MENTAL HEALTH INSTRUMENTS
METHODOLOGY - SCOPE AND LIMITATIONS

Technical Manual 87-06

Chantal Perrault
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Chantal Perrault

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This survey was conducted by the ministère de la Santé et des Services sociaux and the Départements de santé communautaire (DSC) under the direction of Aline Emond.
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The Québec Health survey was commissioned by the ministère de la Santé et des Services sociaux together with the 32 départements de santé communautaire (DSC). The survey is intended to respond to the needs of planners and decision-makers and to supplement existing information concerning various aspects of both the physical and psychological well-being of the inhabitants of Québec.

The survey focussed on three main areas: the factors determining state of health, the state of health per se and the consequences arising from the state of health.

There is currently a lack of sufficient data concerning health status. Existing data are based mainly on cases which are already taken care by official health care system. No systematic study has yet been made of illness not treated within the system, such as self-medication, risk factors, or long-term consequences of treated or untreated ailments.

The Québec Health survey was begun in 1980 upon the completion of the Canada Health Survey, and even sooner when it became evident that the Québec component of its sample was too small and unrepresentative of the Québec regions.

Scope of the survey

The choice of topics and questions to be included in the survey was determined by an evaluation of the usefulness and pertinence of data as well as by an evaluation of its comparability with other information sources. Moreover, the survey was designed as a continuation of the Canada Health Survey. Finally, the methods and questions used in this first Québec Health survey originate almost entirely from questionnaires or surveys, utilized or carried out in contexts similar to those of the Québec Health survey. We wanted to avoid questions non validated in a population context.

The definition of the contents of the survey was based on three main sources:

- the contents of the Canada Health Survey;
- the components of the 1983 pilot study carried out in the DSCs of Verdun and Rimouski;
- the specific objectives outlined by representatives of the ministère de la Santé et des Services sociaux responsible for the project, and the recommendations of task forces in charge of developing the questionnaires.

The list of topics covered and of questions used in the questionnaire was established by various committees. Some revision of the formulation of questions was necessary in order to reduce the administration time of the questionnaire and make the self-administered questionnaire more readily comprehensible. Following the recommendations of consultants and task forces, certain topics were excluded in this initial survey (see Table 1 listing the topics to be reviewed). These topics will undergo further study in order to be included in a future survey. The relevance of topics included in the survey (see Table 1) will then be examined in detail to determine their predictive value with regards to the objectives to be achieved.
### Table 1
Topics included in the Québec Health survey (1987)(*)

<table>
<thead>
<tr>
<th>DETERMINING FACTORS</th>
<th>HEALTH STATUS</th>
<th>CONSEQUENCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>lifestyle</td>
<td>physical</td>
<td>use of health services</td>
</tr>
<tr>
<td>family history</td>
<td>psychological</td>
<td>effect on ability to function</td>
</tr>
<tr>
<td>environment</td>
<td>social</td>
<td></td>
</tr>
<tr>
<td></td>
<td>perceived/observed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>positive/negative</td>
<td></td>
</tr>
</tbody>
</table>

**SPECIFIC TOPICS**

<table>
<thead>
<tr>
<th>LIFESTYLE</th>
<th>PHYSICAL HEALTH</th>
<th>USE OF HEALTH SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>alcohol use</td>
<td>activity limitation</td>
<td>professionals consulted</td>
</tr>
<tr>
<td>tobacco use</td>
<td>short-term conditions</td>
<td>place of consultation</td>
</tr>
<tr>
<td>physical activities</td>
<td>chronic conditions</td>
<td>use of medication</td>
</tr>
<tr>
<td>use of motor vehicles</td>
<td>vision/hearing</td>
<td></td>
</tr>
<tr>
<td>sleeping</td>
<td>accidents/injuries</td>
<td></td>
</tr>
<tr>
<td>preventive measures for women</td>
<td>impairments</td>
<td></td>
</tr>
<tr>
<td>drug abuse</td>
<td>general perception</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FAMILY HISTORY</th>
<th>PSYCHOLOGICAL HEALTH</th>
<th>EFFECT ON ABILITY TO FUNCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>personal history</td>
<td>suicide</td>
<td>disability days</td>
</tr>
<tr>
<td>family history</td>
<td>psychological problems</td>
<td>mobility</td>
</tr>
<tr>
<td></td>
<td>positive mental health</td>
<td>need for assistance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ENVIRONMENT</th>
<th>SOCIAL HEALTH</th>
</tr>
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<tbody>
<tr>
<td>occupation</td>
<td>social problems</td>
</tr>
<tr>
<td>income</td>
<td></td>
</tr>
<tr>
<td>age</td>
<td></td>
</tr>
<tr>
<td>sex</td>
<td></td>
</tr>
<tr>
<td>education</td>
<td></td>
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<tr>
<td>social support</td>
<td></td>
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<tr>
<td>stressful events</td>
<td></td>
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</table>

Topics not included in the 1987 survey to be reviewed for inclusion in future surveys
- mental health of children under 15
- bio-medical data (e.g. cholesterol, glucose, blood pressure, etc.)
- eating habits
- sexual behaviour
- occupational health

(*) This list is modelled on that of the Canada Health Survey
Survey methodology

The target population of the 1987 survey includes all households of all of the provincial health regions in Québec except for region 10 (Nouveau-Québec) and the Indian reservations.

The household samples were taken in first stage sample units (FSSU). These units were determined from the division of the Province into 11 provincial health regions and then into 32 DSCs (département de santé communautaire). Each of the 32 DSCs was divided into geographic areas. These areas are made up of a census tract or a group of contiguous census groups. In urban DSCs the geographic areas which constitute FSSUs are made up of blocks, parts of blocks or block clusters. Samples were taken in two different stages in each DSC. The first stage consisted of a random sample of FSSUs proportional to the number of private households in the FSSU (according to the 1981 census). The second stage consisted of selecting a random sample of households taken from the FSSUs chosen previously. In this way, a total of 13 700 households were chosen.

