

*Semi-Structured Assessment
for the
Genetics of Alcoholism*

Specifications

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SSAGA: GENERAL SPECIFICATIONS

The Semi-Structured Assessment for the Genetics of Alcoholism (SSAGA) is an instrument designed to assess physical, psychological and social manifestations of alcohol abuse or dependence and other psychiatric disorders. It is a semi-structured interview which capitalizes on prior research in psychiatric epidemiology. As such, it relies heavily on items previously validated by other research interviews, including DIS, CIDI, HELPER, SAM, SADS, and SCID.

FORMAT:

The interview is formatted with an index in the left margin, questions in the center, and coding space in the right margin. The index is there to refer questions to the respective criteria in the respective diagnostic systems. Since the SSAGA is polydiagnostic, the left margin codes will reveal which diagnostic system, and which particular criterion each question covers. The following key applies:

DIAGNOSTIC SYSTEMS:

3R = DSM-III-R
DSM = DSM-III
FGN = Feighner
RDC = Research Diagnostic Criteria
ICD = ICD-10

SYMPTOM CRITERIA: These appear at the end of the index code:

e.g. AD3RA4 = Alcohol Dependence, DSM-III-R system, criterion A, item 4.
RDCALC = Research Diagnostic Criteria system, Alcohol
DSMALC = DSM-III, Alcohol
FGNALCC2 = Feighner system, Alcohol, criterion C, item 2.
AICDD3 = Alcohol, ICD-10 system, criterion D, item 3.

DIAGNOSES:

The following diagnoses are covered by the SSAGA:

SOM-SOMATIZATION
AA,AD,ALC-ALCOHOL ABUSE AND DEPENDENCE
D,DR,DA,DD-MARIJUANA ABUSE AND DEPENDENCE
D,DR,DA,DD-DRUG ABUSE AND DEPENDENCE
ANRX,BUL-EATING DISORDERS (ANOREXIA, BULIMIA)
DEP-DEPRESSION
DYS-DYSTHYMIA
MAN-MANIA
ASP,CON,DIS-ANTISOCIAL PERSONALITY DISORDER
PAN,PANIC,HYST,ANX-PANIC
AGP,AGPH,PHOB-AGORAPHOBIA
SOPH,SOPH,PHOB-SOCIAL PHOBIA
OCD-OBSESSIVE/COMPULSIVE DISORDER

These sections are fully diagnostic.

There are six additional sections:

DEMOGRAPHICS
MEDICAL HISTORY
TOBACCO
PSYCHOSIS
COMORBIDITY
SUICIDAL BEHAVIOR

 * CHECK E5. IF NEVER MORE THAN 3 DRINKS, SKIP TO SECTION F. *
 * CHECK E4-E4A. IF BOTH CODED 00, SKIP TO SECTION F. *

RECORDING ANSWERS:

Answers are recorded in the right margin. All notes and comments should be recorded in the left-hand margin, unless otherwise stipulated. Some areas of the interview have special areas in which to record comments.

1. Some questions require that a precoded answer be circled:

e.g. E9 Have you ever wanted to or tried stop or to stop or cut down on drinking? NO...(SKIP TO E10)...1
 YES.....5

Only one number should be circled, and the interviewer should be careful to circle clearly.

2. Some require that the answer be filled in:

e.g. A3 How much do you weigh? ___ LBS.
 A. What is the most you have ever weighed? ___ LBS.
 B. How old were you when you first weighed (# LBS in A)? __ AGE

When recording age, if R. gives you two consecutive numbers ("Oh, I was 19 or 20"), record the younger age for first having done something (AGE ONS), and the older age for the most recent time (AGE REC). If a range is given ("Oh, I was between 20 and 24") always take the middle number, in this case 22. The same principles hold for the number of times that an experience has occurred. For example, for question E2 in the alcohol section, if a subject says that s/he has had 10-12 drinks in 5-6 hours, 11 drinks and 330 minutes would be coded in the available spaces.

While filling in the answers, no space(s) should be left empty. Zeros should be filled in to the left of the number (e.g. age 9 = 09, two times = 02).

When an interviewer is uncertain how to code a response, s/he should write enough information in the left-hand margin for an informed decision to be made by the editor.

Only questions skipped by specific instruction(s) are to be left blank.

Refusals to answer should be marked by RF, so that the editor can put in the appropriate code.

If a subject says s/he does not know a particular answer, ask "Could you give me your best guess?" If the subject cannot even guess, and simply does not know the answer, it should be marked by DK, so that the editor can insert the appropriate code, unless specified otherwise in the interviewer's instructions.

PROBING/CODING:

The probing codes appear as a boxed set of numbers: CODE: 1 2 3 4 5 . Sometimes questions will need to be probed. Probing is done from the right to the left.
 A flow chart to illustrate probing is found on page 10A.

Probing attempts to determine the cause of a specific symptom as well as whether that symptom was clinically significant. Clinical significance is assessed in two ways: First, if R. saw a Dr./other health professional about a specific problem, then clinical significance is assumed and a 2 code cannot be given; Second, if R. did not see a Dr./other health professional, or only spoke with one over the phone, significance may be assessed by affirmative reply to interference with life or activities a lot. Clinically significant symptoms are assigned a 5, 4, or 3 code, depending on etiology. Conversely, code 2 indicates that a symptom was below the threshold for clinical significance, regardless of etiology. In summary, SSAGA probes are defined below:

5= yes, the symptom is present and possibly psychiatric in origin:
i.e., cause is outright psychiatric disorder (e.g. depression, schizophrenia)
or vague emotional complaint (e.g. stress, nerves)
or vague complaint that doctor could not pinpoint and found nothing abnormal on examination, x-ray, or lab tests
(may, at times, have been caused by physical illness or alcohol or drugs **but not always**)
AND saw a Dr./other health professional (interference assumed),
or R. acknowledges symptom interfered a lot with life or activities

4= yes, the symptom is present, but always due to physical illness/injury or condition,
AND saw a Dr./other health professional (interference assumed),
or R. acknowledges symptom interfered a lot with life or activities

3= yes, the symptom is present, but either always due to taking medication, drugs, or alcohol,
or sometimes due to taking medication, drugs or alcohol and sometimes due to physical illness, injury or condition
AND saw a Dr./other health professional (interference assumed)
or R. acknowledges symptom interfered a lot with life or activities

2= yes, the symptom is present, but does/did not interfere with life or activities a lot. A 2 is coded for every non-clinically significant symptom, regardless of its cause(s). **If R. saw a Dr. or other health professional about the symptom, then clinical significance is assumed and a 2 code**

is not possible.

1= no, never had the symptom

Example C1 Have you ever had a lot of problems with _____
body pains such as headaches?

/ CODE: 1 2 3 4 5 /

WHOM SAW: _____ WHAT TOLD: _____

IF ANSWERED NO, CODE 1 AND GO TO THE NEXT QUESTION.

IF ANSWERED YES, ASK:

Did you see a doctor or any other health professional about your headaches?

DOCTOR/OTHER (HEALTH) PROFESSIONAL:

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

IF YES, RECORD THE PROFESSIONAL IN "WHOM SAW" AND ANY COMMENTS OR DIAGNOSIS IN THE "WHAT TOLD" LINE AND START PROBING.

IF NO PROFESSIONAL SEEN, RECORD "NONE" OR A SLASH (/) IN "WHOM SAW" LINE, AND START PROBING.

Probe for the cause and significance of the symptom, starting from right to left: (ie, 5-2)

CODE: 1 2 3 4 5

Before circling either 3, or 4 the following must be established:

- A) That the symptom was always due to (a) specific cause(s)
- B) That the symptom interfered a lot with R.'s life/activities

If not always due to a specific reason, proceed with probing, checking for the next code to the left.

HIERARCHY OF CODES:

Sometimes a particular symptom will have more than one cause. For example, headaches will sometimes be caused by eye strain (4), and headaches will sometimes be caused by taking speed (3), and headaches will sometimes be caused by tension over problems at work (5). In this case, there is a hierarchy by which to code a symptom:

Code 5 takes precedence over 4 and 3

(e.g., headaches sometimes due to eye strain, sometimes to drinking, **but sometimes due to nothing at all**, no Dx by the doctor, nothing unusual found with lab tests or X-rays **will be coded 5**)

Code 3 takes precedence over 4

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

Simply put, symptoms which could possibly be of psychiatric relevance always take priority, followed by symptoms which are related to use of medication, drugs and/or alcohol.

EXAMPLES:

1. Probing for 5: (definite or possible psychiatric relevance)

IF SAW A DR./OTHER HEALTH PROFESSIONAL ASK:

- A. **AND PROBLEM DIAGNOSED AS DEFINITELY PSYCHIATRIC, ENTER THE PROFESSIONAL ON THE "WHOM TOLD" LINE, AND RECORD DIAGNOSIS/COMMENTS ON THE "WHAT TOLD" LINE. CODE 5 IMMEDIATELY.**
- B. **IF NOTHING UNUSUAL FOUND BY DOCTOR/OTHER HEALTH PROFESSIONAL AFTER TESTS OR X-RAYS, CODE 5 IMMEDIATELY.**

IF DID NOT SEE DR./OTHER HEALTH PROFESSIONAL, START PROBING CODE 4

2. Probing for 4: (always due to physical illness/injury/condition)

IF SAW A DOCTOR OR OTHER HEALTH PROFESSIONAL, AND SOMETHING UNUSUAL FOUND ON EXAMINATION, OR WITH TESTS OR X-RAYS ASK:

- a) "Was Sx **always** due to a physical illness or injury, or physical condition?"*

IF YES, CODE 4 AND GO TO THE NEXT QUESTION

IF NO, ASK:

b) *"When Sx was not due to a physical illness or injury, was it always the result of taking medication, drugs or alcohol?"*

IF YES, CODE 3

IF NO, CODE 5

* *In some cases, a Dr.'s tests will reveal a substance-related cause. In this case the following would be asked:*

c) *"Was Sx **always** the result of taking medication, drugs or alcohol?"*

IF YES, CODE 3

IF NO, ASK:

d) *"When Sx was not the result of taking medication, drugs or alcohol was it always due to a physical illness, injury or condition?"*

IF YES, CODE 3

IF NO, CODE 5

IF NEVER SAW A DR./OTHER HEALTH PROFESSIONAL, ASK:

e) *"Was Sx ever due to a physical illness or injury, or physical condition?"*

IF NO, PROBE FOR CODE 3

IF YES, ASK:

f) *"Was Sx **always** due to a physical illness or injury, or physical condition?"*

IF NO, PROBE FOR CODE 3

IF YES ASK:

g) *"Did Sx interfere with your life or activities **a lot**?"*

IF NO, CODE 2

IF YES, CODE 4

3. *Probing for 3: (Due to medication, drugs, or alcohol)*

IF SAW A DR./OTHER HEALTH PROFESSIONAL, AND IF SYMPTOM NEVER DUE TO A PHYSICAL ILLNESS OR INJURY ASK:

a) *"Was Sx ever the result of taking medication, drugs, or alcohol?"*

IF YES, ASK:

b) *"Was Sx always due to taking medication/drugs/alcohol:*

IF YES, CODE 3.

IF NO, CODE 5.

IF SAW A DR./OTHER HEALTH PROFESSIONAL, AND IF SYMPTOM NOT ALWAYS DUE TO A PHYSICAL ILLNESS OR INJURY ASK:

c) "When Sx was not due to a physical illness, was it **always** due to taking medication, drugs, or alcohol?"

IF YES, CODE 3.

IF NO, CODE 5.

IF R. DID NOT SEE A DR./OTHER HEALTH PROFESSIONAL, ASK:

d) "Was Sx ever the result of taking medication, drugs, or alcohol?"

IF YES, ASK:

e) "Was Sx always due to taking medication/drugs/alcohol?" (or, if sometimes due to physical illness or injury "When Sx not due to a physical illness or injury was it always the result of taking medication, drugs, or alcohol?")

IF YES, PROBE FOR CODE 2 (INTERFERENCE)

IF R. ADMITS SYMPTOM INTERFERED A LOT, CODE 3

IF R. CLAIMS THAT SYMPTOM DID NOT INTERFERE A LOT, CODE 2

IF NO TO e. PROBE FOR CODE 2 (INTERFERENCE)

IF R. ADMITS SYMPTOM INTERFERED A LOT, CODE 5 BECAUSE NO OTHER CODE FULLY EXPLAINS SYMPTOM

IF R. CLAIMS THAT SYMPTOM DID NOT INTERFERE A LOT, CODE 2

4. Probing for 2 (severity)

THIS CODE DETERMINES WHETHER R. FELT THAT A SYMPTOM, ALTHOUGH PRESENT, DID NOT INTERFERE WITH HIS/HER LIFE OR ACTIVITIES A LOT. WHEN R. HAS SEEN A DR./OTHER HEALTH PROFESSIONAL ABOUT A SYMPTOM, THE INTERFERENCE PROBE IS NOT ASKED (CLINICAL SIGNIFICANCE IS MET BY R.'s HELP-SEEKING BEHAVIOR). THE CODE 2 PROBE IS ALWAYS ASKED WHEN R. HAS NOT SEEN A DR./OTHER HEALTH PROFESSIONAL.

"Did Sx interfere with your life or activities a lot?"

IF NO, CODE 2

IF YES, CIRCLE THE APPROPRIATE CODE (5, 4, 3).

IF YES, AND SOMETIMES DUE TO A 4 AND/OR 3, BUT SOMETIMES OCCURRED AT OTHER TIMES, THIS WILL BE CODED A 5, BY DEFAULT, TO INDICATE POSSIBLE PSYCHIATRIC RELEVANCE. THIS 5 WOULD MEAN UNEXPLAINED BUT SIGNIFICANT, I.E., POSSIBLY PSYCHOGENIC.

To summarize, interviewers must probe all possible etiologies of each symptom, regardless of whether the individual saw a Dr./other health professional or not. If the respondent never saw a Dr./other health professional about the symptom, then the interference probe must be asked. If the interference code is asked and R. claims that the symptom was present but did not interfere with life or activities a lot, a 2 should be coded. If the symptom did interfere and was not always explained by either physical illness, injury, condition or use of medication, drugs or alcohol, (or a combination of physical and substance-related causes) then a 5 is coded. If a doctor has stated that the symptom is entirely psychiatric, interference is assumed and a 5 coded. If a problem is due entirely to a physical illness, injury or condition as stated by a Dr., then a 4 is coded. If a Dr. was not consulted, but R. believes a problem is always due to physical causes and this problem interferes with R.'s life/activities a lot, then a 4 is likewise coded. If a problem is sometimes due to a physical illness/injury/condition and at all other times due to medication/drugs/alcohol (and if no Dr. seen, the symptom interfered a lot), then a 3 is coded. In all cases where a Dr. is not consulted, if R. claims that the symptom did not interfere, then a 2 is coded.

Be certain to document all decisions made in coding a response.

The entry on the "WHOM SAW" and "WHAT TOLD" lines will tell whether the respondent had seen/ talked to a health professional about the problem, or volunteered an explanation by him/herself. The only exception to this pattern is when a subject states that a psychiatric diagnosis, such as Schizophrenia, has been given to him/her by a Doctor, or that s/he has been hospitalized for a specific psychiatric diagnosis, but claims non-interference. In this case a 5 may be coded, and the fact that R. felt that this did not interfere with life or activities a lot should be noted on the "WHAT TOLD" line.

