



(For research team) WP5 baseline evaluation (A and B). Participant code: _____

RHAPSODY
research and strategy for dementia in the young

RHAPSODY

(Research to Assess Policies and Strategies for Dementia in the Young)

The questionnaire is anonymous. Please answer as honestly and accurately as you can. The information you provide will be treated with respect (as explained in the information sheet provided).

The information you provide is important and appreciated.

For dates, please use the form /_/_/ /_/_/ /_/_/_/_/.
 DD MM YYYY

For example: July 13, 1952: /_1/_3_/ /_0/_7_/ /_1_/9_/5/_2_/
 DD MM YYYY

Date : |_|_| |_|_| |2|0|1|6|

DD MM YYYY

Participant Code: |_|_|_|_|_|

Researcher (Surname, first name): _____

1. Background Information Questionnaire

This questionnaire asks about you, the person you care for, and the services that are available.

There is no right or wrong answer – we are interested in your experience.

Section A : Criteria

1.	What is your relationship with the person with dementia who you care for?	<input type="checkbox"/> Spouse/partner <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other relative <input type="checkbox"/> Friend
2.	Do you live in the same household as the person with dementia?	<input type="checkbox"/> Yes, all of the time <input type="checkbox"/> Yes, some of the time <input type="checkbox"/> No If no, where does the person with dementia live? <input type="checkbox"/> Care institution <input type="checkbox"/> Other household <input type="checkbox"/> Other _____
3.	Is English the language you usually speak at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Do you agree with the following statement: I know how to get information from the internet using a computer, tablet or smartphone.	<input type="checkbox"/> Yes <input type="checkbox"/> No <u>If your answer is no, the researcher may consider discontinuing.</u>

Section B: About yourself (as the carer)

5.	What year were you born?	<div style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <div style="text-align: right;">DD MM YYYY</div>
6.	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
7.	Over the last 4 weeks , how would you rate your overall health?	<input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Very poor
8.	Have you attended college or university beyond the age of 18 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	What is your employment status?	<input type="checkbox"/> Employed full time (35 hr/wk or more) <input type="checkbox"/> Employed part-time (Less than 35 hr/wk) <input type="checkbox"/> Full-time carer <input type="checkbox"/> Not employed <input type="checkbox"/> Retired <input type="checkbox"/> Other, please specify : _____ _____
10.	How many hours a week do YOU provide assistance, care, supervision or companionship to the person with dementia?	<input checked="" type="checkbox"/> < 5 hours <input type="checkbox"/> 5 -10 hours <input type="checkbox"/> >10 hours
11.	When did you begin care-giving?	<div style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <div style="text-align: right;">MM YYYY</div>
12.	Over the last 4 weeks , about how many days away from your caring responsibilities have you had? (Please add half days together to give a total number of days.)	<input type="checkbox"/> < 5 days <input type="checkbox"/> 5 -10 days <input type="checkbox"/> > 10 days
13.	Roughly how long can you leave the person you care for at home alone?	<input type="checkbox"/> Not at all <input type="checkbox"/> Up to 1 hour <input type="checkbox"/> Up to a ½ day <input type="checkbox"/> A whole day <input type="checkbox"/> A whole day and night

Section D: About the medical and paramedical services you and the person with dementia receive

22	<p>In the last 12 months, which type(s) of doctor has the person you care for seen about dementia? (<i>Please check all that apply</i>)</p> <p>How many appointments has the person had in the last 12 months?</p>	<p>Psychiatrist <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Neurologist <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Geriatrician (specialist in care of older people) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>General practitioner (GP) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other <input type="checkbox"/> Yes <input type="checkbox"/> No (please specify) : _____</p> <p><input type="checkbox"/> < 5 appointments</p> <p><input type="checkbox"/> 5 -10 appointments</p> <p><input type="checkbox"/> 10-15 appointments</p> <p><input type="checkbox"/> > 15 appointments</p>
23.	<p>In the last 12 months, has the person you care for seen any other health professional about dementia</p> <p>How many such appointments has the person had in the last 12 months?</p>	<p>Nurse <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Psychologist <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Speech and language therapist <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Physiotherapist <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please specify : _____</p> <p><input type="checkbox"/> < 5 appointments</p> <p><input type="checkbox"/> 5 -10 appointments</p> <p><input type="checkbox"/> 10-15 appointments</p> <p><input type="checkbox"/> > 15 appointments</p>
24	<p>Does the person you care for have any prescribed medications for dementia (I.E. for memory, behavior or mood symptoms?)</p>	<p><input type="checkbox"/> Yes, please state name and dose of medication (if known)</p> <p>_____</p> <p><input type="checkbox"/> No</p>
25	<p>Have you (the carer) had appointments with any of the following professionals in the last 12 months?</p>	<p>Family practitioner/ GP <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Psychologist <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Psychiatrist <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please specify _____</p>