The list of private households in each of the FSSU chosen was completed by an on-site enumeration. The enumeration precedes each wave of data collection.

Data collection

Data are collected by private interviews held directly in the households chosen and by a self-administered questionnaire.

Data collection are completed in the course of eight waves of three weeks held throughout 1987 so as to take into account seasonal health problems. The 13 700 households are equally divided among the eight waves. Thus, at each wave, each of the provincial health regions, each of the DSCs and one-eighth of the FSSUs chosen were visited. Ten households are chosen per FSSU per wave.

Survey organization

This survey is a unique undertaking made possible by the concerted efforts of a large number of partners from the health and social services network, the Ministère and the universities of Québec. The project was initiated by planners of the Ministère in response to their need for data. A first serie of objectives of the survey were then established and a contract signed with Douglas Hospital for the development of an instrument to measure mental health.

Following these initial stages, a pilot study was planned in collaboration with the Douglas Hospital and the Ministère with the active participation of the DSCs of Rimouski and Verdun. This led to a combined effort on the part of the DSCs and the ministère de la Santé et des Services sociaux to carry out the 1987 Québec Health survey.

The two parties agreed to assign the management of the project to a Project Manager answering directly to an administrative committee. The latter was made up of six members, three from each party. This committee is responsible for ensuring the scientific and technical quality of the survey and supervising the Project Manager’s activities. It also facilitates the participation of the parties’ human resources of the project.

The methodology was developed in cooperation with the Bureau de la Statistique du Québec. The development of the questionnaire and of the analysis framework was carried out with the help of recommendations from the DSCs, the Ministère and of the universities. Data collection and entry was contracted out to a private firm following a call for bids.

The technical papers

The series of technical papers of which this publication forms a part is aimed at examining various aspects of the Québec Health survey. The purpose of these documents is to provide information to prospective users of the survey and to serve as reference instruments for the planning of future surveys scheduled for 1992 and 1997.

Aline Emond
Project Manager
INTRODUCTION

One of the objectives of Santé Québec is to measure the mental health status of the Québec population.

In any country, data on mental health status is a matter of obvious interest. Discussions on concepts and methodology still persist, since a consensus on the irreducible elements of health and mental illness remains to be reached. Moreover, the reliability and validity of data measuring instruments vary according to set objectives. Consequently, the results obtained in wide mental health surveys are dependent upon the conceptual framework adopted and the limitations of the survey instruments used.

In Québec, there is a lack of useful data available for planning services and increasing our knowledge on mental health. Efforts by Santé Québec to achieve a "measurement" of the Québec population mental health status must be seen in this context.

The QHS** therefore decided to publish this sixth Technical Manual intended for planners and future data bank users. The purpose of this manual is to:

1. clearly define the conceptual framework within which the mental health survey is carried out, and the choice of variables;
2. bring up the scope and limitations of the instruments used to collect data on the psychological health status of the Québec population.

In order to make this text easier to read, very few bibliographical references are given. Reference material is grouped in the bibliography according to the major headings of the table of contents.

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* While the survey was being carried out and this manual was being prepared, the author, Ms. Chantai Perrault, was mental health advisor at the Maisonneuve-Rosemont DSC.

** QHS: Québec Health Survey.
PART ONE
Conceptual framework and choice of variables
Part One/Conceptual framework and choice of variables

1. Three generations of researchers: three conceptual frameworks

For over one hundred years in North America, efforts have been made to measure mental health status, or to evaluate, within a given society, the prevalence of various mental health problems and the risks associated with the occurrence of these problems. While the objective remains the same, the definition of a mental health problem varies under the combined effects of prevailing ideologies and of difficulties encountered along the way in the methodology applied. In order to provide a better understanding of Santé Québec's choices, we will give a short summary of the conceptual and methodological approach of "three generations of researchers" (Dohrenwend and Dohrenwend, 1982), whose objective was to measure the population's mental health status and to discover its determining factors and consequences.

1.1 First generation: endogenous causes and treated cases

This first generation began with the Jarvis studies in 1855, and ended with the Second World War. The first hypothesis on mental health problem distribution among the population were based on patient medical records. This generation believed in the endogenous nature of mental illness. As a result, its contribution consisted in bringing to the fore factors associated with care and services, and the importance of the frequency of cases which are not diagnosed and are untreated within the general population.

1.2 Second generation: social environment and psychological distress

The U.S. Army had a significant influence on research on mental health in North America. During the 1939-1945 War, every soldier recruited for overseas duty had to be given a clean bill of mental and physical health. The greatest number of rejects were those with a mental health problem (Weissman and Klerman, 1978). Moreover, many soldiers who were supposed to be mentally fit developed psychiatric problems after being exposed to combat or prisoners camps. This became one of the factors which again raised the issue of the endogenous nature of mental illness, and gave rise to theories on the effect of an unfavourable environment on the onset of mental health problems. A few years later, the works of Selye on stress fed and strengthened this trend.

Problems associated with recruiting and subsequent combat situations led the Army Research Branch to design simple, efficient, swift and economical screening instruments to assist clinical opinions and to set thresholds of vulnerability to psychiatric problems.

As a result, "check lists" or lists of symptoms were developed. These lists inspired the questionnaires on which were based the mental health scales used in mental health surveys conducted in North America.

Subsequently, many researchers became interested in the relationship between exposure to stress situations, various socio-economic conditions, and mental health problems.