In the general spirit of the SSAGA, the interviewer will have to probe, remember as much as possible, and use good judgement in case of any inconsistencies. In other words, the coding system is to be strictly followed, whereas the probing pattern is adaptable; sometimes it will require more, sometimes fewer questions to be asked.

EXAMPLE/WHOM SAW/WHAT TOLD

Some questions will have an Example line to be filled out by the interviewer. This is to be sure that the respondent has understood the question correctly, or rather that what the respondent had in mind as an example actually fits the specific diagnostic criterion.

Interviewers will ask respondents whether each symptom experienced was reported to a doctor or any other health professional. If R. saw a Dr./other health professional, or spoke with one by phone, then any diagnosis/anything told to R. by any of these professionals should be recorded on the "WHAT TOLD" line. The type of professional should be recorded on the "WHOM SAW" line, and the type of contact (in person/over the phone) should also be indicated. If no help was sought for a particular problem, this should be indicated with a "none" or a slash (/) through the "WHOM SAW" line, with any cause provided by R in the "WHAT TOLD" line, to indicate that the appropriate probing was followed. For example:

"Yes, I've had pains in the joints, but only when I hurt my toe hitting the chair barefoot. The pain was gone in two days. I never spoke to anyone about it, because I knew it wasn't broken. It did interfere with my life a lot because I couldn't walk properly for about a week because the pains would come back." The correct code here will be 4, "none" will be recorded on the "WHOM SAW" line and "toe, hit chair barefoot" will be entered on the "WHAT TOLD" line.

ONSET/RECENCY CODES

Onset and/or recency are sometimes asked for specific symptoms that are coded positively.

- e.g. E10 Did you ever need a drink just after you had gotten up (that is before breakfast)? NO...(ASK A).....1
YES..(ASK B).....5
- A. Did you ever take a drink just after you had gotten up? NO..(SKIP TO E11)...1
YES.....5
- B. How old were you the first time? AGE ONS: _/_
ONS: 1 2 3 4 5
- C. Did this happen 3 or more times? NO.....1
YES.....5

Age of onset is coded in the spaces provided (e.g. 19 years old will be filled in as 1/9). If R. says, "Oh, I was either 19 or 20" always take the younger age for onset, and the older age for recency. If R. gives a **range** of values, such as "I was between 18 and 20 when I first did that, use the midpoint (19) as the age of onset.

In the case of episodic illness, such as dysthymia or major depression, the recency would be the age and recency code of **the end** of the most recent episode.

Onset/Recency codes mean the following:

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

Clustering

In the Alcohol, Marijuana, and Drug sections, questions are asked to assess clustering of symptoms for both DSM-III-R and ICD-10 diagnostic systems. Tally sheets are completed for each section, based on the respondent's answers to questions in each of these three sections. DSM-III-R clustering requires R.'s endorsement of at least two symptoms, one in each of at least two different groups. ICD-10 clustering requires R.'s endorsement of at least three symptoms, one in each of three different groups.

Clustering is the occurrence of symptoms within a period lasting at least one month but possibly continuing for several years, or the recurrence of these symptoms within a several year period. If symptoms have occurred sporadically throughout the respondent's life (e.g., one problem when R. was 18, another when 25, another when 30), or have all occurred within a period of less than one month, this would not constitute clustering. Similarly, if R. experienced many symptoms within a one week period when R. has been involved in hazing for a fraternity, for example, no clustering would result. For clustering to occur, symptoms do not have to all occur at the same time, or even on the same day. Rather, they must co-occur, being part of a pattern in which R. is experiencing several problems repeatedly, all within a span of one month to a few years.

A. DEMOGRAPHICS

General:

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

Question by question specifications:

- A1 *If R. is a transsexual, record sex s/he was born with.*
- A2 *Round height up to nearest whole number.*
- A3 *Includes weight gain during pregnancy; interviewer should note this if it is the cause of the weight gain.*
- A6 *This question implies any legal adoption. Adoption by a family member should be noted in the margin.*
- A7 *If the subject had a twin or other multiple who died at birth or when it was very young, this should be noted, but still coded as "yes" (5).*
- A8A *Record code from card A1.*
- A8B *This determines the country of origin of R.'s 4 biological grandparents. Spaces for 8 ethnic codes are provided in cases where R. is aware that his/her grandparent is a mixture of two ethnicities. Ask where R.'s Mother's Mother was born. Next, ask about their Mother's Father. If R. is unable to provide any more information than "my Mother's Mother was English, use the code for English in both columns. If R. states that his/her background is American, check to see whether his/her background is Native American, and if not then use code 67 (American, N.O.S.). The Unknown code should be used only as a last resort.*
- A8C *If R. says that s/he is an Atheist or an Agnostic, make note of this. If R. then says s/he has attended religious services in the past 12 months, determine what services these were.*
- A8D *In case of an alternative religion with no organized services, record "000". Organized meetings for alternative religions should be included. "Television church", or watching services on the television (particularly when this is done as a regular part of religious exposure) counts. Make a note of this in the margin.*
- A9 *The interview elicits dates of widowhood. If R. says that s/he is widowed, be certain to obtain the year his/her spouse died, and code this year in the space provided. "Separated" includes both legal and informal separations from a legal partner, and would not include separation from a live-in partner.*
- A9 *This question refers to **legal** marriages only, not live-in relationships that because of their length would in some states qualify as common-law marriages. Marriages between members of the same sex and marriages that were annulled do not count-they are not included as **legal**. If R. has married the same person twice, this counts as two separate marriages.*
- A10 *This question refers to live-in relationships "as though you were married" and **not** to marriages, or to roommate situations, and emphasis should be placed on the durations of "at least a year". This also includes homosexual live-in relationships.*
- A12 *Information from A9 is used to phrase A12. If A11 is coded as only once, A12 would begin "So, you've never been divorced". In any other case "How many times have you been divorced" should be read. Marital instability may be of psychiatric relevance.*

- A13 *The phrase "Other than when separated just before a divorce" should only be read if A12 is coded 01 or more. This separation refers to any marriage/s or live-in situation/s. Separations that are due to job, school, or military necessity do not qualify. The intent is that the couple was not getting along. R. should thus be reminded that this number should be the **total** of all separations in all such relationships. The "last time" R. separated should not include the final separation just before a divorce.*
- A14 *"How many times have you been pregnant?" includes pregnancies that were terminated by abortion or miscarriage and babies that were stillborn.*
- A14C *Children who were given up for adoption, who were produced out of wedlock, and children that R. never took care of should be included in this total. If R. cannot remember the month of birth, then try to get year. There is space for 8 children; others should be noted in the space between questions A14C and D. Do not include step children (these were not parented by R.)*
- A14D *"Acting as a parent" means that R. was responsible for any child's well being, providing food, clothing, and/or shelter. This includes step children and adopted children. This would be the individual that is responsible for making decisions about the care of the child, and would not normally include housekeeping, au pair, Nanny and other paid working situations where the care of children was part of the arrangement. Simply paying child support and having no say in child-rearing would not count.*
- A15A,B *Asked only if R. reports 12 or fewer years of education.*
- A15C *If R. is currently enrolled in school, this would be coded "no".*
- A15D *The date of all graduations that apply to R. are asked. If R. has multiple college and/or graduate degrees, code the most recent graduation of each. If R. has both a Masters and a Ph.D., code the date the Ph.D. was awarded. Make notes of the other graduation dates in the margin. A.S.N. and B.S.N. nursing degrees should be included under the "college" category.*
- A15D *"Other School" is to be used for technical schools, such as auto mechanic and secretarial, as well as for LPN, and other special degrees including registered nursing (R.N.) degrees awarded based on additional training following a college degree. This **does not include** 6-month training programs, such as cable line school, and no technical degree should be coded if R. does not even have a GED.*
- A15E *This is asked of everyone, to help assess whether R. did not complete his/her education because s/he is still in school or working toward a degree. Failure to complete education has been implicated as a risk factor for psychiatric disorders.*
- A16 *This question asks about work for pay only. If R. has been hospitalized and his/her employer is holding the job until R. can return to work this counts. This would also include situations like sabbaticals and paid leave of absences (such as maternity leave) after which time R. would be expected to return to work. If R. is a teacher and works only 9 months out of the year (generally with the summer months off), count this as 12 month employment.*
- A17 *If R. volunteers that s/he is self-employed (which might include free-lance writing, farming, contracting, consulting, selling) this should be included as full-time even if R. went without a "job" for several weeks or even months. Work in federal job corps programs should be counted.*
- A17A *Full-time work status is 37.5 hours per week or longer.*
- A17B *R. is given card A3, and asked to list the code of the income category that best fits his/her situation. Current **household** gross income is the combined pre-tax income of R. and spouse (or spouse equivalent), and would include other members of the household that would be contributing money for maintenance and payment of general expenses. Do not combine income of roommates who are not significant others. If R. is in a live-in relationship with a lover and shares bills and responsibilities with his/her live in partner, then the two*

incomes should be included. Also included are payments of child support, alimony, social security, disability, welfare and food stamps. Students with part-time jobs should include this income with parents' income. Married couples that live with parents, who pay rent but do not combine incomes with the parents, should not include the parents' income. People, such as Farmers who have large outlays of money for equipment/supplies should use their taxable income as reported to the IRS. The sale of property does not count as income.

- A18 If R. states that s/he has been in the military Reserves this should not count **unless** s/he has been called up for active duty.*
- A18A If R. does not know the type of discharge s/he was given, you may read the choices to him/her. If R. reports a discharge that is "other than honorable", use the code "7".*
- A18B "Highest rank ever achieved" in **any** branch of the military should be recorded as a formal rank (e.g. Sergeant) as well as a letter-number combination pay grade (e.g. E4).*

B. MEDICAL HISTORY

General:

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

Question by question specifications:

- B2 The state of Rs health, coded in B1 is inserted here. Record the explanation if his/her health has not always been this way.
- B3 This is a list of medical illnesses of neurophysiological relevance. If R. says "Oh, I have high blood pressure", or "I get headaches all the time", or "I know that I have heart disease because my father, uncle, grandfather and brother all had heart disease", you must follow-up with "did a doctor ever tell you had...". The year that R. was diagnosed by the doctor is to be coded for each "yes". If the problem was not diagnosed by a doctor, record the year R. first developed the problem.

Definitions and descriptions:

2. **Abnormal blood pressure**-The following findings are considered abnormal: systolic pressure persistently above 100; pulse pressure constantly greater than 50. Blood pressure varies with age, sex, muscular development, and according to states of worry and fatigue. Usually, it is lower in women than in men, low in childhood, and higher in elderly individuals.
3. **Migraine headaches**-Paroxysmal (convulsive or spasmodic) attacks of headaches, frequently unilateral, usually accompanied by disordered vision and gastrointestinal disturbances. They are thought to be the result of vaso dilation of extracerebral cranial arteries.
4. **Head injury**- Blunt trauma to the cranial vault will have differing consequences and final outcomes depending on whether the injury was penetrating or non-penetrating. Non-penetrating injuries can result in fractures of bones that directly affect adjacent brain tissue. Bleeding (hemorrhage) from head injuries may occur at various sites, depending on the site of the injury, which have different prognostic implications. In an epidural hemorrhage, the blood is in a layer between the skull and a sheath-like covering of the brain (the dura). Sometimes the blood accumulates slowly with neurological symptoms proceeding to coma within hours to days. In a subdural hematoma the hemorrhage is located between the brain and the dura or sheath-like covering of the brain. The neurological consequences are obvious almost immediately. A chronic version of the acute subdural hematoma caused by a minor blow to an elderly person may result in a slow period of mental decline over weeks.
5. **Concussion**-An injury (to the head) resulting from impact with an object. Violent shaking and agitation of the brain and the transient functional impairment resulting from this injury. The effects include loss of consciousness (usually), loss of reflexes, brief cessation of breathing, slowing of the heart, and changes in blood pressure. Amnesia and confusion may last only briefly or several days.
6. **Epilepsy/Seizure**-A recurrent paroxysmal disorder of cerebral function characterized by sudden, brief attacks of altered consciousness, motor activity, or sensory phenomena. Epilepsy is the sudden disorderly electrical discharge of cerebral brain cells with disturbance in sensation, loss of consciousness, impaired

mental functioning, convulsive movements. Seizures can be classified as Generalized such as Grand mal (tonic clonic); Petit mal (absence); Partial simple (focal seizures such as Jacksonian (motor) or sensory or somatosensory (visual, etc.)); or Partial complex (with impaired consciousness including temporal lobe or psychomotor seizures). Convulsive seizures are the most common form of attacks, but any recurrent seizure pattern is considered epilepsy.

Do not count seizures which are a result of alcohol withdrawal.

7. **Unconscious-Conscious** describes a particular state of arousal in which a person is fully responsive to stimuli. With clouding of consciousness some distractibility, inattention and incoherence is observed. Stupor describes minimal mental activity with the patient arousable only with repeated and vigorous stimuli. Coma is a sleep-like state which in its deepest state means no response to stimuli (a vegetative state). Disturbances of consciousness include altered states of consciousness involving hypnosis, multiple personality disorders, dissociative disorders and hallucinogenic drugs.

8. **Meningitis**-An infection of the layers covering the brain caused by viruses (aseptic meningitis) or bacteria infections such as Hemophilus influenza, Neisseria meningitides or streptococcus pneumonia, resulting in inflammation of the membrane of the spinal cord or brain.

9. **Encephalitis**-Infection and inflammation of the brain itself is called encephalitis. Its symptoms include convulsions, delirium, confusion, stupor, mutism, hemiparesis (weakness on one side of the body) etc. associated with an aseptic meningitis.

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

11. **Hardening of the Arteries**-The destruction of the arterial vasculature due to the effects of certain lipoproteins. Athero-sclerosis cause lesions or plaques in the vessel. The fibrous plaque is stiff as compared to the flexibility of the healthy blood vessel thus giving rise to the term hardening of the arteries.

12. **Heart Disease**-Diseases that affect the heart can be congenital such as a malformed heart; acquired, i.e., cardiomyopathy; intrinsic such as arrhythmias, the irregular beating of the heart; anatomic such as an abnormal valve controlling blood flow into and out of the heart; infectious such as endocarditis; ischemic due to atherosclerosis of the vessels flowing to the heart (coronary arteries); or secondary to external problems such as heart failure due to hypertension.

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

14. **Thyroid disease**-The thyroid controls the rate of metabolic activity in the body and the rate of activity of other cells in the body. Hyperthyroid is the result of too much thyroid hormone of which Grave's disease is one kind. Thyrotoxicosis is a hyper-metabolic state due to elevation of thyroid hormone that can cause heart failure. The opposite is the clinical state of hypothyroidism in which weight gain, skin thickening, lethargy and mental dullness are observed. Cancer of the thyroid is common in individuals who received radiation treatment near the neck for an unrelated condition.

B4A As stated, begin with the most recent hospitalization. Include hospitalization for normal pregnancies. If R. was a student, and "hospitalized" in the college infirmary, this counts. Information will be used to obtain medical records. Therefore, it is essential that the list of non-psychiatric, non-substance abuse related hospitalizations be **as complete as possible**. If the hospital name cannot be recalled, then the location e.g.

city and state, should be obtained. Total number of hospitalizations, even if the stay was just overnight, must be recorded. If R. has had numerous hospitalizations, the information can be recorded in the margins.

B4B Common procedures done on an outpatient basis include arthroscopy, liposuction, augmentation mammoplasty, d&c, some forms of cosmetic and reconstructive surgery, and dental surgeries.

