities. It describes a pervasive feeling of illness which is non-specific but

disruptive enough to cause the individual to feel that s/he **cannot** manage normal daily responsibilities and assume a normal role.

C8.11 Weight loss must be unintentional.

C8.12 Weight loss must be sudden and unexpected.

C8.16 This must have occurred after R became sexually active. If R volunteers that s/he has never had sex, the interviewer may silently code 1 for questions C8.16-C8.19.

D: TOBACCO

General:

The Tobacco section assesses DSM-IV Nicotine Dependence for cigarette smokers.

Question by question specifications:

- D 1 pack of cigarettes = 20 cigarettes
- D1A-D R is asked if s/he has ever used tobacco. Only count using a whole cigarette, cigar, pipeful, or pinch, so a few puffs would not be sufficient to code YES.
- D3 This question determines who will continue in the section, and who will be skipped out. Smoking a total of 100 or more cigarettes in one's lifetime is necessary to continue.
- D4 This question assesses the most typical pattern of cigarette smoking.
- D5-D9 Note: R should focus on the month (or longer period) when s/he was smoking or using tobacco the most. We are not interested in a period of a few days when R was smoking heavily. If R always used at the same level and reports that s/he had no period of "heaviest" use, then ask R to focus on the time when s/he was smoking regularly.
- D5 This question is non-diagnostic. We ask "about" how many minutes after waking did R usually smoke his/her first cigarette. If R cannot give a number, code "-09" and ask A: the "Don't Know" questions of "within the first five minutes?" etc. Code for the smallest duration.
- D7 Emphasize "places where it was forbidden." The given examples may not fit every situation (e.g., 10-20 years ago non-smoking regulations were not as common). The interviewer may need to probe with other examples as needed, such as: church, school, work, library, hospital, etc.
- D9 The question doesn't ask specifically about smoking in bed, just whether R smoked when s/he was very sick. However, if R did endorse smoking in bed, be sure to code that in D13.
- D10 This question asks about chain smoking cigarettes, that is smoking one cigarette right after another.

- D10A Emphasize everyday or nearly everyday. We want to code the length of the period R chain smoked on a daily or nearly daily basis. (We are not asking for the number of hours of chain smoking.)
- D13 This question addresses Abuse, not Dependence, so it is not a tally sheet item. Even if R claims smoking in bed isn't dangerous (e.g., he would sit up) count the behavior as YES.
- D14 Get examples of why R thought about stopping or cutting down. If the only reason is pregnancy, code NO.
- D14A R is asked if s/he has ever tried to quit using tobacco. Quitting smoking during pregnancy counts. Switching from one form of tobacco to another does not count as quitting (e.g., stopped smoking cigarettes but chewed tobacco instead). If R states that s/he has never tried to quit using tobacco, but at some point stopped using tobacco, code NO. We will still be able to capture R's longest period of abstinence in D15.
- D17 These problems should stem from the use of tobacco, not withdrawal. Withdrawal problems are coded in D16. It is reasonable to code problems that stemmed from tobacco use and continued even after R stopped using tobacco.
- D17A Obtain examples of how functioning was affected.
- D18 In this question, we ask if tobacco caused persistent or chronic health problems. Shortness of breath is not considered a serious health problem, so it would not be coded.
- D19 This question asks if R smoked when s/he had a condition that was worsened by smoking. Examples of illnesses that count are asthma, bronchitis, pneumonia, and gum disease. If high blood pressure wasn't coded in D19 (i.e., R didn't endorse that tobacco use caused high blood pressure), then high blood pressure can count in D19. Illnesses that are not clearly exacerbated by smoking should be reviewed by a local clinician.
- D21 Clustered experiences must be from 3 different boxes. As with all clustering questions, the interviewer should circle the symptoms that cluster.

E: ALCOHOL

General:

Alcohol is a fully diagnostic section that assesses Alcohol Abuse/Dependence for DSM-III-R, DSM-IV, Feighner, and ICD-10 criteria. Card E1 is used to clarify and define alcohol equivalents used in the SSAGA.

Respondents are given the opportunity to skip out of this section in the following three cases: 1) If they have never had one full drink of alcohol (item E1A); 2) If they never had more than 3 drinks within a 24-hour period (item E6); 3) If they have never consumed alcohol at least once a month for 6 months or more **and** have never been drunk (items E5, E5A).

Question by question specifications:

- E1 R is asked if s/he has **ever** had a full drink of alcohol in his/her lifetime. Do not include sipping wine when taking communion or having only a small portion of one drink.
- E2 This question assesses (A) negative reactions when exposed to minimal amounts of alcohol and (B) whether any of these reactions kept R from drinking alcohol on at least one other occasion (other than when the negative reaction took place). Note that reactions to specific types of alcohol (e.g., only wine) are NOT coded here.
- E2 Stress "any type of alcohol" and "1 or 2 drinks."
- E2A1 The definition of "flush or blush" is included in the sentence.
- E2A1.a Stress "the first few minutes" after the drink. The flushing syndrome typically occurs very soon after exposure to alcohol.
- E2A6 The definition of palpitations is included in the sentence.
- E2B If R stopped drinking during the drinking session when the negative reaction took place but at no other time, this would not count. R does not have to experience the reactions every time s/he has been exposed to alcohol. In most cases, these reactions will only happen early in one's drinking career.
- E3 R is asked about alcohol consumption within the past seven days, starting with the previous day. There are four main categories to assess: Beer, Wine, Liquor, Other. Record the "other" type of drink on the line provided. The Beer category

includes Lite Beer (do not count non-alcoholic beer). The Wine category includes wine coolers and champagne. Liquor includes straight liquor and simple mixtures, like vodka and orange juice, scotch and soda, rum and Coke, etc. The Other category includes liqueurs, sherry, port wine, malt liquor (like Zima), fortified wine, complex liquor mixtures like Long Island Iced Teas and Margaritas, and drinks that do not fall under the previous categories (for instance Ouzo and Hard cider). **Whenever an alcoholic beverage is recorded under "other," the interviewer should specify the drink.** An equivalency chart is provided. The interviewer may need to remind R what hard liquor is.

The interviewer asks R about each category of alcohol separately, starting with the previous day and continues in this manner for each of the preceding 6 days. The following dialogue is given as an example:

IVR: *"Yesterday was Friday. How many beers or lite beers did you have on Friday?"*

R: *"Four."*

IVR: *"How much wine did you have yesterday (Friday)?"*

R: *"I split a bottle with my girlfriend when I got home. We finished it off with dinner."*

[IVR codes "half a bottle" as 3 drinks]

IVR: *"How many drinks of (hard) liquor did you have yesterday?"*

R: *"None."*

IVR: *"Did you have any other alcoholic beverage yesterday?"*

R: *"No."*

IVR: *"How about Thursday. Did you have any beer or lite beer on Thursday?..."*

The interviewer proceeds in this fashion asking by day and by drink type to get a pattern of usage for the past week. When possible, avoid using "Don't Know" codes. If R cannot remember how much s/he drank, try prompting with "was it one drink, two drinks, ten drinks...".

E3B Note that this is coded on the timeline.

E4A This question asks R how many weeks out of the last 26 s/he drank. It may be

necessary to help R establish when the last 6 months began. Note the skip instruction to E5 if R replies that s/he has not had anything to drink in the last 6 months. If R had something to drink every week, 26 is coded.

- E4B If R reports any drinking in the last 6 months, ask R to think about a week which would be an example of R's typical drinking pattern. If R reports that the past week (E3) typifies his/her drinking, then the interviewer should verify with R on a drink-by-drink, day-by-day basis that the previous week represents her/his typical drinking week over the last 6 months. **"Typical" does not mean worst.** If R drank only 1 week out of the last 26, that week would be recorded. The fact that R is an infrequent drinker would be reflected in E4 which would be coded "1" (1 week out of the last 26).
- E4C Asks R to think about his/her heaviest drinking week in the last 6 months and report how many days in that week s/he drank. If R reports that s/he did not have a "heaviest" week (i.e., all weeks looked like the typical week), code 8 and skip to E5.
- E4D Asks R to report how many drinks s/he had on a typical day during R's heaviest week of drinking in the past 6 months.
- E4E If R had more than one week, code the most recent.
- E5 "Regular" drinking is defined as drinking at least once a month for 6 consecutive months. This is coded on the timeline.
- E5A The SSAGA-II standard definition of "drunk" is defined as slurred speech or being unsteady on one's feet.
- Box E5C Interviewer must check to see if R ever smoked cigarettes since the two following questions probe smoking behavior when drinking.
- E5C Asks whether R almost always smoked when drinking.
- E5C.1 Asks whether R almost always drank when smoking.
- E6 This elicits largest number of drinks taken in 24 hours across R's lifetime. The largest number of drinks in a 24-hour period is the total number of alcoholic drinks (beer, wine, liquor, etc.) R consumed within a 24-hour period. So, if the largest amount of alcohol R had was a 1/2 case of beer, a bottle of wine, and a fifth of gin, the total number of drinks would be 12+6+20=38 drinks. The interviewer would code "038" in the spaces provided. Card E1 is provided for such conversions.
- E6A Records the largest number of drinks in a 24-hour period during the last 6 months.
- Box E6 Provides a skip out of the alcohol section for Rs who have never had more than 3 drinks in a 24-hour period in their lifetime or for Rs who never drank regularly and

have never been drunk (E5 and E5A must both be coded 00). Note that the skip applies to lifetime consumption, NOT to the last 6 months.

- E7 This item asks about the longest period of total abstinence from alcohol. During these periods, not even a single drink should be consumed. Code in months. If R has never drunk regularly (E5), use the age at which R was first drunk (E5A).
- E7A Asks for the total number of 3-month or longer periods of abstinence. This should be completed even if R cannot specify the month/year of these in E7B.
- E7B Asks R to specify when these episodes of abstinence began and ended. These periods of abstinence are important for comorbidity assessment, and the interviewer may have to work with R to obtain these periods. For example, if R cannot remember periods of abstinence, try to determine whether s/he drinks on holidays, birthdays, etc., and then work around these occasions. Some information is better than none. Record abstinent years if the specific months cannot be determined, even after prompting with seasons. These are all coded on the timeline.
- E8 Drinking "almost every day" is defined as drinking at least 4 days out of 7 for one week or more.
- E8A Focuses on the period of heaviest drinking almost every day for at least one week. Code the largest number that was drunk on at least 4 days in a week. That is, if R drank 7, 10, 12, 8, 15 drinks on different days during the week, record 8 (because R drank at least 8 drinks 4 days out of 7). If R reports 2 periods of heavy drinking for at least one week, code the period in which the greater amount of alcohol was consumed on a daily basis.
- TALLIES A boxed instruction informs the interviewer that some "5" responses will now need to be marked on the tally sheets labeled "A," "B," and "C" for DSM-III-R, DSM-IV, and ICD-10, respectively. Beginning at E9, the interviewer should be alert for questions that have an "A," "B," or "C" to the right of the of the "5" response. Whenever these occur, the interviewer must mark that experience on the appropriate tally sheet. For example, at E9D there is an "A," "B," and "C" to the right of the "5" response. The interviewer must mark these experiences on each of these tally sheets.
- E9 Beginning with E9 and ending with E9G, R is asked to review whether s/he had any tolerance to drinking for feeling an effect (E9-E9D) or feeling drunk (E9E-E9I).
- E9A1 Asks R to consider how many drinks it **first** took to feel an effect from drinking

alcohol after s/he started drinking regularly. R may need to think of the first several times s/he drank to answer this question. R should report how many drinks it took to feel **any** effect from drinking, e.g., a slight buzz.

- E9A2 This question assesses how many drinks R needed to feel any affect of alcohol after s/he had been a regular drinker. The reference to "drinking for some years" is meant to indicate a period of time when R drank regularly. Code the highest number of drinks R typically needed to feel an effect (for example, during his/her heaviest drinking period). Do not code a one-time situation when R was able to drink a lot more than usual, e.g., when R had a full stomach.
- E9C/D Code silently. Note skip instructions to E10. Card E2 is used to illustrate a 50 percent or more increase to obtain the same effect. For the purpose of this interview, tolerance requires a 50% increase and threshold of increasing to 5 drinks for women or 6 drinks for men to get an effect. One drink to 6, 2 drinks to 6, 3 drinks to 6, and 4 drinks to 6 all count, as they represent a 50 percent or greater increase. Five drinks to 6 does not count.
- E9E Asks R to determine if s/he could drink more than at the beginning of drinking career before getting drunk.
- E9F1 Asks R to consider how many drinks it **first** took to feel drunk (as defined earlier: feeling unsteady on feet or experiencing slurred speech) from drinking alcohol. R should report how many drinks it took to feel drunk the first few times R became drunk.
- E9F2 Code the highest number of drinks R ever needed to feel drunk.
- E9H / E9I See E9C/D.
- E10 Code unsuccessful efforts or persistent desire to stop or cut down when R was experiencing problems due to drinking. As instructed in interview, do not count cutting down due to dieting or pregnancy, because these are not harmful effects of alcohol.
- E10B-D All unsuccessful efforts count in E10C and E10D, so we ask about every attempt--even when R was pregnant.
- E11 Many people decide not to drink at certain times, but the intent of this item is that rules were developed **specifically** to **control** drinking. Any such rule would count, not just those mentioned here.

- E12 This item asks R if s/he **did not adhere** to the self-imposed restrictions of promising self not to drink on a particular occasion or promising self to have only a certain **number** of drinks on a particular occasion. Restrictions must be set **before** a drinking session begins and must represent an effort to **control** drinking.
- Do not code reports of drinking more than R expected to, just those occasions when R had set a limit and than did not adhere to it.
- E13 Refers to a self-imposed restriction of **deciding** not to get drunk **before** a particular drinking occasion. Note this is an occasion when R became drunk when s/he did not **want** to, **not** simply when s/he did not **expect** to get drunk.
- E14 Activities must be greatly reduced, not just missed a few times. Thus, missing a day or two of school, some exercise routines, or missing a family celebration once would not count. The intent is to determine if R has chosen drinking over other activities.
- E15 By "several days" we mean 3 or more days in a row.
- E16 The question includes the definition of binge-drinking: 2 days or more of continuous drinking, which is interrupted only by sleep.
- E16A Neglect of responsibilities must be during a period of binge drinking. It includes school, household, child care, and work responsibilities. It should not be broadly interpreted as "failing to get dressed". If R volunteers that the binges were planned and R did not neglect responsibilities, then this would not count.
- E16B Code only the number of binges when R neglected responsibilities.
- E17 Blackouts are periods of time when R was drinking heavily and was **conscious** but could not remember what had happened. Blackouts may be of short or long duration, but must be periods of at least several minutes about which R can recall nothing.
- E18 A characteristic sign of dependence, the intent of this item is a **need** for alcohol in the morning.
- E18A Directly asks R about drinking before breakfast. This is asked regardless of answer to E18. Do not count drinks at brunch.
- E18C Refers to either E18 or E18A, whichever has been coded "5." If both, read: "how old were you the (first/last) time you took a drink ...?"

- E21 Use of alcohol with medication(s) must be contraindicated. R must be aware at the time of alcohol consumption that drinking while taking a particular drug or medication was hazardous. The intent of this question is that R drank despite the fact that s/he knew it was harmful to do so. If a doctor told R it was dangerous to drink with specific medications, and R drank anyway, it counts because R was made aware that the combination could be hazardous. Illegal substances also count. Do not count drugs that are not dangerous even if R thought they were. Dangerous drugs include those with a sedative effect, such as tranquilizers, downers, antidepressants, antipsychotics, anxiolytics, and other sedatives. Interviewer should probe for number of drinks and quantity of medication/drugs used and record on "specify" line. In addition, R should be asked why s/he thought that combination was harmful.
- E21B Interviewer should obtain the earliest age onset and latest age recency for any dangerous mix (i.e., mix at onset can be different from mix at recency).
- E21D The harmful consequences of mixing alcohol and drugs are sought. Things like falling asleep for 18 hours count.
- E22 This item asks whether R did certain activities that increased his/her chance of injury, for example driving a car when drunk. Simply being a passenger when the driver is also drunk, hitch-hiking, or taking rides from strangers do not count.
- E23 DWIs and DUIs are counted as arrests for drunk driving. Count even if the charges were later dropped or reduced to another offense.
- E24 All accidents count, even those not reported to the police.
- E25 Stress "often". Note that the interference may be due to being under the influence and/or recovering from its effects.
- E26 This item assesses family, social, or occupational problems that R may have had in relation to use of alcohol. For each "Yes" response (5), the interviewer is instructed to determine whether the behavior occurred 3 or more times, and to code this in Column II.
- E26.1 Objections that occur long after R has stopped drinking (such as describing drinking at age 20 to someone 10 years later, and that person objecting to his/her alcohol consumption) do not count.
- E26.2 Losing a partner, significant other, mate, or spouse counts as losing friends.
- E26.5-8 Do NOT count if hitting and fighting were only in self-defense, as in domestic

violence.