In the 1950s, a further look at the objectivity of psychiatric diagnoses and the easy use of the U.S. Army check lists gave impetus to the development of mental health scales* based on the definition of a series of symptoms as a whole rather than on the identification of diagnostic criteria. Through these scales an attempt is made to appraise the frequency of people with sufficiently numerous and intense symptoms to be classified in a group "very likely at risk for a degree of psychological distress level that would require intervention" (Radloff, 1977).

Mental health scales were widely used in more than sixty mental health surveys. Two well known examples are the Stirling County Survey in Canada, and the Midtown Manhattan Study in the United States.

These surveys, have been the object of a critical review, carried out by Link and Dohrenwend for the President's Commission on Mental Health. The review concluded that:

- mental health scales give an indirect and imprecise measurement of the prevalence of mental health problems. On the other hand, the scales give an accurate and valid indication of what some people call "demoralization" and others "psychological distress"**.

- the prevalence of psychological distress seems to be constantly and consistently associated with age, sex, marital status, unfavorable economic

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* Also known as impairment scales.

** Since the expression "I am demoralized", as used in Québec, mostly refers to a depressive state, we shall use the term "psychological distress" for the remainder of this text.
conditions, mental health problems, chronic illnesses and recourse to care and services. It appears to be a highly significant indicator for estimating the risk of clinical illness among the population sub-groups which are exposed to chronic or unexpected stress.

Psychological distress in mental health problems taken as a whole is comparable to fever in infectious diseases. Although it is a measurable symptom evidencing a health problem, it cannot by itself shed light on the etiology and severity of the specific problem to which it relates.

1.3 Third generation: multiple causes and specific syndromes

According to some research findings, the psychosocial environment is a determining factor in certain mental problems, while in other problems heredity seemed to be the primary factor.

In order to further etiological knowledge, instruments must be designed to measure the frequency of specific syndromes within a given population. However, specific syndromes cannot be identified unless a majority of clinicians reach a consensus on what constitutes the objective and irreducible criteria of a specific syndrome.

An attempt was made to solve part of these problems in the Diagnostic and Statistical Manual of Mental Disorders (third edition, DSM-III), adopted in 1980 by the American Psychiatric Association. It consists of an identification and classification code of psychiatric disorders, based on a series of precise objective criteria necessary for reaching a diagnosis, and agreed to by all clinicians regardless of the school of thought – psychoanalysis, behaviourism, and so on – to which they may belong.

This code made it possible to develop instruments whose objective is to identify specific syndromes within the population, according to the criteria outlined in DSM-III. Best known among these instruments is the Diagnostic Interview Schedule (DIS), developed by a team of researchers headed by Dr. Lee Robins. The DIS was used in a survey on mental health conducted in five different regions of the United States by the National Institute of Mental Health, under the Epidemiological Catchment Area Program.

As regards mental health, the objectives given priority within this framework are akin to the general survey model attempting to grasp the determining factors and the consequences of health status. These objectives are to:

- evaluate the prevalence of the most frequent psychological problems;
- identify the environmental elements associated with this prevalence;
- assess the impact of these problems on the individual’s ability to function.

In 1981, the ministère de la Santé et des Services sociaux asked the psychosocial research unit of the Douglas Hospital Centre to select mental health indicators which would meet these objectives, and to propose adequate instruments designed to identify the problems sought and to measure their impact.

The Douglas team, aware of research development in the field, and of the works put out by the Epidemiological Catchment Area Program, looked into two possible choices:

- the use of mental health scales designed to determine depressive and anxious state and capable of supplying a reliable indication of psychological distress traceable to current conditions within the environment; or
- the use of questionnaires designed to diagnose the syndromes themselves, such as affective disorders (severe, mild, reactional depression), anxiety disorders (phobia, panic), and so on.

The research team decided to follow the suggestion of A.H. Leighton, senior investigator in the Stirling County Study, and of H.B. Murphy, and chose the first option consisting in measuring psychological distress (negative aspect) and psychological well-being (positive aspect). In 1981, it was too early to recommend the use of instruments making it possible to find specific diagnoses among a vast population, particularly within the framework of a general survey. Further studies were necessary to determine valid and reliable instruments, and the costs involved in the methodology used by the Epidemiological Catchment Area Program would have been prohibitive.

Santé Québec’s mental health section is therefore similar to the second generation studies.

The task at hand is the measurement of certain aspects of mental health throughout Québec among citizens aged 15 or over, using instruments already used for the same purposes in similar surveys. Determining factors in the psychosocial environment have been selected on the basis of previous or concurrent research. Santé Québec has set out to draw a picture of certain mental health problems within a psychosocial context which, according to current knowledge, seems to have an effect on these problems. Later on, when perusing the results, researchers should be able to develop hypotheses giving rise to further studies leading to a greater knowledge of mental health.

The determining factors of physical and mental health are outlined in Technical Manual 87-03: Sources and rationalizations of questions used in the Québec Health Survey. To avoid repetition, we shall focus on the reasons for selecting the determining factors and the instruments to be used.

3. Health status

3.1 Psychological problems

The term "psychological problems" applies to any pattern of behaviour occurring in an individual and associated with psychological pain, and a reduced ability to perform regular tasks. This definition is quite close to the definition of mental disorders given in DSM-III. It covers reactional crisis conditions as well as schizophrenic disorders.

The term "psychological problems" has been used because it is more precise than the term "mental health problems", and less medical sounding than the term "mental disorders".*

3.1.1 Mild psychological problems

While the word "mild" used here refers to problems which may be associated with psychological pain of great intensity, these problems can presumably be prevented or cured through a light infrastructure of care and services.

