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Father-Daughter Interactional Patterns Associated with Adolescent Depression: An Examination of Attachment and Communication within the Dyad

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Running head: FATHER-DAUGHTER INTERACTIONAL PATTERNS

Father-Daughter Interactional Patterns Associated With Adolescent Depression: An Examination of Attachment and Communication within the Dyad

Natasha Demidenko, M.A.

Thesis submitted to the Faculty of Graduate and Postdoctoral Studies

In partial fulfillment of the requirements for the Ph.D. degree in Clinical Psychology

School of Psychology

Faculty of Social Sciences

University of Ottawa

Your file Votre référence
ISBN: 978-0-494-32397-7
Our file Notre référence
ISBN: 978-0-494-32397-7

Acknowledgements

I would like to thank my thesis committee, Drs. Catherine Lee, Valerie Whiffen, Mario Cappelli, and Heather Sears, for their guidance, suggestions, and helpful comments on drafts of the dissertation. Thank you for providing me with a very supportive and warm environment for the defence. I would like to particularly thank Drs. Whiffen and Sears for travelling to Ottawa for my thesis defence.

I would like to especially thank Dr. Catherine Lee, who was also a co-investigator on the OMHF grant that supported this research. Catherine, thank you for your dedication to this project. You contributed greatly towards its outcome. Thank you for your valuable suggestions and thoroughness with multiple drafts of both articles. Over the years in the doctoral program, I have learned a great deal from you about professional practice in the field of clinical psychology.

To my supervisor, Dr. Ian Manion: Thank you Ian, for your enduring sensitivity throughout a long and sometimes challenging process (especially when it came to recruiting all of our fathers and daughters!). Despite some of these challenges, I always left your office feeling supported and optimistic. You were consistently caring and respectful, open and available. You are a true mentor. Thank you for being such a down-to earth individual and for providing me with a safe environment that promotes creativity and the free exchange of ideas. I will miss our research meetings! You are truly an exceptional supervisor and a wonderful person.

I would like to thank my dear friend, Dalit, for her friendship and encouragement. I was so happy to go through this stage of my life with you by my side.

Acknowledgements con'd.

Thank you to my parents, Anatole and Nadia Demidenko, for encouraging and believing in me. Thank you for instilling in me your strong work ethic and for teaching me that I could do anything I wanted to in life. Spasiba mama e papa – tseluyu vas.

Finally, to my sweetness Patrick: Thank you for your undying support over these past 12 years as I worked towards my academic and professional goals. You always believed that I could do it and were proud of me, even at times when I was discouraged. Thank you for encouraging me, and always unselfishly giving me the space and time to work towards achieving my goals. You truly are my backpack! Most importantly, thank you for being my safe haven and secure base. I love you Momo!

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General Abstract

The present study was designed to examine the links between father-daughter attachment, paternal acceptance and rejection, emotional availability (EA), adolescents' affective perception of parents, and the quality of father-daughter communication in adolescents with and without depression, taking into consideration paternal general psychopathology and maternal mood disorder. Fifty-one adolescent girls diagnosed with a depressive disorder (CDA) and 65 never-depressed girls (NDA), ages 13 to 19, and their fathers, completed semi-structured diagnostic interviews and measures of parent-adolescent attachment and communication. Mothers completed a diagnostic interview for mood disorders. In the first manuscript, we found that girls in the CDA group were more likely than those in the NDA group to have fathers with psychopathology and mothers with mood disorders. Girls in the CDA group reported more negative attachment with fathers, less perceived warmth, more overall rejection, more negative affect about their fathers, lower EA, and more negative communication than did girls in the NDA group. After controlling for marital status, depressed adolescents' scores of perceived maternal EA and negative affect towards mothers were comparable across the two groups. Fathers from the CDA and NDA groups did not differ in their ratings of warmth and rejection, but did report more negative communication with their adolescents compared to fathers of girls in the NDA group. Adolescents with depressed mothers reported more negative relationships with their fathers than adolescents with nondepressed mothers, indicating an important relationship between maternal depression and the father-adolescent relationship.

In manuscript 2, investigation of the combined sample of depressed and nondepressed adolescents revealed that girls' perceptions of paternal EA and undifferentiated rejection predicted girls' depressive symptomatology above and beyond the presence of paternal psychopathology and maternal mood disorder. By adopting a multirater design, including extensive data on fathers and data on mothers, including clinical and nonclinical samples within one study, accounting for Axis I disorders together with depressive symptomatology, and including a balance of intact and single-parent families, this study addressed some of the gaps in the previous research. The findings of this thesis support taking an interpersonal and familial approach to treating depression in adolescents, addressing adolescents' perceptions of their relationships with both fathers and mothers.

Background and Theory

This thesis contains two research reports based on results of a study that was conducted to examine the importance of attachment-related variables and communication in the relationships of adolescent girls, with and without a depressive disorder, and their fathers. Diagnostic information was collected from mothers as well, and adolescent girls rated their relationships with both parents separately. The following sections introduce the reader to the constructs of interest, namely the significance of adolescent depression, particularly for girls, and interpersonal constructs associated with adolescent depression such as father-daughter attachment, emotional availability, and communication. Two complementary theories that have been used to conceptualize the impact of distressed family relationships on adolescent outcomes and the importance of studying fathers when doing research on adolescent development and psychopathology are presented; these are attachment and interpersonal theories. In order to develop a comprehensive understanding of the experience of adolescent depression that will generate knowledge that is applicable to the treatment of depression, one must first recognize that adolescent depression occurs in a relational context, typically one that includes parents, mothers and fathers alike.

Depression in Adolescence

Clinical depression in adolescence is a serious problem that can persist, recur, and that may be associated with an increased risk for other psychopathology, most notably conduct disorders, anxiety disorders, and substance abuse (Kaslow, 1996; King, et al., 2006). Clinical depression is also associated with poor psychosocial functioning and risk

for suicide in adolescence as well as in adulthood (Cappelli, et al., 1995; Duffy, Manion, & Davidson, 1994; Kaslow, 1996; Stewart, Manion, Davidson, & Cloutier, 2001).

Prevalence rates of adolescent depression vary depending on the criteria and methods used to evaluate the presence of the disorder or its symptomatology. At any point in time, two to five percent of youth meet criteria for a depressive disorder, and by age 18, up to 20% or more of community youth are thought to experience subthreshold depressive symptomatology (Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993; Lewinsohn, Shankman, Gau, & Klein, 2004). There is also research to suggest that the prevalence of depressive disorders rises as adolescents increase in age, peaking in the late adolescent years and early 20s at rates of 11-13% (Weissman, Warner, Wickramaratne, Moreau, & Olfson, 1997).

When a consensus survey was done in 1994 and 1995, Canadian youth aged 15 to 19 were most likely (9%) to have had a major depressive episode in the previous year, whereas successive age groups displayed a decline in prevalence (Statistics Canada, 2001). Of the adolescents who develop major depressive disorder (MDD), there is a high recurrence rate and a greater than 85% cumulative probability for further depressive episodes by early adulthood (Kovacs, 1996). Finally, there is evidence to suggest that adolescents who experience depression go on to have lower life satisfaction, poorer global functioning, lower quality of relationships with family, smaller social networks, greater major and minor adversity, and greater mental health treatment utilization than adolescents who had had non-mood disorders or no disorders (Lewinsohn, Rohde, Seeley, Klein, & Gotlib, 2003). Furthermore, compared to other mental disorders experienced in adolescence, MDD has been found to be the only significant predictor of

future suicide attempts (Lewinsohn, Rohde, Seeley, & Baldwin, 2001). In Canada, nearly one-quarter of all deaths in 1998 among 15 to 24 year olds were a result of suicide (Public Health Agency of Canada, 2002), and suicide is considered the second leading cause of adolescent mortality in Canada (Davidson & Manion, 1996).

The relationship between gender and prevalence of adolescent depression is striking and the present study included girls in the sample exclusively for this reason. After puberty, young women (ages 12 to 23) are twice as likely to experience MDD than their male counterparts (Lewinsohn et al., 2001), and are 2 to 3 times more likely to develop dysthymic disorder (DD) as adults than are men (Public Health Agency of Canada, 2002). In line with these findings, girls' suicide attempt hazard rates (i.e., rate at which past suicide attempts or potentially self-injurious fatal behaviours were positively endorsed) among those ages 14 to 19 were also significantly higher than that of boys (Lewinsohn et al., 2001). Research has also shown some qualitative differences between boys and girls' depressive symptoms. Girls diagnosed with MDD or DD have been found to report more experiences of guilt and body dissatisfaction compared to boys (Bennett, Ambrosini, Kudes, Metz, & Rabinovich, 2005). Other differences, such as greater sadness, self-disappointment, self-blame, feelings of failure, concentration problems, fatigue, and health worries, in girls compared to boys have been found (Bennett et al., 2005).

The reasons for these gender differences in unipolar depression are not well understood, although biological differences must be considered (Birmaher et al., 1996). Gender socialization and interpersonal theories have suggested that whereas boys are socialized to have instrumental traits, such as decisiveness and independence, girls are

encouraged to develop interpersonal and expressive traits, such as empathy and caring for others, and to place a great deal of importance on relational harmony (Whiffen & Demidenko, 2005). Theorists such as Gilligan (1982) have suggested that the social constraints imposed on girls to be more passive and restrictive in their behaviours so as to fit within the female gender role may increase girls' risk for internalizing disorders such as depression. In addition, adolescent girls suffer more interpersonal violence and sexual abuse as well as body dissatisfaction and eating disorders compared to boys, which may also heighten the risk for depression (Whiffen & Demidenko, 2005). Thus, when girls' relationships with parents and peers are distressed or when they experience violations in their attachment relationships (as is the case with abuse), they may be at higher risk for unipolar depression (Shaw & Dallos, 2005; Whiffen & Demidenko, 2005).

Psychopathology in parents has been identified as another risk factor for adolescent depression (Klein, Lewinsohn, Rohde, Seeley, & Olino, 2005; Klein, Shankman, Lewinsohn, Rohde, & Seeley, 2004). In particular, children of depressed parents are 1.5 to 3 times more likely to develop depression compared to children of mentally healthy or physically ill parents (APA, 2000; Downey & Coyne, 1990; Klein et al., 2005), with rates of major depression ranging from 7-13% per year for children (Johnson, Hays, Field, Schneiderman, & McCabe, 2000). By adolescence, these children display a lifetime risk for depression as high as 45% (Hammen, 2000). It should be noted that these studies have predominantly studied mothers rather than both parents (Phares, Fields, Kamboukos, & Lopez, 2005).

Putting Adolescent Depression into an Interpersonal/Attachment Context

In the past 20 years, research has demonstrated the usefulness of understanding depression in an interpersonal context (Coyne, 1990; Gotlib & Lee, 1989, 1996; Johnson et al., 2000; Joiner & Coyne, 1999; Mufson, et al., 2004). Consequently, there has been a growing recognition that assessment and treatment must take into account family variables, social support, and culture (Allen et al., 2006; Hammen, Brennan, & Shih, 2004; Kaslow, 1996). It is clear that, although family functioning is strongly linked to psychopathology, the precise mechanisms of risk may not be the same at different developmental stages (Lee & Gotlib, 1994). Thus, although research conducted with depressed children may yield useful hypotheses about the family functioning of depressed adolescents, it is erroneous to assume that patterns observed at one developmental period would be evident in another.

Research on nondepressed samples has highlighted the importance of the parent-adolescent attachment relationship in healthy family functioning (Baron & MacGillivray, 1989; Goldberg, 1997; Sund & Wichstrom, 2002; Vivona, 2000). It is hypothesized that security of attachment to one's parents and closeness within the family are determinants of the development of psychopathology in adolescence and adulthood (Goldberg, 1997). In fact, adolescent depression has been inversely related to the level of support, attachment, and approval adolescents experience in their family environment (Sheeber, Hops, Alpert, Davis, & Andrews, 1997). Theorists have suggested a link between insecure or problematic attachment and depression (Bowlby, 1980; Bowlby, 1988). Some empirical research has also used attachment theory to better understand adolescent psychopathology (Allen, Hauser & Borman-Spurrell, 1996; Shaw & Dallos, 2005).

The present study was designed to examine the nature of father-adolescent attachment and the quality of father-adolescent communication in adolescent girls with and without a depressive disorder. The following section provides two complementary theoretical frameworks for understanding father-adolescent interactional patterns in the context of adolescent depression, along with a rationale for studying the constructs of interest.

Two Complementary Proposed Theories: Attachment and Interpersonal Perspectives

It has been suggested that depressed adolescents tend to come from distressed families (Hammen, 1991). Attachment theory proposes that the security of attachment to one's parents and the closeness that is maintained within the family can have direct implications for the development of psychopathology in adolescence and adulthood (Bowlby, 1980; Bowlby, 1988; Goldberg, 1997). Some authors have argued that an adequate understanding of any disorder requires an understanding of the interpersonal context in which people develop and live (Chiariello & Orvaschel, 1995). In the case of the majority of adolescents, this interpersonal context includes the family of origin.

Even though friendships and romantic relationships gain emotional importance during adolescence, adolescents still identify their parents as the most significant attachment figures in their lives (West, Spreng, Rose, & Adam, 1999). The contemporary conceptualization of adolescence is as a time of role negotiation and struggle for mutuality with parents, rather than simply a turbulent period in which individuals attempt to separate and distance themselves from their parents (Lamb, 2004; Powers & Welsh, 1999; Shulman & Seiffge-Krenke, 1997). Specifically, some authors have emphasized that one of the primary developmental tasks of adolescence involves

negotiating greater autonomy from parents while still maintaining closeness and intimacy (Laursen & Collins, 1994; Pavlidis & McCauley, 2001). Moreover, it is now understood that adolescent autonomy and, by extension adolescent identity, optimally develop in the context of close and positive family relationships (Shulman & Collins, 1993). Furthermore, research has indicated that the same qualities that make for optimal mothering, also make for optimal fathering, namely being responsive, attentive, and warm to one's child (Dix, 1991).

Attachment theory predicts that an adolescent's vulnerability to clinical depression is increased in a cold, inflexible, and emotionally unavailable or absent family context. In this context, primary attachment figures (i.e., parents) are either emotionally rejecting, neglectful, or inconsistent in their emotional support (Bowlby, 1988). The lack of emotional availability from attachment figures through loss or parental depression is proposed to be a precursor to insecure parent-adolescent attachment bonds (Bowlby, 1988). It is hypothesized that, whereas a secure parent-adolescent attachment fosters autonomy and competence, anxious or otherwise insecure attachment constitutes a general risk factor for depressive symptoms (Kobak, Sudler, & Gamble, 1992). According to this theory, the child or adolescent quickly learns that he or she cannot consistently depend on his or her attachment figures for support and, as a result, experiences a separation, loss, and grieving for the attachment figure (Bowlby, 1980).

In insecure attachment, the child learns to view him or herself and the parent negatively at the individual level. Interpersonally, communication between parent and child becomes defined by hostile and angry interchanges that lack warmth, empathy, and cooperation from both partners. This repeated negative cycle of communication is

suggested to promote a child's sense of uncertainty in the parent's emotional availability and create a fear of rejection and/or anger about the parent's lack of availability (Kobak & Esposito, 2004).

Depression has been conceptualized as a consequence of this grieving process and as a result of the child feeling rejected and neglected by his or her primary attachment figures. Bowlby (1988) highlighted that the repeated rejection a child feels from his or her attachment figure translates into an internal model of self that is unlovable and unworthy. In this model, others become seen as unpredictable, emotionally unavailable, and, depending on the extent of the rejection or abuse experienced by the child, potentially dangerous. To summarize, attachment theory suggests that, for a child to form an optimally adaptive internal working model of self, the child must bond with a caregiver who provides consistent nurturance, soothes negative affect states, and tolerates the child's full display of emotions towards self and others (Herring & Kaslow, 2002). As a result, the child also learns that others have the capacity to be caring, loving, and safe.

An interpersonal theoretical framework complements attachment theory in that it emphasizes the individual's everyday socio-emotional context as vital to understanding the maintenance of various disorders, including clinical depression (Coyne, Burchill, & Stiles, 1991). As in attachment theory, interpersonal theories place an emphasis on understanding the interactional patterns that become established and subsequently repeated in the context of one's significant relationships (i.e. parent-child relationships) (Teyber, 2000). Parent-child interactional patterns, positive or negative, are hypothesized to become incorporated into the child or adolescent's personality and aid the child in

avoiding or minimizing anxiety, defending against disapproval, and maintaining self-esteem (Teyber, 2000). For example, repetitive interactions with parents that are painful, anxiety-provoking, rejecting, or neglectful are presumed to create internal images of self as helpless, ineffectual, or insignificant, and may reinforce images of others as critical, untrustworthy, or emotionally unavailable. Similarly, communication between parent and child that involves a high degree of negative affect, for example, uncontained anger; a lack of cooperation in negotiating tasks; belittling, critical or rude comments; and communication that is lacking in the parent's ability to use metacognitive skills to reflect on the situation and take multiple perspectives (of both self and child), further reinforces the self (i.e., adolescent) as helpless, insignificant, and/or unlovable (Kobak & Esposito, 2004). Interpersonal patterns and defences learned in childhood and adolescence are assumed to then become overgeneralized to other relationships outside of the family and become part of one's adult character (Teyber, 2000). Both attachment and interpersonal perspectives form the theoretical basis for this thesis of the complex nature of adolescent depression and its manifestation within the context of the father-adolescent relationship.

There is strong empirical support for the link between attachment constructs and adolescent depression or well-being (Allen et al., 1996; Essau, 2004; Kobak et al., 1992; Papini & Roggman, 1992; Sund & Wichstrom, 2002; Vivona, 2000; Wilkinson & Walford, 2001). Thus, it is important to briefly discuss the theoretical and empirical links between the proposed theories previously described and the constructs of interest in the present study, particularly the construct of attachment. Existing and growing evidence suggests that parental emotional availability (EA) is related to parent-child attachment as well as to healthy parenting (Biringen, 2000). Mahler, Pine and Bergman (1975)

discussed EA as the supportive maternal presence; namely, they suggested that a mother's "quiet supportiveness" signals her encouragement and acceptance of her child's growing autonomy and exploration of the environment, such that the child is able to return to the mother for "emotional refueling" and a secure base when he or she needs to. In attachment terms, the construct of EA refers to the mother's clarity of perception regarding her child's signals and communications, and her ability to promptly respond to these signals (Bowlby, 1973).

Apart from sensitivity, parental EA also consists of structuring (i.e., ability of a parent to support learning and exploration without overwhelming the child's autonomy), nonintrusiveness (i.e., parent's ability to be available to the child without being interfering, overprotective, or overwhelming), and nonhostility (i.e., ways of communicating with the child or behaving towards the child in ways that are generally patient, pleasant, and harmonious) (Biringen, 2000). In keeping with Bowlby's (1988) and Ainsworth et al.'s (1978) notion of a secure base, Goldberg, Grusec, and Jenkins (1999) emphasized the notion of parental protection and confidence in the caregiver's protection as essential elements of the parent-child attachment bond.

Conceptually, the notion of EA converges with theoretical and empirical evidence that shows highly involved parenting behaviours to be associated with a child's greater sense of security, and thus secure parent-child attachment (Bretherton, 2000). EA also involves parental expression of care or warmth towards the child, and the ability to provide protection for one's child without a high degree of intrusiveness. Empirical investigations have lent support to the link between attachment and EA (Aviezar, Sagi, Joels, & Ziv, 1999; Easterbrooks, Lyons-Ruth, Biesecker, & Carper, 1996; Kogan &

Carter, 1996). For example, in a longitudinal study, Easterbrooks et al. (1996) found that securely attached infants and their mothers evidenced greater EA when the child was age seven; this involved parents showing greater sensitivity, and optimal structuring /intrusiveness levels. Easterbrooks et al. (1996) also found that maternal depression in infancy predicted impaired EA in mother-child dyads at age seven, regardless of whether mothers were still experiencing depressive symptoms.

There is also preliminary evidence of short-term negative reactions to emotional unavailability. For example, Field (1986) found that when mothers were asked to simulate emotional unavailability by appearing depressed and remaining still-faced in laboratory experiments, their infants displayed distress regardless of whether their mothers were physically available to them. Interestingly, maternal emotional unavailability was more distressing to infants than was physical absence, highlighting the importance of an emotional bond between parent and child (Field, 1986). In a community sample of 76 adult men, Oliver and Whiffen (2003) found that adult attachment insecurity fully mediated the link between perceived maternal rejection in childhood and higher levels of depressive symptomatology; perceived paternal rejection from childhood was also directly associated with depressive symptoms. This study highlighted the link between retrospective reports of men's early attachment relationships with parents and depressive symptomatology in adulthood, supporting the idea of continuity of attachment patterns across developmental stages.

As previously discussed, communication is an integral part of the parent-adolescent attachment relationship (Kobak & Esposito, 2004). Positive, nonhostile, and harmonious communications have been suggested to be an essential part of EA (Biringen,

2000). In order for a child to feel that she or he has a "secure base" (Ainsworth, Blehar, & Waters, 1978, p 20) from which to explore the world, both Bowlby (1988) and Ainsworth and colleagues (1978) emphasized the need for a line of communication to be maintained between the child and his or her base (i.e. the parent). Indeed, attachment security, a high level of parental EA, and open communication are closely linked (Kobak & Esposito, 2004). Theorists suggest that security in the parent-child relationship fosters open communication, such that in times of crisis or high stress, a child who is confident in his or her parent's availability, can openly and directly communicate both positive and negative emotions at the behavioural/interpersonal level (Bretherton, 1990). This generally positive and open line of communication allows the child to express his or her needs and ideas, while experiencing the parent as receptive (i.e., hearing the child, acknowledging him or her, being assertive when necessary, regulating his or her own affect so as not to act out his or her frustrations on the child) (Biringen, 2000). Research has shown that adolescents who are able to maintain strong attachments to their parents also report a greater emotional connectedness within the family, and tend to feel more freedom to express their own point of view with parents (Papini, Roggman, & Anderson, 1991).

In summary, theoretical and empirical studies have suggested that attachment and EA (Biringen, 2000) as well as communication (Bretherton, 1990; Kobak & Esposito, 2004) are important aspects of the parent-child relationship. Given that the theoretical underpinnings of the present thesis have been discussed, it is pertinent to now discuss the rationale for focusing on the relationship between fathers and daughters.

Importance of Examining the Father-Adolescent Relationship

To date, the bulk of the research conducted on family interactions and adolescent psychopathology has focused on the adolescent's relationship with his or her mother (Phares, 1992). Phares and Compas (1992) found that fathers were underrepresented in child and family research that focused on clinical outcomes. Furthermore, many studies designed to examine parent-adolescent relationships have examined only the mother-adolescent relationship (Allen et al., 2006; Heaven, Newbury, & Mak, 2004; Pavlidis & McCauley, 2001), or have asked adolescents to comment on their relationships without including parents themselves (Hale, Van Der Valk, Engels, & Meeus, 2005; Sund & Wichstrom, 2002; Vivona, 2000). Yet we know that children of depressed fathers are at comparable risk for emotional and behavioural problems compared to children of depressed mothers (Phares & Compas, 1992). The absence of research on the father-child or father-adolescent relationship, paternal attachment and warmth, and paternal contributions to family functioning in general is not unique to the study of psychopathology. Indeed it is a characteristic of much of the research on the parent-child relationship (Lamb, 1986; 1997; 2004).

Recently, there has been a greater appreciation of the importance of including fathers in research on family functioning and psychopathology, although there continues to be a shortage of research on fathers (Phares, Fields, et al., 2005). Parenting roles for men and women have shifted, and some fathers today play a more nurturing role in the family than in past decades (Levant, 1990). In addition, there has been a greater recognition of the significant contributions that fathers make to the well being of their

children (Lamb, 2004; Shulman & Seiffge-Krenke, 1997), thus making this type of research essential and timely.

It is clear that fathers' roles are changing and that many men are more involved in the care of their children than their own fathers were (Bouchard & Lee, 1997; 2000). Recent Canadian data indicate that, although in early childhood mothers spend more time with their children than do fathers, by the time their children reach adolescence, fathers spend as much or more time with their offspring than do mothers (Statistics Canada, 2000). Given the increased involvement of fathers with their adolescent sons and daughters, it is imperative that we understand qualities of the father-adolescent relationship that are associated with adolescent depression. Furthermore, given that fathers and mothers may have disparate experiences of their families and therefore different perceptions of child and adolescent functioning, important information may be gained from studying fathers as separate from mothers. Subsequently, a greater understanding of these factors will have significant implications for preventative work with adolescents and their families as well as treatment of adolescent depression.

Rationale for the Present Study

Research has demonstrated the importance of examining adolescent depression in the context of the family system, and emphasized the important links between parenting, parent-adolescent relationships, and adolescent psychopathology (Kaslow, 1996). Studies have suggested that adverse family processes characterized by high levels of parent-child conflict, criticism, and anger, and the absence of supportive and facilitative parent-child interactions are associated with an increased risk for adolescent depression (Sheeber, Hops, & Davis, 2001). Other studies have demonstrated that adolescents with

insecure attachment patterns show indicators of depression, such as low self-esteem, psychological distress, and difficulties with emotional regulation (Armsden & Greenberg, 1987; Cooper, Shaver, & Collins, 1998).

Studies looking at the offspring of depressed parents (Hammen & Brennan, 2003; Marmorstein & Iacono, 2004) have found strong support for the impact of maternal mood disorder and psychopathology on child and youth outcomes, but research on the influences of paternal psychopathology on child and youth outcomes is less developed (Phares, Fields, et al., 2005). In addition, whereas some research has failed to find an association between paternal and youth depression (Marmorstein & Iacono, 2004), other research has found a link between paternal depression and anxiety (Bosco, Renk, Dinger, Epstein, & Phares, 2003; Klein et al., 2005) and adolescents' internalizing behaviour problems or internalizing/externalizing disorders (Ohannessian et al., 2005). Thus, the relationship between parental and youth psychopathology warrants further investigation.

Notably, most of the above research focused solely on the mother-adolescent relationship (Phares, 1992). In recent years, shifting expectations in parenting roles for men and women (Cowan & Cowan, 2000) have highlighted the need to better understand the adolescent's relationship with his or her father. The traditional role of breadwinner and chief disciplinarian has been evolving to a newer, more nurturing involved role (Levant, 1990).

Many of the earlier studies identified the importance of the attachment bond between mother and child (Kogan & Carter, 1996; Radke-Yarrow, Cummings, Kuczynski, & Chapman, 1985). More recently, research has emphasized the importance of the father's nurturing role and his level of emotional availability in the father-

adolescent relationship (Kerns, Tomich, Aspelmeier, & Contreras, 2000; Lieberman, Doyle, & Markiewicz, 1999; Phares & Compas, 1992). Although emotional availability has not been extensively studied in fathers, related research on father-child attachment has suggested that fathers show similar patterns of attachment to their children as mothers (Fox, Kimmerly, & Schafer, 1991; Kerns et al., 2000), and has highlighted the differential positive effects of mother- and father-adolescent attachment on adolescent functioning (Benson, Harris, & Rogers, 1992). Thus, it becomes relevant to explore the perceived emotional availability that *adolescents* feel in their relationships with their fathers, and to explore the differences between depressed and nonclinical groups of youth.

There are theoretical and research-based rationales for the importance of examining the father-adolescent relationship in the present studies. Like adolescents' relationships with mothers, their relationships with fathers are also continually changing as they mature (Lamb, 1997; 2004). Although mothers tend to be the primary caregivers more often than not, the father-adolescent relationship has important implications for an adolescent's healthy development in terms of the process of identity formation, separation and individuation, attitude and values development, and the like (Shulman & Seiffge-Krenke, 1997). In reviewing some of the research on the amount of time adolescents spend with each parent, the nature of parent-adolescent communication patterns, the degree of closeness adolescents report feeling in relation to each parent, and the amount of conflict adolescents experience with each parent, Lamb (1997; 2004) noted that adolescents often report important differences in the relationships they have with

each parent on the above variables (for a discussion on these specific differences see Lamb, 1997; 2004).

Furthermore, authors (Lamb, 1997; 2004; Shulman & Seiffge-Krenke, 1997) have suggested that differences in a child's relationship with each parent changes over the various developmental periods of the child's life, highlighting the need to study the father-adolescent relationship as separate from the father-child relationship. Similarly, the *role of the father* changes as the child matures and enters adolescence, as does the specific nature of his involvement with the child (Shulman & Seiffge-Krenke, 1997; Zimmerman, Salem, & Notaro, 2000). Other research that has examined the differences between adolescents' relationships with mothers and fathers on variables such as communication, parenting, and the like, have also found important differences in the way adolescents interact with each parent (Collins & Russell, 1991; Shek, 2000).

In summary, the theoretical and empirical literature supports the need to explore the father-adolescent relationship, given that there is evidence to suggest that adolescents experience the relationships with their fathers differently than they do relationships with mothers (Zimmerman et al., 2000). In addition, the developmental and attachment literatures highlight the importance of the father-adolescent relationship with regards to its impact on adolescent well-being (Shulman & Seiffge-Krenke, 1997).

The following study was designed to address some of the gaps in previous research. For example, the present study focused on the understudied father-adolescent relationship and its links to adolescent depression. Assessing paternal and adolescent psychopathology separately, as well as maternal mood disorder allowed us to account for the interactional effects of adolescent depression, paternal psychopathology, and maternal

depression within a single study. Adopting a multi-perspective design where adolescent girls rated the quality of their relationships with both parents separately, and fathers rated their relationships with their daughters, enabled us to better understand the complexities involved in the father-daughter relationship. Including a clinically diagnosed adolescent group as well as a never depressed, healthy adolescent sample made a normative comparison possible. Including clinician-rated, diagnostic measures as well as participant-rated measures of depressive symptomatology provided us with a more comprehensive clinical picture.

The two manuscripts that follow explore the link between adolescent depression and father-daughter relationships differently. In the first manuscript, adolescent girls from clinical and nonclinical groups were compared on attachment and communication variables. An original contribution of this study was the comparison of adolescent and father ratings of acceptance, rejection, and communication, and adolescent ratings of emotional availability, perception of parents, and attachment, taking into account paternal psychopathology and maternal mood disorder. In the second manuscript, the samples of adolescent girls from clinical and nonclinical groups were combined into one sample to predict depressive symptomatology from adolescent perceptions of paternal emotional availability, undifferentiated rejection, and problems in communication.

Whereas in the first manuscript we examined depression (i.e., in terms of clinical diagnosis) or lack of depression (i.e., never experiencing a diagnosable depressive episode) in two discrete groups, in the second manuscript the construct of depression was explored along a continuum with the assessment of depressive symptomatology rather than diagnosis. At any given time adolescents may report some depressive symptoms,

albeit very mild in many cases, and therefore in the second manuscript, we were interested in predicting these symptoms using key constructs highlighted by attachment and interpersonal theories. Moreover, although both manuscripts include perceptions of paternal emotional availability as a key construct, the second manuscript focused on two additional specific aspects associated with problematic parent-adolescent attachment (or insecure attachment), rejection (Bowlby, 1988; Rohner, 1999) and problems in communication (Kobak & Esposito, 2004). Each manuscript begins with a synthesis of the recent research in the area of adolescent depression as it relates to family variables, such as attachment and communication.

Running head: FATHER-DAUGHTER RELATIONSHIPS

An Examination of Parental Psychopathology and Father-Daughter Attachment and Communication in Depressed and Nondepressed Adolescent Girls

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Abstract

The present study was designed to examine the links between markers of reported father-daughter attachment (including perceived emotional availability (EA)), and the quality of father-daughter communication in adolescents with and without depression. Parental psychopathology was also explored. Fifty-one adolescent girls diagnosed with a depressive disorder and 65 never-depressed girls, ages 13 to 19, and their fathers, completed semi-structured diagnostic interviews assessing various Axis I disorders, and measures of parent-adolescent attachment and communication. Mothers completed a diagnostic interview for mood disorders. Depressed girls were more likely than their nondepressed counterparts to have fathers with diagnosable psychopathology or mothers with mood disorders. Compared to nondepressed girls, girls diagnosed with a depressive disorder reported lower attachment, less perceived paternal warmth and more perceived overall rejection, less perceived paternal EA, more negative affect about their fathers, and more problematic communication. However, fathers of depressed girls only reported greater communication problems with their adolescents compared to fathers of nonderpessed girls. When both adolescents' and fathers' reports of the relationship, as measured by the above variables, were compared based on the presence or absence of psychopathology in fathers, no significant differences were found. An unanticipated finding was that daughters of depressed mothers reported more problematic relationships with their fathers and mothers than did daughters of unaffected mothers. The findings of the present study support taking an interpersonal and familial approach to assessing and treating depression in adolescents, addressing adolescents' perceptions of their relationship with both fathers and mothers.

An Examination of Parental Psychopathology and Father-Daughter Attachment and Communication in Depressed and Nondepressed Adolescent Girls

Depression in adolescence is a serious problem that can persist, recur, and that may be associated with an increased risk for other psychopathology, most notably conduct disorders, anxiety disorders, and substance abuse (King et al., 2006). Two to five percent of youth meet criteria for a depressive disorder, and by age 18, up to 20% or more of community youth are thought to experience subthreshold depressive symptomatology (Lewinsohn et al., 1993; Lewinsohn et al., 2004). To date, the bulk of the research conducted on family interactions and adolescent psychopathology has focused on the adolescent's relationship with his or her mother (Phares, Fields, et al., 2005). Since Phares and Compas (1992) noted the dearth of research in the area of fathers and family functioning, there has been a growing recognition of the importance of fathers and an attempt to include fathers in research. Research on fathers still lags behind research on mothers however, and there remains a paucity of research in this area (Phares, Lopez, Fields, Kamboukos, & Duhig, 2005). Fathers' roles are changing and men are more involved in the care of their children than their own fathers were (Bouchard & Lee, 2000; Rohner & Veneziano, 2001). Shifting expectations in parenting roles for men and women, as well as the increasing recognition of the significant contributions that fathers make to the well being of their children (Lamb, 2004) have made this type of research necessary and timely.

Attachment theory has suggested a link between insecure or problematic attachment, the perception by the child that his or her parent is emotionally unavailable, a lack of open communication, and depression (Bowlby, 1988; Shaw & Dallos, 2005).

Specifically, attachment theory predicts that an adolescent's vulnerability to clinical depression is increased in a rigid, cold, and emotionally unavailable family context. In this context, primary attachment figures (i.e. parents) are either emotionally rejecting, neglectful, or inconsistent in their emotional support, resulting in deleterious effects on parent-child communication as well (Bowlby, 1988).

Consistent with the predictions of attachment theory, research to date has demonstrated that, to successfully negotiate the developmental tasks of autonomy, identity, and individuation, adolescents require close and positive relationships with parents (Pavlidis & McCauley, 2001; Shulman & Seiffge-Krenke, 1997). However, depressed children and adolescents typically describe a less secure, communicative, warm, and supportive family environment than do nondepressed children or adolescents (Herring & Kaslow, 2002; Kaslow, Deering, & Racusin, 1994). There appear to be important gender differences in these patterns as well (Bennett et al., 2005). For example, some research has found that the inverse association between depressive symptoms and the presence of cohesive and supportive family relationships is stronger for adolescent girls than for adolescent boys (Avison & McAlpine, 1992; Makri-Botsari, 2005). Other research has found family discord (including stressful life events, parenting impairments, marital discord, and low family intimacy) to be a modest mediator of girls' depressive symptoms; this relationship was not found for boys (Davies & Windle, 1997). Finally, the growing body of evidence of the efficacy of Interpersonal Therapy for adolescent depression (IPT-A) (Mufson et al., 2004) demonstrates that restoration of adolescents' relationships with parents is associated with recovery from depression.

As noted above, family research on adolescent psychopathology has tended to examine the mother-adolescent relationship (Phares, Fields, et al., 2005; Rohner & Veneziano, 2001). Hale et al. (2005) highlighted the strong, direct association between adolescents' perceived parental rejection and adolescent depressive symptoms in a sample including both mothers and fathers. Because data on mothers and fathers were combined, it is unknown whether the patterns differed by parental gender. Furthermore, as the study did not include parents' perceptions of the parent-adolescent relationship, it is possible that the pattern of results reflects a mono-informant bias. As we cannot generalize from what we know about the mother-adolescent relationship to fathers, it is necessary to directly evaluate the father-adolescent dyad (Shulman & Seiffge-Krenke, 1997). The present study was designed to address this issue by including father and youth ratings of their own functioning as well as of their dyadic relationship.

Because of the strong evidence of increased risk of major depressive disorder in adolescents of parents with diagnosable disorders (King et al., 2006; Marmorstein, Malone, & Iacono, 2004), it is essential to investigate the links between adolescent depression, parental psychopathology and attachment-related/interpersonal variables. In using PsychInfo and Medline searches, we did not become aware of any study that examined adolescent depression, maternal depression, and paternal psychopathology, focusing on girls' and fathers' perceptions of the father-daughter attachment relationship.

The present study was designed to examine the links between paternal psychopathology, father-daughter attachment, the quality of father-daughter communication, and the impact of maternal mood disorder, in adolescents with and without a depressive disorder. As there are differences between the father-daughter and

father-son relationship (Lamb, 2004), it is important to take adolescent gender into account. Because depression is more prevalent in adolescent girls than in boys (Bennett et al., 2005) and because of the inherent difficulties in recruiting a sample of depressed adolescent males, we examined the father-daughter relationship.

Adolescent depression and the parent-child relationship

Studies examining diagnosable depression. Many studies have examined ratings of the parent-adolescent relationship in adolescents diagnosed with a depressive disorder. Depressed children and adolescents report less secure attachment to parents than do those with no disorder, or those with other psychiatric disorders (Armsden, McCauley, Greenberg, Burke, & Mitchell, 1990; Essau, 2004; Pavlidis & McCauley, 2001). However, the role of the father-adolescent relationship remains less studied as most studies either included only mothers (Hammen & Brennan, 2001; Pavlidis & McCauley, 2001; Sheeber et al., 1997; Sheeber & Sorensen, 1998), mostly mothers (Armsden et al., 1990; Brennan, Katz, Hammen, & Le Brocque, 2002; Sanford et al., 1995), or did not differentiate between maternal and paternal attachment (Essau, 2004).

The few studies that have included fathers (Brennan et al., 2002; Shiner & Marmorstein, 1998) measured general aspects of family functioning, asking adolescents and parents to rate levels of parental regard, conflict, and family climate (Shiner & Marmorstein, 1998) and observing paternal expressed [negative] emotion (Brennan et al., 2002); these studies highlighted the unique relationship that these variables have with adolescent depression. Adolescent reports of greater father-adolescent conflict and poorer regard for both parents distinguished depressed adolescents with ever-depressed mothers from ever-depressed adolescents with never-depressed mothers or nondepressed

comparison youth, highlighting the systemic nature of depression in families (Shiner & Marmorstein, 1998). In addition, research found persistence versus remittance of a major depressive episode in youth to be predicted by adolescents' ratings of low father involvement, along with adolescents' comorbid substance abuse or anxiety disorder, and lower responsiveness to maternal discipline (Sanford et al., 1995). As has been the case with other research, youth and predominantly mothers participated in this research.

Studies examining depressive symptomatology. Other studies have explored depressive symptoms in high school or community adolescent samples, and measured aspects of family functioning (Allen et al., 2006; Bosco et al., 2003; Cole & McPherson, 1993; Hale et al., 2005; Heaven et al., 2004; Sund & Wichstrom, 2002; Videon, 2005). Adolescent perceptions of high paternal rejection (Hale et al., 2005), adolescent perceptions of low paternal acceptance (Bosco et al., 2003), paternal perceptions of low fatherly warmth (Heaven et al., 2004), and adolescents' low satisfaction with the father-youth relationship (Videon, 2005) were associated with depressive symptomatology in youth. Allen et al. (2006) found that adolescents' ability to negotiate autonomy with parents was central in whether youth developed depressive symptoms. However, some of these studies only included youth reports of the parent-adolescent relationship (Bosco et al., 2003; Hale et al., 2005; Videon, 2005), or included only one parent (Allen et al., 2006; Heaven et al., 2004). Without the inclusion of parent reports of the adolescent-parent relationship, it is not possible to determine whether the phenomenon simply reflects depressed adolescents' tendency to view the environment negatively.

In summary, there is some limited evidence to suggest a link between adolescent depressive symptoms and adolescent ratings of impaired father-adolescent relations, as

well as between adolescent ratings of their relations with fathers and clinician ratings of depression. However, few studies gathered reports of the father-adolescent relationship from both the parent and adolescent perspectives, and therefore they may have been subject to single rater bias (Armsden et al., 1990; Essau, 2004). Furthermore, some studies (Armsden et al., 1990; Essau, 2004) included a combined measure of parent attachment, without separating attachment to mothers and fathers. Finally, no studies assessed adolescent and paternal depression simultaneously within a single study. The present study was designed to address these limitations by adopting a multi-informant perspective in a study that compares both clinic and nonclinic youth, and that includes a thorough examination of both adolescent and paternal psychopathology.

Parental depression and the parent-child relationship. Children of depressed mothers and children of depressed fathers have a comparable risk of impaired child-parent communication and decreased affective expression (Jacob & Johnson, 1997), as well as a greater risk of developing Axis I disorders (Marmorstein et al., 2004). In general, adolescents of depressed mothers have greater psychosocial problems within the family and outside of the home compared to adolescents of nondepressed mothers, and have been found to report less secure and more dismissing or fearful cognitions about relationships (Hammen & Brennan, 2001). However, the majority of the research in this area has focused on the effects of maternal psychopathology on youth outcomes (Hammen et al., 2004). Notwithstanding this, some research has found paternal depressive mood to be an important and unique predictor of adolescent functioning (Thomas & Forehand, 1991), and the impact of having a depressed parent in general has

been found to affect adolescents' affective expression with the nondepressed parents in these households (Jacob & Johnson, 1997).

Some research has found that depressed fathers showed a lower frequency of positive, engaging behaviours with their youth compared to nondepressed or alcoholic fathers (Jacob, Krahn, & Leonard, 1991). Jacob and Johnson (1997) found that paternal communication, rather than maternal communication, appeared to moderate the link between a diagnosis of paternal depression and child depressive symptoms.

The above studies illustrate the usefulness of examining depression within a family context (Lewinsohn et al., 1994; Lewinsohn et al., 2004), and highlight the impact that depression in one family member can have on the interactions of all family members (Jacob & Johnson, 1997). As most studies did not compare depressed and nondepressed adolescents, it is difficult to identify patterns that are specific to depression from those that characterize family interactions with adolescents in general.

