Gender and stress-related propensities to depression and substance use disorder from childhood to maturity: A prospective study

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Abstract

Gender and stress-related propensities to depression and substance use disorder from childhood to maturity: A prospective study

Kevyn Lee-Genest, Ph.D.

Concordia University, 2010

More women than men receive a diagnosis of depression and more men than women receive a diagnosis of substance use disorder. The purpose of the present study was to examine the relevance of gender in assessing the risk factors of the two disorders over the life course from childhood to emerging adulthood. The theoretical perspective that framed the design of the study centered on a developmental cumulative stress/resource model. The model places emphasis on a life trajectory of risk factors that is marked by linkages between negative conditions and family circumstances, maladaptive peer relations, and schooling problems in childhood and stresses, socioeconomic disadvantage, and personal resource deficiencies in adulthood. The question of gender specificity was examined in two ways. (1) Variable-centered analysis modeled life trajectories leading to depression and substance use disorder, and (2) person-centered analysis defined the profiles of individuals who shared similar life patterns of risk and resources, and determined the causal attributions of those who were depressed.

Data spanning 25 years were provided by 617 participants of the Concordia Longitudinal Risk Project. In line with epidemiological reports, more women than men met the diagnostic criteria for depression and more men than women qualified for a diagnosis of substance use disorder. The results of structural equation modeling indicated that the male and female patterns of relationships among the child and adult

variables that defined the life trajectories to depression and substance use disorder were essentially alike. There were a number of gender differences, however. Characterizing the women more than the men were linkages in childhood between family adversity and social withdrawal and between quality of peer relations and school performance. In addition, childhood aggression in the women but not the men mediated the association between family adversity in childhood and disadvantaged socioeconomic position in adulthood. The results of latent class analysis provided another perspective on the relevance of gender. Five distinct configurations of risk factors were associated with depression and substance use disorder. The most and least advantaged of the profiles comprised a greater proportion of women than men, but both genders were equally represented in the profiles with less extreme patterns. Also, the clustering of aggression, elevated stress, and low socioeconomic position predicted depression and substance use disorder in both the men and women. Finally, there were gender differences in causal attributions. Men were more likely to attribute their depression to ongoing interpersonal conflict, and women to cite negative experiences in childhood as a causal factor.

The findings of the study suggest that gender differences in the prevalence rates of depression and substance use disorder may best be explained by differences in help-seeking behaviour, in symptom reporting contexts and conditions, and in gender-related exposure to particular kinds of stress and modes of coping. More research along these lines is warranted.

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As I think about the ways in which to describe the many people who have helped me over these years, the words *Very Patient* emerge, without surprise, as a constant .....

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Introduction

Overview

Stress, personality, and family background are all key factors in the development of psychological disturbance. Psychological disturbance is more likely to occur in individuals who experience greater levels of stress (Gillespie, Whitfield, Williams, Heath, & Martin, 2005; Surtees et al., 2005; Turner & Lloyd, 2004), demonstrate certain personality and behavioural characteristics such as aggression (Loeber, Farrington, Stouthamer-Loeber & VanKammen, 1998; Rutter et al., 1997), grow up in adverse family situations (Poulton et al., 2002) or whose parents received a diagnosis of a psychiatric disorder themselves (Kessler, Davis & Kendler, 1997). Gender is also a significant factor in psychological disturbance. By adulthood, women are more likely to receive a diagnosis of depression than men, and men more likely to receive a diagnosis of substance use disorder than women (Kessler et al., 1994; Kessler, McGonagle, Schwartz, Blazer & Nelson, 1993; Grant, 1997; Wilsnack, Wilsnack, Kristjanson, Vogeltanz-Holm & Gmel, 2009). Following earlier research efforts that sought to identify these as specific individual factors, more recent paradigms have focused on the interrelationships among them (e.g. Jacobs et al., 2006; Kendler & Prescott, 2006). The general purpose of this prospective study was (a) to examine life trajectory factors that predispose some individuals to depression and others to substance use disorder and (b) to determine the relevance of gender in differentiating between the precursors of these diagnoses.

If the risk factors for psychopathological processes are diverse, it may be argued that the experience of stress is their common feature. Research, however, has also demonstrated that there is great diversity in many aspects of the experience of stress. Perception of what constitutes stress differs across individuals (Lazarus & Folkman, 1984). Individuals differ in the amount of stress they generate and feel on a day-to-day basis as a function of personality and genetic factors, and they respond differently to negative life events (Bolger & Zuckerman, 1995; Kendler et al., 1995; Lakdawalla & Hankin, 2008). Although adverse conditions do not invariably generate psychopathological processes (e.g. Cohen & Wills, 1985), the diverse ways in which the stress process unfolds accounts for the robust links that have been reported between stressors in their many forms and psychological disturbance.

Paralleling the variety of ways in which people perceive, generate and respond to stress is the significant variation observed in the outcomes of stress. From a theoretical stance, it has been posited that stressful circumstances elicit differing manifestations of distress from men and women as a function of the influence of gender role conventions (Aneshensel & Pearlin, 1987). Pearlin (1989) has suggested that the inclusion of more than one outcome of the stress process for study is desirable because it increases our understanding of the many outcomes attributable to stress while providing more information about differences in stress - related response patterns that lead to psychiatric disorder in different sociodemographic groups.

Gender differences associated with the development of depression and substance misuse have been noted in stress-related studies that deal with such aspects as exposure to negative life events, relationship issues, and maladaptive coping strategies (Gjerde, 1995;

Hammen, Henry & Daley, 2000; Mulia, Schmidt, Bond, Jacobs & Korcha, 2008; Nolen-Hoeksema, 1987; Ratliff-Crain & Baum, 1990; Rudolph, 2002; Schmaus, Laubmeier, Boquiren, Herzer & Zakowski, 2008; Tennant, 2002). At the same time, however, there is evidence of life course vulnerabilities to depression that are similar in men and women (Kendler, Gardner & Prescott, 2002; Kendler, Gardner & Prescott, 2006). There is evidence, as well, of a diminishing gender gap with regard to the incidence of substance use disorder in the younger cohorts of more recent prospective studies (Keyes, Grant & Hasin, 2008). It may therefore prove more informative to examine gender effects prospectively as part of a configuration of unfolding stress-related variables over the life course that are likely to have a bearing on the risk of depression and substance use disorder. It should also prove more useful to move beyond dichotomous gender role conceptualizations of externalizing and internalizing behaviours such as aggression and withdrawal, and outcomes such as substance use disorder and depression to examine gender in both its psychological and sociological frames of reference. Relevant in this kind of examination are theories such as stress process theory (Pearlin, Menaghan, Lieberman & Mullan, 1981) that focus on the individual within a broader societal context.

Most prospective studies of psychiatric risk model linear relationships between risk factors and disorder using a variable-centered approach. It has been observed, however, that variable-centered data may in fact describe relatively few individuals in a given sample (von Eye & Bergman, 2003). The choice to employ a person-centered approach may be particularly appropriate in prospective designs that are intended to delineate differing developmental pathways to a given psychiatric disorder or a given

pathway of antecedents to differing diagnostic outcomes (Rogosch & Cicchetti, 2004). Focus on the person, rather than on the particular risk factors, allows us to ask if there are groups of individuals distinguishable by features that they share - possibly including gender, but not necessarily - who are at risk for depression and substance use disorder. In addition, examination of the causal attributions of those at the receiving end of a psychiatric diagnosis extends and potentially enriches a person-centered perspective of life trajectory psychiatric risk factors.

The aims of the study, therefore, were to partner a person-centered strategy with the variable-centered approach so as to (1) define life course pathways to depression and substance use disorders; (2) define and differentiate between the characteristics shared by individuals vulnerable to depression and those vulnerable to substance use disorder; (3) assess the relevance of gender in examining the question of vulnerability to depression and substance use disorder; (4) assess the consistency of the findings with stress process theory; and (5) assess for similarity in causal attributions among individuals with a lifetime diagnosis of depression.

Literature Review

It has become standard practice to take multiple risk factors into account when studying the development of depression and substance use disorder. Developmental psychopathologists in particular have encouraged longitudinal examination of the interactions among diverse elements of people's lives, observing that different disorders may result from similar precursors and similar disorders from varying configurations of antecedent situations (Coie et al., 1993; Cicchetti, 2006). Kendler and Prescott (2006)

refer to this perpetual motion of causal processes and situations that etch pathways toward outcomes as the "dance through time".

If the dance through time is the constant, directional engagement between a person and his or her environment, gender, undoubtedly, is an essential element in this dance. The unequal distribution of prevalence rates in depression and substance use disorder between men and women attests to this importance; and yet, the nature of the relations between gender, environment, and diagnostic outcome remains unclear. How gender is related to environment and psychological disorder is a significant issue, not only because of gender differences in prevalence rates, in biological and genetic underpinnings, and in psychosocial factors such as self-esteem and interpersonal relations, but also because the male/female divide is one of distinct socio-demographic profiles. Bearing in mind the broad spectrum of factors involved, the question arises as to whether men and women develop different psychological disorders because of essential differing characteristics or whether there is an equivalence in differing outcomes that stems from effects of social position and socialization processes.

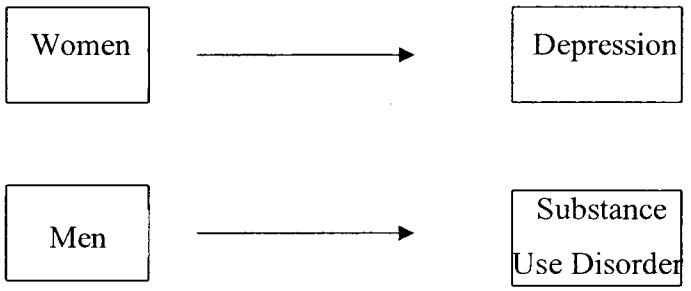
Epidemiological perspectives. According to numerous epidemiological studies, the lifetime prevalence rate for depression in women is about twice that in men and the lifetime prevalence rate of substance use disorder in men is about twice that in women (Hasin, Goodwin, Stinson & Grant, 2005; Hasin, Stinson, Ogburn & Grant, 2007; Jacobi et al., 2004; Kessler et al., 1994). Although women tend to seek psychological services overall at higher rates than do men, the one-year prevalence rates for depression in women and substance use disorder in men are similar across numerous studies (Bijl, Ravelli & van Zessen, 1998; Joska & Flisher, 2005). Figure 1 presents a model of

depression and substance use disorder based on epidemiological findings that depicts the clear, substantiated demarcation between men and women.

Epidemiological studies have the merit of drawing from substantial and representative population samples; the force of their statistical findings is indisputable at a first level. However, the descriptive facts of these numbers raise more questions than they answer and may therefore best be taken as a starting point in elaborating a more meaningful model of how men and women tend to develop differing psychological problems.

Figure 1

An Epidemiological Model of Depression, Substance Use Disorder and Gender

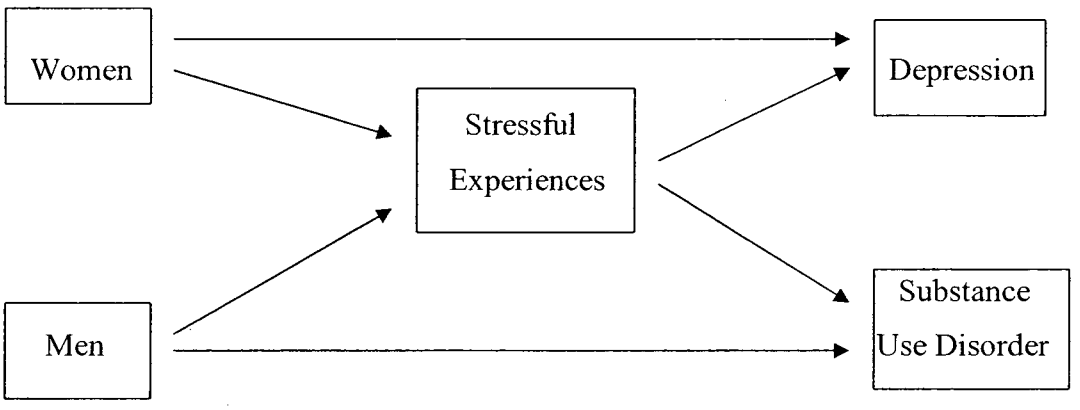


Stressful experiences. For both men and women, psychological distress is associated with stress. Stressors are broadly defined as those situations in which perceived demands exceed perceived resources, creating frustrations, conflicts, and pressures (Carson, Butcher & Mineka, 2000; Lazarus & Folkman, 1984). The pioneering work of Selye (1956) revealed the physiological impact of stressors on the living

organism, and since then it has become clear that numerous biological and psychological systems can be modified by the experience of stress over the course of development (Cicchetti & Walker, 2001). Literature reviews (e.g., Paykel, 1994) and meta-analyses (e.g., Kraaij, Arensman & Spinhoven, 2002) consistently demonstrate that individuals across various age groups who experience greater numbers of negative events are at greater risk for depression, and although fewer large-scale studies of these types are available concerning substance use disorder, stressful events also appear to play a significant role in their development (Andersen & Teicher, 2009; Lloyd & Turner, 2008). The inclusion of stressful experiences in the epidemiological model of the development of depression and substance use disorder for men and women is shown in Figure 2.

Figure 2

Stressful Experiences in the Development of Depression, Substance Use Disorder and Gender



Gender has a bearing on the experience of stress. There is evidence of differential exposure to stressful experiences for males and females, with a number of studies finding that on average women report more negative events than men (Bolger & Zuckerman, 1995; Hammen, 1991; McDonough & Walters, 2001). However, literature on the relation between gender and stress has emphasized that it is important to distinguish between exposure and vulnerability. In support of the idea that women respond with greater vulnerability to stressors, Matud (2004) found that when men and women reported the same number of negative events, women rated them as less desirable and less controllable than men. Taking a different approach, Day and Livingstone (2003) controlled for stressor exposure by presenting men and women with identical scenarios and found that women rated three of the five scenarios as more distressing than men did.

The observation of average patterns, however, leaves substantial room for questions about their meaning. A number of authors have argued that the apparent differences in male/female behaviour – including stress-related behaviours associated with psychiatric disorder – are largely explained by differences attributable to the organization of society, thereby leading to what Epstein (1988) has called "deceptive distinctions" made between men and women. The stress process model (Pearlin, 1989; Pearlin, Menaghan, Lieberman & Mullan, 1981) draws attention to gender relevant social stratification processes that affect mental health.

Stress process theory. Current trends in psychology make standard reference to the role of gender and environmental stress factors in the development of psychopathology, but the use of broader sociological perspectives as framework for understanding pathways to diagnostic outcomes is relatively infrequent (Mayer, 2004).

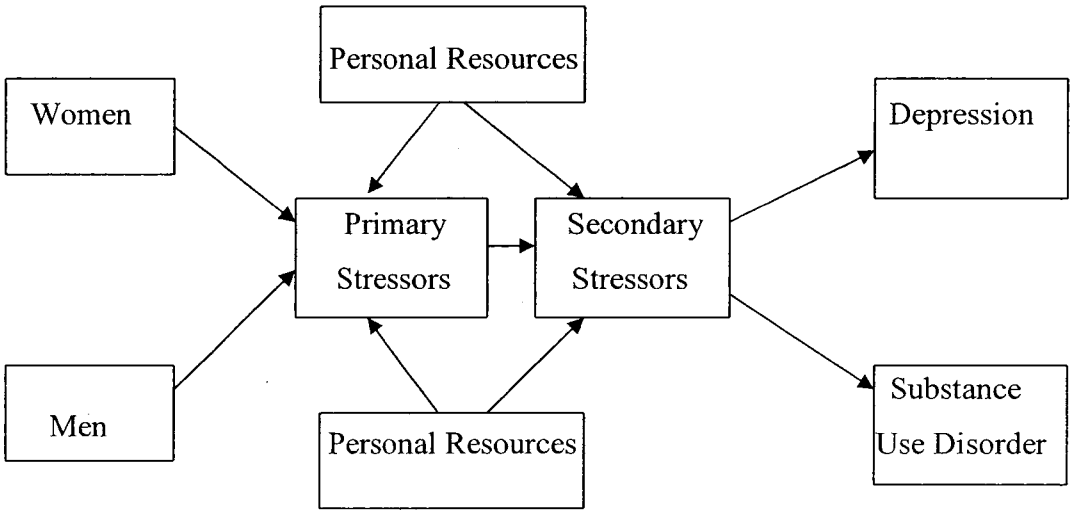
Theories in which to contextualize psychological processes may, however, be useful in improving our understanding of how factors such as gender and socioeconomic position are related to depression and substance misuse by adding a dimension of meaning to such robust associations. Situating psychological constructs within a sociological perspective should help avoid the trap of becoming "prisoners of the proximate" (McMichael, 1999), that is, of focusing exclusively on the micro level while failing to consider implications of macro-level influences.

The stress process model (see Figure 3) treats psychological disturbance as an outcome of unequal experiences of stress attributable to the unequal positions of individuals within social structures (Pearlin, 1989; Pearlin et al., 1981). This theoretical model depicts a chronological flow from a primary stressor that leads to secondary stressors by affecting the individual's subsequent experiences. Together, primary and secondary stressors create stress clusters that are characterized by both discrete negative events and chronic strains. The transactional nature of the relation between events and chronic strains means that each type of stressor may lead to the other and that they provide meaning for each other. Within the stress process model, the contextualization of depression and substance misuse does not preclude the recognition that personal resources, such as mastery and coping mechanisms, modify the effects of stress. In this way, there is an explicit acknowledgement of the interplay between the individual and the social/societal, and the recognition that individuals adapt in their own ways to larger structures (Bartley, Davey Smith & Blane, 1998).

Essential to this theory is the concept of embeddeness of events within a context and the priority of considering the "problematic continuities of people's lives" (Pearlin,

Figure 3

The Stress Process Model of Depression and Substance Use Disorder



1989, p. 244) when analysing outcomes of stress. Specifically, the stress process model locates these problematic continuities within larger social structures, such as gender and social class. It is assumed that inequalities in psychological outcomes arise, first, from differences in risk and protective factors (Pearlin, 1989), and second, from differences in the effects of these factors across socio-demographic categories.

Variations in research findings concerning effects of adversity on mental health attest to why these effects have been described as probabilistic rather than deterministic (Rutter, 1989). The probabilistic nature of this relation depends to some degree on gender (e.g. Bolger, Patterson, Thompson & Kupersmidt, 1995; Thoits, 1995). Sex differences in behaviour and in psychological outcomes refer to those differences

discernable as a function of the biologically based sex characteristics of individuals. It has been argued, however, that the physical characteristics of sex are the basis of processes in socialization and social stratification that must be termed *gender* (Lorber, 1994). Further, because strictly sex-based biological explanations of gender differences in prevalence rates of depression and substance use disorder show equivocal results (Bebbington, 1998), interest in explanations focussing on the psychosocial dimensions of gender have continued to grow.

Researchers that adhere to a structuralist perspective argue that depression is more prevalent in women than men because of stress factors that are embedded in social systems that reflect social rank, such as unequal employment opportunity (Golding, 1988; Rosenfield, Lennon & Raskin White, 2005; Simon, 2007). It is noteworthy that depression is particularly prevalent for individuals in the poorest groups (DeNavas-Walt et al., 2006; Ferrie et al., 2003; Jayakody & Stauffer, 2000), and that the poorest groups comprise a sizeable proportion of single mothers (Goldberg, 2009). But beyond this is the notion that inequalities tend to converge, such that it is the association between gender and social position more specifically that leads to social inequalities and, presumably, to consequent differences in health outcomes (Thoits, 1995). This view is supported by research findings that show similar rates of depression in men and women with similar socioeconomic positions (Ross & Mirowsky, 2006).

A second perspective places emphasis on the issue of gender and socialization processes. Research relevant to gender and psychological disturbance reveals, for example, that whereas the experience of emotion generally shows no more variation across than within genders, the expression of emotion is highly socialized (Brody & Hall,

1993; Fischer, 2000; Kring & Gordon, 1998). Gendered socialization begins early: Parents are particularly likely to express disapproval when confronted with feminine behaviour from their preschool sons, and to reinforce their preschool daughters for compliant, non-directive behaviour (Idel, Wood & Desmarais, 1993; Keenan & Shaw, 1997; Maccoby, 1998). Gender differences can be understood to refer more specifically to differences arising from societal expectations regarding masculine and feminine behaviours, or what West and Zimmerman (1987) have described as "doing gender." Doing gender implies that males and females respond differently to their surroundings based on socialization processes that have taught them appropriate or socially condoned manners of responding (Gelfand & Teti, 1990). Early experiences of social reinforcement can direct girls toward internalizing behaviours and boys toward externalizing behaviours (Chaplin, Cole & Zahn-Waxler, 2005; Keenan & Shaw, 1997; Sroufe & Rutter, 1984), through processes such as the parental transmission of values concerning aggressive behaviours (Dodge, Pettit & Bates, 1994).

Girls may respond particularly negatively to interpersonal stressors. Parental conflict or indifference and difficulties in peer relationships, for example, are likely to lead to particularly deleterious outcomes for them. In a similar manner, boys who have been socialized to value achievement- and independence-oriented goals may respond particularly negatively to stressors involving failure in these areas. In addition, responses to stress emerge from gendered norms of behaviour (Aneshensel, Rutter & Lachenbruch, 1991). Girls and women tend to turn inwards under stress, showing fewer salient signs of distress by developing internalizing symptoms such as depression (Broidy & Agnew, 1997; De Coster, 2005). Boys and men are more likely to turn outwards in stressful

situations, expressing their distress through more transparent actions, leading to externalizing symptoms such as excessive substance use (e.g. McLoyd, 1998). It has been argued, moreover, that the lower prevalence rate of depression in men may reflect socialization processes that result in differing symptom presentation, less frequent reporting of depressive symptoms, or the masking of symptoms as a result of regular substance use (Addis, 2008; Esposito-Smythers, Penn, Stein, Lacher-Katz & Spirito, 2008). It is in this context that the sections that ensue examine environmental stressors, person attributes, and personal resources.

Childhood Stressors. In the chronological flow toward emerging mental health states, there is often a traceable line between early and later circumstances: Adverse conditions in the childhood environment are associated with the later development of depression and problematic substance use (D'Onofrio et al., 2007; Goodman, 2002; Rodgers, 1994; Risser, Bönsch & Schneider, 1996; Tsoory, Cohen & Richter-Levin, 2007; Turner & Lloyd, 2003). Not surprisingly, as adverse conditions increase in scope or chronicity – the stress clustering brought on by relations among problematic aspects of the childhood environment – the risk for negative outcomes also increases (Gutman, McLoyd & Tokoyawa, 2005; Rutter, 1974; Wickrama, Conger & Abraham, 2005).

Childhood family environment. A family history of depression is predictive of depression and a family history of alcohol misuse is predictive of alcohol misuse (Chassin, Curran, Hussong & Colder, 1996; Cleveland & Wiebe, 2003; Nierenberg et al., 2006; Sher, Walitzer, Wood & Brent, 1991; Weissman et al., 2006; Williamson et al., 1995). Recent research has sought to explain this traceable line by examining mediating and moderating conditions and processes (Goodman & Gotlib, 1999; Grant et al., 2006).

It has been observed, for example, that a genetic vulnerability to alcohol misuse and depression is most likely to be expressed under stress-provoking conditions, with magnified risk occurring when stress is experienced in the early childhood years (Caspi et al., 2003; Eley et al., 2004; Rudolph & Flynn, 2007; Sher, Martin, Wood & Rutledge, 1997). Drawing on several areas of research, Hazel and colleagues (2008) observed that the relation between stress and depression may stem from heightened and persisting exposure to stress in individuals who experienced adverse conditions in childhood. They noted that adolescents who had a history of financial hardship, childhood chronic illness, parental discord or separation, maternal stressful life events or psychiatric disorder were more likely to continue experiencing similar stressors at age 15, and that this stress burden mediated the relation between early adversity and late-adolescent depression. This finding is significant because it draws attention to the idea that the experience of early stress has the potential to become enduring, such that parents' socioeconomic position or experience of depression is predictive of similar phenomena in their children (Downey & Coyne, 1990; Ermisch & Francesconi, 2001; Goodman & Gotlib, 1999; Mazumder, 2001; Mulligan, 1999; McGue, Pickens & Svikis, 1992).

Parental divorce. Enduring stress effects may stem from patterns of children's adjustment to divorce. Hetherington (1999), for example, has noted that "For many children, problems diminish with time as the family restabilizes but, on average, children of divorced parents are less socially, emotionally, and academically well-adjusted than children in non-divorced families" (p. 131). For children in the wake of divorce, there may be a transition period of adjustments to disruptions in schooling and friendships (Amato, 2001; Kelly, 2000; Størksen, Røysam, Moum & Tambs, 2005). Long-term

effects include completion of fewer years of formal education and difficulty in sustaining intimate relationships (Amato & De Boer, 2001; Cherlin et al., 1998; Rodgers, 1994). Many children living in a single-parent home following divorce, however, do not show problematic school outcomes (Hetherington & Kelly, 2002) and a growing number of studies have sought to clarify the nature of the effects of divorce on achievement and interpersonal relationships. Sun and Li (2001) conducted a wide-scale epidemiological study in which they examined the academic performance of more than 10,000 children, and re-assessed the same children two years later. They found that those children whose parents divorced in the interval between the two evaluations were already showing poorer academic performance at the time of the first assessment compared to those children whose families remained intact. Academic achievement and family functioning measured prior to the divorce largely accounted for the lower academic performance in children from the divorced families. The findings suggest that it is the effects of living with prolonged parental conflict preceding divorce that contribute to a worsening of school performance (Amato & Keith, 1991).

Economic hardship. Economic hardship at any point during the life cycle is a risk factor for mental health, but particularly so during the formative years of childhood (Goosby, 2007; Willms, 2002). Children growing up in high-stress environments tend to show lower levels of mastery across many developmental domains (Brown & Low, 2008; Kurtz, 1994). The relation between family socioeconomic position in general - and financial strain in particular - and academic achievement has been widely investigated (McLanahan & Sandefur, 1994; Raver, Gershoff & Aber, 2007; White, 1982). In their study of 7-, 8-, and 9-year-olds, Bolger and colleagues (1995) observed "a remarkable

range of difficulties encountered at school by children whose families experienced persistent economic hardship" (p. 1122). Children living in poverty are already lagging behind their more affluent peers when they begin their school career, a finding that has been attributed to family income rather than to other factors such as mother's education, children's birth weight, or family structure (Duncan & Magnuson, 2005; Lee & Burkham, 2002). By kindergarten and grade 1, standardized test scores are stratified by family socioeconomic position (Entwisle, Alexander & Olson, 2005), which has a bearing on risk of premature school leaving (Duncan & Brooks-Gunn, 2001).

Economic hardship in the early family environment is also related to less satisfactory peer relationships (Kuperminc, Blatt, Shahar, Henrich & Leadbeater, 2004; Patterson, Vaden, Griesler & Kupersmidt, 1991). Children from families with low income may have feelings of social exclusion that impinge on healthy development in many domains, including choice of peer affiliations and social competence (Bolger, Patterson, Thompson & Kupersmidt, 1995; Lempers, Clark-Lempers & Simons, 1989). Children's reports of feelings of loneliness and exclusion are validated by findings that relate persistent economic strain in the family to the lower popularity ratings they receive from their peers (Bolger et al., 1995). Such evidence both substantiates the importance of financial strain as a potentiator of later distress and draws attention to the long-term repercussions of financial hardship on parents' wellbeing and parenting competencies (Conger, Patterson & Ge, 1995; Reitman, Currier & Stickle, 2002).

The accumulation of stressors. Stressors tend to accumulate, notably for children living in poverty. In their focus on the pervasive effects of poverty, Conger and colleagues (1992, 2002) combined the factors reviewed in the preceding section in their

family stress model of economic hardship. In this model, economic pressure - a state of daily irritations and difficulties resulting from insufficient income - develops in the home environment and leads to parental emotional instability, a general negativity concerning the future, and depression. These parental states affect children's wellbeing in part through the repercussions of economic pressures on parenting quality. Lempers, Clark-Lempers and Simons (1989) among others (e.g., Gutman & Eccles, 1999) found that economic hardship increased adolescents' feelings of loneliness and depression both directly and indirectly through related deficits in parental nurturance and discipline.

Stressors also accumulate outside the family home. Families are situated within a broader environment, and those living with low income must deal with the pervasive stressors encountered in disadvantaged neighbourhoods. Low-income neighbourhoods typically offer inadequate resources, confrontations with violence, under-serviced schooling, and high levels of unemployment. The accumulation of adverse circumstances such as these increase parental distress and difficulty in parenting, and lead to a wide range of negative childhood and adolescent outcomes (Leinonen, Solantaus & Punamaki, 2003; Sampson, Morenoff & Gannon-Rowley, 2002). Certain neighbourhood factors, such as income level or educational attainment, may reflect, at least in part, individual characteristics of a neighbourhood's residents while others clearly denote attributes of the community itself (Pong, 1998; Sirin, 2005). A number of studies indicate that it is the ongoing stressors associated with unfavourable neighbourhood surroundings, rather than individual income bracket per se, that are more specifically implicated in negative health outcomes (Coulton & Pandey, 1992; Ensminger, Juon & Fothergill, 2002; Silver, Mulvey & Swanson, 2002). Given the significance of the

childhood environment for psychosocial development, it is not surprising that family environment stressors have a bearing not only on children's academic achievement, but also on their interactions with peers. The following section examines the relevance of gender in the contribution of aggressive and socially withdrawn behaviours in childhood to the stress accumulation process, and to depression and substance use disorder in maturity.

Person characteristics in childhood. Evidence of gender differences in the person characteristics that contribute to stress-reactive behaviours argues for the inclusion of the internalizing-externalizing dimensions of behaviour in modeling gendered life trajectories of stress-related depression and substance misuse. The stress process model provides an explanatory model of why and how individuals develop different psychological disorders as a function of factors associated with their social position, the stressors they encounter, and the interplay that occurs with personal resources. The stress process model refers to the internalizing – externalizing features of stress-reactive behaviors only indirectly. Gender differences in such behaviours, however, are relevant to personal resources, social networks, and stress-related outcomes (Lazarus, 1967; Turner, 1983) and we therefore included them to create an enhanced version of the stress process model.

Aggression. Individuals who engage in aggressive behaviour over the course of time narrow the scope of options available to them, limiting access to positive reinforcement and eliciting negative feedback from their social surroundings (Caspi, Elder & Bem, 1988). Moving against the world sets a potentially stressful course, with related problematic outcomes. Childhood aggressive behaviours are predictive of poor

academic achievement and early school leaving (Englund, Egeland, Oliva & Collins, 2008; Farrington, 1991; Fontaine et al., 2008; Moffitt, Caspi, Dickson, Silva & Stanton, 1996; Walker & Nabuzoka, 2007) and of problematic peer relations, particularly in girls (Bolger & Patterson, 2001; Dodge, Coie, Pettit & Price, 1990; Vaillancourt & Hymel, 2006). The low educational attainment of aggressive children often leads to adverse work experiences, reliance on welfare, and unemployment (Farrington, 1991; Kivimäki et al., 2003; Moffitt et al., 1996). Although children with high levels of aggression develop friendships, the long-term effects of aggressive behaviour include frequent negative social interactions and a higher incidence of divorce (Inness, LeBlanc & Barling, 2008; Kinnunen, Pulkkinen, 2003; Parker & Asher, 1993; Rys & Bear, 1997; Vanheusden et al., 2008).

There is ample evidence of the association between childhood externalizing behaviours such as aggression and later substance misuse (Brook, Whiteman, Finch & Cohen, 1996; King, Iacono & McGue, 2004; Kuperman et al., 2005). Krueger and colleagues (2002), using a large sample of participants from the Minnesota Twin Family Study, found that genetic effects largely accounted for a higher order risk factor that included a number of externalizing disorders, such as conduct disorder and alcohol dependence. At the same time, it has been shown that children with externalizing behaviours are at greater risk for excessive alcohol consumption if, in addition to a family history of alcohol abuse, they are also exposed to poor parenting practices (Sher, 1991).

Aggressive behaviour is also associated with depression. Rutter (2001) has suggested that individuals who show antisocial behaviour "generate interpersonal stresses and create disadvantageous psychosocial situations" (p. 266) and that such environments

are conducive to the development of depression. This conceptualization of a causal pathway from aggression to depression has received substantial validation (Block, Gjerde & Block, 1991; Crick, Ostrov & Werner, 2006; Ellis, Crooks & Wolfe, 2009; Huesmann, Dubow & Boxer, 2009; Panak & Garber, 1992; Rowe, Maughan & Eley, 2006; Vitaro, Brendgen & Tremblay, 2002). Comorbidity of aggression and depression has also been demonstrated (Coie & Dodge, 1998). For example, Morrow and colleagues (2008) reported that peer rejection as well as peer victimization, mediated the concurrent relation between aggression and depression in Grades 4 and 5 school children. The inverse causal relation – depression leading to aggression – has also been posited (Berkowitz, 1989), although this causal explanation has received little empirical support (Rutter, 2001). Of note, a good number of the studies cited show similar patterns of antecedents and outcomes in males and females.

In an early analysis of gender differences and similarities, Maccoby and Jacklin (1974) noted that aggression was one of the few personality domains that showed a clear gender distinction. Indeed, the consistency of findings showing a higher level of aggression in males than females led Hall (2002) to observe that, "The claim that men commit most acts of physical violence is possibly the nearest that criminology has come to producing an indisputable fact" (p. 36). These findings notwithstanding, the relation between gender and aggression is not unequivocal. There has been an increase in the numbers of girls and women engaging in a wide range of aggressive behaviours (Stahl, 2000). There are also mixed findings regarding the biological, sex-based origins of male-female differences in aggression (Ramirez, 2003). A number of studies, in showing no relation between testosterone and aggressive behaviour draw attention to the relevance of

the gender effects of environmentally mediated processes (Constantino et al., 1993; O'Connor, Archer, Hair & Wu, 2002; Schaal et al., 1996), including responses to stressors in the childhood family environment (Bolger & Patterson, 2001; Henderson, Sayger & Horne, 2003; Kempton, Armistead, Wierson & Forehand, 1991; Loeber & Stouthamer-Loeber, 1986; Wilson, Hurtt, Shaw, Dishion & Gardner, 2009). One such process, gender role socialization of the expression of aggression, begins to influence the behaviour of children at a young age. Socialization practices tend to encourage boys to take on characteristics of aggression that are associated with masculinity, and girls to refrain from expressing aggressive impulses - in line with the value placed on their role to enhance interpersonal relationships through empathy and sensitivity (Cobb, Cairns, Miles & Cairns, 1995; de Coster, 2005; Goodey, 1997; Surrey, 1991; Weisbuch, Beal & O'Neal, 1999). Consistent with the tenor of this research, Dietz and Jasinski (2003) found that women who identified strongly with traditional feminine gender roles were more likely to engage in *less overt* forms of aggression than those who endorsed items reflecting a masculine gender role. It has been argued, therefore, that the consistency of gender differences in aggressive behaviour demonstrated across studies may reflect the methods employed for its measurement. Crick and Grotpeter (1995) have observed that most studies of aggression fail to consider the importance of the less overt relational aggression that is more frequent in girls and women. If aggression is present in both men and women, a question that warrants attention concerns the role of gender in the relation between aggressive behaviour in childhood, whatever the form, the experience of stress, and the risk of substance use disorder and depression in adulthood.

Social withdrawal. Like aggression, social withdrawal is associated with stressors in the childhood family environment, such as parental conflict and divorce, parental depression and family economic hardship (Forehand, McCombs, Long, Brody & Fauber. 1988; McLeod & Shanahan, 1993; Pettit, Olino, Roberts, Lewinsohn & Seeley, 2008; Mills & Rubin, 1993). Social withdrawal refers to those behaviours that separate individuals from their social environment and lead to a low level or absence of social exchange (Rubin & Burgess, 2001; Rubin, Burgess & Coplan, 2002). In withdrawing from their peers, shy children compound their sense of social wariness by failing to engage fully in normative social interactions, thereby accentuating deficits in social competence (Rubin, Burgess & Coplan, 2002; Rubin et al., 1991; Young, Rankin & Bradley, 1998). The lower social competence observed in socially withdrawn children has a bearing both on how well they are liked by others and on the level of social support they receive (Coplan, Gavinski-Molina, Lagacé-Séguin & Wichmann, 2001; Gazelle & Rudolph, 2004; Karevold, Røysamb, Ystrom & Mathiesen, 2009; Liebowitz, 1999; Rubin, Wojslawowicz, Rose-Krasnor, Booth-LaForce & Burgess, 2006; Shields, 2005). As with children, shyness in adults is related to poor-quality relationships with friends, family, and romantic partners (DeLongis & Holtzman, 2005; Nelson et al., 2008). Importantly, clinical studies show that social withdrawal in socially anxious individuals does not necessarily indicate a lack of desire for social contact (Liebowitz, 1999). The discrepancy between desired and actual level of contact may contribute to the development of depression.

Cheek and Watson (1989) observed that the tension and awkwardness in social interactions experienced by shy individuals often carry over into the academic milieu.

Rapport and colleagues (2001) found that withdrawal was negatively related to classroom performance and remained so after controlling for level of intelligence, early achievement, and internalizing problems. A number of studies have shown that shyness is inversely associated with years of formal education, with implications for long-term employment status (Caspi, Elder & Bem, 1988; Kerr, Lambert & Bem, 1996; Kokko, Pulkkinen & Puustinen, 2000; Risi, Gerhardstein & Kistner, 2003).

The internalizing profile of socially withdrawn children may predispose them to depression, particularly if there is familial risk. Social withdrawal in early childhood is predictive of depressive symptoms in middle childhood, adolescence and early adulthood (Asendorpf, Denissen & van Aken, 2008; Boivin, Hymel & Bukowski, 1995; Leve et al., 2005; Nelson et al., 2008; Realmuto, August & Hektner, 2000; Rubin et al., 1995; Mun, Fitzgerald, Puttler, Zucker & von Eye, 2001). Social withdrawal is also cited as a buffer against substance misuse (Bruch, Rivet, Heimberg & Levin, 1997; Eggleston, Woolaway-Bickel & Schmidt, 2004; Ham & Hope, 2005). At the same time, the frequent comorbidity between social anxiety and substance misuse has been shown (Kessler, Stang, Wittchen, Stein & Walters, 1999; Morris, Stewart & Ham, 2005). Hill and colleagues' (1999) observational study of children at high and low risk for alcoholism found that high-risk children demonstrated more instances of behavioural inhibition with a peer than did low-risk children. It has been posited that the discomfort experienced by socially avoidant individuals leads to the use of substances as a coping strategy (Bell, Malizia & Nutt, 1999; Buckner & Schmidt, 2008; Stewart et al., 2006). Discrepant findings showing both buffer and risk effects of social withdrawal may be explained in

part by the tendency of socially anxious women to become depressed and socially anxious men to turn to substance use (Keller, 2003; Yonkers, Dyck & Keller, 2001).

In studies of early child temperament there are no gender differences reported in behavioural inhibition (Kagan, Reznick & Snidman, 1988). By adulthood, however, social anxiety disorder, which includes social avoidance or withdrawal as a symptom, is more prevalent in women than men (Kessler, Berglund, Demler, Jin & Walters, 2005). Nonetheless, men seek treatment for social anxiety disorder more frequently than women and report greater concerns about being shy (Lazarus, 1982; Weinstock, 1999). Teachers and parents view shyness and withdrawal in boys less positively than in girls (Coplan, Gavinski-Molina, Lagacé-Séguin & Wichmann, 2001; Hane, Cheah, Rubin & Fox, 2008), and children themselves perceive their own behaviour differently according to their gender. Nelson and his colleagues found that, by age seven, whether or not girls engaged in solitary play did not affect their perceptions of their acceptance by peers, whereas it did in withdrawn boys (Nelson, Rubin & Fox, 2005).

There appear to be few studies directly investigating gender differences in social withdrawal and depression. Research does show, however, that in comparison with girls, social withdrawal in boys is related to lower self-worth, poorer self-reported social skills, greater loneliness, and more negative peer status (Boivin & Hymel, 1997; Morison & Masten, 1991; Rubin, Chen, & Hymel, 1993). Such processes may explain why social withdrawal in childhood is a greater risk factor for a range of potentially negative outcomes for boys than for girls (Coplan, Prakash, O'Neil & Armer, 2004; Eisenberg et al., 1998; Morison & Masten, 1991; Rubin et al., 1993; Stevenson-Hinde & Glover,

1996). Given the small body of information available on gender differences in the relation between social withdrawal and depression, further research is warranted.

