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Pathways to Adult Depression from Childhood Aggression and Withdrawal

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Abstract

Pathways to adult depression from childhood aggression and withdrawal

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Structural equation modeling was used to examine pathways from aggression and social withdrawal in childhood to depression and to externalizing and internalizing behaviours in adulthood. It was hypothesized that children's aggression and withdrawal are influenced by early family environment and create enduring negative person/environment relations which lead to an increased risk of early depression and stress over time. Stress and previous depressive episodes, in turn, increase the risk of adult depression. It was further hypothesized that aggression and withdrawal in childhood are related to externalizing and internalizing behaviours in adulthood, which are also related to adult depression. The sample was drawn from the Concordia Longitudinal Risk Project and comprised 146 participants. Peer ratings of aggression and withdrawal were collected when participants were in grades 1,4 or 7 in 1978. Assessments of adolescent depression, negative life experiences, adult depression and adult aggression and withdrawal were made over a period spanning 23 years. Findings showed that negative family environment was related to aggression but not to withdrawal in childhood. A direct path led from childhood aggression to adult depression, whereas the pathway from childhood withdrawal to adult depression was mediated by adolescent depression and negative life experiences. Childhood aggression and adult externalizing behaviour were not related, but childhood and adult withdrawal were linked via adolescent depression and negative life experiences. Adult depression and adult aggression and withdrawal were unrelated. The implications of these findings are discussed, particularly the idea that contrasting behaviour styles in childhood can lead to similar clinical outcomes in adulthood.

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Diverse areas of research have shown that the risk of depression increases with the negative qualities of an individual's experience. Depression has been linked to early adversity and prolonged exposure to stress in both humans and animals (Anisman & Zacharko, 1992; Heim, Owens, Plotsky & Nemeroff, 1997a; Willner, 1995). Studies examining depression in individuals who experienced abuse (Browne & Finkelhor, 1986), poverty (McLeod & Shanahan, 1996), or chronic illness (Bennett, 1994) in childhood, for example, have related greater levels of adversity to greater levels of problematic functioning across the life course. Together, these studies underscore both the multiplicity of factors potentially involved in the development of depression and the idea that the influence of any given factor is multidirectional. The negative effects of poverty, for example, are not limited to the area of physical health, but also concern emotional, social, and occupational factors. Over time, the compounding effects of numerous stressors in an environment of poverty may influence most spheres of an individual's life. Long-term outcomes, including depression, may reflect far more than a series of discrete deprivations.

Analogous to circumstances of poverty, prolonged negative person/environment relations occurring as a function of maladaptive individual characteristics may have discernible direct effects and also create diffuse adverse conditions that substantially influence an individual's life course. Despite the contrasting behaviours associated with childhood aggression and social withdrawal, longitudinal research has targeted both as behavioural precursors of problematic adult functioning in numerous domains. High levels of childhood aggression and withdrawal not only evoke negative person/environment interactions but also increase the likelihood of long-term problematic outcomes, including the exacerbation of existing adverse circumstances (Caspi, Elder & Bem, 1987; Little & Garber 1995; Rubin, 1993).

The focus of the present study is the examination of trajectories to depressive symptoms reported by individuals who demonstrated varying levels of aggressive and

withdrawn behaviour in their school environments as children. Children who show high levels of aggression and social withdrawal may readily sustain negative relations with their environment, producing what Caspi and Elder have termed patterns of cumulative and interactional continuity (e.g., Caspi & Elder, 1988). Cumulative continuity refers to the process whereby the outcomes of maladaptive behaviours lead to increasingly limiting contexts within which individuals can evolve. The resulting restricted and suboptimal environments tend to reinforce the very behaviour that led to the initial unfavourable environment selection. The complementary concept of interactional continuity describes the repetitive back-and-forth between individual and environment that persists in a given way over time. Behaviours that elicit responses with short-term benefits, no matter how socially dysfunctional, are not replaced even when evoked responses become decreasingly favourable. The socially dysfunctional behaviour persists in good part because of a failure to experience and learn alternative forms of interaction.

The presence of aggression or social withdrawal in childhood, however, does not necessarily result in repeated negative relational experiences. It is their persistence over time and the severity of these behaviours that may initiate processes of cumulative and interactional continuity. For example, it has been noted that aggressive behaviour is frequent in many children, especially during their preschool years, but in the majority of cases it subsides over the course of childhood (Cairns & Cairns, 1994; Frick, 1998). This suggests that most children who have bouts of aggressive behaviour do not enter into a negative interactional process persistent enough to become self-perpetuating. For some, however, patterns of behaviour that often elicit negative responses from others do become entrenched and may have a substantial influence on the life course.

The model of trajectories to depression proposed here is grounded in the theory of cumulative and interactional continuity and draws also from empirical findings concerning both the relative stability of early behaviours and the recurrent nature of depressive symptoms. Tracing the pathways from childhood through to adulthood, it is suggested that

the more pronounced the early aggressive and withdrawn behaviour, the more likely individuals are to have repeated problematic experiences in numerous domains of their lives. The prolongation of stress occurring as a result of negative person/environment relations is expected to be linked with manifestations of depressive symptoms, which in turn increase the risk of a recurrence of depression. The risk of depressive symptomatology in adulthood is further heightened with the accumulation of negative experiences.

In the sections that follow, definitions and descriptions of aggression, withdrawal, and depression, and of family characteristics that may influence the expression of aggression and withdrawal in childhood are reviewed. The review continues with research pertaining to the life course patterns of aggression and withdrawal and to ways in which they may be linked to the development of negative person/environment relations. Finally, findings concerning stress and depression, and the links between aggression, withdrawal and depression are considered.

Aggression

Aggression typically refers to behaviours that are intended to cause or threaten harm in either verbal or physical form (e.g., Eron, 1997). The inclusion of harmful intent in the definition of aggression is not agreed upon by all authors, however. Loeber and Hay (1997), for example, argue that because intentions are not observable and are often denied by those who commit aggressive acts, postulated intent does not necessarily clarify the meaning of aggression. These reservations notwithstanding, the idea of harmful intent serves to target individuals who engage aggressive acts designed to inflict harm.

To capture the diversity of aggressive behaviour, consideration of the influence of gender and age is essential. Studies of aggressive behaviour and gender have shown that aggression is frequently expressed differently in males and females. In contrast with physical aggression, the concepts of indirect and relational aggression have been introduced to describe behaviour that is intended to harm another person's social relationships or

standing through mechanisms such as peer exclusion or gossip (Cairns, Cairns, Neckerman, Ferguson & Gariépy, 1989; Crick & Grotpeter, 1995). These behaviours constitute a particularly common expression of aggressive tendencies in females. When both relational and physical forms are included in measurement of aggressive behaviour, comparable levels of aggression have been reported across gender (Crick et al., 1999).

The behavioural expression of aggression evolves as a function of age, which may also be gender dependent. For many individuals, engaging in physical aggression is confined to early childhood. Cairns and Cairns (2000) cite observational studies of children that document a marked decrease in the percentage of aggressive interactions with peers: from 50% at age one to 3%-6% once children reach the age of ten. In addition, there is a shift from direct aggression, such as physical violence, to more indirectly aggressive behaviours with increasing age. Whereas females begin to favour indirect forms of aggression in childhood, males tend to make this shift at a substantially later phase (Cairns, Cairns, Neckerman, Ferguson & Gariépy, 1989). Although the decrease in physical aggression over childhood is normative, an escalation in the use and effects of physical violence and intimidation occurs in a minority of individuals through adolescence (Farrington, 1986, 1994). Adolescent escalation of aggression may be a continuation from earlier behaviours, or it may reflect a late-onset, often adolescence-bound, departure from previous patterns (Moffitt, 1993). Early-onset aggression is frequently linked to more severe and long-lasting forms of aggression, although there is substantial variability amongst individuals (Loeber & Hay, 1997).

Social Withdrawal

Social withdrawal has been described as shyness or inhibition. Rubin and Asendorpf (1993) suggest that social withdrawal is an umbrella term that subsumes both qualities, the essential reference point being the act of engaging in solitary behaviour. Social withdrawal, as a construct, has also included the idea of self-initiated withdrawal away from others and other-initiated neglect or rejection. Rubin and Asendorpf have

argued, however, that social withdrawal and peer-imposed isolation are different processes that should not be confused with one another. Nonetheless, observational studies of children have indicated that the two processes are associated: children who interact rarely with others are also more likely to be rejected by their peers (Rubin & Mills, 1988), especially as they grow older (Younger, Gentile & Burgess, 1993).

Inhibition typically refers to dispositional fearfulness that is particularly evident in novel situations. Marked inhibition becomes manifest by two years of age in 10% to 15% of children (Kagan, Reznick, Clarke, Snidman & Garcia-Coll, 1984) and, at least in early childhood, does not appear to be related to gender (Hetherington & Parke, 1999). Although the physiological and inherited aspects of inhibition have been substantiated by an important body of research (e.g., Kagan, Snidman & Arcus 1993) environmental factors and social learning processes, which include gender role socialization, may move children away from extreme manifestations of inhibition or consolidate the innate biases. Along these lines, Asendorpf (1990) has suggested that social-evaluative concerns become an important factor in inhibition. He found that over the first years of school, children's level of inhibition correlated with their unsuccessful attempts to initiate interactions with classmates, even after fearfulness of unfamiliar persons was taken into account.

Depression

Feelings of sadness and absence of pleasure are the key features of depression. Beyond this primary description, the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, APA, 1994) requires that at least four additional symptoms (e.g., low self-esteem and sleep disturbance) be present for a minimum period of two weeks in order to diagnose a major depressive disorder, along with evidence of significant distress or impaired functioning.

Diagnosis of depression via the DSM-IV is based on a categorical approach that assesses the presence of a set of symptoms, whereas dimensional approaches evaluate the severity of depression according to an additive model of symptoms. Modest to moderate

relations between the two have been found (Jensen et al., 1996), and the degree of comparability remains a subject of debate (Fechner-Bates, Coyne & Schwenk, 1994). However, substantial psychosocial dysfunction and elevated risk for the development of subsequent major depressive disorder have been related to subthreshold levels of depression (Lewinsohn, Solomon, Seeley, & Zeiss, 2000; Maier, Gänsicke. & Weiffenbach, 1997). Recent studies that lend support to a continuous, rather than a discrete model of depression (Flett, Vredenburg & Krames, 1997; Ruscio & Ruscio, 2000) also provide support for the relevance of subthreshold depression.

Although depressive symptoms may be traced to clear causes in some instances, the development of depression is best situated within a genetic/environmental model. In a study highlighting the joint contribution of genetics and environmental factors, Kendler et al. (1995) found that monozygotic twins were more likely than dizygotic twins to develop depression if one twin had already been diagnosed with an affective disorder, dizygotic twins were at greater risk than non-twin siblings, and the development of depression following the experience of a life stressor was more likely in individuals whose twin had already experienced a depressive episode. Participants in this study were female, and, while gender does not appear to be a moderating factor in childhood, by mid-adolescence females become twice as likely as males to develop a depressive disorder (Nolen-Hoeksema & Girgus, 1994). Lifetime prevalence rates for major depressive disorder in the general population are between 10% and 25% for women and 5% and 12% for men (APA, 1994).

Family Characteristics and the Expression of Aggression and Withdrawal in Childhood

Inhibition, as noted above, appears to have a strong genetic component, and genetics also play a role in the development of aggression, as suggested by twin and adoption studies (e.g., Carey, 1996). However, genetic factors, although acknowledged, were not examined in the present study. The influence of the family environment on children's behaviour has also been widely demonstrated. Clearly, the family environment

involves a multiplicity of factors that may be inextricably interrelated, such as parenting characteristics (see the meta-analysis by Rothbaum & Weisz, 1994) and parental psychopathology (Campbell, March, Pierce, Ewing & Szumowski, 1991; Engfer, 1993). Three components of the family environment are considered here as factors representing the numerous intercorrelated sources of influence that have a bearing on children's problematic behaviour.

Substantial evidence has linked family socioeconomic status to children's and adolescents' aggressive and antisocial behaviour (Farrington, 1994; Loeber, Farrington, Stouthamer-Loeber & Van Kammen, 1998; McLeod & Shanahan, 1996; Offord, Boyle & Racine, 1991). Increased stress due to an array of related factors such as interparental conflict, poor housing (also related to social withdrawal in Loeber et al., 1996), and difficult employment conditions likely account for a significant proportion of the association between socioeconomic status and children's acting-out behaviours. Rowe (1993), as do others, also notes that socioeconomic status cannot, in fact, be completely separated from genetic factors that contribute, for example, to an individual's educational attainment. Nonetheless, whether it is possible to state specifically what is measured by socioeconomic status does not alter its well-documented relationship with childhood behaviour.

The often negative impact on children's behaviour of single parenting has also been supported by extensive research (e.g., Hetherington, Bridges & Insabella, 1998; Workman & Beer, 1992). It is likely that the frequently ensuing reduction in socioeconomic status, increase in associated stressors and parental emotional distress are partly responsible for these findings. The presence of marital discord prior to and following separation and divorce has been related to both externalizing and internalizing behaviour in children (Harrist & Ainslie, 1998; Portes, Howell, Brown, Eichenberger & Mas, 1992).

Finally, the number of siblings in a family may create environmental restrictions that affect children's behaviour. Economic strain and decreased parental availability may

become problematic as a result of large family size. The number of siblings has been related to both aggressive and withdrawn behaviours in children (Klonsky, Dutton & Liebel, 1990; Loeber et al., 1996).

Longitudinal Patterns of Aggression and Withdrawal

The salience of aggressive behaviours and their cost to society have resulted in extensive research on the long-term patterns of aggression. More recently, the long-term outcomes of social withdrawal in childhood have also become a focus of interest (e.g., the Concordia Longitudinal Risk Project, 1976; the Waterloo Longitudinal Project, 1980). In considering patterns of behaviour over time, the question of continuity and stability arises. Caprara and Cervone (2000) caution that the distinction between these terms "cannot be other than arbitrary and provisional" (p. 145) until consensus on their definitions has been attained. For the purposes of this discussion, stability refers to the maintenance in degree of a psychological quality in an individual relative to other individuals, rather than an absolute maintenance of degree; continuity refers to the enduring presence of a quality, allowing for modifications in the form of its manifestation over time. As such, it is recognized that psychological and behavioural qualities may persist while nonetheless evolving across the life course.

Aggression Over Time

Since Olweus' (1979) important review of studies indicating the diachronic stability of aggression, longitudinal research has continued to corroborate these findings. Overall, in relation to others, individuals with higher levels of aggressive behaviours at one point tend to maintain higher levels at later points (e.g., Moscowitz, Schwartzman & Ledingham 1985; Pollack, Gilmore, Stewart & Mattison, 1989). A finding of particular relevance to the present study that emerges from a review of the recent literature is the substantial interindividual variability in stability over time, however. More specifically, it is the

individuals at the extremes of the aggression continuum who tend to show the greatest rates of stability.

Short-term longitudinal studies examine repeated measures of aggression over a limited period and are particularly pertinent during childhood and adolescence when rapid change is occurring. A fairly consistent finding is that the closer together in time that measurements are taken, the greater the correlation between them (e.g., Chess & Thomas, 1990) and the more likely individuals are to retain similar relative positions (Cairns & Cairns, 2000). Moderate to high stability of aggression using various measures was found in children between the ages of 2 and 5 by Cummings, Iannotti and Zahn-Waxler (1989). Although the overall tendency across children was a decrease in all forms of aggressive behaviour, individual differences were maintained over time. These and other authors have found that early stability is particularly robust for boys (e.g., Keenan, Shaw, Delliquadri, Giovanelli & Walsh, 1998), although findings concerning gender differences are not consistent in childhood. Dumas, Neese, Prinz & Blechman (1996), for example, reported no gender differences in stability and change of aggressive behaviour in elementary-school children over an 8-month period. Similarly, in their examination of cross-contextual stability of aggression, Dubow and Reid (1994) found that an assessment of aggressive behaviour in three, but not fewer, settings was predictive of aggression two years later for both boys and girls. Together, these studies suggest both moderate stability and continuity of aggression in early through middle childhood.