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

B5 Count any check-ups or routine visits to doctors, D.O.s (Doctors of Osteopathy), eye doctors, as well as visits due to illness/injury, or for emergency care.

B6A This question is used to screen for medications R. has taken at anytime in his/her life. For every "yes" response, the Interviewer should elicit the name of the medication, to be coded later by the Editor. Headache medication should be prescription **only** (i.e., not aspirin), and medication taken to have more energy includes items such as diet pills and other caffeine-containing products. Vitamins do not count, even when given as shots. This does not include any illegal drugs R was using (for example, taking cocaine for more energy).

B6B Ask only for medications used on a lifetime basis identified in B6A.

B6B.8 Ask every respondent for any other medication that s/he might have used within the past 30 days.

B7 Designed to facilitate rapport with R., keep response under 10 minutes. This would include any period in R.'s life that has been upsetting, including work and social difficulties such as loss of a job or breakup of a love relationship. Record what R. says in as much detail as possible, including dates or ages when troublesome events took place. Also record whether R. sought professional help, took medication, or was hospitalized. This question is useful as reference when completing other sections of SSAGA. Before moving on to question B8, always ask R. whether s/he has any other examples of troubling times that stand out as particularly upsetting.

R. should be allowed to speak freely; however, some structuring of information may be necessary to elicit psychiatrically relevant information. For example, if R. elaborates about the details of the death of his grandmother, but gives no information about how this death affected him, the interviewer should ask R. about what **he** was experiencing at this time.

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

B8 Even if R. reported no troubling time, s/he is asked if s/he ever spoke with a professional (including a general medical doctor) about emotional or psychiatric problems.

B9 Number of times as a patient in a psychiatric hospital or ward, including a chemical dependency unit. The specifics of the hospitalizations are required for obtaining medical records. Include information about outpatient or day hospital care.

B9B To gather more information about the population sampled, the reason why R. was hospitalized where s/he was during the current or most recent stay is recorded.

C. SOMATIZATION

General:

The essential features of Somatization Disorder are recurring multiple somatic complaints lasting at least several years for which medical attention was sought but for which no definite diagnosis was obtained. Somatization is defined as the conversion of mental experiences or states into bodily functions. Although most people have various aches and pains and other physical complaints not explained by a known medical illness, they rarely mention them to a doctor or professional, and rarely do these interfere with a person's life. This distinguishes individuals with Somatization Disorder from those experiencing everyday aches and pains.

Generally, persons with this disorder have vague and complicated medical histories that begin before the age of 30. The histories often include repeated visits to physicians and clinics, the use of many medications (often at the same time) prescribed by different physicians, frequent hospitalizations and operations. Complaints almost always involve the following organ systems or types of symptoms: gastrointestinal difficulties, female reproductive difficulties, psychosexual problems, cardiopulmonary symptoms, and conversion or pseudo-neurologic symptoms. "Conversion" symptoms are unexplained symptoms suggesting neurologic disease such as amnesia, unconsciousness, paralysis, "spells", aphonia (loss of voice), difficulty walking, anesthesia, and blindness. These symptoms are sometimes referred to as pseudo-neurological or grand hysterical symptoms. Unexplained means that physical examinations and/or tests have failed to reveal a satisfactory explanation for the symptoms. Often the person believes that s/he has been "sickly" for much or most of his/her life.

Somatization is a fully diagnostic section that ascertains DSM-III-R, RDC, Feighner, modified RDC (Pearly-Guze), and DSM-III Somatization disorder. This section has further been organized along proposed guidelines for DSM-IV, so that if R. has not had 4 or more body pains, s/he skips out of the section. In addition, the first 11 questions of the Somatization section differ in format from other SSAGA sections. They have been organized so that only if 4 or more body pains are present will the individual continue with severity coding. There are skip-outs throughout the Somatization section, so that if R. has continued through the body pain questions s/he may still skip out if no gastrointestinal problems are present. To continue through Somatization the following must be coded 3,4, or 5: Body pains, 4+; gastrointestinal problems, 1+; neurological problems, 1+; general problems, 1+. The coding structure (1,2,3,4,5) is a method of determining both severity and etiology of the problem. See General Specifications Section for details.

Sometimes R. will answer, after s/he has been asked about pains in the joints, that s/he has pains in the leg or arm. Tell R. that these will be asked about later. They should be noted, and then the question should be re-asked, with emphasis on "other than in the arms or legs". Some respondents will mention pains that are not listed, such as a "painful, burning sensation on the forehead". All pains not listed should be recorded under the "other pains" line.

Determining Symptom Cause:

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

1) Multiple direct causes (no causal chain).

R: Sometimes the pain is caused by my ulcer. Other times it is from stress. It does interfere with my life because I have to take time off from work.

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

2) Chained causes

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

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

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

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

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

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

Question by question specifications:

GENERAL NOTE: ALWAYS STRESS A LOT OF PROBLEMS WITH EACH INDIVIDUAL SYMPTOM. IF R. ASKS WHAT IS MEANT BY "A LOT OF PROBLEMS" RESPOND THAT "A LOT OF PROBLEMS" MEANS WHATEVER R. CONSIDERS IT TO BE.

C4.2 *Nausea-not vomiting, feeling sick to stomach but not actually vomiting*

C4.5 *"3 or more foods making you sick" This refers to 3 or more **different** types of food, not 3 of the same type of food (eg. ice cream, cheese, whipped cream are all milk products and thus the same type of food).*

C6.1 *Blindness must last several seconds or more.*

C6.3 *Hearing must be lost completely.*

C6.4 *Inability to move a part of the body, and not just numbness.*

C6.7 *Feeling loss must be for a few minutes or more.*

C6.8 *Losing feeling must be for a few minutes or more.*

C6.11 *Seizure is defined in the question.*

C6.13 *Time period for amnesia stated in question.*

C6.14 *Time period for loss of voice is stated in question.*

C8.1 *"Exerting yourself" would include exercising, sports, physical labor or other heavy or strenuous physical activity. Hyperventilation is synonymous with shortness of breath.*

- C8.3 *"Fainting spells" in which R. must actually pass out. If R. does not pass out, and simply gets dizzy spells, this would be coded in C8.5.*
- C8.4 *"Heart beating so hard" must not be due to vigorous exercise, or watching scary movies. The symptom must occur spontaneously.*
- C8.5 *A period of dizziness where R. does not pass out. If R. says s/he experienced vertigo or a period of lightheadedness, these are included.*
- C8.6 *"Sickly" is left for R. to define, but refers to someone who either gets sick easily or is in generally poor health.*
- C8.7 *"Regular activities" are normal daily activities for R. The time period must be for at least several weeks.*
*"Not well enough to carry on" describes an inability to perform normal daily activities. It describes a pervasive feeling of illness which is non-specific but disruptive enough to cause the individual to feel that s/he **cannot** manage normal daily responsibilities and assume a normal role.*
- C8.8 *Time period for feeling tired or lack of energy is at least two weeks.*
- C8.11 *Weight loss must be unintentional.*
- C8.12 *Weight loss must be sudden. This question implies that the loss is unexpected.*
- C8.16 *This must have occurred after R. has become sexually active.*
- C8.20 *If R. says always due to menopause, code a 4.*
- C8.22 *Irregular periods are monthly periods that do not come on a regular cycle. There is a different number of days (i.e. 25, 35) between periods.*

D. TOBACCO

General:

Tobacco is a non-diagnostic section that assesses average use of all forms of tobacco: cigarettes, cigars, pipes, chewing tobacco and snuff.

Pack years, a common measurement of exposure to tobacco, is calculated in the following way:

$$\frac{\text{cigarettes/day} \times \# \text{ years smoking}}{20 \text{ (\# cigarettes/pack)}}$$

All time periods should be converted to months. Any period less than one month should be coded "000"

Question by question specifications:

D1A Daily use for a month or more is the necessary duration for any form of tobacco use.

D1B This is the total amount of time R. has smoked, excluding periods of abstinence.

D1C **This is not** the largest number of cigarettes smoked per day (for example). This is the **average** number, which is a more stable measure of usage over time. This question is not checking for the period of smoking most, but rather for an average daily amount.

D1D Age of onset and recency are coded for daily tobacco use after having passed the screen of "a month or more". If R. quit daily smoking several years ago, but resumed within the last week, even though R. had only been smoking for a week, recency of smoking would be the current week.

D2 For each form of tobacco that R. has said he has used daily for a month or more (D1A), s/he is asked if s/he has ever tried to quit. If R. states that s/he has never tried to quit, but at some point stopped using tobacco, this should be coded as "yes".

D2B Determine the longest period of time that R. has gone without any form of tobacco. (coded in D2). If R. has never quit for at least a one month period, the interviewer should code "000". Quitting smoking during pregnancy counts. If R. abstained from tobacco for many years, the total duration of this abstinence should be recorded. If R. is currently abstaining, the longest abstinent period may be the date R. quit using tobacco to the date of the interview.

E. ALCOHOL

General:

Alcohol is a fully diagnostic section that assesses alcohol abuse/dependence for DSM-III-R, Feighner and ICD-10 criteria. Typical ("past week") drinking behavior (drinking quantity and frequency) is also obtained. Respondents are given the opportunity to skip out of this section in the following three cases: 1. If they have never had even one drink of alcohol (item E1A); 2. If they never had more than three drinks within a 24 hour period (item E5); 3. If they have never consumed alcohol at least once a month for 6 months or more **and** have never been drunk (items E4, E4A).

Respondents personal definition of "a drink" may vary. Card E2 is used to clarify and define alcohol equivalents for standardization.

Question by question specifications:

E1 R. is asked if s/he has **ever** had a single drink of alcohol in his/her lifetime. This would not include sipping wine when taking communion, or having only a (small) portion of one drink. If R. says no, this is verified with E1A, "So you have never had even one drink of alcohol?" If R. still says no, s/he will then skip out of the section.

E2 If R. has had **at least** one drink, then s/he is asked about alcohol consumption within the past seven days, starting with the previous day. There are four main categories to assess: Beer/Lite Beer, Wine, Liquor, Other (specify). The Other category should be used for cocktails or mixed liquor drinks that are complex (that is for a drink that is not just a simple combination like vodka and orange juice or Scotch and soda, which would be coded under the LIQUOR category), or in cases where the Interviewer is not certain what category an alcoholic beverage falls under (for instance Ouzo and Hard cider). The Other category is also used for liqueurs, sherry and port wine, as well as Malt liquor and fortified wine. Non-alcoholic beer does not count. **Whenever an alcoholic beverage is named, particularly in the case of mixed drinks, this should be specified next to the number of drinks consumed on a particular day.** The interviewer should record R.'s drinks as specifically as possible.

The interviewer asks R. about each category of alcohol separately, starting with the previous day, and continues in this manner for each of the preceding 6 days. In addition, R is asked how long it took to drink the given amount in each category. This time information is needed to determine the length of the drinking session. That is, a person who drank 2 shots at 9:00 p.m and had a whiskey sour at 11:00, which s/he finished drinking at 11:15 had a drinking session that lasted for 2 1/4 hours. The following dialogue is given as an example:

I: Yesterday was Friday. How many Beers or Lite Beers did you have on Friday?

R: Four.

I: How long did it take you to drink those four beers?

R: Well, I spent about 2 1/2 hours at the bar with my friends, so I would have to say it took that whole time.

The interviewer would multiply 2 1/2 x 60 to achieve a total of 150 minutes to drink these 4 beers.

I: How much wine did you have yesterday (Friday)?

R: I split a bottle with my girlfriend when I got home. We finished it off with dinner, so I guess that was about 45 minutes.

The interviewer has to code "half a bottle" as 3 drinks, which took a total of 45 minutes to consume.

I: How many drinks of (hard) liquor did you have yesterday?

R: None.

The interviewer codes "0" in the "Amnt" column, and "0" in the "Min" column.

I: Did you have any other alcoholic beverage yesterday?

R: No.

The interviewer again codes "0" in the "Amnt" column and "0" in the "Min" column.

I: How about Thursday. Did you have any beer or lite beer on Thursday?...

The interviewer proceeds in this fashion to ask R. day by day and drink type by drink type to get a pattern of usage for the past week.

If R. cannot remember how much s/he drank or how long it took, R. should be prompted, i.e., "was it one drink, two drinks..." or "did you drink during Happy Hour...". A "Don't Know" response should only be used if the subject, when prodded by the interviewer, absolutely cannot estimate an answer.

In cases where R. spent time drinking beverages from different categories during one drinking session, then the number of drinks should be divided into the total amount of time spent during the drinking session to arrive at an average amount of time per drink, which would then be multiplied by the number of drinks in a given category. (This would not apply to shots, which generally take a matter of seconds to consume, and would simply be recorded as needing one minute to drink.) Following is an example:

R: On Saturday night I went out to a bar with friends and had a six-pack, a bottle of wine, and two shots of tequila. I spent about 5 hours at the bar, and I really don't know how long it took me to drink the beer or the wine.

*The interviewer would code 2 minutes for the shots under the "Liquor" column, and would divide the remaining amount of time (298 minutes) by the total number of drinks **other than** the 2 shots (12). This would yield @24 minutes per drink, which would then be multiplied by 6 for the time it took to consume the beer, and by 6 for the time it took to consume the wine. The number of minutes recorded in the beer and wine columns would be 149.*

*E3 This question follows the same form as E2. If R. tells the interviewer that the past week (E2) was not a typical drinking week for him/her, then the interviewer must establish "typical drinking" within the past 6 months. **"Typical" does not mean worst.** This would be assessed day by day, drink category by drink category starting with a typical Monday and continuing through the other days. If the week was typical, the interviewer does not ask E3, but instead skips to E4.*

If R. has had nothing to drink in E2, with a recency of drinking of 2 or 3 (falling within the past 6 months), and does state that, for example, one weekend per month s/he drinks a case of beer/day, this should not be recorded as "typical", because most weekends s/he does not drink, and a "5" should be coded for E3. If the binge drinking weekend happened to fall within the past week, however, it is recorded in E2 and a "1" is coded for E3. "0s" are coded in all spaces for E3B.

E4 "Regular drinking" is defined in the question.

E4A Age when first got drunk is defined in the question: the first time speech was slurred or R. was unsteady on his/her feet because of drinking.

E5 The largest number of drinks in a 24-hour period is the total number of alcoholic drinks (beer, wine, liquor, etc.) R. consumed within a 24-hour period. So, if the largest amount of alcohol R. had was a 1/2 case of beer,

a bottle of wine, and a fifth of gin, the total number of drinks would be $12+6+20=38$ drinks. The interviewer would code "038" in the spaces provided. Card E2 is provided for such conversions.

