BEHAVIOURAL PROBLEMS IN CHILDREN OF MOTHERS WHO HAD DEPRESSION
(Based on Maternal Reports of Behaviour)

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CERTIFICATE

This is to certify that this is a bonafide work done by **Dr. G. K. Kannan** in partial fulfillment of the requirement for **M.D (PSYCHIATRY BRANCH XVIII)** PART III examination of **THE TAMIL NADU DR.M.G.R MEDICAL UNIVERSITY CHENNAI to** be held in September 2006.

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INDEX

INTRODUCTION

Parental psychiatric illness: The implications for children

The risks for children with a mentally ill parent have been recognized and researched for over half a century (Janet, P. *et al*., 1926 & Rutter, M. *et al.*, 1984). Since more patients are cared for in the community, more patients are now parents (up to 60%) and many care for young children (Oates, M. *et al*., 2001). Advances in our understanding of genetics mean that the heritability of specific major illnesses has been calculated. Bipolar disorder is estimated to have a heritability of 80%, depression 34 - 48% and schizophrenia 75% (Rutter, M. *et al*., 1999).

Unipolar depression is to be ranked fourth by 2020 in the measure of disability adjusted life years. Given the high prevalence of depression, this puts a large number of children at risk of developing future psychiatric problems. Psychological development of a child depends on the interaction of biological self and behaviour with the environment. The child actively interacts with the environment and the whole development is better understood by the social learning model. Children of mothers with depression suffer from both a vulnerable biology and the effects of faulty parenting. Not only that, these children also have poor models to emulate. The dynamic interaction of these factors predisposes them to emotional and behavioral disturbances.

The impact of parental mental illness on children is important in everyday clinical practice and the subject of a recent Royal College of Psychiatrists report. There has been considerable attention paid to the link

between fatal child abuse and parental mental illness. The services that may support families and children have received rather less attention until recently (Gopfert, M. *et al*., 1996; Weir, *et al*., 1999 & Reder, P. *et al*., 2000).

All preventive strategies have to be focussed on the developing brain and psyche as psychological and social derangements in early life leave children with working models that are faulty. These models then become deeply ingrained to the extent that they influence feelings, thoughts and behaviour unconsciously and automatically later in adult life. Hence there is a great need for early intervention.

The preventive interventions employed can be classified as universal interventions and targeted interventions. Whereas in a universal intervention strategy, all people in a geographical area are involved; in targeted interventions, only people at high risk of developing the illness are targeted. The targeted interventions can be either *selective* (*i.e*) children of parents with mood disorders or *indicative* (*i .e*) children showing mild symptoms of conduct disorders.

Sound knowledge regarding the emotional problems in children of depressed mothers would form the primary requisite for the more ambitious "selective-targeted interventions to prevent future psychiatric disturbances" in this group at risk .

REVIEW OF LITERATURE

Maternal Depression

The incidence of major depression among young women is alarmingly high, reaching perhaps 9% (Boyd & Weissman, 1981). Most vulnerable are non-working mothers of preschool children, among whom the rate reaches as high as 40% (Brown & Harries, 1978; Richman, Stevenson & Graham, 1982).

Many studies have documented the variety of negative outcomes for children and adolescents associated with having a depressed parent (Cummings & Davies, 1994; Downey & Coyne 1990; Goodman & Gotlib et al., 1999). Much of the research area has been focussed on mothers, in part because of the generally higher prevalence of clinical depression in females as well as the specific risk of postpartum depression.

Research in this area has focussed on both the homotypic links between parental depression and child depression, as well as heterotypic connections between parental depression and other problems such as impaired cognitive development, insecure and / or disorganized attachment styles, difficult temperament, high stress reactivity, school problems, and externalising psychopathology (Ashman & Dawson, 2002; Hay 1997; Lee & Gotlib *et al*., 1989; Lyons - Ruth, Connell, Grunebaum & Botein, 1990; Radke- Yarrow, *et al*., 1998).

Genetic Influence

Behavioural genetic research has emphasized the potential heritability of depression itself as well as that of personality and cognitive factors (*e.g*., neuroticism, behavioural inhibition, low self-esteem) that might predispose to depression. Although some studies have found high heritability of clinical depression in adults (*e.g*., Kendler, *et al*., 1995) this finding generally has been restricted to major depression and not to sub clinical depressive symptoms. Heritability of depression in childhood and adolescence is unclear (Goodman & Gotlib *et al*., 1999). Still, it remains clear that genetic factors are part of the intergenerational transmission of depression,though there are inherent limitations to familial aggregation studies (Todd, *et al*., 1993).

Fox and Hickok *et al*., (1993) reported an additive increase in risk for depression with increasing number of depressed relatives using a child pro-band design.

Other influences

Evidence counter to a purely genetic model comes from Weissman, *et al*., (1987). In his study although the children of probands had a rate of depression 1.6 times higher than the children of controls, the controls also had a measurable risk of depressive disorder, with a slightly later age of onset. It is difficult to separate genetic and non-genetic variance when the children of depressed parents are subject not only to genetic risk, but also exposed to upbringing by a depressed parent, and possible disruptions in family life. The role of social and environmental factors in depression is very marked (Brown

& Harris, 1978) and marital discord, in particular, is strongly related both to depression in women and disorder in children (Cox *et al*., 1987). These factors may be precipitants or products of depression, and may also have an independent effect on child behaviour.

Social Modeling and Interaction

Social modeling could result in children adopting some of the features of depression. Jaenicke, *et al*., (1987), however, were able to look at maternal self-criticism and child self-criticism and show that while they were not related (i.e. no modeling effect), the children were self-critical if their depressed mothers were critical of them.

It may be that maternal irritability, which is not peculiar to depression but is a common concomitant (Cox, *et al*., 1987), has a more direct effect on children than specific depressive symptoms. Other common symptoms associated with depression like anxiety, loss of energy, sleep disturbance, suicidal thoughts, ideas of reference, retardation, self-depreciation etc. are perhaps less likely to have a direct effect on the child, but may severely incapacitate the mother and change her interactions with her children, or precipitate family disruption.

None of these findings offer a definitive route by which a depressed mother influences her child's behaviour and development. While a pattern of lowered responsiveness and lack of fine reciprocity to the child seems to be a general finding, Cox, *et al*., (1987) found that it was only one of a number of possible patterns.

Goodman & Gotlib *et al*., (1999) have proposed an integrative and developmental model for the transmission of psychopathology to children of depressed mothers, that incorporates: (1) heritability of depression; (2) dysfunctional early neuroregulatory mechanisms; (3) exposure to negative maternal cognitions, behaviour and affect; (4) exposure to a stressful environment, as key mechanisms putting their offspring on a path to psychological dysfunction, skill deficits and maladaptive cognitive styles.

The findings of the study by Keith B. Burt, *et al*., (2005) show evidence for a linear but not a threshold model of cumulative risk; more the risks, worse the child's outcome. Moreover the presence of multiple risks in early childhood continues to explain variations in predicting adolescent behaviour outcomes even after excluding the effect of risk in middle childhood. The results support the need for comprehensive prevention and early intervention efforts with high-risk children, such that there does not appear to be a point beyond which services for children are hopeless and that every risk factor we can reduce matters.

Keller, *et al*., (1986) have shown that within a group of children living with a depressed parent, almost every measure of severity and chronicity of depression in the parent had a significant association with current impaired adaptation and psychiatric problems in the child. This effect was stronger for mothers than fathers, which may reflect the more immediate effects that mothers as primary caretakers tend to have on the lives of young children. This suggests a non-genetic influence.

Postnatal depression

This is a common problem affecting 10-15 % of new mothers. It is associated with a range of long-term consequences for both mother and infant, including insecure attachment, emotional and behavioural problems and cognitive deficits (Murray, L. *et al*., 1997).

A study from Sweden followed a sample of 45 women who had high or low Edinburgh Post natal Depression Scale scores at 2 months postpartum and videotaped mother and infant interaction at 15-18 months of age. They found some differences in the interaction of formerly depressed mothers with their children. The children were less focussed in free play, less securely attached and less joyful on reunion after a separation (Edhborg, *et al*., 2002).

It has been suggested that prevention or prompt treatment of postnatal depression would benefit both mother and child, although as yet there is insufficient evidence to recommend a prevention programme (McLennan, et al., 2002).

What about fathers?

Much research into the impact of parental mental illnesses or psychopathology in children has been focussed on mother's needs. Caplan & McCorquodale, *et al*., while reviewing the literature in 1985, referred to `mother blaming', with 72 types of child psychopathology attributed directly to the deficiencies in the mother's care. Connell & Goodman, *et al*., (2002)

provide a scholarly meta-analysis of recent work on the association between psychopathology in fathers compared with mothers to redress the balance. They conclude that externalizing problems in children were seen equally related to psychopathology in mothers and fathers, but internalizing problems were more often related to the mother's psychopathology.

They caution that the difference is small and some of the variation in observed effect sizes seems more related to the methodology of the study than differences between parents. Paternal psychopathology (particularly alcoholism and depression) seems to have a closer link to behavioural problems in older children, whereas maternal depression is more strongly linked to emotional and behavioral problems in young children. Possible explanations for the differences between mothers and fathers include the growing understanding of the impact of intrauterine environment on children (Field, T. *et al*., 1999). Connell and Goodman, (2002) consider the limitations of the research available and highlight the need to look at pathways and mechanisms as well as associations.

Types of behavioural problems

Biederman and colleagues (2001) provide a detailed study of young high-risk children whose parents have panic disorder or major depression as compared with children whose parents have neither panic disorder nor major depression. They found that panic disorders in parents was associated with increased risk for panic disorder and agoraphobia in children (whether or not

the parents also had major depression). Parental major depression was associated with an increased risk for major depression, social phobia and disruptive disorder in children.

Parental panic disorder and parental major depression were also found to be associated with increased risk for separation anxiety and multiple anxiety disorders in children. In this discussion the authors stress the preliminary nature of these findings and caution that much of the information about younger (under 12) children came from the mothers, who may have responded differently depending on their own psychopathology.

Parental depression has been associated with a range of adverse outcomes for children including depressive disorder, behavioural problems, emotional disorders and interpersonal difficulties (Downey, G. *et al*., 1990; Beardslee, W. R. *et al*., 1998).

Nomura, *et al*., (2001) followed up parents who had been treated at Yale University Depression Unit for 10 years along with their children. Having parents with major depressive disorder (MDD) increased the risk for MDD, anxiety disorder and alcohol dependence in young people. Further analysis showed different effects depending on which parent had MDD. Mother's MDD was a stronger predictor of MDD in male children and father's MDD was a stronger predictor of MDD in female children.

Having a father with MDD increased the risk for conduct disorder in children, while having a mother with MDD increased the risk for substance abuse. Additional data from this team indicate that parents who have MDD are much more likely to have poor marital adjustment, a low family cohesion and divorce (Nomura, *et al*., 2001).

A community – based study of 522 families from Australia considered the relationship between paternal depression, maternal depression and chronic family stresses in predicting young people's psychopathology. Family discord was directly measured using a 5 minute speech sample for expressed emotion and young people were interviewed directly about family stress (rather than relying on parental report). Maternal and paternal depression were found to increase the risk of youth externalizing disorders in families in which the parents were depressed. Paternal substance misuse also played a key role in predicting young people's depression (Brennan, P.A. *et al*., 2002).

Children of depressed mothers are also at increased risk of developing emotional and behavioural problems including antisocial behaviour (ASB). Psychosocial theories posit that the link between maternal depression and children's behaviour problems as effect of "nurture" that is, depressed mothers provide inadequate parenting, poor quality interactions and stressful family contexts that promote behavioural problems in their children. If this psychosocial account is correct it would imply that treating maternal depression

should improve parenting and family functioning and consequently improve children's behaviour.

The Avon Longitudinal Study of Parents and Children (O'Connor, *et al*., 2002) reported findings on maternal antenatal anxiety and children's behavioural and emotional problems at 4 years of age. In this paper the links between data on maternal antenatal anxiety and child behavioural and emotional problems are reported (as rated by mothers on the Strengths and Difficulties Questionnaire) (Goodman, R. *et al*., 1997). A strong link was found between maternal ante natal anxiety and childhood behaviour problems particularly hyperactivity and inattention in boys. Unfortunately the Strengths and Difficulties Questionnaire does not differentiate anxiety symptoms. The authors note this limitation of the study, but do hypothesize that the effects they had may be related to hypothalamo-pituitary axis dysfunction similar to that found in animal studies (Newport, D.J. *et al*., 2002).

Coping strategies

It is clear from clinical experience (and research) that living with a parent who is clinically depressed can itself be a stressful experience for a child. An exploratory study from New England reported on the perceptions depressed parents have of their child's experience of their depression symptoms. They looked in detail at the range of coping strategies children may use (*e.g*. acceptance, distraction and problem solving). They found that the children reported as using coping strategies showed less anxiety, depression

and aggression symptoms while children reported as ruminating and experiencing intrusive thoughts had more symptoms. The findings are preliminary (and open to bias since all come from parental report) but could provide a frame work to begin to exploring children's own experiences directly (Langrock, A.M. *et al*., 2002).

Influence of sex of child

Findings on the relationship between parental dysphoria, child gender, and child adjustment reveal interesting patterns (Davies & Windle *et al*., 1997), including that boys may be more vulnerable in early and middle childhood while girls become more vulnerable during adolescence (Cummings & Davies *et al*., 1997). In addition, boys may be more likely to develop behaviour problems while girls may be more likely to develop emotional problems (Cummings & Davies *et al*., 1994).

Influence of age of the child

Goodman, et.al., (1999) & Fielding, *et al*., (1988) found links between maternal depression and behavioural problems primarily in older children .

Laroche, *et al*., (1989) reported that among 3-16 year olds, expression of dysphoria in the home increased with age for children of depressed mothers but not for children of well mothers .

Laroche, *et al*., (1989) argue that older children are at particular risk because maternal depression interferes with the ability to regulate emotions, behaviour, attachment styles and healthy peer relation.

Aim of the study

1) To study the behavioural problems in children of mothers who had depression.

2) To find out if there is a relationship between the severity of the mother's depression and the behavioural problems in the child.

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Null Hypothesis

1) There is no difference in the behavioural problems between children born to mothers who had depression and those born to normal mothers.

2) There is no correlation between the behavioural problems in the child and severity of depressive episodes in the mother.

3) There is no gender difference in the behavioural problems of all children put together .

4) There is no difference in the behavioural problems between different age groups amongst the combination of both groups of children.

5) There is no difference in the family history of mental illness between mothers who had depression and normal mothers

MATERIALS AND METHODS

The protocol for the study was presented and approved by the Ethics Committee of the Institute Of Mental Health. The study was conducted in the Institute of Mental Health Chennai. The study had a cross-sectional design. The study sample was recruited between Dec 2004 – Dec 2005. The cases were selected from patients attending the out patient department of the Institute of Mental Health. The controls were selected from attendants of patients in Govt. Gen Hospital- Chennai.

Sampling

Consecutive female patients satisfying the criteria were selected.

Sample size

A sample size of 60 in each group will have 80% power to detect a difference in mean score of -0.0620 (the difference between the group I mean of 3.750 and group II mean of 4.370 for a behaviour in the Temperament Measurement Schedule), assuming that the common standard deviation is 1.2 using a two group t - test with 2 sided significance level of .05.

Cases

Inclusion criteria

Females attending IMH out –patient department.

ICD-10 diagnosis 0f unipolar depression .

Remission as screened by MINI

Having biological children between 4-14 years.

Exclusion criteria

Mothers with major/ chronic medical problems.

Mothers whose children were suffering from mental retardation, epilepsy, any other chronic illness or perinatal complications were left out.

Mothers whose husbands had any psychopathology including substance abuse were also excluded.

Controls

Inclusion criteria

Female attendants of patients in Govt. General Hospital- Chennai.

No current psychopathology – as per MINI & BPRS.

No history of affective disorder as per SADS-L.

Having biological children between 4-14 years.

Exclusion Criteria

Mothers with major /chronic medical problems.

Mothers whose children were suffering from mental retardation, epilepsy any other chronic illness or perinatal complications were left out.

Mothers whose husbands had any psychopathology or substance abuse were also excluded.

The cases who were selected from the new case OPD were diagnosed as per ICD-10 by a senior psychiatrist. The diagnosis was confirmed after an independent interview by the unit consultant. Such cases were followed till the patient achieved remission as per the MINI interview schedule.

The SADS – L was administered to rule out manic episodes in the past and to assess the severity of the depressive episodes in the cases.

Patients who were diagnosed to be suffering from depression and were attending the OPD for review were included if they were in remission. The MINI interview schedule was administered to establish remission. SADS-L was administered to retrospectively validate the diagnosis and to assess the severity.

Before the interview an informed consent was obtained from the mother. A semi-structured proforma was used to collect information about the socio- demographic situation.

The psychopathology of the husband and his substance use pattern were assessed based on information by the mother. 29 mothers attending IMH OPD qualified for cases while 35 mothers who were attendants of patients in Govt. General Hospital were selected as controls.

Any psychopathology in the control mothers was ruled out based on the MINI interview schedule and also the BPRS scale. The psychopathology of her husband and his drinking habits were obtained during the interview. Totally there were 67 children born to mothers who had depression and 72 children born to the control mothers.

Among them 60 children born to mothers with depression and 66 children born to normal mothers were between the ages of 4-14 years. The behavioural expression of these children was rated by the mothers using the Strengths and Difficulties Questionnaire (parent – rating form). The temperament of these children was assessed by the Temperament Measurement Schedule.

The children were not seen by the interviewer. In most instances both the parents were present during the interview

1. Strengths and Difficulties Questionnaire

2. Mini – International Neuro- Psychiatric Interview

3. Schedule for Affective Disorders & Schizophrenia –Lifetime version

4. Temperament Measurement Schedule –Indian modified version

5. Brief Psychiatric Rating Scale

6. Semi – structured proforma to elicit history

1. STRENGTHS AND DIFFICULTIES QUESTIONNAIRE

The strengths and difficulties questionnaire is a brief 25- item emotional and behavioural assessment questionnaire (Goodman, 1997). It was developed to generate scores in five domains of psychological adjustment among children and adolescents namely hyperactivity –inattention, emotional problems, pro-social behavior, conduct problems and peer problems. The items selected for each domain were based on key symptoms for DSM IV diagnoses (American psychiatric association, 1994). In general the SDQ can be used as a screening tool for clinical assessment of mental disorders and epidemiological research.

2. Mini- International Neuro- Psychiatric Interview

It is a short structured interview developed by an international group of psychiatrists and clinicians. The MINI is designed to diagnose DSM-IV and ICD –10 psychiatric disorders for multi-center clinical trials and epidemiology studies as well as a first step in outcome tracking in non research clinical settings. It is a brief instrument that is divided into modules corresponding to diagnostic categories such as major depressive disorders, dysthymia, mania, hypomania, panic disorder, social phobia, post traumatic –stress disorder, non

alcoholic substance use disorders, psychotic disorders, anorexia nervosa and generalized anxiety disorder.

3. Schedule for Affective Disorder and Schizophrenia – Lifetime version

This scale, developed by J. Endicott and R. L. Spitzer, attempts to resolve the diagnostic dilemma between schizophrenia and mood disorders that has existed in psychiatry for many years. SADS-L uses a semi structured interview, with open ended questions designed to obtain information to make a diagnosis using Research Diagnostic Criteria (RDC).

4. Temperament Measurement Schedule

The temperament measurement schedule was used to assess the temperament characteristics of children. This schedule measures nine temperament variables as described by Thomas and Chess with 45 items, 5 each for 9 variables to be rated on a 5 point scale. The extreme scores of 1 and 5 are provided with a definition with mid point score of 3. The scores lesser than 3 are in the negative direction and those greater than 3 are in the positive direction depending on intensity and frequency of the behaviour measured by each item. The mean score on the constituting temperament variable is computed by dividing the total score by 5.

5. Brief Psychiatric Rating Scale

The Brief Psychiatric Rating Scale developed by David Lukoff, Keith H. Nuechterlein and Joseph Ventura has 24 items. The manual for BPRS contains an interview schedule, symptom definitions and specific anchor points for rating of symptoms. The ratings for items 1-10 and 19-22 are based on the parent's answers to the interviewer's questions. The time frame for the questions is past two weeks. Items 11-18, 23 and 24 are based on the patients behaviour during the interview and the time frame covered is the interview period only. Ratings of 2-3 indicate a non pathological intensity of a symptom, whereas ranges of 4-7 indicate a pathological intensity of that symptom.

