This is to certify that the

dissertation entitled

THE RELATIONS BETWEEN SOCIAL SUPPORT AND ADJUSTMENT FOR THE OFFSPRING OF DEPRESSED AND NONDEPRESSED MOTHERS

presented by

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has been accepted towards fulfillment
of the requirements for

Ph.D. degree in Psychology

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Date 4/25/91

THE RELATIONS BETWEEN SOCIAL SUPPORT AND ADJUSTMENT FOR THE OFFSPRING OF DEPRESSED AND NONDEPRESSED MOTHERS

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A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Psychology

1991

ABSTRACT

THE RELATIONS BETWEEN SOCIAL SUPPORT AND ADJUSTMENT FOR THE OFFSPRING OF DEPRESSED AND NONDEPRESSED MOTHERS

By

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It has been suggested that the offspring of depressed parents are at greater risk for developing psychopathology than the offspring of nonpsychiatrically ill parents. However, not all children are equally affected by having a depressed parent. In order to account for differences in the ways in which children cope with being raised by a depressed parent, social support was hypothesized to moderate the effects of being raised by a depressed parent and foster positive adjustment. The purpose of the present research was to examine the social support networks of the offspring of depressed and nondepressed mothers and to determine the relations between the elements of support and psychiatric and behavioral adjustment for these children.

As a subsample derived from a large research project at the National Institute of Mental Health, thirty primarily caucasian, middle and upper middle class children with depressed mothers and thirty children with nondepressed mothers participated in the study. The children completed a questionnaires which assessed psychiatric symptomatology and quantitative and qualitative aspects of social support. The mothers completed questionnaires assessing the children's psychiatric symptomatology and behavior problems.

Results indicated that the two groups of children did not differ significantly on any of the quantitative or qualitative elements of social support. When the two groups were combined, there was evidence in favor of the direct effect model of social support, whereby the more support children had, the better their adjustment was. However, the elements of support were of differential importance in their relation to adjustment, and some elements were negatively correlated with adjustment. In addition, the mechanisms that foster adjustment were dependent on the age and sex of the children. The implications for intervention and future research were discussed.

To Mom, Dad, Beth, Rob, and Max

ACKNOWLEDGEMENTS

I first would like to thank the members of my guidance and dissertation committees, Drs. Bertram Karon, Joseph Reyher. They challenged me to think and present ideas as a professional, and they listened to me as they would to a colleague. I also would like to thank Dr. Norman Abeles, who served as a dissertation committee member and as the chair of my guidance committee. Although he expressed concern about the difficulties of finishing graduate school from a distance, he provided me with much of the support I needed to complete the process.

In addition, I owe much thanks to Dr. Robert Caldwell, who served as a member of my guidance committee, but more important, as the chair of my dissertation committee. Also concerned about the long distance nature of our relationship, he nevertheless was willing to gamble on the possibility of a successful outcome. Once decided, he remained a constant source of support and inspiration. His conviction to never except less than my best effort helped me to produce a document about which I feel confident, as well as to mold me into a thoughtful, professional psychologist.

I also am grateful to Dr. Marian Radke Yarrow, Chief of the Laboratory of Developmental Psychology at the National Institutes of Health for allowing me to use a subsample of the laboratory's data for my research.

I also must thank my mother, father, and sister. From the day I began filling out graduate school applications to the evening of the conferral of my doctoral degree, they were always available to provide me with whatever I needed in the way of support. They have remained invested in my progress, reassuring in the face of my setbacks, and delighted in my accomplishments.

Finally, I owe much to my husband, Robert. Since the first day I met him on the students' tour of MSU, he has helped me through graduate school and life by virtue of his strength of character, his wonderful sense of humor, and his unfaltering love and understanding. His consistent support as a colleague and a husband remain my major source of confidence and inspiration.

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Introduction

Mental health researchers, clinicians, and epidemiologists have long been interested in the precursors to adult mental illness. In addition, many mentally ill adults report that their symptoms or problems began while they were children or adolescents. Therefore, researchers have chosen to gain a better understanding of the precursors of adult mental illness by examining the development of psychological disturbance in children. In particular, researchers have looked at children who they deem especially vulnerable to developing psychological problems. Children are thought to be at risk for developing psychopathology for many reasons, including if they are from lower social classes (e.g., Sameroff, Barocas, & Seifer, 1982), if their parents are experiencing marital difficulties (Shaughency & Lahey, 1985), or if one or both of their parents has some form of mental illness (Rutter & Quinton, 1984). By elucidating the early manifestations of mental illness and charting the course of its development, psychologists may be better able to treat mental illness and perhaps even prevent it from occurring.

The Offspring of Affectively Ill Parents

There has been recent interest concerning the socio-emotional development of children whose parents are mentally ill. Due to its relative prevalence in the adult population, affective illness in parents and its impact on children has received the most attention. Research from many areas of mental health suggests that offspring of depressed parents are more likely to have psychological difficulties than children of well parents. These difficulties can be classified into three broad categories: psychiatric diagnoses and prevalence rates of mental illness; psychosocial outcomes; and cognitive outcomes.

Prevalence Rates

In the early stages of research on the offspring of depressed parents, the focus was on determining whether these children were at greater risk for developing psychiatric disorders than the children of well parents. Consequently, studies of prevalence rates of psychiatric disturbance in these two groups of children were undertaken. However, the results from several studies have yielded widely disparate rates of disturbance. For the offspring of parents with unipolar affective illness, the prevalence rates for psychiatric disturbance ranged from 11% (Welner, Welner, McCrary, & Leonard, 1977) to 74% (Hammen, Adrian, Gordon, Burge, Jaenicke, & Hiroto, 1987). In contrast, the

rates of psychiatric disturbance among the children of control subjects ranged from 0% (Welner et al., 1977) to 29% (Hammen et al., 1987).

In addition to higher prevalence rates of general psychiatric disturbance, children of depressed parents seem to be more likely than children of parents who are not depressed to exhibit symptoms indicative of affective illness, such as depression. For children of parents with unipolar affective illness, the prevalence of depressive symptoms ranged from 7% (Welner et al., 1977) to 42% (Hammen et. al., 1987). The rates of depression among the offspring of control parents ranged from 1.6% (Weissman, John, Merikangas, Prusoff, Wickramaratne, Gammon et al., 1986) to 30% (Billings & Moos, 1982). These widely different rates of illness appear to be due largely to methodological inconsistencies among studies (which will be discussed below), and render interpretations of the results difficult. However, there appears to be initial evidence to suggest that the children of depressed parents are more likely to develop psychiatric symptomatology than children of well parents.

Psychosocial Outcomes

While research findings have suggested that the offspring of affectively ill parents could be distinguished from the offspring of well parents in terms of psychiatric symptoms and diagnoses, many investigators were interested

in examining whether these two groups of children differed on psychological and/or social dimensions as well. Differences between the offspring of affectively ill and well parents on measures of psychosocial functioning have been noted as early as birth and infancy. For example, infants born to depressed mothers were reported to have more delivery and total birth problems than infants of either schizophrenic or control mothers (Sameroff et al., 1982). It was also found that infants whose mothers looked depressed showed lower activity levels, more negative and less frequent positive facial expressions, and fewer vocalizations than infants whose mothers did not look depressed (Field, 1984). Weissman, Paykel, and Klerman (1972) found the infants of depressed mothers to be more tyrannical and less able to separate appropriately from their mothers. In addition, depressed mothers who were disengaged from their infants, reacted intrusively to their infants, or who handled their infants roughly tended to have infants who were withdrawn and seldom showed positive affective expression, even when their mothers showed some positive maternal behavior (Cohn, Matias, Tronick, Connell, & Lyons-Ruth, 1986). Field (1984) speculated that these infants' behavior is an attempt to reinstate normal interactions with their depressed mothers; when their mothers are not able to respond appropriately, the infants become distressed, protest, look wary, and look away.

Because they have come to expect their mothers to be nonresponsive, this distressed behavior often seems to carry over to times when their mothers are able to respond appropriately to their children.

Later, the year-old offspring of depressed mothers were reported to be deviant on measures of attachment when compared with control offspring (Naslund, Persson-Blennow, McNeil, Kaij, & Malmquist-Larsson, 1985). In another study, 55% of infants whose parents had major unipolar affective illness were reported to be insecurely attached, compared with 20% of control infants and 25% of infants whose parents had minor unipolar affective illness. Ambivalent and avoidant attachment was associated with the most severe maternal history (Radke-Yarrow, Cummings, Kuczynski, & Chapman, 1985). Another group of researchers (Lyons-Ruth, Zoll, Connell, & Grunebaum, 1986) reported that higher maternal depression scores were associated with greater affectivity, more covert hostility, and more interference with toddlers' goal-directed activity. In addition, it was found that mothers who reported the least frequent and the most frequent depressive symptoms had toddlers who were more insecurely attached, while mothers reporting moderately frequent depressive symptoms had fewer insecurely attached toddlers.

Several investigators have found evidence to indicate that the children of depressed mothers continue to show

signs of disturbance. For example, between the ages of three and four, these children were reported to be more whiny, less cooperative with family members and others, and more bizarre than children of mothers who had no mental illness (Seifer, Sameroff, & Jones, 1981). As they get older, these children show increasingly more symptoms of psychological disturbance than children whose parents are psychologically healthy. For example, the offspring of depressed mothers had more depressive symptoms, such as moodiness, crying for no reason, excessive worry (Kashani, Burk, & Reid, 1985; Welner et al., 1977), being fearful and anxious (Billings & Moos, 1983; Conners, Himmelhock, Goyette, Ulrich, & Neil, 1979; Welner et al., 1977), sleeping and eating problems (Kashani et al., 1985), low self-esteem and worthlessness (Kashani et al., 1985), and suicidal thoughts and/or behaviors (Weissman et al., 1986; Weissman, Prusoff, Gammon, Merikangas, Leckman, & Kidd, 1984; Welner et al., 1977). In addition to symptoms of depression, these children appear more likely to exhibit other symptoms of psychological disturbance, such as hyperactivity (Conners et al., 1979; Weissman et al., 1972) and conduct problems (Billings & Moos, 1983; Rutter & Quinton, 1979; Weintraub, Neale, & Liebert, 1975; Weissman et al., 1984; Welner et al., 1977).

The children of depressed mothers were also reported to experience more interpersonal difficulties than the children

of well parents. For example, researchers have reported more problems with family members, which have included competing with siblings for parental attention (Weissman et al., 1972), frequent fighting (Welner et al., 1977), and verbal clashes with parents, with a high degree of impaired communication, resentment, and hostility between adolescents and their mothers (Weissman & Siegel, 1972).

Problems with peers were also apparent (Billings & Moos, 1983), including rivalry with peers for attention (Weissman et al., 1972) and physical clashes (Weissman & Siegel, 1972). Grunebaum, Cohler, Kauffman, and Gallant (1978) found that their sample of children whose mothers were depressed were more likely to prefer engaging in solitary activities, rather than doing things with others, and Welner and her coworkers (1977) reported that these children were more likely to be perceived as loners and apprehensive around people. Fisher, Harder, and Kokes (1980) and Kokes, Harder, Fisher and Strauss (1980) found that classmates reported the children of depressed mothers to be more compliant, less academically skilled, and more socially intrusive than the rest of their peers. In addition, severity of mothers' psychopathology was positively correlated to peer and teacher ratings of friendliness and social competence (Kokes et al., 1980).

The family environments of children with a depressed parent has also been examined, and has been found to differ

from well families on a number of characteristics. These families have reported higher levels of chronic stress, or unpleasant life events, than well families (Hammen et al., 1987). Examples of types of stressors more often seen in these families include low socioeconomic status (Sameroff et al., 1982), spouses with psychiatric disorders (Rutter & Quinton, 1984) and parental marital dissatisfaction and disruption (Jacobson, Fasman, & DiMascio, 1973). These families have been reported to exhibit less cohesion, expressiveness, independence, active orientation, moral emphasis, organization, and more conflict than well families (Billings & Moos, 1983).

Further, the symptoms associated with the parents' affective illness may affect the quality of the parent - child relationship. For example, depressed mothers of infants were reported to be more helpless, overconcerned or hostile (Weissman, et al., 1972). Lyons-Ruth and his coworkers (1986) found that maternal depression was associated with increased covert hostility, affectivity, and interference with their infants' goal-directed activity. Field (1984) reported that mothers who looked depressed during mother-child interactions demonstrated lower activity levels, fewer positive and more frequent negative facial expressions, fewer vocalizations toward their infants, and spent less time looking at and touching their infants than mothers who did not look depressed. In a study examining

depressed mood in new fathers, it was found that depressed fathers engaged in parenting behaviors less frequently than nondepressed fathers. Perhaps to compensate, the wives of these depressed men engaged in more tactile stimulation of their infants than wives whose husbands were not depressed (Zaslow, Pederson, Cain, Suwalsky, & Kramer, 1985). Weissman and colleagues (1972) found that depressed mothers of school-aged children were irritable, self-preoccupied, uninvolved with their children, and intolerant of their children's noise and activity. In the same sample, mothers of adolescents were found to be guilty and worried, as well as envious and competitive with their children.

In sum, there appears to be a large body of evidence to suggest that the children of depressed parents exhibit patterns of impaired psychosocial functioning at a higher rate than children of well parents. These patterns of impairment are detectable from birth, and appear to persist as the children grow older. The observed psychosocial difficulties take the form of increased psychological symptomatology and maladaptive behavior, impaired social relations, disrupted family environments, and disturbed parent-child interactions.

Cognitive Outcomes

In addition to the psychological and social problems for which the offspring of affectively ill parents appear to be at risk, investigators have examined whether these

children are also at risk for developing cognitive difficulties. Fewer researchers have attempted to answer this question, and their findings are mixed. Again, differences between the two groups of children have been found early in their development. Lyons-Ruth et al. (1986) found that the severity of maternal depression and maternal IQ scores accounted for the most variance (30%) in infants' mental development scores, while severity of maternal depression and level of maternal communication accounted for the most variance (25%) in infants' motor development. In addition, one group of researchers (Grunebaum, Cohler, Kauffman, & Gallant, 1978) has consistently found that as children of affectively ill parents grow older, they can be differentiated from children of well parents on the basis of cognitive measures. Using the Continuous Performance Test, which measures attention, children of unipolar and bipolar mothers were slower to reach a correct response, and made more errors overall than children of either schizophrenic or well mothers. On the Embedded Figures Test (EFT), the offspring of affectively ill parents had a greater number of nonlooking responses, which correlated with the number of overall failures (Gamer, Gallant, Grunebaum, & Cohler, 1977). These children also had a greater number of failures on the EFT, as well as lower intelligence scores, as measured by the Weschler Preschool and Primary Scale of Intelligence (Cohler et al., 1977). Further, several

researchers have reported that the children of depressed mothers were more likely to exhibit academic problems (Billings & Moos, 1983; Weissman, et al., 1984), such as failing grades (Weissman & Siegel, 1972), dullness, lower cognitive competence, and academic problem solving (Kokes, et al., 1980). There is also data to suggest that these children are more likely to demonstrate behaviors that are less compatible or associated with academic success, such as impatience, inattentiveness, withdrawal, lower comprehension and creative initiative, and poorer ability to relate to the teacher (Weintraub, et al., 1975).

However, these findings are challenged by the findings of other investigators. Sameroff, Seifer, and Zax (1982) reported no differences between the IQ scores of 30 month-old children of depressed mothers and the IQ scores of schizophrenic or control mothers, as measured by the Bayley Scales of Infant Development and the Stanford-Binet. They found similar results when these children were 48 months of age, with no differences in IQ scores being reported for the children of depressed, schizophrenic, or control mothers as measured by the verbal scale of the Weschler Preschool and Primary Scales of Intelligence and the Peabody IQ test. In addition, Weissman and her colleagues (Weissman, John, Merikangas, Prusoff, Wickramaratne, Gammon, et al., 1986) found no differences between the children of depressed parents and the children of well parents on measures of

intelligence, as measured by the Weschler Intelligence Scale for Children, and the Peabody Picture Vocabulary Test. Further, Fisher and his coworkers (1980) reported that the sons of affectively ill psychotic parents had higher IQ scores and higher cognitive competence scores than the sons of schizophrenic or control parents. It is possible that the presence of methodological differences among the studies, such as different age ranges of children, different measures of cognitive abilities, and differences in the diagnostic status of the ill parents, may be an important contributing factor as to why such contradictory results were obtained. Clearly, more research is needed to better document and explain the relation between parental affective disorder and offspring cognitive abilities.

Methodological Issues

While there appears to be substantial evidence to suggest that the children of affectively ill parents are more impaired psychologically, socially, and cognitively than the children of well parents, there are several methodological flaws in the research which may call the above findings into question. These problems will be discussed in the following sections.

The first methodological problem concerns the use of demographic data. The demographic characteristics of a child's family provide important information about the environment in which a child is raised. These data include

age, sex, marital status, socioeconomic status, and race, as well as information about the parents' illness, such as age of onset, length of illness, severity of illness, and number of episodes or hospitalizations. Inclusion of these data is important for two reasons. First, it permits the comparison of findings across studies for subjects of similar background and severity of illness. Second, such data can provide researchers with information about factors that may make important contributions to the health or impairment of both parents and offspring. Many of the studies on the offspring of affectively ill parents do not report any demographic information (e.g., Harder et al., 1980), while a few report on only one variable, such as race (e.g., Weissman et al., 1986). This lack of information severely limits the generalizability of the findings to other children.

The second methodological problem is the absence of control groups in many studies. Control groups are necessary to ensure that the effects found in the target group are due to the independent variable and not due to sample characteristics. In the literature on the offspring of affectively ill parents, many researchers have not included control subjects (e.g., Kashani et al., 1985). Therefore, it is difficult to be truly certain that the effects reported for the offspring of affectively ill parents were found because the parents were affectively ill

and not for some reason unrelated to their illness.

In reviewing the literature on the offspring of depressed parents, it appears that many different diagnostic categories are used to group parents. For example, some studies recruit subjects who only have unipolar affective illness (e.g., Welner et al., 1977). Other studies compare patients with bipolar and unipolar affective illness (e.g., McKnew, Cytryn, Efren, Gershon, & Bunney, 1979), while still others combine bipolar and unipolar affectively ill parents into one single category (Gamer et al., 1977). In addition, some studies group together subjects from several different diagnostic categories, such as alcoholism, schizophrenia, neurosis, depression, and personality disorder (Cooper, Leach, Storer, & Tonge, 1977). Use of these widely disparate diagnostic groups makes comparison between studies extremely difficult, because different parental diagnoses may have different implications for offspring outcome.

Another issue with regard to parental diagnoses concerns the way in which these diagnoses are made. The majority of studies use either Research Diagnostic Criteria (RDC) or the Diagnostic and Statistical Manual for Mental Disorders (DSM-III) to arrive at parental diagnoses. These two systems are the most widely used and accepted means for arriving at a standard psychiatric diagnosis. However, a substantial number of studies have employed diagnostic criteria other than the RDC or the DSM-III. These other

diagnostic systems have included the Camberwell Psychiatric Register (Rutter & Quinton, 1984), the Current and Past Psychopathology Scales (CAPPS) (Sameroff, et al., 1982; Weintraub, et al., 1975), Feighner criteria (Conners et al., 1979; Welner et al., 1977), the Beck Depression Inventory (BDI) (Field, 1984), the Center for Epidemiological Studies Depression Scale (CES-D) (Cohn et al., 1986; Lyons-Ruth et al., 1986), and clinical interviews (e.g., Seifer et al., 1981). Other researchers have not reported how their diagnoses of the mothers were made (Cohler et al., 1976, 1977; Fisher et al., 1980; Grunebaum et al., 1878). Comparing results based on these different classification systems is problematic because it is not clear whether a diagnosis of affective disorder from one system is the same as a diagnosis of affective disorder from another system. Therefore, it is not clear whether similar groups of offspring are being compared.

In addition to the lack of clarity with regard to the selection of parents for research, there are also problems with the procedures used to select offspring. For example, some researchers report the use of more than one child per family (e.g., Kashani et al., 1985) while others do not report how many children from each family were used (e.g., Kauffman, Grunebaum, Cohler, & Gamer, 1979). Using two or more children from each family as subjects violates the assumption of independent observations (Hammen et al.,

1986). Researchers should remember this assumption when selecting children for use as subjects.

Another important offspring variable is the sex of the children selected to participate in research. This distinction is useful because what may be true for girls at a particular age may or may not be true for boys at that age. Girls and boys mature physically and psychologically at different rates, they may have different relationships with each parent, their siblings and their peers, and they may be more or less likely to manifest certain types of problems or pathology as a result of their sex. Again, a sizable group of investigators do not report the sex of the offspring they have studied (e.g., Seifer et al., 1981). As with other demographic variables, it is very difficult to draw general conclusions from these studies because one cannot determine if the findings pertain solely to boys, solely to girls, or if there are no differences based on gender.

Perhaps one of the most significant methodological flaws in this literature is that investigators tend to use subjects whose ages vary widely. A considerable number of studies have used children whose ages ranged from infancy and early childhood to late adolescence and early adulthood (e.g., Billings & Moos, 1983). From a methodological standpoint, this sampling technique is flawed because children of widely differing ages vary in their ability to

report on their emotional well-being, due to age differences in cognitive capabilities and emotional self-awareness. In addition, it has been found that children vary according to age in their agreement with their parents as to their psychological health (Orvaschel, Weissman, Padian, & Lowe, 1981; Weissman et al., 1986).

From a conceptual standpoint, it makes very little sense to discuss outcomes for these children as a group because of the different cognitive and emotional changes children experience as they mature. What may be a major occurrence in the life of a six-year old is not likely to have the same impact on a seventeen-year old. For example, researchers examining the teacher ratings of the offspring (aged 5-14) of affectively disordered and well parents found that the children of affectively ill parents were more likely to need to feel and be close to the teacher (Weintraub, Neale, & Liebert, 1975). However, the sample used in this study is comprised of more children between the ages of five and ten (N=77) than between the ages of eleven and fourteen (N=37). One would expect this need to feel close to the teacher would be stronger for younger children, and to decrease as the children moved into and through adolescence. However, this developmental difference was not taken into account. Therefore, this finding may be due to having a sample that consists of younger children rather than being raised by a parent with affective illness. To

imply, then, that the above finding is salient for children of all ages is misleading.

Finally, there is one last problem that appears characteristic of much of the offspring literature to date. While some researchers have investigated the familial characteristics of children who have a depressed mother, no one appears to have examined how these children perceive and interact with their families. Further, children interact with and are influenced by many people outside their immediate family, including grandparents and other relatives, peers, neighbors, teachers, and other professionals. The availability of these social relations, or social supports, has been linked to the physical and psychological health of adults (Kessler, Price, & Wortman, 1985). However, researchers are only beginning to understand the relationships between children's social supports and adjustment.

Social Support and Children

The research on social support and children is based largely on the wealth of information that has been gathered on the relationships between stress, social support, and adjustment in adults. Life stress researchers consistently have found that stress was able to account for only ten percent of the variance in adult behavior and adjustment

problems (Wertlieb, Wiegel, & Feldstein, 1987). Research then turned to the investigation of moderator variables, such as social support, to explain the mechanisms by which the deleterious effects of stress can be altered or modified (see Cohen & Willis, 1985; Kessler & MacLeod, 1985 for recent reviews). However, while this interest in adult social support as a link between stress and adjustment has received considerable attention in the literature, the investigation of social support and children has only recently begun to be of similar interest.

The Construct of Social Support

Although social support is by now a well-known and well-researched topic, there is still not one single definition that is used by all investigators. Efforts to measure social support have been impeded by disagreement as to how the construct is best conceptualized (Gesten & Jason, 1987). It seems that social support typically has been defined according to the specific research interests of individual investigators. However, there are several properties of social support that appear to be more widely accepted. One common way that support has been conceptualized is through its content or functions. House (1981) divided support into four content or function areas: emotional, instrumental, information, and appraisal. Bogat and her colleagues (Bogat, Chin, Sabbath, & Schwartz, 1985) conceptualized support similarly, classifying it into

emotional, companionship, information and advice, and tangible aid. This conceptualization represents one of the few taxonomies of social support that has been developed for use with children as well as adults.