- E6 Almost every day means at least 4 days out of 7 for a week or more.
- E6A Focuses on the period of heaviest drinking almost every day for at least a week. Code the lowest common denominator for the week. That is, if R. drank 7, 10, 12, 8, 15 drinks on different days during the week the number to be coded is 7. If R. reports 2 periods of heavy drinking for at least one week, code the period in which the greater amount of alcohol was consumed on a daily basis.
- E6B Duration of the period assessed in E6A.
- E7 This question is assessing both (A) negative reactions to one or two drinks of alcohol and (B) whether any of these reactions kept R. from drinking alcohol. These reactions must have caused R. not to drink on at least one occasion other than when the negative reaction took place. If R. stopped drinking during the drinking session when the negative reaction took place but at no other time, this would not count.
- Skip Instruction:** Following E7 is a major skip instruction that tells the interviewer that if R. never had more than 3 drinks in a 24-hour period OR if R. never drank regularly and has never been drunk that the rest of the alcohol section is skipped and the interviewer proceeds to F1.
- E8 This item asks about the longest period of total abstinence from alcohol. During these periods, not even a single drink should be consumed. Code in months. If R. has never drank regularly (E4), use the age when R. was first drunk (E4A).
- E8A Asks for the total number of 3-month or longer periods of abstinence. This should be completed even if R. cannot specify the month/year of these in E8B.
- E8B Asks R. to specify when these episodes of abstinence began and ended. These periods of abstinence are important for comorbidity assessment, and the interviewer may have to work with R. to obtain these periods. For example, if R. cannot remember periods of abstinence try to determine whether s/he drinks on holidays, birthdays, etc., and then work around these occasions. Some information is better than none. Record abstinent years if the specific months cannot be determined, even after prompting with seasons.
- E9 Unsuccessful efforts or persistent desire to stop or cut down on drinking during a pregnancy would count. Cutting down due to calories does not count.
- E10 A characteristic sign of dependence, the intent of this item is a need for alcohol in the morning.
- E10A A "second chance" provided for R.s who deny need.
- E10C Refers to either E10 or E10A, whichever has been coded "5".
- E11 A "strong desire" or "craving" for alcohol may persist long after R. has given up drinking. Therefore, the age when R. has experienced this feeling may be after the age R. stopped drinking.
- E12 Definition of binge-drinking is provided, (2 days or more of continuous drinking is interrupted only by sleep).
- E12A Neglect of responsibilities must be during a period of binge drinking.
- E12B Code the number of binges when neglected responsibilities. If never neglected responsibilities, code the number of binges when did not neglect responsibilities.

- E13 *Drinking larger quantities, more frequently, or at times when self-imposed restrictions on drinking have been made. This item implies that there was intent to control the drinking, but that this was unsuccessful.*
- E14 *Refers to a time when R. became drunk when s/he did not **want** to, and **not** simply when s/he did not expect to get drunk.*
- E15 *Period of time is defined in question.*
- E17 *This item assesses family, social, or occupational problems that R. may have had in relation to use of alcohol. For each "Yes" response (5), the Interviewer is instructed to determine whether the behavior occurred 3 or more times, and to code this in column II.*
- E17.1 *Objections that occur long after R. has stopped drinking (such as describing drinking while 20 and in college to someone 10 years later, and that person objecting to his/her alcohol consumption) do not count.*
- E18 *This item is non-diagnostic, but it assesses behaviors common to some alcoholics (particularly females).*
- E18.A *Family/friends objecting to any drinking at all is a rule-out for any item coded yes in E18. This would include religious objections to alcohol use.*
- E18.B *Drinking under the legal age is a rule-out for any item coded yes in E18.*
- E20 *Card E1 is used to illustrate a 50% or more increase to obtain the same effect. As the card illustrates, for the purpose of this interview, tolerance begins with a baseline of 4 drinks and needing 6 drinks to get the same effect as the 4 drinks used to produce. 1 drink to 6, 2 drinks to 6 and 3 drinks to 6 would also count, as they represent a greater than 50% increase.*
- E21 *Many people decide not to drink at certain times, but the intent of this item is that rules were developed **specifically to control** drinking. Any type of rule would count, not just the items mentioned here.*
- E25 *Code the age R. **realized** that s/he was an excessive drinker.*
- E26 *Feeling guilty about the number of calories in drinks does not count. Feeling guilty about drinking because of religious/social beliefs counts.*
- E27 *DWIs and DUIs are counted as arrests for drunk driving.*
- E28 *If in the military, being detained by security or the military police would count*
- E29 *R. must have had an accidental injury while under the effects of alcohol, particularly when drunk. Minor mishaps, such as stubbing a toe, would not count.*
- E30 *This item implies that R. must have been doing certain activities that increased his/her chance of injury, for example driving a car and not simply being a passenger when the driver is also drunk.*
- E31 *Blackouts are defined in the question-periods of time when R. was drinking heavily and was conscious but could not remember what happened. Blackouts may be of short or long duration, but must be periods of at least several minutes about which R. can recall nothing.*
- E32 *This question assesses withdrawal symptoms when R. stopped or cut down on drinking.*
- E32C *If more than one symptom is endorsed in E32, R. is asked whether two or more of these symptoms occurred together (clustered), and is then asked to name these symptoms.*

- E32D *The interviewer should read the withdrawal symptoms that were coded "yes". Code all problems that R. says occurred together in column II.*
- E32E *This question asks when the clustering of withdrawal symptoms, or a withdrawal syndrome, first occurred.*
- E32H *This requires R. to have deliberately taken a drink on 3 or more different occasions to either keep from having or to relieve **any** withdrawal symptom.*
- E32I *This requires R. to have deliberately used another substance, either medication or drug (other than non-prescription pain killers such as aspirin or Tylenol) to relieve any withdrawal symptom at any time. The name(s) of the medication/drug should be recorded.*
- E34 *This item describes delirium tremens (DT's), a rare and severe withdrawal symptom.*
- E36 *This assesses drinking despite pre-existing physical health problems that could be exacerbated by drinking. Pregnancy is not counted as a serious physical illness if R. only told that drinking would harm the fetus and not the mother. Illnesses such as the flu, stomach aches, measles, etc. do not count as serious. Insulin dependent diabetes would count. However, diabetes that is controlled by diet would only count if R. consumed more than an average of one drink per month.*
- E36C *Use of alcohol with medication(s) must be contraindicated. R. must be aware at the time of alcohol consumption that drinking while taking a particular drug or medication was hazardous. The intent of this question is that R. drank despite the fact that s/he knew it was harmful to do so. If a Dr. told R. not to drink with specific medications and R. drank anyway this should also count as R. was made aware that the combination could be hazardous.*
- E36D *Illegal substances count.*
- E37 *This question assesses psychological and emotional problems that may have been caused by drinking. The specifications of "more than 24 hours" and "interfered with your functioning" have been added to emphasize the severity of the symptoms.*
- E38 *This question assesses help-seeking behavior. R. must have brought the problem to a professional's attention, not simply acknowledged having the problem when queried by a professional.*
- E39 *If R. has ever been treated for a drinking problem (either voluntarily or involuntarily) this is coded in E39.*

INTERVIEWER BOX: THE INTERVIEWER SCANS DSM-III-R ALCOHOL TALLY SHEET E FOR SYMPTOMS, AND IF ANY IS/ARE CHECKED, CONTINUES WITH E40

Clustering (E40, E41): Clustering is the occurrence of symptoms within a period lasting at least one month but possibly continuing for several years, or the recurrence of these symptoms within a several year period. If symptoms have occurred sporadically throughout the respondent's life (e.g., one problem when R. was 18, another when 25, another when 30), or have all occurred within a period of less than one month, this would not constitute clustering. Similarly, if R. experienced many symptoms within a one week period when R. has been involved in hazing for a fraternity, for example, no clustering would result. For clustering to occur, symptoms do not have to all occur at the same time, or even on the same day. Rather, they must co-occur, being part of a pattern in which R. is experiencing several problems repeatedly, all within a span of one month to a few years.

- E40 *If any DSM-III-R item has been checked on the tally sheet, R. is asked for recency of this/these symptom(s). The tally sheet is divided into groups which are separated by dotted lines. Symptoms are checked on the left-hand side of the page and symptom groups are checked on the right. If at least one item is checked in a group, then the group is also checked. Be certain that R. understands that the recency should be the last time*

any problems occurred, and not the last time any problem occurred 3 or more times. If R. has endorsed E35B, E36 or E37A, than the recency coded should always be the date and age of last use.

E40A *If three or more DSM-III-R symptom groups are checked in different groups, R. is asked whether there was ever a period of a month or more when 3 or more symptoms (from 3 different groups) occurred together, and the onset and recency of this clustering (E40C).*

E40B *If only two groups are checked, R. is asked whether there was ever a period of a month or more when at least 2 symptoms coded in different groups occurred together, and the onset and recency of this clustering (E40C).*

INTERVIEWER BOX: THE INTERVIEWER SCANS ICD-10 ALCOHOL TALLY SHEET E FOR ANY SYMPTOMS AND IF ANY IS/ARE CHECKED, CONTINUES WITH E 41.

E41 *R. is asked the recency of ICD-10 symptom(s). Be certain that R. understands that this is the recency of the symptom happening once, and not 3 or more times. If R. has endorsed E35B, E36 or E37A, than the recency coded should always be the date and age of last use.*

E41A *R. is asked whether there was ever a period of a month or more when three or more symptoms (from three different groups) occurred together, and the onset and recency of this clustering (E41B).*

E41C *R. is asked whether 3 or more ICD-10 symptoms have occurred within the past 12 months.*

E42 *Each numbered question (E9,E10,E11...E37) is counted as one code "5", even if the question contains many sub-parts that are coded "5", with the following exceptions: E32/E32.H, E33/E33.D, E34/E34.D, E35/E35.B, E36/E36.C. Any of the preceding pairs count as two code "5"s. E42 will help determine whether R. continues past question M11 in the Antisocial Personality section.*

F. MARIJUANA

General:

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

Marijuana is usually smoked, but it can be ingested orally. It is often used in combination with other substances such as alcohol and cocaine. Symptoms associated with marijuana use include tachycardia, increased appetite, paranoid ideation, panic attack, listlessness and dysphoric effects following cessation of use. Maladaptive behavioral effects include impaired judgement and interference with social or occupational functioning. With cannabis abuse, use is episodic and the person exhibits symptoms of maladaptive behavior, such as driving while under its influence. According to a community study done from 1981-1983 using DSM-III criteria (as described in DSM-III-R), approximately 4% of the U.S. adult population has met DSM-III-R criteria for Cannabis Abuse at some time during their lives. Dependence is usually characterized by daily or almost daily use.

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

Question by question specifications:

- F3 Stress "longest" and "**almost** every day". Duration of use should be coded using the lowest common denominator, that is, if R. stated that the longest period of use was 1.5 months, code "0006 weeks".
- F4 A "whole" day is defined as all waking hours in a twenty-four hour period.
- F5 Stress "a month or more".
- F6 Stress "interfered with your functioning" and "for more than 24 hours".
- F6.5 Hallucinations with marijuana use are rare and usually mild. This question refers to hallucinations caused by marijuana use, and not where hallucinations were the expected effect of the marijuana, unless these were of particular severity and duration.
- F7 Unsuccessful efforts or persistent desire to stop or cut down during a pregnancy would count.
- F10.D Refers to either total number of times where a single withdrawal symptom occurred (F10) **or** total number of times where a clustering of withdrawal symptoms occurred (F10C), whichever R. has previously endorsed.
- F13 R. may either have given up important activities 3 or more times **or** may have given up important activities for a period of a month or more (or both) to count as a positive symptom.
- F17 All drugs including alcohol that R. has used in combination with marijuana should be recorded. The "3" code is to be used if R. **only** used marijuana together with alcohol.
- F18 Implies that R. initiated discussion of marijuana use with any health professional.

Clustering (F19, F20): Clustering is the occurrence of symptoms within a period lasting at least one month but possibly continuing for several years, or the recurrence of these symptoms within a several year period. If symptoms have occurred sporadically throughout the respondent's life (e.g., one problem when R. was 18, another when 25, another when 30), or have all occurred within a period of less than one month, this would not constitute clustering. Similarly, if R. experienced many symptoms within a one week period when R. has been involved in hazing for a fraternity, for example, no clustering would result. For clustering to occur, symptoms do not have to all occur at the same time, or even on the same day. Rather, they must co-occur, being part of a pattern in which R. is experiencing several problems repeatedly, all within a span of one month to a few years.

F19 DSM-III-R Tally sheet F should be checked for any symptoms, and if at least one symptom has been endorsed, R. is asked F19 (recency). Be certain that R. understands that the recency should be the last time any problems occurred, and not the last time any problem occurred 3 or more times. Onset and recency of clustering are asked if R. has answered yes to either F19A or F19B. If 3 or more symptoms (at least one symptom from 3 or more different groups) are checked R. is asked clustering of 3 or more symptoms F19A. If 2 symptoms are checked from different groups, R. is asked clustering of 2 symptoms (F19B). If R. has endorsed F6A or F12A then the recency coded should always be the date and age of last use.

F20 ICD-10 Tally sheet F should be checked for any symptoms, and if at least one symptom has been endorsed, R. is asked F20. Be certain that R. understands that the recency should be the last time any problems occurred, and not the last time any problem occurred 3 or more times. Questions F20.A, B, C are asked only if 3 or more symptoms are endorsed from different groups. If R. has endorsed F6A then the recency coded should always be the date and age of last use.

F21 This question is a tabulation of "yes" answers in separate questions, and not of the many "yes" answers that may be coded in sub-parts, with the following exceptions: F10/F10.A, F11.A/F11.C. Each question in the preceding two pairs counts as one "5". The skip instruction in the Antisocial Personality directs the interviewer to continue with questions past M11 if F21 is coded "5".

F22 Periods of abstinence lasting 3+ months during the period of marijuana use (if present) are obtained. The interviewer should work with R. to date any abstinent periods of 3 or more months, as they may be important in determining comorbidity. If R. cannot/will not date these periods, the interviewer should still obtain the total number of periods of 3+ months of abstinence. DK should be entered wherever R. is unable to provide month and/or year.

G. DRUGS

General:

*This is a fully diagnostic section that assesses drug abuse/dependence and incorporates the following diagnostic systems: DSM-III-R, Feighner, and ICD-10. The drug section is similar in form and content to the alcohol and marijuana sections. The interviewer hands R. a card that lists many licit and illicit drugs. If R. denies ever having taken drugs except when prescribed, in the amount prescribed, the interviewer is asked to verify any use by asking R., "So you have **never** used cocaine? Or stimulants? Or sedatives?" until each drug class has been verified as a definite "no". At this point R. would skip to the next section.*

G1 assesses the number of times R. has used drugs in each drug class as well as the onset and recency of use. If R. has tried several drugs, such as cocaine, stimulants, and hallucinogens, but no drug has been used 11 or more times, R. will be asked onset and recency of his/her drug use, and some other basic questions, and will then skip to the next section. If R. has used more than one drug in a single class, all will be asked about at the same time throughout the drug section. That is, if R. has used Quaaludes 3 times, Librium 4 times, and Secanol 4 times (and thus having used sedatives 11 or more times), the interviewer would ask about all three (i.e., "Quaaludes, Librium, and Secanol", and not just Sedatives). G1 assesses use of any drug: however the diagnostic drug section itself specifically focuses on the use of cocaine, stimulants, sedatives and opiates, as well as one other drug used most by R. The interviewer should circle all drugs that R. has used on card G2.

The interviewer should carefully check all drugs that R. has used. Using card G1 as a reference, R. may focus on illegal substances, without mentioning that s/he has abused prescription drugs unless specifically queried. It is especially important to check for prescription drug abuse if use was indicated in the Medical History section of SSAGA.

If R. has used hallucinogens, such as LSD, or a combination drug such as Speedballs, 11 or more times, this information should be recorded in the "5" or "Other" column of G2. The specific name or type of drug should be recorded in the space provided for later coding by the Editor. If R. has used two or more drugs that cannot be coded in the cocaine, stimulants, sedatives or opiates columns, as indicated by card G2, R. is asked about the drug s/he used the most, and this drug will be coded throughout the section in column 5. If R. says s/he used two other drugs the same number of times, ask about the one that caused the most problems. If R. has used T.'s and Blues 11 or more times, this should be recorded in the "Opiates" column.