Short-term longitudinal studies are of undeniable value, but they provide necessarily limited insight into possible compounding effects of aggressive behaviour over time. Long-term longitudinal studies represent a considerable investment in time and funding, and increase the risk of attrition. They also provide an outstanding opportunity to trace individual and group life-course trajectories, and to evaluate whether and how early manifestations of aggression constitute a risk factor for later problems. Numerous studies have followed individuals from childhood through adolescence and into maturity, often

with substantial sample sizes. In examining such studies, though, it is useful to recall Cairns et al.'s (1989) cautioning against the failure to consider developmental change in the behavioural expression of aggression when assessing stability over time, particularly with regard to gender differences. These authors have argued that stability assessed via correlational methods may not best depict longitudinal patterns. Bearing this in mind, research employing various statistical procedures has indicated that the stability of aggression increases as a function of age (Huesmann, Eron, Lefkowitz & Walder, 1984; Loeber & Hay, 1997).

Cairns et al. (1989) evaluated aggressive behaviour in children from grade 4 through grade 9 and found that individual differences in aggression remained stable over the 6 years. An analysis of the factor structure of aggression for boys and girls revealed the importance of girls' developmental shift towards greater use of indirect forms of aggression between childhood and adolescence. Also, despite boys' higher levels of physical fighting and the increase in potential resultant harm, overall mean scores reflected a substantial drop in fighting in boys over the course of the study. Over a similar time span, Haapasalo and Tremblay (1994) examined the relation between levels of fighting and engagement in delinquent acts. Stability of fighting was positively correlated with delinquency, although those boys who also reported low levels of punishment by their parents were somewhat buffered from engaging in delinquent behaviour. The authors suggest that punishment, or perception thereof, may differentially affect children who are more or less aggressive. While this is a plausible interpretation, it is possible that punishment, as a form of parent-child interaction, also exemplifies an overall relationship. A high level of parental punishment may correspond to other negative parent-child dynamics, which reflect characteristics of the child, the parent, and the child and parent together. The association between a child's high level of physical fighting and his parents' high use of punishment will likely engage the processes of cumulative and interactional continuity cited above. The

relationship illustrates the idea of maintenance of adverse person/environment relations associated with an ongoing aggressive style.

The consistency of findings regarding stability of aggression extends to studies following children into adulthood. Both Pulkkinen and Pitkänen (1993) in Jyväskylä, Finland and Huesmann et al. (1984) in New York, for example, have demonstrated moderate stability of measures of aggression following children from age 8 into adulthood. The Cambridge Study in Delinquent Development (Farrington, 1989, 1994) has also documented strong correlations between early measures of aggression in boys and antisocial, violent behaviour at age 32. In this study, half of the most aggressive participants at first assessment remained in the most aggressive category at age 32. Of particular interest, Farrington (1991) found that violent and nonviolent frequent offenders were remarkably similar across many characteristics, such as antisocial behaviour. Although it has been argued that violent and nonviolent offenders are qualitatively different (e.g., Loeber & Hay, 1997. define aggression solely in terms of physical harm), the findings from the Cambridge study suggest that underlying similarities increase as does the frequency of aggressive acts. Frequent offenders, whether violent or nonviolent, may have evolved a generally hostile pattern of interaction with their environments. The targeted outcomes studied by Farrington, soccer hooliganism, wife assault, and criminal charges are vivid descriptions in themselves of how aggressive behaviour in childhood may entail prolonged negative relations with the environment.

Withdrawal over time

Evidence for the stability and continuity of withdrawn behaviour is less clear than it is for aggressive behaviour, largely due to the limited amount of research on the subject. Findings from a number of studies do suggest, however, that social withdrawal is moderately stable over time. More specifically, following a pattern similar to aggressive behaviour, some researchers suggest that it is those with the most extreme levels of withdrawal who tend to demonstrate the most consistency in behaviour over time.

Asendorpf (1993) has called inhibition "a temperamental trait par excellence" (p. 274) because it tends to be stable. The study of inhibition has focused on infants and young children, and has been largely influenced by the work of Kagan and colleagues (e.g., Kagan & Moss, 1962). Extreme-group comparisons in short-term longitudinal studies have shown that children rated as most and least inhibited at 21 months of age exhibit corresponding levels of inhibited behaviours at age 4 (Kagan et al., 1984). Whereas some authors have found that significant results are confined to extreme groups (Kagan, Reznick & Gibbons, 1989; Schneider, Richard, Younger, & Freeman, 2000) others have noted moderate stability across the full dimension of inhibition using research designs similar to those employed by Kagan's group (e.g., Cherny, Fulker, Corley, Plomin & DeFries, 1994). Inhibited behaviours also continue to show moderate stability over longer periods of time. Novosad annd Thoman (1999), for example, found moderate stability on the approach-avoidance dimension of temperament in children rated yearly from age 4 through 11.

Rubin, Hymel and Mills (1989) observed moderate stability of social withdrawal across 2-year intervals between kindergarten and grade 4. Yearly ratings of withdrawal from grade 2 to grade 5 made by peers on the Revised Class Play (Masten, Morison & Pellegrini, 1985) produced higher stability correlations and were also statistically significant across the 3 years. Interestingly, peer and observer ratings correlated only on behaviours denoting what Rubin et al. termed passive (constructive or exploratory play) but not active (sensorimotor and dramatic play) withdrawal. Moscowitz, Schwartzman and Ledingham (1985) also used peer ratings to evaluate the stability of withdrawal, and found that ratings made by children in grade 1 were not significantly related to subsequent ratings, whereas those initially obtained in grades 4 and 7 showed moderate to strong correlations with ratings obtained 3 years later. In addition, one third of the children who had originally received withdrawal ratings placing them at or beyond the 95th percentile retained extreme-group status.

A limited number of studies have followed children assessed on withdrawn behaviours into adolescence and adulthood. Kerr, Lambert, Stattin and Klackenberg-Larsson (1994) examined patterns of inhibition from the first year of life through to age 16. Comparisons between the extremes of the inhibition dimension (10% of the sample at each end) and the middle of the distribution revealed a significant difference in stability for girls, but not for boys, through to age 16. Because similar proportions of males and females were rated as inhibited in a given year, the authors suggest that it is not an unwillingness on mothers' parts to describe sons as inhibited. Rather, they propose that conformity with broader social norms may explain the greater stability of females' inhibition. Gest (1997), unlike Kerr et al., found that stability of inhibition from childhood to late adolescence and early adulthood did not depend on extreme-group status. Inhibition assessed by trained examiners and by peer ratings on the Revised Class Play in children aged 8 to 12 produced robust correlations with self-report questionnaires, interviews, and parental ratings of participants' peer relations 10 years later.

Participants in the Berkeley study (Caspi, Elder & Bem, 1989) who were rated as very shy by their teachers at ages 10 to 12 were more likely to be described similarly at age 30 by psychologists using a Q-sort technique than those rated as moderately or not shy in childhood. Finally, Caspi (2000) discusses findings from the Dunedin study in terms of personality coherence. Participants were evaluated by psychologists on a number of behavioural characteristics including shyness, fearfulness, and task withdrawal, at age 3. A composite of these behaviour ratings was predictive of nonassertive personality styles and of socially withdrawn behaviour at age 21. In this study, the idea of continuity of social withdrawal despite developmental change was highlighted. Caspi's evocation of long-term personality coherence, which concerns both aggressive and withdrawn tendencies, appears to be a cogent reflection of a large body of research.

Given the stability of aggression and withdrawal and the negative person/ environment relations it fosters, an enduring climate of stress is likely to develop along

with an increase in risk of exposure to specific stressful events. Both chronic and acute stressors are associated with the onset of depressive episodes. The next section relates findings concerning stress-related depression.

Relation Between Stress and Depression

The relation between stress and depression has been underscored in various psychosocial theoretical frameworks and is also a focus in neurophysiological research. A review of recent literature reveals the interdependence of the biological and psychosocial domains, drawing attention to the biopsychosocial nature of the depressive disorders. An area of research that is of particular relevance to the present study concerns both the diathesis-stress and what is now termed the stress-diathesis (Plotsky, Owens & Nemeroff, 1998) models of depression.

Cognitive models of depression (e.g., Beck & Weishaar, 1995) center on dysfunctional attitudes and negative attributional styles regarding the self, others, and one's environment as predisposing factors for depression. Under conditions of stress, the tendency to make negative assumptions about one's ability to cope or one's essential worth as a person, for example, may become sufficiently salient to trigger a depressive episode. The interplay of continued negative thoughts and stress may become self-perpetuating. Prospective research in this field first measures the presence of dysfunctional attitudes and negative attributional styles, the diathesis, and subsequently follows participants over time to assess the effect of such attitudes interacting with stressful life events on the development of depression. In their review of studies testing this model, Lewinsohn, Joiner and Rohde (2001) report mixed findings and note only two studies that clearly support the cognitive diathesis-stress model of depression. It is possible that these equivocal findings reflect a missed earlier step that is etiologically relevant. In effect, a *stress*-diathesis model may also be useful when considering long-term processes that lead to depression. Important in this conceptualization of the etiology of depression is the idea of neural plasticity and the recognition of environmental influence on neurological events.

Changes in neural pathways due to the impact of a stressor may produce additional spreading effects. Such neurological change may constitute a diathesis for the production of later depression under renewed experiences of adversity (Post, 1992).

Stress-diathesis models of pathogenesis have been tested principally in animal studies, although they have also received attention in certain areas of human research. The link between physical or sexual abuse in childhood and depressive symptomatology in adolescence and adulthood, for example, has been widely investigated. In a review dealing with the impact of child sexual abuse, Browne and Finkelhor (1986) cite depression in adulthood as the most common psychopathological correlate of early abuse. In their comparison of children who were the targets of physical abuse and children who witnessed violence in the home, Jaffe, Wolfe, Wilso and Zak (1986) found that the two groups displayed comparable levels of depressotypic symptoms, and that both differed from a control group of children who had not had such experiences. Empirical data such as those reported by Browne and Finkelhor are consistent with findings of animal studies that affirm the stress-diathesis model.

Under normal circumstances, a mild stressor activates the hypothalamic-pituitary-adrenal (HPA) axis. This is an adaptive process that triggers the release of corticotropin releasing factor (CRF) and a cascade of hormonal responses; metabolic functioning is thus enhanced for coping with the stressor (LeDoux, 1996). Acute stressors applied in experimental research, for example, result in an increased release of CRF (Heim et al., 1997b), and directly injected CRF produces symptoms in rats that are analogous to human depression and anxiety, such as suppressed exploratory behaviour and reduced feeding (Heim et al., 1997a). Heim and colleagues (1997b) draw attention to the link between the substantial evidence indicating that CRF is over-produced in human depression and the fact that CRF plays a regulatory role in the HPA stress response. In addition, mild or moderate levels of stress prolonged over a period of weeks have also been related to the development of depression-analogous symptoms in rats that may then be reversed by administration of

antidepressant medication (Willner, 1995). Although animal studies demonstrating depression-like behavioural responses to stressors such as pain may not be directly comparable to human responses to psychosocial stress, they serve to affirm the significant role of stress in the development of depression in humans.

The experience of early adversity may have a particularly detrimental effect on psychological health (e.g., Post et al., 1998). At the same time there is ample evidence of the important role of negative life events across the life span in depression. In a review of 29 studies, Paykel (1994) notes that the presence of an increased number of negative life events preceding the onset of depression was reported in every study. Brown, Harris and Hepworth (1994) found that the majority of first depressive episodes in their sample was triggered by an important stressor, and that stressful life events continued to predict subsequent episodes in nonpsychotic depression. Similarly, Hammen, Davila, Brown, Ellicott and Gitlin (1992) found that measures of both chronic and acute negative life experiences were linked to the severity of depressive episodes in their follow-up of previously depressed patients. These authors interpret the interaction between stress and depression as "stress generation," suggesting that depressive responses to stress contribute to the continued experience of stress via resultant processes such as dysfunctional interpersonal relations. Other authors emphasize the decreasing importance of stress for the onset of a depressive episode as a function of the number of previous episodes (Ghaziuddin, Ghaziuddin & Stein, 1990; Kendler, Thornton & Gardner, 2001).

It is clear that the relation between stress and depression is multifaceted. Although not explicitly addressed in the present review, differential reactions to stress, and, indeed, differential perceptions of what constitutes and is experienced as stress undoubtedly play a determining role in the stress/depression relation. Current directions in research show that the questions being asked no longer concern whether stress and depression are related; they focus, rather, on how specific stressors may predict specific depressive symptoms (Levitan et al., 1997; Monroe et al., 2001). The notion that certain personality and behavioural

characteristics may be conducive to creating chronic stressful conditions, which in turn increase the risk of depression, may be difficult to substantiate directly. Empirical data do suggest, however, that higher levels of problematic childhood behaviours, such as aggression and withdrawal, increase the risk of depression. The following section examines these findings.

Aggression, Withdrawal, and Depression

Aggression has been linked with a variety of problematic outcomes, including depression. By contrast, given the wide citation of Achenbach and Edelbrock's clinical findings (e.g., 1981) regarding the relation between both externalizing and internalizing behaviours in childhood and psychosocial maladjustment, the relatively few studies attesting to the connection between internalizing behaviour, such as withdrawal, and psychopathology is noteworthy. A small body of research that does so is emerging, although results remain equivocal. For example, shyness reported at the beginning of the academic year in an undergraduate sample was predictive of depression at the end of the year if social support was also rated as low (Joiner, 1997). Gest (1997) reported that males who were rated as inhibited in childhood demonstrated an increase in emotional distress over time that was significantly different from those rated as uninhibited; inhibition in adulthood was correlated with emotional distress. These findings are similar to those reported by Caspi, Moffitt, Newman & Silva (1998) who found that inhibition ratings at age 3 predicted depression at age 21. Conversely, Nilzon and Palmérus (1998) found that depression at ages 9 through 11 predicted social withdrawal at ages 12 to 14, particularly in boys. Morison and Masten (1991), however, did not find a relation between withdrawn behaviours in elementary-school children and internalizing symptoms at a 7-year follow-up.

Research has also linked both aggression and withdrawal with peer rejection (Bukowski & Newcomb, 1984; Cairns et al., 1989; Coie, Dodge, Terry & Wright, 1991; Rubin, 1993) and all three appear to be implicated in a complex relationship with

depression. This would suggest that children's aggressive or withdrawn behaviour, peer rejection and depression are mutually influential (Little & Garber, 1995). Children who are rejected by their peers are at an increased risk of depression, but children who are depressed are also more likely to be rejected; aggressive and withdrawn behaviours may cause, mediate, or result from both processes. Using a sample of approximately 1200 1st- through 4th-grade students, Volling, MacKinnon-Lewis, Rabiner and Baradaran (1993) found that peer-rejected withdrawn children were most likely to be described by others as unhappy, whereas non-rejected withdrawn children were not characterized in this way. Findings from the Waterloo Longitudinal Project further indicate that by early adolescence passive-withdrawn children, that is, children who are shy and sensitive, are disliked by their peers and that passive withdrawal as such predicts depression (Rubin, 1993; Rubin, Hymel & Mills, 1989). Taking another approach, Hecht, Inderbitzen and Bukowski (1998) examined their subjects' responses to the Children's Depression Inventory (Kovacs, 1981) and concluded that rejected-aggressive and rejected-submissive children and adolescents differentially endorsed depression subscales. Whereas rejected-aggressive subjects scored significantly higher on interpersonal difficulties and feelings of ineffectiveness, the rejected-submissive group scored higher on the anhedonia scale.