Statistics

1] The socio demographic details of the patient were studied using the descriptive statistics

2] The scores of the two groups (*i.e.*) children of depressed mothers and children of normal mothers on the SDQ & TMS were compared using the two group student t - test.

3] The relationship between severity of depression in the mother and the behavioral problem in the child was studied using the Pearson correlation.

4] The children of all mothers were put together and divided into different groups based on their sex . Student t - test was used to study the difference between the groups.

5] The children were divided into three groups based on their age and the difference in their behaviour was studied using the one way anova.

RESULTS

SOCIO-DEMOGRAPHIC CHARACTERISTICS

.TABLE – I

SAMPLE CHARACTERISTICS – NUMBER OF FAMILIES AND CHILDREN IN EACH GROUP

S. No	Group	Depressed mother	Normal mothers	Total
1	Families	29	35	64
2	Children	60	66	126

S.No – serial number

The study consists of 29 families in the unipolar and 35 families in the control group. In this study there were 60 children of unipolar depressed mothers and 66 children of control mothers.

TABLE II

PARENTS AGE AND EDUCATION

	Case (n = 29)		Control (n = 35)		t	df	Sig. (2-tailed)
	Mean	S D	Mean	S D			
Mother's age	33.59	5.72	30.34	4.47	2.55	62	0.013*
Mother's Education	7.14	5.03	7.43	4.87	-0.23	62	0.816
Father's Education	8.59	4.70	7.74	4.53	0.73	62	0.469
Father's age	40.41	6.11	36.77	7.23	2.15	62	0.035*

Case- families in which the mother had depression;Control-families in which mothers were normal;%-percentage

*P<.05 n- number; SD – standard deviation; t –student t ;df –degree of freedom.

The mean age of mothers amongst the cases was 33.59 years as against 30.34 years in the control group and this difference was significant. Mean age of fathers was 40.4 and 36.78 years for the case and control group respectively. Both the parents in the control group were significantly younger compared to the parents of cases. The mean years of education of mothers and fathers in both groups remained comparable.

TABLE - III

RELIGION

Religion Amongst families	Group		Total (%)
	Case (%)	Control (%)	
Christian	2 (6.90)	2 (5.71)	4 (6.25)
Hindu /Christian	– –	1 (2.86)	1 (1.56)
Hindu	25 (86.21)	31 (88.57)	56 (87.50)
Muslim	2 (6.90)	1 (2.86)	3 (4.69)
Total	29	35	64

Case- families in which the mother had depression; Control-families in which mothers were normal;%-percentage

The families predominantly followed Hinduism, cases (88.57%) and controls (87.5%). Christianity and Islam were the other religions practised. The percentages were comparable between the two groups.

TABLE - IV

FAMILY TYPE

Family Type	Group		Total
	Case(n=29)	Control(n=35)	
Joint	8 (27.59%)	11 (31.43%)	19 (29.69%)
Nuclear	19 (65.52%)	24 (68.57%)	43 (67.19%)
Broken	2 (6.90%)	–	2 (3.13%)
Total	29	35	64

Case- families in which the mother had depression; Control-families in which mothers were normal; %- percentage n -number

The type of family common in both groups was nuclear family (cases 65.52%; controls 68.57%). In two families among the cases the parents were separated.

TABLE V

NUMBER OF CHILDREN IN THE FAMILY

No. of children in a family	Group		Total no. of families
	Case(n=29)	Control(n=35)	
1	7 (24.14%)	5 (14.29%)	12 (18.75%)
2	12 (41.38%)	15 (42.86%)	27 (42.19%)
3	6 (20.69%)	13 (37.14%)	19 (29.69%)
4	3 (10.34%)	2 (5.71%)	5 (7.81%)
6	1 (3.45%)	–	1 (1.56%)

Case- families in which the mother had depression; Control-families in which mothers were normal; %- percentage .

The number of children in the families varied from 1 to a maximum of 6. Totally there were 67 children born to mothers who had depression and 72 children born to the mothers of the control group. Of them 60 amongst the cases and 66 amongst controls who were between 4-14 years were selected .

TABLE VI

SEX DISTRIBUTION IN THE CHILDREN

Sex of the child	Group		Total
	Case	Control	
Female	39	35	74
Male	21	31	52
Total	60	66	126

Case-children born to mothers who had depression ;Control- children born to normal mothers

There were 39 females in the case group and 35 in the control group.

TABLE - VII

AGE DISTRIBUTION OF THE CHILDREN

Child's age in years	Group		Total
	Case	Control	
	Count	Count	Count
< 8	15 (25%)	34 (52%)	49 (39%)
8 – 12	18 (30%)	20 (30%)	38 (30%)
> 12	27 (45%)	12 (18%)	39 (31%)
Total	60	66	126

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Case-children born to mothers who had depression ;Control- children born to normal mothers ;% -percentage.

This table shows the distribution of children according to their age group. There was significant difference in the age of the children between the two groups.

Greater number of children in the case group (45%) were above 12 years of age. Whereas greater number (39%) of children in the control group were less than 8 years of age. The children in the control group were younger and the difference was statistically significant.

TABLE - VIII

COMPARISON OF THE SCORES OF THE CHILDREN OF MOTHERS WHO HAD DEPRESSION AND CHILDREN OF NORMAL MOTHERS ON THE STRENGTHS AND DIFFICULTIES QUESTIONNAIRE (parent rated form)

Problem/ behaviour of children	Case (n = 60)		Control (n = 66)		t	df	Sig. (2-tailed)
	Mean	S D	Mean	S D			
Emotion	2.85	2.51	2.26	1.84	1.52	124	0.131
Conduct	2.87	2.28	2.36	2.24	1.25	124	0.214
Hyperactivity	3.72	2.50	3.95	2.34	-0.55	124	0.582
Peer related	1.90	1.45	2.50	1.66	-2.16	124	*0.033
Total problem	11.33	4.98	11.08	5.35	0.28	124	0.781
Pro-social behaviour	7.55	2.34	6.70	2.75	1.87	124	0.064

Case-children born to mothers who had depression ;Control- children born to normal mothers ; * p<.05 n- number; SD – standard deviation; t –student t ; df –degree of freedom.

This table shows the scores of the children across the five domains emotional problems, conduct problems, hyperactivity, peer related problem, total problems and pro-social behaviour.

The scores among the two groups were similar in most domains. The peer related problems were higher in the control group than amongst the cases and it was statistically significant.

TABLE - IX

COMPARISON OF THE SCORES OF THE CHILDREN OF MOTHERS WHO HAD DEPRESSION AND CHILDREN OF NORMAL MOTHERS ON THE TEMPERAMENT MEASUREMENT SCHEDULE

Temperament of the children	Case (n = 60)		Control (n = 66)		t	df	Sig. (2-tailed)
	Mean	S D	Mean	S D			
Approach withdrawal	3.26	0.81	3.00	0.82	1.73	124	0.085
Adaptability	3.29	0.86	3.32	0.89	-0.21	124	0.831
Threshold of responsiveness	3.28	0.84	2.89	0.85	2.59	124	0.011*
Mood	3.48	0.71	3.63	0.67	-1.27	124	0.207
Persistence	3.28	0.84	3.56	0.64	-2.16	124	0.033*
Activity	3.52	0.80	3.53	0.71	-0.05	124	0.959
Intensity	3.37	0.72	3.47	0.68	-0.81	124	0.417
Distractibility	3.00	0.70	2.95	0.75	0.41	124	0.679
Rhythmicity	3.26	0.65	3.00	0.35	2.83	124	0.005*

Case-children born to mothers who had depression ;Control- children born to normal mothers ; * p<.05 n- number; SD – standard deviation; t –student t ; df –degree of freedom.

Table IX shows the scores across temperamental traits , approach withdrawal, adaptability, threshold of responsiveness, mood, persistence, activity level, intensity, distractibility and rhythmicity.

The cases had lesser mean scores on persistence (case 3.28; control 3.56) ($p<0.05$). The controls had lower threshold of responsiveness when compared to cases (control mean 2.89 ; cases mean 3.28) ($p<0.05$).

The controls were lower on the scores of rhythmicity (control mean 3.00; cases mean 3.26) ($p<0.05$).

TABLE- X

COMPARISON OF THE SCORES OF THE CHILDREN OF MOTHERS WHO HAD DEPRESSION AND CHILDREN OF NORMAL MOTHERS ON THE TEMPERAMENT RELATED FACTORS

Behaviour	Case (n = 60)		Control (n = 66)		t	df	Sig. (2-tailed)
	Mean	S D	Mean	S D			
Sociability	9.83	1.84	9.22	1.79	1.87	124	0.063
Emotionality	6.75	1.03	7.19	1.00	-2.44	124	*0.016
Energy	6.89	1.20	7.00	1.08	-0.54	124	0.591

Case-children born to mothers who had depression ;Control- children born to normal mothers ; * p<.05 n- number; SD – standard deviation; t –student t ; df –degree of freedom.

Temperaments were grouped into three factors. Approach withdrawal, adaptability, threshold of responsiveness were grouped into sociability. Mood and persistence were grouped into the factor emotionality. Activity and intensity were grouped into the factor energy.

Cases had higher score on sociability. The cases had statistically significant lower score on the factor of emotionality.

TABLE - XI

SEVERITY OF DEPRESSION AMONGST THE GROUP OF MOTHERS WHO HAD DEPRESSION

Factors	Minimum	Maximum	Mean	S D
Number of depressive episodes	1	14	3.02	2.95
Longest duration in months	2	9	4.33	2.04
Age at first episode	19	40	31.10	4.47
Age at last consultation	20	46	33.25	5.44

SD – standard deviation.

On an average the mothers had suffered from three episodes of depression with mean age of onset 31, the mean of the longest duration of illness was 4.33 months, the mean age at last consultation was 33.

TABLE - XII

RELATION OF SUICIDAL IDEATION DURING DEPRESSIVE EPISODE IN THE MOTHER AND BEHAVIOURAL PROBLEMS IN THE CHILD

Behaviour of the children	cases (n = 31)		controls(n = 29)		t	df	Sig. (2-tailed)
	Mean	S D	Mean	S D			
Sociability	9.96	1.69	9.68	2.00	0.58	58	0.566
Emotionality	6.85	1.03	6.64	1.04	0.80	58	0.427
Energy	6.97	1.03	6.81	1.37	0.51	58	0.611
Conduct	2.65	2.26	3.10	2.32	-0.78	58	0.441
Hyperactivity	3.71	2.18	3.72	2.84	-0.02	58	0.982
Peer related	1.90	1.56	1.90	1.35	0.02	58	0.986
Total problem	10.77	4.35	11.93	5.60	-0.90	58	0.373
Pro-social	7.35	2.68	7.76	1.94	-0.66	58	0.509

Cases - children of mothers who had suicidal ideation during the depressive episodes; controls–childrenof mothers who did not have suicidal ideation during the depressive episodes

n- number; SD – standard deviation; t –student t ; df –degree of freedom.

The cases group was divided into two based on the presence of suicidal ideation in the mother. The behavioural problems in the children of these two groups of mothers were not significantly different.

TABLE - XIII

CORRELATION BETWEEN SEVERITY OF DEPRESSION IN MOTHER AND BEHAVIOURAL PROBLEMS IN THE CHILD.

Behaviour		Age at the I episode	Number of episodes	Longest duration in months
Emotion	Pearson Correlation	0.18	0.23	-0.09
	Sig. (2-tailed)	0.16	0.08	0.47
	n	60	60	60
Conduct	Pearson Correlation	-0.01	0.09	0.16
	Sig. (2-tailed)	0.95	0.50	0.23
	n	60	60	60
Hyperactivity	Pearson Correlation	0.15	0.02	0.11
	Sig. (2-tailed)	0.26	0.89	0.40
	n	60	60	60
Peer related	Pearson Correlation	-0.15	-0.03	-0.03
	Sig. (2-tailed)	0.26	0.84	0.83
	N	60	60	60
Pro-social	Pearson Correlation	-0.11	-0.16	0.03
	Sig. (2-tailed)	0.41	0.22	0.81
	N	60	60	60
Sociability	Pearson Correlation	-0.01	0.15	-0.08
	Sig. (2-tailed)	0.95	0.24	0.54
	N	60	60	60
Emotionality	Pearson Correlation	0.03	0.16	-0.09
	Sig. (2-tailed)	0.80	0.23	0.48
	N	60	60	60
Energy	Pearson Correlation	0.12	0.00	-0.03
	Sig. (2-tailed)	0.37	0.97	0.84
	N	60	60	60

n- number ; Sig- significance

Again it was tested if there was a correlation between factors indicating the severity of depression in mother (age at onset, number of episodes , longest duration of illness) and behavioural problems in the child. It was found that there was no correlation.

TABLE - XIV

DIFFERENCE IN BEHAVIOUR BETWEEN BOYS AND GIRLS

	Female (n = 74)		Male (n = 52)		t	df	Sig. (2-tailed)
	Mean	S D	Mean	S D			
Sociability	9.51	1.94	9.51	1.69	0.01	124	0.994
Emotionality	7.05	0.96	6.88	1.13	0.91	124	0.364
Energy	7.06	1.11	6.78	1.16	1.38	124	0.169
Emotion	2.73	2.24	2.27	2.12	1.16	124	0.248
Conduct	2.49	2.29	2.77	2.23	-0.69	124	0.492
Hyperactivity	3.68	2.57	4.08	2.16	-0.92	124	0.359
Peer related	2.18	1.60	2.27	1.57	-0.33	124	0.745
Total Problem	11.07	5.38	11.38	4.86	-0.34	124	0.736
Pro-social	7.46	2.50	6.60	2.64	1.86	124	0.065

- $p<.05$ n- number; SD – standard deviation; t –student t ; df –degree of freedom.

The scores of both the groups were pooled together. An attempt was made to find if the children's behavioural problems were influenced by their sex. No significant difference was found.

TABLE - XV

DIFFERENCE IN BEHAVIOUR AMONG DIFFERENT AGE GROUPS

Behaviour	Age < 8 (n =49) in years		Age 8 –12 (n=38) in years		Age>12(n = 39) in years		F	df	p
	Mean	S D	Mean	S D	Mean	S D			
Sociability	9.19	1.75	9.81	1.66	9.61	2.07	1.336	(2,123)	0.267
Emotionality	6.96	1.02	7.09	1.01	6.90	1.09	0.348	(2,123)	0.707
Energy	6.96	1.00	6.76	1.27	7.12	1.16	0.992	(2,123)	0.374
Emotional*	2.06	1.84	2.18	2.15	3.49	2.39*	5.6	(2,123)	0.004
Conduct	2.90	2.31	2.08	1.98	2.74	2.42	1.523	(2,123)	0.222
Hyperactivity	4.31	2.25	3.45	2.42	3.64	2.55	1.570	(2,123)	0.212
Peer related	2.24	1.55	2.29	1.86	2.10	1.35	0.147	(2,123)	0.863
Total Problem	11.51	5.29	10.00	4.73	11.97	5.31	1.570	(2,123)	0.212
Pro-social	6.63	2.64	7.79	2.17	7.03	2.80	2.209	(2,123)	0.114

*p<.05; n- number; SD – standard deviation; F –one way anova ; df –degree of freedom.

When the two groups were put together, the emotional problems were more in older children and the difference was statistically significant. Other behavioural problems did not change with the age of the child in this sample.

TABLE - XVI

FAMILY HISTORY OF PSYCHIATRIC ILLNESS IN THE FIRST DEGREE RELATIVES OF PARENTS

	H/o mental illness in first degree relative	H/o suicide in first degree relative	H/o depression in first degree relative	H/o substance dependence in first degree relative	H/o psychosis in first degree relative
Case mothers	3	0	2	2	
Case fathers	3	2	2	0	
Control mothers	0	0	0	0	
Control fathers	0	0	0	0	

Case mother – mother who had depression; case father –father whose wife had depression

Amongst the mothers of cases there was a family history of suicide in three, alcohol dependence in two, schizophrenia in one and one relative had cannabis induced psychosis.

Amongst the fathers of cases three fathers had a family history of suicide, two relatives had history of alcohol dependence and two had sisters who were diagnosed to be suffering from depression.

Amongst the parents of controls no first degree relative was reported to have a psychiatric problem. This retrospective analysis shows that there is a

higher degree of psychiatric morbidity among the first degree relatives of people with mental illness.

DISCUSSION

The study was done in an attempt to elucidate the type of behavioural problems in children of mothers with depression. The cross-sectional design was chosen because of the practical difficulties with follow up rates of less than 30% in the site of study. Cross-sectional studies that included parents with diagnosis of unipolar depression have been done previously by Weissman, *et al*., (1987).

The effect of maternal depression alone was chosen to be studied as the illness is highly prevalent (10-20%) and the effect of depression in mothers was stronger than that of fathers (Samuelson & Klerman, *et al*., 1986).

The mothers were interviewed after remission to minimize the coloring of the feedback by the mother's mood state although previous research show little evidence that depressed individuals provide biased reports of child adjustment. The children were not seen by the interviewer as the inference could be biased . Ideally an expert in Child and Adolescent psychiatry who is blind to the diagnosis of the mother should have evaluated all the 126 children for at least a few times and administered an interview schedule . This could not be done due to difficulty in the feasibility of such an exercise.

The sample of mothers chosen were by and large outpatients and only one among them had been hospitalized, 2 had psychotic symptoms. One mother had made a suicidal attempt, while another had attempted twice. Hence

the sample of patients was not representative of all depressed mothers. The sample was of the less severe type.

In this study the children of mothers with depression had higher scores in the domains of emotional problems, conduct problems and total problems on the strengths and difficulties questionnaire. This is similar to the findings in Biderman, *et al*., (2002), Downey, G. *et al*., (1990) & Beardslee, W.R. *et al*., (1998) where parental depression has been associated with a range of adverse outcomes for children, including depressive disorder, behavioural problems and emotional disorders. However the difference was not statistically significant .

In this study the cases had a higher pro-social score on the strengths and difficulties questionnaire. This does not necessarily mean that children are better adjusted when exposed to parental symptoms. Children with whom others refuse to play may have social problems. At the same time, children readily included in play groups may be manifesting harmful conciliatory or ingratiating tendencies. These tendencies may be related to lower self-esteem or social anxiety (Cummings *et al*., 1994). This again was not statistically significant unlike reported in most studies.

In this study the cases had lesser peer related problems. And the difference was statistically significant. Probably these children were pro-social so as to compensate for the difficult relations with the mother. Whether such behavior is adaptive or maladaptive needs to be studied. This finding is similar to that found in certain previous studies (Cummings, E.M. *et al*.,1994).

The cases had higher scores on the domains of persistence and rhythmicity in the Temperament Measurement Schedule when compared to controls. But the controls had lower scores on the domain of threshold to responsiveness when compared to cases. These findings are in contrast to the findings of the study conducted by Sameer, *et al*., (in JIPMER in 2004), where they found that the cases had more impersistence, less rhythmicity and less threshold for responsiveness when compared to controls.

Also when the individual domains were grouped into five factors namely Sociability, Emotionality, Energy, and Distractibility & Rhythmicity ; the cases were more social and the controls had more emotional problems. This difference was statistically significant. This is partially in agreement with the study by Weissman, *et al*., (1987) which showed that the cases had high energy, low sociability & low adaptability when compared to normal controls.

Whether early stress has made these children more resilient is to be studied. May be the stable father or others in the family compensated for the role of the mothers. Another possibility is that behavioural problems were lesser because of the less severe nature of illness in most mothers and that all of them were treated early within a month or two of symptom onset .

There was no relation to the severity of depression in the mothers. Suicidal ideation, number of episodes, age at onset of illness and duration of illness were not related to the behavioural problems. This is different from the findings of Keller, *et al*., (1986) who showed that severe and more chronic

depression in parents was associated with an increase in psychopathology and poor adaptive functioning in their children. Results from other studies (Grigoroue *et al*., 1989 & Laroche, *et al*., 1989) also support this clinical hypothesis. Hammen, *et al*., (1987) & Weissman, *et al*., (1987) demonstrated that severity of psychopathology in children increases with the number of episodes of illness in their parent.