Barrera (1981) has developed what is perhaps the most comprehensive conceptualization of social support in childhood and adolescence. He argued that a definition of social support must include three broad-based components. First, it must outline a description of the providers of support. Second, it must explicate the activities involved in the provision of that support; these are likely to include help in mastering emotional distress, sharing responsibilities, providing advice, teaching skills, and providing material aid. These activities are similar in nature to those outlined both by House and Bogat. Finally, it is important to assess the individual's subjective appraisal of support. It is becoming increasingly obvious that how an individual, child or adult, views the support he is receiving is more important than an objective assessment of that support. This last component is being studied through measures of children's satisfaction with the support they are receiving (e.g., Barrera, 1981; Compas, Wagner, Slavin, & Vannatta, 1986; Compas, Wagner, Slavin, & Vannatta, 1986).

While few studies have specifically investigated the relevance of the content and/or function of social support

for children, there is evidence to suggest that certain elements of social support may be associated with children's healthy psychological functioning. For example, emotional support, in particular, appears to be one of the functions that is an important contributor to children's adjustment (e.g., Unger and Wandersman, 1988). Other investigators have looked at source of support, and have differentiated support received from parents, support received from other family members, and support received from friends and the community (e.g., Barrera, 1981; Cauce, Felner, & Primavera, 1982; Unger & Wandersman, 1988; Walker & Greene, 1987; Wertlieb, et al., 1987). It appears that social support from different sources may serve to sustain children by providing them with different types of support. Perceived availability of social support may help to bolster a child's self-esteem and confidence, and provide him with role models whose qualities and characteristics he can experiment with and internalize. However, it remains unclear what distinguishes these varied types of support from their distinct sources, as well as what makes them so important to children's functioning.

The Mechanisms of Social Support

As there is confusion concerning the best way to conceptualize the construct of social support, there is also disagreement concerning the mechanisms by which social support acts to foster adjustment. In the literature, two

models concerning how social support works have been posited. The "direct effect" hypothesis states that social support is directly related to adjustment, so that the more support available to an individual, the better his/her overall adjustment. The "buffer" hypothesis asserts that social support buffers or moderates the relationship between adversity and adjustment. Hence, if a person is faced with some type of adversity, or negative life event, having available social support should decrease the effect of that negative event.

In the literature on adult social support, the evidence in favor of either model is inconsistent, due largely to methodological differences between studies (Alloway & Bebbington, 1987). The same inconsistencies appear to hold true for social support and children. There are a number of studies that lend support to the direct effect model (Barrera, 1981; Cauce et al., 1982; Compas, Slavin, et al., 1986; Compas, Wagner, et al., 1986; Felner, Ginter, & Primavera, 1982; Sandler, 1980; Sandler & Barrera, 1984). Although it appears that the quality of a child's social support (e.g., who are his supporters, how often he is in contact with them, how satisfied he is with their support) is related to symptom levels, this relation varies as a function of several individual characteristics, such as gender, age and socioeconomic status (Compas, 1987).

While the studies investigating the direct effect model all appear to lend support to the model, regardless of methodological inconsistencies, the evidence for the buffer hypothesis is less consistent. For example, Compas, Slavin, et al. (1986) and Gad and Johnson (1980) did not find any interaction between life events and social support in predicting adjustment. Barrera (1981) found that negative, or unpleasant, life events interacted with total size of the social network and unconflicted network size in predicting depression; however, no interactions occurred in predicting anxiety or total symptom level. Hotaling, Atwell, and Linsky (1978) found that social support moderated the relationship between life events and physical and psychological illness in adolescents. There have been no studies that have specifically addressed the above inconsistencies. However, it may be the case that social support only moderates the relationship between adversity and health for certain types of subjects, specific aspects of social support, particular symptoms, or all three (Compas, 1987).

Results of Studies on Social Support and Children

Researchers have chosen several methodologies to examine the relationship between social support and adjustment in children. One popular line of investigation has been to evaluate the properties of social support for adolescents who are undergoing major life transitions, such

as the transition from middle school to high school, or from high school to college. For example, Hotaling and his coworkers (1978) interviewed a group of college freshmen concerning their senior year of high school to examine the impact of this stressful life change on their illness patterns. They used frequency of contact with family as the social support variable to be assessed, as breaking away from the family marks the removal of an important resource for the adolescent. They found that for students reporting high degrees of stress, 77% of those with low social support reported poor health, while 50% of those with high social support reported poor health. They therefore concluded that social support had a protective effect on the impact of the transition to college.

More recent data about social support and the nature of the transition from high school to college comes from two studies by Compas and his colleagues. Two hundred forty-three high school seniors attending a freshman orientation program were asked about the number of supportive persons in their lives and how satisfied they were with the support they were receiving. They found that there was a correlation between perceived support and symptomatology, as measured by the Hopkins Symptom Checklist. Specifically, it was found that lower levels of satisfaction with support were significantly associated with symptoms of anxiety, depression, somatization, and interpersonal sensitivity.

However, the number of supporters reported was not related to these symptoms (Compas, Slavin, et al., 1986).

In a continuation of the above study (Compas, Wagner, et al., 1986), social support and the stress of school transition was examined longitudinally. A subgroup of the above 243 high school seniors was asked about levels of stress, social support, and symptoms at an orientation session (Time 1), during the first week of classes (Time 2), and after Thanksgiving vacation (Time 3.) The investigators found a high degree of stability of life event scores, social support and symptomatology across all three times. In addition, they also found Time 1 satisfaction with support significantly predicted life events and symptoms at Time 2. However, none of the associations at Time 2 predicted Time 3 variables, although the relationship between Time 2 symptoms and Time 3 satisfaction with support approached significance. The authors concluded that their results lend support to the theory that social support and psychological symptoms are reciprocally, not linearly, related across time.

Other investigators have looked at relationship between social support and the transition from middle school to high school. For example, Felner et al. (1982) attempted to assess whether entering high school was a difficult transition for adolescents and, if so, how to make this transition easier. They implemented a primary prevention

program to increase new students' social support by assigning them to a homeroom class and teacher that served as their primary source of guidance, support, and information about their new school. Results indicated that the students who participated in the project had significantly better grade point averages, more positive self-concepts, and saw the school environment as being more organized and having more teacher support.

It appears then, that social support has a significant impact on the relationship between the stress of school transition and subsequent adjustment. Three distinct components of social support - number of supporters, source of support, and satisfaction with support - have been shown to be related to a variety outcomes. These outcomes have included physical health, mental health, school attendance, and grade point average. However, this literature lacks information with regard to other life transitions, such as entering into adolescence, or coping with chronic parental illness. It is unclear whether the relationships between social support and adjustment would remain the same when a different life transition is assessed. In addition, there is no information concerning how younger children adjust to school or other life transitions. It may be the case that the support available to children when they are young and how they perceive and utilize that support can influence their later utilization of and satisfaction with support,

and consequently their adjustment.

Another tactic used by researchers to investigate the nature of social support in childhood has been to examine the relationship between children's social support and "problem" behavior. This problem behavior typically has included drug and alcohol use, and teenage pregnancy. For example, Newcomb and Bentler (1988) looked at the relationships between adolescent drug use, the availability of good social supports, and a variety of outcomes, including problems with drugs, physical health, psychological well-being, and interpersonal relationships. Their subjects were assessed over an eight year period from seventh and ninth grade to young adulthood. Even after controlling for potential confounding effects, every adolescent outcome factor measured was reduced by earlier social support. Thus, the authors concluded that their results demonstrated support for a main effect of social support, and that "difficulties in interpersonal relations seem to provide a surprisingly powerful indicator of psychosocial dysfunction over time (p. 74)".

Other investigators have examined the relationships between social support and a specific type of drug, alcohol. Baer, Garmezy, McLaughlin, Pokorny, and Wernick (1987) assessed life events, family support, and alcohol use among 425 seventh grade students. They found that overall, the degree to which life events were related to alcohol use was

not mitigated when there was less conflict in the family environment (more family support). In addition, family conflict was negatively correlated with alcohol use for both girls and boys. However, there were some gender differences. Girls' use of alcohol was related to life events and family conflict, while boy's use of alcohol was related only to family conflict.

Another significant social issue of adolescence concerns teenage pregnancy and motherhood. In one of the most referenced studies of social support in children, Barrera (1981) examined the relationship between stress, social support, and psychiatric symptoms for 86 pregnant adolescents. He found that the size and quality of social support networks influenced the association between life events and depression. More significantly, he found that girls who reported feeling satisfied with the social support they were receiving were found to have smaller relationships between life changes and depressive symptoms.

Many teenage pregnancies result in girls deciding to carry their babies to term and raising them at home. Some researchers have assessed the relationship between stress, social support, and adjustment for these adolescent girls both during the pregnancy as well as after they have brought their babies home and are attempting to cope with motherhood. For example, Unger and Wandersman (1988) evaluated the psychosocial functioning of teenage girls

experiencing their first pregnancy during the second or third trimester of the pregnancy and again when their infants were eight months of age. They looked at the degree to which subjects reported feeling that their needs for support were satisfied. Results indicated that maternal perceptions of satisfaction with familial and partner support were associated with her overall life satisfaction when her infant was eight months old, regardless of whether these perceptions were assessed prenatally or postpartum.

The above studies provide evidence of the importance of social support for adolescents confronted by particular types of stresses, such as drug use or pregnancy. Again, the importance of social support was evidenced for several different outcomes, including physical health, psychological adjustment, and interpersonal relationships. However, one point needs to be addressed which may limit the generalizability of the studies. There are vast differences in subject selection that make it difficult to compare results from various studies. First, the ages of the children assessed ranges from seventh graders to young adults in the Newcomb study, seventh grade students in the Baer group, and thirteen to eighteen years of age in the Unger study and the Barrera Study. In addition, the adolescent girls in the Unger study were predominantly black and lower class, while Baer and his colleagues used mainly white students from middle-class backgrounds. It makes

little sense to compare the results obtained from children of such widely varying ages and socioeconomic backgrounds because what constitutes satisfying supportive behavior may differ as a function of age, race, and/or social class, even thought the measure of support does not change.

The last strategy used by childhood social support researchers has been to examine the construct of social support in children who are not experiencing any particular stressful circumstances. An example of this type of investigation is Bryant's (1985) work on sources of support in children's neighborhoods. In one of the few studies of young children's support networks, she took seven and ten year old children on a walk in their neighborhoods to identify sources of personal, familial, and neighborhood support. She found differences with respect to gender, family size, and age. First, it appeared that girls of both ages experienced more intensive relationships and a less extensive casual network of relationships than boys. Second, children from small families were more intimately involved with their parents than children from large families, while children from large families seemed to acquire more support from their grandparents and peers than did children from small families. Finally, she found that the relevance of social support in predicting socio-emotional functioning was greater at age ten than at age seven, with the lives of these older children characterized

by the development of more elaborate intrapersonal, interpersonal, and environmental sources of support.

An extension of the above findings to adolescents was described by Walker and Greene (1987). Eleven to nineteen year old children attending an outpatient medical clinic for the first time reported on life stresses, family cohesion, peer supports, and psychophysiological symptoms. Several findings were noteworthy. Males and females who perceived their family as low in cohesion reported more symptoms than those who reported high family cohesion, except when the latter had a high degree of stressful life events. There were also were some interesting differences between males and females. Evidence in favor of the buffer hypothesis of social support was found for males: as negative life events increased, males with low peer support reported more symptoms, while males with high peer support appeared to be unaffected. For low levels of life events, there was no relation between peer support and symptomatology. Therefore, it seems that peer support is critical for males only when they experience a great many stressful events.

The picture was very different for females, and it may be the case that peer support is important for females regardless of how many stressful events they experience. At high levels of support, females reported few symptoms when negative life events were infrequent. As life events increased, so did symptom levels. In addition, females with

low peer support had consistently high symptom levels. The authors postulated that social isolation could have represented a stressor in its own right and directly contributed to symptomatology in these girls. They also noted that, due to cultural proscriptions, women are more likely to report physical symptoms that men.

Other investigators have evaluated children who are under no particular stresses at the time of the study, but because of specific living conditions they are thought to be "at risk" for developing psychopathology. One such study was done by Wertlieb and his coworkers (1987). They examined the relationship between family support and behavior symptoms in a group of six and nine year old children, a subset of these children having had experienced a marital separation or divorce in the past four years. They found that for either low or high levels of stress, lower levels of social support were associated with more behavior symptoms, while higher levels of social support were associated with fewer behavior symptoms. Thus, the authors concluded that their results supported the direct effect of social support.

Finally, Cauce and her colleagues (1982) evaluated a group of adolescents who were considered to be at risk for psychopathology because of low SES. Their study examined the relationships between social support, school performance, and self-concept in ninth and eleventh grade

inner-city students. Based on their findings, three categories of support were identified: family support; formal support (such as teachers or clergy); and informal support (friends or other adults). For family support, it was found that black adolescents rated their families as more supportive than either hispanic or white adolescents. In addition, younger males and older females found their families to be more supportive than older males and younger females. With regard to formal support, older adolescents found this source of support to be more helpful than younger adolescents. In addition, there was a significant age by sex by race interaction; older hispanic adolescents found formal support more helpful than did younger hispanic adolescents, while black and white males rated formal support as more helpful than their female counterparts, with this trend was reversed for hispanic adolescents. With regard to informal sources of support, females rated this source of support as more helpful than males, while black and white adolescents rated informal support as more helpful than hispanic adolescents.

Social support was also related to academic functioning and self-concept. Higher levels of informal support were related to lower academic averages and greater absenteeism. This unexpected findings may be due to the value placed on academic achievement in lower class environments, as well as the typical adolescent pressure to conform to one's peer

group. With regard to self-concept, higher levels of perceived support were associated with higher peer self-concept scores for males but not for females. In addition, for black females, high family support was related to a poorer scholastic self-concept, while the reverse held true for the other groups of adolescents.

It seems, then, that there is a relationship between social support and adjustment for children who are not currently experiencing stressful life circumstances, or who are considered "at risk" because of parental marital difficulties or low SES. These relationships held up across several different outcome measures. These outcomes ranged from socio-emotional functioning to peer and family relations to psychophysiological symptoms to behavior symptoms to school functioning.

As before, it is difficult to generalize from the results of the above studies for several reasons. First, one of the studies used the mothers' perceptions of how supportive the family was for the children (Wertlieb et al., 1987). This methodology is problematic, because it is unclear whether the children's perceptions were similar to or different from those of their mother's. Future research should endeavor to ascertain information about social support directly from children, so as to be sure of the usefulness of the data.

As with the research on life transitions and social issues, there are differences in subject composition that make comparisons between studies difficult. For example, one cannot assume that what constitutes support for a six year old is necessarily the same as for a nineteen year old. In addition, one of the studies did not interview children directly, but instead relied on mothers' reports to ascertain what was supportive for the child (Wertlieb et al., 1987). Further, differences in race and SES existed that could potentially contribute to differences in levels of support and interpretations of supportive behavior, as different ethnicities often seem to place dissimilar value on being supportive and having support (Cauce et al., 1982).

It is important to note that all of the researchers whose studies were reviewed above utilized components of social support that met the needs of their particular research. However, there may be other aspects of support that were not assessed, and which may be important to arriving at a better understanding of the relationships between children's social support, stressful circumstances, and adjustment. In a review of the social support literature, Barrera (1986) has organized the operationalizations of social support into three broad categories: social embeddedness; perceived support, and enacted support. Social embeddedness "refers to the connections (relationships) that individuals have to

significant others (e.g., parents, siblings, friends) in their social environments (p. 415)." It is that component of social support that has been typically measured by instruments that assess the number of supporters in one's network. Perceived support is the cognitive appraisal of being connected to and supported by others. It is represented in the literature by instruments that assess subjects' satisfaction with the support they receive. Finally, enacted support refers to the mechanisms by which individuals receive support; what people do when they provide support. Here, researchers can examine and compare different kinds of supportive responses and actions as well as the timing of these supportive behaviors. This component of social support is assessed by obtaining information about the types of supporters in peoples' networks, and the frequency with which they are in contact with those supporters. While there exist other methods for operationalizing social support, these three concepts "appear to capture meaningful similarities and differences that exist among commonly used conceptualizations (p. 438)."

In his review, Barrera suggested that each different conceptualization of social support is more applicable to some models of the relationships between stress, social support, and adjustment than to others. He stated that measures of social embeddedness most likely contributed to the prediction of psychological adjustment that is

independent of stressful life events. Measures of perceived support were consistently negatively associated with adjustment, as well as measures of life stress. Enacted support was largely positively associated with measures of adjustment and stress. It appears that to capture all the important and diverse relationships between stress, social support, and adjustment, it is necessary to include measures that represent each of these three components of social support.

Rationale

There is increasing evidence in the literature suggesting that the offspring of affectively disordered parents are at greater risk for developing psychopathology than the offspring of nonpsychiatrically ill parents. These "at-risk" children are reported to have more psychiatric diagnoses (e.g., Hammen et al., 1986), more interpersonal (e.g., Weissman & Siegel, 1972) and emotional problems (e.g., Kashani et al., 1985), and more cognitive deficits (e.g., Grunebaum et al., 1978) than children of well parents. These disturbances appear as early as infancy (Lyons-Ruth et al., 1986), and seem to continue through childhood and adolescence (Kokes et al., 1980). However, the literature on the offspring of depressed parents is full of methodological inconsistencies that make conclusions based on this research difficult to substantiate.

In addition, not all children are equally affected by having an affectively ill parent. Some children grow and develop normally without demonstrating any of the psychopathology reported by researchers. In order to account for the differences in the ways in which children cope with living with and being raised by a depressed parent, it is necessary to establish the existence of moderator variables; variables that buffer for children the relationship between the stress of having an affectively disordered parent and healthy adjustment.

Social support is a variable that has been shown to moderate the effects of different types of stressors for children and foster positive psychosocial adjustment. However, a large part of the social support literature is flawed in part due to the lack of consensus among investigators concerning how best to conceptualize social support. Because of this lack of consensus, researchers assess only those particular components of social support relevant to their study. As a result, they often neglect elements of social support that are equally or more critical to an understanding of psychological adjustment (Barrera, 1986). In addition, there has been no systematic investigation of whether there are differences in the social support networks of the offspring of affectively ill parents and the offspring of well parents, or if there is a relationship between social support and adjustment among

these two groups of children.

The purpose of the present research is to examine the social support networks of the offspring of depressed parents and the offspring of nondepressed parents and to determine the relationships between the elements of social support and psychiatric and behavioral adjustment for these children. This research will seek to delineate a typology of social support that assesses components of social support - social embeddedness, perceived support, and enacted support - that appear to be consistently associated with stress and adjustment (Barrera, 1986). The specific components to be assessed will include type of support, source of support, frequency of contact with support, how contact is initiated, and satisfaction with support. These components will be analyzed, both separately and together, to determine which elements of social support are most predictive of positive adjustment in these two groups of children.

The present study derives from a longitudinal research project at the Laboratory of Developmental Psychology (LDP) and sponsored by the National Institute of Mental Health. Begun eight years ago, this ongoing project is an investigation of the child rearing practices and family environments of depressed and well parents and their children. The protocol of this project has included the administration of standard psychiatric interviews, cognitive

tests, neuropsychological tests, self-concept assessments, behavior ratings, and life event schedules, as well as extensive observation of the family members in a naturalistic "apartment" in the laboratory.

Research on the psychosocial functioning of the offspring of depressed parents as well as the research on children's social support networks typically studied dissimilar or unrepresentative populations. The LDP research project sought to rectify this flaw in several ways. First because mothers are usually the primary caretaker of their children, it is likely that depression in mothers will have more devastating consequences for children than depression in fathers. Therefore, the longitudinal project recruited families where the mothers had a history of depression.

In addition, many researchers investigating the adjustment of the offspring of depressed parents combined many different parental diagnostic groups, as well as based their assessments of the parents on diagnostic systems of questionably reliability. Therefore, the LDP study chose to include only those parents who were diagnosed by Research Diagnostic Criteria, Third Edition (RDC) (Spitzer & Endicott, 1981) as having Bipolar, Major Unipolar, or Minor Unipolar illness. Parents with Schizophrenia, Substance Abuse Disorders, or Antisocial Personality Disorder were excluded from the sample.

For the present study, one additional exclusion was made; those parents with Bipolar illness were not included in the sample. It was thought that Bipolar illness, with its unpredictable high and low phases, was sufficiently different so that parental Bipolar illness may not have the same effect on children as Unipolar illness. Therefore, the parents in the present study were diagnosed as having Major Unipolar Disorder or Minor Unipolar Disorder.

Based on the Research Diagnostic Criteria (1981), the subjects of the LDP study were included in the sample based on two further subclassifications: definite and probable illness. For inclusion in the Definite Major Unipolar Disorder category, subjects must have had one or more distinct periods with dysphoric mood or pervasive loss of interest, have had dysphoric features for at least two weeks, have sought or been referred for help, and have endorsed at least five symptoms (e.g., appetite problems, sleep problems, excessive guilt, psychomotor agitation or retardation) for a current (within the past four months) episode and four symptoms for a past episode. The criteria for Probable Major Unipolar Disorder are the same as above except that the episode may be of one to two weeks duration and that four symptoms are required for a current episode and three for a past episode. For inclusion in the Definite Minor Unipolar Disorder category, subjects must have had an episode of illness in which a relatively persistent

depressed mood dominates the clinical picture (or is coequal with anxiety), have had an episode which lasted at least two weeks, have endorsed at least two symptoms per episode, and have had impairment in functioning, sought help, or taken medication. The criteria for Probable Minor Unipolar Disorder are the same except that the episode must have lasted at least one week. All subjects must have evidenced depressive episodes that developed with no significant signs of psychiatric disturbance in the year prior to the development of the current episode with the exception of the symptoms associated with the target disorder. The diagnosis of a spouse does not affect inclusion of a mother except if the spouse is diagnosed with Schizophrenia or Antisocial Personality Disorder; these families are not included.

For inclusion in the nondepressed sample, subjects may have no RDC diagnoses at any time in the past in either parent. An episode of minor depression that occurred before the birth of any children does not necessarily disqualify a parent. Subjects with a history of therapy or minor affective disturbance may be included in the sample. In addition, subjects must not have had a serious chronic illness, postpartum, or bereavement reaction in the past year (Belmont, 1989).

At the initiation of the study, the most widely used diagnostic classification system was the RDC. Subsequently, the DSM system has become the more widely used system, and

has been extensively revised. In order to make the most reliable and generalizable diagnoses, the LDP staff decided that at the current round of data collection (from which the present study derives), the parents would be diagnosed according to DSM-III-R criteria. (However, in order to make comparisons to past data, RDC diagnoses were also obtained).

The assessment instruments used to obtain diagnoses for parents and children, as well as the instrument used to assess children's social support measure, are based on informant self-report. While the technique of self-report is the most widely used and perhaps the best method to yield information on psychiatric diagnoses and social network characteristics, there are problems which could limit the utility of the information obtained. Self-report instruments are subjective rather than objective measures of behavior, and are subject to various types of bias, such as demand characteristics, attempts on the part of subjects to "look good" and therefore under-report psychopathology. These limitations will be discussed in greater detail in the discussion section.

Further, many studies used subjects with widely varying age ranges. In order to study both inter- and intrafamily differences, the LDP project chose to assess two siblings from each family. At the start of the project, one sibling was between the ages of 18 and 24 months of age, and the older sibling was between five and eight years of age. The

ages and the assessment times were controlled so that family interactions and child characteristics would be closely related to specific developmental periods, as well as so that a cross-sectional/longitudinal design could be employed (e.g., the younger sibling at the second assessment would be the same age as the older sibling at the second assessment). For the present study, because the nature of children's social relationships change as they approach and enter adolescence, is unlikely that social relations are the same at age eight or nine as they are at age twelve or thirteen. By using these two groups of children, it will be possible to view the development of social relations for socially disordered as well as normal children. For the present study, one group of children (both target and control) ranged in age from eight to eleven years; and the other group of children (both target and control) ranged in age from twelve to fifteen years.

Descriptive Analyses

As there have been no systematic investigations of the social support networks of the offspring of depressed parents, the first step will be to describe the composition of their networks. Because the children of depressed parents often have difficulty with interpersonal relations (e.g., Welner et al., 1977), it is possible that they do not have the social skills to seek out or maintain the necessary social support. Therefore, this study will determine the

total number of supporters as well as the amount of different types of supporters in the networks of the children of depressed mothers and control children. It is hypothesized that the offspring of depressed mothers will have fewer total supporters and fewer individual types of supporters than the offspring of control mothers.