In a meta-analysis of studies examining parental psychopathology and child adjustment, Connell and Goodman (2002) found that maternal psychopathology was more associated with emotional and behavioral problems in younger children, and paternal psychopathology was more closely related to these problems in older children, indicating that it is essential to examine paternal psychopathology in the study of youth psychopathology. In light of the evidence suggesting the importance of father involvement in child rearing (Bouchard & Lee, 2000; Lamb, 2004; Lee, 2006), it is critical to examine emotional and interactional aspects of the father-child relationship. As research has highlighted the usefulness of parent ratings (e.g., Thomas & Forehand, 1991) it would be helpful to compare them to adolescent ratings of the parent-adolescent

relationship, and to adolescents' perceptions of their own symptoms. Given the low concordance between adolescent and parent ratings of the same construct (Avery, Massat, & Lundy, 1998), each participant contributes an important perspective of his or her own functioning and relationships, and thus it is essential to include both adolescent and father perspectives. Finally, no studies have simultaneously assessed diagnosed paternal and adolescent depression (as well as comorbidity in both groups) while focusing on comparisons between depressed and nondepressed adolescents and the father-adolescent relationship.

A Priori Hypotheses

In the present study we examined two groups: currently-depressed adolescent girls and their fathers (CDA), and nondepressed adolescent girls and their fathers (NDA). First, it was predicted that the proportion of fathers with a history of psychopathology or current psychopathology would be higher among depressed adolescents than among nondepressed adolescents. The same effect was predicted for mothers of depressed adolescents.

Second, adolescents and fathers in the CDA group were both predicted to report greater disruption in their relationship compared to the NDA group on measures of attachment, warmth, rejection, perceptions of fathers' emotional availability, negative affect about fathers, and communication. Third, we predicted greater disruption on the above relationship variables in those families where a father had a history of psychopathology or current psychopathology than in families where the father was free of psychopathology.

Secondary Research Questions

To examine whether adolescents' perceptions of their fathers differed based on whether adolescents had depressed or nondepressed mothers, specific questions were asked to better understand the associations between adolescent depression, maternal mood disorder, and aspects of father-daughter relations. Given the literature that has identified systemic effects of depression on family relationships (Cummings & Davis, 1999), adolescents with depressed mothers were compared to those with never depressed mothers on measures of perceived paternal warmth, overall paternal rejection, paternal attachment, paternal EA, negative affect towards father, and paternal communication. Father perceptions of their own paternal warmth, overall rejection, and communication with their daughters, were also compared in fathers with and without depressed spouses.

Furthermore, three post-hoc analyses were conducted focusing on adolescent perceptions of the mother-adolescent relationship and the association with parental psychopathology or mood disorder. First, depressed adolescents were compared to nondepressed adolescents on perceived maternal attachment, EA, and negative affect towards mother. This was explored in order to present a more balanced perspective of adolescents' perceptions of both parents, and so as not to bias the manuscript towards fathers only, recognizing the complex systems at play in families (Cummings & Davies, 1999). Second, adolescents with affected fathers were compared to those with unaffected fathers on the above variables. Finally, adolescents with depressed (affected) mothers were compared to those with never depressed (unaffected) mothers on the above variables.

Method

Participants

An a priori power analysis suggested that, in order to detect a medium effect size maintaining a .05 alpha level and a power of .80, 56 to 58 dyads per group were necessary. A medium effect size was hypothesized as this is consistent with previous research. Only adolescent girls between the ages of 13 to 19 were included. A total of 186 adolescent girls signed forms indicating interest in participation. Five out of 56 girls assigned to the CDA group and 64 out of 130 girls assigned to the NDA group were unable to participate for various reasons such as scheduling problems or loss of interest in participating. Two of these girls were told they were not eligible for participation during the screening phone interview because they were adopted.

The way in which girls in the CDA and NDA were approached about the study may have contributed to differences in participation rates. For example, each depressed girl (and in some cases her father or mother) was approached individually and typically informed about the study through her treating clinician. Also, treating clinicians typically already had established contact with one or both parents, unlike in the NDA group where parents were only contacted after adolescents expressed interest in the study. Girls in the NDA group were primarily approached within classroom settings, making the recruitment process less personal. Girls in the NDA group may have also felt less motivation to participate compared to girls in the CDA group, perhaps because they simply had less experience with mental health issues.

A total of 66 adolescent girls and their fathers were included in the final NDA sample; one was subsequently excluded due to the questionable validity of the father's

reports. Therefore, the final sample consisted of 51 dyads in the CDA subgroup and 65 dyads in the NDA subgroup yielding a total sample of 116 father-adolescent dyads. All father-daughter dyads who attended the research session and signed the consent forms completed the study.

Adolescents and their fathers were assigned to one of the two groups based on the diagnostic status of the adolescent. Depressed adolescents were recruited through various mental health services from child and adolescent psychiatric clinics in two regional hospitals. Nondepressed adolescents and their fathers were recruited from the community as well as from secondary schools in the region. General inclusion criteria for all adolescents and fathers included at least regular face-to-face contact with their biological child/father (i.e. minimum of one contact per month over the last 12 months), and being functional in English (i.e, able to complete assessment battery). Adolescents in the CDA group had to meet DSM IV criteria for a major depressive episode or dysthymic disorder within past 12 months as diagnosed by a clinician at the center from which they were recruited. It was considered appropriate to retain the three girls with bipolar illness in the sample in the face of some research (Robertson, Kutcher, Bird, & Grasswick, 2001) that did not find significant differences between adolescents diagnosed with unipolar and bipolar disorders on measures of father- and mother-adolescent relationships. Adolescents in the NDA group had never experienced a major depressive disorder or dysthymic disorder lifetime, and had not experienced an Axis I psychiatric illness in the past 12 months (as determined by the telephone screening and the diagnostic interview conducted by the principal investigator).

Exclusion criteria for all adolescents and fathers included the presence of a developmental and/or learning disability precluding their ability to complete the assessment battery, and the presence of psychotic spectrum disorders. Paternal psychopathology was assessed in both groups of fathers. Given that the time and circumstances of an adoption, as well as the adolescent's life experiences prior to an adoption may have presented a series of confounds, adolescents from adoptive families were also excluded (Iftene & Roberts, 2004; Irhammar & Cederblad, 2005).

The present study included resident and non-resident biological parents so as to increase the generalizability of findings and to facilitate recruitment. Two independent research ethics boards at the recruiting facilities approved the present study (see Appendix A).

Procedure

Adolescents included in the CDA group were referred directly from their clinical programs to the study by their referring clinician after receiving a diagnosis of major depressive disorder, dysthymic disorder, or bipolar disorder in the past 12 months. Clinicians asked interested adolescents to complete a consent form indicating their interest in writing, thus allowing the investigator of the study to initiate telephone contact (see Appendix B). The principal investigator (PI) contacted the adolescent by phone to complete the initial screening, and invited fathers to participate at this time. Participants in the NDA group were self-referred in response to advertisements in community newspapers and through active recruitment in local secondary schools. Interested students completed consent forms allowing the PI to contact them for screening (see Appendix B).

Mothers of participating adolescents were contacted by telephone after completion of testing with fathers and adolescents, and asked to complete the mood disorder module of the Mini International Neuropsychiatric Interview Plus (MINI Plus; Sheehan, Janavs, et al., 2003). Fathers and adolescents had the choice of completing the interview and testing at one of the two treatment facilities or in their home.

Following informed consent (see Appendix C), the PI and another graduate student trained in the screening measures interviewed each father and adolescent separately and administered the self-report battery to the participants. Fathers and daughters were interviewed in separate rooms to ensure privacy and confidentiality, and to prevent additional biasing of responses. All participating fathers and daughters completed a diagnostic interview (MINI Plus for ages 17 and up or MINI Kid for ages 16 and younger; see Appendix D), and a Beck Depression Inventory-II (Beck, Steer, & Brown, 1996) followed by the appropriate self-report battery. Blindness of interviewers was not ensured. Testing took an average of 1.5 to 2 hours to complete with each family. Complete demographic data (including family constellation, SES, treatment history, etc.) were collected from each father (see Appendix E). Participants who chose to complete testing at one of the treatment facilities were given $30.00 to cover costs, such as hospital parking. Adolescent participants who chose to complete the testing in their homes were given volunteer hours to be used towards their community service requirements for secondary school. All families were offered a summary of the study findings, to be sent to them after completion of the study.

Measures

Rationale for measures and subscales. As previously identified in the introduction, the primary constructs of interest in this study are parent-adolescent attachment and communication, that is, the interpersonal expression of the attachment bond (Kobak & Esposito, 2004). Rather than solely using a general measure of attachment to assess the core theoretical aspects of attachment, several attachment-related measures were included to operationalize attachment more comprehensively than one measure could. Specific constructs, including warmth (and acceptance) (Biringen, 2000; Rohner, 1999), overall rejection (including neglect and hostility) (Bowlby, 1988; Rohner, 1999), emotional availability (Biringen, 2000; Lum & Phares, 2005), and affective perception of parents (Phares & Renk, 1998), are all core aspects of attachment, and thus were measured independently to assess their relationship with adolescent depression. Specific measures assessing each of these aspects of attachment are presented next.

MINI Plus (see Appendix D). The MINI Plus (Sheehan, Janavs, et al., 2003) is a semi-structured interview for individuals over 16 years of age that yields current and lifetime diagnoses of the major Axis I psychiatric disorders in the DSM-IV and ICD-10. A major advantage of the MINI Plus is the ease and speed of administration compared to that of other, longer clinical interviews, such as the SCID (Antony & Barlow, 2002). Sheehan et al. (1997) found that most of the MINI (clinician rated) diagnoses were characterized by good to very good kappa values (ranged from 0.50 for current simple phobia to 0.90 for anorexia). Sensitivity was 0.70 or greater, and specificities, negative predictive values, and efficiency scores were 0.85 or greater across all of the diagnoses. More recent research has also demonstrated good and very good sensitivity and

specificity, respectively (Balazs & Bitter, 2000). The majority of the reported kappa values were 0.90 or higher and 0.75 or greater (Sheehan et al., 1997), indicating excellent interrater and test-retest reliability, respectively. Construct validity has also been demonstrated (Balazs et al., 2001). In the current sample, administration time was an average of 1.5 hours.

Mini International Neuropsychiatric Interview for Children and Adolescents (MINI KID; see Appendix D). The MINI KID (Sheehan, Shytle, et al., 2003) was developed from the original MINI as a structured clinical interview for children and adolescents up to the age of 16. The format and structure is similar to that of the MINI Plus, however the wording of various items is more youth-appropriate. In addition, the MINI KID takes less time than the MINI Plus (and the KID SCID) to administer. The MINI KID also includes assessment of other relevant childhood disorders, such as ADHD, Conduct Disorder, and Oppositional Defiant Disorder. Both the MINI KID and the MINI have been used with youth samples (with youth as young as 12 years of age) (LeBlanc, Almudevar, Brooks, & Kutcher, 2002). Kappas have been found to be good to very good (.60 to over .80), indicating reasonable interrater reliability (Balazs et al., 2001). Sensitivity was good to very good in the majority of disorders, and specificity was very good in the majority of disorders. Average administration time in this study was 1.5 hours.

The Parental Acceptance Rejection Questionnaire (PARQ). The PARQ scale (Parent and Child versions) (Rohner, 1999) (see Appendix E for Child version) was used in the present study to measure some of the core aspects of parent-child attachment, namely warmth and lack of warmth or rejection. This 60-item measure using a 4-point

Likert scale was used to measure fathers' and adolescents' perceptions of their relationship in terms of four subscales: Warmth/Affection (independent of other subscales; higher scores are more positive), Aggression/Hostility, Neglect/ Indifference, Undifferentiated Rejection (i.e. feeling unloved, unwanted, or uncared about without any objective indicators of parental coldness, aggression, or neglect), and a PARQ total score (a combined score of three negative subscales; higher scores indicate more problems). Internal consistency for the PARQ is acceptable, with Cronbach's alphas ranging from .72 to .90 with a median alpha of .82 for the child version (Luce, 1992). The Warmth and Undifferentiated Rejection subscales of the PARQ demonstrate solid convergent validity correlations (.83 and .74, respectively) with a number of standardized measures (e.g. Child's Report of Parent Behavior Inventory) (Rohner, 1999). Good construct validity has also been demonstrated (Rohner, 1999). Cronbach's alpha reliability coefficients for the Child PARQ (father version) were .96 (Warmth only) and .95 (Total score) for adolescents. For the Parent PARQ, coefficients were .92 (Warmth only) and .90 (Total score) for fathers in the current sample.

The Inventory of Parent and Peer Attachment (IPPA Revised). The IPPA (Armsden & Greenberg, 1989) (see Appendix E) was used to separately evaluate adolescents' attachment (in terms of a total combined score of Trust, Communication, and Alienation) to mothers and fathers based on attachment theory (higher total scores indicate better attachment). Youth were only asked about their relationships with each parent, not peers. Adolescents were asked to respond to items using a 5-point Likert scale. The IPPA is psychometrically sound (Armsden & Greenberg, 1987). A 3-week test-retest reliability of .93 has been reported for the parent attachment measure. Using

only the mother and father subscales from the revised IPPA, Papini et al. (1991) reported Cronbach's alphas of .88 and .89 for the mother and father subscales, respectively. Convergent and discriminant validity has also been demonstrated (Armsden & Greenberg, 1989). Cronbach's alpha reliability coefficients for the adolescent-reported IPPA total in the current sample were considered good at .77 and .78 (father and mother subscales respectively) (Garson, n.d.).

The Perception of Parents Scale (POP). The POP scale (Phares & Renk, 1998) (see Appendix E) was used to measure another important aspect of the parent-child attachment relationship, adolescents' internal representations of their fathers and their mothers, regardless of amount of actual contact with each of these parents (Phares & Renk, 1998). This is a 15-item, self-report instrument measuring adolescents' perceptions of positive and negative affect in relation to their mothers and fathers (only the 5 items of the negative affect subscale were used). Adolescents are asked to answer each item using a 6-point Likert scale (higher scores indicate more positive perceptions). Internal consistency was strong for the negative affect subscales towards mothers (.81), and towards fathers (.84) (Phares & Renk, 1998). Test-retest reliabilities showed stability over one week for negative affect subscales for mothers and fathers (.70 and .82, respectively). Convergent validity between the POP measure and the Children's Report of Parental Behavior Inventory-Revised (CRPBI-R) was demonstrated. Cronbach's alpha reliability coefficients for the adolescent-reported POP-Negative Affect subscale were .84 and .86 (father and mother subscales, respectively) in the current sample.

The Lum Emotional Availability of Parents scale (LEAP). The LEAP scale (Lum & Phares, 2005) (see Appendix E) was used to measure adolescents' perceptions of their

mother's and father's emotional availability (EA) separately in the form of a 15-item self-report questionnaire (higher scores indicate greater EA). Emotional availability has been defined as the level of parental responsiveness, sensitivity, and emotional involvement (Biringen & Robinson, 1991), and is central to the measurement of attachment. The LEAP scale shows good reliability and validity with a college sample and a clinical/non-clinical youth sample (Lum & Phares, 2005). The alpha coefficient for the LEAP total scale was .98 for both the mother and father forms. Convergent validity between the LEAP scale and similar measures (i.e., the Parental Bonding Instrument, the Brief Symptom Inventory, and the Profile of Mood States) was demonstrated (Lum & Phares, 2005). Cronbach's alpha reliability coefficients for the adolescent-reported LEAP total were .96 and .97 (father and mother subscales, respectively) in the current sample.

The Inventory of Parent Adolescent Communication (IPAC). The IPAC (Barnes & Olson, 1985; see Appendix E for Adolescent version) is a 20-item self-report instrument consisting of two subscales, Open Communication and Problems in Communication, used to measure communication between adolescents and their fathers (higher scores indicate better communication). In this report we used the total score, which incorporates both positive aspects (free flowing exchange of factual and emotional information, lack of constraint and degree of understanding/satisfaction in interactions) and negative aspects of communication (negative interactional patterns, hesitancy to share, and selectivity/caution in information shared). These negative and positive aspects of communication are related to more general parent-adolescent attachment bonds, such that less attachment security is thought to translate into more problematic communication whereas security at the individual level is thought to foster open communication at the

interpersonal level (Kobak & Esposito, 2004). Thus, it was important to include a specific measure of communication.

Barnes and Olson (1985) found Cronbach's alphas to range from .80 to .92 for the two subscales. Test-retest reliability coefficients over 4 to 5 weeks were found to be .78 for Problems in Family Communication, .87 for Open Family Communication, and .88 for the overall instrument (Barnes & Olson, 1985). Cronbach's alpha reliability coefficients for the adolescent- and father-reported IPAC total scores were .92 and .79, respectively, in the current sample.

Results

Descriptive Statistics

All analyses were conducted using an alpha of .05 unless otherwise stated, and eta^2 was calculated for all tested hypotheses as a measure of effect size. The CDA subgroup was comprised of 51 adolescent girls who met criteria for major depressive disorder, dysthymic disorder, or bipolar disorder within the past 12 months, and their fathers. Twelve (23.5%) of these adolescents met criteria for current depression (last 2 weeks), and 39 (76.5%) met criteria for lifetime depression with the most recent episode occurring in the past 12 months. The NDA subsample consisted of 65 never-depressed, currently healthy adolescent girls and their fathers. Four (7.8%) mothers from the CDA subgroup and six (9.2%) mothers from the NDA subgroup could not participate for the following reasons: language barrier (i.e., not speaking English), mother was deceased, or adolescent preferred that mother not be contacted. Table 1 presents demographic data for fathers and mothers. The samples were representative of families within the Ottawa-Gatineau region in terms of socioeconomic status (SES) and income, and highest

education level attained (Statistics Canada, 2000), and suggested that participating families fell within the middle to upper SES bracket. The majority of participating families were Caucasian.

There was no significant difference in age between the two subgroups of adolescents (CDA: M = 15.92, SD = 1.47; NDA: M = 16.28, SD = 1.26), t (114) = -1.40, ns. However, fathers, t (114) = -2.64, $p < .01$, and mothers, t (111) =-2.61, $p = .01$, in the NDA subgroup were significantly older than their counterparts in the CDA subgroup (see Table 1). Fathers in the NDA group were more likely to have partially or fully completed

Table 1. Mean Age, Education, Marital Status, and Income for Parents of Youth.

Variable	Participant	CDA	NDA
Mean Age (SD)	Father	47.86 (4.77)*	50.48 (5.66)*
	Mother	45.90 (4.24)*	48.27 (5.20)*
Education	Father	68.6% college or higher*	74.3% college or higher*
	Mother	58.0% college or higher	59.0% college or higher
Marital Status	N/A	60.8% married*	78.5% married*
		39.2% separated/divorced*	21.5% separated/divorced*
Income	N/A	78.4% make 76K or more	78.5% make 76K or more

* $p < .05$

graduate studies compared to fathers in the CDA group, χ^2 (3, N = 116) = 9.39, $p = .03$; this effect was not seen for mothers, χ^2 (3, N = 115) = 2.12, ns. There was no difference in family income between the two groups, χ^2 (1, N = 115) = .002, ns. Parents in the CDA group were more likely than the NDA group parents to be divorced or separated, χ^2 (1, N

$= 116) = 4.31, p = .04$. Correlations between demographic and dependent variables are presented in Appendix F.

In the CDA and NDA groups respectively, 90.2% and 89.2% of the sample were primarily English speaking, and the remainder spoke French or another language. In the CDA group, 90.2% of girls had Major Depressive Disorder; 3.9% had Dysthymic Disorder; and 5.9% had Bipolar Disorder[1] as their primarily diagnosis. Only 19.7% of youth met criteria for one disorder; 45.1% met criteria for two comorbid disorders, and 35.2% had three or more comorbid disorders. The following are comorbid disorders in the CDA sample: 56.9% with Anxiety Disorder; 25.5% with Substance/Alcohol Dependence; 11.8% with Substance/Alcohol Abuse; 17.6% with Eating Disorder; 13.7% with ADHD; and 17.6% with ODD/Conduct Disorder. Given that the majority of the CDA group had one or more comorbid disorders, presence of comorbid disorders was dichotomously coded and entered as a covariate in the primary analyses. It was not a significant covariate, and therefore analyses were presented without its inclusion.

Table 2 presents a summary of diagnoses for fathers and mothers, respectively. In some cases, participants may have met criteria for more than one diagnosis, therefore percentages do not sum to 100 and are not mutually exclusive.

Hypothesis 1. To examine whether the proportion of fathers with psychopathology (lifetime or current, including Antisocial Personality Disorder) would be greater among depressed adolescent girls than nondepressed girls a 2 x 2 Chi square test of independence was calculated. We were only interested in capturing a persistent and chronic pattern of drug or alcohol dependence, and not examining one or two

[1] T-tests were completed to compare girls with bipolar illness to girls with unipolar depression on all dependent variables. There were no significant differences; therefore, girls with bipolar illness were kept in the sample.

incidences of substance abuse, therefore presence of lifetime or current substance or alcohol dependence was included, but lifetime or current substance or alcohol abuse was not, as this would have biased the rates of psychopathology in a liberal direction. As predicted, more adolescents in the CDA group compared to those in the NDA group had fathers who were diagnosed with a disorder, χ^2 (1, N = 116) = 8.60, $p < .01$.

To examine whether the proportion of mothers with mood disorder (lifetime or current) would be greater among depressed versus nondepressed adolescent girls a 2 x 2 Chi square test of independence was conducted.

Table 2. Summary of Paternal and Maternal Diagnoses in CDA and NDA Groups.

Paternal Diagnosis	CDA Group (n = 51)	NDA Group (n = 65)
Major Depression	39.2% (n= 20)	13.6% (n= 9)
Dysthymic Disorder	5.9 % (n = 3)	1.5% (n = 1)
Bipolar Disorder	5.9% (n = 3)	1.5% (n = 1)
Anxiety Disorder	23.5% (n = 12)	9.1% (n = 6)
Substance/Alcohol Dependence	21.6% (n= 11)	12.1% (n = 8)
Substance/Alcohol Abuse	15.7% (n = 8)	15.2% (n = 10)
ADHD	3.9% (n = 2)	0%
Antisocial Personality	5.9% (n = 3)	0%
Other Disorder[a]	2.0% (n = 1)	4.5% (n = 3)
Any Mood Disorder	47.1% (n = 24)	15.4% (n = 10)
Presence of at least 1 disorder (including substance/alcohol abuse)	55.0% (n = 33)	45.0% (n = 27)
No disorder (unaffected)	32.1 % (n = 18)	67.9% (n = 38)
Fathers with only 1 disorder	27.5% (n = 14)	27.7% (n = 18)
Fathers with at least 1 comorbid disorder	15.7 % (n = 8)	10.8% (n = 7)
Fathers with 2 comorbid disorders	11.8% (n = 6)	1.5% (n = 1)
Fathers with 3 comorbid disorders	3.9% (n = 2)	0%
Fathers with 4 or more comorbid disorders	5.9% (n = 3)	1.5% (n = 1)

Maternal Diagnosis[b]	CDA Group (n = 47)	NDA Group (n = 59)
Major Depression	49.0% (n= 25)	16.7% (n= 11)
Dysthymic Disorder	7.9 % (n = 4)	3.0% (n = 2)
Bipolar Disorder	9.8% (n = 5)	0%
Adjustment with Dep. Features	2.0% (n = 1)	3.0% (n = 2)
Other Disorder[c]	0%	3.0% (n = 2)
Any Mood Disorder	60.8% (n = 31)	20.0% (n = 13)
No disorder (unaffected)	31.4% (n = 16)	70.8% (n = 46)
Any Mood Disorder	60.8% (n = 31)	20.0% (n = 13)

[a]Other disorders for fathers: Adjustment Disorder with depressed mood and Mood Disorder due to a General Medical Condition.
[b]Only mood disorders were assessed for mothers.
[c]Other disorders for mothers: Premenstrual Dysphoric Disorder or Substance Induced Mood Disorder (Single Episode).

More adolescents in the CDA group compared to those in the NDA group had mothers who had or currently were suffering from a mood disorder, χ^2 (1, N = 106) = 20.79, $p < .01$.

Hypothesis 2. Recognizing that girls being in a current episode of depression may influence their ratings of their fathers, all analyses were completed with and without the 12 girls in a current episode of depression (past 2 weeks). There were no differences in the results, therefore this subgroup was retained in the sample. Given the significant differences between the CDA and NDA groups on marital status, all analyses were conducted including marital status as a covariate. The majority of results remained unchanged, therefore results are presented without the inclusion of marital status as a covariate. In the one case where marital status altered the results, these are presented later in the results section.

Adolescents and fathers in the CDA group were compared to their counterparts in the NDA group on a set of attachment and communication variables. As two MANOVAs were conducted, a Bonferroni correction for Type I error was made, setting

alpha at .025. A between-subjects MANOVA was performed on six adolescent-rated dependent variables: youth perceptions of fathers' warmth (PARQ Warmth subscale) and coldness, neglect/indifference, and undifferentiated rejection (comprising the PARQ total score independent of Warmth); attachment to fathers (comprising IPPA total score), emotional availability of father (LEAP total score), negative affect in relation to fathers (POP-Neg. Affect); and communication with fathers (IPAC total score) (see Table 3).

Table 3. Means (Standard Deviations) for Attachment and Communication Variables Reported by Adolescent Girls for Fathers and Mothers, and Father Reports, Separately by Youth Group.

Variables	CDA group (n = 51)	NDA group (n = 65)
Fathers rated by adolescent daughters		
PARQ-Warmth	65.24 (14.21)*	72.40 (6.78)*
PARQ total (excl. warmth)	102.04 (34.78)*	81.12 (13.36)*
IPPA total	82.08 (13.23)*	89.63 (7.73)*
LEAP total	64.24 (17.71)*	77.29 (8.74)*
POP[a]	21.73 (5.76)*	26.20 (2.69)*
IPAC total	65.18 (18.56)*	76.80 (10.82)*
Mothers rated by adolescent daughters		
IPPA total	86.02 (12.37)	89.08 (11.81)
LEAP total	68.38 (18.26)**	76.69 (15.96)**
POP[a]	22.36 (5.64)**	24.84 (5.02)**
Adolescent daughters rated by fathers		
Paternal PARQ-Warmth	74.12 (7.30)	74.29 (6.19)
Paternal PARQ total	85.08 (19.31)	83.66 (16.42)
Paternal IPAC total	72.22 (13.86)*	78.66 (12.32)*

*$p < .025$; **$p < .017$; [a]Represents Negative Affect subscale of the POP.

There was a significant omnibus effect for group, (Wilks' Lambda) F (6, 109) = 6.35, $p < .01$, eta^2 = .26. Inspection of the univariate tests revealed significant differences between groups on all dependent variables with the CDA group showing more negative scores than the NDA group, (PARQ Warmth), F (1, 114) = 12.83, $p < .01$, eta^2 = .10; (PARQ total), F (1, 114) = 19.82, $p < .01$, eta^2 = .15; (IPPA total), F (1, 114) = 14.77, $p < .01$, eta^2 = .12; (LEAP total), F (1, 114) = 27.00, $p < .01$, eta^2 = .19; (POP-Neg. Affect), F (1, 114) = 30.73, $p < .01$, eta^2 = .21; (IPAC total), F (1, 114) = 17.80, $p < .01$, eta^2 = .14.

The second MANOVA examined fathers' perceptions of their own warmth (PARQ Warmth subscale); coldness, neglect/indifference, and undifferentiated rejection (comprising the PARQ total score independent of Warmth score) towards youth, and their perceptions of communication (comprising the total IPAC score) comparing fathers of adolescents in the CDA group with fathers of adolescents in the NDA group. There was a significant omnibus effect for group, (Wilks' Lambda) F (3, 112) = 4.13, $p < .01$, eta^2 = .10. Inspection of the univariate tests revealed only one significant between groups difference with fathers in the CDA group reporting more negative communication than fathers in the NDA group, (PARQ Warmth) F (1, 114) = .02, ns, eta^2 < .01; (PARQ total), F (1, 114) = .18, ns, eta^2 < .01; (IPAC total), F (1, 114) = 7.01, $p < .01$, eta^2 = .06.

Hypothesis 3. To examine whether adolescents' and fathers' perceptions differed in youth with and without affected fathers (i.e., fathers diagnosed with any disorder), a series of four MANOVAs was conducted to differentiate groups based on paternal affected status (i.e., fathers with diagnoses versus fathers with no diagnoses). A Bonferroni correction for Type I error was made to correct alpha; alpha was set at .013. Adolescent perceptions of paternal warmth (PARQ-Warmth), paternal rejection (PARQ

total), attachment (IPPA total), EA (LEAP total), negative affect towards father (POP-Neg. Affect), and communication (IPAC total) were compared in the two groups. Means and standard deviations are presented in Table 4.

Table 4. Means (Standard Deviations) for Adolescent and Father Reports of Paternal Rejection, Attachment, and Communication, and Adolescent Reports of Maternal Attachment, Split by Paternal Affected Status.

Variable	Affected Fathers (n = 42)	Unaffected Fathers (n = 74)
Fathers rated by adolescent daughters		
PARQ-Warmth	68.00 (13.49)	69.96 (9.76)
PARQ total	95.69 (33.28)	87.27 (22.54)
IPPA total	86.31 (11.96)	86.31 (10.69)
LEAP total	69.48 (16.63)	72.73 (13.76)
POP[a]	22.74 (5.28)	25.08 (4.39)
IPAC total	69.83 (17.09)	72.74 (14.98)
Mothers rated by adolescent daughters		
IPPA total	87.88 (13.39)	87.66 (11.41)
LEAP total	70.90 (20.58)	74.25 (15.41)
POP[a]	23.31 (5.36)	24.00 (5.47)
Adolescent daughters rated by fathers		
Paternal PARQ-Warmth	74.31 (7.29)	74.16 (6.34)
Paternal PARQ total	86.83 (19.46)	82.84 (16.56)
Paternal IPAC total	75.21 (14.17)	76.18 (12.95)

[a]Represents Negative Affect subscale of the POP.

The omnibus F test was not significant, F (6, 109) = 1.94, ns, eta^2 = .09. The same analysis was completed using fathers' perceptions of their own warmth (PARQ-Warmth), rejection (PARQ total score), and communication (IPAC total) as dependent variables, and paternal affected status as the independent variable. There were no significant differences between affected and unaffected fathers on their own reports of

warmth (Warmth-PARQ) or rejection towards their adolescents (PARQ total), or communication (IPAC total), $F(3, 112) = 2.16$, ns, $eta^2 = .06$.

To examine whether adolescents' perceptions of their relationships with their fathers differed based on whether youth had depressed or nondepressed mothers, a MANOVA was conducted comparing groups divided according to maternal affected status (lifetime presence of mood disorder or no lifetime mood disorder) on adolescent perceptions of paternal warmth (PARQ-Warmth); overall paternal rejection (PARQ total score); paternal attachment (IPPA total); paternal EA (LEAP total); negative affect towards father (POP-Neg. Affect); and paternal communication (IPAC total). Means and standard deviations are presented in Table 5.

Table 5. Means (Standard Deviations) for Adolescent and Paternal Reports of Paternal Rejection, Attachment, and Communication, Split by Maternal Affected Status.

Variable	Affected Mothers ($n = 44$)	Unaffected Mothers ($n = 62$)
Fathers rated by adolescent daughters		
PARQ-Warmth	67.77 (10.67)	71.06 (9.93)
PARQ total	96.95 (27.46)*	83.69 (21.43)*
IPPA total	83.64 (9.90)	88.11 (10.74)
LEAP total	66.30 (14.96)*	75.63 (12.63)*
POP[a]	22.18 (4.98)*	25.89 (3.78)*
IPAC total	66.18 (15.02)*	75.92 (13.97)*
Mothers rated by adolescent daughters		
IPPA total	86.43 (11.21)	89.69 (11.29)
LEAP total	69.43 (17.88)**	77.45 (14.21)**
POP[a]	22.14 (5.17)**	25.47 (4.52)**
Adolescent daughters rated by fathers		
Paternal PARQ- Warmth	73.80 (5.97)	75.76 (5.21)
Paternal PARQ total	86.55 (16.98)	79.68 (14.50)
Paternal IPAC total	71.84 (12.86)*	80.50 (11.44)*

*$p < .0125$; ** $p < .017$; [a]Represents Negative Affect subscale of the POP.

The omnibus F test was significant, (Wilks' Lambda) F (6, 99) = 4.38, $p < .01$, $eta^2 = .21$. Inspection of the univariate tests revealed that adolescents with affected mothers consistently reported more negative scores towards their fathers than did adolescents with unaffected mothers on paternal rejection (PARQ total) F (1, 104) = 7.79, $p < .01$, $eta^2 = .07$; EA (LEAP total), F (1, 104) = 12.04, $p < .01$, $eta^2 = .10$; negative affect (POP-Neg. Affect), F (1, 104) = 18.97, $p < .01$, $eta^2 = .15$; and communication (IPAC total), F (1, 104) = 11.75, $p < .01$, $eta^2 = .09$. There were no differences in adolescent reports of paternal warmth between groups divided according to mothers' affected status, (PARQ-Warmth), F (1, 104) = 2.66, ns, $eta^2 = .02$. In the case of adolescent reports of paternal attachment, these differences were not significant at the corrected alpha level of .0125, (IPPA total), F (1, 104) = 4.77, ns, $eta^2 = .04$.

Given research that has indicated systemic effects of depression on the family unit (Cummings & Davies, 1999), we examined whether fathers' perceptions of youth differed in fathers with and without depressed partners. The groups were split by maternal affected status, and father reports of paternal warmth (PARQ-Warmth), paternal rejection (PARQ total score), and communication (IPAC total) with adolescents were entered as dependent variables. The omnibus F test was significant, (Wilks' Lambda) F (3, 102) = 4.41, $p < .01$, $eta^2 = .12$. Means and standard deviations are presented in Table 5. Inspection of the univariate tests revealed that fathers from families with affected spouses reported more negative communication scores than did fathers with unaffected spouses, F (1, 104) = 13.29, $p < .01$, $eta^2 = .11$. The univariate test for paternal reports of warmth, F (1, 104) = 3.23, ns, $eta^2 = .03$, and rejection, F (1,104) = 5.00, ns, $eta^2 = .05$, were not significant using the corrected alpha level of .0125.

Because the youth-parent relationship can vary depending in part on the gender of the parent (Ohannessian et al., 2005), three post-hoc MANOVAs were conducted on adolescent perceptions of maternal attachment, EA, and negative affect splitting groups in three ways: by adolescent, paternal, and maternal affected status. In order to control for Type I error, Bonferroni's correction was used for this set of analyses, setting alpha at .017. When split by adolescent groups, marital status was a significant covariate, F (3, 109) = 4.79, $p < .01$, eta^2 = .12, and the omnibus F test for group was no longer significant as it had been prior to including marital status as a covariate, (Wilks' Lambda) F (3, 109) = 2.50, ns, eta^2 = .06. Means and standard deviations are presented in Table 3. Prior to including marital status as a covariate, univariate tests demonstrated that the CDA group reported significantly lower EA, F (1, 112) = 6.70, p = .01, eta^2 = .06, and greater negative affect towards their mothers, F (1, 112) = 6.17, p = .02, eta^2 = .05; there were no reported differences between groups on attachment, F (1, 112) = 1.81, ns, eta^2 = .02 (see Table 3). However, these effects were no longer significant after accounting for marital status. Adolescents with separated or divorced parents reported lower EA in relation to mothers and greater negative affect towards their mothers (M = 65.94, SD = 19.57; M = 20.82, SD = 6.14, respectively) than adolescents with married or common law parents (M = 75.94, SD = 15.70; M = 24.95, SD = 4.63).

Next, groups were split by paternal affected status and adolescent reports of maternal attachment, EA, and negative affect were compared, leading to a nonsignificant omnibus result, (Wilks' Lambda) F (4, 110) = 1.51, ns, eta^2 = .04. Therefore, univariate tests were not reported. Means and standard deviations are presented in Table 4. Finally, groups were split by maternal affected status and the above adolescent-reported variables

were compared, leading to a significant omnibus result, (Wilks' Lambda) F (3, 102) = 4.59, $p < .01$, eta^2 = .12. Means and standard deviations are presented in Table 5. Univariate tests indicated significantly lower EA, F (1, 104) = 6.60, $p = .01$, eta^2 = .06, and greater negative affect towards mothers, F (1, 104) = 12.38, $p < .01$, eta^2 = .11, by adolescents with affected mothers compared to adolescents with unaffected mothers. Attachment scores were comparable across the two groups, F (1, 104) = 2.16, ns, eta^2 = .02.

Discussion

Summary of Principal Findings

Link between parental psychopathology and adolescent depression. Adolescents diagnosed with a depressive disorder were more likely to have a mother with a mood disorder or a father with any Axis I disorder (including mood disorder) compared to adolescents without any diagnosis. This is consistent with previous research (Essau, 2004; Klein et al., 2005; Marmorstein et al., 2004; Rohde, Lewinsohn, Klein, & Seeley, 2005) that has found that both maternal and paternal psychopathology increase the risk for adolescent depression. Although parental psychopathology may be a critical factor in explaining some of the differences between clinical and healthy samples, one must study it in tandem with parent-youth relationship variables to gain a comprehensive understanding of adolescent depression.

Adolescents' perceptions of the father-adolescent relationship. Consistent with predictions, adolescents girls who were diagnosed with depression in the past 12 months reported less attachment to their fathers, more perceived paternal rejection and neglect, less perceived paternal warmth, more negative affect towards fathers, less perceived

paternal emotional availability, and more negative communication compared to nondepressed adolescents. Eta^2 calculations of effect sizes were small to approaching medium for the analyses completed (Cohen, 1992), and ranged from .10 to .21 the six dependent variables; eta^2 is an appropriate measure of variance accounted for (Vacha-Haase & Thompson, 2004). These findings are consistent with research that has shown a relationship between clinically elevated depression scores in adolescents who also reported poorer relations with their parents (Field, Diego, & Sanders, 2001), as well as research that showed an inverse relationship between adolescent depression and youth perceptions of parental attachment (Armsden et al., 1990), and paternal and familial support (Barrera & Garrison-Jones, 1992; Sheeber et al., 1997). Results from the present study extend findings from previous studies by including fathers as primary respondents. Similar to Essau (2004), we also found overall parental attachment scores to be lower in our CDA versus NDA groups, however the present study further clarified that these reported attachments were lower in relation to fathers not mothers. However, fathers did not differ in their own reports of warmth and rejection in relation to their adolescents.

As in Shiner and Marmorstein (1998), the above results were found despite the fact that the majority of adolescents interviewed were not in a current episode (past 2 weeks) of depression, strengthening the notion that family difficulties persist beyond the length of the depressive episode (Lewinsohn et al., 1994), and are unlikely to be due strictly to a depressive response bias. Furthermore, by exploring the impact of marital status on these results, we may be certain that it did not have a confounding effect. Youth depression is associated with potentially enduring psychosocial impairments including disrupted peer relationships and academic functioning (Birmaher et al., 2004),

as well as the greater likelihood of parental psychopathology (King et al., 2006) which is associated with disrupted family relationships. All of these factors may contribute to parent-youth relationship difficulties persisting beyond the major depressive episode.

Father reports of the father-adolescent relationship. Fathers of adolescents in the CDA group reported lower communication scores than did fathers of adolescents in the NDA group; however, self-reports of paternal warmth and rejection were comparable among the two groups of fathers. These findings highlighted a discrepancy between father-daughter reports that was striking. The literature has found support for discrepancies in parent-adolescent reports, albeit primarily of adolescent symptomatology, finding parent reports more reliable than adolescent reports on certain symptoms (e.g., ADHD symptoms) (Hartung, McCarthy, Milich, & Martin, 2005). In other research, whereas adolescents reported less affectionate and helpful behaviour towards parents during early and middle adolescence (over 2 years), parents reported no changes in adolescent behaviour over this time frame (Eberly & Montemayor, 1999).

Discrepancies between adolescent and parent reports may be related to a number of factors (Hartung et al., 2005). First, it should be noted that fathers simply did not complete as many measures of the parent-adolescent relationship as did adolescents; therefore we obtained less information from fathers in this regard. It may be that we would have found more consistencies between father and adolescent reports of their relationship had we had access to more measures of fathers' perceptions of the father-adolescent attachment relationship. Second, it may be that fathers are simply more accurate than their daughters. Third, fathers and daughters may have each provided accurate reports, but each may have had a different framework for evaluating the

relationship. For example, fathers may have been rating the perceived quality of their life-long relationship with their child, whereas adolescents may have focused solely on the more recent interactions during adolescence. Fourth, discrepancies in father-daughter reports may also be linked to the phenomena of study—in this case, attachment and communication. That is, similar discrepancies may not have arisen for other variables (i.e., if conduct disorder symptoms were assessed as in Hartung et al., 2005). Fifth, discrepancies between father and daughter reports may have also been influenced by the format used to collect the data. For example, although self-report measures allowed for efficient data collection, they did not allow for as much in-depth exploration of father and daughter responses regarding the attachment relationship as would be the case with formal attachment-based interviews (Hartung et al., 2005). Observational research or the use of analogue methodologies may help to clarify the accuracy of father versus adolescent perceptions.

If the discrepancies were due to inaccuracy on the part of adolescents (perhaps caused by cognitive distortions related to depression), then one would have expected that these misperceptions would have been generalized to both parents. However, the patterns of results for adolescent reports on fathers versus mothers did not support this explanation. Therefore, the patterns of adolescents' responses are not simply a consequence of the depression, but likely represent longer standing relationship issues within these families, as has been suggested in the literature on families with depression (Herring & Kaslow, 2002).

Finally, some fathers may have been less likely to admit to "neglecting" or "rejecting" behaviors for fear of being seen as "bad" or "unloving" parents. In contrast, it

may have been less stigmatizing to admit to communication problems particularly since our culture often normalizes the challenges involved in communicating with one's teenager (ParenTalk Newsletter, 1995). In addition, given that the father focus was made explicit in the recruitment process, it is possible that the fathers who consented to participate were more likely to underestimate or simply not be aware of certain negative parenting behaviors. This interpretation is consistent with results reported by Costigan and Cox (2001), who found that fathers who participated in research were generally from families that were biased towards more positive functioning in terms of marital satisfaction and enriched environment. However, if participating fathers did in fact come from higher functioning families, at least in part, then the relatively higher degree of relationship problems reported by depressed as opposed to nondepressed adolescents becomes all the more relevant from a clinical standpoint. Again, including observational measures of parent-adolescent interactions together with an in-depth interview of the attachment relationship may help to elucidate the discrepancies in father-adolescent reports.