The possible reasons for the different results in this study are, this sample has mothers with less severe depression and the sample was more or less similar as far as the severity of depression is concerned. Hence it is possible that no big effect on the child's behaviour was noted with change in severity of depression .

Male children on both groups put together had higher conduct problems, hyperactivity, peer related and total problems while girls had more emotional disturbances and pro-social behaviour. These findings are similar to findings of Cummings & Davies, *et al*., (1994) that boys may be more likely to develop behaviour problems while girls may be more likely to develop emotional problems. But the differences found in this study were not statistically significant. The sample size was not calculated for this intra group analysis, at higher sample size this result may become statistically significant .

The scores of children whose mothers had depression was divided into groups based on their age. No difference was found between groups of different ages. This is in contrast to the report by Keith B. Burt, *et al*., (2005)

that there is a reason to believe that most salient mediators of inter generational transmission of depression would vary depending on the age and developmental status of the offspring .

It is interesting to note that a history of mental illness in the first degree relatives was more common amongst the parents of cases.

Amongst the mothers of cases there was family history of suicide in three, alcoholism in two, schizophrenia in one and one relative had cannabis induced psychosis.

Amongst the fathers of cases three had family history of suicide, one relative had history of alcohol dependence and two had sisters with a diagnosis of depression .

Amongst the parents of controls no first degree relative was reported to have a psychiatric problem. This retrospective analysis shows that there is a higher degree of psychiatric morbidity among the first degree relatives of people with mental illness.

May be, many children in the study who are at risk will develop psychiatric illnesses if followed up for a longer period. It would be useful to look at the type of behavioural problems that they exhibited in early childhood as that would give scope for early intervention and prevention.

The lower rate of behaviour problems and higher pro-social behaviour in the cases may be because

(1) The children had developed more resilience using other positive factors available like a stable relationship with the other parent.

2) The depressive symptoms in the mothers were less severe.

3) Most depressive episodes had occurred by the time child was > 5 years of age hence the attachment and social relatedness were not affected.

4) The children have not grown old enough to develop problems.

LIMITATIONS

1. Some of the mothers can turn out to have bipolar disorders in future

2. Only maternal reports were obtained. It would have been better if information from the teacher & the other parent was obtained along with an interview of the children by an expert.

3. Cross sectional design of the study.

4. Children with a higher age group should have also been included into the study

5. Hospital based sample, hence it is difficult to generalize the findings of the study .

SUMMARY AND CONCLUSION

The children of mothers with depression had more emotional problems than children of normal mothers.

These children also had lower persistence.

Contrary to the expectations based on previous studies; in this study the cases were better on sociability & peer relatedness.

The controls had poorer threshold for responsiveness and less rhythmicity.

The difference in the results from existing literature has to be read with caution against the background of certain limitations including the cross sectional design and relying solely on maternal reports for results .

However it seems that children born to mothers who had moderate or mild depression, born to mothers who were treated early and those whose mothers developed depression after they were at least five are less prone to have behavioural problems .

It is possible that a limited amount of stress in the presence of other positive factors actually improves resilience through effective coping .Follow up of these children into their adulthood might throw more light on their problems and get us closer to the truth .It might help us plan for preventive interventions based on predictors of future psychiatric problems .

Meanwhile early & effective treatment of depression in the mother appears to be the first step in the prevention of future psychiatric problems in their children .

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Strengths and Difficulties Questionnaire

P4-16

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months.

Child's Name ..... Male/Female

Date of Birth .....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Mother/Father/Other (please specify:)

Thank you very much for your help

M.I.N.I.

MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW

English Version 5.0.0

DSM-IV

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M.I.N.I. 5.0.0 (July 1, 2005)

Patient Name:		***Patient Number:***	
Date of Birth:		***Time Interview Began:***	
Interviewer's Name:		***Time Interview Ended:***	
Date of Interview:		***Total Time:***	

	MODULES	TIME FRAME	MEETS CRITERIA	DSM-IV	ICD-10
A	MAJOR DEPRESSIVE EPISODE	Current (2 weeks)	☐	296.20-296.26 Single	F32.x
		Recurrent	☐	296.30-296.36 Recurrent	F33.x
	MDE WITH MELANCHOLIC FEATURES Optional	Current (2 weeks)	☐	296.20-296.26 Single 296.30-296.36 Recurrent	F32.x F33.x
B	DYSTHYMIA	Current (Past 2 years)	☐	300.4	F34.1
C	SUICIDALITY	Current (Past Month) Risk: ☐ Low ☐ Medium ☐ High	☐		
D	MANIC EPISODE	Current	☐	296.00-296.06	F30.x-F31.9
		Past	☐		
	HYPOMANIC EPISODE	Current	☐	296.80-296.89	F31.8-F31.9/F34.0
		Past	☐		
E	PANIC DISORDER	Current (Past Month)	☐	300.01/300.21	F40.01-F41.0
		Lifetime	☐		
F	AGORAPHOBIA	Current	☐	300.22	F40.00
G	SOCIAL PHOBIA (Social Anxiety Disorder)	Current (Past Month)	☐	300.23	F40.1
H	OBSESSIVE-COMPULSIVE DISORDER	Current (Past Month)	☐	300.3	F42.8
I	POSTTRAUMATIC STRESS DISORDER Optional	Current (Past Month)	☐	309.81	F43.1
J	ALCOHOL DEPENDENCE	Past 12 Months	☐	303.9	F10.2x
	ALCOHOL ABUSE	Past 12 Months	☐	305.00	F10.1
K	SUBSTANCE DEPENDENCE (Non-alcohol)	Past 12 Months	☐	304.00-.90/305.20-.90	F11.1-F19.1
	SUBSTANCE ABUSE (Non-alcohol)	Past 12 Months	☐	304.00-.90/305.20-.90	F11.1-F19.1
L	PSYCHOTIC DISORDERS	Lifetime	☐	295.10-295.90/297.1/	F20.xx-F29
		Current	☐	297.3/293.81/293.82/ 293.89/298.8/298.9	
	MOOD DISORDER WITH PSYCHOTIC FEATURES	Lifetime	☐	296.24/296.34/296.44	F32.3/F33.3/
		Current	☐	296.24/296.34/296.44	F30.2/F31.2/F31.5/ F31.8/F31.9/F39
M	ANOREXIA NERVOSA	Current (Past 3 Months)	☐	307.1	F50.0
N	BULIMIA NERVOSA	Current (Past 3 Months)	☐	307.51	F50.2
	ANOREXIA NERVOSA, BINGE EATING/PURGING TYPE	Current	☐	307.1	F50.0
O	GENERALIZED ANXIETY DISORDER	Current (Past 6 Months)	☐	300.02	F41.1
P	ANTISOCIAL PERSONALITY DISORDER Optional	Lifetime	☐	301.7	F60.2

DISCLAIMER

Our aim is to assist in the assessment and tracking of patients with greater efficiency and accuracy. Before action is taken on any data collected and processed by this program, it should be reviewed and interpreted by a licensed clinician. This program is not designed or intended to be used in the place of a full medical and psychiatric evaluation by a qualified licensed physician – psychiatrist. It is intended only as a tool to facilitate accurate data collection and processing of symptoms elicited by trained personnel.

GENERAL INSTRUCTIONS

The M.I.N.I. was designed as a brief structured interview for the major Axis I psychiatric disorders in DSM-IV and ICD-10. Validation and reliability studies have been done comparing the M.I.N.I. to the SCID-P for DSM-III-R and the CIDI (a structured interview developed by the World Health Organization for lay interviewers for ICD-10). The results of these studies show that the M.I.N.I. has acceptably high validation and reliability scores, but can be administered in a much shorter period of time (mean 18.7 ± 11.6 minutes, median 15 minutes) than the above referenced instruments. It can be used by clinicians, after a brief training session. Lay interviewers require more extensive training.

INTERVIEW:

In order to keep the interview as brief as possible, inform the patient that you will conduct a clinical interview that is more structured than usual, with very precise questions about psychological problems which require a yes or no answer.

GENERAL FORMAT:

The M.I.N.I. is divided into **modules** identified by letters, each corresponding to a diagnostic category.

•At the beginning of each diagnostic module (except for psychotic disorders module), screening question(s) corresponding to the main criteria of the disorder are presented in a **gray box**.

•At the end of each module, diagnostic box(es) permit the clinician to indicate whether diagnostic criteria are met.

CONVENTIONS:

Sentences written in « normal font » should be read exactly as written to the patient in order to standardize the assessment of diagnostic criteria.

Sentences written in « CAPITALS » should not be read to the patient. They are instructions for the interviewer to assist in the scoring of the diagnostic algorithms.

Sentences written in « **bold** » indicate the time frame being investigated. The interviewer should read them as often as necessary. Only symptoms occurring during the time frame indicated should be considered in scoring the responses.

Answers with an arrow above them (⍱) indicate that one of the criteria necessary for the diagnosis(es) is not met. In this case, the interviewer should go to the end of the module, circle « **NO** » in all the diagnostic boxes and move to the next module.

When terms are separated by a *slash (/)* the interviewer should read only those symptoms known to be present in the patient (for example, question H6).

Phrases in (parentheses) are clinical examples of the symptom. These may be read to the patient to clarify the question.

RATING INSTRUCTIONS:

All questions must be rated. The rating is done at the right of each question by circling either Yes or No. Clinical judgment by the rater should be used in coding the responses. The rater should ask for examples when necessary, to ensure accurate coding. The patient should be encouraged to ask for clarification on any question that is not absolutely clear.

The clinician should be sure that <u>each dimension</u> of the question is taken into account by the patient (for example, time frame, frequency, severity, and/or alternatives).

<u>Symptoms better accounted for by an organic cause or by the use of alcohol or drugs should not be coded positive in the M.I.N.I.</u> The M.I.N.I. Plus has questions that investigate these issues.

For any questions, suggestions, need for a training session, or information about updates of the M.I.N.I., please contact :

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A. MAJOR DEPRESSIVE EPISODE

(\ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

A1	Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks?	NO	YES
A2	In the past two weeks, have you been much less interested in most things or much less able to enjoy the things you used to enjoy most of the time?	NO	YES
	IS **A1** OR **A2** CODED **YES?**	NO	YES

A3 **Over the past two weeks, when you felt depressed or uninterested:**

a	Was your appetite decreased or increased nearly every day? Did your weight decrease or increase without trying intentionally (i.e., by ±5% of body weight or ±8 lbs. or ±3.5 kgs., for a 160 lb./70 kg. person in a month)? IF **YES** TO EITHER, CODE **YES.**	NO	YES *
b	Did you have trouble sleeping nearly every night (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)?	NO	YES
c	Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still almost every day?	NO	YES *
d	Did you feel tired or without energy almost every day?	NO	YES
e	Did you feel worthless or guilty almost every day?	NO	YES
f	Did you have difficulty concentrating or making decisions almost every day?	NO	YES
g	Did you repeatedly consider hurting yourself, feel suicidal, or wish that you were dead?	NO	YES

ARE **5** OR MORE ANSWERS (**A1-A3**) CODED **YES**?

NO **YES ***

MAJOR DEPRESSIVE EPISODE, CURRENT

IF PATIENT HAS CURRENT MAJOR DEPRESSIVE EPISODE CONTINUE TO A4, OTHERWISE MOVE TO MODULE B:

A4	a	During your lifetime, did you have other periods of two weeks or more when you felt depressed or uninterested in most things, and had most of the problems we just talked about?	NO	YES
	b	Did you ever have an interval of at least 2 months without any depression and any loss of interest between 2 episodes of depression?		

NO **YES**

MAJOR DEPRESSIVE EPISODE, RECURRENT

* If patient has Major Depressive Episode, Current, code **YES** in corresponding questions on page 5

MAJOR DEPRESSIVE EPISODE WITH MELANCHOLIC FEATURES (optional)

(\ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

IF THE PATIENT CODES POSITIVE FOR A CURRENT MAJOR DEPRESSIVE EPISODE (**A3** = **YES**), EXPLORE THE FOLLOWING:

A5	a	During the most severe period of the current depressive episode, did you lose almost completely your ability to enjoy nearly everything?	NO	YES
	b	During the most severe period of the current depressive episode, did you lose your ability to respond to things that previously gave you pleasure, or cheered you up? **IF NO:** When something good happens does it fail to make you feel better, even temporarily?	NO	YES
		IS EITHER **A5a** OR **A5b** CODED **YES**?	\ NO	YES

A6 **Over the past two week period, when you felt depressed and uninterested:**

	a	Did you feel depressed in a way that is different from the kind of feeling you experience when someone close to you dies?	NO	YES
	b	Did you feel regularly worse in the morning, almost every day?	NO	YES
	c	Did you wake up at least 2 hours before the usual time of awakening and have difficulty getting back to sleep, almost every day?	NO	YES
	d	IS **A3c** CODED **YES** (PSYCHOMOTOR RETARDATION OR AGITATION)?	NO	YES
	e	IS **A3a** CODED **YES** FOR ANOREXIA OR WEIGHT LOSS?	NO	YES
	f	Did you feel excessive guilt or guilt out of proportion to the reality of the situation?	NO	YES

ARE **3** OR MORE **A6** ANSWERS CODED **YES**?

NO	**YES**
Major Depressive Episode **with** ***Melancholic Features Current***	

B. DYSTHYMIA

(\ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

IF PATIENT'S SYMPTOMS CURRENTLY MEET CRITERIA FOR MAJOR DEPRESSIVE EPISODE, DO NOT EXPLORE THIS MODULE.

B1	Have you felt sad, low or depressed most of the time for the last two years?	\ NO	YES
B2	Was this period interrupted by your feeling OK for two months or more?	NO	\ YES
B3	**During this period of feeling depressed most of the time:**		
a	Did your appetite change significantly?	NO	YES
b	Did you have trouble sleeping or sleep excessively?	NO	YES
c	Did you feel tired or without energy?	NO	YES
d	Did you lose your self-confidence?	NO	YES
e	Did you have trouble concentrating or making decisions?	NO	YES
f	Did you feel hopeless?	NO	YES
	ARE **2** OR MORE **B3** ANSWERS CODED **YES**?	\ NO	YES
B4	Did the symptoms of depression cause you significant distress or impair your ability to function at work, socially, or in some other important way?		

NO **YES**

DYSTHYMIA
CURRENT

C. SUICIDALITY

In the past month did you:

				Points
C1	Suffer any accident?	NO	YES	0
	IF NO TO C1, SKIP TO C2; IF YES, ASK C1a,:			
C1a	Plan or intend to hurt yourself in that accident either passively or actively?	NO	YES	0
	IF NO TO C1a, SKIP TO C2: IF YES, ASK C1b,:			
C1b	Did you intend to die as a result of this accident?	NO	YES	0
C2	Think that you would be better off dead or wish you were dead?	NO	YES	1
C3	Want to harm yourself or to hurt or to injure yourself?	NO	YES	2
C4	Think about suicide?	NO	YES	6

IF YES, ASK ABOUT THE INTENSITY AND FREQUENCY OF THE SUICIDAL IDEATION:

Frequency		Intensity	
Occasionally	π	Mild	π
Often	π	Moderate	π
Very often	π	Severe	π

C5	Have a suicide plan?	NO	YES	8
C6	Take any active steps to prepare to injure yourself or to prepare for a suicide attempt in which you expected or intended to die?	NO	YES	9
C7	Intentionally injure yourself without suicide intent?	NO	YES	4
C8	Attempt suicide?	NO	YES	10
	Hoped to be rescued / survive π			
	Expected / intended to die π			

In your lifetime:

C9	Did you ever make a suicide attempt?	NO	YES	4

IS AT LEAST **1** OF THE ABOVE CODED **YES**?

NO **YES**

IF YES, ADD THE TOTAL NUMBER OF POINTS FOR THE ANSWERS (C1-C9) CHECKED 'YES' AND SPECIFY THE LEVEL OF SUICIDE RISK AS FOLLOWS:

SUICIDE RISK CURRENT

1-8 points	Low	π
9-16 points	Moderate	π
≥ 17 points	High	π

MAKE ANY ADDITIONAL COMMENTS ABOUT YOUR ASSESSMENT OF THIS PATIENT'S CURRENT AND NEAR FUTURE SUICIDE RISK IN THE SPACE BELOW:

D. (HYPO) MANIC EPISODE

(\ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE **NO** IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

D1	a	Have you **ever** had a period of time when you were feeling 'up' or 'high' or 'hyper' or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.) IF PATIENT IS PUZZLED OR UNCLEAR ABOUT WHAT YOU MEAN BY 'UP' OR 'HIGH' OR 'HYPER', CLARIFY AS FOLLOWS: By 'up' or 'high' or 'hyper' I mean: having elated mood; increased energy; needing less sleep; having rapid thoughts; being full of ideas; having an increase in productivity, motivation, creativity, or impulsive behavior. IF NO, CODE NO TO **D1b**: IF **YES** ASK:	NO	YES
	b	Are you currently feeling 'up' or 'high' or 'hyper' or full of energy?	NO	YES
D2	a	Have you **ever** been persistently irritable, for several days, so that you had arguments or verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or over reacted, compared to other people, even in situations that you felt were justified? IF NO, CODE NO TO **D2b**: IF **YES** ASK:	NO	YES
	b	Are you currently feeling persistently irritable?	NO	YES
			\	
		IS **D1a** OR **D2a** CODED **YES**?	NO	YES

D3		IF **D1b** OR **D2b** = **YES**: EXPLORE ONLY **CURRENT** EPISODE, OTHERWISE IF **D1b** AND **D2b** = **NO**: EXPLORE THE MOST SYMPTOMATIC **PAST** EPISODE **During the times when you felt high, full of energy, or irritable did you:**		
	a	Feel that you could do things others couldn't do, or that you were an especially important person?	NO	YES
	b	Need less sleep (for example, feel rested after only a few hours sleep)?	NO	YES
	c	Talk too much without stopping, or so fast that people had difficulty understanding?	NO	YES
	d	Have racing thoughts?	NO	YES
	e	Become easily distracted so that any little interruption could distract you?	NO	YES
	f	Become so active or physically restless that others were worried about you?	NO	YES
	g	Want so much to engage in pleasurable activities that you ignored the risks or consequences (for example, spending sprees, reckless driving, or sexual indiscretions)?	NO	YES
			\	
		ARE **3** OR MORE **D3** ANSWERS CODED **YES** (OR **4** OR MORE IF **D1a** IS **NO** (IN RATING PAST EPISODE) AND IF **D1b** IS **NO** (IN RATING CURRENT EPISODE)) ?	NO	YES

D4 Did these symptoms last at least a week **and** cause significant problems at home, at work, socially, or at school, **or** were you hospitalized for these problems?

NO ↓ YES ↓

THE EPISODE EXPLORED WAS A: π ***HYPOMANIC EPISODE*** π ***MANIC EPISODE***

IS **D4** CODED **NO**?

SPECIFY IF THE EPISODE IS CURRENT OR PAST.

NO	**YES**
HYPOMANIC EPISODE	
CURRENT	π
PAST	π

IS **D4** CODED **YES**?

SPECIFY IF THE EPISODE IS CURRENT OR PAST.