	How many such appointments have you (the carer) had in the last 12 months?	<input type="checkbox"/> < 5 appointments <input type="checkbox"/> 5 -10 appointments <input type="checkbox"/> > 10 appointments
26	Are you currently taking any medication for problems with mood, stress or sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes, please state name and dose of medication _____ _____ _____ _____

Section E: About the support services you and the person with dementia receive

27	Does anyone else help you with the care of the person with dementia? (If no, continue to question 30.)	<input type="checkbox"/> <input type="checkbox"/> No. I am the only carer (go to question 29) <input type="checkbox"/> <input type="checkbox"/> Yes, other people help. <div style="text-align: right;">Son / Daughter <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> <input type="checkbox"/> No</div> <div style="text-align: right;">Friend / Neighbour <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> <input type="checkbox"/> No</div> <div style="text-align: right;">Professional or voluntary worker <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> <input type="checkbox"/> No</div> <div style="text-align: right;">Other (please specify) _____</div>
28	If yes, about how many hours of help provided per week?	<input type="checkbox"/> <input type="checkbox"/> From friends / family: <div style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/> < 5 hours <input type="checkbox"/> <input type="checkbox"/> 5 - 10 hours <input type="checkbox"/> <input type="checkbox"/> > 10 hours</div> <input type="checkbox"/> <input type="checkbox"/> From paid help: <div style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/> < 5 hours <input type="checkbox"/> <input type="checkbox"/> 5 - 10 hours <input type="checkbox"/> <input type="checkbox"/> > 10 hours</div>
29	Does the person you care for require help with personal care, such as washing or dressing?	<input type="checkbox"/> <input type="checkbox"/> Yes. If yes, who helps with this? <div style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/> Me <input type="checkbox"/> <input type="checkbox"/> Professional care (nurse / home help) <input type="checkbox"/> <input type="checkbox"/> Other, please specify _____</div> <input type="checkbox"/> <input type="checkbox"/> No
30	Are there organisations (public or charity organisations) who ever take care of the person with dementia at a centre so that you can take a break and have time off from caring?	<i>Individual or Group activity organized by professionals/ volunteers</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <div style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/> < 5 times per month <input type="checkbox"/> <input type="checkbox"/> 5 - 10 times per month <input type="checkbox"/> <input type="checkbox"/> > 10 times per month</div> <i>Adult day center</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <div style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/> < 5 times per month <input type="checkbox"/> <input type="checkbox"/> 5 - 10 times per month <input type="checkbox"/> <input type="checkbox"/> > 10 times per month</div>

		<p><i>Short-stay care (e.g. 1 night, 1 weekend)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> < 5 times per month</p> <p><input type="checkbox"/> <input type="checkbox"/> 5 -10 times per month</p> <p><input type="checkbox"/> <input type="checkbox"/> > 10 times per month</p> <p><i>Respite care center (more than 1-2 nights)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> < 5 times per month</p> <p><input type="checkbox"/> <input type="checkbox"/> 5 -10 times per month</p> <p><input type="checkbox"/> <input type="checkbox"/> > 10 times per month</p>
31	Have you ever attended a support group for carers?	<p><input type="checkbox"/> <input type="checkbox"/> No, I have never attended a group for carers</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, in the past but not currently</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yes, I currently attend a support group for carers</p> <p>If yes, please state the name and type of group :</p> <p>Name of group/ Service provider _____</p> <p>Type of group :</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Discussion group</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Training or educational programme for carers</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other : _____</p>
32	If you or the person with dementia use any support services or resources not mentioned above, please describe them here :	<p>_____</p> <p>_____</p>

2. Coping with Caregiving Questionnaire

How well informed do you feel about coping with early onset dementia?

To understand your experience of living with someone with young onset dementia, it is important to us to know how well informed you feel about ways of caring and coping. **Please read each item below, and tick the box that best indicates how well informed you feel today about the topic.**

	Topic	Very poorly informed 1	Poorly informed 2	Moderately informed 3	Quite well informed 4	Very well informed 5	Not Applicable to my situation 9
1	Symptoms of young onset dementia						
2	Dementia treatments (drugs and/or therapies)						
3	Differences between dementia in younger and older people						
4	The different ways dementia affects individuals						
5	How to help with memory problems						
6	How to help with language problems						
7	How to help with orientation problems						
8	How to help with depression and anxiety						
9	How to help with agitation and anger						
10	How to cope with changes in your relationship						
11	How to cope with your own emotions (anger, grief, guilt)						
12	Finding out about legal and financial matters						
13	Where to find out about community support						
14	How to ask others for practical help						
15	When respite or residential care may help						
16	How talking to others about dementia may help						
17	How to relax and find time to look after yourself						

Data not used

3. Revised Scale for Caregiving Self-Efficacy

We are interested in how confident you are that you can keep up your own activities and also respond to caregiving situations. Please think carefully about the questions asked below and be as frank and honest as you can about what you really think you can do. Please think about each item and state how confident you are that you could do each item.

Rate your degree of confidence from 0 to 100 using the scale below.

0	10	20	30	40	50	60	70	80	90	100
Cannot do at all					Moderately certain can do					Certain can do

For example, a rating of 20% confidence means that it is unlikely, but not totally out of the question for you to be able to perform the activity. A rating of 100% means that you are absolutely certain that you could perform the activity whenever you wished. A 50 confidence rating means that if you gave it your best effort, chances are about 50-50 that you could perform the activity. You can use any score between 0 and 100 (10, 20, 30, etc.) to express your confidence.

--- Please make all your ratings based on what you could do **TODAY**, as the person you are **NOW** rather than on the person you used to be, or the person you would like to be. Rate how you think you would do as you are **TODAY**. ---

PRACTICE RATING

To familiarize you with the rating form, please complete this practice item first.

0	10	20	30	40	50	60	70	80	90	100
Cannot do at all					Moderately certain can do					Certain can do

If you were asked to lift objects of different weights right now, how confident are you that you can:

Physical Strength

1. Lift a 10 pound 5 kilogram (kg) object *Certainty (0-100)* _____%
2. Lift a 20 pound 10 kg object *Certainty (0-100)* _____%
3. Lift a 50 pound 20 kg object *Certainty (0-100)* _____%
4. Lift a 100 pound 45 kg object *Certainty (0-100)* _____%

As a guide, a typical bag of sugar weighs just over 2 pounds (1 kilogram), so a 10 pound object would be similar to a shopping bag holding 4 bags of sugar.

For the questions below, please rate **how confident you are that you can do the following activities**. If a question is *absolutely* not applicable to your situation, write N/A.

0	10	20	30	40	50	60	70	80	90	100
Cannot do at all					Moderately certain can do					Certain can do

Self-Efficacy for Obtaining Respite

5. How confident are you that you can ask a friend/family member to stay with the person with young onset dementia (YOD) for a day when you need to see the doctor yourself?

Certainty (0-100) _____%

6. How confident are you that you can ask a friend/family member to stay with the person with YOD for a day when you have errands to be done?

Certainty (0-100) _____%

7. How confident are you that you can ask a friend or family member to do errands for you?

Certainty (0-100) _____%

8. How confident are you that you can ask a friend/family member to stay with the person with YOD for a day when you feel the need for a break?

Certainty (0-100) _____%

9. How confident are you that you can ask a friend/family member to stay with the person with YOD for a week?

Certainty (0-100) _____%

0	10	20	30	40	50	60	70	80	90	100
Cannot do at all					Moderately certain can do					Certain can do

Self-Efficacy for Responding to Disruptive Patient Behaviors

10. When the person with YOD forgets their daily routine and asks when lunch is right after they have eaten, how confident are you that you can answer him/her without raising your voice?

Certainty (0-100) _____%

11. When you get angry because the person with YOD repeats the same question over and over, how confident are you that you can say things to yourself that calm you down?

Certainty (0-100) _____%

12. When the person with YOD complains to you about how you're treating him/her, how confident are you that you can respond without arguing back? (e.g., reassure or distract him/her?)

Certainty (0-100) _____%

13. When the person with YOD asks you 4 times in the first one hour after lunch when lunch is, how confident are you that you can answer him/her without raising your voice?

Certainty (0-100) _____%

14. When the person with YOD interrupts you for the fourth time while you're making dinner, how confident are you that you can respond without raising your voice?

Certainty (0-100) _____%

All caregivers sometimes have negative thoughts about their situation. Some thoughts may be brief and easy to get rid of. Other times, thoughts may be hard to put out of your mind, just like a silly tune is sometimes hard to get out of your mind. We would like to know how well you can turn off any of the following thoughts. Use the same confidence rating. Don't be concerned about how often the thoughts come up. We want you to rank your confidence that you can turn off or get rid of each type of thought when it does come up."

If you have absolutely never had the thoughts in one of the items, put "N/A" (not applicable) on the line for rating confidence.

0	10	20	30	40	50	60	70	80	90	100
Cannot do at all					Moderately certain can do					Certain can do

Self-Efficacy for Controlling Upsetting Thoughts about Caregiving

15. How confident are you that you can control thinking about unpleasant aspects of taking care of the person with YOD?

Certainty (0-100) _____%

16. How confident are you that you can control thinking how unfair it is that you have to put up with this situation (taking care of the person with YOD)?

Certainty (0-100) _____%

17. How confident are you that you can control thinking about what a good life you had before the person with YOD illness and how much you've lost?

Certainty (0-100) _____%

18. How confident are you that you can control thinking about what you are missing or giving up because of the person with YOD?

Certainty (0-100) _____%

19. How confident are you that you can control worrying about future problems that might come up with the person with YOD?

Certainty (0-100) _____%

4. Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate by circling how often you felt or thought a certain way.

In the last month, how often...	Never	Almost Never	Sometimes	Fairly Often	Very Often
	0	1	2	3	4
1. ... have you been upset because of something that happened unexpectedly?					
2. ... have you felt that you were unable to control the important things in your life?					
3. ... have you felt nervous and stressed?					
4. ... have you felt confident about your ability to handle your personal problems?					
5. ... have you felt that things were going your way?					
6. ... have you found that you could not cope with all the things that you had to do?					
7. ... have you been able to control irritations in your life?					
8. ... have you felt that you were on top of things?					
9. ... have you been angered because of things that were outside of your control?					
10. ... have you felt difficulties were piling up so high that you could not overcome them?					

5. E5-EQ-DL Health Questionnaire

Under each heading, please tick the ONE box that best describes your health TODAY.

MOBILITY

- I have no problems in walking about ☐
- I have slight problems in walking about ☐
- I have moderate problems in walking about ☐
- I have severe problems in walking about ☐
- I am unable to walk about ☐

SELF-CARE

- I have no problems washing or dressing myself ☐
- I have slight problems washing or dressing myself ☐
- I have moderate problems washing or dressing myself ☐
- I have severe problems washing or dressing myself ☐
- I am unable to wash or dress myself ☐

USUAL ACTIVITIES (e.g. work, study, housework, family or leisure activities)

- I have no problems doing my usual activities ☐
- I have slight problems doing my usual activities ☐
- I have moderate problems doing my usual activities ☐
- I have severe problems doing my usual activities ☐
- I am unable to do my usual activities ☐

PAIN / DISCOMFORT

- I have no pain or discomfort ☐
- I have slight pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have severe pain or discomfort ☐
- I have extreme pain or discomfort ☐

ANXIETY / DEPRESSION

- I am not anxious or depressed ☐
- I am slightly anxious or depressed ☐
- I am moderately anxious or depressed ☐
- I am severely anxious or depressed ☐
- I am extremely anxious or depressed ☐

6. Burden Scale for Family Care-givers, short version (BSFC-s)

We are asking you for information about your present situation. The present situation comprises your caregiving deduced from the illness of your family member (or friend).

The following statements often refer to the type of your assistance. This may be any kind of support up to nursing care.

Please draw an "X" for the best description of your present situation. Please answer every question!

	strongly agree	agree	disagree	strongly disagree
1. My life satisfaction has suffered because of the care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I often feel physically exhausted.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. From time to time I wish I could "run away" from the situation I am in.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Sometimes I don't really feel like "myself" as before.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Since I have been a caregiver my financial situation has decreased.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. My health is affected by the care situation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. The care takes a lot of my own strength.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I feel torn between the demands of my environment (such as family) and the demands of the care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I am worried about my future because of the care I give.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. My relationships with other family members, relatives, friends and acquaintances are suffering as a result of the care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Revised Memory and Behaviour Checklist

Instructions: The following is a list of problems people with dementia sometimes have. Please indicate if any of these problems have occurred during the past week. If so, how much has this bothered or upset you when it happened? Use the following scales for the frequency of the problem and your reaction to it. Please read the descriptions of the ratings carefully.

Frequency ratings:

0 = never occurred
1 = not in the past week
2 = 1 to 2 times in the past week
3 = 3 to 6 times in the past week
4 = daily or more often
9 = don't know / not applicable

Reaction ratings:

0 = not at all
1 = a little
2 = moderately
3 = very much
4 = extremely
9 = don't know / not applicable

Please answer all the questions below. Please circle a number from 0-9 for both frequency and reaction.

		Frequency	Reaction (how much it bothered you)
1	Asking the same question over and over.	0 1 2 3 4 9	0 1 2 3 4 9
2	Trouble remembering recent events (i.e. items in newspaper or on TV).	0 1 2 3 4 9	0 1 2 3 4 9
3	Trouble remembering significant past events.	0 1 2 3 4 9	0 1 2 3 4 9
4	Losing or misplacing things.	0 1 2 3 4 9	0 1 2 3 4 9
5	Forgetting what day it is.	0 1 2 3 4 9	0 1 2 3 4 9
6	Starting, but not finishing, things.	0 1 2 3 4 9	0 1 2 3 4 9
7	Difficulty concentrating on a task.	0 1 2 3 4 9	0 1 2 3 4 9
8	Destroying property.	0 1 2 3 4 9	0 1 2 3 4 9
9	Doing things that embarrass you.	0 1 2 3 4 9	0 1 2 3 4 9
10	Waking up other family members up at night.	0 1 2 3 4 9	0 1 2 3 4 9
11	Talking loudly and rapidly.	0 1 2 3 4 9	0 1 2 3 4 9
12	Appears anxious or worried.	0 1 2 3 4 9	0 1 2 3 4 9

Frequency ratings:

0 = never occurred
1 = not in the past week
2 = 1 to 2 times in the past week
3 = 3 to 6 times in the past week
4 = daily or more often
9 = don't know / not applicable

Reaction ratings:

0 = not at all
1 = a little
2 = moderately
3 = very much
4 = extremely
9 = don't know / not applicable

13	Engaging in behavior that is potentially dangerous to self or others.	0 1 2 3 4 9	0 1 2 3 4 9
14	Threats to hurt oneself.	0 1 2 3 4 9	0 1 2 3 4 9
15	Threats to hurt others.	0 1 2 3 4 9	0 1 2 3 4 9
16	Aggressive to others verbally.	0 1 2 3 4 9	0 1 2 3 4 9
17	Appears sad or depressed.	0 1 2 3 4 9	0 1 2 3 4 9
18	Expressing feelings of hopelessness or sadness about the future (e.g. "Nothing worthwhile ever happens" / "I never do anything right")	0 1 2 3 4 9	0 1 2 3 4 9
19	Crying and tearfulness.	0 1 2 3 4 9	0 1 2 3 4 9
20	Commenting about death of self or others (e.g. "Life isn't worth living")	0 1 2 3 4 9	0 1 2 3 4 9
21	Talking about feeling lonely.	0 1 2 3 4 9	0 1 2 3 4 9
22	Comments about feeling worthless or being a burden to others.	0 1 2 3 4 9	0 1 2 3 4 9
23	Comments about feeling like a failure, or about not having any worthwhile accomplishments in life.	0 1 2 3 4 9	0 1 2 3 4 9
24	Arguing, irritability and/or complaining.	0 1 2 3 4 9	0 1 2 3 4 9