The next step will be to determine whether the children of depressed mothers differ from the children of nondepressed mothers with regard to who they nominate as supportive. Research indicates that the offspring of depressed parents seem to have particular difficulty with peer relations (e.g., Billings & Moos, 1983). It is therefore hypothesized that overall, they will nominate fewer peers as supporters than the children of well parents. However, as children approach adolescence, they begin to rely more on peers for support (Kriegler, 1987). Consequently, it is hypothesized that the adolescents of nondepressed mothers will nominate peers most often, the adolescent children of depressed mothers parents will nominate peers next often, then the younger children of nondepressed and the younger children of depressed respectively. Conversely, it is hypothesized that the younger children of depressed mothers will be likely to nominate more family members than either of the other three groups of children.

The next variable that will be important to investigate concerns how frequently these children are in contact with their supporters. While the issue of frequency of contact between children and supporters has not been examined in the literature, it seems plausible that the more frequently children have support available to them, the less likely they will be vulnerable to stress and psychopathology. Because almost all children are in daily contact with parents and siblings, it is hypothesized that the offspring of depressed mothers will not differ from the offspring of nondepressed mothers with regard to the amount of contact they have with their parents and their siblings. However, it is hypothesized that the children of depressed mothers will be in contact less frequently with supporters outside the family than the children of nondepressed mothers.

There is evidence to suggest that the children of depressed parents are more withdrawn socially than are children of well parents (e.g., Grunebaum et al., 1978). It follows, then, that these children will be less likely to seek out and initiate contact with others in their environment. It is therefore hypothesized that the offspring of depressed mothers will be less likely to initiate contact with the supporters in their network than the offspring of nondepressed mothers.

The last element of social support to be evaluated is satisfaction with the support being received. If children

are more skillful at initiating and maintaining social relations and interacting with people, it is likely that they will feel more satisfied with their relationships. The children of depressed parents are less proficient at developing and maintaining social ties and interacting with people (e.g., Weissman et al., 1984; Weissman & Siegel, 1972), so it is possible that they feel less satisfied with their relationships with others. Therefore, it is hypothesized that the offspring of depressed mothers will report less satisfaction with the support they are receiving than the children of nondepressed mothers.

Relationship between Social Support and Adjustment

Once the typological characteristics of the children's social support networks have been delineated, the relationships between social support and adjustment can be examined. Adjustment will be assessed, as it is in the LDP longitudinal project, using two standard measures of childhood functioning: psychiatric diagnoses and behavior symptoms.

The first analysis will seek to determine which element of social support is most predictive of better adjustment for both groups of children. There has been no research done to ascertain which element of support is most related to adjustment. The literature suggests that perceived satisfaction with support is one of the elements of social support that may be most positively related to children's

adjustment (Barrera, 1981). Therefore, this study seeks to determine if satisfaction with support is the element of social support most crucial to healthy adjustment in children. It is hypothesized that for both groups of children, satisfaction with support will be the element of social support that is most predictive of positive adjustment.

Once the relationship between overall social support and adjustment is determined, a more in-depth examination of the individual components of social support and their individual contribution to children's well-being will be undertaken. Each component of social support will be analyzed separately to determine which level of that component is most predictive of positive adjustment. First, there is research to indicate that the more support an individual has available to him/her, the better his/her adjustment (e.g., Weimer, Hatcher, & Gould, 1983). Therefore it is predicted that children who have larger networks will be better adjusted than children whose networks are smaller.

It remains unclear whether different types of social support are differentially related to positive adjustment in children. The research to date on the relationship between type of support and adjustment in children has emphasized the importance of emotional support (e.g., Unger & Wandersman, 1988). However, there have been no direct tests

of the superiority of emotional support at predicting psychological functioning in children. The present study will test this hypothesis. Based on the literature, it is hypothesized that the presence of emotional support is most predictive of positive adjustment in both groups of children.

As discussed earlier, children of varying ages are likely to regard different sources of support as differentially helpful. For example, Kriegler (1987) reported that young adolescent children nominated more peers as supporters than did younger children. It is possible, then, that different sources of support are related to positive adjustment for adolescents and younger children. It is hypothesized that for adolescents, support from peers is most predictive of well-being, while for younger children, support from parents is most predictive of positive functioning.

The availability of support is an important factor in determining the relationship between social support and adjustment. It appears that there is a positive relationship between the frequency with which an individual is in contact with supporters and his/her psychological adjustment (Barrera, 1986). However, the relationship between availability of support and adjustment in children is not clear. Based on the literature, it is therefore hypothesized that frequency of contact with supporters is

predictive of positive adjustment.

If the children of depressed parents are more socially inappropriate than the children of nondepressed parents (e.g., Seifer et al., 1981), it is possible that how they seek out and initiate contact with the supporters is impaired. This impairment could take one of two forms. If the children of depressed mothers are more socially withdrawn (e.g., Grunebaum et al., 1978), they may be more likely than the children of nondepressed mothers to initiate less contact than their supporters. Conversely, if they are more emotionally needy (e.g., Weissman et al., 1972), they may be more likely than the children of nondepressed mothers to initiate more contact than their supporters. Both of these forms of contact could be problematic in relation to adjustment, because each seems to represent an imbalance, or asymmetry, in the way the children communicate. It is therefore hypothesized that the level of initiation of contact that is most predictive of positive adjustment is where children and supporters seek out each other with similar frequency.

In addition, there is evidence from the literature on social support and children to suggest that satisfaction with support is an important contributor to children's health and well-being (e.g., Compas, et al., 1986). It is likely that the more satisfied children are with the support they are receiving, the better adjusted they are. However,

this premise has not been tested with children of depressed mothers. In order to ascertain the validity of this finding, it is hypothesized that the highest level of satisfaction with social support with be most predictive of children's adjustment.

Finally, there is disagreement in the literature as to whether social support has a direct effect on adjustment or whether it acts as a buffer between stress and adjustment. If social support does act as a buffer, it is hypothesized that support will have more of an effect for the children of depressed mothers than for the children of nondepressed mothers.

Hypotheses

The following hypotheses will examine various elements, or components, of social support. These elements will include number of supporters, types of support, sources of support, frequency of contact with supporters, initiation of contact with supporters, and satisfaction with support received.

I. Descriptive Analyses

Hypothesis 1: The offspring of depressed mothers will report fewer supporters than the offspring of nondepressed mothers.

Hypothesis 2: The offspring of depressed mothers will report fewer emotional, companionship, information, and

tangible aid supporters than the offspring of nondepressed mothers.

Hypothesis 3A: The offspring of depressed mothers will report fewer peers as supporters than the offspring of nondepressed mothers.

Hypothesis 3B: The adolescent offspring of nondepressed mothers will report the most number of peers in their networks, followed by the adolescent offspring of depressed mothers, followed by the younger children of nondepressed and depressed mothers respectively.

Hypothesis 4A: The offspring of depressed mothers will report the same level of contact with family members, but less contact with individuals outside the family than the offspring of nondepressed mothers.

Hypothesis 4B: The offspring of depressed mothers will report being less likely to initiate contact with supporters than the offspring of nondepressed mothers.

Hypothesis 5: The offspring of depressed mothers will report being less satisfied with the support they are receiving than the offspring of nondepressed mothers.

II. Relationship between Social Support and Adjustment

Hypothesis 6: Satisfaction with support is the element of social support that is most predictive of children's psychiatric diagnoses and behavior symptoms.

Hypothesis 7: The more supporters children report, the better their adjustment will be, as assessed by psychiatric

diagnoses and behavior symptoms.

Hypothesis 8: Emotional support is the type of support that is the best predictor of children's psychiatric diagnoses and behavior symptoms.

Hypothesis 9A: For younger children, support from parents is the source of support that is most predictive of psychiatric diagnoses and behavior symptoms.

Hypothesis 9B: For adolescent offspring, support from peers is the source of support that is the most predictive of psychiatric diagnoses and behavior symptoms.

Hypothesis 10: The more frequently children are in contact with supporters, the better their adjustment will be, as assessed by psychiatric diagnoses and behavior symptoms.

Hypothesis 11: The more shared, or mutual, the initiation of contact is between children and their supporters, the better their adjustment will be, as assessed by psychiatric diagnoses and behavior symptoms.

Hypothesis 12: The more satisfied children are with the support they receive, the better their adjustment will be, as assessed by psychiatric diagnoses and behavior symptoms.

Hypothesis 13: If social support is a buffer between the stress of having a depressed mother and adjustment, then social support will have more of an effect for the children whose mothers are depressed than those whose mothers are not depressed.

Method

As previously stated, the present study is part of a larger ongoing research project sponsored by the National Institute of Mental Health to examine the rearing practices of affectively ill and control mothers and the adjustment of their offspring. Only those measures and procedures relevant to this particular study will be discussed.

Subjects

Thirty children with a depressed mother and 30 children with a nondepressed mother, living in or near a large east coast city, ranging in age from eight to fifteen, participated in this study. There were two distinct age groups: the younger children were between the ages of eight and eleven; and their older siblings were between the ages of twelve and fifteen.

The sample consisted of mostly middle and upper-middle class, Caucasian, intact families. There was a smaller sample of economically deprived, inner-city, largely single parent Black families. At the outset, the staff at the LDP had planned to have intact families of two distinct social classes: one middle class group and one lower class group. It was found that the majority of lower class families who fit the project criteria for depressed and nondepressed groups were fatherless; therefore the sample criteria were modified to include single mothers and their children.

At the onset of the study eight years ago, the subjects were recruited through notices placed throughout the community, including daycare centers, religious buildings, and women's centers. The notice stated that the Laboratory of Developmental Psychology at the National Institute of Mental Health was looking for mothers with children between the ages of eighteen months and two years with an older sibling between the ages of five and eight to participate in a study examining childrearing practices. A standard psychiatric instrument (Schedule for Schizophrenia and Affective Disorders-Lifetime) ((SADS-L; Endicott & Spitzer, 1979), which made diagnoses according to Research Diagnostic Criteria (RDC) was used to screen parents. Eligibility for the study was based on mother's psychiatric status: to be eligible, mothers in the target group were given a diagnosis of a major depressive disorder, either major or minor depression or bipolar disorder. Mothers in the control group had to be free of current or past psychiatric disorder. Mothers who had schizophrenia, antisocial personality disorder, or substance abuse disorder were excluded from the sample. If the mothers were eligible, the fathers were then interviewed. Families were excluded if fathers were given a diagnosis of schizophrenia or antisocial personality disorder. Fathers in the control group had to be free of current or past psychiatric disorder.

For the present round of data collection, the children families were recontacted and asked to return to the laboratory for additional procedures. Each family member received $10.75 for the first hour of participation and $5.00 for each subsequent hour, based on a standard National Institutes of Health payment scale for normal volunteers (i.e., those who are not receiving any treatment at NIH).

Procedure

Once the families agreed to participate again, an appointment for them to come to the laboratory was scheduled. Each family spent an average of eight hours at the LDP; the procedures relevant to the present study took approximately four hours to complete. Before the initiation of any procedures, all family members read and signed consent forms. The mothers and fathers were interviewed separately, first about themselves and then about their children. The children were interviewed separately about themselves.

The data were collected, scored, and interpreted by trained personnel with either a bachelor's degree in psychology, a master's degree in clinical or developmental psychology, a doctorate in clinical psychology, or a medical degree in psychiatry. All personnel received extensive training in the administration, scoring, and interpretation of all relevant instruments, as well as training on the use of the DSM-III-R manual. The training of all personnel who

interviewed the children was conducted by one person (WH).

Tests and Measurements

The Children's Social Support Questionnaire (CSSQ). The CSSQ (Bogat, Chin, Sabbath, & Schwartz, 1983) is a questionnaire designed to assess the social support networks of children. It was selected because of its ability to conceptualize social support as a multidimensional construct that encompasses both quantitative (e.g., number of supporters) and qualitative (e.g., source of support, satisfaction with support). It consists of 16 items divided into four sections representing four types of social support: companionship; information and advice; tangible aid; and emotional support. For each type of support, there are four questions (i.e., when you go to movies, parties, video arcades, etc., who do you go with?), and subjects were asked to nominate as many as ten people for each question. On the last two pages of the questionnaire, subjects transferred the names of the supporters they had written for the 16 questions. The subjects indicated for each supporter their relationship to the supporter, the frequency of contact with that supporter, who initiates contact, and how satisfied they are with the support they are receiving. For the present study, the CSSQ was completed by all the children.

The validity of the CSSQ has been shown in its ability to discriminate between younger (six to ten years old) and

older (eleven years or older) children. In addition, it has discriminated between depressed and nondepressed children, and children whose parents are undergoing marital difficulties and children whose parents' marriages are stable. (Kriegler, 1987).

The Diagnostic Interview for Children and Adolescents - Revised (DICA-R). The DICA-R is a structured diagnostic interview designed to assess psychiatric symptomatology in children between the ages of six and 18 (Reich, 1988). It is based on the DICA, which was developed mainly for clinical and epidemiological research (Herjanic & Campbell, 1977). The difference between the two instruments is that the DICA was designed to yield DSM-III diagnoses, while the DICA-R was designed to yield DSM-III-R diagnoses. This instrument has been designed to be administered by clinicians as well as lay people having extensive interview-specific training.

The interview takes approximately one hour to complete, and can be administered to both children and parents. It yields information on the presence or absence of 185 symptoms, as well as their onset, duration, severity, and associated impairments (Herjanic & Reich, 1982). The interview is divided according to 18 DSM-III-R categories. One or more questions has been designed to assess each symptom for each disorder. Each diagnostic section has instructions that list the specific DSM-III-R instructions

for arriving at a diagnosis in that section, and each section is then scored based on the specific DSM-III-R criteria for that diagnosis (Reich, 1988; Welner, Reich, Herjanic, Jung, & Amado, 1987). There are three versions of the DICA-R: the DICA-RC, for children between the ages of six and twelve; the DICA-RA, for children between the ages of 13 and 18; and the DICA-RP, for parents. All versions are the same with respect to content areas, order of items, and general wording, although some less sophisticated language may be used in the DICA-RC. The DICA-RP is supplemented by items covering pregnancy, developmental history, and medical history. For the present study, the DICA-R was completed by the children, the mothers, and the fathers. Each informant's diagnostic summary was was used individually, as well as combined (method described below) to yield a single research diagnosis.

The validity of the DICA is supported by its ability to discriminate between matched samples of children referred either to pediatric or psychiatric clinics (Herjanic & Campbell, 1977; Welner, et al., 1987). Inter-interview agreement on diagnoses, using the kappa statistic and based on psychiatrist ratings, has been found to range from .76 for anxiety disorders to 1.00 for attention deficit disorder and conduct disorder (Welner et al., 1987). Interrater reliability ranges average .85 to .89 (Herjanic & Reich, 1982). Parent-child agreement on diagnoses, using the kappa

statistic, ranges from .49 for enuresis to .80 for conduct disorder (Welner et al., 1987). Low parent-child agreement may not necessarily reflect inadequacies on the part of the instrument. Parents may be acute observers, but they do not always have access to their children's feelings. In addition, as children mature, they engage in an increasing number of activities about which their parents do not have accurate information. The most logical way to resolve parent-child discrepancies with regard to diagnosis is to rely more heavily on the children's information concerning internal symptoms - neurotic, somatic, and psychotic symptoms - and to rely more heavily on the parents' information for observable symptoms - relationship problems, school behavior, and academic problems (Herjanic & Campbell, 1977; Reich, personal communication, 1988). For younger children, information from parents should be given more weight overall, while for older children, information from parents should be given less weight (Reich, personal communication, 1988).

For the present study, interviewers administered, scored, and arrived at a final research diagnosis by employing the above outlined methods. When children and their parents were in agreement with regard to diagnosis, the final research diagnosis recorded was simply the diagnosis arrived at by each family member (child, mother, and father). When these three subjects arrived at different

diagnoses, the final research diagnosis was arrived at by determining whether the symptoms of that diagnosis were more internal or observable, as well as by determining the child's age. If the symptoms were internal and the child was older (or appeared mature and insightful), then the child's diagnosis was recorded as the final research diagnosis. If the symptoms were more external and the child was younger, the parents' diagnoses were recorded as the final research diagnosis.

When the interviewers had determined the final research diagnosis for each case, they gave their final form (which included the final research diagnosis along with a short paragraph elaborating on the symptoms of the child and any significant concerns) to the project child psychiatrist. If he had any questions, he consulted with the interviewer, and returned to the raw data if necessary to resolve any discrepancies between himself and the interviewer.

The DICA was chosen because of its demonstrated reliability and validity, its correspondence with the DSM-III-R, it's straightforwardness and relative ease of administration, its ability to be administered by individuals possessing a more basic understanding of clinical issues, and its ability to yield information concerning a wide variety of symptoms and diagnoses.

The Achenbach Child Behavior Checklist (CBCL). The CBCL (Achenbach & Edelbrock, 1981; 1983) is a 138 item self-

administered questionnaire that yields information on children's behavior problems and competencies. The items are broken down into 20 items that assess social competence and 118 items that comprise the behavior problems scale. For the present study, only the behavior problem items were used.

Factor analyses of the responses to the behavior problem items by 2,300 clinic referred children yielded a different set of factors for males and females, as well as for three age groupings (4-5 years, 6-11 years, and 12-16 years). The profiles generated for each grouping consisted of eight or nine factors, depending on age (social withdrawal, depressed, immature, somatic complaints, sex problems, schizoid, aggressive, delinquent, hyperactive, uncommunicative, and obsessive-compulsive). Norms for the factor scales were collected on 1,300 normal children of diverse ethnic and socioeconomic background (Achenbach & Edelbrock, 1983).

Reliability information revealed a one-week test-retest reliability coefficient of .95 and a three-month test-retest coefficients of .84 for behavior problems. Pearson coefficients across factors and age by sex groupings ranged from .61 to .96. Interparent agreement was .985 for behavior problems on a clinical sample of children (Achenbach & Edelbrock, 1983). The CBCL has demonstrated discriminant validity in differentiating clinic referred and

nonreferred children, hyperactive and normal children (Barkley, 1981; Edelbrock & Rancurello, 1985; Mash & Johnston, 1983), children of maritally distressed and nondistressed mothers (Bond & McMahon, 1984), depressed and nondepressed children (Seagull & Weinshank, 1984), and maltreated and control children (Salzinger, Kaplan, Pelcovitz, Samit, & Krieger, 1984). In addition, the CBCL appears useful as a screening measure for psychopathology in a primary-care pediatric setting (Costello & Edelbrock, 1985), as well as way to assess changes in conduct problems after a parent training program on child management (Webster-Stratton, 1985).

For the present study, the CBCL was completed by the mothers. The factor scores were used to evaluate the nature of the differences in psychopathology between the children of depressed and well mothers.

The CBCL was chosen for its reliability and validity, its ability to be quickly self-administered, and its ability to produce information based on behaviors (as opposed to the DICA's reliance more on internal symptoms). Together, the DICA and the CBCL yield a great deal of information on children's internal feelings and perceptions and external behaviors.

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Results

I. Descriptive Analyses

Results for Hypothesis 1 are presented in Table 1. A t-test was performed to determine whether the offspring of depressed mothers reported fewer total supporters than the offspring of nondepressed mothers. There were no significant differences between the two groups for total supporters.

Results for Hypothesis 2 are also presented in Table 1. A series of t-tests were performed to determine whether the offspring of depressed mothers reported fewer emotional, companionship, information and advice, and tangible aid supporters that the offspring of nondepressed mothers. There were no significant differences between the two groups for number of emotional supporters, number of companionship supporters, number of information and advice supporters, or number of tangible aid supporters.

Results for Hypothesis 3A are also presented in Table 1. A t-test was performed to determine whether the offspring of depressed mothers nominated fewer peers as supporters than the offspring of nondepressed mothers. There were no significant differences between the two groups on number of peers nominated as supporters.

Table 1

Mean Number of Supporters for the Offspring of Depressed and Control Mothers.

	Depressed (n=30)		Control (n=30)	
	M	SD	M	SD
Total Supporters	14.07	(3.75)	14.47	(4.02)
Emotional Supporters	7.70	(3.01)	8.67	(4.57)
Companionship Supporters	10.07	(3.56)	9.13	(3.94)
Information/ Advice Supporters	7.13	(3.42)	7.37	(3.18)
Tangible Aid Supporters	5.67	(3.13)	5.87	(2.61)
Peer Supporters	8.83	(4.31)	8.07	(3.70)

Results for Hypothesis 3B are presented in Tables 2A and 2B. An analysis of variance was performed to determine whether the adolescent offspring of nondepressed mothers reported the most peers as supporters, followed by the adolescent offspring of depressed mothers, followed by the younger children of nondepressed and depressed mothers respectively. A two-by-two design was employed, where the column variable represented age (adolescent: age 12-16; child; age 8-11), and the row variable represented mother psychiatric status. The outcome variable was the number of peers reported as supporters. There was a significant main effect for age ($F(1,59)=4.37$, $p<.05$), whereby adolescents

reported more peers as supporters than younger children. There was no main effect for psychiatric status of mother, nor was there a significant interaction effect between age and psychiatric status.

Table 2A

Number of Peer Supporters as a Function of Subject Age for the Offspring of Depressed and Control Mothers.

	M	SD
Children (ages 8-11)		
Total Sample	7.59	3.26
Depressed	7.94	3.72
Control	7.17	2.81
Adolescents (ages 12-16)		
Total Sample	9.72	4.62
Depressed	10.00	4.88
Control	9.42	4.52

Table 2B

Relationship Between Age and Peer Support for the Offspring of Depressed and Control Mothers.

SOURCE OF VARIATION	SUM OF SQUARES	DF	MEAN SQUARE	F
Main Effects	76.36	2	38.18	2.47
AGE	67.54	1	67.54	4.37*
GROUP	7.24	1	7.24	.47
2-Way Interactions				
AGE X GROUP	.13	1	.13	.01
Explained	76.49	3	25.50	1.65
Residual	866.36	56	15.47	
Total	942.85	59	15.98	

* $p \leq .05$

Results for Hypothesis 4A are presented in Table 3. A t-test was performed to determine whether the offspring of depressed mothers reported the same amount of contact with family members as the offspring of nondepressed mothers. There were no differences between the two groups on amount of family contact. A second t-test was performed to determine whether the offspring of depressed mothers reported less contact with non-family members than the offspring of nondepressed mothers. There were no differences between the two groups on amount of non-family contact.

Results for Hypothesis 4B are also presented in Table 3. A t-test was performed to determine whether the offspring of depressed mothers initiated contact with their supporters less frequently than the offspring of nondepressed mothers. No significant differences were found between the two groups on initiation of contact with supporters.

Results for Hypothesis 5 are also presented in Table 3. A t-test was performed to determine whether the offspring of depressed mothers reported less satisfaction with the support they receive than the offspring of nondepressed mothers. No significant differences were found between the two groups on satisfaction with support received.

Table 3

Mean Network Characteristics for the Offspring of Depressed and Control Mothers

	Depressed (n=30)		Control (n=30)	
	M	SD	M	SD
Amount of Family Contact	5.10	(.60)	4.95	(.78)
Amount of Non-Family Contact	5.13	(.59)	4.97	(.77)
Initiation of Supporter Contact	1.97	(.29)	2.03	(.17)
Satisfaction with Support Received	4.26	(.79)	4.38	(.49)

II. Relationships between Social Support and Adjustment

For the following hypotheses, the results for the CBCL are in terms of standardized T scores based on Achenbach's normed sample.

Results for Hypothesis 6 are presented in Tables 4 and 5. Pearson Product Moment Correlation analyses were performed to determine if satisfaction with support received was the element of social support that best predicted adjustment [1]. Correlations between the elements of support and psychiatric diagnoses and behavior problems are presented in Table 4. There were significant negative correlations between satisfaction and Total Externalizing Problems (r=-.22, $p \leq .05$), combined overall DICA diagnoses (r=-.23, $p \leq .05$), and DICA diagnoses based on child report (r=-.30, $p \leq .01$). There was a significant negative

relationship between number of supporters and DICA diagnoses based on mother report (r=-.28, $p \leq .01$). Amount of shared contact was negatively related to Total Externalizing Problems (r=-.26, $p \leq .05$), and DICA diagnoses based on mother report (r=-.29, $p \leq .01$). Type of support was not significantly related to any measure of adjustment.

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Table 4

Correlations Between Elements of Support and Psychological Adjustment (N=60).