- E26B Interviewer should review all symptoms coded 5.
- E26C One type of experience or any combination of experiences could have occurred 3 or more times.
- E28 Count arrests specifically for being drunk, such as public intoxication and drunk & disorderly. Do not count crimes committed when drunk; those are coded in M29. For example, R was drunk and arrested for assault and battery. It is coded under M29, not E28, because charge was not for public intoxication or drunk & disorderly, even if being drunk helped lead to the arrest. Also, count any official detention, for example, if R was in the military, count being detained by security or the military police.
- E29 R must have had a serious accidental injury while under the effects of alcohol, particularly when drunk. Examples include a sprained ankle or a cut requiring stitches. Minor mishaps, such as stubbing a toe or getting bruises, do not count.
- E31 Only code the health problems that drinking caused. Do not count reasons other than alcohol for these conditions. Make sure R connects the condition with the drinking.
- E31.1 Liver damage should be coded under E31.7 if not diagnosed as a disease.
- E31.6 Read phrase in parentheses if R has reported blackouts.
- E32 This assesses drinking despite pre-existing and serious physical health problems that could be exacerbated by drinking. Stress serious and physical. Emotional problems, such as depression or mood swings, do not count. Pregnancy is not counted as a serious physical illness if R was only told that drinking would harm the fetus and not the mother. Illnesses such as the flu, stomach aches, measles, etc. do not count as serious, (even if R reports that drinking caused the flu to develop into pneumonia). Insulin-dependent diabetes counts. However, diabetes that is controlled by diet only counts if R consumed more than an average of one drink per month.
- E32C This question directly assesses whether the illness was made worse because the stem question E32 only queries "might have been made worse."
- E33 This question assesses psychological and emotional problems that may have been caused by drinking. The specifications of "more than 24 hours" and "interfered with your functioning" have been added to emphasize the severity of the

symptoms.

- E34A Code the age R first **realized** that s/he was an excessive drinker, as the question is phrased "thought that ..."
- E35 Feeling guilty about the number of calories in drinks does not count, but feeling guilty about drinking because of religious/social beliefs does count. R must feel guilty about his/her drinking in general -- not just about something s/he did when drinking.
- E37 Stress that symptoms must be for most of the day for 2 days or longer.
- E37C If more than one symptom is endorsed in E37 (coded in Col. I), R is asked whether two or more of these symptoms occurred together (clustered).
- E37D R is asked to identify the withdrawal symptoms which clustered. The interviewer should read the withdrawal symptoms that were coded "yes." Code all problems that R says occurred together in Column II-IV where there is a place to code. Note: some spaces are blank because that particular criteria system does not recognize the symptom as a withdrawal symptom. Note that "shakes" is required for Tally A. The other tally sheets are marked if the required number of symptoms clustered.
- E37E This question asks when the clustering of withdrawal symptoms (withdrawal syndrome) first occurred. R should date the first occurrence of any clustering of problems.
- E37F Count the number of times that R had the withdrawal syndrome, not just an individual symptom.
- E37G This question assesses impairment caused by the DSM-IV withdrawal symptoms. (column III)
- E37H Refer to all withdrawal symptoms endorsed. (column I)
- E37I This requires R to have deliberately taken a drink on 3 or more different occasions to either keep from having or to relieve **any** withdrawal symptom.
- E37J This requires R to have deliberately used, either prescribed or non-prescribed, medications or drugs (other than non-prescription pain killers such as aspirin or Tylenol) to relieve any withdrawal symptom at any time. The name(s) of the medication/drug should be recorded. Note that medications prescribed by a doctor and/or given in treatment count here.

- E39 This item describes delirium tremens (DTs), a rare, severe, and life-threatening withdrawal syndrome.
- E40-42 Clustering: See general notes on clustering on page 15.
- E40A R is asked to identify which symptoms clustered. The IVR circles those on the tally sheet. This information will be used to characterize further the alcohol phenotype.
- E40C These dates get coded on the timeline.
- E41A If three or more DSM-IV symptom groups (as indicated by checks in the lower right-hand side of each box), R is asked whether the experiences endorsed (from 3 different groups) ever occurred together over a period of at least 12 months. Stress "12 months" to ensure that R has heard this time frame, which is different from E40.
- Box E42 The symptoms included on this tally are different from those on Tallies A and B. Be sure to give R a chance to review the symptoms and make a determination about clustering.
- E43 This question assesses help-seeking behavior. R must have brought the problem to a professional's attention, not simply acknowledged having the problem when queried by a professional.
- E44 If R has ever been treated for a drinking problem (either voluntarily or involuntarily) this is coded here. Note the skip instructions at E44C.
- E44D Sometimes AA or other self-help is not considered treatment, so the question is asked directly only for those who deny receiving treatment in E44.

F: MARIJUANA

General:

The Marijuana section of the SSAGA-II is fully diagnostic for the following criteria systems: DSM-IV, Feighner, DSM-III-R, and ICD-10. Marijuana has been separated from the general Drug section because use of marijuana is relatively common (according to DSM-III-R Cannabis is the most widely used illicit psychoactive substance in the United States) and because there are thought to be fewer negative withdrawal, physical, and emotional effects from marijuana, when compared with other drugs such as cocaine, stimulants, and sedatives.

Marijuana is usually smoked, but it can be ingested orally as well. It is often used in combination with other substances such as alcohol and cocaine. Symptoms associated with marijuana use include tachycardia, increased appetite, paranoid ideation, panic attack, listlessness and dysphoric effects following cessation of use. Maladaptive behavioral effects include impaired judgement and interference with social or occupational functioning. With cannabis abuse, use is episodic and the person exhibits symptoms of maladaptive behavior, such as driving while under its influence.

This section parallels in form and content the Alcohol and Drug sections since all come under the umbrella term of psychoactive substance use. The threshold for entry into this section -- use of marijuana 21 times or more within a single year -- differs from that of the "Drug" section. This threshold was selected because occasional recreational use is not uncommon in many sub-samples of the population. If an individual denies ever having used marijuana then s/he will immediately skip to the next section. If R has used marijuana/hashish but never at least 21 times within a single year, R will be asked questions in F2 and then will skip to section G.

Question by question specifications:

- F2E Periods of abstinence lasting at least 3 months since the time R began marijuana use are obtained. The interviewer should work with R to date any abstinent periods of 3 or more months, as they may be important in determining comorbidity. If R cannot/will not date these periods, the interviewer should still obtain the total number 3 or more months of abstinence from marijuana use. "Don't know" responses should be entered wherever R is unable to provide month and/or year.
- F3 Stress "longest" and "**almost** every day." Duration of use should be coded as simply and as specifically as possible; that is, if R stated that the longest period of use was 1.5 months, code "0006 weeks".
- F4 A "whole" day is defined as all waking hours in a twenty-four hour period.

- F5 Stress "a month or more."
- F6 Stress "interfered with your functioning" and "for more than 24 hours." Make sure R connects the symptoms with marijuana use.
- F6.5 Hallucinations with marijuana use are rare and usually mild. Code if these were of particular severity and duration.
- F6A Items in Column II are coded on the tally sheets.
- F7 Unsuccessful efforts would count; however, a persistent desire to stop or cut down during a pregnancy would not count.
- F7A Only Tally A is marked for this symptom. Tallies B and C require several efforts as determined in F7B.
- F8 This must be more than R intended, not just more than was expected.
- F10E Refers to total number of times where a clustering of withdrawal symptoms occurred (F10C), whichever R has previously endorsed in Column II.
- F11B Must be a serious accident, not just a bruise or a small cut.
- F13 Note that the legal or police troubles must be specified.
- F14 Stress "often."
- F17 R must either have given up important activities 3 or more times and/or must have given up important activities for a period of one month or more to count as a positive symptom.
- F18 All drugs -- including alcohol -- that R has used in combination with marijuana should be recorded. The "3" code is to be used if R used marijuana **only** with alcohol, and no other substances. Spaces are provided for recording specific substances. If more than 4, code the 4 used most with marijuana.
- F19-F21 Clustering: See general notes on clustering on page 15.
- F19C A grouped onset and recency question.
- F19B If R answers "No" to F19A, R is asked whether there was ever a period of at least one month when at least 2 experiences, each from a different group, ever

"clustered," i.e. ever occurred together over a period of at least one month. If R answers "Yes," R is then asked for the onset and recency of this clustering (F19C).

- F19C This gets coded on the timeline.
- F22 This question assesses help-seeking behavior. R must have brought the problem to a professional's attention, not simply acknowledged having the problem when queried by a professional.
- F23 If R has ever been treated for a problem with marijuana (either voluntarily or involuntarily) this is coded here.
- F23D Provides those who deny treatment for marijuana an opportunity to report attendance at a self-help group, like a Narcotics Anonymous meeting.

G: DRUGS

General:

This is a fully diagnostic section that assesses Drug Abuse and Drug Dependence, using the DSM-III-R, DSM-IV, Feighner, and ICD-10 diagnostic systems. The Drug section is similar in form and content to the Tobacco, Alcohol, and Marijuana sections.

The interviewer starts by handing R a list of drugs. The interviewer should circle all drugs that R has used on card G2 and ask if R used any other drugs not on the list. If R denies ever taking drugs except as prescribed, the interviewer should verify the negative by asking, "*So you have never used cocaine or crack? Or stimulants, like speed, uppers, or amphetamines? Or sedatives, like downers, barbiturates, or sleeping pills?.....Or have you tried anything else that was not this page?*" until each drug class has been verified as a definite "NO". The interviewer should carefully check all drugs that R has used. Using Card G1 as a reference, R may focus on illegal substances and not mention that s/he has abused prescription drugs unless specifically queried. It is especially important to check for prescription drug abuse if R reported use in the Medical History section of the SSAGA. If R has not used any illicit drugs or misused any prescription drugs, then s/he skips to the next section.

If R has used any drug (other than as prescribed), the interviewer proceeds to G1 and asks for the number of times R used drugs within each drug class. The questions throughout the section are also asked about each class of drug, not each specific drug.

The section allows for coding a total of five classes of drugs: cocaine, stimulants, sedatives, opiates, and the class of drugs used most from those remaining (i.e., PCP, hallucinogens, solvents, combination drugs, or drugs that don't fit in any other category). The specific name or type of drug that will be coded in this fifth column should be recorded in Box G1. If R reports using equal amounts of drugs in more than one of these "other" classes, the interviewer should ask about the class of drugs that caused the most problems.

Generally, questions in the Drug section are asked in rows -- meaning that if more than one drug class is being coded, the interviewer asks the question for each coded drug class before moving on to the next question. So, for example:

IVR: "*Have you ever wanted to cut down or tried to cut down on cocaine but found that you couldn't?*"

R: "*Yes.*"

IVR: "*Did this happen with stimulants?*"

R: "*Yes.*"

IVR: "*Did this happen with opiates?*"

R: "*No.*"

(Some respondents may need the stem question repeated more often.)

Exceptions to this general pattern include questions G11, G18, and questions that have follow-up "IF YES, ASK:" subquestions. These exceptions should be coded by column, i.e., the questions and subquestions are completed for one drug class before continuing on to the next column.

Question by question specifications:

- G1 Do not count any over the counter (OTC) medications. Also, "prescribed" refers to medications prescribed for R. If R took someone else's prescription when it was not prescribed for R, it counts here. However, do not count: (1) using a prescription drug as needed after the period for which it was prescribed, or (2) taking someone else's prescription meds if R has the identical prescription and R is taking the medication as prescribed.
- G1A "Number of times" really means the number of different occasions. If R took ten pills in one night, count as one time. If R took one pill on ten different days, count as ten times. Record the total number of times R used drugs in a particular class. For example, if R used Valium ten times and Librium ten times, then s/he has used sedatives twenty times. Code T's and Blues as Opiates. Code Ecstasy as Other. Code crank as stimulants (amphetamines). Code ice as combination (it's a combination of cocaine and amphetamines, with the it's primary component amphetamine). For prescription drugs, count the number of times they were used when not prescribed or more than prescribed. Even though there is only a single line to record the number of times, interviewers can code numbers containing up to 4 digits, or, in other words, a maximum of 9999 times.
- G1D This question refers to the hypothesized "kindling" effect of cocaine. It is asked of anyone who has ever used cocaine.
- G1E Do not count using alcohol and cocaine together if there was no intent for the alcohol to help R feel better when coming down.
- G1G Count any needle sharing -- even if R claims s/he used the needle first.
- G1H "Favorite" is left up to R to decide. It is not necessarily the drug used most, but the one R enjoyed the most. Marijuana can be included here, but not alcohol. If R claims to have no favorite drug, record "NONE" and the editor will code "000".
- G1I If R states s/he has used two or more drugs together, then record in the margin all the drugs used at the same time. The editor can only code two drugs per occasion (1a and 1b used together; 2a and 2b used together). "Together" is generally defined as using at the same time or within two hours of each other. This may include prescription drugs and illicit drugs, but alcohol and marijuana do not

count.

- Box G1 This box directs the interviewer to continue asking about the class of drugs used 11 or more times, and also to choose which class (if any) of the remaining substances will be coded in Column 5. If any PCP, HAL, SOL COMB used 11 or more times, interviewer should choose the one used most and code in Col. 5.
- G2A These get coded on the timeline.
- G2B Note the longest period R used (DRUG) "almost every day". SSAGA-II's standard definition of "almost every day" is at least 4 days out of 7. Code in units that gives the most accuracy, for example, 1 year 2 months = 14 months.
- G2D.3 This gets coded on timeline.
- G3 "A whole day" is defined as most waking hours in a twenty-four hour period.
- G6 Stress "a month or more".
- G7&G7A Count persistent or unsuccessful efforts desire to stop or cut down during pregnancy.
- G11 Issue of prophylactic treatment for withdrawal: Sometimes the facilities will institute treatment for withdrawal so that individuals will not experience the symptoms for two days or longer. These cases may need to be addressed by a clinician.
- G11A This question assesses withdrawal symptoms. Stress "for 2 days or longer." Because not all withdrawal symptoms are common among all classes of drugs, coding spaces are deliberately missing for symptoms that cannot apply to a particular drug. This question is to be completed by column, asking about one drug class completely (G11A-F) before moving on to the next class.
- G13D "Any problem" refers only to the problems mentioned in G13A.
- G18 In G18.1,.2,.3,and .5, stress "for more than 24 hours" and "to the point that it interfered with your functioning."
- G18.4 Refers to hallucinations caused by drugs when is was not the expected effect of the drug. For hallucinogens, add the phrase "other than desired effects of the drug" and do not count hallucinations if they were expected -- instead, only count "bad trips".

- G19-21 See general notes on clustering on page 15.
- G19 The interviewer should ensure that R understands that recency is the last time any problem occurred -- not the last time a problem occurred 3+ times. If 3 or more boxes are marked, R is asked about clustering. These get coded on timeline.
- G23A.3 "Outpatient Program for something other than drugs" may include visits for treatment to a doctor's office. "Any other place or program" may include specific programs such as methadone clinics.

H: EATING DISORDERS

General:

Section H, Eating Disorders, covers Anorexia Nervosa (H1-H9) and Bulimia Nervosa (H9-H16) and is fully diagnostic for DSM-III-R and DSM-IV criteria. Two screening questions are asked for Anorexia Nervosa, and if the subject answers "NO" to either, a diagnosis of Anorexia is not possible and s/he skips to question H9. If the subject answers "NO" to either H10 or H11, or there are no positives coded in H13, the rest of the section is skipped because a diagnosis of Bulimia is not possible.

Both disorders are characterized by marked disturbances in eating behavior. The essential features of Anorexia Nervosa are: refusal to maintain body weight at a normal minimum weight for age and height; intense fear of gaining weight or becoming fat, even though greatly underweight; a distorted body image; and amenorrhea in females. However, if a woman is taking birth control pills, do not count amenorrhea.

The essential features of Bulimia Nervosa are: recurrent episodes of binge eating (a minimum average of 2 binge-eating episodes a week for at least three months); a feeling of lack of control over eating behavior during the eating binges; use of laxatives or other measures (fasting, vomiting, etc.) in order to prevent weight gain from the eating binge; and persistent overconcern with body shape and weight.

Question by question specifications: Anorexia

- H1 Stress "a lot of weight on purpose."
- H2 Stress "too **thin**."
- Box H2 Note skip instruction reference to H2A.
- H3 This question elicits the respondent's lowest weight brought about by deliberate weight loss.

H4 Record height in feet and inches as follows: Five feet ten inches = 5 1 0; six feet one inch = 6 0 1.