Likeability. The above examination of the developmental pathways of individuals who showed internalizing or externalizing behaviours as children makes clear the importance of the social sphere. For this reason, likeability as an attribute in childhood was included in the present study. Children who are rated as high in likeability by peers tend to be perceived as helpful, trustworthy, as having friends, and as being academically successful (Parkhurst & Asher, 1992; Rubin, Bukowski & Parker, 1998). How well children are liked by their peers shows moderate stability over time, although this stability appears to be lower for boys than for girls (Jiang & Cillessen, 2005). Likeability is related to quality and stability of children's friendships (Lansford et al., 2006; Newcomb & Bukowski, 1983), and is also predictive of good school performance, perhaps in part as a function of favourable teacher/student relationships (Farsides & Woodfield, 2003; Laidra, Pullmann, & Allik, 2007; Shiner, 2000).

There are few longitudinal studies following likeability in childhood through to adulthood. Nonetheless, there is evidence of the increased risk of depression and substance misuse in individuals who were disliked or rejected by their childhood peers. Prinstein and LaGreca (2004), for example, reported that likeability in childhood buffered against substance misuse in adolescent girls. Reinherz and colleagues (2000) found that peer rejection in early childhood was predictive of both depression and substance misuse in young women, and early peer problems predicted depression in young men. More recent research has focused on childhood likeability as a protective factor with regard to both externalizing and internalizing disorders in adulthood, notably through its positive

association with positive resources and its negative association with stress (Schwartzman et al., 2009). At the same time, studies employing popularity ratings demonstrate an inverse relation between popularity and risk for substance misuse, notably in adolescence (Allen et al., 2005; Diego, Field & Sanders, 2003; Scheier & Botvin, 1998). In summary, the evidence reviewed here suggests that aggressive and socially withdrawn behavioural characteristics and the degree to which individuals are liked in childhood have a bearing on the interactions with the environment that shape the stress processes of adulthood.

Stressors in adulthood. Aneshensel, Rutter, and Lachenbruch (1991) have observed that medical and sociological models of health differ in their interpretation of stress, in that the former views the experience of stress as abnormal, and the latter as "an orderly consequence of social organization" where "high rates of disorder among some social groups are seen as the inevitable by-product of ordinary facets of social life .... that are often advantageous to other social groups" (p. 167). In this perspective, the "ordinary" progression from strong school achievement to well paying employment in an individual from a high socioeconomic background is more likely to lead to lower levels of overall stress and disorder than the "ordinary" progression from low school achievement in an individual of low socioeconomic position to low paying employment and higher levels of stress.

Socioeconomic position. Socioeconomic position has been defined as the relative position of individuals in terms of social and economic factors, and the associated capacity to create or consume the goods valued in postindustrial societies (Boyd, 2008). The hierarchy stress theory proposes that individuals of lower socioeconomic position are more likely to show poorer health than those of higher socioeconomic position because

they lack structural and material possessions and because low status in a social hierarchy is inherently stressful (Wilkinson 1997). To this effect, Ross (2000) has stated that,

> Over and above the characteristics of the individuals who live there, neighborhood disadvantage affects adult mental health.... The daily stressors associated with disorder, trouble, crime, danger, and the perception that social order has broken down, are associated with depression – with feeling run-down, tired, hopeless and sad. (p.184).

Thus, there has been some discussion among social scientists as to how socioeconomic position is best measured. The general consensus is that inclusion of more than one index is useful (e.g., Benzeval & Judge, 2001). The three domains frequently examined are income, education and occupation reflecting different aspects of social stratification (Siegrist & Marmot 2006; Adler & Ostrove, 1999). In addition, neighbourhood quality is increasingly referenced as a measure of overall conditions of living (Carle, Bauman & Short, 2009; Robert, 1998).

As in childhood, financial hardship in adulthood is a primary stressor that leads to and exacerbates secondary stressors in numerous life domains, contributing to demoralization and emotional distress (Angel et al., 2003; Blacksher, 2002; Chou & Chi, 2001; Pearlin, 1989; Pearlin et al., 2005; Vinokur, Price & Caplan, 1996). Financial insecurity is a mediating force, explaining, for example, the relation between job loss and later depressive symptoms (Price, Choi & Vinokur, 2002; Vinokur & Schul, 1997). Income is also directly related to recent and lifetime drug and alcohol misuse (Mincy, Sawhill & Wolf, 1990; Warner, Kessler, Hughes, Anthony & Nelson, 1995).

Individuals living in difficult economic circumstances are exposed not only to the stresses of inadequate resources but also to the stresses associated with the power differentials of differential wealth. It has been observed that despite improvement of financial status in the least well paid sections of the population, the overall pattern of socially distributed health has not changed (Blane, Brunner & Wilkinson, 1996). Key to this point is the understanding that the concept of poverty includes the issue of duration. Although many individuals experience periods of financial compromise, chronic poverty is associated with a significant increase in problematic outcomes (Brooks-Gunn & Duncan, 1997). Whelan and Maitre (2008) in attesting to the existence of a chronically "economically vulnerable class" note that "descriptive accounts of the dynamics of income poverty and deprivation involve significant overestimation of the level of exits from such states" (p. 656).

Boyd's (2008) recent analysis of census data demonstrates that ratings of occupational status closely correspond with income and education. Overall, individuals in paid employment have fewer negative mental health concerns than those who are not part of the paid work force (Mcdonough, Walters & Strohschein, 2002). Disparities in outcomes of depression have at least in part been attributed to the fact that despite continuing increases in the opening of traditionally male dominated occupations to women, sex-related employment categories within the labour market persist and women continue to occupy lower paying positions than their male counterparts (Cross & Bagilhole, 2002; Iyer, 2002).

Occupation as an index of socioeconomic position reflects income, prestige and acquired skills - factors that are clearly related to social inequalities. At the same time,

information concerning employment is necessarily limited to those individuals who take part in the labour market (Krieger, Williams & Moss, 1997). Education is therefore a useful refining measure of socioeconomic position because it provides information about individuals who have lower employment rates, a situation that may notably be the case for women (Arber & Cooper, 2000). Women who have obtained post-secondary degrees report less emotional distress than those with fewer years of education (Mcdonough, Walters & Strohschein, 2002). More specifically, robust inverse relationships have been noted between educational attainment and depression and drug and alcohol use (Crum & Anthony, 2000; Miech, Caspi, Moffitt, Wright & Silva, 1999; Poulin, Webster & Sinle, 1997; Warner et al., 1995).

The individual's own perceptions of his or her living conditions are also increasingly recognized as an important component in measuring socioeconomic position. Subjective experience of the neighbourhood of residence may be seen to fall under the heading of social capital, a concept that describes the collective value of an individual's social networks, and that includes, for example, the idea of trustworthiness experienced in a community (Putnam, 2001; van Oorschot, Arts & Gelissen, 2006). A growing number of studies now include a subjective measure such as perceived financial pressure, impression of neighbourhood resources and safety, or subjective "sense of place" (Muhajarine, Labonte, Williams & Randall, 2008) that is of relevance to the risk of depression. Such studies have documented both concurrent and prospective associations between this kind of assessment of neighbourhood and depression (Ellaway, Macintyre & Kearns, 2001; Latkin & Curry, 2003; Weden, Carpiano & Robert, 2008).

Negative life events and daily hassles. As noted above, there is long-standing evidence linking negative experiences with unfavourable changes in mental health (Brown & Harris, 1989). The relation between negative life events and adult mental health, however, is complex. A number of studies have not found a relation between negative life events and alcohol misuse, and others have shown only modest effects with regard to depressive symptoms (Graham & Schmidt, 1999; Kraaij, Arensman & Spinhoven, 2002). Dohrenwend (2000), however, noted that the greater the uncontrollable negative changes following an event the more likely the onset of a disorder. Many authors suggest that the relation between stressful events and psychological distress is strongest when there is an antecedent state of vulnerability (for a review see Monroe & Simons, 1991), a diathesis that may have genetic, cognitive, or personality underpinnings. In prospective as well as cross-sectional research, however, causal direction may not always be clear (Johnson & Pandina, 2000). Skaff, Finney and Moos (1999) discuss "the ubiquitous problem of reciprocal effects" (p. 50), observing that drinking and depression may increase the number and perceived magnitude of stressful circumstances while simultaneously decreasing adaptive responses. For these reasons, it is desirable to complement negative events checklists with other indices of stress.

Negative events are often associated with more chronic, daily stressors (Welsh, 2009). Medical illness and physical pain, for example, may precede depression. In a large epidemiological sample, Angst and colleagues (2002) found that 65% of individuals treated for depression presented some medical condition. Individuals with longer lasting and more severe medical symptoms report higher levels of depressive symptomatology

and reciprocally exacerbating adverse effects (Currie & Wang, 2004; Tang, Yu & Yeh, 2010). Substance misuse is frequently co-morbid with a wide variety of medical conditions (Draper & McCance-Katz, 2005). Modest effect sizes reported in studies of the relation between negative life events and mental health, however, have prompted researchers to focus on the effects of day-to-day tensions (Chamberlain & Zika, 1990; DeLongis, Coyne, Dakof, Folkman & Lazarus, 1982; Lazarus, 1999). Numerous studies have attested to the robust association of "daily hassles" with alcohol misuse (Armeli, Tennen, Todd, Affleck & Kranzler, 2000; Crum, Muntaner, Eaton & Anthony, 1995) and with depressive symptoms (Cummins, 1990). Daily hassles also act as the proximal stressor that mediates the link between earlier adversity and later health outcomes (Back et al., 2008; Hutchinson & Williams, 2007). Taken together, research on stressful situations underscores their relevance as stressors to mental health status. For both men and women, higher overall levels of stress are predictive of depression and substance misuse. In terms of a life trajectory perspective, it may be, as some authors have argued, that childhood adversity initiates a sequence of maladaptive behaviours, or as others have maintained, is relevant only as a vulnerability that is evident in the face of the challenges of adulthood (Cherlin, Chase-Lansdale & McRae, 1998).

An issue raised at this juncture is that of how individuals manage their daily lives. Can the relation between childhood and adulthood adversity and ensuing disturbance in psychological wellbeing be explained by variations across individuals in the personal resources that they bring into their relationships with the environment? The following sections examine the impact of personal resources on the association between adverse experience and depression and substance use disorder.

Personal Resources. The experience of stress and how it is managed has an important bearing on health and quality of life (Zeidner & Endler, 1996). Research on resilience provides a salient demonstration of the fact that children can overcome early adversity and go on to achieve satisfaction across life domains (Luthar & Latendresse, 2005; Videon, 2002). Individuals regulate their responses to environmental conditions in various ways, increasing or decreasing their experiences of stress through processes involving personal attributes. The intervention of personal resources, including the attribute of peer likeability in childhood discussed earlier, has an impact on outcomes otherwise expected by social position. Personal resources are an essential component of the stress process, in which mentally healthy individuals select themselves out of difficult circumstances and are able to manage those that cannot be avoided (Thoits, 2006).

Self-esteem. Self-esteem is "the level of global regard that one has for the self as a person" (Harter, 1993, p. 88). Self-esteem has long been associated with mental health, with high self-esteem viewed as a protective factor likely to foster health-enhancing behaviours such as adaptive stress management. Although the importance of self-esteem for happiness and well-being has been contested by some (Baumeister, Campbell, Krueger & Vohs, 2003), the association between low self-esteem and depression (Cozzarelli, 1993; Mann, Hosman, Schaalma & de Vries, 2004; Orth, Robins & Roberts, 2008; Rutter, 1992; Tennen & Affleck, 1993) and low self-esteem and substance misuse (Griffin-Shelley, Sandler & Lees, 1990; Guindon, 2009; Martin, Bliven & Boisvert, 2008; Vega, Zimmerman, Warheit, Apospori & Gil, 1993) have been demonstrated empirically both concurrently and prospectively. A number of authors have proposed explanatory models of the relation between self-esteem and a range of negative

phenomena. Two such examples are the self-esteem vulnerability model (Brown, Andrews, Bifulco & Veiel, 1990; Harris, Borsanyi, Messari, Stanford & Cleary, 2000) and the sociometric model of self-esteem (Leary, Schreindorfer & Haupt, 1995). These models describe the relevance of relationships between self-esteem and stress or, more specifically, interpersonal stress in the sociometric model, for psychological disturbances such as depression and substance misuse. The interpersonal contingent self-esteem model of gender differences in depression includes gender as a significant moderating factor in this relationship (Cambron, Acitelli & Pettit, 2009). Research has produced varying results concerning gender differences in levels of self-esteem, with earlier work often showing few male/female differences (Hattie, 1992). A more recent meta-analysis, however, indicated a small but meaningful gender effect, with males scoring higher than females on measures of self-esteem (Kling, Hyde, Showers & Buswell, 1999). Gender effects have also been uncovered in levels of self-esteem when additional relevant information is considered, such as age and domains of functioning (McLeod & Owens, 2004; Twenge & Campbell, 2002; Twenge & Crocker, 2002). Gentile and colleagues (2009), for example, observed that when self-esteem was measured according to specific domains of functioning gender differences were often quite large.

The tendency for women to have lower self-esteem than men has been cited as an explanation for their higher levels of depression (Allgood-Merten, Lewinsohn & Hops, 1990; Marcotte, Fortin, Potvin & Papillon, 2002). In line with the idea of gendered pathways, the relation between low self-esteem and substance misuse appears to be stronger in men than in women. Two large-scale studies, one concurrent and the other prospective, found that men with low self-esteem were more likely to misuse both

alcohol and cannabis than women (Huurre et al., 2010; Veselska et al., 2009). Of note, these findings are not consistent with those of an earlier study where low self-esteem was found to be more predictive of later excessive substance use for women than for men (Walitzer & Sher, 1996).

Social support. Social support, or the help and availability that people consider they can count on from their partner, friends and family, is a concept integral to the stress process (Thoits, 2006). As noted by Coyne and Downey (1991), "the concept of social support was originally seen as a balance to the more negative view that social relationships were sources of stress " (p. 414). Greater levels of social support tend to be associated with a greater ability to avoid the negative consequences of adversity, and to experience higher levels of happiness and better mental health outcomes in general (Cohen, 2004; Diener & Seligman, 2002; Dohrenwend, 1998; Ren, Skinner, Lee & Kazis, 1999; Stroebe & Stroebe, 1996). In her study of women and depression, Warren (1997) found that both negative life events and depression were inversely related to social support. Conversely, low social support has been related to higher rates of internalizing problems (Sinokki et al., 2009; Vanheusden, 2008). In addition, there is a longstanding view that social support is an important aspect in relapse prevention of drug and alcohol addiction (Groh, Jason, & Keys, 2008; Scherbaum & Specka, 2008). Greenglass and Fiksenbaum (2009) noted that the relation between social support and positive affect may be explained in part by the positive association between social support and proactive coping strategies. In helping people deal more effectively with life stressors, social support lessens the effect of these stressors on depression (Chou & Chi, 2001).

Many studies of social support focus on women and provide evidence that women have greater levels of social support than men (Meyer, Schwartz & Frost, 2008; Turner & Lloyd, 1999). At the same time, Burleson (2003) cites research that attests to the idea that men and women value social support for similar reasons. This raises the question of how gender pertains to the relation between social support and psychological distress. Skaff and colleagues (1999) observed that although women reported more depression than men, the stressors and resources that affected depression were similar in men and women – except in terms of the importance of social support from friends. In effect, in this study, women's greater experience of friends' support was related to fewer days of depression and fewer days intoxicated during the course of the previous month, whereas there was no such relation for men. Similarly, in their study of risk and resilience in men and women, Powers, Ressler and Bradley (2009) showed the attenuating effect on depression of friends' social support in women, but not in men, who had experienced emotional abuse or neglect in childhood.

To summarize, the research literature on stressors and personal resources indicates that there is a life trajectory of stress-related effects; an association between stressors in childhood and stressors in adulthood; between child and adult stressors and depression, and between child and adult stressors and substance misuse. Further, such effects are attenuated by personal resources and augmented by maladaptive childhood aggression and social withdrawal. Differences between men and women in their proximal responses to adverse family environments, and in their personal resources may set different pathways - described as "fateful trajectories" by Hagan and Foster (2003) - for both experiencing and dealing with the stressors that occur during adulthood. At the

same time, social structures including gender and class organize individuals' experiences of themselves within their social environments and constrain opportunities to transcend these structures through the limits that these structures impose. Focusing on gender differences alone, therefore, may result in deceptive distinctions and an incomplete understanding of the risk factors of depression and substance use disorder. The stress process model draws attention to gender differences in terms of social contexts that have a bearing on the experience of stress and its effects. It draws attention, therefore, to the need for a combination of methodological approaches that can more fully capture social contextual effects.

Multi-method strategies. Most longitudinal studies on depression and substance misuse are variable-centered. While clearly informative, the variable-centered approach may in fact describe relatively few individuals directly (von Eye & Bergman, 2003). A limitation can also arise from the assumption that the variables under analysis covary in the same way for everyone. Within-group variation may be left unaccounted for, leading to potentially erroneous data interpretations (Block, 2000). Also of concern for researchers interested in viewing the person as an "integrated, hierarchically organized totality, rather than a summation of variables" (Magnusson, 1998, p. 51), is the potential for misleading interpretations of findings when the focus is placed on only part of a complex system. Scores on measures of aggressive behaviour, for example, may be more meaningful when they are interpreted in light of the individual's scores on a number of other measures rather than in isolation.

Person-centered approaches cluster individuals with similar *patterns* of data, and by doing so, provide contextual meaning for any given variable (von Eye &

Bergman, 2003). Within-individual correlations of variables are as relevant as those between individuals, particularly in longitudinal studies that examine developmental pathways (Rogosch & Cicchetti, 2004). Focusing on the person as well as on variables allowed us to ask, as an additional study objective, whether there were individuals at risk for depression and substance use disorder who shared particular kinds of risk profiles; and further, whether gender was a salient differentiating factor among the profiles.

In line with the aims of a multi-method approach, the final segment of the study examined the relevance of personal beliefs of the individual about the causes of his or her psychiatric problems. Gender differences in causal attribution may be associated with socialization processes that, as noted earlier, encourage girls to place particular value on interpersonal relationships, and boys to place value on achievement as markers of self-worth. Although there has been a dearth of research in this domain (Brown et al., 2007), two studies lend support to such gender differences. A large-scale epidemiological study showed that men tended to cite problems at work and unemployment and women more frequently cited relationship problems (Angst et al., 2002). In their study on gender and depression, Johansson and colleagues (2009) reported that men offered predominantly "outer" explanations, such as job pressures, whereas women tended to provide "inner" explanations involving personality characteristics as causes for depression. Although not a well-established empirical finding, the authors observed that men and women tend to present stereotypically gendered explanations when prompted to discuss their beliefs. The aim in the present study, therefore, was to determine whether gender differences in self-reported attributions for personal depression were consistent with those reported previously, and, more relevantly, consistent with or amplifying our understanding of

gender differences revealed in a variable- and person-centered prospective study of life trajectory risk factors.

Rationale and Hypotheses

There is an extensive research literature on the adverse effects of stress in childhood, in adolescence, and in the various phases of maturity. Less frequent are prospective, longitudinal studies that examine stress and its adverse effects over the developmental life course as risk factors for depression and substance use disorder. Still less frequent are prospective, longitudinal studies that take into account the psychosocial developmental underpinnings of gender to enhance our understanding of differences between men and women in stress-related susceptibilities to these psychological disorders. Considerable evidence has accrued, however, that points to differential negative effects of family adversity in boys and in girls. Poverty, divorce, and parental depression have been shown to undermine parenting competencies that have a bearing on children's emotional, cognitive, and social development; and both developmental theory and empirical evidence draw attention to gender differences in socialization processes that, under conditions of family adversity, may increase the probability of aggression and underachievement in boys, and social withdrawal and peer rejection in girls.

I. Accordingly, the first hypothesis of the study pertains to stress-related factors in childhood that may be associated with the risk of later depression in women and substance use disorder in men:

(a) Family adversity is associated with aggression and primary school underachievement in boys;

(b) Family adversity is associated with social withdrawal and peer rejection in girls.

II. In line with stress process theory, there is a chronological flow from family adversity as the primary childhood stressor to secondary stressors (underachievement, troubled peer relations) that, together, create stress clusters of negative life circumstances and events and chronic strain in adolescence and early maturity. Thus, the second hypothesis:

(a) Family adversity in childhood is associated directly or indirectly with adversity in adulthood;

(b) Childhood aggression and primary school underachievement mediate the relationship between family adversity in childhood and adversity in maturity in men;

(c) Childhood withdrawal and troubled peer relations mediate the relationship between family adversity in childhood and adversity in maturity in women.

III. Epidemiological surveys and stress process theory draw attention to the susceptibility of women to depression and men to substance use disorder. Thus, we expected: (a) An association between adversities in adulthood and depression in women;

(b) An association between adversities in adulthood and substance use disorder in men.

IV. As noted above (see II), the chronological flow from family adversity as the primary childhood stressor to secondary stressors in childhood creates stress clusters of negative life circumstances and events and chronic strain in maturity. The primary stress and ensuing stress clusters define a life trajectory of risk factors for depression and substance use disorder. Thus, the fourth hypothesis:

(a) Family adversity, aggression, and underachievement in childhood and adversities in adulthood define the life trajectory of risk factors for substance use disorder in men;

(b) Family adversity, social withdrawal, and troubled peer relations in childhood and adversities in adulthood define the trajectory of risk factors for depression in women.

V. According to the stress process model, personal resources attenuate the effects of stress, thereby reducing the risk for psychological disturbance. Empirical evidence points to the gendered relation between self-esteem and substance use disorder. There is also evidence that draws attention to the particular relevance of interpersonal strengths as attributes in women that protect against depression. We hypothesize, therefore, that self-esteem and social support in maturity attenuate the risk of depression in women and that self-esteem attenuates the risk of depression and substance use disorder in men.

VI. A person-centered approach affords the opportunity to distinguish and group individuals by the level of risk they share – from relatively low to high – for depression and for substance use disorder. We posed a series of questions rather than hypotheses.

(a) Are there risk profiles that are prototypically 'female' or 'male'?

(b) Are childhood risk factors a key distinguishing feature among the profiles- and if so, which of the factors in childhood are particularly relevant to the risk of later depression or substance use disorder?

(c) Similarly, which of the risk factors of adulthood are a distinguishing feature of vulnerabilities to depression or substance use disorder?

(d) Are there risk features that distinguish between the risk profiles of depression and those of substance use disorder?

(e) To what extent do the indices of stress in childhood and maturity differentiate the risk profiles?

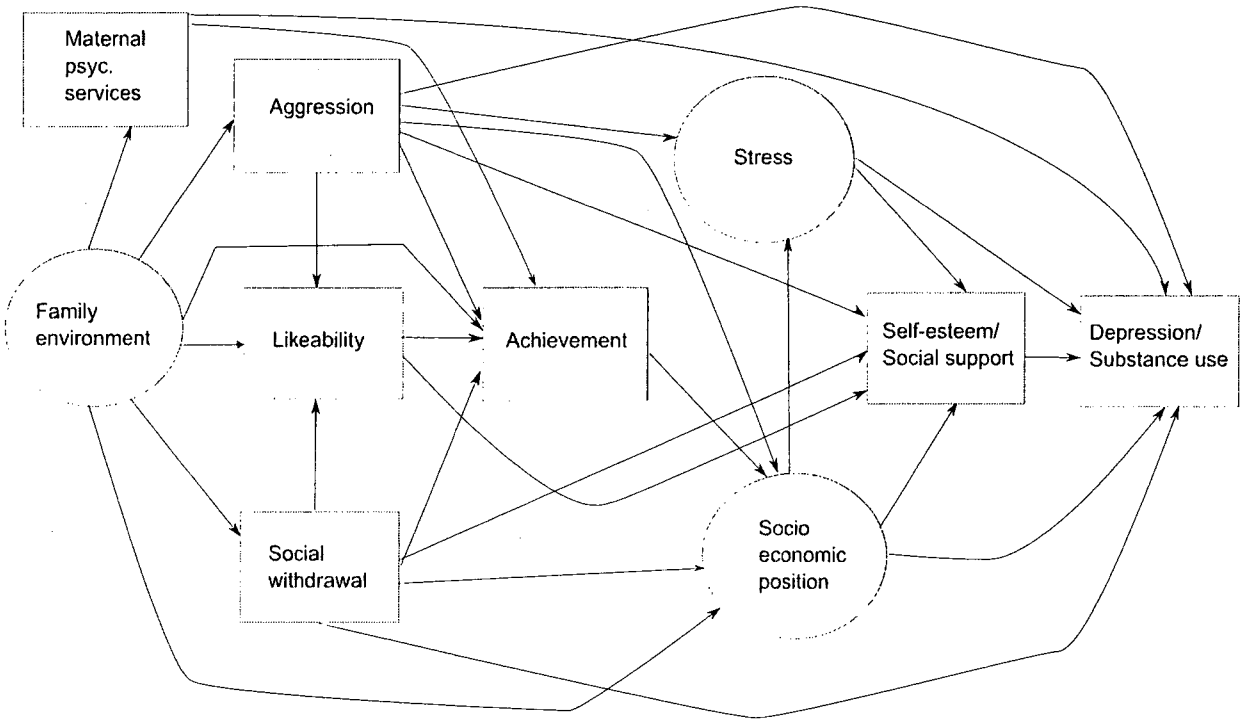
VII. There is tentative evidence of gender differences in the causal attributions of depression that may be associated with socialization effects. Thus, it is hypothesized that

women attribute their depression to perceived difficulties in interpersonal relationships and men attribute their depression to perceived difficulties in achievement.

The theoretical enhanced stress process model of pathways from family environment in childhood to depression and substance use disorder in adulthood is depicted in Figure 4. The model is predicated on the following assumptions: A negative family environment in childhood including maternal psychological distress is associated with maladaptive childhood aggression and withdrawal, and decreases the likelihood of peer likeability and satisfactory school achievement. Such childhood outcomes in turn are related to a higher level of adult stress and lower levels of SEP, self-esteem, and social support. Higher stress and lower resources in turn help explain a heightened risk of depression and substance use disorder.

Figure 4

Theoretical Enhanced Stress Process Model of Depression and Substance Use Disorder



Method

Data for this study derive from the databank of the Concordia Longitudinal Risk Project (CLRP, Schwartzman, Ledingham & Serbin, 1985). The CLRP is a multi-wave prospective research program that was launched in 1976 with the original purpose of examining the relations between children's behavioural styles, social-environmental factors and ensuing problematic life experiences. The project has addressed the issue of risk by documenting key aspects of psychosocial development in conjunction with aggressive and socially withdrawn behaviour in childhood as rated by participants' classmates at school. The participants were classified into the following four groups: High aggression (peer nominations (same-sex Z-score) placing them above the 95th percentile on aggression and below the 75th percentile on withdrawal); high social withdrawal (peer nominations placing them above the 95th percentile on social withdrawal and below the 75th percentile on aggression); high aggression *and* social withdrawal (peer nominations placing them above 75th percentile on ratings of aggression and withdrawal); and control subjects (peer nominations placing them below the 75th percentile on both aggression and withdrawal). The original 1770 participants (861 boys, 909 girls) who constituted the follow-up sample were French-speaking children attending grades 1, 4 and 7 in neighbourhoods of low to middle socioeconomic position in Montreal, Quebec.

Sample

The base pool of participants in the present study were those who took part in the 1999-2003 wave of data collection, which included clinical interviews for the assessment of psychiatric disorders. Mean scores of aggression and social withdrawal did not differ

between this sample and the original research population. Six hundred and eighty participants completed the clinical interviews, of whom 388 were female and 292 were male. The mean age at the time of the clinical interview was 34 with a standard deviation of 2.8 years. Thirty-five participants were excluded from the present study because of excessive missing data, leaving a sample size of 645 (376 females (58.3%), 269 males).

Measures

All measures were presented to participants in French, either in their already existing French forms or in English-to-French translations.

Childhood aggression, social withdrawal and likeability. Peer nominations were the basis of the CLRP's first wave of data collection. Participants in the study nominated classmates using the three-factor Pupil Evaluation Inventory (PEI: Pekarik, Prinz, Liebert, Weintraub & Neale, 1976; see Appendix A). Administration of the PEI took place in the classroom. Children each selected up to four classmates who best fit item descriptions for each of the PEI's three orthogonal factors – aggression, social withdrawal, and likeability - with girls and boys evaluated separately. In this way, all children received a score on aggression, withdrawal and likeability. The PEI comprises 34 items. Aggression items describe various aspects of aggressive/externalizing behaviour. Withdrawn items describe socially anxious, avoidant, and peer-alienating behaviours. Likeability items focus on affiliation-enhancing behaviours and positive regard of others; the scale thus includes the constructs of both likeability and popularity. Within each subscale, inter-item reliability is moderate to high, as demonstrated by split-half correlations that are all above .70 for males and females on the three scales (Pekarik et al., 1976). The PEI (French version) shows good inter-rater reliability, strong external

validity in its concordance with behavioural observations made by trained observers and stability over time (Ledingham, Younger, Schwartzman & Bergeron, 1982; Moskowitz, Schwartzman & Ledingham, 1985; Serbin, Lyons, Marchessault, Schwartzman & Ledingham, 1987). The total number of peer nominations received by each child for each of the three subscales was subjected to square root transformation to reduce skew, and converted to *Z*-scores for each sex and within each classroom to control for class size, age and gender effects on baseline rates.

Stressors in the childhood family environment. Four variables were included for assessment of stressors in participants' childhood family environment: parental marital status, family social standing, neighbourhood socioeconomic index and maternal medical visits for emotional disturbance. The first three of these measures were obtained during the first wave of data collection and were combined via principal components analysis for data reduction purposes. See Table 1 for component loadings.

Parental marital status. This categorical variable indicates whether participants' parents were or were not living together at the time of initial data collection. Information concerning parental marital status was obtained during a brief telephone interview conducted between 1987 and 1990.

Family Occupational Prestige (Nock & Rossi, 1979). This instrument establishes an operational definition of the concept of social standing as applied to households. It is a composite measure based on the mean of occupation score of adults sharing responsibility for a household. Occupations were assigned scores from 1 for unskilled worker to 9 for professor or physician. In a reliability check of the FOP, the authors of this measure reported "considerable" agreement among raters. Information

concerning family occupational prestige was obtained during a brief telephone interview conducted between 1987 and 1990.

Neighbourhood disadvantage factor. Postal codes corresponding to the location of participants' childhood homes served as the basis for gathering information relative to the socioeconomic status of their neighbourhoods. A factor was constructed that indexed percentage of residents not having completed high school, of unemployed residents, of those with an annual family revenue of less than $20, 000, and of single parent households. High scores on this factor indicate greater levels of neighbourhood disadvantage.

Maternal medical visits for emotional disturbance. Direct measures of maternal depression during participants' childhood were unavailable. The number of medical visits made by participants' mothers for reasons coded as neuroses (depression and anxiety) were used as a proxy measure. Information was obtained from the Régie de l'Assurance Maladie du Québec (RAMQ) utilizing identity protection procedures approved by the Commission d'accès à l'information du Québec to link and incorporate RAMQ health data with the CLRP databank. Health data on the participants and their families were available from 1981 onwards.

Childhood academic achievement. Scores obtained in elementary school on standardized tests in French and Mathematics were provided by the Montreal Catholic School Board. The two test scores were combined and converted to a standardized score (Stanine scores: mean = 5, standard deviation = 1).

Table 1

Component Loadings of the Family Environment Factor

Variable	Component loading
Parental marital status	.69
Family occupational prestige	.68
Neighbourhood disadvantage	-.62

Socioeconomic position in adulthood. Lawlor, Ebrahim and Davey Smith (2005) have observed that, "societies are stratified in multiple ways that lead to degrees of economic, political, social, and cultural advantage" (p. 785). In line with this current multi-faceted understanding of socioeconomic position, a factor comprising adult educational attainment, income, occupational prestige and perceptions of neighbourhood safety was constructed using principal components analysis (see Table 3). Participants provided the relevant sociodemographic information in the 1999-2003 wave of data collection (see Appendix B).

Education. Education was the total number of years of education completed by participants.

Income. Family income was calculated as the sum total of revenue reported for the household.

Occupational prestige was assessed using the Nock and Rossi (1979) measure, as described above.

Neighbourhood context. The Measuring Neighborhood Context Scale (Coulton, Korbin & Su, 1996) consists of a number of subscales that target personal impressions of neighbourhood quality/safety (see Appendix C). Items are answered on a scale of 1-10 (1 = mostly false, 10 = mostly true). Items were combined using principal components analysis to conserve on the number of variables used in the study, while aiming to capture the multiple facets of participants' perceptions of their neighbourhood (See Table 2). Items concern areas such as deleterious conditions in the neighbourhood, rate of turnover of residents or proportion of renters, the likelihood of physical or verbal retaliation following intervention with others and concerns about becoming victims to crime or violence. Coulton and colleagues (1996) observed high reliability (*alpha* above .70) in all subscales with the exception of Victimization (*alpha* =.43) which showed greater variability across respondents. In terms of validity, they found that high-risk neighbourhoods showed higher scores on residential mobility, disorder, and threat of victimization than low-risk neighbourhoods. Participants completed this measure during 1999-2003.

Table 2

Component Loadings of the Neighborhood Context Factor

Variable	Component loading
Mobility	.63
Disorder	.72
Victimization	.52
Retaliation	.58

Table 3

Component Loadings of the Adult Socioeconomic Position Factor

Variable	Component loading
Education	.79
Income	.71
Occupational prestige	.83
Neighbourhood context	-.54

Stressors in adulthood. To capture the multivariate experience of stressors in adulthood - acute and chronic events of social, medical and financial origins - a composite measure was created using principal components analysis (See Table 4).

Negative life events. The Life Experiences Survey (LES: Sarason, Johnson & Siegel, 1978; see Appendix D) asks respondents to rate a series of 47 items (plus 10 items addressed to students) on a 7-point scale ('extremely negative' to 'extremely positive'). Items for the survey describe common experiences, or life changes, in areas such as social relationships, employment, health and finances. Item values may be summed separately for negative and positive experiences or together for a total 'change' score. Sarason, Johnson and Siegel (1978) describe this instrument as moderately reliable. They also provide evidence of a number of positive correlates of the LES, suggesting moderate convergent validity. Participants in the present study completed the LES during Wave 3 of data collection (1989-1990), and the sum total of weighted negative experiences was retained for use.

Daily hassles. The Daily Hassles Scale (DHS: Kanner, Coyne, Schaefer & Lazarus, 1981; see Appendix E) is a 117-item self-report questionnaire that measures the degree to which respondents experience the "irritating, frustrating, distressing demands that to some degree characterize everyday transactions with the environment" (p. 3). To complete the DHS, respondents first select those events - such as losing things, being stuck in traffic jams, or having arguments - that they have experienced during the previous month. Next, they rate the level of severity of each item on a 3-point scale. The authors have noted strong test-retest reliability, suggesting that people tend to perceive

the same number of hassles from one month to the next. A total hassles score was derived by addition of response values. The DHS was administered in 1999-2003.

Physical health problems. The total number of visits to a physician for reasons other than psychiatric, as documented by RAMQ was the measure used to assess this variable.

Table 4

Component Loadings of the Adult Stress Factor

Variable	Component loading
Negative life events	.78
Daily hassles	.57
Medical visits	.72

Personal resources. Two measures of personal resources in adulthood were used: Social support and self-esteem.

Social support. To measure level of satisfaction with perceived social support, participants completed the Social Support Questionnaire - Short Form Revised (SSQSR: Sarason, Sarason, Shearin, & Pierce, 1987) in 1999-2003 (see Appendix F). The SSQSR is a six-item questionnaire. Respondents first generate a list of individuals they include in their support network by answering questions such as 'Whom can you really count on to help you feel more relaxed when you are under pressure or tense?' and 'Who accepts you totally, including your best and your worst points?' Next, they rate their degree of satisfaction with the support they receive from these relationships on a 6-point scale (1 = very unsatisfied, 6 = very satisfied). The authors of this instrument note that the SSQSR items are "very general in nature and reflect the affective aspects of relationships" (p. 507) rather than instrumental support. Sarason and colleagues describe this six-item version of the Social Support Questionnaire as psychometrically sound.

Self-esteem. Participants completed the Rosenberg Self-esteem Scale (Rosenberg, 1965) in 1993 (see Appendix G). The Rosenberg Self-esteem Scale was developed to measure global self-esteem. It has often been reported as a total summed score (e.g., Hagborg, 1993). Attitude toward the self is measured on ten items that are rated on a four-point Likert scale ranging from "strongly agree" to "strongly disagree". Strong construct validity (Rosenberg, 1965; Rosenberg, 1979) and test-retest reliability (McCarthy & Hoge, 1982) have been reported.

Depression and substance use disorder. Licensed clinical psychologists assessed the presence of past and current psychiatric disorders, including depression and

substance use disorders, using the French form of the Structured Clinical Interview for the DSM-IV, Axis I/ Non-patient Edition (SCID-I/NP; First, Spitzer, Gibbon & Williams, 1996; see Appendix H). A Kappa inter-rater reliability coefficient of 0.91 was reported for axis-I of the SCID (Schwartzman et al., 2009). For the purposes of this study, depression was defined as the occurrence of a lifetime or current major or minor depressive episode. A diagnosis of lifetime or current substance use disorder included abuse of or dependence on such chemical substances as alcohol, cannabis or opiates. Participants received a present/absent rating for these diagnoses. The semi-structured SCID interview was administered between 1999 and 2001 and took place either in the laboratory or in the home, as preferred following completion of consent forms.

Personal attributions of depression. Study participants who were diagnosed with a depressive disorder during the 1999-2001 SCID administration were contacted in 2002 and asked to complete the Reasons for Depression Questionnaire (RFD: Addis, Truax & Jacobson, 1995; Thwaites, Dagnan, Huey & Addis, 2004). The RFD is a 48-item self-report measure that asks respondents to assess the degree to which existential, characterological, interpersonal conflict, intimacy, achievement, childhood, relationship, physical and biological reasons explain their depression (see Appendix I). Items are scored on a four-point Likert scale. The authors reported adequate internal consistency for all subscales of the RFD. Intercorrelations among subscales in both depressed and non-depressed samples suggest that people attribute their feelings of depression to more than one causal domain. Items were summed within each of the eight subscales to produce scores by causal domain.

Results

Four statistical strategies were used to examine the relevance of gender in assessing stress-related propensities to depression and substance use disorder from childhood to maturity. These were: (1) first-order correlational analysis; (2) structural equation modeling to map out linkages of risk and protective factors across developmental time; (3) latent variable mixture modeling to group individuals sharing similar life trajectory risk profiles and χ^2 analysis to test for group differences; and (4) multivariate analysis of variance (MANOVA) to examine causal attributions for depression and differences among life trajectory risk profiles.

Data Preparation

Data of the Concordia Longitudinal Risk project (CLRP) collected between 1976 and 2003 were used in the present study. Specific objectives, sample size, and measures of the CLRP varied with the particular wave of data collected over the study's 30-year timespan. The strategy here, therefore, was to base sample size on the greatest number of individuals missing the least amount of data across the measures used in the present study. The sample that met this criterion consisted of 622 participants for whom information on the marital status of their parents was available. (1) Adjusting for outliers (beyond three standard deviations from the mean) and for distributional skew (square-root transformation), (2) establishing that multicollinearity was not problematic (tolerance for all variables was greater than .1), and (3) using the Mahalanobis distance test with alpha set at .001 to identify multivariate outliers reduced sample size from 622 to 617 participants - 257 men (42%) and 360 women.

The next step was to address the question of missing data. When data are missing completely at random (MCAR) or missing at random (MAR) - that is, when missingness is assumed to be a truly random process or to depend on the observed data and not on the unobserved data, unbiased replacement values may be imputed (Rubin, 1976). For the study's data set, Little's test for MCAR based on a missing values analysis (MVA, SPSS v. 17) indicated that continuation to the next step of data imputation was appropriate. Increasingly, researchers have understood the importance of retaining cases with missing values on certain variables in order to improve accuracy of generalization. Even large amounts of missing data are considered "recoverable" as long as there is sufficient information linking variables together (Little, in press). Advances in dealing with missing data have led to the technique of multiple imputation (MI). Similar to other processes for imputing missing data, MI produces imputed values from the available data. MI is a particularly robust process because it models data variability by including a random error component and by generating multiple data sets from which to draw a final estimated set of imputations (Schafer, 1999). Multiple imputation was performed in the present study using Amelia II (Honaker, King & Blackwell, 2006). Table 5 lists the number of cases and percent with missing values on the study's variables.