NO	**YES**
MANIC EPISODE	
CURRENT	π
PAST	π

E. PANIC DISORDER

(\ MEANS : CIRCLE NO IN E5, E6 AND E7 AND SKIP TO F1)

E1	a	Have you, on more than one occasion, had spells or attacks when you **suddenly** felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way?	\ NO	YES
	b	Did the spells surge to a peak within 10 minutes of starting?	\ NO	YES
E2		At any time in the past, did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?	\ NO	YES
E3		Have you ever had one such attack followed by a month or more of persistent concern about having another attack, or worries about the consequences of the attack?	NO	YES
E4		**During the worst spell that you can remember:**		
	a	Did you have skipping, racing or pounding of your heart?	NO	YES
	b	Did you have sweating or clammy hands?	NO	YES
	c	Were you trembling or shaking?	NO	YES
	d	Did you have shortness of breath or difficulty breathing?	NO	YES
	e	Did you have a choking sensation or a lump in your throat?	NO	YES
	f	Did you have chest pain, pressure or discomfort?	NO	YES
	g	Did you have nausea, stomach problems or sudden diarrhea?	NO	YES
	h	Did you feel dizzy, unsteady, lightheaded or faint?	NO	YES
	i	Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from part or all of your body?	NO	YES
	j	Did you fear that you were losing control or going crazy?	NO	YES
	k	Did you fear that you were dying?	NO	YES
	l	Did you have tingling or numbness in parts of your body?	NO	YES
	m	Did you have hot flushes or chills?	NO	YES
E5		ARE BOTH **E3,** AND **4** OR MORE **E4** ANSWERS, CODED **YES**?	NO	YES ***PANIC DISORDER LIFETIME***
		IF YES TO E5, SKIP TO E7.		
E6		IF **E5** = **NO,** ARE ANY E4 ANSWERS CODED **YES**?	NO	YES ***LIMITED SYMPTOM ATTACKS LIFETIME***
		THEN SKIP TO **F1.**		
E7		In the past month, did you have such attacks repeatedly (2 or more) followed by persistent concern about having another attack?	NO	YES ***PANIC DISORDER CURRENT***

F. AGORAPHOBIA

F1	Do you feel anxious or uneasy in places or situations where you might have a panic attack or the panic-like symptoms we just spoke about, or where help might not be available or escape might be difficult: like being in a crowd, standing in a line (queue), when you are alone away from home or alone at home, or when crossing a bridge, traveling in a bus, train or car?	NO	YES

IF **F1** = **NO**, CIRCLE **NO** IN **F2**.

F2	Do you fear these situations so much that you avoid them, or suffer through them, or need a companion to face them?	NO	YES ***AGORAPHOBIA CURRENT***

IS **F2** (CURRENT AGORAPHOBIA) CODED **NO**

and

IS **E7** (CURRENT PANIC DISORDER) CODED **YES**?

NO **YES**

PANIC DISORDER without Agoraphobia CURRENT

IS **F2** (CURRENT AGORAPHOBIA) CODED **YES**

and

IS **E7** (CURRENT PANIC DISORDER) CODED **YES**?

NO **YES**

PANIC DISORDER with Agoraphobia CURRENT

IS **F2** (CURRENT AGORAPHOBIA) CODED **YES**

and

IS **E5** (PANIC DISORDER LIFETIME) CODED **NO**?

NO **YES**

AGORAPHOBIA, CURRENT without history of Panic Disorder

G. SOCIAL PHOBIA (Social Anxiety Disorder)

(\ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO AND MOVE TO THE NEXT MODULE)

G1	In the past month, were you fearful or embarrassed being watched, being the focus of attention, or fearful of being humiliated? This includes things like speaking in public, eating in public or with others, writing while someone watches, or being in social situations.	\ NO	YES
G2	Is this social fear excessive or unreasonable?	\ NO	YES
G3	Do you fear these social situations so much that you avoid them or suffer through them?	\ NO	YES
G4	Does this social fear disrupt your normal work or social functioning or cause you significant distress?		

NO **YES**

SOCIAL PHOBIA
(Social Anxiety Disorder)
CURRENT

H. OBSESSIVE-COMPULSIVE DISORDER

(⎿ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO AND MOVE TO THE NEXT MODULE)

H1	In the past month, have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive, or distressing? (For example, the idea that you were dirty, contaminated or had germs, **or** fear of contaminating others, **or** fear of harming someone even though you didn't want to, **or** fearing you would act on some impulse, **or** fear or superstitions that you would be responsible for things going wrong, **or** obsessions with sexual thoughts, images or impulses, **or** hoarding, collecting, **or** religious obsessions.) (DO NOT INCLUDE SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PROBLEMS. DO NOT INCLUDE OBSESSIONS DIRECTLY RELATED TO EATING DISORDERS, SEXUAL DEVIATIONS, PATHOLOGICAL GAMBLING, OR ALCOHOL OR DRUG ABUSE BECAUSE THE PATIENT MAY DERIVE PLEASURE FROM THE ACTIVITY AND MAY WANT TO RESIST IT ONLY BECAUSE OF ITS NEGATIVE CONSEQUENCES.)	NO YES ↓ SKIP TO **H4**
H2	Did they keep coming back into your mind even when you tried to ignore or get rid of them?	NO YES ↓ SKIP TO **H4**
H3	Do you think that these obsessions are the product of your own mind and that they are not imposed from the outside?	NO YES **obsessions**
H4	In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, arranging things, or other superstitious rituals?	NO YES **compulsions**
	IS **H3** OR **H4** CODED **YES**?	⎿ NO YES
H5	Did you recognize that either these obsessive thoughts or these compulsive behaviors were excessive or unreasonable?	⎿ NO YES
H6	Did these obsessive thoughts and/or compulsive behaviors significantly interfere with your normal routine, occupational functioning, usual social activities, or relationships, or did they take more than one hour a day?	**NO YES** ***O.C.D. CURRENT***

I. POSTTRAUMATIC STRESS DISORDER (optional)

(\ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

I1	Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? EXAMPLES OF TRAUMATIC EVENTS INCLUDE: SERIOUS ACCIDENTS, SEXUAL OR PHYSICAL ASSAULT, A TERRORIST ATTACK, BEING HELD HOSTAGE, KIDNAPPING, FIRE, DISCOVERING A BODY, SUDDEN DEATH OF SOMEONE CLOSE TO YOU, WAR, OR NATURAL DISASTER.	\ NO	YES
I2	Did you respond with intense fear, helplessness or horror?	\ NO	YES
I3	During the past month, have you re-experienced the event in a distressing way (such as, dreams, intense recollections, flashbacks or physical reactions)?	\ NO	YES

I4		**In the past month:**		
	a	Have you avoided thinking about or talking about the event ?	NO	YES
	b	Have you avoided activities, places or people that remind you of the event?	NO	YES
	c	Have you had trouble recalling some important part of what happened?	NO	YES
	d	Have you become much less interested in hobbies or social activities?	NO	YES
	e	Have you felt detached or estranged from others?	NO	YES
	f	Have you noticed that your feelings are numbed?	NO	YES
	g	Have you felt that your life will be shortened or that you will die sooner than other people?	NO	YES
		ARE **3** OR MORE **I4** ANSWERS CODED **YES**?	\ NO	YES
I5		**In the past month:**		
	a	Have you had difficulty sleeping?	NO	YES
	b	Were you especially irritable or did you have outbursts of anger?	NO	YES
	c	Have you had difficulty concentrating?	NO	YES
	d	Were you nervous or constantly on your guard?	NO	YES
	e	Were you easily startled?	NO	YES
		ARE **2** OR MORE **I5** ANSWERS CODED **YES**?	\ NO	YES

I6	During the past month, have these problems significantly interfered with your work or social activities, or caused significant distress?	**NO** **YES** ***POSTTRAUMATIC STRESS DISORDER CURRENT***

J. ALCOHOL ABUSE AND DEPENDENCE

(⌊ MEANS: GO TO DIAGNOSTIC BOXES, CIRCLE NO IN BOTH AND MOVE TO THE NEXT MODULE)

		⌊	
J1	**In the past 12 months**, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions?	NO	YES

J2 **In the past 12 months**:

a	Did you need to drink more in order to get the same effect that you got when you first started drinking?	NO	YES
b	When you cut down on drinking did your hands shake, did you sweat or feel agitated? Did you drink to avoid these symptoms or to avoid being hungover, for example, "the shakes", sweating or agitation? IF **YES** TO EITHER, CODE **YES**.	NO	YES
c	During the times when you drank alcohol, did you end up drinking more than you planned when you started?	NO	YES
d	Have you tried to reduce or stop drinking alcohol but failed?	NO	YES
e	On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovering from the effects of alcohol?	NO	YES
f	Did you spend less time working, enjoying hobbies, or being with others because of your drinking?	NO	YES
g	Have you continued to drink even though you knew that the drinking caused you health or mental problems?	NO	YES

ARE **3** OR MORE **J2** ANSWERS CODED **YES**?

***** IF YES, SKIP J3 QUESTIONS, CIRCLE N/A IN THE ABUSE BOX AND MOVE TO THE NEXT DISORDER. DEPENDENCE PREEMPTS ABUSE.

NO **YES***

ALCOHOL DEPENDENCE
CURRENT

J3 **In the past 12 months:**

a	Have you been intoxicated, high, or hungover more than once when you had other responsibilities at school, at work, or at home? Did this cause any problems? (CODE **YES** ONLY IF THIS CAUSED PROBLEMS.)	NO	YES
b	Were you intoxicated more than once in any situation where you were physically at risk, for example, driving a car, riding a motorbike, using machinery, boating, etc.?	NO	YES
c	Did you have legal problems more than once because of your drinking, for example, an arrest or disorderly conduct?	NO	YES
d	Did you continue to drink even though your drinking caused problems with your family or other people?	NO	YES

ARE **1** OR MORE **J3** ANSWERS CODED **YES**?

NO **N/A** **YES**

ALCOHOL ABUSE
CURRENT

K. NON-ALCOHOL PSYCHOACTIVE SUBSTANCE USE DISORDERS

(\ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

Now I am going to show you / read to you a list of street drugs or medicines.

K1 a **In the past 12 months**, did you take any of these drugs more than once, to get high, to feel better, or to change your mood? \ NO YES

CIRCLE EACH DRUG TAKEN:

Stimulants: amphetamines, "speed", crystal meth, “crank”, "rush", Dexedrine, Ritalin, diet pills.

Cocaine: snorting, IV, freebase, crack, "speedball".

Narcotics: heroin, morphine, Dilaudid, opium, Demerol, methadone, codeine, Percodan, Darvon, OxyContin.

Hallucinogens: LSD ("acid"), mescaline, peyote, PCP ("angel dust", "peace pill"), psilocybin, STP, "mushrooms", “ecstasy”, MDA, MDMA, or ketamine (“special K”).

Inhalants: "glue", ethyl chloride, “rush”, nitrous oxide ("laughing gas"), amyl or butyl nitrate ("poppers").

Marijuana: hashish ("hash"), THC, "pot", "grass", "weed", "reefer".

Tranquilizers: Quaalude, Seconal ("reds"), Valium, Xanax, Librium, Ativan, Dalmane, Halcion, barbiturates, Miltown, GHB, Roofinol, “Roofies”.

Miscellaneous: steroids, nonprescription sleep or diet pills. Any others?

SPECIFY MOST USED DRUG(S): _____

CHECK ONE BOX

ONLY ONE DRUG / DRUG CLASS HAS BEEN USED ☐

ONLY THE MOST USED DRUG CLASS IS INVESTIGATED. ☐

EACH DRUG CLASS USED IS EXAMINED SEPARATELY (PHOTOCOPY K2 AND K3 AS NEEDED) ☐

b SPECIFY WHICH DRUG/DRUG CLASS WILL BE EXPLORED IN THE INTERVIEW BELOW IF THERE IS CONCURRENT OR SEQUENTIAL POLYSUBSTANCE USE:_____

K2 **Considering your use of (NAME THE DRUG / DRUG CLASS SELECTED), in the past 12 months:**

a Have you found that you needed to use more (NAME OF DRUG / DRUG CLASS SELECTED) to get the same effect that you did when you first started taking it? NO YES

b When you reduced or stopped using (NAME OF DRUG / DRUG CLASS SELECTED), did you have withdrawal symptoms (aches, shaking, fever, weakness, diarrhea, nausea, sweating, heart pounding, difficulty sleeping, or feeling agitated, anxious, irritable, or depressed)? Did you use any drug(s) to keep yourself from getting sick (withdrawal symptoms) or so that you would feel better? NO YES

IF **YES** TO EITHER, CODE **YES**.

c Have you often found that when you used (NAME OF DRUG / DRUG CLASS SELECTED), you ended up taking more than you thought you would? NO YES

d Have you tried to reduce or stop taking (NAME OF DRUG / DRUG CLASS SELECTED) but failed? NO YES

e On the days that you used (NAME OF DRUG / DRUG CLASS SELECTED), did you spend substantial time (>2 HOURS), obtaining, using or in recovering from the drug, or thinking about the drug? NO YES

f Did you spend less time working, enjoying hobbies, or being with family or friends because of your drug use? NO YES

g Have you continued to use (NAME OF DRUG / DRUG CLASS SELECTED), even though it caused you health or mental problems? NO YES

ARE **3** OR MORE **K2** ANSWERS CODED **YES**?

SPECIFY DRUG(S): _____

***** IF YES, SKIP K3 QUESTIONS, CIRCLE N/A IN THE ABUSE BOX FOR THIS SUBSTANCE AND MOVE TO THE NEXT DISORDER.
DEPENDENCE PREEMPTS ABUSE.

NO **YES ***

SUBSTANCE DEPENDENCE
CURRENT

Considering your use of (NAME THE DRUG CLASS SELECTED), in the past 12 months:

K3 a Have you been intoxicated, high, or hungover from (NAME OF DRUG / DRUG CLASS SELECTED) more than once, when you had other responsibilities at school, at work, or at home? Did this cause any problem? NO YES

(CODE **YES** ONLY IF THIS CAUSED PROBLEMS.)

b Have you been high or intoxicated from (NAME OF DRUG / DRUG CLASS SELECTED) more than once in any situation where you were physically at risk (for example, driving a car, riding a motorbike, using machinery, boating, etc.)? NO YES

c Did you have legal problems more than once because of your drug use, for example, an arrest or disorderly conduct? NO YES

d Did you continue to use (NAME OF DRUG / DRUG CLASS SELECTED), even though it caused problems with your family or other people? NO YES

ARE **1** OR MORE **K3** ANSWERS CODED **YES**?

SPECIFY DRUG(S): _____

NO **N/A** **YES**

SUBSTANCE ABUSE
CURRENT

L. PSYCHOTIC DISORDERS AND MOOD DISORDER WITH PSYCHOTIC FEATURES

ASK FOR AN EXAMPLE OF EACH QUESTION ANSWERED POSITIVELY. CODE **YES** ONLY IF THE EXAMPLES CLEARLY SHOW A DISTORTION OF THOUGHT OR OF PERCEPTION OR IF THEY ARE NOT CULTURALLY APPROPRIATE. BEFORE CODING, INVESTIGATE WHETHER DELUSIONS QUALIFY AS "BIZARRE".

DELUSIONS ARE "BIZARRE" IF: CLEARLY IMPLAUSIBLE, ABSURD, NOT UNDERSTANDABLE, AND CANNOT DERIVE FROM ORDINARY LIFE EXPERIENCE.

HALLUCINATIONS ARE SCORED "BIZARRE" IF: A VOICE COMMENTS ON THE PERSON'S THOUGHTS OR BEHAVIOR, OR WHEN TWO OR MORE VOICES ARE CONVERSING WITH EACH OTHER.

		Now I am going to ask you about unusual experiences that some people have.			BIZARRE
L1	a	Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you? **NOTE**: ASK FOR EXAMPLES TO RULE OUT ACTUAL STALKING.	NO	YES	YES
	b	**IF YES:** do you currently believe these things?	NO	YES	YES (**L6**)
L2	a	Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking?	NO	YES	YES
	b	**IF YES:** do you currently believe these things?	NO	YES	YES (**L6**)
L3	a	Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Have you ever felt that you were possessed? CLINICIAN: ASK FOR EXAMPLES AND DISCOUNT ANY THAT ARE NOT PSYCHOTIC.	NO	YES	YES
	b	**IF YES:** do you currently believe these things?	NO	YES	YES (**L6**)
L4	a	Have you ever believed that you were being sent special messages through the TV, radio, or newspaper, or that a person you did not personally know was particularly interested in you?	NO	YES	YES
	b	**IF YES:** do you currently believe these things?	NO	YES	YES (**L6**)
L5	a	Have your relatives or friends ever considered any of your beliefs strange or unusual? INTERVIEWER**:** ASK FOR EXAMPLES. ONLY CODE **YES** IF THE EXAMPLES ARE **CLEARLY** DELUSIONAL IDEAS NOT EXPLORED IN QUESTIONS L1 TO L4, FOR EXAMPLE, SOMATIC OR RELIGIOUS DELUSIONS OR DELUSIONS OF GRANDIOSITY, JEALOUSY, GUILT, RUIN OR DESTITIUTION, ETC.	NO	YES	YES
	b	**IF YES:** do they currently consider your beliefs strange?	NO	YES	YES
L6	a	Have you ever heard things other people couldn't hear, such as voices? HALLUCINATIONS ARE SCORED "BIZARRE" ONLY IF PATIENT ANSWERS **YES** TO THE FOLLOWING:	NO	YES	
		IF YES: Did you hear a voice commenting on your thoughts or behavior or did you hear two or more voices talking to each other?	NO		YES
	b	**IF YES:** have you heard these things in the past month?	NO	YES	YES (**L8b**)

L7 a Have you ever had visions when you were awake or have you ever seen things other people couldn't see? NO YES

CLINICIAN: CHECK TO SEE IF THESE ARE CULTURALLY INAPPROPRIATE**.**

b **IF YES:** have you seen these things in the past month? NO YES

CLINICIAN'S JUDGMENT

L8 b IS THE PATIENT CURRENTLY EXHIBITING INCOHERENCE, DISORGANIZED SPEECH, OR MARKED LOOSENING OF ASSOCIATIONS? NO YES

L9 b IS THE PATIENT CURRENTLY EXHIBITING DISORGANIZED OR CATATONIC BEHAVIOR? NO YES

L10 b ARE NEGATIVE SYMPTOMS OF SCHIZOPHRENIA, E.G. SIGNIFICANT AFFECTIVE FLATTENING, POVERTY OF SPEECH (ALOGIA) OR AN INABILITY TO INITIATE OR PERSIST IN GOAL-DIRECTED ACTIVITIES (AVOLITION), PROMINENT DURING THE INTERVIEW? NO YES

L11 a ARE 1 OR MORE « a » QUESTIONS FROM L1a TO L7a CODED **YES OR YES BIZARRE** AND IS EITHER:

MAJOR DEPRESSIVE EPISODE, (CURRENT OR RECURRENT)
OR
MANIC OR HYPOMANIC EPISODE, (CURRENT OR PAST) CODED **YES**? NO YES
L13

IF NO TO L11 a, CIRCLE NO IN BOTH 'MOOD DISORDER WITH PSYCHOTIC FEATURES' DIAGNOSTIC BOXES AND MOVE TO L13.

b You told me earlier that you had period(s) when you felt (depressed/high/persistently irritable).

Were the beliefs and experiences you just described (SYMPTOMS CODED **YES** FROM **L1a** TO **L7a**) restricted exclusively to times when you were feeling depressed/high/irritable?

IF THE PATIENT EVER HAD A PERIOD OF AT LEAST 2 WEEKS OF HAVING THESE BELIEFS OR EXPERIENCES (PSYCHOTIC SYMPTOMS) WHEN THEY WERE NOT DEPRESSED/HIGH/IRRITABLE, CODE NO TO THIS DISORDER.

IF THE ANSWER IS NO TO THIS DISORDER, ALSO CIRCLE NO TO L12 AND MOVE TO L13

NO **YES**

MOOD DISORDER WITH *PSYCHOTIC FEATURES*

LIFETIME

L12 a ARE 1 OR MORE « b » QUESTIONS FROM L1b TO L7b CODED **YES OR YES BIZARRE** AND IS EITHER:

MAJOR DEPRESSIVE EPISODE, (CURRENT)
OR
MANIC OR HYPOMANIC EPISODE, (CURRENT) CODED **YES**?

IF THE ANSWER IS YES TO THIS DISORDER, CIRCLE NO TO L13 AND L14 AND MOVE TO THE NEXT MODULE

NO **YES**

MOOD DISORDER WITH *PSYCHOTIC FEATURES*

CURRENT

L13 ARE 1 OR MORE « b » QUESTIONS CODED **YES BIZARRE**?

OR

ARE 2 OR MORE « b » QUESTIONS CODED **YES** (RATHER THAN **YES BIZARRE**)?

AND DID AT LEAST TWO OF THE PSYCHOTIC SYMPTOMS OCCUR DURING THE SAME 1 MONTH PERIOD?

NO **YES**

PSYCHOTIC DISORDER
CURRENT

L14 IS **L13** CODED **YES**

OR

ARE 1 OR MORE « a » QUESTIONS FROM L1a TO L7a, CODED **YES BIZARRE**?

OR

ARE 2 OR MORE « a » QUESTIONS FROM L1a TO L7a, CODED **YES** (RATHER THAN **YES BIZARRE**)

AND DID AT LEAST TWO OF THE PSYCHOTIC SYMPTOMS OCCUR DURING THE SAME 1 MONTH PERIOD?