Most symptom questions in the drug section are asked in rows, meaning that if more than one drug class has been coded in G2, R. will be asked whether the symptom was present for each coded drug class. So, for example:

I: Have you ever wanted to cut down or tried to cut down on a drug but found that you couldn't?

R: Yes.

I: Did this happen with cocaine?

R: Yes.

I: Did this happen with stimulants?

R: Yes.

I: Did this happen with opiates?

R: No.

Questions G11 and G13 are exceptions, coded by column, i.e. all symptoms are coded for one drug class and then for the next drug class, etc.

Question by question specifications:

G1 "Prescribed" refers to medications prescribed in R.'s name.

G1 Number of times used in life should be recorded for all drugs used in a particular class. If R. has used Valium 10 times and Librium 10 times, then s/he would have used sedatives 20 times. Code T's and Blues in the Combination column, and if used 11 or more times (or 11 or more times in combination with other Opiates) code T's and Blues as Opiates in G2 when continuing with the section.

G1A.1 The number of times prescription drugs were used when not prescribed or more than prescribed should be included.

G1D This question refers to the hypothesized "kindling" effect of cocaine. It is asked of anyone who has ever used cocaine.

G1G This is a general question that refers to sharing a needle for any drug use, and does not just refer to cocaine. The coding just happens to fall under the cocaine heading).

G1H "Favorite" is left up to R. to decide. It is not necessarily the drug used most, but the one R. enjoyed the most. Marijuana would be included here, but alcohol would not be. If R. claims no favorite drug, code "000".

G1I If R. states s/he has used two or more drugs together record all drugs used in combination. Alcohol does not count. If R. has any question about what constitutes "together", it would be drugs used at the same time or within two hours of each other. This would include illicit drugs as well as abused prescription medications.

G2 Note the **longest** period R. used DRUG "almost every day". Almost every day would mean at least 4 days out of 7. Code the lowest common denominator of time, for example, 1 year 2 months of use = 14 months of use.

- G3 A whole day is defined as all waking hours in a twenty-four hour period.
- G6 Stress "a month or more".
- G7 Unsuccessful efforts or persistent desire to stop or cut down during a pregnancy would count.
- G11A This question assesses withdrawal symptoms. Because not all withdrawal symptoms are common with each of the four classes of drugs, there are deliberately missing codes corresponding to symptoms that cannot apply to that particular drug. This question is to be completed by column, asking about one drug class completely (G11A-D) before moving on to the next class.
- G13E "Any problem" refers only to the problems mentioned in G13A-D.
- G15 In G15.1,.2,.3,and .5, stress "for more than 24 hours" and "to the point that it interfered with your functioning."
- G15.4 Refers to hallucinations caused by the drug use, and not where hallucinations were the expected effect of the drug (hallucinogens).
- G18A "Outpatient, other" refers to visits for treatment to a Doctor's office, including general Medical Doctors (General Practitioners) as well as Psychiatrists.
- "Other, specify" would include specific programs such as methadone clinics. This would include outpatient and inpatient methadone programs.

Clustering (G19, G20): Clustering is the occurrence of symptoms within a period lasting at least one month but possibly continuing for several years, or the recurrence of these symptoms within a several year period. If symptoms have occurred sporadically throughout the respondent's life (e.g., one problem when R. was 18, another when 25, another when 30), or have all occurred within a period of less than one month, this would not constitute clustering. Similarly, if R. experienced many symptoms within a one week period when R. has been involved in hazing for a fraternity, for example, no clustering would result. For clustering to occur, symptoms do not have to all occur at the same time, or even on the same day. Rather, they must co-occur, being part of a pattern in which R. is experiencing several problems repeatedly, all within a span of one month to a few years.

- G19 DSM-III-R Tally sheet G should be checked for any symptoms, and if at least one symptom has been endorsed, R. is asked G19 (recency). Be certain that R. understands that the recency should be the last time any problems occurred, and not the last time any problem occurred 3 or more times. If at least one symptom is checked in 3 or more different groups, R. is asked clustering of 3 (or more) symptoms (G19A). If at least one symptom is checked in 2 different groups, R. is asked clustering of 2 symptoms (G19B). Onset and recency of clustering are asked if R. has answered yes to either G19A or G19B. If R. has endorsed G12C.1, G12D.1, G13E, or G15A then the recency coded should be the date and age of last use.
- G20 ICD-10 Tally sheet G should be checked for any symptoms, and if at least one symptom has been endorsed, R. is asked G20. Be certain that R. understands that the recency should be the last time any problems occurred, and not the last time any problem occurred 3 or more times. Only if 3 or more groups are endorsed does the interviewer ask G20A-C. If R. has endorsed G12C.1, G12D.1, or G15A then the recency coded should be the date and age of last use.
- G21 This is a tabulation of whole symptom groups that are coded "yes" (5). So, for example, if G15.1, .2, .4, and .5 were coded 5 for every drug class coded, this would count as one symptom group per drug class. The tabulation is a total for all drug classes coded, but is not drug class specific, so coding 5 for G15.1, .2, .4 and .5, if 3 drugs were used and these were the **only** problems that R. had, the total symptom count would be 1 in

G21. The only exceptions to this would be the following "pairs", which would each count as a separate "5": G11/G11.D, G12.A1/G12.B1, G12.C1, G12.D1. This question will be referred to in the Antisocial Personality section to help determine whether R. will continue past M11.

G22 The interviewer is instructed to obtain 3 month periods of abstinence, if any exist, between the ages of R.'s onset and recency of use for each drug class.

H. EATING DISORDERS

General:

Section H, Eating Disorders, covers Anorexia Nervosa (H1-H9) and Bulimia Nervosa (H9-H15) and is fully diagnostic for DSM-III-R criteria. Two screening questions are asked for Anorexia Nervosa, and if the subject answers "no" to either a diagnosis of Anorexia is not possible and s/he skips to question H9. If the subject answers "no" to either H10 or H11 the rest of the section is skipped because a diagnosis of Bulimia is not possible.

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

The essential features of Bulimia Nervosa are: recurrent episodes of binge eating (a minimum average of 2 binge-eating episodes a week for at least one month); a feeling of lack of control over eating behavior during the eating binges; self-induced vomiting or use of laxatives or diuretics or strict dieting or fasting or vigorous exercise in order to prevent weight gain; and persistent overconcern with body shape and weight.

Question by question specifications: Anorexia

H2 Stress "**too thin**".

H3 This question elicits the subject's lowest weight, brought about by deliberate weight loss.

H3.A Ask only if R. does not know his/her lowest weight.

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

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

WOMEN - WRIST CIRCUMFERENCE

less than 5-1/2" - sm. frame
5-1/2" - 6-1/2" - md. frame
>6-1/2" and more - lg. frame

MEN - CHEST/SHOE SIZE

<38" chest or less, <8 shoe size - sm.frame
38"-44" chest, 8-10 shoe size - med. frame
>44" chest, shoe size >10 - lg. frame

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

H8 If the subject says that a medical disorder caused the weight loss, note the disorder and whether it was diagnosed by a doctor or other health professional.

Question by question specifications: Bulimia

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

H11 If duration requirement is not met, the interviewer skips to the next section.

H12 R. must perceive that eating was out of control.

H13 Assesses methods to prevent weight gain from binges. Exercising and dieting must be excessive and specifically used to counteract the binge.

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

I.DEPRESSION

General information:

This section is fully diagnostic for the following criteria systems: DSM-III-R, RDC (original and modified), and Feighner. SSAGA assesses both most severe and current (within the past 30 days) episodes. If R. has had at least one week of either feeling "depressed, sad, blue, or irritable, or not enjoying things s/he usually enjoyed", the full section will be administered. Even if the current episode does not meet full criteria, if another episode (most severe) meets criteria the diagnosis is made for lifetime. Diagnosis is made on the basis of most severe episode.

The diagnosis of Major Depressive disorder, is not made in SSAGA if an organic factor(s) initiated and/or maintained the disturbance, if the disorder was a normal reaction to the death of a loved one, or if delusions or hallucinations were (are) present for 2 weeks outside the period of abnormal mood. In addition, there must not be a diagnosis of mania or unequivocal hypomania if Major Depressive disorder is to be diagnosed. If a rule-out condition exists, R. is asked whether at least 1 other episode occurred, and if so, whether this episode differed, and how it differed from the episode just coded.

When symptoms may be confounded by substance use and a "clean" episode has been identified, the interviewer should verify with R. when reviewing questions I5 -I14 that the symptom occurred during a period when R. was "not drinking heavily/more than usual or taking drugs (whichever is relevant to R's situation), based on DSM-III-R tally sheets E, F and G.

Clean vs. Dirty: General Rules

Rule 1. A clean episode of depression is an episode that does not begin in the context of significant alcohol/substance use.

Rule 2. A dirty episode is any affective episode that begins during a period of substance use resulting in at least 3 substance-related problems (not necessarily in different groups) on the III-R tally sheets. Even though R. may initially say "no" to I4E because of the phrasing "drinking more than usual", if the depression begins during a period when 3+ symptoms are present, I4E should be coded "yes". Proceed to I4F in an attempt to identify a true **clean** episode.

Rule 3. If R. has an episode of depression beginning anytime within 6 weeks of abstinence from a given substance, this episode is considered **dirty**.

Scenario 1:

A 36 yo R. has had 3+ problems with alcohol and cocaine. His recency of clustering is 34 for both, at which time he stopped using these substances. He has also been using marijuana daily since the age of 20, with no problems. R. claims that his most severe episode of depression began at age 36. Is this clean or dirty?

According to rule #1 above and the screening in I4E, this episode is considered clean.

Scenario 2:

A 36 yo R. has had 3+ problems with alcohol and cocaine. His recency of clustering for alcohol symptoms is 34. His recency of clustering for cocaine symptoms is also 34. He began an episode of depression at age 36. However, he is still using both of these substances. Is this episode clean or dirty?

See rule #2 above. Because R. is experiencing no symptomatology, this is considered a **clean** episode. I4E would be coded yes, and R. would proceed with I4F. If no other totally substance free episode is identified, then this episode will be coded as the most severe. I4K may be coded as clean.

Scenario 3:

A 36 yo R. has had 3+ problems with alcohol. His recency of clustering is age 36 and during the time he was drinking, a depression began. He stopped drinking, the clustering of alcohol-related symptoms stopped, and the depression persisted for an additional 5 months. Is this episode clean or dirty?

According to rule #3 above and the screening in I4E, the portion of the depression including the first 6 weeks of abstinence from alcohol are dirty. However, this episode may be broken up into 2 episodes, the latter portion of which is clean, and can be coded as such.

Scenario 4:

A 36 yo R. has had 3+ problems with alcohol, cocaine, and marijuana. His recency of problems is 34 for alcohol and cocaine, at which time he stopped using these substances. He has also been using marijuana daily since the age of 20, and is currently still using and having one/two problem(s). R. claims that his most severe episode of depression began at age 36. Is this clean or dirty?

The threshold for defining problems according to rule #2 is 3+. Therefore, this episode is clean.

*** When in doubt about the status of a specific episode, obtain as much information as possible about an episode and contact the site clinician(s).**

Question by question specifications:

- I1,I2 Checks on inclusion criteria. If both coded "no", the remainder of the section is skipped.
- I3 Assesses presence of current episode, occurring within "past 30 days".
- I4 The most severe period is left up to R. to define. However, if R. gives an extremely long period (for example, 5 years), ask R. whether there was a period during this 5 year span that seemed a little worse. If R. can identify a shorter, slightly more severe period, use these dates and duration for most severe episode.
- I5 First symptom box of depression. Weight loss or gain of 5% of body weight within a month, or increase or decrease in appetite nearly every day is the DSM-III-R guideline for this symptom.
- I5E Make certain that the period of weight gain/loss coincides with the depressive episode, i.e., it cannot be longer than the stated period of depressed mood/loss of interest.
- I8 Checks for psychomotor retardation. These symptoms must have occurred to the extent that they were noticeable to others.
- I13 Emphasize more difficulty. This must be a change from R.'s usual state.
- I14 Thinking a lot about death or dying can be either R.'s death or the death of someone else. Frequent thoughts of death in response to mourning would count.
- I15 Checks the number of symptom groups (boxes) endorsed in I5-I14. If at least 3 symptom groups were positive, R. continues. If fewer than 3 positive, the interviewer goes back to I5 asking about the most severe episode, or (if already coding for the most severe episode), skips to the next section.

- I16A *This question establishes criteria necessary for DSM-III-R diagnosis. The interviewer determines whether four or more of the symptom groups endorsed in I5-I14 were present **nearly every day** for at least two weeks. Make certain that R. does not think symptoms must be present every day.*
- I16B-D *If R denies mood and loss of interest/enjoyment in either the current episode (I3 B&C) or the most severe episode [I4 C & D (or I4 I & J)], s/he is given a second chance to establish 4 or more symptoms clustering with mood/loss of interest.*
- I17 *Checks for the presence of psychotic symptoms during the episode of depression. The content of any delusions or hallucinations must be specifically detailed so that the interviewer can code I18 appropriately. All examples given by R. should be judged for plausibility, and vague examples such as feeling worthless, guilty, or simply a bad person should be coded as "no". Specific examples should be reviewed by a clinician to determine whether they are truly psychotic.*
- I17E *This is the duration of R.'s psychotic symptoms after his/her mood returned to normal.*
- I18 *Interviewer should code I18 silently. It must be determined if the psychotic symptoms mentioned in I17 were mood-congruent or mood-incongruent. DSM-III-R states that mood congruent psychotic features would be "delusions or hallucinations whose content is entirely consistent with ...a depressed mood" (p. 223, DSM-III-R). Therefore, these hallucinations/delusions should involve themes of either personal inadequacy, guilt, disease, death, nihilism, or deserved punishment. Mood-incongruent delusions/ hallucinations include such symptoms as thought insertion, thought broadcasting, and ideas of being controlled, where the content has no apparent relationship to the depressed mood. Persecutory delusions, common in psychotic depressions are considered mood-congruent. Any delusions that are manic in nature would be mood- incongruent.*
- I19-I22 *These questions determine what kind of help, if any, R. received for the depressive episode and is invaluable for determining level of impairment. If the subject received ECT (shock treatments), was hospitalized for two days or longer, or psychotic symptoms were present, s/he is considered incapacitated.*
- I22 *Hospitalization must be **for depression** and not secondary to alcohol or drugs.*
- I24 *This question focuses on disruption of major role to help determine level of impairment/incapacitation. If R. was completely unable to function in this role for 2 days or longer, s/he is considered incapacitated. If functioning continued, but there was a decrease in performance that was noticeable to others, then s/he was impaired. Major role is defined as the individual's full-time occupation (or in the case of someone who both works and manages the home, that which R. feels is his/her major role).*
- I24D *Assesses impairment in a minor role. A minor role could be social functioning, functioning at home if the major role is work, or functioning at work if the major role is school. The minor role that was affected must be specified.*
- I26-I31 *These questions are used to further delineate the depressive episode, by considering whether organic or non-organic factors were present to initiate or maintain the episode. Organic factors would include physical illness (hypothyroidism, Cerebrovascular accident (CVA), Stroke, Multiple Sclerosis (MS), Mononucleosis, Hepatitis, Cancer, Parkinson's, HIV, Cushings or other endocrine illnesses etc.), pregnancy, use of prescription medications (such as blood pressure medications-Propranolol, Inderal, Aldomet, Reserpine, Serpasil; sedatives or hypnotics, tranquilizers-Valium, Librium, Tranxene, Serax, Ativan; heart medication-Digitalis, Digoxin; or steroids-prednisone), or use of street drugs or alcohol. Normal bereavement following the death of someone close to R. (less than 6 months) and bereavement due to a third trimester*

abortion/miscarraige would also be a disqualifier for diagnosis of Major Depression. Careful documentation of these items will determine whether an episode discussed is "clean" or "dirty".