BOX H5 The interviewer is asked to estimate R's frame size. If possible to measure frame size, this is done by measuring wrist circumference in women and asking chest and shoe size in men, using the following guidelines:

WOMEN - WRIST CIRCUMFERENCE

MEN - CHEST/SHOE SIZE

less than 5-1/2 - sm. frame

<38" chest or less, <8 shoe size - sm. frame

5-1/2" - 6-1/2" - md. frame

38"-44" chest, 8-10 shoe size - med. frame

>6-1/2" and more - lg. frame

>44" chest, shoe size >10 -lg. frame

H6 "**Intensely afraid**" should be emphasized.

H6A The pathological response is "No." This constitutes denial of the seriousness of the weight loss.

H8 If the subject says that a medical disorder caused the weight loss, note the disorder and whether it was diagnosed by a doctor or other health professional. "Anorexia" does NOT constitute a medical disorder.

Question by question specifications: Bulimia

H10 Note that binges occur in a "discrete period of time" and last minutes, perhaps hours, but not days. Binges may occur several times within a single day, or once per day on a daily basis, or less frequently (as long as frequency criteria are met).

Do not count binges which occur only on holidays such as Thanksgiving or Christmas.

H12 R must perceive that eating was out of control.

H13 Exercising and dieting must be excessive and specifically used to counteract the binge.

H13.1 Self-induced vomiting includes ingestion of known purgatives such as syrup of Ipecac.

H14 Note that we are dating the syndrome of binge-eating and purging (H13), not just

binge-eating.

H16 Determines if binge-eating behavior and anorexia occurred at the same time.

I: DEPRESSION

General information:

This section is fully diagnostic for the following criteria systems: DSM-III-R, DSM-IV, RDC (original and modified), and Feighner. SSAGA-II assesses up to four separate episodes: most severe, current (within the past 30 days), an additional clean, and an additional dirty episode. If R has ever had at least one week of depressed mood, loss of interest, or inability to enjoy things s/he usually enjoyed, the full section will be administered.

The diagnosis of Major Depressive disorder is not made in SSAGA-II if an organic factor initiated and/or maintained the disturbance, if the disorder was a normal reaction to the death of a loved one, or if delusions or hallucinations were present for 2 weeks outside the period of abnormal mood. In addition, there must not be a diagnosis of Mania or unequivocal Hypomania if Major Depressive disorder is to be diagnosed.

DSM-IV explicitly states (and DSM-III-R implies) that there are certain conditions related to intoxication or withdrawal from substances where it is not possible to determine whether an independent major psychiatric disorder exists. This is because substances of abuse (including alcohol) change moods and thinking styles during intoxication or withdrawal. These changes can result in symptoms that are identical to those observed in major psychiatric disorders (such as major depressive disorder, schizophrenia, panic disorder, social phobia, etc.). However, when the psychiatric syndrome is substance-induced, it is highly likely to be temporary and to markedly improve within days to weeks of abstinence.

Similarly some individuals develop depressive symptoms while taking antihypertensive pills, but the depressions usually disappear when they stop taking the pills. Thus, the prognosis and treatment needs of substance-induced psychiatric syndromes are a good deal different than those psychiatric syndromes that develop outside the context of intoxication or withdrawal from substances.

However, a substance-induced (i.e., "dirty") disorder can only be diagnosed when the drug being taken is capable of producing this particular type of psychiatric syndrome. It is also imperative that the amount of the drug be high enough to be capable of producing the psychiatric picture.

For stimulants, intoxication can cause severe anxiety, and withdrawal can cause depression. For the depressants, it's just the opposite -- intoxication is likely to cause the depression and withdrawal produces anxiety.

Other drugs of abuse can cause mood swings. These include the hallucinogens (e.g., LSD, mescaline, peyote, etc.) and daily high doses of the cannabinoids (e.g., marijuana) as well as daily intoxicating doses of the opiates (heroin, prescription pain pills taken for a high, etc.). Therefore, major depressive disorder probably should not be diagnosed in the context of heavy daily use of

these substances.

The SSAGA-II is structured to assess the "cleanest" episode possible for the "most severe" episode. In the SSAGA-II we define "clean" episode as one that does not follow the death of a loved one or an organic precipitant of depressions, such as heavy substance use, some prescription medications, and childbirth/abortion/miscarriage. (A current episode is recorded whether clean or dirty and does not skip out of the clean-vs-dirty screener.) The following example shows how the SSAGA-II ascertains a clean episode for the most severe column.

[Assume that in I4, R told the IVR his most severe episode started in 02/90 at age 30.]

IVR: *Did this episode of feeling depressed begin within 6 months of learning about the death of someone close to you?*

R: *Yes, my wife died in January of 1990.*

IVR: *Did you have another episode of feeling (depressed/uninterested/irritable) that did not follow the death of someone close to you?*

R: *Yes.*

IVR: *When did this episode begin?*

R: *June of 1993, when I was 33.*

IVR: *During the 2 weeks before this episode of feeling (depressed/ uninterested/irritable) began -- that is the one when you were 33 years old -- how many days a week did you drink alcohol?*

[NOTE: the IVR is now asking about episode #2, which started when R was 33. The IVR may need to remind R which episode to focus on.]

R: *4 days a week.*

IVR: *During the 2 weeks before this episode began, what was the largest number of drinks you had in one day?*

R: *A case of beer.*

IVR: *On the days when you drank during the 2 weeks before this episode began, how many drinks would you typically have in a day?*

R: *I usually drank around 6 beers a day.*

[NOTE: 6 beers a day for 4 days a week = "dirty" so the IVR tries to find another episode.]

IVR: *Did you have another episode of feeling (depressed/ uninterested/irritable) that did not follow a time when you had been drinking daily or almost daily and did not follow the death of someone close to you?*

R: *Yes, in August of 1985, when I was 25.*

IVR: *During the 2 weeks before this episode of feeling (depressed/ uninterested/irritable) began, were you taking any of the following drugs for a high or intoxication daily or almost daily?*

[NOTE: the IVR is now asking about episode #3, which started when R was 25.]

R: *No.*

IVR: *Did this episode of feeling (depressed/uninterested/irritable) begin within the 6 weeks that followed an episode of a serious physical illness, like thyroid disease, a neurological disorder, or AIDS? [NOTE: the IVR is still asking about episode #3, which started when R*

was 25. The IVR may need to remind R which episode to focus on.]

R: *No.*

IVR: *Did this episode of feeling (depressed/uninterested/irritable) begin within 6 weeks of starting or changing the dose of prescription medication such as tranquilizers, pills for high blood pressure, heart medicines, or steroids?*

[NOTE: the IVR is still asking about episode #3, which started when R was 25. The IVR may need to remind R which episode to focus on.]

R: *No.*

[NOTE: This episode has been identified as the most severe "clean" episode, so the IVR will continue through the section asking R about this episode when R was 25. The IVR should remind R which episode to focus on.]

Question by question specifications:

- I1,I2 Checks on inclusion criteria. If both coded "no," the remainder of the section is skipped. These questions should be asked without reference to a particular event (i.e., count episodes occurring during PMS and menopause). The intent is to establish an episode of dysphoria or loss of interest.
- I3 Assesses the presence of a current episode (defined as occurring within the past 30 days). Include the episode if R endorses feeling depressed 4 out of 7 days during the week. Note that the episode does not have to start in the past 30 days, it only has to have been present in the past 30 days. If there is a current episode, the instructions lead the IVR to skip to I5 and proceed through the section before returning to I4. That means if a current episode exists, the IVR goes through the clean-vs-dirty screener and the symptom list for the current episode before ever asking about the most severe episode.
- I4 The most severe episode must last at least one week. "Most severe" is left for R to define. However, if R gives an extremely long period (for example, 5 years), ask R whether there was a period during this 5-year span that seemed a little worse. If R can identify a shorter, more severe period, use these dates and duration for most severe episode. Include the episode if R endorses feeling depressed 4 out of 7 days a week. If the most severe episode is the same as the current episode and that episode is clean (i.e., no * items circled in I5-I10), then the IVR skips to Box I13, question C; codes YES, Most severe=current; and skips to I34 to assess an additional clean episode. When the current episode and the most severe episode are the same, the data remains coded in the current column, and the most severe column is left blank.
- I5-10 These questions are used to further delineate the depressive episode, by considering whether organic or non-organic factors were present to initiate or

maintain the episode. If R reports an episode that followed the death of a loved one or an organic factor that could precipitate depression, the SSAGA-II attempts to find another episode that is clean and lasted for at least one week.

Organic factors that may precipitate depression include:

- a serious neurological or endocrine illnesses [such as hypothyroidism, cerebrovascular accident (CVA), stroke, multiple sclerosis (MS), mononucleosis, hepatitis, cancer of brain/lung/pancreas, Parkinson's, AIDS, lupus and Cushing's]
- childbirth/miscarriage/abortion
- use of prescription medications (such as blood pressure medications--Propranolol, Inderal, Aldomet, Reserpine, Serpasil; sedatives, hypnotics, or tranquilizers--Valium, Librium, Tranxene, Serax, Ativan; heart medication--Digitalis, Digoxin; or steroids--prednisone), or
- regular drug use or heavy alcohol use. There are now 2 ways to define heavy alcohol use: (1) 3+/5+ drinks daily or almost daily (*which is always defined as 4 out of 7 days*) and (2) at least 5 drinks (for men or women) two or more days a week, each week for the 6 weeks preceding the episode.

Note: when ascertaining another episode, the whole question should be read, not just the part(s) endorsed. For example, if R reported his episode that was not precipitated by alcohol or drug use, but did follow a death, the IVR tries to find another episode. The IVR must read the entire question, including parts about alc/drugs, not just the phrase about the death of a loved one. This follows the general SSAGA-II convention that only phrases in parentheses are optional. Whenever an additional episode is ascertained, the questions that follow will be about that last episode recorded.

- I6/I7 When getting information about prescription and illegal drugs, try to obtain as much detail as possible. Ask for more information as necessary (i.e., how many/ how much/how often/ for how long, and if prescription, how many times the prescription was refilled). Tegretol and Tagamet do not count.
- I8 Include depressions that began within 3 months before the death (if the death was anticipated) and 6 months after the death (or learning of the death). Do not count as bereavement if R became depressed one year after the death of loved one, because s/he just started to deal with the death. Death of a friend counts, but make sure it was a friend and not just an acquaintance. Death of a pet does not count.
- I9 The intent is to code organic precipitants of depressions. Diabetes, herpes, and malaria do not count. Some cancers may not count, so record as much detail as possible so that a clinician can be consulted. See note for I5-I10 for a list.

- I10 Count all abortions and miscarriages, regardless of trimester.
- I11 The IVR should only get directed here when no clean episode exists. This is text for the IVR to use in order to explain that the following questions will refer to the most severe episode reported in I4 (that is, if all episodes are "dirty," ask about the most severe "dirty" episode).
- I12 Begin completing Tally Sheet for Section I. Mark every item labeled with a "+."
- Box I13 If any asterisked item was circled in I5-I10, then the episode is "dirty." If there were no * items circled, the episode is "clean." If the episode that was finally ascertained as "most severe" is the same episode that was coded in the current column, the IVR is instructed to skip to I34 (leaving the symptoms coded in the current column).
- I14-23 Symptom boxes of depression. If R claims physical illness and depression, try to tease apart which symptoms were due to physical illness and which were due to depression. If R is unable to do this, code the symptoms R endorses and make marginal notes. Consult a clinician as needed. Rs who endorse depression during a period of combat may endorse symptoms which could be directly attributable to the environment (such as sleep problems, weight loss, thoughts of death). These symptoms should be coded despite the "bad fit."
- I14 Weight loss or gain of 5% of body weight within a month, or increase or decrease in appetite nearly every day is the DSM-III-R guideline for this symptom. Count any weight loss or gain that cannot be explained by a physical condition, even if R offers an explanation (e.g., R lost a lot of weight during a depression which he feels was more due to drinking heavily and not eating than due to the depression). As a general rule, the SSAGA-II counts symptoms that appear to meet the intent of the question regardless of R's explanation.
- I14E Make certain that the period of weight gain/loss coincides with the depressive episode (i.e., it cannot be longer than the stated period of depressed mood/loss of interest.)
- I15F Do not count sleeping more than usual to make up for the lost sleep at night. If R reports trouble sleeping, along with sleeping too much, probe for how much sleep R gets per day. Sleeping at times R otherwise would not -- in order to compensate for lack of sleep at night -- does not count if the total amount of sleep time was what R usually got.
- I17 Checks for psychomotor retardation. These symptoms must have occurred to the

extent that they were noticeable to others. Do not include others noticing that R's face and voice were flat.

- I22 Emphasize more difficulty. This must be a change from R's usual state.
- I23 Thinking a lot about death or dying can be either R's death or the death of someone else. Frequent thoughts of death in general or R's dying count even if it is in response to mourning. However, do not count thinking specifically about the loved one's death (or a dying loved one).
- Box I24 Checks the number of symptom groups (boxes) endorsed in I14-23. If at least 5 boxes were positive on the tally sheet, R continues. If fewer than 4 boxes were positive, the interviewer goes back to I4 to ask about the most severe episode, or if already coding for the most severe episode, the interviewer skips to I34.
- I25A This question establishes criteria necessary for DSM-III-R and DSM-IV diagnoses. The interviewer determines whether R had **mood/loss of interest** and four or more other symptom groups present **nearly every day** (4/7 days) for at least two weeks. Make certain that R does not think symptoms must be present every day. **A total of five boxes** must cluster, and one of those boxes must be Box A (depressed mood) or Box B (loss of interest/enjoyment).
- I25B-C If R denies mood and loss of interest/enjoyment in I12, s/he is given a second chance to establish 4 or more symptoms clustering with mood/loss of interest.
- I26 Probe according to standard probe flow chart. Checks for the presence of psychotic symptoms during the episode of depression. The content of any delusions or hallucinations must be specifically detailed so that the interviewer can code I26 appropriately. All examples given by R should be judged for plausibility, and vague examples such as feeling worthless, guilty, or simply a bad person should be coded as "no." Specific examples should be reviewed by a clinician to determine whether they are truly psychotic. Consult a clinician regarding PTSD flashbacks. Do not count symptoms that are clearly attributable to another psychiatric diagnosis; for example, an R with severe OCD who had a 1-year period of loss of interest, partly due to her fears about germs which she did not believe, but affected her behavior, would not count as being delusional. Likewise, do not count distorted images concerning food and body when R is positive for anorexia nervosa.
- I26E This is the duration of R's psychotic symptoms after his/her mood returned to normal.
- Box I26 Interviewer should code Box I26 silently. It must be determined if the psychotic symptoms mentioned in I26 were mood-congruent or mood-incongruent. DSM-

III-R states that mood congruent psychotic features are "delusions or hallucinations whose content is entirely consistent with . . . a depressed mood" (p. 223, DSM-III-R). Therefore, these hallucinations/delusions should involve themes of either personal inadequacy, guilt, disease, death, nihilism, or deserved punishment. Mood-incongruent delusions/hallucinations include such symptoms as thought insertion, thought broadcasting, and ideas of being controlled, where the content has no apparent relationship to the depressed mood. Persecutory delusions (common in psychotic depressions) are considered mood-congruent. Any delusions that are manic in nature (e.g., possessing extraordinary powers) are considered mood- incongruent.

I27-30 These questions determine what kind of help (voluntary or involuntary), if any, R received for the depressive episode and is invaluable for determining level of impairment. If the respondent received ECT (shock treatments), was hospitalized for two days or longer, or psychotic symptoms were present, s/he is considered incapacitated. Note that R need not have initiated treatment; help-seeking behavior is not the issue.

- I27 Clergy counts as "other professional." The intent of this question is to determine whether R received treatment for any symptom related to depression. The treatment may or may not have been a direct result of depression -- it could have been for depression-related symptoms (like sleep difficulty) and this will still count.
- I28 If R was taking antidepressants before the episode began, code as positive. Count any medications prescribed to R for depressive symptoms, even if they are not antidepressants. For example, if R was prescribed sleeping pills to help him/her sleep, count it.
- I30 Hospitalization must be **for depression** or depressive symptoms and not secondary to alcohol or drugs. Do not count a halfway house as a hospital.
- I31 A major role must be determined by R. Even if R is homeless and jobless, perhaps panhandling is the major role. Everyone occupies the majority of his/her days in some way (i.e., personal hygiene, etc.). Occasionally, an editor or a clinician may choose to override R's answer if there is clearly evidence of impairment. For example, R reported that his job was his major responsibility during his most severe episode of depression, and he denied impairment at his job. However, R reported that he lost his home due to neglecting to pay his mortgage. A case like this clearly indicates impairment and so coding may be adjusted to reflect such.
- I32 This question focuses on disruption of major role to help determine level of impairment/incapacitation. If R was completely unable to function in this role for at least 2 days in a row, s/he is considered incapacitated. If functioning continued, but there was a decrease in performance that was noticeable to others, then s/he was impaired. Major role is defined by the respondent in I31. Impairment or incapacitation should be from the depression, not a physical condition. If R has both a physical condition and depression, try to differentiate the mood problems from the physical.
- I32C If R has missed work, it must be 2+ days in a row. Some situations may need a clinician to review to best capture level of impairment/incapacitation. For example, you may be advised to code "impaired" if R's boss, who was also a friend, urged him to take a couple of months off, even though R states that he could have functioned if he had kept working.
- I32D Assesses impairment in a minor role. A minor role could be social functioning, functioning at home if the major role is work, or functioning at work if the major role is school. The minor role that was affected must be specified.