Since depressive or anxious state are the most common conditions, a mental health scale based mainly on the symptoms of depressive state and anxiety has been used for measuring the intensity of psychological distress (see Part Two).

We are dealing here with the recognition of symptoms and not the identification of diagnoses for depression, anxiety or other such conditions: to reach such a level of accuracy, instruments capable of defining diagnoses would have been necessary.

3.1.2 Suicidal thoughts and suicide attempts

In Québec as in most Western countries, suicide is a major problem which is becoming more and more prevalent among youth and older people (Charron, 1982). The Québec Health survey is attempting to discover the prevalence – over a lifetime and over a period of 12 months – of suicidal thoughts and suicide attempts. This will make it possible to determine research hypotheses and to better focus on suicide prevention.

3.1.3 Severe psychological problems

Severe mental problems are recognized as those which are particularly disabling; their prognosis is bad at the present time. While their prevalence is fairly low, their social and economic costs are enormous.

The survey framework is not the best one to study these problems. Institutions are excluded from the sampling, and the persons directly involved are not

* Task force mandated to review the mental health program (summer of 1986).
Part One/Conceptual framework and choice of variables

easily reached through a self-administered questionnaire. The instruments used will only make it possible to find out, through help from the household respondent, how some problems are distributed.

Severe psychological problems identified in this manner are:
- mental retardation
- other severe cognitive disorders
- depression
- long-lasting psychotic disorders.

3.2 Psychological well-being (positive mental health)

According to the World Health Organization, health is a state of physical and psychological well-being. It cannot be solely defined in the negative as the absence of illness disability. Such a definition is an attractive one within the field of mental health.

On the one hand, psychoanalytical tradition has always maintained that mental health was characterized by the expression of internal energy which, if it is not repressed, allows human beings to fulfill their intellectual, sexual and emotional needs. On the other hand, social science tradition maintains that there is no limit to the potential fulfillment of humans, provided they are placed in a favorable environment.

Mental health can be defined as a dynamic force with many components: the ability to cope with stress, to control one's emotions, to put one's energy to use, and so on. Since these components can be determined, it is assumed that their relative contribution to the health status can be measured. Since 1960, a number of researchers have concentrated their efforts on measuring positive mental health.

Following the Canada Health Survey, which attempted in 1979 to measure the psychological well-being of Canadians, the Douglas team proposed that a measurement of positive mental health be included in the Québec Health survey. This measurement was to be based on a subjective perception of seven factors of psychological well-being, each having a positive and a negative side.

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective feeling of being:</td>
<td>Subjective feelings of being:</td>
</tr>
<tr>
<td>• full of energy</td>
<td>• exhausted</td>
</tr>
<tr>
<td>• in control of one's emotions</td>
<td>• overwhelmed by emotions</td>
</tr>
<tr>
<td>• in good spirits</td>
<td>• in low spirits</td>
</tr>
<tr>
<td>• interested in life</td>
<td>• bored</td>
</tr>
<tr>
<td>• without stress</td>
<td>• stressed</td>
</tr>
<tr>
<td>• in good relationship with others</td>
<td>• lonely</td>
</tr>
<tr>
<td>• in a state of physical well being</td>
<td>• worried by one's health</td>
</tr>
</tbody>
</table>

4. Determining factors

Mental health status, like physical health status, varies according to major socio-demographic indicators: sex, age, income, and marital status. Other elements are added, however, to these determining factors and have an influence on various health components. This applies more particularly to stressful events and to social support.

4.1 Stressful events

Mental health research has contributed to identifying certain events which can cause stress and increase vulnerability to the latent development of psychosocial or psychological problems.

Since the early 1970s, various mental health surveys have attempted to measure the impact of some of these so-called stressful events: Canada Health Survey, the OHS pilot project*, phase 2 of the Epidemiological Catchment Area Program.

Only certain stressful events have been selected for measurement. Some researchers think that any event, whether happy or unhappy, which leads to a change in a person's life is a source of stress and consequently a source of vulnerability. Others claim that, on the contrary, according to the knowledge we have at the present time, selection of too large a number of those events must be avoided since the cause and effect relationship has only been recognized in a limited number of events. According to the literature, significant statistical correlations appear only in cases of events leading to an important loss or to a significant disruption of a person's way of life.

* For more information on the pilot survey, refer to Technical Manual No. 5.
4.1.1 Recent events

Eight recent events (which occurred within the last 12 months) have been selected for the purposes of the QHS. The pilot survey had studied 17 events. The eight events selected are among the eleven rated on the Holmes and Rahe scale as events most likely to induce severe stress.

The events selected are:
- moving away from one’s area
- loss of a regular job
- the early days of retirement
- serious personal illness
- serious illness in the family
- separation or divorce
- death of a spouse
- death of a loved one (other than a spouse).

4.1.2 Past events

In addition, the QHS will collect and compare data on four family disruptive events which could have occurred during childhood (before the age of 12), and which are claimed by many authors to be risk factors in the development of persistent psychological problems. The mother’s death has shown up as a factor of depression among women. Separation from parents during childhood has repercussions in the teenage years, and placement in a foster home appears to be associated with a number of adjustment problems among young adults. Considering the number of people reached by the Québec Health survey, we thought it might be interesting to find out if respondents whose childhood has been affected by a major family disruptive event are more liable than others to show symptoms of psychological distress.

The events selected are:
- mother’s death
- father’s death
- parents’ divorce or separation
- placement in a foster home.

4.2 Social support: acting as a buffer

According to Bozzini and Tessier (1985), one aspect among the many social and psychic determining factors of health and illness is persistently apparent for researchers and practitioners of various fields: the impact on health of the presence or the absence of social integration, of social interaction and support networks to which individuals might or might not have access.