Table 5

Variables with Missing Values

		Missing	
Variable	N	Count	Per cent
Marital status	622	0	0.0
Childhood neighbourhood	583	34	5.5
Childhood family prestige	545	72	11.6
Maternal psy. services	611	6	1.0
School achievement	583	34	5.5
Negative events	463	154	24.9
Daily hassles	463	154	24.9
Social support	463	154	24.9
Neighbourhood quality	586	31	5.0
Self-esteem	306	311	50.4

Descriptive data. As expected, chi-square analyses revealed significant gender differences in the prevalence rates of depression and substance use (See Table 6). As expected, a greater percentage of women (41%) than men (31%) described experiencing symptoms of major or minor depression at some period during adulthood and more men (47%) than women (20%) described the lifetime occurrence of substance dependence or abuse. Comorbidity of depression and substance use disorder was found in 88 individuals, or 14 per cent of sample, of whom the greater proportion were men (50, 57%) ($\chi^2(1, N = 617) = 9.71, p = .00$).

Table 6

Depression and Substance Use Disorder by Gender

Diagnosis	Men	Women	Pearson chi-square
No Depression	178	213	6.58**
Depression	79	147	
No substance use disorder	136	287	49.98***
Substance use disorder	121	73	
Total	257	360	

** $p = .01$, *** $p = .00$

All variables were examined by gender. In childhood, there was no gender difference in parental marital status: Twenty-four per cent of both boys and girls had parents who were living apart. Family occupational prestige and average neighbourhood socioeconomic position were also similar for boys and girls: Family environment as a factor therefore did not differentiate between the boys and the girls. Similarly, there were no gender differences relative to the measure of maternal psychiatric services for emotional disturbance. The childhood peer nominations concerning aggression, social withdrawal, and likeability resulted in similar levels of these measures for girls and boys. In terms of school performance, girls performed at a higher level than boys on the Mathematics and French achievement tests [$F(1, 615) = 8.91, p = .00$]. In adulthood, (and somewhat unexpectedly), men and women did not differ on educational attainment, yearly family income, employment prestige or neighbourhood quality, nor did they differ on the foregoing socioeconomic variables combined as a factor. There were, however, gender differences on the adult stress factor [$F(1, 615) = 35.31, p = .00$]. Women registered higher scores on average than men on the measures of negative life events and medical concerns, but not on daily hassles. No gender differences were found in self-esteem or social support. Table 7 presents means and standard deviations by gender for variables included in the analyses.

Pearson correlation coefficients were computed for all continuous variables. The correlational matrix for male and female samples is presented in Table 8. Using the Bonferroni criterion to control for Type 1 error (see Tabachnick & Fidell, 2001), correlation coefficients at or beyond the .01 level were treated as significant beyond chance. Inspection of the tables indicates the following as key features of the matrices:

(1) the men and women were generally similar in their correlational patterns; (2) the variables eliciting the strongest associations in both the men and women were childhood likeability, school achievement in childhood, adult socioeconomic position, and self-esteem in adulthood; (3) school achievement and adult socioeconomic position elicited the largest number of significant associations in both samples; maternal emotional disturbance and social support the smallest number; (4) gender differences were indicated in the associations of family environment with maternal psychiatric services for emotional disturbance (male -.20 vs female -.12), with aggression (male -.09 vs. female -.18), and with self-esteem (male .20 vs female .11); the association of aggression and withdrawal (-16 vs .01), and the association of adult stresssors and self-esteem (-.12 vs -.27).

Table 7

Means and Standard Deviations of Variables by Gender

Variable	Men ($N = 257$)	Women ($N = 360$)
	Mean (SD)	Mean (SD)
Family environment	0.01 (1.00)	-0.01 (1.01)
Maternal psy. services	0.21 (0.34)	0.30 (0.90)
Childhood aggression	1.50 (0.28)	1.54 (0.31)
Childhood withdrawal	1.89 (0.26)	1.88 (0.25)
Childhood likeability	1.96 (0.23)	1.99 (0.25)
School achievement	4.67 (1.49)	5.06 (1.68)
Socioeconomic position	-0.02 (0.95)	0.02 (1.04)
Stress	-0.29 (0.92)	0.19 (1.00)
Self-esteem	22.51 (3.79)	22.11 (3.66)
Social support	5.54 (0.37)	5.60 (0.35)

Table 8

Intercorrelations Among Study Variables

Variable	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
1. Family environment	---	-.12	-.18**	-.20**	.13	.33**	.33**	-.09	.05	.11
2. Maternal psy. services	-.20**	---	-.00	.08	-.06	-.08	-.07	-.03	-.03	-.10
3. Aggression	-.09	.02	---	.01	-.13	-.25**	-.23**	.18**	-.05	-.17**
4. Withdrawal	.01	.11	-.16	---	-.23**	-.34**	-.22**	.08	.01	-.14**
5. Likeability	.13	-.05	-.10	-.19**	---	.56**	.33**	-.13	.01	.25**
6. School achievement	.29**	-.07	-.29**	-.19**	.41**	---	.48**	-.17**	.05	.18**
7. Socioecon. position	.23**	.08	-.23**	-.08	.30**	.45**	---	-.15**	.04	.47**
8. Stress	-.13	.08	.16**	-.02	-.09	-.14	-.14	---	-.07	-.27**
9. Social support	.04	-.11	-.04	-.08	.02	.01	.01	-.07	---	.17**
10. Self-esteem	.20**	-.12	-.12	-.20**	.27**	.26**	.49**	-.12	.19**	---

Note. Correlations for females ($N = 360$) are above the diagonal. Correlations for males ($N = 257$) are below the diagonal.

** $p < .01$

Structural Equation Modeling

Structural equation modeling (SEM) provides estimates of relations among variables based on a hypothesized model, and in this sense it is predominantly a confirmatory technique. These derived estimates are then compared to the actual interrelationships in the existing data: A good concordance between the two may be interpreted as evidence of support of the hypothesized model. Model goodness of fit may be determined by several indices: the chi-square test statistic, which evaluates whether the population covariation matrix is equal to the covariance matrix implied by the model; the comparative fit index (CFI), which compares the model being tested to one in which no relations exist amongst included variables; the root-mean square error of approximation (RMSEA), which estimates the lack of fit of a model compared to a perfect fit; and the size of the residuals. Model fit is considered good if the *p*-value associated with the chi-square is larger than .05, the CFI is above 0.90, the RMSEA is less than or equal to 0.05, and all standardized residuals are below 0.1. In addition to these fit indices, acceptability of a model requires an appropriate parameter/sample size ratio. If model fit is deemed acceptable, the next step is to examine the standardized path coefficients, which show the strength and direction of relationships between linked variables.

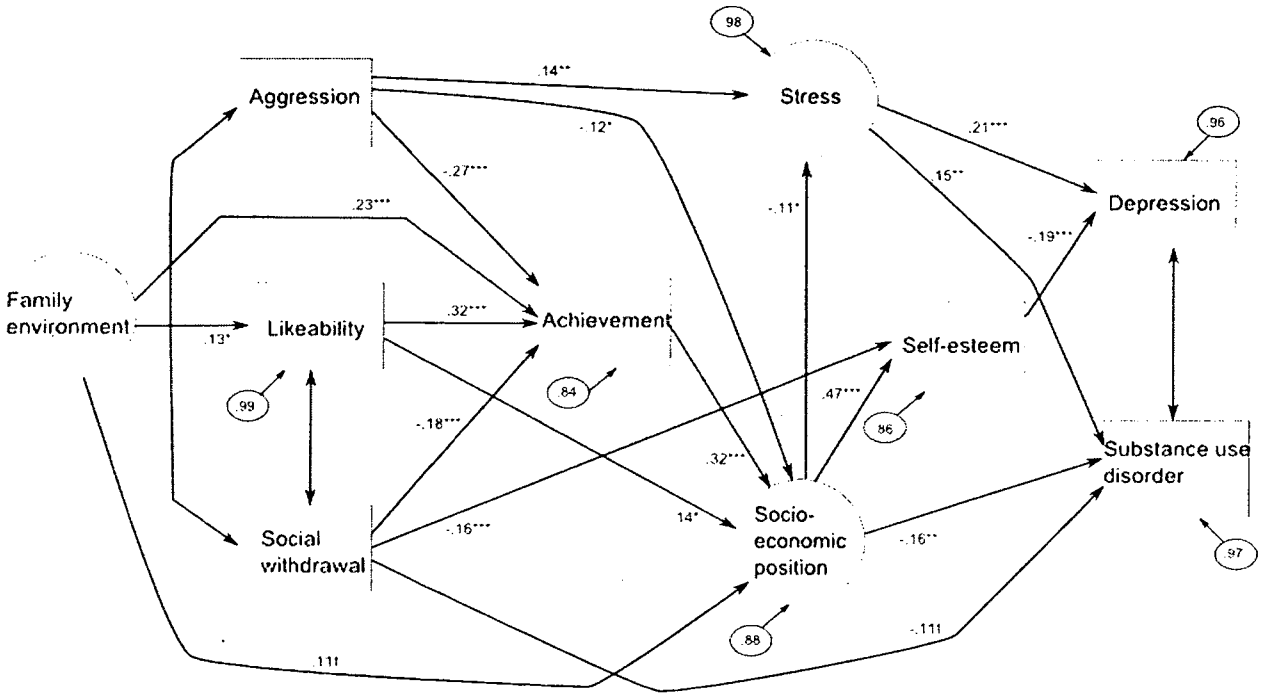
To test for concordance by gender of the data with the theoretical model, we analyzed the data separately for men and for women using EQS 6.1 (Bentler, 2004).

Men (see Figure 5). A number of modifications were undertaken to ensure model parsimony and to enhance model fit. First, social support showed no meaningful associations with other variables in the analysis and was removed. Standardized path

coefficients were next examined. The non-significant pathways between family environment and childhood aggression and social withdrawal were removed, as were those between withdrawal and socioeconomic position and stress in adulthood. In addition, the hypothesized paths between socioeconomic position and depression and between stress and self-esteem failed to reach statistical significance and were also removed. Following these changes, model fit obtained was good ($\chi^2(24) = 20.63, p > .05$; CFI = 1.00; RMSEA = 0.00; standardized residuals below .10; 32 free parameters for a sample size of 257). The final model for the men highlighted direct linkages between (a) childhood family environment and childhood likeability (.13), school achievement (.23), and marginally, adult SEP (.11); (b) childhood aggression and school achievement (-.27), adult SEP (-.12), and adult stress (.14); (c) childhood withdrawal and school achievement (-.18), adult self-esteem (.16), and marginally, substance use disorder in adulthood (.11); (d) childhood likeability and school achievement (.32), and adult SEP (.14); (e) adult SEP and adult self-esteem (.47), adult stress (-.11), and substance use disorder (-.16); (f) adult stress and depression (.21) and substance use disorder (.15); and (g) adult self-esteem and depression (.19). Using the Sobel test for mediation, childhood school achievement was significant in mediating between childhood family environment and adult socioeconomic position (4.04, $p < .00$), childhood likeability mediated between family environment and adult socioeconomic position (2.03, $p < .05$) and adult self-esteem was significant in mediating between socioeconomic position and depression (-2.34, $p < .05$). Table 9 presents path coefficients and variance components for the male model. The model accounted for 9% of the variance in depression and 6% of the variance in substance use disorder.

Figure 5

Structural Equation Model of Depression and Substance Use Disorder: Male Sample



$N = 257$

† $p < .10$ * $p < .05$ ** $p < .01$ *** $p < .001$

Table 9

Path Coefficients, Explained and Error Variance, and Robust Standard Errors for the Stress Process Model of Depression and Substance Use Disorder: Male Sample

Criterion	Predictors	Unstandardized	SE	Standardized	R^2	$1-R^2$
Likeability	Family	.03*	.01	.13	.02	.98
Achievement	Family	.34***	.08	.23	.29	.71
	Aggression	-1.41***	.30	-.27		
	Withdrawal	-1.01***	.30	-.18		
	Likeability	2.04***	.36	.32		
Socioeconomic	Family	.10†	.05	.11	.23	.77
Position (SEP)	Aggression	-.40*	.19	-.12		
	Likeability	.57*	.25	.14		
	Achievement	.21***	.04	.32		
Stress	Aggression	.44**	.20	.14	.04	.96
	SEP	-.11*	.05	-.11		
Self-esteem	Withdrawal	-2.34**	.85	-.16	.26	.74
	SEP	1.89***	.19	.47		
Depression	Stress	.10***	.03	.21	.09	.91
	Self-esteem	-.02***	.01	-.19		
Substance use	Withdrawal	-.21†	.11	-.11	.06	.94
disorder	SEP	-.08**	.03	-.16		
	Stress	.08**	.03	.15		

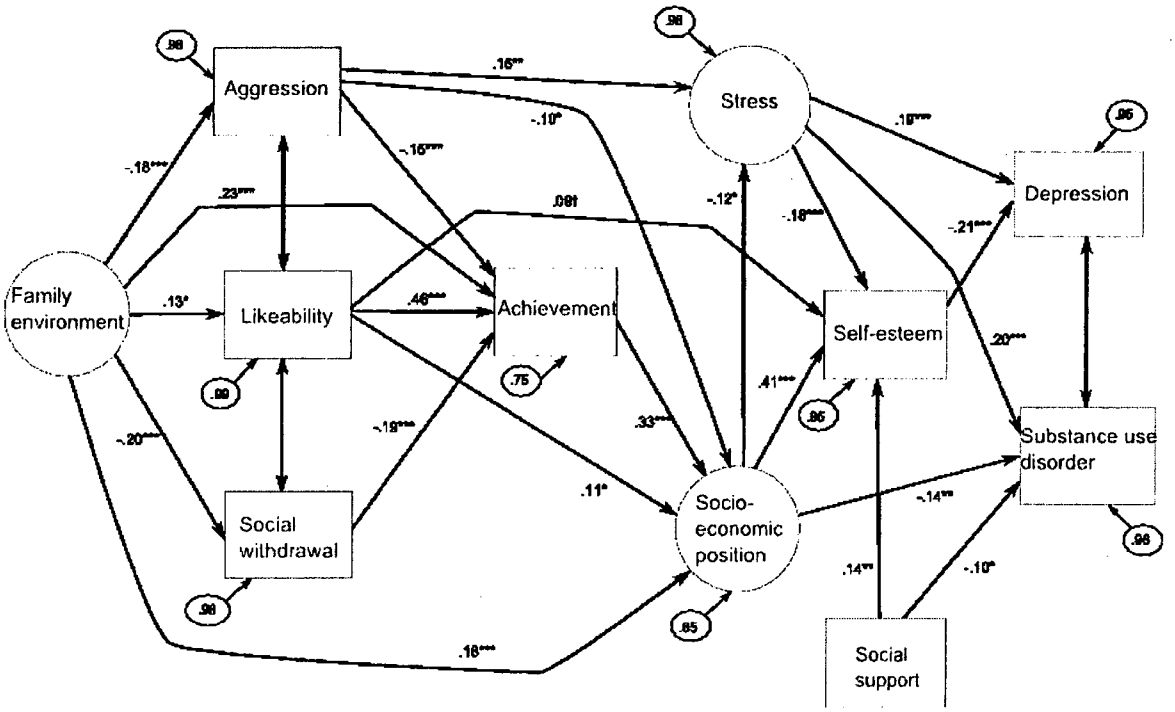
† $p < .10$ * $p < .05$ ** $p < .01$ *** $p < .001$

Women (see Figure 6). As with the male sample, a number of modifications were undertaken to ensure model parsimony and to enhance model fit. The paths from social withdrawal to self-esteem and to substance use disorder were not statistically significant and were removed. Similarly, the link between social support and depression failed to reach significance and was removed. The trimmed model met goodness of fit criteria ($\chi^2(30) = 35.51, p > .05$; CFI = .99; RMSEA = 0.02; standardized residuals below .10; 36 free parameters for a sample size of 360). The final model for the women revealed direct linkages (a) between childhood family environment and childhood aggression (-.18), childhood withdrawal (-.20), childhood likeability (.13), school achievement (.20), and adult SEP (.18); (b) between childhood aggression and school achievement (-.15), adult SEP (-.10), and adult stress (.15); (c) between childhood withdrawal and school achievement (-.19); (d) between childhood likeability and school achievement (.46), adult SEP (.11), and marginally, adult self-esteem (.09); (e) between adult SEP and adult self-esteem (.41), adult stress (-.12), and substance use disorder (-.14); (f) between adult stress and self-esteem (-.18), substance use disorder (.20), and depression (.19); (g) between adult self-esteem and depression (.21), and (h) between social support and self-esteem (.15), and substance use disorder (-.10). Sobel tests for mediation were conducted and found significant for the mediating role of childhood aggression between family environment and SEP in adulthood (2.44, $p < .05$), of childhood likeability between family environment and SEP in adulthood (2.28, $p < .05$), of school achievement between childhood family environment and adult SEP (-4.46, $p < .00$), and of self-esteem between adult stress and depression (3.10, $p < .01$) and between SEP and depression (-3.59, $p < .00$). See Table 10 for path coefficients. Together,

predictor variables accounted for 10% of the variance in depression and 8% of the variance in substance use disorder.

Figure 6

Structural Equation Model of Depression and Substance Use Disorder: Female Sample



$N = 360$

† $p < .10$ * $p < .05$ ** $p < .01$ *** $p < .001$

Table 10

Path Coefficients, Explained and Error Variance, and Robust Standard Errors for the Stress Process Model of Depression and Substance Use Disorder: Female Sample

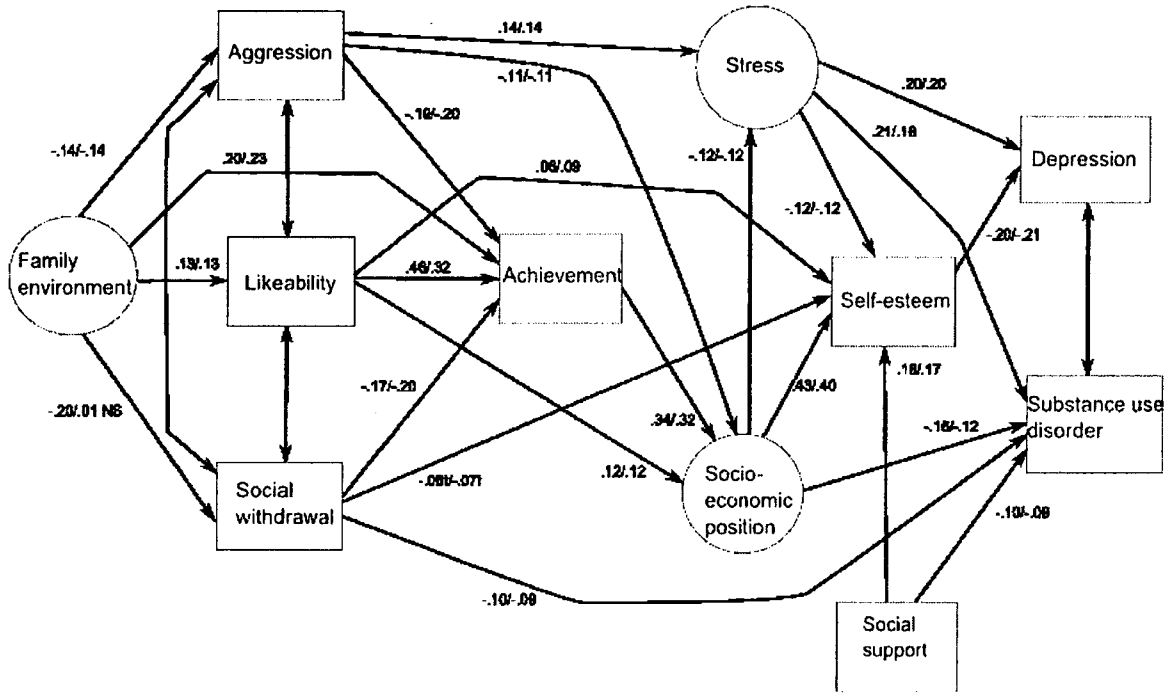
Criterion	Predictors	Unstandardized	SE	Standardized	R^2	$1-R^2$
Aggression	Family	-.05***	.02	-.18	.03	.97
Withdrawal	Family	-.05***	.01	-.20	.04	.96
Likeability	Family	.03*	.01	.13	.02	.98
Achievement	Family	.34***	.07	.23	.43	.57
	Aggression	-.83***	.23	-.15		
	Withdrawal	-1.32***	.29	-.19		
	Likeability	3.19***	.29	.46		
Socioeconomic	Family	.19***	.05	.18	.28	.72
Position (SEP)	Aggression	-.35*	.16	-.10		
	Likeability	.47*	.23	.11		
	Achievement	.20***	.04	.33		
Stress	Aggression	.49**	.17	.15	.05	.95
	SEP	-.11*	.05	-.12		
Self-esteem	Likeability	1.38†	.70	.09	.28	.72
	SEP	1.44***	.17	.41		
	Stress	-.66***	.17	-.18		
	Social supp.	1.62**	.48	.14		
Depression	Stress	.09***	.03	.19	.10	.90
	Self-esteem	-.03***	.01	-.21		
Substance use	SEP	-.05**	.02	-.14	.08	.92
disorder	Stress	.08***	.02	.20		
	Social supp.	-.12*	.06	-.10		

† $p < .10$ * $p < .05$ ** $p < .01$ *** $p < .001$

Group comparisons. To test the comparability of male and female trajectories, and to obtain a parsimonious model of the data while avoiding chance fluctuations or minor differences across gender, multiple-group comparison analyses were conducted. First, a model including all paths from the established models was run, with all paths left free to vary. This model fit the data very well: $\chi^2(54) = 51.15, p = .59$; CFI = 1.00; RMSEA = 0.00. Single paths were then constrained successively to be equal across groups to test for differences in coefficients. Using this more stringent test of gender differences, only the paths between family environment and childhood withdrawal ($\chi^2(1) = 6.54, p = .01$) and between likeability and achievement ($\chi^2(1) = 5.80, p = .02$) were found to differ between males and females. The differences between the chi-square values of each of the constrained tests and the model with all paths free to vary based on the change in degrees of freedom (1) were significant. In each case, the strength of association between these variables was stronger for girls than boys. A final model was therefore tested in which all paths were constrained to be equal except for the two paths showing significantly different coefficients. This model fit the data well ($\chi^2(76) = 66.31$, $p = .78$; CFI = 1.00; RMSEA = 0.00). The chi-square difference test indicated that the final model (see Figure 7) provided a better fit of the data than the all-free-to-vary model.

Figure 7

Final Structural Equation Model of Depression and Substance Use Disorder: Male and Female Samples



Coefficients are significant at $p < .05$ except as marked † = $p < .10$ NS = not significant
Note: First coefficient refers to females, second coefficient refers to males

Person-centered Analyses

Five indices of model identifiability for proneness to depression and substance use disorder were used. As a baseline requirement, classes had to include at least 5 % of cases to be considered meaningfully different from other classes. Second, the Bayesian Information Criterion (BIC) was used to compare models with differing numbers of parameters. Model fit improvement leads to a lower BIC value. Third, the entropy coefficient, an index of class distinctiveness (range: 0-1), was examined for a minimum value of 0.80 to indicate good class separation (Muthén & Muthén, 2007). Fourth, the Lo-Mendell-Rubin (LMR) likelihood ratio test was performed. The LMR test is a significance test that compares a given model to a model with one less class. A significant LMR test suggests that the more complex model provides a better fit for the data. Finally, latent class probabilities were examined to assess the probability that cases were consistently placed in each class. A higher posterior probability level indicates greater likelihood of such consistency, with values closer to 1.0 suggesting good reliability of classification (Muthén & Muthén, 2000). In line with Hipp and Bauer's (2006) recommendations to generate extensively varied starting values in order "to fully probe the parameter space" (p. 49) and avoid local solutions, analyses were conducted using 1000 randomized start values run for 50 iterations each.

A series of LPA was conducted to detect profiles of stressors, resources and the childhood dimensions of aggression, social withdrawal and likeability using Mplus Version 5.2 (Muthén & Muthén, 2007). The predictive value of the obtained latent profiles was then tested in relation to adult depression and substance use disorder.

Analyses were conducted in a step-wise fashion, beginning with a two-class model. Table 11 displays fit indices results for two-, three-, four-, five-, and six-class models. The data best supported a five-class solution. First, all classes comprised more than 5% of cases. The comparatively lower BIC value obtained for successive analyses of two, three, four and five classes, the entropy value and the maintained significance of the LMR test all suggested the superiority of a five-class solution over solutions with fewer classes. The six-class solution showed acceptable entropy and remained statistically significant in terms of the LMR test, suggesting that six enhanced stress process profiles could provide a better model of subtypes than the five-class solution. At the same time, the BIC value for this solution increased and inspection of iteration history revealed eight failures to converge. Consequently, the five-class solution was retained. Table 12 presents the posterior probabilities. These probabilities were .90 or above for each class, as shown on the diagonal, indicating that there was little overlap in the probabilities of belonging to more than one class.

In the retained solution, cases were classified into one large class and four smaller classes. Class 1 comprised 43% (n = 262) of the sample. Similar proportions of men and women were classified into this group, with 49% of the male sample and 38% of the female sample making up Class 1. This profile grouped individuals characterized by average scores on all variables. Within the stress process framework, class 1 may be described as a normative stress-adaptive profile.

Table 11

Fit Statistics for 2-, 3-, 4-, 5- and 6-Class Models

Model	BIC	Entropy	LMR
2-Class	12234	0.72	$p < .00$
3-Class	12110	0.81	$p < .00$
4-Class	11999	0.98	$p < .00$
5-Class	11811	0.90	$p < .00$
6-Class	12058	0.91	$p < .05$

Note: BIC = Bayesian Information Criterion; LMR = Lo-Mendell-Rubin likelihood ratio test

Table 12

Average Latent Class Probabilities for Most Likely Latent Class Membership

	Class				
	Class 1	Class 2	Class 3	Class 4	Class 5
Class 1	**0.92**	0.07	0.00	0.01	0.00
Class 2	0.10	**0.90**	0.00	0.00	0.00
Class 3	0.00	0.00	**0.99**	0.01	0.00
Class 4	0.00	0.00	0.01	**0.98**	0.01
Class 5	0.00	0.00	0.00	0.06	**0.94**

Class 2 comprised 19% (n = 121) of the sample. Proportionally, women dominated this group: Case classification resulted in 24 % of women and 13% of men falling into Class 2 (odds ratio = 2.39, $p < .00$). Individuals in this class were rated in childhood as showing similar moderate levels of aggression and social withdrawal to those in Class 1. Their likeability scores, however, were markedly higher than those of all other groups. In addition, individuals with this profile had the least difficult family environments, highest school achievement scores, highest socioeconomic position and lowest stress in adulthood and highest self-esteem. The conjunction of moderate behavioural indices, low stress, and advantageous childhood experiences grouped

children who were to become successful, adaptive adults. This is an advantaged/low stress group of individuals.

Class 3 comprised 15% (n = 90) of the sample, with approximately the same proportions of men and women (16% and 14% respectively). The principal distinguishing feature of individuals in this class was their high social withdrawal and low aggression in childhood. Despite their high withdrawal, individuals in this profile displayed average scores on all other variables, including likeability. They also registered moderately low stress levels in adulthood, similar to those seen in Class 2. High childhood withdrawal and moderate levels of stress and personal resources characterized the individuals in this class as reserved/stress adaptive.

Individuals in Class 4 comprised 14% (n = 89) of the sample. There was a greater proportion of women than men in this class (16% of the female sample; 13% of the male sample; odds ratio = 1.73, $p < .05$). The Class 4 profile was characterized by a number of problematic factors. In childhood, peers found these individuals to be both highly aggressive *and* highly withdrawn. Childhood peer likeability ratings of likeability were the lowest among all the class profiles. Family environment in childhood achievement, and socioeconomic position in adulthood were all in the low range, and stress level in adulthood was the highest among the profiles. In addition, individuals with this profile showed the lowest self-esteem. The Class 4 profile is one that demonstrates perpetuated stress as a key distinguishing feature.

Class 5 comprised 9% (n = 55) of the sample, with equal proportions of men and women. Class 5 resembled Class 3 except for childhood behaviour ratings. Unlike the members of Class 3, Class 5 included individuals who had been rated as highly

aggressive in childhood, but received low ratings on social withdrawal, and moderate-range likeability scores that were similar to those of the members of Class 1 and Class 3. Class 5 individuals were in the average range on the other measures. Class 5 describes individuals who share an aggressive stress-reactive profile. Means of the continuous variable indicators of the five classes are presented in Table 13.

The associations between the five stress process profiles and depression and substance use disorder were next determined. The χ^2 test for depression was statistically significant, χ^2 $(4, N = 617) = 10.05, p = .04$. Individuals in the classes with the lowest levels of childhood aggression and adult stressors, Classes 1, 2 and 3, were least likely to be depressed in adulthood. Class 4, with the highest level of stress in childhood and adulthood and high aggression and withdrawal in childhood, and Class 5, notable for its high level of childhood aggression, showed the highest level of depression.

The χ^2 test between the five classes and substance use disorder was also significant, $\chi^2 (4, N = 617) = 17.13, p = .00$. Low stress, low aggression and high withdrawal were associated with a decreased likelihood of substance use disorder, as evidenced by its low frequency in Class 2 (22%) and Class 3 (20%). Classes 1 (37%), 4 (39%), and 5 (35%) showed the strongest association with substance use disorder. Figure 8 depicts the association of depression and substance use disorder with class membership.

To complete this analysis, a three-way χ^2 test was performed to determine whether the relation between class and depression and substance use disorder differed by gender. The test for depression was not significant, indicating that the differential prevalence rate of depression between genders did not depend on class. The test for substance use disorder, however, was statistically significant, $\chi^2 (4, N = 617) = 14.20, p =$

.01. This suggests that not only were men more likely than women to have substance use disorder, but this relationships also depended on class. Further inspection revealed that men in class 4 were significantly more likely than men in class 3 (63% and 29% respectively)

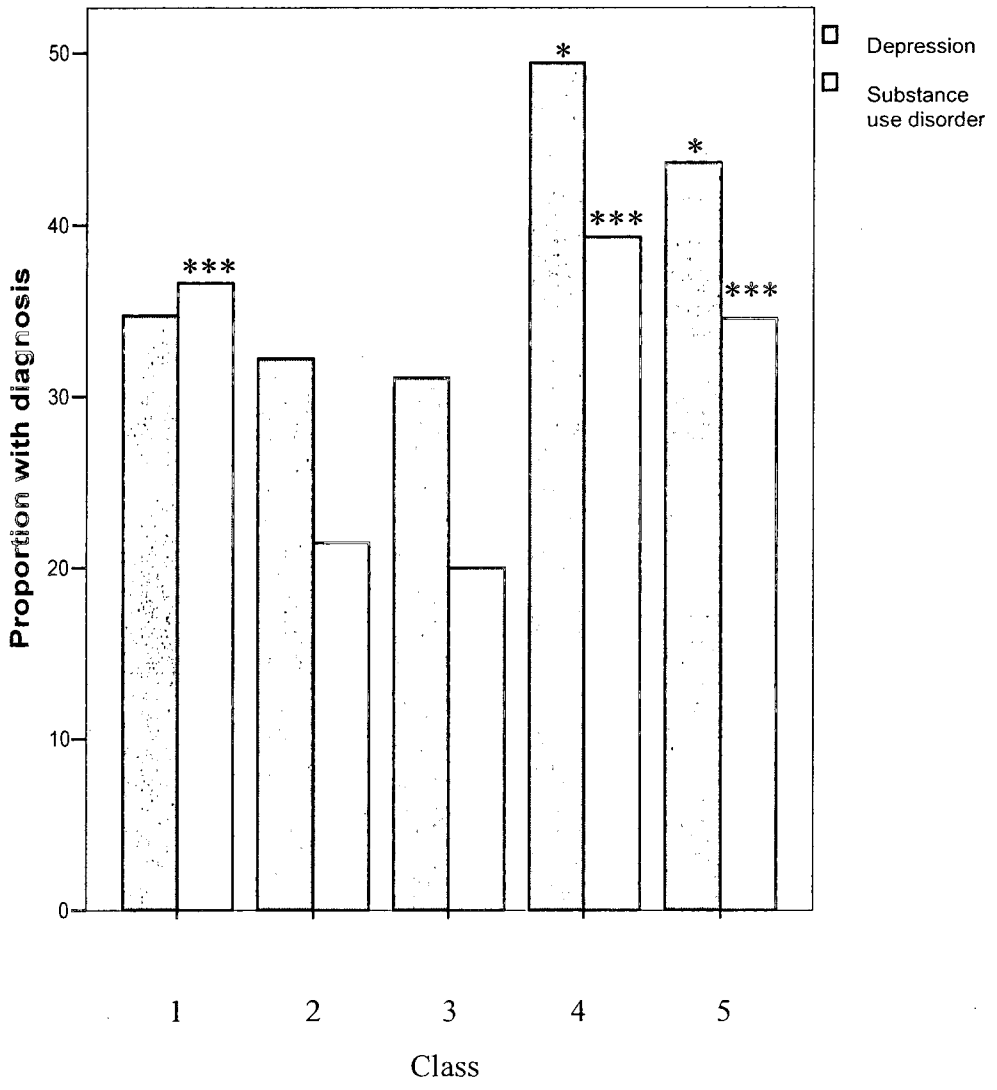
Table 13

Means (and Standard Errors) of Continuous Variable Indicators in the 5-Class Model

	Class 1 $n = 262$	Class 2 $n = 121$	Class 3 $n = 90$	Class 4 $n = 89$	Class 5 $n = 55$
Family environment	-0.07 (.07)	0.50 (.10)	-0.10 (.10)	-0.37 (.11)	-0.10 (.11)
Aggression	1.43 (.01)	1.40 (.01)	1.25 (.02)	1.93 (.02)	2.08 (.01)
Withdrawal	1.76 (.01)	1.75 (.01)	2.31 (.01)	2.13 (.02)	1.65 (.03)
Likeability	1.92 (.02)	2.22 (.03)	1.93 (.03)	1.87 (.02)	1.99 (.03)
School achievement	4.66 (.11)	6.61 (.17)	4.44 (.19)	3.83 (.15)	4.54 (.25)
SEP	-0.22 (.07)	1.06 (.11)	-0.13 (.10)	-0.58 (.10)	-0.29 (.14)
Stress	0.03 (.07)	-0.28 (.07)	-0.19 (.10)	0.43 (.12)	0.05 (.13)
Self-esteem	21.79 (.27)	24.66 (.38)	22.09 (.40)	20.47 (.43)	22.30 (.59)
Social support	5.57 (.02)	5.60 (.03)	5.58 (.04)	5.53 (.04)	5.57 (.05)

Figure 8

The 5-Class Model: Proportions of Cases with Depression and Substance Use Disorder



* $p < .05$
*** $p < .001$

Personal Attributions for Depression

Two sets of MANOVAS were performed to examine, first, the relation between RFDQ subscales and gender, and second, the relation between RFDQ subscales and the stress process profiles. Gender as a main effect was significant (Wilk's λ (.89), F (9, 156) = 2.11, p = .01; Hotelling's Trace (.12), F (9, 156) = 2.11, p = .01). Although there were no gender differences across most of the subscales, univariate tests indicated that contrary to expectations, men were more likely than women to report interpersonal conflict as an attribution related to depression (p = .04). In addition, women gave greater weight to items on the childhood subscale than men (p = .04). No differences between the men and the women were found regarding achievement issues as a particularly salient factor in their depression.

The stress process profiles derived from the latent profile analysis were then entered into a MANOVA with the RFDQ subscales. The multivariate effects were statistically significant (Wilk's λ (.71), F (36, 575.10) = 1.54, p = .01; Hotelling's Trace (.37), F (36, 606) = 1.56, p = .01). The effects again stemmed from differences on the interpersonal conflict and childhood subscales of the RFDQ. First, individuals in Class 4 were more likely to endorse items from the childhood scale than those in Class 2 (p = .01); and individuals in Class 5 endorsed these items more than those in Class 2 and marginally more than those in Class 1 (p = .01, p = .07) respectively. Following post hoc analysis, the relation between the classes and interpersonal conflict was reduced to a trend. Class 4 and Class 5 showed a marginal tendency (p = .09) to give greater causal weight to interpersonal conflict in comparison with the Class 2 profile.

Discussion

It is well established that more women than men receive a diagnosis of depression, and more men than women receive a diagnosis of substance use disorder. It is also well recognized that stress is a causal or precipitating factor of psychiatric disturbance. The present study was designed, therefore, to go beyond an epidemiological accounting to examine the relevance of gender in the context of a stress process perspective on the risk factors of depression and substance use disorder over the life course from childhood to middle maturity. To do so, we broadened the study's conceptual and methodological framework in three ways. First, in examining for gender differences, we treated depression and substance use disorder as alternative or co-occurring forms of stress-reactive negative outcomes of life course adversities in both the men and women. Second, we expanded the stress process model (Pearlin, Menaghan, Lieberman & Mullan, 1981) to include the childhood behavioural patterns of aggression and social withdrawal. Aggression and withdrawal are relevant to the stress process model both in terms of their relation to stress and to psychiatric disorder, and because they can be seen to reflect the effects of gender socialization, or "situated conduct" (West & Zimmerman, 1987). Third, we approached the data from two perspectives by conducting both variable-centered and person-centered analyses. Understanding average trajectories from stressors and personal resources to mental health outcomes can be greatly enhanced by examining the frequently unobserved heterogeneity in how these variables are interrelated.

We tested the applicability of an enhanced stress process model of depression and substance use disorder for men and women. Overall, findings from variable- and person-centered strategies highlight many similarities in men and women in the links between

earlier and later stressors, their relation to depression and substance use disorder, the buffering effect of personal resources, and the causal attributions of depression. A number of gender differences were noted. Structural equation modeling revealed a stronger association in girls compared to boys between family environment and childhood withdrawal, and between childhood likeability and academic achievement. Latent profile analysis uncovered five distinct patterns in the way elements of the enhanced stress process model clustered that could be designated as 'normative stress-adaptive', 'advantaged/low stress', 'reserved stress-adaptive', 'perpetuated stress' and 'aggressive stress-reactive'. Two of the groups – the advantaged/low stress and the perpetuated stress groups – comprised a greater proportion of women than men. Latent class membership was associated with both depression and substance use disorder and with causal attributions of depression.

It is noted here that the prevalence rates of lifetime depression and substance use disorder found in the present study were higher than those typically reported. This may be accounted for by the decision to include subthreshold depression (minor depression) and both substance dependence and abuse. As noted by Kessler and colleagues (1997) who reviewed prevalence rates for major and minor depression, decreasing the number of symptoms used to define a disorder "increases dramatically" (p. 27) the lifetime prevalence rate. Findings pertinent to the study's specific hypotheses are reviewed in the following sections.

Family adversity is associated with aggression and primary school underachievement in boys, and with social withdrawal and peer rejection in girls

Our hypothesis of gender-specific associations between adverse conditions in the family environment and children's psychosocial functioning received partial support. Structural equation modeling indicated that family adversity and social withdrawal were associated in girls but not boys. The association of family adversity with aggressive behaviour, peer rejection and underachievement, however, was evident in both the boys and girls.

The greater propensity of girls as compared to boys to withdraw and to internalize in the face of family adversity is consistent with the research literature in this area. Girls become more passive than boys in response to coercive family patterns, more withdrawn in the context of parental marital discord, and more likely to develop social phobia when exposed to ongoing family conflict (Compton, Snyder, Schrepferman, Bank, & Shortt, 2003; Harrist & Ainslie, 1998; DeWit et al., 2005). In a study of children's behavioural inhibition and parental depression and anxiety, girls were more likely than boys to show behavioural inhibition in association with lower socioeconomic position and parental divorce when the parental psychiatric risk factors were controlled (Hirshfeld-Becker et al., 2004).