- I34-I35 Note: these two questions are shorthand versions of the questions I5-I32. If you have any question about how to define something, check the analogous question earlier in the section. For example, "around the time of childbirth, abortion, miscarriage" is defined in I10 as "2 weeks before to 6 weeks after."
- I36 Total all episodes -- clean and dirty. All episodes should be recorded on the timeline. To count episodes, take into consideration periods of 2 months or more when R's mood returns to normal as signifying the end of an episode.
- I36A Onset of first episode of depression and recency of the end of the last episode.
- I37A Checks for overmedication following treatment for depression, or adverse reaction to drugs used to treatment.

J: DYSTHYMIA

General information:

Dysthymia is depressed mood for most of the day, more days than not, for at least two years. Concurrent with persistently depressed mood there must be depressive symptoms, but they are usually not as severe as those of a major depressive episode. The major distinction between Dysthymia and Major Depressive Disorder is the number of symptoms needed for diagnosis and the minimum time required (2 years as opposed to 1-2 weeks). It is important to remember, however, that Major Depressive Disorder may sometimes persist for many years. Major Depressive Disorder consists of one or more discrete major depressive episodes that can be distinguished from the person's usual functioning, whereas Dysthymia is characterized by a chronic mild depressive syndrome that is usually present for many years. When Dysthymia has been present for many years, it can be difficult to distinguish the mood disturbance and associated symptomatology from the person's usual mood and functioning when not affected by depression. **Major Depression in Partial Remission** is the diagnosis given if the initial dysthymic period of at least 2 years duration directly follows a Major Depressive episode. The diagnosis of Dysthymia can be made following a Major Depressive Disorder only if there has been a full remission of the Major Depressive Episode lasting at least six months prior to the onset of Dysthymia.

People with Dysthymia frequently have a superimposed Major Depressive Disorder (often referred to as "double depression"). When a Major Depressive Disorder is superimposed on preexisting Dysthymia (which has been present for at least two years), both diagnoses should be recorded since it is likely the person will continue to have Dysthymia after recovering from the Major Depressive Disorder.

If a respondent claims to have experienced low mood for a prolonged period, or even the majority of his/her life, determine whether there were breaks of 2 months or more when mood was normal (not sad, down or blue) so that this long period can be broken into shorter periods. If an individual has had an episode of Major Depression just prior to what s/he considers one prolonged period of dysthymia (for example 10 years), the episode should be broken into (at least) two periods. The first two years should be listed in J1 (which will then be discounted in J2 because of the Major Depression). Years three through ten should be recorded in J2B. If this episode is not broken into shorter periods by the interviewer (remember that there needs to have been a minimum of 6 months remission following the Major Depression), then the respondent will skip out when s/he reaches J2.

Question by question specifications

J2 Checks for exclusion criteria. An episode of major depression during the first two years of the dysthymic period, or during the 6 months just prior to the onset of dysthymia would preclude making the diagnosis.

- J2A The interviewer should attempt to establish another period of 2 years or more when R was sad, down or blue. Severe depression is a short hand expression for major depressive episode. For those Rs with depressive histories that qualify for diagnosis, we will have to take R's word about severe since we may not have characterized all the episodes. For others, dates that overlap with the previously discussed depressive episodes ought to be identified easily. If R says no to J2, but has gone through the depression section for the time period identified for dysthymia, Rs should be reminded of what s/he had told IVR re: depressive episode.
- J3-J6 Checks for exclusion criteria. If an episode is found to be dirty, the interviewer must attempt to identify a "clean" episode. IVR needs to confirm that this additional dysthymic episode did not have a major depressive episode in the first 2 years or in the 6 months preceding (See text in J2 to use in probing). If a "clean" episode cannot be identified, complete the section anyway, obtaining information on the period initially identified in J2B or J1A. Refer to page 41 in Depression section for a description of clean and dirty.
- J3 Heavy use (5+ for men and 3+ for women) daily or almost daily disqualifies the dysthymic episode.
- J3D The Interviewer should attempt to establish another period of 2 years or more when R was sad, down, or blue and was not drinking heavily daily or almost daily. IVR also must confirm that there was no depression in the first 2 years or in the 6 months prior to this episode.
- J4 Drug use (of drugs on Card I) daily or almost daily disqualifies the dysthymic episode. Use medication list for codes.
- J5 A serious physical illness (i.e., neurologic disorder, thyroid disease, etc.) within 6 weeks of the start of a dysthymic period would disqualify it. Use illness list for codes. Neurological disorders include strokes, brain tumors, MS, and a head injury.
- J6 A dysthymic episode occurring after a change in certain prescription medicines disqualifies it. Use the medication list for codes.
- Box J7 The intent is to direct IVR to code a clean episode or, if no clean episode exists, to code the most severe dirty episode.
- J8 Checks for exclusion criteria. If a period of "normal" mood lasting two months or longer occurred during the two year period, this period is disqualified as being

dysthymic.

J9

We are looking for impaired functioning during this period due to the dysthymia.

K: MANIA AND HYPOMANIA

General information:

The Mania section of the SSAGA-II is diagnostic for DSM-III-R, DSM-IV, RDC, and Feighner criteria. A Manic episode is defined in DSM-III-R as a period of abnormally and persistently elevated, expansive, or irritable mood co-occurring with at least three out of a possible seven manic symptoms, four if mood disturbance is only irritability. During a manic episode a person feels/acts clearly differently than his/her normal self. It is important to emphasize this sudden (and spontaneous) change in functioning, because most people have periods of time, usually event-related, where their mood may be elevated and keep their behaviors altered. (An example would be elated mood following a marriage proposal, during which time a person might alter sleeping and eating patterns. Another example would be the feeling of elation after winning a competition).

The interviewer is required to carefully judge the example(s) given by R in K1.A-D; this will determine whether R will continue with the section, or skip out. If the interviewer has any uncertainty as to whether the example(s) qualify as mania, s/he should continue with the section. Additionally, if manic mood has been present during the past 30 days, whether this episode is clean or dirty, it will be coded first. The most severe episode should be "clean", but if no identifiable severe "clean" episode has occurred, code for the most severe "dirty" episode.

If R has had at least one manic episode, the interviewer is instructed to skip the hypomania questions because the diagnosis of hypomania is precluded by the mania diagnosis. By definition, the mood disturbance in hypomania is not severe enough to cause marked impairment in social or occupational functioning or to require hospitalization (as is required in the definition of a Manic episode). Hypomania requires the presence of at least two symptoms along with the mood disturbance.

Question by question specifications

- K1 Count episodes due to PMS, whether diagnosed by an MD or not.
- K1A Includes a "3" code to indicate whether this change in mood occurred only at a time when R was under the influence of a substance. For Rs who have reported an episode of depression, be sure to stress "other than when you were depressed."
- K1B Interviewer should not confuse irritability occurring only in specific circumstances (e.g., with the respondent's spouse) with the generalized irritability characteristic of an irritable manic episode. Includes a "3" code to indicate whether this change in mood occurred only at a time when R was under the influence of a substance. Irritability that occurred during withdrawal from a drug does not count as a "3"

code, -- it gets coded "1." Irritability endorsed during pregnancies count here. The following questions will allow us to determine if this was a manic episode.

- Box K1C Box for interviewer to code whether R endorses or denies mood disturbance in K1A and K1B. If K1A and K1B are both coded either 1 or 3, the SSAGA-II cleaning program expects this box to be coded 1.
- K1D.b This is a thumbnail sketch of a manic episode. The intent is to elicit from R the possibility that an episode of manic mood plus some other common symptoms of mania occurred together. If R has acknowledged a mood disturbance, interviewer asks whether symptoms were present during period of abnormal mood. If R denied mood disturbance in K1A and B, interviewer provides R with a second chance to proceed with the section by simply asking whether symptoms were ever present. Once a sx is endorsed, the IVR reads "During this period were you also:" instead of stem. Symptoms must co-occur during the same period of time (i.e., cluster). However, whether or not R admits to mood disturbance in K1A or K1B, if at least 2 symptoms are not endorsed in K1E, R will skip to hypomania.
- K1G A minimum of two symptoms is necessary, accompanied by the mood change, to continue with the section.
- K2 Episode must last at least 2 days to be considered an episode. If it lasts for less than 2 days, the IVR continues to K3 and only codes for the most severe episode. If a 2+ day current episode exists, skip to K4 and ask clean/dirty question and symptom questions before returning to K3 for most severe.
- K5-9 These questions are used to further delineate the manic episode, by considering whether organic or nonorganic factors were present to initiate or maintain the episode.
- K5/6 Determines whether R was using prescription or illegal drugs or drinking heavily (see definitions in I5) daily or almost daily just prior to the manic episode. The interviewer must specify what substance R was using, and in the case of alcohol, how much s/he was drinking 2 weeks prior to the episode.
- K8 Emphasize "serious." Relevant illnesses include Multiple Sclerosis, HIV, head injury, Hyperthyroidism, Lupus, Cushing's, Brain Tumors, and Encephalitis.
- K12-18 List of manic symptomatology. As in the Depression section, interviewer should not count chronic symptoms representative of a possible personality disturbance. Be certain that R acknowledges a change from normal state when endorsing a symptom.

K12

During manic episode, R may be more promiscuous, more productive at work, and/or much more social than usual. R may start many projects, etc.

- K15 Emphasize "important." This question implies that R has/had special talents or abilities that other people do/did not have, or has/had them to a much greater degree.
- K16 Checks for sleep disturbance during Manic episode. Minor sleep pattern changes may not meet criteria for this symptom. Emphasize "need" as R must feel rested after only a few hours of sleep. For example, needing 5 hours of sleep instead of 6 will not count as a manic symptom, whereas needing 3 hours instead of 6 would.
- K17 Assesses distractibility, i.e., attention too easily drawn to unimportant or irrelevant external stimuli.
- K20-28 These questions are used to determine the level of impairment or incapacitation during the episode. If R received ECT, was hospitalized, experienced delusions or hallucinations during the episode, was completely unable to function in principal role for at least two days, or was unable to carry on a conversation, then incapacitation will be coded. If there was a decrease in functioning but it was not severe enough to incapacitate the person, then impairment will be coded. Impairment would indicate a diagnosis of hypomania rather than mania. If, in question K28A or K28D R indicates that s/he was much more productive, more energetic, etc., than this would be used to code improvement in functioning in K29. **Improvement in functioning**, would indicate that R was able to do much more than usual, (write more, sell more, study more, etc.). Sometimes with a mild episode, the high energy level and reduced need for sleep leads to what R perceives as improvement in his/her functioning.
- K20A Behavior during the episode must have caused problems for others.
- K21 Determines whether psychotic symptoms were present, and if so, whether they persisted outside the period of altered mood.
- K23 Code yes if R sought help during or after the manic episode.
- K26 Hospitalization must be for the manic episode.
- K28 It is OK to adjust the coding to capture the impairment of functioning. For example, the editor could recode K27 and K28 in the following case: R claimed that his major responsibility was home and this functioning was not affected; however he reported that he was fired from his job because he didn't go to work. If there is a choice between improvement and incapacitation, opt for the negative.
- K30 This section characterizes additional clean episodes only.

- K32 Total number of episodes (clean and dirty), including those already coded. Record all episodes on the timeline.
- K33 Checks whether R ever experienced an episode with mixed affective states, e.g., R's mood was elevated or expansive at the same time R was experiencing depressive symptoms. If symptoms are endorsed, check if this time period was included in a Major Depressive Episode in Section I.
- K34 Checks for periods of rapid cycling between mania/hypomania and depression.
- K34A If R reports switching back and forth between feeling high and feeling depressed every few hours, every few days and every few weeks, code for every few hours and make a marginal note that R endorsed all time frames. Always circle the shortest unit cited.
- K35 Checks for the presence of hypomania, if no manic episode has been coded. Record example and follow exclusion rules as stated. Episodes occurring as part of Pre-menstrual Syndrome (PMS) count, be sure to specify. Hypomania endorsed due to quitting smoking should be coded a "3," but other episodes of irritability due to withdrawal or depression do not count here. Hypomanic episodes do not get recorded on the timeline.
- K35A These sx should be while not under the influence of drugs or alcohol as in K1D.

L: PSYCHOSIS

General information:

Section L, Psychosis, is a non-diagnostic survey of the subject's experiences of delusions and hallucinations. It is adapted for SSAGA-II from the SCID-P, and screens for subjects who might have a psychotic disorder. Delusions are fixed false beliefs, such as the idea that one's personal thoughts are being broadcast by national television. Delusions are based on incorrect inference about external reality and are firmly sustained in spite of what almost everyone else believes and in spite of what constitutes incontrovertible and obvious proof to the contrary. Hallucinations are false sensory experiences: seeing, hearing, smelling, tasting or feeling something which is not present. Hallucinations are sensory perceptions without the external stimulation of the relevant sensory organ. Examples are: feeling bugs crawling all over one's skin when they are not; seeing Martians and vampires seated at the dining table; hearing voices when no one else is in the area.

The hallucinations and delusions covered in the Psychosis Section could result from a high fever, drug or alcohol use, or depression. Hence, each psychotic symptom is probed using the CODE 1 2 3 4 5 pattern for symptom attribution and severity. Further, some religious or culturally supported beliefs may be hard to distinguish from non-bizarre delusions (for instance, the conviction of some highly religious people that they talk with, and receive instructions from God). For this reason, interviewers are asked to record multiple detailed examples of every psychotic symptom. Plausible examples should not be probed. Any psychotic symptom coded 5 should be brought to the attention of a clinician to determine whether R should be seen by a clinician for completeness and accuracy of diagnosis.

NOTE: Examples based in reality should be coded "1." For example, if R felt that others were talking about him/her and thinks that this was probably true (for example, noticed the group stopped talking when R entered the room), do not code this positive.

Question by question specifications:

- L1 Checks for auditory hallucinations. These hallucinations must occur when the respondent is **fully awake**, and can be heard either inside or outside his/her head. Stress "completely awake."
- L1A The respondent must have heard more than two words, and these words must have been heard more than twice. They must have no apparent relation to depression or elation.
- L1D Checks to see whether there was a voice keeping a running commentary on the respondent's behavior or thoughts as they occurred.
- L1E Checks to see whether two or more voices were conversing with each other. If R

- heard noises and not voices, code "00".
- L2 Checks for visual hallucinations experienced by the respondent while completely awake. The interviewer should be certain to distinguish hallucinations from illusions, which are misperceptions of real external stimuli. Illusions should not be coded.
- L3 This item queries tactile hallucinations (e.g., electricity, bugs). Obtain an example before coding.
- L4 This item asks about olfactory hallucinations.
- L6 This item assesses somatic delusions, the content of which involves change or disturbance in body functioning. The purpose of this screen is to identify individuals who may require follow-up by a clinician to determine whether psychotic symptomatology/schizophrenia is actually present. "5" codes should represent truly unexplainable phenomena and not residual damage from substance use/medical illness/aging/physical trauma.
- L7 Assesses other delusions (such as delusions of guilt, jealousy, nihilism, poverty). Stress "crime" or "punished." The intent is to elicit delusional thinking, not just reasonable guilt about having actually done something hurtful.
- L8 This item checks for thought broadcasting, a delusion that one's thoughts are audible to others. We mean that the person feels his/her thoughts could actually be heard, not just that others knew what s/he was thinking.
- L9 This item assesses delusions of being controlled, i.e., feelings, impulses, thoughts or actions are experienced as being under the control of some external force. This question does not include people who feel dominated or directed by others (such as parent or spouse). This question seeks to identify persons who believe that someone or something outside of themselves is controlling their thoughts or actions against their will.
- L9A Checks for delusions of thought insertion. This belief that someone or something outside of R's control was forcibly putting thoughts into R's head is perceived by the respondent as an unwanted, intrusive violation of personal integrity.
- L9B Checks for delusions of thought withdrawal, the idea that R's thoughts are literally removed from his/her head against his/her will, leaving R devoid of thought.
- L10 This item checks delusions of reference, that is, personal significance is falsely attributed to objects or events in the environment. For example, R may falsely believe that people on TV or songs on the radio are specifically about him/her. Or

R may think that gestures or comments by others are directed at R even though they aren't. Do not count examples that are obviously not delusional -- such as an attractive or unusual person being noticed by others.