	Satisfaction	Number	Frequency	Type	Contact
Total Behavior Problems	-.15	-.16	.20	-.16	-.33**
Total Internalizing Problems	-.09	-.10	.20	-.13	-.32**
Total Externalizing Problems	-.22*	-.20	.19	-.18	-.33**
Diagnoses-Combined Report	-.23*	-.22*	.10	-.04	-.20
Diagnoses-Child Report	-.30**	-.14	.02	-.10	-.04
Diagnoses-Mother Report	-.18	-.28**	.16	.04	-.35**
Diagnoses-Father Report	-.04	-.03	-.04	.05	-.16
Satisfaction		.05	.01	.13	.10

* $p \leq .05$
** $p \leq .01$

In order to test whether satisfaction with support received was the element of support that best predicted adjustment, t-scores which test the difference between the above correlations were computed [2]. These t-scores are presented in Table 5. Satisfaction was not a significantly better predictor for any outcome measure, nor were any other elements of support significantly better predictors of adjustment.

Table 5

T Scores for the Difference Between Elements of Support (N=60).

	Satisfaction vs. Number	Satisfaction vs. Frequency	Satisfaction vs. Type	Satisfaction vs. Contact
Total Behavior Problems	-.03	-.26	.06	.61
Total Internalizing Problems	-.03	-.56	-.23	1.29
Total Externalizing Problems	.07	.15	.19	-.64
Diagnoses-Combined Report	.06	.73	1.12	.15
Diagnoses-Child Report	.90	1.57	1.20	1.45
Diagnoses-Mother Report	-.53	.16	.87	-.99
Diagnoses-Father Report	.03	-.04	-.06	-.68

Results for Hypothesis 7 are presented in Tables 4 and 6. Pearson Product Moment Correlation analyses were performed to determine if there was a significant negative correlation between number of supporters nominated and psychiatric diagnoses and behavior problems. These correlations are presented in the second column of Table 4. There was a significant negative relationship between total number of supporters and combined overall DICA diagnoses (r=-.22, $p \leq .05$) and DICA diagnoses based on mother report (r=-.28, $p \leq .05$).

In order to better understand the particular elements contributing to the significant relationships between number of supporters and Total Externalizing Problems, the above analyses were redone using the separate behavior problem scales. Because these scales are different for boys and girls and for younger and older children, these subsequent analyses were performed for four different samples: girls ages 8-11 (n=19); boys ages 8-11 (n=16); girls ages 12-16 (n=16), and boys ages 12-16 (n=9). These results are presented in Table 6. There were no significant relationships between number of supporters and behavior problems for boys or girls of either age.

Table 6

Correlations Between Total Number of Supporters and Behavior Problem Scales

	Girls 8-11 (n=19)	Boys 8-11 (n=16)	Girls 12-16 (n=16)	Boys 12-16 (n=9)
Scale 1	-.12	-.08	.11	-.06
Scale 2	-.37	-.32	.02	-.02
Scale 3	-.32	-.12	-.12	-.19
Scale 4	-.22	.18	-.02	-.06
Scale 5	-.05	.19	-.08	.24
Scale 6	-.21	-.14	-.37	-.20
Scale 7	-.04	-.14	-.28	-.28
Scale 8	-.17	-.33	-.04	-.23
Scale 9	.03	-.07	*	-.19

* no Scale 9 for girls ages 12-16

Results for Hypothesis 8 are presented in Tables 7 and 8. To determine whether emotional support was the type of support that best predicted adjustment, Pearson Product Moment Correlation analyses were first performed [1]. Correlations between type of support and psychological adjustment are presented in Table 7. There were significant positive relationships between Companionship support and Total Behavior Problems (r=.33, $p \leq$.01), Total Internalizing Problems (r=.32, $p \leq$.01), and Total Externalizing Problems (r=.35, $p \leq$.01). There were no significant relationships between adjustment and Information and Advice support, Emotional support, or Tangible Aid support.

Table 7

Correlations Between Types of Support and Psychological Adjustment (N=60)

	Emotional Support	Information Support	Tangible Aid Support	Companionship Support
Total Behavior Problems	-.16	-.10	.01	.33**
Total Internalizing Problems	-.13	-.04	.01	.32**
Total Externalizing Problems	-.18	-.10	.01	.35**
Diagnoses-Combined Report	-.04	-.11	-.10	.07
Diagnoses-Child Report	-.10	-.05	-.03	.03
Diagnoses-Mother Report	.04	-.16	-.09	.08
Diagnoses-Father Report	.05	-.14	-.11	-.04
Emotional Support		.30**	.24*	-.20#

* $p \leq .05$
** $p \leq .01$

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Then, to directly test whether emotional support was the type of support that best predicted adjustment, difference scores between the above correlations were computed [2]. These difference scores are presented in Table 8. No type of support was a significantly better predictor of psychological adjustment than any other type of support.

Table 8

T Scores for the Difference Between Type of Support (N=60)

	Emotional Support vs. Information Support	Emotional Support vs. Tangible Aid Support	Emotional Support vs. Companionship Support
Total Behavior Problems	.40	1.38	-.87
Total Internalizing Problems	.61	.74	-.95
Total Externalizing Problems	.54	1.11	-.85
Diagnoses-Combined Report	-.45	-.35	-.13
Diagnoses-Child Report	.30	.40	.34
Diagnoses-Mother Report	-.80	-.36	-.20
Diagnoses-Father Report	-.59	-.38	.02

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Results for Hypothesis 9A are presented in Tables 9 and 10. To determine whether parental support was the source of support that best predicted adjustment for younger children, Pearson Product Moment Correlation analyses were first performed [1]. Correlations between source of support and psychological adjustment for younger children are presented in Table 9. There were significant negative correlations between parental support and DICA diagnoses based on child report (r=-.29, $p \leq .05$).

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Table 9

Correlations Between Source of Support and Psychological Adjustment for Younger Children (n=35)

	Parent	Peer	Sibling	Grand-parent	Other Relative	Other Adult
Total Behavior Problems	-.23	-.04	-.24	-.14	-.04	.09
Total Internalizing Problems	-.23	-.01	-.22	-.11	-.06	.18
Total Externalizing Problems	-.21	.02	-.27	-.03	-.08	-.04
Diagnoses-Combined Report	-.07	.13	-.18	-.08	-.11	-.13
Diagnoses-Child Report	-.01	.24	-.29*	.00	-.15	-.19
Diagnoses-Mother Report	-.11	-.11	-.02	-.10	-.08	.02
Diagnoses-Father Report	.13	.21	-.18	.09	.01	-.06
Parent		.00	-.01	.13	-.09	.17

* $p \leq .05$

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Then, difference scores between the above correlations were computed to directly test whether parental support was the source of support that best predicted psychological adjustment for younger children [2]. These difference scores are presented in Table 10. No source of support was a significantly better predictor of adjustment for younger children than parental support.

Table 10

T Scores for the Difference Between Source of Support for Younger Children (n=35)

	Parent vs. Peer	Parent vs. Sibling	Parent vs. Grand-parent	Parent vs. Other Relative	Parent vs. Other Adult
Total Behavior Problems	.72	-.04	.38	.76	.60
Total Internalizing Problems	.84	.07	.49	.70	.21
Total Externalizing Problems	.69	-.26	.70	.49	.70
Diagnoses-Combined Report	-.24	-.44	-.04	-.16	-.24
Diagnoses-Child Report	-.85	-1.07	.04	-.54	-.71
Diagnoses-Mother Report	.12	.34	.06	.11	.40
Diagnoses-Father Report	-.31	-.19	.15	.45	.29

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Results for Hypothesis 9B are presented in Tables 11 and 12. To determine whether peer support was the source of support that best predicted adjustment in older children, Pearson Product Moment Correlation analyses were first performed [1]. These correlations are presented in Table 11. Support from peers, parents, grandparents, and other relatives were not significantly related to any outcome measure. There were significant negative relationships between support from siblings and Total Behavior Problems ($r=-.49$, $p\leq.01$), Total Internalizing Problems ($r=-.34$, $p\leq.05$), and Total Externalizing Problems ($r=-.61$, $p\leq.001$). Support from other adults was significantly correlated with Total Internalizing Problems ($r=-.43$, $p\leq.05$).

Table 11

Correlations Between Source of Support and Psychological Adjustment for Older Children (n=25)

	Peer	Parent	Sibling	Grand-parent	Other Relative	Other Adult
Total Behavior Problems	.10	-.06	-.49**	-.19	.06	-.32
Total Internalizing Problems	.14	.01	-.34*	-.12	-.16	-.43*
Total Externalizing Problems	-.04	-.10	-.61***	-.15	.16	-.13
Diagnoses-Combined Report	-.22	-.06	-.25	-.23	-.01	.05
Diagnoses-Child Report	-.12	-.15	-.29	-.19	.01	.16
Diagnoses-Mother Report	-.20	.08	-.27	-.21	-.03	-.14
Diagnoses-Father Report	-.06	.13	-.11	-.15	-.14	.03
Peer		.17	-.19	-.06	-.33*	.02

* $p \leq .05$
** $p \leq .01$
*** $p \leq .001$

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Difference scores between the above correlations were then computed in order to determine whether support from peers was the source of support that best predicted adjustment for older children [2]. These difference scores are presented in Table 12. Support from siblings was a significantly better predictor of Total Externalizing Problems than support from peers (t=-2.67, $p \leq .01$). There were no other significant difference scores.

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Table 12

T Scores for the Difference Between Source of Support for Older Children (n=25)

	Peer vs. Parent	Peer vs. Sibling	Peer vs. Grand-parent	Peer vs. Other Relative	Peer vs. Other Adult
Total Behavior Problems	.17	-1.64	.39	.15	-1.04
Total Internalizing Problems	.49	-.79	.11	-.06	1.42
Total Externalizing Problems	-.21	-2.67**	-.46	-.40	-.43
Diagnoses-Combined Report	.61	-.12	-.07	.71	.76
Diagnoses-Child Report	-.10	-.64	-.29	.39	-.19
Diagnoses-Mother Report	.45	-.27	-.05	.58	.27
Diagnoses-Father Report	-.26	-.20	-.42	-.29	.11

** $p \leq .01$

13.

Results for Hypothesis 10 are presented in Tables 4 and 13. Pearson Product Moment Correlation analyses were performed to determine if there was a significant negative correlation between frequency of contact with supporters and number of psychiatric diagnoses and behavior problems. Correlations between frequency of contact and adjustment are presented in the third column of Table 4. There were no significant correlations between frequency of contact with supporters and behavior problems or DICA diagnoses.

In order to better understand the specific elements contributing to the above significant relationships, the analyses were redone using the separate behavior problem scales. These analyses are presented in Table 13. There were no significant relationships between frequency of contact and behavior problems scales for children of either age or sex.

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Table 13

Correlations Between Frequency of Contact with Supporters and Behavior Problem Scales

	Girls 8-11 (n=19)	Boys 8-11 (n=16)	Girls 12-16 (n=16)	Boys 12-16 (n=9)
Scale 1	.07	.32	-.21	.12
Scale 2	.06	.33	.07	.16
Scale 3	.15	.13	.05	.14
Scale 4	.12	-.05	.05	.10
Scale 5	.07	.18	.39	-.39
Scale 6	-.08	.16	.11	.13
Scale 7	-.08	.04	.23	-.15
Scale 8	.18	.29	.26	.04
Scale 9	.20	.16	[a]	-.23

[a] no Scale 9 for girls ages 12-16

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Results for Hypothesis 11 are presented in Tables 4 and 14. Pearson Product Moment Correlation analyses were performed to determine if there was a significant negative relationship between the amount of shared contact between subjects and supporters and number of psychiatric diagnoses and behavior problems. These correlations are presented in the last column of Table 4. There were significant negative relationships between amount of shared contact and Total Behavior Problems (r=-.34, $p\leq$.01), Total Internalizing Problems (r=-.32, $p\leq$.05), Total Externalizing Problems (r=-.33, $p\leq$.01), and DICA diagnoses based on mother report (r=-.35, $p\leq$.01).

Again, the above analyses were redone using the separate behavior problem scales to determine the unique contributions to the above significant findings. These correlations are presented in Table 14. For girls ages 8-11, there were significant negative relationships between amount of shared contact and Scale 1-Depressed (r=-.42, $p\leq$.05), Scale 2-Social Withdrawal (r=-.39, $p\leq$.05), Scale 4-Schizoid-Obsessive (r=.39,$p\leq$.05), Scale 5-Hyperactive (r=-.41, $p\leq$.05) and Scale 6-Sex Problems (r=-.55, $p\leq$.01). For boys ages 8-11, significant negative correlations were found between amount of shared contact and Scale 2-Depressed (r=-.45, $p\leq$.05), Scale 5-Somatic Complaints (r=-.55, $p\leq$.01), Scale 7-Hyperactive (r=-.47, $p\leq$.05), Scale 8-Aggressive (r=-.58, $p\leq$.01), and Scale 9-Delinquent (r=-.60, $p\leq$.001).

For girls ages 12-16, there were significant negative correlations between amount of shared contact and Scale 1-Anxious Obsessive (r=-.57, $p \leq .01$), Scale 2-Somatic Complaints (r=-.53, $p \leq .05$), Scale 3-Schizoid (r=-.46, $p \leq .05$), Scale 5-Immature-Hyperactive (r=-.48, $p \leq .05$), Scale 6-Delinquent (r=-.63, $p \leq .01$), Scale 7-Aggressive (r=-.66, $p \leq .01$), and Scale 8-Cruel (r=-.61, $p \leq .01$). There were no significant relationships between amount of shared contact and adjustment for boys ages 12-16.

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Table 14

Correlations Between Initiation of Contact with Supporters and Behavior Problem Scales

	Girls 8-11 (n=19)	Boys 8-11 (n=16)	Girls 12-16 (n=16)	Boys 12-16 (n=9)
Scale 1	-.42*	-.30	-.57**	.05
Scale 2	-.39*	-.45*	-.53**	-.24
Scale 3	-.17	-.37	-.46*	-.01
Scale 4	-.39*	.01	-.42	.11
Scale 5	-.41*	-.55**	-.48*	.16
Scale 6	-.55**	-.08	-.63**	.13
Scale 7	-.32	-.47*	-.66**	.19
Scale 8	-.24	-.58**	-.61**	.09
Scale 9	-.06	-.60**	▲	.15

▲ no Scale 9 for girls ages 12-16
* $p \leq .05$
** $p \leq .01$

Results for Hypothesis 12 are presented in Tables 4 and 15. Pearson Produce Moment Correlation analyses were performed to determine if there was a negative relationship between satisfaction with support received and psychiatric diagnoses and behavior problems. Correlations between satisfaction and adjustment are presented in the first column of Table 4. There were significant negative correlations between total satisfaction and Total Externalizing Problems (r=-.22, $p \leq .05$), overall combined DICA diagnoses (r=-.23, $p \leq .05$), and DICA diagnoses from child report (r=-.30, $p \leq .01$).

Again, in order to better understand the unique elements contributing to the above relationships, the analyses were redone using the separate behavior problem scales. The results from these analyses are presented in Table 15. There were no significant relationships between satisfaction with support and adjustment for girls ages 8-11. For boys ages 8-11, there were significant negative relationships between satisfaction and Scale 5-Somatic (r=-.53, $p \leq .05$), Scale 7-Hyperactive (r=-.57, $p \leq .01$), and Scale 9-Delinquent (r=-.50, $p \leq .05$). For girls ages 12-16, there were significant negative relationships between satisfaction and Scale 3-Schizoid (r=-.73, p=.001), Scale 4-Depressed Withdrawal (r=-.42, p=.05), Scale 5-Immature-Hyperactive (r=-.76, $p \leq .001$), Scale 6-Delinquent (r=-.64, p<.01), Scale 7-Aggressive (r=-.54, p=.01), and Scale 8-Cruel (r=-.48,

$p<.05$). There were no significant relationships between satisfaction and adjustment for boys ages 12-16.

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Table 15

Correlations Between Satisfaction with Support Received and Behavior Problem Scales

	Girls 8-11 (n=19)	Boys 8-11 (n=16)	Girls 12-16 (n=16)	Boys 12-16 (n=9)
Scale 1	-.07	.17	.02	.17
Scale 2	-.21	.06	-.08	.09
Scale 3	.11	-.16	-.73***	.19
Scale 4	.07	-.41	-.42*	.16
Scale 5	.01	-.53*	-.76***	-.29
Scale 6	-.15	-.09	-.64**	.31
Scale 7	.26	-.57**	-.54*	-.14
Scale 8	.00	-.25	-.48*	.13
Scale 9	.22	-.50*	^	-.06

^ no Scale 9 for girls ages 12-16
* $p \leq .05$
** $p \leq .01$
*** $p \leq .001$

Results for Hypothesis 13 are presented in Table 16. Mutiple regression analyses were performed to determine if social support acts as a buffer between the stress of being cared for by a depressed mother and psychological adjustment. If social support is a buffer, then it should have more of an effect for the children of depressed mothers than for the children of well mothers. In other words, the level of adjustment (degree of symptomatology) should be the same for the children of depressed and control mothers under conditions of high support. However, under conditions of low support, the children of depressed mothers should exhibit more symptomatology (i.e., have poorer adjustment) than the children of nondepressed mothers.

For the present analyses, adjustment was assessed by examining separately the outcome measures from the DICA and the CBCL. Social support was assessed by adding together each child's values for various elements of support, yielding a Total Support score. Mother diagnosis was entered in the first block of the regression equation, Total support was entered in the second block, and the interaction between these two variables was entered on the third block. If the addition of the interaction term significantly increases the amount of variance accounted for (i.e., the R^2 change), then the buffering hypothesis is supported. The relationships between stress, Total Support, and adjustment are presented in Table 16.

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Table 16

The Multiple Regression Contributions of the Relationships Between Maternal Diagnosis and Total Support to the Prediction of Different Adjustment Measures.

Adjustment Measure	R^2 Change Maternal Dx.	R^2 Change Tot. Support	R^2 Change Interaction
Total Behavior Problems	.24***	.10**	.00
Total Internalizing Problems	.35***	.04	.00
Total Externalizing Problems	.15**	.13**	.00
Diagnoses-Combined Report	.06	.02	.00
Diagnoses-Child Report	.01	.01	.01
Diagnoses-Mother Report	.19***	.02	.01
Diagnoses-Father Report	.04	.00	.00

** $p<.01$
*** $p<.001$

Post-Hoc Analyses. Results from earlier analyses indicated that only certain elements of social support were related to specific adjustment measures. Based on these findings, it was thought that social support may be better understood as a multidimensional rather than a unitary construct. Therefore, Hypothesis 13 was reanalysed, using separate elements of social support rather than a Total Support Score. Mutiple regression analyses were performed to determine if total number of supporters, satisfaction with support, amount of emotional support, frequency of contact with supporters, or amount of shared contact with supporters act as a buffer between the stress of being cared for by a depressed mother and psychological adjustment. There were no significant interactions between stress and support element for any of the adjustment measures; therefore, the buffering hypothesis was not supported.

Discussion

The purpose of the present study was two-fold. The first goal was to delineate the social network characteristics of the offspring of depressed mothers, and compare these characteristics to those of the offspring of well mothers. It was predicted that the social support networks of children whose mothers were depressed would be smaller in overall number and more restricted in composition than the networks of children whose mothers were not depressed. These differences would reflect the disordered social relationships that appear to be characteristic of children living with a depressed mother.

The second goal of this study was to determine the nature of the relationships between children's social support networks and their psychological adjustment. It was predicted that the elements of support would be inversely related to measures of childhood psychological functioning. It was also predicted that particular elements of social support would be more strongly related to adjustment than other elements. The existence of these relationships would lend support to the findings of other researchers indicating psychological disturbance in the offspring of mothers with depression, as well as begin to understand the contributing factors to this disturbance.

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Descriptive Network Characteristics

The findings from the present study indicate that there is considerable variation in the social support networks of children of both depressed and nondepressed mothers. The variation exists in terms of how many supporters they report in their networks, what types of supporters they report, the different sources of support they describe, how often they are in contact with their supporters, the frequency with which they initiate contact with their supporters, and how satisfied they are with the support they receive. It is striking, however, that there were no significant differences between children of depressed and nondepressed mothers on any of the above elements of support. From the descriptive analyses, the only significant finding was that older children had more peers in their networks than younger children, regardless of maternal diagnosis. This finding is in keeping with much past research (e.g., Kriegler, 1987) which also found that as children approach and move through adolescence, they rely increasingly on peers for support.

If the absence of significant differences between the children of depressed and nondepressed mothers can be taken at face value, then it is in direct conflict with much of the literature on the offspring of depressed mothers. The literature indicates that children who are raised by a depressed mother are more socially withdrawn (e.g., Welner et al., 1977), and have particular difficulty with

interpersonal relationships (e.g., Billings & Moos, 1983; Weissman et al., 1984). If social support is an indicator of how well a child is functioning in his/her social world, then on the basis of this study, the children of depressed mothers appear to be functioning socially on the same level as children whose mothers are not depressed. However, the literature on the offspring of depressed mothers has focused largely on the adjustment of infants and toddlers. The result of this focus is that there is little data on the adjustment of these children as they grow older. It is possible that the children of depressed mothers lag behind as toddlers, but then "catch up" socially to the children of well mothers. It is also important to take into account the methodological shortcomings of the above cited research. It is possible that their results cannot be taken at face value.

It is possible that methodological issues could account for the discrepancies between this study and previous studies. One such issue involves the use of a self-report format to assess social support. While such questionnaires are widely used in the study of both children and adult's social support networks, there are problems with this technique. Because such a questionnaire is subjective rather than objective in nature, it is difficult to ascertain the intent and motivations of the person completing it. On the CSSQ, a child could be actively

lying, in order to create a favorable impression, or to portray his/her social world based on how (s)he wishes her network to be, rather than how his/her network really is. In addition, children often have difficulty understanding and/or expressing their feelings. Younger children especially may not possess the necessary awareness or understanding of the complex nature of their social environment to complete the questionnaire in a way that accurately reflects their social network. It is also possible that the children of depressed mothers and the children of well mothers have different expectations of what constitutes supportive behavior. The children of depressed mothers may come from such socially impoverished environments that what seems very supportive to them may appear minimally supportive to children of well mothers. Such differing expectations are obscured by the use of a self-report instrument such as the CSSQ.

Conversely, there are also advantages to using self-report measures. Other individuals, such as parents, are influenced by the same demand characteristics as their children, and may respond based on their own individual motivations. In addition, adults do not always possess a sophisticated understanding of their own feelings, let alone their children's feelings. Further, parents may simply not possess the knowledge to adequately rate the quality of their children's interactions, many of which occur away from

home and from their direct observation. Therefore, children may, in fact, be as good if not better reporters of their experience of social support as their parents.

Based on the above discussion, future research should seek to augment and clarify information on network characteristics acquired from one only source of data. In addition to children's (or parents') reports of their networks, data from naturalistic observation, from peer reports, and/or from teacher ratings would help set to rest the questions that arise from relying solely on one source of data. In addition, questionnaires focusing on supportive behaviors rather than on network characteristics may more accurately reflect the hypothesized differences between these two groups of children.

Another potential methodological complication involves the demand characteristics of the laboratory setting. The naturalistic "apartment" was designed to put families at ease, so that they would behave as they would in their own homes. However, they were aware that their behavior was being monitored. It is difficult to determine the degree to which individuals' responses were reflective of their feeling "at home", perhaps more able to admit to negative aspects of themselves, or feeling as if they needed to portray themselves as "normal". In addition, the liaison between the project and the families was a woman with whom these families maintained a relationship, albeit

intermittent, over many years. Again, family members may have felt close enough to her to more freely admit to difficulties, or conversely may have felt the need to hide problems from her for fear of disappointing her. While one can rarely remove all such demand characteristics from a setting, it is important to be aware that they do exist and serve as possible sources of influence.

Relationships Between Social Support and Adjustment

Overall, two types of analyses were performed to examine the nature of the relationships between children's social support and their psychological adjustment. Correlational analyses were performed to determine whether such relationships existed. Then difference scores between correlations were computed to determine whether some elements of support were stronger predictors of adjustment than other elements.

Correlational Analyses

As predicted, significant relationships were found between many elements of social support and many measures of adjustment. These relationships were largely inverse in nature, in that the more of each support element a child reported, the fewer psychological problems were reported for that child. However, not every element of support was related to a measure of adjustment, and different elements were related to different indicators of adjustment. First, it appears that the more people a child considers to

be in his/her support network, the less likely it is that (s)he will exhibit psychological disturbance. It is possible that the more supporters children have, the greater variety of information and viewpoints to which they can be exposed. Such exposure can broaden children's knowledge base and endow them with a greater understanding of the diversity of human experiences.