Gender socialization is of relevance in helping to explain the gendered link between family adversity and withdrawal. The socialization processes that reinforce interpersonal sensibilities take place early, primarily within the family domain, and are directed more at girls than at boys (Gilligan, 1982). Over the course of development, girls would be expected more than boys to (1) become sensitive to, involved in, and

affected by family difficulties; (2) internalize the distress they perceive in other family members, thereby increasing their own distress (Buchanan, Maccoby & Dornbusch, 1991; Davies & Lindsay, 2001; Zahn-Waxler, 2000); and (3) use social withdrawal as a preferred behavioural style to defend against the perceived dangers of interpersonal contact in their peer relations.

The negative association between social withdrawal and peer liking that we found here has likewise been substantiated by previous research. Shy or socially anxious children are seen as less friendly than non-shy children and are at risk for peer rejection (Caspi, Elder & Bem, 1988; Wood, Cowan & Baker, 2002). The fact that peer dislike of social withdrawal in both the boys and the girls was only revealed when the link was explicitly tested for gender comparisons may reflect the mixed observations available in the literature. Kingery and colleagues (2010) have noted the small number of studies examining gender differences in the relation between social withdrawal and peer acceptance. In their research review, they observed "some evidence" of a stronger negative association between peer acceptance and social anxiety in girls compared to boys. This conclusion differs from that of Nelson and colleagues (2005) who found greater social difficulties for withdrawal in boys. It may be that social withdrawal differentially affects the peer relationships of boys and girls. Because shy, passive, or withdrawn behaviour is not typical of male socialization patterns, socially withdrawn boys stand out as being different, which can foster peer rejection. In girls, social withdrawal runs counter to the affiliative or communal processes that characterize girls' interpersonal relationships. Socially withdrawn girls are consequently also at risk for peer difficulties.

The study's findings are in line with those that reveal few gender differences in the effects of adverse family experiences such as parental divorce and poverty on children's *externalizing* problems including aggression (Amato, 2001; Buehler, Krishnakumar, Stone, Gerard & Pemberton, 1997; Dadds, Atkinson, Turner, Blums & Lendich, 1999; Dodge, Bates & Pettit, 1994; Kupersmidt, DeRosier & Patterson, 1995). Similarly, researchers who have examined the association between family adversity and academic and peer problems have found comparable risk for boys and girls (Backett-Milburn, Cunningham-Burley & Davis, 2003; Haynie, South & Bose, 2006; Krevans & Gibbs, 1996; Radziszewska, Richardson, Dent & Flay, 1996; Størksen, Røysamb, Moumc & Tambsa, 2005).

It may be, however, that girls and boys respond in a similar manner but to different aspects of family adversity. Boys have been shown to be particularly susceptible to neighbourhood disadvantage compared to girls (Halpern-Felsher et al., 1997). Levanthal and Brooks-Gunn (2004) found that male adolescents scored 10 points lower than female adolescents on achievement tests in low- as opposed to high-income neighbourhoods. Girls, as noted above, appear to be particularly sensitive to family conflict and problematic parenting practices, that either co-occur with or result from parental divorce or socioeconomic stresses. Elder, Nguyen and Caspi (1985) found that economic hardship was associated with rejection from fathers – more so for girls than for boys. Rejecting behaviours in fathers in turn "strongly influenced" the behaviours of their daughters. The authors suggested as an explanation that daughters were more targeted for rejection in times of hardship than were sons and that the greater interpersonal sensitivity of girls caused them to react more strongly.

Family adversity in childhood is associated directly or indirectly with adversity in adulthood

As hypothesized, a direct relation was found between conditions in the family environment in childhood and socioeconomic position in adulthood in both the women and the men. This finding is consistent with evidence of socioeconomic continuity across generations (Mazumder, 2001; Mulligan, 1999). Further, it endorses the view of Pearlin and colleagues (2005) that because health status is related to socioeconomic position it is important to consider the conditions – some of which "are embedded within the family of origin and exist before the individual is born" (p. 207) – that contribute to socioeconomic position attainment.

Socioeconomic position in maturity was associated with family environment in childhood and stress in adulthood in both the male and female samples. The view that low socioeconomic position is inherently stressful has been supported by evidence of increased exposure to multiple forms of stress under conditions of social disadvantage (McLeod & Kessler, 1990; Turner & Avison, 2003; Turner & Turner, 2005) and as manifested by elevated cortisol levels in low-income individuals with limited education (Cohen, Doyle & Baum, 2006).

The maintenance of socioeconomic position over time and its relation to the experience of stress involves an interplay between person and environment that reflects processes of socialization and social stratification. The sociologist Bourdieu (see King, 2000) has described the 'habitus' as a person's enduring set of dispositions formed during childhood that are generated by the internalization of one's place in the social structure. Such internalization extends to the formation of a basic understanding of life's

opportunities – or lack thereof – associated with the individual's social position that influences his or her behaviour and choices. The concept of the habitus provides a theoretical basis for the extensive empirical research literature that links risk factors across development. In a similar vein, Wheaton and Clarke (2003) have evoked the term "life history of social contexts" in reference to the often defining quality of children's early environments for subsequent experiences and to gain an understanding of the effects of cumulative stress. The despair of the working-class adolescent boys described by Willis (as cited by Hagan & Foster, 2003, p. 58) as they realize "the looming reality of the bleak socioeconomic fates" that await them is a compelling case in point that attests to the likelihood of the reproduction of contexts.

Childhood aggression and primary school underachievement mediate the relationship between family adversity in childhood and adversity in maturity in men, and childhood withdrawal and troubled peer relations mediate the relationship between family adversity in childhood and adversity in maturity in women

Although there were distinct gender differences in the mediating roles of childhood adjustment variables, the disparities were not in line with the specific predictions. Childhood aggression was not the hypothesized mediating influence between childhood family and adult adversity in the male sample and aggression mediated the association between family environment and socioeconomic position in the female sample, whereas withdrawal did not. In addition, troubled peer relations and primary school underachievement were not gender-specific as mediating agents. These

findings suggest that childhood social adjustment provides a partial explanation for the relation of family environment in childhood and socioeconomic position in adulthood. What stands out for both males and females is the degree to which behavioural problems exert their influence on the course of development through their impact on peer relationships and primary school achievement. As noted by Maughan and McCarthy (1997):

> [A] common pattern seems one where problems at one developmental period increase risks of poor adaptation at the immediately succeeding stage. For many individuals, this process will act to amplify difficulties across development. (p. 158).

The problem of aggression in childhood is certainly one that frequently amplifies and perpetuates difficulties into adulthood through its effects on school achievement and social functioning. Comparisons of the male and female structural equation models suggest that girls who are aggressive are at greater risk than boys of maintaining low socioeconomic position across time. An important way in which children of low socioeconomic position can alter their social status is through education and occupational attainment. Aggression in girls may interfere with a number of processes that can facilitate such a change. As in boys, aggression in girls is related to poor school performance. Girls who display aggressive behaviour, however, tend to have more negative self-perceptions than boys (Cillessen & Mayeux, 2007), a factor that may contribute to problematic school experiences. But perhaps of greater consequence for girls are the adverse effects of aggression together with peer alienation on their academic achievement. Although aspects of aggressive behaviour in girls frequently promote

popularity with peers, aggression is not well regarded (Estell, Farmer, Pearl, Van Acker & Rodkin, 2008). Unlike aggression, likeability is predictive of good school performance (Farsides & Woodfield, 2003; Laidra, Pullmann, & Allik, 2007; Shiner, 2000; Wentzel & Asher, 1995), and more strongly predictive of academic achievement in the girls compared to the boys in our study.

There is good evidence of a strong relationship between peer relations and children's school achievement (Osterman, 2000; Parker, Rubin, Erath, Wojslawowicz & Buskirk, 2006; Swenson & Strough, 2008; Van Boxtel & Mönks, 1992). Evident as well is that there are gender differences in this association. Girls but not boys who show relational aggression or who are rejected by peers tend to have negative attitudes towards school and difficulty engaging in schoolwork (Hoglund, 2007; Zettergren, 2003). The propensity of boys to emphasize their independence and girls to emphasize their connections with others (Cross & Madson, 1997) may explain the greater impact of positive peer relations on wellbeing for girls than boys and hence their greater ability to concentrate on schoolwork when they feel accepted by their peers. In addition, the traits that foster peer problems in girls may also be viewed with particular disfavour by teachers, thereby reducing further the probability of positive school experiences.

The study's sequential linkage of childhood family environment, academic achievement and socioeconomic position in adulthood is very much in accord with previous research findings (Battin-Pearson et al., 2000; Grabowski, Call & Mortimer, 2001). Pearlin's (2010) view of education as, "a gateway to subsequent statuses" (p. 213) has been shown to be valid as early as the primary level. Work by Feinstein and Bynner

(2004) clearly reveals the weight of family socioeconomic position on early school achievement, subsequent educational attainment, and employment potential.

Undoubtedly, the association between academic achievement and family income encompasses many interrelated processes that contribute to the intergenerational maintenance of social position. Beyond the question of available resources and their evident impact on how well prepared a child will be to evolve in the adult world, family values, attitudes, and expectations, rooted at least partly in socioeconomic rank are also relevant (e.g., Duncan, Yeung, Brooks-Gunn & Smith, 1998). Family expectations emanating from social position confer a level of familiarity with the academic environment, such that it may be more easily entered by children of higher socioeconomic position. In line with the concept of the habitus, children of lower socioeconomic position may have less preparation for the school environment and fewer expectations about remaining there (Dumais, 2002; Garg, Melanson & Levin, 2007).

Adversities in adulthood are associated with depression in women and substance use disorder in men

The findings did not support the hypothesis. Despite the higher prevalence rates recorded for depression in women and substance use disorder in men, and the fact that these disparities mirror those reported in epidemiological surveys, the men and women were essentially similar in their propensities to both disorders as a function of the adversities they experienced in adulthood. These findings are consistent with those of a number of studies that find no moderating effect of gender on the relation of stress to depression (Bouma, Ormel, Verhulst & Oldehinkel, 2008; Eberhart, Shih, Hammen & Brennan, 2006) and substance misuse (Mossakowski, 2008).

A recent study has shown that after controlling for relevant health behaviours, socioeconomic factors explain a significant amount of the variation in health outcomes (Dunn, 2010). To this effect, and as we also found, income, education and neighbourhood quality are inversely associated with drug and alcohol misuse (Buu et al., 2009; Cook et al., 2009; Crum, Ensminger, Ro & McCord, 1998; Morgenstern, Hogue, Dasaro, Kuerbis & Dauber, 2008; Schulenberg, Bachman, O'Malley & Johnston, 1994). The sense of financial strain that frequently accompanies low income can foster distress by decreasing the individual's sense of control over his or her life circumstances (Heflin & Iceland, 2009; Keith, 1993; Chou & Chi, 2001; Pearlin, Menaghan, Lieberman & Mullan, 1981). Substance use as a coping mechanism has also been found to increase in relation to financial stress (Peirce, Frone, Russell & Cooper, 1996).

Gender differences in the prevalence rates of depression and substance use disorder may best be explained as a reflection of gendered responses to stressful circumstances. Nolen-Hoeksema (2004) notes that although the predictors of substance misuse are similar in men and women, there may be gender differences in exposure to certain risk factors. Lemke and colleagues (2008), for example, found that men were more likely than women to be exposed to heavy drinking in peers. The authors concluded that, "this pattern is consistent with expectations based on the heavier alcohol consumption of men as manifested in men's friendships and work relationships and in their partner relationships" (p. 700). Whereas the influence of peers on men's substance use has received strong support (Barrett & Turner, 2006), the influence of peers in this regard is less evident in women (Clark & Lohéac, 2007).

By contrast, research on depression has produced substantial evidence of greater sensitivity to the stresses of interpersonal relationships in women than men, and, more specifically to the stresses that affect others (Davis, Matthews, & Twamley, 1999; Kessler & McLeod, 1984; Thoits, 1995). Our findings, however, are not consistent with evidence of gender differences in socioeconomic position as a cause or a correlate of depression. We did not find gender differences on any of the variables that constituted our socioeconomic factor. It is possible that the social changes that have been brought about by the women's movement have altered the understanding that many women have had that, in effect, assumed immobility in their social positions. Women now repeat grades less than men, have higher high school graduation rates and are more likely to obtain undergraduate degrees (Jacobs, 1996). Reynolds and Burge (2008) have found these advances to be directly related to changes since the 1970s in the expectations of girls about their academic, and, we might add, their employment potential. Taken together, studies of stress indicate that gender differences in the susceptibility to depression and substance use disorder pertain more to differences in exposure and sensitivity to, and patterns of coping with particular kinds of stressors that are not readily evident when general markers of socioeconomic and interpersonal distress are used.

Gender differences in the prevalence rates of depression and substance use disorder may also derive from the stigmatic aspects of non-conforming gender role behaviour. More women seek professional help than men for depression, and men often fail to meet the diagnostic criteria of the disorder by reporting fewer symptoms than women (Angst et al., 2002; Joska & Flisher, 2005; Wålinder & Rutz, 2001). Similarly, more men than women seek and receive treatment for substance use disorder (Green,

2006; Mojtabai, Olfson & Mechanic, 2002). The clear similarities between men and women in the relation of stress to both internalizing and externalizing forms of disturbance as shown in our path models, together with the possibility of underestimates of depression in men and substance misuse in women signal the value of determining whether there are gender differences in the underpinnings of stress and help-seeking behaviours.

Family adversity, aggression, and underachievement in childhood and adversities in adulthood define the life trajectory of risk factors for substance use disorder in men, and family adversity, social withdrawal, and troubled peer relations in childhood and adversities in adulthood define the trajectory of risk factors for depression in women

The hypothesis of distinctive gendered life trajectories to depression and substance use disorder was not supported. Structural equation modeling of the pathways to the two disorders revealed more similarities than differences between the study's men and women. All the risk indicators hypothesized were relevant to diagnostic outcome, whether depression or substance use disorder, in both the male and female samples. Findings of the Dunedin study underscore the similarity of pathways for boys and girls whose antisocial behaviour persists (Moffitt, Caspi, Rutter & Silva, 2001).

There were gender differences, however, in the relative strengths and associations of particular predictor variables. Family adversity, for example, was more evident as a risk factor in the women than in the men. It had a bearing on all three dimensions of peer relations in childhood in the women. Its relevance as a risk factor in the men was limited to its negative effects on childhood peer likeability and only marginally on childhood

aggression. The pathway to problematic outcomes from childhood family adversity and aggression that was evident in the female sample was also noted in the Dunedin study (Odgers et al., 2008).

The picture that emerges from this aspect of the findings is one in which interpersonal circumstances in childhood – in both the family and peer domains – are particularly relevant as a source of cumulative stress for women. As interpersonal stressors increase, whether in relation to aggression and withdrawal, or to external environmental factors in childhood, the ensuing psychological distress that occurs in women is most likely to be manifested as depression. In terms of gender similarities, however, it was the salience of primary school academic achievement in funnelling the adverse effects of negative childhood experience over the life course in both the male and female samples that was a noteworthy feature of the findings.

Self-esteem and social support in maturity attenuate the risk of depression in women and that self-esteem attenuates the risk of depression and substance use disorder in men

This hypothesis received qualified support. As predicted, self-esteem attenuated the risk of depression in both the men and the women; and social support attenuated the risk of substance use disorder in the women and marginally in the men via its positive linkage with self-esteem. Contrary to expectations, however, self-esteem had no bearing on the risk of substance use disorder in the men. In addition, neither self-esteem nor social support qualified as statistically significant markers of gender differences between the male and female life trajectory risk models.

The positive influence of self-esteem on psychological wellbeing in general and depression in particular is a well-established finding (McGee, Williams & Nada-Raja, 2001; Orth, Robins, Trzesniewski, Maes & Schmitt, 2009; Reinherz, Giaconia, Hauf, Wasserman & Silverman, 1999). Macphee and Andrews (2006) found that self-esteem was the strongest of several predictors of depression in adolescents, and Lewinsohn.and colleagues (1997) found it to be strongly specific to depression. The relevance of social support as a protective factor in dealing with adversity and emotional distress has also received broad support (e.g., Holahan & Moos, 1981; Kessler & McLeod, 1985). At the same time, however, it should be noted that self-esteem and social support are, in effect, wide-ranging constructs that convey and pertain to a wide range of behaviours, contexts, and motives. Thus, the qualified support that this hypothesis received in the present study may be viewed as a reflection of the complexities and challenges of this field of personality study.

Patterns of Risk and Resources

We undertook latent class analysis with the assumption that the indicators of risk and resources were associated and that we could determine the number of underlying latent classes that explain this association. We were interested in the idea that while individual variables may not show particularly strong gender differences, gender differences in the patterns of interrelationships among them may be "large and interesting" (Birkelund, Goodman & Rose, 1996).

Are there risk profiles that are prototypically 'female' or 'male'? Two of the five profiles obtained were distinctive in their predominance of women. These two profiles were also distinctive in their polarized patterns of risk and resources. Women

were more than twice as likely as men to be part of the advantaged/low stress group and almost twice as likely as men to be part of the perpetuated stress group. The configurations of risk and resources found in the present study support the idea that risk factors tend to cluster in the same individuals (Masten & Coatsworth, 1998). What stands out about the two profiles in which there were proportionally more women than men is the extent of the clustering in opposing directions. Why might women be more likely than men to fall into the most and least advantaged groups?

There is extensive empirical research on this aspect of the findings. The study by Feinstein and Bynner (2004) concerning the stability of academic achievement scores in children between ages 5 and 10 helps to shed light on the clustering of risk in general, and in women in particular. These authors found that the likelihood of 'low-score persistence' was greater in girls of low socioeconomic position compared to their male counterparts. Low-score persistence was, however, less likely for girls than boys of high socioeconomic position. Subsequently, low- and high-score persisters respectively attained lower and higher indices of socioeconomic position. Of particular interest to the present study, women who had been high-score persisters had the lowest risk of low income. These findings are complemented by evidence from Roxburgh (2009) who found that the beneficial effect of education on emotional wellbeing was greater for women than for men when the level of socioeconomic resources was high. She noted that, "it may be that women with high education experience greater gains in well-being compared with men because women who achieve this status are a smaller, more select group" (p. 374).

Girls from higher socioeconomic backgrounds whose family environment includes intact parental marital status and advantaged neighbourhoods may be most able to benefit from a positive school orientation, thereby accumulating advantages and resources and setting a course for the relatively lower stress, continued success, and greater well-being associated with higher socioeconomic position. The high advantage profile described here included individuals who showed moderate levels of aggressive and socially withdrawn behaviour and were, in addition, most frequently nominated as likeable by their classroom peers. Undoubtedly, positive interpersonal relations for girls further consolidate the long-term potential offered by an advantageous family environment by enhancing their sense of self-worth, competence, and social acceptance.

The same line of reasoning can help explain the greater proportion of women relative to men in the perpetuated stress profile. A number of studies have found that low socioeconomic position is more strongly predictive of poor achievement in boys compared to girls, whereas this gender difference is not apparent at higher socioeconomic levels (e.g., Dekkers, Bosker & Driessen, 2000). Nonetheless, what the perpetuated stress profile seems to indicate is that although boys from adverse family environments tend to fare less well than their female counterparts, girls growing up in adversity who *also* show problematic behavioural features are particularly susceptible to the effects of accumulated stress. As discussed above, aggressive behaviour in children is predictive of ongoing psychosocial difficulties. Aggression as non-normative behaviour is less well tolerated in girls than in boys and aggressive girls are therefore at risk for peer rejection (Bukowski, Gauze, Hoza & Newcomb, 1993; Prinstein & La Greca, 2004). The low level of peer acceptance in the perpetuated stress profile is, however, clearly related to the

high level of social withdrawal. The combination of aggression and withdrawal has been recognized as particularly problematic (Boivin, Poulin & Vitaro, 1994; Ledingham & Schwartzman, 1984). Girls showing these behavioural features alienate themselves from others doubly by acting outside of gender norms on the one hand, and failing to compensate by meeting affiliation needs on the other. In association with high stress in the family environment, the pattern of negative experiences in school and with peers may make coping increasingly difficult as stressful experiences accumulate (Hobfoll, 1989). Consequently, the pattern of high stress and low resources is likely to continue into adulthood, as evidenced in this profile.

Practices of socialization may further explain the polarization of female-dominant profiles. Socialization processes in the childhood family environment, such as use of harsh discipline and degree of parental warmth, are related to socioeconomic position (Dodge, Pettit & Bates, 1994). As observed by Dodge and colleagues, parents in low socioeconomic environments may show less warmth toward their daughters than toward their sons. This type of experience contributes to shaping expectations about interpersonal relations, with implications for peer acceptance. Parents also expect girls to settle in to the constraints of the school setting more readily than boys (Entwistle, Alexander & Olson, 2007). Sex-role socialization theory suggests that because girls are socialized to be less disruptive and more compliant than boys, they should fare well in a setting that tends to favour disciplined students. Girls such as those in the advantaged/low stress group who are friendly and outgoing are likely to contribute to a favourable classroom experience. Girls whose behaviour sets them apart from social expectations, such as those in the perpetuated stress group, may contribute to creating an

unfavourable classroom experience. The classroom experience is clearly of key significance, given the role of academic achievement as nexus between earlier and later socioeconomic position.

Bourdieu (in Dumais, 2002) has, moreover, observed that financial hardship curtails opportunities to move beyond typically gendered pathways. This idea has been supported by research showing that low-income parents tend to expect girls to take stereotypically female jobs, whereas such expectations are not found in parents of higher socioeconomic position (Entwistle, Alexander & Olson, 2007). Such expectations within economically difficult circumstances may have a strong bearing on the maintenance of low paying, low status employment in women while conversely broadening employment opportunities within economically advantaged spheres.

Are childhood risk factors a key distinguishing feature among the profiles- and if so, which of the factors in childhood are particularly relevant to the risk of later depression or substance use disorder? Which of the risk factors of adulthood are a distinguishing feature of vulnerabilities to depression or substance use disorder? All the study's risk factors contributed to the distinction among profiles. The only variable to show no differences across groups was the index of satisfaction with social support.

Consistent with the idea of cumulative risk (Rutter, 1979), individuals in the perpetuated stress group and the aggressive stress-reactive group were the most likely to develop depression and substance use disorder as adults. Additional analyses revealed a gendered distribution of these two disorders within each group. The common component in these two profiles - aggressive behaviour in childhood - has been cited as a risk factor

for depression and substance abuse in men and women (Fergusson, Horwood & Ridder, 2007; Gjerde, Block & Block, 1988; Skara et al., 2008). In the perpetuated stress group, childhood aggression in combination with social withdrawal and the clustering of stressors from childhood through to adulthood provide a strong explanatory basis for the development of psychological disturbance. Ensminger and colleagues (2002), for example, followed grade 1 boys into adulthood and found that those who were both aggressive and shy were at risk for subsequent illicit drug use.

Although the aggressive stress-reactive group evidenced levels of stress and socioeconomic position in adulthood that were comparable to those of the normative-stress group, they were also similar to those in the perpetuated stress group. This suggests that socioeconomic position was marginally low and stress was marginally high in this profile. It is likely that the combination of high aggressive tendencies, moderately elevated stress, and moderately low socioeconomic position increased the probability of chronic stress over time. To this effect, Hagan (1997) reported that individuals who had delinquent tendencies but were non-depressed in adolescence became depressed contending with negative employment experiences as adults.

In line with previous research (e.g., Luthar & McMahon, 1996), members of the high aggression profile were liked as children. Association with other individuals who are also high in aggression is likely, however, and this increases the probability of substance misuse (Giancola & Parker, 2001). Aggressive individuals may also lack a sense of connection with other people. Gjerde and colleagues (1988) found that 18-year-old males and females with depressive symptoms described themselves as aggressive and alienated from others.

Membership in the high social withdrawal group did not predict depression. This finding is consistent with those of previous studies that show no particular deleterious outcomes associated with childhood withdrawal (e.g., Bowker, Rubin, Rose-Krasnor & Booth-LaForce, 2008), but inconsistent with those of other studies (e.g., Boivin, Poulin & Vitaro, 1994). Withdrawal may be a more robust precursor of depression when there are additional negative circumstances, such as poor social relations (Rubin, Coplan & Bowker, 2009).

Are there risk features that distinguish between the risk profiles of depression and those of substance use disorder? Apart from the buffering effect of childhood withdrawal on the development of substance use disorder, there were no risk features that distinguished between the risk profiles of depression and those of substance use disorder. Social withdrawal as a protective factor in externalizing behaviours including substance misuse has been reported (Siewert, Stallings & Hewitt, 2004). Analysis of class profiles showed that high social withdrawal was protective against substance use disorder only in the absence of high aggression, that is, in the reserved stress-adaptive group.

The perpetuated stress group and the aggressive stress-reactive group were at risk for both disorders. Within these high-risk groups, the men and women developed depression at similar rates. The men, however, were more likely to develop substance use disorder than the women. The question of comorbidity is relevant here. The rate of comorbidity of depression and substance use disorder was higher in the men than the women. Comorbidity between these two disorders is known to be frequent (Swendsen & Merikangas, 2000) and, although the findings are mixed, some studies have shown a

greater risk of comorbidity in men (Verhagen et al., 2008). Kuo and colleagues (2006), for example, found that men were more likely than women to develop an alcohol disorder in association with lifetime or concurrent major depression. Although substance-related depression cannot be ruled out, self-medication can explain the association between substance misuse and depression (Khantzian, 1997). Self-medication through substance use is one way to avoid dealing directly with depressive feelings (Brownhill, Wilhelm, Barclay & Schmied, 2005). Many authors contend, moreover, that depression is frequently masked in males by avoidant and risk-taking behaviours (e.g., Hankin et al., 1998). This may help explain why at moderate levels of stress – as those shown in three of the profiles found here – men show significantly higher levels of substance misuse and lower levels of depression than women. The practice of engaging in substance use as a means of managing adverse affective responses to stress and feelings of depression is in keeping with traditional gender role conventions. Internalizing symptoms are redirected toward an externalized expression that is, itself "a natural domain of boys and men" (Haines, Johnson, Carter & Kamal, 2009, p. 2030). Interestingly, the women in the high-risk profiles continued to show significantly lower levels of substance use disorder than their male counterparts. The noted narrowing of the gender gap in substance misuse that has been observed over recent years is particularly evident in studies using cohorts younger than those who participated in the present study. For many women, excessive substance use remains outside of gender behavioural norms that "precede [and] constrain" individual choices (Butler, 1993, p. 234). Women, and notably those in the role of caregivers, are less

likely to engage in behaviours that may explicitly jeopardize their relationships with others (Korcuska & Thombs, 2003).

To what extent do the indices of stress in childhood and maturity differentiate the risk profiles? The salient finding emerging from our latent class analyses was the accumulation of the effects of stress over time. We found that individuals who started life in the most advantageous neighbourhoods with higher socioeconomic position and non-divorced parents were likely to continue experiencing lower stress than those in less advantaged childhood environments. Children from advantaged family environments were also likely to do well at school and become adults with high self-esteem, in contrast with the lower school achievement and self-esteem in less affluent individuals. These findings are consistent with the predictions of Wheaton and Clarke's (2003) compound (dis)advantage model, in which health outcomes are expected to be a function of personal and neighbourhood advantage.

Causal attributions of depression

We expected that women would cite problems centering on interpersonal relationships and men on achievement issues as reasons for depression. Men, however, gave greater weight to interpersonal conflict and women to negative childhood factors. We also found that individuals in the perpetuated stress and aggressive stress-reactive classes were more likely than those in other classes to select childhood issues as explanatory.

Given the extensive literature on the salience of interpersonal issues for women's wellbeing, the finding that women did not register more concern than men about personal relationships was surprising. It may reflect the nature of the measure, which placed

emphasis on interpersonal respect and criticism. Rudolph (2002) has suggested that whereas girls respond with greater stress to difficulties in close friendships, boys show increased stress in relation to status within the peer group. In line with this perspective, Shih and colleagues (2006) found that adolescent males showed higher rates of depression than females under conditions of high chronic stress associated with social difficulties beyond the domain of friendship. In a similar vein, Liu and colleagues (2008) found that interpersonal conflict in the workplace elicited negative emotions in men more than women. The authors speculated that women have greater ability to cope with such conflicts. Women's positive self-perceptions relative to interpersonal relationships have been shown to act as a buffer against depression (Eberhart, Shih, Hammen & Brennan, 2006). Men with less positive perceptions of their ability in this domain may deal less well with interpersonal conflict.

The fact that a greater percentage of women than men attributed their depression to negative childhood experiences is consistent with the results of our latent class analysis where a greater proportion of women than men qualified for membership in the profile with disadvantaged family environment as a key feature. Hardt and Rutter (2004) reviewed evidence regarding the validity of recollections as an index of adverse childhood events. They concluded that such recollections are likely to be correct and unaffected by current mood states. The gender difference revealed in both the latent class analysis and personal attributions is consitent with previous reports. Girls have been found to be more affected by family conflict than boys (Gore, Aseltine & Colten, 1993), more likely to engage in ruminative modes of coping (Nolen-Hoeksema, 1987), and to recall more emotion-evoking events or circumstances of childhood (Davis, 1999).

The fact that there was no gender difference in attributions to achievement issues as a reason for depression was also unexpected. Traditional socialization practices have emphasized agentic goals in men and communal goals in women (Eagley, 1987). The measure used in the study does not deal with specific areas of achievement. The male and female participants of the study may have responded similarly to concerns about achievement while referring to differing, and perhaps typically gendered, spheres of functioning. Equally plausible is an explanation that centers on the fact that gender role socialization has evolved considerably over recent decades. Salari and Zhang (2006) have shown that compared to older cohorts, men and women born after 1965 show significantly less attachment to the traditional gender role separation between male as "good provider" and female as "kin keeper." They found that in terms of wellbeing, failure to succeed financially affected women adversely and disappointing family involvement adversely affected men.

Limitations of the Study

A number of limitations warrant attention. First, the count of medical acts coded as 'neuroses' by physicians that we used in the study as a proxy measure of maternal emotional disturbance was likely to be incomplete. A good proportion of individuals with emotional difficulties do not seek medical help, and utilization of medical services is to some degree irregularly distributed within the population (Houle, Beaulieu, Lespérance, Frasure-Smith & Lambert, 2010). The number of outliers and the positive skew in the distribution of scores may have reflected an unequal tendency to consult with a medical practitioner in addition to differences in baseline prevalence rates that could be expected across socio-demographic strata.

Second, there was no information concerning parental personality attributes or parenting practices concurrently obtained with measures of family environment and children's aggression and social withdrawal. There is a substantial research literature that underscores the importance of parenting style for children's adjustment, both as a direct effect and as an attenuating/exacerbating factor relative to the effects of stressful conditions over the life course (Baumrind, 1967, 1991; Bolger, Patterson, Thompson & Kupersmidt, 1995; Browne, Wells, Bushnell & Hornblow, 1995; Gerra et al., 2007; Maccoby & Martin, 1983; Repetti, Taylor & Seeman, 2002). A concurrent measure of parenting practices might have shed more light on our findings concerning gender in the association of family environment and children's aggression and social withdrawal.

Third, the use of factor scores to index general stress levels in childhood and adulthood may have precluded the identification of gender-specific sources of stress – for example, the greater sensitivity of women to interpersonal stressors and men to work stressors (Eagley, 1987). In addition, the use of events checklists as a major component of a measure of general stress may have underestimated the effects of social stress on the mental health of young adults (Turner & Avison, 2003) and thus have obscured gender differences in this area that have an important bearing on gender differences in susceptibilities to depression and substance use disorder.

Conclusions and Future Directions

The recent observation in the field of medicine that, "Health in the 21st century is a complex interplay of forces from the genetic to the relational to the political" (Emans et al., 2010, p. 102) is relevant to the question of emerging directions in psychological research. The increasing trend toward transdisciplinary inquiry served as an orienting

force for the present project's integration of sociological and psychological perspectives and its use of multimodal analytic strategies.

In his discussion of the sociological study of stress, Pearlin (1989) observed that although sociological information is often gathered for research purposes, such information is frequently not considered to be a fundamental aspect of the question at hand. Data that may be essential for understanding the stress process are sometimes treated "as analytic noise that needs to be controlled statistically" (p. 243): One objective of the present study was to focus on ways in which gender and socioeconomic adversity shape the developmental trajectories toward depression and substance use disorder. A meaningful finding, derived from the use of person- and variable-centered methodologies, was the fact that there are sufficient similarities between men and women to speak of a general stress process, but also sufficient distinctions to support the notion of a certain intractability in social organization (Connell, 1988). Clearly, there are important ways in which the processes of socialization and social ordering influence the experiences people have, the choices they make, and their reactions and responses to resulting circumstances. If the stress process is a dance through time, this dance appears to follow differing rhythms for different groups of people, even when the steps themselves show certain patterned similarities. At the same time, the very fact that many individuals within the most adversity-ridden profiles did not develop depression or substance use disorder invites continuing investigation. As Zill and colleagues (1993) have noted, "the fact that a young person comes from a divorced family does not, in itself, tell us a great deal about how he or she is faring on embarking into adulthood." (p.100).

A recent examination of the stress process model (Meyer, Schwartz & Frost, 2008) has discussed the idea that because women, as a group, are no longer disadvantaged "in the sense addressed by stress theory" (p. 377), gender has lost much of its relevance for understanding the implications of disadvantage for stress. Results from the present study identifying the male/female similarities in the average levels of socioeconomic position, the comparable relations between socioeconomic position and stress, and between these two factors and psychological disorder, may, at first glance, seem to support this contention. Closer inspection of the results, however, indicates that gender discrepancies remain in the social stratification of stress and its related outcomes. First, our analysis of risk profiles provided evidence that the most disadvantaged group, with the highest risk of disorder, included a preponderance of women. Second, by adding behavioural dimensions that reflect aspects of gender norms to the stress process model, we uncovered two gender/stress relationships of note. Girls growing up in adverse family conditions were more likely than boys to show socially withdrawn behaviours, and these factors foster problematic school and peer experiences with implications for long-term adjustment. Also, childhood adversity and subsequent socioeconomic position in adulthood were mediated by aggression in girls but not boys, suggesting that gender non-normative behaviour is particularly likely to hinder girls' ability to move beyond their original socioeconomic conditions. Third, male gender and low socioeconomic position predicted substance use disorder. While we found that low socioeconomic position was an equivalent predictor of substance use disorder in women, the greater prevalence of substance use disorder in men suggests the importance of socialization processes. Gendered expectations of behaviour that discourage the expression of emotional distress

and that direct toward action – including engagement in risky behaviours – facilitate the development of substance misuse in men.

Risman (1998) has noted that, "as a social structure, gender is realized in our personalities, in expectations for our behavior in social situations, in the organization of cultural ideologies and social institutions like work and family" (p. 429). Along similar lines, Shanahan and Hofer (2005) have observed that although behaviours are partly heritable, they are also distributed in the population according to such factors as socioeconomic position. Differences in the ensemble of opportunities for success, socioeconomic structures, and behavioural norms create differing psychologies (Steele & Sherman, 1999) and these in turn are reflected in differing responses to the stress process.

Future directions for this line of research will benefit from a number of enhancements. First, at the level of variable selection, subsequent research could focus on how particular types of stressors and personal resources vary by gender, socioeconomic position, and diagnostic outcome. Also of interest would be the inclusion of explicit information concerning early and later experiences pertaining to gender socialization. Second, at the level of methodologies, a strong argument has been advanced concerning the importance of taking repeated measures of socioeconomic position, notably in the interest of determining the amount of time children spend living in disadvantaged circumstances. Timing, duration and sequencing of poverty have all been cited as significant modifiers of the effects of socioeconomic position on children's psychosocial development and implications for long-term outcomes (Wagmiller, Kuang, Aber, Lennon & Alberti, 2006). Examination of this issue in terms of gender could improve our understanding of how family circumstances differentially affect girls and

boys. Another methodological development in the investigation of differing experiences and outcomes of the stress process would involve the undertaking of a qualitative component. As indicated by findings in the present study, personal views obtained from a self-report measure differed to some extent from our theoretically based expectancies. More open-ended explorations of individuals' lived experiences of the processes involved in the development of depression and substance misuse, those concerning aspects of socialization for example, could further enhance our understanding of the complexities involved in gendered pathways toward these deleterious outcomes. Third, at the level of orientation, two areas of study will undoubtedly provide significant insight into the nature of the stress process. Advances in the field of behavioural genetics have already begun to elucidate the impact of genetic factors in predisposing people to the development of depression, for example (e.g., Silberg, Rutter, Neale & Eaves, 2001). Research that identifies the genetic underpinnings of stress reactivity, depression, and substance use disorder and the nature of their transactions with proximal and distal environmental processes will help answer questions such as those concerning the relevance of childhood experiences to mental health status over the life course (see Paris, 2000). Equally important is an historical perspective that will follow shifting social values and demographics to examine the effects of societal changes on the nature of the stress process and the incidence of psychological disorder.

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Appendix A: Family Occupational Prestige

Pour en connaître plus sur les différences d'âge dans les familles, on aimerait avoir le nom (pour mettre nos dossiers à jour) et la date de naissance des membres de la famille (immédiate), et des autres pers. avec qui tu as pu vivre. On commence par ton père: son nom, au complet c'est...

PRÉNOM & NOM:	LIEN:	DATE DE NAISS.:
_____	Père _____	___ ___ 19 ___ (jour mois an)
_____ (Nom de fille)	Mère _____	___ ___ 19 ___
_____	_____	___ ___ 19 ___
_____	_____	___ ___ 19 ___
_____	_____	___ ___ 19 ___
_____	_____	___ ___ 19 ___
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_____	_____	___ ___ 19 ___
_____	_____	___ ___ 19 ___
_____	_____	___ ___ 19 ___
_____	_____	___ ___ 19 ___

En 1977 S: Age _____ Vivait avec: 1 2 3 4: _____ De 19 ___ à 19 ___

- Travail du père (autre): _____ Occ. ____ Pr. ____
- Travail de mère (autre): _____ Occ. ____ Pr. ____

Appendix B: Peer Evaluation Inventory

ÉVALUATION PAR LES PAIRS - garçons

Voici la liste des items présentés aux enfants et le facteur correspondant à chacun.

A - Agressivité
I - Isolement social
P - Popularité

Les énoncés précédés de - - correspondent à la version présentée en première année.

L'énoncé # 1 ne se rattache à aucun facteur et ne sert que de pratique.

La liste concernant les filles est identique à celle rédigée ci-dessous.

- - 1. Ceux qui sont plus grands que les autres.

P 2. Ceux qui aident les autres.

A 3. Ceux qui ne sont pas capables de rester assis tranquilles.

A 4. Ceux qui essaient de mettre les autres dans le trouble.

- - I 5. Ceux qui sont trop timides pour se faire des ami(e)s facilement.

- - I 6. Ceux qui se sentent trop facilement blessés.

A 7. Ceux qui prennent des airs supérieurs et qui pensent qu'ils valent mieux que tout le monde.

A 8. Ceux qui font les clowns et qui font rire les autres.

- - A 9. Ceux qui commencent la chicane à propos de rien.

I 10. Ceux qui ne semblent jamais s'amuser.

I 11. Ceux qui sont bouleversés quand ils ont à répondre aux questions en classe.

A 12. Ceux qui disent aux autres enfants quoi faire.

I 13. Ceux qui sont d'habitude les derniers choisis pour participer à des activités de groupe.

- - P 14. Ceux que tout le monde aime.

A 15. Ceux qui s'empêtrent tout le temps et se mettent en difficultés.

- - A 16. Ceux qui rient des gens.

- - I 17. Ceux qui ont très peu d'ami(e)s.

A 18. Ceux qui font des choses bizarres.

P 19. Ceux qui sont tes meilleurs amis.

- - A 20. Ceux qui ennuient les gens qui essaient de travailler.

A 21. Ceux qui se mettent en colère quand ça ne marche pas comme ils veulent.

- - A 22. Ceux qui ne portent pas attention au professeur.

A 23. Ceux qui sont impolis avec le professeur.

- - I 24. Ceux qui sont malheureux ou tristes.

P 25. Ceux qui sont particulièrement gentils.

- - A 26. Ceux qui se comportent comme des bébés.

A 27. Ceux qui sont méchants et cruels avec les autres enfants.

- - I 28. Ceux qui ne veulent pas jouer.

A 29. Ceux qui vous regardent de travers.