Social support seems to act as a buffer and reduce the risks brought on by unfavourable conditions or stressful events. "Social support" and "social networks" refer to global entities which include some elements that are more important than others as factors of protection against psychological distress and suicidal behaviour. In the survey, data were collected on the following four elements:
- interaction within the social network
- satisfaction with the social network
- access to someone to confide in
- access to help in times of crisis.

4.2.1 Interaction within the social network

Following the Health Insurance Study (Donald, 1978), the annual frequency of social interactions with the family circle and friends has been analysed and compared with a measurement of social isolation over the last two months.

4.2.2 Satisfaction with the social network

Satisfaction found by a person within his or her various relations (not merely the presence of a spouse, children, relatives or friends) gives an indication of how that person will make use of the social network in time of stress. Obviously, if there is no spouse, no friends or no family, they cannot be called upon in time of stress, but being surrounded by such people does not necessarily mean there is enough confidence in one’s immediate circle to lean on them when problems are experienced.

Instruments measuring the quality of informal social support always pose the problem of interpretation since they are highly subjective. Moreover, we may wonder which direction cause and effect relationship will take, if such a relationship exists. Does a lack of friends make a person more vulnerable to depression? Or do persistent symptoms of irritability and despondency, often related to depressive state, keep friends away?

Among the questions used during the QHS pilot project, only those whose answers had produced significant statistical results or those easier to interpret...
were used. They dealt with personal satisfaction regarding:

- social life in general,
- relationship with friends,
- relationship with spouse,
- relationship with others in the work environment.

4.2.3 Access to someone to confide in

Apart from the size of the available social network, to have a trustworthy person to confide in appears to be a significant psychological disorientation preventive in time of crisis. The QHS has therefore included a question designed to ascertain the presence or the absence of a person in whom one may confide within his or her own social circle.

4.2.4 Access to help in times of crisis

Access to concrete help – organization, ready assistance, financial assistance, and so on – seems to reduce the risk of psychiatric decompensation and of greater psychological distress. A question on the subject has been added.
PART TWO
Measuring instruments
In this second part, we will review the instruments selected, and concentrate on their possibilities and their limitations.

We will deal with:

- Mental health status measuring instruments;
  - F.W. Ilfeld’s Psychiatric Symptom Index (PSI)
  - Santé Québec Well-Being Index (BESQ)
  - questions on suicidal thoughts and suicide attempts
  - questions on severe psychological problems

- Instruments designed to find specific psychosocial factors in mental health;
  - questions on stressful events
  - questions on social integration.

1. F.W. Ilfeld’s Psychiatric Symptom Index (PSI)

SAQ (Self-administered questionnaire), section V: “Various health problems”, questions 30 to 58

The PSI is an abbreviated version of the Hopkins Symptom Distress Checklist, a mental health scale which includes 54 items of significant clinical symptomatology and covers, according to its author, four specific dimensions:

- depression
- anxiety
- aggressiveness
- cognitive disorders.

Ilfeld eliminated somatic symptoms from the 54 original items, because they could have an organic cause. He selected for the four dimensions mentioned above the symptoms found most significant through a factorial analysis. Following this selection, 28 questions remained, to which Ilfeld added one dealing with the feeling of solitude. Those 29 questions became part of the Psychiatric Symptom Index (Ilfeld, 1976).

The PSI, like any other mental health scale, distributes mental health “scores” computed on the basis of a serie of questions calling for closed answers and dealing with a variety of psychological or physical symptoms which are believed to be related to various psychiatric disorders, neurotic ones mostly.

V- VARIOUS HEALTH PROBLEMS

The following questions are about various aspects of your health.

How you felt last week could be different from how you felt during the past year. Please tell us how often DURING THE PAST WEEK did you

<table>
<thead>
<tr>
<th>Question</th>
<th>Circles</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 - Feel low in energy or slowed down?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>31 - Feel faint or dizzy?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>32 - Have your heart pound or race when not physically active?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>33 - Have trouble concentrating?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>34 - Feel hopeless about the future?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>35 - Feel lonely?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>36 - ‘Have your mind go blank’?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>37 - Lose sexual interest or pleasure?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>38 - Sweat when not working hard or overheated?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>39 - Feel downhearted or blue?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>40 - Feel tense or under pressure?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>41 - Lose your temper?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>42 - Have an upset or sour stomach?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>43 - Feel bored or have little interest in things</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>44 - Notice your hands trembling?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>45 - Feel fearful or afraid?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>46 - Have trouble remembering things?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>47 - Have trouble going to sleep or staying asleep?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>48 - Cry easily or feel like crying?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>49 - Feel short of breath?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>50 - Have a poor appetite?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>51 - Have to avoid certain things places activities because they frightened you?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>52 - Feel nervous or shaky inside?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>53 - Have any thoughts about possibly ending your life?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>54 - Feel critical of others?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>55 - Feel easily annoyed or irritated?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>56 - Get angry over things that are not too important?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>57 - Have difficulty making decisions?</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>58 - Have tightness or tension in your neck, back or other muscles?</td>
<td>1 2 3 4</td>
</tr>
</tbody>
</table>
As in other mental health scales, Ilfeld’s objective is to use the quantity and quality of reported symptoms for establishing, within the target population, the frequency of individuals:

1. likely to have a psychiatric diagnosis,
2. presenting a fairly high risk,
3. presenting a low risk.

**Major uses**

- Research on the social origins of stress. Principal Investigator: Leonard L. Perlin, from the Laboratory of Socio-environmental Studies (National Institute of Mental Health).
  
  Place: Chicago area
  
  Sampling: 2299 adults, 18 to 64 years old, living at home
  
  Questionnaire: administered by an interviewer (Ilfeld, 1976).