- L11 This item assesses grandiose delusions, the content of which involves exaggerated power, knowledge, or importance.
- L12 This item assesses persecutory delusions, i.e., that the individual (or his/her group) is being attacked, harassed, cheated, persecuted or conspired against. These beliefs are paranoid in nature, and R must feel that people want to hurt, persecute, or plot against him/her for no apparent or sensible reason.
- L13 This item asks the respondent's understanding of the content of his/her delusions coded in L1-L12 to assess whether they are an acceptable part of R's subculture, or whether they are bizarre. Bizarre delusions are those that involve a phenomenon that R's subculture would regard as totally implausible. (An example would be thought broadcasting or being controlled by a dead person).

CLINICIAN CODE: This code is left for a clinician to determine whether the respondent's delusions are systematized, i.e., a single delusion has multiple elaborations, or a group of delusions are all related to a single event or theme. Non-bizarre delusions are simply unlikely, not totally implausible. An example of a non-bizarre delusion is the belief of a 90-year-old bedridden man in a nursing home that he is having a torrid affair with a young nurse. On the other hand, if he believed that he was romancing a Martian, his delusion would be considered bizarre.

- L14 Assesses whether delusions (non-bizarre or bizarre) or hallucinations ever lasted for 6 months or longer. (If the delusions were present "on and off for 6 months or more" use the "more times than not" rule and check with a clinician).

M: ANTISOCIAL PERSONALITY

General:

The Antisocial Personality (ASP) section of the SSAGA-II is fully diagnostic for DSM-III-R and DSM-IV ASPD, DSM-III-R and DSM-IV Conduct Disorder; and Feighner Antisocial Personality Disorder. Antisocial Personality Disorder is characterized by a long-lasting pattern of impulsive and irresponsible behavior, a craving for excitement and new experiences, and a consistent disregard for the rights of other people. Subjects with Antisocial Personality Disorder engage in a variety of destructive behaviors including lying, conning or manipulating others, and threatening others or abusing them verbally or physically. Other pathological behaviors include flagrant promiscuity or marital infidelity, irresponsible financial decisions or default of responsibilities, and unstable work habits (quitting without notice, frequent absenteeism, etc.). People with ASP may appear either charming and persuasive, or violent and threatening to others whatever they have found works to get them what they want.

Persons with Antisocial Personality Disorder often use illegal substances and alcohol, in part due to their craving for new experiences. There is a tendency toward poly-substance use. It is the experimentation and novelty that appeals to a person with this disorder, not necessarily the high that is achieved. ASP frequently coexists with substance use disorders, and the typical person with ASP is often a regular substance user/abuser. Not only is substance abuse/dependence a very common complication of ASP, substance abuse by itself may also result in irresponsible or violent acts. Since Substance Use Disorders and Antisocial Personality Disorder frequently coexist, it may be difficult to determine the cause(s) of a given behavior.

To further distinguish Antisocial Personality symptoms from symptoms that are directly related to substance use, the interviewer must first determine whether a specific symptom occurred only while **under the influence of** drugs and/or alcohol, or at other times as well. The interviewer must ask to R specifically if the behavior occurred only while **under the influence of** a particular substance, (not just in relation to drug use or to efforts to obtain the drug). The age of onset of behaviors which occurred while R was under the influence of drugs/alcohol (labeled ONS A/D) and at other times as well (labeled AGE ONS) is coded if the behavior occurred at times when R was under the influence of drugs/alcohol and at times when R was not under the influence of drugs/alcohol. If the behavior never occurred while R was under the influence of drugs/alcohol, the ONS A/D would be left blank.

For many questions in this section there are 3 codes to help determine that a behavior occurred only under the influence of alc/drugs and may not necessarily indicate pure antisocial behavior. Symptoms coded 3 will, therefore, not be included on the checklist. We have also included an additional code in this section, the 6 code. A 6 code indicates that a behavior occurred at times when under the influence and at times when not under the influence. Only 5 and 6 codes get marked on the tally sheet for section M.

The SSAGA-II provides for an examination of the relationship between ASP, Conduct Disorder, and substance use (drugs/alcohol). As previously stated, ASP, by definition, begins before the age of 15 and cannot be diagnosed if behavioral problems did not occur before this age. However, Conduct Disorder has no age restrictions for diagnosis.

Obtaining AGE ONS (and ONS A/D): If R states that a behavior occurred at the age of 15 it is essential that the interviewer check whether the behavior occurred before R's 15th birthday. This age cut-off is essential for the DSM-III-R diagnosis of Antisocial Personality. If R reports not knowing the exact age of onset, code the ranges as follows: "under 13"=-1, "13-14"=-2, "15-17"=-3, and "18 or older"=-4.

Standard A/D probing in the ASP section: The standard A/D probe is printed at the beginning of the section. This probe allows the interviewer to assess the relationship between the experience endorsed and substance use. For all questions with 1/3/5/6 coding options, start by asking the stem question as written. If the respondent answers "NO," **code 1**. If the respondent answers "YES" to the stem question, then start the A/D probe:

IVR: *Did this ever happen when you were under the influence of alcohol (or drugs)?*

If the answer to ever under the influence is "NO," **code 5**. (YES, CLEAN)

If the answer is "YES," ask:

Did this only happen when you were under the influence of alcohol (or drugs)?

If YES, only when under the influence, **code 3**. (ONLY A/D)

If NO, sometimes when under the influence/sometimes not, **code 6**. (BOTH)

Generally, the "3" and "6" codes are used for the more typical drugs, but there is some evidence that aggressive behavior may be related to anabolic steroid use. Situations where R reports aggressive behavior while using performance-enhancing steroids should be reviewed by a clinician to determine if the behavior is considered a "3" or a "5".

Age minimums: In some cases it might seem that certain behaviors for children who are too young to know right from wrong should not be coded, for example when a 3 year old steals a candy bar. However, we will not set a minimum age for child conduct, but recommend obtaining examples for the behaviors. These will then be decided on a case by case basis.

Double coding: In general, double coding should be avoided, but there are some cases where double coding may be appropriate. For example, when an R reports arrests for armed robbery and/or mugging, we code that in both M29 (arrests in general) and in M16 (stealing through force and threat). In M29, we code a total count of arrests. In M16, we are getting a specific and serious ASP symptom. Some allowable cases of double coding will be noted throughout the specs. Some cases may have to be individually reviewed. In general, an act (behavior) and a sanction (e.g., arrest) may be double-coded; two acts stemming from the same behavior (e.g., vandalism and breaking and entering) may not.

Tally sheet instructions: The tally sheet is divided into two sections. The top half of the sheet refers to conduct disorder sx. Mark only the items coded 5 or 6. As in other sections, the tally

sheet items are specially marked. In the ASP section, they are labeled with the letter A and/or B, directing the interviewer to the appropriate part of the tally. There are only 3 questions where onset is relevant for Part A. Those items are only marked when the symptom first occurs before the age of 13. All other conduct disorder symptoms are marked on Part A of the tally regardless of the age when they occurred. However, age does matter for Part B of the tally. Part B is only marked if the behavior ever occurred after the age of 15.

Question by Question Specifications:

- M1 Hooky refers to not attending school for an entire day (not just cutting class) when expected to -- even if parents are aware of the absence. This would include R telling parents that s/he is sick when s/he is not and parents then giving permission for R to stay home. Twice in one year means twice in one school year, that is September to June.
- M1B Refers to the first time R played hooky, not the first year s/he did it twice.
- M2 R must have been expelled from school for behavioral/disciplinary reasons. Thus, expulsion due only to poor grades does not count. The same applies to in-school suspensions.
- M3 Stress running away overnight. Running away implies that the caregiver was not aware of the location of the child. If R ran away from one parent to be with the other parent, the first parent must not know where R went in order for the symptom to count. Running away from home also includes running away from foster homes or alternative residential facilities. Although there are many legitimate reasons why children might run away, such as parental substance abuse or verbal abuse, these are not exclusionary. Running away to avoid physical and/or sexual abuse are the only exclusionary circumstances and should not be entered on the tally sheet.
- M3A Only other (code 4) would count toward an ASP diagnosis. Code for this first. If an R also ran away for physical and/or sexual abuse this should be noted in the margins.
- M3C.1 At least one week is a requirement for diagnosis. It is coded on Tally Sheet A.
- M4 This question was designed to address the DSM-IV criterion concerning serious violations of rules. Endorsing this behavior will only count before the age of 13

(and will therefore not go on the tally unless this condition is met).

- M5 This refers to the same criterion as in M4 and counts in the same manner (only if occurred before the age of 13).
- M6 Refers to **initiating** physical fights, that is, throwing the first punch. Do not count verbal taunts. Emphasize starts fights and with your brothers or sisters.
- M6B Emphasize other than your brothers and sisters. Do not double code fighting with spouse/partner in M27. Count it in M6B if both parties hit; if R is the only one hitting (partner does not strike back), code it in M27.
- M6D Read introduction in parentheses if M6=1 and M6B=1. These are physical fights involving R, whether or not s/he started them. Fighting or getting into frequent fights as part of one's job (bouncer, police officer) does not count. The age of onset doesn't necessarily have to be 15 here, however, the age of recency must be 15 or more to be marked on the tally. For fights with siblings, someone must have been hurt to count it here.
- M7 Assesses persistent refusal to conform to rules imposed by adults. Defiance must be frequent, and cannot be passive. Stress the word "often."
- M8 Temper tantrums implies spontaneous and unjustified outbursts as a child in order to get what is desired. Often should be stressed.
- M9 This question implies physical or emotional injury to other children. Being mean includes verbal abuse toward other children, name calling, and taunting. Bullying of sibs counts.
- M10 Do not include exterminating rats, mice, or insects. Killing animals by hunting, fishing, or self-defense also does not count.
- M11 "A lot" should be emphasized and, as always, R defines "a lot." Lies told to avoid physical and/or sexual abuse do not count.
- M11A As outlined in the DSM-IV, here we are looking for habitual lying to obtain goods or favors or to avoid obligations. Emphasize "often."
- M11B This question refers specifically to using a false name or alias. Emphasize "ever." The use of a false name or alias should be for the same reasons as in M11A. As emphasized in the bold letters, exclude minors using false IDs to buy alcohol or to gain entry to a bar. Also exclude forging signatures to skip school. This should be counted in M1 as truancy.

- M11C Here we are looking for the earliest age that R demonstrated any of these behaviors. In terms of lying, we are looking for the age when R first told a lot of lies or lied often, not the age s/he first lied.
- M12 This question addresses the ICD-10 criterion for conduct disorder having to do with not taking responsibility for one's mistakes or misbehavior.
- M13/M13A The criterion behind this question is the same as in M11. This question was designed to look at other aspects of lying or deceitfulness to obtain goods or favors, i.e. cheating to obtain a better grade or a higher score, etc. Stress often in both M13 and M13A.
- M14 Interviewer should emphasize more than once in M14 stem question, M14B, and M14D.
- M14 As a general rule throughout the SSAGA, count the behavior regardless of R's explanation or attempt to justify. For example, code yes even if R stole money from her father and outside of the home to feed her brothers and sisters and pay the bills.
- M14A Don't count small amounts of change. Only count if more than a few dollars.
- M14D Forgery means forgery in the legal sense (i.e., without permission) and for the purpose of obtaining money or valuables. A child signing his/her parents name on a report card to avoid showing the report card to his/her parents does not count. Signing for a spouse with permission doesn't count either.
- M15 Break into means forcible or illegal entry. This may include slashing a screen door, breaking a window, crawling in through an unlocked window, or finding and illegally using a house key. It does not include means taken to get into one's own house or car when locked out. Keep in mind here that although breaking and entering may include damaging property, it is not the same as vandalism and should not be double coded in M18. Pure vandalism involves the destruction of property but without the intent to enter illegally. Do not code vandalism here.
- M16 Threatening them means threatening to do bodily harm. No weapon need be present. In some situations it may be appropriate to double code here. For example when R reports arrests for armed robbery and/or mugging in M29, it should also be coded here.
- M17 In order to qualify as conduct disorder behavior, fire setting must be deliberate. R should have intentionally set a fire, not have been playing with matches. Fires set accidentally do not count. However, intentional fires that accidentally spread to

larger fires do count.

- M17A This question checks for fire setting with the intent to do damage. This aspect was added to fire setting criterion for conduct disorder in the DSM-IV.
- M18 This question assesses for vandalism, willful or malicious defacement of another's property. Damaging property includes egging houses/cars, smashing mailboxes, soaping windows, stealing street signs, etc. Taking hood ornaments would also count here. Egging houses and cars, soaping windows and toilet papering trees would not count if only done as a prank on Halloween. As stated in M15, if breaking and entering includes damage to property, do not double code here. A rule of thumb: If it can be cleaned up, and doesn't require replacement or repair, then it does not count here. Otherwise, if it does need to be replaced or repaired, it is counted.
- M19 Read introduction in parentheses only if R reports fighting. Do not include minor things like pulling hair. The term injured indicates a certain level of severity. Physically injuring siblings on purpose counts.
- M20 Refers to the use of any violent weapon such as sticks, guns, knives, clubs, rods, chains, spikes, baseball bats and brass knuckles. This may or may not be in the context of a fight. Get an example if you are not sure. Do not count using a weapon in self-defense.
- M21 Masturbation and oral/genital contact count. Petting should be judged on a case-by-case basis.
- M22 Assesses for conduct disorder behavior in terms of duration and clustering. IVR must circle the symptoms that cluster.
- M23-M39 Most of these questions ask about specific illegal activities that occur after the age of 15.
- M23.1 This question refers to the deliberate writing of a check with no intention of having the funds to cover it.
- M23.2 Buying stolen property means acting as a fence i.e., buying with intent to resell or buying for personal use despite knowing the object had been stolen. Selling stolen property includes selling property from one's own thefts or acting as an agent for a thief. Legal gambling (Las Vegas or riverboat casinos) does not count. If R buys drugs and then gets reimbursed from friends, do not count. Count only if selling for profit.

- M23.3 Payment for sex may have been in any form, including money, drugs, jewelry, property, clothes, or maintenance (as in a Sugar Daddy type relationship.) Masturbating people as part of one's job in a massage parlor counts.
- M23A Stress that R could have been arrested. It is important to get examples here to make sure that behavior was severe enough to qualify.
- M24 This question is designed to get at repeated failure to honor financial obligations. Stress often here.
- M25A This includes being remiss in alimony/child support payments.
- M25B This does not include being outside in the yard while the children are inside (within earshot), but does include going to a neighbor's house or running a quick errand of 30 minutes or longer. Do not count emergency situations. This can include other people's children if R was responsible for them (e.g., when babysitting).
- M25C Implies persistent neglect. Emphasize that a neighbor must have assumed child care responsibility. Do not count emergency situations.
- M25E Interviewer should emphasize because you spent the money on yourself.
- M26 The subject may have been officially or unofficially accused of child abuse or neglect (officially by a doctor, policeman, or social worker; unofficially by a neighbor, relative or friend). Do not ask R to elaborate on the accusation of child abuse.
- M28 Only moving violations -- which include DUI's and DWI's -- count. If an R does not bring up a DUI here, but you know about it from the alcohol section, you can add it silently. Do not include tickets for parking violations, not wearing a seat belt, burned out tail light, improper registration of vehicle, etc. Do not count moving violations for non-motorized vehicles (such as bicycles). The exception to this exclusion would be multiple tickets/citations indicating negligence in the maintenance of a vehicle. Count even if charges were later reversed or reduced to a non-moving violation. The 3 code for this question is for illicit use of substances. If R was using prescriptions as prescribed, count as a 5. The following are some specific examples of how to code this question:
- *Code Yes for tickets received for driving without a license, (meaning license was taken away, not simply left at home) driving without a windshield, etc. These are willful violations of the law. Relatively minor infractions such as driving without a taillight should be coded Yes if they have been committed repeatedly.

*Do not count tickets truck drivers may receive for an overweight truck, for running scales, or for log book violations. Although these things are illegal, it is not the decision of the trucker to carry a heavier load than s/he is supposed to. Rather, it is the decision of the company to overfill the truck and/or avoid the scales. A log-book violation is working/driving over the allowed guidelines. The trucker may do this because of the desire/need for additional money, as this is the basis upon which they are paid (usually). Therefore, these items should be coded No. As always, record this information in the margins.

M29

Any arrest counts here (even if R was never convicted or the charges were later dropped), except for traffic violations, public intoxication, and drunk and disorderly conduct. DO NOT code DUI s, DWI's, or minor traffic violations here. Serious crimes, such as vehicular homicide and manslaughter, count. Although these violations involve a motor vehicle, they are not simple traffic violations. Record all reasons for arrests. (For example, if R was arrested 20 times, the interviewer records all reasons: R was arrested 5 times for assault, 3 times for breaking and entering, and 12 for larceny.) Code 3 if R was under the influence at the time the act was committed, regardless of when the arrest occurred. Generally, try to not double code the same behavior, but we can code the act and the sanction separately. For example: if R was arrested for breaking and entering, code the act in M15 and the arrest in M29. The following are specific examples that may help clarify this question:

*R was drunk and arrested for assault and battery. Coded under M29, not E28, because charge was not for public intoxication or drunk & disorderly, even if being drunk helped lead to the arrest.