A 30. Ceux qui veulent faire les fins devant la classe.

- - A 31. Ceux qui disent qu'ils peuvent battre tout le monde.

- - I 32. Ceux que l'on ne remarque pas beaucoup.

- - A 33. Ceux qui exagèrent et racontent des histoires.

- - A 34. Ceux qui se plaignent toujours et qui ne sont jamais contents.

- - P 35. Ceux qui semblent toujours comprendre ce qui se passe.

Appendix C: Sociodemographic Information

L'INDIVIDU DANS SON MILIEU
Renseignements sociodémographiques

Tous ces renseignements sont traités de façon totalement confidentielle

1.Sexe ☐ M ☐ F

2.Âge _____ ans Date de naissance AN ____ MO ____ JR ____

3.**État civil**

Note: "Conjoints de fait": désigne deux personnes qui vivent ensemble comme si elles étaient mariées. Il s'agit de ton état actuel; même si tu es légalement divorcé(e) ou autre, mais que tu vis avec un(e) conjoint(e) présentement, inscris conjoint de fait.

		Depuis quelle date?
☐ Célibataire	☐ Conjoint	AN MO JR
☐ Marié(e)	☐ Séparé(e)	____ ____ ____
☐ Divorcé(e)	☐ Veuf/veuve	

4. **Nombre d'enfants** _____
Si enceinte (ou conjointe enceinte), bébé attendu pour: AN ____ MO ____

Sinon, prévoyez-vous avoir un enfant dans les prochains 12 mois? OUI ____ NON ____
dans les prochains 24 mois? OUI ____ NON ____

Pour <u>chaque enfant</u>:

1 - Inscrire le nom, le sexe, la date de naissance
2 - Encercler "**TE**" si c'est ton enfant (tu es le parent biologique)
"**EC**" si l'enfant du conjoint (le conjoint actuel est le parent biologique)
"**EA**" si c'est un enfant adopté /"**FA**" en foyer d'accueil et qui vit chez toi
Si "TE" et "EC" sont vrais, encercler les deux.
3 - Indiquer si l'enfant vit avec toi, **OUI** ou **NON** ou **GP** (garde partagée)
4 - Inscrire l'année scolaire (si applicable) ainsi que si l'enfant fréquente une classe ou une école spéciale.

(Si tu as plus de quatre enfants, inscrire leurs informations sur une feuille séparée.)

1 NOM _____ SEXE ☐ M ☐ F AN ____ MO ____ JR ____

L'enfant est: TE EC EA / FA Vit avec toi: OUI ☐ NON ☐ GP ☐

Année scolaire: _____ Classe spéciale: _____

2 NOM _____ SEXE ☐ M ☐ F AN ____ MO ____ JR ____

L'enfant est: TE EC EA / FA Vit avec toi: OUI ☐ NON ☐ GP ☐

Année scolaire: _____ Classe spéciale: _____

3 NOM _____ SEXE ☐ M ☐ F AN MO JR ___ ___ ___

L'enfant est: TE EC EA / FA Vit avec toi: OUI ☐ NON ☐ GP ☐

Année scolaire: _____ Classe spéciale: _____

4 NOM _____ SEXE ☐ M ☐ F AN MO JR ___ ___ ___

L'enfant est: TE EC EA / FA Vit avec toi: OUI ☐ NON ☐ GP ☐

Année scolaire: _____ Classe spéciale: _____

5. **Ta scolarité** complétée (dernière année terminée): _____
En quoi? (spécialisation/général): _____

Étudies-tu présentement? OUI : Temps plein ☐ partiel ☐ NON ☐
Si oui, quel diplôme postules-tu _____ pour quand? ___/___/___/

6. **As-tu un emploi** (rappel: renseignements gardés confidentiels)?

OUI ☐

Occupation: _____
_____

Tes tâches: _____
_____

Combien d'heures/sem.? _____

Salaire de l'heure _____ $

Depuis quand es-tu à cet emploi? inscrire la date
AN MO
___/___/

NON ☐

As-tu déjà eu un emploi?

Oui ☐ Non ☐

⇓

En quoi? _____

Pendant combien de temps?
____ an(s) ____ mois

Quand as-tu arrêté de travailler:
date: ____/____/
AN MO

Au cours des 12 derniers mois, as-tu bénéficié de:

Oui ☐ Non ☐ l'Assurance chômage?

Oui ☐ Non ☐ Prestations d'aide sociale?

Oui ☐ Non ☐ la CSST? (préciser:_____)

Appendix D: Measuring Neighborhood Context Scale

ÉVALUATION DU VOISINAGE

1. DISPONIBILITÉ DES SERVICES. Veuillez cocher chaque service existant dans votre voisinage.

- ☐ Garderie
- ☐ Terrain de jeu ou parc
- ☐ Centre récréatif
- ☐ Supermarché ou épicerie affiliée à une chaîne
- ☐ Dépanneur
- ☐ Pharmacie
- ☐ Clinique médicale, bureau de médecin
- ☐ Buanderie
- ☐ Nettoyage à sec
- ☐ Banque
- ☐ Encaissement de chèque (ex. Insta-Chèqu
- ☐ École élémentaire
- ☐ Bibliothèque

2. UTILISATION DES SERVICES. Veuillez faire un crochet pour chaque service que vous ou votre famille avez utilisé au cours des deux derniers mois.

- ☐ Garderie
- ☐ Terrain de jeu ou parc
- ☐ Centre récréatif
- ☐ Supermarché ou épicerie affiliée à une chaîne
- ☐ Dépanneur
- ☐ Pharmacie
- ☐ Clinique médicale, bureau de médecin
- ☐ Buanderie
- ☐ Nettoyage à sec
- ☐ Banque
- ☐ Encaissement de chèques (ex. Insta-Chèque)
- ☐ École élémentaire
- ☐ Bibliothèque

3. QUALITÉ DES SERVICES. Sur une échelle de 1 à 10, où le 1 veut dire « TRÈS MAUVAIS » et le 10 veut dire « EXCELLENT », comment évalueriez-vous chacun des services suivants de votre voisinage. Écrivez votre réponse dans le carré à la gauche de chaque service.

- ☐ Garderie
- ☐ Terrain de jeu ou parc
- ☐ Centre récréatif
- ☐ Supermarché ou épicerie affiliée à une chaîne
- ☐ Dépanneur
- ☐ Pharmacie
- ☐ Clinique médicale, bureau de médecin
- ☐ Buanderie
- ☐ Nettoyage à sec
- ☐ Banque
- ☐ Encaissement de chèque (ex. Insta-Chèque)
- ☐ École élémentaire
- ☐ Bibliothèque

4. ACTIVITÉS RELIGIEUSES. Au cours des deux derniers mois, est-ce que vous (ou des membres de votre famille) avez pris part aux activités suivantes. Si oui, faites un crochet.

- ☐ Été à la messe ou à tout autre service religieux.
- ☐ Participé à des activités à l'église (ou tout autre établissement religieux), à part les services religieux.

5. ACTIVITÉS DE VOISINAGE. Au cours des deux derniers mois, est-ce que vous (ou des membres de votre famille) avez pris part aux activités suivantes. Si oui, faites un crochet.

- ☐ Été à une rencontre de voisinage ou de bloc (par ex., Opération Tandem, Parents-Secours).
- ☐ Fait de la surveillance de quartier.

6. INTERACTION. Sur une échelle de 1 à 10, où le 1 veut dire « SURTOUT FAUX » et le 10 veut dire « SURTOUT VRAI », comment évalueriez-vous chacune des phrases suivantes:

_____ Lorsqu'il fait beau, les gens du voisinage se visitent les uns les autres à l'extérieur.
_____ Les gens de mon voisinage se visitent les uns les autres à l'intérieur de leur maison ou appartement.
_____ Les gens de mon voisinage se prêtent diverses choses les uns les autres.
_____ Les gens s'assurent que les résidences des voisins sont en sécurité lorsque ceux-ci sont absents.
_____ La plupart des enfants du voisinage courent l'Halloween aux alentours.

7. INTERVENTION. Sur une échelle de 1 à 10, où le 1 veut dire « SURTOUT FAUX » et le 10 veut dire « SURTOUT VRAI », comment évalueriez-vous chacune des phrases suivantes.

_____ Les voisins devraient se mêler de leurs affaires concernant les enfants des autres.
_____ De nos jours, n'importe qui va se permettre de réprimander un enfant sur son comportement si les parents ne sont pas dans les alentours.
_____ Tout adulte a le droit de réprimander un enfant du voisinage sur son comportement si les parents ne sont pas aux alentours.

8. RÉPLIQUES. Sur une échelle de 1 à 10, où le 1 veut dire « SURTOUT FAUX » et le 10 veut dire « SURTOUT VRAI », comment évalueriez-vous chacune des phrases suivantes.

_____ Les enfants du voisinage vont probablement crier ou sacrer après quelqu'un qui les réprimande sur leur comportement.
_____ Les adolescent(e)s du voisinage vont probablement crier ou sacrer après quelqu'un qui les réprimande sur leur comportement.
_____ Les parents du voisinage vont probablement crier ou sacrer après quelqu'un qui réprimande leurs enfants.
_____ Les enfants du voisinage pourraient répliquer physiquement si un voisin les réprimandait sur leur comportement.
_____ Les adolescent(e)s du voisinage pourraient répliquer physiquement si un voisin les réprimandait sur leur comportement.
_____ Les parents de mon voisinage pourraient répliquer physiquement si quelqu'un réprimendait leurs enfants.
_____ Les parents devraient être fâchés si un voisin réprimandait leurs enfants sur leurs comportements.

9. UN ARRÊT À LA DÉLINQUANCE. Sur une échelle de 1 à 10, où le 1 veut dire « TRÈS PEU PROBABLE » et le 10 veut dire « TRÈS PROBABLE », à quel point est-ce probable qu'une personne de votre voisinage intervienne dans les situations suivantes, sachant qu'il s'agit d'un enfant de 5-6 ans.

_____ Si un enfant peinturait ou écrivait sur une auto ou une maison (édifice).
_____ Si un enfant était en possession d'un revolver.
_____ Si un enfant était en possession d'un couteau.
_____ Si un enfant jouait avec des allumettes.
_____ Si un enfant faisait du vol à l'étalage.
_____ Si un enfant prenait quelque chose dans la maison, sur le parterre ou dans le garage d'un voisin.

10. UN ARRÊT AUX MAUVAIS COMPORTEMENTS. Sur une échelle de 1 à 10, où le 1 veut dire « TRÈS PEU PROBABLE » et le 10 veut dire « TRÈS PROBABLE », à quel point est-ce probable qu'une personne de votre voisinage intervienne dans les situations suivantes, sachant qu'il s'agit d'un enfant de 5-6 ans.

_____ Si un enfant en frappait un autre du même âge.
_____ Si un enfant prenait des fleurs sur le parterre du voisin.
_____ Si un enfant lançait des roches à un chien.
_____ Si un enfant lançait des roches à un autre enfant.

11. ASSISTANCE Sur une échelle de 1 à 10, où le 1 veut dire « TRÈS PEU PROBABLE » et le 10 veut dire « TRÈS PROBABLE », à quel point est-ce probable qu'une personne de votre voisinage intervienne dans les situations suivantes, sachant qu'il s'agit d'un enfant de 5-6 ans.

_____ Si un enfant se promenait tout seul et semblait perdu.
_____ Si un enfant tombait de sa bicyclette et pleurait.
_____ Si un adulte donnait une fessée à un enfant sur la rue.
_____ Si un enfant était laissé tout seul à la maison le jour.
_____ Si un enfant était laissé tout seul à la maison le soir.

12. QUALITÉ DU VOISINAGE. Sur une échelle de 1 à 10, où le 1 veut dire « SURTOUT FAUX » et le 10 veut dire « SURTOUT VRAI », comment évalueriez-vous chacune des phrases suivantes.

_____ L'endroit où je demeure est une place où il fait bon vivre.
_____ L'endroit où je demeure est une bonne place pour élever les enfants.
_____ Les gens qui ont emménagé dans le voisinage au cours de la dernière année sont bons pour le voisinage.
_____ J'aimerais sortir de ce voisinage.
_____ Il y a des enfants dans le voisinage avec lesquels je ne voudrais pas que mes enfants jouent.
_____ Les gens qui ont emménagé dans le voisinage au cours de la dernière année ne sont pas bons pour le voisinage.
_____ Règle générale, la police intervient dans des délais raisonnables lorsqu'on l'appelle.
_____ Il y a trop de circulation dans le voisinage.
_____ Il y a suffisamment d'arrêts d'autobus dans le voisinage.
_____ L'endroit où je demeure est convenablement situé dans la ville.
_____ Si je devais quitter ce voisinage, ça me ferait de la peine de partir.

13. MOBILITÉ. Sur une échelle de 1 à 10, où le 1 veut dire « SURTOUT FAUX » et le 10 veut dire « SURTOUT VRAI », comment évalueriez-vous chacune des phrases suivantes.

_____ À peu près la moitié des résidents aux alentours sont des locataires.
_____ Dans le voisinage, les gens déménagent et emménagent beaucoup.

14. CHANGEMENT POSITIF.

_____ Sur une échelle de 1 à 10, diriez-vous que votre voisinage a changé pour le mieux, changé pour le pire ou demeuré à peu près le même au cours des deux dernières années. Le 1 indique « CHANGÉ POUR LE PIRE » et le 10 indique « CHANGÉ POUR LE MIEUX ».

15. DÉSORDRE. Sur une échelle de 1 à 10, où le 1 veut dire « RAREMENT » et le 10 veut dire « FRÉQUEMMENT », à quelle fréquence les choses suivantes se produisent-elles dans votre voisinage ?

_____ Des déchets, des détritus ou des papiers qui traînent partout sur le trottoir ou dans la rue.
_____ Des graffitis sur les édifices et sur les murs.
_____ Des véhicules abandonnés.
_____ Des édifices vacants, abandonnés ou placardés.
_____ Des vendeurs de drogues ou des drogués qui traînent les rues.
_____ Des ivrognes qui traînent les rues.
_____ Des adultes sans emploi qui flânent.
_____ De jeunes adultes qui flânent.
_____ Des activités de gangs.
_____ Des maisons ou des parterres mal entretenus.
_____ Des propriétaires ou des concierges toujours absents.
_____ Des groupes de jeunes enfants (pré-adolescents) qui se comportent mal ou qui sèment la pagaille.
_____ Des groupes d'adolescents qui se comportent mal ou qui sèment la pagaille.
_____ Des groupes d'adultes qui se comportent mal ou qui sèment la pagaille.

16. INQUIÉTUDES. Sur une échelle de 1 à 10, où le 1 veut dire « AUCUNE INQUIÉTUDE » et le 10 veut dire « DE GRANDES INQUIÉTUDES », à quel point chacune des choses suivantes vous inquiète-t-elle ?

_____ De faire endommager votre propriété.
_____ De vous faire voler quelque chose sur ou dans votre propriété.
_____ De marcher tout(e) seul(e) le jour.
_____ De marcher tout(e) seul(e) la nuit tombée.
_____ De laisser les enfants sortir pendant la journée.
_____ De laisser les enfants sortir la nuit tombée.
_____ De vous faire voler pendant le jour.
_____ De vous faire voler la nuit.
_____ D'être victime d'un viol.
_____ D'être agressé(e) ou battu(e).
_____ D'avoir un enfant abusé sexuellement par un étranger.
_____ D'avoir un enfant abusé sexuellement par une personne qu'il connaît.
_____ Qu'un enfant se fasse kidnapper.
_____ D'être victime d'un meurtre.

17. IDENTITÉ

Avez-vous un nom pour votre «coin», votre bout de quartier ? Oui ___Non ___ Si oui, préciser: _____

Appendix E: Life Experiences Survey

No d'identification _____

ÉVÉNEMENTS

Maintenant, je te présente une liste d'événements qui peuvent apporter des changements dans la vie des gens et qui demandent une certaine adaptation sur le plan social. Nous allons passer chacun de ces événements un par un et tu vas me dire si c'est arrivé pour toi dans les 12 derniers mois, c'est-à-dire depuis _____ 1988.

NOTE: Si un événement ne s'est pas produit, encercler le " 0 ".
S'il s'est produit, faire un crochet à côté de l'item pour le repérer plus facilement à la deuxième étape.

Nous allons maintenant revenir sur les événements qui te sont arrivés depuis un an et je vais te demander de me dire quel impact cet événement a eu sur ta vie. Un événement peut avoir un impact extrêmement positif (très très plaisant) qu'on évalue à " 1 ", ou encore peut avoir un impact extrêmement négatif (très très déplaisant) qu'on évalue à " 7 ". Entre les deux, il y a les chiffres 2 3 4 5 et 6. Le "4", par exemple, veut dire qu'un événement a eu un impact qui n'était ni positif ni négatif.

NOTE: Reprendre les items cochés et inscrire le niveau d'impact pour chacun.

1	Extrêmement positif		5	Légèrement négatif
2	Modérément positif	4 Ni positif ni négatif	6	Modérément négatif
3	Légèrement positif		7	Extrêmement négatif

1.	Mariage	0	1	2	3	4	5	6	7
2.	Détention en prison ou autre institution comparable	0	1	2	3	4	5	6	7
3.	Décès du conjoint ou de la conjointe	0	1	2	3	4	5	6	7
4.	Changement important dans les habitudes de sommeil (beaucoup plus ou beaucoup moins que d'habitude)	0	1	2	3	4	5	6	7
5.	Décès d'un membre de ta famille	0	1	2	3	4	5	6	7
6.	Changement important dans tes habitudes alimentaires (ex., manger beaucoup plus ou beaucoup moins)	0	1	2	3	4	5	6	7
7.	Saisie d'une hypothèque ou d'un prêt	0	1	2	3	4	5	6	7
8.	Décès d'un(e) ami(e) intime	0	1	2	3	4	5	6	7
9.	Réalisation personnelle remarquable	0	1	2	3	4	5	6	7
10.	Infraction mineure (ex., contravention de vitesse, trouble à l'ordre public)	0	1	2	3	4	5	6	7

1	Extrêmement positif		5	Légèrement négatif
2	Modérément positif	4 Ni positif ni négatif	6	Modérément négatif
3	Légèrement positif		7	Extrêmement négatif

11.	Changement dans ta situation au travail (ex., responsabilités différentes, changement important dans les conditions ou les heures de travail, etc.)	0	1	2	3	4	5	6	7
12.	Nouvel emploi	0	1	2	3	4	5	6	7
13.	Maladie grave d'un membre de ta famille	0	1	2	3	4	5	6	7
14.	Problèmes de nature sexuelle	0	1	2	3	4	5	6	7
15.	Problèmes avec l'employeur (danger de perdre ton emploi, d'être suspendu, d'avoir une démotion, etc.)	0	1	2	3	4	5	6	7
16.	Changement important dans ta condition financière (bien meilleure ou bien pire)	0	1	2	3	4	5	6	7
17.	Changement important dans tes relations avec les membres de ta famille (rapprochement ou éloignement accrus)	0	1	2	3	4	5	6	7
18.	Ajout d'un membre à la famille (naissance, adoption, membre de la famille qui emménage)	0	1	2	3	4	5	6	7
19.	Problèmes à prendre soin des parents ou des beaux-parents	0	1	2	3	4	5	6	7
20.	Changement de résidence	0	1	2	3	4	5	6	7
21.	Séparation d'avec ton conjoint (à cause de conflits)	0	1	2	3	4	5	6	7
22.	Changement dans tes activités religieuses (fréquentation accrue ou diminuée)	0	1	2	3	4	5	6	7
23.	Réconciliation avec ton conjoint	0	1	2	3	4	5	6	7
24.	Changement important dans le nombre de conflits avec ton conjoint (beaucoup plus ou beaucoup moins qu'avant)	0	1	2	3	4	5	6	7
25.	Homme "marié": changement dans la situation d'emploi de ta conjointe (commence à travailler, cesse de travailler, nouvel emploi, etc.)	0	1	2	3	4	5	6	7

1	Extrêmement positif					5	Légèrement négatif		
2	Modérément positif	4	Ni positif ni négatif			6	Modérément négatif		
3	Légèrement positif					7	Extrêmement négatif		

26.	Femme "mariée" changement dans la situation d'emploi du conjoint (commence à travailler, cesse de travailler, nouvel emploi, etc.)	0	1	2	3	4	5	6	7
27.	Changement important dans le genre habituel ou le nombre d'activités récréatives	0	1	2	3	4	5	6	7
28.	Emprunt de plus de 10 000 $ (ex., achat d'une maison, d'un commerce, etc.)	0	1	2	3	4	5	6	7
29.	Emprunt de moins de 10 000 $ (ex., achat d'une auto, d'un téléviseur, prêt étudiant, etc.)	0	1	2	3	4	5	6	7
30.	Congédié(e) de ton emploi	0	1	2	3	4	5	6	7
31.	Maladie ou accident grave	0	1	2	3	4	5	6	7
32.	Changement important dans les activités sociales (ex., parties, cinéma, sorties, visites [beaucoup plus ou beaucoup moins])	0	1	2	3	4	5	6	7
33.	Changement dans les conditions de vie familiale (construction d'une maison, redécoration, détérioration de la maison ou du voisinage, etc.)	0	1	2	3	4	5	6	7
34.	Divorce	0	1	2	3	4	5	6	7
35.	Accident ou maladie grave d'un(e) ami(e) intime	0	1	2	3	4	5	6	7
36.	Prise de la retraite	0	1	2	3	4	5	6	7
37.	Fils ou fille qui quitte le foyer (ex. mariage, études, etc.)	0	1	2	3	4	5	6	7
38.	Séparation temporaire d'avec ton conjoint (à cause de l'emploi, voyage, etc.)	0	1	2	3	4	5	6	7
39.	Autre événement que tu aimerais ajouter _____	0	1	2	3	4	5	6	7
40.	Autre événement que tu aimerais ajouter _____	0	1	2	3	4	5	6	7
41	Autre événement que tu aimerais ajouter _____	0	1	2	3	4	5	6	7

Appendix F: Daily Hassles Scale

No d'identification _____

TRACAS ET JOIES DE LA VIE QUOTIDIENNE

Nous vivons chaque jour des situations qui nous causent des tracas et d'autres qui nous apportent de petites ou de grandes joies. Les tracas sont des situations qui nous ennuient, nous irritent ou nous fâchent. Les joies, elles, nous rendent de bonne humeur, font qu'on se sent bien. Certains tracas et certaines joies se produisent assez fréquemment alors que d'autres sont relativement rares. Certains ont des effets passagers alors que d'autres sont plus durables. Nous vous présentons ici un certain nombre de situations de la vie quotidienne. Certaines ne vous auront causé que des tracas ou alors que de la joie; tandis que d'autres, auront été, dans la même journée, à la fois sources de tracas et de joie.

Veuillez indiquer à quel point chaque énoncé a été une source de tracas et une source de joie pour vous aujourd'hui, respectivement dans la colonne TRACAS et dans la colonne JOIES. Pour toutes les situations, vous devez encercler deux réponses, une dans chaque colonne.

VEUILLEZ REMPLIR CE QUESTIONNAIRE À LA TOUTE FIN DE LA JOURNÉE, JUSTE AVANT D'ALLER VOUS COUCHER. Merci!

Pour chaque énoncé, veuillez encercler deux chiffres, un dans la colonne « TRACAS » et un dans la colonne « JOIES », qui correspondent à ce que vous avez vécu **aujourd'hui** pour chacune des situations suivantes en vous servant des échelles ci-dessous.

TRACAS 0 = non ou ne s'applique pas 1 = un peu 2 = passablement 3 = beaucoup					JOIES 0 = non ou ne s'applique pas 1 = un peu 2 = passablement 3 = beaucoup			
0	1	2	3	1. Vos enfants	0	1	2	3
0	1	2	3	2. Vos parents ou vos beaux-parents	0	1	2	3
0	1	2	3	3. Autres membres de la parenté	0	1	2	3
0	1	2	3	4. Votre conjoint(e)	0	1	2	3
0	1	2	3	5. Le temps passé avec votre famille	0	1	2	3
0	1	2	3	6. La santé et le bien-être d'un membre de votre famille	0	1	2	3
0	1	2	3	7. Le sexe	0	1	2	3
0	1	2	3	8. L'intimité	0	1	2	3
0	1	2	3	9. Vos obligations familiales	0	1	2	3
0	1	2	3	10. Vos ami(e)s	0	1	2	3
0	1	2	3	11. Vos collègues de travail	0	1	2	3
0	1	2	3	12. Vos client(e)s, patient(e)s, etc.	0	1	2	3
0	1	2	3	13. Votre superviseur ou employeur	0	1	2	3
0	1	2	3	14. La nature de votre travail	0	1	2	3
0	1	2	3	15. Votre charge de travail	0	1	2	3
0	1	2	3	16. Votre sécurité d'emploi	0	1	2	3
0	1	2	3	17. Rencontrer des échéances ou des objectifs à votre travail	0	1	2	3

0 = non ou ne s'applique pas
1 = un peu
2 = passablement
3 = beaucoup

0	1	2	3	18.	Avoir assez d'argent pour les nécessités de la vie (nourriture, vêtements, logement, assurances etc.)	0	1	2	3
0	1	2	3	19.	Assez d'argent pour l'éducation	0	1	2	3
0	1	2	3	20.	Assez d'argent pour les urgences	0	1	2	3
0	1	2	3	21.	Assez d'argent pour le superflu (vacances, sorties, etc.)	0	1	2	3
0	1	2	3	22.	Aider financièrement quelqu'un qui ne vit pas avec vous	0	1	2	3
0	1	2	3	23.	Vos placements	0	1	2	3
0	1	2	3	24.	Votre consommation de cigarettes	0	1	2	3
0	1	2	3	25.	Votre consommation d'alcool	0	1	2	3
0	1	2	3	26.	Votre consommation de drogues	0	1	2	3
0	1	2	3	27.	Votre apparence physique	0	1	2	3
0	1	2	3	28.	La contraception	0	1	2	3
0	1	2	3	29.	L'exercice	0	1	2	3
0	1	2	3	30.	Les soins médicaux pour vous	0	1	2	3
0	1	2	3	31.	Votre santé	0	1	2	3
0	1	2	3	32.	Vos aptitudes physiques	0	1	2	3
0	1	2	3	33.	La température	0	1	2	3
0	1	2	3	34.	Les événements qui font la manchette	0	1	2	3
0	1	2	3	35.	Votre environnement (par ex. qualité de l'air, niveau de bruit, espaces verts, etc.)	0	1	2	3
0	1	2	3	36.	Les événements politiques ou sociaux	0	1	2	3
0	1	2	3	37.	Votre voisinage (les voisins, le milieu, etc.)	0	1	2	3
0	1	2	3	38.	Conservation, protection (de l'eau, de l'électricité, du pétrole, etc.)	0	1	2	3
0	1	2	3	39.	Vos animaux de compagnie	0	1	2	3
0	1	2	3	40.	La préparation des repas	0	1	2	3
0	1	2	3	41.	Les travaux domestiques	0	1	2	3
0	1	2	3	42.	Les petites réparations	0	1	2	3
0	1	2	3	43.	L'entretien du terrain	0	1	2	3
0	1	2	3	44.	L'entretien du véhicule	0	1	2	3
0	1	2	3	45.	La paperasse (les factures, les formulaires, etc.)	0	1	2	3
0	1	2	3	46.	La détente à la maison (télé, musique, lecture, etc.)	0	1	2	3
0	1	2	3	47.	La quantité de temps libre	0	1	2	3
0	1	2	3	48.	Les activités récréatives en dehors (cinéma, sports, restaurants, marche, etc.)	0	1	2	3
0	1	2	3	49.	Manger (à la maison)	0	1	2	3
0	1	2	3	50.	L'église ou les organisations communautaires	0	1	2	3
0	1	2	3	51.	Les problèmes légaux, juridiques	0	1	2	3
0	1	2	3	52.	Votre capacité d'organisation	0	1	2	3
0	1	2	3	53.	Vos engagements sociaux	0	1	2	3

Appendix G: Social Support Questionnaire- Short Form Revised

No d'identification _____

S.S.Q.

DIRECTIVES:

Les questions suivantes portent sur les gens qui t'apportent de l'aide et du soutien. Chaque question comprend deux parties. Dans la première partie, tu vas me donner les noms des gens que tu connais, sur qui tu peux compter pour de l'aide ou du soutien, selon chaque question. Donne-moi seulement les initiales de chaque personne, ainsi que le lien que tu as avec cette personne (ex. : frère, patron, conjoint, etc.).

Pour la seconde partie, je vais te demander de me dire jusqu'à quel point tu es satisfait(e) du soutien que tu reçois dans son ensemble.

> Si le participant ne reçoit aucun soutien pour une question donnée, encerclez le mot "personne", mais demandez-lui d'évaluer tout de même le degré de satisfaction qu'il en retire. Ne pas inscrire plus de neuf personnes par question.

1a. Sur qui peux-tu compter qui soit réellement fiable si tu as besoin d'aide?

Personne	a)	d)	g)
	b)	e)	h)
	c)	f)	i)

1b. Degré de satisfaction:

6 - très satisfait(e)	5 - assez satisfait	4 - un peu satisfait	3 - un peu insatisfait	2 - assez insatisfait	1 - très insatisfait

****

2a. Sur qui peux-tu réellement compter pour t'aider à te sentir plus détendu(e) lorsque tu es sous pression ou stressé(e)?

Personne	a)	d)	g)
	b)	e)	h)
	c)	f)	i)

2b. Degré de satisfaction:

6 - très satisfait(e)	5 - assez satisfait	4 - un peu satisfait	3 - un peu insatisfait	2 - assez insatisfait	1 - très insatisfait

****

3a. Quels sont ceux qui t'acceptent totalement, autant avec tes points les pires qu'avec les meilleurs?

Personne	a)	d)	g)
	b)	e)	h)
	c)	f)	i)

3b. Degré de satisfaction:

6 - très satisfait(e)	5 - assez satisfait	4 - un peu satisfait	3 - un peu insatisfait	2 - assez insatisfait	1 - très insatisfait

****

4a. Sur qui peux-tu réellement compter pour prendre soin de toi, peu importe ce qui t'arrive?

Personne	a)	d)	g)
	b)	e)	h)
	c)	f)	i)

4b. Degré de satisfaction:

6 - très satisfait(e)	5 - assez satisfait	4 - un peu satisfait	3 - un peu insatisfait	2 - assez insatisfait	1 - très insatisfait

****

5a. Sur qui peux-tu réellement compter pour te remonter le moral lorsque tu vois tout en noir?

Personne	a)	d)	g)
	b)	e)	h)
	c)	f)	i)

5b. Degré de satisfaction:

6 - très satisfait(e)	5 - assez satisfait	4 - un peu satisfait	3 - un peu insatisfait	2 - assez insatisfait	1 - très insatisfait

****

6a. Sur qui peux-tu réellement compter pour te réconforter lorsque tu es à l'envers?

Personne	a)	d)	g)
	b)	e)	h)
	c)	f)	i)

6b. Degré de satisfaction:

6 - très satisfait(e)	5 - assez satisfait	4 - un peu satisfait	3 - un peu insatisfait	2 - assez insatisfait	1 - très insatisfait

Appendix H: Rosenberg Self-esteem Scale

EDS

Pour ce questionnaire, nous te demandons de nous indiquer à quel point tu es en accord ou en désaccord avec les énoncés suivants, en encerclant le chiffre correspondant.

1. Fortement en désaccord
2. En désaccord
3. En accord
4. Fortement en accord

1.	J'ai le sentiment d'être une personne de valeur, au moins sur un pied d'égalité avec les autres.	1	2	3	4
2.	Je sens que j'ai un certain nombre de bonnes qualités.	1	2	3	4
3.	À tout considérer, je suis porté(e) à penser que je suis un(e) raté(e).	1	2	3	4
4.	Je suis capable de faire les choses aussi bien que la plupart des autres.	1	2	3	4
5.	Je sens qu'il n'y a pas grand chose dans ma vie dont je puisse être fier(fière).	1	2	3	4
6.	Je prends une attitude positive face à moi-même.	1	2	3	4
7.	Dans l'ensemble, je suis satisfait(e) de moi.	1	2	3	4
8.	J'aimerais avoir plus de respect pour moi-même.	1	2	3	4
9.	Je me sens certainement inutile certains jours.	1	2	3	4
10.	Il y a des fois où je pense que je ne suis bon(ne) à rien.	1	2	3	4

A. ÉPISODES DE TROUBLES THYMIQUES

SONT ÉVALUÉS DANS LA PRÉSENTE SECTION : L'ÉPISODE DÉPRESSIF MAJEUR, LES ÉPISODES MANIAQUE ET HYPOMANIAQUE, LA DYSTHYMIE ET LES TROUBLES THYMIQUES ATTRIBUABLES À UNE MALADIE PHYSIQUE OU À UNE INTOXICATION AINSI QUE CERTAINES FORMES PARTICULIÈRES DE CES ÉPISODES. LA DÉPRESSION MAJEURE ET LES TROUBLES BIPOLAIRES SONT DIAGNOSTIQUÉS À L'AIDE DU MODULE D.

ÉPISODE DÉPRESSIF MAJEUR ACTUEL

À présent, je vais vous poser quelques questions additionnelles au sujet de votre humeur.

Au cours des 6 derniers mois...

...y a-t-il eu une période pendant laquelle vous étiez déprimée(e), triste ou découragée pratiquement toute la journée presque chaque jour ?

SI OUI : Combien de temps cette période a-t-elle duré ? (Au moins deux semaines ?)

... y a-t-il eu une période au cours de laquelle vous avez éprouvé beaucoup moins d'intérêt ou de plaisir pour les choses ou les activités qui vous plaisent habituellement ?

SI OUI : Cela s'est-il produit presque tous les jours ? Combien de temps cette période a-t-elle duré ? (Au moins deux semaines ?)

CRITÈRES DIAGNOSTIQUES

A. Au moins cinq des symptômes suivants doivent avoir été présents pendant une même période d'une durée d'au moins deux semaines et avoir représenté un changement par rapport au fonctionnement antérieur. Une humeur dépressive (1) ou une perte d'intérêt ou de plaisir (2) doivent faire partie des symptômes.

(1) humeur dépressive présente pratiquement toute la journée, presque tous les jours, signalée par le sujet (p.ex., sensation de tristesse ou de vide) ou observée par les autres (p.ex., air larmoyant). Remarque : Peut se traduire par de l'irritabilité, chez les enfants et les adolescents.	?	1	2	3	A1
(2) Diminution marquée de l'intérêt ou du plaisir dans toutes ou presque toutes les activités, pratiquement toute la journée, presque tous les jours (signalée par le sujet ou observée par les autres).	?	1	2	3	A2

SI NI L'ITEM (1) NI L'ITEM (2) NE SONT COTÉS "3", PASSER À LA PAGE A.12 (ÉPISODE DÉPRESSIF MAJEUR PASSÉ)

REMARQUE : COTER "1" LES ITEMS SUIVANTS, SI LES SYMPTÔMES SONT MANIFESTEMENT DUS À UNE MALADIE PHYSIQUE OU ENCORE, À UN DÉLIRE OU À DES HALLUCINATIONS N'AYANT AUCUN LIEN AVEC L'HUMEUR.

LES QUESTIONS SUIVANTES PORTENT SUR LES DEUX PIRES SEMAINES DES 6 DERNIERS MOIS (OU LES DEUX DERNIÈRES SEMAINES SI L'ÉTAT DÉPRESSIF DU SUJET EST RESTÉ UNIFORME PENDANT LES 6 MOIS)

Durant ces (DEUX SEMAINES)...

... avez-vous perdu ou gagné du poids ? (Combien de kilos ou de livres ?) (Cherchiez-vous à perdre du poids ?)

SI NON : Comment qualifieriez-vous votre appétit ? (Si vous le comparez à votre appétit habituel ?) (Étiez-vous obligé(e) de vous forcer à manger ?) (Mangiez-vous [plus ou moins] que d'habitude ?) (Cela s'est-il manifesté presque tous les jours ?)

(3) Gain ou perte de poids significatif (p.ex. variation de plus de 5 % en un mois) sans que le sujet ait suivi de régime ou encore, augmentation ou diminution de l'appétit presque tous les jours. Remarque : Chez les enfants, prendre en compte l'absence d'augmentation de poids prévue.

? 1 2 3 A3

Cocher selon le cas :
Perte de poids ou d'appétit ___ A4
Augmentation de poids ou d'appétit ___ A5

... comment qualifieriez-vous votre sommeil ? (Aviez-vous de la difficulté à vous endormir ou à rester endormi(e), vous réveilliez-vous trop souvent ou trop tôt, OU dormiez-vous trop ? Combien d'heures par nuit dormiez-vous comparativement à votre habitude ? Était-ce presque toutes les nuits ?

(4) Insomnie ou hypersomnie presque tous les jours.

? 1 2 3 A6

Cocher selon le cas :
Insomnie ___ A7
Hypersomnie ___ A8

... étiez-vous si agité(e) ou si nerveux(se) que vous ne pouviez tenir en place ? (Votre agitation était-elle si prononcée que les autres l'ont remarquée ? Qu'ont-ils remarqué ? Était-ce presque tous les jours ?)

SI NON : Est-ce le contraire qui s'est produit — parliez-vous ou bougiez-vous plus lentement que d'habitude ? (Votre lenteur était-elle si prononcée que les autres l'ont remarquée ? Qu'ont-ils remarqué ? Était-ce presque tous les jours ?)

(5) Agitation ou ralentissement psychomoteur, presque tous les jours (non seulement un sentiment subjectif de fébrilité ou de ralentissement intérieur mais une manifestation constatée par autrui).

REMARQUE : TENIR COMPTE DU COMPORTEMENT DU SUJET DURANT L'INTERVIEW.

? 1 2 3 A9

Cocher selon le cas :
Ralentissement psychomoteur ___ A10
Agitation ___ A11

... aviez-vous de l'énergie ? (Vous sentiez-vous toujours fatigué(e) ? Presque tous les jours ?

(6) Fatigue ou perte d'énergie presque tous les jours.

? 1 2 3 A12

Durant cette période...

... quelle opinion aviez-vous de vous-même ? (Que vous n'étiez bon(ne) à rien ?) (Presque tous les jours ?)

SI NON : Vous sentiez-vous coupable à propos de choses que vous auriez faites ou auriez dû faire ? (Presque tous les jours ?)

(7) Sentiments d'indignité ou culpabilité excessive ou inappropriée (qui peut être délirante) presque tous les jours (non seulement du remords ou un sentiment de culpabilité du fait d'être malade).

REMARQUE : COTER "1" OU "2" S'IL S'AGIT SEULEMENT D'UNE BAISSE DE L'ESTIME DE SOI SANS INDIGNITÉ.

? 1 2 3 A13

Cocher selon le cas :

Indignité ___ A14
Culpabilité inappropriée ___ A15

... aviez-vous de la difficulté à réfléchir ou à vous concentrer ? (À quel genre d'activités cela a-t-il nui ?) (Presque tous les jours ?)

SI NON : Aviez-vous de la difficulté à prendre des décisions concernant la vie quotidienne ? (Presque tous les jours ?)

(8) Diminution de la capacité de réfléchir ou de se concentrer ou indécision presque tous les jours (signalée par le sujet ou observée par les autres).

? 1 2 3 A16

Cocher selon le cas :

Diminution de la capacité de réfléchir ___ A17
Indécision ___ A18

... étiez-vous déprimé(e) au point de penser beaucoup à la mort ou qu'il vaudrait mieux que vous soyez mort(e) ? Pensiez-vous à vous blesser ?

SI OUI : Avez-vous cherché à vous blesser ?

(9) Pensées récurrentes sur la mort (plus que la seule peur de mourir), idées suicidaires récurrentes sans projet précis, tentative de suicide ou projet précis pour se suicider.

REMARQUE : COTER "1" DANS LES CAS D'AUTOMUTILATION SANS INTENTION DE SUICIDE.

? 1 2 3 A19

Cocher selon le cas :

Pensées concernant sa mort ___ A20
Idées suicidaires ___ A21
Projet précis de suicide ___ A22
Tentative de suicide ___ A23

AU MOINS CINQ DES SYMPTÔMES CI-DESSUS [DE A(1) À A(9)] SONT COTÉS "3" ET AU MOINS L'UN DE CES SYMPTÔMES EST LE (1) OU LE (2).