Contrary to prediction, lifetime history of psychopathology in fathers did not affect fathers' ratings of their own levels of parental warmth, rejection, and communication. It is possible that there was no genuine difference between groups in the construct evaluated, namely paternal psychopathology. There may also be other explanations for this unexpected null finding. In the case of fathers currently affected with psychopathology, being affected may have made them less sensitive to their interpersonal behaviours with their daughters. In other cases, one may speculate that the lack of impact of lifetime psychopathology on fathers' ratings or the lack of differences

in fathers' ratings across the CDA and NDA groups may have resulted because of an intergenerational effect. Namely, when these fathers compare their parenting to their fathers' parenting, they may observe enormous differences in the positive direction (e.g., more egalitarian roles, more nurturing, more child care duties). The nuances of their fathering in terms of attachment and EA may be less apparent to them because in the larger context they see positive improvements.

Similarly, adolescent ratings of the relationship with fathers or mothers did not differ based on whether adolescents had fathers with or without lifetime psychopathology. It may be that paternal psychopathology is less likely to be salient to adolescents, perhaps because it is less likely to express itself within the father-adolescent relationship. Again here, it may be possible to tease out the existence of any real differences by including observational methodologies.

The relationship between maternal mood disorder and the father-daughter relationship. The present study's findings contribute significantly towards our understanding of both the father-adolescent and father-adolescent-mother relationship. Of particular interest was the finding related to maternal depression and adolescents' relationships with their fathers. When adolescents with depressed and nondepressed mothers were compared, adolescents with depressed mothers reported significantly more perceived paternal rejection, less maternal and paternal EA, more negative paternal communication, and more negative affect related to fathers and mothers, compared to adolescents with unaffected mothers. It is noteworthy that the majority (87%) of mothers were not in a current episode of depression at the time of the study.

These are interesting and unanticipated findings that underline the value of examining adolescents' relationships with both parents. It was striking that these differences would exist when splitting the sample by presence of maternal mood disorder and not paternal affected status. However, we need to exercise caution in interpreting these differences. It would be necessary to re-run these analyses comparing adolescent perceptions based on maternal and paternal mood disorder status only and not paternal psychopathology more generally. The current sample of fathers with mood disorders versus those without mood disorders did not allow for sufficient power to compare adolescent responses.

Despite estimating needing up to 58 dyads per group, significance of the results in combination with the post-hoc power analyses demonstrated that power was ample for both analyses with the present sample. Given that both affected fathers and mothers were likely to have depressed adolescents, there was no reason to believe that there were more depressed adolescents in the affected mother group than in the affected father group (therefore potentially contributing to more negative scores in the former group). Rather, these findings may suggest a gender effect, such that having a depressed mother not only impacts the adolescent's perceptions of the relationship with mother, but also impacts their perceptions of the father-adolescent relationship. These findings have significant clinical implications and require replication.

One can speculate that when mothers suffer from depression (particularly if the depression occurs during the course of the marriage), fathers may experience increased marital demands, such that they find themselves investing most of their emotional resources to help their partners and thus are, less emotionally available for their

daughters, leading to lower perceived availability by daughters. Alternatively, the presence of depression in the family may give rise to more conflictual and hostile exchanges between spouses as well as parents and adolescents (e.g., Jacob & Johnson, 1997). Marital distress may be the result of these more negative interactions. Some research (Christensen & Heavey, 1990) has shown that men often respond to marital distress by withdrawing from their spouses and their children. Along these lines, Belsky and colleagues (1989) has shown that the father-daughter relationship is particularly vulnerable to marital distress.

In addition, marital conflict may also precede parental depression. There is ample evidence of the link between depression and marital conflict (Whiffen & Demidenko, 2005). In fact, there is some evidence that men's parenting is more strongly related to the marital relationship than is women's so that marital conflict associated with maternal depression may be linked to mens' diminished involvement in parenting (Coiro & Emery, 1998). However, from the time they are girls, females are more likely than males to be socialized into caregiving roles and to place a high degree of importance on maintaining relational harmony (Whiffen & Demidenko, 2005). Women may also be more likely than their male counterparts to invest equally in their roles as wives and mothers, even in cases where they have partners with psychopathology. Therefore, in keeping with previous observations (Jacob & Johnson, 1997), depression and perhaps psychopathology in general appears to have systemic effects on the interactions of families that may in part be dependent on the gender of the affected individuals. Given that the marital relationship was not the focus of the current study and that related constructs were not

assessed, the above interpretations remain speculative, warranting more focused investigation.

Adolescents' perceptions of the mother-adolescent relationship. Post-hoc analyses revealed that, after controlling for marital status in parents, adolescents in the CDA group did not differ from those in the NDA group on their reports of perceived maternal EA and negative affect in relation to mothers. Girls with separated or divorced parents reported less perceived maternal EA and more negative affect in relation to their mothers than did girls from intact families. This is in contrast to Bosco et al. (2003), who found that there was a significant association between adolescent girls' internalizing problems and greater negative affect towards mothers as well as fathers. However, the present study expanded on this previous research by taking into account the impact of marital status, including a greater number of intact and nonintact families, and by including adolescents who met diagnostic criteria for a depressive disorder.

Daughters with separated or divorced parents may experience increased stress in relation to their mothers, in part because they may find themselves exposed to greater maternal disclosures or worries (e.g., financial concerns, mother's dating, discussions about mother's sadness/grief about loss of marriage or negative discussions about fathers) than do girls from intact families (Koerner, Kenyon, & Rankin, 2006). Given that children typically continue to live with their mothers after marital breakdown (Statistics Canada, 2006), being exposed to greater maternal disclosures may serve to decrease perceived EA and increase negative affect in relation to mothers.

Finally, the majority of our sample included girls with depression in the past 12 months. Thus, our finding of comparable levels of reported maternal attachment in the

CDA and NDA groups were consistent with Armsden et al. (1990), who compared levels of parental attachment (primarily including mothers) in adolescents with resolved depression and nonpsychiatric controls.

Limitations and Future Directions

Because the present study was a cross-sectional examination of father-adolescent relational differences in two groups of adolescents, no causal statements can be made. A longitudinal examination of the father-mother-adolescent relationship following families from pre-adolescence, prior to the onset of adolescent depression, and measuring relationship variables at multiple time points through adolescence is required to clarify important interactional patterns and to suggest potential causal links.

Notably, the relationships between young men and their fathers and mothers were not studied here. Given that some gender differences between adolescent girls' and boys' experiences of depression have been found (Bennett et al., 2005), and youths' relationships with parents may differ according to gender of both parties (Bosco et al., 2003), future research including equal samples of male and female youth would be essential to clarify interactional differences. The challenges of recruiting large enough samples of depressed male adolescents would have to be overcome however.

In addition, it would be prudent for future research to build on the present findings by including other informant reports of family relationships such as those of siblings, including direct observations of family interactions, or asking participants to engage in analogue situations to obtain behavioral measures. Further, the inclusion of marital relationship measures would have enabled the exploration of the possible

mediating role of marital functioning in the relationship between father-adolescent attachment and adolescent depression.

To enhance the external validity of our research, we included adolescents with a primary diagnosis of clinical depression as well as other comorbid disorders. In fact, only 20% of our clinical sample included adolescents with pure depression. However, in dichotomously coding presence of comorbid disorder and including it as a covariate, it proved not to be a significant covariate and therefore was not included in the analyses. Therefore, it appears unlikely that the differences found between girls in the CDA and NDA groups are attributable to girls experiencing a combination of various disorders or the cumulative impact of having more than one disorder.

Another limitation involved measurement. Statistically significant differences were found between groups on self-report measures of the parent-adolescent relationship; however, as these measures do not include clinical cut-off scores, the clinical significance of the results obtained is less obvious. Finally, the majority of the participants were Caucasian, therefore the generalizability of these findings to parent-adolescent relationships among other ethnic groups is unknown.

Clinical Implications

The findings of this study support previous research (Essau, 2004) that has suggested prevention and intervention for adolescent depression consider the familial aspects of depression and address these within a family context. Research supporting the efficacy of interpersonal therapy for adolescent depression (IPT-A) (Mufson et al., 2004) has underscored the importance of treating youths' depressive symptoms in the interpersonal context within which they occur. It is noteworthy that, whereas adolescents

of depressed mothers rated their relationships with fathers as significantly more negative than did adolescents of nondepressed mothers, the only difference between husbands of depressed wives and husbands of nondepressed wives was with respect to more negative communication with their daughters. The results of this study underline discrepancies in relationship reports between depressed adolescents and their fathers, highlighting the need to consider both perspectives in a clinical context.

Currently, there are no treatments for adolescent depression that meet scientific criteria for being "efficacious" (Oswald & Mazefsky, 2006), although there is mounting evidence in support of IPT-A (Mufson et al., 2004). In addition, a small, randomized clinical trial (Diamond, Siqueland, & Diamond, 2003) has provided initial support for an attachment-based family therapy approach for depressed adolescents, incorporating work on adolescent affect, parenting, parent-adolescent reengagement, and attachment ruptures. More research is required to explore the efficacy of such family-based approaches.

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Running Head: PREDICTING ADOLESCENT DEPRESSION

Predictors of adolescent depressive symptomatology: A focus on perceived paternal emotional availability and rejection

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Abstract

The present study was designed to predict depressive symptoms in adolescent girls using adolescents' perceptions of paternal emotional availability (EA), rejection, and communication, as well as paternal psychopathology and maternal mood disorder. Adolescent girls aged 13-19 and their fathers participated in the study. The sample included 51 clinic referred girls who had been diagnosed with a major depressive, dysthymic or bipolar disorder and 65 never-depressed, community referred girls. Both girls and their fathers completed semi-structured diagnostic interviews and measures of parent-adolescent acceptance/rejection and communication. In addition, mothers completed a diagnostic interview for mood disorders. Adolescent perceptions of paternal EA and undifferentiated rejection accounted for 19% of the variance in adolescent depressive scores above and beyond the 17% accounted for by paternal and maternal psychopathology. Once these variables were taken into account, problems in father-adolescent communication did not explain additional variance in depressive symptoms. When zero-order correlations were examined, father reports of their own rejection of their daughters and problems in communication were not significantly related to youth depressive symptoms. This study highlights the integral role that fathers play in the psychological well-being of their daughters, and expands the research on fathers and developmental psychopathology. Finally, the results support using a family-based interpersonal approach to therapy for the treatment of adolescent depressive symptomatology.

Predictors of adolescent depressive symptomatology:

A focus on perceived paternal emotional availability and rejection

Two to four percent of adolescents meet criteria for Major Depressive Disorder (MDD) (King et al., 2006), and as many as 20% or more of community youth experience subthreshold depressive symptomatology (Lewinsohn et al., 1993; Lewinsohn et al., 2004). A number of researchers have identified links between adolescent depression and the family environment, specifically variables such as parental rejection and hostility, high negative emotion, and poor communication (Katz, 1998; Sheeber et al., 2001). Similarly, adolescent perceptions of their parents as sources of support are a key factor in protecting adolescents from the onset of depression (McFarlane, Bellissimo, Norman, & Lange, 1994). The purpose of the present study was to predict adolescent depressive symptoms from adolescents' perceptions of paternal emotional availability (EA), paternal rejection, and father-adolescent communication.

Consistent with attachment theory, research has demonstrated that secure attachment is based on the child's confidence in his or her parent's emotional availability (EA) rather than on the parent's immediate and continuous physical presence (Ainsworth et al., 1978; Goldberg, Grusec, & Jenkins, 1999). Thus, attachment theory proposes that an adolescent's vulnerability to depression, and perhaps psychopathology in general, is increased in the context of parental relationships that are cold, unaffectionate, rejecting, and one where parents are emotionally unavailable (Bowlby, 1980; 1988). This is supported by research that has found high levels of parental EA to be associated with low ratings of psychological maladjustment in youth (Lum & Phares, 2005). Attachment theory also predicts that feeling persistently rejected by one's primary caregivers

contributes to the creation of depressive or negative internal model of self, and that children or adolescents who are persistently rejected fail to develop a sense of self as loveable and worthy (Bowlby, 1988). Insecure attachment may predispose adolescents to future emotional problems, and, when combined with socio-cultural roles, expectations, and gender, may lay the groundwork for the emergence of depressive symptoms (Shaw & Dallos, 2005). Just as secure parent-child attachment is thought to lay the foundation for a child's self-worth and an adolescent's emerging sense of identity and autonomy, so too is positive parent-adolescent communication vital for an adolescent's ability to negotiate the developmental tasks of this period (Barnes & Olson, 1985).

In the past 10 years, we have seen an increase in the amount of the research on fathers and adolescents' normal and abnormal development and psychopathology. However, there still remains a dearth of research in this area (Phares, Fields, et al., 2005). Based on a review of recent published research and graduate dissertations in the area of developmental psychopathology, Phares and colleagues (Phares, Fields, et al., 2005; Phares, Lopez, et al., 2005) argued for the need to further examine fathers in research on child and adolescent well-being. Fathers' roles have changed and men have become more involved in the care of their children than their own fathers were (Bouchard & Lee, 2000). There is evidence to suggest that fathers play a significant role in the well-being and normative development of their children and adolescents (Lamb, 2004), as well as in developmental psychopathology (Videon, 2005). Furthermore, it is clear that fathers have an impact on adolescent development that is distinct from that of mothers (Shulman & Seiffge-Krenke, 1997). Given that parental EA and parental rejection may significantly influence the development of depressive symptomatology, it is important to

investigate these variables in the context of youths' perceptions of their family relationships, particularly father-youth relationships.

Research has demonstrated a link between disruptions in parent-adolescent attachment or insecure attachment in adolescents and adolescent depression (Cooper et al., 1998; Herring & Kaslow, 2002). In particular, earlier studies found a relationship between one aspect of attachment, adolescents' ratings of rejection by the father, and adolescents' self-reported depressive symptoms (Baron & MacGillivray, 1989). This relationship was particularly pronounced in the context of fathers and their adolescents. In all cases when variables were entered together, perceptions of paternal rejection accounted for at least three times as much of the variance in self-rated depressive symptoms as did the next most powerful predictor -- perception of mothers' psychological control. Other research (Papini & Roggman, 1992; Papini et al., 1991) found an inverse relationship between adolescent feelings of depression and anxiety and their attachment to both parents. Barrera and Garrison-Jones (1992) found that adolescents' satisfaction with father support, but not satisfaction with mother support, significantly predicted depressive symptoms in an inpatient sample.

The findings found in early studies have been extended in recent work that has examined larger, nonclinical high school or community youth samples exploring predictors of depressive symptomatology. However, several of these studies only included youth as participants (Field et al., 2001; Hale et al., 2005; Sund & Wichstrom, 2002; Videon, 2005; Wilkinson & Walford, 2001), leaving unanswered the impact of parental variables, such as parental psychopathology, on adolescent depressive symptomatology. In a nationally representative sample of over 20, 000 American

students, Videon (2005) found that higher levels of adolescents' satisfaction with the father-adolescent relationship predicted fewer depressive symptoms. This effect remained significant even after adolescents' relationships with their mothers were added to the regression, indicating unique variance explained by the father-adolescent relationship. Similarly, other research (Sanford et al., 1995) found that when mother- and father-related variables were entered together (low father involvement and poor response to mother's discipline), both were significantly associated with persistence of MDD. However, the researchers used a clinical sample exclusively, making it unclear as to whether similar patterns would be seen in nonclinical or mixed samples.

In general, the presence of secure parent-adolescent attachment appears to be a protective factor, whereas the absence of secure attachment acts as a risk factor for depression. Especially for girls, adolescents' perceived parental rejection (Hale et al., 2005) and alienation (Sund & Wichstrom, 2002) have been found to predict more severe depressive symptoms. For some youth, general attachment to parents has been found to be associated with enhanced levels of adolescent well-being and lower levels of psychological distress (Wilkinson & Walford, 2001).

Recent studies that have investigated the perceptions of both parents and youth together have further illuminated our understanding of the importance of the parent-adolescent relationship (Allen et al., 2006; Bosco et al., 2003; Brennan et al., 2002; Heaven et al., 2004). Bosco et al. (2003) found that internalizing behaviors were related to negative perceptions of both fathers and mothers, higher levels of parental psychopathology and lower adolescent-rated maternal control, lower levels of adolescent-rated parental acceptance, and lower paternal EA, with these patterns being particularly

pronounced for girls. However, these researchers included only a community sample of adolescents, and primarily recruited intact families (Bosco et al., 2003). Heaven et al. (2004) found that low fatherly warmth, as rated by fathers, was associated with an increased likelihood of depressive symptoms. The only study that included youth, mothers and fathers, and involved assessment of diagnostic status (Brennan et al., 2002) reported an interaction effect of maternal and paternal depression in the prediction of youth depression. In addition, after controlling for the main and interaction effects of maternal and paternal depression, fathers' expressed (negative) emotion (EE) contributed to the prediction of youth depression.

Along these lines, depression in a family member has been documented to impact parent-adolescent communication (Cummings & Davies, 1999). For example, depressed parents often demonstrate negative emotions and despair as well as mixed expressions of personal responsibility and helplessness (Thompson & Caulkins, 1996). In addition, through their communication with their children, depressed parents may increase their children's sense of responsibility and guilt for their parents' depression (Zahn-Waxler, Kochanska, Krupnick, & McKnew, 1990).

Taken together, these studies demonstrate that adolescents who report more problems in their relations with parents are also at greater risk for depressive symptoms. However, because the majority of the above studies only examined nonclinical samples (Allen et al., 2006; Bosco et al., 2003; Hale et al., 2005; Heaven et al., 2004; Sund & Wichstrom, 2002; Videon, 2005; Wilkinson & Walford, 2001), many included only adolescent participants (Hale et al., 2005; Sund & Wichstrom, 2002; Videon, 2005; Wilkinson & Walford, 2001); and others focused on youth from primarily intact, 2-parent

families (Bosco et al., 2003; Brennan et al., 2002), it is unclear to what extent these findings apply to mixed clinical and nonclinical samples of youth from both intact and single parent families. In addition, the exploration of parental psychopathology and youth perceptions of parent-youth attachment within a single study, the inclusion of multi-rater data from both parents and youth, and the inclusion of measures of EA and rejection which have rarely been studied, are included in the present study to expand on previous research.

In a previous report (Demidenko, Manion, Lee, & Wilson, unpublished manuscript), we described differences between depressed and nondepressed (as based on diagnosis) adolescents' perceptions of their relationships with fathers primarily, as well as mothers. A significant contribution of this report was the inclusion of fathers' perceptions of their relationships with their daughters, and subgroups of clinical and nonclinical adolescents. We also examined how adolescents' perceptions varied on the basis of paternal psychopathology or maternal mood disorder. In this report, we used the same sample, but combined the clinical and nonclinical groups so that the adolescent girls were not distinguished by their diagnostic status. Instead, girl' self-reported depressive symptomatology was predicted from a set of adolescent-rated variables, along with paternal psychopathology and maternal mood disorder. A significant contribution of this report was the inclusion of clinic and community referred adolescents within a single sample, inclusion of measures of emotional availability and a specific measure of undifferentiated rejection, which have rarely been studied, and the examination of the construct of depression on a continuum. Such an examination has not been presented in the research to date.

A Priori Hypotheses and Rationale for Scales.

Adolescent girls' reports of lower paternal EA, higher undifferentiated rejection, and more problematic father-daughter communication were predicted to be associated with higher adolescent self-reported depressive symptomatology. Given that research has found that parental psychopathology predicts psychopathology in offspring (Klein et al., 2005), presence of paternal psychopathology and maternal mood disorder were entered into regression equation at the first step.

Emotional availability and undifferentiated rejection were chosen as variables of interest based primarily on theoretical grounds, as they typify the core aspects of attachment (or lack of attachment) (Biringen, 2000; Bowlby, 1988; Lum & Phares, 2005; Rohner, 1999), and are more specific than an overall measure of attachment which has typically been used in previous research. Problems in communication may be conceptualized as the behavioural outcome of compromised parent-child attachment and emotional availability (Kobak & Esposito, 2004), thus, the contribution of problematic communication was also assessed.

Method

Participants

Full details about participants are reported in Demidenko et al. (unpublished manuscript). An a priori power analysis suggested that, in order to detect a medium effect size maintaining a .05 alpha level and a power of .80, 115 father-daughter dyads would be required for a multiple regression using six variables (Cohen, 1988). As described in Demidenko et al. (unpublished manuscript), only adolescent girls between the ages of 13 to 19 were included. The decision to include only girls was largely due to the higher

prevalence of MDD in adolescent girls versus boys (Bennett et al., 2005). A total of 186 adolescent girls signed forms to indicate interest in participation. Five out of 56 girls recruited through a mental health clinic and 64 out of 130 girls recruited through the community and secondary schools were unable to participate for various reasons, such as lack of youth or father interest, or scheduling difficulties. The way in which clinic-referred and community-referred girls were approached about the study may have contributed to differences in participation rates. For example, each depressed girl (and in some cases her father or mother) was approached individually and typically informed about the study through her treating clinician. Whereas community referred girls were primarily approached within classroom settings, making the recruitment process less personal. These girls may have also felt less motivation to participate compared to clinic referred girls, perhaps because they simply had less experience with or interest in mental health issues.

A total combined sample of 116 father-adolescent dyads was included. All father-daughter dyads who appeared for participation in the study and signed consent forms, completed the study. For 8.6% (n = 10) of the sample, maternal diagnostic information on lifetime mood disorder was not available (e.g., in some cases mothers were deceased, unable to speak English, or adolescents preferred mothers not to be contacted).

Inclusion criteria for all adolescents and fathers included at least regular face-to-face contact with their biological child/father (i.e. minimum of one contact per month over the last 12 months), and ability in English sufficient to comprehend the assessment battery. Adolescents recruited through mental health clinics had to have met DSM IV

criteria for a major depressive episode or dysthymic disorder within past 12 months according to the clinician at the centre from which they were recruited. Adolescents recruited through the community had never experienced major depressive episode or dysthymic disorder lifetime, and had not suffered from an Axis I psychiatric illness in the past 12 months (as determined by telephone screening and diagnostic interview by principal investigator). Exclusion criteria for all adolescents and fathers included the presence of a developmental and/or learning disability precluding their ability to complete the assessment battery, and the presence of psychotic spectrum disorders. Paternal psychopathology was assessed in all fathers. Adoptive families were excluded, given that the time and circumstances of the adoption, as well as the adolescent's life experiences prior to the adoption may have presented a series of confounds (Iftene & Roberts, 2004; Irhammar & Cederblad, 2005).

The present study included 2-parent and single parent biological families (i.e. single father or mother families) so as to increase the generalizability of findings and to facilitate recruitment. Two independent research ethics boards at the recruiting facilities approved the present study (see Appendix A).

Procedure

As described in Demidenko et al. (unpublished manuscript), adolescents diagnosed with a depressive disorder were referred to the study by the referring clinician who had already diagnosed major depressive disorder, dysthymic disorder, or bipolar disorder (most recent episode, major depressive) in the past 12 months. Clinicians asked interested adolescents to complete a consent form indicating their interest in writing, thus allowing the investigator of the study to initiate telephone contact (see Appendix B). The

principal investigator (PI) contacted the adolescent by phone to complete the initial screening, and invited fathers to participate at this time. Participants without current psychopathology were self-referred in response to advertisements in community newspapers and through active recruitment in local secondary schools. Interested students completed consent forms allowing the PI to contact them for screening (see Appendix B).

Mothers were contacted by telephone after completion of testing with fathers and adolescents, and asked to complete the mood disorder module of the Mini International Neuropsychiatric Interview Plus (MINI Plus; Sheehan, Janavs, et al., 2003). Participants had the choice of completing the interview and testing at one of the two treatment facilities or in their home.

Following informed consent (see Appendix C), the PI and another graduate student trained in the screening measures interviewed each father and adolescent separately and administered the self-report battery to the participants. Fathers and daughters were interviewed in separate rooms to ensure privacy and confidentiality, and to prevent additional biasing of responses. All participating fathers and daughters completed a diagnostic interview [MINI Plus for ages 17 and up (Sheehan, Janavs, et al., 2003) or the MINI Kid for ages 16 and younger (Sheehan, Shytle, et al., 2003)], and a Beck Depression Inventory-II (BDI-II) (Beck et al., 1996) followed by the appropriate self-report battery. Testing took an average of 1.5 to 2 hours to complete with each family. Complete demographic data (including family constellation, SES, treatment history, etc.) were collected from each father (see Appendix E). Participants who chose to complete testing at one of the treatment facilities were given $30.00 to cover costs,

such as hospital parking. Adolescent participants who chose to complete the testing in their homes were given volunteer hours to be used towards their community service requirements for secondary school. All families were offered a summary of the study findings, to be sent to them after completion of the study.

Measures

The Beck Depression Inventory-II (BDI-II). The BDI-II (Beck et al., 1996) has 21 items, and is used to assess depressive symptoms over the past two weeks in individuals 13 years or older on a 4-point scale (ranging from "not present" to "severe"). Beck et al. (1996) reported internal consistency coefficients of .92 for an outpatient sample and .93 for a college sample. Test-retest reliability over one week for a sample of 26 outpatients was .93. Construct validity was demonstrated by correlating the BDI-II with the BDI-IA (Amended version); the correlation was .93 (Beck et al., 1996). The BDI-II shows adequate convergent validity when compared to the Beck Hopelessness Scale (r = .68), the Scale for Suicide Ideation (r = .37), and the Revised Hamilton Psychiatric Rating for Depression (HRSD-R; r = .71). Discriminant validity is demonstrated by higher correlations between the BDI-II and the HRSD-R than the BDI-II and the Revised Hamilton Anxiety Rating Scale (r = .47) (Beck et al., 1996). Cronbach's alpha for the current sample was .96 (BDI-total) for adolescents, and .93 for fathers.

The Lum Emotional Availability of Parents scale. The LEAP scale (Lum & Phares, 2005; see Appendix D) assesses an adolescent's perceptions of his or her mother's and father's emotional availability separately in the form of a 15-item self-report questionnaire. Emotional availability (EA) has been defined as the level of parental responsiveness, sensitivity, and emotional involvement (Biringen & Robinson,

1991). This construct is reported as central to the measurement of attachment in parent-child relationships (Bowlby, 1988). The LEAP scale shows good reliability and validity with a college sample and a clinical/non-clinical youth sample (Lum & Phares, 2005). The internal consistency alpha for the LEAP total scale was .98 for both the mother and father forms (Lum & Phares, 2005). Convergent validity between the LEAP scale and similar measures (i.e., the PBI, the Brief Symptom Inventory, and the Profile of Mood States) was demonstrated (Lum & Phares, 2005). Cronbach's alpha for the current adolescent sample was .97 (LEAP total-father).

The Parental Acceptance Rejection Questionnaire (PARQ; see Appendix D for Child version). The Undifferentiated Rejection subscale (UR) from the PARQ (Parent and Child versions) (Rohner, 1999) was used to measure fathers' and adolescents' perceptions of undifferentiated rejection in their relationship (i.e. feeling unloved, unwanted, or uncared about without any objective indicators of parental coldness, aggression, or neglect). Participants answer 10 items about rejection using a 4-point Likert scale. Higher scores indicate more rejection. Internal consistency for the PARQ-UR is good, with a Cronbach's alpha of .72 for the child version (Rohner, 1999). The PARQ-UR child version demonstrates solid convergent validity correlations a number of standardized measures (e.g. alpha = .74 with the Child's Report of Parent Behavior Inventory). Construct validity is also good (Luce, 1992). Cronbach's alpha for the PARQ-UR in the current sample was .88 for adolescents, and .76 for fathers.

The Inventory of Parent Adolescent Communication. The 10-item Problems in Communication subscale of the IPAC (Barnes & Olson, 1985; see Appendix D for Adolescent version), was used measure negative aspects of communication, negative

interactional patterns, hesitancy to share, and selectivity/caution in information shared between fathers and adolescents. Higher scores on the subscale represent more positive communication. Negative aspects of communication are seen as related to more general parent-adolescent attachment bonds such that less attachment security is thought to translate into more problematic communication at the interpersonal level (Kobak & Esposito, 2004). In three samples, Barnes and Olson (1985) found initial Cronbach's alpha of .77 to .78 for the Problems in Communication subscale. Test-retest reliability coefficients over 4 to 5 weeks were found to be .78 for Problems in Family Communication (Barnes & Olson, 1985). Cronbach's alpha for the current sample (for the Problems in Communication) was .80 for adolescents, and .76 for fathers.

Results

The sample consisted of 116 adolescent girls and their fathers. This sample combined depressed, clinic referred (n=51) and nondepressed, community referred (n = 65) girls. Clinic referred girls met criteria for major depressive disorder (MDD; 90.2%), dysthymic disorder (3.9%), or bipolar disorder (5.9%) within the past 12 months. Community recruited girls had never experienced diagnosable depression, and did not meet criteria for any other Axis I disorder in the past 12 months.

Prior to analyses, independent groups T tests were conducted to determine whether there were any key demographic differences between girls of different diagnostic statuses and their fathers. The clinical and community recruited samples were comparable in age (Clinic: M = 15.92, SD= 1.47; Community: M = 16.28, SD = 1.26), t (114) = -1.40, ns). Community recruited fathers (M = 50.48, SD = 5.66), t (114) = -2.64, $p < .01$, and mothers (M = 48.27, SD = 5.20), t (111) =-2.61, p = .01 were significantly older than

their clinic recruited parents (fathers: $M = 47.86$, $SD = 4.77$; mothers: $M = 45.90$, $SD = 4.24$). Community recruited fathers were more likely to have partially or fully completed graduate studies (74.3% attained college or higher) compared to clinic recruited fathers (68.6% attained college or higher), χ^2 (3, N = 116) = 9.39, $p = .03$; this effect was not seen for mothers, χ^2 (3, N = 115) = 2.12, ns. There was no difference in family income between the two groups, χ^2 (1, N = 115) < .01, ns, with over 78% of families earning $76,000 or greater. Parents of clinic recruited adolescents (60.8% married; 39.2% separated/divorced) were more likely than parents of community referred adolescents (78.5% married; 21.5% separated /divorced) to be divorced or separated, χ^2 (1, N = 116) = 4.31, $p = .04$. The samples were representative of families within the Ottawa-Gatineau region in terms of socioeconomic status (SES) and income, and highest education level attained (Statistics Canada, 2001) and suggested that participating families fell within the middle to upper SES bracket. The majority of the sample was Caucasian.

Approximately 36% of the total combined father sample met criteria for at least one Axis I disorder or antisocial personality disorder, and 63.8% of fathers did not meet criteria for any disorder (lifetime). Approximately 38% of mothers met criteria for a mood disorder of some kind, and 53.4% did not meet criteria for a mood disorder (lifetime).

As in Demidenko et al. (unpublished manuscript), correlations between the demographic and criterion variables were reviewed to explore the possibility of including demographic variables as covariates (see Appendix F). Due to the significant difference between clinic and community referred groups on parents' marital status, the following hierarchical regression was done with and with marital status as a covariate. As marital

status did not explain any variance in the regression equation, results were presented without the inclusion of this variable. As neither father's education nor age was significantly correlated with the independent variables, they were not considered as covariates.

To examine whether adolescent girls' depressive symptoms could be predicted from a set of attachment and communication variables, a hierarchical multiple regression was conducted using youth BDI-II scores as the outcome variable, and adolescent perceptions of fathers' emotional availability (LEAP), undifferentiated rejection (PARQ-UR), and problems in communication (IPAC) as predictor variables. In order to control for psychopathology in fathers and maternal mood disorder, these variables were entered in the first step. Due to some missing maternal data, the regression was conducted using a total sample of 106 adolescents. Selection of predictors was initially based on theory (see Measures section); attachment-related variables were proposed as most important, and therefore were entered in the second step of the regression. Zero order correlations between the independent and dependent variables were examined, and independent variables with a correlation of greater than .70 were not put into the equation to avoid redundancy. Likewise, independent variables that were modestly correlated with the dependent variable were not included according to rules for predictors as described by Tabachnick and Fidell (2001).

To address the assumptions for multiple regression, variables were inspected for skewness, normality, linearity, and homoscedasticity. Inspection of standardized scores and graphical methods revealed three univariate outliers; all were considered to be representative of the intended population, and were treated uniformly. Following the

recommendations of Tabachnik and Fidell (2001), scores were brought in towards the mean (minimum increment required to reduce standardized score to less than +/-3.29). With the use of a $p < .001$ criterion for Mahalanobis Distance, no multivariate outliers among the cases were found. The adolescent BDI-II distribution was positively skewed, with most scores falling in the low end of the distribution. There was no bimodal distribution. These results are consistent with the fact that the majority of the subsample of clinically depressed adolescents were not currently in an episode of major depression.

A logarithmic (log10) transformation was used to address moderate to severe skewness in BDI-II, LEAP and PARQ-UR scores (Tabachnick & Fidell, 2001). Multiple regressions were conducted on raw and transformed data (Tabachnick & Fidell, 2001). Because the results were identical, untransformed data are reported for ease of interpretation.

Table 1 displays the zero-order correlations between the variables, the unstandardized regression coefficients (B), standard error of the coefficients, Beta, and R^2 change (see Appendix F for full correlation matrix). In order to control for the impact of having a father affected with a mental illness and a mother with a mood disorder, paternal psychopathology and presence of maternal mood disorder were entered in the first step. R was significantly different from zero in the first and second steps. Step 1 indicated that presence of paternal psychopathology and maternal mood disorder significantly predicted variance in youth depression scores, $R = .41$, $F(2, 103) = 10.60$, $p < .01$. After Step 2, with EA and UR added to the equation, R^2 was significantly increased, $R = .60$, $F(4, 101) = 14.40$, $p < .01$. Approximately 36% of the variance accounted for in youth depressive scores was explained by EA (LEAP), rejection (PARQ-UR), paternal psychopathology

and maternal mood disorder. In Step 3, problems in communication as perceived by youth did not explain any additional variance.

Pearson correlations between adolescent depression scores and father reports of undifferentiated rejection (UR) and problems in communication were examined to explore the possibility of conducting post-hoc regression analyses using father-reported data as predictors (as this was not predicted a priori). An inspection of the correlation matrix revealed nonsignificant associations between adolescent depression scores and father reports of UR (r = .11, ns) towards adolescents and problems in communication with adolescents (r = -.16, ns), so further analyses were not warranted.

Table 1. Hierarchical Regression of Girls' Perceptions of Emotional Availability (EA), Undifferentiated Rejection (UR), and Problems with Communication (PC) on Girls' Depression Scores, Controlling for Paternal Psychopathology (PP) and Maternal Mood Disorder (MMD).

Variables[2] $N = 106$	Youth BDI-II	PP	MMD	EA	UR	PC	*B*	SE *B*	β	sr^2
Step 1										
PP	.26**	---					5.20	2.39	.18	
MMD	.37**	.20*	---				5.00	2.44	.18	.17***
Step 2										
EA	-.47***	-.06	-.32**	---			-.19	.10	-.20	
UR	.48***	.12	.22*	-.57***	---		.63	.30	.23	.19***
Step 3										
PC	-.46***	-.08	-.31**	.60***	-.65***	---	-.23	.21	-.13	.008
Intercept	21.90									
Means	13.01	N/A	N/A	71.55	14.62	34.78				
Std. Dev.	13.98	N/A	N/A	14.87	5.36	7.73				

*$p < .05$; **$p < .01$; ***$p < .0005$

[2] Please note: PP represents paternal lifetime psychopathology; MMD represents lifetime maternal mood disorder; EA is daughters' perceived paternal emotional availability; UR is daughters' perceived paternal undifferentiated rejection; PC is daughters' perceptions of problems in communication with fathers.

Discussion

The present study examined the importance of adolescents' ratings of paternal EA and rejection in predicting their depressive symptoms in a mixed sample of depressed and never-depressed adolescent girls, after controlling for parental psychopathology. As predicted, girls who experienced their fathers as less emotionally available and more rejecting reported more depressive symptoms. These findings support previous research that showed a direct relationship between adolescent perceptions of parental rejection and adolescent depressive symptomatology, an effect particularly strong for girls (Hale et al., 2005). However, the present study expands on Hale et al.'s work (2005) by underlining the importance of perceived paternal rejection, as opposed to focusing on parental rejection in general. Moreover, the present study underscored the importance of perceived paternal EA in predicting youth depressive symptoms. Our findings are consistent with one previous study (Bosco et al., 2003) that demonstrated a link between lower paternal EA and higher levels of internalizing behaviour problems. EA has been thought to be a core aspect of the attachment relationship between parent and child (Ainsworth et al., 1978; Lum & Phares, 2005), yet has rarely been studied, particularly in relation to fathers.

Interestingly, when marital status of parents was entered into the regression model as a covariate, it was not significant, indicating that it did not account for variance in adolescents' depressive symptoms. This is in contrast to research that has found an increase of depressive and anxiety symptoms associated with the event of parental divorce itself (Strohschein, 2005). In the present sample, inspection of the correlation

matrix revealed a modest association between adolescent depressive symptoms and marital status (approximately 4% shared variance).

Another important aspect of the study was the lack of a relationship between girls' depressive symptomatology and father-reported rejection and problems in communication as rated by fathers. Given the significant relationship between youths' perceived rejection by fathers and depressive symptomatology, one would also expect a significant relationship between fathers' own reports of rejection and youth depressive symptomatology. This was not the case, and proved to be an interesting finding. Fathers may be less in tune with their own parenting behaviors (e.g., rejecting behaviors or problematic communication) when their adolescents report greater depressive symptomatology. In part, they may view any relational problems as originating with the adolescents, as adolescents may also become more rejecting of parents' attempts to reach out (perhaps in part because of the sadness and apathy that defines depression). Thus, the lack of a relationship between fathers' own rejection and youth depressive symptomatology may be a consequence of fathers and adolescents being misattuned to one another. Another possibility may be that adolescents with higher depressive symptomatology may have somewhat skewed (negative) perceptions of the parenting relationship (Katz, 1998).

The inclusion of diagnostic measures of paternal psychopathology and maternal mood disorder was a strength of this study. Paternal psychopathology and maternal mood disorder were significant predictors of adolescent girls' depression scores and each contributed unique variance to explaining depressive symptoms. This finding highlights the significant contribution that both maternal and paternal psychopathology make with

respect to youth psychological outcomes, and is in keeping with previous research (Connell & Goodman, 2002) that has found comparable risk for psychopathology in youth when either father or mother is disordered or experiences psychopathology. Our findings also support the findings reported by Klein and colleagues (2005) that MDD in fathers and mothers was independently associated with MDD in offspring.

The findings of the present study have direct implications for treatment of adolescent depression and are worthy of further investigation. The importance of father-adolescent variables, such as EA and rejection, suggest an interpersonal approach to treatment that includes relationships between adolescent, father, and mother. Such an approach may be more relevant than individual therapy, and can perhaps more directly target both the perceived and unperceived problems in the parent-adolescent relationship. Attachment-based family therapy (ABFT) (Diamond et al., 2003) to treat adolescent depression has received some support, although this approach has not been yet been tested in larger clinical trials as is the case for interpersonal therapy (IPT-A). In this approach, families work together to reframe interactions, repair parent-adolescent alliances and trust, and process attachment failures (Diamond et al., 2003). There is also solid evidence to suggest that adolescents treated with IPT-A to address role disputes, grief in relationships, role transitions, and interpersonal deficits show a greater reduction in depressive symptoms, and better overall functioning than those treated with supportive therapy (Mufson et al., 2004).

There are several notable strengths of the present study. First, it included a combination of clinical (inpatient and outpatient) adolescents diagnosed with a primary mood disorder as well as a high school/community sample, thus extending

generalizability, and expanding on previous research that primarily focused on school samples (Field et al., 2001; Hale et al., 2005; Sund & Wichstrom, 2002; Videon, 2005; Wilkinson & Walford, 2001). Second, the present study included a mix of intact families and families with heterogeneous family compositions (i.e., blended families, stepfamilies). Third, the clinical sample did not solely consist of adolescents with pure depression, but also included adolescents with comorbid disorders as is typically the case in clinical treatment settings. Fourth, inclusion of EA, a core aspect of the parent-child attachment relationship (Biringen, 2000) but rarely studied, was a notable strength of this study. Because EA is a specific feature of the attachment relationship, it may be easier to measure over time than attachment in general, and may have more exact treatment implications (Biringen, 2000). After all, in treatment, it may be more straightforward to work on changing EA than attachment in general. Finally, despite combining clinic and community referred samples into one sample, depressive symptomatology scores were representative of what would be expected in a normal population, and there was no bimodal distribution. This made the findings more generalizable.

There are also several limitations of the present study. First, the cross-sectional nature of the study precludes causal statements. Second, although it was a strength to include both clinical and nonclinical samples in the present study, different variables may predict depressive symptoms for the two samples. A larger overall sample would have made it possible to calculate a multiple regression for the clinical and nonclinical samples separately. Third, the majority of the participants were Caucasian, therefore the generalizability of these findings to parent-adolescent relationships among other ethnic groups is unknown. Fourth, only adolescent girls were included. The relationship

patterns identified in the present study may differ for boys experiencing depressive symptoms. Finally, the present findings require replication with equal samples of adolescent boys and girls, and inclusion of adolescent and mother reports of maternal EA, rejection, and communication. Including a measure of mothers' expressed EA, and perhaps an observational measure of EA to both parents would expand on the richness of the present findings.

Having such data available would allow for a more comprehensive regression model or examination of a mediational/moderational model, to explore the associations between adolescent depression, parental psychopathology, and maternal and paternal EA, rejection, and communication. Adding observational measures of interaction between parents and youth, or analogue measures would also elucidate the present findings and add another layer of complexity to the study of father-adolescent relationships.

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General Discussion

In the first manuscript, adolescent girls from clinical and nonclinical groups were compared on attachment and communication variables. In addition, adolescent and father ratings of acceptance, rejection, and communication, and adolescent ratings of emotional availability, perception of parents, and attachment were compared, taking into account paternal psychopathology and maternal mood disorder.

In the second manuscript, clinic and community referred adolescent girls were combined into one sample to predict depressive symptomatology from adolescent perceptions of paternal emotional availability, undifferentiated rejection, and problems in communication. The novel contribution of the second manuscript was the exploration of depressive symptomatology along a continuum. In doing so, we were interested in predicting these symptoms using key constructs highlighted by attachment and interpersonal theories – EA, rejection, and communication problems.