- QHS pilot project. Principal Investigator: Viviane Kovess, from the Douglas Hospital psychosocial research unit.
  
  Place: DSCs of Rimouski and Verdun.
  
  Sampling: 3138 persons, 15 years old and over, living at home.
  
  Questionnaire: self-administered (Kovess, 1985).

**Validation**

Ilfeld considered that the Hopkins Symptom Distress Checklist was well validated, and used its abbreviated version fully in the Chicago Survey. He was careful, however, to check some factors designed to confirm the validity of the reduced list. He used the following three criteria:

- visits to professional health services for mental health problems during the past year;
- use of psychotropic drugs during the past week;
- the degree of “tension” noted by the interviewer.

Taking account of the major socio-economic determining factors (age, sex, education, income, occupation, marital status), the "p" value remains lower than 0.001 for these three criteria.

Ilfeld’s questionnaire has been translated into French by researchers from the QHS pilot project. The absence of significant differences between answers supplied by francophones and anglophones leads us to believe that the French version is as reliable as the English version.

**Scoring the answers**

In the Chicago Survey, Ilfeld’s scoring is as follows: each answer to the 29 questions is rated from 0 to 3:

- never = 0
- from time to time = 1
- fairly often = 2
- very often = 3.

The summation of individual scores is divided by the maximum score (29 X 3), and multiplied by 100 in order to achieve standardized scores.

In the Santé Québec pilot project, the scoring is different. In order to spread out the answers and to obtain better data on sub-groups (Kovess, 1985), the following values were attributed to the answers:

- never = 0
- from time to time = 1
- fairly often = 3
- often = 5.

In this survey, the scores calculation suggested by Ilfeld were used.

\[
\text{PSI score} = \frac{\sum Q_{30-58} 	imes 100}{3 \times 29}
\]

Through a factorial analysis Ilfeld tried to bring out four psychological dimensions.

The following questions concern depressive symptoms:

SAQ: #30, 34, 35, 37, 39, 43, 47, 48, 50, 53.

The following questions concern anxiety symptoms:

SAQ: #31, 32, 38, 40, 42, 44, 45, 49, 51, 52, 58.

The following questions identify aggressivity symptoms:

SAQ: #41, 54, 55, 56.

The following questions identify cognitive disturbance symptoms:

SAQ: #33, 36, 46, 57.

In the course of their analysis researchers could, if they so wish, try and check through a factorial analysis if the foregoing questions really apply to those factors in the Québec sample; or they could use algorithms to explore these elements on the basis of data from the survey.
Symptomatology cut points

The PSI, like most mental health scales, attempted to separate respondents into groups having a high, average or low symptomatology. Ilfeld explained that he defined his groups arbitrarily on the basis of prior epidemiological studies. High symptomatology accounted for the 15% of the sample with the highest scores, while average symptomatology accounted for the next 25% of sample on the ranking, and the low symptomatology represented the 60% with the lowest scores.

In the Chicago Survey, 15% of the respondents scored 20 or more, making up for a high symptomatology, while in the QHS pilot project 15% of the sample is equivalent to a score of 30 or more (Kovess, 1985). This difference has not been explained so far. In neither the PSI nor in other mental health scales is it possible to rely on objective criteria to determine at which symptomatology level a person topples over the edge of health into illness. This difficulty, often mentioned by various authors, is inherent in the use of impairment scales.

Consequently, the decision of thresholds or cut points is left to the discretion of the authors. A population with high symptomatology may vary from 8% to 25% according to the scales used and the population studied.

In order to get around this problem and to avoid making decision about a critical threshold, we suggest analyses based on quintiles of the reference population.

<table>
<thead>
<tr>
<th>Symptomatology</th>
<th>Chicago Survey</th>
<th>Québec Health survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>15%</td>
<td>20% 5th quintile</td>
</tr>
<tr>
<td>Average</td>
<td>25%</td>
<td>20% 4th quintile</td>
</tr>
<tr>
<td>Low</td>
<td>60%</td>
<td>20% 3rd quintile</td>
</tr>
</tbody>
</table>

There are 6 possible answers to each of these 14 questions; all questions relate to the month preceding the administration of the questionnaire.

Some of the QHS measurements are expected to be repeated periodically. It would be interesting, therefore, to keep an eye on the evolution of environmental characteristics and, at the same time, on the evolution of the psychic distress scores within population quintiles.

2. Santé Québec Well-Being Index (BESQ)

SAQ, "Your well-being", questions 92a to 92n

- Source

The Santé Québec Well-Being Index is inspired by H.J. Dupuy's General Well-Being Scale, created in the United States in 1969 for the National Center for Health Statistics, and used in two major surveys, among others:

- the National Health and Nutrition Examination Survey, 1971, 1974,
- the Health Insurance Study, 1974.

Dupuy's scale is an instrument designed to measure psychological well-being, or positive mental health. The original scale included 25 questions probing various elements of psychological well-being. Dupuy's scale has been thoroughly validated, and it is considered one of the better indices of psychological well-being. Its effectiveness in the identification of symptomatology levels has been compared with other instruments (negative mental health scales); its performance compared favourably with other instruments.

More particularly, questions 1 to 14 probe the positive and negative sides of six subjective psychological adaptation indicators:

| I level of energy | 2 questions |
| II control of emotions | 3 questions |
| III state of morale | 2 questions |
| IV interest in life | 2 questions |
| V perceived stress | 3 questions |
| VI perceived health status | 2 questions |

We know that the higher the symptomatology level, the higher the risk of experiencing serious problems. We know also, that sociocultural conditions have a significant, although little understood, influence on the symptomatology of psychological distress. Sociocultural conditions of the environment evolve in our post-industrial societies.
The indicators used by Santé Québec were:
1. energy
2. control of emotions
3. state of morale
4. interest in life
5. perceived stress
6. perceived health status
7. satisfaction about relationship

The questions are formulated as an affirmation rather than an interrogation; for each of the seven indicators, one question probes the positive side, and one question the negative side. The person interviewed chooses from 4 possible answers to each question. In addition, the reference period becomes the year preceding the administration of the questionnaire.