However, it appears that "too much of a good thing" can be harmful. Contrary to predictions, the more frequently children were in contact with their supporters, the more psychological problems they had. This finding could be explained by the as yet largely unexplored influence of negative social support. Previous research has generally neglected to consider that support may impede, rather than foster, adjustment (Cauce, Felner, & Primavera, 1982). Findings from the present study indicate that distinct elements of social support may have different kinds of relationships with children's psychological health.

The differential nature of the relationships between positive and negative social support and adjustment may also explain the finding that the more companionship supporters children reported, the poorer their adjustment was. While not predicted, this finding is not surprising. Peer pressure and the desire to conform is of increasing developmental importance during late childhood and early adolescence. The more children spend time with peers, the

more they will be persuaded to test limits and engage in undesirable behaviors; so while they feel competent and supported socially, their adjustment suffers. The present study did not examine the relationships between proportion of peers in a network, companionship support, and psychological adjustment; this may prove a worthwhile area for future research.

For emotional support, in contrast, higher levels of support were associated with lower levels of psychological disturbance. Therefore, specific types of support appear to have different relationships with children's adjustment. These findings underscore the importance of examining social support, not as a unitary phenomenon, but as a multidimensional construct.

As different types of support are associated with various levels of psychological adjustment, so too are different sources of support. As predicted, the younger and older children in this sample differed with regard to relationships between source of support and adjustment. However, the actual differences obtained were not those predicted. For younger children, the more support they received from parents, siblings, and peers, the less psychological disturbance they exhibited. For older children, the more support they had from siblings and other adults, the better their adjustment. The relationship between parental support and adjustment for younger children

was as predicted, and is in agreement with previous research findings (e.g., Kriegler, 1987) indicating the importance of parental support for younger children. The strong relationships between adjustment and sibling support for both groups of children were not predicted. Siblings can be considered either family support or peer support depending on the needs of a particular individual. Prior research noting the significance of family resources for children (e.g., Walker & Greene, 1987) does not distinguish between types of family support (i.e., parental versus sibling support). Therefore, for younger children, support from siblings may be as important a resource, if not more important, as parental support.

For older children, there is controversy in the literature over the relative importance of family versus peer support. Some researchers have stated that the importance of family support does not necessarily decline as children approach adolescence (e.g., Walker & Greene, 1987). Consistent with this line of research, siblings are simply an extension of family support, as with younger children. Other researchers have found that peers have been shown to be increasingly more important than parents as support sources (e.g., Kriegler, 1987). Based on this research, siblings can be thought of as "in-house" peers. Future research is needed to clarify the relationships for children between different sources of support and adjustment, as well

as to further define these differing sources for older and younger children.

Social support appears to be a "two-way street". As it is important for children to maintain contact with their supporters, it also appears important for supporters to maintain contact with children. The present study found that the more mutual the initiation of contact with supporters was, the better children's psychological adjustment. This is consistent with research that found that psychologically impaired individuals often receive more support than they give (Leavy, 1983). For psychological health, it seems that children need to give as much as they receive in relationships.

Further, satisfaction with support was also inversely related to children's adjustment, in that the more satisfied children were with the support they were receiving, the fewer psychological problems were reported for them. This finding is consistent with much of the literature on children's social support networks and adjustment (e.g., Barrera, 1981; Unger & Wandersman, 1988) that finds a strong association between satisfaction with support and several measures of psychological well-being. It is clear then, that children's subjective appraisal of their support is a crucial factor in their psychological adjustment.

Finally, consideration must be given to the possibility that good psychological health provides children with the

skills necessary to seek out and establish supportive relationships, rather than supportive relationships providing the basis for good mental health. Because much of the present research is correlational in nature, the direction of the association between support and adjustment cannot presently be ascertained. Future research should seek to clarify the mechanisms of influence that account for the relationship between social support and psychological health.

Outcome Measures

Results from the present study indicated that social support was associated with only some measures of psychological adjustment, and different elements of support were related to different outcome measures. The outcome measure most often related to elements of support was Total Externalizing Behaviors. DICA diagnoses based on mother report, Total Internalizing Behavior Problems, and DICA diagnoses based on child report were next most likely to be associated with support elements. DICA diagnoses based on father report were not correlated with any element of social support.

It appears that, to some extent, how much an outcome measure was related to support depended on who reported on children's diagnoses and behavior problems. The lack of association between fathers' reports and support could indicate that fathers are less "tuned in" to the

psychological worlds of their children. This explanation is consistent with the still present societal view that fathers concern themselves less with the emotional lives of their children than mothers. On the other hand, there were strong associations between CBCL Internalizing and Externalizing Behavior Problems, and DICA diagnoses, both reported by mothers, and all elements of social support. Depressed and well mothers appear more aware of their children's psychological health and their interpersonal relationships than fathers. Based on these results, it seems as if mothers and fathers may have different roles in their children's lives regardless of maternal psychiatric status, with mothers maintaining closer proximity to their children's social, behavioral, and emotional development.

Sex and Age Differences

In order to better understand the nature of the correlations between social support and behavior problems, analyses were performed to examine the relationships between support and the individual behavior problem scales. There were sex as well as age differences present. For girls ages 8-11, social support was correlated with social withdrawal, somatic complaints, hyperactivity, and sex problems. These findings are consistent with research indicating that women place greater value in maintaining close interpersonal relationships characterized by emotional sharing than men (Brehm, 1985), and that the importance of relationships is

closely related to their psychological functioning. However, the symptoms associated with social support are on the mild to moderate side of both the internalizing and the externalizing continua. It seems that social support is associated with less serious psychological problems for younger girls.

Upon examination of the relationships between social support and psychological adjustment for adolescent girls, the picture is somewhat different. Social support was correlated with more problems, as well as more serious problems, including depressed-withdrawal, anxious-obsessive, immature-hyperactive, aggressive, delinquent, cruel, and schizoid. As with younger girls, these problems represent both internalizing and externalizing disorders; however, the problems reported for adolescent girls appear to reflect a greater degree of pathology. The results from the present study support the existence of a stronger relationship for older girls between social support and psychological disturbance than for younger girls.

It is also possible that there may be a developmental component influencing the relationship between social support and levels of psychological problems for girls. It may be that lower levels of social support when girls are latency aged is associated with a mild to moderate degree of psychological symptomatology. As girls move into and through adolescence, social support may be a more crucial

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determinant of psychological health than for the younger girls, such that lower levels of support are associated with more serious psychopathology. It may be that the more years girls live with lower levels of social support, the worse their psychological health becomes. In order to clarify the nature of the relationship between social support and adjustment for girls, longitudinal research must be conducted to determine the patterns of social support and mental health over time for girls at different ages.

For boys ages 8-11, social support was correlated with more externalizing disorders, such as uncommunicative, aggressive, hyperactive, and delinquent. Support was related to two internalizing symptoms, obsessive compulsive and somatic complaints. Thus, while social support seems to be somewhat more strongly related to psychological symptomatology for younger boys than for younger girls, the types of symptoms exhibited by boys and girls appear to be different. However, this is consistent with findings that girls tend to exhibit more internalizing symptoms, and boys exhibit more externalizing symptoms.

For boys ages 12-16, there were no correlations between social support and any of the behavior problem scales. Other researchers have found associations for adolescent boys between social support and some measures of adjustment, such as self-concept (e.g., Cauce, Felner, & Primavera, 1982). However, it has not yet been clearly established

that social support is an important contributing factor to their levels of psychiatric diagnoses or behavior problems. It may be the case that social support is not as important to adolescent boys' psychiatric symptomatology as other factors, such as genetic predisposition. Developmentally, the role of social support appears to decrease for boys as they approach and move through adolescence.

Thus, it appears that social support may be differentially related to psychological symptomatology as a function of children's age and sex. While some researchers have found that the relationships between social support and total number of psychological symptoms did not differ for boys and girls (e.g., Compas et al., 1986b), there has been little investigation of whether differences exist for the types of symptoms reported for boys and girls. However, these results must be interpreted with caution. The small number of children in each group limits the generalizability of the findings. Further, these age and sex groupings were established based on the results of factor analyzing the CBCL. It may be the case that such groupings are not meaningful for understanding either DICA diagnoses or social support. Future research should continue to examine social support from a developmental perspective, as well as to establish whether differences exist for boys and girls.

Prediction of Adjustment

Beyond establishing that relationships existed between social support and psychological symptomatology, a goal of this study was to determine whether particular elements of support predicted adjustment better than other elements. Satisfaction with support, as hypothesized, was a better predictor of DICA diagnoses based on child report than frequency of contact with supporters, source of support, type of support, and initiation of contact with supporters. However, satisfaction was not a better predictor of any particular measure of adjustment. Further, no other element of social support was a stronger predictor of adjustment. In addition, support from siblings was a significantly better predictor for older children of Total Externalizing Problems than support from peers. However, sibling support was not more strongly predictive than other support sources of the remaining measures of adjustment, nor were any other support sources more predictive of the various measures of adjustment.

To summarize, the results from the present study indicate that certain elements of social support are significantly related to specific aspects of children's psychological adjustment. In addition, the strength of the relationship between support and adjustment changes as a function of children's age and sex.

The Buffer Hypothesis

The majority of significant findings to this point lend support to the direct effect model of social support, in that the more support children have had, the better their adjustment has been (i.e., the fewer psychiatric symptoms they exhibit). One hypothesis was designed to test the buffer hypothesis, to see if social support moderates the relationship between the stress of being cared for by a depressed mother and positive psychological functioning. The present study did not find support for the buffer hypothesis. This lack of results is not surprising, as the evidence in the literature in favor of the buffer hypothesis is inconsistent at best.

One explanation for the lack of support for the buffer hypothesis is that, for some adjustment measures, there was no relationship between the stress of being raised by a depressed mother and psychological adjustment. Specifically, for DICA diagnoses from child report, father report, and combined report, stress did not significantly predict level of symptomatology. Without a relationship between stress and adjustment, the buffer hypothesis cannot be tested.

However, relationships were found between stress and adjustment for the other adjustment measures, without demonstrating support for the buffer hypothesis. Another explanation for this failure to find evidence for the buffer

hypothesis is that perhaps examining social support as a unitary phenomenon was not the proper level of analyses. Based on results discussed earlier, the present study found that only certain elements of support were related to adjustment. However, analyzing the elements of social support individually did not yield results in favor of the buffering hypothesis.

A different explanation for the nonsignificant findings focuses on the way in which social support was conceptualized in this study. Several researchers (Cohen, Mermelstein, Kamarck, & Hoberman, 1985; Kessler & McLeod, 1985; Procidano & Heller, 1983; Wethington & Kessler, 1986) have concluded that social support shows a more consistent stress-buffering effect when the perception of available support, rather than the support actually received, is highlighted. The present study focused on received support rather than perceived support, what children reported they actually acquired in the way of tangible support rather than what they hoped or expected to acquire. Future research should continue to investigate the stress-buffering role of social support by focusing on children's perceptions of the availability of support.

Methodological Issues

There are several methodological issues inherent in the present study that may have influenced the outcome of the findings. First, the difficulties inherent in interpreting

a self-report measure such as the CSSQ have already been addressed. Problems also exist with the two outcome measures used. The CBCL is a highly respected and widely used assessment of childhood psychopathology. One of its strengths is that it has been statistically derived; however, this is also one of its weaknesses. While the items chosen for each factor make sense statistically, they often do not make sense intuitively. For example, the factor Sex Problems for girls ages 6-11 consists of 'sex preoccupation', 'sex problems', and 'plays with sex parts too much', as well as 'prefers older children', 'feels guilty', and 'excess talk'. Although items for other factors, such as Delinquent, make more intuitive sense, there is variability among the different factors as to how well the individual items actually "fit" the factor under which they were statistically placed. Further, the same item may load on different factors depending on the age and sex of the child. For example, the item 'suicidal talk' loads on the Depressed factor for boys ages 6-11, but loads on the Schizoid-Obsessive factor for girls ages 6-11. Therefore, interpretations based on these factors, often to plan intervention strategies, can be risky, because the name of the factor does not necessarily represent the types of problems implied by that name, and represent the same thing for all children.

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The DICA was chosen to help offset some of the problems intrinsic in the CBCL. It was thought that having both measures would allow for information from several sources, as well as possess different psychometric properties. The DICA, like the CBCL, is a widely used measure of childhood symptomatology and diagnoses. The various diagnostic categories are clinically, rather than statistically, derived. However, the DSM-III-R, the diagnostic system upon which the DICA is based, was established to understand adult mental illness. Similarly, the DICA is based on a questionnaire developed to assess adult psychiatric symptomatology. However, it has not yet been established whether psychopathology in childhood mimics psychopathology in adulthood. Questions therefore can be raised about the validity of the DICA for assessing childhood emotional disorders. It is possible that because the DICA is based on an adult classification of psychological symptoms, it is not a true measure of psychological problems in children.

Further, there is considerable debate as to whether the DSM classification system is the most meaningful way to understand and quantify mental illness. Diagnostic categories often overlap and share symptoms, and a particular symptom can be present in a number of syndromes. For example, depression is an important component in several diagnoses, and can range from the more mild Adjustment Disorder with Depressed Mood to the more severe

Schizoaffective Disorder. In addition, the DSM system is culturally-based, and its method of classifying behavior may not be relevant to populations whose cultures are divergent from here in the industrialized west. Future investigation should seek to better understand and describe the unique aspects of individuals with psychiatric disorders rather than attempt to fit them into neat diagnostic packages.

In addition to problems with the instruments used to assess childhood functioning, there are problems with the actual sample assessed. First, the sample consisted largely of middle and upper-middle class, intact families, and thus is clearly not representative of the population at large. There was one black, low SES family in the depressed group, while none of the families in the control group were of the same SES; given the small sample size, the inclusion of this family could represent a source of bias. In addition, the number of subjects used is too small to ensure both reliability and validity of the findings obtained. Further, in order to meet inclusion criteria, the depressed mothers had to be non-hospitalized, as well as be free of antisocial personality disorder or drug abuse at the time of entrance into the study. This profile of maternal depression may not be representative of the population at large. Similarly, the normal volunteers had to be free of any psychopathology. It is not clear that the 'normal' population is pathology-free. Thus, the findings obtained

for the present sample may not be generalizable to the larger population.

Finally, problems exist with the design of the present study. The analyses that sought to establish a relationship between social support and psychological adjustment were correlational in nature. Therefore, the directionality of the relationship cannot be verified, nor can causation be determined. The causal links between support and psychopathology cannot be ascertained. Future research must establish whether social support is a leading influence in children's mental health, or whether other mechanisms are responsible for the link between support and adjustment.

In addition, due to the large number of hypotheses examined, many analyses were performed. According to the Bonferroni principle, it is possible that some of the significant findings were obtained based on the number of analyses performed rather than on the actual data. In the present study, 421 separate analyses were performed, and 53 of those analyses reached significance at the .05 level of significance or better. Given the number of analyses, it is likely that a proportion of the findings significant at the .05 level are spurious, and should be interpreted with caution.

Further, the present study used a cross-sectional design. Again, the causal connections between maternal depression, social support, and psychological adjustment

cannot be clearly understood. Studies employing a longitudinal scheme must be undertaken in order to determine whether the relationships between maternal diagnostic status, social support and psychological symptomatology are different for children at different points in their development.

Conclusions

The present study sought to examine and clarify the role that social support plays in maintaining healthy psychological functioning in the children of depressed and well mothers. The first striking result was that no differences appeared between the children of depressed and well mothers on any element of support. If the findings from past studies which document deficiencies in the social and emotional worlds of the offspring of depressed mothers are correct, then it may be possible that the children themselves do not perceive that they are receiving any less support than the children of nondepressed mothers. They may believe that the amount and quality of support they receive is "as good as it gets".

However, when the two groups of children were combined, the findings provided evidence in favor of a direct effect model of social support, whereby the more support children had, the better their adjustment was. The more supporters in children's networks, the more mutual the support was, and the more satisfied children were with the support they received, the less psychological disturbance they had. Further, emotional support was more strongly related to positive mental health than either tangible aid or information and advice support. Support from siblings was the source of support most strongly related to positive

adjustment, even above support from parents and peers. It is clear, then, that the different elements of social support do not appear to be of equal importance in the maintenance of children's psychological health.

Further, the presence of social support was not always associated with fewer symptoms, and the role of social support was not consistent for subgroups of the sample. The more often children were in contact with their supporters, and the more companionship support they had, the poorer their adjustment was. In addition, the strength of the relationships between social support and adjustment varied according to children's age and sex. There was no relationship between any element of support and adjustment for adolescent boys, while associations were found between support and mild to moderate psychological distress for both younger girls and boys, and stronger relationships existed between support and moderate to severe psychological disturbance for adolescent girls.

Finally, the failure to consistently find an element of support that more strongly predicted children's adjustment than any other element was unexpected. It may be the case that, for children, having different types of support available rather than relying only on one type fosters the best psychological adjustment. The finding that only certain elements of social support were predictive of adjustment also suggests the possibility of another variable

or variables that serve to influence the support-adjustment relationship in this sample of children.

The findings from the present study have implications for intervention and prevention with children who are deemed to be at risk for developing psychological disturbance. Increasing family support, especially sibling support, would seem to be of particular importance. For example, family therapy could work on strengthening sibling alliances as a means of reversing current symptoms or warding off future symptoms. Group work with sets of siblings using a peer counseling model could facilitate the development of social skills and mutual understanding as well as fortify sibling bonds. Whatever the method, the emphasis would be on strengthening supportive relationships to foster children's healthy psychological adjustment.

It is also clear from the present study that what constitutes problematic adjustment and what works to foster positive adjustment may be dependent on children's age and sex. Intervention strategies must be tailored both to the specific problems children are experiencing (or are at risk for experiencing) and to their particular stage of development. Future research should continue to explore which elements of support are related to which types of psychological disturbance, as well as ascertain the existence of variables which are responsible for the support-adjustment link in children.

It is clear, then, that social support continues to be best understood as a complex construct whose impact on children's emotional health must be evaluated as a function of the nature of the support being provided as well as the characteristics of the person who receives that support. Methodological issues, such as generalizability of the present sample and psychometric properties of the instruments used to assess social support and psychological adjustment, limit the generalizability of the conclusions drawn. However, the results of the present study can serve as guidelines for future research. Investigators need to continue to search for methods to promote healthy psychological functioning in children who are raised by depressed mothers, as well as determine the mechanisms which serve to protect some of these children from developing any type of psychological symptoms. The role that supportive relationships play in the evolution of emotional disturbance in children is one factor which researchers should consider in order to help answer these questions.

Appendix A

Children's Social Support Questionnaire (CSSQ)

CSSQ

Date _____ Subject ID _____

**Directions: We would like to know about the people that are important to you. There will be some questions, with blank lines after them. For each question, write the names of family members, relatives, friends, or other people you know who best answer the question. You may write up to 10 different people for each question.

Question #1: Who do you hang out with (for example, at their house, your house, around the neighborhood, at school, etc.)?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Question #2: Who do you think are fun people to talk with (for instance about things you like to do or T.V. shows, etc.)?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Question #3: When you go to movies, parties, video arcades, etc., who do you go with?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Question #4: Do you belong to scouts, clubs, etc., or do you do other activities with kids your age? IF yes, who are your friends at these activities?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Question #5: Who gives you information or advice about religious things, like church or synagogue or god?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Question #6: Who gives you information or advice about personal things (for example, problems between you and your parents, how to make friends, etc.)?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Question #7: Who teaches you how to do things (for example, fix a bike, play a game, cook, make extra money, etc.)?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Question #8: Who talks to you about fun things to do (for example, what is a good movie to see, what is a good record to listen to, what is a good book to read, etc.)?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Question #9: Who can you count on to help you do things that need to get done (for example, homework, fixing a toy, chores, etc.)?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Question #10: Who takes you to places you need to go?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Question #11: Who lets you borrow a little bit of money if you need it (for things like a coke, some candy, a video game, etc.)?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Question #12: Who lets you borrow something from them if you need it (like a sweater, a jacket, a toy, a record, a book, etc.)?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Question #13: Who listens to you when you need to talk about something personal, something that you want to keep secret or you feel embarrassed about?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Question #14: Who makes you feel better when you are upset?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Question #15: Who cares about you?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Question #16: Who can you really count on to always be there for you?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Directions: For the next 5 questions, circle the number next to the best answer.

Question #17: Everybody has arguments or fights sometimes. Who do you think you argue or fight with the most?

1. my mother
2.. my father
3. my sister - write name and age _____
4. my brother - write name and age _____
5. another relative - write name and relation _____
6. a friend in my neighborhood - write name and age _____
7. a friend at school - write name and age _____
8. another adult - write name and who it is _____

Question #18: Who do you think you argue or fight with the second most?

1. my mother
2.. my father
3. my sister - write name and age _____
4. my brother - write name and age _____
5. another relative - write name and relation _____
6. a friend in my neighborhood - write name and age _____
7. a friend at school - write name and age _____
8. another adult - write name and who it is _____

Question #19: Who do you think you argue or fight with the least?

1. my mother
2.. my father
3. my sister - write name and age _____
4. my brother - write name and age _____
5. another relative - write name and relation _____
6. a friend in my neighborhood - write name and age _____
7. a friend at school - write name and age _____
8. another adult - write name and who it is _____

Question #20: When there are fights or arguments in your house or at school or with your friends. what part do you usually play in them?

1. I usually do not take part in arguments or fights.
2. I usually start arguments or fights.
3. I usually take part in arguments or fights, but I do not start them.
4. Sometimes I start arguments or fights, sometimes I do not (about 50-50).
5. I usually try to make peace, calm everybody down.
6. I usually go to my room or outside or away from whoever is fighting.

Question #21: How do most arguments or fights that you take part in get worked out or settled?

1. I am the one who usually settles or works things out.
2. The person/people I am arguing or fighting with usually settles or works things out.
3. We usually work things out together.
4. Things do not get settled or worked out.

Name	Male or Female? 1 2	What is your relationship with this person? (Circle all that apply) 1. Mate/spouse 2. Relative/family 3. Friend 4. Neighbor 5. Co-worker 6. Professional (e.g., teacher, doctor, minister, social worker) 7. Other (State relationship in the margin)	How often do you have contact with this person? A. A few times a year (or less) B. Once a month C. A few times a month D. Once a week E. A few times a week F. Everyday	How satisfied are you with your relationship with this person? 1. Very dissatisfied 2. Somewhat dissatisfied 3. Neutral (neither satisfied nor dissatisfied) 4. Somewhat satisfied 5. Very satisfied
1. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
2. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
3. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
4. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
5. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
6. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
7. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
8. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
9. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
10. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
11. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
12. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
13. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
14. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
15. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
16. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
17. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
18. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
19. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
20. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
21. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
22. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
23. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
24. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5

Name	Male or Female? 1 2	What is your relationship with this person? (Circle all that apply) 1. Mate/spouse 2. Relative/family 3. Friend 4. Neighbor 5. Co-worker 6. Professional (e.g., teacher, doctor, minister, social worker) 7. Other (State relationship in the margin)	How often do you have contact with this person? A. A few times a year (or less) B. Once a month C. A few times a month D. Once a week E. A few times a week F. Everyday	How satisfied are you with your relationship with this person? 1. Very dissatisfied 2. Somewhat dissatisfied 3. Neutral (neither satisfied nor dissatisfied) 4. Somewhat satisfied 5. Very satisfied
1. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
2. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
3. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
4. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
5. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
6. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
7. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
8. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
9. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
10. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
11. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
12. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
13. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
14. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
15. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
16. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
17. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
18. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
19. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
20. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
21. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
22. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
23. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5
24. _____	1 2	1 2 3 4 5 6 7	A B C D E F	1 2 3 4 5

Appendix B

Diagnostic Interview for Children and Adolescents-Revised (DICA-R)

INTERVIEWER: (CIRCLE ONE)

PERSONAL INTERVIEW.....1
TELEPHONE INTERVIEW.....2

DRAFT 5-R

DICA-R-C

DSM-III-R VERSION
DECEMBER, 1988

REVISED VERSION OF DICA
FOR CHILDREN AGES 6-12

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INTERVIEWER'S NAME_____

DATE OF INTERVIEW_____

TIME STARTED_____

TIME ENDED_____

JOINT INTERVIEW

GENERAL INFORMATION

In this interview I am going to ask you a number of questions about yourself. Things like what you like to do and how you feel about different things. I'd like to also ask you some questions about your family, your friends and about your school. Okay?