*R had 4 DUI s, which in Indiana counts as a felony, and he was convicted for these. However, the skip in M28 (where we would not code these DUI s) would cause us to miss his felony conviction. M28 is for more serious traffic offenses, such as manslaughter or vehicular homicide. We do not code DUIs, even though that means we will miss the felony conviction.

*R was arrested because she was storing her brother s things, which included a stolen TV (she didn t know it was stolen). The charged were dropped. Count the arrest regardless of the outcome.

*R stated he was taken home by police for being drunk and sleeping in a car parked at his high school; he doesn t recall being arrested. Coded as not arrested. If R had been arrested or detained, this would only count in the alcohol section.

*R was in prison for drunk driving; was also arrested at the same time for assault

and theft. Count as one arrest for the assault and theft.

*R convicted of DUI with injuries, which is a felony. We would code this as an arrest and a felony in M29C because this is more than a simple DUI charge.

*R deliberately wrote a bad check, but was not under the influence of alcohol or drugs at that time. However, when was arrested for writing the bad check, R was under the influence of marijuana and carrying marijuana. R was arrested and charged with writing a bad check and possession of marijuana. M29 should be coded 5 because R was not under the influence when R wrote the bad check. Count as only one arrest.

*R was not arrested, but held in jail for 6 hours because of her child's truancies. This case was not coded as an arrest. However, if R had been arrested -- even if for a child's behavior -- it would have been coded in M29.

- M29C The definition of a felony, according to Webster's Dictionary, is any crime for which punishment by federal law may be death or imprisonment for more than one year. Examples include: murder, kidnapping, extortion, armed robbery.
- M29D R must be in jail overnight. The IVR can code yes silently if information already given in M29.
- M29E Determines whether R has been arrested after being released from jail (for the first time arrested for something other than using drugs or alcohol) and has thus been unable to profit from experience. Possession of drugs, selling drugs, and open container infractions all count here because they are acts "other than using alcohol or drugs."
- M30 This question is looking for the person who "job hops." Do not include job changes that R volunteers were due to life transitions such as graduation, marriage and maternity, and do not include seasonal summertime employment of full-time students. If a person has both a full-time and part-time job, changes in the part-time job do not count--only count changes in the main job.
- M30A Do not include changing majors while in school. The intent is to code dropping out of different academic programs.
- M31 Absences count as positive even if R says his/her boss did not find out or he/she did not get into trouble.
- M32 This question identifies persons who had at least six months of unemployment in the last five years. This does not have to be 6 consecutive months in a row.

Periods of time that R wanted a job but could not find one, periods that R did not work because s/he did not want to, periods of time that R did not work due to psychiatric disability all count as unemployment. If R has seasonal work (e.g., farming or construction), the usual lay off season is not counted as unemployment. If R is involved in legal action(s) to regain a job after being terminated and is not working another job although fit and able to work, the period of time from R's job loss to the legal resolution of R's suit would not count as a period of unemployment.

- M33 This question asks about wanderlust or vagrancy. It implies that R has/had no fixed address. These individuals have no regular place to live, and move from friend's house to friend's house, or sleep in shelters or on the street. The interviewer should not include people whose only travel without prior arrangements was during vacation or while on leave from job or school. Emphasize a month or more. If R had no fixed address only when s/he ran away to escape physical abuse, do not count.
- M35 Includes heterosexual and homosexual intercourse and homosexual activity that doesn't necessarily qualify as intercourse. As indicated in the parentheses, rape is not included as first sexual intercourse. Masturbation is not included. This must be the first sexual intercourse that R willingly and knowingly took part in. For example, we cannot code a young child's experience as consensual intercourse if the child did not really understand what s/he was doing. Many ASP individuals engage in sexual intercourse at an early age. Sometimes, however, an R will endorse an age that almost seems impossible such as age 3 or 4. These cases need to be considered on a case by case basis. In general, there is no rule about a minimum age for consensual sex.
- M35A This question addresses promiscuity. Both homosexual and heterosexual relations count. Petting does not count. Count all partners -- including spouses. If R was raped, do not count as partner (must be voluntary).
- M36 Relations may be either homosexual or heterosexual. Any infidelity would count, including open-ended and agreed upon liaisons that might occur in open marriage situations. If R is in the process of divorce, and living separately or separated with the intent to file for divorce, do not count.
- M37 This question is designed to get at behavior that is risky to R or others. Technically, anyone could transmit an STD. What we are looking for here is unprotected sex with a clearly high risk person, such as a prostitute or IV drug user, or someone known to have an STD.

- M38 This question looks at reckless disregard for safety of self or others as outlined in the DSM-IV. Do not code driving under the influence if it has already been coded in E22.
- M39 This question elicits chronic, profound deceit. "Conning" can include lying for its own sake rather than for any particular end, or lying for some gain to the person himself or herself. It also implies awareness of rules and deliberate and ostentatious breaking of these rules. The subject gets a kick out of deceiving others. Emphasize to the point that you would often go out of your way to put something over on them.
- M40 This implies that the wishes of R and those of others are not the same, and not just that others were not consulted about their wishes.
- M41 The intent of this question is to identify the person who has been constantly irritable and/or frequently loses his/her temper with family members, co-workers or others. This irritability frequently leads to arguments and/or fights.
- M42 The intent of this question is to determine whether R claims responsibility for the troubles/mistakes in his/her life.
- M43 Interviewer should ask M43 if at least 2 items are marked on part B of Tally Sheet M.
- M43A The intent of this question is to determine whether R felt remorse for any behavior(s) that negatively impacted others. Code as not feeling guilty (code 1) if a person didn't feel guilty at the time but now does looking back after some time.
- M43B The intent of this question is to determine whether R feels justified in having harmed or taken advantage of others.

N: SUICIDAL BEHAVIOR

General information:

Suicidal Behavior is a non-diagnostic section that assesses suicidal ideation and attempts. Only if R stated explicitly in the Depression section that s/he attempted suicide should the interviewer include the word "further" when reading the introductory sentence. There may be some respondents who think about, seriously consider, or attempt suicide but do not go through the Depression section (I) or the Dysthymia section (J) because they do not meet duration criteria. Still, others may ponder or attempt suicide when not depressed. Thus, N1, N2, and N12 are asked of all respondents. Although the total number of suicide attempts is obtained, the interviewer is instructed to ask questions N3-N9 for the most serious attempt only. R must determine for him/herself which attempt was the most serious.

Question by question specifications

- N1A-D Check for onset, persistence and severity of suicidal thoughts.
- N2 Include situations where R had a specific plan and actually took some action, even if s/he did not follow through (i.e., putting a gun to their head, but not pulling the trigger or driving to a bridge and standing as if ready to jump, but not jumping).
- N3 If multiple suicide attempts were made, record the method of the most serious attempt, determined by asking R which attempt s/he considers to be the most serious. This could be the attempt that R was certain would be lethal, or it could be the attempt that caused the most serious medical consequences.
- N5 Medical treatment does not include psychiatric care in this question.
- N6 Hospital admission after the attempt must be for treatment of physical trauma caused by a suicide attempt. Admission to a "close watch" unit to prevent R from doing harm to him/herself does not count.
- N7 Count as "YES," if R said at the time s/he did want to die, but looking back on it after some therapy, thinks it may have been a cry for help.
- N9 If multiple suicide attempts were made, reiterate to R that this question refers only to the most serious attempt. If R states that s/he thought everyone hated her/him, in the context of depression, code it under N9.1 (when feeling depressed), not under other (N9.6).
- N9.6 Include circumstances that are not obviously included under N9.1-5 (the interviewer does not need to probe extensively).

- N10A Code the method R used in the most serious attempt.
- N10B Code how far R got with the attempt.
- N11 Intent, coded by the interviewer, represents R's desire to actually die. The interviewer codes intent, based on R's response to N7 and N8. Although examples are given for each level of lethality, choosing the severity level that best represents R's most serious attempt may prove difficult. As always, when in doubt, the issue may be brought to the attention of a clinician. For this reason, recording specific details of R's suicide plan and/or attempt, will help the coding process.
- N12 Do not include suicide attempts here -- only attempts to hurt oneself.

O: POST-TRAUMATIC STRESS DISORDER (PTSD)

General:

The PTSD section of the SSAGA-II is fully diagnostic for both DSM-III-R and DSM-IV criteria. PTSD is characterized by the development of a variety of specified symptoms in response to exposure to a psychologically distressing event which is generally outside the range of normal human experience. The event is one that would be noticeably distressing to almost anyone and must be accompanied by intense fear, terror, and helplessness.

Events which produce PTSD range in nature to include a serious threat to one's life, death of one's child, military combat, natural catastrophes like hurricanes and earthquakes, seeing serious harm or death inflicted on another person, or a serious threat to one's self or a close friend or relative (e.g., kidnapping of a child). These events are contrasted with "normal" human events such as chronic illness, business loss, simple bereavement, or marital conflict. PTSD is manifested in characteristic symptoms related to the event, often also called "the stressor". Such characteristic symptoms listed among criteria for diagnosis include reexperiencing the traumatic event; avoidance of or numbed response to stimuli associated with the event; and increased arousal in general or regarding situations reminiscent of the event.

Diagnoses for other psychiatric disorders do not preclude a diagnosis of PTSD unless the other disorder(s) are the stressor for the PTSD. Careful evaluation of events and their consequences as well as the reported symptoms are required in these cases to ensure the post-traumatic syndrome is more than a normal response to the event. Impairment can range from mild to severe and can appear in any or all facets of R's life. Some symptoms may mimic phobic or panic attack responses or depression. Symptoms of avoidance may interfere with personal relationships, or social and occupational functioning.

PTSD can be diagnosed at any age. However, symptoms of PTSD begin immediately or shortly after the event occurred. While the full syndrome may not appear for months or years, avoidance symptoms will likely occur very early on. Symptoms of depression and anxiety are common and may occur severely enough to substantiate a clinical diagnosis for anxiety or depression. Other potential signs of PTSD include impulsivity (as in a sudden change in lifestyle), organic mental disorder (muteness, difficulty concentrating, emotional lability, etc.), and guilt. According to DSM-III-R, psychoactive substance use is a common complication.

If R has not reported regular use of substances at the time the event occurred (e.g., R was raped at 14 but started alc/drugs at 18), do not probe each sx for a 3 code.

Question by question specifications:

O1 This screening question for PTSD ascertains whether or not R has experienced a

stressful event. Several examples are provided, though it is up to the judgement of R and the interviewer to assess the amount of distress likely caused by the event. Space to list up to 3 examples of such an event is provided, and codes for the type of event are on Card O. The codes may be added after the interview has been completed, during the self-edit.

- O1A If multiple events were listed in O1, R must identify the most distressing event to him/her. All information obtained in the section will be in reference to this "most distressing" event.
- O1B This question ascertains the standard response experienced relative to a markedly distressing event as described in DSM-III-R and DSM-IV.
- O2-O22 According to the instruction just before O2, this is a series of questions assessing potential symptoms which R might have experienced in response to the most distressing event coded in O1A during the period lasting a month or more endorsed in O1D. It is important to keep R focused on this episode during which multiple symptoms were experienced. Though intoxication is not a clear exclusion for PTSD, both 3 and 6 codes are provided here as in ASPD in addition to a 5 code. Thus, symptoms which occurred exclusively when intoxicated (3), during both intoxicated and sober states (6), and those solely while sober (5) should be coded accordingly. This series of questions is grouped according to DSM-III-R and DSM-IV criteria for the following types of symptoms:
- O2-O6: Symptoms indicative of reexperiencing the event.
 - O8-O14: Persistent avoidance of stimuli associated with the event or numbing of general responsiveness.
 - O16-O20: Persistent symptoms of increased arousal
- O2 This question asks about recurrent, unwanted, and unpleasant recollections (visions, thoughts, etc.) of the event which R tries to block.
- O4 This question refers to sensations of the event recurring flashbacks (including those immediately upon awakening or during intoxicated states), illusions, hallucinations, or other experiences of "re-living" the event.
- O5,O6 These questions assess intense psychological distress in response to reminders of the event such as the anniversary (O5), similar situations, or other phenomena which symbolize the event (O6).
- Box O7 Because at least one of the symptoms in this group must be present to fulfill diagnostic criteria, if none are coded 5, the interviewer skips to the next section.

- O8 This question ascertains whether R had thoughts or feelings about the event, perhaps not as unpleasant as those described in O2, which R tried to avoid but was unable to do so.
- O9 Similar to O8, this question examines R's potential avoidance of activities, social contexts, people, and places which reminded R of the event. Again, this does not require that there was an extreme or unpleasant reaction to those situations, but active avoidant behavior that R is aware of is required. Examples are asked to clarify R's response.
- O10 This question seeks evidence that R may have subconsciously avoided or blocked recollections of the event (psychogenic amnesia). If memory loss was due to an injury during the event, consult a clinician as to how to code.
- O11 This question seeks to assess *markedly diminished* interest in significant activities to R after the stressor occurred. An example would be a professional football player who quit playing football as part of a PTSD syndrome. The emphasis here is both on the significance of the activity in R's life prior to the event, and a marked reduction of that activity.
- O12 R may have experienced a feeling of estrangement or distance from others relative to social relationships prior to the event. This question seeks to determine whether R has either distanced himself/herself from social relationships, or has a significant impression that estrangement has increased since the event. Examples are required to ascertain the level of impairment.
- O13 This question examines R's insight into a loss of emotional response, or flattened affect, since the occurrence of the event. R may have symptoms of a loss of emotion, termed "emotional anesthesia", which impairs R's ability to experience feelings of intimacy and tenderness.
- O14 This question examines whether R experienced feelings of hopelessness since the event occurred. This experience can be manifested in the feeling of not needing to plan for the future or not having interest in what might occur in the future. The distinction between examples like "why worry about going to college" (which is a positive code) versus "I don't know what I'm going to do tomorrow" (negative code) is important to proper coding of this question.
- Box O15 As in O7, at least one question in this series of questions must be coded 3, 5, or 6 to meet diagnostic criteria. Thus if there are no 3's, 5's, or 6's, interviewers are skipped to the next section.
- O16 This is the first in a series of questions related to physical manifestations of a

response to the most distressing event. The questions probe changes in the person's behavior after the event, during the month or longer of most, or most intense feelings. This question assesses a potential sleep disturbance, either having trouble falling asleep or staying asleep since the event. If a person has always been a "light" sleeper it will be important to ascertain and document that significant changes in sleeping occurred since the event. Difficulty staying asleep may be experienced as being easily awakened or waking often.

- O17 This symptom can be experienced as a general increase in aggression and can be accompanied by a fear of losing control.
- O18 This question examines a general distractibility most commonly observed as difficulty concentrating, focusing on detail, or completing tasks.
- O19 R may have experienced an increase in his/her startle response since the event. It is important to differentiate an increased response to unexpected events from a "jumpy" person.
- O20 Consistent with an exaggerated startle response, R may also report a heightened sense of his/her surroundings (hypervigilance). This increased arousal sensation may include visual, auditory, olfactory, and other sensory cues.
- Box O21 As in O7 and O15, O21 assesses the presence of any 3, 5, or 6 codes in the preceding series of questions (O16-O20). As at least one must be present to meet diagnostic criteria, if none are present, skip to the next section.
- O22 Review the symptoms coded 3, 5, or 6 in questions O6-O20. This question should confirm that this syndrome did occur for longer than one month.
- O22A Code the longest duration that these symptoms occurred together as a syndrome since the event.
- O22B Code the amount of time according to the units specified below O22B between the occurrence of the event and the beginning of any syndrome like that discussed in questions O6-O20.
- O22C Record the most recent time when a syndrome like that discussed in questions O6-O20 was experienced.
- O22D This question focuses on examples of significant impairment in functioning in various facets of R's life. It is important to clearly document any examples offered and to clarify that the examples offered exceed normal disruptions in human relationships (e.g., more than just an argument with a friend or spouse). Look for

adverse consequences as a result of the change in functioning since the event as evidence of impairment.

O23

This question addresses treatment seeking by R in response to R's experiences since the event. This is non-diagnostic, but it is necessary to determine whom R saw and what precipitated the visit to the health professional.

P: GENERALIZED ANXIETY DISORDER (GAD)

General:

The GAD section is fully diagnostic for criteria specified in DSM-III-R and DSM-IV. GAD is characterized by pervasive unrealistic and excessive worry about two or more life situations when no imminent adverse consequences are likely--for example, worry about something happening to a child when no danger is present, concern over finances when there are no debts, etc. A diagnosis of GAD requires a 6 month or longer period of such worry over life events occurring nearly daily. Examples given in DSM-III-R for adolescents include worry over scholastic, social, or academic endeavors.