Exploring attachment using subconstructs, rather than a global measure of attachment as has been the case in the much of the past research, can enhance our knowledge about the key aspects of father-adolescent relationships that may foster resiliency or that may need to be addressed in treatment with depressed adolescents and their families. The approach of refining and measuring attachment more narrowly has been supported in the literature (Goldberg et al., 1999). In addition, whereas both manuscripts included perceptions of paternal emotional availability as a key construct, the second manuscript focused on two specific issues associated with problematic parent-adolescent attachment (or insecure attachment), undifferentiated rejection (Bowlby, 1988; Rohner, 1999) and problems in communication (Kobak & Esposito, 2004).

Summary of Findings

The first manuscript highlighted differences between currently depressed (CDA) and nondepressed (NDA) adolescent girls in terms of father-daughter attachment, paternal acceptance and rejection, emotional availability (EA), negative affect related to fathers, and father-daughter communication. As predicted, girls in the CDA group reported more negative attachment to fathers, less perceived warmth, more overall perceived rejection (including hostility and neglect), more negative affect in relation to fathers, lower EA, and more negative communication compared to girls in the NDA group. Once differences in marital status were accounted for, girls in the CDA group no longer differed from girls in the NDA group in their perceptions of maternal EA and negative affect in relation to mothers. These findings are discussed in detail further on in this section. Attachment to mothers was comparable across the two groups of adolescents. Interestingly, whereas the girls from the CDA group reported more negative relationships with their fathers than did girls in the NDA group, fathers from the CDA and NDA groups did not differ in their ratings of warmth and overall rejection towards their adolescent daughters. They did however, report more negative communication with their adolescents compared to fathers in the NDA group.

The findings in the second manuscript complemented those of the first manuscript, drawing attention to the importance of relational variables in the experience of adolescent depression. Regardless of whether we examined relational variables in association with a diagnosable depressive disorder or depressive symptomatology, an important correlation was evident. In manuscript 2, even when clinic and community referred girls were combined into a single sample, attachment-related variables, such as

girls' perceptions of paternal EA and undifferentiated rejection, predicted depressive symptomatology in girls above and beyond the presence of paternal psychopathology and maternal mood disorder.

Both reports expanded upon previous research that demonstrated a link between the quality of the parent-adolescent relationship and diagnosed adolescent depression (Essau, 2004; McCleary & Sanford, 2002; Pavlidis & McCauley, 2001; Shiner & Marmorstein, 1998) or depressive symptomatology (Baron & MacGillivray, 1989; Bosco et al., 2003; Hale et al., 2005; Heaven et al., 2004; Sund & Wichstrom, 2002; Vivona, 2000). By adopting a multirater design, including data on mothers and extensive data on fathers, including clinical and nonclinical samples within one study, accounting for Axis I disorders together with depressive symptomatology, and including a balance of intact and single parent families, the present studies addressed some of the gaps in the previous research.

Namely, much of previous research has focused on adolescent reports of parental relationships only (Hale et al., 2005; Sund & Wichstrom, 2002; Videon, 2005; Vivona, 2000); included primarily mothers when including parent participants (Armsden et al., 1990; Hammen & Brennan, 2001; Pavlidis & McCauley, 2001; Sanford et al., 1995; Sheeber et al., 1997; Sheeber & Sorensen, 1998); studied clinical groups (Essau, 2004; Pavlidis & McCauley, 2001; Sanford et al., 1995) or school/community samples exclusively (Allen et al., 2006; Baron & MacGillivray, 1989; Hale et al., 2005; Sund & Wichstrom, 2002; Videon, 2005; Wilkinson & Walford, 2001); studied either diagnoses (Essau, 2004; McCleary & Sanford, 2002; Pavlidis & McCauley, 2001; Shiner & Marmorstein, 1998) or symptomatology exclusively (Baron & MacGillivray, 1989;

Bosco et al., 2003; Hale et al., 2005; Heaven et al., 2004; Sund & Wichstrom, 2002; Vivona, 2000); and primarily studied youth from intact families (Bosco et al., 2003; Brennan et al., 2002).

To address the potentially confounding effect of marital status on the results found in either report (given that there were significant differences between clinical and nonclinical groups on marital status), all analyses were conducted with and without marital status as a covariate. It is of note that, in most cases, results in the two reports were unaltered even after including this covariate, and therefore were presented without the covariate.

In the first manuscript, once marital status was included as a covariate when investigating group differences on adolescents' reports of perceived maternal EA, maternal attachment, and negative affect in relation to mothers, the significant differences previously found between the CDA and NDA groups for EA and negative affect were no longer evident. That is, in the case of adolescents' experiences with their mothers, girls with separated or divorced parents reported less perceived EA from mothers and more negative affect towards mothers than girls from intact families. As previously discussed, if girls are particularly vulnerable to the emotional sequelae of problematic family relationships (Davies & Windle, 1997; Whiffen & Demidenko, 2005), then the stress that marital separation engenders may, at least in part, be responsible for some mother-adolescent relational problems. Because children tend to live with their mothers after marital breakdown (Statistics Canada, 2006), the stress associated with marital separation may have more of a chance to thrive in the relationships between girls and their mothers, rather than girls and their fathers. In addition, girls living with mothers who have been

separated or divorced may have exposure to a greater number of maternal disclosures (e.g., complaints about the marriage, complaints about the father, mother's dating, financial or daily living concerns) (Koerner et al., 2006) that may compound the adolescent's stress and deplete the mother-adolescent relationship.

In the second manuscript, marital status was not a significant covariate and therefore was not used. These results highlight, that whereas marital status of parents explains certain group differences between depressed and nondepressed girls, it did not explain the majority of group differences. Including both intact and non-intact families was a strength of the present study, and made these results more generalizable to clinical populations seen in practice.

Rather than reiterate issues discussed in the individual articles themselves, this section will discuss the significance of the study's findings more globally. The findings presented in the manuscripts pointed to important differences in perceptions between youth and fathers, and speak to the importance of including youth and parents in research on adolescent psychopathology. In studying parental expressed emotion, adolescent social functioning, and adolescent depression, McCleary and Sanford (2002) also found a discrepancy in parent and youth reports of youth social functioning, with parents reporting worse social functioning than adolescents. However, in McCleary and Sanford (2002), both parents and adolescents were rating adolescents' behaviour, whereas in the present research fathers were asked to rate their own behaviour towards their daughters.

The discrepancies in daughters' perceived paternal warmth and overall rejection and fathers' own reports of warmth and rejection (i.e., manuscript 1) were an interesting and a surprising finding. Furthermore, because analyses were conducted with and

without currently depressed girls (i.e., past 2 weeks) and remained identical, discrepancies between fathers and daughters were not a result of adolescents reporting while in an acute phase of depression. These discrepancies in father-daughter reports may have enormous treatment implications. In the case that daughters perceive relationship problems and fathers do not, daughters may be more likely than their fathers to see the virtue in interpersonal interventions; fathers, on the other hand, may be less convinced of the usefulness of family interventions for adolescent depression.

Perhaps the most surprising and unexpected findings were those found when groups were divided according to paternal and maternal diagnostic status. Adolescent and father reports of the relationship did not differ significantly based on whether fathers had a diagnosis or were free of any disorder. This was not the case when groups were divided based on maternal mood status. Compared to adolescent daughters of nondepressed mothers, girls of depressed mothers actually reported poorer relationships with their fathers as evidenced by greater perceived rejection, lower EA, greater perceptions of negative affect in relation to fathers, and more negative communication compared to adolescents of nondepressed mothers. Husbands of depressed wives also reported greater negative communication with their adolescents compared to husbands of nondepressed wives. These findings are fascinating and novel, and require replication. Moreover, these findings suggest a gender difference that would have enormous implications for treatment of depression within a family context.

As suggested in the discussion of the first manuscript, father-daughter relationships in families with depressed mothers may be compromised in comparison to father-daughter relationships in families with never-depressed mothers. The research has

documented a negative effect of depression on marital relations (Benazon & Coyne, 2000), increasing the amount of stress for the couple, and marital conflict. In addition, there is strong evidence to suggest that global marital quality is related to more optimal parenting in intact marriages (Coiro & Emery, 1998). Although marital conflict or satisfaction was not measured in the present study, families with depressed adolescents were more likely to have experienced parental separation or divorce, suggesting that perhaps these families may have also experienced greater conflict in the past.

The "spillover effect" has been supported by other researchers (Kerig, Cowan, & Cowan, 1993) who have found that maritally dissatisfied fathers are more negative with their daughters compared to their sons, and show this negativity regardless of their daughters' behaviours in specific interactions. This effect refers to the process of a parent expressing negative affect engendered in the marital relationship in the parent-child relationship as well (Coiro & Emery, 1998). It has been suggested that, because fathers' roles are less clearly defined by social convention than are mothers' roles, fathering may be more sensitive to external influences such as marital discord if it exists in the couple (Erel & Burman, 1995). Thus, when fathers have a wife with depression and/or are experiencing marital discord, they may withdraw from their relationships with their daughters for various reasons. Fathers may withdraw because they require extra resources to support their spouses. In the case of marital difficulties, they may withdraw from all family relationships to some extent due to the aversive nature of these relationships. Alternatively, the presence of depression within the family may also engender more conflictual, hostile exchanges between family members (Chiariello & Orvaschel, 1995; Jacob & Johnson, 1997), causing more fragmentation between family

members. For example, fathers of daughters that are depressed may repeatedly find themselves in hostile, painful, or otherwise negative interactions with their daughters. These interactions may cause fathers to feel rejected themselves, perhaps even incompetent to help their daughters, subsequently causing them to withdraw.

However, when fathers suffer from psychopathology, as was the case in 50% of the total sample, adolescents' relationships with mothers appeared to remain intact. Because women have been socialized into caregiving, relational roles from early in their development (Whiffen & Demidenko, 2005), they may continue to invest equally into the wife and mother roles, despite having a partner with psychopathology. The present study did not include measures of marital satisfaction or conflict, thus one can only speculate about the existence of these difficulties in the families interviewed. It is suggested that future research examining the father-daughter relationship in the context of depression include measures of marital functioning.

In summary, the findings of these studies suggest that both mothers and fathers are unique and important, yet not independent, contributors to adolescent psychopathology, as defined either by diagnosis or symptomatology. The present study has demonstrated the importance of studying attachment-related variables, such as parental emotional availability, parental rejection and attachment, and communication, in relation to the father-adolescent relationship, highlighting that this relationship is important and demands attention if we are to comprehensively understand adolescent development. It was once believed that fathers played a small, supportive role in childcare and rearing. The current studies' findings are consistent with the few researchers who have emphasized the important role of fathers on adolescent

development and psychopathology (Bosco et al., 2003; Phares, 1992; Phares & Compas, 1992; Phares, Fields, et al., 2005). The findings complement the work of Rohner and Veneziano (2001) who emphasized the importance of father's love (as operationalized by measures of warmth and rejection), in addition to mother's love, in fostering offsprings' psychological well-being, or in contributing to their mental health problems. The links between these findings and attachment/interpersonal theories are discussed in the following section.

Implications for Theory

The present studies emphasized the importance of an adolescent girl's familial environment and her relationships with both father and mother, and demonstrated that these variables are significantly related to youth depression. Paternal and maternal attachment, paternal and maternal EA, paternal acceptance and rejection, negative affect in relation to fathers and mothers, and communication with fathers were all demonstrated to have a relationship to adolescent clinical depression or symptomatology. Thus, these reports' findings lend further support to attachment and interpersonal theories, although, given the cross-sectional design, it was impossible to make any statements about directionality or etiology of depression. Results also suggested that, in keeping with other researchers that have argued for a more specific, perhaps narrower, definition of attachment (Goldberg et al., 1999), it may be prudent to examine specific aspects of the parent-youth attachment relationship (e.g., EA, rejection) rather than use global measures of attachment (i.e., IPPA total score). This point relates to the clinical applicability of the findings and will be addressed in the following section.

The findings of the present studies are consistent with family systems models of depression that suggest that depression in one family member has an impact on the relationships that that individual has with other family members (Phares, Duhig, & Watkins, 2002). Family systems approaches draw the focus away from the "individual patient", and instead emphasize familial relationships, reciprocity, and shared responsibility (Nichols, 1996). In the first manuscript, it was demonstrated that, not only did adolescents of depressed mothers have more negative relationships with their mothers than did adolescents of nondepressed mothers, but these youth also described more negative relationships with their fathers, suggesting an indirect effect of maternal depression on the adolescent-father relationship.

If we consider the impact of psychopathology in families to be systemic, it follows then that treatment for depressed youth must address their interpersonal contexts. Treatment implications that follow from the present studies findings are discussed in the subsequent section.

Clinical Implications

It is important to consider the following issues when discussing the clinical implications of the current research: the issue of discrepancies in father-daughter perceptions; the impact of having a depressed mother on the father-daughter relationship; and revisiting whether more specific measures of attachment may be useful in clinical practice. Firstly, it was quite striking that, although daughters with a depressive disorder perceived their fathers as less emotionally available, and generally perceived less warmth and more rejection from their fathers, their fathers did not perceive their own behaviours as lacking in warmth or as rejecting. If parents are one of the most important supports for

youth (Shulman & Seiffge-Krenke, 1997; West et al., 1999), and the majority of youth live with their families of origin as was the case in the present studies, then arguably treatment for depression must take into account an adolescent's psychosocial environment including his or her relationships.

In their research on Interpersonal Therapy for depression in adolescence (IPT-A), Mufson and colleagues (2004) have done just that. Namely, they have had success in treating adolescent depression by relating symptoms to one or more of four problem areas (i.e., grief, role disputes, role transitions, and interpersonal deficits). Thus far, two independent clinical trials have shown IPT-A to be efficacious for treating adolescent depression (Mufson, Weissman, Moreau, & Garfinkel, 1999; Rossello & Bernal, 1999). Mufson et al. (1999) found that 32 adolescents who were randomly assigned to IPT-A sessions versus biweekly symptom monitoring sessions, showed greater improvement in depressive symptoms, social functioning, functioning with peers, and specific problem-solving after 12 weeks. In a randomized clinical trial, Rossello and Bernal (1999) found youth assigned to either IPT-A or CBT treatments showed an improvement in depressive symptoms posttreatment compared to youth in the wait-list control group. In addition, 82% of youth in the IPT-A group versus 59% in the CBT group were considered "functional" after treatment.

Given the literature that suggests adolescent girls are highly invested in relational harmony and suffer when close relationships are distressed (Shaw & Dallos, 2005), an interpersonal approach that provides girls with the opportunity to talk about their significant relationships and to develop strategies for dealing with relationship difficulties may be quite appropriate. Secondly, if we have empirical evidence to suggest that

insecure attachment bonds with parents may be related to depressive symptomatology (Sund & Wichstrom, 2002; Vivona, 2000; Wilkinson & Walford, 2001), a family approach may be very fitting to address both the discrepancies in parent-youth perceptions of the relationship, and the impact of having a mother with depression on the father-adolescent relationship. Attachment-based family approaches (Diamond et al., 2003) work from the assumption that problematic relationships with close others maintain depressive symptoms and associated interpersonal behaviours as well as maladaptive coping strategies (Joiner & Coyne, 1999). In the case of adolescent depression and the daughter's problematic relationship with her father, an attachment-based approach would focus on exploring their current attachment relationship to find relational ruptures and problematic interaction patterns that would be targeted for change (Diamond et al., 2003). For example, repeated misperceptions between father and daughter may increase relational tension, lead to more frequent arguments, that subsequently lead to each individual avoiding the other. Over time, this pattern may become well engrained and thus, more resistant to change by either party. Similarly, if an adolescent experiences her father as withdrawing from the family as a result of marital tension and/or maternal depression, her relationship with her father may become strained and distant.

An attachment-based family approach would enable family members to work on building more secure attachments to one another by rekindling existing attachments, or forging secure relationships for the first time (Diamond et al., 2003). The benefit of such an approach is the opportunity it provides for in-session, dyad- or triad-focused interactions that allow parents and youth to "try on" new ways of interacting with one

another in a safe, secure environment. Such work can facilitate emotionally corrective experiences for families that, over time, provide an antidote to tense, hostile and critical, and hurtful interactions. Having said this, some families may need to participate in more than one form of therapy, concurrently or sequentially, depending on the other issues at hand such as parental psychopathology, marital distress, trauma, and the like. For example, a parent with a mood disorder may benefit from his or her own individual sessions, in combination with family sessions for adolescent-related issues and general family functioning. In addition, given that the etiology of adolescent depression is multifaceted and involves a number of different risk factors including those that are biological in nature (Beardslee & Gladstone, 2001), other treatments (including pharmacological) in combination with individual or family-based psychotherapies may be appropriate.

Finally, it is important to address whether more specific measures of attachment would be beneficial to clinical practice. One of the strengths of the current research was its focus on specific aspects of the father-daughter attachment relationship such as emotional availability, affective perception of parents, acceptance (i.e., warmth), and rejection. In particular, both emotional availability and rejection emerged as important variables in understanding depressive symptomatology. Thus, one may argue that, in better understanding the specific aspects of the attachment relationship that are related to adolescent depressive symptomatology, one may be in a stronger position to target these relational variables in therapy. For example, during the course of therapy it may be more straightforward to target observed relationship difficulties, such as problems in emotional availability, with specific intervention strategies, than to explore attachment in general.

Limitations and Future Research

There were several limitations of the present research that were explored in the previous discussion sections. Rather than reiterate these issues here, limitations are discussed more globally and linked to directions for future research. First and foremost, perhaps the most striking limitation was the cross-sectional design used in the current research. Although this design was very appropriate for providing the researchers with an understanding of the relationship between adolescent diagnosis of Axis I disorders or depressive symptomatology and the perceived parent-adolescent relationship, it was not possible to make any causal statements about the link between these constructs. Longitudinal, prospective research that assesses youth prior to them becoming ill and follows them over time, measuring relationship variables at each time point, would be instrumental in furthering our understanding of the clinical course of youth depression and the relationship between parental and youth psychopathology. Moreover, such research would be instrumental in elucidating the causal role of parental psychopathology and familial protective factors for youth depression. Although some longitudinal research does exist (Hofstra, Van der Ende, & Verhulst, 2002; Klein et al., 2005; Klein et al., 2004; Lewinsohn et al., 2003; Weissman et al., 1997), these studies primarily examined clinical course and genetic/familial correlates of mood disorder in youth rather than psychosocial and parent-youth relationship variables as related to youth depressive disorder.

Although the current research has emphasized the psychosocial aspects of adolescent depression, there are biological and genetic determinants of mood disorder (Birmaher et al., 1996) that were not explored as they were beyond the scope of this

study. Research examining father-adolescent relationships of biologically high-risk youth, depressed but not high risk youth, and youth from unaffected families on relationship variables would provide some distinction between genetic and psychosocial correlates of depression.

In addition, the present research focused on adolescent girls' relationships with their fathers. Given that some research has found differences in the experience of depression for girls versus boys (Bennett et al., 2005), it would be essential to replicate this research with equal samples of clinical and nonclinical adolescent boys and girls. Recruitment of depressed adolescent boys can be a challenging undertaking given the lower incidence of depression in adolescent boys versus girls (Nolen-Hoeksema & Girgus, 1994). Further, adolescent boys may be less likely to present to clinics for treatment of depressive symptoms, given that the expression of depressed affect (e.g., particularly crying and overt sadness) may be less socially acceptable in boys than in girls. Thus, adolescent males may express depressive symptoms differently than females, expressing more externalizing types of behaviours (e.g., anger outbursts, oppositional behaviour) or avoidant/escapist behaviours (e.g., substance use). One may argue that although these "acting out" behaviours frequently raise concern in parents and teachers, they are more socially acceptable for boys as compared to girls since they tend to be consistent with traditional gender roles.

As the focus of the present study was on fathers and their adolescent daughters, we had a limited amount of maternal data available and did not have maternal ratings of the mother-adolescent relationship or comprehensive diagnostic information. Given that the research has found that both parents contribute unique, yet interdependent, influences

to adolescent development (Bosco et al., 2003; Lamb, 2004), it would be most informative to include similar information from both parents and youth.

Although marital status was examined as a covariate in the two manuscripts, future studies would benefit from considering this variable in the design phase of the study instead (i.e., recruiting adolescents in order to get equal groups of intact and non-intact families). The use of covariates may be controversial, as it only provides a statistical control (Tabachnick & Fidell, 2001), and is typically not the best option for dealing with nuisance variables (if in fact we can even consider marital status a nuisance variable) (Kirk, 1968). Because marital status is not independent of adolescent diagnostic status, or in the case of the second manuscript, adolescent depressive symptomatology, it may be considered more prudent to consider this variable in the design of the study as covariates should preferably be independent of the outcome variable (Tabachnick & Fidell, 2001).

In the present study, measures of acceptance and rejection completed by fathers were proxy measures of attachment. Reliability analyses suggested that these measures were psychometrically sound in the current sample. However, more generally, there exists a paucity of measures for parent-rated attachment to children/youth. There is a need to develop more of these measures, not solely because they are useful in research on correlates of adolescent depression, but also because they may be helpful in informing clinical intervention with families. In clinical practice, it is common practice to administer symptom-rating scales to patients that inform us about frequency, intensity, and duration of symptomatology. However, one may argue that it is less commonplace to administer relationship-based questionnaires that inform us about an individual's current

interpersonal world, as well as their early attachment relationships. The availability of a greater number of psychometrically sound, relatively brief relationship measures may be very useful in daily clinical practice with adolescents. Such measures can help clinicians understand how adolescent patients view themselves in relation to key others (i.e., parents). If we acknowledge the relational aspects of depressed mood highlighted by the present studies, then it follows that measures that help us understand these relational variables (prior to initiating treatment) may be useful in guiding intervention strategies for depressed mood.

Sample sizes in the current studies precluded the examination of relationship differences among the four potential subgroups of depressed and nondepressed youth with affected and unaffected fathers. Replication of the current studies with equal groups of youth and fathers with and without psychopathology would help to further differentiate interactional patterns between depressed and nondepressed youth and their fathers. Again, these distinctions would be helpful for clinical interventions with parents and youth, particularly for clinicians working within an interpersonal therapy framework. In a similar vein, the quality of the parent-adolescent relationship may also differ by the nature of the psychopathology being experienced by the parent (e.g., mood disorder versus personality disorder). Such differences also require further exploration.

Finally, although not a great limitation, there were demographic differences between the clinical and non-clinical groups that may have suggested a selection bias among the comparison sample. It should be noted that, in the current sample, demographics among both clinical and comparison groups were comparable to those of the region, and therefore were thought to be representative of a typical community

sample. However, fathers and mothers in the comparison group were older and fathers had higher education levels than fathers in the clinical group. These findings are fairly typical of comparison groups in this type of research. For example, Anderman, Cheadle, Curry, Diehr, Shultz, et al. (1995) reported that among community samples, parents consenting to participate in research with their adolescents tended to be Caucasian and better educated than non-consenting parents. One may speculate that higher educated parents and their children may be more willing than less educated families to participate in research strictly for the altruistic contribution it may have towards science.

In summary, the present research supported the inclusion of the father-adolescent relationship when trying to understand adolescent depression. Fathers are a critical part of an adolescent's development, and the father-adolescent relationship has important consequences for adolescent health. In terms of directions for future research, the present studies demonstrated the need to include both mothers and fathers in developmental psychopathology research, suggesting that it is no longer adequate to only include mothers. By having a good understanding of the relationship factors related to adolescent depression, we are in a stronger position to aim our research towards examining factors related to prevention of youth depression and resiliency within families. In revisiting attachment theory, these studies support the importance of variables such as adolescent perceptions of paternal warmth, emotional availability, attachment, and rejection in facilitating our understanding of the phenomenon of youth depression. Clinically, these studies give support to the idea of clinicians addressing depressed youths' important interpersonal relationships in therapy. Finally, findings indirectly encourage the

inclusion of the father-adolescent relationship in the assessment and treatment of youth depression.

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Contributions of Collaborators

Natasha Demidenko, M.A.: proposed the hypotheses; designed the study; clinical interviewer of families; facilitated recruitment and advertising for study; analyzed the data; wrote the two articles, general introduction, and general discussion; primary author on the two articles

Dr. Ian Manion: thesis supervisor; co-investigator on Ontario Mental Health Foundation (OMHF) research grant that supported this research; edited the manuscript; consulted on preparation of articles for publication

Dr. Catherine M. Lee: co-investigator on OMHF research grant that supported this research; edited the two articles for submission

Dr. Dwayne C. Schindler: statistics consultant

Julie Wilson, M.A.: research assistant and clinical interviewer; organized portion of recruitment process

Appendix A

Children's Hospital of Eastern Ontario
Children's Hospital of Eastern Ontario
Centre hospitalier pour enfants de l'Ontario

December 12, 2002

Dr. Ian Manion
Director of Research, Mental Health Patient Service Unit
Children's Hospital of Eastern Ontario

Re: Father –Adolescent Interactional Patterns Associated with Adolescent Depression: an examination of attachment, family cohesion, and communication within the dyad (Protocol # 02/50e)

Dear Dr. Manion,

Thank you for advising the Research Ethics Board of the amendments to the above-mentioned protocol. Accordingly, please consider this the final approval of the project. Please notify us of any further developments in the project including an annual report, reports of adverse events, reports of subject recruitment, reports of any study amendments, and a study termination report. The principal investigator must also maintain copies of all pertinent information related to the research activities in this project, including copies of informed consent agreements obtained from all participants. Finally, the REB must be notified if one of the principal investigator leaves this institution or the project.

Wishing you success in your project.

Regards,

Dr. Carole Gentile, C.Psych.
Chair, Research Ethics Board

401 Smyth Road, Ottawa, ON K1H 8L1, Canada
Tel: (613) 737-7600 www.cheo.on.ca

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ROYAL OTTAWA HOSPITAL
HÔPITAL ROYAL OTTAWA

A division of the Royal Ottawa Health Care Group / Une division des Services de santé Royal Ottawa

RESEARCH ETHICS BOARD

November 13, 2003
Ms. Natalie Demidenko
Principal Investigator

Re: REB# 2003-23
Father-Daughter Interactional Patterns Associated with Adolescent Depression: An Examination of Attachment and Communication within the Dyad

---

Dear Ms. Demidenko,

This letter is to acknowledge receipt of your letter (dated November 5, 2003) which addresses concerns expressed to you in our letter (dated October 23, 2003) for the above-titled protocol.

Your responses and modifications to the protocol and Information and Consent forms have been reviewed and your protocol has now received **unconditional approval.**

Please note that this approval is contingent upon maintaining adherence to the normal approval process, namely,

- reporting to the Board any adverse events of the project in progress
- seeking prior approval from the Board of any direct use of public media to recruit research participants

Approval will be reconsidered if Hospital resources are used beyond those specified on the Checklist of Resources or the Impact on Hospital resources and/or if Grant funding applied for is not received. However, in either case, the protocol can be re-submitted with revised Checklist information and will be reconsidered.

Annual progress reports must be submitted to the Board for continuation of Research Ethics approval. A termination report is required at the conclusion of the study.

Sincerely,

Alan Douglass, MD FRCPC
Dip. ABSM; Dip ABPN
Chair, Research Ethics Board

Appendix B

CHEO Research Ethics Board
APPROVAL
Chair's Signature: [signature]
Date: 12·5·04

PERMISSION TO BE CONTACTED ABOUT RESEARCH: INFORMATION FOR YOUTH AND FAMILIES

You (or your youth) has been referred to the Mood and Anxiety Clinic at the Children's Hospital of Eastern Ontario (CHEO), whose goal is to help children, youth and families with mood or anxiety problems. As another one of our goals is to improve upon existing treatments, we are actively involved in research. One particular study that is on-going at the moment focuses on learning more about father-youth relationships when youth are depressed and also when they are not depressed. This project has been approved by the CHEO Ethics Research Board.

Participation in this research project is VOLUNTARY, which means that you can decide not to participate in this study at any time, and this does not affect the services you receive at CHEO. Your participation in the father-youth study would also be CONFIDENTIAL, and in most cases we could not share the information with anyone without your written consent. **Signing this form does not obligate you to participate in this study**. By signing this form, you are simply agreeing to be contacted regarding this particular study if we feel you may be interested. If we contact you and you are not interested in participating, you simply need to let us know.

By signing this form, I agree to be contacted regarding the father-youth relationship research study in the future, and understand that I am under no obligation to participate. I will receive the usual standard of care from the Mood/Anxiety Clinic, whether or not I agree to be contacted. ***Youth aged 16 and under will need the permission of their parent or guardian to participate in any studies.***

_____ _____ ____

PLEASE PRINT NAME SIGNATURE AGE

_____ _____

Telephone (daytime), or parent's work Telephone (evening)

For any questions regarding this form, feel free to contact Risa Mallory (rmallory@cheo.on.ca) or Natasha Demidenko (ndemidenko@cheo.on.ca) at 613-737-7600, ext. 3909.
For any questions regarding your rights as a patient, feel free to contact the CHEO patient representative, Christine Khouri at 613-737-7600.

Appendix C

Father-Adolescent Relationships and Adolescent Depression

Informed Consent Form

Drs. Ian Manion, Catherine Lee, and Anne Duffy from the Departments of Psychology and Psychiatry at the Children's Hospital of Eastern Ontario (CHEO), University of Ottawa, and the Royal Ottawa Hospital respectively, are undertaking research with two groups of adolescents, those who experience feelings of depression and those who do not. We are also asking their fathers to participate in this research.

We are trying to find out more about the nature of father-adolescent relationships when adolescents are experiencing feelings of depression and also when they are not experiencing depression. If you agree to participate, you will be interviewed either at CHEO or at your home. During the interview, we will be asking you questions about different life experiences, your relationship with your father or with your son/daughter, and feelings of sadness. The interview will be held at your convenience and usually lasts about 3 ½ hours. Your family will be reimbursed $30 for any expenses that you may have had through your participation in the study.

If you and your father/son/daughter decide to participate, you would be free to drop out of the study (or stop the interview) at any time. Your participation in the study is fully voluntary and will no way affect any services that you receive or could receive from the hospital. The information that you provide will help us greatly in our efforts to better understand family relationships as they relate to depression. All gathered information will remain completely confidential. If you wish and if you are involved with another health care professional (psychiatrist, physician, psychologist), this information may be shared with him/her provided that you sign a consent for release of information. This will ensure that you get the best help possible from this professional. In the event that we receive any disclosure of physical or sexual abuse, or if we have any concerns about serious suicide risk, for any participant, then this will be disclosed to the appropriate professional. A summary of the results of this research will be available to you at your request. All results will be presented in group format and will not identify any individuals.

If you have any concerns or questions, they can be directed to Dr. Ian Manion at 737-7600, ext. 3909. You may contact the Chair of the CHEO Research Ethics Committee for information regarding patients' rights in research studies at 738-3272; however, this person cannot provide any medical information with regard to this study.

If you agree to participate in this study, please sign below.

Adolescent: _____
(name) (signature) (date)

Adult: _____
(name) (signature) (date)

Witness: _____
(name) (signature) (date)

Study explained by: _____
(name) (signature) (date)

Appendix D

M.I.N.I. PLUS

MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW

English Version 5.0.0

USA: D. Sheehan, J. Janavs, R. Baker, K.Harnett-Sheehan, E. Knapp, M. Sheehan
University of South Florida - Tampa

FRANCE: Y. Lecrubier, E. Weiller, T. Hergueta, P. Amorim, L.I. Bonora, J.P. Lépine,
Hôpital de la Salpétrière - Paris

M.I.N.I. Plus 5.0.0 (November 1, 2003)

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

	MODULES	TIME FRAME	MEETS CRITERIA	DSM-IV	ICD-10
A	MAJOR DEPRESSIVE EPISODE	Current (2 weeks)	o	296.20-296.26 Single	F32.x
		Recurrent	o	296.30-296.36 Recurrent	F33.x
	MOOD DISORDER DUE TO A GENERAL MEDICAL CONDITION	Current	o	293.83	F06.xx
		Past	o	293.83	F06.xx
	SUBSTANCE INDUCED MOOD DISORDER	Current	o	29x.xx	none
		Past	o	29x.xx	none
	MDE WITH MELANCHOLIC FEATURES	Current (2 weeks)	o	296.20-296.26 Single	F32.x
				296.30-296.36 Recurrent	F33.x
B	DYSTHYMIA	Current (Past 2 years)	o	300.4	F34.1
		Past	o	300.4	F34.1
C	SUICIDALITY	Current (Past Month)	o	none	none
		Risk: o Low o Medium o High			
D	MANIC EPISODE	Current	o	296.00-296.06	F30.x-F31.9
		Past	o	296.00-296.06	F30.x-F31.9
	HYPOMANIC EPISODE	Current	o	296.80-296.89	F31.8-F31.9/F34.0
		Past	o	296.80-296.89	F31.8-F31.9/F34.0
	BIPOLAR II DISORDER	Current	o	296.89	F31.8
		Past	o	296.89	F31.8
	MANIC EPISODE DUE TO A GENERAL MEDICAL CONDITION	Current	o	293.83	F06.30
		Past	o	293.83	F06.30
	HYPOMANIC EPISODE DUE TO A GENERAL MEDICAL CONDITION	Current	o	293.83	none
		Past	o	293.83	none
	SUBSTANCE INDUCED MANIC EPISODE	Current	o	291.8-292.84	none
		Past	o	291.8-292.84	none
	SUBSTANCE INDUCED HYPOMANIC EPISODE	Current	o	291.8-292.84	none
		Past	o	291.8-292.84	none
E	PANIC DISORDER	Current (Past Month)	o	300.01/300.21	F40.01-F41.0
		Lifetime	o	300.01/300.21	F40.01-F41.0
	ANXIETY DISORDER WITH PANIC ATTACKS DUE TO A GENERAL MEDICAL CONDITION	Current	o	293.89	F06.4
	SUBSTANCE INDUCED ANXIETY DISORDER WITH PANIC ATTACKS	Current	o	291.8-292.89	none
F	AGORAPHOBIA	Current	o	300.22	F40.00
G	SOCIAL PHOBIA (Social Anxiety Disorder)	Current (Past Month)	o	300.23	F40.1
H	SPECIFIC PHOBIA	Current	o	300.29	F40.2
I	OBSESSIVE-COMPULSIVE DISORDER	Current (Past Month)	o	300.3	F42.8
	OCD DUE TO A GENERAL MEDICAL CONDITION	Current	o	293.89	F06.4
	SUBSTANCE INDUCED OCD	Current	o	291.8-292.89	none
J	POSTTRAUMATIC STRESS DISORDER	Current (Past Month)	o	309.81	F43.1
K	ALCOHOL DEPENDENCE	Past 12 Months	o	303.9	F10.2x
	ALCOHOL DEPENDENCE	Lifetime	o	303.9	F10.2x
	ALCOHOL ABUSE	Past 12 Months	o	305.00	F10.1
	ALCOHOL ABUSE	Lifetime	o	305.00	F10.1
L	SUBSTANCE DEPENDENCE (Non-alcohol)	Past 12 Months	o	304.00-.90/305.20-.90	F11.0-F19.1
	SUBSTANCE DEPENDENCE (Non-alcohol)	Lifetime	o	304.00-.90/305.20-.90	F11.0-F19.1
	SUBSTANCE ABUSE (Non-alcohol)	Past 12 Months	o	304.00-.90/305.20-.90	F11.0-F19.1
M	PSYCHOTIC DISORDERS	Lifetime	o	295.10-295.90/297.1/	F20.xx-F29

		Current	O	297.3/293.81/293.82/ 293.89/298.8/298.9	
	MOOD DISORDER WITH PSYCHOTIC FEATURES	Current	O	296.24	F32.3/F33.3
	SCHIZOPHRENIA	Current	O	295.10-295.60	F20.xx
		Lifetime	O	295.10-295.60	F20.xx
	SCHIZOAFFECTIVE DISORDER	Current	O	295.70	F25.x
		Lifetime	O	295.70	F25.x
	SCHIZOPHRENIFORM DISORDER	Current	O	295.40	F20.8
		Lifetime	O	295.40	F20.8
	BRIEF PSYCHOTIC DISORDER	Current	O	298.8	F23.80-F23.81
		Lifetime	O	298.8	F23.80-F23.81
	DELUSIONAL DISORDER	Current	O	297.1	F22.0
		Lifetime	O	297.1	F22.0
	PSYCHOTIC DISORDER DUE TO A GENERAL MEDICAL CONDITION	Current	O	293.xx	F06.0-F06.2
		Lifetime	O	293.xx	F06.0-F06.2
	SUBSTANCE INDUCED PSYCHOTIC DISORDER	Current	O	291.5-292.12	none
		Lifetime	O	291.5-292.12	none
	PSYCHOTIC DISORDER NOS	Current	O	298.9	F29
		Lifetime	O	298.9	F29
	MOOD DISORDER WITH PSYCHOTIC FEATURES	Lifetime	O		F31.X3/F31.X2/F31.X5
	MOOD DISORDER NOS	Lifetime	O	296.90	F39
	MAJOR DEPRESSIVE DISORDER WITH PSYCHOTIC FEATURES	Current	O	296.24	F33.X3
		Past	O	296.24	F33.X3
	BIPOLAR I DISORDER WITH PSYCHOTIC FEATURES	Current	O	296.04-296.64	F31.X2/F31.X5
		Past	O	296.04-296.64	F31.X2/F31.X5
N	ANOREXIA NERVOSA	Current (Past 3 Months)	O	307.1	F50.0
O	BULIMIA NERVOSA	Current (Past 3 Months)	O	307.51	F50.2
	BULIMIA NERVOSA PURGING TYPE	Current	O	307.51	F50.2
	BULIMIA NERVOSA NONPURGING TYPE	Current	O	307.51	F50.2
	ANOREXIA NERVOSA, BINGE EATING/PURGING TYPE	Current	O	307. 1	F50.0
	ANOREXIA NERVOSA, RESTRICTING TYPE	Current	O	307. 1	F50.0
P	GENERALIZED ANXIETY DISORDER	Current (Past 6 Months)	O	300.02	F41.1
	GENERALIZED ANXIETY DISORDER DUE TO A GENERAL MEDICAL CONDITION	Current	O	293.89	F06.4
	SUBSTANCE INDUCED GAD	Current	O	291.8-292.89	none
Q	ANTISOCIAL PERSONALITY DISORDER	Lifetime	O	301.7	F60.2
R	SOMATIZATION DISORDER	Lifetime	O	330.81	F45.0
		Current	O		
S	HYPOCHONDRIASIS	Current	O	300.7	F45.2
T	BODY DYSMORPHIC DISORDER	Current	O	300.7	F45.2
U	PAIN DISORDER	Current	O	300.89/307.8	F45.4
V	CONDUCT DISORDER	Past 12 Months	O	312.8	F91.8
W	ATTENTION DEFICIT/HYPERACTIVITY DISORDER (Children/Adolescents)	Past 6 Months	O	314.00/314.01	F90.0/F90.9/ F98.8
	ATTENTION DEFICIT/HYPERACTIVITY	Lifetime	O	314.00/314.01	F90.0/F98.8
	DISORDER (Adults)	Current	O		
X	ADJUSTMENT DISORDERS	Current	O	309.xx	F43.xx
Y	PREMENSTRUAL DYSPHORIC DISORDER	Current	O		
Z	MIXED ANXIETY-DEPRESSIVE DISORDER	Current	O		

WARNING

EVEN IF A PATIENT HAS A CLEAR LIFE STRESS AGGRAVATING THEIR SYMPTOMS FIRST EXPLORE THE OTHER DIAGNOSES ABOVE. NEVER USE AN ADJUSTMENT DISORDER DIAGNOSIS IF THE DISTURBANCE MEETS CRITERIA FOR ANY OF THE ABOVE DISORDERS.

GENERAL INSTRUCTIONS

The M.I.N.I. was designed as a brief structured interview for the major Axis I psychiatric disorders in DSM-IV and ICD-10. Validation and reliability studies have been done comparing the M.I.N.I. to the SCID-P for DSM-III-R and the CIDI (a structured interview developed by the World Health Organization for lay interviewers for ICD-10). The results of these studies show that the M.I.N.I. has acceptably high validation and reliability scores, but can be administered in a much shorter period of time (mean 18.7 ± 11.6 minutes, median 15 minutes) than the above referenced instruments. It can be used by clinicians, after a brief training session. Lay interviewers require more extensive training. The M.I.N.I. Plus is a more detailed edition of the M.I.N.I. Symptoms better accounted for by an organic cause or by the use of alcohol or drugs should not be coded positive in the M.I.N.I. The M.I.N.I. Plus has questions that investigate these issues.

INTERVIEW:

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

GENERAL FORMAT:

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

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

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

CONVENTIONS:

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

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

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

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

When terms are separated by a *slash (/)* the interviewer should read only those symptoms known to be present in the patient (for example, questions M20-M23).

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

RATING INSTRUCTIONS:

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

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

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

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

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A. MAJOR DEPRESSIVE EPISODE

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

FOR PATIENTS WHO APPEAR PSYCHOTIC BEFORE STARTING THE INTERVIEW, OR WHO ARE SUSPECTED TO HAVE SCHIZOPHRENIA, PLEASE ADOPT THE FOLLOWING ORDER OF ADMINISTRATION OF MODULES:

1) PART 1 OF MODULE M (PSYCHOTIC DISORDERS M1-M18).
2) SECTIONS A-D (DEPRESSION TO (HYPO)MANIC EPISODE).
3) PART 2 OF MODULE M (PSYCHOTIC DISORDERS M19-M23).
4) OTHER MODULES IN THEIR USUAL SEQUENCE.

IF MODULE M HAS ALREADY BEEN EXPLORED AND PSYCHOTIC SYMPTOMS HAVE BEEN IDENTIFIED (M1 TO M10b), EXAMINE FOR EACH POSITIVE RESPONSE TO THE FOLLOWING QUESTIONS IF THE DEPRESSIVE SYMPTOMS ARE NOT BETTER EXPLAINED BY THE PRESENCE OF A PSYCHOTIC DISORDER AND CODE ACCORDINGLY.

A1	a	Have you **ever** been consistently depressed or down, most of the day, nearly every day, for at least two weeks?	NO	YES
		IF **A1a = YES**:		
	b	Have you been consistently depressed or down, most of the day, nearly every day, for the past 2 weeks?	NO	YES
A2	a	Have you **ever** been much less interested in most things or much less able to enjoy the things you used to enjoy most of the time over at least 2 weeks?	NO	YES
		IF **A2a = YES**:		
	b	In the past 2 weeks, have you been much less interested in most things or much less able to enjoy the things you used to enjoy most of the time.	NO	YES
			□	
		IS **A1a** OR **A2a** CODED **YES?**	NO	YES

IF CURRENTLY DEPRESSED (**A1b** OR **A2b = YES**): EXPLORE ONLY CURRENT EPISODE.
IF **NO**: EXPLORE THE MOST SYMPTOMATIC PAST EPISODE.