Listen now because this is really important. If I ask you a question that you don't want to answer; just say that you don't want to answer that question, and we'll skip to the next one. (It is important, however, that you answer the questions as truthfully as possible, and remember I won't tell anyone what you tell me - not even your parent(s) unless, like I told you before, if we find out that somebody might be getting hurt. The information you give to us is confidential - that means that no one will know what you've told me

DEMOGRAPHICS

1. Sex (OBSERVED)

MALE.....1
FEMALE.....2

2. Race (OBSERVED)

CAUCASIAN.....1
BLACK.....2
HISPANIC.....3
ORIENTAL.....4
AMERICAN INDIAN.....5
OTHER(SPECIFY)_____6

3. How old are you?

4. When is your birthday?

5. What grade are you in?
(PROBE: WHAT GRADE DID YOU JUST FINISH?
WHAT GRADE WILL YOU BE STARTING IN THE FALL?)
KINDERGARTEN = 55
NOTE TO INTERVIEWER: IF SUMMER OR CHILD NOT IN SCHOOL, CODE LAST GRADE COMPLETED

6. Can you tell me how many people live in your home at the present time?

7. Can you tell me who they are?

RECORD AGES NEXT TO NAME AND RELATIONSHIP TO CHILD(REN)

_____ _____

_____ _____

_____ _____

_____ _____

8. A. Do you have any brothers or sisters who live away from home?

IF NO, SKIP TO Q.9
IF YES, CONTINUE:

B. How many brothers and sisters do you have that live away from home?

9.

THE BEHAVIOR DISORDERS:

Coding
NO.....1
YES.....2
SOMETIMES.....3

INTRODUCTION: Child

In this section I will ask you mostly about how you get along with your family and friends and what school is like.

NOTE TO INTERVIEWER: THE CODING THROUGHOUT THE INTERVIEW IS:

CODE FOR "I DON'T KNOW" = 8

ATTENTION DEFICIT - HYPERACTIVITY DISORDER: STANDARD PROBES

Do you get in trouble for that over and over?

Does your Mom (or the teacher) speak to you a lot about that?

Has the teacher spoken to your Mom about_____?

Has the teacher/school sent a note home?

Do you think this is a big problem for you? I mean would life be a lot easier for you if this wasn't happening?

A. ATTENTION DEFICIT - HYPERACTIVE DISORDER

13. When you're in school, do you have trouble sitting in your seat for a long time?
(PROBE: IN THE CLASSROOM IS THE TEACHER ALWAYS TELLING YOU TO GO BACK TO YOUR SEAT?)

14. Are people always telling you to sit still or to stop moving or squirming about?
(PROBE: FIDGETING IN YOUR SEAT, PLAYING WITH YOUR HANDS AND FINGERS - JUST NEVER ABLE TO SIT STILL?)

15. Is it hard for you to play quietly, either by yourself or with other kids?
(PROBE: ARE PEOPLE ALWAYS TELLING YOU THAT YOU'RE TOO NOISY AND THAT YOU ARE ALWAYS RUNNING AROUND, OR THAT YOU NEVER PLAY QUIETLY?)

16. Do people tell you that you talk all the time or that you never stop talking?

17. When you're playing by yourself or with other kids, would you say that you get restless pretty quickly and want to move on to something else?
(PROBE: DO YOU GET TIRED OF DOING ONE THING EVEN IF THE OTHER KIDS DON'T WANT TO STOP? --OR-- DOES YOUR MOTHER OR DO THE OTHER KIDS TELL YOU THAT YOU NEVER STICK WITH ONE THING?

18. When you do your schoolwork or your homework, do you often find that you are daydreaming, or thinking about something else?
(PROBE: DOES THE TEACHER COMPLAIN THAT YOU DON'T FINISH YOUR WORK?)

19. Do you have problems in school because even after the teacher explains the lesson to you, you're still not sure what you're supposed to do?
(PROBE: IS IT EASIER TO DO YOUR WORK IF SOMEONE LIKE A PARENT OR A TEACHER SITS DOWN WITH YOU AND EXPLAINS WHAT TO DO WHILE YOU ARE DOING IT?)

20. Do you find that it's hard to keep your mind on your work when there are other things are going on in the same room?
(PROBE: LIKE WHEN OTHER KIDS AROUND YOU TALK IN CLASS, OR IF YOU HEAR NOISES OUTSIDE?)

21. Do people complain or get mad because you interrupt them or butt into conversations or games?

22. **Does the teacher or do your parents ever say that you start answering a question before they finish asking it?**
(PROBE: THAT YOU START TALKING BEFORE THEY ARE FINISHED?)

23. Do you find it hard waiting your turn when you're playing with other children or waiting in line?
(PROBE: DO YOU GET RESTLESS AND START CLOWNING AROUND OR PUSHING AHEAD IN LINE?)

24. **Do people get upset with you for doing dangerous things, like running out into the street without looking?**
(PROBE: CLIMBING UPON THINGS THAT ARE DANGEROUS -OR- CLIMBING ON SOMETHING THAT YOU MIGHT FALL OFF OF?)

25. **Do people tell you that you're messy or sloppy with your work or in the way you dress?**

26. **Are you always losing things like pencils, notebooks, or papers from school?**
(PROBE: ARE YOU ALWAYS FORGETTING TO BRING HOME PAPERS FROM SCHOOL OR INFORMATION, FOR EXAMPLE, A NOTICE ABOUT A PTA MEETING, ABOUT THE SCHOOL PLAY, ABOUT A FIELD TRIP?)

27. **Do your parents or teachers ever complain that you're not really listening to them?**

IF 2 OR FEWER POSITIVES, Q. 13-27, SKIP TO OPPOSITIONAL DISORDER, Q. 34, PAGE 8.
IF 3 OR MORE POSITIVES, CONTINUE.

28. **How old were you when you first had these problems that you've just told me about?**
(PROBE: WERE YOU LIKE THAT IN FIRST GRADE? WERE YOU ALWAYS LIKE THAT?) CODE IN YEARS

IF RELEVANT, ASK:

29. How old were you when you first started to get better?

30. Did your Mom (or Dad) ever take you to a doctor because you were having these problems?

IF NO, SKIP TO Q.33
IF YES, CONTINUE:

31. Did the doctor give you any medicine to help you with these problems?

IF NO, SKIP TO Q.33
IF YES, CONTINUE:

32. Do you know the name of the medicine?

RECORD_____

33. Have these problems started to get better?

B. OPPOSITIONAL/DEFIANT DISORDER:

STANDARD PROBES

IS THIS A BIG PROBLEM FOR YOU?
IS THIS A BIG PROBLEM FOR YOUR PARENTS?
DOES IT HAPPEN OVER AND OVER?
ARE YOUR PARENTS VERY UPSET ABOUT THIS?
DO THE TEACHERS COMPLAIN ALOT ABOUT YOU DOING THIS?

34. A. Do you often argue with your parents, your teachers or other adults?

IF NO, SKIP TO Q.35
IF YES, CONTINUE:

B. Who do you argue with the most?

RECORD _____

C. How often does it happen?

EVERY DAY OR AT LEAST ONCE A WEEK.....2
TWICE A MONTH.....3
COUPLE OF TIMES A YEAR.....4

35. A. Do you often lose your temper or get angry when you can't get people to do things the way that you want them done?

IF NO, SKIP TO Q.36
IF YES, CONTINUE:

B. How often does it happen?

EVERY DAY OR AT LEAST ONCE A WEEK.....2
TWICE A MONTH 3
COUPLE OF TIMES A YEAR.....4

36. A. Do you ever just refuse to do things that your parents, teachers, or other adults have asked you to do?

IF NO, SKIP TO Q.37
IF YES, ASK: What sort of things do you refuse to do?

RECORD_____

B. How often does it happen?

EVERY DAY OR AT LEAST ONCE A WEEK.....2
TWICE A MONTH.....3
COUPLE OF TIMES A YEAR.....4

37. A. Do people say that you do things on purpose to annoy or bug them?

(EXAMPLES:
--GRABBING ANOTHER KID'S HAT OR MAKING FUNNY NOISES, THINGS LIKE THAT?
--ARGUING WITH PEOPLE, PLAYING PRACTICAL JOKES, TEASING PEOPLE (LIKE MAKING FUN OF THEM OR CALLING THEM NAMES)?

IF NO, SKIP TO Q.38.
IF YES, CONTINUE:

B. How often does it happen?

EVERY DAY OR AT LEAST ONCE A WEEK.....2
TWICE A MONTH.....3
COUPLE OF TIMES A YEAR.....4

38. Do you you get angry or crabby when people ask you to do things for them?
(PROBE: DOES IT MAKE YOU MAD WHEN THEY ASK YOU TO RUN AN ERRAND, CLEAN YOUR ROOM, OR DO SOMETHING FOR THEM?)

39. Do your parents, friends or your brother(s)/sister(s) get on your nerves a lot?
(PROBE: EVERYDAY OR NEARLY EVERYDAY?)

40. **When someone does something unfair to you, do you try to get back in some mean way, like by saying mean things to them or about them?**
(PROBE: SAYING THINGS THAT YOU KNOW AREN'T TRUE, BLAMING THEM FOR THINGS THEY REALLY DIDN'T DO?)

41. A. **Do you swear a lot or use what most people would consider to be bad language even in front of grown-ups?**

IF NO, SKIP TO Q.42
IF YES, CONTINUE:

B. **How often does it happen?**

EVERY DAY OR AT LEAST ONCE A WEEK.....2
TWICE A MONTH.....3
COUPLE OF TIMES A YEAR.....4

42. **Everyone has troubles, problems, or things that go wrong for them. Think about your problems and troubles and tell me if they are mostly caused by people messing things up for you or are they mostly your own fault?**
(PROBE: FOR EXAMPLE, IF YOU GET A BAD GRADE AT SCHOOL, DO YOU SAY THAT THE TEACHER IS NO GOOD, OR THAT THE TEST WASN'T FAIR?)

SELF TO BLAME.....1
OTHERS TO BLAME.....2
SOME OF BOTH.....3

43. **Do people complain that you bully other children or are mean to them?**

--IF NO TO 3 OR FEWER QUESTIONS, Q. 34-43
SKIP TO NEXT SECTION, CONDUCT DISORDER, Q.45
--IF YES TO 4 OR MORE QUESTIONS, CONTINUE:

44. A. **Let's see, you've told me that you _____ (LIST A FEW SYMPTOMS). Are these things a big problem for you, or for your parents and teachers?**
(PROBE: DO YOU FEEL THAT EVERYDAY YOU ARE GETTING INTO SOME KIND OF TROUBLE?)

B. **Has this been going on for six months or more?**

C. **CONDUCT DISORDER:**

Most kids do things that get them in trouble with their parents or teachers. I am going to ask you about different ways of getting into trouble. Okay?

45. A. Have you ever been suspended from school?

NOTE TO INTERVIEWER: IN-SCHOOL SUSPENSIONS COUNT.

IF NO, THEN SKIP TO Q.46
IF YES, CONTINUE:

B. How many times has it happened?

4+ TIMES.....2
2-3 TIMES.....3
1 TIME.....4

C. Can you tell me why you were suspended?

RECORD_____

_____

46. A. Have you ever been expelled from school (kicked out for the rest of the year)?

IF NO, SKIP TO Q.47
IF YES, CONTINUE:

B. Can you tell me why you were expelled?

RECORD_____

_____

47. A. Have you ever skipped school (PLAYED HOOKEY/ TAKEN A DAY OFF FROM SCHOOL WITHOUT PERMISSION)?

IF NO, SKIP TO Q.48
IF YES, CONTINUE:

B. How often have you done that?

6-10+ TIMES.....2
3-5 TIMES.....3
1-2 TIMES.....4

IF NO TO Q.'S 45, 46, AND 47, SKIP TO Q. 50.
IF YES TO EITHER Q.'S 45, 46, OR 47, CONTINUE.

48. How old were you the first time you _____?
(were suspended, expelled, or skipped school)

49. How old were you the last time you had any of these problems?

50. A. Have you ever been blamed for cheating in schoolwork ?

IF NO TO A, SKIP TO Q.51 A.
IF, YES, CONTINUE:

B. How often have you done that?

6-10 TIMES.....2
3-5 TIMES.....3
1-2 TIMES.....4

C. How old were you the first time this happened?

D. How old were you the last time that happened?

51. A. Have you ever stolen anything, like money from someone's purse or shoplifted something at a store?

B. Have you ever stolen things under any other circumstances?

IF NO, SKIP TO Q.52
IF YES, CONTINUE:

C. How many times have you done this?

6-10+ TIMES.....2
3-5 TIMES.....3
1-2 TIMES.....4

52. A. Do you often lie or make up stories to get of trouble?
(PROBE: LIKE TELLING THE TEACHER THAT YOU HAD A BAD HEADACHE AND COULDN'T DO YOUR HOMEWORK WHEN YOU REALLY JUST HADN'T DONE IT?)

B. Do you often tell lies for no reason at all?
(PROBE: LIKE TELLING YOUR FRIENDS THAT YOU'VE MET A FAMOUS PERSON WHEN YOU REALLY HADN'T - THINGS LIKE THAT?)
IF NO TO A AND B, SKIP TO Q. 53.
IF YES TO EITHER A OR B, CONTINUE.
C. How often have you done that?

6-10+ TIMES.....2
3-5 TIMES.....3
1-2 TIMES.....4

D. How old were you the first time you started doing things like that?

E. How old were you the last time?

53. A. Have you ever set any fires that you weren't supposed to set?

IF NO TO Q.53A, SKIP TO Q.54
IF YES, CONTINUE:

B. How often have you done that?

6-10+ TIMES.....2
3-5 TIMES.....3
1-2 TIMES.....4

C. How old were you the first time?

D. How old were you the last time it happened?

E. How did it happen and what happened because of the fire(s)?

RECORD_____

_____

ACCIDENTAL.....1
DELIBERATE.....2

54. A. Have you ever run away from home overnight or longer? (MUST HAVE RUN AWAY FROM PARENTAL OR PARENT-SURROGATE'S HOME WITHOUT LETTING PARENTS KNOW HIS/HER WHEREABOUTS)

DESCRIBE:_____

_____

IF NO TO Q.54A, SKIP TO Q.55
IF YES, CONTINUE:

B. How many times have you done that?

6-10+ TIMES.....2
3-5 TIMES.....3
1-2 TIMES.....4

C. How old were you the first time it happened?

D. How old were you the last time it happened?

55. A. Have you ever gotten into fights with other kids? (PROBE: FIGHTS WHERE YOU REALLY HIT ONE ANOTHER NOT JUST ARGUMENTS OR SCREAMING MATCHES?)

IF NO TO Q.55A, SKIP TO Q.56
IF YES, CONTINUE:

B. How often have you gotten into fights with kids?

6-10+ TIMES.....2
3-5 TIMES.....3
1-2 TIMES.....4

C. Have you ever hurt someone badly in a fight - like giving them a black eye or a bloody nose?

IF NO TO Q.55C, SKIP TO Q.56
IF YES, CONTINUE:

D. How many times have you hurt someone in a fight?

4-5 TIMES.....2
2-3 TIMES.....3
1 TIME.....4

IF YES TO ANY FIGHTING, CONTINUE:

E. Who usually starts these fights, you or the other person?

OTHER PERSON.....1
SELF.....2
SOME OF BOTH.....3

56. A. Have you ever been in a fight were you've used something in addition to your hands, such as sticks, rocks, or sharp objects? (Did you ever use a knife or a gun?)

RECORD_____

IF NO TO Q. 56A, AND YES TO Q. 55A, SKIP TO Q. 57.
IF NO TO Q. 55A AND Q. 56A, SIP TO Q.58.
IF YES TO Q. 56A, CONTINUE.

B. How often have you done that?

3+ TIMES.....2
1-2 TIMES.....3

C. How old were you the first time this happened?

D. How old were you the last time?

57. Did these problems with fighting last for over six months?

58. A. Have you ever mugged someone or held them up and robbed them?

B. How old were you the first time this happened?

C. How old were you the last time?

59. A. Have you ever injured a small animal such as a cat, a dog, or a squirrel?
(PROBE: TORMENTED A LARGER ANIMAL, SUCH AS A HORSE OR COW? DO NOT COUNT ORDINARY INSECT KILLING, FLY SWATTING, SPIDER KILLING ETC. AND DO NOT COUNT HUNTING ACTIVITIES)

IF NO TO Q.59A, SKIP TO Q. 60
IF YES, CONTINUE:

B. How often have you done that?

2-10+ TIMES.....2
1 TIME.....3

C. How did it happen? (THE INJURY OR DEATH OF THE ANIMAL)
RECORD_____

ACCIDENTAL, UNINTENTIONAL.....1
DELIBERATE, AND CRUEL.....2

D. How old were you the first time it happened?

E. How old were you the last time it happened?

60. A. Were you ever so angry with someone that you tried to hurt them in some way?

IF NO TO Q.60A, SKIP TO Q. 61
IF YES, CONTINUE:

B. What did you actually do?

RECORD_____

ACCIDENTAL, UNINTENTIONAL.....1
DELIBERATE, AND CRUEL.....2

61. A. Have you ever wrecked someone else's property on purpose? (PROBE: HERE ARE SOME EXAMPLES: (1) BREAKING WINDOWS IN A SCHOOL OR SOME OTHER BUILDING, (2) SCRATCHING A CAR, (3) THROWING ROCKS AT CARS)

B.....

C. How often have you done that?

4-10 TIMES.....2
2-3 TIMES.....3
ONE TIME.....4

D. How old were you when it first happened?

E. How old were you the last time it happened?

62. A. Have you ever been in trouble with the police or juvenile court?

B.....

C.....

IF NO, SKIP TO Q.63 A.
IF YES, CONTINUE:

D. Can you tell me what happened? RECORD

_____

_____

E. How often has that happened?

6-10+ TIMES.....2
3-5 TIMES.....3
1-2 TIMES.....4

F. How old were you the first time that happened?

G. How old were you the last time that happened?

ALCOHOL USE AND ABUSE:

63. A. Have you taken a drink of beer, wine, or other alcohol?
(PROBE: DO NOT COUNT SIPS GIVEN BY PARENTS ON SOCIAL OCCASIONS)

NO.....1
YES.....2

IF NO, SKIP NEXT SECTION: CIGARETTE SMOKING, Q.85
IF YES, CONTINUE:

B. How often have you taken a drink without your parents permission?
(CODE MOST FREQUENT RESPONSE)

EVERYDAY OR A COUPLE OF TIMES A WEEK....2
ONCE A WEEK.....5
ONCE A MONTH.....6
LESS THAN ONCE A MONTH.....7
OTHER_____.....8

C. When you do drink, what do you usually have?
(PROBE: "COOLERS," BEER, WINE, HARD LIQUOR?)

COOLERS

BEER

WINE

HARD LIQUOR

OTHER_____

D. What's the most you drank at one time?

A SIXPACK OF BEER/BOTTLE OF WINE/ 4/5 DRINKS OF HARD LIQUOR OR MORE 2

2-3 GLASSES OF WINE/ 3-4 CANS OF BEER/ 2-3 DRINKS OF HARD LIQUOR 3

1 GLASS OF WINE/ 1 BEER/ 1 DRINK HARD LIQUOR 5

E. Have you ever been drunk?

NO.....1
YES.....2

IF NO, SKIP TO Q.64
IF YES, CONTINUE:

F. How many times have you been drunk? (7+ = 7)

G. How old were you when you first took a drink?

H. How old were you the last time?

NOTE TO INTERVIEWER: IF STILL DRINKING, CODE PRESENT AGE

IF DRINKING DOES NOT SEEM TO BE A PROBLEM, SKIP TO NEXT SECTION, CIGARETTE SMOKING, Q.85

IF DRINKING LOOKS LIKE IT MIGHT POSSIBLY BE A PROBLEM, CONTINUE:

64. A. Have any members of your family ever told you that you were drinking too much?

B. Have any of your friends told you that they thought you were drinking too much?
(PROBE: HAS ANYONE ELSE EVER TOLD YOU THAT YOU WERE DRINKING TOO MUCH?)

C. Have you ever thought that perhaps you were drinking too much?

D. When you've been drinking, have you ever gotten really angry at someone?
(PROBE: SHOUTED OR YELLED AT THEM?)

E. When you've been drinking have you ever started thinking about all your problems and started crying?

F. Have you ever had "blackouts" - that is, you did something while you were drinking and you couldn't remember having done it?
(PROBE: THE ONLY WAY YOU FOUND OUT ABOUT IT IS THAT SOMEONE TOLD YOU ABOUT IT. EXAMPLE: YOU CAN'T REMEMBER HOW YOU GOT HOME. FRIENDS SAY YOU SHOUTED AT THEM BUT YOU CAN'T REMEMBER ANY SHOUTING.)

IF NO TO Q. 64A-F, SKIP TO CIGARETTE SMOKING, Q. 85

G. Have you ever tried to stop or cut down on drinking but found that you couldn't?

RECORD_____

_____

H. Have you ever found that you needed to drink more and more in order to feel "high"?

65. Have you ever missed school because you had been drinking and you were too sick to go?

66. Did your grades go down because your drinking interferred with your studies?

67. Have you ever had a drink at school?
(PROBE: SOME KIDS KEEP BOTTLES IN THEIR LOCKERS)

68. Have you ever been sent home from school (or suspended) because of drinking?

SKIP TO Q. 70

69. Have you ever had trouble driving when you've been drinking? Example: found you were driving in the wrong lane - found that you had driven the car up onto the sidewalk, ever go to the wrong house, ever hit a tree or scraped against a wall.

70. A. Has there ever been a time when you needed a drink every day or nearly every day just to keep going?

IF NO, SKIP TO Q.71
IF YES, CONTINUE:

B. How long did that period last? (CODE IN WEEKS)

IF NO POSITIVES FROM Q. 64A THROUGH Q. 70B,
SKIP TO CIGARETTE SMOKING, Q. 85.
IF ANY POSITIVES, CONTINUE.

71. A. Has there ever been a time when you needed a drink every day or nearly every day just to unwind?

IF NO, SKIP TO Q.72
IF YES, CONTINUE:

B. How long did that period last - when you drank to unwind? CODE IN WEEKS

72. A. Have you ever taken a drink in the morning - around breakfast time?

IF NO, SKIP TO Q.73
IF YES, CONTINUE:

B. How often have you done this? (7+ = 7)

73. Have you ever had any fits or seizures after stopping or cutting down while drinking?

74. Have you ever had the D.T.s?
NOTE TO INTERVIEWER:
IF RESPONDENT DOES NOT KNOW WHAT D.T.s ARE, EXPLAIN:
(DELIRIUM TREMENS: That is when you saw things or heard things that weren't really there - like hallucinations. Sometimes people with D.T.s feel bugs or insects crawling all over their body.)

75. How old were you when you first had these problems with drinking that you've told me about?

76. How old were you the last time?
IF STILL HAPPENING, CODE PRESENT AGE

77. Have any of your friends dropped you because they said you were drinking too much?

78. A. **Have you ever gotten into physical fights when drinking?**

IF NO, SKIP TO Q. 79
IF YES, CONTINUE:

B. How many fights have you gotten into?

6-10+ TIMES.....2
3-5 TIMES.....3
1-2 TIMES.....4

IF NO POSITIVES SO FAR, THE INTERVIEWER HAS THE OPTION OF SKIPPING OUT OF THIS SECTION AND GOING TO NEXT SECTION, CIGARETTE SMOKING.
IF ANY POSITIVES, CONTINUE:

79.

80.

81. **Have you ever gone on binges or benders? (PROBE: WHEN YOU KEPT DRINKING FOR A COUPLE OF DAYS WITHOUT SOBERING UP)**

82. A.....

B.....

C.....

83. A. How old were you when you started drinking?

B. How old were you the last time you had a drink?

84.

CIGARETTE SMOKING:

85. Have you ever smoked cigarettes?

IF NO, SKIP TO NEXT SECTION: GLUE SNIFFING, Q.87
IF YES, CONTINUE:

86. A. Have you ever smoked regularly - everyday?

B. How old were you when you first started smoking?

C. How old were you the last time you smoked?

GLUE SNIFFING:

87. A. Have you ever sniffed glue or other fumes like hairspray to get "high"?

IF NO, SKIP TO NEXT SECTION, MARIJUANA, Q. 88
IF YES, CONTINUE:

B. How many times have you sniffed glue or anything like that?

6-10+ TIMES.....2
3-5 TIMES.....3
1-2 TIMES.....4

C. How old were you the first time you sniffed glue?

D. How old were you the last time you sniffed glue or _____(USE CHILD'S WORDS)?

IF STILL SNIFFING GLUE OR SIMILAR FUMES, CODE PRESENT AGE

MARIJUANA:

88. A. Have you ever smoked marijuana?

IF NO, SKIP TO NEXT SECTION, STREET DRUGS, Q. 89
IF YES, CONTINUE:

B. Have you smoked marijuana more than a couple of times?

IF NO, SKIP TO NEXT SECTION, STREET DRUGS, Q. 89
IF YES, CONTINUE:

C. How old were you when you first smoked marijuana?

D. How old were you the last time you smoked it?

E. Have you ever smoked marijuana almost every day for as long as a month or more?

F. Did you ever find that you had to smoke more and more marijuana in order to get high?

IF NO TO Q. 88 E AND F, SKIP TO STREET DRUGS, Q. 89.
IF YES TO EITHER, CONTINUE.