GAD is not diagnosed in the context of disorders frequently associated with GAD, including mood disorders and psychotic disorders, or when anxiety symptoms are derived from an organic condition like hyperthyroidism, caffeine intoxication, or alcohol or other substance use. GAD may be diagnosed in addition to other Axis I disorders when the worry is unrelated to the other disorder. That is, worries about R's own symptoms do not count. For example, GAD may be present in someone also suffering from Anorexia Nervosa only if the anxiety is not related to a concern over weight, gaining weight, body dysmorphism, etc.

Symptoms observed as part of GAD include motor tension, autonomic hyperactivity, and vigilance. These can be evidenced, for motor tension, in trembling, twitching, feeling shaky, muscle tension or achy/sore muscles, restlessness, and fatigability. Signs of autonomic hyperactivity include shortness of breath, feelings of smothering, palpitations/heart acceleration, sweating/clammy hands, dry mouth, dizziness/light-headedness, nausea, diarrhea/abdominal distress, flushes/chills, frequent urination, and trouble swallowing. Vigilance can be observed in behaviors such as scanning, feeling on edge, exaggerated startle response, difficulty concentrating, trouble falling asleep or staying asleep, and irritability.

GAD can be associated with mild depressive symptomatology, and impairment in social or occupational functioning is relatively minor. According to DSM-III-R onset is likely in the 20s and 30s. Earlier onset or much later onset should be scrutinized carefully.

Question by question specifications:

- P1 This screening question is designed to ascertain the general characteristic of GAD during a specific episode. Focus R on the period of 6 months or more when worrying about several things during lifetime was at its worst. Examples of the worries are written in P1A. Be sure to ask for all examples of different worries/concerns at that time.
- P1B The interviewer should code here--without asking--whether or not there are 2 worries elicited by P1 and listed in P1A. If fewer than 2 examples are given, skip

- to next section.
- P1C Standard probes/codes are provided to elicit potential organic, medical, illness, or substance-related causes of period of worrying. If coded 2 skip to next section; otherwise continue.
- P1D This question along with P1D1 ascertains the likelihood that R or someone close to R considered the episode of worry to be unrealistic or excessive.
- P1E This question ascertains the intrusive nature of the worries and difficulty controlling them, as required by DSM-IV.
- P2 This series of questions P2.1-P2.18 lists the possible symptoms of GAD as described in DSM-III-R and DSM-IV. These are coded as either present or absent during the 6 month episode being reviewed. It is important that these symptoms all relate to the 6 month period described in P1 and also occurred more days than not during that period.
- P3 This question ascertains the number of caffeinated drinks being consumed during the episode of 6 months or longer during which the worrying occurred. Caffeine intoxication is a likely organic cause for GAD-like symptoms and may otherwise be overlooked by R. Because there is no clear cutoff for use of caffeinated beverages, this is not offered as a definite exclusion or skip out.
- P6 This question establishes the age of the first period of worrying similar to the one reviewed in this section and the age of the most recent occurrence of such a period. It does not necessarily establish the age at which the period reviewed began and ended. It is asking for the first/last time such a period occurred since multiple periods are not uncommon.

Q: OBSESSIVE-COMPULSIVE DISORDER (OCD)

General Information:

The Obsessive-Compulsive Disorder section of the SSAGA-II is fully diagnostic for DSM-IV and DSM-III-R criteria. The essential features of this disorder are recurrent obsessive thoughts and/or irrational compulsive behaviors that a person feels compelled to perform. The obsessions or compulsions are severe enough to cause marked distress, be time-consuming, or significantly interfere with a person's normal routine (e.g., occupational functioning, or usual social activities or relationships with others). At some point, adults with this disorder recognize that the obsessions or compulsions are excessive or unreasonable. They also realize that these thoughts, while unwelcome, are their own and not inserted into their mind by an outside force.

Obsessions are persistent and distressing thoughts/impulses/images that are experienced as unwanted and senseless. The most common obsessions involve thoughts of violence (e.g., injuring one's child), profanity (e.g., cursing aloud in church), sexual imagery (e.g., a recurrent pornographic image), contamination (e.g., becoming infected by shaking hands), a need to have things in a certain order (e.g., distress when things are asymmetrical), and doubt (e.g., repeatedly wondering whether one has hurt someone in a traffic accident).

Compulsions are purposeful, repetitive behaviors (e.g., hand washing) or mental acts (e.g., counting, repeating words silently) that are performed to reduce anxiety associated with an obsession or to prevent some dreaded event/situation. In some cases, individuals may perform stereotyped acts without knowing why they are doing them. The most common compulsions involve washing and cleaning, counting, checking, requesting assurance, repeating actions, and arranging things in a certain order.

In addition to obsessions and compulsions, people suffering from OCD generally exhibit indecisiveness, highly controlled emotions, concerns about cleanliness and neatness, and rigidly structured lifestyles (both work and leisure activities).

Question by question specifications

- Q1A Feelings of guilt or persistent thoughts of needing to lose weight are not counted. Distinguish obsessive brooding (thinking repetitively about unpleasant circumstances or about possible alternative actions) from obsessions. Brooding thoughts are not experienced as senseless because the ideation is regarded as meaningful, although possibly excessive.
- Q5 Obsessive thoughts that only take place during periods of depression do not count.

- Q6 This question identifies obsessive thoughts that occur only under the influence of substances or during withdrawal from them.
- Q9 This question checks for compulsions. Emphasize "over and over."
- Q13 Because compulsive behaviors that only take place during periods of depression do not count towards diagnosis, we must ask this.
- Q14 This question identifies compulsions that occur only under the influence of substances or during withdrawal from them.

R: SOCIAL PHOBIA

General Information:

The Social Phobia section is fully diagnostic for DSM-IV and DSM-III-R Criteria. Social Phobia is a persistent fear of one or more situations in which the subject must interact with others socially (e.g., a party) or perform (e.g., a concert). The subject fears that in these situations s/he will act in a way that is embarrassing and will consequently be judged as anxious, weak, crazy, or stupid. The person with Social Phobia typically will avoid the feared situation or, less commonly, force himself or herself to endure the situation with intense anxiety. During some phase of the disturbance, exposure to the specific phobic stimulus (or stimuli) almost invariably provokes an immediate anxiety response (e.g., palpitations, trembling, blushing, shaking, or difficulty breathing, etc.). Many people feel uncomfortable in some social situations, especially (for example), public speaking. Adults (not necessarily children) with Social Phobia recognize that their fear goes beyond this and is **excessive or unreasonable**. The avoidant behavior either a) interferes with such domains as normal routine, occupational functioning, and relationships with others; or b) is accompanied by marked distress about having the fear.

DSM-IV notes that social phobias involving fear of public speaking are the most common. Phobias about speaking to strangers or meeting new people are less prevalent, while those related to writing, eating in public, and using public lavatories are the least frequent.

Question by question specifications

- R1 Social phobia must be distinguished from social uneasiness or shyness, which is quite common. Under Specify, determine the reason R is fearful of the situations listed. The key feature is potential embarrassment. Specific common social phobic situations are provided to code individually. When probing, all situations coded 5 in R1-R6 should be included.
- R1 Instructions: Sometimes a physical condition, like a stroke or a handicap, might lead someone to endorse a fear in R1.1-R1.6. If the fear was only because R was embarrassed to speak on account of his/her physical disability, interviewers are instructed to code "4." Similar reasoning is applied to psychiatric conditions (like anorexia) that might lead to fears of certain social situations; that is, code 5 in these situations.
- R1.6 The fear of using public restrooms should be a fear of an action when others are (or could be) present. Do not count fears of germs.
- R10 If R meets/met criteria for Anorexia Nervosa and/or Bulimia Nervosa, the fear(s) coded in R1.4 must be unrelated to the eating disorder. The anorexic's fear of exhibiting the abnormal eating behavior, for example, gets coded 5 in R10 and disqualifies a diagnosis of social phobia.

S: AGORAPHOBIA

General Information:

Agoraphobia is a fully diagnostic section incorporating DSM-IV and DSM-III-R criteria. Agoraphobia is defined in DSM-IV as: "...anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having a Panic Attack or panic-like symptoms. Typical situations are clustered and include being outside the house alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or automobile.

The initial phase of agoraphobia often consists of recurrent panic attacks, and the anticipatory fear of having another attack often causes incapacitation in at least one of the following ways: a) the agoraphobic refuses to enter situations in which such attacks were previously experienced (e.g., travel is restricted); b) the situations are endured with considerable distress/fear of another panic attack; or c) the agoraphobic will only enter these situations when accompanied by a companion.

The agoraphobic may stay in the house and avoid open spaces and public places. Staying in familiar surroundings provides a sense of security in case an attack occurs. Although the severity of the disturbance waxes and wanes, the avoidance of a wide range of frequently encountered situations may grossly interfere with social functioning and job related activities. Agoraphobics, dominated by their fears and avoidance behaviors, increasingly restrict their range of activities. The agoraphobic person may become housebound or may refuse to leave his/her home if unaccompanied.

Question by question specifications

- S1 Describes agoraphobic situations. The interviewer should pause frequently so that R can more easily understand and process the detailed description and the examples provided.
- S2 For S2 stem and S2A, the interviewer obtains examples of phobic situations. In S2C, it is important to find out why R is afraid of the situation. This will help screen out, for example, individuals who are afraid of bridges because they think the bridge might collapse.
- S3 This list consists of typical symptoms experienced by subjects while in agoraphobic situation(s).
- S6 Checks the efficacy of obtaining relief from agoraphobic fears by self-medicating with alcohol, drugs, and/or prescription medication.

T: PANIC

General Information:

The Panic Disorder section of SSAGA-II is fully DSM-IV and DSM-III-R diagnostic. The essential features of Panic Disorder are recurrent and unpredictable panic (anxiety) attacks, followed by at least one month of a) concern about having another attack; b) worry about the implications or consequences of the attack (e.g., fear of a heart attack); or c) a significant change in behavior associated with the attack (e.g., quitting a job). Episodes, marked by clear onset and termination, can last from minutes to hours. Panic attacks typically begin with sudden intense apprehension, fear and terror and are often accompanied by feelings of impending doom. People who experience panic attacks frequently develop fears of certain situations associated with the attacks (e.g., Panic Disorder with Agoraphobia).

At least two unexpected Panic Attacks are necessary for DSM-IV diagnosis, although most subjects have many more (DSM-III-R requires four attacks within a 4-week period.). People with Panic Disorder may have predictable attacks as well as unexpected ones. In some cases these additional attacks may be part of co-morbid anxiety disorders such as Social Phobia. The severity and frequency of attacks vary considerably. The most common symptoms are shortness of breath, palpitations, chest pain or discomfort, choking or smothering sensations, and the fear of "going crazy" or doing something uncontrollable during the attack. Both DSM-III-R and DSM-IV require the presence of at least 4 out of 13 physiological symptoms.

These attacks must not be precipitated by exposure to a specific phobic stimulus and cannot be attributable to the direct physiological effects of a substance (e.g., caffeine or amphetamine intoxication) or a general medical condition (e.g., hyperthyroidism). For this reason, the 1 2 3 4 5 probing pattern is used in question T1 to determine the etiology(ies) of the panic attacks. Use of the 3 and 4 codes would include, in addition to the above examples, withdrawal from certain substances (e.g., barbiturates, alcohol), and allergic reactions to certain foods and food additives (monosodium glutamate-MSG).

Question by question specifications:

- T1 An example must be elicited prior to coding. If the example does not qualify as a panic attack, code "1" and skip to section U.
- T4 After every few symptoms interviewer should reiterate "During this worst spell..." so that all symptoms coded occurred during the same (worst) spell.
- T6 Checks both whether symptoms were unexpected and whether they worsened rapidly.

U: COMORBIDITY

General:

There are two ways to define comorbidity: having two or more disorders (ever) and having disorders overlap in time. The SSAGA-II uses the second definition and therefore asks about the overlap of 1) substance dependence and psychiatric disorder episodes and 2) heavy substance use that may have precipitated the psychiatric disorder or episode.

The first part of the Comorbidity section is a general review of R's history (as compiled on the timeline). This means every respondent gets into the section. Interviewers start by reviewing the ages and/or years of R's life events (such as marriages, divorces, births of children, or any other major markers that R uses). Interviewers next review any information recorded about substance use, abstinence, and clustering. If information about psychiatric episodes is recorded, that will be the third area to review. Rs who do not have both substance use and psychiatric episodes will skip out of the section at this point. But for those who do have both, the interviewer continues and asks U3A and U3B for each psychiatric disorder. In U3A and U3B, the interviewer asks about the relationship between substance use/clustering and the onset of a psychiatric episode/syndrome. The interviewer asks about episodes when discussing depression, dysthymia, and mania, but when discussing the other, and more chronic, disorders, the interviewer only needs to ask about the onset of the problems (rather than every episode).

For example, assume R started drinking at age 18 and had clustering onset at age 23. She denied any drug use. She had periods of depression that started at ages 20, 25, and 30; she reported social phobia onset=15 & recency=35; and she reported panic attacks onset=21 and recency=35. The interviewer asks U3A and U3B one disorder at a time. When asking U3A, the interviewer repeats the question for each episode that occurred during times of regular use.

DEPRESSION:

IVR: *"Now I'd like to ask you some questions about the relationship between these experiences. I will start with the episodes of depression that you told me about. You said you had an episode of feeling depressed that started at age 20."*

IVR HANDS ALCOHOL TALLY A TO R AND ASKS:

IVR: *"Around the time that episode began, were you having experiences from 3 or more boxes found on this alcohol tally sheet?"*

EVEN THOUGH R PREVIOUSLY REPORTED THAT CLUSTERING STARTED AT AGE 23, IVR ASKS FOR CONFIRMATION. IF R REPORTS CLUSTERING WHEN THIS EPISODE STARTED AT AGE 20, IVR NEEDS TO GO BACK TO THE ALCOHOL SECTION TO RECONCILE. IF YES, IVR RECORDS INFO ON TIMELINE AND GOES TO NEXT EPISODE. IF NO, IVR ASKS: *"Around the time that episode began, were you drinking heavily daily or almost daily?"* RECORD ON TIMELINE.

IVR: "You said you had an episode of feeling depressed that started at age 25. Around the time that episode began, were you having experiences from 3 or more boxes found on this alcohol tally sheet?" IF YES, IVR RECORDS ON THE TIMELINE. IF NO, IVR ASKS: "Around the time that episode began, were you drinking heavily daily or almost daily?" IF YES TO HEAVY USE, RECORD ON TIMELINE.

IVR: "And you said you had an episode of feeling depressed that started at age 30. Around the time that episode began, were you having experiences from 3 or more boxes found on this alcohol tally sheet?" IF YES, IVR RECORDS ON THE TIMELINE AND GOES TO U3B. IF NO, IVR ASKS: "Around the time that episode began, were you drinking heavily daily or almost daily?". IF YES TO HEAVY USE, RECORD ON TIMELINE.

IVR REVIEWS THE INFO ABOUT ALL EPISODES OF DEPRESSION AND ASKS IN A CONFIRMATORY WAY:

IVR: "So, according to the information on this page, your episodes of feeling depressed sometimes (but not always) started around a time when you were experiencing some problems with alcohol?"

IVR CODES ANSWER IN COLUMN I.

IVR: "and your episodes of feeling depressed always [or sometimes, or never] started around a time when you were drinking heavily daily or almost daily?"
IVR CODES IN COLUMN II.

SOCIAL PHOBIA:

BECAUSE ONSET OF R'S SOCIAL PHOBIA WAS BEFORE THE ONSET OF REGULAR DRINKING, U3A CAN BE SKIPPED. IVR CONFIRMS BY ASKING U3B.

IVR: "So, according to the information on this page, your problems with doing things in front of others, (like speaking or using public restrooms) never started around a time when you were having some problems with alcohol -- is that correct?" IVR CODES ANSWER IN COLUMN I.

IVR: "and your problems with panic episodes also never started around a time when you were drinking heavily daily or almost daily?" CODE IN COLUMN II.

PANIC ATTACKS:

IVR: "Now I will ask you about the episodes of panic that you told me about. You said you first had episodes of panic at age 21. "Around the time the problems with panic episodes began, were you having experiences from 3 or

more boxes found on this alcohol tally sheet?"

EVEN THOUGH R PREVIOUSLY REPORTED THAT CLUSTERING STARTED AT AGE 23, IVR ASKS FOR CONFIRMATION. IF R REPORTS CLUSTERING WHEN THE PANIC ATTACKS STARTED AT AGE 21, IVR NEEDS TO GO BACK TO THE ALCOHOL SECTION TO RECONCILE AND RECORD ON TIMELINE. IF NO, IVR ASKS: "*Around the time that began, were you drinking heavily daily or almost daily?*"

IVR REVIEWS THE ONSET OF PANIC ATTACKS AND ASKS IN A CONFIRMATORY WAY:

IVR: "*So, according to the information on this page, your problems with panic episodes never started around a time when you were experiencing some problems with alcohol?*" IVR CODES ANSWER IN COLUMN I.