- I26 To count as "serious" an illness must be potentially life-threatening.*
- I32 Checklist to assess any (other) clean episodes.*
- I32F Include clean episodes already coded (if any) in total.*
- I33 Checklist to assess any (other) dirty episodes.*
- I33F Include dirty episodes already coded (if any) in total.*
- I34 Onset of first episode of depression and recency of the end of the last episode.*
- I35A Checks for overmedication following treatment for depression, or adverse reaction to drugs used in treatment.*

J. DYSTHYMIA

General information:

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

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

If a subject claims to have experienced low mood for a prolonged period, or even the majority of his/her life, determine whether there were breaks of 2 months or more when mood was normal (not sad, down or blue) so that this long period can be broken into shorter periods. If an individual has had an episode of Major Depression just prior to what s/he considers one prolonged period of dysthymia (for example 10 years), the episode should be broken into (at least) two periods, the first two years being listed in J1 (which will then be discounted in J2 because of the Major Depression), and years three through ten being recorded in J2B and J2C. If this episode is not broken into shorter periods by the interviewer (remembering that there needs to have been a minimum of 6 months remission following the Major Depression), then because of the Major Depression, the respondent will skip out when s/he reaches J2.

Question by question specifications

- J2 Checks for exclusion criteria. An episode of major depression during the first two years of the dysthymic period, or during the 6 months just prior to the onset of dysthymia would preclude making the diagnosis.
- J2A The interviewer should attempt to establish another period of 2 years or more when R. was sad, down or blue.
- J3 Checks for exclusion criteria. Use of street drugs, excessive use of alcohol, use of certain prescription medications, and serious physical illness would disqualify the dysthymic episode.
- J3A The interviewer must attempt to identify a "clean" episode. If a "clean" episode cannot be identified, complete the section anyway, obtaining information on the period initially identified in J3. Refer to page 41 in Depression section for a description of clean and dirty.
- J5 Checks for exclusion criteria. If a period of "normal" mood lasting two months or longer occurred during a two year period, this period is disqualified as being dysthymic.

K. MANIA

General information:

The Mania section of SSAGA is diagnostic for DSM-III-R, RDC and Feighner criteria. A Manic episode is defined in DSM-III-R as a period of abnormally and persistently elevated, expansive or irritable mood co-occurring with at least three out of a possible 7 manic symptoms, 4 if mood disturbance is only irritability. During a manic episode a person feels/acts clearly differently than his/her normal self. It is important to emphasize this sudden (and spontaneous) change in functioning, because most people have periods of time, usually event-related, where their mood may be elevated, and their behaviors altered. (An example would be elated mood following a marriage proposal, during which time a person might alter sleeping and eating patterns. Another example would be the feeling of elation after winning a competition).

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

Clean vs. Dirty: General Rules

- Rule 1. A clean episode of mania is an episode that does not begin in the context of significant alcohol/substance use.
- Rule 2. A dirty episode is any affective episode that begins during a period of substance use resulting in at least 3 substance-related problems (not necessarily in different groups) on the III-R tally sheets. Even though R. may initially say "no" to I4E because of the phrasing "drinking more than usual" and this represents approximately a 50% increase in alcohol consumption, if the depression begins during a period when 3+ symptoms are present, K3C should be coded "yes". Proceed to K3D in an attempt to identify a true **clean** episode.
- Rule 3. If R. has an episode of mania beginning anytime within 6 weeks of abstinence from a given substance, this episode is considered **dirty**.

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

Question by question specifications

K1A Includes a "3" code to indicate whether this change in mood occurred only at a time when R. was under the influence of a substance.

K1B Interviewer should not confuse irritability occurring only in specific circumstances (e.g., with the subject's spouse) with the generalized irritability characteristic of an irritable manic episode.

Includes a "3" code to indicate whether this change in mood occurred only at a time when R. was under the influence of a substance. Irritability that occurred during withdrawal from a drug would not count as a "3" code, and would be coded as "1".

- K1C Checks for persistence of symptoms. They must last throughout the day or intermittently for two days or more.*
- K1D Box for interviewer to code whether R denies mood disturbance in K1A and K1B.*
- K1E Checklist of manic symptoms. If R. has acknowledged a mood disturbance, interviewer asks whether symptoms were present during period of abnormal mood. If R. denied mood disturbance in K1A and B, interviewer provides R. with a second chance to proceed with the section by simply asking whether symptoms were ever present. However, whether or not R admits to mood disturbance in K1A or K1B, if at least 2 symptoms are not endorsed in K1E, R will skip to hypomania.*
- K2 Checks for current episode.*
- K2B Checks for organic (alcohol, street drug) exclusion factors.*
- K3C Checks for organic (alcohol increase of approximately 50%, street drug use) exclusion factors in most severe episode.*
- K3D Checks for "clean episode" if most severe is felt to be precipitated by drugs or alcohol. If there is a clean episode, this is the one that should be asked about.*
- K4-K10*
List of manic symptomatology. As in the Depression section, interviewer should not count chronic symptoms representative of a possible personality disturbance. Be certain that R. acknowledges a change from normal state when endorsing a symptom.
- K4 During manic episode, R. may be more promiscuous, more productive at work, and/or much more social than usual. R. may start many projects, etc.*
- K7 Emphasize "important". This question implies that R. has/had special talents or abilities that other people do/did not have, or has/had them to a much greater degree.*
- K8 Checks for sleep disturbance during Manic episode. Minor sleep pattern changes may not meet criteria for this symptom. Emphasize "need" as R. must feel rested after only a few hours of sleep. For example, needing 5 hours of sleep instead of 6 will not count as a manic symptom, whereas needing 3 hours instead of 6 would.*
- K9 Assesses distractibility, i.e., attention too easily drawn to unimportant or irrelevant external stimuli.*
- K11 A minimum of two symptoms are necessary, accompanied by the mood change, to continue with the section.*
- K12-K21*
*These questions are used to determine the level of impairment or incapacitation during the episode. If R. received ECT, was hospitalized, experienced delusions or hallucinations during the episode, was completely unable to function in principal role for at least two days, or was unable to carry on a conversation, then incapacitation will be coded. If there was a decrease in functioning but it was not severe enough to incapacitate the person, then impairment will be coded. Impairment would indicate a diagnosis of hypomania rather than mania. If, in question K20A or K21 R. indicates that s/he was much more productive, more energetic, etc., than this would be used to code improvement in functioning in K22. **Improvement in functioning**, would indicate that R. was able to do much more than usual, (write more, sell more, study more, etc.). Sometimes with a mild episode, the high energy level and reduced need for sleep leads to what R. perceives as improvement in his/her functioning.*
- K13A Behavior during the episode must have caused problems for others.*

- K14 *Determines whether psychotic symptoms were present, and if so, whether they persisted outside the period of altered mood.*
- K18 *Hospitalization must be for the manic episode.*
- K23 *Emphasize "serious". Relevant illnesses include Multiple Sclerosis, HIV, Hyperthyroidism, Lupus, Cushing's, Brain Tumors, and Encephalitis.*
- K25 *Determines whether R was using cocaine or other street drugs or drinking more than usual just prior to the manic episode. The interviewer must specify what substance R. was using, and in the case of alcohol, how much s/he was drinking normally, and then just prior to the episode.*
- K26 *Determines the presence of additional clean episodes.*
- K28 *Total number of clean episodes, including those already coded.*
- K29 *Checks whether R. ever experienced an episode with mixed affective states, e.g., R.'s mood was elevated or expansive at the same time R. was experiencing depressive symptoms.*
- K30 *Checks for periods of rapid cycling between mania/hypomania and depression.*
- K31 *Checks for the presence of hypomania, if no manic episode has been coded. Record example and follow exclusion rules as stated. Periods occurring as part of Pre-menstrual Syndrome (PMS) count -make a note of this in the margin.*

L. PSYCHOSIS

General information:

Section L, Psychosis, is a non-diagnostic survey of the subject's experiences of delusions and hallucinations. It is adapted for SSAGA from the SCID-P, and screens for subjects who might have a psychotic disorder. Delusions are fixed false beliefs, such as the idea that one's personal thoughts are being broadcast by national television. Delusions are based on incorrect inference about external reality and are firmly sustained in spite of what almost everyone else believes and in spite of what constitutes incontrovertible and obvious proof to the contrary. Hallucinations are false sensory experiences: seeing, hearing, smelling, tasting or feeling something which is not present. Hallucinations are sensory perceptions without the external stimulation of the relevant sensory organ. Examples are: feeling bugs crawling all over one's skin when they are not; seeing Martians and vampires seated at the dining table; hearing the voice of a dead relative.

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

Question-by-Question Specifications

- L1 Checks for auditory hallucinations. These hallucinations must occur when the respondent is **fully awake**, and can be heard either inside or outside his/her head.
- L1A The respondent must have heard more than two words, and these words must have been heard more than twice. They must have no apparent relation to depression or elation.
- L1C Checks to see whether there was a voice keeping a running commentary on the respondent's behavior or thoughts as they occurred.
- L1D Checks to see whether two or more voices were conversing with each other. If R. heard noises and not voices, code "00".
- L2 Checks for visual hallucinations experienced by the respondent while completely awake. The interviewer should be certain to distinguish hallucinations from illusions, misperceptions of real external stimuli. Illusions should not be coded.
- L3 This item checks for tactile hallucinations (e.g., electricity, bugs).
- L4 This item checks for olfactory hallucinations.
- L6 This item checks delusions of reference (i.e., personal significance is falsely attributed to objects or events in the environment).
- L7 This item assesses grandiose delusions, the content of which involves exaggerated power, knowledge, or importance.
- L8 This item assesses somatic delusions, the content of which involves change or disturbance in body functioning.

- L9 *This item assesses persecutory delusions, i.e., that the individual (or his/her group) is being attacked, harassed, cheated, persecuted or conspired against. These beliefs are paranoid in nature, and R. must feel that people want to hurt, persecute, or plot against him/her for no apparent reason.*
- L10 *Assesses (other) delusions (guilt, jealousy, nihilism, poverty).*
- L11 *This item assesses delusions of being controlled, i.e., feelings, impulses, thoughts or actions are experienced as being under the control of some external force. This question does not include people who feel dominated or directed by others (such as parent or spouse). This question seeks to identify persons who believe that someone or something outside of themselves is controlling their thoughts or actions against their will.*
- L11A *Checks for delusions of thought insertion. This belief that someone or something outside of R.'s control was forcibly putting thought into R.'s head is perceived by the respondent as an unwanted, intrusive violation of personal integrity.*
- L11B *Checks for delusions of thought withdrawal, the idea that R.'s thoughts are literally removed from his/her head against his/her will, leaving R. devoid of thought.*
- L12 *This item checks for thought broadcasting, a delusion that one's thoughts are audible to others.*
- L13 *This item attempts to determine whether the respondent's delusions are systematized, i.e., a single delusion has multiple elaborations, or a group of delusions are all related to a single event or theme.*
- L13A *This item asks the respondent's understanding of the content of his/her delusions coded in L5-L12 to assess whether they are an acceptable part of R.'s subculture, or whether they are bizarre. Bizarre delusions are those that involve a phenomenon that R.'s subculture would regard as totally implausible. (An example would be thought broadcasting or being controlled by a dead person).*
- L14 *Assesses whether delusions (non-bizarre or bizarre) or hallucinations ever lasted for 6 months or longer. Non-bizarre delusions are simply unlikely, not totally implausible. An example of a non-bizarre delusion is the belief of a 90 year old bedridden man in a nursing home that he is having a torrid affair with a young nurse. On the other hand, if he believed that he was romancing a Martian, his delusion would be considered bizarre.*
- L14A *Checks for impairment in functioning due to the delusions/hallucinations.*

M. ANTISOCIAL PERSONALITY

General:

The Antisocial Personality (ASP) section of the SSAGA is fully diagnostic for DSM-III-R Conduct Disorder, Feighner Antisocial Personality Disorder, and ICD-10 Dissocial Personality Disorder. The combination of ICD-10 Childhood Conduct Disorder and Adult Dissocial Personality Disorder is equivalent to Antisocial Personality Disorder. All diagnostic systems require the onset of problem behaviors in childhood or early adolescence that continue into adulthood.

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

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

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

When obtaining AGE ONS (and ONS A/D), if R. states that a behavior occurred at the age of 15 it is essential that the interviewer check whether the behavior occurred before R.'s 15th birthday. This age cut-off is essential for the DSM-III-R diagnosis of Antisocial Personality.

The SSAGA provides for an examination of the relationship between ASP, Conduct Disorder, and substance use (drugs/alcohol). Persons with few behavioral problems and no significant substance use problems as children seldom display antisocial behaviors as adults. Therefore, the ASP section of the SSAGA can be terminated for those persons who do not exhibit 2 or more childhood behavior problems. As previously stated ASP, by definition, begins before the age of 15 and cannot be diagnosed if behavioral problems did not occur before this age. However, the frequency of antisocial behavior among persons with substance abuse/dependence may be high. Therefore, the shaded box after M11 instructs interviewers to administer the full ASP section to all subjects who report two or more substance-related problems.

Question by Question Specifications:

- M1 "Hooky" refers to not attending school for an entire day (not cutting class) when expected to - even if parents are aware of the absence. This would include R. telling parents that s/he is sick when s/he is not and parents then giving permission for R. to stay home. "Twice in one year" means twice in one school year, that is September to June.
- M2 R. must have been expelled from school for behavioral/disciplinary reasons. Thus, expulsion due only to poor grades does not count.
- M3 Stress running away overnight. Running away to avoid physical and/or sexual abuse does not count. Running away implies that the caregiver was not aware of the location of the child. If R. ran away from one parent to be with the other parent, the first parent must not know where R. went in order for the symptom to count.
- M4 "A lot " should be emphasized and, as always, R. defines a lot. Ask M4.A before coding as lies told to avoid physical and/or sexual abuse do not count. Also, if lying only occurred when R. was under the influence of drugs or alcohol, code "3" rather than "5". False identification, often used by adolescents to purchase alcohol or gain access to clubs, counts as using a false name or alias. Stage or pen names do not count as aliases.
- M4B R. is asked for the age when s/he first "told a lot of lies", not when s/he first told a lie.
- M5 Interviewer should emphasize "more than once."
- M5D "Forgery" means forgery in the legal sense (i.e. without permission). A child signing his/her parents name on a report card to avoid showing the report card to his/her parents would count. Do not count if a parent allows a child to borrow a credit card.
- M6 "Damaged" includes egging houses/cars, smashing mailboxes, soaping windows, stealing street signs, etc. Egging houses/cars, soaping windows and toilet papering trees would not count if only done as a prank on Halloween.
- M7 Refers to **initiating** physical fights. Emphasize "starts fights" and "other than with your brothers or sisters".
- M7B Read introduction in parentheses if M7=1. These are physical fights involving R., whether or not s/he started them. Fighting, or getting into frequent fights as part of one's job (bouncer, police officer) does not count. The age of onset **must** be at least 15.
- M8 Refers to the use of any violent weapon such as sticks, guns, knives, clubs, rods, chains, spikes, baseball bats and brass knuckles.
- M9 Read introduction in parentheses only if R. reports fighting. Do not include minor things like pulling hair. The term "injured" indicates a certain level of severity. Physically injuring siblings on purpose counts.
- M10 Only moving violations, including DUI's and DWI's, count. Do not include tickets for parking violations, not wearing a seatbelt, burned out tail light, improper registration of vehicle, etc. Do not count moving violations to non-motorized vehicles (such as bicycles). The exception to this exclusion would be multiple tickets/citations indicating negligence in the maintenance of a vehicle.
- M11B Note that arrests are being counted, not convictions. Count an arrest even if the subject was not convicted of the crime for which s/he was arrested.
- M11C The definition of a felony, according to Webster's Dictionary, is any crime for which punishment by federal law may be death or imprisonment for more than one year.