G. When you've been smoking marijuana, have you ever done things you wouldn't ordinarily do?

H. Did you find that you were hanging out mostly with other kids who smoked marijuana?

I. Did you find that you were staying away from everyone and just smoking marijuana on your own?

J. When you were smoking marijuana, did your grades go down?

K. Have you ever felt very anxious after smoking marijuana?

L. Have you ever felt very suspicious after smoking marijuana - like people were doing things behind your back without telling you - leaving you out?

M. When you've been smoking marijuana have you ever felt that time was slowing down, i.e., 5 minutes seemed like an hour?

STREET DRUGS:

89. A. Have you ever taken any "street drugs"?
(PROBE: COCAINE, CRACK, SPEED - UPPERS, DOWNERS - THAT SORT OF THING?)

B. Have you taken any other drugs that weren't prescribed for you by a doctor?
(PROBE: LIKE GETTING VALIUM OR SLEEPING PILLS FROM A FRIEND, OR SWIPING SOME FROM YOUR PARENTS' PRESCRIPTION?)

RECORD ALL "STREET DRUGS"_____

_____

C. How old were you the you first time you took any of these drugs?

D. How old were you the last time?
NOTE TO INTERVIEWER:
IF RESPONDENT IS STILL TAKING DRUGS, CODE PRESENT AGE

E. Have you ever taken any of these drugs 5 times or more?

IF NO, SKIP TO NEXT SECTION, AFFECTIVE DISORDERS, Q.90
IF YES, CONTINUE:

F. What drugs have you taken more than 5 times?
(CODE: NO = 1; YES = 2)

COCAINE

CRACK

SPEED: SPEED OR UPPERS: AMPHETAMINE, DEXATRINE, RITALIN, ETC.

HEROIN

PSYCHEDELICS (LSD, MESCALINE, PEYOTE, DMT, PCP)

DOWNERS (LIKE SECONAL OR ANY OTHER BARBITUATES OR SLEEPING PILLS)

G. Have you ever used any of these drugs we've been talking about everyday for say - two weeks or maybe even longer than two weeks?

H. Has there ever been a time when you found that you were taking more and more_____(NAME ALL DRUGS) to feel the effect?

I. Have you ever tried to cut down on_____and found that you really couldn't?

J. Have you ever worried about the amount of_____ you were taking and made rules for yourself so you wouldn't take so much? (FOR EXAMPLE, TAKING _____ONLY ON WEEKENDS, OR ONLY IN THE EVENING?)

K. Have you ever felt that _____was taking a lot of your time? For example, did you find that you were spending a lot of time getting_____, taking_____, and then recovering from the effects?

L. Did taking_____cause a lot of problems for you? For example, missing school (or job), grades going down, arguing with family or friends, or losing friends?

M. Did taking_____make you give up some of your outside activities (SPORTS, OTHER EXTRA-CURRICULAR ACTIVITIES?)

N. Did you find that you were spending most of your time with other people who were taking drugs?

O. Did you ever get in trouble with the police because of_____?

P. Did you ever have bad side effects from the drugs - like feeling depressed, paranoid, or that you were losing your mind?

IF NO, END THIS SECTION
IF YES, CONTINUE:

Q. Even though you were having these feelings_____ (NAME FEELINGS) did you keep on taking_____ anyway?

AFFECTIVE DISORDERS:

MAJOR DEPRESSIVE DISORDER

All the questions so far have been about the kinds of things you do. Now I'm going to ask you how you feel about different things, okay?

90. Are you the kind of kid who gets down or in bad moods a lot of the time?

NOT VERY OFTEN.....1
MOST OF THE TIME.....2
SOME OF THE TIME.....3

91. A. Was there ever a time in your life when you felt sad, miserable and depressed a lot more than usual? (PROBE: NOT JUST ORDINARY UPS AND DOWNS - BUT FEELING REALLY SAD)

B. Was there ever a time in your life when you felt tearful or sad but you didn't know why?

C. Was there ever a time in your life when you found yourself being snappish, irritable (crabby or cranky) a lot more than usual?

D. You've told me_____. Was there anything going on in your life that made you feel that way?

RECORD_____

_____

E. How old were you when this was happening?

PERVASIVE ANHEDONIA:

92. **Have you ever felt that nothing you did seemed to be any fun (even things that you used to like doing)? (PROBE: LIKE DOING THINGS WITH YOUR FRIENDS)**

93. A. Can you tell me some of your favorite things to do? (CODE: NO = 1: YES = 2)

RECORD_____

_____

_____

IF NO, SKIP TO NEXT SECTION, APPETITE GAIN, Q.95
IF YES, CONTINUE:

B. **Has there ever been a time when you didn't feel like doing any of these things?**

RECORD_____

IF NO, SKIP TO APPETITE GAIN, Q. 95.
IF YES, CONTINUE.

C. Was there something also going on that mad you drop _____? (USE CHILD"S EXAMPLES)

94. How old were you when this was happening?

SYMPTOMS:

APPETITE LOSS/GAIN

95. A. Sometimes when people are having a hard time, they don't feel hungry and sometimes they may even lose weight. Has there ever been a time when you were not very hungry a lot of the time?
(PROBE: AT A TIME WHEN YOU WEREN'T SICK)

IF NO, SKIP TO Q.96
IF YES, CONTINUE:

B. Did you actually lose any weight?

C. How much did you lose?
(RECORD IN POUNDS)

96. A. Sometimes when people feel low, instead of losing weight they find that they are hungry all of the time. Has this ever happened to you?

IF NO, SKIP TO NEXT SECTION, SLEEP DISTURBANCES, Q.97
IF YES, CONTINUE:

B. Did you actually gain weight?

C. How much did you gain?
(RECORD IN POUNDS)

IF NO, SKIP TO SLEEP DISTURBANCE, Q.97
IF POSITIVE (E.G. LOST APPETITE OR FELT MORE HUNGRY), CONTINUE:

D. Could you tell me a little more about the time(s) when you lost your appetite or were hungrier than usual?
(CODE: NO = 1; YES = 2)

IF YES, RECORD_____

_____

E. How old were you when this was happening?

SLEEP DISTURBANCE:

97. Have you ever had a lot more trouble than usual falling asleep at night?
(PROBE: NOT JUST ONE NIGHT, BUT MOST NIGHTS, SAY FOR A WEEK OR LONGER)

98. Sometimes when kids feel sad or worried, they wake up in the middle of the night and can't get back to sleep even though they try. Has this ever happened to you?

IF NO, SKIP TO Q.99
IF YES, CONTINUE:

B. Did it happen more than one or two times?

99. A. Have you ever woken up early in the morning (alot earlier than usual for you), and couldn't get back to sleep no matter how hard you tried?

IF NO, SKIP TO Q.100
IF YES, CONTINUE:

B. Did this happen more than one or two times?

100. A. Has there ever been a time when you were feeling sad and you slept more than usual during the day or night?

IF NO POSITIVES, SKIP TO PSYCHOMOTOR RETARDATION, Q.101
IF ANY POSITIVES, CONTINUE:

B. Do you remember how long these sleeping problems lasted? CODE IN DAYS

C. How old were you when this was happening?

PSYCHOMOTOR RETARDATION AND/OR AGITATION:

101. **Has there ever been a time when you felt more restless than usual and had difficulty sitting still?**

RECORD_____

102.A. **Has there ever been a time when you felt slowed down and it took you longer to move around or do things?**

RECORD_____

B. How old were you when this was happening?

FATIGUE:

103.A. **Has there ever been a time when you've felt more tired than usual, or dragged out a lot of the time? (PROBE: LIKE YOU DIDN'T HAVE THE ENERGY TO DO ANYTHING - WHEN JUST GETTING UP AND WALKING AROUND WAS HARD TO DO, AND WHILE NOT SICK)**

B. How old were you when this was happening?

WORTHLESSNESS OR EXCESSIVE GUILT:

104. **Has there ever been a time when you felt that everything you did was wrong and nothing would ever go well for you?**
(PROBE: YOU FELT LIKE YOU WERE ALWAYS SAYING THE WRONG THINGS, OR THAT YOUR FRIENDS DIDN'T REALLY LIKE YOU?)
(PROBE: EVERYBODY FEELS THAT WAY SOME OF THE TIME - I'D LIKE TO KNOW IF THIS WAS A LOT MORE THAN USUAL)

105.A. **Has there ever been a time when you felt that everything was your fault and you felt guilty about a lot of things?**
(PROBES: YOU FELT YOUR FAMILY WOULD BE BETTER OFF WITHOUT YOU OR THAT IF YOUR MOTHER/FATHER WAS IN A BAD MOOD IT WAS BECAUSE OF YOU)

B. How old were you when this was happening?

TROUBLE CONCENTRATING OR INDECISIVENESS:

106. A. **Was there ever a time when you couldn't keep your mind on your work and your parents and teachers complained about it a lot?** (PROBE: DID IT SEEM TO YOU THAT YOU WERE DAYDREAMING A LOT?)

IF NO, SKIP TO C. IF YES, CONTINUE.

B. **Did your grades go down when you were having problems keeping your mind on your work?**

C. **Was there ever a time when you had a lot more trouble than usual making decisions?** (PROBE: WHETHER TO GO OUT WITH YOUR FRIENDS OR STAY IN, WHETHER YOU SHOULD WATCH TV OR NOT, OR WHAT YOU WANTED TO EAT OR WEAR)

D. How old were you when this was happening?

SUICIDAL IDEATION:

107. **Have you ever felt that everything in your life was going wrong and that nothing would ever be alright again?**

108.

109. A. Have you ever wished that you were dead?

B. Have you ever thought about killing yourself?

110. A. **Did you ever** have a plan about how you were **going to kill yourself?**

IF NO, SKIP TO MANIA, Q.113A.
IF YES, CONTINUE:

B. **Can you tell me about it?** (CODE: NO = 1; YES = 2)

RECORD_____

111. **How old were you when you** first felt this way?

112. **How long did these feelings last?**
(CODE IN DAYS)

113. A. **Have you ever tried to kill yourself?**

IF NO TO Q. 113A., SKIP TO Q. 113G.
IF YES, CONTINUE.

B. **Have you tried it more than once?**

C. Did you see a doctor or counselor?

D. What did he/she say? (CODE: NO = 1; YES = 2)

RECORD_____

E. How old were you the first time you tried to kill yourself?

ASK ONLY IF RELEVANT

F. How old were you the last time you tried to kill yourself?

G. Let's see, you've told me that you've_____ (NAME SYMPTOMS). Did some of these things happen at the same time? For instance, when you were_____did you also_____?

NOTE TO INTERVIEWER: DO SYMPTOMS CLUSTER? YES___ NO___

H. Was there anything going on in your life to explain why you felt this way? YES___ NO___

RECORD_____

MANIC EPISODE:

114. Have you ever felt super happy, as if you were on top of the world?

115. A. Have you ever felt so good that everything seemed absolutely wonderful?

(IF YES, ASK TO DESCRIBE: (CODE NO = 1; YES = 2)

RECORD_____

B. Do you remember how long that feeling lasted? (CODE IN DAYS)

116. Have you ever felt really happy like I've asked you, and also felt crabby and irritable sometimes?

IF YES, ASK TO DESCRIBE: (CODE: NO = 1; YES = 2)

RECORD_____

IF #114, #115, OR #116 ANSWERED POSITIVE, CONTINUE:

IF NEGATIVE, SKIP TO ANXIETY DISORDERS, Q.125

117. Has there ever been a time when you were feeling really happy, and you slept alot less than usual because you weren't feeling tired?

118. Has there ever been a time when you were feeling really happy, and you talked a lot more and a lot faster than usual?

119. Has there ever been a time when your thoughts or ideas were racing through your mind?
(PROBE: DID YOU FEEL THAT YOUR THOUGHTS WERE COMING SO FAST THAT YOU COULDN'T EXPLAIN ONE IDEA BEFORE ANOTHER CAME INTO YOUR MIND?)

120. Has there ever been a time when you were feeling really happy, and you found that it was hard to keep your mind on one thing at a time?
(PROBE: WERE THERE TOO MANY THINGS THAT YOU WANTED TO DO AND YOU DIDN'T KNOW WHICH ONE TO DO FIRST?)

121.A. Has there ever been a time when you were feeling really happy, and you felt like you had more energy than usual? For example, were you always running around doing things?

B. Has there ever been a time when you were feeling really happy, and your family, teachers, or friends told you that you were acting differently from your usual self?

C. Have you ever felt really happy, and you felt that you were a very important person, or you had special powers or could do things that other people couldn't do?

D. Has there ever been a time when you felt really happy, and you did things without thinking first, and you got into trouble because of how you were acting?
(PROBE: DID YOU CAUSE PROBLEMS FOR YOUR FAMILY OR FRIENDS BY BEING LOUD, OBNOXIOUS, TEASING, LOOKING FOR FIGHTS?)
(PROBE: DID YOU SPEND A LOT OF MONEY, BORROW FROM YOUR FRIENDS, OR DRESS IN BRIGHT COLORS (WEAR MORE MAKE-UP) MORE THAN USUAL FOR YOU?)

E. Did your family, teacher, or friends think you needed to see a doctor because of how you were acting, or did your behavior interfere with doing your school work or your chores as you usually did?

IF NO POSITIVES, Q. 114-121, SKIP TO SEPARATION ANXIETY, Q. 125.
IF ANY POSITIVES, CONTINUE.

122. How old were you when these things first happened?

123. How old were you when these things happened the last time?

124. How long did these feelings last?

ANXIETY DISORDERS:

SEPARATION ANXIETY DISORDER:

Some kids worry a lot about being away from their parents or away from home. I'm going to ask you some questions about how you feel when you're away from your parents or away from home.

125. Has there ever been a time when you were away from your parents and you worried a lot about something bad happening to them (like they might get sick or get hurt or die)?

126. Has there ever been a time when you really worried that something bad might happen to you (like getting kidnapped or killed), so that you couldn't see your parents again?

127. Has there ever been a time when you refused to go to school (or tried to stay home), because you were afraid that something bad (like sickness, accident, or death) might happen to your parents while you were away?

128. Did you ever need to have your Mom/Dad, older brother or sister, or another adult stay close to you so you could get to sleep at night, because you were afraid to be alone.

129. Has there ever been a time in your life when you were afraid to be left all by yourself in a room in your home?

130. Have you ever had a chance to visit a friend or sleep over at someone's house and refused to go, because you were afraid to leave home?

131. Have you ever gone away from home for a few days, like visiting relatives and been so upset and worried that you went back home right away, or you wanted to go home <u>really</u> badly?

132. Has there ever been a time when you had scary dreams about something bad happening to you, your parents, or other people in the family?

133. Has there ever been a time when you had to leave home to go to school or some place else, and you got headaches or stomachaches or felt sick to your stomach or even threw up?

134. Has there ever been a time when you threw tantrums or cried and begged your parents to stay home when they planned to go somewhere?

IF NO POSITIVES FROM Q.128 THRU 134, SKIP TO <u>AVOIDANT DISORDER</u>, Q.136

IF ANY POSITIVES, CONTINUE

135. A. How old were you when you started having these feelings that we've been talking about?

B. How old were you the last time you had these feelings that we've been talking about?

AVOIDANT DISORDER:

136. Were you ever the kind of person whose feelings would get hurt if someone like a parent or a teacher told you that you made a mistake?
(PROBE: WAS THERE EVER A TIME WHEN PEOPLE TOLD YOU THAT YOU WERE TAKING THINGS TOO SERIOUSLY?)

137. Have you ever had a period of six months or more when you didn't have any close friends outside of your family?

DESCRIBE_____

_____

138. Was there ever a time when you felt so shy that you couldn't make friends even though you wanted to?

139. Was there ever a time when you found that it was easy to be with your family but awful to be with other people including other kids?
(PROBE: UNLESS YOU KNEW THE PEOPLE REALLY WELL?)

140. Was there ever a time when you wished that you could make some friends but somehow just couldn't?

IF NO POSITIVES, Q.'S 136-140, SKIP TO OVERANXIOUS DISORDER, Q. 142.
IF ANY POSITIVES, CONTINUE

141. A. How old were you when you first started to be uncomfortable around new people, or easily hurt when criticized?

B. How old were you the last time you felt like that?

OVERANXIOUS DISORDER:

142. Were you ever a worrier? Has there ever been a time when you worried more than most children your age?

143. Have you ever worried a lot about things before they happen, for example, starting school in the fall, taking a test, or going to see a doctor?

144. A. Have you ever worried a lot about little things that you've done in the past, like something you've said that might have been taken the wrong way?

B. Give me an example. (CODE: NO = 1; YES = 2)

_____

_____

145. Has there ever been a time when you worried a lot that your parents or teacher would be disappointed with your grades?

146. Has there ever been a time when you were always worried that you couldn't do things well enough to please your parents or teachers?

147. Have you ever actually been sick from worry, that is, you worried so much that your head hurt or your stomach got upset?

148. Have you ever worried a lot about how you looked, about what you said, or about how you acted in front of your friends?
(PROBE: EVERYONE FEELS THAT WAY A LITTLE BIT, I'M TALKING ABOUT FEELING THAT WAY A LOT, MORE THAN MOST OF YOUR FRIENDS)

149. A. Has there ever been a time when you were always asking your parents or teacher to check and see if your work was done correctly?

IF NO POSITIVES, Q. 142-149, SKIP TO DYSTHYMIC DISORDER, Q. 150.
IF ANY POSITIVES, CONTINUE

B. How old were you when you first started worrying like this?

C. How old were you when you last worried like this?
IF STILL WORRIED, CODE PRESENT AGE

DYSTHYMIC DISORDER:

Now I'm going to ask you some more questions about the way you feel. In the other set of questions, I asked you if you'd ever had a period of a couple of weeks or so, when you felt really down. Now I'm going to ask you what you were like most of the time in the past year.

Some of the questions may sound like the ones you have already answered. However, I really would like you to think about them again, and answer them for me.

150. **In the past year have you felt sad, blue, down in the dumps, or low for long periods of time (MONTHS)?**
IF NO, ASK: Have you ever felt like that at any other time?

RECORD_____

151. **In the past year have you lost interest in almost all of your usual activities and pastimes?**

IF NO, ASK: Has that ever happened to you at any other time?

RECORD_____

152. **In the past year, have you found yourself feeling crabby and irritable a lot of the time?**

IF NO, ASK: Have you ever felt that way any other time?

153. **During the past year did you ever have trouble falling asleep, waking up in the middle of the night or very early in the morning?**
IF NO, ASK: Have you ever had alot of trouble sleeping most nights?

154. **Some kids have trouble falling asleep, but other kids sleep more than they really need to. For example, they take naps during the day, go to bed early at night, and sometimes they even sleep in class. Are you like that at all?**
IF NO, ASK: Have you ever slept more than you really needed to?

155. Have you ever had weeks or even longer when you felt tired out all the time - all dragged out - no energy?

156. Do you often feel that you're not as good as the other kids, e.g., not as smart, or good-looking, or as well-liked by the other kids, as good at sports, things like that?

157. Do you have times when you just can't seem to get things done? For example, it takes you forever to do your homework, and then you get a lot of it wrong anyway?

158. In the past year, if someone praised you or bought you a present as a reward for something, did you find that it didn't make you feel really happy and you didn't care very much about it?

159. Do you have times when it seems like your body slows down, and you feel that you move very slowly, or don't talk very much?

160. Are there times when your eyes fill up with tears, but you are not actually crying?

SIMPLE PHOBIA:

161. Is there anything that you are <u>really</u> afraid of?

DESCRIBE:_____

162. Have you ever had to talk in front of people (like in class) and found you were so afraid that you couldn't speak?

163. I'm going to read you a list of things that lots of people your age are afraid of and you tell me if you've ever been afraid of them. (CODE: NO = 1; YES = 2)

NOTE TO INTERVIEWER:
THESE THINGS SHOULD "PARALYZE THE CHILD WITH FEAR"

DARK

DOGS OR OTHER ANIMALS

BUGS

HIGH PLACES

BEING ALONE (AT HOME OR OUTSIDE)

CROWDS

OTHERS (SPECIFY)_____

IF NEGATIVE FOR ALL PHOBIAS, THEN SKIP TO
NEXT SECTION, OBSESSIVE COMPULSIVE DISORDER, Q.166
IF POSITIVE, CONTINUE:

164. Do you try to avoid _____ (ASK ABOUT SPECIFIC PHOBIA THAT THE KID ANSWERED POSITIVELY) or if you can't avoid it are you very miserable?

165. Could you give me an example?

_____

_____

OBSESSIVE COMPULSIVE DISORDER:

OBSESSIONS:

166. Have you ever had thoughts or ideas that you couldn't keep out of your mind?
(PROBE: THINGS THAT YOU DIDN'T WANT TO THINK ABOUT, BUT NO MATTER HOW HARD YOU TRIED YOU COULDN'T PUSH THEM OUT OF YOUR HEAD?
DID THESE THOUGHTS KEEP COMING INTO YOUR HEAD FOR NO GOOD REASON?
[VERIFY THAT THE THOUGHTS ARE INTRUSIVE AND SENSELESS.])

167. Have you ever seen things or heard sounds that didn't make sense to you, but you couldn't shake them out of your mind?
(PROBE: EVEN THOUGH THEY DIDN'T MAKE SENSE, YOU JUST COULDN'T GET RID OF THEM, NO MATTER HOW HARD YOU TRIED?)

IF NO TO Q. 166 AND 167, SKIP TO COMPULSIONS, Q. 173.
IF YES TO EITHER, CONTINUE.

168. Was this a real problem for you? Did you find that you couldn't concentrate on other things, because these thoughts (images and/or sounds) kept coming back to your mind?

169. Have you ever tried to stop these thoughts (sounds/images) by thinking of something else?

170. These repeated thoughts that you've been having, are they your own thoughts? What I mean is, are they coming from inside your head, or is it more like somebody is putting them inside your head?
(CODE YES IF THOUGHTS ARE FROM INSIDE THE HEAD.)

171. How old you were you the first time you started having these thoughts (hearing sounds/seeing images)?

172. How old were you the last time?
NOTE TO INTERVIEWER:
IF STILL HAPPENING, CODE PRESENT AGE

COMPULSIONS:

173. Have you ever found that you were doing something over and over again and you couldn't figure out why? (PROBE: SOME COMMON EXAMPLES ARE WASHING YOUR HANDS OVER AND OVER, BECAUSE YOU'RE WORRIED YOU MIGHT HAVE GERMS ON THEM; GOING BACK OVER AND OVER TO CHECK ON SOMETHING LIKE WHETHER OR NOT YOU LEFT THE WATER RUNNING; - OR COUNTING TO 100 BEFORE YOU MAKE A TELEPHONE CALL, THINGS LIKE THAT?)

RECORD_____

_____

IF Q.'S 166-170 ARE ALL NEGATIVE, AND Q. 173 IS NEGATIVE, SKIP TO PTSD, Q. 179.
IF ANY POSITIVES, Q.'S 166-170 AND Q. 173 IS POSITIVE, CONTINUE.
IF NO POSITIVES, Q.'S 166-170, BUT Q. 173 IS POSITIVE, FINISH SECTION AND RETURN TO Q. 166 AND VERIFY NEGATIVE ANSWERS.

174. Do you feel that if you do these these things _____(CHILD'S WORDS) that the thoughts _____(NAME THOUGHTS) will stop?

175. Do you feel in your heart of hearts that you're really spending too much time_____(CHILD'S WORDS)?

176. Is _____(CHILD'S WORDS) a big problem for you? For example, does it upset you, or take too much time out of your day?