Zoccolillo (1992) reviewed all studies published since 1970 concerning the co-occurrence of conduct disorder and emotional disorders (anxiety and depressive disorders) and noted that every study reported a relation between the two. Studies of clinical and community samples have reported similar results (Harrington, Fudge, Rutter, Pickles & Hill, 1991; McConnaughy & Achenbach, 1993). McConnaughy and Skiba (1993) found a 40% concordance rate between the aggressive behavior and anxious/depressed syndromes in cases that met threshold cutoff points in a large sample of children and adolescents who were rated by their parents on the Child Behavior Checklist (Achenbach & Edelbrock, 1983). Evidence of the relation between depression and antisocial personality is less robust in adulthood. In a large epidemiologic study, Robins, Tipp and Pryzbeck (1991) reported

that affective and anxiety disorders were more than twice as likely in adults with antisocial personality disorder. Other research, however, has not replicated these findings (e.g., Cloninger, Bayon & Przybeck, 1997).

The Present Study

The diverse nature of the studies surveyed here emphasizes the fact that direct relations between childhood aggression and withdrawal and the development of depression are not readily apparent. The aim of the present study was to examine whether these linkages were in fact apparent over a time span that has rarely been reported in the research literature. Based on the idea that prolonged negative person/environment relations create or exacerbate stressful life circumstances, and that such circumstances increase the risk of depression, it was hypothesized that:

(1) the family environment contributes to the level of children's aggressive and withdrawn behaviours

(2) higher levels of both aggression and withdrawal in childhood increase the likelihood of depression in adulthood;

(3) the links between childhood aggression and withdrawal and adult depression are strengthened by mediating stressful life experiences including depression in adolescence;

(4) depression in adolescence is related to depression in adulthood.

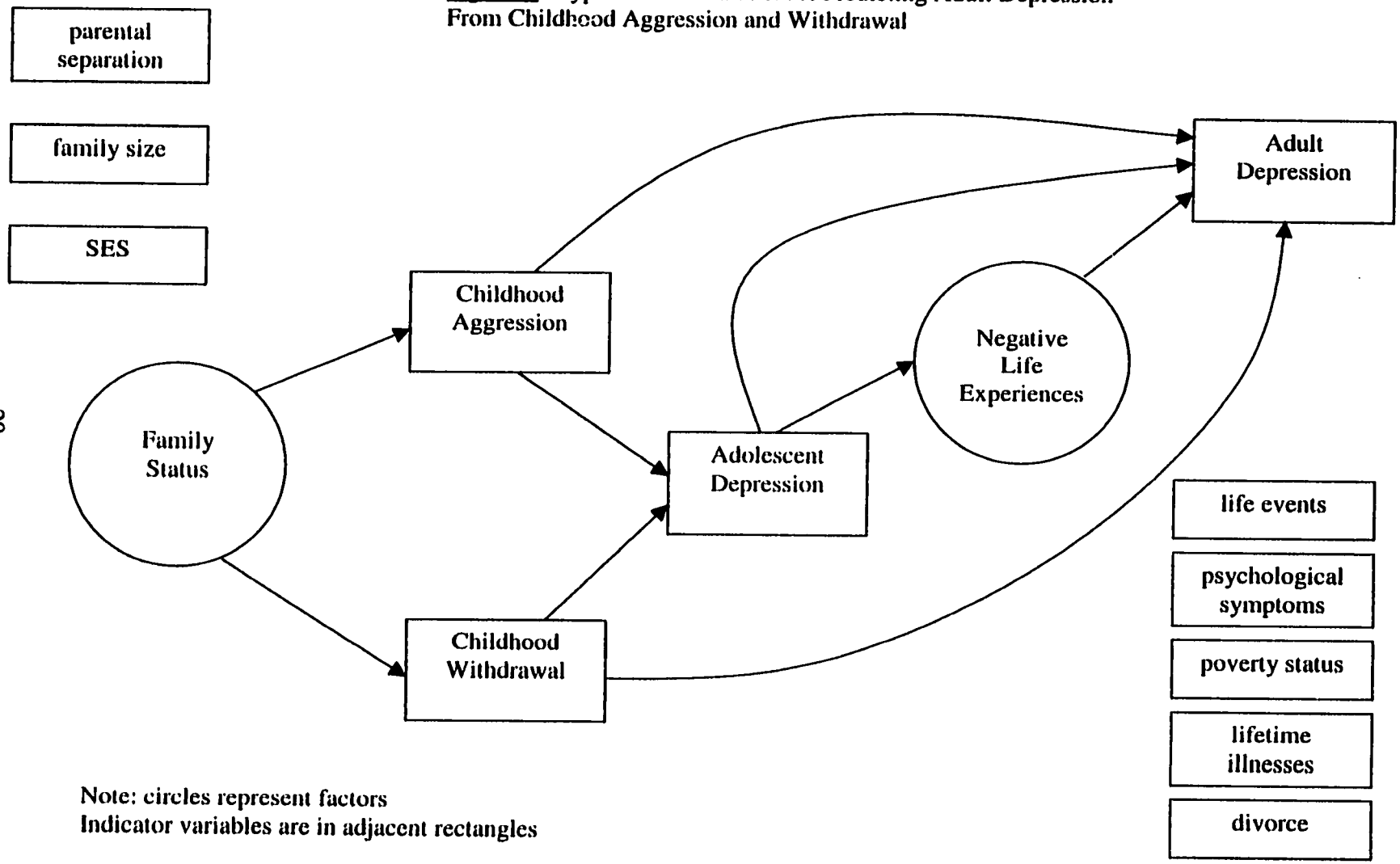
The hypothesized model is presented in Figure 1. It was further hypothesized that:

(5) aggression and withdrawal in childhood are associated with externalizing and internalizing behaviours respectively in adulthood and

(6) adult externalizing and internalizing behaviours are related to adult depression

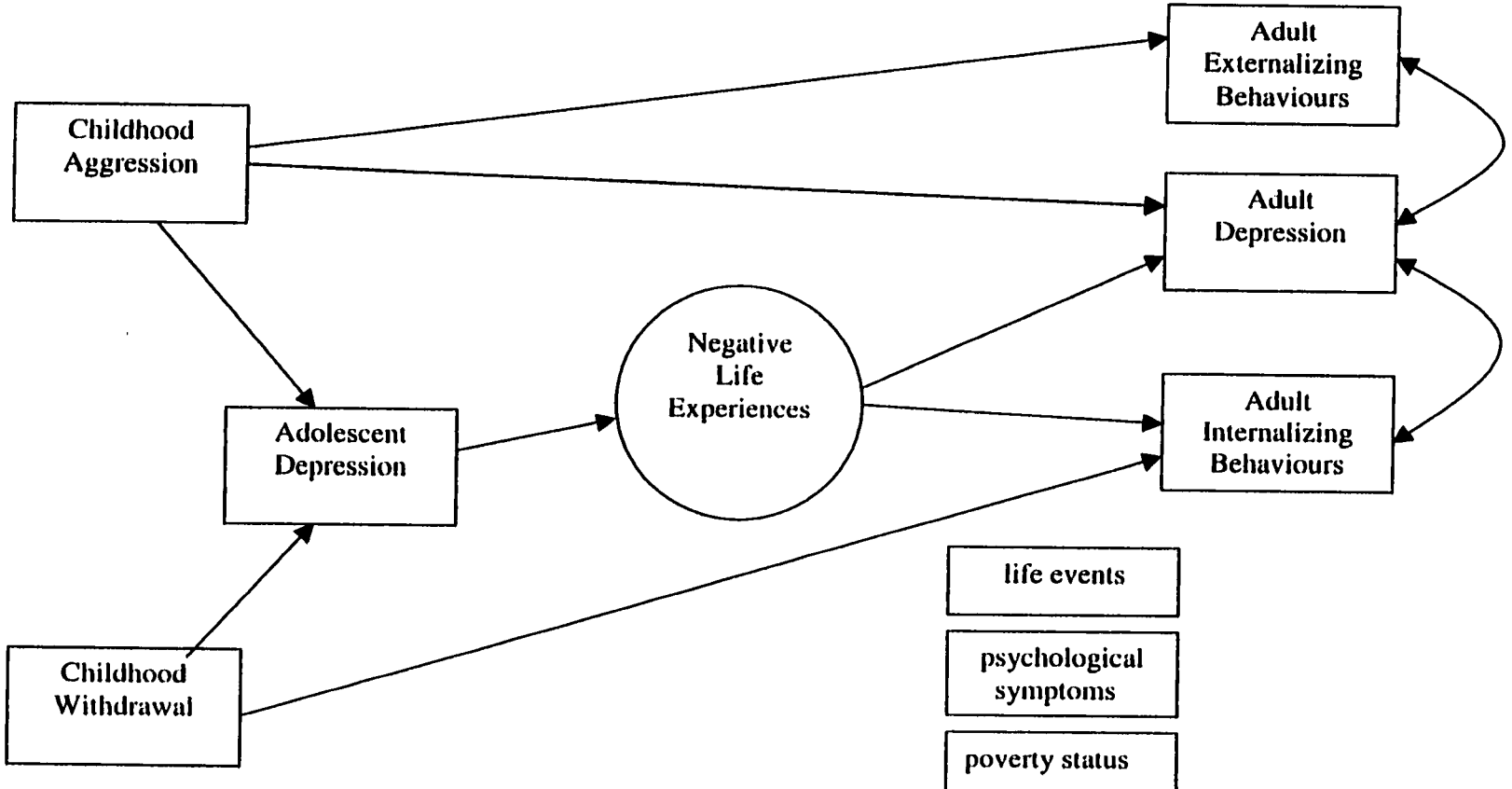
The model depicting this second set of hypotheses is presented in Figure 2.

Figure 1. Hypothesized Path Model Predicting Adult Depression From Childhood Aggression and Withdrawal



Note: circles represent factors
Indicator variables are in adjacent rectangles

Figure 2. Hypothesized Path Model Predicting Adult Depression and Adult Externalizing and Internalizing Behaviours From Childhood Aggression and Withdrawal



Note: Circles represent factors
Indicator variables are in adjacent rectangles

Method

Participants

Participants in this study comprised a subsample of the Concordia High Risk Project's research population. The Concordia High Risk Project is a longitudinal study that was launched in 1976 to follow the life course of individuals at risk for the development of schizophrenia and other psychological disorders. Participants were 1770 French-speaking children from primarily low-income families in Montreal (861 boys, 909 girls), enrolled in grades 1, 4, and 7 at time of selection. Children considered to be at risk for later maladjustment were identified according to the high levels of aggressive or withdrawn behaviour ascribed to them by their peers. Boys and girls were assessed by classmates on separate occasions in order to take age- and gender-specific norms for the dimensions of aggression and withdrawal into account (Schwartzman, Ledingham & Serbin, 1985). Children who received aggression scores at or above the 95th percentile and withdrawal scores below the 75th percentile were identified as aggressive. Those who received withdrawal scores at or above the 95th percentile and aggression scores below the 75th percentile were identified as withdrawn. Children whose aggression and withdrawal scores both fell at or above the 75th percentile were identified as aggressive-withdrawn. while those whose scores on both factors fell below the 75th percentile and above the 25th percentile were identified as control subjects. Ten percent of the sample was identified as aggressive, 13 % as withdrawn, and 14% as aggressive/withdrawn. Control subjects comprised the remaining 63% of the sample.

Participants in the present study were those who completed two measures of depressive symptoms administered since the inception of the High Risk Project. The first of these measures was a behaviour checklist that included depression-related items; it was administered in 1985 to 408 participants (mean age 15.91, SD 2.31). The second was a clinical interview administered to 340 participants beginning in 1999 and ongoing at the time of this study (mean age 32.51, SD 2.34). Attrition across the extended time span of

the study, due to participants' choice to discontinue, excessive distance from the testing location, or death, as well as time constraints, reduced the number of participants available for the second time point. The final sample, therefore, consisted of 146 participants (63 males, 83 females), of whom 15 had been rated as aggressive in childhood, 22 as withdrawn, 18 as aggressive-withdrawn, and 91 as controls. Due to the sample size of the present study dimensional z-scores were used for predictive purposes rather than membership in the original extreme groups. Chi-square analyses indicated that the distribution of this subsample, both in terms of mean aggression and withdrawal z-scores and gender, mirrored the original High Risk population ($p > .05$).

All measures completed by the participants of this study were administered in French. French translation from the original English was effected by bilingual research assistants in the Department of Psychology who compared independent translations and agreed on final wording.

I. Measurement of Family Status

Based on the cumulative stressor model for prediction of later behaviour problems (Rutter, Cox, Tupling, Berger & Yule, 1975; Shaw, Vondra, Dowdell Hommerding, Keenan & Dunn, 1994), a factor was constructed to reflect family characteristics presumed to predate children's aggression and withdrawal. Socioeconomic status of the family was measured by the Household Prestige Scale (Nock & Rossi, 1978, 1979), which assigns a value based on occupational category and educational attainment of both parents. The second variable of interest was parental separation, divorce, or death prior to children's participation in the study. There are several reasons why this variable is of interest in the present study. First, marital discord, preceding separation or divorce, has been linked to children's disruptive behaviour (Amato, 1993). Second, a frequent outcome of separation or divorce, as well as parental death, is adverse economic status; it has been argued that the importance of this outcome is such that it should not be controlled when examining effects, such as increased aggression, on children (Golombok, 1999; Munroe Blum, Boyle &

Offord, 1989). Finally, the number of children in a family has been linked to both aggressive and withdrawn behaviour (Farrington, 1991; Loeber, Farrington, Stouthamer-Loeber & Van Kammen, 1998) and was included in this factor. Results of factor analyses may be found in Appendix B.

II. Measurement of Aggression and Withdrawal in Childhood

Pupil Evaluation Inventory (PEI, Pekarik, Prinz, Liebert, Weintraub & Neale, 1976). The PEI is a 34-item instrument that evaluates children on the dimensions of aggression, withdrawal, and likeability via peer nomination. A subset of 17 items is typically administered to grade-1 children. Items related to aggression refer both to behaviours with evident hostile intent such as "Those who try to get other people into trouble" and "Those who are mean and cruel to other children," and to extraverted, impulsive behaviours such as "Those who play the clown and get others to laugh." The withdrawal dimension includes items that reflect both voluntary social isolation, such as "Those who often don't want to play," and peer-rejection induced isolation, such as "Those who are chosen last to join in group activities" (see for example, Rubin, Hymel & Mills, 1989). Items concerning likeability, such as "Those whom everybody likes," were scored but did not contribute to participant selection. The multiple-informant input and behaviour-specific items of the PEI have generally resulted in high reliability and validity. Schwartzman, Ledingham and Serbin (1985) found high interitem reliability for both genders on the aggression scale (alpha coefficients of .94 -.98) across primary and secondary school students, and similarly high interitem reliability on the withdrawal scale (.86 - .94) for all grades except grade 1 (.65 - .72). Test-retest reliability was moderate for aggression ratings across grades 1, 4, and 7 (.45 - .67) and for withdrawal (.46 - .71), except for those first rated in grade 1 (.35 for boys and .06 for girls).

Information letters and consent forms were sent to parents of children in the target classrooms; parental consent was obtained for all students participating in the study. Administration of the PEI took place in the classroom. Each child completed the inventory

twice, once for girls and once for boys, nominating up to four of his or her classmates for each item. All children received a score on each dimension. See Appendix A for all questionnaires.

III. Measurement of Negative Life Experiences

The following four measures were combined through factor analysis to reflect stressful life experiences. The occurrence of separation and/or divorce of participants across the span of the longitudinal project was also included in this factor.

Statistics Canada Low-Income Cutoff (LICO, Ross, Shillington & Lochead, 1994). The LICO is a measure reflecting socioeconomic status that takes family income, number of individuals living in the household, and population density of the family's place of residence into account. The average proportion of income allocated to essential expenditures (housing, food and clothing) by families in Canada is estimated on a regular basis, and families who spend a significantly greater proportion of their income on such essentials are considered to fall within the low-income bracket. At present, the low-income cutoff point is estimated at 55% of earnings spent on essentials. The sociodemographic questionnaire completed by Concordia Longitudinal Project participants in the 1999-2001 wave of data collection provided the necessary information for calculating a LICO scores. Scores were divided into three categories representing welfare recipients, individuals with paid employment whose family income fell below the low-income cutoff, and individuals whose family income placed them above the low-income cutoff.