NO **YES**

PSYCHOTIC DISORDER
LIFETIME

M. ANOREXIA NERVOSA

(\ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

M1	a	How tall are you?	O ft OO in. O O O cm.	
	b.	What was your lowest weight in the past 3 months?	O O O lbs. O O O kgs.	
	c	IS PATIENT'S WEIGHT EQUAL TO OR BELOW THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT? (SEE TABLE BELOW)	NO	YES

In the past 3 months:

M2		In spite of this low weight, have you tried not to gain weight?	NO	YES
M3		Have you intensely feared gaining weight or becoming fat, even though you were underweight?	NO	YES
M4	a	Have you considered yourself too big / fat or that part of your body was too big / fat?	NO	YES
	b	Has your body weight or shape greatly influenced how you felt about yourself?	NO	YES
	c	Have you thought that your current low body weight was normal or excessive?	NO	YES
M5		ARE 1 OR MORE ITEMS FROM **M4** CODED **YES**?	NO	YES
M6		FOR WOMEN ONLY: During the last 3 months, did you miss all your menstrual periods when they were expected to occur (when you were not pregnant)?	NO	YES

FOR WOMEN: ARE **M5 AND M6** CODED **YES**?

FOR MEN: IS **M5** CODED **YES**?

NO	YES
ANOREXIA NERVOSA **CURRENT**	

HEIGHT / WEIGHT TABLE CORRESPONDING TO A BMI THRESHOLD OF 17.5 KG/M^2

Height/Weight														
ft/in	4'9	4'10	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10
lbs.	81	84	87	89	92	96	99	102	105	108	112	115	118	122
cm	145	147	150	152	155	158	160	163	165	168	170	173	175	178
kgs	37	38	39	41	42	43	45	46	48	49	51	52	54	55

Height/Weight					
ft/in	5'11	6'0	6'1	6'2	6'3
lbs.	125	129	132	136	140
cm	180	183	185	188	191
kgs	57	59	60	62	64

The weight thresholds above are calculated using a body mass index (BMI) equal to or below 17.5 kg/m^2 for the patient's height. This is the threshold guideline below which a person is deemed underweight by the DSM-IV and the ICD-10 Diagnostic Criteria for Research for Anorexia Nervosa.

N. BULIMIA NERVOSA

(⎝ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

N1	In the past three months, did you have eating binges or times when you ate a very large amount of food within a 2-hour period?	⎝ NO YES
N2	In the last 3 months, did you have eating binges as often as twice a week?	⎝ NO YES
N3	During these binges, did you feel that your eating was out of control?	⎝ NO YES
N4	Did you do anything to compensate for, or to prevent a weight gain from these binges, like vomiting, fasting, exercising or taking laxatives, enemas, diuretics (fluid pills), or other medications?	⎝ NO YES
N5	Does your body weight or shape greatly influence how you feel about yourself?	⎝ NO YES
N6	DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?	NO YES ↓ Skip to N8
N7	Do these binges occur only when you are under (____lbs./kgs.)? INTERVIEWER: WRITE IN THE ABOVE PARENTHESIS THE THRESHOLD WEIGHT FOR THIS PATIENT'S HEIGHT FROM THE HEIGHT / WEIGHT TABLE IN THE ANOREXIA NERVOSA MODULE.	NO YES

N8 IS **N5** CODED **YES** AND IS EITHER **N6** OR **N7** CODED **NO**?

NO **YES**

BULIMIA NERVOSA
CURRENT

IS **N7** CODED **YES**?

NO **YES**

ANOREXIA NERVOSA
Binge Eating/Purging Type
CURRENT

O. GENERALIZED ANXIETY DISORDER

(\ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

O1	a	Have you worried excessively or been anxious about several things over the past 6 months?	NO	YES
	b	Are these worries present most days?	NO	YES
		IS THE PATIENT'S ANXIETY RESTRICTED EXCLUSIVELY TO, OR BETTER EXPLAINED BY, ANY DISORDER PRIOR TO THIS POINT?	NO	YES
O2		Do you find it difficult to control the worries or do they interfere with your ability to focus on what you are doing?	NO	YES
O3		FOR THE FOLLOWING, CODE **NO** IF THE SYMPTOMS ARE CONFINED TO FEATURES OF ANY DISORDER EXPLORED PRIOR TO THIS POINT**.**		
		When you were anxious over the past 6 months, did you, most of the time:		
	a	Feel restless, keyed up or on edge?	NO	YES
	b	Feel tense?	NO	YES
	c	Feel tired, weak or exhausted easily?	NO	YES
	d	Have difficulty concentrating or find your mind going blank?	NO	YES
	e	Feel irritable?	NO	YES
	f	Have difficulty sleeping (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)?	NO	YES

ARE **3** OR MORE **O3** ANSWERS CODED **YES**?

NO **YES**

GENERALIZED ANXIETY DISORDER
CURRENT

P. ANTISOCIAL PERSONALITY DISORDER (optional)

(\ MEANS : GO TO THE DIAGNOSTIC BOX AND CIRCLE NO.)

P1 **Before you were 15 years old, did you:**

a	repeatedly skip school or run away from home overnight?	NO	YES
b	repeatedly lie, cheat, "con" others, or steal?	NO	YES
c	start fights or bully, threaten, or intimidate others?	NO	YES
d	deliberately destroy things or start fires?	NO	YES
e	deliberately hurt animals or people?	NO	YES
f	force someone to have sex with you?	NO	YES
		\	
	ARE **2** OR MORE **P1** ANSWERS CODED **YES**?	NO	YES

DO NOT CODE **YES** TO THE BEHAVIORS BELOW IF THEY ARE EXCLUSIVELY POLITICALLY OR RELIGIOUSLY MOTIVATED**.**

P2 **Since you were 15 years old, have you:**

a	repeatedly behaved in a way that others would consider irresponsible, like failing to pay for things you owed, deliberately being impulsive or deliberately not working to support yourself?	NO	YES
b	done things that are illegal even if you didn't get caught (for example, destroying property, shoplifting, stealing, selling drugs, or committing a felony)?	NO	YES
c	been in physical fights repeatedly (including physical fights with your spouse or children)?	NO	YES
d	often lied or "conned" other people to get money or pleasure, or lied just for fun?	NO	YES
e	exposed others to danger without caring?	NO	YES
f	felt no guilt after hurting, mistreating, lying to, or stealing from others, or after damaging property?	NO	YES

ARE **3** OR MORE **P2** QUESTIONS CODED **YES**?

NO **YES**

ANTISOCIAL PERSONALITY DISORDER
LIFETIME

THIS CONCLUDES THE INTERVIEW

REFERENCES

Sheehan DV, Lecrubier Y, Harnett-Sheehan K, Janavs J, Weiller E, Bonara LI, Keskiner A, Schinka J, Knapp E, Sheehan MF, Dunbar GC. Reliability and Validity of the MINI International Neuropsychiatric Interview (M.I.N.I.): According to the SCID-P. European Psychiatry. 1997; 12:232-241.

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Translations	**M.I.N.I. 4.4 or earlier versions**	**M.I.N.I. 4.6/5.0, M.I.N.I. Plus 4.6/5.0 and M.I.N.I. Screen 5.0:**
Afrikaans	R. Emsley	W. Maartens
Arabic		O. Osman, E. Al-Radi
Bengali		H. Banerjee, A. Banerjee
Brazilian Portuguese	P. Amorim	P. Amorim
Bulgarian	L.G.. Hranov	
Chinese		L. Carroll, Y-J. Lee, Y-S. Chen, C-C. Chen, C-Y. Liu, C-K. Wu, H-S. Tang, K-D. Juang, Yan-Ping Zheng.
Croatian		In preparation
Czech		P. Zvlosky
Danish	P. Bech	P. Bech, T. Schütze
Dutch/Flemish	E. Griez, K. Shruers, T. Overbeek, K. Demyttenaere	I. Van Vliet, H. Leroy, H. van Megen
English	D. Sheehan, J. Janavs, R. Baker, K. Harnett-Sheehan, E. Knapp, M. Sheehan	D. Sheehan, R. Baker, J. Janavs, K. Harnett-Sheehan, M. Sheehan
Estonian		J. Shlik, A. Aluoja, E. Khil
Farsi/Persian		K. Khooshabi, A. Zomorodi
Finnish	M. Heikkinen, M. Lijeström, O. Tuominen	M. Heikkinen, M. Lijeström, O. Tuominen
French	Y. Lecrubier, E. Weiller, I. Bonora, P. Amorim, J.P. Lepine	Y. Lecrubier, E. Weiller, P. Amorim, T. Hergueta
German	I. v. Denffer, M. Ackenheil, R. Dietz-Bauer	G. Stotz, R. Dietz-Bauer, M. Ackenheil
Greek	S. Beratis	T. Calligas, S. Beratis
Gujarati		M. Patel, B. Patel
Hebrew	J. Zohar, Y. Sasson	R. Barda, I. Levinson, A. Aviv
Hindi		C. Mittal, K. Batra, S. Gambhir
Hungarian	I. Bitter, J. Balazs	I. Bitter, J. Balazs
Icelandic		J.G. Stefansson
Italian	I. Bonora, L. Conti, M. Piccinelli, M. Tansella, G. Cassano, Y. Lecrubier, P. Donda, E. Weiller	L. Conti, A. Rossi, P. Donda
Japanese		T. Otsubo, H. Watanabe, H. Miyaoka, K. Kamijima, J.Shinoda, K.Tanaka, Y. Okajima
Korean		In preparation, Anxiety Disorder Association of Korea
Latvian	V. Janavs, J. Janavs, I. Nagobads	V. Janavs, J. Janavs
Lithuanian		A. Bacevicius
Norwegian	G. Pedersen, S. Blomhoff	K.A. Leiknes , U. Malt, E. Malt, S. Leganger
Polish	M. Masiak, E. Jasiak	M. Masiak, E. Jasiak
Portuguese	P. Amorim	P. Amorim, T. Guterres
Punjabi		A. Gahunia, S. Gambhir
Romanian		O. Driga
Russian		A. Bystritsky, E. Selivra, M. Bystritsky
Serbian	I. Timotijevic	I. Timotijevic
Setswana		K. Ketlogetswe
Slovenian	M. Kocmur	M. Kocmur
Spanish	L. Ferrando, J. Bobes-Garcia, J. Gilbert-Rahola, Y. Lecrubier	L. Ferrando, L. Franco-Alfonso, M. Soto, J. Bobes-Garcia, O. Soto, L. Franco, G. Heinze, C. Santana
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Urdu		A. Taj, S. Gambhir

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SADS-L

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Schedule for Affective Disorders and Schizophrenic - Life-time version
SADS – L

Card No: 1___
(1-2)

Name of Subject
being Interviewed _____ Subject D No.

_____ _____
(3 – 10)+

If Relative of index Subject,
Name of
Index Subject _____

_____

Study No. _____ Fater's Name _____ Rater's No _____
(11-12) (13-14)

Rater is : Interviewer –1
Observer – 2

Age of
Subject _____
(16-17)

Sex of
Subject

Male – 1
Female - 2
(18)

Status at Time at Evaluation: Inpatient –1 Date of Evaluation_____ Group Code _____
Out patient – 2 (20-25) (20-27)
Non patient – 4
Other – 5 _____
(19)

Type of Evaluation : Admission –1 Hospital ID No._____ Service _____ Form No. 93___
Followup –2 (29-35) (35) (79-80)
Other –3 _____
(28)

There are two versions of the SADS, the regular version (SADS) and the lifetime version (SADS-L). The SADSL is similar to Part II of the SADS except that the time period covered in the SADS-L includes any current disturbance. Thus the SADS-L is more suitable for use in studies when there is no current episode or when a detailed description of the current episode is not needed.

Before using the SADS-L the interviewer should study carefully the manual of instructions and all the definitions and instructions that appear throughout the instrument. The interviewer should also be familiar with the RDC. The diagnoses are made at the level of "probable". Although the instrument contains an interview guide and assumes that the subject will be interviewed, all available sources of information should be used. In addition the interviewer should be thoroughly familiar with the intent of the evaluation and the items to be judged and should modify the interview as necessary, to assure that the ratings are as valid as possible.

❖ Developed by Robery L. Spitzer, M.D. and Jean Endicott, Ph.D. with the assistance of the other participants in the NIMH Clinical Research Branch Collaborative program on the Psychobiology of Depression.

Supported by NIMH Grants MH – 21411 and MH – 23864.

Investigators wishing to use these criteria should contact Dr.Jean Endicott at the Department of Research Assessment and Training, New York State Psychiatric Institute, 722 West 188th Street, New York, NY, 10032, to obtain the most recent instructional materials, score sheets, etc.

+ Keypunch: Duplicate on all cards.

BEGINNING OF INTERVIEW AND RATINGS

The rater should first introduce himself to the subject and explain that the interview will focus on the sub ject's problems or difficulties and that some of the questions are standard questions that need to be asked of everyone who is interviewed. He should then obtain or confirm enough basic demographic information, such as age, marital status, and date admitted to the clinic or hospital, so that both the rater and the subject have an opportunity to orient themselves prior to beginning the interview. If necessary, the interviewer may wish to ask further questions about school, work, and other key areas, to facilitate rapport and to give a context for later questions.

If the subject is currently in or recovering from an episode of psychiatric illness, the rater should get the subject to give an account of the history of the present illness in a brief unstructured interview. This may last as long as 10 to 15 minutes. The purpose of this portion of the interview is to clarify the essential features of the present illness, particularly those of high differential diagnostic value. This is particularly important if the subject is disorganized and would find it difficult to shift continually back and forth in describing current and past difficulties. It is important to have an overview of past illnesses and to have the intent of the RDC definitions in mind. It will usually be necessary to use the interview guide and items more flexibly than is the with part I of the SADS.

BACKGROUND INFORMATION

Now I would like to ask you some questions about your past

Highest completed school grade
How far did you get in school ?

(Did you have any special training ?

0 No information
1 Completed graduate school (M.A., M.S., M.E., M.B.A., M.D., Ph.D., L.L.E)
2 Four year college graduate
3 1-3 years college graduate
4 High school graduate
5 10-11 years of school (part high school)
6 7-9 years of school
7 Under 7 years of school

Adolescent friendship patterns (ages 12-18)
Determine presence of special friends, amount of contact, who initiated contact, enjoyment in being with friends and participation in group activities. If there has been a change over time, not the level in the latter portion of the time period.

When you were in your teens, how much time did you spend with friends?

Did you have many close friends ?

Did you have one or more "best" friends ?
(Did you usually enjoy being with them ?)

(Did you do things in groups ?) (Did you ever initiate group activities or did you pretty much follow their lead ?) (were you more a leader or follower ?)

0 No information

1 Superior, e.g. very outgoing and popular, spent a good deal of time with many special friends and with groups of friends

2 Very good, e.g., had many special friends, enjoyed group activities, and often initiated seeking out others.

3 Good, e.g. had several special friends and generally enjoyed group activities but usually did not take initiative in seeking out others.

4 Fair, e.g. had 1 or 2 special friends but was often uncomfortable in group situations.

5 Poor, e.g. preferred to be by himself most of the time or participated in activities with others rarely and without enthusiasm

6 Grossly inadequate, e.g., engaged almost exclusively in solitary pursuits or was actively avoided or disliked

---

* The card number and column assignment for each are indicated to the right of the black line.

Current martial status If not already known: *Have you ever been married (before) ? (What about living with ..... for more than1 year ?) (How many times ?)*	0	No information
	1	"Single" – never married and not presently living with someone of the opposite sex for more than year 215
	2	"Married" or now living with someone of the opposite sex for at least 1 year
	3	Windowed
	4	Separated if legally married or apart from common-law spouse with chance of returning
	5	Divorced or left common-law spouse for good
Total time in past 5 year did not work at all at some paying job because of psychopathology – <u>When he was expected to work</u> (including any time in the current episode) If a student or housewife who was expected to work but who had not worked full-time, determine if this was primarily due to psychopathology. Note: Information on work history is 1 of the criteria for Antisocial Personality. *What kinds of work have you done ?* *What have you been doing the past 5 years ?* *Was there any time when you were out of work ?* *(Why ? How long ? Other times ?) (Were any of these time when you were out of work due to your own problems ?* *If you add up all the time that you were unable to work because you were in the hospital) in the past 5 years, how much would it come to?*	0	No information, did not work <u>at all</u> because was not expected to work (e.g., retired, student, housewife, physically ill) or some other reason not related to psychopathology. 216
	1	Virtually no time at all out of work (or absenteeism) because of reasons related to psychopathology.
	2	Only a few days to 1 month
	3	Up to 6 months (10% of time)
	4	Up to 1 years (20% of time)
	5	Up to 2 years (40% of time)
	6	Up to 3 years (60% of time)
	7	Up to 4 years (80% of time)
	8	Up to almost 5 years
	9	Worked none, or practically none, of the time because of reasons related to psychopathology

OVERVIEW OF PSYCHIATRIC DISTURBANCE

The interviewer should use this portion of the interview to <u>get a general idea of the presence and course of psychiatric disturbance although</u> this section contains few specific items to be judged. The information obtained here should be used in later sections to modify questions to focus the interview on crucial areas that need clarification.

Inquire about any current psychiatric disturbance NOTES

If a known psychiatric patient: *I would like to hear about your problems or difficulties. What led to your coming to the (hospital, clinic) now ?*

If a patient refers to long-term difficulties : What I would like to focus on now is what led to your culties you are having in your life now.

How different has this trouble been from the way you were before or usually are ?

How long was it from when you first noticed that something was wrong until you went to (treatment facility) ?

(continued on next page).

Are you feeling better now, or is it at its worst now ?

If feeling better now: *How lone has it been since you were (descriptions of full blown condition) ?*

The following questions are a guide to determine previous psychopathology particularly episodes of illness.

Have you ever seen any one (else) for emotional problems, your nerves, or the way you were feeling or acting (before this time) ?
If yes, determine age, reasons type of contact, duration, and symptoms for each period of treatment using probes such as:

(Whom did you see ..... ? (What kinds of problems were you having then)
(Any other times ?)

Outpatient treatment. Include contact with any professionally trained person for help with emotional or behavioral problems (include pills from M.D. for "nerves")

0	No information	217
1	No contact	
2	Consultation or brief period of treatment	
3	Continuous treatment at least 8 months or serveral brief periods	
4	Continuous treatment lasting several years or numerous brief periods	

How old were you when you first someone for ..... ?

Did you ever go to a director of

Number of psychiatric hospitalizations. Do not include transfers from 1 hospital to another. Best estimate of minimum number if exact number is unknown.

Were you ever a patient in a psychiatric hospital or ward (before) ?

(How many time ?) (How old were you them ?)

__	Age at first outpatient care (Leave blank if never)	218-19
__	Number (Note minimum number rather than a range or a question mark 99 if 100 number ous or ill-define 1 to count)	220-21
__	Age at first hospitalization (Leave blank if Never)	222-23

Total time of psychiatric hospitalizations
Best estimate if exact time is unknown

		224
0	No information	
1	Never hospitalized	
2	Less than 3 months	
3	Less than 6 months	
4	Less than 1 year	
5	Less than 2 years	
6	Less than 5 years	
7	5 or more years	

Were there any (other) times when you or someone else felt you needed help because of your feelings, your nerves, or the way you were acting ?

NOTES

Determine age, duration, circumstances, and symptoms.

EPISODES OF ILLNESS WITH MANIC OR MAJOR DEPRESSIVE SYNDROME

In the following sections, determine if the subjects has ever had an episode, i.e., a relatively discrete period impaired functioning or psychopathology that can be clearly distinguished from prior and subsequent functioning, which meets or Major Depressive Syndrome are not met, but there is evidence of some affective disturbance, the disturbance should be noted in later sections.

Episodes of illness that contain periods that meet the full criteria for both Manic Syndrome and Major Depressive Syndrome (e.g., depressed then manic, manic then depressed, depressed then manic then depressed should be described in both sections. If 2 periods of Major Depressive Syndrome are separated by less than 2 months of a significant remission (with or without medication) they should be counted as only 1 episode . The same principle applies to counting episodes of Manic Syndrome.