A3 **Over the two week period when you felt depressed or uninterested,**

		Current Episode		Past Episode	
a	Was your appetite decreased or increased nearly every day? Did your weight decrease or increase without trying intentionally (I.E., BY ±5% OF BODY WEIGHT OR ±8 LBS. OR ±3.5 KGS. FOR A 160 LB./70 KGS. PERSON IN A MONTH)? IF **YES** TO EITHER, CODE **YES**.	NO	YES	NO	YES
b	Did you have trouble sleeping nearly every night (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)?	NO	YES	NO	YES
c	Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still almost every day?	NO	YES	NO	YES
d	Did you feel tired or without energy almost every day?	NO	YES	NO	YES
e	Did you feel worthless or guilty almost every day?	NO	YES	NO	YES

IF **A3e = YES**: ASK FOR AN EXAMPLE.
THE EXAMPLE IS CONSISTENT WITH A DELUSIONAL IDEA. o NO o YES

	f	Did you have difficulty concentrating or making decisions almost every day?	NO	YES	NO	YES
	g	Did you repeatedly consider hurting yourself, feel suicidal, or wish that you were dead?	NO	YES	NO	YES
A4		ARE **3** OR MORE **A3** ANSWERS CODED **YES** (OR **4 A3** ANSWERS, IF **A1a** OR **A2a** ARE CODED **NO** FOR PAST EPISODE OR IF **A1b** OR **A2b** ARE CODED **NO** FOR CURRENT EPISODE)?	NO	YES	☐ NO	YES

VERIFY IF THE POSITIVE SYMPTOMS OCCURRED DURING THE SAME 2 WEEK TIME FRAME.

IF **A4** IS CODED **NO** FOR CURRENT EPISODE THEN EXPLORE **A3a - A3g** FOR MOST SYMPTOMATIC PAST EPISODE.

A5 Did the symptoms of depression cause you significant distress or impair your ability to function at work, socially, or in some other important way? ☐ NO YES

A6 Are the symptoms due entirely to the loss of a loved one (bereavement) and are they similar in severity, level of impairment, and duration to what most others would suffer under similar circumstances? If so, this is uncomplicated bereavement.

HAS UNCOMPLICATED BEREAVEMENT BEEN RULED OUT? ☐ NO YES

A7 a Were you taking any drugs or medicines just before these symptoms began?
π No π Yes

b Did you have any medical illness just before these symptoms began?
π No π Yes

IN THE CLINICIAN'S JUDGMENT: ARE EITHER OF THESE LIKELY TO BE DIRECT CAUSES OF THE PATIENT'S DEPRESSION? IF NECESSARY ASK ADDITIONAL OPEN-ENDED QUESTIONS.

A7 (SUMMARY): HAS AN ORGANIC CAUSE BEEN RULED OUT? NO YES UNCERTAIN

A8 CODE **YES** IF **A7(SUMMARY) = YES** OR **UNCERTAIN**.

SPECIFY IF THE EPISODE IS CURRENT AND/ OR PAST OR BOTH (RECURRENT).

NO	YES
Major Depressive Episode	
Current	o
Past	o

A9 CODE **YES** IF **A7b = YES** AND **A7 (SUMMARY) = NO**.

SPECIFY IF THE EPISODE IS CURRENT AND/ OR PAST OR BOTH (RECURRENT).

NO	YES
Mood Disorder Due to a General Medical Condition	
Current	o
Past	o

A10 CODE **YES** IF **A7a = YES** AND **A7 (SUMMARY) = NO**.

SPECIFY IF THE EPISODE IS CURRENT AND/ OR PAST OR BOTH (RECURRENT).

NO	YES
Substance Induced Mood Disorder	
Current	o
Past	o

CHRONOLOGY

A11 How old were you when you first began having symptoms of depression? ☐ age

A12 During your lifetime, how many distinct times did you have these symptoms of depression (daily for at least 2 weeks)? ☐

MAJOR DEPRESSIVE EPISODE WITH MELANCHOLIC FEATURES (optional)

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

IF THE PATIENT CODES POSITIVE FOR A CURRENT MAJOR DEPRESSIVE EPISODE (**A8 = YES, CURRENT**), EXPLORE THE FOLLOWING:

A13 a	During the most severe period of the current depressive episode, did you lose almost completely your ability to enjoy nearly everything ?	NO	YES
b	During the most severe period of the current depressive episode, did you lose your ability to respond to things that previously gave you pleasure, or cheered you up? **IF NO,** DOUBLE CHECK ANSWER BY ASKING: When something good happens, does it fail to make you feel better, even temporarily?	NO	YES
	☐ IS EITHER **A13a** OR **A13b** CODED **YES**?	NO	YES

A14 **Over the past two week period, when you felt depressed and uninterested:**

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

ARE **3** OR MORE **A14** ANSWERS CODED **YES**?

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

SUBTYPES OF MAJOR DEPRESSIVE EPISODE	Mark all that apply.
Mild	o 296.21/296.31
Moderate	o 296.22/296.32
Severe without psychotic features	o 296.23
Severe with psychotic features	o 296.24
In partial remission	o 296.25
In full remission	o 296.26
Chronic	o
With catatonic features	o
With melancholic features	o
With atypical features	o
With postpartum onset	o
With seasonal pattern	o
With full interepisode recovery	o
Without full interepisode recovery	o

IF **A8** OR **A9** OR **A10** = **YES**, SKIP TO SUICIDALITY □

B. DYSTHYMIA

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

If patient's symptoms <u>currently</u> meet criteria for major depressive episode, do NOT explore <u>current</u> dysthymia, but do explore PAST dysthymia. Make sure that the past dysthymia explored is not one of the past major depressive episodes, and that it was separated from any prior major depressive episode by at least 2 months of full remission. [APPLY THIS RULE ONLY IF YOU ARE INTERESTED IN EXPLORING DOUBLE DEPRESSION.]

SPECIFY WHICH TIME FRAME IS EXPLORED BELOW: o Current o Past

B1	Have you felt sad, low or depressed most of the time for the last two years? (OR IF EXPLORING PAST DYSTHYMIA: "In the past, did you ever feel sad, low or depressed for 2 years continuously?")	□ NO	YES
B2	Was this period interrupted by your feeling OK for two months or more?	NO	□ YES

B3	**During this period of feeling depressed most of the time:**		
a	Did your appetite change significantly?	NO	YES
b	Did you have trouble sleeping or sleep excessively?	NO	YES
c	Did you feel tired or without energy?	NO	YES
d	Did you lose your self-confidence?	NO	YES
e	Did you have trouble concentrating or making decisions?	NO	YES
f	Did you feel hopeless?	NO	YES
	ARE **2** OR MORE **B3** ANSWERS CODED **YES**?	□ NO	YES
B4	Did the symptoms of depression cause you significant distress or impair your ability to function at work, socially, or in some other important way?	□ NO	YES

B5 Were you taking any drugs or medicines just before these symptoms began?
Did you have any medical illness just before these symptoms began?
IN THE CLINICIAN'S JUDGMENT: ARE EITHER OF THESE LIKELY TO BE DIRECT CAUSES OF THE PATIENT'S DEPRESSION?

HAS AN ORGANIC CAUSE BEEN RULED OUT? NO YES

IS **B5** CODED **YES**?

NO	YES
DYSTHYMIA	
Current	o
Past	o

CHRONOLOGY

B6 How old were you when you first began having symptoms of 2 years of continuous depression? ☐ age

---

C. SUICIDALITY

In the past month did you:

				Points
C1	Think you would be better off dead or wish you were dead?	NO	YES	1
C2	Want to harm yourself?	NO	YES	2
C3	Think about suicide?	NO	YES	6
C4	Have a suicide plan?	NO	YES	10
C5	Attempt suicide?	NO	YES	10
	In your lifetime:			
C6	Did you ever make a suicide attempt?	NO	YES	4

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

IF **YES,** ADD THE TOTAL NUMBER OF POINTS FOR THE ANSWERS (C1-C6) CHECKED 'YES' AND SPECIFY THE LEVEL OF SUICIDE RISK AS FOLLOWS:

NO	YES	
SUICIDE RISK CURRENT		
1-5 points	Low	π
6-9 points	Moderate	π
≥ 10 points	High	π

D. (HYPO) MANIC EPISODE

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

FOR PATIENTS WHO APPEAR PSYCHOTIC BEFORE STARTING THE INTERVIEW OR WHO ARE SUSPECTED TO HAVE SCHIZOPHRENIA, PLEASE ADOPT THE FOLLOWING ORDER OF ADMINISTRATION OF MODULES:

1) PART 1 OF MODULE M (PSYCHOTIC DISORDERS M1-M18).
2) SECTIONS A-D (DEPRESSION TO (HYPO)MANIC EPISODE).
3) PART 2 OF MODULE M (PSYCHOTIC DISORDERS M19-M23).
4) OTHER MODULES IN THEIR USUAL SEQUENCE.

IF MODULE M HAS ALREADY BEEN EXPLORED AND PSYCHOTIC SYMPTOMS HAVE BEEN IDENTIFIED (**M1** TO **M10b**), EXAMINE FOR EACH POSITIVE RESPONSE TO THE FOLLOWING QUESTIONS IF THE (HYPO)MANIC SYMPTOMS ARE NOT BETTER EXPLAINED BY THE PRESENCE OF A PSYCHOTIC DISORDER AND CODE ACCORDINGLY.

D1 a Have you **ever** had a period of time when you were feeling 'up' or 'high' or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.) — NO YES

IF NO, CODE NO TO **D1b**. IF **YES** ASK:

b Are you **currently** feeling 'up' or 'high' or full of energy? — NO YES

IF PATIENT IS PUZZLED OR UNCLEAR ABOUT WHAT YOU MEAN BY 'UP' OR 'HIGH', CLARIFY AS FOLLOWS: BY 'UP' OR 'HIGH' I MEAN: HAVING ELATED MOOD; INCREASED ENERGY; NEEDING LESS SLEEP; HAVING RAPID THOUGHTS; BEING FULL OF IDEAS; HAVING AN INCREASE IN PRODUCTIVITY, MOTIVATION , CREATIVITY, OR IMPULSIVE BEHAVIOR.

D2 a Have you **ever** been persistently irritable, for several days, so that you had arguments or verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or over reacted, compared to other people, even in situations that you felt were justified? — NO YES

IF NO, CODE NO TO **D2b**. IF **YES** ASK:

b Are you **currently** feeling persistently irritable? — NO YES

□

IS **D1a** OR **D2a** CODED **YES**? — NO YES

D3 IF **D1b** OR **D2b** = **YES**: EXPLORE ONLY **CURRENT** EPISODE, OTHERWISE
IF **D1b** AND **D2b** = **NO**: EXPLORE THE MOST SYMPTOMATIC **PAST** EPISODE

During the times when you felt high, full of energy, or irritable did you:

		Current Episode		Past Episode	
a	Feel that you could do things others couldn't do, or that you were an especially important person? IF YES, ASK FOR EXAMPLES. THE EXAMPLES ARE CONSISTENT WITH A DELUSIONAL IDEA. π No π Yes	NO	YES	NO	YES
b	Need less sleep (for example, feel rested after only a few hours sleep)?	NO	YES	NO	YES
c	Talk too much without stopping, or so fast that people had difficulty understanding?	NO	YES	NO	YES

d	Have racing thoughts?	NO	YES	NO	YES
e	Become easily distracted so that any little interruption could distract you?	NO	YES	NO	YES
f	Become so active or physically restless that others were worried about you?	NO	YES	NO	YES
g	Want so much to engage in pleasurable activities that you ignored the risks or consequences (for example, spending sprees, reckless driving, or sexual indiscretions)?	NO	YES	NO	YES

D3(SUMMARY): ARE **3** OR MORE **D3** ANSWERS CODED **YES** (OR **4** OR MORE IF **D1a** IS **NO** (IN RATING PAST EPISODE) OR **D1b** IS NO (IN RATING CURRENT EPISODE)? RULE: ELATION/EXPANSIVENESS REQUIRES ONLY THREE D3 SYMPTOMS WHILE IRRITABLE MOOD ALONE REQUIRES **4** OF THE **D3** SYMPTOMS. NO YES NO YES

VERIFY IF THE SYMPTOMS OCCURRED DURING THE SAME TIME PERIOD.

D4 a Were you taking any drugs or medicines just before these symptoms began?
π No π Yes

b Did you have any medical illness just before these symptoms began?
π No π Yes

IN THE CLINICIAN'S JUDGMENT: ARE EITHER OF THESE LIKELY TO BE DIRECT CAUSES OF THE PATIENT'S (HYPO)MANIA? IF NECESSARY, ASK ADDITIONAL OPEN ENDED QUESTIONS.

D4 (SUMMARY): HAS AN ORGANIC CAUSE BEEN RULED OUT? NO YES UNCERTAIN

D5 Did these symptoms last at least a week and cause problems beyond your control at home, work, school, or were you hospitalized for these problems? NO YES NO YES

IF **D5** IS CODED **NO** FOR CURRENT EPISODE, THEN EXPLORE **D3, D4** AND **D5** FOR THE MOST SYMPTOMATIC PAST EPISODE.

D6

IF **D3** (SUMMARY) = **YES** AND **D4 (SUMMARY)** = **YES** OR **UNCERTAIN** AND **D5** = **NO**, AND NO DELUSIONAL IDEA WAS DESCRIBED IN **D3a**, CODE **YES** FOR HYPOMANIAC EPISODE.

SPECIFY IF THE EPISODE IDENTIFIED IS CURRENT OR PAST.

NO	YES
HYPOMANIC EPISODE	
Current	o
Past	o

D7 IF **D3 (SUMMARY)** = **YES** AND **D4 (SUMMARY)** = **YES** OR **UNCERTAIN** AND EITHER **D5** = **YES** OR A DELUSIONAL IDEA WAS DESCRIBED IN **D3a**, CODE **YES** FOR MANIC EPISODE.

SPECIFY IF THE EPISODE IDENTIFIED IS CURRENT OR PAST.

NO	YES
MANIC EPISODE	
Current	o
Past	o

D8 IF **D3 (SUMMARY)** AND **D4b** AND **D5** = **YES** AND **D4 (SUMMARY)** = **NO**, CODE **YES**?

SPECIFY IF THE EPISODE IDENTIFIED IS CURRENT OR PAST.

NO	YES
(Hypo) Manic Episode Due to a General Medical Condition	
Current	o
Past	o

D9 IF **D3 (SUMMARY)** AND **D4a** AND **D5** = **YES** AND **D4 (SUMMARY)** = **NO**, CODE **YES**?

SPECIFY IF THE EPISODE IDENTIFIED IS CURRENT OR PAST.

NO	YES
Substance Induced (Hypo) Manic Episode	
Current	o
Past	o

IF **D8** OR **D9** = **YES**, GO TO NEXT MODULE.

SUBTYPES

Rapid Cycling

Have you had four or more episodes of mood disturbance in 12 months?

NO	YES
Rapid Cycling	

Mixed Episode

PATIENT MEETS CRITERIA FOR BOTH MANIC EPISODE AND MAJOR DEPRESSIVE EPISODE NEARLY EVERY DAY DURING AT LEAST A ONE WEEK PERIOD.

NO	YES
Mixed Episode	

Seasonal Pattern

THE ONSET AND REMISSIONS OR SWITCHES FROM DEPRESSION TO MANIA OR HYPOMANIA CONSISTENTLY OCCUR AT A PARTICULAR TIME OF YEAR.

NO	YES
Seasonal Pattern	

With Full Interepisode Recovery

Between the two most recent mood episodes did you fully recover?

NO	YES
With Full Interepisode Recovery	

CIRCLE ONE

MOST RECENT EPISODE WAS A **MANIC / HYPOMANIC / MIXED / DEPRESSED** EPISODE

SEVERITY

X1	Mild	o
X2	Moderate	o
X3	Severe without psychotic features	o
X4	Severe with psychotic features	o
X5	In partial remission	o
X6	In full remission	o

CHRONOLOGY

D10 How old were you when you first began having symptoms of manic/hypomanic episodes? ☐ age

D11 Since the first onset how many distinct times did you have significant symptoms of mania/ hypomania? ☐

E. PANIC DISORDER

(□ MEANS: GO TO E6 AND E7 AND E8 AND E9 AND E10, CIRCLE NO TO ALL AND MOVE TO NEXT MODULE – MODULE F)

E1	a	Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way?	□ NO	YES
	b	Did the spells peak within 10 minutes?	□ NO	YES
E2		At any time in the past, did any of those spells or attacks come on unexpectedly or spontaneously, or occur in an unpredictable or unprovoked manner?	□ NO	YES
E3		Have you ever had one such attack followed by a month or more of persistent concern about having another attack, or worries about the consequences of the attack?	NO	YES
E4		During the worst spell that you can remember:		
	a	Did you have skipping, racing or pounding of your heart?	NO	YES
	b	Did you have sweating or clammy hands?	NO	YES
	c	Were you trembling or shaking?	NO	YES
	d	Did you have shortness of breath or difficulty breathing?	NO	YES
	e	Did you have a choking sensation or a lump in your throat?	NO	YES
	f	Did you have chest pain, pressure or discomfort?	NO	YES
	g	Did you have nausea, stomach problems or sudden diarrhea?	NO	YES
	h	Did you feel dizzy, unsteady, lightheaded or faint?	NO	YES
	i	Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from part or all of your body?	NO	YES
	j	Did you fear that you were losing control or going crazy?	NO	YES
	k	Did you fear that you were dying?	NO	YES
	l	Did you have tingling or numbness in parts of your body?	NO	YES
	m	Did you have hot flushes or chills?	NO	YES
		E4 (SUMMARY): ARE **4** OR MORE **E4** ANSWERS CODED **YES**?	NO	YES
E5	a	Were you taking any drugs or medicines just before these symptoms began? π No π Yes		
	b	Did you have any medical illness just before these symptoms began? π No π Yes		
		IN THE CLINICIAN'S JUDGMENT: ARE EITHER OF THESE LIKELY TO BE DIRECT CAUSES OF THE PATIENT'S PANIC DISORDER?		
		E5 (SUMMARY): HAS AN ORGANIC CAUSE BEEN RULED OUT?	NO	YES

IF **E5 (SUMMARY)** IS CODED **NO**, SKIP TO **E9**.

E6 DOES **E3** AND **E4 (SUMMARY)** AND **E5 (SUMMARY)** = **YES**? NO YES

PANIC DISORDER
LIFETIME

IF **E6** = **YES**, SKIP TO E8.

E7 IF **E6** = **NO**, ARE ANY E4 ANSWERS CODED **YES**? NO YES

LIMITED SYMPTOM ATTACKS
LIFETIME

THEN SKIP TO **F1**.

E8 In the past month, did you have such attacks repeatedly (2 or more), followed by persistent concern about having another attack? NO YES

PANIC DISORDER
CURRENT

(IF THIS IS DENIED BY THE PATIENT—CHALLENGE BY REVIEWING THE SYMPTOMS ENDORSED IN **E4).**

E9 ARE **E3** AND **E4 (SUMMARY)** AND **E5b** ALL CODED **YES** AND **E5 (SUMMARY)** CODED **NO**?

NO	YES
Anxiety Disorder with Panic Attacks Due to a General Medical Condition **CURRENT**	

E10 ARE **E3** AND **E4 (SUMMARY)** AND **E5a** ALL CODED **YES** AND **E5 (SUMMARY)** CODED **NO**?

NO	YES
Substance Induced Anxiety Disorder with Panic Attacks **CURRENT**	

CHRONOLOGY

E11 How old were you when you first began having symptoms of panic attacks? ☐ age

E12 During the past year, for how many months did you have significant symptoms of panic attacks or worries about having an attack? ☐

F. AGORAPHOBIA

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

IF **F1** = **NO**, CIRCLE **NO** IN **F2** AND IN **F3**.

F2 Have you ever feared these situations so much that you avoided them, or suffered through them, or needed a companion to face them? **NO** **YES**

AGORAPHOBIA **LIFETIME**

F3 Do you **NOW** fear or avoid these places or situations? **NO** **YES**

AGORAPHOBIA **CURRENT**

	CHECK ONLY IF **YES**	
IS AGORAPHOBIA *CODED* **YES**?	**F2** o lifetime	**F3** o current
IS PANIC DISORDER CODED **YES**?	**E6** o lifetime	**E8** o current

F4 a IS PANIC DISORDER, CURRENT (**E8**), CODED **YES**,

AND

IS AGORAPHOBIA, CURRENT (**F3**), CODED **NO?**

NO **YES**

Panic Disorder, Current *without* *AGORAPHOBIA*

b IS PANIC DISORDER, CURRENT (**E8**), CODED **YES**,

AND

IS AGORAPHOBIA, CURRENT (**F3**), CODED **YES?**

NO **YES**

Panic Disorder, Current *with* *AGORAPHOBIA*

c IS PANIC DISORDER, LIFETIME (**E6**), CODED **NO**,

AND

IS AGORAPHOBIA, CURRENT (**F3**), CODED **YES?**

NO **YES**

AGORAPHOBIA, CURRENT without history of Panic Disorder

d IS AGORAPHOBIA, CURRENT (**F3**) CODED **YES**,

AND IS PANIC DISORDER CURRENT (**E8**) CODED **NO**,

AND IS PANIC DISORDER, LIFETIME (**E6**) CODED **YES**?

NO **YES**

AGORAPHOBIA, CURRENT **without current Panic Disorder but with a past history of Panic Disorder**

e IS AGORAPHOBIA, CURRENT (**F3**) CODED **YES**, **NO** **YES**

AND LIMITED SYMPTOM ATTACKS (**E7**) CODED **NO**? ***AGORAPHOBIA, CURRENT*** **without history of Limited Symptom Attacks**

CHRONOLOGY

F5 How old were you when you first began to fear or avoid these situations (agoraphobia)? ☐ age

F6 During the past year, for how many months did you have significant fear or avoidance of these situations (agoraphobia)? ☐

G. SOCIAL PHOBIA (Social Anxiety Disorder)

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

G1 In the past month, were you fearful or embarrassed being watched, being the focus of attention, or fearful of being humiliated? This includes situations like speaking in public, eating in public or with others, writing while someone watches, or being in social situations. ☐ NO YES

G2 Is this fear excessive or unreasonable? ☐ NO YES

G3 Do you fear these situations so much that you avoid them or suffer through them? ☐ NO YES

G4 Does this fear disrupt your normal work or social functioning or cause you significant distress?

NO **YES**

SOCIAL PHOBIA
(Social Anxiety Disorder)
CURRENT

SUBTYPES

Do you fear and avoid 4 or more social situations? NO YES

If YES ∏ generalized social phobia (social anxiety disorder)

If NO ∏ social phobia (social anxiety disorder), not generalized

CHRONOLOGY

G5 How old were you when you first began to fear social situations? ☐ age

G6 During the past year, for how many months did have you have significant fear of social situations? ☐

H. SPECIFIC PHOBIA

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

H1	In the past month, have you been excessively afraid of things like: flying, driving, heights, storms, animals, insects, or seeing blood or needles?	□ NO	YES
H2	Is this fear excessive or unreasonable?	□ NO	YES
H3	Do you fear these situations so much that you avoid them or suffer through them?	□ NO	YES
H4	Does this fear disrupt your normal work or social functioning or cause you significant distress?	**NO**	**YES**

SPECIFIC PHOBIA
CURRENT

CHRONOLOGY

H5	How old were you when you first began to fear or avoid this situation?	□ age
H6	During the past year, how many times have you had significant fear of this situation?	□

I. OBSESSIVE-COMPULSIVE DISORDER

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

I1	In the past month, have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive, or distressing? (For example, the idea that you were dirty, contaminated or had germs, **or** fear of contaminating others, **or** fear of harming someone even though you didn't want to, **or** fearing you would act on some impulse, **or** fear or superstitions that you would be responsible for things going wrong, **or** obsessions with sexual thoughts, images or impulses, **or** hoarding, collecting, **or** religious obsessions.) (DO NOT INCLUDE SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PROBLEMS. DO NOT INCLUDE OBSESSIONS DIRECTLY RELATED TO EATING DISORDERS, SEXUAL DEVIATIONS, PATHOLOGICAL GAMBLING, OR ALCOHOL OR DRUG ABUSE BECAUSE THE PATIENT MAY DERIVE PLEASURE FROM THE ACTIVITY AND MAY WANT TO RESIST IT ONLY BECAUSE OF ITS NEGATIVE CONSEQUENCES.)	NO □ to I4	YES
I2	Did they keep coming back into your mind even when you tried to ignore or get rid of them?	NO □ to I4	YES
I3	Do you think that these obsessions are the product of your own mind and that they are not imposed from the outside?	NO	YES

obsessions

I4	In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, arranging things, or other superstitious rituals?	NO	YES **compulsions**

IS **I3** OR **I4** CODED **YES**? ☐ NO YES

I5	Did you recognize that either these obsessional thoughts or compulsive behaviors were excessive or unreasonable?	☐ NO	YES
I6	Did these obsessions or compulsions significantly interfere with your normal routine, occupational functioning, usual social activities, or relationships, or did they take more than one hour a day?	NO	YES

I7 a Were you taking any drugs or medicines just before these symptoms began?
π No π Yes

b Did you have any medical illness just before these symptoms began?
π No π Yes

IN THE CLINICIAN'S JUDGMENT: ARE EITHER OF THESE LIKELY TO BE DIRECT CAUSES OF THE PATIENT'S OBSESSIVE COMPULSIVE DISORDER?

I7 (SUMMARY): HAS AN ORGANIC CAUSE BEEN RULED OUT? NO YES

ARE **I6** AND **I7 (SUMMARY)** CODED **YES?**

NO **YES**

O.C.D.
CURRENT

I8 ARE **I6** AND **I7b** CODED **YES**

AND **I7 (SUMMARY)** CODED **NO**?

NO **YES**

O.C.D.
CURRENT
Due to a General Medical Condition

I9 ARE **I6** AND **I7a** CODED **YES**

AND **I7 (SUMMARY)** CODED **NO**?

NO **YES**

Current Substance Induced
O.C.D.

CHRONOLOGY

I10	How old were you when you first began having symptoms of OCD?	☐ age
I11	During the past year, for how many months did you have significant symptoms of OCD?	☐

J. POSTTRAUMATIC STRESS DISORDER (optional)

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

J1	Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? EXAMPLES OF TRAUMATIC EVENTS INCLUDE: SERIOUS ACCIDENTS, SEXUAL OR PHYSICAL ASSAULT, A TERROIST ATTACK, BEING HELD HOSTAGE, KIDNAPPING, FIRE, DISCOVERING A BODY, SUDDEN DEATH OF SOMEONE CLOSE TO YOU, WAR, OR NATURAL DISASTER.	□ NO	YES
J2	Did you respond with intense fear, helplessness or horror?	□ NO	YES
J3	During the past month, have you re-experienced the event in a distressing way (such as, dreams, intense recollections, flashbacks or physical reactions)?	□ NO	YES

J4	**In the past month:**			
	a	Have you avoided thinking about or talking about the event ?	NO	YES
	b	Have you avoided activities, places or people that remind you of the event?	NO	YES
	c	Have you had trouble recalling some important part of what happened?	NO	YES
	d	Have you become much less interested in hobbies or social activities?	NO	YES
	e	Have you felt detached or estranged from others?	NO	YES
	f	Have you noticed that your feelings are numbed?	NO	YES
	g	Have you felt that your life will be shortened or that you will die sooner than other people?	NO	YES
		J4 (SUMMARY): ARE **3** OR MORE **J4** ANSWERS CODED **YES**?	□ NO	YES
J5	**In the past month:**			
	a	Have you had difficulty sleeping?	NO	YES
	b	Were you especially irritable or did you have outbursts of anger?	NO	YES
	c	Have you had difficulty concentrating?	NO	YES
	d	Were you nervous or constantly on your guard?	NO	YES
	e	Were you easily startled?	NO	YES
		J5 (SUMMARY): ARE **2** OR MORE **J5** ANSWERS CODED **YES**?	□ NO	YES
J6		During the past month, have these problems significantly interfered with your work or social activities, or caused significant distress?	NO	YES

IS **J6** CODED **YES?**

NO	YES
Posttraumatic Stress Disorder **CURRENT**	

CHRONOLOGY

J7 How old were you when you first began having symptoms of PTSD? ☐ age

J8 Since the first onset how many illness periods of PTSD did you have? ☐

J9 During the past year, for how many months did you have significant symptoms of PTSD? ☐

K. ALCOHOL ABUSE AND DEPENDENCE

(□ MEANS: GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN BOTH AND MOVE TO THE NEXT OPTIONAL K. MODULE)

		□ NO	YES
K1	**In the past 12 months**, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions?		

K2 **In the past 12 months**:

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

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

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

NO	YES*
ALCOHOL DEPENDENCE **CURRENT**	

K3 **In the past 12 months:**

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

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

NO	N/A	YES
ALCOHOL ABUSE **CURRENT**		

(Optional) K. LIFETIME ALCOHOL ABUSE AND DEPENDENCE

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

		□ NO	YES
K4	**Did you ever** have 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions?		

K5 **In your lifetime:**

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

ARE **3** OR MORE **K5** ANSWERS CODED **YES?**

* IF YES, SKIP K6 QUESTIONS, CIRCLE N/A IN ABUSE BOX
MOVE TO NEXT DISORDER. DEPENDENCE PREEMPTS ABUSE

NO	YES*
ALCOHOL DEPENDENCE **LIFETIME**	

In your lifetime:

K6 a	Have you been intoxicated, high, or hungover more than once when you had other responsibilities at school, at work, or at home? Did this cause any problems? (CODE YES ONLY IF THIS CAUSED PROBLEMS.)	NO	YES
b	Were you intoxicated in any situation where you were physically at risk, for example, driving a car, riding a motorbike, using machinery, boating, etc.?	NO	YES
c	Have you had any legal problems because of your drinking, for example, an arrest or disorderly conduct?	NO	YES
d	Have you continued to drink even though your drinking caused problems with your family or other people?	NO	YES

ARE **1** OR MORE **K6** ANSWERS CODED **YES?**

NO	N/A	YES
	ALCOHOL ABUSE LIFETIME	

L. NON-ALCOHOL PSYCHOACTIVE SUBSTANCE USE DISORDERS

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

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

L1 a **Have you ever taken** any of these drugs more than once to get high, to feel better, or to change your mood? □ NO YES

CIRCLE EACH DRUG TAKEN:

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

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

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

Hallucinogens: LSD ("acid"), mescaline, peyote, PCP ("Angel Dust", "peace pill"), psilocybin, STP, "mushrooms", ecstasy, MDA, or MDMA.

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

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

Tranquilizers: Quaalude, Seconal ("reds"), Valium, Xanax, Librium, Ativan, Dalmane, Halcion, barbiturates, Miltown.

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

Specify MOST USED Drug(s): _____

CHECK ONE BOX

ONLY ONE DRUG / DRUG CLASS HAS BEEN USED □

ONLY THE MOST USED DRUG CLASS IS INVESTIGATED. □

EACH DRUG CLASS USED IS EXAMINED SEPARATELY (PHOTOCOPY L2 AND L3 AS NEEDED) □

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

L2 **Considering the (name of drug / drug class selected), in your lifetime:**

a Have you found that you needed to use more (name of drug / drug class selected) to get the same effect that you did when you first started taking it? NO YES

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

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

c Have you often found that when you used (name of drug / drug class selected), NO YES

you ended up taking more than you thought you would?

d Have you tried to reduce or stop taking (name of drug / drug class selected), but failed? NO YES

e On the days that you used (name of drug / drug class selected), did you spend substantial time (> 2 hours) in obtaining, using or in recovering from drug(s), or thinking about drug(s)? NO YES

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

g Have you continued to use (name of drug / drug class selected) even though it caused you health or mental problems? NO YES

ARE **3** OR MORE **L2** ANSWERS CODED **YES**?

SPECIFY DRUG(S): _____

NO **YES**

SUBSTANCE DEPENDENCE

LIFETIME

L3 a Have you used (most used drug, any drug) in the past 12 months? NO YES

b ARE **3** OR MORE **L2** ANSWERS CODED **YES** WITHIN THE PAST 12 MONTHS? NO YES

ARE **L3a** AND **b** CODED **YES**?

SPECIFY DRUG(S): _____

NO **YES**

SUBSTANCE DEPENDENCE

CURRENT

Considering your use of (name the drug / drug class selected), in the past 12 months:

L4 a Have you been intoxicated, high, or hungover from (name of drug / drug class selected) more than once, when you had other responsibilities at school, at work, or at home? Did this cause any problem? (CODE YES ONLY IF THIS CAUSED PROBLEMS.) NO YES

b Have you been high or intoxicated from (name of drug / drug class selected) more than once, in any situation where you were physically at risk, (for example, driving a car, riding a motorbike, using machinery, boating, etc.)? NO YES

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

d Did you continue to use (name of drug / drug class selected) even though it caused problems with your family or other people? NO YES

ARE **1** OR MORE **L4** ANSWERS CODED **YES**?

SPECIFY DRUG(S): _____

NO **YES**

SUBSTANCE ABUSE

CURRENT

CHRONOLOGY

L5 How old were you when you first began having problems with drug abuse? ☐ age

M. PSYCHOTIC DISORDERS - Part 1

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

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

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

ALL OF THE PATIENT'S RESPONSES TO THE QUESTIONS SHOULD BE CODED IN COLUMN A. USE THE CLINICIAN JUDGMENT COLUMN (COLUMN B) ONLY IF THE CLINICIAN KNOWS FROM OTHER OUTSIDE EVIDENCE (FOR EXAMPLE, FAMILY INPUT) THAT THE SYMPTOM IS PRESENT BUT IS BEING DENIED BY THE PATIENT.

Now I am going to ask you about unusual experiences that some people have.

			COLUMN A Patient Response			COLUMN B Clinician Judgment (if necessary)	
					BIZARRE		BIZARRE
M1	a	Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you?	NO	YES	YES	YES	YES
	b	IF **YES**: Do you currently believe these things? NOTE: ASK FOR EXAMPLES, TO RULE OUT ACTUAL STALKING.	NO	YES	YES ⟨M6	YES	YES ⟨M6
M2	a	Have you ever believed that someone was reading your mind or could hear your thoughts or that you could actually read someone's mind or hear what another person was thinking?	NO		YES		YES
	b	IF **YES**: Do you currently believe these things?	NO		YES ⟨M6		YES ⟨M6
M3	a	Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Have you ever felt that you were possessed? CLINICIAN: ASK FOR EXAMPLES AND DISCOUNT ANY THAT ARE NOT PSYCHOTIC.	NO		YES		YES
	b	IF **YES**: Do you currently believe these things?	NO		YES ⟨M6		YES ⟨M6
M4	a	Have you ever believed that you were being sent special messages through the TV, radio, or newspaper, or that a person you did not personally know was particularly interested in you?	NO	YES	YES	YES	YES
	b	IF **YES**: Do you currently believe these things?	NO	YES	YES ⟨M6	YES	YES ⟨M6
M5	a	Have your relatives or friends ever considered any of your beliefs strange or unusual? INTERVIEWER: ASK FOR EXAMPLES. CODE **YES** ONLY IF THE EXAMPLES ARE **CLEARLY** DELUSIONAL IDEAS (FOR EXAMPLE, SOMATIC OR RELIGIOUS DELUSIONS OR DELUSIONS OF GRANDIOSITY, JEALOUSY, GUILT, RUIN OR DESTITUTION OR OTHERS NOT EXPLORED IN **M1** TO **M4**).	NO	YES	YES	YES	YES
	b	IF **YES**: Do they currently consider your beliefs strange?	NO	YES	YES	YES	YES

				BIZARRE			BIZARRE
M6	a	Have you ever heard things other people couldn't hear, such as voices? HALLUCINATIONS ARE SCORED "BIZARRE" ONLY IF PATIENT ANSWERS YES TO THE FOLLOWING: IF **YES:** Did you hear a voice commenting on your thoughts or behavior,or did you hear two or more voices talking to each other?	NO	YES	YES	YES	YES
	b	IF **YES**: Have you heard these things in the past month? SCORE AS "YES BIZARRE" IF PATIENT HEARD A VOICE COMMENTING ON THEIR THOUGHTS OR BEHAVIOR OR HEARD TWO OR MORE VOICES TALKING TO EACH OTHER.	NO	YES	YES (M8	YES	YES (M8
M7	a	Have you ever had visions when you were awake or have you ever seen things other people couldn't see? CLINICIAN: CHECK TO SEE IF THESE ARE CULTURALLY INAPPROPRIATE.	NO	YES		YES	
	b	IF **YES**: Have you seen these things in the past month?	NO	YES		YES	

CLINICIAN'S JUDGMENT

M8	b	Is the patient currently exhibiting incoherence, disorganized speech, or marked loosening of associations?	NO	YES
M9	b	Is the patient currently exhibiting disorganized or catatonic behavior?	NO	YES
M10	b	Are negative symptoms of schizophrenia, for example, significant affective flattening, poverty of speech (alogia) or an inability to initiate or persist in goal-directed activities (avolition) prominent during the interview?	NO	YES
M11	a	IS THERE AT LEAST ONE "**YES**" FROM **M1** TO **M10b**?	NO	YES

M11 b

ARE THE ONLY SYMPTOMS PRESENT THOSE IDENTIFIED BY THE CLINICIAN FROM **M1** TO **M7** (COLUMN B) AND FROM **M8b** OR **M9b** OR **M10b**?

IF **YES**, SPECIFY IF THE LAST EPISODE IS CURRENT (AT LEAST ONE "b" QUESTION IS CODED "**YES**" FROM **M1** TO **M10b**) AND/OR LIFETIME (ANY QUESTION CODED **YES** FROM **M1** TO **M10b**) AND PASS TO THE NEXT DIAGNOSTIC SECTION.

IF **NO**, CONTINUE.

NO **YES**

PSYCHOTIC DISORDER NOT OTHERWISE SPECIFIED*

Current o
Lifetime o

***Provisional diagnosis due to insufficient information available at this time.**

WARNING: IF AT LEAST ONE "b" QUESTION IS CODED **YES**, CODE **M11c** AND **M11d**.
IF ALL "b" QUESTIONS ARE CODED NO, CODE ONLY **M11d**.

M11c

FROM **M1** TO **M10b**: ARE ONE OR MORE "b" ITEMS CODED "**YES BIZARRE**"?

OR

ARE TWO OR MORE "b" ITEMS CODED "**YES**" BUT NOT "**YES BIZARRE**"?

NO
Then Criterion "A" of Schizophrenia is not currently met

YES
Then Criterion "A" of Schizophrenia is currently met

M11d FROM **M1** TO **M10b**: ARE ONE OR MORE "a" ITEMS CODED "**YES BIZARRE**"

OR

ARE TWO OR MORE "a" ITEMS CODED "**YES**" BUT NOT "**YES BIZARRE**"?
(CHECK THAT AT LEAST 2 ITEMS OCCURRED DURING THE SAME TIME PERIOD.)

NO
Then Criterion "A" of Schizophrenia is not met Lifetime

OR IS **M11c** CODED **"YES"**

YES
Then Criterion "A" of Schizophrenia is met Lifetime

M12 a Were you taking any drugs or medicines just before these symptoms began?
π No π Yes

b Did you have any medical illness just before these symptoms began?
π No π Yes

c IN THE CLINICIAN'S JUDGMENT, ARE EITHER OF THESE LIKELY TO BE DIRECT CAUSES OF THE PATIENT'S PSYCHOSIS?
(IF NECESSARY, ASK OTHER OPEN-ENDED QUESTIONS.)
π No π Yes

d HAS AN ORGANIC CAUSE BEEN RULED OUT? NO YES UNCERTAIN

IF **M12d = NO**: SCORE **M13 (a, b)** AND GO TO THE NEXT DISORDER
IF **M12d = YES**: CODE **NO** IN **M13 (a, b)** AND GO TO **M14**
IF **M12d = UNCERTAIN**: CODE **UNCERTAIN** IN **M13 (a, b)** AND GO TO **M14**

M13a IS **M12d** CODED **NO** BECAUSE OF A GENERAL MEDICAL CONDITION?

NO **YES**

IF **YES**, SPECIFY IF THE LAST EPISODE IS

CURRENT (AT LEAST ONE "b" QUESTION IS CODED **YES** FROM **M1** TO **M10b**) AND/OR LIFETIME ("a" OR "b") QUESTION IS CODED **YES** FROM **M1** TO **M10b**.

PSYCHOTIC DISORDER
Due to a General Medical Condition
Current o
Lifetime o
Uncertain, code later o

M13 b IS **M12d** CODED **NO** BECAUSE OF A DRUG?

NO **YES**

IF **YES**, SPECIFY IF THE LAST EPISODE IS

CURRENT (AT LEAST ONE QUESTION "b" IS CODED **YES** FROM **M1** TO **M10b**) AND/OR LIFETIME (ANY "a" OR "b" QUESTION CODED **YES** FROM **M1** TO **M10b**).

Substance Induced
PSYCHOTIC DISORDER
Current o
Lifetime o
Uncertain, code later o

M14 How long was the longest period during which you had those beliefs or experiences? _____
IF <1 DAY, GO TO THE NEXT SECTION.

M15 a During or after a period when you had these beliefs or experiences, did you have difficulty working, or difficulty in your relationships with others, or in taking care of yourself? NO YES

b IF **YES**, how long did these difficulties last? _____
IF ≥6 MONTHS, GO TO **M16.**

c Have you been treated with medications or were you hospitalized because of these beliefs or experiences, or the difficulties caused by these problems? NO YES

d IF **YES**, what was the longest time you were treated with medication or were hospitalized for these problems? _____

M16 a THE PATIENT REPORTED DISABILITY (**M15a CODED YES**) OR WAS TREATED OR HOSPITALIZED FOR PSYCHOSIS (**M15c = YES**). NO YES

b CLINICIAN'S JUDGMENT: CONSIDERING YOUR EXPERIENCE, RATE THE PATIENT'S **LIFETIME** DISABILITY CAUSED BY THE PSYCHOSIS.

absent	o	1
mild	o	2
moderate	o	3
severe	o	4

M17 WHAT WAS THE TOTAL DURATION OF THE PSYCHOSIS, TAKING INTO ACCOUNT THE ACTIVE PHASE (**M14**) AND THE ASSOCIATED DIFFICULTIES (**M15b**) AND PSYCHIATRIC TREATMENT (**M15d**).

1 o ≥1 day to <1 month
2 o ≥1 month to <6 months
3 o ≥>6 months

CHRONOLOGY

M18 a How old were you when you first began having these unusual beliefs or experiences? ☐ age

b Since the first onset how many distinct times did you have significant episodes of these unusual beliefs or experiences? ☐

PSYCHOTIC DISORDERS - PART 2

DIFFERENTIAL DIAGNOSIS BETWEEN PSYCHOTIC AND MOOD DISORDERS

CODE THE QUESTIONS **M19** TO **M23** ONLY IF THE PATIENT DESCRIBED AT LEAST 1 PSYCHOTIC SYMPTOM (**M11a = YES** AND **M11b = NO**), NOT EXPLAINED BY AN ORGANIC CAUSE (**M12d = YES** OR **UNCERTAIN**).

M19 a DOES THE PATIENT CODE POSITIVE FOR CURRENT AND/OR PAST MAJOR DEPRESSIVE EPISODE (QUESTION **A8** CODED **YES**)? NO YES

b IF **YES**: IS **A1** (DEPRESSED MOOD) CODED **YES**? NO YES

c DOES THE PATIENT CODE POSITIVE FOR CURRENT AND/OR PAST MANIC EPISODE (QUESTION **D7** IS CODED **YES**)? NO YES

d IS **M19a** OR **M19c** CODED **YES**? NO YES
↓
STOP. Skip to M24

NOTE: VERIFY THAT THE RESPONSES TO THE QUESTIONS **M20** TO **M23** REFER TO THE PSYCHOTIC, DEPRESSIVE (**A8**) AND MANIC EPISODES (**D7**), ALREADY IDENTIFIED IN **M11c** AND **M11d, A8 AND D7**.

IN CASE OF DISCREPANCIES, REEXPLORE THE SEQUENCE OF DISORDERS, TAKING INTO ACCOUNT IMPORTANT LIFE ANCHOR POINTS/MILESTONES AND CODE **M20** TO **M23** ACCORDINGLY.

M20 When you were having the beliefs and experiences you just described (GIVE EXAMPLES TO PATIENT), were you also feeling depressed/high/irritable at the same time?

NO YES
↓
STOP. Skip to M24

M21 Were the beliefs or experiences you just described (GIVE EXAMPLES TO PATIENT) restricted exclusively to times you were feeling depressed/high/irritable?

NO YES
↓
STOP. Skip to M24

M22 Have you ever had a period of two weeks or more of having these beliefs or experiences when you were not feeling depressed/high/irritable?

NO YES
↓
STOP. Skip to M24

M23 Which lasted longer: these beliefs or experiences or the periods of feeling depressed/high/irritable?

1 o mood
2 o beliefs, experiences
3 o same

M24 AT THE END OF THE INTERVIEW, GO TO THE DIAGNOSTIC ALGORITHMS FOR PSYCHOTIC DISORDERS.

CONSULT ITEMS **M11a** AND **M11b**:

IF THE CRITERION "A" OF SCHIZOPHRENIA IS MET (**M11c** AND/OR **M11d** = **YES**) GO TO DIAGNOSTIC ALGORITHMS I

IF THE CRITERION "A" OF SCHIZOPHRENIA IS NOT MET (**M11c** AND/OR **M11d** = **NO**) GO TO DIAGNOSTIC ALGORITHMS II

FOR MOOD DISORDERS GO TO DIAGNOSTIC ALGORITHM III.

N. ANOREXIA NERVOSA

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

N1 a How tall are you? □ft □□in. / □□□cm.

b What was your lowest weight in the past 3 months? □□□lbs. / □□□kgs.

IS PATIENT'S WEIGHT LOWER THAN THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT? (SEE TABLE BELOW) □ NO YES

In the past 3 months:

N2 In spite of this low weight, have you tried not to gain weight? □ NO YES

N3 Have you feared gaining weight or becoming fat, even though you were underweight? □ NO YES

N4 a Have you considered yourself fat or that part of your body was too fat? NO YES

b Has your body weight or shape greatly influenced how you felt about yourself? NO YES

c Have you thought that your current low body weight was normal or excessive? NO YES

N5 ARE 1 OR MORE ITEMS FROM **N4** CODED **YES**? □ NO YES

N6 FOR WOMEN ONLY: During the last 3 months, did you miss all your menstrual periods when they were expected to occur (when you were not pregnant)? □ NO YES

FOR WOMEN: ARE **N5** AND **N6** CODED **YES**?
FOR MEN: IS **N5** CODED **YES**?

□ **NO** **YES**

ANOREXIA NERVOSA
CURRENT

CHRONOLOGY

N7 How old were you when you first began having symptoms of anorexia? □ age

N8 Since the first onset how many distinct illness periods of anorexia did you have? □

N9 During the past year, for how many months did you have significant symptoms of anorexia? □

TABLE HEIGHT / WEIGHT THRESHOLD (height-without shoes; weight-without clothing)

Female Height/Weight														
ft/in.	4'9	4'10	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10
lbs.	84	85	86	87	89	92	94	97	99	102	104	107	110	112
cms.	145	147	150	152	155	158	160	163	165	168	170	173	175	178
kgs.	38	39	39	40	41	42	43	44	45	46	47	49	50	51

Male Height/Weight															
ft/in.	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10	5'11	6'0	6'1	6'2	6'3
lbs.	105	106	108	110	111	113	115	116	118	120	122	125	127	130	133
cms.	155	156	160	163	165	168	170	173	175	178	180	183	185	188	191
kgs.	47	48	49	50	51	51	52	53	54	55	56	57	58	59	61

The weight thresholds above are calculated as a 15% reduction below the normal range for the patient's height and gender as required by DSM-IV. This table reflects weights that are 15% lower than the low end of the normal distribution range in the Metropolitan Life Insurance Table of Weights.

O. BULIMIA NERVOSA

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

O1	In the past three months, did you have eating binges or times when you ate a very large amount of food within a 2-hour period?	□ NO	YES
O2	In the last 3 months, did you have eating binges as often as twice a week?	□ NO	YES
O3	During these binges, did you feel that your eating was out of control?	□ NO	YES
O4	Did you do anything to compensate for, or to prevent a weight gain from these binges, like vomiting, fasting, exercising or taking laxatives, enemas, diuretics (fluid pills), or other medications?	□ NO	YES
O5	Does your body weight or shape greatly influence how you feel about yourself?	□ NO	YES
O6	DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?	NO ↓ Skip to O8	YES
O7	Do these binges occur only when you are under (_____lbs./kgs.)? INTERVIEWER: WRITE IN THE ABOVE PARENTHESIS THE THRESHHOLD WEIGHT FOR THIS PATIENT'S HEIGHT FROM THE HEIGHT/WEIGHT TABLE IN THE ANOREXIA NERVOSA MODULE.	NO	YES
O8	IS **O5** CODED **YES** AND **O7** CODED **NO** OR SKIPPED?	**NO**	**YES**

BULIMIA NERVOSA
CURRENT

CHRONOLOGY

O9	How old were you when you first began having symptoms of bulimia?	☐ age
O10	Since the first onset how many illness periods of bulimia did you have?	☐

O11 During the past year, for how many months did you have significant symptoms of bulimia? ☐

SUBTYPES OF BULIMIA NERVOSA

Do you regularly engage in self induced vomiting, misuse of laxatives, diuretics or enemas?

[IN THE NON-PURGING TYPE THE PATIENT HAS USED OTHER COMPENSATORY BEHAVIORS SUCH AS FASTING OR EXCESSIVE EXERCISE, BUT NOT PURGING.]

NO	YES
Non-Purging Type	Purging Type

BULIMIA NERVOSA

SUBTYPES OF ANOREXIA NERVOSA

Binge-Eating/Purging Type

IS **O7** CODED **YES**?

NO **YES**

ANOREXIA NERVOSA
Binge Eating/Purging Type
CURRENT

Restricting Type

Do you lose weight without purging?

NO **YES**

ANOREXIA NERVOSA
Restricting Type
CURRENT

P. GENERALIZED ANXIETY DISORDER

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

P1	a	Have you worried excessively or been anxious about several things over the past 6 months?	□ NO	YES
	b	Are these worries present most days?	□ NO	YES
		IS THE PATIENT'S ANXIETY RESTRICTED EXCLUSIVELY TO, OR BETTER EXPLAINED BY, ANY DISORDER PRIOR TO THIS POINT?	□ NO	YES
P2		Do you find it difficult to control the worries or do they interfere with your ability to focus on what you are doing?	□ NO	YES
P3		FOR THE FOLLOWING, CODE **NO**, IF THE SYMPTOMS ARE CONFINED TO FEATURES OF ANY DISORDER EXPLORED PRIOR TO THIS POINT.		
		When you were anxious over the past 6 months, most of the time did you:		
	a	Feel restless, keyed up or on edge?	NO	YES
	b	Feel tense?	NO	YES
	c	Feel tired, weak or exhausted easily?	NO	YES
	d	Have difficulty concentrating or find your mind going blank?	NO	YES
	e	Feel irritable?	NO	YES
	f	Have difficulty sleeping (difficulty falling asleep, waking up in the middle of the night, early morning wakening, or sleeping excessively)?	NO	YES
		SUMMARY OF P3: ARE **3** OR MORE **P3** ANSWERS CODED **YES**?	□ NO	YES
P4		Did these symptoms of anxiety cause you significant distress or impair your ability to function at work, socially, or in some other important way?	□ NO	YES
P5	a	Were you taking any drugs or medicines just before these symptoms began? π No π Yes		
	b	Did you have any medical illness just before these symptoms began? π No π Yes		
		IN THE CLINICIAN'S JUDGMENT: ARE EITHER OF THESE LIKELY TO BE DIRECT CAUSES OF THE PATIENT'S GENERALIZED ANXIETY DISORDER?		
		P5 (SUMMARY): HAS AN ORGANIC CAUSE BEEN RULED OUT?	NO	YES

IS **P5 (SUMMARY)** CODED **YES**?

NO	YES
	Generalized Anxiety Disorder **CURRENT**

P6 IS **P5 (SUMMARY)** CODED **NO** AND **P5b** CODED **YES**?

NO	YES
	Current ***Generalized Anxiety Disorder.*** **Due to a General Medical Condition**

P7 IS **P5 (SUMMARY)** CODED **NO** AND **P5a** CODED **YES**?

NO	YES
	Current Substance Induced ***Generalized Anxiety Disorder***

CHRONOLOGY

P8 How old were you when you first began having symptoms of generalized anxiety? ☐ age

P9 During the past year, for how many months did you have significant symptoms of generalized anxiety? ☐

Q. ANTISOCIAL PERSONALITY DISORDER (optional)

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

Q1 **Before you were 15 years old, did you:**

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

□

ARE **2** OR MORE **Q1** ANSWERS CODED **YES?** NO YES

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

Q2 **Since you were 15 years old, have you:**

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

ARE **3** OR MORE **Q2** QUESTIONS CODED **YES**?

NO	YES
ANTISOCIAL PERSONALITY DISORDER **LIFETIME**	

R. SOMATIZATION DISORDER (optional)

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

R1	a	Have you had **many** physical complaints not clearly related to a specific disease beginning before age 30?		□ NO	YES
	b	Did these physical complaints occur over several years?		□ NO	YES
	c	Did these complaints lead you to seek treatment?		□ NO	YES
	d	Did these complaints cause significant problems at school, at work, socially, or in other important areas?		□ NO	YES
R2		Did you have pain in your:	head	NO	YES
			abdomen	NO	YES
			back	NO	YES
			joints, extremities, chest, rectum	NO	YES
			during menstruation	NO	YES
			sexual intercourse	NO	YES
			urination	NO	YES
		ARE **2** OR MORE **R2** ANSWERS CODED **YES?**		□ NO	YES
R3		Did you have any of the following abdominal symptoms:			
			nausea	NO	YES
			bloating	NO	YES
			vomiting	NO	YES
			diarrhea	NO	YES
			intolerance of several different foods	NO	YES
		ARE **2** OR MORE **R3** ANSWERS CODED **YES?**		□ NO	YES
R4		Did you have any of the following sexual symptoms:			
			loss of sexual interest	NO	YES
			erection or ejaculation problems	NO	YES
			irregular menstrual periods	NO	YES
			excessive menstrual bleeding	NO	YES
			vomiting throughout pregnancy	NO	YES
		ARE **2** OR MORE **R4** ANSWERS CODED **YES?**		□ NO	YES
R5		Did you have any of the following symptoms:			
			paralysis or weakness in parts of your body	NO	YES
			impaired coordination or imbalance	NO	YES
			difficulty swallowing or lump in throat	NO	YES
			difficulty speaking	NO	YES
			difficulty emptying your bladder	NO	YES
			loss of touch or pain sensation	NO	YES
			double vision or blindness	NO	YES
			deafness, seizures, loss of consciousness	NO	YES
			significant episodes of forgetfulness	NO	YES
			unexplained sensations in your body	NO	YES
			(CLINICIAN: PLEASE EVALUATE IF THESE ARE SOMATIC HALLUCINATIONS)		

ARE **2** OR MORE **R5** ANSWERS CODED **YES?** ☐ NO YES

R6 Were the symptoms investigated by your physician? NO YES

R7 Was any medical illness found, or were you using any drug or medication that could explain these symptoms?
π No π Yes

R6 AND R7 (SUMMARY): CLINICIAN: HAS AN ORGANIC CAUSE BEEN RULED OUT? NO YES

R8 Were the complaints or disability out of proportion to the patient's physical illness? NO YES

IS **R7 (SUMMARY)** OR **R8** CODED **YES?** ☐ NO YES

R9 Were the symptoms a pretense or intentionally produced (as in factitious disorder)? ☐ NO YES

IS **R9** CODED **NO?**

NO	YES
SOMATIZATION DISORDER **LIFETIME**	

R10 Are you currently suffering from these symptoms?

NO	YES
SOMATIZATION DISORDER **CURRENT**	

S. HYPOCHONDRIASIS

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

S1 In the past six months, have you worried a lot about having a serious physical illness? ☐ NO YES
DO NOT CODE YES IF ANY PHYSICAL DISORDER CAN ACCOUNT FOR THE PHYSICAL SENSATIONS OR SIGNS THE PATIENT DESCRIBES.

S2 Have you had this worry for 6 months or more? ☐ NO YES

S3 Have you ever been examined by a doctor for these symptoms? ☐ NO YES

S4 Have your illness fears persisted in spite of the doctor's reassurance? ☐ NO YES

S5 Does this worry cause you significant distress, or does it interfere with your ability to function at work, socially, or in other important ways? NO YES

S6 IS **S5** CODED **YES?**

NO	YES
HYPOCHONDRIASIS **CURRENT**	

T. BODY DYSMORPHIC DISORDER

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

T1	Are you preoccupied with a defect in your appearance?	□ NO	YES
T2	Has this preoccupation persisted in spite of others (including a physician) genuinely feeling that your worry was excessive?	□ NO	YES
T3	Does this preoccupation cause you significant distress, or does it interfere significantly with your ability to function at work, socially, or in some other important way?	NO	YES
T4	IS **T3** CODED **YES?**	**NO**	**YES**

BODY DYSMORPHIC DISORDER
CURRENT

U. PAIN DISORDER

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

U1	Currently, is pain your main problem?	□ NO	YES
U2	Currently, is the pain severe enough to need medical attention?	□ NO	YES
U3	Currently is the pain causing you significant distress, or interfering significantly with your ability to function at work, socially, or in some other important way?	□ NO	YES
U4	Did psychological factors or stress have an important role in the onset of the pain, or did they make it worse, or keep it going?	□ NO	YES
U5	Is the pain a pretense or intentionally produced or feigned? (As in factitious disorder?)	NO	□ YES
U6	Did a medical condition have an important role in the onset of the pain, or did the medical condition make it worse, or keep it going?	NO	YES
U7	Has the pain been present for more than 6 months?	NO ↓ Acute	YES ↓ Chronic
U8	IS **U6** CODED **NO?**	**NO**	**YES**

PAIN DISORDER
associated with psychological factors
CURRENT

U9 IS **U6** CODED **YES?**

IF **U8** OR **U9** ARE CODED YES
AND **U7** = **NO**, ADD: ACUTE TO DIAGNOSIS TITLE
AND **U7** = **YES**, ADD: CHRONIC TO DIAGNOSIS TITLE

NO	YES

PAIN DISORDER
associated with psychological factors and general medical condition
CURRENT

V. CONDUCT DISORDER Age 17 or Younger

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

Please involve the family or significant caregiver in eliciting this information.

V1 **In the past 12 months** have you:

a	bullied, threatened or intimidated others	NO	YES
b	started fights	NO	YES
c	used a weapon that could harm someone (for example, knife, gun, bat, broken bottle)	NO	YES
d	deliberately hurt people	NO	YES
e	deliberately hurt animals	NO	YES
f	stolen things using force (for example, armed robbery, mugging, purse snatching, extortion)	NO	YES
g	forced anyone to have sex with you	NO	YES
h	deliberately started fires to damage property	NO	YES
i	deliberately destroyed things belonging to others	NO	YES
j	broken into someone's house or car	NO	YES
k	lied repeatedly to get things or "conned" (tricked) other people	NO	YES
l	stolen things	NO	YES
m	stayed out late at night in spite of your parents forbidding you, starting before age 13 years	NO	YES
n	run away from home at least twice	NO	YES
o	often skipped school, starting before age 13 years	NO	YES
		□	
	ARE **3** OR MORE **V1** ANSWERS CODED **YES** WITH AT LEAST ONE CODED **YES** IN THE PAST 6 MONTHS?	NO	YES

□

V2 Did these behaviors cause significant problems at school, at work, or with friends and family? NO YES

IS **V2** CODED **YES?**

NO	YES

CONDUCT DISORDER
CURRENT

Subtypes	**Mark all that apply.**
With ADHD	o
With history of physical or sexual abuse	o
With history of traumatic divorce	o
With history of adoption	o
With other stresses	o

W. ATTENTION DEFICIT/HYPERACTIVITY DISORDER
(Children/Adolescents)

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

Please involve the family or significant caregiver in eliciting this information.

In the past 6 months have you often:

W1	a	Failed to pay attention to details or made careless mistakes in school, work or other activities?	NO	YES
	b	Had difficulty paying attention when playing or doing some work?	NO	YES
	c	Seemed not to listen when spoken to directly?	NO	YES
	d	Not followed instructions, or failed to finish schoolwork or chores (even though you understood the instructions and weren't trying to be difficult)?	NO	YES
	e	Had difficulty getting organized?	NO	YES
	f	Avoided or disliked things that require a lot of thinking (like schoolwork or homework)?	NO	YES
	g	Lost things you needed?	NO	YES
	h	Become easily distracted by little things?	NO	YES
	i	Become forgetful in your day to day activities?	NO	YES
		W1 (SUMMARY): ARE **6** OR MORE **W1** ANSWERS CODED **YES**?	NO	YES

In the past 6 months have you often:

W2	a	Squirmed in your seat or fidgeted with your hands or feet	NO	YES
	b	Left your seat in class when you were not supposed to?	NO	YES
	c	Run around and climbed a lot when you shouldn't or others didn't want you to?	NO	YES
	d	Had difficulty playing quietly?	NO	YES
	e	Felt like you were "driven by a motor" or were always "on the go"?	NO	YES
	f	Talked too much?	NO	YES
	g	Blurted out an answer before the question was completed?	NO	YES
	h	Had difficulty waiting your turn?	NO	YES
	i	Interrupted or intruded on others?	NO	YES
			□	
		W2 (SUMMARY): ARE **6** OR MORE **W2** ANSWERS CODED **YES**?	NO	YES
			□	
W3		Did you have some of these hyperactive-impulsive or inattentive symptoms before you were 7 years old?	NO	YES
			□	
W4		Have some of these symptoms caused significant problems in two or more of the following situations: at school, at work, at home, or with family or friends?	NO	YES

IS **W4** CODED **YES?**

NO	YES
Attention Deficit/Hyperactivity Disorder CURRENT	

ATTENTION DEFICIT/HYPERACTIVITY DISORDER

(Adult)

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

As a child:

W5	a	Were you active, fidgety, restless, always on the go?	NO	YES
	b	Were you inattentive and easily distractible?	NO	YES
	c	Were you unable to concentrate at school or while doing your homework?	NO	YES
	d	Did you fail to finish things, such as school work, projects, etc.?	NO	YES
	e	Were you short tempered, irritable, or did you have a "short fuse", or tend to explode.	NO	YES
	f	Did things have to be repeated to you many times before you did them?	NO	YES
	g	Did you tend to be impulsive without thinking of the consequences?	NO	YES
	h	Did you have difficulty waiting for your turn, frequently needing to be first?	NO	YES
	i	Did you get into fights and/or bother other children?	NO	YES
	j	Did your school complain about your behavior?	NO □	YES
		W5 (SUMMARY): ARE **6** OR MORE **W5** ANSWERS CODED **YES**?	NO □	YES
W6		Did you have some of these hyperactive-impulsive or inattentive symptoms before you were 7 years old?	NO	YES

As an adult:

W7	a	Are you still distractible?	NO	YES
	b	Are you intrusive, or do you butt in, or say things that you later regret either to friends, at work, or home?	NO	YES
	c	Are you impulsive, even if you have better control than when you were a child?	NO	YES
	d	Are you still fidgety, restless, always on the go, even if you have better control than when you were a child?	NO	YES
	e	Are you still irritable and get angrier than you need to?	NO	YES
	f	Are you still impulsive? For example, do you tend to spend more money than you really should?	NO	YES
	g	Do you have difficulty getting work organized?	NO	YES
	h	Do you have difficulty getting organized even outside of work?	NO	YES

	i	Are you under-employed or do you work below your capacity?	NO	YES
	j	Are you not achieving according to people's expectations of your ability?	NO	YES
	k	Have you changed jobs or have been asked to leave jobs more frequently than other people?	NO	YES
	l	Does your spouse complain about your inattentiveness or lack of interest in him/her and/or the family?	NO	YES
	m	Have you gone through two or more divorces, or changed partners more than others?	NO	YES
	n	Do you sometimes feel like you are in a fog, like a snowy television or out of focus?	NO	YES
		W7 (SUMMARY): ARE **9** OR MORE **W7** ANSWERS CODED **YES**?	NO	YES
W8		Have some of these symptoms caused significant problems in two or more of the following situations: at school, at work, at home, or with family or friends?	NO	YES

IS **W8** CODED **YES?**

NO	YES
	Adult Attention Deficit/Hyperactivity Disorder

X. ADJUSTMENT DISORDERS

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

EVEN IF A LIFE STRESS IS PRESENT OR A STRESS PRECIPITATED THE PATIENT'S DISORDER, DO NOT USE AN ADJUSTMENT DISORDER DIAGNOSIS IF ANY OTHER PSYCHIATRIC DISORDER IS PRESENT. SKIP THE ADJUSTMENT DISORDER SECTION IF THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOTHER SPECIFIC AXIS I DISORDER OR ARE MERELY AN EXACERBATION OF A PREEXISTING AXIS I OR II DISORDER.

ONLY ASK THESE QUESTIONS IF PATIENT CODES NO TO ALL OTHER DISORDERS.

X1		Are you having emotional or behavioral symptoms as a result of a life of stress? [Examples include anxiety/depression/misbehavior/physical complaints (examples of misbehavior include fighting, driving recklessly, skipping school, vandalism, violating the rights of others, or doing illegal things)].	NO	YES
X2		Did these emotional/behavioral symptoms start within 3 months of the onset of the stressor?	NO	YES
X3	a	Are these emotional/behavioral symptoms causing marked distress beyond what would be expected?	NO	YES
	b	Are these emotional/behavioral symptoms causing significant impairment in your ability to function socially, at work, or at school?	NO	YES
X4		Are these emotional/behavioral symptoms due entirely to the loss of a loved one (bereavement) and are they similar in severity, level of impairment and duration to what most others would suffer under similar circumstances? (If so this is uncomplicated bereavement.)		
		HAS UNCOMPLICATED BEREAVEMENT BEEN RULED OUT?	NO	YES
X5		Have these emotional/behavioral symptoms continued for more than 6 months after the	NO	YES

stress stopped?

ARE THE FOLLOWING EMOTIONAL/BEHAVIORAL SYMPTOMS PRESENT?

Qualifiers: MARK ALL THAT APPLY.

A Depression, tearfulness or hopelessness. o

B Anxiety, nervousness, jitteriness, worry. o

C Misbehavior (for example, fighting, driving recklessly, skipping school, vandalism, violating other's rights, doing illegal things). o

D Work problems, school problems, physical complaints or social withdrawal. o

IF MARKED:

- A only, then code as Adjustment disorder **with depressed mood**. 309.0
- B only, then code as Adjustment disorder **with anxious mood**. 309.24
- C only, then code as Adjustment disorder **of conduct**. 309.3
- A and B only, then code as Adjustment disorder **with mixed anxiety and depressed mood**. 309.28
- C and (A or B), then code as Adjustment disorder **of emotions and conduct**. 309.4
- D only, then code as Adjustment Disorder **unspecified**. 309.9

IF **X5** IS CODED **NO**, THEN CODE DISORDER **YES** WITH QUALIFIER.

NO **YES**
Adjustment Disorder
***with*_____**
(see above for qualifiers)

Y. PREMENSTRUAL DYSPHORIC DISORDER

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

Y1	During the past year, were most of your menstrual periods preceded by a period lasting about one week when your mood changed significantly?	□ NO	YES
Y2	During these periods, do you have difficulty in your usual activities or relationships with others, are you less efficient at work, or do you avoid other people?	□ NO	YES
Y3	During these premenstrual episodes (but not at in the week after your period ends) do you have the following problems most of the time:		
a	Do you feel sad, low, depressed, hopeless, or self-critical?	NO	YES
b	Do you feel particularly anxious, tense, keyed up or on edge?	NO	YES
c	Do you often feel suddenly sad or tearful, or are you particularly sensitive to others' comments?	NO	YES
d	Do you feel irritable, angry or argumentative?	NO	YES
	ARE 1 OR MORE **Y3** ANSWERS CODED **YES**?	□ NO	YES
e	Are you less interested in your usual activities, such as work, hobbies or meeting with friends?	NO	YES
f	Do you have difficulty concentrating?	NO	YES

g Do you feel exhausted, tire easily, or lack energy? NO YES

h Does your appetite change, or do you overeat or have specific food cravings? NO YES

i Do you have difficulty sleeping or do you sleep excessively? NO YES

j Do you feel you are overwhelmed or out of control? NO YES

k Do you have physical symptoms such as breast tenderness or swelling, headaches, joint or muscle pain, a sensation of bloating, or weight gain? NO YES

ARE **5** OR MORE **Y3** ANSWERS CODED **YES**?

IF **YES,** DIAGNOSIS MUST BE CONFIRMED BY PROSPECTIVE DAILY RATINGS DURING AT LEAST 2 CONSECUTIVE CYCLES.

NO **YES**
Premenstrual Dysphoric Disorder Probable
CURRENT

Z. MIXED ANXIETY-DEPRESSIVE DISORDER

DO NOT USE THIS MODULE ALONE WITHOUT FIRST COMPLETING ALL THE ANXIETY AND MOOD DISORDERS.

(☐ **MEANS : GO TO THE DIAGNOSTIC BOX AND CIRCLE NO.**

[SKIP THIS DISORDER IF PATIENT 'S SYMPTOMS HAVE ALREADY MET CRITERIA FOR ANY OTHER DISORDER AND CODE **NO** IN THE DIAGNOSTIC BOX.]

Z1 Have you been depressed or down consistently for at least a **month**? ☐ NO YES

Z2 When you felt depressed did you have any of the following symptoms for at least **one month**:

a. Did you have difficulty concentrating or find your mind going blank? NO YES

b. Did you have trouble sleeping (difficulty falling asleep, waking up in the middle of the night, early morning wakening, or sleeping excessively)? NO YES

c. Did you feel tired or low in energy? NO YES

d. Did you feel irritable? NO YES

e. Did you worry too persistently for at least a month? NO YES

f. Did you cry easily? NO YES

g. Were you always on the lookout for possible dangers? NO YES

h. Did you fear the worst? NO YES

i. Did you feel hopeless about the future? NO YES

j. Was your self-confidence low, or did you feel worthless? NO YES

☐

Summary of Z2: ARE **4** OR MORE **Z2** ANSWERS CODED **YES**? NO YES

☐

Z3 Do these symptoms cause you significant distress or impair your ability to function at work, socially, or in some other important way? NO YES

Z4 a Were you taking any drugs or medicines just before these symptoms began?

b Did you have any medical illness just before these symptoms began?

IN THE CLINICIAN'S JUDGMENT are either of these likely to be direct causes of the patient's symptoms?

		☐ NO	YES	UNCERTAIN
	HAS AN ORGANIC CAUSE BEEN RULED OUT?			

			☐		
Z5	a. The patient's symptoms meet criteria for:	Major Depression **LIFETIME**		NO	YES
		Dysthymia **LIFETIME**	☐	NO	YES
		Panic Disorder **LIFETIME**	☐	NO	YES
		Generalized Anxiety Disorder **LIFETIME**	☐	NO	YES
	b. The patient's symptoms **CURRENTLY** meet criteria for:	any other anxiety disorder	☐	NO	YES
		any other mood disorder	☐	NO	YES
	c. The patient's symptoms are better accounted for by another psychiatric disorder.		☐	NO	YES

Z6 IS **Z5c** CODED **YES?**

NO	**YES**
	MIXED ANXIETY - DEPRESSIVE DISORDER **CURRENT**

THIS CONCLUDES THE INTERVIEW

DSM-IV/ICD-10 DIAGNOSTIC/BILLING CODES FOR M.I.N.I. DIAGNOSES

Major Depressive Disorder

Single Episode/F32.x

296.20/F32.9	Unspecified
296.21/F32.0	Mild
296.22/F32.1	Moderate
296.23/F32.2	Severe Without Psychotic Features
296.24/F32.3	Severe With Psychotic Features
296.25/F32.4	In Partial Remission
296.26/F32.4	In Full Remission

Recurrent/F33.x

296.30/F33.9	Unspecified
296.31/F33.0	Mild
296.32/F33.1	Moderate
296.33/F33.2	Severe Without Psychotic Features
296.34/F33.3	Severe With Psychotic Features
296.35/F33.4	In Partial Remission
296.36/F33.4	In Full Remission

Dysthymia

300.4/F34.1

Mania

Bipolar I, Single Manic Episode/F30.x

296.00	Unspecified
296.01/F30.1	Mild
296.02/F30.1	Moderate
296.03/F30.1	Severe Without Psychotic Features
296.04/F30.2	Severe With Psychotic Features
296.05/F30.8	In Partial Remission
296.06/F30.8	In Full Remission

Bipolar I, Most Recent Episode: Manic/F31.x

296.40/F31.0	Hypomanic
296.40	Unspecified
296.41/F31.1	Mild
296.42/F31.1	Moderate
296.43/F31.1	Severe Without Psychotic Features
296.44/F31.2	Severe With Psychotic Features
296.45/F31.7	In Partial Remission
296.46/F31.7	In Full Remission

Bipolar I, Most Recent Episode: Depression/F31.x

296.50	Unspecified
296.51/F31.3	Mild
296.52/F31.3	Moderate
296.53/F31.4	Severe Without Psychotic Features
296.54/F31.5	Severe With Psychotic Features
296.55/F31.7	In Partial Remission
296.56/F31.7	In Full Remission

Bipolar I, Most Recent Episode: Mixed/F31.6

296.60	Unspecified
296.61/F31.3	Mild
296.62/F31.3	Moderate
296.63/F31.4	Severe Without Psychotic Features
296.64/F31.5	Severe With Psychotic Features
296.65/F31.7	In Partial Remission
296.66/F31.7	In Full Remission
296.70/F31.9	Bipolar I Disorder, Most Recent Episode: Unspecified
296.80/F31.9	Bipolar I Disorder, NOS
296.89/F31.8	Bipolar II Disorder

Panic Disorder/F40.01

300.01/F41.0	Without Agoraphobia
300.21/F40.01	With Agoraphobia

Agoraphobia

300.22/F40.00	Without History of Panic Disorder

Social Phobia (Social Anxiety Disorder)

300.23/F40.1

Specific Phobia

300.29/F40.2

Obsessive-Compulsive Disorder

300.30/F42.8

Generalized Anxiety Disorder

300.02/F41.1

Substance Dependence/Abuse

303.90/F10.2x	Alcohol Dependence
305.00/F10.1	Alcohol Abuse
305.20/F12.1	Cannabis Abuse
305.30/F16.1	Hallucinogen Abuse
305.40/F13.1	Sedative, Hypnotic, or Anxiolytic Abuse
305.50/F11.1	Opioid Abuse
305.60/F14.1	Cocaine Abuse
305.70/F15.1	Amphetamine Abuse
305.90/F15.00	Caffeine Intoxication
305.90/F18.1	Inhalant Abuse
305.90/ F19.00-F19.1	Other (or Unknown) Substance Abuse
305.90/F19.1	Phencyclidine Abuse

Psychotic Disorders

295.10/F20.1x	Schizophrenia, Disorganized Type
295.20/F20.2x	Schizophrenia, Catatonic Type
295.30/F20.0x	Schizophrenia, Paranoid Type
295.40/F20.8	Schizophreniform Disorder
295.60/F20.5x	Schizophrenia, Residual Type
295.70/F25.x	Schizoaffective Disorder
295.90/F20.3x	Schizophrenia, Undifferentiated Type
297.10/F22.0	Delusional Disorder
297.30/F24	Shared Psychotic Disorder
293.81/F06.2	Psychotic Disorder Due to..... (Indicate the General Medical Condition) With Delusions
293.82/F06.0	Psychotic Disorder Due to ..... (Indicate the General Medical Condition) With Hallucinations
293.89/F06.4	Anxiety Disorder Due to..... (Indicate the General Medical Condition)
293.89/F06.x	Catatonic Disorder Due to..... (Indicate the General Medical Condition)
298.80/F23.xx	Brief Psychotic Disorder
298.90/F29	Psychotic Disorder NOS

Anorexia Nervosa

307.10/F50.0

Bulimia Nervosa

307.51/F50.2

Posttraumatic Stress Disorder

309.81/F43.1

Suicidality

no code assigned

Antisocial Disorder

301.70/F60.2

Somatoform Disorders

300.81/F45.0	Somatization Disorder
300.70/F45.2	Hypochondriasis
300.70/F45.2	Body Dysmorphic Disorder

Pain Disorders

307.80/F45.4 Pain Disorder Associated with Psychological Factors

307.89/F45.4 Pain Disorder Associated with Both Psychological Factors and a General Medical Condition

Conduct Disorder

312.80/F91.8

Attention Deficit Disorder

314.01/F90.0 Attention Deficit/Hyperactivity Disorder, Combined Type

314.00/F98.8 Attention Deficit/Hyperactivity Disorder, Predominately Inattentive Type

314.01/F90.0 Attention Deficit/Hyperactivity Disorder, Predominately Hyperactive-Impulsive Type

Adjustment Disorders

309.00/F43.20 Adjustment Disorder with Depressed Mood

309.24/F43.28 Adjustment Disorder with Anxiety

309.28/F43.22 Adjustment Disorder with Mixed Anxiety & Depressed Mood

309.30/F43.24 Adjustment Disorder with Disturbance of Conduct

309.40/F43.25 Adjustment Disorder with Mixed Disturbance of Emotions & Conduct

309.90/F43.9 Adjustment Disorder, Unspecified

Premenstrual Dysphoric Disorder

no code assigned

CRITERION FOR RULING OUT OTHER AXIS I DISORDERS

[In the event of comorbidity, the following algorithm (or hierarchy of disorders based on DSM-IV) can be used to reduce the number of comorbid disorders down to those likely to be clinically meaningful.]

Question			Yes	No
Are the symptoms of X	restricted exclusively to or better explained by	Y, Z?	o	o

If diagnosis X is made, call up question, insert diagnosis X in column 1, and the corresponding Y, Z diagnosis in Column 2.

In any mix where:

	Diagnosis X			**Diagnosis Y, Z, etc.**
A	Major Depressive Disorder (MDE)	is present, leave it unless disorder is restricted exclusively to, or better explained by, diagnosis Y, Z:		Manic, Hypomanic, or Mixed Episodes, Schizoaffective Disorder, Schizophreniform Disorder, Delusional Disorder or Psychotic Disorder NOS
B	Dysthymia			MDE or Mania
C	Suicidality			Can coexist with any other Axis I disorder
D	(Hypo)Manic Episode	"	"	MDE concurrently during the same week = mixed episode
E	Panic Disorder (PD)	"	"	Social Phobia, Specific Phobia, OCD, PTSD
F	Agoraphobia (AG)	"	"	Social Phobia, Specific Phobia, OCD or PTSD
G	Social Phobia (Soc Ph) (Social Anxiety Disorder)	"	"	PD or Agoraphobia
H	Specific Phobia (Sp Ph)	"	"	PD or AG or OCD or PTSD
I	Obsessive-Compulsive Disorder	"	"	Any Axis I Disorder
J	Posttraumatic Stress Disorder	"	"	Agoraphobia
K	Alcohol Dependence/Abuse	"	"	Can coexist with any other Axis I disorder
L	Drug Dependence/Abuse (Non-alcohol)	"	"	Can coexist with any other Axis I disorder
M	Psychotic Disorders (Psy)	"	"	Can coexist with any other Axis I disorder
N	Anorexia Nervosa (AN)	"	"	Can coexist with any other Axis I disorder
O	Bulimia Nervosa (BN)	"	"	Can coexist with any other Axis I disorder
P	Generalized Anxiety Disorder	"	"	MDE, Dys, Mania, PD, Psy, Soc Ph, Sp Ph, OCD, PTSD, Anxiety Disorder
Q	Antisocial Personality Disorder	"	"	Mania or Psychotic
R	Somatization Disorder	"	"	Can coexist with any other Axis I disorder
S	Hypochondriasis	"	"	GAD, OCD, PD, MDE, Separation Anxiety Disorder, another Somatoform disorder, Delusional disorder, Body Dysmorphic Disorder
T	Body Dysmorphic Disorder	"	"	MDE, PD, AN, Soc Ph, Sp Ph, OCD, PTSD, Psychotic
U	Pain Disorder	"	"	MDE, Mania, PD, GAD, OCD, PTSD, Soc Ph, Sp Ph, Psy, Dyspareunia
V	Conduct Disorder	"	"	Can coexist with any other Axis I disorder, ADHD
W	Attention Deficit Hyperactivity Disorder (ADHD)	"	"	Psychotic, Mania, Anxiety Disorder, MDE, Conduct Disorder
X	Adjustment Disorders	"	"	Any Axis I Disorder
Y	Premenstrual Dysphoric Dis.	"	"	PD, MDE, Dysthymic Disorder or a Personality Disorder
Z	Mixed Anxiety-Depressive Dis.	"	"	Any other psychiatric disorder.

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Translations	M.I.N.I. 4.4 or earlier versions	M.I.N.I. 4.6/5.0, M.I.N.I. Plus 4.6/5.0 and M.I.N.I. Screen 5.0:
Afrikaans	R. Emsley	W. Maartens
Arabic		O. Osman, E. Al-Radi
Bengali		H. Banerjee, A. Banerjee
Brazilian Portuguese	P. Amorim	P. Amorim
Bulgarian	L.G.. Hranov	
Chinese		L. Carroll, Y-J. Lee, Y-S. Chen, C-C. Chen, C-Y. Liu, C-K. Wu, H-S. Tang, K-D. Juang, Yan-Ping Zheng.
Croatian		In preparation
Czech		P. Zvlosky
Danish	P. Bech	P. Bech, T. Schütze
Dutch/Flemish	E. Griez, K. Shruers, T. Overbeek, K. Demyttenaere	I. Van Vliet, H. Leroy, H. van Megen
English	D. Sheehan, J. Janavs, R. Baker, K. Harnett-Sheehan, E. Knapp, M. Sheehan	D. Sheehan, R. Baker, J. Janavs, K. Harnett-Sheehan, M. Sheehan
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Farsi/Persian		K. Khooshabi, A. Zomorodi
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French	Y. Lecrubier, E. Weiller, LI. Bonora, P. Amorim, J.P. Lepine	Y. Lecrubier, E. Weiller, P. Amorim, T. Hergueta
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Greek	S. Beratis	T. Calligas, S. Beratis
Gujarati		M. Patel, B. Patel
Hebrew	J. Zohar, Y. Sasson	R. Barda, I. Levinson, A. Aviv
Hindi		C. Mittal, K. Batra, S. Gambhir
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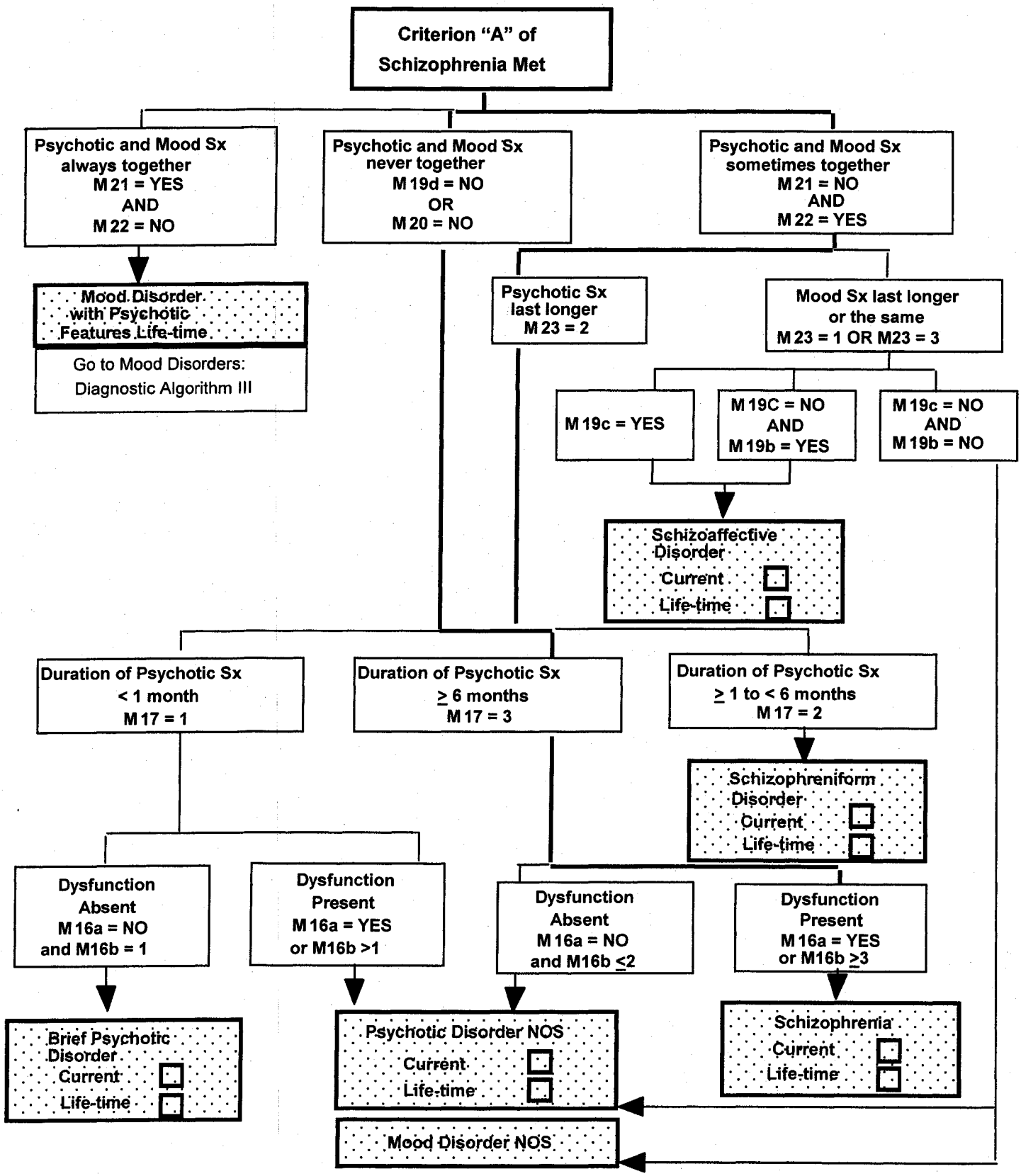
Validation studies on the M.I.N.I. were made possible, in part, by grants from SmithKline Beecham and the European Commission.
The authors are grateful to: Dr. Pauline Powers for her advice on the Anorexia Nervosa and Bulimia modules
Dr. Humberto Nagera for his advice on the ADHD (both for children and adults) modules
Drs. Jonathan Cohen and Donald Klein for their suggestions in the Panic Disorder module of the MINI Plus
Prof. Istvan Bitter and Dr. Judit Balazs for contributing the module on Mixed Anxiety-Depressive Disorder

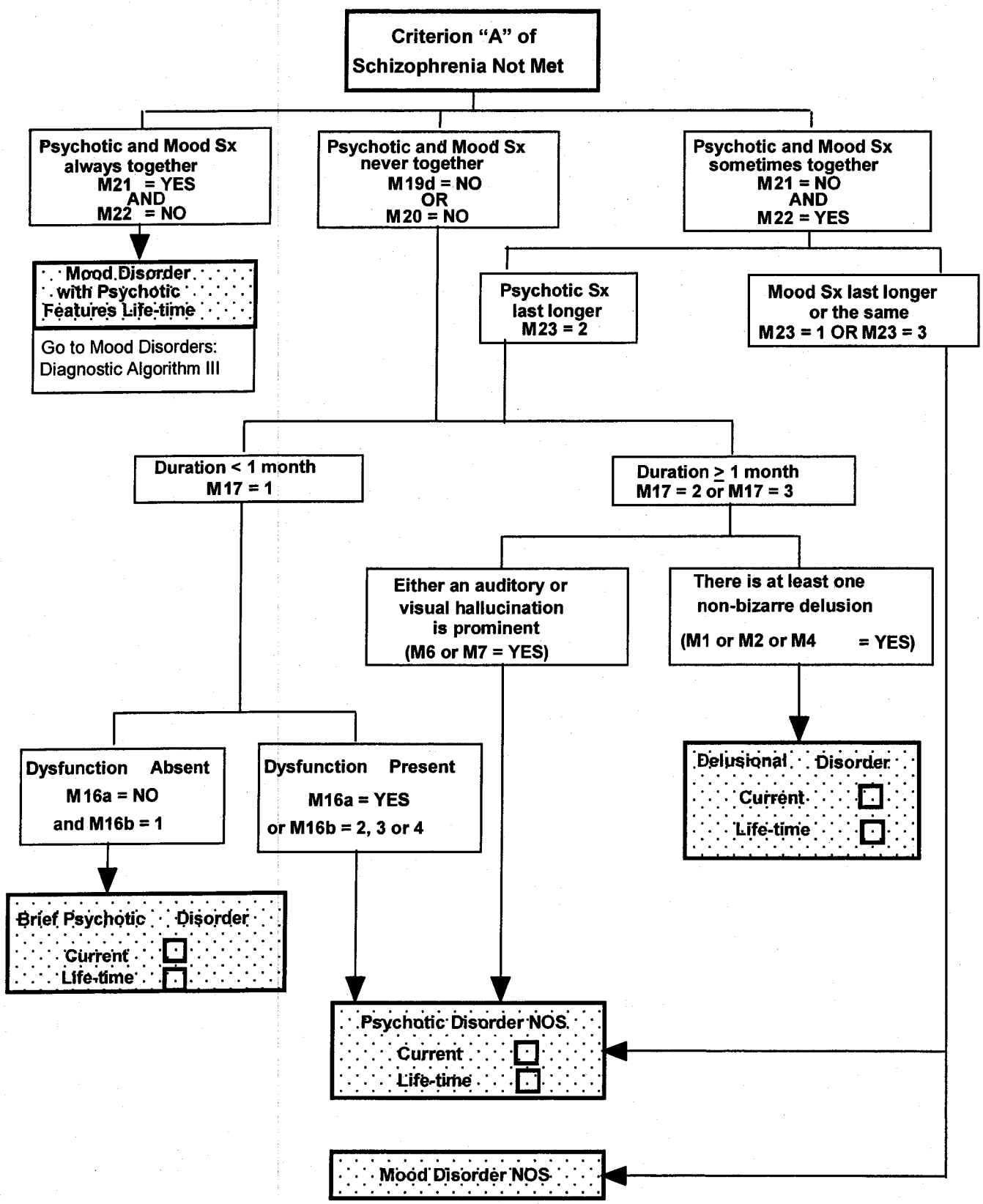
PSYCHOTIC DISORDERS: DIAGNOSTIC ALGORITHMS I

Circle the appropriated diagnostic box both for current and life-time diagnosis. One positive diagnosis excludes the others. If criterion A of schizophrenia is not currently met, but is present in life-time, current and life-time diagnosis may be different.



PSYCHOTIC DISORDERS: DIAGNOSTIC ALGORITHMS II

Circle the appropriated diagnostic box both for current and life-time diagnosis. One diagnosis excludes the others. If criterion A of schizophrenia is not currently met, but present in life-time, current and life-time diagnosis may be



MOOD DISORDERS: DIAGNOSTIC ALGORITHM III

Consult Modules:

A [Major Depressive Episode]
D [(Hypo)manic Episode]
M [Psychotic Disorders]

MODULE M:

1 a	IS **M20** CODED **NO**?	NO	YES	™	GO TO **2c**
b	IS **M21** CODED **NO** AND **M22** CODED **YES**?	NO	YES	™	CODE **NO** IN **2c**, **2d** AND **2e**
c	IS **M21** CODED **YES** OR **M22** CODED **NO**?	NO	YES		

MODULES A and D:

2 a IS A DELUSIONAL IDEA IDENTIFIED IN **A3e**? No o Yes o

b IS A DELUSIONAL IDEA IDENTIFIED IN **D3a**? No o Yes o

c Is **A8 = YES** (Major Depressive Episode present)
and
D6 and D7 = NO (Hypomanic and Manic Episodes absent)?

Specify:
WITHOUT Psychotic Features: IF **1a = YES** and **2a = NO**
WITH Psychotic Features: IF **1a = NO** and **2a = YES**

Specify if last depressive episode is current or past (Question A8)

NO	YES
MAJOR DEPRESSIVE DISORDER	
without PF	o
with PF	o
current	o
past	o

d Is **D7 = YES** (Manic Episode present)?

Specify:
WITHOUT Psychotic Features: IF **1a = YES** and **2a = NO** and **2b = NO**
WITH Psychotic Features: IF **1a = NO** and **2a = YES** and **2b = YES**

Specify if the last mood episode is current or past (Question A8 or D6 or D7)

NO	YES
BIPOLAR I DISORDER	
without PF	o
with PF	o
current	o
past	o

e Is **A8 = YES** (Major Depressive Episode present)
and
D6 = YES (Hypomanic Episode present)
and
D7 = NO (Manic Episode absent)?

Specify if the last mood episode is current or past (Question A8 or D6)

NO	YES
BIPOLAR II DISORDER	
current	o
past	o

M.I.N.I. KID

MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW
for Children and Adolescents

English Version 4.0

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

	MODULES	TIME FRAME	MEETS CRITERIA	DSM-IV	ICD-10
A	MAJOR DEPRESSIVE EPISODE	Current (Past 2 weeks)	☐	296.20-296.26 Single	F32.x
B	SUICIDALITY	Current (Past Month)	☐	N/A	N/A
		Risk: ☐ Low ☐ Medium ☐ High			
C	DYSTHYMIA	Current (Past 1 year)	☐	300.4	F34.1
D	(HYPO)MANIC EPISODE	Current Past	☐ ☐	296.00-296.06	F30.x-F31.9
E	PANIC DISORDER	Current (Past Month) Lifetime	☐ ☐	300.01/300.21	F40.01-F41.0
F	AGORAPHOBIA	Current	☐	300.22	F40.00
G	SEPARATION ANXIETY DISORDER	Current (Past Month)	☐	309.21	F93.0
H	SOCIAL PHOBIA (Social Anxiety Disorder)	Current (Past Month)	☐	300.23	F40.1
I	SPECIFIC PHOBIA	Current (Past Month)	☐	300.29	N/A
J	OBSESSIVE COMPULSIVE DISORDER	Current (Past Month)	☐	300.3	F42.8
K	POST TRAUMATIC STRESS DISORDER	Current (Past Month)	☐	309.81	F43.1
L	ALCOHOL DEPENDENCE	Past 12 Months	☐	303.9	F10.2x
L	ALCOHOL ABUSE	Past 12 Months	☐	305.00	F10.1
M	SUBSTANCE DEPENDENCE (Non-alcohol)	Past 12 Months	☐	304.00-.90/305.20-.90	F11.1-F19.1
M	SUBSTANCE ABUSE (Non-alcohol)	Past 12 Months	☐	304.00-.90/305.20-.90	F11.1-F19.1
N	TOURETTE'S DISORDER	Current	☐	307.23	F95.2
	MOTOR TIC DISORDER	Current	☐	307.22	F95.1
	VOCAL TIC DISORDER	Current	☐	307.22	F95.1
	TRANSIENT TIC DISORDER	Current	☐	307.21	F95.0
O	ADHD COMBINED	Past 6 Months	☐	314.01	F90.0
	ADHD INATTENTIVE	Past 6 Months	☐	314.00	F98.8
	ADHD HYPERACTIVE/IMPULSIVE	Past 6 Months	☐	314.01	F90.0
P	CONDUCT DISORDER	Past 12 Months	☐	312.8	F91.x
Q	OPPOSITIONAL DEFIANT DISORDER	Past 6 Months	☐	313.81	F91.3

R	PSYCHOTIC DISORDERS	Lifetime Current	☐ ☐	295.10-295.90/297.1/ 297.3/293.81/293.82/ 293.89/298.8/298.9	F20.xx-F29
	MOOD DISORDER WITH PSYCHOTIC FEATURES	Current	☐	293.89	F32.x3/F33.x3/ F30.x2/F31.x2/F31.x5
S	ANOREXIA NERVOSA	Current (Past 3 Months)	☐	307.1	F50.0
T	BULIMIA NERVOSA	Current (Past 3 Months)	☐	307.51	F50.2
U	GENERALIZED ANXIETY DISORDER	Current (Past 6 Months)	☐	300.02	F41.1
V	ADJUSTMENT DISORDERS	Current	☐	309.24/309.28 309.3/309.4	F43.xx
W	PERVASIVE DEVELOPMENTAL DISORDER	Current	☐	299.00/299.10/299.80	F84.0/.2/.3/.5/.9

INTERVIEWER INSTRUCTIONS

INTRODUCING THE INTERVIEW

The nature and purpose of the interview should be explained to the child or adolescent prior to the interview. A sample introduction is provided below:

"I'm going to ask you a lot of questions about yourself. This is so that I can get to know more about you and figure out how to help you. Most of the questions can be answered either 'yes' or 'no'. If you don't understand a word or a question, ask me, and I'll explain it. If you are not sure how to answer a question, don't guess - just tell me you are not sure. Some of the questions may seem weird to you, but try to answer them anyway. It is important that you answer the questions as honestly as you can so that I can help you. Do you have any questions before we start?"

For children under 13, we recommend interviewing the parent and the child together. Questions should be directed to the child, but the parent should be encouraged to interject if s/he feels that the child's answers are unclear or inaccurate. The interviewer makes the final decision based on his/her best clinical judgement, whether the child's answers meet the diagnostic criterion in question. *With children you will need to use more examples than with adolescents and adults.*

GENERAL FORMAT:

The MINI is divided into **modules** identified by letters, each corresponding to a diagnostic category.
•At the beginning of each diagnostic module (except for psychotic disorders module), screening question(s) corresponding to the main criteria of the disorder are presented in a **gray box**.
•At the end of each module, diagnostic box(es) permit the clinician to indicate whether diagnostic criteria are met.

CONVENTIONS:

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

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

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

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

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

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

FORMAT OF THE INTERVIEW

The interview questions are designed to elicit specific diagnostic criteria. The questions should be read verbatim. If the child or adolescent does not understand a particular word or concept, you may explain what it means or give examples that capture its essence. If a child or adolescent is unsure if s/he has a particular symptom, you may ask him/her provide an explanation or example to determine if it matches the criterion being investigated. If an interview item has more than 1 question, the interviewer should pause between questions to allow the child or adolescent time to respond.

Questions about the duration of symptoms are included for diagnoses when the time frame of symptoms is a critical element. Because children may have difficulty estimating time, you may assist them by helping them connect times to significant events in their lives. For example, the starting point for "past year" might relate to a birthday, the end or beginning of a school year, a particular holiday or another annual event.

RATING INSTRUCTIONS:

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

The clinician should take each dimension of the question into account (for example, time frame, frequency, severity, and/or alternatives).

Symptoms better accounted for by an organic cause or by the use of alcohol or drugs should not be coded positive in the MINI KID.

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

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A. MAJOR DEPRESSIVE EPISODE

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

In the past two weeks:

A1		Have you felt sad or depressed? Felt down or empty? Felt grouchy or annoyed? IF YES TO ANY, CODE **YES**	NO	YES
A2	a	Have you been bored a lot or much less interested in things (Like playing your favorite games)? Have you felt that you couldn't enjoy things? IF YES TO ANY, CODE **YES**	NO	YES
		IS **A1** OR **A2** CODED **YES?**	NO	YES
	b	Have you felt this way most of the day ?	NO	YES
	c	Have you felt this way almost everyday?	NO	YES

A3 **In the past two weeks, when you felt depressed / grouchy / uninterested:**

a	Were you less hungry or more hungry most days? Did you lose or gain weight without trying? [i.e., by ±5% of body weight or ±8 lbs. in the past month]? IF **YES** TO EITHER, CODE **YES**	NO	YES
b	Did you have trouble sleeping almost every night ("trouble sleeping" means trouble falling asleep, waking up in the middle of the night, waking up too early or sleeping too much)?	NO	YES
c	Did you talk or move slower than usual? Were you fidgety, restless or couldn't sit still? IF **YES** TO EITHER, CODE **YES**	NO	YES
d	Did you feel tired most of the time?	NO	YES
e	Did you feel bad about yourself most of the time? Did you feel guilty most of the time? IF **YES** TO EITHER, CODE **YES**	NO	YES
f	Did you have trouble paying attention? Did you have trouble making up your mind? IF **YES** TO EITHER, CODE **YES**	NO	YES
g	Did you feel so bad that you wished that you were dead? Did you think about hurting yourself? Did you think about killing yourself? IF **YES** TO ANY, CODE **YES**	NO	YES

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

NO	YES
MAJOR DEPRESSIVE EPISODE CURRENT	

B. SUICIDALITY

					Points
B1	a	**Have you ever** felt so bad that you wished you were dead?	NO	YES	1
	b	Have you ever tried to hurt yourself?	NO	YES	2
	c	Have you ever tried to kill yourself?	NO	YES	4

IF **YES** TO ANY, CODE **YES**

NO	YES

SUICIDE RISK LIFETIME

In the past month did you:

B2	Wish you were dead?	NO	YES	1
B3	Want to hurt yourself?	NO	YES	2
B4	Think about killing yourself?	NO	YES	6
B5	Think of a way to kill yourself?	NO	YES	10
B6	Try to kill yourself?	NO	YES	10

IS AT LEAST **1** OF THE ABOVE (B1-B6) CODED **YES**?

NO **YES**

SUICIDE RISK CURRENT

IF YES ADD THE TOTAL NUMBER OF POINTS FOR THE ANSWERS (B1-B6) CHECKED 'YES' AND SPECIFY THE LEVEL OF SUICIDE RISK AS FOLLOWS:

1-5 points	Low
6-9 points	Moderate
≥ 10 points	High

C. DYSTHYMIA

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

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

In the past year:

C1	a	Have you felt sad or depressed? Felt down or empty? Felt grouchy or annoyed? IF YES TO ANY, CODE **YES**	NO	YES
	b	Have you felt this way most of the time?	NO	YES
C2		**In the past year**, have you felt OK for two months or more in a row?	NO	YES
C3		**During the past year**, most of the time:		
	a	Were you less hungry than you used to be? Were you more hungry than you used to be? IF YES TO EITHER, CODE **YES**	NO	YES
	b	Did you have trouble sleeping ("trouble sleeping" means trouble falling asleep, waking up in the middle of the night, waking up too early or sleeping too much)?	NO	YES
	c	Did you feel more tired than you used to?	NO	YES
	d	Did you feel less confident of yourself? Did you feel bad about yourself? IF YES TO EITHER, CODE **YES**	NO	YES
	e	Did you have trouble paying attention? Did you have trouble making up your mind? IF YES TO EITHER, CODE **YES**	NO	YES
	f	Did you feel that things would never get better?	NO	YES
		ARE **2** OR **MORE** ITEMS FROM **C3 a-f** CODED **YES**	NO	YES
C4		Did these feelings of being depressed / grouchy / uninterested upset you a lot? Did they cause you problems at home? At school? With friends? IF YES TO ANY, CODE **YES**	NO	YES

IS **C4** CODED **YES?**

NO	YES
	DYSTHYMIA **CURRENT**

D. (HYPO) MANIC EPISODE

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

D1	a	Has there **ever** been a time when you were so happy that you felt really 'up' or 'high'? By 'up' or 'high' I mean feeling really good; full of energy; needing less sleep; having racing thoughts or being full of ideas. DO NOT CONSIDER TIMES WHEN PATIENT WAS INTOXICATED ON DRUGS OR ALCOHOL OR DURING SITUATIONS THAT NORMALLY OVER STIMULATE AND MAKE CHILDREN VERY EXCITED LIKE CHRISTMAS, BIRTHDAYS, ETC. IF NO TO ALL, CODE NO TO **D1b**; IF YES **TO ANY**, ASK:	NO	YES
	b	Are you currently feeling 'up' or 'high' or full of energy?	NO	YES
D2	a	Has there **ever** been a time when you were so grouchy or annoyed, that you yelled or started fights; or yelled at people not counting your family? Have you or others noticed that you have been more grouchy than other kids, even when you thought you were right to act this way? DO NOT CONSIDER TIMES WHEN PATIENT WAS INTOXICATED ON DRUGS OR ALCOHOL OR DURING SITUATIONS THAT NORMALLY OVER STIMULATE AND MAKE CHILDREN VERY GROUCHY OR ANNOYED. IF NO TO ALL, CODE NO TO **D2b**; IF **YES** TO ANY, ASK:	NO	YES
	b	Are you currently feeling grouchy or annoyed?	NO	YES
		IS **D1a** or **D2a** CODED **YES?**	NO	YES

D3 IF **D1b** OR **D2b** = **YES**: EXPLORE ONLY **CURRENT** EPISODE, OTHERWISE
IF **D1b** AND **D2b** = **NO**: EXPLORE THE MOST SYMPTOMATIC **PAST** EPISODE

During the time(s) when you felt up, high, full of energy or irritable did you:

a	Feel that you could do things others couldn't do? Feel that you are a very important person? IF **YES** TO EITHER, CODE **YES**	NO	YES
b	Need less sleep (Did you feel rested after only a few hours of sleep)?	NO	YES
c	Talk too much without stopping? Talk so fast that people couldn't understand you? IF **YES** TO EITHER, CODE **YES**	NO	YES
d	Have racing thoughts?	NO	YES
e	Get distracted very easily by little things?	NO	YES
f	Get so active or fidgety that people worry about you?	NO	YES
g	Want to do fun things even if you could get hurt doing them? Want to do things even though it could get you into trouble? (Like staying out late or skipping school)? IF **YES** TO EITHER, CODE **YES**	NO	YES
	ARE **3** OR MORE **D3** ANSWERS CODED **YES** (OR **4** OR MORE IF **D1a** IS **NO** [IN RATING PAST EPISODE] OR **D1b** IS **NO** [IN RATING CURRENT EPISODE])?	NO	YES

For at least one week or more:

D4 Did they cause problems at home? At school? With friends? With other people? Were you put into the hospital for these problems?
IF **YES** TO ANY, CODE **YES**

NO YES

↓ ↓

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

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

SPECIFY IF THE EPISODE IS CURRENT OR PAST.

NO **YES**

HYPOMANIC EPISODE

CURRENT
PAST

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

SPECIFY IF THE EPISODE IS CURRENT OR PAST.

NO **YES**

MANIC EPISODE

CURRENT
PAST

E. PANIC DISORDER

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

E1	a	Have you ever been really frightened or nervous for no reason; or have you ever been really frightened or nervous in a situation where most kids would not feel that way? IF YES TO EITHER, CODE YES	NO	YES
	b	Did this happen more than one time?	NO	YES
	c	Did this nervous feeling increase quickly over the first few minutes?	NO	YES
E2		Has this ever happened when you didn't expect it?	NO	YES
E3		After this happened, were you afraid it would happen again? Did you worry for a month or more that it would happen again? IF YES TO BOTH, CODE YES	NO	YES
E4		**Think about the time you were the most frightened or nervous for no good reason:**		
	a	Did your heart beat fast or loud?	NO	YES
	b	Did you sweat? Did your hands sweat a lot? IF YES TO EITHER, CODE YES	NO	YES
	c	Did your hands or body shake?	NO	YES
	d	Did you have trouble breathing?	NO	YES
	e	Did you feel like you were choking? Did you feel you couldn't swallow? IF YES TO EITHER, CODE YES	NO	YES
	f	Did you have pain or pressure in your chest?	NO	YES
	g	Did you feel like throwing up? Did you have an upset stomach? Did you have diarrhea? IF YES TO ANY, CODE YES	NO	YES
	h	Did you feel dizzy or faint?	NO	YES
	i	Did things around you feel strange or like they weren't real? Did you feel or see things as if they were far away? Did you feel outside of or cut off from your body? IF YES TO ANY, CODE YES	NO	YES
	j	Were you afraid that you were losing control of yourself? Were you afraid that you were going crazy? IF YES TO EITHER, CODE YES	NO	YES
	k	Were you afraid that you were dying?	NO	YES
	l	Did parts of your body tingle or go numb?	NO	YES

m Did you feel hot or cold? NO YES

E5 ARE **BOTH E3,** AND **4** OR MORE **E4** ANSWERS, CODED YES? NO YES
PANIC DISORDER LIFETIME

IF YES TO E5, SKIP TO E7

E6 IF **E5**=NO, ARE 1, 2 OR 3 SYMPTOMS IN **E4a-m** CODED YES? NO YES
LIMITED SYMPTOM ATTACKS LIFETIME

THEN SKIP TO **F1.**

E7 **In the past month,** did you have these problems more than one time? If this happened, did you worry for a month or more that it would happen again? NO YES
PANIC DISORDER

IF **YES** TO EITHER, CODE **YES** *CURRENT*

F. AGORAPHOBIA

F1 Do you feel anxious, scared, or uneasy in places or situations where you might become really frightened; like being in a crowd, standing in a line (queue), when you are all alone, or when crossing a bridge, traveling in a bus, train or car? NO YES

IF **YES** TO ANY, CODE **YES**

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

F2 Are you so afraid of these things that you try to stay away from them? Or you can only do them if someone is with you? Or you do them, but it's really hard for you? NO YES

IF **YES** TO ANY, CODE **YES**

AGORAPHOBIA CURRENT

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

AND

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

NO **YES**

PANIC DISORDER without Agoraphobia CURRENT

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

AND

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

NO **YES**

PANIC DISORDER with Agoraphobia CURRENT

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

AND

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

NO **YES**

AGORAPHOBIA, CURRENT without history of Panic Disorder

G. SEPARATION ANXIETY DISORDER

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

G1	a	**In the past month,** have you been really afraid about being away from someone close to you; or have you been really afraid that you would lose somebody you are close to ? (Like getting lost from your parents or having something bad happen to them) IF YES TO EITHER, CODE **YES**	NO	YES
	b	Who are you afraid of losing or being away from _____ ?		
G2	a	Did you get upset a lot when you were away from _____ ? Did you get upset a lot when you thought you would be away from _____ ? IF YES TO EITHER, CODE **YES**	NO	YES
	b	Did you get really worried that you would lose _____ ? Did you get really worried that something bad would happen to _____ ? (like having a car accident or dying). IF YES TO EITHER, CODE **YES**	NO	YES
	c	Did you get really worried that you would be separated from _____ ? (Like getting lost or being kidnapped?)	NO	YES
	d	Did you refuse to go to school or other places because you were afraid to be away from _____ ?	NO	YES
	e	Did you get really afraid being at home if _____ wasn't there?	NO	YES
	f	Did you *not want to go to sleep unless* _____ *was there?*	NO	YES
	g	Did you have nightmares about being away from _____ ? Did this happen more than once? IF NO TO EITHER, CODE **NO**	NO	YES
	h	Did you feel sick a lot (like headaches, stomach aches, nausea or vomiting, heart beating fast or feeling dizzy) when you were away from _____ ? Did you feel sick a lot when you thought you were going to be away from _____ ? IF YES TO EITHER, CODE **YES**	NO	YES
		G2 SUMMARY: ARE AT LEAST **3** OF **G2a-h** CODED **YES**?	NO	YES
G3		Has this persisted for at least 4 weeks?	NO	YES
G4		Did your fears of being away from _____ really bother you a lot? Cause you a lot of problems at home? At school? With friends? In any other way? IF YES TO EITHER, CODE **YES**	NO	YES

ARE **G1, G2 SUMMARY, G3** AND **G4** CODED **YES**?

NO	YES
	SEPARATION ANXIETY DISORDER

H. SOCIAL PHOBIA (Social Anxiety Disorder)

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

H1	**In the past month**, were you afraid or embarrassed when others were watching you? Were you afraid of being teased? Like talking in front of the class? Or eating or writing in front of others? IF YES TO ANY, CODE **YES**	NO	YES
H2	Are you more afraid of these things than other kids your age?	NO	YES
H3	Are you so afraid of these things that you try to stay away from them? Or you can only do them if someone is with you? Or you do them but it's really hard for you?	NO	YES
H4	Does this fear really bother you a lot? Does it cause you problems at home or at school? Does this make you afraid to go to school? Does this make you want to be alone? *IF **YES** TO ANY, CODE **YES***		

NO **YES**

SOCIAL PHOBIA
(Social Anxiety Disorder)
CURRENT

I. SPECIFIC PHOBIA

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

I1	**In the past month,** have you been really afraid of something like: snakes or bugs? Dogs or other animals? High places? Storms? The dark? Or seeing blood or needles?	NO	YES
I2	List any specific phobia(s): _____		
I3	Are you more afraid of _____ than other kids your age are?	NO	YES
I4	Are you so afraid of _____ that you try to stay away from it / them? Or you can only be around it / them if someone is with you? Or can you be around it / them but it's really hard for you? IF **YES** TO ANY, CODE **YES**	NO	YES
I5	Does this fear really bother you a lot? Does it cause you problems at home or at school? Does it keep you from doing things you want to do? IF **YES** TO ANY, CODE **YES**	NO	YES

IS **I5** CODED **YES?**

NO **YES**

SPECIFIC PHOBIA CURRENT

J. OBSESSIVE COMPULSIVE DISORDER

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

J1 **In the past month,** have you been bothered by bad things that come into your mind that you couldn't get rid of? Like bad thoughts or urges? Or nasty pictures? For example, did you think about hurting somebody even though you knew you didn't want to? Were you afraid you or someone would get hurt because of some little thing you did or didn't do? Did you worry a lot about having dirt or germs on you? Did you worry a lot that you would give someone else germs or make them sick somehow? Or were you afraid that you would do something really shocking?

IF **YES** TO ANY, CODE **YES**

DO NOT INCLUDE SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PROBLEMS.
DO NOT INCLUDE OBSESSIONS DIRECTLY RELATED TO EATING DISORDERS, SEXUAL BEHAVIOR, OR ALCOHOL OR DRUG ABUSE BECAUSE THE PATIENT MAY DERIVE PLEASURE FROM THE ACTIVITY AND MAY WANT TO RESIST IT ONLY BECAUSE OF ITS NEGATIVE CONSEQUENCES

NO YES
↓
Skip to **J4**

J2 Did they keep coming back into your mind even when you tried to ignore or get rid of them?

NO YES
↓
Skip to **J4**

J3 Do you think that these things come from your own mind and not from outside of your head?

NO YES
obsessions

J4 **In the past month,** did you do something over and over without being able to stop doing it, like washing over and over? Straightening things up over and over? Counting something or checking on something over and over? Saying or doing something over and over?

IF **YES** TO ANY, CODE **YES**

NO YES
compulsions

IS **J3** OR **J4** CODED **YES**?

NO YES

J5 Did these thoughts or actions cause you to miss out on things at home? At school? With friends? Did they cause you problems with other people? Did these things take more than one hour a day altogether?

IF **YES** TO ANY, CODE **YES**

NO **YES**

O.C.D. CURRENT

K. POSTTRAUMATIC STRESS DISORDER (optional)

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

K1	Has anything really awful happened to you? Like being in a flood, tornado or earthquake? Like being in a fire or a really bad accident? Like seeing someone get killed or hurt really bad. Like being attacked by someone?	NO	YES
K2	Did you respond with intense fear, feel helpless or horrified or did you become agitated or fall apart?	NO	YES
K3	**In the past month**, has this awful thing come back to you in some way? Like dreaming about it or having a strong memory of it?	NO	YES

K4 **In the past month:**

a	Have you tried not to think about this awful thing?	NO	YES
b	Have you tried to stay away from things that might remind you of it?	NO	YES
c	Have you had trouble remembering some important part of what happened?	NO	YES
d	Have you been much less interested in your hobbies or your friends?	NO	YES
e	Have you felt cut off from other people?	NO	YES
f	Have you noticed that you don't have strong feelings about things?	NO	YES
g	Have you felt that your life will be shortened or that you will die sooner than other people?	NO	YES

SUMMARY OF K4: ARE AT LEAST **3** OF **K4** RESPONSES CODED **YES**? NO YES

K5 **In the past month:**

a	Have you had trouble sleeping?	NO	YES
b	Have you been moody or angry for no reason?	NO	YES
c	Have you had trouble paying attention?	NO	YES
d	Were you nervous or "jumpy"?	NO	YES
e	Would you jump when you heard noises? Or when you saw something out of the corner of your eye? IF YES TO EITHER, CODE **YES**	NO	YES

SUMMARY OF K5: ARE AT LEAST **2** of **K5a-e** CODED **YES**? NO YES

K6 **In the past month,** have these problems upset you a lot? Have they caused you to have problems at school? At home? With your friends? NO YES
IF **YES** TO ANY, CODE **YES**

ARE **SUMMARIES K1, K2, K3 , K4, K5 & K6** CODED **YES?**

NO	YES
PTSD **CURRENT**	

L. ALCOHOL ABUSE AND DEPENDENCE

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

L1 **In the past year**, have you had 3 or more drinks of alcohol in a day? At those times, did you have 3 or more drinks in 3 hours? Did you do this 3 or more times in the past year? NO YES

IF **NO** TO ANY, CODE **NO**

L2 **In the past year:**

a Did you need to drink more alcohol to get the same feeling you got when you first started drinking? NO YES

b Whenever you cut down on drinking or stopped drinking, did your hands shake? Did you sweat? Did you feel nervous or like you couldn't sit still? Did you ever drink to keep from getting those problems? Did you drink again to keep from getting a hangover? NO YES

IF **YES** TO ANY, CODE **YES**

c When you drank alcohol, did you end up drinking more than you had planned to? NO YES

d Have you tried to cut down or stop drinking alcohol? Did you find out that you couldn't do it? NO YES

IF **NO** TO EITHER, CODE **NO**

e On days when you drank, did you spend more than two hours doing it? Count the time it took you to get the alcohol, drink it, and get over it. NO YES

f Did you spend less time on other things because of your drinking (Like school, hobbies, or being with friends)? NO YES

g Did you keep on drinking even though you knew that it caused problems (Like with your health or with your mind)? NO YES

ARE **3** OR MORE ITEMS FROM **L2 a-g** CODE **YES**?

NO **YES***

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

ALCOHOL DEPENDENCE
CURRENT

In the past year:

L3 a Have you been drunk or hungover more than once when you had something important to do, like schoolwork or responsibilities at home? Did this cause any problems? NO YES

CODE **YES** ONLY IF THIS CAUSED PROBLEMS

b Were you drunk more than once while doing something risky (Like riding a bike, driving a car, or using machines)? NO YES

c Have you had legal problems more than once because of your drinking (Like getting arrested or stopped by the police)? NO YES

d Have you kept drinking even though your drinking caused problems with your family? With other people? NO YES

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

ARE **1** OR MORE OF **L3** ANSWERS CODED **YES**?

NO	YES
	ALCOHOL ABUSE **CURRENT**

M. NON-ALCOHOL PSYCHOACTIVE SUBSTANCE USE DISORDERS

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

M1 a Now I am going to read you a list of street drugs or medicines. Stop me if, **in the past year,** you have taken any of them more than one time to get high? To feel better or to change your mood? **NO** **YES**

CIRCLE EACH DRUG TAKEN:

Stimulants: amphetamines, "speed", crystal meth, "crank", Dexadrine, Ritalin, diet pills.

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

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

Hallucinogens: LSD ("acid"), mescaline, peyote, PCP ("angel dust", "peace pill"), ketamine ("special K"), "Robo", psilocybin, STP, "mushrooms", 2CB, Ecstasy, MDA, or MDMA.

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

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

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

Miscellaneous: Steroids, non prescription sleep or diet pills, GHB. Any others?

Specify MOST USED Drug(s): _____

CHECK ONE BOX

ONLY ONE DRUG / DRUG CLASS HAS BEEN USED ☐

ONLY THE MOST USED DRUG CLASS IS INVESTIGATED. ☐

EACH DRUG CLASS USED IS EXAMINED SEPARATELY (PHOTOCOPY M2 AND M3 AS NEEDED) ☐

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

M2 Think about your use of (NAME THE DRUG/DRUG CLASS SELECTED) **over the last year:**

a Did you need to take more of the drug to get the same feeling you got when you first started taking it? NO YES

b Whenever you cut down or stopped using the drug(s), did your body feel bad or did you go into withdrawal? ("Withdrawal" might mean feeling sick, achy, shaking, running a temperature, feeling weak, having an upset stomach or diarrhea, sweating, feeling your heart pounding, trouble sleeping, feeling nervous, moody or like you can't sit still.) Did you use the drug(s) again to keep from getting sick or to feel better? NO YES

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

c When you used (NAME THE DRUG/DRUG CLASS SELECTED), did you end up taking more than you had planned to? NO YES

d Have you tried to cut down or stop taking (NAME THE DRUG/DRUG CLASS SELECTED)? Did you find out that you couldn't do it? NO YES

IF **NO** TO EITHER, CODE **NO**

e On days when you took (NAME THE DRUG/DRUG CLASS SELECTED), did you spend more than two hours doing it? Count the time it took you to get (NAME THE DRUG/DRUG CLASS SELECTED), use it and get over it. NO YES

f Did you spend less time on other things because of your use of (NAME THE DRUG/DRUG CLASS SELECTED)? Like school, hobbies or being with friends? NO YES

g Did you keep on using (NAME THE DRUG/DRUG CLASS SELECTED) even though you knew it caused problems? Like with your health or with your mind? NO YES

CODES **POSITIVE** FOR **CURRENT PSYCHOACTIVE SUBSTANCE DEPENDENCE** (At least **three M 2's** are coded **YES)?** specify drug(s):

_____

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

NO	YES*
SUBSTANCE DEPENDENCE CURRENT	

Think about your use of (NAME THE DRUG/DRUG CLASS SELECTED) over the last year:

In the past year:

M3 a Have you been high or hungover from the drug(s) more than once, when you had something important to do? Like schoolwork or responsibilities at home? Did this happen more than one time? Did this cause any problems? NO YES

CODE **YES** ONLY IF THIS CAUSED PROBLEMS

b Have you been high from the drug(s) more than once while doing something risky (Like riding a bike, driving a car, or using machines)? NO YES

c Have you had legal problems because of your use of the (NAME THE DRUG/DRUG CLASS SELECTED) more than once? (Like getting arrested or stopped by the police)? NO YES

d Have you kept using the (NAME THE DRUG/DRUG CLASS SELECTED) even though it caused problems with your family? With other people? NO YES

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

ARE **M3a** or **b** or **c** or **d** CODED **YES?**

NO	YES
SUBSTANCE ABUSE CURRENT	

N. TIC DISORDERS

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

N1	a	In the past month did you have movements of your body called "Tics"? "Tics" are quick movements of some part of your body that are hard to control. A tic might be blinking your eyes over and over, twitches of your face, jerking your head, making a movement with your hand over and over, or squatting, or shrugging your shoulders over and over.	NO	YES
	b	Have you ever had a tic that made you say something or make a sound over and over and it was hard to stop it? Like coughing or sniffling or clearing your throat over and over when you did not have a cold; or grunting or snorting or barking; having to say certain words over and over, having to say bad words, or having to repeat sounds you hear or words that other people say? IF BOTH **N1A** AND **N1B** ARE CODED **NO**, CIRCLE **NO** IN ALL DIAGNOSTIC BOXES AND SKIP TO **O1**	NO	YES
N2	a	Did these "tics" happen many times a day?	NO	YES
	b	Did they happen nearly every day for at least 4 weeks?	NO	YES
	c	Did they happen for a year or more?	NO	YES
	d	Did they ever go away completely for 3 months in a row during this time?	NO	YES

N3 Did these "tics" upset you a lot? Did they get in the way of school? Did they cause you problems at home? Did they cause you problems *with friends? Did other kids pick on you because of your tics?* NO YES

IF **YES** TO ANY, CODE **YES**

N4 Did the tics only occur when you are taking Ritalin, Adderal, Cylert, Dexedrine, Provigil, or other medications for ADHD ? NO YES

N5 a ARE **N1a**+ **N1b** + **N2a** + **N2c** AND **N3** CODED **YES**?

NO **YES**
TOURETTE'S DISORDER, CURRENT

N5 b ARE **N1a** + **N2a** + **N2c** + **N3** CODED **YES** AND IS **N1b** CODED **NO?**

NO **YES**
MOTOR TIC DISORDER, CURRENT

N5 c ARE **N1b** + **N2a** + **N2c** + **N3** CODED **YES** AND IS **N1a** CODED **NO?**

NO **YES**
VOCAL TIC DISORDER, CURRENT

N5 d ARE **N1 (a or b)** AND **N2a** AND **N2b** AND **N3** CODED **YES,** AND **N2c** CODED NO.?

NO	YES
	TRANSIENT TIC DISORDER, CURRENT

O. ATTENTION DEFICIT/HYPERACTIVITY DISORDER

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

SCREENING QUESTION FOR 3 DISORDERS (ADHD, CD, ODD)

O1		Has anyone (teacher, baby sitter, friend or parent) complained about your behavior? IF NO TO THIS QUESTION, ALSO CODE NO TO CONDUCT DISORDER AND OPPOSITIONAL DEFIANT DISORDER?	NO	YES

In the past six months:

O2	a	Have you often not paid enough attention to details? Made careless mistakes in school?	NO	YES
	b	Have you often had trouble keeping your attention focused when playing or doing schoolwork?	NO	YES
	c	Have you often been told that you do not listen when others talk directly to you?	NO	YES
	d	Have you often had trouble following through with what you were told to do (Like not following through on schoolwork or chores)? Did this happen even though you understood what you were supposed to do? Did this happen even though you weren't trying to be difficult? IF **NO** TO ANY, CODE **NO**	NO	YES
	e	Have you often had a hard time getting organized?	NO	YES
	f	Have you often tried to avoid things that make you concentrate or think hard (like schoolwork)? Do you hate or dislike things that make you concentrate or think hard? IF **YES** TO EITHER, CODE **YES**	NO	YES
	g	Have you often lost or forgotten things you needed? Like homework assignments, pencils, or toys?	NO	YES
	h	Do you often get distracted easily by little things (Like sounds or things outside the room)?	NO	YES
	i	Do you often forget to do things you need to do every day (Like forget to comb your hair or brush your teeth)?	NO	YES
		O2 SUMMARY: ARE **6** OR **MORE** OF THE ITEMS FROM **O2a-i** ABOVE CODED **YES**	NO	YES

In the past six months:

O3	a	Have you often fidgeted with your hands or feet? Squirmed in your seat? IF **YES** TO EITHER, CODE **YES**	NO	YES
	b	Did you often get out of your seat in class when you were	NO	YES

not supposed to?

c Have you often run around or climbed on things when you weren't supposed to? Did you want to run around or climb on things even though you didn't? NO YES

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

d Have you often had a hard time playing quietly? NO YES

e Were you always "on the go"? NO YES

f Have you often talked too much? NO YES

g Have you often blurted out answers before the person or teacher has finished the question? NO YES

h Have you often had trouble waiting your turn? NO YES

i Have you often interrupted other people? Like butting in when other people are talking or busy or when they are on the phone? NO YES

O3 SUMMARY: ARE **6** OR **MORE** OF THE ITEMS FROM **O3a-i** ABOVE CODED **YES** NO YES

O4 Did you have problems paying attention, being hyper, or impulsive before you were 7 years old? NO YES

O5 Did these things cause you problems at school? At home? With your family? With your friends? NO YES

CODE **YES** IF **TWO OR MORE** ARE ENDORSED

IS **O2** SUMMARY & **O3** SUMMARY CODED **YES**?