Even if inspired from the Dupuy Scale, the Santé Québec Well-Being Index (BESQ), following all these changes, is an original index which has yet to be validated.

**Measurements and assessment criteria**

**Opposition of pairs**

One of the features of positive mental health scales is the probing of the positive affect and the negative affect of a psychological indicator. To probe the subjective perception of the energy level, the BESQ requires the respondent to qualify each of the following two statements:

SAQ92a: I felt full of pep and energy
   (1) Hardly ever; (2) Less than half time; (3) More than half time; (4) Most of the time.

SAQ92b: I felt exhausted, worn out, at the end of my rope
   (1) Hardly ever; (2) Less than half time; (3) More than half time; (4) Most of the time.

Some authors claimed that a certain independence exists between positive and negative affect measurements. On the other hand, in the Canada Health Survey the gamma coefficients between positive and negative scores varied by only 0.10 to 0.15, while in the Dupuy Scale the independence of positive and negative scores has not been demonstrated (Ware et al., 1979). In their analysis researchers will ascertain that, within each pair, the circling of answers I or II to a question corresponds to the circling of III or IV in answer to the paired question. Pre-testing carried out at this stage on the basis of available preliminary data seems to indicate the opposition of negative and positive feelings.
positive affects in each pair, except for the perceived health status.

- Other validation criteria

If the BESQ Index has an effectiveness comparable to other scales, there should be, according to what has been published, significant statistical differences between respondents with a low level of psychological well-being and those with a high level of psychological well-being, as regards:
  - the presence of a chronic health problem,
  - the level of income.

These relationships could be evaluated during the analysis. The first report on the survey data will reflect validation and reliability measurements which will help future users in more advanced relevant analyses.

Scoring the BESQ Index

Our method of scoring is similar to that used by Dupuy for computing his emotional adaptation indicators (Fazio, 1977).

For the questions concerning positive affect, answers are rated as follows:

- Hardly ever: 0
- Less than half time: 1
- More than half time: 2
- Most of the time: 3

For the negative affect, questions are rated in reverse order:

- Hardly ever: 3
- Less than half time: 2
- More than half time: 1
- Most of the time: 0

Points are added from 0 to 6 for each pair; then the results of the pairs are added up. On the BESQ Index a score varying between 0 and 42 is therefore obtained (see Table: “Scoring the Well-Being Index”). A high score (35 to 42) indicates a positive emotional adaptation.

3. Questions on suicidal thoughts and suicide attempts

SAQ, section VI: “Suicide”, questions 59 to 62

The questions concerning suicidal thoughts and suicide attempts were not tested during the QHS pilot project. They were formulated and prepared by Michel Tousignant, principal investigator in a large-scale project on the suicidal behaviour of Cegep students in the Montréal area. This study revealed that clear and precise questions on the subject did not seem to call for understatement or unanswered questions. The questions were included in the SAQ, a strictly confidential questionnaire. Their purpose was to collect data on specific facts and gave rise to a “yes” or “no” answer. Consequently, these questions avoided any attempt to qualify the number of suicidal actions and the life environment where these actions may have taken place. We attempted by this procedure to reduce the understatements. According to preliminary data the number of unanswered questions is lower than 4%.

The questions are formulated with a view to gathering information on the frequency of serious suicidal thoughts and of suicide attempts within the past year, and during the previous years.

VI- SUICIDE

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>59-Did you ever SERIOUSLY think about committing suicide taking your life?</td>
<td>1</td>
<td>2 → Go to Q 63</td>
</tr>
<tr>
<td>60-Did this happen during the past twelve months?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>61-Did you ever attempt suicide try to take your life?</td>
<td>1</td>
<td>2 → Go to Q 63</td>
</tr>
<tr>
<td>62-Did this happen during the past twelve months?</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

4. Questions concerning severe psychological problems

ICQ, section VII: “Chronic health problems”, questions 45i, 45m, 45y, 45z, 45bb

The Québec survey, using the same methodology as the Canada Health Survey, took a census of chronic health problems in each household. This information was supplied by the head of the household. The Canada Health Survey questionnaire focused on two mental health problems:

- Mental retardation
## TABLE: SCORING THE WELL-BEING INDEX

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>POSITIVE AFFECT</th>
<th>NEGATIVE AFFECT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>QAA 92</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1. Energy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. I have been feeling full of pep and energy</td>
<td>I Hardly ever</td>
<td>II Less than half time</td>
<td>III More than half time</td>
</tr>
<tr>
<td><strong>2. Control of emotions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. I had no problems handling my feelings (no tensing up)</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>3. Morale</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. I felt cheerful and light-hearted</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>4. Interest in life</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Many interesting things happened</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>5. Stress</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. I felt reasonably relaxed</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>6. Perception of health status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. My health gave me no concern</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>7. Quality of relationship</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. I felt quite loved and appreciated</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
While we kept the question concerning mental retardation (ICQ, 45), we replaced "Some emotional disorders or other" by 4 more specific questions.

ICQ 45: Is there anyone in the household who has:
- depression
- periods of excessive nervousness or irritability
- periods of confusion or frequent important memory losses
- a period of 6 months or more when he (she) has visions, hears voices or thinks that someone is spying on him (her).