IVR: "*and your problems with panic episodes never started around a time when you were drinking heavily daily or almost daily?*" IVR CODES IN COLUMN II.

Question by question specifications:

- U1 If R changes an age or year after reviewing the timeline, go back to the appropriate SSAGA-II section to reconcile and make needed changes.
- U3 Interviewers should use appropriate phrases when describing psychiatric episodes. Use R's own words to describe the episode or phrases similar to those provided under Box U2.
- U3A If R reports clustering during a specific episode, the IVR does not need to also ask about heavy use. The IVR only asks about heavy use during the episodes with no clustering.
- U3B If R says ALWAYS to clustering, then the IVR does not need to ask about heavy use. So, if U3B.1=ALWAYS, the IVR should return to the U3 stem for the next disorder (or if no other disorder, skip to section V, subject comments).
- U3B.2 Read the phrase "when they didn't start around a time when you were having problems with alc/mj/drugs" if R ever clustered during an episode. If U3B.1 is ALWAYS WHEN CLUSTERED, leave Column II blank. The only episodes that get coded in Column II are the ones without any clustering.
- U3C This question can be answered silently by the interviewer after thoroughly reviewing the disorders with R. Note that if CLUSTERING and HEAVY USE are both ALWAYS, then SUBSTANCE RELATED is ALWAYS, and likewise if CLUSTERING and HEAVY USE are both NEVER, then SUBSTANCE RELATED is NEVER. However, if CLUSTERING and HEAVY USE are both SOMETIMES, then SUBSTANCE RELATED can either be coded ALWAYS or

SOMETIMES, depending on the situation. Every affective episode and every psychiatric syndrome should have been reviewed, so the IVR can tell by looking at the timeline if the episodes were always or sometimes substance-related.

W: INTERVIEWER'S OBSERVATIONS

General:

All items on this rating sheet refer to behavior, attitudes, cognition, and appearance during the interview (do not assess based on neuropsychological test scores). If a respondent describes many fights in his/her past but is totally cooperative and congenial during the assessment, do not check "aggressive." Similarly, if a respondent reports paranoid episodes but does not act this way during the interview, do not rate him/her as "suspicious."

It is good practice to review all items under a category before deciding whether or not a respondent was "normal." Your first impression may be that a respondent was within normal limits; however after reading specific items, you may decide otherwise.

Definitions in quotes are from (a) the Psychiatric Dictionary (Fifth Edition) by Robert Campbell, published by Oxford University Press in 1981; (b) The Neuropsychiatric Mental Status Examination, by Michael Taylor, published by Pergamon Press in 1986; and (c) the Comprehensive Assessment of Symptoms and History (CASH) by Nancy Andreasen (1987).

Question by question:

- W.B4 Seductive dress can apply to either gender. In male respondents, for example, it may take the form of clothing which emphasizes the torso to an inappropriate degree for an interview (open shirts, etc.).
- W.B5 Inadequate dress refers to two possibilities: an individual may be overdressed for warm weather or underdressed for cold weather.
- W.C 1 Increased amount overlaps somewhat with constantly fiddling but is focused primarily on "major motor" phenomena such as frequent walking or pacing. Fiddling is more concerned with small motor movements like tapping a pencil or a foot.
- W.C 4 Tics are "Any brief, recurrent, inappropriate irresistible movement involving a relatively small segment of the body...(e.g., yawning, sniffing, spasmodic cough, spitting)...coordinated rhythmical movements involving the jaw, lips, tongue, and palate...grimacing, blinking, shrugging, wry [twisted] neck..." Note that tics can include noises and words.
- W.C5 Tremor refers to "shaking or trembling" which can occur while the respondent is at rest or, in some cases, only when he or she makes a voluntary movement. Another type of tremor consists of involuntary twitching of muscles such as those around the eyes, which should be coded here rather than under "tics."

- W.D1 Blocking: "Sudden cessation in the train of thought or in the midst of a sentence. The patient is unable to explain the reason for the sudden stoppage." (Bleuler, quoted by Campbell). "The patient suddenly becomes silent, immobile and unresponsive and after a few moments becomes animated again and begins speaking" (Taylor). Blocking should not be confused with unsuccessful attempts to recall information ("I'm blocking on that name").
- W.D2 Circumstantial: An overabundance of detail or associated ideas. "Circumstantial speech refers to tightly linked associations, but with extra, non-essential associations interspersed. The speech takes a circuitous route before reaching its goal" (Taylor). A patient of Bleuler's, quoted in Campbell: "I am writing on paper. The pen I use for it is from a factory called Perry & Co., the factory is in England. I am assuming that. After the name Perry Co., the city of London is scratched in; but not the country. The City of London is in England. That I know from school."
- W.D3 Tangential: A pattern of language in which the person digresses from the original topic through a series of associations. If severe or repetitive enough, the main point is lost and communication may become impossible: "What is my opinion? Well, I might have thought about it a long time and you know there are many things to consider, some this way, some that" (Taylor).
- W.D4 Perseveration: "Involuntary continuation or recurrence of an experience or activity, most typically verbal..."(Campbell). In some instances, this may involve repetition of stock phrases or words: "That's my situation. Situations change and it can't be helped. My situation is my problem, I've got to situation myself just right" (example from Taylor).
- W.D5 Flight of ideas refers to "jumping from topic to topic, often in response to external stimuli. Multiple lines of thought can occur" (Taylor). The author provides an example: "What happened in the Army is my business. I'll mind my business, you mind yours. Are you sure you work here? You're awfully nosy! I don't like questions. I'd rather be outside. I like the out of doors. It's raining now but it won't tomorrow..."
- W.D7 Illogical (illogicality) is "A pattern of speech in which conclusions are reached which do not follow logically. This may take the form of non sequiturs (it does not follow), in which the subject makes a logical inference between two clauses which is unwarranted..."(Andreasen) Example: "Parents can be anything...that has taught you something...a person can look at a rock and learn something from it, so that would be a parent." Do not include here delusional beliefs, statements which are clearly due to cultural or religious values, or the products of a

subnormal intelligence.

- W.E3 Stupor: A level of alertness between drowsiness and unconsciousness; "...sensibilities are deadened or dazed and the subject has little or no appreciation of the nature of his surroundings" (Campbell)
- W.F3 Push of speech: a strong drive to talk, often rapidly. It may be difficult to interrupt him or her.
- W.F7 Mute means R exhibits no speech.
- W.F10 Neologisms are approximations of real words: "I can't rutton this shirt" (Taylor). Usually the correct form of the word is readily identifiable. These should be distinguished from malapropisms or mispronunciations due to lack of education.
- W.G Angry Outbursts overlaps closely in meaning with Irritable, Hostile, Aggressive, Manipulative, Uncooperative, and Negativistic. Some discrimination is possible, and a positive rating on one trait should not always imply a positive rating on the others. Outbursts are discrete, brief episodes of yelling or similar behavior. Irritable behavior is more subtle and can be more long-lasting; a subject might show impatience, for example, throughout the interview. Hostile individuals are not necessarily irritable, and they might not have angry outbursts, but their attitude should be manifested in some nonverbal or verbal behavior during the interview (e.g, angry looks or antagonistic statements). Aggressive subjects may literally push the interviewer or dominate them verbally to an extreme degree. Manipulative individuals also tend to get their way, but not necessarily through hostile tactics--they might, for example, persuade the interviewer to shorten a session because of fatigue. Uncooperative is an umbrella term for subjects who intentionally, for one reason or another, don't fully comply with the interview. Negativistic subjects interpret themselves, others, and/or events in a bad or pessimistic light. They might not be angry, but could be depressed instead.
- W.G3 Impulsive behaviors are performed suddenly and with insufficient forethought. They may be motoric (e.g., jumping up and running to get a candy bar), verbal (e.g., blurting out an answer to a question before it is finished), or cognitive (e.g., not thinking through the answer to a question).
- W.G6 Sensitive: overly reactive to criticism or teasing ("thin-skinned"). It does not, in this context, refer to people who are empathic to others' distress.
- W.G7 Apathetic subjects usually have blunted affect. For example, s/he may show little affection for significant others and evidence no plans or enthusiasm for the future.

- W.G8 "The withdrawn person appears aloof, detached, disinterested, removed, and apart..."(Campbell).
- W.G9 Evasive subjects are more deliberate than indecisive individuals; the interviewer should sense that an intentional cover-up is taking place.
- W.G10 A passive subject is one who (a) appears to take little initiative; (b) doesn't question what he or she is asked to do; and/or (c) delays, forgets, or otherwise incompletely performs requests.
- W.G12 Naive: A lack insight into one's own behavior and/or that of others. Naive respondents may express surprise at some basic, well-known facet of society (e.g., politicians lie), or they might not realize their impact on others (e.g., seductiveness of their posture and clothing).
- W.G13 A subject who is overly dramatic expresses flashes of emotion that are fleeting, shallow, and insincere. For example: "*You can't imagine how terrified I felt when I learned the interview would take four hours!!*" Rolling eyes and avoidance of eye contact may accompany such displays.
- W.G15 The term dependent in the context of the SSAGA-II suggests that R frequently asks for clarification of questions, solicits the examiner's advice on answers, or otherwise requests reassurance too often.
- W.G17 Demanding Rs will require a lot of attention and/or favors from you. This concept overlaps with manipulative; the latter implies a more calculated or deliberate set of behaviors.
- W.G19 Callous means an individual is emotionally insensitive or tough. It refers to an attitude towards others and should not be confused with flat affect, in which all emotions are weak, not simply empathy.
- W.H2 Inappropriate affect implies a mismatching of content and mood. Laughing at the death of a loved one or crying without apparent reason are two examples.
- W.H3 Flat affect refers to a restricted intensity and range of mood, such as when an individual describes a recent tragedy with only a trace of sadness. This flatness is not the same as inappropriate affect, in which the tragedy might be recalled with glee or joy.
- W.H6 Subjects who exhibit labile mood "...shift rapidly and frequently during a short

period of time" (Taylor) Such individuals are not overly dramatic if the interviewer senses that the emotions are genuine.

- W.I6 Antisocial attitudes can be expressed with or without hostility. These might include opinions which range from the usefulness of speeding to the joys of polydrug ingestion to the benefits of multiple partners.
- W.I7,13,26 Suspiciousness, Feels persecuted, and Delusion of persecution are related but not identical concepts. The first can refer to a wariness about being interviewed (or anything else). For example, a respondent might grill the interviewer at length about the consent form. The second applies when a respondent feels another person or group of people are deliberately making things hard for him/her. A delusion of persecution means the interviewer judges such a suspicion to be ill-founded or highly exaggerated. For example, R may state that he is targeted by the CIA for murder. Remember that the first two traits do not require the interviewer to judge their appropriateness.
- W.I8 Poverty of content means R provides minimal information. Generalities, filler words, and vague replies are common. Language tends to be overly abstract or concrete and repetitive. The subject may speak at some length but still not provide enough material to answer the question (paraphrased from Andreasen).
- W.I10 Obsessions refer exclusively to repetitive, intrusive, and inappropriate thoughts, whereas compulsions refer to acts bearing the same characteristics.
- W.I11 Feelings of unreality will be apparent only if R verbalizes them. For example, he/she might state that the interview seems dreamlike or unreal.
- W.I22 Illusions involve distortions of real perceptions, such as seeing cargo fly off a passing truck late at night or mistaking the smell of bacon for that of candy. Hallucinations are perceptions which entirely lack an external stimulus. Delusions are beliefs which represent persistent misinterpretations of the environment or one's own person.
- W.I23 Remember that the traits listed in this section must occur during the interview to be rated as present. In order to code hallucinations as present, the subject must experience hallucinations during the SSAGA. This may be deduced either from verbal report or from behavior (e.g., answers to the door or jumps back suddenly as if he/she has seen something).
- W.I27 Delusion of grandeur: R mistakenly thinks that she/he (a) holds a title, degree or prestigious position; (b) possesses large sums of money, (c) is extremely talented (in music, athletics, etc.), and/or (d) is on a special mission to help people.

- W.I28 Delusion of reference: R incorrectly believes that stray remarks, TV and radio shows, songs, billboard signs, etc. are specifically directed at him/her. Statements like "this song was written for me" should be questioned, as they simply may be a figure of speech.
- W.I29 Delusion of influence: R thinks that he/she has been controlled or affected in implausible ways: "The rays come from the television station...into the antenna..sometimes they make me weak and I can't move" (example from Taylor). The belief that thoughts have been taken out of one's head by someone else is another example.
- W.I30 A somatic delusion is the erroneous conviction that something is wrong with one's body. This preoccupation may involve structure ("my stomach is rotting"; "I have lost my pancreas") or function ("I have Grave's disease"; "My liver doesn't work right").
- W.I32 Systematized delusions are highly organized, complex systems of thought. Often they are of longstanding duration and over time have become more elaborate.
- W.J1 Time: does the respondent know the year, season, month, day of the week, day of the month, and time of day?
- W.J2 Place: does the subject know what country and state he or she is in? Does he or she know the hospital or clinic where the interview is being conducted?
- W.J3 Person: does R know his or her own identity and that of key people in the environment? Forgetting the name of the examiner does not count.
- W.K1 Clouding of consciousness is a general impairment of orientation, attention, and perception. It is less severe than stupor, which is close to unconsciousness. In other words, R may be noticeably "out of it" but still communicable.
- W.K3 Amnesia refers to loss of memory, usually partial but sometimes near-total. R may have difficulty recalling events prior to a specific point in time (retrograde amnesia), or subsequent to that point (anterograde amnesia). Poor recent memory and poor remote memory are less extreme counterparts of anterograde and retrograde amnesia.
- W.K6 Confabulation means R fills in memory gaps with fabricated information, sometimes narrated in great and convincing detail. Confabulation may be deliberate or unintentional.
- W.L Intellect Your assessment of R's intellectual performance should be based on

clinical impressions gathered during the interview, rather than formal cognitive testing. This should be assessed apart from education level achieved.

W.M1 Poor insight: R does not seem to fully grasp (a) the probable motivations or causes of his/her behavior (e.g., the link between marital stress and his/her drinking); or (b) the impact of their behavior on others (e.g., the link between his/her drinking and getting fired).

W.M2 Poor judgment: In this context, insight refers primarily to understanding, whereas judgment pertains largely to behavior. A subject who exhibits poor judgment does so by acting without enough regard for consequences. During the SSAGA, for example, R might not allow enough time to be interviewed.

W.M3,4,5 Unrealistic regarding degree of illness, Doesn't know why being treated, and Unmotivated for treatment: The first term characterizes an individual who realizes there are problems but minimizes them. The second descriptor is more severe; it refers to a subject who has no idea he/she requires help. If a person scores positive on the second term, he or she should also get a positive score for the first term, but the reverse is not necessarily true. The last term does not address insight; it can include individuals who realize they need help but either lack the will to participate or don't believe treatment will work. Thus, a person who fits this third item may or may not fit the previous two terms.

Rating Box This scale should apply to the entire interview, not the observations you have just completed.

INTERVIEWER NARRATIVE ABOUT THE RESPONDENT

The Interviewer Narrative About the Respondent is intended to afford the interviewer freedom, after the interview, to ask questions about the Respondent's life and then to record (after the Respondent has left), not only information about R's life but also general observations made during the interview. Guidelines follow below for obtaining additional information/providing important comments:

1. Obtain additional data about the person, such as:

Information about his/her life in general. What is a typical week like for R? Is s/he happy/satisfied with work (what is this work)? What are his/her other interests, hobbies, complaints. Is s/he generally happy with his/her life? Does s/he have many/few friends? Does s/he maintain close ties with family? How does s/he view him/herself in relation to co-workers, supervisors, colleagues, family, partner?

Briefly summarize information about R's problems and when they began, as documented in SSAGA. Supplement with additional information about his/her help-seeking behavior, therapy, medications, and impairment caused by specific episode(s)/ substances. Comment on R's perceptions of his/her problems.

2. Record additional information about R's behavior/attitude during the interview, which could affect the validity of the responses. This could include: Remarking on R's responses -- did s/he always say "yes" or "no" to everything (was s/he hostile/trying too hard to please the interviewer)? Did R seem to understand the questions, or did questions need to be paraphrased? Did R take questions too literally? What was R's affect like during the interview? Was there anything unusual about R's appearance, dress, or hygiene?
3. Describe any difficulties you encountered conducting the interview (e.g., subject was interrupted frequently by family members, space was not totally private, etc).

The above guidelines are provided to underscore the importance of providing thorough and complete information when interviewing. This information becomes part of the overall picture of R, and will help put in perspective the quality of the data obtained during the interview.