NO YES
Attention Deficit/ Hyperactivity Disorder
COMBINED

IS **O2** SUMMARY CODED YES AND **O3** SUMMARY CODED **NO**?

NO YES
Attention Deficit/ Hyperactivity Disorder
INATTENTIVE

IS **O2** SUMMARY CODED **NO** AND **O3** SUMMARY CODED **YES**?

NO YES
Attention Deficit/ Hyperactivity Disorder
HYPER/IMPULSIVE

P. CONDUCT DISORDER

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

SCREENING QUESTION

P1 IF QUESTION O1 IN ADHD IS ANSWERED NO, CODE NO TO CONDUCT DISORDER

IF O1 WAS NOT ASKED ALREADY, ASK THE QUESTION BELOW

(Has anyone (teacher, baby sitter, friend, parent) complained about your behavior?) NO YES

P2 **In the past year:**

a	Have you bullied or threatened other people?	NO	YES
b	Have you started fights?	NO	YES
c	Have you used a weapon to hurt someone? Like a knife, gun, bat, or other object?	NO	YES
d	Have you hurt someone (physically) on purpose?	NO	YES
e	Have you hurt animals on purpose?	NO	YES
f	Have you stolen things using force? Like robbing someone using a weapon or grabbing something from someone like purse snatching?	NO	YES
g	Have you forced anyone to have sex with you?	NO	YES
h	Have you started fires on purpose in order to cause damage?	NO	YES
i	Have you destroyed things that belonged to other people on purpose?	NO	YES
j	Have you broken into someone's house or car?	NO	YES
k	Have you lied many times in order to get things from people or to get out of things? Tricked other people into doing what you wanted? IF **YES** TO EITHER, CODE **YES**	NO	YES
l	Have you stolen things that were worth money (Like shoplifting or forging a check)?	NO	YES
m	Have you often stayed out a lot later than your parents let you? Did this start before you were 13 years old? IF **NO** TO EITHER, CODE **NO**	NO	YES
n	Have you run away from home two times or more?	NO	YES
o	Have you skipped school often? Did this start before you were 13 years old? IF **NO** TO EITHER, CODE **NO**	NO	YES
	P2 SUMMARY: ARE AT LEAST 3 ITEMS IN **P2a-o** ABOVE CODED **YES** WITH AT LEAST ONE PRESENT IN THE PAST 6 MONTHS ?	NO	YES

P3 Did these behaviors cause big problems at school? At home? With your family? Or with your friends?

IF YES TO ANY, CODE YES

NO	YES
CONDUCT DISORDER CURRENT	

Q. OPPOSITIONAL DEFIANT DISORDER

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

IF CODED POSITIVE FOR CONDUCT DISORDER, CIRCLE NO IN DIAGNOSTIC BOX AND MOVE TO THE NEXT MODULE.

SCREENING QUESTION

IF QUESTION O1 IN ADHD IS ANSWERED NO, CODE NO TO OPPOSITIONAL DEFIANT DISORDER

IF O1 WAS NOT ASKED ALREADY, ASK THE QUESTION BELOW

(Has anyone (teacher, baby sitter, friend, parent) complained about your behaviour?) NO YES

Q1 **In the past six months:**

a	Have you often lost your temper?	NO	YES
b	Have you often argued with adults?	NO	YES
c	Have you often refused to do what adults tell you to do? Refused to follow rules? IF **YES** TO EITHER, CODE **YES**	NO	YES
d	Have you often annoyed people on purpose?	NO	YES
e	Have you often blamed other people for your mistakes or for your bad behavior?	NO	YES
f	Have you often been "touchy" or easily annoyed by other people?	NO	YES
g	Have you often been angry and resentful toward others?	NO	YES
h	Have you often been "spiteful" or quick to "pay back" somebody who treats you wrong?	NO	YES

Q1 SUMMARY: ARE **4** OR **MORE** OF **Q1a-h** ABOVE, CODE **YES**? NO YES

Q2 Did these behaviors cause problems at school? At home? With your family? Or with your friends? NO YES

IF **YES** TO ANY, CODE **YES**

ARE **Q1** SUMMARY & **Q2** CODED **YES**?

NO **YES**
OPPOSITIONAL DEFIANT DISORDER
CURRENT

R. PSYCHOTIC DISORDERS

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

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

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

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

Now I am going to ask you about unusual experiences that some people have.

					BIZARRE
R1	a	Have you ever believed that people were secretly watching you? Have you believed that someone was trying to get you, or hurt you? IF **YES** TO EITHER, CODE **YES** **NOTE**: ASK FOR EXAMPLES TO RULE OUT ACTUAL STALKING	NO	YES	YES
	b	**IF YES**: Do you believe this now?	NO	YES	YES R6
R2	a	Have you ever believed that someone was reading your mind? Or that someone could hear your thoughts? Or that you could actually read someone else's mind? Or hear what they were thinking?	NO	YES	YES
	b	**IF YES**: Do you believe this now?	NO	YES	YES R6
R3	a	Have you ever believed that someone or something put thoughts in your mind that were not your own? Have you believed that someone or something made you act in a way that was not your usual self? **NOTE**: ASK FOR EXAMPLES AND DISCOUNT ANY THAT ARE NOT PSYCHOTIC	NO	YES	YES
	b	**IF YES**: Do you believe this now?	NO	YES	YES R6
R4	a	Have you ever believed that you were being sent special messages through the TV or radio? Through your toys? IF **YES** TO EITHER, CODE **YES**	NO	YES	YES
	b	**IF YES**: Do you believe this now?	NO	YES	YES R6
R5	a	Has your family or friends ever thought that any of your beliefs were strange or weird? Please give me an example. INTERVIEWER:. ONLY CODE **YES** IF THE EXAMPLES ARE **CLEARLY** DELUSIONAL AND ARE NOT EXPLORED IN QUESTIONS R1 TO R4, FOR EXAMPLE, SOMATIC OR RELIGIOUS DELUSIONS OR DELUSIONS OF GRANDIOSITY, JEALOUSY GUILT, RUIN OR DESTITIUTION, ETC.	NO	YES	YES
	b	**IF YES**: Do they think that your beliefs now are strange?	NO	YES	YES
R6	a	Have you ever heard things other people couldn't hear, such as voices? [HALLUCINATIONS ARE SCORED "BIZARRE" ONLY IF PATIENT ANSWERS YES TO THE FOLLOWING]: **IF YES**: Did you hear a voice talking about you? Did you hear more than one voice talking back and forth?	NO	YES	YES
	b	**IF YES**: Have you heard these things in the past month?	NO	YES	YES R8b

R7 a Have you ever had visions or have you ever seen things other people couldn't see? NO YES

NOTE:CHECK TO SEE IF THESE ARE CULTURALLY INAPPROPRIATE.

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

CLINICIAN'S JUDGMENT

R8 b IS THE PATIENT CURRENTLY EXHIBITING INCOHERENCE, DISORGANIZED SPEECH, OR MARKED LOOSENING OF ASSOCIATIONS? NO YES

R9 b IS THE PATIENT CURRENTLY EXHIBITING DISORGANIZED OR CATATONIC BEHAVIOR? NO YES

R10 b ARE NEGATIVE SYMPTOMS OF SCHIZOPHRENIA, E.G. SIGNIFICANT AFFECTIVE FLATTENING, POVERTY OF SPEECH (ALOGIA) OR AN INABILITY TO INITIATE OR PERSIST IN GOAL DIRECTED ACTIVITIES (AVOLITION), PROMINENT DURING THE INTERVIEW? NO YES

R11 ARE **1 OR MORE** ‹‹ b ›› QUESTIONS CODED **YES** BIZARRE?

OR

ARE **2 OR MORE** ‹‹ b ›› QUESTIONS CODED **YES** (RATHER THAN **YES** BIZARRE)?

NO **YES**

PSYCHOTIC DISORDER

CURRENT

R12 ARE **1 OR MORE** ‹‹ a ›› QUESTIONS CODED **YES** BIZARRE?

OR

ARE **2 OR MORE** ‹‹ a ›› QUESTIONS CODED **YES** (RATHER THAN **YES** BIZARRE)?

CHECK THAT AT LEAST TWO SYMPTOMS OCCURRED DURING THE SAME TIME PERIOD

NO **YES**

PSYCHOTIC DISORDER

LIFETIME

R13 ARE **1 OR MORE** ‹‹ b ›› QUESTIONS **FROM R1b TO R7b** CODED **YES** AND IS EITHER CURRENT MAJOR DEPRESSION OR CURRENT OR PAST BIPOLAR DISORDER CODED YES? **NO** **YES**

R14 Did you have the beliefs and experiences you just described [GIVE EXAMPLES TO PATIENT] only when you were feeling depressed? high? very moody?

NO **YES**

MOOD DISORDER WITH PSYCHOTIC FEATURES

CURRENT

S. ANOREXIA NERVOSA (optional)

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

S1	a	How tall are you?	ft	in. cm.
	b.	What was your lowest weight in the past 3 months?		lbs. kgs.
	c	IS PATIENT'S WEIGHT LOWER THAN THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT? (SEE TABLE BELOW)	NO	YES

In the past 3 months:

S2		Have you been trying to keep yourself from gaining any weight?	NO	YES
S3		Have you been afraid of gaining weight? Have you been afraid of getting fat? IF **YES** TO EITHER, CODE **YES**	NO	YES
S4	a	Have you seen yourself as being too fat? Have you seen your body as being unattractive? IF **YES** TO EITHER, CODE **YES**	NO	YES
	b	Has your weight strongly affected how you feel about yourself? Has your body shape strongly affected how you feel about yourself? IF **YES** TO EITHER, CODE **YES**	NO	YES
	c	Have you thought that your low weight is *not* a serious problem?	NO	YES
S5		ARE **1** OR **MORE** ITEMS FROM **S4** CODED **YES**?	NO	YES
S6		FOR POST PUBERTAL **FEMALES** ONLY: During the last 3 months, did you miss all your menstrual periods when they were expected to occur (when you were not pregnant)?	NO	YES

FOR GIRLS : ARE **S5** AND **S6** CODED YES?

FOR BOYS :, IS **S5** CODED YES?

NO **YES**

ANOREXIA NERVOSA
CURRENT

TABLE HEIGHT WEIGHT THRESHOLD (height-without shoes; weight-without clothing)

Female Height/Weight														
ft/in.	4'9	4'10	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10
lbs.	84	85	86	87	89	92	94	97	99	102	104	107	110	112
cms.	144.8	147.3	149.9	152.4	154.9	157.5	160.0	162.6	165.1	167.6	170.2	172.7	175.3	177.8
kgs.	38	39	39	40	41	42	43	44	45	46	47	49	50	51

Male Height/Weight															
ft/in.	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10	5'11	6'0	6'1	6'2	6'3
lbs.	105	106	108	110	111	113	115	116	118	120	122	125	127	130	133
cms.	154.9	157.5	160.0	162.6	165.1	167.6	170.2	172.7	175.3	177.8	180.3	182.9	185.4	188.0	190.5
kgs.	47	48	49	50	51	51	52	53	54	55	56	57	58	59	61

The weight thresholds above are calculated as a 15% reduction below the normal range for the patient's height and gender asrequired by DSM-IV. This table reflects weights that are 15% lower than the low end of the normal distribution range in the Metropolitan Life Insurance Table of Weights.

T. BULIMIA NERVOSA (optional)

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

	In the past 3 months:		
T1	Did you have eating binges? An "eating binge" is when you eat a very large amount of food within two hours.	NO	YES
T2	Did you have eating binges two times a week or more?	NO	YES
T3	During an eating binge, did you feel that you couldn't control yourself?	NO	YES
T4	Did you do anything to keep from gaining weight? Like making yourself throw up or exercising very hard? Trying not to eat for the next day or more? Taking pills to make you have to go to the bathroom more? Or taking any other kinds of pills to try to keep from gaining weight? IF **YES** TO ANY, CODE **YES**	NO	YES
T5	Does your weight strongly affect how you feel about yourself? Does your body shape strongly affect how you feel about yourself? IF **YES** TO EITHER, CODE **YES**	NO	YES
T6	DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?	NO ↓ Skip to T8	YES
T7	Do these binges occur only when you are under (_____lbs./kgs.)? INTERVIEWER: WRITE IN THE ABOVE ( ), THE THRESHOLD WEIGHT FOR THIS PATIENT'S HEIGHT FROM THE HEIGHT/WEIGHT TABLE IN THE ANOREXIA NERVOSA MODULE	NO	YES

T8 IS **T5** CODED **YES** AND **T7** CODED **NO** OR SKIPPED?

NO **YES**

BULIMIA NERVOSA
CURRENT

T9 IS **T7** CODED **YES**?

NO **YES**

ANOREXIA NERVOSA
Binge Eating Type
CURRENT

U. GENERALIZED ANXIETY DISORDER

(MEANS : GO TO END OF DISORDER, CIRCLE NO AND MOVE TO NEXT DISORDER)

SKIP THIS DISORDER IF THE PATIENT'S ANXIETY IS RESTRICTED TO OR BETTER EXPLANINED BY ANY DISORDER PRIOR TO THIS POINT.

U1	a	**For the past six months**, have you worried a lot or been nervous? Have you been worried or nervous about more than one thing (Like school, your health, or something bad happening)? Have you been more worried than other kids your age? IF **YES** TO ANY, CODE **YES**	NO	YES
	b	Do you worry most days?	NO	YES
		IS THE PATIENT'S ANXIETY RESTRICTED EXCLUSIVELY TO, OR BETTER EXPLAINED BY, ANY DISORDER PRIOR TO THIS POINT?	NO	YES

U2		Do you find it hard to stop worrying? Do the worries make it hard for you to pay attention? IF **YES** TO EITHER, CODE **YES**	NO	YES
U3		FOR THE FOLLOWING, CODE **NO** IF THE SYMPTOMS ARE CONFINED TO FEATURES OF ANY DISORDER EXPLORED PRIOR TO THIS POINT. When you are worried, do you, most of the time:		
	a	Feel like you can't sit still?	NO	YES
	b	Feel tense?	NO	YES
	c	Feel tired or weak?	NO	YES
	d	Have a hard time paying attention?	NO	YES
	e	Feel grouchy or annoyed?	NO	YES
	f	Have trouble sleeping almost every night ("trouble sleeping" means trouble falling asleep, waking up in the middle of the night, wakening up too early or sleeping too much)?	NO	YES

ARE **3** OR MORE OF **U3a-f** CODED **YES**?

NO	YES

G. A. D.
CURRENT

V. ADJUSTMENT DISORDERS

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

EVEN IF A LIFE STRESS IS PRESENT OR A STRESS PRECIPITATED THE PATIENT'S DISORDER, DO NOT USE AN ADJUSTMENT DISORDER DIAGNOSIS IF ANY OTHER PSYCHIATRIC DISORDER IS PRESENT. SKIP THE ADJUSTMENT DISORDER MODULE IF THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOTHER SPECIFIC AXIS I DISORDER OR ARE MERELY AN EXACERBATION OF A PREEXISTING AXIS I OR II DISORDER.

ONLY ASK THESE QUESTIONS IF PATIENT CODES **NO** TO ALL OTHER DISORDERS.

V1 Are you stressed out about something? Is this making you upset or making your behavior worse? NO YES

IF **NO** TO EITHER, CODE **NO**

[Examples include anxiety/depression/physical complaints; misbehavior such as fighting, driving recklessly, skipping school, vandalism, violating the rights of others, or illegal activity].

IDENTIFIED STRESSOR: _____

DATE OF ONSET OF STRESSOR: _____

V2 Did your upset/behavior problems start soon after the stress began? [Within 3 months of the onset of the stressor] NO YES

V3 a Are you more upset by this stress than other kids your age would be? NO YES

b Are these problems causing you to have trouble in school? Trouble at home? Trouble with your family or with your friends? NO YES

IF **YES** TO ANY, CODE **YES**

V4 ARE THESE EMOTIONAL/BEHAVIORAL SYMPTOMS DUE ENTIRELY TO THE LOSS OF A LOVED ONE (BEREAVEMENT) AND ARE THEY SIMILAR IN SEVERITY, LEVEL OF IMPAIRMENT AND DURATION TO WHAT MOST OTHERS WOULD SUFFER UNDER SIMILAR CIRCUMSTANCES? (IF SO THIS IS BEREAVEMENT)

HAS BEREAVEMENT BEEN RULED OUT? NO YES

V5 Have these problems gone on even though the stressful thing is over? Did these problems go on for 6 months or more after the stress stopped? NO YES

IF **NO** TO EITHER, CODE **NO**

ARE THESE EMOTIONAL / BEHAVIORAL SYMPTOMS?: **Mark all that apply.**

QUALIFIERS:

A Depression, tearfulness or hopelessness.

B Anxiety, nervousness, jitteriness, worry.

C Misbehavior (Like fighting, driving recklessly, skipping school, vandalism, violating other's rights, doing illegal things).

D School problems, physical complaints or social withdrawal.

IF MARKED:

A A only, then code as Adjustment disorder with depressed mood. 309.0
B B only, then code as Adjustment disorder with anxious mood. 309.24
C C only, then code as Adjustment disorder of conduct. 309.3
D A and B only, then code as Adjustment disorder with mixed anxiety and depressed mood. 309.28
E C and (A or B), then code as Adjustment disorder of emotions and conduct. 309.4
F D only, then code as Adjustment Disorder unspecified. 309.9

IF **V1** AND **V2** AND **(V3a or V3b)** ARE CODED **YES,** AND **V5** IS CODED **NO,** THEN CODE DISORDER **YES** WITH **QUALIFIER.**

IF **NO,** CODE **NO** TO ADJUSTMENT DISORDER.

NO **YES**
Adjustment Disorder with_____
(see above for qualifiers)

W. PERVASIVE DEVELOPMENT DISORDER

(MEANS : GO TO END OF DISORDER, CIRCLE NO AND MOVE TO NEXT DISORDER)

W1	Since the age of 4, have you had difficulty making friends? Do you have problems because you keep to yourself? Is it because you are shy or because you don't fit in? IF YES TO ANY, CODE **YES**	NO	YES	UNSURE
W2	Are you fixated on routines and rituals or do you have interests that are special and intrude on other activities?	NO	YES	UNSURE
W3	Do other kids think you are weird or strange or awkward?	NO	YES	UNSURE
W4	Do you child play mostly alone, rather than with other children?	NO	YES	UNSURE

W5 ARE **W1 + W2 + W3 + W4** CODED **YES**? IF SO, CODE YES.

IF ANY (W1 THROUGH W5) ARE CODED UNSURE, CODE UNSURE.

OTHERWISE CODE NO.

NO **UNSURE** **YES**
PERVASIVE DEVELOPMENT DISORDER

CURRENT

THIS CONCLUDES THE INTERVIEW

Acknowledgment:
We would like to thank Mary Newman, Berney Wilkinson, and
Marie Salmon for their help and suggestions

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International Advisory Committee for MINI Kid version 2.0

Manuel Bouvard	Phillipe Mazet
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Naomi Breslau	Stephan Renou
Martine Flament	Frank Verhulst
Donald Klein	Lars von Knorring
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Translations	**M.I.N.I. KID 3.0**
English	D. Sheehan, D. Shytle, K.Milo
Spanish	M. Soto
French	Y. Lecrubier, T. Hergueta
Hungarian	J. Balazs

Appendix E

Demographic Questionnaire

1. Adolescent's name: _____

2. Adolescent's sex: ❑ male ❑ female

3. Adolescent's date of birth: ___/___/___ Age: _____
dd mm yy

4. Home address: _____
_____

5. Phone numbers:
Home: _____

Business (father): _____
(mother): _____

6. School name: _____

7. Current school grade: _____

8. Father's name: _____

a) Age: _____

b) Education: **(please check appropriate category)**

❑ Up to and including grade 8
❑ High school level ___ gr 9 ___ gr 10 ___ gr 11 ___ gr 12 ___ gr13
❑ Some college or university
❑ Completed college program
❑ Completed undergraduate university degree
❑ Some graduate work completed
❑ Completed Master's or Doctorate degree or program leading to professional certification

9. Mother's name: _____

a) Age: _____

b) Education: **(please check appropriate category)**

❑ Up to and including grade 8
❑ High school level ___ gr 9 ___ gr 10 ___ gr 11 ___ gr 12 ___ gr 13
❑ Some college or university
❑ Completed college program
❑ Completed undergraduate university degree
❑ Some graduate work completed
❑ Completed Master's or Doctorate degree or program leading to professional certification

10. **Annual family income: (please check appropriate category)**

- ❑ Up to and including 31,000
- ❑ 32,000 to 50,000
- ❑ 51,000 to 75,000
- ❑ 76,000 to 110,000
- ❑ Over 110,000

11. **Parent's marital status: (please check appropriate category)**

❑ Married	If so, for how long?	____(years)
❑ Common-law	If so, for how long?	____(years)
❑ Separated or divorced	If so, for how long?	____(years)

If parents of adolescent are married or common-law status, please skip to question 12.

a) Are you remarried or living common law? **(please check one)**
- ❑ Yes — If so, for how long? ____(years)
- ❑ No

b) Is your ex-partner remarried or living common law? **(please check one)**
- ❑ Yes — If so, for how long? ____ (years)
- ❑ No

c) How much **face-to-face contact** does your adolescent have with you per week?
____ **days per week**

d) How much **face-to-face contact** does your adolescent have with her mother?
____ **days per week**

e) How often do you talk to your adolescent on the phone?
____ **minutes per week** *(approximate)*

12. How often do you do an activity with your adolescent (e.g., go to a movie, go shopping, do a sport together, spend time talking, etc.)
____ **hours per week** *(approximate)*

13. Primary language spoken at home: _____

14. Family household members by name, age, and relationship to the adolescent: (please list members in the household the adolescent lives). **If your adolescent lives in 2 households, please list family members in EACH household.**

Name	Age	Relationship
a)		
b)		
c)		
d)		
e)		
f)		
g)		

15. **Family health status:**

a) Do any immediate family members suffer from or have they suffered from a chronic physical illness? ➡ **If not, please proceed to part b).**

Relative (relationship to adolescent)	Name of illness

b) Do any immediate family members (including yourself, the adolescent's mother, sister, or brother) suffer or have they suffered from a mental illness (e.g. depression, anxiety, etc.)? ➡ **If not, please proceed to part c).**

Relative (relationship to adolescent)	Name of illness

c) Do any second degree relatives in the family (i.e., grandparents, aunts, uncles, cousins) suffer from or have suffered from a mental illness (e.g., depression, anxiety, etc.)? ➡ **If not, please proceed to item 15.**

Relative (relationship to adolescent)	Name of illness

16. **Current medical treatment:**

a) Is your adolescent currently taking any medications for mental health reasons? (e.g., antidepressants) **(please check one)**

❑ Yes **If yes, please list:** _____
❑ No

b) Are you currently taking any medications for mental health reasons? (e.g., antidepressants) **(please check one)**

❑ Yes **If yes, please list:** _____
❑ No

17. **Psychotherapy treatment:**

a) Is your adolescent currently receiving any form of counseling or talk therapy? **(please check one)**

❑ Yes
If yes, please describe : _____

❑ No

b) Are you currently receiving any form of counselling or talk therapy? **(please check one)**

❑ Yes
If yes, please describe : _____

❑ No

18. **Hospitalizations:**

a) Has your adolescent ever been hospitalized for mental health reasons? **(please check one)**

❑ Yes
If yes, please list reason : _____

❑ No

b) Have you ever been hospitalized for mental health reasons?

❑ Yes
If yes, please list reason : _____

❑ No

19. **Please describe any problems or difficulties that you may presently be experiencing with your adolescent:**

CHILD PARQ: Father

Name (or I.D. number) _____

Date _____

The following pages contain a number of statements describing the way fathers sometimes act toward their children. I want you to think about how each one of these fits the way your father treats you.

Four lines are drawn after each sentence. If the statement is basically true about the way your father treats you then ask yourself: "Is it almost always true?" or "Is it only sometimes true?" If you think your father almost always treats you that way, put an X on the line ALMOST ALWAYS TRUE; if the statement is sometimes true about the way your father treats you then mark SOMETIMES TRUE. If you feel the statement is basically untrue about the way your father treats you then ask yourself, "Is it rarely true?" or "Is it almost never true?" If it is rarely true about the way your father treats you put an X on the line RARELY TRUE; if you feel the statement is almost never true then mark ALMOST NEVER TRUE.

Remember, there is no right or wrong answer to any statement, so be as honest as you can. **Respond to each statement the way you feel your father really is rather than the way you might like him to be.** For example, if he almost always hugs and kisses you when you are good, you should mark the item as follows:

	TRUE OF MY FATHER		NOT TRUE OF MY FATHER	
1. My father hugs and kisses me when I am good.	Almost always true	Sometimes true	Rarely true	Almost never true
	X			

_____

Respondent's significant male caretaker (if not Father)

Ronald P. Rohner, 1976,1997

	TRUE OF MY FATHER		NOT TRUE OF MY FATHER	
MY FATHER	**Almost always true**	**Sometimes true**	**Rarely true**	**Almost never true**
1. Says nice things about me				
2. Nags or scolds me when I am bad				
3. Totally ignores me				
4. Does not really love me				
5. Talks to me about our plans and listens to what I have to say				
6. Complains about me to others when I do not listen to him				
7. Takes an active interest in me				
8. Encourages me to bring my friends home, and tries to make things pleasant for them				
9. Ridicules and makes fun of me				
10. Ignores me as long as I do not do anything to bother him				
11. Yells at me when he is angry				
12. Makes it easy for me to tell him things that are important to me				
13. Treats me harshly				
14. Enjoys having me around him				
15. Makes me feel proud when I do well				
16. Hits me, even when I do not deserve it				
17. Forgets things he is supposed to do for me				
18. Sees me as a big bother				
19. Praises me to others				
20. Punishes me severely when he is angry				
21. Makes sure I have the right kind of food to eat				
22. Talks to me in a warm and loving way				
23. Gets angry at me easily				

	TRUE OF MY FATHER		NOT TRUE OF MY FATHER	
MY FATHER	**Almost always true**	**Sometimes true**	**Rarely true**	**Almost never true**
24. Is too busy to answer my questions	_____	_____	_____	_____
25. Seems to dislike me	_____	_____	_____	_____
26. Says nice things to me when I deserve them	_____	_____	_____	_____
27. Gets mad quickly and picks on me	_____	_____	_____	_____
28. Is concerned who my friends are	_____	_____	_____	_____
29. Is really interested in what I do	_____	_____	_____	_____
30. Says many unkind things to me	_____	_____	_____	_____
31. Ignores me when I ask for help	_____	_____	_____	_____
32. Thinks it is my own fault when I am having trouble	_____	_____	_____	_____
33. Makes me feel wanted and needed	_____	_____	_____	_____
34. Tells me that I get on his nerves	_____	_____	_____	_____
35. Pays a lot of attention to me	_____	_____	_____	_____
36. Tells me how proud he is of me when I am good	_____	_____	_____	_____
37. Goes out of his way to hurt my feelings	_____	_____	_____	_____
38. Forgets important things I think he should remember	_____	_____	_____	_____
39. Makes me feel not loved any more if I misbehave	_____	_____	_____	_____
40. Makes me feel what I do is important	_____	_____	_____	_____
41. Frightens or threatens me when I do something wrong	_____	_____	_____	_____
42. Likes to spend time with me	_____	_____	_____	_____
43. Tries to help me when I am scared or upset	_____	_____	_____	_____
44. Shames me in front of my friends when I misbehave	_____	_____	_____	_____
45. Tries to stay away from me	_____	_____	_____	_____
46. Complains about me	_____	_____	_____	_____

	TRUE OF MY FATHER		NOT TRUE OF MY FATHER	
MY FATHER	**Almost always true**	**Sometimes true**	**Rarely true**	**Almost never true**
47. Cares about what I think and likes me to talk about it	_____	_____	_____	_____
48. Feels other children are better than I am no matter what I do	_____	_____	_____	_____
49. Cares about what I would like when he makes plans	_____	_____	_____	_____
50. Lets me do things I think are important, even if it is inconvenient for him	_____	_____	_____	_____
51. Thinks other children behave better than I do	_____	_____	_____	_____
52. Makes other people take care of me (for example, a neighbor or relative)	_____	_____	_____	_____
53. Lets me know I am not wanted	_____	_____	_____	_____
54. Is interested in the things I do	_____	_____	_____	_____
55. Tries to make me feel better when I am hurt or sick	_____	_____	_____	_____
56. Tells me how ashamed he is when I misbehave	_____	_____	_____	_____
57. Lets me know he loves me	_____	_____	_____	_____
58. Treats me gently and with kindness	_____	_____	_____	_____
59. Makes me feel ashamed or guilty when I misbehave	_____	_____	_____	_____
60. Tries to make me happy	_____	_____	_____	_____

ID#: ____

IPPA

Instructions: The following questionnaire asks you about your relationships with important people in your life; your mother, your father, and your close friends. Please read each statement and choose the item that tells how true the statement is for you now. (If you have more than one person acting in role, example: natural mother and step-mother, answer the questions for the one you feel has most influenced you.)

A = Almost Never or Never True
B = Not Very Often True
C = Sometimes True
D = Often True
E = Almost Always or Always True

1. My mother respects my feelings.	A B C D E
2. I feel my mother does a good job as my mother.	A B C D E
3. I wish I had a different mother.	A B C D E
4. My mother accepts me as I am.	A B C D E
5. I like to get my mother's point of view on things I'm concerned about.	A B C D E
6. I feel it's no use letting my feelings show around my mother.	A B C D E
7. My mother can tell when I'm upset about something.	A B C D E
8. Talking over my problems with my mother makes me feel ashamed or foolish.	A B C D E
9. My mother expects too much from me.	A B C D E
10. I get upset easily around my mother.	A B C D E
11. I get upset a lot more than my mother knows about.	A B C D E
12. When we discuss things, my mother cares about my point of view.	A B C D E
13. My mother trusts my judgment.	A B C D E
14. My mother has her own problems, so I don't bother her with mine.	A B C D E
15. My mother helps me to understand myself better.	A B C D E
16. I tell my mother about my problems and troubles.	A B C D E
17. I feel angry with my mother.	A B C D E
18. I don't get much attention from my mother.	A B C D E
19. My mother helps me to talk about my difficulties.	A B C D E
20. My mother understands me.	A B C D E
21. When I am angry about something. my mother tries to be understanding.	A B C D E
22. I trust my mother.	A B C D E
23. My mother doesn't understand what I'm going through these days.	A B C D E
24. I can count on my mother when I need to get something off my chest.	A B C D E
25. If my mother knows something is bothering me, she asks me about it.	A B C D E
26. My father respects my feelings.	A B C D E
27. I feel my father does a good job as my father.	A B C D E
28. I wish I had a different father.	A B C D E
29. My father accepts me as I am.	A B C D E
30. I like to get my fathers point of view on things I'm concerned about.	A B C D E

A = Almost Never or Never True
B = Not Very Often True
C = Sometimes True
D = Often True
E = Almost Always or Always True

31. I feel it's no use letting my feelings show around my father.	A B C D E
32. My father can tell when I'm upset about something.	A B C D E
33. Talking over my problems with my father makes me feel ashamed or foolish.	A B C D E
34. My father expects too much from me.	A B C D E
35. I get upset easily around my father.	A B C D E
36. I get upset a lot more than my father knows about.	A B C D E
37. When we discuss things, my father cares about my point of view.	A B C D E
38. My father trusts my judgment.	A B C D E
39. My father has his own problems, so I don't bother him with mine.	A B C D E
40. My father helps me to understand myself better.	A B C D E
41. I tell my father about my problems and troubles.	A B C D E
42. I feel angry with my father.	A B C D E
43. I don't get much attention from my father.	A B C D E
44. My father helps me to talk about my difficulties.	A B C D E
45. My father understands me.	A B C D E
46. When I am angry about something, my father tries to be understanding.	A B C D E
47. I trust my father.	A B C D E
48. My father doesn't understand what I'm going through these days.	A B C D E
49. I can count on my father when I need to get something off my chest.	A B C D E
50. If my father knows something is bothering me, he asks me about it.	A B C D E

PERCEPTIONS OF PARENTS

Children, teenagers, and young adults often have many different feelings toward their mother and father. Even if they do not have contact with their mother or father anymore, they may still have feelings or opinions about them. Please think about your own biological mother and biological father currently and answer the following questions. If you no longer have contact with one or both of your parents, please try to answer the questions based on how you remember them. Please do not spend too much time on any one question.

1 = Not at all Never	2 = Not much or Rarely	3 = Somewhat or Sometimes	4 = Pretty much or Pretty Often	5 = Very much or Very Often	6 = Extremely or Always

WITH REGARD TO HOW YOU FEEL ABOUT EACH OF YOUR BIOLOGICAL PARENTS, HOW MUCH DO YOU FEEL:

	MOTHER	FATHER
Respect toward your:	1 2 3 4 5 6	1 2 3 4 5 6
Anger toward your:	1 2 3 4 5 6	1 2 3 4 5 6
Happy when you think about your:	1 2 3 4 5 6	1 2 3 4 5 6
Love toward your:	1 2 3 4 5 6	1 2 3 4 5 6
Grateful for your:	1 2 3 4 5 6	1 2 3 4 5 6
Proud of your:	1 2 3 4 5 6	1 2 3 4 5 6
Caring toward your:	1 2 3 4 5 6	1 2 3 4 5 6
Confused or puzzled by your:	1 2 3 4 5 6	1 2 3 4 5 6
Disappointed or let down by your:	1 2 3 4 5 6	1 2 3 4 5 6
Comforted thinking about your:	1 2 3 4 5 6	1 2 3 4 5 6
Anxious/nervous about your:	1 2 3 4 5 6	1 2 3 4 5 6
Closeness toward your:	1 2 3 4 5 6	1 2 3 4 5 6
Upset when you think about your:	1 2 3 4 5 6	1 2 3 4 5 6
Appreciative of (thankful for) your:	1 2 3 4 5 6	1 2 3 4 5 6
Positive feelings toward your:	1 2 3 4 5 6	1 2 3 4 5 6

LEAP SCALE

Instructions: In this questionnaire, you will read statements about your parents. You will be asked to rate your **MOTHER's** and **FATHER's** behavior. For all questions, answer the statement as to how each parent acts toward you and circle your answer. If you are not living with your biological parents now, please rate the behavior of whomever you consider to be your mother or father (e.g., adoptive parent, step-parent, etc.).

Never	Rarely	Sometimes	Often	Very Often	Always
1	2	3	4	5	6

Please rate your **MOTHER's** and **FATHER's** behavior by circling your answer.

	MY MOTHER:	MY FATHER:
1. supports me	1 2 3 4 5 6	1 2 3 4 5 6
2. consoles me when I am upset (Example: pays attention and is curious about me)	1 2 3 4 5 6	1 2 3 4 5 6
3. shows she/he cares about me	1 2 3 4 5 6	1 2 3 4 5 6
4. shows a genuine interest in me (Example: pays attention and is curious about me)	1 2 3 4 5 6	1 2 3 4 5 6
5. remembers things that are important to me	1 2 3 4 5 6	1 2 3 4 5 6
6. is available to talk at any time	1 2 3 4 5 6	1 2 3 4 5 6
7. asks questions in a caring manner	1 2 3 4 5 6	1 2 3 4 5 6
8. spends extra time with me just because she/he wants to	1 2 3 4 5 6	1 2 3 4 5 6
9. is willing to talk about my troubles	1 2 3 4 5 6	1 2 3 4 5 6
10. pursues talking with me about my interests (Example: tries to talk to me about what I like)	1 2 3 4 5 6	1 2 3 4 5 6
11. values my input (Example: cares about my ideas)	1 2 3 4 5 6	1 2 3 4 5 6
12. is emotionally available to me	1 2 3 4 5 6	1 2 3 4 5 6
13. makes me feel wanted	1 2 3 4 5 6	1 2 3 4 5 6
14. praises me (Example: tells me good things about myself)	1 2 3 4 5 6	1 2 3 4 5 6
15. is understanding	1 2 3 4 5 6	1 2 3 4 5 6

Parent-Adolescent Communication

Adolescent and Father Form

Howard L. Barnes & David H. Olson

Response choices

1	2	3	4	5
Strongly Disagree	Moderately Disagree	Neither Agree Nor Disagree	Moderately Agree	Strongly Agree

_____ 1. I can discuss my beliefs with my father without feeling restrained or embarrassed.

_____ 2. Sometimes I have trouble believing everything my father tells me.

_____ 3. My father is always a good listener.

_____ 4. I am sometimes afraid to ask my father for what I want.

_____ 5. My father has a tendency to say things to me which would be better left unsaid.

_____ 6. My father can tell how I'm feeling without asking.

_____ 7. I am very satisfied with how my father and I talk together.

_____ 8. If I were in trouble, I could tell my father.

_____ 9. I openly show affection to my father.

_____10. When we are having a problem, I often give my father the silent treatment.

_____11. I am careful about what I say to my father.

_____12. When talking to my father, I have a tendency to say things that would be better left unsaid.

_____13. When I ask questions, I get honest answers from my father.

_____14. My father tries to understand my point of view.

_____15. There are topics I avoid discussing with my father.

_____16. I find it easy to discuss problems with my father.

_____17. It is very easy for me to express all my true feelings to my father.

_____18. My father nags/bothers me.

_____19. My father insults me when she is angry with me.

_____20. I don't think I can tell my father how I really feel about some things.

Appendix F

Correlation Matrix: Demographic and primary variables of interest used in manuscripts 1 and 2.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26
1. Father's education (n = 116)	-	.4**	-.14	.33**	.33**	.22*	-.23*	-.07	.06	.04	-.08	.02	.09	-.14	.04	.08	.09	.13	.06	.07	.04	-.03	.00	.12	.14	-.14
2. Mother's education (n = 115)		-	-.22*	.2*	.31**	.23*	-.16	-.12	.1	.08	-.12	-.09	.11	-.08	.09	.03	.12	.19*	.13	.1	.09	.1	.02	-.04	.00	-.02
3. Marital status (n = 116)			-	-.17	-.08	-.14	.18*	.22*	.02	.04	.03	.05	.01	.21*	-.04	-.16	-.15	-.35**	-.06	-.26**	-.24**	-.24**	.18*	.06	.03	.14
4. Income (n = 115)				-	.15	.09	-.21*	-.04	-.08	-.01	-.3	-.07	-.04	-.04	-.2*	.14	.04	.22*	-.09	.22*	-.04	-.1	.06	.02	.1	-.13
5. Father's age (n = 116)					-	.7**	-.26**	-.08	-.01	.01	-.08	-.08	.04	-.3**	-.00	-.14	.13	-.02	.05	-.12	.08	.05	-.11	-.04	.03	-.22*
6. Mother's age (n = 113)						-	-.27**	-.13	.04	.07	-.12	-.12	.04	-.28**	.08	-.03	.21*	.08	.12	.00	.03	-.05	-.1	-.04	-.02	-.17
7. Father's axis 1 diagnosis (n = 116)							-	.2*	-.09	-.12	.15	.16	.08	.24*	.00	.01	-.23*	-.06	-.11	-.09	.11	.14	.01	-.04	-.1	.47**
8. Mother's mood diagnosis (n = 106)								-	-.32**	-.31**	.26**	.22*	-.16	.37**	-.21*	-.14	-.4**	-.33	-.32**	-.24*	.21*	.14	-.17	-.34**	-.32**	.22*
9. Adolescent communication (n = 116)									-	.93**	-.81**	-.71**	.73**	-.44**	.74**	.31**	.75**	.34**	.79**	.35**	-.34**	-.35**	.31**	.5**	.47**	-.2*
10. Adolescent problems with communication (n = 116)										-	-.71**	-.68**	.57**	-.41**	.57**	.26**	.73**	.38**	.64**	.32**	-.31**	-.35**	.24**	.45**	.46**	-.22*
11. Adolescent PARQ total (n = 116)											-	.88**	-.91**	.39**	-.7**	-.34**	-.75**	-.36**	-.83**	-.41**	.37**	.41**	-.33**	-.5**	-.5**	.23*
12. Adolescent rejection (n = 116)												-	-.66**	.4**	-.51**	-.27**	-.66**	-.3**	-.61**	-.36**	.35**	.44**	-.26**	-.44**	-.46**	.29**
13. Adolescent warmth (n = 116)													-	-.3**	.74**	.32**	.61**	.25**	.84**	.35**	-.31**	-.33**	.33**	.44**	.4**	-.14

Correlation Matrix: Demographic and primary variables of interest used in manuscripts 1 and 2 (continued).

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26
14. Adolescent BDI-II (n = 116)														-	-.3**	-.21*	-.35**	-.32**	-.41**	-.34**	.04	.11	-.02	-.19**	-.16	.31**
15. IPPA total - father (n = 116)															-	.35**	.62**	.21*	.77**	.29**	-.30**	-.26**	.28**	.47**	.39**	-.19*
16. IPPA total - mother (n = 114)																-	.26**	.63**	.42**	.86**	-.14	-.16	.19*	.18	.13	.00
17. POP negative affect - father (n = 116)																	-	.46**	.68**	.31**	-.21*	-.24**	.14	.39**	.44**	-.34**
18. POP negative affect – mother (n = 114)																		-	.37**	.74**	-.13	-.07	.18	.19*	.2*	-.18
19. LEAP total - father (n = 116)																			-	.52**	-.22*	-.23*	.24*	.42**	.34**	-.12
20. LEAP total - mother (n = 114)																				-	-.19*	-.19*	.25**	.25**	.19*	-.08
21. Father PARQ total (n = 116)																					-	.81**	-.86**	-.71**	-.65	.28**
22. Father rejection (n = 116)																						-	-.58**	-.55**	-.53**	.24*
23. Father warmth (n = 116)																							-	.66**	.55**	-.23*
24. Father communication (n = 116)																								-	.92**	-.42**
25. Father problems with communication (n = 116)																									-	-.43**
26. Father BDI-II (n = 116)																										-

Note. PARQ= parental acceptance-rejection questionnaire; BDI-II = Beck depression inventory-II; IPPA = inventory of parent and peer attachment; POP = perception of parents scale; LEAP = Lum emotional availability of parents scale.
* $p < .05$, ** $p < .01$