Symptom Check List-90-Revised (SCL-90-R, Derogatis, 1977). The SCL-90-R is a self-report checklist of physical and psychological symptoms. Respondents rate to what degree each of the 90 items is applicable to them using a 5-point scale that ranges from "not at all" to "extremely." A global severity index is calculated that combines number and severity of symptoms. The list of symptoms covers the dimensions of somatization, obsessive-compulsive tendencies, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. Internal consistency alpha

coefficients for the symptoms dimensions range from .77 to .90 and test-retest reliabilities range from .78 to .90, indicating good reliability (Derogatis, 1977). The SCL-90 was administered to 438 participants in 1989, during the third major wave of data collection; another sample (n = 431) completed the SCL-90 between 1993 and 1995 in the context of an adjunct project. SCL-90 scores from either one of the two administrations were available for participants in the present study.

Life Experiences Survey (LES, Sarason, Johnson & Siegel, 1978). The LES elicits information regarding common, potentially stressful, life events that have occurred during the previous year. The 47 items of the first section are directed toward respondents from the general population and the 10 in the second section are designed more specifically for students. Participants rate each item on a 7-point scale ranging from "extremely negative" to "extremely positive." This format yields both positive and negative change scores, which may be summed to provide a total change score. Items cover change in areas such as intimate relationships ("Sexual difficulties"), occupation ("New job"), health ("Major change in eating habits"), and finances ("Borrowing more than $10, 000 [buying home, business, etc]"). Test-retest reliability is moderately good. Sarason, Johnson and Siegel note that the test-retest reliability may not be stronger because during the period between testings participants may in fact experience change that is reflected in score changes. Studies have indicated that the negative life change score is related to the experience of psychological distress (Sarason, Johnson & Siegel, 1978). Participants in the Concordia study completed this measure during the third wave of data collection (1988-91).

Health Questionnaire. Participants completed a health questionnaire that was constructed for the purposes of the Concordia project. The health questionnaire requests information concerning the lifetime experience of specific health problems, use of medication, hospitalization and health services. A total past illness score was calculated for inclusion in the factor.

This questionnaire was part of a package that was given to participants to complete at home following their clinical interview in 1999-2001, during the fourth wave of data collection. Also included in the package were the NEO-S (Costa & McCrae, 1989) the Measure of Parenting Style (Parker et al., 1997), the MacArthur Foundation's Childhood Victimization questionnaire, the Conflict Tactics Scales (Strauss, 1979), the Neighborhood Context Questionnaire (Coulton, Korbin & Su, 1996), the Daily Hassles and Uplifts Scale (DeLongis, Folkman & Lazarus, 1988), and the Stress Coping Questionnaire (Parker et al., 1998).

IV. Measurement of Depression

Child Behavior Checklist - Youth Self-Report (YSR, Achenbach & Edelbrock, 1983). Measurement of depressive symptoms in adolescence was obtained from the YSR. The YSR is a widely employed behaviour checklist that assesses externalizing and internalizing problem behaviours for adolescents between the ages of 11 and 18. The checklist comprises 112 items that are rated on a 3-point scale. A 110-item version of the YSR was administered to a subsample of Concordia Project participants. For the present study, a subscale of YSR items related to common depressive symptoms was required. The derivation of a depression scale from the Child Behavior Checklist has been the object of much research. Empirical validation of the parent-report CBCL failed to define a specific depression scale across gender, although a depressed/withdrawn factor was found for girls (Achenbach and Edelbrock, 1983). For the YSR, Achenbach and Edelbrock (1987) derived a depression syndrome that was differentially composed for males and females. In their revised manual of 1991, however, this was replaced by the anxious/depressed syndrome, which has remained in use since. Although pure depression scales have been constructed from YSR items by several authors (e.g., Hepperlin, Stewart & Rey, 1990; Clarke, Lewinsohn, Hops. & Seeley, 1992), the YSR anxious/depressed syndrome was retained for this study because it has strong psychometric properties and has

been replicated with a large sample (Achenbach, Connors, Quay, Verhulst & Howell, 1989).

The YSR yields continuous scores for each subscale and syndrome. However, in order to match the scoring procedure of the adult measure of depression administered subsequently, scores on the anxious/depressed syndrome were transformed into a dichotomous variable. Achenbach (1991) included raw and T-score cutoff points for the anxious/depressed syndrome that separate normal, borderline and clinical threshold response intervals for each gender. Accordingly, T-scores below 12 for males and below 15 for females were adopted to approximate DSM-IV absence of depressive disorder criteria; T-scores of 12 and above for males and 15 and above for females were considered to approximate the combined DSM-IV subthreshold and threshold diagnoses of a depressive disorder. It should be noted that such cutoff points are not equivalent to a DSM-IV diagnosis, but are, rather, intended to reflect levels of distress (see, for example, Gould, Bird & Jaramillo, 1993). Finally, at the time of administration, one item of the scale concerning suicidal tendencies was dropped because it was deemed ethically inappropriate to question a non-clinical sample on this subject. The raw score cutoff was therefore lowered by the two points that are allotted to this item.

The YSR was administered during the second wave of data collection, between 1982 and 1985. Participants (n = 316) were brought to the research lab at Concordia University for a day of testing, and completed the YSR at that time.

Structured Clinical Interview for the DSM-IV, Axis I/Non-patient Version (SCID-I/NP, First, Spitzer, Gibbon & Williams, 1996). Information about level of depressive symptoms in adulthood was gathered using the SCID-IV. The SCID/NP is a semistructured interview that screens for psychological disorders according to DSM-IV Axis I criteria in individuals who have not been identified as psychiatric or medical patients. Diagnosis involves determining if a depressive disorder is present, subthreshold, or absent. Test-retest reliability of the SCID has been evaluated across multiple settings (Williams et

al., 1992). For major diagnostic categories, such as major depressive disorder, the strength of reliability coefficients depends on whether patient or non-patient populations are being assessed. Whereas reliabilities for patient populations are moderately strong, those for non-patient samples are lower, averaging .37 for current diagnoses. Williams and colleagues (1992) have noted, however, that "the reliability of any interviewer-administered instrument is a function of many factors, including the reliability of the diagnostic criteria themselves, the characteristics of the interviewers ..., the study method ..., and the characteristics of the subject sample" (p. 632).

Because this study was concerned with presence of significant depressive symptoms but not necessarily with the clinical diagnosis of a depressive disorder, subthreshold and threshold categories were collapsed. The outcome was thus a present/absent dichotomy. Concordia Project participants (n = 363) were contacted by mail with a demographic update questionnaire and request for participation in the clinical interview during the fourth wave of data collection. The appointment was arranged by telephone and written informed consent was obtained. A trained psychologist conducted the interview at Concordia University or in the participant's home. Participants received a depression "present" score if they reported a depressive episode in adulthood that did not overlap with a threshold anxious/depressed score on the YSR.

V. Measurement of Aggressive and Withdrawn Behaviours in Adulthood

Stress Coping Questionnaire (Parker et al., 1998). The Stress Coping Questionnaire (SCQ) was developed to examine externalizing and internalizing behavioural responses to stress (called "acting out" and "acting in" by Parker et al.). The SCQ includes 21 items; respondents rate each item's likelihood of occurring when they are under stress on a 4-point scale. "Acting out" responses include items such as "Storm around" and "Be reckless (e.g. driving)"; "acting in" responses include items such as "Withdraw from social situations" and "Become very quiet." Parker et al.'s study, conducted with patients in remission from major depressive disorder, indicated that although the majority of

participants reported reacting to common stressors with internalizing behaviours, a sizeable minority used externalizing responses. Furthermore, there was considerable overlap in use of these two forms of behaviour. That is to say, over one quarter of the participants reported that they responded to stressful situations by both "acting out" and "acting in." According to its authors, the SCQ is useful "in studies pursuing the extent to which such broad behavioral responses dispose to a range of psychiatric conditions (especially depression and anxiety)" (p. 347). For the Concordia Project one item was dropped because of its ambiguity. At the time of this study, evaluations of the psychometric properties of the SCQ had not been reported by its authors.

The SCQ was included in a questionnaire package given to study participants following the administration of the SCID-IV as of June 2000 (see above for details). As a result, a number of participants who had already completed all stages of this data collection wave chose not to respond to the request for completion of an additional questionnaire. Participants were asked to complete and return all questionnaires and were paid $50 upon their receipt.

Results

The hypothesized model of pathways to depression in adulthood from aggression and social withdrawal in childhood was analyzed using structural equation modelling. Included in the model is a childhood latent family variable with an expected relationship to children's behaviour. The model continues chronologically from assessment of aggression and withdrawal to an initial measure of depressive symptoms in adolescence, a composite of stress-related measures gathered across early adulthood, and the final outcome of recently assessed depressive symptomatology.

Data Preparation

Over the course of the Concordia High Risk Project, representative subsamples of participants completed different sets of measures for different purposes, thereby limiting the number of participants for whom complete data were available in the present study. Because the criterion for inclusion in this study was availability of scores on both the adolescent and adult measures of depression, mean scores were substituted for missing values on other measures. Missing values occurred on the SCL-90 (12), the LICO (2), the number of siblings (5)[1] and on the Household Prestige Scale (1). A larger number of values (35) was missing from the Stress Coping Questionnaire, which was included in examination of the second hypothesis; deletion of cases with incomplete data records seemed a more reasonable approach under these circumstances. Screening for univariate outliers revealed a small number of outlying cases (between one and two) on the measures of the number of children in the family, the Household Prestige Scale, the family status factor, the Life Events Survey, the past illnesses questionnaire, the negative life experiences factor, and the SCQ. In order to retain all participants, those scores falling more than 3 standard deviations beyond the mean were corrected to this distance. Tests for skewness of the predictor variables indicated that the family status factor, childhood

[1]Note: missing values for number of siblings were replaced by 2, not by the mean (3.2) because a small number of large families resulted in an inflated, nonrepresentative mean.

aggression, childhood withdrawal, adolescent depression, and the negative life experiences factor had positively skewed distributions. Of the skewed variables, the decision was made to transform all but the family status factor and adolescent depression. In these two cases, the presence of skewness was deemed sufficiently representative of the broader population to retain the original distribution. The family status factor was composed of two skewed variables, parental separation and number of children in the family; the remaining indicator variable, the Household Prestige Scale, was not significantly skewed. With regard to the skewed adolescent depression variable, the low number of participants with a score indicating presence of depression in adolescence, and the fact that this variable was scored as a 0-1 dichotomy, resulted in the majority of cases falling below the calculated mean, entailing positive skewness. See Table 1 for a description of the family status factor. Square-root transformations adequately reduced the skewness of all manipulated variables. A Mahalanobis distance analysis revealed no multivariate outliers at $p < .001$.

Hypothesis I

It was hypothesized that as the level of early aggressive and withdrawn behaviours increases, problematic relations between individuals and their environment are at an increased risk of becoming enduring and of leading to depressive symptoms over time.

As a preliminary step, correlations were calculated between all variables to be entered into the path analysis. The matrix, means, and standard deviations of prepared data may be found in Table 2. The differential relations between aggressive and withdrawn behaviours in childhood and the other variables of interest are readily apparent upon examination of the correlation matrix.

Unlike correlational analyses, path analysis is a structural equation modelling technique that simultaneously evaluates relations amongst a set of variables and produces regression coefficients for all specified connections. It is a confirmatory rather than an exploratory technique, because variable selection is grounded in theory (Tabachnick &

Table 1

Indicator Variables of the Family Status Factor

1. Parental Marital Status Prior to 1978

	Frequency	Percent
Separated	22	15.06
Death of parent	2	0.01
Not separated	124	84.93

2. Number of Children Per Family

Number	Frequency	Percent
1	8	5.5
2	55	37.7
3	41	28.1
4	20	13.7
5	12	8.2
6+	10	7.0

3. Mean, Standard Deviation and Range of the Household Prestige Scale

Mean: 431.8 (SD 111.9; range 269.0 - 812.0)

Note. Values are uncorrected for outliers

Table 2

Correlation Matrix for Variables Included in the Path Analysis to Adult Depression, Means and Standard Deviations

Variables	1.	2.	3.	4.	5.	6.
1. Family status	..	.22**	.10	-.03	.16	.02
2. Childhood aggression		..	.00	.04	.11	.22**
3. Childhood withdrawal			..	.20*	.04	.023
4. Adolescent depression				..	.22**	.24**
5. Negative life experiences					..	.33***
6. Adult depression						..
M	-.02	1.53	1.88	.09	1.10	.34
SD	.93	.30	.25	.29	.40	.47

Note. N = 146

*p < .05 **p <.01 ***p<.001

Fidell, 1996). Nevertheless, the processes of building and trimming allow the researcher to test alternative pathways within a given model in order to arrive at an optimal, theory-consistent solution (Kline, 1998). The overall adequacy of the hypothesized model is based on how closely the estimated model matches the observed data. This goodness of fit is evaluated via comparison of the estimated covariance matrix, which is derived from the regression coefficients and the sample covariance matrix. An important aspect of path analysis is that it allows for testing of both direct and indirect pathways between variables. Path analysis was performed with EQS Version 5.7a (Bentler, 1985-1998), and preliminary and additional analyses were done with SPSS 10 (SPSS Inc, 2001).

The longitudinal nature of the data and the desire to model pathways from contrasting behaviours to equifinality determined the choice of path analysis as an appropriate analytical technique. Nonetheless, the size of the available sample called for caution. Structural equation modelling is generally considered to be best suited to large numbers of subjects because the stability of covariances rises with sample size (Tabachnick & Fidell, 1996). Although there is no absolute standard concerning acceptable size, a ratio of one estimated parameter per ten subjects is recommended (Kline, 1998). Accordingly, every effort was made to restrict the number of parameters in the present analysis to obtain an appropriate subjects/parameters ratio. The resulting model is essentially a simplified preview of pathways from early behaviours that lead to later distress. Sample size constraints precluded the incorporation of all relevant variables, and of performing separate analyses by gender.