These questions will make it possible to differentiate some of the serious psychological problems. However, care must be exercised when interpreting the results, for the following reasons:

(a) In popular parlance in Québec the term "depression" tends to be referred to as a series of psychological disorders serious enough to impair the regular functioning of a person, but which cannot be associated with psychosis ("folie") or addictions. The term "depression", for most people, seems to cover a variety of neurotic disorders.

(b) Serious nervousness and irritability are symptoms shared by many psychiatric syndromes such as depression, anxiety and various psychotic disorders. The results will no doubt show the distribution of symptoms serious enough to be reported by the household respondent.

(c) While confusion and serious and frequent loss of memory may relate to mental health problems, they can also apply to problems of a neurological or cerebrovascular nature. Consequently, age and other reported chronic physical problems will have to be considered when analysing the results.

(d) Question 45bb is based on DSM-III criteria used in detecting schizophrenic disorders. An affirmative answer to this question will likely identify a person with schizophrenic disorders. On the other hand, individuals who experienced their first hallucinations within the past 6 months will not be detected. Moreover, other criteria must be present in order to reach a precise diagnosis.

5. Questions on recent stressful events
SAQ, section XIII: 'The important changes in your life', questions 97 to 104.

Elsewhere in this manual, we indicated how the eight chosen events have been selected (Part One, 4.1.1).
Like in the Canada Health Survey and in the QHS pilot project, the questions on recent events have been included in the SAQ. However, while those two surveys were limited to taking census of the events, this survey is asking respondents to qualify the stress they felt. This has been inspired by the second wave questionnaire of the Epidemiological Catchment Area Program, which used two possible qualifications: very stressing events and slightly stressing events. In order to obtain a wider range of answers, our questionnaire gives a choice of four answers: extremely stressful events, more or less stressful, slightly stressful and not at all stressful.

6. Questions on past events
SAQ, section XIII: “The important changes in your life”, questions 93 to 96

For reasons explained in the first part of this manual, 4 questions have been included in the SAQ, concerning major family disruptive events which occurred before the respondent reached the age of 12. The events chosen were the death of the father or mother, separation or divorce of the parents and placement in a foster home. Questions on this type of event bring out, to our knowledge, relevant and out-of-the-ordinary information in mental health surveys. The questions were carefully selected. Specific information is obtained without the threat of embarrassing questions such as those concerning sexual abuse.

As regards events which took place more than one year before a questionnaire administration, some authors have concluded that respondents’ memory concerning dates and emotions felt was not very reliable. Therefore, the questions were formulated in the form of demographic information calling for “yes” or “no” answers.

7. Questions on social integration
SAQ, section XI: “Your life in general”, questions 84 to 91; section XVI, “Work”, question 136

Question 84 is designed to evaluate the frequency in the past year of respondent’s social interactions with people around him (her). Question 85 evaluates the frequency in the past two months of leisure time spent alone or with other people.

Questions 86, 87, 88 and 89 evaluate, on a scale of 1 to 4, the respondent’s degree of satisfaction regarding his (her) social life in general, or regarding his (her) relationship with spouse, friends and children. Questions 90 and 91 attempt to determine the presence or absence of someone who can be confided in, and the presence or absence of someone who can help in times of crisis. In addition, question 136 brings out further light on the help the person can count on when difficulties are encountered at work. On the basis of these questions a social integration index could be developed.
XI- YOUR LIFE IN GENERAL

The following questions are about your relationships with the people around you and the satisfaction you get from life.

84 During the past 12 months how often did you participate in family gatherings, meetings with friends or acquaintances?

CIRCLE YOUR ANSWER

- More than once a week
- Once a week
- At least once a month
- About once a year
- Never

85 Which one of the following best describes how you spent your leisure time during the past 2 months?

CIRCLE YOUR ANSWER

- Almost all of it by myself
- More than half of it by myself
- About half of it by myself and half of it with others
- More than half of it with others
- Almost all of it with others

86 How would you describe your social life?

CIRCLE YOUR ANSWER

- Very satisfactory
- Somewhat satisfactory
- Somewhat unsatisfactory
- Very unsatisfactory

87 a) Do you have friends?

CIRCLE YOUR ANSWER

- Yes
- No

b) If YES, in general are you satisfied with your relationships with your friends?

CIRCLE YOUR ANSWER

- Very satisfied
- Somewhat satisfied
- Somewhat unsatisfied
- Very unsatisfied

88 a) Do you have children of your own?

CIRCLE YOUR ANSWER

- Yes
- No

b) If YES, do you find your relationship with your children?

CIRCLE YOUR ANSWER

- Very satisfactory
- Somewhat satisfactory
- Somewhat unsatisfactory
- Very unsatisfactory

89 a) Are you presently married or living with someone?

CIRCLE YOUR ANSWER

- Yes
- No

b) If YES, how do you feel about this relationship?

CIRCLE YOUR ANSWER

- Very satisfactory
- Somewhat satisfactory
- Somewhat unsatisfactory
- Very unsatisfactory

90 In your surroundings or in your family, is there someone you can confide in or talk to freely about your problems?

CIRCLE YOUR ANSWER

- Yes
- No

91 In your surroundings or in your family, is there someone who can help you in case of necessity?

CIRCLE YOUR ANSWER

- Yes
- No

XVI- WORK

RESPOND ONLY IF YOU ARE PRESENTLY GAINFULLY EMPLOYED (SALARIED OR SELF EMPLOYED) IF NOT, GO TO Q 137

136 Do your employer, foreman or workmates help you if you encounter difficulties in your work?

CIRCLE YOUR ANSWER

- Always
- Often
- Sometimes
- Rarely
- Never
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Mental health instruments methodology - scope and limitations