M11E Determines whether R. has been arrested after being released from jail (for something other than drugs or alcohol) and has thus been unable to profit from experience.

SKIP BOX AFTER M11

If less than two AGE ONS are less than 18, and if E42, F20, and G20 are all coded 1, then F. will skip out of ASP at this point.

M12 Assesses persistent refusal to conform to rules imposed by adults. Defiance must be frequent, and cannot be passive.

M13 "Temper tantrums" implies spontaneous and unjustified outbursts as a child in order to get what is desired. "Often" should be stressed.

M14 This question implies physical or emotional injury to other children. "Being mean" includes verbal abuse toward other children, name calling, and taunting.

M15 Do not include exterminating rats, mice or insects. Killing animals by hunting or fishing does not count. If the animal was the aggressor, and hurting the animal was self-defense, this does not count.

M16 Do not include the occasional lighting of matches as a way to "show off" to peers, or fires set accidentally. Do not include turning on the stove when told not to do so by an adult. Do include small fires, such as burning paper and twigs either outdoors or indoors which are set deliberately and without adult approval. Include uncontained fires such as lawn burning.

M17 This question elicits chronic, profound deceit; lying for its own sake rather than for any particular end. It also implies awareness of rules and deliberate and ostentatious breaking of these rules. The subject gets a kick out of deceiving others. Emphasize "to the point that you would go out of your way to put something over on them."

M18 "Break into" means forcible or illegal entry. This may include slashing a screen door, breaking a window, crawling in through an unlocked window, or finding and illegally using a house key. It does not include means taken to get into one's own house or car when locked out.

M19 "Threatening them" means threatening to do bodily harm. No weapon need be present.

M20 ICD-10 and DSM-III-R require age of onset before the 15th birthday listed in all 5.*

M21 Interviewer should emphasize "could have been arrested for." No arrest need have been made.

M21.2 Buying stolen property means acting as a "fence" i.e., buying with intent to resell or buying for personal use despite knowing the object had been stolen. Selling stolen property includes selling property from one's own thefts or acting as an agent for a thief. Legal gambling (Las Vegas) does not count.

M21.3 Payment for sex may have been in any form, including money, drugs, jewelry, property, clothes or maintenance (as in a "Sugar Daddy" type relationship.) Masturbating people as part of one's job in a massage parlor counts.

M21A R. is asked whether s/he has done anything else that s/he could have been arrested for even if s/he wasn't. Do not ask R. to elaborate. Curfew violations as a child do not count. If R. states that s/he has driven drunk (e.g., here or in the alcohol section), this does not count as an arrestable behavior. Traffic violations, such as speeding, do not count.

M21B This question asks if R. has done any of these behaviors three or more times.

- M22 *If R. is 18 at the time the interview is administered, even if R. has had a friendship/love relationship that has lasted continuously for more than one year, this question must be coded "no", which in this case would mean "not applicable".*
- M23 *Includes heterosexual and homosexual intercourse. Rape is not included as first sexual intercourse. Masturbation is not included. This must be the first sexual intercourse that R. willingly took part in.*
- M23A *This question addresses promiscuity. Both homosexual and heterosexual relations count. Petting does not count. The subject's spouse does count as a partner. If R. was raped, do not count as partner (must be voluntary).*
- M24 *Relations may be either homosexual or heterosexual.*
- M24A *If R. has not had a sexual relationship lasting even a year this question would be coded "no", which in this case would mean "not applicable".*
- M25 *Any infidelity would count, including open-ended and agreed upon liaisons that might occur in "open marriage" situations.*
- M26 *Masturbation and oral/genital contact count. Petting should be judged on a case-by-case basis.*
- M27 *The subject may have been officially or unofficially accused of child abuse (officially by a doctor, policeman, or social worker; unofficially by a neighbor, relative or friend). Do not ask R. to elaborate on the accusation of child abuse.*
- M29 *Do not include job changes that R. volunteers were due to life transitions such as graduation, marriage and maternity, and do not include seasonal summertime employment of full-time students. This question is looking for the person who "job hops". Also, if a person has both a full and part-time job, changes in his part-time job do not count-it is changes in main job only.*
- M29A *"Enrolled in and dropped out of 3 or more academic programs" does not include changing majors while in school.*
- M30 *Absences count as positive even if R. says his/her boss did not find out or he/she did not get into trouble. Coding here is in the usual manner (e.g. possibly due to medical condition, due to alcohol, etc.).*
- M31 *This question identifies persons who had at least six months of unemployment in the last five years. Periods of time that R. wanted a job but could not find one, periods that R. did not work because he/she did not want to, periods of time that R. did not work due to psychiatric disability all count as unemployment. If R. has seasonal work (e.g.,farming or construction), the usual layoff season is not counted as unemployment. If R. is involved in legal action(s) to regain a job after being terminated and is not working another job although fit and able to work, the period of time from R.'s job loss to the legal resolution of R.'s suit would not count as a period of unemployment.*
- M32 *This question asks about wanderlust or vagrancy. It implies that R. has/had no fixed address. These individuals have no regular place to live, and move from friend's house to friend's house, or sleep in shelters, or on the street. The interviewer should not include people whose only travel without prior arrangements was during vacation or while on leave from job or school. Emphasize "a month or more".*
- M34.1 *This includes being remiss in alimony/child support payments.*

- M34.2 This does not include being outside in the yard while the children are inside ("within earshot"), but does include going to a neighbor's house or running a "quick" errand of 30 minutes or longer. Do not count emergency situations.*
- M34.3 Implies persistent neglect. Emphasize that a neighbor must have assumed child care responsibility. Do not count emergency situations.*
- M34.5 Interviewer should emphasize "because you spent the money on yourself".*
- M35 This implies that the wishes of R. and those of the others are not the same, and not just that others were not consulted about their wishes.*
- M36 The intent of this question is to identify the person who has been constantly irritable and/or frequently loses his/her temper with family members, co-workers or others. This irritability frequently leads to arguments and/or fights.*
- M37 The intent of this question is to determine whether R. claims responsibility for the troubles/mistakes in his/her life.*
- M37A The intent of this question is to determine whether R. shifts blame for his/her mistakes onto others, therefore making R. a "victim".*
- M38 Interviewer should ask M38 if at least one item is checked on Tally Sheet M. The intent of this question is to determine whether R. felt remorse for any behavior(s) that negatively impacted others.*
- M38A The intent of this question is to determine whether R. feels justified in having harmed or taken advantage of others.*

N. SUICIDAL BEHAVIOR

General information:

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

Question by question specifications

N1A-D Check for onset, persistence and severity of suicidal thoughts.

N3 If multiple suicide attempts were made, record the method of the most serious attempt, determined by asking R. which attempt s/he considers to be the most serious. This could be the attempt that R. was certain would be lethal, or it could be the attempt that caused the most serious medical consequences.

N5 Medical treatment does not include psychiatric care.

N6 Hospital admission after the attempt must be for treatment of physical trauma caused by a suicide attempt. Admission to a "close watch" unit to prevent R. from doing harm to him/herself does not count.

N9 If multiple suicide attempts were made, reiterate to R. that this question refers only to the most serious attempt.

N10 Lethality, the actual seriousness of the suicide attempt, is coded by the interviewer. The interviewer uses information obtained in N3, N5 and N6 to assess lethality.

N11 Intent, coded by the interviewer, represents R.'s desire to actually die. The interviewer codes intent based on R.'s response to N7 and N8. Although examples are given for each level of lethality, choosing the severity level that best represents R.'s most serious attempt may prove difficult. As always, when in doubt, the issue may be brought to the attention of a clinician. For this reason, the more specific the details of R.'s suicide plan and/or attempt, the easier the codification process.

O. PANIC

General Information:

The Panic Disorder section of SSAGA is fully DSM-III and DSM-III-R diagnostic. The section is also fully diagnostic for Anxiety Neurosis, the anxiety disorder detailed by Feighner Criteria. The essential feature of Panic Disorder is recurrent panic (anxiety) attacks with unpredictable onset. Each attack, marked by unambiguous onset and termination, can last from minutes to hours. Panic attacks typically begin with the sudden onset of intense apprehension, fear and terror, often accompanied by feelings of impending doom. People who experience panic attacks often develop fears of certain situations associated with the attacks (secondary phobias). During at least some of the attacks, at least 4 of the 13 symptoms listed in DSM-III-R must develop suddenly and increase in intensity within 10 minutes of the beginning of the first symptom noticed in the attack. The most common symptoms of panic attacks are shortness of breath, palpitations, chest pain or discomfort, choking or smothering sensations, and the fear of "going crazy" or doing something uncontrollable during the attack.

For a definite diagnosis, DSM-III requires 3 attacks within a 3-week period. DSM-III-R requires four attacks within a 4-week period. These attacks must not be precipitated by exposure to a specific phobic stimulus, cannot be a reaction to a life-threatening situation, and cannot be due to marked physical exertion. It is important to distinguish Panic Disorder from Simple Phobia and/or Social Phobia. People who meet DSM-III-R criteria for a specific phobic stimulus may experience panic attacks immediately before or upon exposure to this stimulus. The attacks in Panic Disorder, by definition, must be unexpected, i.e., the person never knows if or when an attack will occur in a given situation. People with panic disorder may have simple and/or social phobias.

The 1 2 3 4 5 probing pattern is used in question O1 to determine the etiology(ies) of the panic attacks. Withdrawal from some substances (e.g., barbiturates) and intoxication resulting from some psychoactive substances (e.g., caffeine or amphetamines) may induce panic attacks. Persons with alcohol abuse or dependence commonly experience anxiety attacks, particularly when hung-over. Certain medical conditions, such as mitral valve prolapse have a strong association to Panic Disorder. In addition, symptoms produced by allergic reactions to certain foods and food additives (monosodium glutamate-MSG) may be similar to those seen in panic attacks.

Question by question specifications:

- O1 An example must be elicited prior to coding. If the example does not qualify as a panic attack, code "1" and skip to section P. R. must have experienced the attack, not simply thought it likely to occur in a given situation.
- O3 Emphasize a month or more.
- O4 R. must select one of his/her worst attacks and determine which symptoms occurred during the attack. After every few symptoms interviewer should reiterate "During this worst spell..." so that all symptoms coded occurred during the same (worst) spell.
- O6 Checks both whether symptoms were unexpected **and** whether they worsened rapidly.
- O10 Both prescription medications and abusing alcohol and/or drugs counts.

P. AGORAPHOBIA

General Information:

Questions P1-P6 assess Agoraphobia. Agoraphobia is a fully diagnostic section incorporating DSM-III, DSM-III-R and RDC Criteria. Agoraphobia is defined in DSM-III-R as: "...As a result of this fear, the person either restricts travel or needs a companion when away from home, or else endures agoraphobic situations despite intense anxiety. Common agoraphobic situations include being outside the home alone, being in a crowd or standing in a line, being on a bridge, and traveling in a bus, train, or car." The most disabling of the phobic disorders, Agoraphobia is so debilitating that some persons are unable to leave their home for months or years at a time. Although agoraphobics are often crippled by fear, they rarely require hospitalization. Agoraphobia usually develops in the mid-to-late twenties, almost never occurring before 18 or after 35 years of age. Agoraphobics may experience one or more spontaneous panic attacks that lead to anticipatory anxiety. These in turn lead to phobic avoidance.

According to DSM-III-R, Agoraphobics fear having a limited symptom attack, that is developing a small number of panic-like symptoms, and this fear causes incapacitation. Agoraphobics fear being in places or situations from which escape might be difficult (or embarrassing) or in which help might not be available in the event of suddenly developing a symptom(s) that could be incapacitating or extremely embarrassing. The agoraphobic stays in the house and avoids open spaces and public places, to be secure in familiar surroundings in case an attack occurs. The initial phase of agoraphobia often consists of recurrent panic attacks, and the anticipatory fear of having another attack often causes the agoraphobic to refuse to enter situations in which such attacks were previously experienced. Although the severity of the disturbance waxes and wanes, the avoidance of a wide range of frequently encountered situations may grossly interfere with social functioning and job related activities. Agoraphobics, dominated by their fears and avoidance behaviors, increasingly restrict their range of activities. The agoraphobic person may become housebound or may refuse to leave his/her home if unaccompanied.

Question by question specifications

- P1 Describes agoraphobic situations. The interviewer is asked to pause at the end of each sentence so that R. can more easily understand and process the detailed description and the examples provided.
- P2 Specific agoraphobic situations are queried. The interviewer probes using the general probing pattern to code the agoraphobic situation. Obtain example of phobic situation and response.
- P3 Checks for typical symptoms experienced by R. while in agoraphobic situation(s) coded in P2.
- P4 The interviewer should obtain a specific example of what R. did to avoid an agoraphobic situation.
- P5 Checks for exclusion criterion. In order to meet criteria for Agoraphobic Disorder R. should never have met criteria for Panic Disorder. If s/he did meet criteria for Panic Disorder, the diagnosis would be a subtype of Panic Disorder (Panic Disorder with Agoraphobia).
- P6A Checks the efficacy of obtaining relief from agoraphobic fears by self-medicating with alcohol, drugs, and/or prescription medication.

P. SOCIAL PHOBIA

General Information:

The Social Phobia section is fully diagnostic section for DSM-III, DSM-III-R, and RDC Criteria. Social Phobia is a persistent fear of one or more situations in which the subject is exposed to possible scrutiny by others, and fears that s/he may do something or act in a way that will be humiliating or embarrassing. The essential feature in Social Phobia is intense, irrational fear of situations in which an he/she may be exposed to scrutiny or evaluation by others and is accompanied by a compelling desire to avoid such situations. During some phase of the disturbance, exposure to the specific phobic stimulus (or stimuli) almost invariably provokes an immediate anxiety response (e.g., palpitations,

trembling, difficulty breathing, blushing, or shaking, etc.). If the phobic situation(s) cannot be avoided, it/they must be endured with intense anxiety. Many people feel uncomfortable in some social situations, especially (for example), public speaking. The person **must** recognize that his/her fear is **excessive or unreasonable**. The avoidant behavior interferes with occupational or with usual social activities, or relationships with others, or there is marked distress about having the fear. DSM-III-R notes that social phobias involving fear of public speaking and generalized fear of most social situations tend to be fairly common, while social phobias related to writing or eating in public and using public lavatories are much more rare.

The lifetime prevalence rate of Social Phobia in the general population is only 2.7%. Many cases of social phobia are unreported because people with this disorder are often adept at avoiding the phobic stimulus/stimuli. Moreover, since the disorder rarely results in incapacitation, people with social phobia may escape physician's notice. Social phobias may interfere with career advancement or impede achievement of educational goals. Social phobia may exist comorbidly with Agoraphobia, simple phobia, or any other psychiatric disorder.