177. How old were you when you first remember feeling that you had to do_____(USE CHILD'S WORDS)?

178. How old were you the last time you had to do_____ (USE CHILD'S WORDS)?

POST TRAUMATIC STRESS DISORDER:

179. Have you ever had a terrible - really frightening experience? For example: were you ever in danger of being killed?
(PROBE: WERE YOU THERE WHEN SOMEONE ELSE WAS BEATEN OR KILLED ? HAS ANYONE CLOSE TO YOU COMMITTED SUICIDE? HAVE YOU EVER HAD YOUR HOUSE AND YOUR POSSESSIONS DESTROYED BY A FLOOD OR FIRE?)

IF POSITIVE, DESCRIBE:

_____

_____

IF NO, SKIP TO EATING DISORDERS, Q.201
IF YES, CONTINUE:

Now I'm going to ask you some questions about how you felt about the_____(TRAUMATIC EVENT), okay?

180. After the_____did you think about it a lot?

181. Were you thinking about it so much that you couldn't push the thoughts out of your mind?

182. After the_____did you dream about it over and over?

183. After the_____were you ever in a situation where maybe just for a minute or so you felt as if it were happening all over again?
(PROBE: YOU FELT AS IF YOU WERE REALLY THERE?)

184. Have you ever been really upset because you saw or heard something that reminded you of the_____
(TRAUMATIC EVENT)?

185. Have you ever gone to a great deal of trouble to avoid things that reminded you of the_____ (TRAUMATIC EVENT)?

186. After the_____was over, did you ever find that you couldn't remember some things about the _____? (PROBE: LIKE YOU HAD AMNESIA FOR PARTS OF THE_____?)

187. After the_____was over, did you feel that you just couldn't get interested in things that you used to like?
(PROBE: LIKE SPORTS - FOOTBALL, SOCCER; PLAYING A MUSICAL INSTRUMENT, YOUR FAVORITE TV PROGRAM, ARCADE GAMES?)

188. After the_____did you ever feel that you weren't that interested in what people said or did?
(PROBE: DID YOU PREFER TO JUST GO OFF BY YOURSELF?)

189. After the_____did you ever feel that you just couldn't really love anybody; that you really didn't have loving feelings about anyone any more?
(PROBE: WHAT IF YOU SAW A LITTLE PUPPY OR A KITTEN, DIDN'T YOU FEEL IT WAS "CUTE OR ADORABLE" OR DID YOU NOT FEEL MUCH ONE WAY OR THE OTHER?)

190. After the_____do you remember feeling that the future didn't hold anything special for you?

NOTE TO INTERVIEWER: IF NO POSITIVES SO FAR IN PTSD, Q. 179-190, SKIP TO EATING DISORDERS, Q.201

IF ANY POSITIVES, CONTINUE:

191. After the____did you find that you were having a lot more trouble than usual either falling asleep or staying asleep?

192. After the _____did you feel very irritable, a lot more than usual?

193. Did you have outbursts of anger a lot more than usual?

194. After the_____do you remember the times when you had a great deal of difficulty concentrating a lot more than usual?

195. Did you feel restless or on edge?

196. Do you remember ever "jumping" when you heard a door slammed, or if someone came up behind you without you realizing it?

197. Did you ever break into a sweat, or feel teary, when you saw something that reminded you of_____?

198. Let's see, you've told me that you_____(NAME POSITIVES)
How long after_____did that start?
(CODE IN WEEKS: LESS THAN A WEEK = 1 WEEK)

RECORD_____

199. How long did they last?
(CODE IN MONTHS. LESS THAN 1 MONTH = 1 MONTH)

200. Would you say that this has been a very real problem for you ?

EATING DISORDERS

ANOREXIA NERVOSA:

201. Have you ever gone on a diet when you actually did lose weight?

202. Did other people in the family nag at you because they thought you weren't eating enough?

IF NO TO Q.201 AND Q.202, SKIP TO BULIMIA, Q.213
IF YES, CONTINUE:

203. How much weight did you lose altogether?

204. How tall were you when you started losing weight? (CODE IN INCHES)

205. Did you feel that you were fat or parts of you were too fat, even when people said you were too thin?

206. When you were dieting were you afraid that you might get fat again, and did you count every calorie? (PROBE: WATCH EVERY MOUTHFUL?)

207. Did your parents take you to a doctor, because they were worried about you losing so much weight?

208. What did the doctor say?

RECORD_____

209. How old were you when you first started being concerned about your weight, like we've been talking about?

210. How old were you the last time you were concerned about your weight - like we've been talking about?

BOYS AND GIRLS UNDER AGE 9, SKIP TO BULIMIA, Q. 213.
GIRLS OVER AGE 9, CONTINUE IF RELEVANT.

211. Had you started your menstrual periods before you began to diet?

IF NO, SKIP TO BULIMIA, Q.213
IF YES, CONTINUE:

212. While you were losing weight, did your periods stop?

BULIMIA:

213. **Have you ever gone on an eating binge and eaten a really large amount of food all at one time (MUCH LARGER THAN USUAL)?**

IF NO, SKIP TO THE NEXT SECTION, ENURESIS, Q.221
IF YES, CONTINUE:

214. How much did you eat?

RECORD_____

IF NO, SKIP TO THE NEXT SECTION, ENURESIS, Q.221
IF YES, CONTINUE:

215. **Did eating large amounts of food like that ever happen more than once a week?**

216. **How long did that period of eating lots and lots of food at least twice a week go on?**

12+ WEEKS.....2
5-11 WEEKS.....3
2-4 WEEKS.....4

217. **When you were bingeing like that, did you try to keep your weight down by taking laxatives, or making yourself throw up?**

218. **Did you exercise a lot?**

219. **Were you ever afraid that you couldn't stop eating?**

220. How old were you when you last ate lots and lots like we've been talking about?

IF PROBLEM STILL PRESENT, CODE CURRENT AGE

ENURESIS:

221. A. Do you wet the bed at night?

IF NO, SKIP TO Q.222.
IF YES, CONTINUE:

B. How often does it happen?

NIGHTLY.....1
MORE THAN ONCE A WEEK,
BUT NOT EVERY NIGHT.....2
2-4 TIMES A MONTH.....3
ABOUT ONCE A MONTH.....4
LESS OFTEN THAN ONCE A MONTH.....5

IF 221A IS POSITIVE, OR IF AGE 6 OR OLDER, SKIP TO Q. 223.

222. A. Did you wet the bed after you were old enough to go to school?

B. Did this happen more than once or twice?

C. How old were you the last time you wet the bed?

223. A. Have you ever wet during the day, so that you had to go change your clothes sometimes?

IF Q. 223A IS POSITIVE, OR IF AGE 6 OR OLDER, SKIP TO Q. 225.

B. How often does that happen?

NIGHTLY.....1
MORE THAN ONCE A WEEK,
BUT NOT EVERY NIGHT.....2
2-4 TIMES A MONTH.....3
ABOUT ONCE A MONTH.....4
LESS OFTEN THAN ONCE A MONTH.....5

224. A. Did you wet during the day, even after you were old enough to go to school?

IF NO, SKIP TO ENCOPRESIS, Q.225
IF YES, CONTINUE

B. Did this happen more than just once or twice?

C. How old were you the last time you wet during the day?

ENCOPRESIS:

225. A. **Did you ever have a bowel movement in your pants or on the floor, or someplace besides the toilet?**

IF NO, SKIP TO SOMATIZATION, Q. 229.

B. **Did this sometimes happen after you were old enough to go to school, and at a time when you were not sick?**

C. **How often has this happened?**

6+ TIMES.....2
3-5 TIMES.....3
1-2 TIMES.....4

D. **Do you still soil in your pants sometimes?**

IF NO, SKIP TO SOMATIZATION, Q. 229.

E. **How old were you the last time it happened?**

FOR GIRLS ONLY (SKIP IF BELOW AGE 9)

MENSTRUATION:

226. A.

B.

C.

D.

GENDER IDENTITY:

FOR GIRLS

227. A.

B.

C.

GENDER IDENTITY

FOR BOYS

228. A.

B.

C.

SOMATIZATION:

229. Do you consider yourself the kind of person who gets sick a lot of the time? (MORE THAN MOST PEOPLE?) (PROBE: HEADACHES, STOMACHACHES?)

230. Do you have to see the doctor a lot more often than other kids your age?

231. Have you had times in your life when you've thrown up a lot (much more than usual - much more than your friends or other people your age)?

232. Have you ever had any of the following problems:

A. Feeling nauseated?
(PROBE: GETTING SICK TO YOUR STOMACH EASILY?)

B. Does your stomach fill up with gas easily?

C. Do you have diarrhea often?

D. Do you get sick easily from eating different foods?

233. Have you ever had problems with severe pain in your arms or legs?

234. Have you ever had problems with back pain?

235. What about pains in your joints (knees, elbows, ankles)?

236. Pain when you go to the bathroom?

237. Other pain (not including headaches)?

RECORD_____

238. Have you ever had trouble with shortness of breath, even though you weren't exercising?

239. Palpitations? (Your heart pounding or beating too fast?)

240. Chest pain? (A tight feeling or pain in the chest?)

241. Feeling faint or lightheaded?

242. Feel a tingling in your face or fingers?

243. Have you ever had problems with amnesia? (That is, you couldn't remember something important that happened to you?)

244. **Did you have to take medication for medical problems?** (PROBE: OTHER THAN OVER THE COUNTER OR PAIN MEDICATION?)

IF YES, ASK FOR DETAILS. (IS IT MEDICALLY EXPLAINED?)

RECORD_____

_____

CHILD PSYCHOSES:

245. A. Have you ever seen things that other people couldn't see - like a vision?

IF NO, SKIP TO Q.246
IF YES, CONTINUE:

B. What did you see?

RECORD_____

C. Did you see_____just before you fell asleep or when you were waking up in the morning?

D. Has it ever happened that when you were watching TV you felt that someone on TV was sending a special message to you and nobody else?

246. A. Have you ever heard voices talking - voices that no one else but you could hear?

B. Please tell me a little more about them.

RECORD_____

C. Do you hear more than one voice?

IF NO, SKIP TO Q.247
IF YES, CONTINUE:

D. Did all the voices talk to you, or did they also talk to each other?

ALL TALKED TO YOU.....1
TALKED TO EACH OTHER.....2
SOME OF BOTH.....3

E. Did the voices tell you to do bad things? For example, did they tell you to hurt yourself, or hurt someone else?

247. Have you ever had the feeling that someone could read your mind?

RECORD_____

248. Has it ever seemed that someone could put thoughts into your head in some magical way?

249. A. Have you ever had the feeling that people were talking about you behind your back?

IF NO, SKIP TO Q.250
IF YES, CONTINUE:

B. Did you think they were planning to poison you, kill you or hurt you in some way?

RECORD_____

_____

250. Have you ever had any other unusual experiences, like the ones we've been talking about?

IF NO POSITIVES, Q. 245-250, SKIP TO PSYCHOSOCIAL STRESSORS, Q. 253.
IF ANY POSITIVES, CONTINUE.

251. A. How old were you when _____ first happened?

B. How old were you the last time these things happened?

252. Have you ever had these experiences at a time when you were not drinking, taking drugs, taking medicine prescribed by a doctor, or were very sick?

RECORD _____

_____

PSYCHOSOCIAL STRESSORS:

Some kids have really big problems at home which worry them a lot, or keep them upset a lot of the time. I want to check what sort of problems you have at your house.

253. A. Is there much quarreling or fighting in the family which bothers you a lot?

IF NO, SKIP TO Q.254 A.
IF YES, CONTINUE:

B. Is the fighting mostly among the children in the family or does it involve grownups?

NONE.....1
CHILDREN MOSTLY.....2
ADULTS MOSTLY.....3
BOTH.....4

254. A. Have any close relatives separated or divorced since you can remember?

IF NO, SKIP TO Q.255
IF YES, CONTINUE:

B. Who was it? (IF MORE THAN ONCE, CIRCLE EACH & CODE 8)

NONE.....1
PARENTS.....2
GRANDPARENTS.....3
AUNTS/UNCLES.....4
COUSINS.....5
FAMILY FRIENDS.....6
OTHER.....7
MORE THAN ONE.....8

255. Are there big money worries, like not having enough money for food or new clothes, or to pay the rent?

256. A. Is someone in the family seriously ill, handicapped or crippled so that you worry about it?

IF NO, SKIP TO Q.257
IF YES, CONTINUE:

B. Who is it? _____

(USE SCALE FROM Q. 257 B)

C. What kind of illness or handicap is it?

RECORD _____

D. Has that person been in the hospital a lot?

257. A. Has someone you cared a lot about died?

IF NO, SKIP TO Q.258
IF YES, CONTINUE:

B. Who was it? (IF MORE THAN ONE, CIRCLE & CODE 8)

PARENT (CHECK M__ F__)...1
GRANDPARENT.....2
SIBLING.....3
CLOSE FRIEND, ADULT.....4
CLOSE FRIEND, PEER.....5
OTHER.....7
MORE THAN ONE.....8

C. Who do you miss the most? (USE CODES IN B. ABOVE)
(WHICH ONE ARE YOU CLOSEST TO?)

D. How old were you when...(NAME CLOSEST PERSON)...died?

E. Are you still very upset about that person's death?

258. A. Does anyone drink a lot and cause disturbances at home which worry you?

IF NO, SKIP TO Q.259
IF YES, CONTINUE:

B. Who is it? (IF MORE THAN ONE, CIRCLE ONES WHICH APPLY AND CODE 8)

FATHER OR STEPFATHER.....1
MOTHER OR STEPMOTHER.....2
BOTH PARENTS.....3
SIBLING(S).....4
OTHER RELATIVE.....5
FRIEND OF FAMILY.....6
OTHER.....7
MORE THAN ONE.....8

259. A. Does anyone from your home have problems with the police?

IF NO, SKIP TO Q.260
IF YES, CONTINUE:

B. Who is it? (IF MORE THAN ONE, CIRCLE ONES WHICH APPLY AND CODE 8)

FATHER (OR SURROGATE)....1
MOTHER (OR SURROGATE)....2
BOTH PARENTS.....3
SIBLING(S).....4
OTHER RELATIVE.....5
FRIEND OF FAMILY.....6
OTHER.....7
MORE THAN ONE.....8

260. Are you scared that someone who lives in or comes to your home might hurt you or someone else there?

261. A. Have you ever been beaten so that you had bruises or marks on your body or were hurt in some way?

IF NO, SKIP TO Q.262
IF YES, CONTINUE:

B. Who hurt you that way?

FATHER (OR SURROGATE)....1
MOTHER (OR SURROGATE)....2
BOTH PARENTS.....3
SIBLING(S).....4
OTHER RELATIVE.....5
FRIEND OF FAMILY.....6
OTHER: _____.....7
MORE THAN ONE.....8

C. How old were you the last time that happened?

262. A. Has anyone else in the family been hurt like that, beaten up or knocked around by someone else?

IF NO, SKIP TO Q.263
IF YES, CONTINUE:

B. Who was hurt?

MOTHER.....1
FATHER.....2
SIBLING.....3
OTHER FEMALE RELATIVE....4
OTHER MALE RELATIVE.....5
FRIEND OF FAMILY.....6
OTHER.....7
MORE THAN ONE ABOVE.....8

C. Are you worried that it might happen again?

263. A. Has someone you have known quite well been killed by someone or by accident?

IF NO, SKIP TO Q.264
IF YES, CONTINUE:

B. Who was killed?

MOTHER.....1
FATHER.....2
GRANDPARENT.....3
SIBLING.....4
CLOSE FRIEND, ADULT.....5
CLOSED FRIEND, PEER.....6
OTHER.....7
MORE THAN ONE ABOVE.....8

C. Do you know how it happened?
(RECORD DECEASED CLOSEST TO CHILD)

MURDER BY UNKNOWN ASSAILANT.....1
MURDER BY KNOWN ASSAILANT.....2
ACCIDENTAL MURDER.....3
DEATH BY AUTO ACCIDENT.....4
DEATH BY OTHER ACCIDENT.....5
SUICIDE.....6
OTHER.....7
METHOD UNKNOWN.....8

IF NO POSITIVES FROM Q.253 THRU Q.263, SKIP TO Q.265
IF ANY POSITIVES, CONTINUE:

264. A. You told me_____(NAME POSITIVES). Has that happened (have those things been happening) in the past year?

If yes, which?

RECORD_____

B. Does it (do those kinds of things) stay on your mind a lot? Upset you still?

C. What would you say bothers you the most?

RECORD_____

265. Is there anything else you would like to tell me?

IF NO, SKIP TO Q.266
IF YES, CONTINUE:

RECORD_____

_____

266. Is there anything going on in your life that you'd like to get some help with?

IF NO, SKIP TO Q.267
IF YES, CONTINUE:

Would you tell me about that?_____

_____

_____

267. Was there anything I asked you in the interview which bothers you?

IF NO, END INTERVIEW
IF YES, CONTINUE:

Please tell me what it was:_____

_____

_____

_____

_____

_____

How does it bother you?_____

_____

_____

_____

TIME INTERVIEW ENDED:_____

Appendix C

Achenbach Child Behavior Checklist (CBCL)

Department of
Health, Education, and Welfare

CHILD BEHAVIOR CHECKLIST - - For ages 4 – 16

CHILD'S AGE	CHILD'S SEX	RACE
	☐ Boy ☐ Girl	

PARENT'S TYPE OF WORK *(Please be specific—for example: auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant, even if parent does not live with child.)*

FATHER'S TYPE OF WORK: _____

MOTHER'S TYPE OF WORK: _____

THIS FORM FILLED OUT BY:
☐ Mother
☐ Father
☐ Other *(Specify)*:

DATE

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

	Compared to other children of the same age, about how much time does he/she spend in each?				Compared to other children of the same age, how well does he/she do each one?			
	Don't Know	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, singing, etc. (Do not include T.V.)

☐ None

	Compared to other children of the same age, about how much time does he/she spend in each?				Compared to other children of the same age, how well does he/she do each one?			
	Don't Know	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

☐ None

	Compared to other children of the same age, how active is he/she in each?			
	Don't Know	Less Active	Average	More Active
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: Paper route, babysitting, making bed, etc.

☐ None

	Compared to other children of the same age, how well does he/she carry them out?			
	Don't Know	Below Average	Average	Above Average
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

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V. 1. About how many close friends does your child have? ☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week does your child do things with them? ☐ less than 1 ☐ 1 or 2 ☐ 3 or more .

VI. Compared to other children of his/her age, how well does your child:

	Worse	About the same	Better
a. Get along with his/her brothers & sisters?	☐	☐	☐
b. Get along with other children?	☐	☐	☐
c. Behave with his/her parents?	☐	☐	☐
d. Play and work by himself/herself?	☐	☐	☐

VII. 1. Current school performance—for children aged 6 and older:

☐ Does not go to school

	Failing	Below average	Average	Above average
a. Reading or English	☐	☐	☐	☐
b. Writing	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Spelling	☐	☐	☐	☐
Other academic subjects: e. _____ (for example: history, science, foreign language, geography).	☐	☐	☐	☐
f. _____	☐	☐	☐	☐
g. _____	☐	☐	☐	☐

2. Is your child in a special class?

☐ No ☐ Yes—what kind?

3. Has your child ever repeated a grade?

☐ No ☐ Yes—grade and reason

4. Please describe any academic or other problems your child has had in school.

☐ None

VIII. Below is a list of items that describe children. For each item that describes your child *now* or *within the past 12 months*, please circle the *2* if the item is *very true* or *often true* of your child. Circle the *1* if the item is *somewhat* or *sometimes true* of your child. If the item is *not true* of your child, circle the *0*.

0	1	2	1.	Acts too young for his/her age
0	1	2	2.	Allergy (describe): _____
				_____
0	1	2	3.	Argues a lot
0	1	2	4.	Asthma
0	1	2	5.	Behaves like opposite sex
0	1	2	6.	Bowel movements outside toilet
0	1	2	7.	Bragging, boasting
0	1	2	8.	Can't concentrate, can't pay attention for long
0	1	2	9.	Can't get his/her mind off certain thoughts; obsessions (describe): _____
				_____
0	1	2	10.	Can't sit still, restless, or hyperactive
0	1	2	11.	Clings to adults or too dependent
0	1	2	12.	Complains of loneliness
0	1	2	13.	Confused or seems to be in a fog
0	1	2	14.	Cries a lot
0	1	2	15.	Cruel to animals
0	1	2	16.	Cruelty, bullying, or meanness to others
0	1	2	17.	Day-dreams or gets lost in his/her thoughts
0	1	2	18.	Deliberately harms self or attempts suicide
0	1	2	19.	Demands a lot of attention
0	1	2	20.	Destroys his/her own things
0	1	2	21.	Destroys things belonging to his/her family or other children
0	1	2	22.	Disobedient at home
0	1	2	23.	Disobedient at school
0	1	2	24.	Doesn't eat well
0	1	2	25.	Doesn't get along with other children
0	1	2	26.	Doesn't seem to feel guilty after misbehaving
0	1	2	27	Easily jealous
0	1	2	28.	Eats or drinks things that are not food (describe): _____
				_____
0	1	2	29.	Fears certain animals, situations, or places, other than school (describe): _____
				_____
0	1	2	30.	Fears going to school
0	1	2	31.	Fears he/she might think or do something bad
0	1	2	32.	Feels he/she has to be perfect
0	1	2	33.	Feels or complains that no one loves him/her
0	1	2	34.	Feels others are out to get him/her
0	1	2	35.	Feels worthless or inferior
0	1	2	36.	Gets hurt a lot, accident-prone
0	1	2	37.	Gets in many fights
0	1	2	38.	Gets teased a lot
0	1	2	39.	Hangs around with children who get in trouble
0	1	2	40.	Hears things that aren't there (describe): _____
				_____
0	1	2	41.	Impulsive or acts without thinking
0	1	2	42.	Likes to be alone
0	1	2	43.	Lying or cheating
0	1	2	44.	Bites fingernails
0	1	2	45.	Nervous, highstrung, or tense
0	1	2	46.	Nervous movements or twitching (describe) _____
				_____
0	1	2	47.	Nightmares
0	1	2	48.	Not liked by other children
0	1	2	49.	Constipated, doesn't move bowels
0	1	2	50.	Too fearful or anxious
0	1	2	51.	Feels dizzy
0	1	2	52.	Feels too guilty
0	1	2	53.	Overeating
0	1	2	54.	Overtired
0	1	2	55.	Overweight
			56.	Physical problems without known medical cause:
0	1	2		a. Aches or pains
0	1	2		b. Headaches
0	1	2		c. Nausea, feels sick
0	1	2		d. Problems with eyes (describe): _____
0	1	2		e. Rashes or other skin problems
0	1	2		f. Stomachaches or cramps
0	1	2		g. Vomiting, throwing up
0	1	2		h. Other (describe): _____
				_____

Please see other side

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): _____
_____
0 1 2 59. Plays with own sex parts in public
0 1 2 60. Plays with own sex parts too much
0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy
0 1 2 63. Prefers playing with older children
0 1 2 64. Prefers playing with younger children
0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): _____
_____
0 1 2 67. Runs away from home
0 1 2 68. Screams a lot
0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe):
_____
_____
0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires
0 1 2 73. Sexual problems (describe):
_____
_____
0 1 2 74. Showing off or clowning
0 1 2 75. Shy or timid
0 1 2 76. Sleeps less than most children
0 1 2 77. Sleeps more than most children during day and/or night (describe): _____
_____
0 1 2 78. Smears or plays with bowel movements
0 1 2 79. Speech problem (describe): _____
_____
0 1 2 80. Stares blankly
0 1 2 81. Steals at home
0 1 2 82. Steals outside the home
0 1 2 83. Stores up things he/she doesn't need (describe):
_____
0 1 2 84. Strange behavior (describe): _____
_____
0 1 2 85. Strange ideas (describe):
_____
0 1 2 86. Stubborn, sullen, or irritable
0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot
0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language
0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe):
_____
0 1 2 93. Talks too much
0 1 2 94. Teases a lot
0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much
0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking
0 1 2 99. Too concerned with neatness or cleanliness
0 1 2 100. Trouble sleeping (describe):
_____
0 1 2 101. Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy
0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud
0 1 2 105. Uses alcohol or drugs (describe):
_____
0 1 2 106. Vandalism
0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed
0 1 2 109. Whining
0 1 2 110. Wishes to be of opposite sex
0 1 2 111. Withdrawn, doesn't get involved with other
0 1 2 112. Worrying
113. Please write in any problems your child has that were not listed above:
0 1 2 _____
0 1 2 _____
0 1 2 _____

PLEASE BE SURE YOU HAVE ANSWERED ALL ITEM

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