Model Estimation and Evaluation

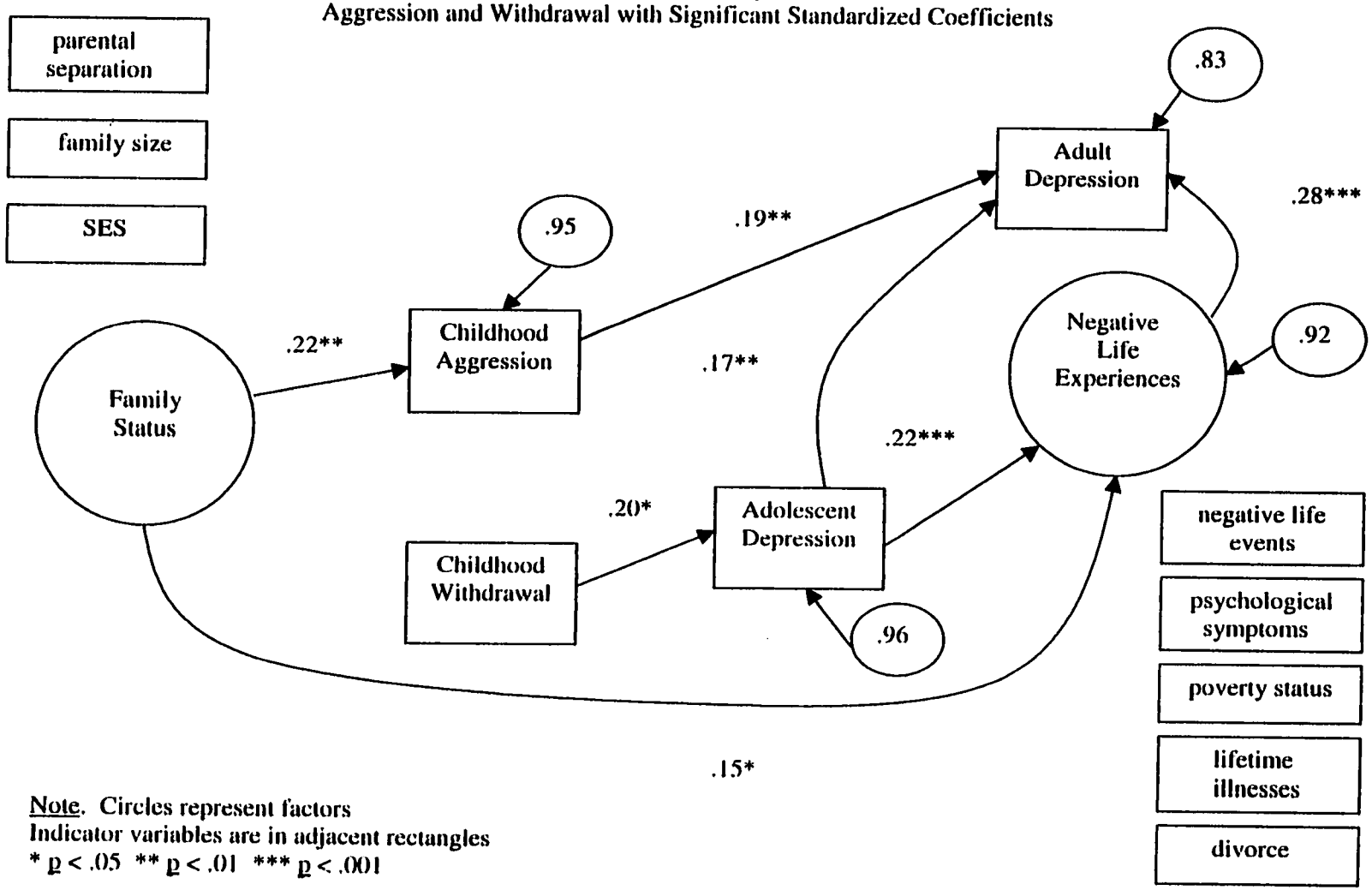
The hypothesized model is recursive by definition because variables were entered along the path in chronological order, reflecting points of measurement. Although the underlying construct may have been ongoing, variables measured at a later date were not assumed to affect variables measured earlier. For example, life stresses during young adulthood were not viewed as affecting childhood withdrawal, even if withdrawn

behaviours continued over time. The hypothesis concerning the association between childhood and adult externalizing and internalizing behaviour was analyzed separately, the results of which are discussed in a later section.

The hypothesized model (see page 20) included pathways from early aggressive and withdrawn behaviours that led both directly and indirectly to adult depression. A robust maximum likelihood procedure was selected for model evaluation with EQS because of the categorical nature of the outcome variable. The resulting overall fit was acceptable. It supported the hypothesis of a pathway from childhood withdrawal to adult depression mediated by depression in adolescence and negative life experiences during young adulthood, and of a direct pathway from aggression in childhood to depression in adulthood. However, the direct path from childhood social withdrawal to adult depression was not significant, nor was the indirect path from childhood aggression to adult depression thereby contravening the hypothesis of similar pathways to depression from contrasting childhood behaviours. In addition, the absence of a pathway between the family status factor and the negative life experiences factor created excessive error within the model. Accordingly, a revised model was tested in which the nonsignificant paths to depression were removed and, because its inclusion was considered to make theoretical sense, a path between the family status and negative life experiences factors was added. Results from this new analysis indicated a model satisfying all criteria for an adequate fit: all standardized residuals fall below 0.10, Satorra-Bentler χ^2 (7, 146) = 2.776, $p > .50$, Bentler-Bonett normed fit index = 0.947, robust comparative fit index = 1.000. Finally, with 14 parameters the parameters/subjects ratio is respected.

The final model is illustrated in Figure 3. It depicts the pathways leading to adult depression as a function of childhood aggression or withdrawal. The model begins with the exogenous family status factor (family size, single parenthood, and socioeconomic status), included in order to reflect the idea that children's behaviour is influenced by their family environment. The associated significant path coefficient leading to childhood

Figure 3. Path Model Predicting Adult Depression From Childhood Aggression and Withdrawal with Significant Standardized Coefficients



Note. Circles represent factors
Indicator variables are in adjacent rectangles
* p < .05 ** p < .01 *** p < .001

aggression ($\beta = .22$, $p = .01$) supports the concept of environmental influence on children's aggressive behaviour, whereas no such relation was found for childhood withdrawal. From here, paths from childhood behaviours to adult depression diverge. Depression in adulthood was directly predicted by childhood aggression ($\beta = .19$, $p = .007$) but not by childhood social withdrawal. Withdrawal in childhood was related to adult depression via a mediated pathway. Withdrawn children were at an increased risk of developing depressive symptoms as adolescents ($\beta = .20$, $p = .02$), and adolescent depression was related to negative life experiences ($\beta = .22$, $p = .001$). In turn, negative life experiences were predictive of depression in adulthood ($\beta = .28$, $p < .000$). In accordance with accepted findings that depressive episodes are often recurrent, the direct path between adolescent and adult depression was statistically significant ($\beta = .17$, $p = .01$). Finally, the family status factor was related to the negative life experiences factor ($\beta = .15$, $p = .05$). Table 3 presents the unstandardized and standardized path coefficients and explained and error variance in the final model. Squared correlation coefficients may be interpreted as the amount of variance accounted for in one variable by another. Hence, for example, the family status factor explains approximately 5% of the variance in childhood aggression, and childhood aggression explains close to 4% of the variance in adult depression. Although these values may seem small, they are reflective of commonly found effect sizes in the behavioural sciences. Moreover, there is no one way to interpret the size of a correlation; correlation coefficients falling in the range of those reaching statistical significance in the present matrix (.20 - .36) are conventionally seen as representing a medium effect size (Cohen, 1988). As Cohen points out, "The fact is that the state of development of much behavioral science is such that not very much variance in the dependent variable is predictable" (p. 78). A correlation as low as .10 may be meaningful in a given discipline, if difficult to discern nonstatistically, and a correlation with a medium effect size (>.11 - < .50) is perceptible by an informed observer. Overall, 17% of the variance in adult depression is explained by the predictor variables included in this analysis.

Table 3

Model I. Path Coefficients and Explained and Error Variance

		Regression coefficients				
Criterion	Predictors	Unstandardized	SE	Standardized	R^2	$1 - R^2$
1. Childhood aggression	Family status	.07**	.03	.22	.05	.95
3. Adolescent depression	Childhood Withdrawal	.22*	.10	.20	.04	.96
4. Life experiences	Family status	.06*	.07	.15	.08	.92
		.09	.10	.07		
	Childhood aggression					
		.31***	.10	.22		
	Adolescent depression					
5. Adult depression	Childhood aggression	.32**	.12	.19	.17	.83
	Adolescent depression	.28**	.12	.17		
	Life experiences	.38***	.08	.27		

Note. Standard errors are robust

* $p < .05$ ** $p < .01$ *** $p < .00$

The revised model supports the idea that both aggressive and withdrawn behaviours in childhood are related to the development of adult depression, albeit following differential pathways. As discussed below, it is clearly recognized that the apparently direct path between childhood aggression and a later outcome of depression is undoubtedly mediated by numerous (if not countless) factors, unidentified in the present study. To gain an additional view of the relation between childhood aggression, withdrawal and depression, scores on each behavioural dimension above the 75th percentile were separated from those falling below this point. A chi-square analysis was performed to determine whether belonging to the high or low aggression group was related to the presence or absence of adult depression. The analysis was repeated for the two levels of withdrawal. Figure 4 shows the results for the aggression analysis, which was statistically significant ($p = .02$). Individuals who received childhood peer ratings placing them in the top quartile of the aggression dimension were more likely to experience depressive symptoms as adults than were individuals whose ratings placed them below the 75th percentile. The chi-square analysis of the withdrawal groups was not statistically significant. A converse pattern was obtained for chi-square analyses with high and low childhood behaviour groups and scores on the adolescent anxious/depressed syndrome. Results indicated a tendency for individuals in the high withdrawal group to report more depressive symptoms ($p = .07$) than those in the low withdrawal group, whereas no difference was found between the aggression groups. The low number of depressed subjects (13), although consistent with general population point prevalence rates, suggests that this result should be interpreted as a finding that warrants future examination when greater numbers of subjects are available.

As mentioned earlier, for reasons of sample size, the influence of gender was not a principal focus of this study. Nonetheless, because prevailing statistics indicate that there are differences in rates of depression between men and women (APA, 1994), gender effects were examined as a supplementary analysis. On the Youth Self-report, six males

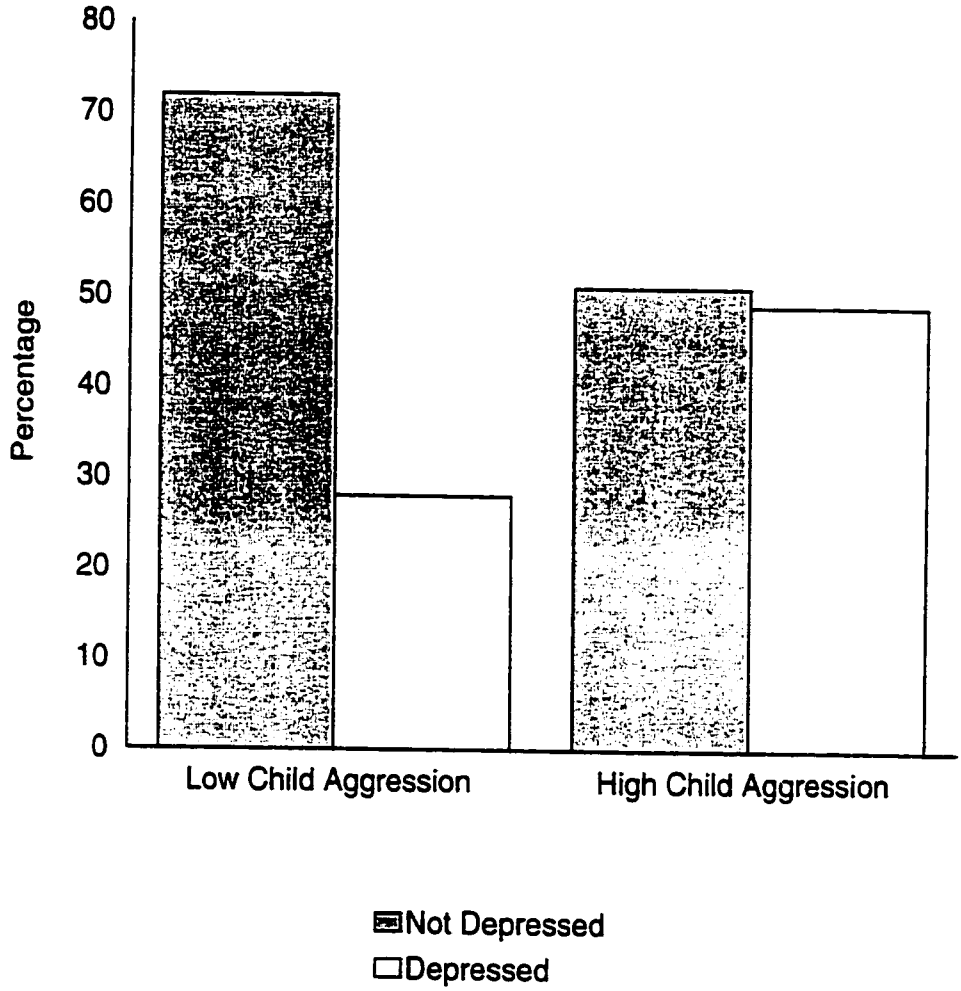


Figure 4. Adult Depression by Childhood Aggression

Difference between high (n = 109) and low (n = 37) childhood aggression on presence/absence of depression in adulthood $p = .02$

and seven females produced high depression scores. Taking total numbers of males and females into account, there was no gender difference on depression during adolescence. More surprisingly, with 21 reports of depression in men and 28 in women, there continued to be no statistical difference in a chi-square analysis of depression by gender in adulthood. Finally, breakdown by high and low aggression group shows that 57% of high aggressive males were depressed in adulthood, compared to 26% of those in the low aggression group. This finding was statistically significant ($p = .03$), and was not replicated in females (44% and 30% respectively). Rates of depression by gender in the withdrawal groups did not differ.

Gender effects were also examined with regard to the three variables forming the family status factor. Parents' marital status was correlated with aggression in both boys ($r = .29$, $p = .02$) and girls ($r = .23$, $p = .03$), but was correlated with withdrawal in girls only ($r = .23$, $p = .03$). Socioeconomic status was significantly correlated with withdrawal in girls only ($r = -.32$, $p = .003$). Finally, the correlation between the number of children in the family and aggression in girls, but not boys, was statistically significant ($r = .23$, $p = .03$).

Hypothesis II

It was hypothesized that through the processes of cumulative and interactive continuity, early aggressive and withdrawn behaviours facilitate the persistence of negative person/environment relations, and the more extreme these behaviours are, the more likely they are to continue into adulthood. As a corollary, it was hypothesized that stress-related externalizing and internalizing behaviours in adulthood are related to the presence of depressive symptoms.

Preliminary correlational analyses are shown in Table 4 and indicate, first, a trend linking childhood aggression and adult externalizing behaviour ($p = .06$), and a significant correlation between adult externalizing behaviour and concurrent adult depression ($p = 02$). Second, adult internalizing behaviour was related to adolescent ($p = .04$) but not adult

Table 4

Correlation Matrix of Variables Included in the Hypothesized Model to Adult Depression, Externalizing and Internalizing Behaviours, Means and Standard Deviations

Variables	1.	2.	3.	4.	5.	6.	7.
1. Childhood aggression	..	.-.002	.04	.07	.22**	.18*	.06
2. Childhood withdrawal		..	.20*	.03	.02	-.07	.02
3. Adolescent depression			..	.20*	.24**	.01	.20*
4. Negative life experiences				..	.36***	.07	.23*
5. Adult depression					..	.22*	.13
6. Adult externalizing behaviour[1]						..	.30***
7. Adult internalizing behaviour[1]							..
M	1.53	1.88	.09	1.10	.34	2.07	6.85
SD	.30	.25	.29	.40	.47	.55	3.33

Note. N = 146

[1] N = 111

*p < .05 **p <.01 ***p<.001

depression, and to the negative life experiences factor ($p = .02$). Finally, and consistent with Parker et al.'s original study (1998), externalizing and internalizing behaviours were significantly correlated ($p = .001$). To analyze these relationships within a model, a path analysis was estimated leading from childhood aggression and social withdrawal to adult externalizing and internalizing behaviours. It will be recalled that the number of participants available for these analyses was reduced to 111. Due to the necessary restriction of parameters, the family status factor employed in the previous analysis was removed. Direct pathways were hypothesized to link childhood aggression and withdrawal to adult externalizing and internalizing behaviours respectively. The direct pathway from childhood aggression and the indirect pathway from childhood withdrawal to adult depression were maintained as in the first model. Because they were measured at the same time and directionality was not inferred, the measures of externalizing and internalizing behaviours were added as covariates of adult depression.

As a variation of the previous model, the second hypothesized model remained statistically acceptable. However, only the moderated pathways from childhood withdrawal through to adult externalizing and internalizing behaviours could be modelled, that is, the paths from the negative life experiences factor to both externalizing ($\beta = .15$, $p = .04$) and internalizing ($\beta = .24$, $p = .001$) behaviours were statistically significant. Path coefficients are presented in Table 5. Despite the initially significant bivariate correlation between childhood aggression and adult externalizing behaviour, the relation between aggression in childhood and similar adult behaviour was not supported within the path analysis. Similarly, the significance of the bivariate correlation between adult externalizing behaviour and adult depression did not translate into a significant covariance in this statistical context. The covariance between adult internalizing behaviour and depression also failed to reach significance. The trimmed model is presented in Figure 5.