Question by question specifications

- P7 Social phobia must be distinguished from social uneasiness or shyness, which is quite common. DSM-III-R states, "The social phobic fear may be circumscribed, such as fears of being unable to continue talking while speaking in public, choking on food when eating in front of others, being unable to urinate in a public lavatory, or having a hand tremble when writing in the presence of others. In other cases the fear(s) of the social phobic may involve most social situations, such as general fears of saying foolish things or not being able to answer questions in social situations."
- P8 Differentiates between Panic Disorder and Social Phobia.
- P12 Checks for awareness of fear as being unreasonable or excessive.
- P13 Checks for exclusion criterion. If R. has had panic attacks (O1 coded 3,4, or 5), the fear of the situations coded in P7 must be unrelated to the fear of having a panic attack.
- P14 If R. meets/met criteria for Anorexia Nervosa and/or Bulimia Nervosa, the fear(s) coded in P7 must be unrelated to the eating disorder. The anorexics fear of exhibiting the abnormal eating behavior, for example, would be coded "5", and would not be considered a social phobia.

Q. OBSESSIVE-COMPULSIVE

General Information:

The Obsessive-Compulsive Disorder section of the SSAGA is fully diagnostic for DSMIII-R and RDC criteria. The essential features of this disorder are recurrent obsessive thoughts and/or irrational compulsive behaviors that a person feels compelled to perform. The obsessions or compulsions are severe enough to cause marked distress, be time-consuming, or significantly interfere with a person's normal routine (e.g. occupational functioning, or usual social activities or relationships with others).

Obsessions are persistent distressing thoughts or impulses experienced as unwanted and senseless, but irresistible. The most common obsessions involve thoughts of violence (e.g.,injuring one's child), contamination (e.g., becoming infected by shaking hands), and doubt (e.g., repeatedly wondering whether one has performed some act, such as having hurt someone in a traffic accident). Compulsions are purposeful, repetitive, intentional behaviors that are performed according to certain rules, or in a stereotyped fashion. Compulsive acts may vary from harmless behaviors (such as not stepping on sidewalk cracks) to time consuming rituals which interfere with everyday activities. The purpose of the behavior is to neutralize discomfort or prevent dreaded future situations or events. The most common compulsions involve hand-washing, counting, checking, and touching.

Obsessive-Compulsive Disorder (OCD) was previously thought to be quite rare, but recent studies show a 2% lifetime prevalence rate of the disorder in the general population. In addition to obsessions and compulsions, people suffering from OCD generally exhibit indecisiveness, highly controlled emotions, concerns about cleanliness and neatness, and rigidly structured lifestyles (both work and leisure activities).

The important point to emphasize is that the compulsive behaviors are senseless and intrusive, and that they are performed to make the individual feel less anxious.

Question by question specifications

- Q1 Checks for obsessions thus, feelings of guilt or persistent thoughts of needing to lose weight are not counted. Distinguish obsessive brooding (thinking repetitively about unpleasant circumstances or about possible alternative actions) from obsessions. Brooding thoughts are not experienced as senseless because the ideation is regarded as meaningful, although possibly excessive. Thought insertion, the idea that thoughts are being put into R.'s mind (a psychotic symptom) does not qualify. R. must believe that his/her thoughts are excessive or unreasonable.*
- Q3 Checks for compulsions. Emphasize "over and over" and "doing things in a certain order".*
- Q4 Checks for severity of obsessions/compulsions by determining whether they caused discomfort for R. or interfered a lot with his/her life or activities.*
- Q5 Checks for persistence of the obsessive thoughts and/or compulsive behaviors. Stress "more than one hour at a time".*

T. Interviewer Observations*

General:

All items on this rating sheet refer to behavior, attitudes, cognition, and appearance at the time of testing. If a subject describes many fights in his/her past but is totally cooperative and congenial during the assessment, do not check "aggressive." Similarly, if an individual recalls paranoid episodes but does not act this way during the interview, do not rate him/her as suspicious.

A second point is to be sure and look at all items under any category before deciding whether a subject was normal. Your first impression may be that an individual was within normal limits; after reading specific items, however, you may decide otherwise.

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

Item by Item:

A. Facial Expression

The terms in this category are not technical and should be self-explanatory.

B. Dress

4. Seductive can apply to males as well as females. In males, for example, it can take the form of clothing which emphasizes the torso to an inappropriate degree for an interview (open shirts, etc.).

5. Inadequate refers to two possibilities: an individual may be overdressed for warm weather or underdressed for cold weather. Look for blatant instances of either.

C. Motor Activity

1. Increased amount overlaps somewhat with constantly fiddling but is focused primarily on "major motor" phenomena such as frequent walking or pacing. Fiddling is more concerned with small motor movements like tapping a pencil or a foot.

4. Tics are "Any brief, recurrent, inappropriate irresistible movement involving a relatively small segment of the body...(e.g., yawning, sniffing, spasmodic cough, spitting)...coordinated rhythmical movements involving the jaw, lips, tongue, and palate...grimacing, blinking, shrugging, wry [twisted] neck..." Note that tics can include noises and words.

5. Tremor refers to "shaking or trembling" which can occur while the patient is at rest or, in some cases, only when he or she makes a voluntary movement. Another type of tremor consists of involuntary twitching of muscles such as those around the eyes. They belong here rather than under "tics."

D. Flow of Thought

1. Blocking: "Sudden cessation in the train of thought or in the midst of a sentence. The patient is unable to explain the reason for the sudden stoppage." (Bleuler, quoted by Campbell). "The patient suddenly becomes silent, immobile and unresponsive and after a few moments becomes animated again and begins speaking" (Taylor). Blocking should not be confused with unsuccessful attempts to recall information ("I'm blocking on that name").

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

E. LEVEL OF CONSCIOUSNESS

3. Stupor: A level of alertness between drowsiness and unconsciousness; "...sensibilities are deadened or dazed and the subject has little or no appreciation of the nature of his surroundings" (Campbell)

F. SPEECH

3. Push of speech: R (respondent) has a strong drive to talk, often rapidly. It may be difficult to interrupt him or her.
7. Mute means R exhibits no speech.
10. Neologisms are approximations of real words: "I can't rutton this shirt" (Taylor). Usually the correct form of the word is readily identifiable. These should be distinguished from malapropisms or mispronunciations due to lack of education.

G. INTERVIEW BEHAVIOR

For many of the following items, no single behavior is "diagnostic." Instead, you will judge their presence through your extended interactions with the individual.

1. Angry Outbursts overlaps closely in meaning with Irritable, Hostile, Aggressive, Manipulative, Uncooperative, and Negativistic. Some discrimination is possible, and a positive rating on one trait should not always imply a positive rating on the others. Outbursts are discrete, brief episodes of yelling or similar behavior. Irritable behavior is more subtle and can be more long-lasting; a subject might show impatience, for example, throughout the interview. Hostile individuals are not necessarily irritable, and they might not have angry outbursts, but their attitude should be manifested in some nonverbal or verbal behavior during the interview (e.g., angry looks or antagonistic statements). Aggressive subjects may literally push the interviewer or dominate them verbally to an extreme degree. Manipulative individuals also tend to get their way, but not necessarily through hostile tactics--they might, for example, persuade the interviewer to shorten a session because of fatigue. Uncooperative is an umbrella term for subjects who intentionally, for one reason or another, don't fully comply with the interview. Negativistic subjects interpret themselves, others, and/or events in a bad or pessimistic light. They might not be angry, but could be depressed instead.

3. Impulsive behaviors are performed suddenly and with insufficient forethought. They may be motoric (e.g., jumping up and running to get a candy bar), verbal (e.g., blurting out an answer to a question before it is finished), or cognitive (e.g., not thinking through the answer to a question).

6. Sensitive here means an individual who is overly reactive to criticism or teasing ("thin-skinned"). It does not, in this context, refer to people who are empathic to others' distress.

7. Apathetic subjects usually have blunted affect. For example, s/he may show little affection for significant others and evidence no plans or enthusiasm for the future.

8. "The withdrawn person appears aloof, detached, disinterested, removed, and apart..."(Campbell).

9. Evasive subjects are more deliberate than indecisive individuals; the interviewer should sense that an intentional cover-up is taking place.

10. A passive subject is one who (a) appears to take little initiative; (b) doesn't question what he or she is asked to do; and/or (c) delays, forgets, or otherwise incompletely performs requests.

12. Naive R's lack insight into their own behavior and/or that of others. They may express surprise at some basic, well-known facet of society (e.g., politicians lie), or they might not realize their impact on others (e.g., seductiveness of their posture and clothing).

13. A subject who is overly dramatic expresses flashes of emotion that are fleeting, shallow, and insincere. "You can't imagine how terrified I felt when I learned the interview would take four hours!!" Rolling eyes and avoidance of eye contact may accompany such displays.

15. The term dependent in the context of the SSAGA suggests that R frequently asks for clarification of questions, solicits the examiner's advice on answers, or otherwise requests reassurance too often.

17. Demanding R's will require a lot of attention and/or favors from you. This concept overlaps with manipulative; the latter implies a more calculated or deliberate set of behaviors.

19. Callous means an individual is emotionally insensitive or tough. It refers to an attitude towards others and should not be confused with flat affect, in which all emotions are weak, not simply empathy.

H. MOOD AND AFFECT

2. Inappropriate affect implies a mismatching of content and mood. Laughing at the death of a loved one or crying without apparent reason are two examples.

3. Flat affect refers to a restricted intensity and range of mood, such as when an individual describes a recent tragedy with only a trace of sadness. This flatness is not the same as inappropriate affect, in which the tragedy might be recalled with glee or joy.

6. Subjects who exhibit labile mood "...shift rapidly and frequently during a short period of time" (Taylor) Such individuals are not overly dramatic if the examiner senses that the emotions are genuine.

I. CONTENT OF THOUGHT

Remember that the traits listed in this section must occur during the interview to be rated as present. For example, in order to code hallucinations as present, the subject must experience hallucinations during the SSAGA. This may be deduced either from verbal report or from behavior (e.g., answers to the door or jumps back suddenly as if he/she has seen something).

6. Antisocial attitudes can be expressed with or without hostility. These might include opinions which range from the usefulness of speeding to the joys of polydrug ingestion to the benefits of multiple partners.

7. Suspiciousness, Feels persecuted, and Delusion of persecution are related but not identical concepts. The first can refer to a wariness about being interviewed (or anything else). For example, a subject might grill the examiner at length about the consent form. The second applies when an individual feels another person or group of people are deliberately making things hard for him/her. A delusion of persecution means the examiner judges such a suspicion to be ill-founded or highly exaggerated. For example, R may state that he is targeted by the CIA for murder. Remember that the first two traits do not require the examiner to judge their appropriateness.

8. Poverty of content means R provides minimal information. Generalities, filler words, and vague replies are common. Language tends to be overly abstract or concrete and repetitive. The subject may speak at some length but still not provide enough material to answer the question (paraphrased from Andreasen).

10. Obsessions refer exclusively to repetitive, intrusive, and inappropriate thoughts, whereas compulsions refer to acts bearing the same characteristics.

12. Feelings of unreality will be apparent only if R verbalizes them. For example, he/she might state that the interview seems dreamlike or unreal.

22. Illusions involve distortions of real perceptions, such as seeing cargo fly off a passing truck late at night or mistaking the smell of bacon for that of candy. Hallucinations are perceptions which entirely lack an external stimulus. Delusions are beliefs which represent persistent misinterpretations of the environment or one's own person.

27. Delusion of grandeur: R mistakenly thinks that she/he (a) holds a title, degree or prestigious position; (b) possesses large sums of money, (c) is extremely talented (in music, athletics, etc.), and/or (d) is on a special mission to help people.

28. Delusion of reference: R incorrectly believes that stray remarks, TV and radio shows, songs, billboard signs, etc. are specifically directed at him/her. Statements like "this song was written for me" should be questioned, as they simply may be a figure of speech.

29. Delusion of influence: R thinks that he/she has been controlled or affected in implausible ways: "The rays come from the television station...into the antenna...sometimes they make me weak and I can't move" (example from Taylor). The belief that thoughts have been taken out of one's head by someone else is another example.

30. A somatic delusion is the erroneous conviction that something is wrong with one's body. This preoccupation may involve structure ("my stomach is rotting"; "I have lost my pancreas") or function ("I have Grave's disease"; "My liver doesn't work right").

32. Systematized delusions are highly organized, complex systems of thought. Often they are of longstanding duration and over time have become more elaborate.

J. ORIENTATION

An orientation screener may be incorporated at a later time. Pay attention to remarks that suggest deficits. R may describe the season incorrectly, refer to the wrong president, or wrongly think he/she is at home when at a clinic.

1. Time: does the patient know the year, season, month, day of the week, day of the month, and time of day?
2. Place: does the subject know what country and state he or she is in? Does he or she know the hospital or clinic where the interview is being conducted?
3. Person: does R know his or her own identity and that of key people in the environment? Forgetting the name of the examiner does not count.

K. MEMORY

Base your assessment of memory on performance during the SSAGA, not neuropsychological test scores.

1. Clouding of consciousness is a general impairment of orientation, attention, and perception. It is less severe than stupor, which is close to unconsciousness. In other words, R may be noticeably "out of it" but still communicable.
3. Amnesia refers to loss of memory, usually partial but sometimes near-total. R may have difficulty recalling events prior to a specific point in time (retrograde amnesia), or subsequent to that point (anterograde amnesia). Poor recent memory and poor remote memory are less extreme counterparts of anterograde and retrograde amnesia.
6. Confabulation means R fills in memory gaps with fabricated information, sometimes narrated in great and convincing detail. Confabulation may be deliberate or unintentional.

L. INTELLECT

Your assessment of R's intellectual performance should be based on clinical impressions gathered during the interview, rather than formal cognitive testing. This should be assessed apart from education level achieved.

M. INSIGHT AND JUDGMENT

1. Poor insight: R does not seem to fully grasp (a) the probable motivations or causes of their behavior (e.g. the link between marital stress and their drinking); or (b) the impact of their behavior on others (e.g., the link between their drinking and getting fired).
2. Poor judgment: In this context, insight refers primarily to understanding, whereas judgment pertains largely to behavior. A subject who exhibits poor judgment does so by acting without enough regard for consequences. During the SSAGA, for example, R might not allow enough time to be interviewed or might not bring any money, assuming that he/she would be paid that day.
3. Unrealistic regarding degree of illness, Doesn't know why being treated, and Unmotivated for treatment: The first term characterizes an individual who realizes there are problems but minimizes them. The second descriptor is more severe; it refers to a subject who has no idea he/she requires help. If a person scores positive on the second term, he or she should also get a positive score for the first term, but the reverse is not necessarily true. The last term does not address insight; it can include individuals who realize they need help but either lack the will to participate or don't believe treatment will work. Thus, a person who fits this third item may or may not fit the previous two terms.

Interviewer Rating Box (bottom of page 104)

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

**We gratefully acknowledge the contributions of Drs. Kramer, Crowe, and Cadoret, as well as other members of the Iowa COGA staff who provided these definitions.*

INTERVIEWER NARRATIVE ABOUT THE RESPONDENT

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

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

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

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

2. Record additional information about R.'s behavior/attitude during the interview, which could affect the validity of the responses. This would include:

Remarking on R.'s responses-did s/he always say "yes" or "no" to everything (was s/he hostile/trying too hard to please the interviewer? Did R. seem to understand the questions, or did questions need to be paraphrased? Did R. take questions too literally? What was R.'s affect like during the interview?

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