EPISODES OF MANIC SYNDROME

This may have been the only disturbance or it may have been part of a mixed affective episode or associated with some other disturbance and fewer than 3 of the associated symptoms, can be noted in a later section under Hypomanic Syndrome.

CRITERIA FOR EPISODE OF MANIC SYNDROME (There are 3 criteria)

Has had 1 or more distinct periods lasting at least 1 week (or any duration if hospitalized) when the predominant mood was either elevated (i.e. unusually good, cheerful, high, expansive) OR irritable (i.e., to alcohol or drug use. Note: This is frequently falsely rated as positive when the subject is merely describing feeling very good in contrast

Did you even have a period that lasted at least a week (or when you were hospitalized). When you felt extremely good or high – clearly different from your normal self. Did friends or your family thinks that this was more than just feeling good ?

What about periods when you felt very irritable and easily annoyed ?

0 No information or not sure

1 Never had a period lasting at least 1 week (or was hospitalized) when the predominant mood was either elevated or irritable)

2 Never had a period when predominant mood was elevated but had atleast 1 period when he was irritable.

3 Had at least 1 period when predominant mood was elevated (with or without irritability).

→ Skip to Episodes of Major Depressive Syndrome, page 8.

		DURING THE MOST SEVERE PERIOD		
II	Had at least 2 symptoms associated with the most sever period of euphoric or irritable mood (inquire for all symptoms) (Do not include if apparently due to alcohol or drug use).			
During the most sever period.....		No info	No	Yes
... Were you more active than usual - either socially, at work, at home, sexually, or physically restless ?		X	1	2
... Were you more talkative than usual or felt a pressure to keep on talking ?.....		X	1	2
.... did your thoughts race or did you talk so fast that if was difficult for people to follow what you were saying ?		X	1	2

	No info	No	Yes
did you feel you were a very important person, had special powers, plans, talents or abilities (grandiosity) ?.....	X	1	2
.... did you need less sleep than usual ?.....	X	1	2
.... did you have trouble concentrating on what was going on because your attention kept jumping to unimportant things around you (distractibility) ?	X	1	2
..... did you do anything foolish that could have gotten you into trouble – like buying things, business investments, sexual indiscretions, reckless driving ?.....	X	1	2

Number of definite symptoms . If euphoric, criterion = 2; if irritable only, criterion = 3.

☐ If criterion II is not met, check here and skip to Episodes of Major Depressive Syndrome, page 9.

IIII Symptoms were so severe that meaningful conversation was impossible, there was serious impairment in functioning, or he was hospitalized,

0 No information
1 No
2 Yes

Were you hospitalized ?

Were you so excited that it was almost impossible to hold a conversation with you ?

Skip to Episodes of Major Depressive Syndrome, page 9

Did it cause troubles with people, with your family, with your work or other usual activities ?

Total number (minimum) of episodes of Manic Syndrome, separated from each other by more than 2months ____ Number (Note minimum number rather than a range of a question mark. 99 t 100 nurnerous of in detained to count)

How many episodes like this have you had ?
It unable to give exact number: *Would you say that you have had at least .... different episodes like that ?*

DETERMINING WHETHER ANY EPISODE OF MANIC SYNDROME MET THE CRITERIA FOR SCHIZO – AFFECTIVE DISORDER, MANIC TYPE.

An episode of illness characterized by a Manic Syndrome is diagnosed either Manic Disorder or Schizo affective Disorder, Manic Type. Some subjects may have met the criteria for both disorders in 2 separate episodes.

First determined if the subject had delusions or hallucinations during any of the episodes of Manic Syndrome. (Do not count if appear to occur as part of a shared religious or subcultural belief system). If so, determine content, duration, and other details needed to make later judgments regarding Schizo-affective Disorder

NOTES

When you were (high, irritable did you have any beliefs a ideas which you later found out were not true – like people being out to get you, or taking about you behind your back or that your thoughts or movements were controlled ?

Did you hear voices or other sounds that other people couldn't hear ?

(Continued on next page.)

Did you have visitors or see things that were not visible to other people ?
What about strange smells or strange feelings in your body ?
Did people have trouble understanding what you were saying when you were not high ?

☐ If there is no evidence, from any source of information, to suggest delusions, hallucinations, or formal though disorder (as defined in the appendix) during the manic periods check here and skip to Other Characteristics of Episodes of Manic Syndrome, below.

If there is evidence of delusions, hallucinations, or marked formal thought disorder (as defined in the appendix), determine if any of the 5 specific types of symptoms noted below, indicative of Schizo-affective Disorder, were present during any of the periods of Manic Syndrome. (Some of these feature are difficult to evaluate for past episodes)

	DURING AT LEAST 1 PERIOD OF MANIC SYNDROME		
	No info	No	Yes
Delusions of being controlled (or influenced) or though broadcasting insertion or withdrawal (as defined in the appendix).....	X	1	2
Have you had the feeling that you were under the control of some force or power other than yourself? (As though you were a robot and with-out a will of your own ? (Or that you were forced to make movements or say things without your willing it ?) (Or think things or have impulses that were not your own ?) Did you feel that your thoughts were broadcast so that other people knew what you were thinking, or that thoughts were put into your head that were not your own or that thoughts were taken away from you by some external force ?			
Non-affective hallucinations of any type (as defined in the appendix) throughout the day for several or intermittently throughout a 1 week period	X	1	2
Auditory hallucinations in which either a voice keeps up a running commentary on the subject' s behaviours or thoughts as they occur, or 2 or more voices converse with each other	X	1	2
* At some time during the perioe of illness had more than 1 week when he exhibited no prominent depressive or manic symptoms but had delusions or hallucinations	X	1	2
* At some time during the period of illness had more than 1 week when he exhibited no prominent manic symptoms but has several instances of marked formal thought disorder (as defined in the appendix) accompanied by either blunted or inappropriate affect, delusions or hallucinations of any type, or grossly disorganized behaviour	X	1	2

→ OTHER CHARACTERISTICS OF EPISODES OF MANIC SYNDROME

For any episode in which at least 1 of the above was present, the most likely diagnosis for that episode is Schizo-affective Disorder, Manic Type. For any episode in which none of the above was present the most likely diagnosis for the episode is Manic Disorder. Note the following information for episodes of either Manic Disorder or Schizo-affective Disorder, Manic Type (or both). Write numbers and circle YES when applicable, otherwise leave blank.

* Subjects often cannot give adequate information about past episodes for these items. In such instances they should be judged present only if there is direct evidence in the interview or the behavior has been adequately described by some one else.

	Manic Disorder	Schizo-off., Menic Type	
Best estimate of number of periods of mania (99 if too numerous to count).....	_____	_____	244-45 246-47
Age at first period of manic syndrome			248-49 250-51
How old were you when you had your first episode of			
Age at last period of manic syndrome if more than 1.....			252-53 254-55
When was the last time you were .....?			
Currently in an episode which includes a period of mania	YES	YES	256 257
If yes, duration in weeks of present period of manic syndrome	_____	_____	258- 60
Best estimate in weeks of longest duration of a period of manic syndrome.....	____	_____	
what was the longest time that ..... lasted ?			
The following items are circled YES if they characterize any of these episodes:			
During any of these episodes.....			
Hospitalized.....	YES	YES	270 271
.....Were you hospitalized ?			
Received ECT.....	YES	YES	272 273
.....Did you receive shock treatment ?			
Received medication.....	YES	YES	274 275
.... did you receive medication			
Immediately preceding, during, or following an episode had a period of at least a few days when he felt depressed, (May or may not have met the full criteria for a Depressive Syndrome).....	YES	YES	313 314
Were you depressed or feeling down for a few days just before, during, or following the time you were "high?".			
Delusions (from previous inquiry).....	YES	YES	315 316
hallucinations (from previous inquiry).....	YES	YES	317 318
Incapacitated-Unable to carry cut any relatively complex goal-directed activity such as work, taking care of the house, or sustaining attention and participation in social or recreational activities . Do not count if due to refusal or lack of motivation to do the tasks			
Were you unable to work (go to school, take care of the house) because you were so .....?	YES	YES	319 320

	Manic Disorder	Schizo-aff Manic Type	
Suicidal gesture or attempt……	Yes	Yes	321
Did You try to kill yourself?			322
All of the episodes of illness apparently followed some form of somatic treatment which might have provoked the Manic Syndrome (e.g., ECT, antidepressants, Cortisone) ……	Yes	Yes	323 324
Were you on any medication or any kind of treatment just before……?			
If yes, describe somatic treatment:…… …… ……			
For Schizo – affective episodes only note the course of symptoms suggestive of Schizophrenia, up to the present. This judgment should be made if a subject has ever met the criteria for Schizo – affective Disorder, Manic Type either currently or in a previous episode. Some subjects diagnosed initially as Acute may later show a Subacute, Subchronic, or even a Chronic Course +.			325

O. Not applicable

1. Acute Schizo-affective Disorder : A through C are required, (A) Sudden onset – less than 3 months from first signs of increasing psychopathology to any of the core schizophrenic symptoms. (B) Short course continuously ill with significant signs of Schizophrenia for less than 3 months. (C) Full recovery from any previous episode.
2. Subacute Schizo-affective Disorder Course is closer to that of Acute Schizo-affective Disorder than that of Chronic Schizo-affective Disorder. Example: First episode with fairly rapid onset and duration of 5 months. Example: Second episode with onset over a period of 6 months and full recovery from first episode.
3. Sub chronic Schizo – affective disorder : Course is closer to that of Chronic Schizo affective Disorder than that of Acute Schizo – affective Disorder. Example: Significant signs of Schizophrenia more or less continuously present for the last year. Example, Second period following a previous period from which he did not fully recover.
4. Chronic Schizo-affective Disorder: Significant signs of Schizophrenia more or less continuously present for at least the last 2 years.

EPISODES OF MAJOR DEPRESSIVE SYNDROME

Periods of dysphoric mood or of pervasive loss of interest or pleasure are categorized here if they are relatively discrete and are associated with other symptoms of the Major Depressive Syndrome. (Do not include bereavement following the loss of a loved one if all the features are commonly seen in members of the subject's group in similar circumstances unless the study design calls for –their inclusion).

The Major Depressive Syndrome may be the only disturbance or may be superimposed on another psychiatric disorder of follow any other disorder, including "Other Psychiatric Disorder", with the exception of Schizophrenia, Residual Subtype.

* Significant signs of Schizophrenia include any of the symptoms of Schizophrenia listed on page 5, or other delusions or hallucinations, extreme social withdrawal, eccentric behaviour, blunted or inappropriate effect, mild formal thought disorder, or unusual thoughts or perceptual experiences.

+ If the course is best characterized by chronic or sub chronic with an exacerbation, note chronic or subchronic here and see item 439 on SADS-L/RDC score sheet.

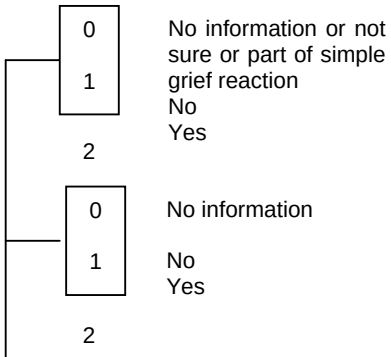
CRITERIA FOR MAJOR DEPRESSIVE SYNDROME

There are 3 criteria listed consecutively so that failure to meet any 1 of them permits the rater to skip the entire section. However, with subjects who may minimize the disturbance in mood during a depressive episode, it may be advisable to explore all 3 criteria before making a final judgement on the first. An episode that meets that first 2 criteria, but not the third, may be recorded later in another section.

1. Has had 1 or more distinct periods lasting at least 1 week during which he was bothered by depressive or irritable mood or had pervasive loss of interest or pleasure. 326

   Did you ever have a period that lasted at least 1 week when you were bothered by feeling depressed, sad, blue, hopeless, down the dumps, that you didn't care anymore, or didn't enjoy anything?

   What about feeling irritable or easily annoyed? 327



II. Sought or was referred for help from someone during dysphoric period(s), took medication, or had impaired functioning socially, with family, at home, at work, or at school.

   During that time did you seek help from anyone, like a doctor, or minister or even a friend, or did anyone suggest that you seek help? Did you take any medication? Did you act differently with people your family, at work, or at school?

Skip to Non-affective Non-organic Psychosis, page 13.

III Had at least 3 (if past episode) or 4(if current episode) symptom, associated with the most common period of depressed or irritable mood or pervasive loss of interest or pleasure, (inquire for all symptoms).

	DURING THE MGST SEVERE PERIOD			
During the most severe period were you bothered by....	No info	No	Yes	328
..Poor appetite or weight loss, or increased appetite or weight gain?.....	X	1	2	329
.. trouble sleeping or sleeping too much.....	X	1	2	330
.... loss of energy, easily fatigued, or feeling tired?.....	X	1	2	
... loss of interest or pleasure in your usual activities or sex (may or may not be pervasive)?.....	X	1	2	331
...feeling guilty or down on yourself?.....	X	1	2	332
... trouble concentrating, thinking, or making decisions?.....	X	1	2	333
... thinking about death or suicide ? (Did you attempt suicide?).....	X	1	2	334
.... being unable to sit still and have to keep moving or the opposite – feeling slowed down and have trouble moving?.....	X	1	2	335
Number of definite symptoms..... Criterion – 4 if current only; 3 if past				336
				337

If criterion III was no met, check here had skip to Non-affective Non-organic Psychosis, page 13.

Total number ((minimum) of Episodes of Major Depressive syndrome ((separated from each other by at least 2 months)	Number (Note minimum number rather than a range or a question mark, 99 if too numerous or ill-defined to count, if current episode is the only one, note 1).

How many episode like this have you had?
If unable to give exact number Would you say that you have had at least .... different episode like that?

DETERMINING WHETHER ANY EPISODE OF MAJOR DERPESSIVE SYNDROME MET THE CRITERIA FOR SCHIZO – AFFECTIVE DISORDER, DEPRESSED TYPE

An episode of illness with the Major Depressive Syndrome is diagnosed either Major Depressive Disorder, Depressive Syndrome Super imposed on Residual Schizophrenia, or Schizo-affective Disorder, Depressed Type. Some subjects may have met the criteria for all three disorders in separate episodes.

First determine if the subject had delusions, hallucinations, or marked formal thought disorder (as defined in the appendix) during any of the episode of Major Depressive Syndrome. (Do not count if appear to occur as part of a shared religious or belief system). If so, determine content, duration, and other details needed to make later judgement.

NOTES

When you were (depressed, down), did you have any beliefs or ideas which you later found out were not true – like people being out to get you, or talking about you behind your back, or that you thoughts or movements were controlled?

Did you hear voices or other sounds that other people couldn't hear have visions or see things that were not visible to other people?... What about strange smells, strange feelings in your body?

Did people have trouble understanding what you were talking about?

If there is no evidence from any source of information to suggest, delusion hallucinations, or marked formal thought disorder (as defined in the appendix) during the episodes of Major Depressive Syndrome, check here and go to Other Characteristics of Episode of Major Depressive Syndrome, page 11. 340

If there is no evidence of delusions, hallucinations, or marked formal thought disorder (as defined in the appendix), determine if any of the 6 specific types of symptoms listed below, indicative of Schizo-affective Disorder were present during any of the episodes of Major Depressive Syndrome. (Some of these features are difficult to evaluate for past episodes). The schizophrenic-like symptoms listed below and the depressive syndrome must overlap to some degree.

If the depressive syndrome appears to have been superimposed on Residual Schizophrenia, it should not be considered an episode of Major Depressive Disorder or Schizo-affective Disorder (See RDC)

	DURING THE MGST SEVERE PERIOD			
Delusions of being controlled (or influenced), or of thought broadcasting, insertion, or withdrawal (as defined in the appendix).....	No Info X	No 1	Yes 2	341

When you were depressed did you have the feeling that you were under the control of some force or power other than yourself or that you were a robot and without a will of your own, or that you were forced to make movements or say things without your willing it, or think things or have impulse that were not your own?

Did you feel that you thoughts were broadcast so that other people knew what you were thinking, or did you feel that thoughts were put into your head that were not your own, or that thoughts were taken away from you by some external force?

	No Info	No	Yes	
Non-effective hallucinations of any type (as defined in the appendix) throughout the day for several days or intermittently throughout a 1 week period	X	1	2	342
Auditory hallucinations in which either a voice keeps up a running commentary on the subjects behaviours or thoughts as they occur, or 2 or more voices converse with each other.....	X	1	2	343
At some time during the period of illness and more than 1 month when he exhibited no prominent depressive or manic symptoms but had delusions or hallucinations (although typical depressive delusions such as delusions of guilt, sin, poverty, nihilism, or self depression or hallucinations with similar content are not included.....	X	1	2	344
Preoccupation with a delusion or hallucination to the relative exclusion of other symptoms or concerns (other than typical depressive delusions of guilt, sin, poverty, nihilism, or self-deprecation, or hallucinations with similar content).....	X	1	2	345
Definite instances of marked formal thought disorder (As defined in the appendix) accompanied by either blunted or inappropriate affect, delusions or hallucinations of any type, or grossly disorganized behaviour.....	X	1	2	346

OTHER OCHARACTERISTICS OF EPISODES OF MAJOR DEPRESSIVE SYNDROME

For any episode of illness in which at least 1 of the above was present, the most likely diagnosis for that episode is Schizo-affective Disorder, Depressed Type. For an episode in which none of the above was present, the most likely diagnosis for the episode is Major Depressive Disorder or Depressive Syndrome Superimposed on Residual Schizophrenia. Note the following information for episodes of either Major Depressive Disorder or Schizo-affective Disorder, Depressed Type (or both). Write numbers can circle YES when applicable, otherwise leave blank.

If all episode of Major Depressive Syndrome were super imposed on residual schizophrenia skip to ..... Non-affective non-organic psychosis page 13.

	Major Dep. Disorder	Schizo-aff., Depressed	
Best estimate of no of periods of major depression			344
(99 if too numerous to count)	_____	_____	345
Age at first period of major depression.....	_____	_____	351
			353
How old were you when you had your first.....			
Age at last period of major depression if more than 1.....	_____	_____	355
			357
When was the last time you were.....?			
Currently in an episode which incluces a period of major			359
depression.....	YES	YES	360
If yes, duration of present period of major depression.....	_____	_____	367
			370
Best estimate in weeks of longest duration of period of major depression	_____	_____	
What was the longest time that .....lasted			
The following items are circles YES if they characterize any of the episode			
During any of these episodes.....			
Hospitalized.....	Yes	Yes	373
... were your hospitalised?			374

* Subjects often cannot give adequate information about past episodes for these items, therefore, case records are of greater importance here.

	Manic Disorder	Schizo-aff Manic Type	
Received ECT.....	Yes	Yes	375 413
.... did you receive shock treatment?			
Received medication.....	Yes	Yes	414 415
... did you receive medication?			
Immediately preceding, during, or following an episode had a period of at least a few days in which he was manic or hypomanic. (May or may not have met the criteria for the Manic Syndrome).....	Yes	yes	416 417
Were you unusually cheerful and energetic at any time, just before, during, or right after you were depressed? If yes, make certain that there were at least some signs that was more than simply feeling good after a depression.			
Delusions.....	Yes	Yes	418 419
Hallucinations.....	Yes	Yes	420 421
Incapacitated – Unable to carry out any relatively complex goal-directed activity such as work, taking care of the house, or sustaining attention and participation in social or (recreational activities, Do not count if due to refusal or lack of motivation to do the tasks.....	Yes	Yes	422 423
Were you unable to work (go to school, take care of the house) feed yourself dress yourself or keep yourself clean?)			
Suicidal gesture or attempt	Yes	Yes	424 425
During..... did you ever try, to kill yourself			
Associated with pregnancy or childbirth (within 2 months).....	Yes	Yes	426 427
Were you pregnant or had you just given birth?			
Associated with menopause (within 3 years).....	Yes	Yes	428 429
All of the episodes apparently followed some form of somatic treatment (or) drug use which might have provoked the depressive syndrome. (e.g serpasil, birth control pills, cortisone , Barbiturates).			
Were you on any medication or any other kind of treatment just before ...?			
If yes, describe somatic treatment			
All of the episodes apparently followed some serious physical illness which led to major changes in living conditions or had a physical illness which often is associated with psychological symptoms (e.g., thyrotoxicosis).....	Yes	Yes	432 433
If yes, describe physical illness.....	Yes	Yes	

Appendix II

TEMPERAMENT MEASUREMENT SCHEDULE

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NO. _____ Date _____ Child's Name _____

Age _____ Date of Birth _____ Sex _____ Education _____

Informant _____ Mother/ Father/ Any other (Specify) _____

Informant's Name: _____ Age _____ Sex _____

Education _____ Occupation _____ Income:

Residence

(Address) (Rural/ Urban)

TEMPERAMENT MEASUREMENT SCHEDULE

INSTRUCTIONS

Information is to be obtained regarding the child's temperament before the onset of symptoms if he has an illness or about when the child has been his most usual self if he has no illness. Informant should be one of the parents, preferably the mother. Each item explores into some area of routine activities of the child which may be repetitious at places but measures different aspects of temperament. Items are generally the probes and minor elaborations are permitted wherever necessary. Score all items on a five –point scale, where 3 denotes the average; 1 and 2 indicate lower and 4 and 5 are higher than the average frequency and intensity of the concerned behaviour.