1 3 A24

PASSER À LA PAGE A.12

(ÉPISODE DÉPRESSIF MAJEUR PASSÉ)

DANS LE DOUTE : Avez-vous eu de la difficulté à faire votre travail, à vaquer à vos occupations à la maison ou à vous entendre avec les autres à cause de votre (épisode dépressif ou AUTRE TERME UTILISÉ POUR LE DÉSIGNER) ?

B. Les symptômes entraînent une détresse marquée ou un handicap notable sur les plans social, professionnel ou autres.

? 1 2 3 A25

PASSER À LA PAGE A.12 (ÉPISODE DÉPRESSIF MAJEUR PASSÉ)

Quelque temps avant la survenue de cet épisode, aviez-vous souffert d'une maladie physique ?

SI OUI : Qu'a dit votre médecin ?

C. Les symptômes ne sont pas directement attribuables aux effets physiologiques d'une substance (p.ex., d'une drogue ou d'un médicament) ni à une maladie physique.

? 1 3 A26

Quelque temps avant la survenue de cet épisode, preniez-vous des médicaments ?

SI OUI : Y avait-il eu un changement dans la dose que vous preniez ?

S'IL EXISTE UN LIEN ENTRE LA DÉPRESSION ET UNE MALADIE PHYSIQUE OU UNE INTOXICATION, PASSER À LA PAGE A.44 (MAL. PHYS. OU INTOX.) ET REVENIR À LA PRÉSENTE SECTION POUR ATTRIBUER UNE COTE DE "1" OU DE "3".

ATTRIBUABLE À UNE MAL. PHYS. OU À UNE INTOX. PASSER À LA PAGE A.12 (ÉPISODE DÉPRESSIF MAJEUR PASSÉ)

ÉPISODE DE TROUBLE THYMIQUE PRIMAIRE

Quelque temps avant la survenue de cet épisode, preniez-vous de l'alcool ou de la drogue ?

Exemples de maladie physique : maladies neurologiques dégénératives (p.ex., maladies de Parkinson et de Huntington), maladie vasculaire cérébrale, troubles du métabolisme ou du système endocrinien (p.ex., carence en vitamine B_{12}, hypothyroïdie), maladies auto-immunes (p.ex., lupus érythémateux disséminé), infections, virales ou autres (p.ex., hépatite, mononucléose, infections par le VIH) et certains cancers (p.ex., cancer du pancréas).

Par intoxication on entend : l'intoxication par l'alcool, les amphétamines, la cocaïne, les hallucinogènes, les drogues inhalées, les opiacés, la phencyclidine, les sédatifs, les hypnotiques, les anxiolytiques et autres substances connues ou non (p.ex., stéroïdes anabolisants).

CONTINUER

(Avez-vous commencé à éprouver ces difficultés peu de temps après la mort d'un de vos proches ?)

D. On peut écarter le deuil comme cause possible des symptômes éprouvés; en effet, ceux-ci ont persisté pendant plus de deux mois après la perte d'un être cher ou ils se caractérisent par une incapacité fonctionnelle marquée, des préoccupations morbides concernant l'indignité du sujet, des idées suicidaires, des symptômes psychotiques ou un ralentissement psychomoteur.

1 2 3 A27

1 = dépresion majeure deuil < 2 mois (critères DSM-IV

2 = dépression majeure deuil 2 à 6 mois

3 = dépression majeure cause deuil > 6 mois ou indép. de deuil

DEUIL SIMPLE PASSER À LA PAGE A.12 (ÉPISODE DÉPRESSIF MAJEUR PASSÉ)

TROUBLE DISTINCT D'UN DEUIL SIMPLE

CONTINUER CI-DESSOUS

LES CRITÈRES A, B, C ET D D'UN ÉPISODE DÉPRESSIF MAJEUR SONT COTÉS "3"

1 3 A28

PASSER À LA PAGE A.12 (ÉPISODE DÉPRESSIF MAJEUR PASSÉ)

ÉPISODE DÉPRESSIF MAJEUR ACTUEL

Combien de périodes comme celle-ci avez-vous connues, où vous avez été [déprimé(e) OU TERME ÉQUIVALENT UTILISÉ] presque tous les jours pendant au moins deux semaines et avez ressenti plusieurs des symptômes que vous venez de décrire, comme (NOMMER LES SYMPTÔMES RELEVÉS CONCERNANT LE PIRE ÉPISODE) ?

Nombre d'épisodes dépressifs majeurs, y compris l'épisode actuel (INSCRIRE 99 SI CE NOMBRE EST TROP ÉLEVÉ POUR ÊTRE COMPTÉ OU SI LES ÉPISODES SONT DIFFICILES À DISTINGUER). ___ ___ A29

Quel âge aviez-vous la première fois que vous avez eu un épisode comme celui-ci ?

Âge du premier épisode dépressif majeur. ___ ___

FORMES PARTICULIÈRES DE L'ÉPISODE DÉPRESSIF MAJEUR ACTUEL

SURVENUE DURANT LE POST-PARTUM

QUESTION À POSER AU BESOIN :
Quand avez-vous commencé à éprouver (NOMMER LES SYMPTÔMES DÉPRESSIFS) ?

Survenue de l'épisode moins de 4 semaines après un accouchement. ? 1 3 A30

SURVENUE DURANT LE POST-PARTUM

DE TYPE CATATONIQUE

D'APRÈS L'OBSERVATION DU SUJET OU SES ANTÉCÉDENTS

CRITÈRES DIAGNOSTIQUES

Au moins deux des critères suivants doivent dominer le tableau clinique :

(1) immobilité motrice manifestée par une catalepsie (y compris une flexibilité cireuse) ou de la stupeur. ? 1 2 3 A31

DÉCRIRE LE COMPORTEMENT PRÉCIS :

(2) activité motrice exagérée (apparemment inutile et non influencée par des stimulations extérieures). ? 1 2 3 A32

DÉCRIRE LE COMPORTEMENT PRÉCIS :

(3) négativisme extrême (résistance apparemment immotivée à tout ordre ou encore, maintien d'une position rigide s'opposant aux efforts destinés à la modifier) ou mutisme. ? 1 2 3 A33

DÉCRIRE LE COMPORTEMENT PRÉCIS :

(4) excentricité des mouvements volontaires se manifestant dans la posture (maintien volontaire de postures inappropriées ou bizarres) ou par des mouvements stéréotypés ainsi que par des tics et des grimaces exagérées. ? 1 2 3 A34

DÉCRIRE LE COMPORTEMENT PRÉCIS :

(5) écholalie (répétition pathologique, fidèle et apparemment inutile d'un mot ou d'une phrase que vient de prononcer quelqu'un d'autre) ou échokinésie (reproduction automatique de gestes exécutés par quelqu'un d'autre). ? 1 2 3 A35

DÉCRIRE LE COMPORTEMENT PRÉCIS :

AU MOINS DEUX CRITÈRES SONT COTÉS "3". 1 3 A36

PASSER À LA PAGE A.8 (DE TYPE MÉLANCOLIQUE)

DE TYPE CATATONIQUE

PASSER À LA PAGE A.18 (ÉPISODE MANIAQUE ACTUEL)

DE TYPE MÉLANCOLIQUE

CRITÈRES DIAGNOSTIQUES

QUESTION À POSER AU BESOIN : Au cours de (PÉRIODE DE L'ÉPISODE ACTUEL), à quel moment vous sentiez-vous le plus mal ?

À ce moment-là...

A. Le sujet a répondu à l'un des critères suivants au cours de l'épisode actuel, au moment où il se sentait le plus mal :

ÉTABLIR LA COTE EN FONCTION DE LA RÉPONSE DU SUJET À L'ITEM A2, PAGE A.1.

(1) perte de plaisir pour tous ou presque tous les types d'activité. ? 1 2 3 A37

Lorsqu'il vous arrive quelque chose d'agréable ou que quelqu'un essaie de vous rasséréner, vous sentez-vous mieux, du moins pendant un certain temps ?

(2) manque de réactivité aux stimulations habituellement agréables (le sujet ne se sent pas beaucoup mieux, même temporairement, lorsque quelque chose d'agréable lui arrive). ? 1 2 3 A38

SI NI L'ITEM (1) NI L'ITEM (2) NE SONT COTÉS "3", PASSER À LA PAGE A.10 (FORME ATYPIQUE)

La sensation que vous éprouvez quand vous vous sentez (TERME ÉQUIVALENT UTILISÉ POUR FAIRE ALLUSION À L'HUMEUR DÉPRESSIVE) diffère-t-elle de celle que vous éprouveriez si un de vos proches mourait ? (Ou si quelque autre événement malheureux survenait ?)

SI OUI : En quoi diffère-t-elle ?

B. Le sujet a répondu à au moins trois des manifestations suivantes :

(1) Caractère distinct de l'humeur dépressive (c'est-à-dire que selon le sujet, les sentiments éprouvés diffèrent tout à fait de ceux qu'il éprouverait après la mort d'un être cher). ? 1 2 3 A39

Habituellement, vous sentez-vous plus mal le matin ?

(2) la dépression est souvent pire le matin. ? 1 2 3 A40

ÉTABLIR LA COTE EN FONCTION DE LA RÉPONSE DU SUJET À L'ITEM A6, PAGE A.2.

DANS LE DOUTE : À quelle heure vous réveillez-vous le matin ? (Est-ce beaucoup plus tôt que d'habitude [avant votre dépression] ? De combien ?)

(3) réveil précoce (au moins deux heures plus tôt que d'habitude). ? 1 2 3 A41

ÉTABLIR LA COTE EN FONCTION DE LA RÉPONSE DU SUJET À L'ITEM A9, PAGE A.2

(4) ralentissement psychomoteur ou agitation notables. ? 1 2 3 A42

ÉTABLIR LA COTE EN FONCTION DE LA RÉPONSE DU SUJET À L'ITEM A3, PAGE A.2.

(5) anorexie ou perte de poids notables. ? 1 2 3 A43

ÉTABLIR LA COTE EN FONCTION DE LA RÉPONSE DU SUJET À L'ITEM A13, PAGE A.3.

DANS LE DOUTE : Vous sentez-vous coupable à propos de choses que vous auriez faites ou auriez omis de faire ?

SI OUI : Pourriez-vous élaborer là-dessus ?

(6) sentiment de culpabilité exagéré ou inapproprié. ? 1 2 3 A44

AU MOINS TROIS DES ITEMS B SONT COTÉS "3". 1 3 A45

→ PASSER À LA PAGE A.10 (FORME ATYPIQUE)

LES CRITÈRES A ET B SONT COTÉS "3". 1 3

→ DE TYPE MÉLANCOLIQUE

FORME ATYPIQUE

CRITÈRES DIAGNOSTIQUES

SI L'ÉPISODE ACTUEL EST DE TYPE CATATONIQUE OU DE TYPE MÉLANCOLIQUE, COCHER L'ESPACE PRÉVU CI-CONTRE ET PASSER À LA PAGE A.18 (ÉPISODE MANIAQUE ACTUEL). ____

Au cours des deux dernières semaines...

REMARQUE : LA QUESTION SUIVANTE A DÉJÀ ÉTÉ POSÉE À LA PAGE A.8, DANS LE CONTEXTE DE L'ÉPISODE DÉPRESSIF MAJEUR DE TYPE MÉLANCOLIQUE :

Les caractéristiques suivantes doivent avoir prédominé au cours des deux dernières semaines, chez le sujet connaissant un épisode dépressif majeur.

Lorsqu'il vous arrive quelque chose d'agréable ou que quelqu'un essaie de vous rasséréner, vous sentez-vous mieux, du moins pendant un certain temps ?

A. Réactivité (c'est-à-dire que l'humeur du sujet peut s'améliorer sous l'effet d'événements heureux, réels ou potentiels). ? 1 2 3 A46

PASSER À LA PAGE A.18 (ÉPISODE MANIAQUE ACTUEL)

B. Au moins deux des caractéristiques suivantes :

ÉTABLIR LA COTE EN FONCTION DE LA RÉPONSE DU SUJET À L'ITEM A3, PAGE A.2.

(1) gain de poids ou augmentation de l'appétit notables; ? 1 2 3 A47

Combien d'heures dormez-vous habituellement (durant une période de 24 heures — y compris les siestes) ?

(2) hypersomnie; ? 1 2 3 A48

REMARQUE : COTER "3" SI LE SUJET DORT PLUS DE 10 HEURES PAR JOUR.

Vous sentez-vous souvent les jambes et les bras lourds (comme s'ils étaient en plomb) ?

(3) pesanteur paralysante (c'est-à-dire sensation de pesanteur dans les bras et les jambes); ? 1 2 3 A49

Êtes-vous particulièrement sensible à la façon dont les autres vous traitent ?

Que se passe-t-il quand on vous rejette, qu'on vous critique ou qu'on vous offense ? (Devenez-vous très abattu(e) ou très fâché(e) ?) (Combien de temps cela dure-t-il ?) (En quoi cela vous a-t-il affecté(e) ?) (Réagissez-vous plus fortement que la plupart des gens ?)

La peur du rejet ou de la critique vous a-t-elle empêché(e) de rencontrer des gens ou de faire certaines choses ?

(4) vulnérabilité de longue date au rejet par les autres (ne se manifestant pas seulement pendant les épisodes de troubles thymiques) résultant en un handicap marqué sur les plans social et professionnel. ? 1 2 3 A50

AU MOINS DEUX CRITÈRES DE B ONT ÉTÉ COTÉS "3".

1 3 A51

PASSER À LA PAGE A.18 (ÉPISODE MANIAQUE ACTUEL)

C. Les symptômes ne répondent ni aux critères de l'épisode dépressif majeur de type mélancolique ni à ceux du type catatonique.

1 3

PASSER À LA PAGE A.18 (ÉPISODE MANIAQUE ACTUEL)

LES CRITÈRES A, B ET C SONT COTÉS "3".

1 3

PASSER À LA PAGE A.18 (ÉPISODE MANIAQUE ACTUEL)

FORME ATYPIQUE

ÉPISODE DÉPRESSIF MAJEUR PASSÉ

⇒ SI LE SUJET N'EST PAS DÉPRIMÉ PRÉSENTEMENT : Avez-vous déjà connu une période pendant laquelle vous étiez déprimé(e) pratiquement toute la journée presque chaque jour ? (Comment vous sentiez-vous ?)

⇒ SI LE SUJET EST DÉPRIMÉ ACTUELLEMENT MAIS NE RÉPOND PAS À TOUS LES CRITÈRES D'UN ÉPISODE DÉPRESSIF MAJEUR ACTUEL : Avez-vous déjà connu une autre période pendant laquelle vous étiez déprimé(e), triste ou découragé(e) pratiquement toute la journée presque chaque jour ? (Comment vous sentiez-vous ?)

SI OUI : Quand cela s'est-il passé ? Combien de temps cette période a-t-elle duré ? (Au moins deux semaines ?)

⇒ SI LE SUJET A CONNU UN ÉPISODE DÉPRESSIF DANS LE PASSÉ : À cette époque, éprouviez-vous beaucoup moins d'intérêt ou de plaisir pour les choses ou les activités qui vous plaisent habituellement?

⇒ SI LE SUJET N'A PAS CONNU D'ÉPISODE DÉPRESSIF DANS LE PASSÉ : Avez-vous connu une période au cours de laquelle vous éprouviez beaucoup moins d'intérêt ou de plaisir pour les choses ou les activités qui vous plaisent habituellement ? (Comment vous sentiez-vous ?)

SI OUI : Quand cela s'est-il passé ? Étiez-vous ainsi presque tous les jours ? Combien de temps cela a-t-il duré ? (Au moins deux semaines ?)

Avez-vous connu plus d'une période comme celle-là ? (Laquelle a été la pire ?)

DANS LE DOUTE : Avez-vous connu de telles périodes au cours de la dernière année ?

CRITÈRES DIAGNOSTIQUES (DE L'EDM)

A. Au moins cinq des symptômes suivants doivent avoir été présents pendant une même période d'une durée d'au moins deux semaines et avoir représenté un changement par rapport au fonctionnement antérieur. Une humeur dépressive (1) ou une perte d'intérêt ou de plaisir (2) doivent faire partie des symptômes.

(1) Humeur dépressive présente pratiquement toute la journée, presque tous les jours, signalée par le sujet (p.ex., sensation de tristesse ou de vide) ou observée par les autres (p.ex., air larmoyant). Remarque : Peut se traduire par de l'irritabilité, chez les enfants et les adolescents.	?	1	2	3	A52
(2) Diminution marquée de l'intérêt ou du plaisir dans toutes ou presque toutes les activités, pratiquement toute la journée, presque tous les jours (signalée par le sujet ou observée par les autres).	?	1	2	3	

A53

SI NI L'ITEM (1) NI L'ITEM (2) NE SONT COTÉS "3", PASSER À LA PAGE A.18 (ÉPISODE MANIAQUE ACTUEL)

REMARQUE : SI LE SUJET A CONNU PLUS D'UN ÉPISODE DÉPRESSIF DANS LE PASSÉ, L'INTERROGER SUR CELUI QU'IL A RESSENTI COMME ÉTANT LE PIRE. CEPENDANT, S'IL A CONNU UN TEL ÉPISODE AU COURS DE LA DERNIÈRE ANNÉE, L'INTERROGER SUR CELUI-CI, MÊME S'IL NE S'AGISSAIT PAS DU PIRE.

LES QUESTIONS SUIVANTES PORTENT SUR LES DEUX PIRES SEMAINES DE L'ÉPISODE EN QUESTION.

Durant ces DEUX SEMAINES...

REMARQUE : COTER "1" LES ITEMS SUIVANTS, SI LES SYMPTÔMES SONT MANIFESTEMENT DUS À UNE MALADIE PHYSIQUE OU ENCORE À UN DÉLIRE OU À DES HALLUCINATIONS N'AYANT AUCUN LIEN AVEC L'HUMEUR.

... avez-vous perdu ou gagné du poids ? (Combien de kilos ou de livres ?) (Cherchiez-vous à perdre du poids ?)

SI NON : Comment qualifieriez-vous votre appétit ? (Si vous le comparez à votre appétit habituel ?) (Étiez-vous obligé(e) de vous forcer à manger ?) (Mangiez-vous [plus ou moins] que d'habitude ?) (Cela s'est-il manifesté presque tous les jours ?)

(3) Gain ou perte de poids importants (p.ex. variation de plus de 5 % en un mois) sans que le sujet ait suivi de régime ou encore, augmentation ou diminution de l'appétit presque tous les jours. Remarque : Chez les enfants, prendre en compte l'absence d'augmentation de poids prévue. ? 1 2 3 — A54

Cocher selon le cas :
Perte de poids ou d'appétit ___ — A55
Augmentation de poids ou d'appétit ___ — A56

... comment qualifieriez-vous votre sommeil ? (Aviez-vous de la difficulté à vous endormir ou à rester endormi(e), vous réveilliez-vous trop souvent ou trop tôt, OU dormiez-vous trop ? Combien d'heures par nuit dormiez-vous comparativement à votre habitude ? Était-ce presque toutes les nuits) ?

(4) Insomnie ou hypersomnie presque tous les jours. ? 1 2 3 — A57

Cocher selon le cas :
Insomnie ___ — A58
Hypersomnie ___ — A59

... étiez-vous si agité(e) ou si nerveux(se) que vous ne pouviez tenir en place ? (Votre agitation était-elle si prononcée que les autres l'ont remarquée ? Qu'ont-ils remarqué ? Était-ce presque tous les jours ?)

SI NON : Est-ce le contraire qui s'est produit — parliez-vous ou bougiez-vous plus lentement que d'habitude ? (Votre lenteur était-elle si prononcée que les autres l'ont remarquée ? Qu'ont-ils remarqué ? Était-ce presque tous les jours ?)

(5) Agitation ou ralentissement psychomoteur, presque tous les jours (non seulement un sentiment subjectif de fébrilité ou de ralentissement intérieur, mais une manifestation constatée par autrui). ? 1 2 3 — A60

Cocher selon le cas :
Ralentissement psychomoteur ___ — A61
Agitation ___ — A62

... aviez-vous de l'énergie ? (Vous sentiez-vous toujours fatigué(e) ? Presque tous les jours ?

(6) Fatigue ou perte d'énergie presque tous les jours. ? 1 2 3 — A63

Durant cette période...

... quelle opinion aviez-vous de vous-même ? (Que vous n'étiez bon(ne) à rien ?) (Presque tous les jours ?)

SI NON : Vous sentiez-vous coupable à propos de choses que vous auriez faites ou auriez dû faire ? (Presque tous les jours ?)

(7) Sentiments d'indignité ou culpabilité excessive ou inappropriée (qui peut être délirante) presque tous les jours (non seulement du remords ou un sentiment de culpabilité du fait d'être malade). ? 1 2 3 A64

REMARQUE : COTER "1" OU "2" S'IL S'AGIT SEULEMENT D'UNE BAISSE DE L'ESTIME DE SOI SANS INDIGNITÉ.

Cocher selon le cas :

Indignité ___ A65

Culpabilité inappropriée ___ A66

... aviez-vous de la difficulté à réfléchir ou à vous concentrer ? (À quel genre d'activités cela a-t-il nui ?) (Presque tous les jours ?)

SI NON : Aviez-vous de la difficulté à prendre des décisions concernant la vie quotidienne ? (Presque tous les jours ?)

(8) Diminution de la capacité de réfléchir ou de se concentrer ou indécision presque tous les jours (signalée par le sujet ou observée par les autres). ? 1 2 3 A67

Cocher selon le cas :

Diminution de la capacité de réfléchir ___ A68

Indécision ___ A69

... étiez-vous déprimé(e) au point de penser beaucoup à la mort ou qu'il vaudrait mieux que vous soyez mort(e) ? Pensiez-vous à vous blesser ?

SI OUI : Avez-vous cherché à vous blesser ?

(9) Pensées récurrentes sur la mort (plus que la seule peur de mourir), idées suicidaires récurrentes sans projet précis, tentative de suicide ou projet précis pour se suicider. ? 1 2 3 A70

REMARQUE : COTER "1" DANS LES CAS D'AUTOMUTILATION SANS INTENTION DE SUICIDE.

Cocher selon le cas :

Pensées concernant sa mort ___ A71

Idées suicidaires ___ A72

Projet précis de suicide ___ A73

Tentative de suicide ___ A74

? = information inappropriée | 1 = FAUX ou absence du symptôme | 2 = symptôme infraliminaire | 3 = VRAI ou présence du symptôme

AU MOINS CINQ DES SYMPTÔMES CI-DESSUS [DE A(1) À A(9)] SONT COTÉS "3" ET AU MOINS L'UN DE CES SYMPTÔMES EST LE (1) OU LE (2).

1 3 A75

CONTINUER À LA PAGE SUIVANTE

SI LA QUESTION N'A PAS DÉJÀ ÉTÉ POSÉE : Y a-t-il eu d'autres périodes où vous étiez (déprimé(e) OU AUTRE TERME ÉQUIVALENT UTILISÉ) et où les symptômes dont on vient de parler étaient encore plus nombreux ou plus prononcés ?

⇒ SI OUI : RETOURNER À LA PAGE A.12 (ÉPISODE DÉPRESSIF MAJEUR PASSÉ) ET VÉRIFIER SI LE SUJET A CONNU UN AUTRE ÉPISODE DÉPRESSIF MAJEUR DONT LES SYMPTÔMES ÉTAIENT PLUS GRAVES OU PLUS NOMBREUX. DANS L'AFFIRMATIVE, QUESTIONNER LE SUJET SUR CET ÉPISODE EN PARTICULIER.

⇒ SI NON : PASSER À LA PAGE A.18, ÉPISODE MANIAQUE ACTUEL.

DANS LE DOUTE : Avez-vous eu de la difficulté à faire votre travail, à effectuer vos tâches à la maison ou à vous entendre avec les autres à cause de votre (épisode dépressif ou AUTRE TERME UTILISÉ POUR LE DÉSIGNER) ?

B. Les symptômes entraînent une détresse marquée ou un handicap notable sur les plans social, professionnel ou autres. ? 1 2 3 A76

CONTINUER

SI LA QUESTION N'A PAS DÉJÀ ÉTÉ POSÉE : Y a-t-il eu d'autres périodes où vous étiez (déprimé(e) OU AUTRE TERME ÉQUIVALENT UTILISÉ) et où vous avez éprouvé encore plus de difficultés que durant la période dont on vient de parler ?

⇒ SI OUI : RETOURNER À LA PAGE A.12 (ÉPISODE DÉPRESSIF MAJEUR PASSÉ) ET VÉRIFIER SI LE SUJET A CONNU UN AUTRE ÉPISODE DÉPRESSIF MAJEUR DONT LES SYMPTÔMES ÉTAIENT PLUS GRAVES OU PLUS NOMBREUX. DANS L'AFFIRMATIVE, QUESTIONNER LE SUJET SUR CET ÉPISODE EN PARTICULIER.

⇒ SI NON : PASSER À LA PAGE A.18, ÉPISODE MANIAQUE ACTUEL.

Quelque temps avant la survenue de cet épisode, aviez-vous souffert d'une maladie physique ?

SI OUI : Qu'a dit votre médecin ?

Quelque temps avant la survenue de cet épisode, preniez-vous des médicaments ?

SI OUI : Y avait-il eu un changement dans la dose que vous preniez ?

Quelque temps avant la survenue de cet épisode, preniez-vous de l'alcool ou de la drogue ?

C. Les symptômes ne sont pas directement attribuables aux effets physiologiques d'une substance (p.ex., d'une drogue ou d'un médicament) ni à une maladie physique (p.ex., à l'hypothyroïdie).

? 1 3 A77

S'IL EXISTE UN LIEN ENTRE LA DÉPRESSION ET UNE MALADIE PHYSIQUE OU UNE INTOXICATION, PASSER À LA PAGE A.44 (MAL. PHYS. OU INTOX.) ET REVENIR À LA PRÉSENTE SECTION POUR ATTRIBUER UNE COTE DE "1" OU DE "3".

ATTRIBUABLE À UNE MAL. PHYS. OU À UNE INTOX.

CONSULTER LA LISTE DES MALADIES PHYSIQUES ET DES INTOXICATIONS POSSIBLES EN PAGE A.4.

ÉPISODE DE TROUBLE THYMIQUE PRIMAIRE

QUESTION À POSER AU BESOIN : Y a-t-il eu d'autres périodes où vous étiez aussi déprimé(e) mais où vous (ne souffriez pas d'une maladie physique OU ne preniez pas de médicaments OU ne preniez pas de drogues, [SELON LE CAS]) ?

⇒ SI OUI : RETOURNER À LA PAGE A.12 (ÉPISODE DÉPRESSIF MAJEUR PASSÉ) ET VÉRIFIER SI LE SUJET A CONNU UN AUTRE ÉPISODE DÉPRESSIF MAJEUR DONT LES SYMPTÔMES ÉTAIENT PLUS GRAVES OU PLUS NOMBREUX. DANS L'AFFIRMATIVE, QUESTIONNER LE SUJET SUR CET ÉPISODE EN PARTICULIER.

⇒ SI NON : PASSER À LA PAGE A.18, ÉPISODE MANIAQUE ACTUEL.

CONTINUER

(Avez-vous commencé à éprouver ces difficultés peu de temps après la mort d'un de vos proches ?)

D. On peut écarter le deuil comme cause possible des symptômes éprouvés par le sujet: en effet, ceux-ci ont persisté pendant plus de deux mois après la perte d'un être cher ou ils se caractérisent par une incapacité fonctionnelle marquée, des préoccupations morbides concernant l'indignité du sujet, des idées suicidaires, des symptômes psychotiques ou un ralentissement psychomoteur.

? 1 2 3 A78

DEUIL SIMPLE

QUESTION À POSER AU BESOIN : Y a-t-il eu d'autres périodes où vous étiez aussi déprimé(e) mais où vous ne veniez pas de perdre un de vos proches ?

AU MOINS UN ÉPISODE DISTINCT D'UN DEUIL SIMPLE

⇒ SI OUI : RETOURNER À LA PAGE A.12 (ÉPISODE DÉPRESSIF MAJEUR PASSÉ) ET VÉRIFIER SI LE SUJET A CONNU UN AUTRE ÉPISODE DÉPRESSIF MAJEUR DONT LES SYMPTÔMES ÉTAIENT PLUS GRAVES OU PLUS NOMBREUX. DANS L'AFFIRMATIVE, QUESTIONNER LE SUJET SUR CET ÉPISODE EN PARTICULIER.

⇒ SI NON : PASSER À LA PAGE A.18, ÉPISODE MANIAQUE ACTUEL.

CONTINUER

LES CRITÈRES A, B, C ET D D'UN ÉPISODE DÉPRESSIF MAJEUR SONT COTÉS "3".

1 3 A79

PASSER À LA PAGE A.18 (ÉPISODE MANIAQUE ACTUEL)

ÉPISODE DÉPRESSIF MAJEUR PASSÉ

Quel âge aviez-vous quand (L'ÉPISODE DÉPRESSIF MAJEUR) a commencé ?

Âge de survenue de l'épisode dépressif majeur coté ci-dessus : __ __ A80

Combien de périodes comme celle-ci avez-vous connues, où vous avez été (déprimé(e) OU TERME ÉQUIVALENT UTILISÉ) presque tous les jours pendant au moins deux semaines et avez ressenti plusieurs des symptômes que vous venez de décrire, comme (NOMMER LES SYMPTÔMES RELEVÉS CONCERNANT LE PIRE ÉPISODE) ?

Nombre d'épisodes dépressifs majeurs (INSCRIRE 99 SI CE NOMBRE EST TROP ÉLEVÉ POUR ÊTRE COMPTÉ OU SI LES ÉPISODES SONT DIFFICILES À DISTINGUER). __ __ A81

REMARQUE : POUR CONSIGNER LA DESCRIPTION DES ÉPISODES PASSÉS, PASSER À LA PAGE J.9 (FACULTATIF).

ÉPISODE MANIAQUE ACTUEL CRITÈRES DIAGNOSTIQUES

SI UN EXAMEN APPROFONDI DE LA MALADIE ACTUELLE NE FOURNIT AUCUNE RAISON DE SOUPÇONNER L'EXISTENCE D'UN ÉPISODE MANIAQUE, COCHER DANS L'ESPACE PRÉVU CI-CONTRE ET PASSER À LA PAGE A.28 (ÉPISODE MANIAQUE PASSÉ) ___ A82

Au cours des 6 derniers mois, avez-vous connu une période où vous vous sentiez si bien dans votre peau, si euphorique ou si exalté(e) que les gens de votre entourage pensaient que vous n'étiez pas dans votre état normal ou au cours de laquelle vous étiez tellement surexcité(e) que cela vous a attiré des ennuis ? (Quelqu'un a-t-il dit que vous étiez maniaque ?) (Ressentiez-vous plus qu'un état de bien-être ?)

SI NON : Avez-vous traversé une période au cours de laquelle vous étiez si irritable qu'il vous arrivait d'apostropher les autres ou de vous disputer ou de vous battre avec d'autres personnes ?

(Avez-vous même apostrophé des gens que vous ne connaissiez pas vraiment ?)

(Comment vous sentiez-vous ?)

A. Une période nettement délimitée, durant laquelle le sujet a une humeur exaltée, expansive ou irritable et ce, de manière anormale et persistante... ? (1) 2 3 A83

Cocher selon le cas :
Humeur exaltée ou expansive ___
Humeur irritable ___ A84 A85

PASSER À LA PAGE A.28 (ÉPISODE MANIAQUE PASSÉ

Combien de temps cette période a-t-elle duré ? (Au moins une semaine ?) (A-t-on dû vous hospitaliser ?)

... durant au moins une semaine (moins, si on a dû hospitaliser le sujet). ? 1 2 3 A86

PASSER À LA PAGE A.25 (ÉPISODE HYPOMANIAQUE ACTUEL)

LES QUESTIONS SUIVANTES PORTENT SUR LA PIRE PÉRIODE DES 6 DERNIERS MOIS DE L'ÉPISODE ACTUEL.

DANS LE DOUTE : Durant (ÉPISODE), quand avez-vous été le plus (TERME UTILISÉ POUR QUALIFIER L'ÉTAT DU PATIENT) ?

Durant cette période...

B. Au cours de cette période de perturbation de l'humeur, au moins trois des symptômes suivants ont persisté (4, si l'humeur n'est qu'irritable) et se sont manifestés de façon marquée :

... quelle opinion aviez-vous de vous-même ? (Vous sentiez-vous plus confiant ou plus sûr(e) de vous qu'à l'accoutumée ?) (Étiez-vous doté(e) de pouvoirs ou de talents particuliers ?)	(1) Augmentation de l'estime de soi ou idées de grandeur.	?	1	2	3	A87
... aviez-vous besoin de moins de sommeil que d'habitude ? SI OUI : Vous sentiez-vous reposé(e) malgré tout ?	(2) Réduction du besoin de sommeil (p.ex., le sujet se sent reposé après seulement 3 heures de sommeil).	?	1	2	3	A88
... parliez-vous plus que d'habitude ? (Est-ce que les autres avaient de la difficulté à vous arrêter ou à vous comprendre ? Avaient-ils de la difficulté à placer un mot ?)	(3) Plus grande volubilité que d'habitude ou besoin de parler sans cesse.	?	1	2	3	A89
... vos pensées se bousculaient-elles dans votre tête ?	(4) Fuite des idées ou sensations subjectives que les pensées défilent très rapidement.	?	1	2	3	A90
... éprouviez-vous de la difficulté à vous concentrer ? Constatiez-vous que n'importe quel détail insignifiant pouvait vous distraire ?	(5) Distractibilité, c'est-à-dire que l'attention du sujet est trop facilement attirée par des stimuli extérieurs insignifiants ou non pertinents.	?	1	2	3	A91
... à quoi passiez-vous votre temps ? (Travail, amis, loisirs ?) (Vous démeniez-vous au point que vos amis ou votre famille en éprouvaient du souci ?)	(6) Augmentation de l'activité orientée vers un but (social, professionnel, scolaire ou sexuel) ou agitation psychomotrice.	?	1	2	3	A92
SI LE SUJET N'A PAS FAIT PREUVE D'UNE ACTIVITÉ ACCRUE : Étiez-vous agité(e) ? (À quel point ?)	Cocher selon le cas : Augmentation de l'activité ___ Agitation psychomotrice ___					A93 A94

Durant cette période...

... avez-vous fait quoi que ce soit qui aurait pu vous attirer des ennuis, à vous ou à votre famille ? (Achats inutiles ?) (Activités sexuelles inhabituelles ?) (Conduite automobile imprudente ?)

(7) Participation intense à des activités agréables mais risquant d'avoir des conséquences dommageables pour le sujet (p.ex., achats inconsidérés, conduite déplacée sur le plan sexuel ou investissements déraisonnables). ? 1 2 3 A95

AU MOINS 3 DES SYMPTÔMES ÉNUMÉRÉS EN B (4, SI L'HUMEUR DU SUJET N'EST QU'IRRITABLE) SONT COTÉS "3". 1 3 A96

→ PASSER À LA PAGE A.28 (ÉPISODE MANIAQUE PASSÉ)

QUESTION À POSER AU BESOIN : Durant cette période, éprouviez-vous des difficultés sérieuses à la maison ou au travail (à l'école) à cause de (NOMMER LES SYMPTÔMES DU SUJET) ou avez-vous dû être hospitalisé(e) ?

C. L'épisode est assez sévère pour entraîner un handicap marqué du fonctionnement professionnel, des activités sociales ou des relations interpersonnelles habituelles ou pour nécessiter l'hospitalisation du sujet afin de prévenir tout risque pour lui ou pour sa famille, ou encore, comporte des caractéristiques psychotiques. 1 3 A97

DÉCRIRE :

→ PASSER À LA PAGE A.26 (CRITÈRE C DE L'ÉPISODE HYPOMANIAQUE ACTUEL)

Quelque temps avant la survenue de cet épisode, aviez-vous souffert d'une maladie physique ?

SI OUI : Qu'a dit votre médecin ?

Quelque temps avant la survenue de cet épisode, preniez-vous des médicaments ?

SI OUI : Y avait-il eu un changement dans la dose que vous preniez ?

Quelque temps avant la survenue de cet épisode, preniez-vous de l'alcool ou de la drogue ?

D. Les symptômes ne sont pas directement attribuables aux effets physiologiques d'une substance (p.ex., d'une drogue ou d'un médicament) ni à une maladie physique. ? 1 3 A98

S'IL EXISTE UN LIEN ENTRE LA MANIE ET UNE MALADIE PHYSIQUE OU UNE INTOXICATION, PASSER À LA PAGE A.44 (MAL. PHYS. OU INTOX.) ET REVENIR À LA PRÉSENTE SECTION POUR ATTRIBUER UNE COTE DE "1" OU DE "3".

ATTRIBUABLE À UNE MAL. PHYS. OU À UNE INTOX.

PASSER À LA PAGE A.28 (ÉPISODE MANIAQUE PASSÉ)

REMARQUE : TOUT ÉPISODE MANIAQUE MANIFESTEMENT PROVOQUÉ PAR UN TRAITEMENT ANTIDÉPRESSEUR PHYSIQUE OU CHIMIQUE (P.EX., MÉDICAMENTS, ÉLECTROCHOCS, PHOTOTHÉRAPIE, ETC.) DOIT ÊTRE CONSIDÉRÉ COMME ÉTANT UN TROUBLE THYMIQUE ATTRIBUABLE À UNE INTOXICATION, PAGE A.46, PLUTÔT QUE COMME UN TROUBLE BIPOLAIRE DE TYPE I.

ÉPISODE DE TROUBLE THYMIQUE PRIMAIRE

Exemples de maladie physique : maladies neurologiques dégénératives (p.ex., maladies de Parkinson et de Huntington), maladie vasculaire cérébrale, troubles du métabolisme (p.ex., carence en vitamine B_{12}) ou du système endocrinien (p.ex., hyperthyroïdie), maladies auto-immunes (p.ex., lupus érythémateux disséminé), infections, virales ou autres (p.ex., hépatite, mononucléose, infections par le VIH) et certains cancers (p.ex., cancer du pancréas).

Par intoxication on entend : l'intoxication par l'alcool, les amphétamines, la cocaïne, les hallucinogènes, les drogues inhalées, les opiacés, la phencyclidine, les sédatifs, les hypnotiques, les anxiolytiques et autres substances connues ou non (p.ex., stéroïdes anabolisants).

CONTINUER CI-DESSOUS

LES CRITÈRES A, B, C ET D DE L'ÉPISODE MANIAQUE SONT COTÉS "3". 1 3 A99

PASSER À LA PAGE A.28 (ÉPISODE MANIAQUE PASSÉ)

ÉPISODE MANIAQUE ACTUEL

Combien de fois avez-vous été (EXALTÉ(E) OU TERME ÉQUIVALENT UTILISÉ) et avez-vous éprouvé (NOMMER LES SYMPTÔMES D'ÉPISODE MANIAQUE RELEVÉS) pendant au moins une semaine (ou avez-vous été hospitalisé(e) ?	Nombre d'épisodes maniaques, y compris l'épisode actuel (INSCRIRE 99 SI CE NOMBRE EST TROP ÉLEVÉ POUR ÊTRE COMPTÉ OU SI LES ÉPISODES SONT DIFFICILES À DISTINGUER). REMARQUE : POUR CONSIGNER LA DESCRIPTION DES ÉPISODES PASSÉS, PASSER À LA PAGE J.14 (FACULTATIF).	__ __	A100
Quel âge aviez-vous la première fois que vous avez eu une période comme celle-ci ?	Âge du premier épisode maniaque.	__ __	

DYSTHYMIE
(ACTUELLE SEULEMENT)

CRITÈRES DIAGNOSTIQUES

SI LE SUJET A DÉJÀ CONNU UN ÉPISODE MANIAQUE OU HYPOMANIAQUE, COCHER CI-CONTRE ET PASSER AU MODULE SUIVANT. ____

⇒ SI LE SUJET N'A PAS CONNU D'ÉPISODE DÉPRESSIF MAJEUR DEPUIS DEUX ANS : Durant les deux dernières années, avez-vous eu une humeur dépressive pratiquement toute la journée et ce, plus d'un jour sur deux ? (Plus de la moitié du temps ?)

SI OUI : Comment vous sentiez-vous ?

A. Humeur dépressive (pouvant se traduire par une humeur irritable chez les enfants et les adolescents) présente pratiquement toute la journée, la majeure partie du temps, signalée par le sujet ou observée par les autres, pendant au moins deux ans (un an pour les enfants et les adolescents), plus souvent qu'autrement ou un jour sur deux.