Table 5

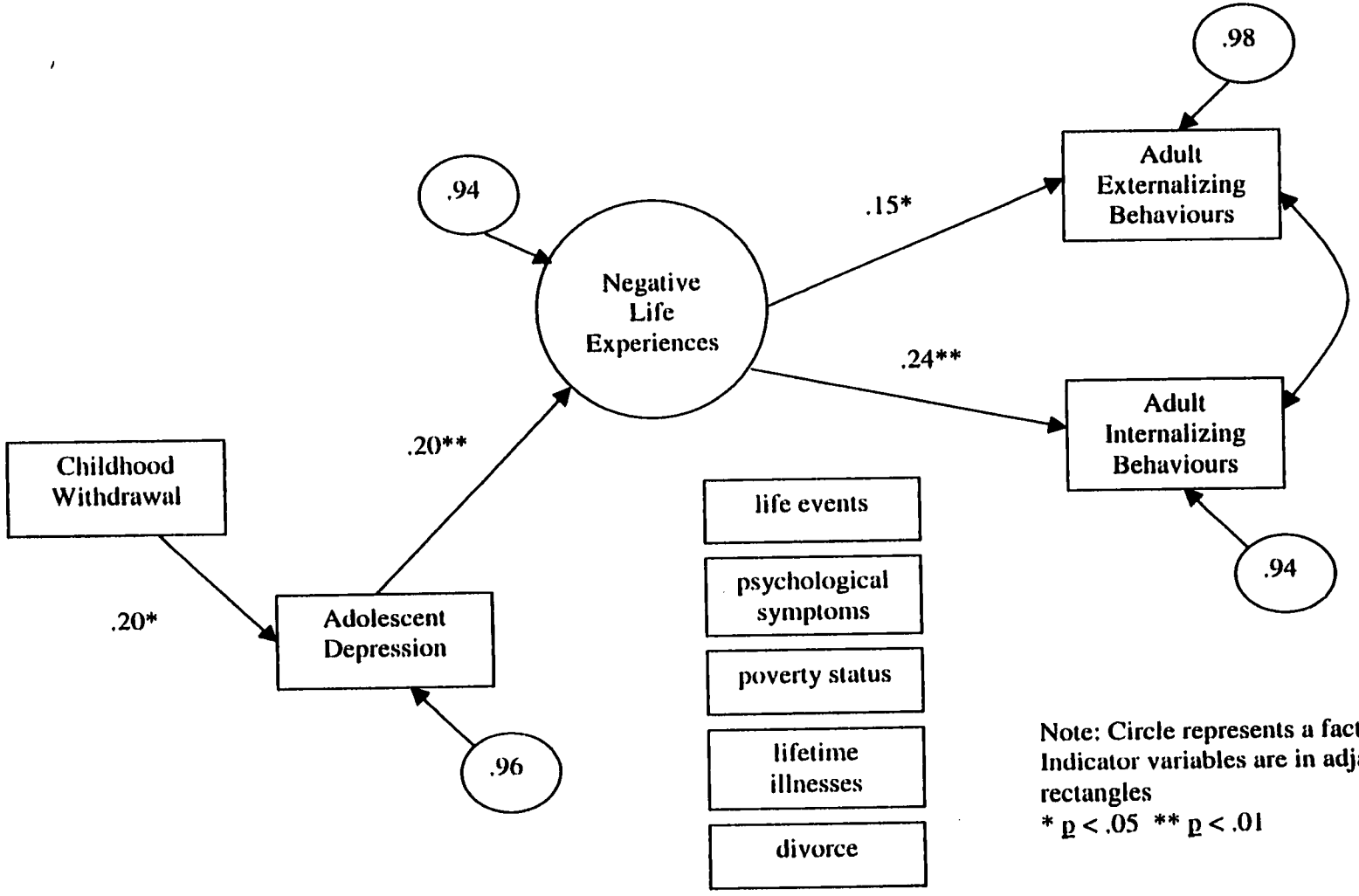
Model II. Path Coefficients and Explained and Error Variance

		Regression coefficients				
Criterion	Predictors	Unstandardized	SE	Standardized	R^2	$1 - R^2$
1. Adolescent depression	Childhood withdrawal	.22*	.11	.20	.04	.96
2. Negative life experiences	Adolescent depression	.30**	.11	.21	.06	.94
3. Adult acting out behaviour	Negative life experiences	.39*	.21	.15	.02	.98
4. Adult acting in behaviour	Negative life experiences	2.65***	.86	.24	.06	.94

Note. Standard errors are robust

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

Figure 5. Path Model Predicting Adult Internalizing and Externalizing Behaviours From Childhood Withdrawal with Significant Standardized Coefficients



Discussion

The Concordia Longitudinal Risk Project provided an exceptional opportunity to examine the long-term relation between aggressive and withdrawn behaviour in childhood and depression in adulthood. The concepts of cumulative and interactional continuity provided the theoretical underpinnings of the study's rationale, namely that aggressive and withdrawn behaviours lead to sustained negative person/environment relations and ultimately to depression. Previous empirical findings were incorporated into this theoretical perspective to develop two longitudinal models. The first model described pathways from childhood aggression and withdrawal to adult depression. Research has shown that aggressive and withdrawn behaviours in childhood, especially as they become more extreme, show moderate stability over time (e.g., Kerr, Lambert, Stattin & Klackenberg-Larson, 1994; Loeber & Hay, 1997). By adolescence, both aggressive and withdrawn individuals are disliked by their peers and are at an increased risk for a variety of problems and the development of depression (Cole & Carpentieri, 1990; Kupersmidt & Coie, 1990; Rubin & Mills, 1988). The accumulation of stressful experiences over time, in addition to previous depressive episodes, increases the risk of depression in adulthood. The second model was derived from the first and examined pathways from childhood aggression and withdrawal to adult externalizing and internalizing behaviour.

From Childhood Aggression and Withdrawal to Adult Depression

Results of the first path analysis show that data obtained from the Concordia sample fit a modification of the hypothesized model. Overall, individuals with higher levels of either aggression or social withdrawal in childhood were at an elevated risk for depression in adulthood compared to those with lower levels of these behaviours. However, different trajectories linked childhood aggression and withdrawal to adult depression. Children rated as withdrawn by their peers were more likely to experience depression in adolescence than those rated as aggressive. Early withdrawal led to later depression via a pathway mediated by adolescent depression and negative life experiences. There was no direct link from

childhood withdrawal to adult depression. In contrast, children with elevated ratings of aggression were highly unlikely to become depressed as adolescents; however, higher ratings of aggression, and particularly those beyond the 75th percentile, were directly predictive of depression in adulthood.

The first step of the model shows that the family status factor, assessing socioeconomic status, parental marital status and family size, predicts aggression but not withdrawal in children. This result is in accord with the well documented association between negative family environments and childhood aggression, yet raises a question concerning the absence of relation between family status and children's withdrawal. The idea of bidirectional processes of influences may account in part for why aggression but not withdrawal is linked with the family environment. As environmental factors influence children's behaviour, children's behaviour also exerts an influence on environmental factors, including parental behaviour (e.g., Shaw & Winslow, 1997). The stressful conditions that are often associated with low SES, single parenthood and large family size may be aggravated by a child's aggressive behaviour, leading to an increase in hostile parental responses. In comparison, withdrawn children living in similarly stressful conditions may elicit fewer strong negative reactions from their parents, thereby avoiding one aspect of environmental stress.

The relation between aggression and family context undoubtedly reflects multiple processes. Low educational attainment and low employment status are linked with economic adversity, and all three have been associated with harsh parenting (Hart & Risley, 1995 and Kagan, Kearsley & Zelazo, 1978, as cited in Hetherington & Parke, 1999); harsh parenting, in turn, has been associated with aggressive behaviour in children (Baumrind, 1971; Eron, Huesmann & Zelli, 1991; Maccoby & Martin, 1983). Similarly, single parenthood and the number of children in the family increase the probability of stress and problematic behaviour in children (Gagnon, Craig, Tremblay, Zhou & Vitaro, 1995; Kupersmidt, Griesler, DeRosier, Patterson & Davis, 1995). These conditions may be

exacerbated by parental depression, which has been found to predict behavioural problems in children (Engfer, 1993; Patterson, Capaldi & Bank, 1991). However, it may be the underlying level of security in children's attachment style that contributes most significantly to how adversity in the family environment influences the development of problematic behaviour (Renken, Egeland, Marvinney, Mangelsdorf & Sroufe, 1989). Insecure attachment style in the child may arise from the primary caregiver's preoccupation with environmental stress or from depression, for example, and has been related to both aggression and withdrawal (Fox & Calkins, 1993; Shaw & Winslow, 1997).

Supplementary findings in the present study concerning the relation between the family context and children's aggression and withdrawal are of interest. Examination of the three components of the family status factor indicates that parental separation is the most important source of influence amongst them. In all correlational analyses, and consistent with existing literature, children's aggression was significantly related to parents' marital status. Marital status was also related to girls' withdrawn behaviour. Parental separation and divorce have been related to internalizing behaviours in children as has marital discord. Wilson and Gottman (1995, cited in Harrist & Ainslie, 1998) propose that children who are highly sensitized to negative emotions in the family environment may generalize resultant feelings of insecurity to other interpersonal relationships, which are then avoided. The link found in this study between parental divorce and withdrawal in girls in particular was not apparent in the literature review, but may be related to the fact that girls are often perceived to demonstrate better adaptation to divorce than boys (Hetherington, 1989). It is possible that in the context of stress surrounding divorce, internalizing responses are evaluated as less problematic than the more common acting-out behaviours. Moreover, parents may miss significant signs of social withdrawal in girls because girls tend to take on greater responsibility in the family following divorce (Hetherington, 1989) and withdrawal may therefore be more evident in the school than in the home environment.

Interestingly, breakdown by gender and childhood behaviour with regard to the Household Prestige Scale also demonstrated a particular link to withdrawal in girls, whereas past research has tended to associate lower socioeconomic status with aggressive behaviour (Haapasalo & Tremblay, 1994; McLeod & Shanahan, 1996). The association between SES and social withdrawal in general has been reported only infrequently and may be particularly pertinent in early but not later childhood (e.g., Mills and Rubin, 1993). The current finding relating the Household Prestige Scale to girls' withdrawal is therefore atypical. It is possible, though, that this relation reflects the link between parental divorce and lowered SES, and that an underlying factor, such as response to marital discord, more directly accounts for the relation with girls' withdrawn behaviour. Finally, the relation between the number of children in the family and aggression was statistically significant in girls but not boys, which is a finding that does not appear to have been noted in previous research. Together these supplementary findings are not typical of past research and indicate that, in the context of the present study, negative family environment appears to have had a stronger influence on girls than on boys, and social withdrawal was related to negative family environment for girls but not for boys. The larger number of women (83) than men (63) in the sample, however, may account for the gender effect.

The second step in the path analysis posited a link between childhood aggression and withdrawal and the adolescent anxious/depressed syndrome measured by the Youth Self-report. As indicated earlier, only the path between social withdrawal in childhood and depression in adolescence was statistically significant. This relation is consistent with past research and with the notion of grouping together internalizing behaviours and psychopathological symptoms, that is, withdrawal and depression. Yet, as Rubin, Stewart and Caplan (1995) have noted, it is not the fact of being socially withdrawn in itself that is assumed to cause depression; rather, depression may be strongly related to other internalizing problems, such as anxiety concerning social evaluation, of which withdrawal is the reflection. Studies have shown, moreover, that many children and adolescents who

are withdrawn are distressed by this fact (e.g., Lazarus, 1982). The importance of the peer group at this age suggests that it is quite possible that the link between social withdrawal and depressive symptoms in adolescence emerges largely in relation to anxiety concerning peer acceptance. Although not all withdrawn individuals desire the company of others, those who do may experience increasingly conflicting feelings as their desire for contact clashes with fears of negative responses from others. Research has shown that the fear of evaluation related to shyness in withdrawn children is frequently accompanied by self-deprecating thoughts (Cheek & Krasnoperova, 1999), a factor that further underscores how withdrawal may become linked with depression.

The absence of a path from aggression to adolescent depression is not consistent with much empirical research (e.g., Capaldi & Stoolmiler, 1999; Zoccolillo, 1992). The present sample size did not permit testing for gender effects, but findings from the Concordia Project using a larger sample have provided support for the link between childhood aggression and depression in young women (Schwartzman, Serbin, Moskowitz & Ledingham, 1995). In addition, although aggressive children are at an increased risk of rejection by their more prosocial peers, studies have demonstrated that they often have as many friends as less aggressive children and may be less likely to experience isolation in the same way as children who are socially withdrawn (Cairns, Cairns, Neckerman, Gest & Gariépy, 1988). Furthermore, it is possible that aggressive children do not respond to peer evaluation in the same, internalizing manner as those who are withdrawn. Children who are aggressive tend to manifest hostile attributional biases (Dodge, 2000) that often result in externally directed feelings of anger. Directing feelings of hostility and blame for problematic interpersonal relations to others may serve to protect the more aggressive children from negative feelings about the self ensuing from negative peer evaluation.

The idea of depression-equivalent aggression may also help to explain why so few aggressive adolescents in this sample acknowledged common symptoms of depression. Gjerde (1995) notes that adolescent males often channel their depressive feelings into

anger, "by acting on the world" (p. 1278), and Chiles, Miller and Cox (1980), using a variety of measures, found that adolescents in a correctional facility increased their acting-out behaviour when they felt depressed. In-depth interviewing might have uncovered this kind of linkage between felt emotion and expressed behaviour in the present sample. It is quite possible, though, that studies examining the relation between aggression and depression in samples of children with conduct disorder, a diagnostic group often employed in such studies, are not comparable to those using a dimensional index of aggressive behaviour.

The next step of the path model examined negative life experiences as a mediating bridge between adolescent and adult depression. The reason for examining the relation between depression and negative life experiences was twofold. First, it was posited that negative life experiences would increase the risk of adult depression beyond the risk engendered by adolescent depressive symptoms. This hypothesis was supported by the findings. Second, research has suggested that individuals with a predisposition for depression may also have a heightened susceptibility to negative life events (Kendler, Thornton & Gardner, 2001; McGuffin & Katz, 1993). The nature of this relation remains unclear. Are some individuals truly at greater genetic risk for both depression and negative events, or is the link due to a combination of genetic and other factors such as negative attitudes, expectancy of failure, risk-taking behaviour and so forth? As Rutter and Rutter (1993) note, temperamental characteristics influence how individuals respond to stress, and, in an inextricably linked manner, stressful experiences also influence these characteristics. Paykel (1994) has cautioned that the origin of stressful situations in an individual's life should be evaluated before it is possible to affirm that it is stress that contributes to depression rather than depression that contributes to stress. The fact that Achenbach (1991) was unable to extract a pure depression scale in the empirical study of children and adolescents further suggests that the anxiety that appears to be indissociable from depression in many young people plays an important role in the relation between

depression and stress. Finally, the influence of anxiety on early onset of major depression has been shown by Parker et al. (1999), who also note that early-onset depression is related to school phobia, behavioural inhibition and avoidant personality traits. The similarity to characteristics of social withdrawal as measured in the present study is noteworthy, and suggests that the interaction of anxiety and withdrawal may have affected a number of participants who acknowledged anxious/depressed symptoms in adolescence and who later met criteria for depression as adults. Although the numbers are small, it is interesting to note that 6 of the 9 participants who were depressed in both adolescence and adulthood had childhood withdrawal ratings beyond the 75th percentile.

Of interest is why withdrawal in childhood directly predicted depression in adolescence but not in adulthood. The anxiety surrounding peer relationships both in childhood and in adolescence again offers a plausible explanation. Social evaluative concerns may be strong in the limited setting of a high school. Adolescents whose responses to social anxiety include withdrawing from the peer group may have few alternative opportunities to interact with others and may develop feelings of loneliness and increased self-doubt. An accumulation of stressful experiences following high school, such as illness or employment loss, may add to feelings of depression. However, individuals who were withdrawn in childhood and adolescence may also begin to gain in self-confidence as they move into broader social systems, perhaps orienting themselves to meet people who are more accepting of shy dispositions and developing competencies in their sphere of employment. In other words, such individuals may benefit from opportunities to create their own environments as adults in a way that was more difficult when they were younger. This would help explain why no direct relationship appears to exist between early withdrawal and adult depression in this study.

Unlike the mediated pathway to adult depression from childhood withdrawal, aggression in childhood led directly to depression in adulthood. Early aggressive behaviour was hypothesized to engage a sustained pattern of negative person/environment

relations that would augment the experience of life stresses and thereby increase the risk of depression. The absence of a relation between childhood aggression and adolescent depressive symptoms has been discussed earlier. The finding that childhood aggression was unrelated to the negative life experiences factor was unexpected. The use of dimensional scores here rather than the original extreme-group design used in many Concordia Project studies may explain the lack of concordance. It is noted, however, that although unrelated to the negative life experiences factor as a whole, childhood aggression was associated with poverty status, one component of the factor, and this association was significant across gender. Analyses of aggression and various types of negative life experience with different samples from the Concordia Project population have previously demonstrated significant relations in such areas as high school dropout and adolescent motherhood (Serbin et al., 1998). Indeed, childhood aggression is strongly related to low educational attainment, which, in turn, has a strong bearing on subsequent socioeconomic status (e.g., Farrington, 1991; Moscowitz & Schwartzman, 1989). These variables could not be included in the present analysis because of the need to limit parameters. Aggression may also be related to additional negative life experiences not included here. Two forms of stressors that may constitute a mediating link between aggression and depression that were not explored in this study are those that result from the penalties of antisocial behaviours, such as involvement in criminal activities, and from the accumulation of daily hassles. It has been noted, for example, that the rate of depression in individuals with antisocial personality disorder is more than twice that of the general population (Robins, Tipp & Pryzbeck, 1991). With regard to daily hassles, it is possible that outwardly turned aggressive behaviour becomes eroded over time, as a lack of coping skills and low social competence lead to an accumulation of unresolved problems.

The robust link between childhood aggression and adult depression undoubtedly reflects multiple mediating processes. Rutter (1996) has pointed out that it is important to differentiate between the origin of a risk factor and the mediating link between risk and

disorder. With regard to the present study, research has demonstrated associations between the risk factor of early adversity, for example, and the development of both children's aggressive behaviour and later depression. The significant pathway between the family status factor and childhood aggression in this sample may be mediated by various mechanisms that also influence the pathway to depression. These may include factors such as the development of poor coping styles that afford limited personal resources for effectively handling problems (Widom, 1997), or coercive family relations that preclude the learning of more prosocial, reciprocally supportive behaviours (Dishion & Patterson, 1997). The later acknowledgement of depression in aggressive individuals in this study may be related to long-standing behavioural patterns that grew from early experience, that were found to be effective in certain respects, and that perhaps initially buffered against internalizing, depressive symptoms. However, the impact of accumulated negative outcomes that are linked to such mediating factors may become increasingly depressogenic.

Finally, the pathway between the family status factor and the negative life experiences factor was not part of the hypothesized model, but was included originally to satisfy statistical requirements of the model. It nonetheless supports the idea that early environment has an important effect on life-course experiences. The absence of relation between childhood aggression and the negative life experiences factor, and between childhood withdrawal and the family status factor indicates that the significant pathway between family status and negative life events does not detract from the other relationships in the model.

From Childhood Aggression and Withdrawal to Externalizing and Internalizing Behaviours in Adulthood

The second path model was derived from the previous one and predicted pathways from childhood aggression and withdrawal to adult externalizing and internalizing behaviours and between the latter behaviours and adult depression. As in the depression model, the path from childhood withdrawal to adult internalizing behaviour was indirect. It

led from childhood withdrawal through adolescent depression and the negative life experiences factor to adult internalizing behaviour. The absence of a direct path from childhood withdrawal to adult internalizing behaviour, and indeed the almost zero correlation between the two, is inconsistent with previous research. Again, as with the depression model, the internalizing behaviours targeted by the Stress Coping Questionnaire may have been retained or prompted only in individuals who had experienced adolescent depression and greater adversity than others.

The prediction of a pathway from childhood aggression to adult externalizing behaviour was not substantiated. Two points are worth noting in this regard: first, path analysis is a more stringent technique than the bivariate correlations often employed in such longitudinal analyses. Second, inference of noncontinuity based on the limited self-report responses of one adult measure may be incorrect (Caspi, Elder & Herbener, 1990). In addition, the correlation of childhood aggression and adult externalizing behaviour in the men, but not in the women, suggests that the effect of gender, which could not be tested in the path analysis, may account for the negative result. This is consistent with previous research, such as that conducted by Pulkkinen and Pitkänen (1993), in which the continuity of aggressive behaviour over long periods of time is often more evident in males than in females.

Finally, the hypothesis of a relation between adult externalizing and internalizing behaviours and depression was not supported. The lack of concordance is particularly surprising with regard to the internalizing scale because many of the internalizing items on the SCQ relate to depressive symptoms (e.g., rumination). The overlap between the externalizing and internalizing factors of the SCQ may have obscured the relationship of each factor with depression. The absence of a relationship between depression and externalizing behaviours in adulthood may also be explained by a decrease in certain individuals in their aggressive behaviour because of an increase in awareness of how penalizing their aggression has been. This process would be in accordance with research

showing that high levels of aggression maintained over adolescence nonetheless begin to decrease during early adulthood (Cairns & Cairns, 2000). Individuals with a history of aggressive behaviour may make conscious efforts to desist in such behaviour, or to dissimulate it, as their experience and understanding of its negative consequences grow. Alternatively, feelings of depression may decrease awareness of self-initiated aggression. It is possible, for example, that a long-standing pattern of aggressive behaviour and hostile attributions continues to prompt the placement of blame for difficult life circumstances outside the self. In such cases, negative person/environment relations over time may enhance the sense of having been mistreated by others and lead to symptoms of depression, while the impact of self-initiated aggression remains unacknowledged.

Limitations of the Study

The models proposed in this study are largely chronologically sequenced, so they may appear to indicate that one step causes the next one. However, despite a statistically sound fit of the data by the models, causality was not demonstrated (Kline, 1998). Unmeasured elements that may make important contributions to the individual's trajectory to depression are not accounted for. Genetic predisposition, for example, may affect early behaviour, the perception of and response to stressful events, and the development of a depressive disorder. The comparison of these models to alternative models that include other relevant variables would also help to clarify the nature of the relation between early behaviour and later depression. The modest magnitude of obtained path coefficients and high error variance attest further to this limitation.

Additional limitations of the present study arise primarily from sample size constraints and from the dependence on archival data. Although the size of the sample met the minimum requirement for path analysis it was smaller than that commonly recommended (Kline, 1998; Tabachnick & Fidell, 1996). A much larger sample would allow the separate path analyses needed to shed light on the important question of gender differences. The present sample size also precluded the use of extreme-group analysis.

Although findings based on dimensional analysis are consistent with those reported elsewhere (e.g., Gest, 1997), they may not highlight sufficiently the particular processes implicated in marked aggression and withdrawal. The number of participants in the present study who met criterion for extreme-group membership was too limited for statistical consideration.

General limitations arising from working with archival data apply to this study. First, the intention to include a measure of adolescent depression restricted the sample to those participants who had completed the YSR in the early 1980s. Every attempt was made to contact all those in that sample, but a substantial proportion (over 50%) was either untraceable within the allotted time or did not consent to take part. Second, although the use of archival data is likely more robust than retrospective data collection, existing measures may be inadequate or inappropriate in a new research context. Third, measures of relevance may be absent. Measures of parental psychopathology, and more specifically of depression, would have been useful in the present study, both in terms of the early family environment and to discern whether familial patterns play a role in the pathway to depression from childhood behaviour. Additional assessments of depression in the participants to examine patterns of recurrence, and repeated assessments of aggression and withdrawal, to determine their continuity, would have strengthened the overall design and the findings.

Future Directions

The limitations enumerated above contain ideas for future directions. Some of these limitations, such as the lack of repeated measures of aggression and withdrawal, are clearly not alterable in the context of a now mature prospective study such as the Concordia Project. A replication of the present study with a larger sample is intended, however, so that gender effects may be examined. Similarly a more in-depth evaluation of current levels of aggression and withdrawal would complement present findings. In addition, the exploration of whether aggression and withdrawal lead to differential patterns of depressive

symptomatology would further clarify the nature of the relationship between these different behavioural styles and depression.

The study described here focused on the development of depression in adulthood and its relation to problematic childhood behaviour. However, most people do not, in fact, develop depression, regardless of difficult life circumstances. Differential coping strategies, social support networks, individual perceptions and attitudes all undoubtedly play a role in the ability to remain depression-free. How individuals who have experienced apparently negative person/environment relations develop the means to avoid depression merits further study.

Summary and Conclusions

The theory of cumulative and interactional continuity (Caspi & Elder, 1988) served to conceptualize pathways linking childhood behaviour to adult depression. Although previous empirical findings pointed to the tenability of the proposed models, the present study did not aim to test Caspi and Elder's theory. Results from the present study show that aggression and withdrawal in childhood lead to depression in adulthood. These findings are in line with related studies that have documented an increased risk for a variety of psychosocial problems. At the same time, these findings also warrant a more extensive inquiry into the nature of the pathways that lead from behaviourally distinct styles in childhood to a similar clinical outcome in adulthood.

The finding that the risk of adult depression in individuals who were withdrawn as children was elevated when they experienced depression in adolescence and further elevated by stressful life experiences highlights the idea that an internalizing behavioural style does not in itself necessarily lead to depression in maturity. However, this finding also points to the importance of early intervention in detecting and treating depression in withdrawn children and adolescents to offset the possibility of recurrence. At the same time, the direct relation found between childhood aggression and adult depression indicates that an externalizing behavioural style does not necessarily protect from depression, and

places further emphasis on the extent of the negative fallout of childhood aggression. Continued study of the factors that mediate pathways to depression will increase our understanding of how early childhood behaviour whether aggressive or withdrawn, leads to the development of depression in adulthood.

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Appendix A

Questionnaires

EVALUATION PAR LES PAIRS

1. Ceux qui sont plus grands que les autres *
2. Ceux qui aident les autres (W)
3. Ceux qui ne sont pas capables de rester assis tranquilles (A)
4. Ceux qui essaient de mettre les autres dans le trouble (A)
5. Ceux qui sont trop timides pour se faire des ami(e)s facilement (L) *
6. Ceux qui se sentent trop facilement blessés (L) *
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 font rire les autres (A)
9. Ceux qui commencent la chicane à propos de rien (A) *
10. Ceux qui ne semblent jamais s'amuser (L)
11. Ceux qui sont bouleversés quand ils ont à répondre aux questions en classe (L)
12. Ceux qui disent aux autres enfants quoi faire (A)
13. Ceux qui sont d'habitude les derniers choisis pour participer à des activités de groupe (L)
14. Ceux que tout le monde aime (W) *
15. Celles qui s'empêtrent tout le temps et se mettent en difficulté (A)
16. Celles qui rient des gens (A) *
17. Celles qui ont très peu d'ami(e)s (L) *
18. Celles qui font des choses bizarres (A)
19. Celles qui sont tes meilleurse amies (W)
20. Celles qui ennuient les gens qui essaient de travailler (A) *
21. Celles qui se mettent en colère quand ça ne marche pas comme elles veulent (A)
22. Celles qui ne portent pas attention au professeur (A) *
23. Celles qui sont impolies avec le professeur (A)

24. Celles qui sont malheureuses ou tristes (L)*

25. Celles qui sont particulièrement gentilles (W)

26. Celles qui se comportement comme des bébés (A)*

27. Celles qui sont méchantes et cruelles avec les autres enfants (A)

28. Ceelles qui ne veulent pas jouer (L) *

29. Celles qui vous regardent de travers (A)

30. Celles qui veulent faire les fines devant la classe (A)

31. Celles qui disent qu'elleslpeuvent battre tout le monde (A) *

32. Celles que l'on ne remarque pas beaucoup (L) *

33. Celles qui exagèrent et racontent des histoires (A) *

34. Celles qui se plaignent toujours et qui ne sont jamais contentes (A) *

35. Celles qui semblent toujours comprendre se qui se passe (W) *

Note: A = Aggressive dimension
W = Withdrawn dimension
L = Likeability dimesnion
* = items included on the grade 1 questionnaire

Septembre 1999

N° d'identification _____
Date: _____

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.

☐ Célibataire	☐ Conjoint de fait
☐ Marié(e)	☐ Séparé(e)
☐ Divorcé(e)	☐ Veuf/veuve

Depuis quelle date?
AN ____ MO ____ JR ____

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 chaque enfant:

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 chomâge?
Oui ☐ Non ☐ Prestations d'aide sociale?
Oui ☐ Non ☐ la CSST? (préciser:_____)

7. **Informations sur le conjoint (renseignements gardés confidentiels):**

AN MO JR

a) Son nom:_____ Date de naissance ____ ____ ____

Son occupation:_____

Ses tâches:_____

Son salaire: _____ $/ heure Nombre d'heures _____ / semaine

AN MO

Il/Elle travaille là depuis: date ____ ____

b) Au cours des 12 derniers mois, a-t-il/elle bénéficié de:

Oui ☐ Non ☐ l'Assurance chomâge?

Oui ☐ Non ☐ Prestations d'aide sociale?

Oui ☐ Non ☐ la CSST? (préciser:_____)

c) Sa scolarité complétée (dernière année terminée):_____

En quoi? (spécialisation/général):_____

Étudie-t-il (elle) présentement? OUI : Temps plein ☐ partiel ☐ NON ☐

Si oui, diplôme postulé?_____ pour quand? (date) ____/____/

8. **Informations sur le père\la mère de tes enfants (si n'habite pas avec toi)**

AN MO JR

a) Son nom:_____ Date de naissance ____ ____ ____

Son occupation:_____

Ses tâches:_____

Son salaire: _____ $/ heure Nombre d'heures _____ / semaine

AN MO

Il/Elle travaille là depuis: date ____ ____

b) Au cours des 12 derniers mois, a-t-il/elle bénéficié de:

Oui ☐ Non ☐ l'Assurance chomâge?

Oui ☐ Non ☐ Prestations d'aide sociale?

Oui ☐ Non ☐ la CSST? (préciser:_____)

c) Sa scolarité complétée (dernière année terminée):_____

En quoi? (spécialisation/général):_____

Étudie-t-il (elle) présentement? OUI : Temps plein ☐ partiel ☐ NON ☐

Si oui, diplôme postulé?_____ pour quand? (date) ____/____/

9. **Disponibilité pour l'entrevue:** un bloc de 2-3 heures

☐ Le matin ☐ L'après-midi
☐ Le soir ☐ La fin de semaine

10. **Je préfère aller à** _____ Guy et Maisonneuve (centre-ville)
_____ 7141 Sherbrooke ouest (N.D.G.)

S.V.P. Vérifier l'adresse et les numéros de téléphone.

_____ _____
No Rue app.

_____ _____ _____
Ville Code postal

Téléphones: Personnel: (_____) _____ - _____
Travail: (_____) _____ - _____
Parents: (_____) _____ - _____
Autre _____: (_____) _____ - _____

Ton numéro de téléphone est à quel nom dans l'annuaire téléphonique: Nom complet et lien avec toi:
_____

Adresse des parents: _____
_____

SCL-90-R

Ci-dessous, se trouve une liste de problèmes et de plaintes que les gens formulent de temps à autre. Veuillez, S.V.P., lire chacune de ces plaintes attentivement. Dès que vous l"aurez fait, indiquez par le numéro approprié la réponse qui décrit le mieux COMMENT CE PROBLEME VOUS A DERANGE OU AFFLIGE DURANT LES SEPT (7) DERNIERS JOURS, AUJOURD'HUI INCLUS.

ECHELLE: 0 pas du tout

1 un peu

2 modérément

3 passablement

4 énormément

EXEMPLE: COMMENT AVEZ-VOUS ETE DERANGE(E) PAR:

_____ 1. Des maux de dos

COMMENT AVEZ-VOUS ETE DERANGE(E) PAR:

_____ 1.des maux de tête

_____ 2. la nervosité ou tremblement intérieur

_____ 3. des pensées désagréables répétées qui ne vous lâchent pas

_____ 4. des évanouissements ou des étourdissements

_____ 5. la perte de l'intérêt ou du plaisir sexuel

_____ 6. le fait d'être porté à critiquer les autres

_____ 7. l'idée que quelqu'un d'autre contrôle vos pensées

_____ 8. le sentiment que les autres surtout sont à blâmer pour vos problèmes

_____ 9. le fait d'avoir de la difficulté à vous rappeler quelque chose

_____ 10. le fait d'être inquiet(e) à propos de la malpropreté ou de la négligence

_____ 11. être facilement ennuyé(e) ou irrité(e)

_____ 12. des douleurs au coeur ou à la poitrine

_____ 13. la peur des espaces ouverts ou d'être sur la rue

_____ 14. le sentiment de manquer d'énergie ou d'être au ralenti

_____ 15. des pensées d'en terminer avec la vie

_____ 16. le fait d'entendre des voix que les autres n'entendent pas

_____ 17. des tremblements

_____ 18. le sentiment qu'on ne peut pas se fier à la plupart des gens

_____ 19. le peu d'appétit

_____ 20. le fait de pleurer facilement

_____ 21. le fait d'être gêné(e) ou mal à l'aise avec des personnes du sexe opposé

_____ 22. le sentiment d'etre pris(e) au piège ou immobilisé(e)

_____ 23. avoir soudainement pris peur sans raison

_____ 24. des accès de colère que vou ne pouviez pas contrôler

_____ 25. être effrayé(e) de sortir seul(e) de la maison

_____ 26. vous blâmer vous-même pour des choses

_____ 27. des douleurs dans le bas du dos

_____ 28. le sentiment de ne plus avancer dans ce que vous faîtes

_____ 29. le sentiment d'Ietre seul(e)

_____ 30. le fait d'avoir le cafard

_____ 31. le fait de vous inquiéter trop à propos de rien

_____ 32. n'être intéressé(e) à rien

_____ 33. vous être senti(e) craintif (ve)

_____ 34. le fait que vos sentiments sont trop facilement blessés

_____ 35. les autres gens sont au courant de vos pensées intimes

_____ 36. le sentiment que les autres ne vous comprennent pas ou sont antipathiques

_____ 37. le sentiment que les gens ne sont pas amicaux ou ne vous aiment pas

_____ 38. d'avoir à faire les choses très lentement pour s'assurer que tout soit correct

_____39. des palpitations ou des battements rapides du coeur

_____40. des nausées ou l'estomac dérangé

_____ 41. le fait de vous sentir inférieur(e) aux autres

_____ 42. des muscles endoloris

_____ 43. le sentiment que vous êtes surveillé(e) ou que les autres parlent de vous

_____ 44. de la difficulté à vous endormir

_____ 45. le fait d'avoir à vérifier et revérifier ce que vous faîtes

_____ 46. de la difficulté à prendre des décisions

_____ 47. la peur de voyager par autobus, métro ou train

_____ 48. de la difficulté à reprendre votre haleine

_____ 49. bouffées de froid ou de chaleur

_____ 50. d'avoir à éviter certaines choses, endroits ou activités parce que vous en avez peur

_____ 51. le fait de vous sentir la tête vide

_____ 52. des engourdissements ou des démangeaisons de différentes parties de votre corps

_____ 53. des serrements de gorge

_____ 54. un sentiment de désespoir face à l'avenir

_____ 55. de la difficulté à vous concentrer

_____ 56. le fait de vous sentir faible de certaines parties de votre corps

_____ 57. de vous sentir tendu(e) ou à bout de nerfs

_____ 58. des sentiments de lourdeur dans les bras ou dans les jambes

_____ 59. de penser à la mort ou à mourir

_____ 60. trop manger

_____ 61. de vous sentir mal à l'aise quand les gens vous regardent ou parlent de vous

_____ 62. avoir des pensées qui ne sont les vôtres

_____ 63. avoir envie de battre, blesser ou faire mal à quelqu'un

_____ 64. vous réveiller aux petites heures du matin

_____ 65. avoir à répéter les mêmes gestes comme toucher, compter, laver

_____ 66. passer des nuits blanches ou avoir le sommeil troublé

_____ 67. avoir des envies de briser ou casser des choses

_____ 68. croire ou avoir l'idée que personne ne veut partager

_____ 69. vous sentir très intimidé(e) par les autres

_____ 70. vous sentir mal à l'aise parmi les foules comme au cinéma ou dans les magasins

_____ 71. sentiment que tout est effort

_____ 72. des crises de frayeurs ou de panique

_____ 73. vous sentir mal à l'aise de manger ou de boire en public

_____ 74. avoir souvent des disputes

_____ 75. vous sentir nerveux (se) lorsque vous êtes seul(e)

_____ 76. les autres ne vous donnent pas le crédit souhaité pour vos accomplissements

_____ 77. le sentiment d'être seul(e) même lorsque vous êtes avec d'autres

_____ 78. vous sentir si agité(e) que vous ne pouvez pas rester assis(e) tranquille

_____ 79. le sentiment d'être bon à rien

_____ 80. le sentiment que quelque chose de mauvais va vous arriver

_____ 81. le fait de crier et de lancer des objets

_____ 82. avoir peur que vous aller vous évanouir en public

_____ 83. le sentiment que les gens prendront avantage de vous si vous les laissez faire

_____ 84. d'avoir des pensées à propos du sexe qui vous dérange beaucoup

_____ 85. l'idée que vous devriez être puni(e) pour vos péchés

_____ 86. des pensées et des impressions de nature effrayantes

_____ 87. l'idée que quelque chose de sérieux ne va pas avec votre corps

_____ 88. ne jamais vous sentir proche d'une autre personne

_____ 89. des sentiments de culpabilité

_____ 90. l'idée que quelque chose ne va pas dans votre esprit

ÉVÉNEMENTS

Maintenant, je te présente une liste d'événements qui peuvent apporter des changements dans la vie des gens et qui demandent une certaine adaption sur le plan social. Nous allons passer chacun de ces évéments un par un, et tu vas me dire si ça t'est arrivé, à toi dans les 12 derniers mois, c'est-à-dire depuis _____ 199__.

> 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 évéments qui te sont arrivés depuis un an et je vai te demander de me dire quel impact cet évément a eu sur ta vie. Un événement peut avoir un impact extrêmement positif (très très plaisant) qu'on évalue à " 1 ", ou encore peut avo 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.	Ton 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 de ton conjoint, de ta conjointe	0	1	2	3	4	5	6	7
4.	Changement important dans tes 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, 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 ta famille (naissance ou adoption [soeur, frère ou ton enfant], membre de la famille qui emménage chez toi)	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, ta conjointe, 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, ta conjointe	0	1	2	3	4	5	6	7
24.	Changement important dans le nombre de conflits avec ton conjoint, ta conjointe (beaucoup plus ou beaucoup moins qu'avant)	0	1	2	3	4	5	6	7
25.	Homme avec conjointe: changement dans sa situation d'emploi (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 avec conjoint : changement dans sa situation d'emploi (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 tes activités sociales (ex., parties, cinéma, sorties, visites [beaucoup plus ou beaucoup moins])	0	1	2	3	4	5	6	7
33.	Changement dans tes conditions de vie familiale (construction d'une maison, redécoration, détérioration de ton domicile ou du voisinage, etc.)	0	1	2	3	4	5	6	7
34.	Ton 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 ta retraite	0	1	2	3	4	5	6	7
37.	Ton fils ou ta fille quitte le foyer (ex., pour se marier, étudier, etc.)	0	1	2	3	4	5	6	7
38.	Séparation temporaire d'avec ton conjoint, ta conjointe (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

QUESTIONNAIRE SUR LA SANTE

Ce questionnaire vise à dresser un portrait global de votre histoire de santé. Répondez au meilleur de votre connaissance et n'hésitez pas à écrire des commentaires, remarques au besoin.

SECTION II; INVENTAIRE DES PROBLEMES DE SANTE

Au cours de la dernière année, puis au cours de toute votre vie avant la dernière année, indiquez par un crochet si vous avez souffert des problèmes de santé suivants:

PROBLEMES DE SANTE	Durant la dernière année	Avant la dernière année
1. Problèmes cardiaques (préciser: angine, infarctus, tachycardie, arythmie. etc):		
2. Problèmes cérébro-vasculaires (préciser: ACV, thrombose, etc):		
3. Problèmes de pression artérielle (préciser: haute ou basse pression):		
4. Ulcères d'estomac		
5. Irritabilité du colon (diarrhée ou constipation prolongées)		
6. Problèmes de digestion, maux d'estomac fréquents		
7. Colite ou maladie de Crohn		
8. Sang dans les selles		
9. Etourdissements		
10. Problèmes de foie (préciser: crise de foie, cirrhose, hépatite, etc):		
11. Diabète		
12. Hypoglycémie		
13. Problèmes de la glande thyroïde (préciser si hypo ou hyperthyroïdie):		
14. Mononucléose		
15. Anémie		

16. Fibrose kystique		
17. Handicap physique (préciser: Dystrophie, paralysie, etc):		
18. Problèmes de vision (préciser: Myopie, presbytie, etc):		
19. Cancer, tumeur (préciser le(s) type(s)):		
20. Problèmes urinaires (préciser: urémie, infections urinaires fréquentes, etc):		
21. Problèmes avec les articulations, jointures (préciser: Arthrite, rhumatismes, goutte, etc):		
22. Douleurs au dos, maux de dos fréquents		
23. Problèmes musculaires (préciser: tendinite, bursite de l'épaule, etc):		
24. Maux de tête, migraines freequentes		
25. Asthme (préciser le type: bronchique, à l'effort, etc):		
26. Autres problèmes respiratoires (préciser: bronchite, pneumonie, etc):		
27. Problèmes de gorge (préciser: laryngite, pharyngite, amygdalite):		
28. Problèmes de sinus		
29. Grosses grippe ou fièvres fréquentes qui vous ont forcé(e) à rester à la maison		
30. Rhumes fréquents		
31. Maux de gorges fréquents		
32. Problèmes de peau (préciser: acné, eczéma, psoriasis, etc):		
33. Epilepsie		
34. Sclérose en plaques		
35. FEMMES: Problèmes gynécologiques (préciser: endométriose, kyste aux ovaires, crampes menstruelles récurrentes et douloureuses, etc):		
36. Maladies transmises sexuellement (gonorhée, herpès, etc) préciser:		

37. SIDA, ou séropositif(ve), préciser		
38. Autres maladies. Préciser: _____ _____ _____ _____ _____		

YSR ANXIOUS /DEPRESSED SYNDROME

Items

12. I feel lonely

14. I cry a lot

18. I deliberately try to hurt myself

31. I am afraid I might think or do something bad

32. I feel that I have to be perfect

33. I feel that no one loves me

34. I feel that others are out to get me

35. I feel worthless or inferior

45. I am nervous or tense

50. I am too fearful or anxious

52. I feel too guilty

71. I am self-conscious or easily embarrassed

89. I am suspicious

103. I am unhappy, sad, or depressed

112. I worry a lot

Note: item 91. (I think about killing myself) is part of the anxious/depressed syndrome but was omitted for administration to the Concordia High Risk sample

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

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

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 (EPISODE DEPRESSIF MAJEUR PASSÉ)

ÉPISODE DÉPRESSIF MAJEUR ACTUEL

Combien de pénodes 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 EPISODE) ?

Nombre d'épisodes dépressifs majeurs, y compris l'épisode actuel (INSCRIRE 99 SI CE NOMBRE EST TROP ÉLEVÉ POUR ÊTRE COMPTÉ OU SI LES EPISODES 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

CRITÈRES DIAGNOSTIQUES

D'APRÈS L'OBSERVATION DU SUJET OU SES ANTÉCÉDENTS

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 ?)

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

SI OUI : En quoi diffère-t-elle ?

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.

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

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

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 REPONSE 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. Cocher selon le cas : Perte de poids ou d'appétit ___ Augmentation de poids ou d'appétit ___	?	1	2	3	A54 A55 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. Cocher selon le cas : Insomnie ___ Hypersomnie ___	?	1	2	3	A57 A58 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). Cocher selon le cas : Ralentissement psychomoteur ___ Agitation ___	?	1	2	3	A60 A61 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).

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	___	?	1	2	3	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).

Cocher selon le cas :

Diminution de la capacité de réfléchir	___	?	1	2	3	A67
Indécision	___					A68
						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.

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

Cocher selon le cas :

Pensées concernant sa mort	___	?	1	2	3	A70
Idées suicidaires	___					A71
Projet précis de suicide	___					A72
Tentative de suicide	___					A73
						A74

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

AU MOINS UN ÉPISODE DISTINCT D'UN 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 ?

⇒ 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 ___ A84

Humeur irritable ___ 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.	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 :					
DANS LE DOUTE : Durant (ÉPISODE), quand avez-vous été le plus (TERME UTILISÉ POUR QUALIFIER L'ÉTAT DU PATIENT) ?						
Durant cette période...						
... 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.	— —	

IDNO _____

SCQ

Voici une liste de choses que les gens peuvent faire lorsqu'ils sont stressés. Pourriez-vous nous dire avec quelle fréquence vous faîtes l'une ou l'autre des choses suivantes, en vous servant du choix de réponses ci-dessous.

0 - jamais
1 - parfois
2 - beaucoup / fréquemment
3 - la plupart du temps
8 - ne s'applique pas

Quand vous êtes stressé(e), à quelle fréquence vous arrive-t-il de...

a)	hausser le ton pour vous imposer dans la conversation ?	0	1	2	3	8
b)	casser des choses de peu de valeur ?	0	1	2	3	8
c)	frapper du poing sur la table ?	0	1	2	3	8
d)	casser des choses de valeur ou de grandes proportions ?	0	1	2	3	8
e)	exploser de colère ?	0	1	2	3	8
f)	crier ?	0	1	2	3	8
g)	élever la voix ?	0	1	2	3	8

h)	frapper une autre personne ?	0	1	2	3	8
i)	vous cogner la tête ?	0	1	2	3	8
j)	vous blesser ou vous mutiler de toute autre façon ?	0	1	2	3	8
k)	agir imprudemment (e.g. en conduisant) ?	0	1	2	3	8
l)	devenir tout(e) tranquille ?	0	1	2	3	8
m)	vous retirer de situations sociales ?	0	1	2	3	8
n)	vous isoler dans une pièce ?	0	1	2	3	8
o)	serrer les dents ?	0	1	2	3	8
p)	laisser les autres s'arranger avec les problèmes ?	0	1	2	3	8
q)	vous réfugier dans votre lit ?	0	1	2	3	8
r)	pleurer tout(e) seul(e) ?	0	1	2	3	8
s)	vous acharner au travail ?	0	1	2	3	8
t)	«bouillir» par en dedans ?	0	1	2	3	8

Appendix B

Factors

Correlations Amongst Indicator Variables in the Family Status Factor

	1.	2.	3.
1. Marital status	..	.24**	-.18*
2. Number of siblings		..	-.22**
3. Household Prestige Scale			..

* $p < .05$ ** $p < .01$

Factor Loadings for Family Status Factor Indicator Variables

Indicator Variable	Factor loading
Socioeconomic status	-.66
Parental marital status	.68
Number of children	.73

Negative Life Experiences Factor

Correlations Amongst Indicator Variables in the Negative Life Experiences Factor

	1.	2.	3.	4.	5.
1. Divorce	..	.22**	.18*	-.26**	.17*
2. SCL-90		..	.19*	-.10	.27**
3. Past illnesses			..	-.16†	.18*
4. Poverty status				..	-.11
5. Negative events					..

Note. † p = .06 * p < .05 ** p < .01

Factor Loadings for Negative Life Experiences Factor Indicator Variables

Indicator variable	Factor loading
Life Events Survey	.59
SCL-90	.63
Poverty status	-.51
Past illnesses	.57
Divorce	.64