FACTOR I: Sociability

Approach withdrawal

Score 1. Feels frightened, cries, withdraws physically
5. Goes and talks spontaneously, rushes into new places, spontaneously holds or touches new things.

1.	What is your child's first reaction when he/she meets a stranger (relative, neighbour, doctor, shopkeeper, bus conductor, etc.)? Does he/she approach the stranger, talk to him or does he/ she feel shy, frightened?	1	2	3	4	5
2.	What is your chil'd first reaction when he/she meets children of his/ her age for the first time? Does he/ she approach them, get friendly or does he/she feel hesitant, shy, frightened?	1	2	3	4	5
3.	If the child is given a new food (or placed in a new situation) what is his/ her first reaction, will he/she try it or does he/ she refuse to do so?	1	2	3	4	5
4.	When your child is introduced to a new game or activity does he/she join in at once or initially prefers to sit on the side and watch?	1	2	3	4	5
5.	What is your child's first reaction when he/ she is offered a new toy, game or clothes? Does he/ she accept it with enthusiasm or does he/ she hesitate, watch from far, preferring his/ her familiar toys games and clothes?	1	2	3	4	5

Average Score:

Adaptability

Score 1. No adaptability – doesn't accept change at all
5. Initial reaction of withdrawal is only momentary.

1.	Food that the child had refused or disliked earlier does he/she still refuse it or has accepted it? How long did he/ she take to accept it?	1	2	3	4	5
2.	If your child, to begin with, is shy with strangers, how long does it take him/ her to get friendly? Just a few minutes or a long time?	1	2	3	4	5
3.	If you child is shy with children in the beginning, how long does it take him/her to mix and get friendly, just a couple of minutes or a long time?	1	2	3	4	5
4.	If the child initially hesitates to join a game, how long does it take her/ him to start participating in it? Immediately, after sometime or never?	1	2	3	4	5
5.	Does your child settle back into school routine quickly after a long holiday or does it take her/ him a long time to do so?	1	2	3	4	5

Average Score:

Threshold of Responsiveness

Score 1. Low threshold – easily bothered by noise. Comments on temperature of food etc.
5. High threshold – not bothered by noise, ignores temperature of food, etc.

1.	Is your child bothered about minor noises of sounds in the surrounding area or does he/ she ignore these?	1	2	3	4	5
2.	Does the child ignore the temperature of food hot or cold?	1	2	3	4	5
3.	Does the child have to be seriously injured before he/ she comments, cries about cuts, and bruises?	1	2	3	4	5
4.	Does the child not react if accidentally touched, pushed or lightly brushed	1	2	3	4	5

by another child?

5.	If there is something new or different about things or people at home, does you child notice it immediately or not?	1	2	3	4	5

Average Score:
Sociality Score

FACTOR II: EMOTIONALITY

Mood

Score 1. Always crying, angry, annoyed, irritable, discontented.
5. Always laughing, giggling, contented, happy.

1.	Is your child generally happy, satisfied or generally unhappy discontented?	1	2	3	4	5
2.	When with other children, does you child seem to be happy and having a good time? Is he/ she generally dissatisfied, angry irritable?	1	2	3	4	5
3.	When playing with other children, does your child argue/ fight with them or not?	1	2	3	4	5
4.	If your child cannot have or do something that he/ she wants, how long does he/ she remain annoyed only momentarily or for a long time?	1	2	3	4	5
5.	When the child is given something that he/ she is fond of and wants, what is the reaction? Is he/she happy smiles only momentarily or for a long time?	1	2	3	4	5

Average Score:

Persistence

Score 1. No persistence no effort at all.
5. Continues till he achieves what he sets out to.

1.	When your child starts on some project like painting, etc. does he/ she complete it no matter how long it takes or does he/ she give it up without completing it.	1	2	3	4	5
2.	If your child finds a game or a piece of work difficult, what does he/ she do? Does he/she quickly turn to another activity or does he keep on trying until he learns that particular game or activity?	1	2	3	4	5
3.	For how long can the child continue on the same activity? For about an hour or less than that?	1	2	3	4	5
4.	If your child gets angry or annoyed how long does it take him/ her get out of the bad mood just a few moments or long time	1	2	3	4	5
5.	If you interrupt your child's activity does he/ she try to go back to it or does he/ she forget it?	1	2	3	4	5

Average Score:
Emotionality Score

FACTOR III: Energy

Activity level

Score 1. Completely still or very little movement.
5. Ways on the move, jumps rather than walks always fidgeting.

1.	How active is your child? Do you find him so active that he/she runs rather than walks or so inactive that he/ she hardly moves?	1	2	3	4	5
2.	Can the child keep still or does he/ she have difficulty in doing so and keep moving and fidgeting?	1	2	3	4	5
3.	Can the child sit still while listening to a story, joke or some interesting incident?	1	2	3	4	5
4.	While playing does the child run and jump about vigorously, or does he/ she move about quietly?	1	2	3	4	5
5.	While eating does the child keep still or move about?	1	2	3	4	5

Average Score:

Intensity

Score 1. Hardly any/ reaction
5. Roaring with laughter, screaming with anger, crying loudly.

1.	What is the child's reaction when given some food which he/ she likes very much? Is the child very happy and eats it with relish or is indifferent towards it?	1	2	3	4	5
2.	If your child is taken away or stopped from an activity that he/ she enjoys very much, how does he/ she react? Does he/ she protest mildly, gets annoyed, angry or starts crying?	1	2	3	4	5
3.	When the child is not given something that he wants, how doe she behave? Not bothered, gets little annoyed, gets angry, cries and yells?	1	2	3	4	5
4.	What is the child's reaction if he/ she or his/ her team loses a game? Does not mind very much, takes it lightly or gets upset, cries?	1	2	3	4	5
5.	What is your child's reaction if another child takes away his/ her toy or book or any other possessions? Does not matter much, gets upset, cries fights with the other child.	1	2	3	4	5

Average Score:
Energy Score:

FACTOR IV: Distractibility

Distractibility

Score 1. Low distractibility – despite special efforts cannot be distracted.
5. Highly distractible on his./ her own

1.	If the child is annoyed or is in a bad mood is it easy or difficult to humour him/ her?	1	2	3	4	5
2.	What does the child generally do, if he/ she is playing or is absorbed in some work, and there is a noise outside his window or on the road, will he/ she continue with the activity or will be easily drawn away from it?	1	2	3	4	5
3.	Is it easy or difficult to console your child with a toy or story when he/ she is crying?	1	2	3	4	5
4.	Do you find that when the child is engrossed in an interesting test, you have to call out a numbers of times before he/ she would respond?	1	2	3	4	5
5.	While the child is eating or reading if someone knocks at the door or comes, doe he/ she immediately stop eating or reading or does he continue with the activity?	1	2	3	4	5

Average Score:
Distractibility Score.

Factor V: Rhythmicity

Ryhthmicity

Score 1. Always extremely irregular.
5. Very fussy about time even when away from home.

1.	Does your child feel hungry at approximately the same time everyday? Are you able to tell roughly at what time he/ she is bound to feel hungry?	1	2	3	4	5
2.	Does you child eat roughly the same amount of food everyday or does it vary from one day to the next? Do you have an idea of how big or small an appetite the child generally has?	1	2	3	4	5
3.	Does your child go to sleep at approximately the same time every night? What time does he/ she generally go to sleep?	1	2	3	4	5
4.	At what time does you child wake up every morning? On weekends or holidays does your child wake up at the same time as on other (school) days or does the time change?	1	2	3	4	5
5.	Does your child have the bowel movement at about the same time everyday.	1	2	3	4	5

Average Score:
Rhythmicity score

Brief Psychiatric Rating Scale (BPRS)
Expanded Version (4.0)

Introduction

This section reproduces an interview schedule, symptom definitions, and specific anchor points for rating symptoms on the BPRS. Clinicians intending to use the BPRS should also consult the detailed guidelines for administration contained in the reference below.

Scale Items and Anchor Points

Rate items 1-14 on the basis of individual's self-report. Note items 7, 12 and 13 are also rated on the basis of observed behaviour. Items 15-24 are rated on the basis of observed behaviour and speech.

1. Somatic Concern

Degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the individual, whether complaints have realistic bases or not. Somatic delusions should be rated in the severe range with or without somatic concern. Note: be sure to assess the degree of impairment due to somatic concerns only and not other symptoms, e.g., depression. In addition, if the individual rates 6 or 7 due to somatic delusions, then you must rate Unusual Thought Content at least 4 or above.

2 Very mild Occasional somatic concerns that tend to be kept to self.

3 Mild Occasional somatic concerns that tend to be voiced to others (e.g., family, doctor).

4 Moderate Frequent expressions of somatic concern or exaggerations of existing ills OR some preoccupation, but no impairment in functioning. Not delusional.

5 Moderately severe Frequent expressions of somatic concern or exaggerations of existing ills OR some preoccupation and moderate impairment of functioning. Not delusional.

6 Severe Preoccupation with somatic complaints with much impairment in functioning OR somatic delusions without acting on them or disclosing to others.

7 Extremely severe Preoccupation with somatic complaints with severe impairment in functioning OR somatic delusions that tend to be acted on or disclosed to others.

"Have you been concerned about your physical health?" "Have you had any physical illness or seen a medical doctor lately? (What does your doctor say is wrong? How serious is it?)"

"Has anything changed regarding your appearance?"

"Has it interfered with your ability to perform your usual activities and/or work?"

"Did you ever feel that parts of your body had changed or stopped working?"

[If individual reports any somatic concerns/delusions, ask the following]:

"How often are you concerned about [use individual's description]?"

"Have you expressed any of these concerns to others?"

2. Anxiety

Reported apprehension, tension, fear, panic or worry. Rate only the individual's statements - not observed anxiety which is rated under Tension.

2 Very mild Reports some discomfort due to worry OR infrequent worries that occur more than usual for most normal individuals.

3 Mild Worried frequently but can readily turn attention to other things.

4 Moderate Worried most of the time and cannot turn attention to other things easily but no impairment in functioning OR occasional anxiety with autonomic accompaniment but no impairment in functioning.

5 Moderately Severe Frequent, but not daily, periods of anxiety with autonomic accompaniment OR some areas of functioning are disrupted by anxiety or worry.

6 Severe Anxiety with autonomic accompaniment daily but not persisting throughout the day OR many areas of functioning are disrupted by anxiety or constant worry.

7 Extremely Severe Anxiety with autonomic accompaniment persisting throughout the day OR most areas of functioning are disrupted by anxiety or constant worry.

"Have you been worried a lot during [mention time frame]? Have you been nervous or apprehensive? (What do you worry about?)"

"Are you concerned about anything? How about finances or the future?"

"When you are feeling nervous, do your palms sweat or does your heart beat fast (or shortness of breath, trembling, choking)?"

[If individual reports anxiety or autonomic accompaniment, ask the following]:

"How much of the time have you been [use individual's description]?"

"Has it interfered with your ability to perform your usual activities/work?"

3. Depression

Include sadness, unhappiness, anhedonia and preoccupation with depressing topics (can't attend to TV or conversations due to depression), hopeless, loss of self-esteem (dissatisfied or disgusted with self or feelings of worthlessness). Do not include vegetative symptoms, e.g., motor retardation, early waking or the amotivation that accompanies the deficit syndrome.

2 Very mild Occasionally feels sad, unhappy or depressed.

3 Mild Frequently feels sad or unhappy but can readily turn attention to other things.

4 Moderate Frequent periods of feeling very sad, unhappy, moderately depressed, but able to function with extra effort.

5 Moderately Severe Frequent, but not daily, periods of deep depression OR some areas of functioning are disrupted by depression.

6 Severe Deeply depressed daily but not persisting throughout the day OR many areas of functioning are disrupted by depression.

7 Extremely Severe Deeply depressed daily OR most areas of functioning are disrupted by depression.

"How has your mood been recently? Have you felt depressed (sad, down, unhappy, as if you didn't care)?"

"Are you able to switch your attention to more pleasant topics when you want to?"

"Do you find that you have lost interest in or get less pleasure from things you used to enjoy, like family, friends, hobbies, watching TV, eating?"

[If individual reports feelings of depression, ask the following]:

"How long do these feelings last?" "Has it interfered with your ability to perform your usual activities?"

4. Suicidality

Expressed desire, intent, or actions to harm or kill self.

2 Very mild Occasional feelings of being tired of living. No overt suicidal thoughts.

3 Mild Occasional suicidal thoughts without intent or specific plan OR he/she feels they would be better off dead.

4 Moderate Suicidal thoughts frequent without intent or plan.

5 Moderately Severe Many fantasies of suicide by various methods. May seriously consider making an attempt with specific time and plan OR impulsive suicide attempt using non-lethal method or in full view of potential saviours.

6 Severe Clearly wants to kill self. Searches for appropriate means and time, OR potentially serious suicide attempt with individual knowledge of possible rescue.

7 Extremely Severe Specific suicidal plan and intent (e.g., "as soon as _____ I will do it by doing X"), OR suicide attempt characterised by plan individual thought was lethal or attempt in secluded environment.

"Have you felt that life wasn't worth living? Have you thought about harming or killing yourself? Have you felt tired of living or as though you would be better off dead? Have you ever felt like ending it all?"

[If individual reports suicidal ideation, ask the following]:

"How often have you thought about [use individual's description]?"

"Did you (Do you) have a specific plan?"

5. Guilt

Overconcern or remorse for past behaviour. Rate only individual's statements, do not infer guilt feelings from depression, anxiety, or neurotic defences. Note: if the individual rates 6 or 7 due to delusions of guilt, then you must rate Unusual Thought Content at least 4 or above, depending on level of preoccupation and impairment.

2 Very mild Concerned about having failed someone, or at something, but not preoccupied. Can shift thoughts to other matters easily.

3 Mild Concerned about having failed someone, or at something, with some preoccupation. Tends to voice guilt to others.

4 Moderate Disproportionate preoccupation with guilt, having done wrong, injured others by doing or failing to do something, but can readily turn attention to other things.

5 Moderately Severe Preoccupation with guilt, having failed someone or at something, can turn attention to other things, but only with great effort. Not delusional.

6 Severe Delusional guilt OR unreasonable self-reproach very out of proportion to circumstances. Moderate preoccupation present.

7 Extremely Severe Delusional guilt OR unreasonable self-reproach grossly out of proportion to circumstances. Individual is very preoccupied with guilt and is likely to disclose to others or act on delusions.

"Is there anything you feel guilty about? Have you been thinking about past problems?"

"Do you tend to blame yourself for things that have happened?"

"Have you done anything you're still ashamed of?"

[If individual reports guilt/remorse/delusions, ask the following]:

"How often have you been thinking about [use individual's description]?"

"Have you disclosed your feelings of guilt to others?"

6. Hostility

Animosity, contempt, belligerence, threats, arguments, tantrums, property destruction, fights, and any other expression of hostile attitudes or actions. Do not infer hostility from neurotic defences, anxiety or somatic complaints. Do not include incidents of appropriate anger or obvious self-defence.

2 Very mild Irritable or grumpy, but not overtly expressed.

3 Mild Argumentative or sarcastic.

4 Moderate Overtly angry on several occasions OR yelled at others excessively.

5 Moderately Severe Has threatened, slammed about or thrown things.

6 Severe Has assaulted others but with no harm likely, e.g., slapped or pushed, OR destroyed property, e.g., knocked over furniture, broken windows.

7 Extremely Severe Has attacked others with definite possibility of harming them or with actual harm, e.g., assault with hammer or weapon.

"How have you been getting along with people (family, co-workers, etc.)?"

"Have you been irritable or grumpy lately? (How do you show it? Do you keep it to yourself?"

"Were you ever so irritable that you would shout at people or start fights or arguments? (Have you found yourself yelling at people you didn't know?)"

"Have you hit anyone recently?"

7. Elevated Mood

A pervasive, sustained and exaggerated feeling of well-being, cheerfulness, euphoria (implying a pathological mood), optimism that is out of proportion to the circumstances. Do not infer elation from increased activity or from grandiose statements alone.

2 Very mild Seems to be very happy, cheerful without much reason.

3 Mild Some unaccountable feelings of well-being that persist.

4 Moderate Reports excessive or unrealistic feelings of well-being, cheerfulness, confidence or optimism inappropriate to circumstances, some of the time. May frequently joke, smile, be giddy, or overly enthusiastic OR few instances of marked elevated mood with euphoria.

5 Moderately Severe Reports excessive or unrealistic feelings of well-being, confidence or optimism inappropriate to circumstances, much of the time. May describe feeling `on top of the world', `like everything is falling into place', or `better than ever before', OR several instances of marked elevated mood with euphoria.

6 Severe Reports many instances of marked elevated mood with euphoria OR mood definitely elevated almost constantly throughout interview and inappropriate to content.

7 Extremely Severe Individual reports being elated or appears almost intoxicated, laughing, joking, giggling, constantly euphoric, feeling invulnerable, all inappropriate to immediate circumstances.

"Have you felt so good or high that other people thought that you were not your normal self?" "Have you been feeling cheerful and `on top of the world' without any reason?"

[If individual reports elevated mood/euphoria, ask the following]:

"Did it seem like more than just feeling good?"

"How long did that last?"

8. Grandiosity

Exaggerated self-opinion, self-enhancing conviction of special abilities or powers or identity as someone rich or famous. Rate only individual's statements about himself, not his/her demeanour. Note: if the individual rates 6 or 7 due to grandiose delusions, you must rate Unusual Thought Content at least 4 or above.

2 Very mild Feels great and denies obvious problems, but not unrealistic.

3 Mild Exaggerated self-opinion beyond abilities and training.

4 Moderate Inappropriate boastfulness, e.g., claims to be brilliant, insightful or gifted beyond realistic proportions, but rarely self-discloses or acts on these inflated self-concepts. Does not claim that grandiose accomplishments have actually occurred.

5 Moderately Severe Same as 4 but often self-discloses and acts on these grandiose ideas. May have doubts about the reality of the grandiose ideas. Not delusional.

6 Severe Delusional - claims to have special powers like ESP, to have millions of dollars, invented new machines, worked at jobs when it is known that he/she was never employed in these capacities, be Jesus Christ, or the Prime Minister. Individual may not be very preoccupied.

7 Extremely Severe Delusional - same as 6 but individual seems very preoccupied and tends to disclose or act on grandiose delusions.

"Is there anything special about you? Do you have any special abilities or powers? Have you thought that you might be somebody rich or famous?"

[If the individual reports any grandiose ideas/delusions, ask the following]:

"How often have you been thinking about [use individuals description]? Have you told anyone about what you have been thinking? Have you acted on any of these ideas?"

9. Suspiciousness

Expressed or apparent belief that other persons have acted maliciously or with discriminatory intent. Include persecution by supernatural or other non-human agencies (e.g., the devil). Note: ratings of 3 or above should also be rated under Unusual Thought Content.

2 Very mild Seems on guard. Reluctant to respond to some `personal' questions. Reports being overly self-conscious in public.

3 Mild Describes incidents in which others have harmed or wanted to harm him/her that sound plausible. Individual feels as if others are watching, laughing or criticising him/her in public, but this occurs only occasionally or rarely. Little or no preoccupation.

4 Moderate Says other persons are talking about him/her maliciously, have negative intentions or may harm him/her. Beyond the likelihood of plausibility, but not delusional. Incidents of suspected persecution occur occasionally (less than once per week) with some preoccupation.