? 1 2 3 A163

PASSER AU MODULE SUIVANT

⇒ SI LE SUJET VIT PRÉSENTEMENT UN ÉPISODE DÉPRESSIF MAJEUR : Revoyons maintenant à quand remontent la plupart des symptômes de (VOTRE ÉPISODE DÉPRESSIF MAJEUR ACTUEL). Durant les deux années qui ont précédé (DATE DU DÉBUT DE L'ÉPISODE ACTUEL), aviez-vous une humeur dépressive pratiquement toute la journée, et ce, plus d'un jour sur deux ? (Plus de la moitié du temps ?)

DATE À PARTIR DE LAQUELLE LE SUJET A SATISFAIT AUX CRITÈRES DE L'ÉPISODE DÉPRESSIF MAJEUR ACTUEL :

Mois et année : ____/____ Âge : _____

⇒ SI LE SUJET A VÉCU UN ÉPISODE DÉPRESSIF MAJEUR AU COURS DES DEUX DERNIÈRES ANNÉES : Revoyons maintenant à quand remontent la plupart des symptômes de (VOTRE ÉPISODE DÉPRESSIF MAJEUR PASSÉ) ainsi que le moment où vous ne souffriez plus de la plupart de ces symptômes. Depuis (DATE OÙ LE SUJET A CESSÉ DE SATISFAIRE AUX CRITÈRES DE L'ÉPISODE DÉPRESSIF MAJEUR), avez-vous quand même eu une humeur dépressive pratiquement toute la journée, et ce, plus d'un jour sur deux ?

SI OUI : Durant les deux années qui ont précédé (DATE DU DÉBUT DE L'ÉPISODE DÉPRESSIF PASSÉ), aviez-vous eu une humeur dépressive pratiquement toute la journée, et ce, plus d'un jour sur deux ? (Plus de la moitié du temps ?)

DATE À PARTIR DE LAQUELLE LE SUJET A SATISFAIT AUX CRITÈRES DE L'ÉPISODE DÉPRESSIF MAJEUR PASSÉ AU COURS DES DEUX DERNIÈRES ANNÉES :

Mois et année : ____/____ Âge : _____

DATE À LAQUELLE LE SUJET A CESSÉ DE SATISFAIRE AUX CRITÈRES DE L'ÉPISODE DÉPRESSIF MAJEUR PASSÉ AU COURS DES DEUX DERNIÈRES ANNÉES :

Mois et année : ____/____ Âge : _____

Durant ces périodes de (TERME ÉQUIVALENT UTILISÉ POUR DÉSIGNER LA DÉPRESSION CHRONIQUE), vous arrive-t-il souvent...	B. Quand le sujet est déprimé, il présente au moins deux des critères suivants :		
... de perdre l'appétit ? (ou alors de trop manger ?)	(1) perte de l'appétit ou hyperphagie	? 1 2 3	A164
... d'avoir de la difficulté à dormir ou encore de trop dormir ?	(2) insomnie ou hypersomnie	? 1 2 3	A165
... de manquer d'énergie ou de vous sentir souvent fatigué(e) ?	(3) baisse de l'énergie ou fatigue	? 1 2 3	A166
... de vous juger sévèrement ? [D'avoir le sentiment d'être un(e) propre à rien ou un(e) raté(e) ?]	(4) faible estime de soi	? 1 2 3	A167
... d'avoir de la difficulté à vous concentrer ou à prendre des décisions ?	(5) difficultés à se concentrer ou à prendre des décisions	? 1 2 3	A168
... d'être désespéré(e) ?	(6) sentiment de désespoir	? 1 2 3	A169
	AU MOINS DEUX DES SYMPTÔMES DU CRITÈRE "B" SONT COTÉS "3".	? 1 2 3	A170
		PASSER AU MODULE SUIVANT	
Durant cette période de dépression prolongée, combien de temps a duré le plus long épisode au cours duquel vous vous êtes senti(e) bien ? (OU VOUS N'AVEZ PAS ÉPROUVÉ DE SYMPTÔMES DE DYSTHYMIE)	C. Au cours de la période de deux ans (d'un an dans le cas des enfants et des adolescents) les symptômes énumérés en "A" et en "B" n'ont jamais été absents pendant plus de deux mois consécutifs. REMARQUE : COTER "1" SI LE SUJET A EU UNE HUMEUR NORMALE PENDANT AU MOINS DEUX MOIS CONSÉCUTIFS.	? 1 3	A171
		PASSER AU MODULE SUIVANT	

Depuis combien de temps vous sentez-vous ainsi ? (Quand avez-vous commencé à vous sentir ainsi ?)

D. Le sujet n'a pas eu d'épisode dépressif majeur au cours des deux premières années du trouble (un an pour les enfants et les adolescents); autrement dit, on peut écarter un trouble dépressif majeur chronique ou la rémission partielle d'un épisode dépressif majeur.

? 1 2 3 A172

PASSER AU MODULE SUIVANT

COMPARER LES DATES DE SURVENUE DES SYMPTÔMES DE DYSTHYMIE ET DES ÉPISODES DÉPRESSIFS MAJEURS PASSÉS POUR VÉRIFIER S'IL Y A EU UN ÉPISODE DÉPRESSIF MAJEUR DURANT LES DEUX PREMIÈRES ANNÉES DE LA DYSTHYMIE.

Âge de survenue de la dysthymie actuelle (INSCRIRE 99 SI ON NE SAIT PAS)

____ ____ A173

SI LA DYSTHYMIE A ÉTÉ PRÉCÉDÉE D'UN ÉPISODE DÉPRESSIF MAJEUR : Maintenant j'aimerais savoir si vous vous étiez complètement rétabli(e) de l'(ÉPISODE DE DÉPRESSION MAJEURE) dont vous souffriez (DATE) avant que ne commence cette longue période d'humeur légèrement dépressive ? (Avez-vous été complètement rétabli(e) pendant au moins deux mois ?)

Remarque : Quand il y a eu un épisode dépressif majeur antérieur, celui-ci doit avoir été en rémission complète (absence de signes et de symptômes significatifs depuis deux mois) avant l'apparition de la dysthymie. Par ailleurs, après les deux premières années de dysthymie (un an pour les enfants et les adolescents), des épisodes dépressifs majeurs peuvent se surajouter : dans ce cas, on peut porter les deux diagnostics.

REMARQUE : COTER "3" DANS LES CAS SUIVANTS : (1) SI LE SUJET N'A JAMAIS CONNU D'ÉPISODE DÉPRESSIF MAJEUR; (2) SI LE SUJET A CONNU UN ÉPISODE DÉPRESSIF MAJEUR DANS LE PASSÉ, MAIS PAS DURANT LES DEUX PREMIÈRES ANNÉES DE LA DYSTHYMIE; (3) SI LE SUJET A CONNU UN ÉPISODE DÉPRESSIF MAJEUR, MAIS QU'IL N'A PRÉSENTÉ AUCUN SYMPTÔME PENDANT AU MOINS DEUX MOIS AVANT L'APPARITION DE LA DYSTHYMIE.

E. N'a jamais présenté d'épisode maniaque ni d'épisode hypomaniaque franc.

1 3 A174

PASSER AU MODULE SUIVANT

SI LE DIAGNOSTIC N'EST PAS ENCORE ÉVIDENT : REVENIR À LA PRÉSENTE SECTION UNE FOIS L'INTERROGATOIRE TERMINÉ.

F. Ne survient pas exclusivement durant l'évolution d'un trouble psychotique chronique tels une schizophrénie ou un trouble délirant. ? 1 3 A175

PASSER AU MODULE SUIVANT

REMARQUE : COTER "3" SI LE SUJET NE SOUFFRE PAS D'UN TROUBLE PSYCHOTIQUE CHRONIQUE OU SI LA DYSTHYMIE N'EST PAS SURAJOUTÉE À UN TROUBLE PSYCHOTIQUE CHRONIQUE.

NON SURAJOUTÉ À UN AUTRE TROUBLE – CONTINUER

Quelque temps avant la survenue de cet épisode, aviez-vous souffert d'une maladie physique ?

SI OUI : Qu'a dit votre médecin ?

Quelque temps avant la survenue de cet épisode, preniez-vous des médicaments ?

SI OUI : Y avait-il eu un changement dans la dose que vous preniez ?

Quelque temps avant la survenue de cet épisode, preniez-vous de l'alcool ou de la drogue ?

G. Les symptômes ne sont pas directement attribuables aux effets physiologiques d'une substance (p.ex., d'une drogue ou d'un médicament) ni à une maladie physique. ? 1 3 A176

S'IL EXISTE UN LIEN ENTRE LA DÉPRESSION ET UNE MALADIE PHYSIQUE OU UNE INTOXICATION, PASSER À LA PAGE A.44 (MAL. PHYS. OU INTOX.) ET REVENIR À LA PRÉSENTE SECTION POUR ATTRIBUER UNE COTE DE "1" OU DE "3".

ATTRIBUABLE À UNE MAL. PHYS OU À UNE INTOX.
PASSER AU MODULE SUIVANT

ÉPISODE DE TROUBLE THYMIQUE PRIMAIRE

Exemples de maladie physique : maladies neurologiques dégénératives (p.ex., maladies de Parkinson et de Huntington), maladie vasculaire cérébrale, troubles du métabolisme ou du système endocrinien (p.ex., carence en vitamine B_{12}, hypothyroïdie) maladies auto-immunes (p.ex., lupus érythémateux disséminé), infections, virales ou autres (p.ex., hépatite, mononucléose, infections par le VIH) et certains cancers (p.ex., cancer du pancréas).

Par intoxication on entend : l'intoxication par l'alcool, les amphétamines, la cocaïne, les hallucinogènes, les solvants volatils, les opiacés, la phencyclidine, les sédatifs, les hypnotiques, les anxiolytiques et autres substances connues ou non (p.ex., stéroïdes anabolisants).

CONTINUER

DANS LE DOUTE : À quel point vos symptômes dépressifs vous empêchent-ils de vivre une vie normale ?

H. Les symptômes entraînent une détresse marquée ou un handicap notable sur les plans social, professionnel ou autres. ? 1 3 A177

PASSER AU MODULE SUIVANT

LES CRITÈRES A, B, C, D, E, F, G ET H DE LA DYSTHYMIE SONT COTÉS "3". 1 3 A178

PASSER AU MODULE SUIVANT

DYSTHYMIE

Indiquer les formes particulières :
1. À début précoce : avant l'âge de 21 ans
2. À début tardif : à partir de 21 ans

A179

DYSTHYMIE DE FORME ATYPIQUE

CRITÈRES DIAGNOSTIQUES

Durant vos périodes de dépression...

Lorsqu'il vous arrive quelque chose d'agréable ou que quelqu'un essaie de vous rasséréner, vous sentez-vous mieux, du moins pendant un certain temps ?

A. Réactivité (c'est-à-dire que l'humeur du sujet peut s'améliorer sous l'effet d'événements heureux, réels ou potentiels). ? 1 2 3 A180

PASSER AU MODULE SUIVANT

B. Au moins deux des critères suivants :

ÉTABLIR LA COTE EN FONCTION DE LA RÉPONSE DU SUJET À L'ITEM B(1), PAGE A. 39.

(1) gain de poids ou augmentation de l'appétit notables. ? 1 2 3 A181

Habituellement, les jours où vous êtes déprimé(e), combien d'heures dormez-vous (durant une période de 24 heures — y compris les siestes) ?

(2) hypersomnie ? 1 2 3 A182

REMARQUE : COTER "3" SI LE SUJET DORT PLUS DE 10 HEURES PAR JOUR.

Avez-vous souvent les jambes et les bras lourds (comme s'ils étaient en plomb) ?

(3) pesanteur paralysante (c'est-à-dire sensation de pesanteur dans les bras et les jambes). ? 1 2 3 A183

Êtes-vous particulièrement sensible à la façon dont les autres vous traitent ?

Que se passe-t-il quand on vous rejette, qu'on vous critique ou qu'on vous offense ? (Devenez-vous très abattu(e) ou très fâché(e) ?) (Combien de temps cela dure-t-il ?) (En quoi cela vous a-t-il affecté(e) ?) (Réagissez-vous plus fortement que la plupart des gens ?)

La peur du rejet ou de la critique vous a-t-elle empêché(e) de rencontrer des gens ou de faire certaines choses ?

(4) vulnérabilité de longue date au rejet par les autres (ne se manifestant pas seulement pendant les épisodes de troubles thymiques) résultant en un handicap marqué sur les plans social et professionnel. ? 1 2 3 A184

AU MOINS DEUX CRITÈRES DE B ONT ÉTÉ COTÉS "3". 1 3 A185

PASSER AU MODULE SUIVANT

LES CRITÈRES A ET B SONT COTÉS "3" 1 3 A186

DE FORME ATYPIQUE

TROUBLE THYMIQUE DÛ À UNE MALADIE PHYSIQUE OU À UNE INTOXICATION

TROUBLE THYMIQUE DÛ À UNE MALADIE PHYSIQUE

CRITÈRES DIAGNOSTIQUES

SI LES SYMPTÔMES NE SONT PAS ASSOCIÉS DANS LE TEMPS À UNE MALADIE PHYSIQUE, COCHER CI-CONTRE ET PASSER À LA PAGE A.46, TROUBLE THYMIQUE DÛ À UNE INTOXICATION. _____ A187

COTER À PARTIR DE L'INFORMATION RECUEILLIE PRÉCÉDEMMENT.

A. Un trouble de l'humeur important et persistant se caractérisant par l'une ou l'autre des manifestations suivantes ou les deux à la fois :

(1) Humeur dépressive ou diminution marquée de l'intérêt ou du plaisir dans toutes ou presque toutes les activités; ? 1 2 3 A188

(2) Humeur exaltée, expansive ou irritable. ? 1 2 3 A189

Pensez-vous que vos (ÉNONCER LES SYMPTÔMES DE TROUBLES THYMIQUES ÉPROUVÉS PAR LE SUJET) aient eu quelque lien que ce soit avec (NOMMER LA MALADIE CONCOMITANTE) ?

SI OUI : Expliquez-moi en quoi.

B. et C. L'anamnèse, l'examen physique et les résultats d'analyses semblent démontrer que le trouble est directement attribuable à une maladie physique; d'autre part, on peut écarter les autres troubles mentaux possibles (p.ex., trouble de l'adaptation avec humeur dépressive) qui pourraient être liés au stress découlant du fait d'être atteint d'une maladie physique. ? 1 2 3 A190

Vos symptômes (ÉNONCER LES SYMPTÔMES ÉPROUVÉS PAR LE SUJET) ont-ils commencé à se manifester ou se sont-ils beaucoup aggravés après le début de votre maladie (NOMMER LA MALADIE CONCOMITANTE) ?

SI OUI ET SI LA MALADIE EST MAÎTRISÉE : Vos symptômes (ÉNONCER LES SYMPTÔMES ÉPROUVÉS PAR LE SUJET) se sont-ils atténués une fois que vous vous êtes rétabli(e) de (NOMMER LA MALADIE CONCOMITANTE) ?

LES FACTEURS SUIVANTS DOIVENT ÊTRE PRIS EN CONSIDÉRATION ET AIDER À CONFIRMER QUE LES SYMPTÔMES DE TROUBLE THYMIQUE ÉPROUVÉS PAR LE SUJET SONT DUS À LA MALADIE PHYSIQUE DONT IL SOUFFRE :

1) LES OUVRAGES MÉDICAUX ONT DÉJÀ ÉTABLI L'EXISTENCE D'UN LIEN ENTRE LES SYMPTÔMES DE TROUBLE THYMIQUE ET LA MALADIE PHYSIQUE EN QUESTION.

2) IL EXISTE UN LIEN TRÈS NET, DANS LE TEMPS, ENTRE L'ÉVOLUTION DES SYMPTÔMES DE TROUBLE THYMIQUE ET CELLE DE LA MALADIE PHYSIQUE DONT SOUFFRE LE SUJET.

3) LES SYMPTÔMES DE TROUBLE THYMIQUE PRÉSENTENT DES CARACTÉRISTIQUES INHABITUELLES (P. EX., ÂGE DE SURVENUE AVANCÉ).

4) IL N'EXISTE PAS D'AUTRE EXPLICATION POSSIBLE DES SYMPTÔMES DE TROUBLE THYMIQUE (P. EX., RÉACTION PSYCHIQUE À LA MALADIE).

PASSER À LA PAGE A.46 (INTOXICATION)

DANS LE DOUTE : À quel point vos symptômes (NOMMER LES SYMPTÔMES DE TROUBLES THYMIQUES ÉPROUVÉS PAR LE SUJET) vous ont-ils empêché(e) de mener une vie normale ?

E. Les symptômes entraînent une détresse marquée ou un handicap notable sur les plans social ou professionnel ou dans d'autres domaines importants de la vie du sujet. ? 1 2 3 A191

PASSER À LA PAGE A.46 (INTOXICATION)

D. La perturbation ne survient pas exclusivement durant le délire. 1 3 A192

DÉLIRE DÛ À UNE MALADIE PHYSIQUE

TROUBLE THYMIQUE DÛ À UNE MALADIE PHYSIQUE

Indiquer le type prédominant du trouble thymique : A193
1. De type dépressif (si le sujet ne répond pas à tous les critères d'un épisode dépressif majeur, mais si son humeur prédominante est dépressive
2. Avec épisode évoquant un épisode dépressif majeur
3. De type maniaque
4. De type mixte

CONTINUER À LA PAGE SUIVANTE

TROUBLE THYMIQUE DÛ À UNE INTOXICATION

CRITÈRES DIAGNOSTIQUES

SI LES SYMPTÔMES NE SONT PAS ASSOCIÉS DANS LE TEMPS À LA CONSOMMATION D'UN PSYCHOTROPE (Y COMPRIS DES DROGUES), COCHER CI-CONTRE ET RETOURNER À LA SECTION RELATIVE AU TROUBLE EN VOIE D'ÉVALUATION.

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TROUBLE EN VOIE D'ÉVALUATION	
EDM actuel	A.4
EDM passé	A.16
Épisode maniaque actuel	A.21
Épisode hypomaniaque actuel	A.27
Épisode maniaque passé	A.31
Épisode hypomaniaque passé	A.36
Dysthymie	A.41
Épisode dépressif mineur	J.3
Trouble bipolaire NS	D.4
Trouble dépressif NS	D.8

COTER À PARTIR DE L'INFORMATION RECUEILLIE PRÉCÉDEMMENT.

A. Un trouble de l'humeur important et persistant se caractérisant par l'une ou l'autre des manifestations suivantes ou les deux à la fois :

(1) Humeur dépressive ou diminution marquée de l'intérêt ou du plaisir dans toutes ou presque toutes les activités; ? 1 2 3 A194

(2) Humeur exaltée, expansive ou irritable. ? 1 2 3 A195

QUESTION À POSER AU BESOIN : Quand avez-vous commencé à éprouver des (NOMMER LES SYMPTÔMES DE TROUBLE THYMIQUE ÉPROUVÉS PAR LE SUJET) ? Aviez-vous déjà commencé à consommer (NOMMER LE PSYCHOTROPE EN QUESTION) ou en aviez-vous diminué ou interrompu la consommation depuis peu ?

B. L'anamnèse, l'examen physique et les résultats d'analyses semblent démontrer soit (1) que les symptômes mentionnés en A sont apparus durant une intoxication ou moins d'un mois après l'arrêt de la consommation de la substance en cause, soit (2) que les symptômes sont liés à l'usage d'un médicament. ? 1 2 3 A196

NON ATTRIBUABLE À UNE INTOXICATION
RETOURNER À LA SECTION RELATIVE AU TROUBLE EN VOIE D'ÉVALUATION

Pensez-vous que vos (ÉNONCER LES SYMPTÔMES DE TROUBLES THYMIQUES ÉPROUVÉS PAR LE SUJET) aient eu quelque lien que ce soit avec (NOMMER LE PSYCHOTROPE) ?

SI OUI : Expliquez-moi en quoi.

POSER LES QUESTIONS SUIVANTES AU BESOIN, POUR ÉCARTER TOUTES LES AUTRES CAUSES POSSIBLES N'AYANT AUCUN LIEN AVEC LA CONSOMMATION DE PSYCHOTROPES :

C. On peut écarter les autres causes possibles de trouble thymique n'ayant aucun lien avec la consommation de psychotropes. ? 1 2 3 A197

On pourra établir que les symptômes du sujet sont attribuables à un trouble thymique autre que celui dû à une intoxication s'ils satisfont à un ou plusieurs des critères suivants :

QUESTION À POSER AU BESOIN : Quelle circonstance est survenue en premier ? Votre consommation de (NOMMER LE PSYCHOTROPE) ou vos symptômes (NOMMER LES SYMPTÔMES DE TROUBLE THYMIQUE) ?

(1) Les symptômes de trouble thymique sont apparus avant l'intoxication ou la dépendance.

QUESTION À POSER AU BESOIN : Avez-vous déjà cessé de consommer (NOMMER LE PSYCHOTROPE) pendant un certain temps ?

SI OUI : Une fois que vous avez cessé de consommer (NOMMER LE PSYCHOTROPE), vos symptômes (LES NOMMER) se sont-ils atténués ou ont-ils continué à se manifester ?

(2) Les symptômes de trouble thymique persistent pendant un bon moment (p.ex., un mois) après la fin d'une période de sevrage ou d'une grave intoxication.

QUESTION À POSER AU BESOIN : Quelle quantité de (NOMMER LE PSYCHOTROPE) consommiez-vous lorsque vous avez commencé à éprouver des symptômes de (LES NOMMER) ?

(3) Les symptômes de trouble thymique sont beaucoup plus prononcés que ce à quoi on pourrait s'attendre compte tenu de la nature ou de la quantité de substance consommée ou de la durée de l'intoxication.

QUESTION À POSER AU BESOIN : Y a-t-il déjà eu d'autres épisodes pendant lesquels vous avez éprouvé des symptômes de (NOMMER LES SYMPTÔMES DE TROUBLE THYMIQUE) ?

SI OUI : Combien ? Consommiez-vous (NOMMER LE PSYCHOTROPE) à cette époque ?

(4) Il semble exister un trouble thymique distinct, qui ne soit pas attribuable à la consommation d'un psychotrope (p.ex., des antécédents d'épisodes dépressifs majeurs récurrents qui ne sont liées à la consommation d'aucun psychotrope).

NON ATTRIBUABLE À UNE INTOXICATION
RETOURNER À LA SECTION RELATIVE AU TROUBLE EN VOIE D'ÉVALUATION

QUESTION À POSER AU BESOIN : À quel point vos symptômes (NOMMER LES SYMPTÔMES DE TROUBLE THYMIQUE ÉPROUVÉS PAR LE SUJET) vous ont-ils empêché(e) de mener une vie normale ?

E. Les symptômes entraînent une détresse marquée ou un handicap notable sur les plans social ou professionnel ou dans d'autres domaines importants de la vie du sujet. ? 1 2 3 A198

RETOURNER À LA SECTION RELATIVE AU TROUBLE EN VOIE D'ÉVALUATION

D. Les symptômes ne surviennent pas exclusivement durant l'évolution du délire.

1 3 A199

DÉLIRE DÛ À UNE INTOXICATION PAR UN PSYCHOTROPE

TROUBLE THYMIQUE DÛ À UNE INTOXICATION PAR UN PSYCHOTROPE

Indiquer le type prédominant de trouble thymique :
1. De type dépressif
2. De type maniaque
3. De type mixte

A200

Indiquer le contexte d'apparition des symptômes de trouble thymique :
1. Pendant l'intoxication
2. Pendant le sevrage

A201

RETOURNER À LA SECTION RELATIVE AU TROUBLE EN VOIE D'ÉVALUATION

E. TROUBLES LIÉS À LA PRISE D'UN PSYCHOTROPE

TROUBLES LIÉS À LA CONSOMMATION D'ALCOOL (PASSÉ OU PRÉSENT)

Quelles sont vos habitudes en ce qui concerne la consommation de boissons alcoolisées ? (Quelle quantité d'alcool buvez-vous ?)

Durant toute votre vie, à quelle époque votre consommation d'alcool a-t-elle été le plus élevée ? (Combien de temps cette période a-t-elle duré ?)

DÉCRIRE LES HABITUDES DE CONSOMMATION DU SUJET ET INDIQUER À QUELLE ÉPOQUE CELLE-CI A ÉTÉ LE PLUS FORTE.

À ce moment-là...

à quelle fréquence buviez-vous ? _____

que buviez-vous ? En quelle quantité ? _____

À ce moment-là...

le fait de boire vous a-t-il causé des ennuis ?

quelqu'un s'est-il plaint du fait que vous buviez ?

SI UNE DÉPENDANCE À L'ALCOOL SEMBLE PROBABLE, COCHER CI-CONTRE ET PASSER À LA PAGE E.4, DÉPENDANCE À L'ALCOOL. ____ E1

SI LE SUJET A DÉJÀ BU DE FAÇON EXCESSIVE OU S'IL LAISSE PERCEVOIR DES SIGNES DE DIFFICULTÉS RELIÉES À SA CONSOMMATION D'ALCOOL, CONTINUER À LA PAGE SUIVANTE, À LA SECTION INTITULÉE « ABUS D'ALCOOL ».

SI LE SUJET N'A JAMAIS BU DE FAÇON EXCESSIVE OU S'IL NE LAISSE PERCEVOIR AUCUN SIGNE DE DIFFICULTÉS RELIÉES À LA CONSOMMATION D'ALCOOL, PASSER À LA PAGE E.9, TROUBLES LIÉS À L'UTILISATION D'AUTRES SUBSTANCES QUE L'ALCOOL.

ABUS D'ALCOOL (PASSÉ OU PRÉSENT)

Permettez-moi de vous poser quelques questions additionnelles sur vos habitudes de consommation de boissons (Préciser période problématique)

Au cours de cette période...
Vous est-il arrivé d'être intoxiqué(e) ou éméché(e) ou encore d'avoir vraiment la gueule de bois à un moment où vous deviez vous occuper de choses importantes, par exemple lorsque vous étiez au travail ou à l'école ou que vous preniez soin d'un enfant ?

SINON : Vous est-il arrivé de manquer quelque chose d'important, par exemple, le travail, l'école ou un rendez-vous parce que vous étiez intoxiqué(e) ou éméché(e) ou que vous aviez vraiment la gueule de bois ?

SI LE SUJET A RÉPONDU OUI À L'UNE DES DEUX QUESTIONS PRÉCÉDENTES : À quelle fréquence cela vous est-il arrivé ? (À quelle époque et pendant combien de temps ?)

Vous est-il déjà arrivé de boire à un moment où il était dangereux de le faire ? (Vous est-il arrivé de conduire en état d'ébriété ?)

SI OUI, QUESTION À POSER AU BESOIN : À quelle fréquence cela vous est-il arrivé ? (À quelle époque et pendant combien de temps ?)

Avez-vous eu des ennuis avec la justice après vous être enivré(e) ?

SI OUI, QUESTION À POSER AU BESOIN : À quelle fréquence cela vous est-il arrivé ? (À quelle époque et pendant combien de temps ?)

QUESTION À POSER AU BESOIN : Avez-vous eu des difficultés avec les autres parce que vous buviez, p.ex., avec des membres de votre famille, des amis ou des collègues de travail ? (En êtes-vous venu(e) aux coups ou encore, avez-vous eu de violentes querelles verbales au sujet de vos habitudes de consommation ?)

SI OUI : Avez-vous quand même continué à boire ? (À quelle époque et pendant combien de temps ?)

CRITÈRES DIAGNOSTIQUES

A. Des habitudes de consommation d'alcool inappropriées entraînant une détresse ou un handicap marqués sur le plan clinique, comme en témoigne la présence d'au moins un des symptômes suivants, durant une période de 12 mois :

(1) consommation d'alcool répétée rendant le sujet incapable de remplir des obligations importantes au travail, à l'école ou à la maison (p. ex., absences répétées du travail ou rendement médiocre lié à la consommation d'alcool; absences, suspensions ou expulsions de l'école, liées à la consommation d'alcool; négligence dans la garde des enfants ou les soins du ménage).	?	1	2	3	E2
(2) consommation d'alcool répétée dans des situations où celle-ci pourrait s'avérer dangereuse (p.ex., conduite d'un véhicule ou d'une machine)	?	1	2	3	E3
(3) démêlés répétés avec la justice, liées à la consommation d'alcool (p.ex., arrestations pour ivresse et inconduite).	?	1	2	3	E4
(4) poursuite de la consommation d'alcool malgré les problèmes sociaux ou personnels persistants ou fréquents causés ou exacerbés par l'alcool (p.ex., querelles avec le conjoint au sujet des conséquences de l'intoxication, violence physique).	?	1	2	3	E5

? = information inappropriée | 1 = FAUX ou absence du symptôme | 2 = symptôme infraliminaire | 3 = VRAI ou présence du symptôme

AU MOINS UN DES ITEMS DE A EST COTÉ "3". 1 3 E6

SI TOUTE DÉPENDANCE PHYSIQUE OU TOUT USAGE COMPULSIF DE L'ALCOOL SEMBLE PEU PLAUSIBLE, PASSER À LA PAGE E.9, TROUBLES LIÉS À L'UTILISATION D'AUTRES SUBSTANCES QUE L'ALCOOL; SINON, CONTINUER AVEC LES QUESTIONS CONCERNANT LA DÉPENDANCE, PAGE E.4.

ABUS D'ALCOOL
CONTINUER L'INTERROGATOIRE, PAGE E.4,
DÉPENDANCE À L'ALCOOL

DÉPENDANCE À L'ALCOOL

Maintenant, j'aimerais vous poser quelques questions additionnelles concernant vos habitudes de consommation.
(Préciser période problématique)

CRITÈRES DIAGNOSTIQUES

A. Des habitudes de consommation d'alcool inappropriées entraînant une détresse ou un handicap marqués sur le plan clinique, comme en témoignent au moins trois des symptômes suivants, survenus n'importe quand durant une même période de 12 mois :

REMARQUE : LES CRITÈRES NE SONT PAS PRÉSENTÉS DANS LE MÊME ORDRE QUE DANS LE DSM-IV.

Au cours de cette période...						
Vous est-il souvent arrivé de constater que, lorsque vous vous mettiez à boire, vous buviez beaucoup plus que prévu ? SINON : Ou de constater que vous buviez beaucoup plus longtemps que prévu ?	(3) souvent, l'alcool est consommé en quantité supérieure OU durant un laps de temps plus long que prévus.	?	1	2	3	E7
Avez-vous essayé de diminuer ou d'arrêter ? SI OUI : Avez-vous déjà arrêté complètement ? (Combien de fois avez-vous essayé de diminuer ou d'arrêter ?) SINON : Auriez-vous souhaité diminuer ou arrêter ? (Cela vous préoccupait-il beaucoup ?)	(4) Le sujet éprouve sans cesse le désir de diminuer ou de maîtriser sa consommation OU il déploie de vains efforts en ce sens.	?	1	2	3	E8
Avez-vous passé beaucoup de temps à boire, à être éméché(e) ou à vous remettre de votre ébriété ?	(5) Le sujet passe un temps considérable à faire le nécessaire pour se procurer de l'alcool, le consommer ou se remettre de ses effets.	?	1	2	3	E9
Vous est-il arrivé de boire si souvent que vous négligiez votre travail, vos loisirs, votre famille ou vos amis ?	(6) Le sujet abandonne ou réduit des activités importantes sur le plan social, professionnel ou récréatif, en raison de sa consommation d'alcool.	?	1	2	3	E10
QUESTION À POSER AU BESOIN : Avez-vous déjà eu des problèmes psychologiques, comme de la dépression, de l'anxiété, de la difficulté à dormir, ou des éclipses ("blackouts") parce que vous buviez ? QUESTION À POSER AU BESOIN : Avez-vous déjà eu des problèmes physiques sérieux, causés ou aggravés par le fait que vous buviez ? SI LE SUJET A RÉPONDU OUI À L'UNE DES DEUX QUESTIONS CI-DESSUS : Avez-vous continué à boire malgré tout ?	(7) Le sujet continue à consommer de l'alcool tout en se sachant affligé d'un problème physique ou psychologique persistant ou récurrent, probablement causé ou exacerbé par l'alcool (p.ex., continue à boire malgré l'aggravation d'un ulcère par l'alcool).	?	1	2	3	E11

? = information inappropriée | 1 = FAUX ou absence du symptôme | 2 = symptôme infraliminaire | 3 = VRAI ou présence du symptôme

Vous a-t-il semblé que vous deviez boire beaucoup plus pour obtenir l'effet recherché que lorsque vous avez commencé à boire ? SI OUI : Combien plus ? SINON : Vous a-t-il semblé qu'une même quantité d'alcool avait beaucoup moins d'effet qu'auparavant ?	(1) tolérance, se manifestant soit par (a), soit par (b) : (a) besoin de quantités nettement plus importantes d'alcool pour s'intoxiquer ou pour obtenir l'effet recherché; (b) effet nettement moindre en cas d'ingestion continue de la même dose.	?	1	2	3	E12
Lorsqu'il vous est arrivé de cesser de boire ou de réduire votre consommation, avez-vous éprouvé des symptômes de sevrage, comme...	(2) sevrage, se manifestant soit par (a), soit par (b) : (a) au moins DEUX des critères suivants :	?	1	2	3	E13
... de la transpiration ou des palpitations ?	– hyperactivité du système nerveux autonome (p.ex., transpiration, pouls supérieur à 100)					
... un tremblement des mains ?	– augmentation du tremblement des mains					
... des troubles du sommeil ?	– insomnie					
... des nausées ou des vomissements ?	– nausées ou vomissements					
... de l'agitation ?	– agitation					
... de l'anxiété ?	– anxiété					
(Avez-vous eu des crises d'épilepsie, ou avez-vous vu, entendu ou ressenti des choses qui ne se passaient pas vraiment ?)	– crises d'épilepsie (grand mal) – illusions ou hallucinations visuelles, auditives ou tactiles transitoires					
SINON : Avez-vous déjà commencé la journée en prenant un verre, ou vous est-il souvent arrivé de boire pour éviter de d'être pris(e) de tremblements ou de vous sentir malade ?	(b) prise d'alcool (ou d'une substance de la classe des sédatifs, des hypnotiques ou des anxiolytiques) pour éviter ou soulager les symptômes de sevrage.	?	1	2	3	E14

QUESTION À POSER AU BESOIN : Quand vous est-il arrivé de (NOMMER LES SYMPTÔMES DE DÉPENDANCE COTÉS "3" – PAGES E.4 ET E.5) ? (Toutes ces manifestations se sont-elles produites à peu près durant la même période?)

AU MOINS TROIS DES ITEMS DE "A" (SYMPTÔMES DE DÉPENDANCE, PAGES E.4 ET E.5) SONT COTÉS "3" ET SONT SURVENUS PENDANT UNE MÊME PÉRIODE DE 12 MOIS. 1 3 E15

DÉPENDANCE À L'ALCOOL

Préciser : E16
1 – Avec dépendance physique (à l'heure actuelle, le sujet présente des signes de tolérance ou de sevrage)
2 – Sans dépendance physique (à l'heure actuelle, le sujet ne présente aucun signe de tolérance ni de sevrage)

PASSER À LA PAGE E.7, CHRONOLOGIE DE LA DÉPENDANCE

SI LES QUESTIONS CONCERNANT L'ABUS D'ALCOOL (PAGES E.1 À E.3) N'ONT PAS ENCORE ÉTÉ POSÉES, PASSER À LA PAGE E.1 AFIN DE VÉRIFIER S'IL Y A ABUS D'ALCOOL.

SI LES QUESTIONS CONCERNANT L'ABUS D'ALCOOL ONT ÉTÉ POSÉES ET ONT PERMIS DE DIAGNOSTIQUER UN ABUS D'ALCOOL, COTER "3", CI-CONTRE; EN REVANCHE, SI ELLES N'ONT PAS PERMIS DE DIAGNOSTIQUER D'ABUS D'ALCOOL, PASSER À LA PAGE E.9, TROUBLES LIÉS À L'UTILISATION D'AUTRES SUBSTANCES QUE L'ALCOOL. 1 3 E17

PASSER À LA PAGE E.9, TROUBLES LIÉS À L'UTILISATION D'AUTRES SUBSTANCES QUE L'ALCOOL

ABUS D'ALCOOL

Quel âge aviez-vous quand vous avez commencé à (NOMMER LES SYMPTÔMES D'ABUS D'ALCOOL COTÉS "3") ?

Âge de survenue de l'abus d'alcool (SI LE SUJET NE SAIT PAS, INSCRIRE 99) ___ ___ E18

DANS LE DOUTE : Avez-vous bu quoi que ce soit, au cours des 6 derniers mois ?

SI OUI : Pourriez-vous préciser ?
(Le fait de boire vous a-t-il causé des ennuis?)

Le sujet a répondu aux critères de l'abus d'alcool au cours des 6 derniers mois. ? 1 3 E19

ABUS PASSÉ

ABUS PRÉSENT

PASSER À LA PAGE E.9, TROUBLES LIÉS À L'UTILISATION D'AUTRES SUBSTANCES QUE L'ALCOOL

? = information inappropriée | 1 = FAUX ou absence du symptôme | 2 = symptôme infraliminaire | 3 = VRAI ou présence du symptôme

CHRONOLOGIE DE LA DÉPENDANCE

Quel âge aviez-vous quand vous avez commencé à (NOMMER LES SYMPTÔMES DE DÉPENDANCE OU D'ABUS D'ALCOOL COTÉS "3") ?

DANS LE DOUTE : Avez-vous bu quoi que ce soit, au cours des 6 derniers mois ?

SI OUI : Pourriez-vous préciser ? (Le fait de boire vous a-t-il causé des ennuis?)

Âge de survenue de la dépendance à l'alcool ou de l'abus d'alcool (SI LE SUJET NE SAIT PAS, INSCRIRE 99) ____ ____

Le sujet a répondu à tous les critères de la dépendance à l'alcool au cours des 6 derniers mois (ou n'a pas connu un mois sans symptômes de dépendance ou d'abus depuis la survenue de sa dépendance). ? 1 3

PASSER À LA PAGE E.8 (TYPES DE RÉMISSION)

DÉPENDANCE PRÉSENTE

DEGRÉ DE GRAVITÉ DE LA DÉPENDANCE

INDIQUER LE DEGRÉ DE GRAVITÉ DE LA DÉPENDANCE PENDANT LA PIRE SEMAINE DES 6 DERNIERS MOIS. (Il sera peut-être nécessaire de poser des questions additionnelles pour connaître les effets de la consommation d'alcool sur la vie sociale et professionnelle du sujet.)

1 Légère : Peu, voire aucun autre symptôme à part ceux requis pour poser le diagnostic; les symptômes n'entraînent qu'une légère incapacité sur le plan professionnel ou dans les activités sociales ou les relations du sujet avec autrui (ou le sujet a répondu aux critères de la dépendance dans le passé et éprouve certaines difficultés à l'heure actuelle).

2 Moyenne : Les symptômes ou l'incapacité fonctionnelle sont de degré « léger » à « sévère ».

3 Sévère : Il existe beaucoup plus de symptômes que ceux requis pour poser le diagnostic et ces symptômes nuisent grandement aux activités professionnelles ou sociales habituelles du sujet ou encore à ses relations avec autrui.

PASSER À LA PAGE E.9, TROUBLES LIÉS À L'UTILISATION D'AUTRES SUBSTANCES QUE L'ALCOOL.

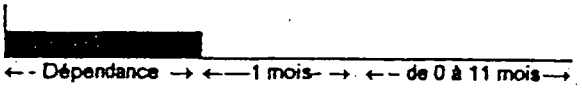
DÉPENDANCE — TYPES DE RÉMISSION

DÉTERMINER LE TYPE DE RÉMISSION UNIQUEMENT SI, À UN MOMENT OU À UN AUTRE DANS LE PASSÉ, LE SUJET N'A RÉPONDU À AUCUN CRITÈRE DE DÉPENDANCE À L'ALCOOL OU D'ABUS D'ALCOOL PENDANT AU MOINS UN MOIS.

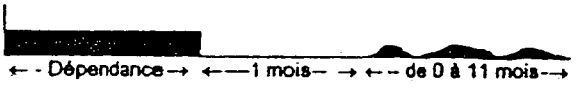
Remarque : On ne doit pas préciser le type de rémission si le sujet suit un traitement de substitution (comportant la prise d'un agoniste) ou s'il vit en milieu supervisé (*voir ci-dessous*).

Nombre de mois écoulés depuis les dernières difficultés concernant la prise d'alcool : ___ ___ ___ E23

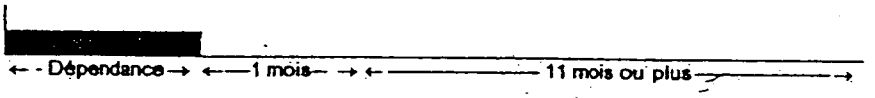
1 Rémission complète au stade précoce : Le sujet n'a répondu à aucun critère de dépendance ou d'abus pendant au moins un mois, mais moins de 12 mois. E24



2 Rémission partielle au stade précoce : Le sujet a répondu à au moins un critère de dépendance ou d'abus pendant au moins un mois, mais moins de 12 mois (sans répondre au nombre de critères nécessaires pour poser un diagnostic de dépendance).



3 Rémission complète et soutenue : Le sujet n'a répondu à aucun critère de dépendance ni d'abus pendant une période de 12 mois ou plus.



4 Rémission partielle et soutenue : Pendant une période de 12 mois ou plus, le sujet n'a pas répondu au nombre de critères requis pour poser un diagnostic de dépendance ou d'abus; cependant, il a répondu à au moins un de ces critères.

Cocher ci-contre : si le sujet suit un traitement de substitution, c'est-à-dire comportant la prise d'un agoniste des récepteurs de la substance envers laquelle il manifeste une dépendance : On lui a prescrit un agoniste (p.ex., Valium) et depuis un mois au moins, il ne répond à aucun critère de dépendance ou d'abus à l'endroit des produits de la classe envers laquelle il manifeste une dépendance (sauf à l'endroit de l'agoniste). Cette catégorie s'applique aussi aux sujets traités par un agoniste partiel ou par une association agoniste – antagoniste. ___ E25

Cocher ci-contre : si le sujet vit en milieu supervisé, c'est-à-dire où l'accès à l'alcool ou aux autres substances contrôlées est restraint, et s'il ne répond pas aux critères de dépendance ou d'abus d'alcool depuis au moins un mois. Exemples : milieu carcéral hautement supervisé où l'on ne tolère pas l'usage des drogues, communautés thérapeutiques et installations hospitalières sous verrous. ___ E26

TROUBLES LIÉS À L'UTILISATION D'AUTRES SUBSTANCES QUE L'ALCOOL
(DÉPENDANCE OU ABUS PASSÉ OU PRÉSENT)

Maintenant, je vais vous interroger au sujet de l'usage que vous faites des drogues ou des médicaments.

PRÉSENTER AU SUJET LA LISTE DE PSYCHOTROPES.

Avez-vous déjà pris une de ces substances pour atteindre un état d'euphorie ou pour mieux dormir, ou encore, pour perdre du poids ou modifier votre humeur ?

DÉTERMINER LE DEGRÉ D'UTILISATION DES PSYCHOTROPES ÉNUMÉRÉS À LA PAGE SUIVANTE À L'AIDE DES LIGNES DIRECTRICES FORMULÉES CI-DESSOUS.

LIGNES DIRECTRICES POUR ÉVALUER LE DEGRÉ D'UTILISATION DES PSYCHOTROPES :

POUR CHAQUE CLASSE DE PSYCHOTROPE UTILISÉ :

⇒ S'IL S'AGIT D'UNE DROGUE ILLICITE : À quelle époque avez-vous consommé le plus de (NOMMER LA DROGUE) ?

(Vous est-il arrivé d'en consommer au moins 10 fois par mois ?)

⇒ S'IL S'AGIT D'UN MÉDICAMENT: Vous est-il déjà arrivé de ne plus pouvoir vous passer de (NOMMER LE MÉDICAMENT) ou vous est-il déjà arrivé d'en prendre beaucoup plus que la dose recommandée ?

Soit (A), soit (B), selon qu'il s'agit d'une drogue illicite ou d'un médicament:

(A) Le sujet a déjà pris la drogue en question plus de 10 fois en l'espace d'un mois.

(B) Le sujet a ressenti une dépendance à un médicament OU en a utilisé en quantité supérieure aux doses recommandées.

À LA PAGE E.10, VIS-À-VIS DE CHAQUE CLASSE DE SUBSTANCES,

⇒ COTER "1" SI LE SUJET N'A JAMAIS UTILISÉ DE DROGUES DE CETTE CLASSE OU S'IL N'EN A UTILISÉ QU'UNE SEULE FOIS OU, DANS LE CAS D'UN MÉDICAMENT, S'IL A PRIS LA SUBSTANCE CONFORMÉMENT AUX DIRECTIVES.

⇒ COTER "2" SI LE SUJET A UTILISÉ UNE DROGUE DE CETTE CLASSE AU MOINS DEUX FOIS, MAIS À UNE FRÉQUENCE MOINDRE QUE CELLE DÉCRITE EN (A) CI-DESSUS.

⇒ COTER "3" SI LE SUJET A UTILISÉ UNE DROGUE À LA FRÉQUENCE DÉCRITE EN (A) OU S'IL SOUFFRE PROBABLEMENT D'UNE DÉPENDANCE À UN MÉDICAMENT — C'EST-À-DIRE SI LA SITUATION DÉCRITE EN (B) EST VRAIE.

? = information inappropriée	1 = FAUX ou absence du symptôme	2 = symptôme infraliminaire	3 = VRAI ou présence du symptôme

ENCERCLER LE NOM DE CHAQUE SUBSTANCE DONT LE SUJET A DÉJÀ FAIT USAGE (OU ÉCRIRE LE NOM DE LA SUBSTANCE SOUS "AUTRE". (Préciser période problématique)	INDIQUER DURANT QUELLE PÉRIODE LA CONSOMMATION A ÉTÉ LE PLUS ÉLEVÉE (ÂGE DU SUJET OU DATE ET DURÉE DE LA PÉRIODE) ET DÉCRIRE LES HABITUDES DE CONSOMMATION DU SUJET.	INDIQUER L'IMPORTANCE DE LA CONSOMMATION (SELON LES LIGNES DIRECTRICES, EN PAGE E.9)				
Au cours de cette période...						
Sédatifs, hypnotiques, anxiolytiques : Quaalude, Seconal, Valium, Xanax, Librium, barbituriques, Miltown, Ativan, Dalmane, Halcion, Restoril ou autre : _____	_____	?	1	2	3	E27
Cannabis : marijuana, haschisch, THC ou autre : _____	_____	?	1	2	3	E28
Stimulants : amphétamines, "speed", méthamphétamine ("crystal"), Dexedrine, Ritalin, "ice" ou autre : _____	_____	?	1	2	3	E29
Opiacés : héroïne, morphine, opium, méthadone, Darvon, codéine, Percodan, Demerol, Dilaudid ou autre non précisé : _____	_____	?	1	2	3	E30
Cocaïne : intranasale, I.V., "freebase", "crack", "speedball" ou autre non précisé : _____	_____	?	1	2	3	E31
Hallucinogènes et PCP : LSD, mescaline, peyotl, psilocybine, DOM (diméthoxyméthylamphétamine ou "STP"), champignons, PCP (poudre d'ange), ecstasy, MDA ou autre : _____	_____	?	1	2	3	E32
Autres : stéroïdes anabolisants, "colle", solvants pour peinture, solvants volatils, oxyde nitreux (gaz hilarant), nitrite d'amyle ("popper"), anorexigènes (pilules pour maigrir) ou pilules pour dormir vendus sans ordonnance ou autres non précisés ou non déterminés : _____	_____	?	1	2	3	E33
	AU MOINS UNE CATÉGORIE DE DROGUES A ÉTÉ COTÉE "2" OU "3"		1		3	E34

PASSER AU MODULE SUIVANT

? = information inappropriée | 1 = drogue jamais consommée ou consommée une fois seulement | 2 = drogue consommée de 2 à 10 fois par mois | 3 = drogue consommée plus de 10 fois par mois ou dépendance à un médicament

SI LE SUJET A CONSOMMÉ DES SUBSTANCES D'AU MOINS TROIS CLASSES DIFFÉRENTES ET S'IL SE PEUT QU'IL LES AIT CONSOMMÉES SANS DISCERNEMENT PENDANT UNE CERTAINE PÉRIODE, LUI POSER LA QUESTION SUIVANTE :

Vous m'avez dit que vous aviez déjà fait usage de (NOMMER LES SUBSTANCES) ou d'alcool. Y a-t-il eu une période au cours de laquelle vous avez consommé beaucoup de drogues différentes en même temps et où le type de drogue vous importait peu, du moment qu'il vous était possible d'atteindre un état euphorique ?

Pendant une même période de 12 mois, le sujet a consommé de façon répétée des psychotropes d'au moins trois classes différentes (exception faite de la caféine et de la nicotine), sans en privilégier un en particulier, et durant cette période, il a (probablement) répondu aux critères de la dépendance aux psychotropes dans leur ensemble, mais à aucun psychotrope en particulier.

REMARQUE : CHEZ LES SUJETS QUI, À UN MOMENT DONNÉ, ONT CONSOMMÉ PLUSIEURS SUBSTANCES SANS DISCERNEMENT ET QUI, AU COURS D'AUTRES PÉRIODES, EN ONT CONSOMMÉ CERTAINES EN PARTICULIER, EN RÉPONSE À CHACUNE DES QUESTIONS DES PAGES SUIVANTES, ENCERCLEZ LA COTE APPROPRIÉE DANS LA COLONNE INTITULÉE POLY (POLYTOXICOMANIE) ET DANS LA COLONNE DE CHAQUE CLASSE DE SUBSTANCES PERTINENTE.

1 2 3 E3

COTER LA COLONNE INTITULÉE POLY

SI AUCUNE DES CLASSES DE SUBSTANCES DE LA PAGE E.10 N'A ÉTÉ COTÉE "3", C'EST-À-DIRE S'IL Y A DES COTES "2" MAIS AUCUNE COTE "3", PASSER À LA PAGE E.21, ABUS DE PSYCHOTROPES.

POUR TOUTES LES QUESTIONS DES PAGES E.12 À E.17, ENCERCLEZ LA COTE APPROPRIÉE DANS CHACUNE DES COLONNES CORRESPONDANT À UNE CLASSE DE SUBSTANCES COTÉE "3" À LA PAGE E.10.

Maintenant, je vais vous poser certaines questions précises au sujet de votre consommation de (NOMMER LES SUBSTANCES COTÉES "3"). (Préciser période problématique)

POUR CHACUNE DES SUBSTANCES COTÉES "3", COMMENCER CHACUNE DES QUESTIONS SUIVANTES PAR :
En ce qui concerne votre consommation de (NOMMER LA SUBSTANCE COTÉE "3")...

Au cours de cette période...
Vous est-il souvent arrivé de constater que, lorsque vous vous mettiez à en prendre, vous en preniez beaucoup plus que vous n'en aviez l'intention ?

SINON : De constater que vous en preniez beaucoup plus longtemps que vous ne l'aviez d'abord prévu ?

REMARQUE : LES CRITÈRES DE DÉPENDANCE NE SONT PAS PRÉSENTÉS DANS LE MÊME ORDRE QUE DANS LE DSM-IV.	SÉD., HYPN., ANXIOL.	CANN.	STIM.	OPIAC.	COC.	HAL. ET PCP	POLY	AUTRE
	3	3	3	3	3	3	3	3
(3) Souvent, la substance est consommée en quantité supérieure OU durant un laps de temps plus long que prévu.	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	?	?	?	?	?	?	?	?
	E36	E37	E38	E39	E40	E41	E42	E43

Avez-vous essayé de diminuer votre consommation de (NOMMER LA SUBSTANCE) ou d'arrêter ?

SI OUI : Avez-vous déjà arrêté complètement ?

(Combien de fois avez-vous essayé de diminuer ou d'arrêter ?)

DANS LE DOUTE : Auriez-vous souhaité arrêter ou diminuer votre consommation de (NOMMER LA SUBSTANCE)

SI OUI : Cela vous préoccupait-il beaucoup ?

	SÉD., HYPN., ANXIOL.	CANN.	STIM.	OPIAC.	COC.	HAL. ET PCP	POLY	AUTRE
	3	3	3	3	3	3	3	3
(4) Le sujet éprouve sans cesse le désir de diminuer ou de maîtriser sa consommation du psychotrope OU il déploie de vains efforts en ce sens.	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	?	?	?	?	?	?	?	?
	E44	E45	E46	E47	E48	E49	E50	E51

? = information inappropriée | 1 = FAUX ou absence du symptôme | 2 = symptôme infraliminaire | 3 = VRAI ou présence du symptôme

Avez-vous passé beaucoup de temps à consommer (NOMMER LA SUBSTANCE) ou à faire le nécessaire pour vous en procurer ? Est-ce que ça vous prenait beaucoup de temps à revenir à la normale après en avoir consommé ? (Combien de temps ? Plusieurs heures ?)

	SÉD., HYPN., ANXIOL.	CANN.	STIM.	OPIAC.	COC.	HAL. ET PCP	POLY	AUTRE
(5). Le sujet passe un temps considérable à faire le nécessaire pour se procurer le psychotrope, pour le consommer ou pour se remettre de ses effets.	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	E52	E53	E54	E55	E56	E57	E58	E59

Vous est-il arrivé de consommer (NOMMER LA SUBSTANCE) si souvent que vous négligiez votre travail, vos loisirs, votre famille ou vos amis ?

	SÉD., HYPN., ANXIOL.	CANN.	STIM.	OPIAC.	COC.	HAL. ET PCP	POLY	AUTRE
(6) Le sujet abandonne ou réduit des activités importantes sur le plan social, professionnel ou récréatif, en raison de sa consommation du psychotrope.	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	?	?	?	?	?	?	?	?
	E60	E61	E62	E63	E64	E65	E66	E67

QUESTION À POSER AU BESOIN : Avez-vous déjà eu des problèmes psychologiques, comme de la dépression parce que vous preniez (NOMMER LA SUBSTANCE) ?

QUESTION À POSER AU BESOIN : Avez-vous déjà eu des problèmes physiques sérieux, causés ou aggravés par le fait que vous preniez (NOMMER LA SUBSTANCE) ?

SI LE SUJET A RÉPONDU OUI À L'UNE DES DEUX QUESTIONS CI-DESSUS : Avez-vous continué à en prendre malgré tout ?

	SÉD., HYPN., ANXIOL.	CANN.	STIM.	OPIAC.	COC.	HAL. ET PCP	POLY	AUTRE
(7) Le sujet continue à consommer la substance tout en se sachant affligé d'un problème physique ou psychologique persistant ou récurrent, probablement causé ou exacerbé par celle-ci (p.ex., continue à prendre de la cocaïne malgré la présence d'une dépression qu'il reconnaît comme étant attribuable à la cocaïne).	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	?	?	?	?	?	?	?	?
	E68	E69	E70	E71	E72	E73	E74	E75

Vous a-t-il semblé que vous deviez prendre beaucoup plus de (NOMMER LA SUBSTANCE) pour atteindre un état de bien-être ou d'euphorie que lorsque vous avez commencé ?

SI OUI : Combien plus ?

SINON : Vous a-t-il semblé qu'une même quantité de (NOMMER LA SUBSTANCE) avait beaucoup moins d'effet qu'auparavant ?

	SÉD., HYPN., ANXIOL.	CANN.	STIM.	OPIAC.	COC.	HAL. ET PCP	POLY	AUTRE
(1) tolérance, se manifestant soit par (a), soit par (b) :								
(a) besoin de quantités nettement plus importantes de la substance pour s'intoxiquer ou pour obtenir l'effet recherché;	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
(b) effet nettement moindre en cas d'ingestion continue de la même dose.	?	?	?	?	?	?	?	?
	E76	E77	E78	E79	E80	E81	E82	E83

IL SE PEUT QUE LA QUESTION SUIVANTE NE S'APPLIQUE PAS DANS LE CAS DU CANNABIS ET CELUI DES HALLUCINOGÈNES ET DE LA PCP.

Lorsqu'il vous est arrivé de cesser de prendre (NOMMER LA SUBSTANCE) ou d'en réduire les doses, avez-vous éprouvé des symptômes de sevrage, autrement dit, cela vous a-t-il rendu(e) malade ?

SI OUI : Quel genre de symptômes avez-vous ressentis ? (CONSULTER LA LISTE DES SYMPTÔMES DE SEVRAGE À LA PAGE E.16)

SI LE SUJET A ÉPROUVÉ DES SYMPTÔMES DE SEVRAGE : Vous est-il souvent arrivé de prendre (NOMMER LA SUBSTANCE), après quelques heures ou plus d'abstinence, afin d'éviter d'avoir de tels symptômes ?

Vous est-il arrivé de prendre (NOMMER DES SUBSTANCES DE LA MÊME CLASSE QUE LE PSYCHOTROPE EN QUESTION), lorsque vous éprouviez (ÉNUMÉRER LES SYMPTÔMES DE SEVRAGE RESSENTIS PAR LE SUJET) afin de vous sentir mieux ?

(2) sevrage, se manifestant soit par (a), soit par (b) :	SÉD., HYPN., ANXIOL.	CANN.	STIM.	OPIAC.	COC.	HAL. ET PCP	POLY	AUTR
(a) le syndrome de sevrage caractéristique de la substance en question	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
(b) la prise de la substance en question (ou d'une substance apparentée) pour éviter ou soulager les symptômes de sevrage.	1	1	1	1	1	1	1	1
	?	?	?	?	?	?	?	?
	E84	E85	E86	E87	E88	E89	E90	E91

? = information inappropriée | 1 = FAUX ou absence du symptôme | 2 = symptôme infraliminaire | 3 = VRAI ou présence du symptôme

LES SYMPTÔMES DE SEVRAGE À DIVERS TYPES DE PSYCHOTROPES (TIRÉS DES CRITÈRES DU DSM-IV)

On trouvera ci-dessous la liste des symptômes de sevrage à diverses classes de psychotropes dont le syndrome de sevrage a été défini. (REMARQUE : On n'a pas défini de syndrome de sevrage au CANNABIS ainsi qu'aux HALLUCINOGÈNES et à la PCP.) Des symptômes de sevrage peuvent se manifester après l'arrêt d'une consommation prolongée d'un psychotrope, en quantités modérées ou fortes, ou encore, par suite d'une diminution de la dose.

SÉDATIFS, HYPNOTIQUES ET ANXIOLYTIQUES

Au moins deux des symptômes suivants, pouvant se manifester entre quelques heures et quelques jours après l'arrêt (ou la diminution) d'une consommation prolongée, à des doses fortes, d'un sédatif, d'un hypnotique ou d'un anxiolytique :

(1) hyperactivité du système neurovégétatif (p.ex., transpiration, tachycardie [pouls supérieur à 100])
(2) augmentation du tremblement des mains
(3) insomnie
(4) nausées et vomissements
(5) illusions ou hallucinations visuelles, tactiles ou auditives transitoires
(6) agitation
(7) anxiété
(8) crises d'épilepsie (grand mal)

STIMULANTS ET COCAÏNE

Dysphorie ET au moins deux des modifications physiologiques suivantes, apparaissant quelques heures ou quelques jours après l'arrêt (ou la diminution) d'une consommation prolongée, à des doses fortes :

(1) fatigue
(2) rêves frappants et pénibles
(3) insomnie ou hypersomnie
(4) augmentation de l'appétit
(5) ralentissement psychomoteur ou agitation

OPIACÉS

Au moins trois des symptômes suivants apparaissant quelques minutes ou quelques jours après l'arrêt (ou la diminution) d'une consommation prolongée (plusieurs semaines au moins) d'un opiacé, à des doses fortes, ou après l'administration d'un antagoniste d'un opiacé (après une période de consommation d'un opiacé) :

(1) dysphorie
(2) nausées ou vomissements
(3) douleurs musculaires
(4) larmoiements ou rhinorrhée
(5) dilatation pupillaire, pilo-érection ou transpiration
(6) diarrhée
(7) bâillements
(8) fièvre
(9) insomnie

QUESTION À POSER AU BESOIN : Quand vous est-il arrivé de (NOMMER LES SYMPTÔMES DE DÉPENDANCE COTÉS "3" – PAGES E.12 À E.15) ? Ces manifestations sont-elles toutes survenues à peu près à la même période?	SÉD., HYPN., ANXIOL.	CANN.	STIM.	OPIAC.	COC.	HAL. ET PCP	POLY	AUTRE
DÉPENDANCE À UN PSYCHOTROPE : Au moins trois symptômes de dépendance sont cotés "3" ET sont survenus pendant une même période de 12 mois.	3	3	3	3	3	3	3	3
	E92	E93	E94	E95	E96	E97	E98	E99
Préciser le type de dépendance :								
– Avec dépendance physique (à l'heure actuelle, le sujet présente des signes de tolérance ou de sevrage)	3	3	3	3	3	3	3	3
– Sans dépendance physique (à l'heure actuelle, le sujet ne présente aucun signe de tolérance ni de sevrage)	1	1	1	1	1	1	1	1
	E100	E101	E102	E103	E104	E105	E106	E107

POUR CHAQUE CLASSE DE PSYCHOTROPE COTÉE "3", PASSER AUX QUESTIONS CONCERNANT LA CHRONOLOGIE, PAGE E.18.

Moins de 3 symptômes de dépendance sont cotés "3".	1	1	1	1	1	1	1	1
	E108	E109	E110	E111	E112	E113	E114	E115

POUR CHAQUE CLASSE DE PSYCHOTROPE COTÉE "1" CI-DESSUS, PASSER À LA PAGE E.21, ABUS DE PSYCHOTROPES (PASSÉ OU PRÉSENT) ET POSER LES 4 QUESTIONS RELATIVES À L'ABUS.

CHRONOLOGIE DE LA DÉPENDANCE

DANS LE DOUTE : Avez-vous pris (NOMMER LA SUBSTANCE), au cours des 6 derniers mois ?

SI OUI : Le fait de prendre (NOMMER LA SUBSTANCE) vous a-t-il causé des ennuis?

Vous est-il arrivé d'être dans un état euphorique au travail ou à l'école ou alors que vous preniez soin d'un enfant ? Vous est-il arrivé de manquer quelque chose d'important parce que vous étiez dans un état euphorique ou en train de vous remettre d'une intoxication ? Vous est-il arrivé de conduire en prenant (NOMMER LA SUBSTANCE) ? Avez-vous eu des ennuis avec la justice à cause de vos habitudes de consommation de (NOMMER LA SUBSTANCE) ?

REMARQUE : IL SE PEUT QUE VOUS AYEZ À CONSULTER LES CRITÈRES D'ABUS À LA PAGE E.21.	SÉD., HYPN., ANXIOL.	CANN.	STIM.	OPIAC.	COC.	HAL. ET PCP	POLY	AUTRE
Le sujet a répondu à tous les critères de la dépendance au cours des 6 derniers mois (ou n'a pas connu un mois sans symptômes de dépendance ou d'abus depuis la survenue de sa dépendance).	3 E116	3 E117	3 E118	3 E119	3 E120	3 E121	3 E122	3 E123
PRÉCISER LA GRAVITÉ DE L'ÉTAT DE DÉPENDANCE À CHAQUE CLASSE DE PSYCHOTROPE COTÉ "3", À LA PAGE SUIVANTE.								
Le sujet n'a présenté aucun symptôme de dépendance ou d'abus au cours des 6 derniers mois ou répond à une partie des critères, après une période d'un mois sans symptômes.	1 E124	1 E125	1 E126	1 E127	1 E128	1 E129	1 E130	1 E131
POUR CHAQUE CLASSE DE PSYCHOTROPE COTÉ "1", INDIQUER LE TYPE DE RÉMISSION, À LA PAGE E.20.								

COTER LE DEGRÉ DE GRAVITÉ DE LA DÉPENDANCE À CHAQUE TYPE DE PSYCHOTROPE AUQUEL LE SUJET EST DÉPENDANT ACTUELLEMENT.

SE SERVIR DE L'ÉCHELLE CI-DESSOUS POUR ÉVALUER LE DEGRÉ DE GRAVITÉ DE LA DÉPENDANCE PENDANT LA PIRE SEMAINE DES 6 DERNIERS MOIS (il sera peut-être nécessaire de poser des questions additionnelles pour connaître les effets du psychotrope sur la vie sociale et professionnelle du sujet).	SÉD., HYPN., ANXIOL.	CANN.	STIM.	OPIAC.	COC.	HAL. ET PCP	POLY	AUTI
	1	1	1	1	1	1	1	1
	2	2	2	2	2	2	2	2
	3	3	3	3	3	3	3	3
	E132	E133	E134	E135	E136	E137	E138	E13

1 Légère : Peu, voire aucun autre symptôme à part ceux requis pour poser le diagnostic; les symptômes n'entraînent qu'une légère incapacité sur le plan professionnel ou dans les activités sociales ou les relations du sujet ave autrui.

2 Moyenne : Les symptômes ou l'incapacité fonctionnelle sont de degré « léger » à « sévère ».

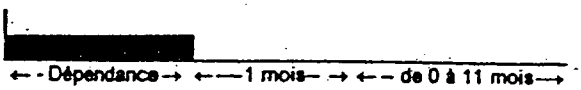
3 Sévère : Il existe beaucoup plus de symptômes que ceux requis pour poser le diagnostic et ces symptômes nuisent grandement aux activités professionnelles ou sociales habituelles du sujet ou encore à ses relations avec autrui.

DÉPENDANCE — TYPES DE RÉMISSION

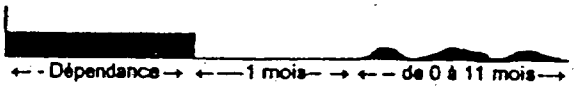
DÉTERMINER LE TYPE DE RÉMISSION UNIQUEMENT SI, À UN MOMENT OU À UN AUTRE DANS LE PASSÉ, LE SUJET N'A RÉPONDU À AUCUN CRITÈRE DE DÉPENDANCE OU D'ABUS PENDANT AU MOINS UN MOIS.

Remarque : On ne doit pas préciser le type de rémission si le sujet suit un traitement de substitution ou s'il vit en milieu supervisé (*voir la définition de ces termes en page E.5*).

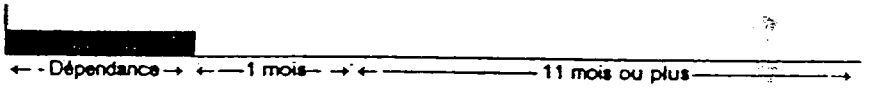
1 Rémission complète au stade précoce : Le sujet n'a répondu à aucun critère de dépendance ou d'abus pendant au moins un mois, mais moins de 12 mois.



2 Rémission partielle au stade précoce : Le sujet a répondu à au moins un critère de dépendance ou d'abus pendant au moins un mois, mais moins de 12 mois (sans répondre au nombre de critères nécessaires pour poser un diagnostic de dépendance).



3 Rémission complète et soutenue : Le sujet n'a répondu à aucun critère de dépendance ni d'abus pendant une période de 12 mois ou plus.



4 Rémission partielle et soutenue : Pendant une période de 12 mois ou plus, le sujet n'a pas répondu au nombre de critères requis pour poser un diagnostic de dépendance ou d'abus; cependant, il a répondu à au moins un de ces critères.

PRÉCISER LE TYPE DE RÉMISSION AU MOYEN DE L'ÉCHELLE CI-DESSOUS.	SÉD., HYPN., ANXIOL.	CANN.	STIM.	OPIAC.	COC.	HAL. ET PCP	POLY	AUTRE
Rémission complète au stade précoce :	1	1	1	1	1	1	1	1
Rémission partielle au stade précoce :	2	2	2	2	2	2	2	2
Rémission complète et soutenue :	3	3	3	3	3	3	3	3
Rémission partielle et soutenue :	4	4	4	4	4	4	4	4
Cocher si le sujet suit un traitement de substitution (prise d'un agoniste) :	—		—	—	—		—	—
Cocher si le sujet vit dans un milieu supervisé :	—	—	—	—	—	—	—	—
	E140	E141	E142	E143	E144	E145	E146	E147

ABUS DE PSYCHOTROPES (PASSÉ OU PRÉSENT)

⇒ POUR CHAQUE CLASSE DE PSYCHOTROPES COTÉE "2" À LA PAGE E.10 (C'EST-À-DIRE, POUR LES SUBSTANCES CONSOMMÉES MOINS DE 10 FOIS PAR MOIS), COMMENCER LA PRÉSENTE SECTION PAR LA PHRASE SUIVANTE :

Maintenant, je vais vous poser quelques questions précises concernant vos habitudes de consommation de (NOMMER LES SUBSTANCES COTÉES "2").

⇒ POUR CHAQUE CLASSE DE PSYCHOTROPES COTÉE "1", À LA PAGE E.17, POUR LAQUELLE LE SUJET N'A PAS RÉPONDU AUX CRITÈRES DE DÉPENDANCE :

Maintenant, j'aimerais vous poser quelques questions additionnelles concernant vos habitudes de consommation de (NOMMER LES SUBSTANCES COTÉES "3" POUR LESQUELLES LE SUJET N'A PAS RÉPONDU AUX CRITÈRES DE DÉPENDANCE).

CRITÈRES DIAGNOSTIQUES

A. Des habitudes de consommation de psychotropes inappropriées entraînant une détresse ou un handicap marqués sur le plan clinique, comme en témoigne au moins un des symptômes suivants, survenu durant une période de 12 mois :

Après avoir pris (NOMMER LA SUBSTANCE), vous est-il souvent arrivé d'être intoxiqué(e) ou dans un état euphorique ou encore, en train de vous remettre d'une intoxication, à un moment où vous deviez vous occuper de choses importantes, par exemple lorsque vous étiez au travail ou à l'école ou que vous deviez prendre soin d'un enfant ?

SINON : Vous est-il arrivé de manquer quelque chose d'important, par exemple, le travail, l'école ou un rendez-vous parce que vous étiez intoxiqué(e) ou dans un état euphorique ou encore, en train de vous remettre d'une intoxication ?

SI LE SUJET A RÉPONDU OUI AUX DEUX QUESTIONS PRÉCÉDENTES : À quelle fréquence cela vous est-il arrivé ? (À quelle époque et pendant combien de temps ?)

(1) consommation répétée d'un psychotrope rendant le sujet incapable de remplir des obligations importantes au travail, à l'école ou à la maison (p. ex., absences répétées du travail ou rendement médiocre lié à la consommation d'un psychotrope; absences, suspensions ou expulsions de l'école liées à la consommation d'un psychotrope; négligence dans la garde des enfants ou les soins du ménage)	SÉD., HYPN., ANXIOL.	CANN.	STIM.	OPIAC.	COC.	HAL. ET PCP	POLY	AUTRE
	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	E148	E149	E150	E151	E152	E153	E154	E155

? = information inappropriée | 1 = FAUX ou absence du symptôme | 2 = symptôme infraliminaire | 3 = VRAI ou présence du symptôme

Vous est-il déjà arrivé de prendre (NOMMER LA SUBSTANCE) à un moment où il était dangereux de le faire ? (Vous est-il arrivé de conduire après avoir pris (NOMMER LA SUBSTANCE), lorsque vous étiez dans un tel état euphorique que cela comportait certains risques ?)

SI OUI, QUESTION À POSER AU BESOIN : À quelle fréquence cela vous est-il arrivé ? (À quelle époque et pendant combien de temps ?)

	SÉD., HYPN., ANXIOL.	CANN.	STIM.	OPIAC.	COC.	HAL. ET PCP	POLY	AUTRE
(2) consommation répétée d'un psychotrope dans des situations ou celle-ci pourrait s'avérer dangereuse (p.ex., conduite d'un véhicule ou d'une machine)	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	E156	E157	E158	E159	E160	E161	E162	E163

Avez-vous eu des ennuis avec la justice à cause de votre consommation de (NOMMER LA SUBSTANCE) ?

SI OUI, QUESTION À POSER AU BESOIN : À quelle fréquence cela vous est-il arrivé ? (À quelle époque et pendant combien de temps ?)

	SÉD., HYPN., ANXIOL.	CANN.	STIM.	OPIAC.	COC.	HAL. ET PCP	POLY	AUTRE
(3) difficultés répétés avec la justice, liées à la consommation d'un psychotrope (p.ex., arrestations pour inconduite liée à la consommation d'une substance).	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	E164	E165	E166	E167	E168	E169	E170	E171

QUESTION À POSER AU BESOIN : Avez-vous eu des difficultés avec les autres parce que vous preniez (NOMMER LA SUBSTANCE), p.ex., avec des membres de votre famille, des amis, ou des collègues de travail ? (En êtes-vous venu(e) aux coups ou encore, avez-vous eu de violentes querelles verbales concernant le fait que vous preniez de la drogue ?)

SI OUI : Avez-vous quand même continué à prendre (NOMMER LA SUBSTANCE) ? (À quelle époque et pendant combien de temps ?)

	SÉD., HYPN., ANXIOL.	CANN.	STIM.	OPIAC.	COC.	HAL. ET PCP	POLY	AUTRE
(4) poursuite de la consommation du psychotrope malgré les problèmes sociaux ou personnels persistants ou fréquents causés ou exacerbés par la substance (p.ex., querelles avec le conjoint au sujet des conséquences de l'intoxication, violence physique)	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	E172	E173	E174	E175	E176	E177	E178	E179

	SÉD., HYPN., ANXIOL.	CANN.	STIM.	OPIAC.	COC.	HAL. ET PCP	POLY	AUTR
ABUS DE PSYCHOTROPES (PASSÉ OU PRÉSENT) :	3	3	3	3	3	3	3	3
Au moins un des items de "A" est coté "3".	1	1	1	1	1	1	1	1
	E180	E181	E182	E183	E184	E185	E186	E187

POUR LES CLASSES DE PSYCHOTROPES AYANT FAIT L'OBJET D'UN ABUS PASSÉ OU PRÉSENT (C'EST-À-DIRE COTÉES "3" À LA QUESTION PRÉCÉDENTE) :	SÉD., HYPN., ANXIOL.	CANN.	STIM.	OPIAC.	COC.	HAL. ET PCP	POLY	AUTRE
Le sujet a éprouvé des symptômes d'abus de la substance au cours des 6 derniers mois.	3	3	3	3	3	3	3	3
DANS LE DOUTE : À quand remontent les dernières difficultés éprouvées en ce qui concerne votre prise de (NOMMER LA SUBSTANCE) ?	1	1	1	1	1	1	1	1
	E188	E189	E190	E191	E192	E193	E194	E195

? = information inappropriée | 1 = FAUX ou absence du symptôme | 2 = symptôme infraliminaire | 3 = VRAI ou présence du symptôme

Sédatifs, hypnotiques et anxiolytiques ("*downers*")

Quaalude ("*ludes*"), Seconal ("*reds*"), Valium, Xanax, Librium, barbituriques, Miltown, Ativan, Dalmane, Halcion, Restoril

Cannabis

Marijuana, haschisch ("hasch"), THC, "pot", herbe, mari, joint

Stimulants ("*uppers*")

Amphétamine, "*speed*", méthamphétamine ("*crystal*", "*ice*"), Dexedrine, Ritalin, anorexigènes ("coupe-faim", pilules pour maigrir)

Opiacés

Héroïne, morphine, opium, méthadone, Darvon, codéine, Percodan, Demerol, Dilaudid

Cocaïne

Par prise intranasale ou i.v., "*freebase*", crack, "*speedball*"

Hallucinogènes (psychédéliques)

LSD (acide), mescaline, peyotl, psilocybine, DOM (diméthoxyméthylamphétamine ou "STP"), champignons, ecstasy, MDA

PCP

Phencyclidine, poudre d'ange

Autres

Stéroïdes anabolisants, "colle", chlorure d'éthyle (fréon), solvants pour peinture, solvants volatils, oxyde nitreux (gaz hilarant), nitrite d'amyle ("*popper*"), somnifères (pilules pour dormir) et anorexigènes (pilules pour maigrir) en vente libre

Appendix J: Reasons for Depression Questionnaire

Questionnaire sur les raisons de déprime

Pour chaque phrase, veuillez indiquer à quel point cela constitue (ou constituait à un moment donné) pour vous une raison d'être déprimé(e) en vous servant de l'échelle suivante:

1 = certainement pas une raison
2 = probablement pas une raison
3 = probablement une raison
4 = certainement une raison

JE ME SENS (ME SUIS SENTI/E) DÉPRIMÉ(E) PARCE QUE ....

1. je vois le monde tel qu'il est vraiment 1 2 3 4
2. je ne peux pas accomplir ce que je veux 1 2 3 4
3. je ne me sens pas aimé(e) 1 2 3 4
4. je suis tout simplement ce genre de personne 1 2 3 4
5. personne ne se soucie vraiment de moi 1 2 3 4
6. je ne peux pas décider quoi faire de ma vie 1 2 3 4
7. c'est comme ça que j'ai appris à être 1 2 3 4
8. je n'ai pas réglé certains problèmes avec ma famille 1 2 3 4
9. je pense à des choses de façon déprimante 1 2 3 4
10. personne ne me comprend vraiment 1 2 3 4
11. ma famille ne m'a pas bien traité(e) quand j'étais enfant 1 2 3 4
12. mon/ma conjoint(e) ne me traite pas bien 1 2 3 4
13. je ne suis pas devenu(e) ce que je voulais devenir 1 2 3 4
14. les autres m'isolent, me mettent à l'écart 1 2 3 4
15. certaines choses me sont arrivées pendant l'enfance 1 2 3 4

Questionnaire sur les raisons de déprime(suite)

1 = certainement pas une raison
2 = probablement pas une raison
3 = probablement une raison
4 = certainement une raison

JE ME SENS (ME SUIS SENTI/E) DÉPRIMÉ(E) PARCE QUE ....

16. je n'ai rien fait d'important dans la vie 1 2 3 4
17. les autres me critiquent 1 2 3 4
18. je ne suis pas à la hauteur de mes propres critères 1 2 3 4
19. je choisis de me sentir déprimé(e) 1 2 3 4
20. je n'ai pas réglé certaines choses qui sont arrivées pendant mon enfance 1 2 3 4
21. je n'ai personne avec qui partager mes pensées et sentiments intimes 1 2 3 4
22. j'ai eu une enfance difficile 1 2 3 4
23. je ne suis pas suffisamment actif/active 1 2 3 4
24. je ne prends pas soin de moi physiquement 1 2 3 4
25. j'ai un déséquilibre chimique 1 2 3 4
26. je suis pessimiste 1 2 3 4
27. j'ai hérité ça de mes parents 1 2 3 4
28. c'est une maladie biologique 1 2 3 4
29. je ne mange pas assez bien 1 2 3 4
30. je ne réalise pas mon plein potentiel 1 2 3 4
31. les autres ne m'aiment pas 1 2 3 4
32. je ne sais pas qui je suis, ce que je signifie 1 2 3 4

Questionnaire sur les raisons de déprime(suite)

1 = certainement pas une raison
2 = probablement pas une raison
3 = probablement une raison
4 = certainement une raison

JE ME SENS (ME SUIS SENTI/E) DÉPRIMÉ(E) PARCE QUE ....

33. je ne fais pas assez d'exercice 1 2 3 4

34. j'ai toujours été comme ça 1 2 3 4

35. mon système nerveux est tout simplement fait comme ça 1 2 3 4

36. je n'ai pas réussi à atteindre un but précis que je m'étais fixé 1 2 3 4

37. je n'arrive pas à me faire des ami(e)s 1 2 3 4

38. je n'arrive pas à faire des choses que je devrais pouvoir faire 1 2 3 4

39. je ne me suis jamais fixé de buts précis dans la vie 1 2 3 4

40. les gens me traitent mal 1 2 3 4

41. je n'ai pas le respect qu'on me doit 1 2 3 4

42. c'est comme ça que je réagis quand ça va mal 1 2 3 4

43. dans le fond, c'est génétique 1 2 3 4

44. ma vie est bloquée où je suis, rien ne change jamais 1 2 3 4

45. dans ma vie, je fais plus attention aux mauvaises choses qu'aux bonnes 1 2 3 4

46. je suis coincé(e) dans un mauvais mariage/
une mauvaise relation amoureuse 1 2 3 4

47. mon/ma conjoint(e) ne me comprend pas 1 2 3 4

48. je ne suis pas bon(ne) pour exprimer mes sentiments intimes 1 2 3 4