5 Moderately Severe Same as 4, but incidents occur frequently, such as more than once per week. Individual is moderately preoccupied with ideas of persecution OR individual reports persecutory delusions expressed with much doubt (e.g., partial delusion).

6 Severe Delusional - speaks of Mafia plots, the FBI or others poisoning his/her food, persecution by supernatural forces.

7 Extremely Severe Same as 6, but the beliefs are bizarre or more preoccupying. Individual tends to disclose or act on persecutory delusions.

"Do you ever feel uncomfortable in public? Does it seem as though others are watching you? Are you concerned about anyone's intentions toward you? Is anyone going out of their way to give you a hard time, or trying to hurt you? Do you feel in any danger?"

[If individual reports any persecutory ideas/delusions, ask the following]:

"How often have you been concerned that [use individual's description]? Have you told anyone about these experiences?"

10. Hallucinations

Reports of perceptual experiences in the absence of relevant external stimuli. When rating degree to which functioning is disrupted by hallucinations, include preoccupation with the content and experience of the hallucinations, as well as functioning disrupted by acting out on the hallucinatory content (e.g., engaging in deviant behaviour due to command hallucinations). Include thoughts aloud (`gedenkenlautwerden') or pseudohallucinations (e.g., hears a voice inside head) if a voice quality is present.

2 Very mild While resting or going to sleep, sees visions, smells odours or hears voices, sounds, or whispers in the absence of external stimulation, but no impairment in functioning.

3 Mild While in a clear state of consciousness, hears a voice calling the individual's name, experiences non-verbal auditory hallucinations (e.g., sounds or whispers), formless visual hallucinations or has sensory experiences in the presence of a modality-relevant stimulus (e.g., visual illusions) infrequently (e.g., 1-2 times per week) and with no functional impairment.

4 Moderate Occasional verbal, visual, gustatory, olfactory or tactile hallucinations with no functional impairment OR non-verbal auditory hallucinations/visual illusions more than infrequently or with impairment.

5 Moderately Severe Experiences daily hallucinations OR some areas of functioning are disrupted by hallucinations.

6 Severe Experiences verbal or visual hallucinations several times a day OR many areas of functioning are disrupted by these hallucinations.

7 Extremely Severe Persistent verbal or visual hallucinations throughout the day OR most areas of functioning are disrupted by these hallucinations.

"Do you ever seem to hear your name being called?"

"Have you heard any sounds or people talking to you or about you when there has been nobody around?

[If hears voices]:

"What does the voice/voices say? Did it have a voice quality?"

"Do you ever have visions or see things that others do not see? What about smell odours that others do not smell?"

[If the individual reports hallucinations, ask the following]:

"Have these experiences interfered with your ability to perform your usual activities/work? How do you explain them? How often do they occur?"

11. Unusual thought content

Unusual, odd, strange, or bizarre thought content. Rate the degree of unusualness, not the degree of disorganisation of speech. Delusions are patently absurd, clearly false or bizarre ideas that are expressed with full conviction. Consider the individual to have full conviction if he/she has acted as though the delusional belief was true. Ideas of reference/persecution can be differentiated from delusions in that ideas are expressed with much doubt and contain more elements of reality. Include thought insertion, withdrawal and broadcast. Include grandiose, somatic and persecutory delusions even if rated elsewhere. Note: if Somatic Concern, Guilt, Suspiciousness or Grandiosity are rated 6 or 7 due to delusions, then Unusual Thought Content must be rated 4 or above.

2 Very mild Ideas of reference (people may stare or may laugh at him), ideas of persecution (people may mistreat him). Unusual beliefs in psychic powers, spirits, UFOs, or unrealistic beliefs in one's own abilities. Not strongly held. Some doubt.

3 Mild Same as 2, but degree of reality distortion is more severe as indicated by highly unusual ideas or greater conviction. Content may be typical of delusions (even bizarre), but without full conviction. The delusion does not seem to have fully formed, but is considered as one possible explanation for an unusual experience.

4 Moderate Delusion present but no preoccupation or functional impairment. May be an encapsulated delusion or a firmly endorsed absurd belief about past delusional circumstances.

5 Moderately Severe Full delusion(s) present with some preoccupation OR some areas of functioning disrupted by delusional thinking.

6 Severe Full delusion(s) present with much preoccupation OR many areas of functioning are disrupted by delusional thinking.

7 Extremely Severe Full delusion(s) present with almost total preoccupation OR most areas of functioning disrupted by delusional thinking.

"Have you been receiving any special messages from people or from the way things are arranged around you? Have you seen any references to yourself on TV or in the newspapers?"

"Can anyone read your mind?"

"Do you have a special relationship with God?"

"Is anything like electricity, X-rays, or radio waves affecting you?"

"Are thoughts put into your head that are not your own?"

"Have you felt that you were under the control of another person or force?"

[If individual reports any odd ideas/delusions, ask the following]:

"How often do you think about [use individual's description]?"

"Have you told anyone about these experiences? How do you explain the things that have been happening [specify]?"

Rate items 12-13 on the basis of individual's self-report and observed behaviour.

12. Bizarre behaviour

Reports of behaviours which are odd, unusual, or psychotically criminal. Not limited to interview period. Include inappropriate sexual behaviour and inappropriate affect.

2 Very mild Slightly odd or eccentric public behaviour, e.g., occasionally giggles to self, fails to make appropriate eye contact, that does not seem to attract the attention of others OR unusual behaviour conducted in private, e.g., innocuous rituals, that would not attract the attention of others.

3 Mild Noticeably peculiar public behaviour, e.g., inappropriately loud talking, makes inappropriate eye contact, OR private behaviour that occasionally, but not always, attracts the attention of others, e.g., hoards food, conducts unusual rituals, wears gloves indoors.

4 Moderate Clearly bizarre behaviour that attracts or would attract (if done privately) the attention or concern of others, but with no corrective intervention necessary. Behaviour occurs occasionally, e.g., fixated staring into space for several minutes, talks back to voices once, inappropriate giggling/laughter on 1-2 occasions, talking loudly to self.

5 Moderately Severe Clearly bizarre behaviour that attracts or would attract (if done privately) the attention of others or the authorities, e.g., fixated staring in a socially disruptive way, frequent inappropriate giggling/laughter, occasionally responds to voices, or eats non-foods.

6 Severe Bizarre behaviour that attracts attention of others and intervention by authorities, e.g., directing traffic, public nudity, staring into space for long periods, carrying on a conversation with hallucinations, frequent inappropriate giggling/laughter.

7 Extremely Severe Serious crimes committed in a bizarre way that attract the attention of others and the control of authorities, e.g., sets fires and stares at flames OR almost constant bizarre behaviour, e.g., inappropriate giggling/laughter, responds only to hallucinations and cannot be engaged in interaction.

"Have you done anything that has attracted the attention of others?"

"Have you done anything that could have gotten you into trouble with the police?"

"Have you done anything that seemed unusual or disturbing to others?"

13. Self-neglect

Hygiene, appearance, or eating behaviour below usual expectations, below socially acceptable standards or life threatening.

2 Very mild Hygiene/appearance slightly below usual community standards, e.g., shirt out of pants, buttons unbuttoned, shoe laces untied, but no social or medical consequences.

3 Mild Hygiene/appearance occasionally below usual community standards, e.g., irregular bathing, clothing is stained, hair uncombed, occasionally skips an important meal. No social or medical consequences.

4 Moderate Hygiene/appearance is noticeably below usual community standards, e.g., fails to bathe or change clothes, clothing very soiled, hair unkempt, needs prompting, noticeable by others OR irregular eating and drinking with minimal medical concerns and consequences.

5 Moderately Severe Several areas of hygiene/appearance are below usual community standards OR poor grooming draws criticism by others and requires regular prompting. Eating or hydration are irregular and poor, causing some medical problems.

6 Severe Many areas of hygiene/appearance are below usual community standards, does not always bathe or change clothes even if prompted. Poor grooming has caused social ostracism at school/residence/work, or required intervention. Eating erratic and poor, may require medical intervention.

7 Extremely Severe Most areas of hygiene/appearance/nutrition are extremely poor and easily noticed as below usual community standards OR hygiene/appearance/nutrition require urgent and immediate medical intervention.

"How has your grooming been lately? How often do you change your clothes? How often do you take showers? Has anyone (parents/staff) complained about your grooming or dress? Do you eat regular meals?"

14. Disorientation

Does not comprehend situations or communications, such as questions asked during the entire BPRS interview. Confusion regarding person, place, or time. Do not rate if incorrect responses are due to delusions.

2 Very mild Seems muddled or mildly confused 1-2 times during interview. Oriented to person, place and time.

3 Mild Occasionally muddled or mildly confused 3-4 times during interview. Minor inaccuracies in person, place, or time, e.g., date off by more than 2 days, or gives wrong division of hospital or community centre.

4 Moderate Frequently confused during interview. Minor inaccuracies in person, place, or time are noted, as in 3 above. In addition, may have difficulty remembering general information, e.g., name of Prime Minister.

5 Moderately Severe Markedly confused during interview, or to person, place, or time. Significant inaccuracies are noted, e.g., date off by more than one week, or cannot give correct name of hospital. Has difficulty remembering personal information, e.g., where he/she was born or recognising familiar people.

6 Severe Disoriented as to person, place, or time, e.g., cannot give correct month and year. Disoriented in 2 out of 3 spheres.

7 Extremely Severe Grossly disoriented as to person, place, or time, e.g., cannot give name or age. Disoriented in all three spheres.

"May I ask you some standard questions we ask everybody?"

"How old are you? What is the date [allow 2 days]"

"What is this place called? What year were you born? Who is the Prime Minister?"

Rate items 15-24 on the basis of observed behaviour and speech.

15 Conceptual disorganisation

Degree to which speech is confused, disconnected, vague or disorganised. Rate tangentiality, circumstantiality, sudden topic shifts, incoherence, derailment, blocking, neologisms, and other speech disorders. Do not rate content of speech.

2 Very mild Peculiar use of words or rambling but speech is comprehensible.

3 Mild Speech a bit hard to understand or make sense of due to tangentiality, circumstantiality, or sudden topic shifts.

4 Moderate Speech difficult to understand due to tangentiality, circumstantiality, idiosyncratic speech, or topic shifts on many occasions OR 1-2 instances of incoherent phrases.

5 Moderately Severe Speech difficult to understand due to circumstantiality, tangentiality, neologisms, blocking or topic shifts most of the time, OR 3-5 instances of incoherent phrases.

6 Severe Speech is incomprehensible due to severe impairment most of the time. Many BPRS items cannot be rated by self-report alone.

7 Extremely Severe Speech is incomprehensible throughout interview.

16. Blunted affect

Restricted range in emotional expressiveness of face, voice, and gestures. Marked indifference or flatness even when discussing distressing topics. In the case of euphoric or dysphoric individuals, rate Blunted Affect if a flat quality is also clearly present.

2 Very mild Emotional range is slightly subdued or reserved but displays appropriate facial expressions and tone of voice that are within normal limits.

3 Mild Emotional range overall is diminished, subdued or reserved, without many spontaneous and appropriate emotional responses. Voice tone is slightly monotonous.

4 Moderate Emotional range is noticeably diminished, individual doesn't show emotion, smile or react to distressing topics except infrequently. Voice tone is monotonous or

there is noticeable decrease in spontaneous movements. Displays of emotion or gestures are usually followed by a return to flattened affect.

5 Moderately Severe Emotional range very diminished, individual doesn't show emotion, smile, or react to distressing topics except minimally, few gestures, facial expression does not change very often. Voice tone is monotonous much of the time.

6 Severe Very little emotional range or expression. Mechanical in speech and gestures most of the time. Unchanging facial expression. Voice tone is monotonous most of the time.

7 Extremely Severe Virtually no emotional range or expressiveness, stiff movements. Voice tone is monotonous all of the time.

Use the following probes at end of interview to assess emotional responsivity:

"Have you heard any good jokes lately? Would you like to hear a joke?"

17. Emotional withdrawal

Deficiency in individual's ability to relate emotionally during interview situation. Use your own feeling as to the presence of an `invisible barrier' between individual and interviewer. Include withdrawal apparently due to psychotic processes.

2 Very mild Lack of emotional involvement shown by occasional failure to make reciprocal comments, appearing preoccupied, or smiling in a stilted manner, but spontaneously engages the interviewer most of the time.

3 Mild Lack of emotional involvement shown by noticeable failure to make reciprocal comments, appearing preoccupied, or lacking in warmth, but responds to interviewer when approached.

4 Moderate Emotional contact not present much of the interview because individual does not elaborate responses, fails to make eye contact, doesn't seem to care if interviewer is listening, or may be preoccupied with psychotic material.

5 Moderately Severe Same as 4 but emotional contact not present most of the interview.

6 Severe Actively avoids emotional participation. Frequently unresponsive or responds with yes/no answers (not solely due to persecutory delusions). Responds with only minimal affect.

7 Extremely Severe Consistently avoids emotional participation. Unresponsive or responds with yes/no answers (not solely due to persecutory delusions). May leave during interview or just not respond at all.

18. Motor retardation

Reduction in energy level evidenced by slowed movements and speech, reduced body tone, decreased number of spontaneous body movements. Rate on the basis of observed behaviour of the individual only. Do not rate on the basis of individual's subjective impression of his own energy level. Rate regardless of medication effects.

2 Very mild Slightly slowed or reduced movements or speech compared to most people.

3 Mild Noticeably slowed or reduced movements or speech compared to most people.

4 Moderate Large reduction or slowness in movements or speech.

5 Moderately Severe Seldom moves or speaks spontaneously OR very mechanical or stiff movements

6 Severe Does not move or speak unless prodded or urged.

7 Extremely Severe Frozen, catatonic.

19. Tension

Observable physical and motor manifestations of tension, `nervousness' and agitation. Self-reported experiences of tension should be rated under the item on anxiety. Do not rate if restlessness is solely akathisia, but do rate if akathisia is exacerbated by tension.

2 Very mild More fidgety than most but within normal range. A few transient signs of tension, e.g., picking at fingernails, foot wagging, scratching scalp several times or finger tapping.

3 Mild Same as 2, but with more frequent or exaggerated signs of tension.

4 Moderate Many and frequent signs of motor tension with one or more signs sometimes occurring simultaneously, e.g., wagging one's foot while wringing hands together. There are times when no signs of tension are present.

5 Moderately Severe Many and frequent signs of motor tension with one or more signs often occurring simultaneously. There are still rare times when no signs of tension are present.

6 Severe Same as 5, but signs of tension are continuous.

7 Extremely Severe Multiple motor manifestations of tension are continuously present, e.g., continuous pacing and hand wringing.

20. Unco-operativeness

Resistance and lack of willingness to co-operate with the interview. The unco-operativeness might result from suspiciousness. Rate only unco-operativeness in relation to the interview, not behaviours involving peers and relatives.

2 Very mild Shows non-verbal signs of reluctance, but does not complain or argue.

3 Mild Gripes or tries to avoid complying, but goes ahead without argument.

4 Moderate Verbally resists but eventually complies after questions are rephrased or repeated.

5 Moderately Severe Same as 4, but some information necessary for accurate ratings is withheld.

6 Severe Refuses to co-operate with interview, but remains in interview situation.

7 Extremely Severe Same as 6, with active efforts to escape the interview

21. Excitement

Heightened emotional tone or increased emotional reactivity to interviewer or topics being discussed, as evidenced by increased intensity of facial expressions, voice tone, expressive gestures or increase in speech quantity and speed.

2 Very mild Subtle and fleeting or questionable increase in emotional intensity. For example, at times seems keyed-up or overly alert.

3 Mild Subtle but persistent increase in emotional intensity. For example, lively use of gestures and variation in voice tone.

4 Moderate Definite but occasional increase in emotional intensity. For example, reacts to interviewer or topics that are discussed with noticeable emotional intensity. Some pressured speech.

5 Moderately Severe Definite and persistent increase in emotional intensity. For example, reacts to many stimuli, whether relevant or not, with considerable emotional intensity. Frequent pressured speech.

6 Severe Marked increase in emotional intensity. For example, reacts to most stimuli with inappropriate emotional intensity. Has difficulty settling down or staying on task. Often restless, impulsive, or speech is often pressured.

7 Extremely Severe Marked and persistent increase in emotional intensity. Reacts to all stimuli with inappropriate intensity, impulsiveness. Cannot settle down or stay on task. Very restless and impulsive most of the time. Constant pressured speech.

22. Distractibility

Degree to which observed sequences of speech and actions are interrupted by stimuli unrelated to the interview. Distractibility is rated when the individual shows a change in the focus of attention as characterised by a pause in speech or a marked shift in gaze. Individual's attention may be drawn to noise in adjoining room, books on a shelf, interviewer's clothing, etc. Do not rate circumstantiality, tangentiality or flight of ideas. Also, do not rate rumination with delusional material. Rate even if the distracting stimulus cannot be identified.

2 Very mild Generally can focus on interviewer's questions with only 1 distraction or inappropriate shift of attention of brief duration.

3 Mild Individual shifts focus of attention to matters unrelated to the interview 2-3 times.

4 Moderate Often responsive to irrelevant stimuli in the room, e.g., averts gaze from the interviewer.

5 Moderately Severe Same as above, but now distractibility clearly interferes with the flow of the interview.

6 Severe Extremely difficult to conduct interview or pursue a topic due to preoccupation with irrelevant stimuli.

7 Extremely Severe Impossible to conduct interview due to preoccupation with irrelevant stimuli.

23. Motor hyperactivity

Increase in energy level evidenced in more frequent movement and/or rapid speech. Do not rate if restlessness is due to akathisia.

2 Very mild Some restlessness, difficulty sitting still, lively facial expressions, or somewhat talkative

3 Mild Occasionally very restless, definite increase in motor activity, lively gestures, 1-3 brief instances of pressured speech.

4 Moderate Very restless, fidgety, excessive facial expressions, or non-productive and repetitious motor movements. Much pressured speech, up to one-third of the interview.

5 Moderately Severe Frequently restless, fidgety. Many instances of excessive non-productive and repetitious motor movements. On the move most of the time. Frequent pressured speech, difficult to interrupt. Rises on 1-2 occasions to pace.

6 Severe Excessive motor activity, restlessness, fidgety, loud tapping, noisy, etc., throughout most of the interview. Speech can only be interrupted with much effort. Rises on 3-4 occasions to pace.

7 Extremely Severe Constant excessive motor activity throughout entire interview, e.g., constant pacing, constant pressured speech with no pauses, individual can only be interrupted briefly and only small amounts of relevant information can be obtained

24. Mannerisms and posturing

Unusual and bizarre behaviour, stylised movements or acts, or any postures which are clearly uncomfortable or inappropriate. Exclude obvious manifestations of medication side effects. Do not include nervous mannerisms that are not odd or unusual.

2 Very mild Eccentric or odd mannerisms or activity that ordinary persons would have difficulty explaining, e.g., grimacing, picking. Observed once for a brief period.

3 Mild Same as 2, but occurring on two occasions of brief duration.

4 Moderate Mannerisms or posturing, e.g., stylised movements or acts, rocking, nodding, rubbing, or grimacing, observed on several occasions for brief periods or infrequently but very odd. For example, uncomfortable posture maintained for 5 seconds more than twice.

5 Moderately Severe Same as 4, but occurring often, or several examples of very odd mannerisms or posturing that are idiosyncratic to the individual.

6 Severe Frequent stereotyped behaviour, assumes and maintains uncomfortable or inappropriate postures, intense rocking, smearing, strange rituals or foetal posturing. Individual can interact with people and the environment for brief periods despite these behaviours.

7 Extremely Severe Same as 6, but individual cannot interact with people or the environment due to these behaviours.

Strengths and Difficulties Questionnaire

P4-16

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months.

Child's Name ..... Male/Female

Date of Birth .....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Mother/Father/Other (please specify:)

Thank you very much for your help

PROFORMA

DETAILS OF MOTHER

Name: Age: Education: Occupation:

Marital Status: Income: Urban/ Rural

Family History:

BPRS: MINI SADS-L

DETAILS OF FATHER

Name: Age Education: Occupation:

Income:

Family History: Religion: Family Details: Family size:

Major family stresses:

DETAILS OF CHILD

Name: Age: Education: School: