

TABLE 1: Assessment Instruments That Examine Health (n=15)

Full citations are listed at the end of the Table.

<i>Instrument Name, Developer, and Online Availability</i>	<i>Citation Using the Instrument</i>	<i>Instrument Description</i>	<i>Psychometric Properties</i>
<p>1. Beck Anxiety Inventory (BAI)</p> <p>Beck & Steer (1990)</p> <p>http://blue.butler.edu/~dluechau/questionnaires/beckanxietyinventory.doc</p>	<p>Resnick, Acierno, Holmes, Kilpatrick & Jager (1999)</p> <p>and</p> <p>Resnick, Acierno, Kilpatrick & Holmes (2005)</p>	<p>The BAI is a self-report instrument designed to assess adults in clinical and research settings for anxiety. The scale consists of 21 items, each describing a common symptom of anxiety that the respondent is asked to rate on a 4-point scale denoting how much he or she has been bothered by each symptom over the past week. Administration takes approximately 5 minutes. Ratings on items are summed to obtain a total score that can range from 0 to 63.</p> <p>It is available in English, Spanish and Dutch.</p>	<p>This scale has been found to have high internal consistency and item-total correlations ranging from 0.30 to 0.71 (median=0.60). The correlation between patients' scores at intake and 1 week later is 0.75. In terms of validity, scores on the BAI have been found to correlate significantly with other self-report and clinician-rated scales concerning anxiety. Source: http://cps.nova.edu/~cpphelp/BAI.html</p>
<p>2. Brief Symptom Inventory (BSI)</p> <p>Derogatis & Melisaratos (1983)</p> <p>Not located online</p>	<p>Roy-Byrne, Russo, Michelson, Zatzick, Pitman & Berliner (2004)</p>	<p>The BSI is a self-administered instrument for adults to report their mental health symptoms to inform clinical decision-making at patient intake and during the course of treatment in multiple settings. Respondents rate each of the 53 items of the BSI using a 5-point scale of distress, ranging from "not at all" to "extremely." Administration takes 8-10 minutes. The ratings can be summed to examine 9 primary symptom dimension subscales: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychosis. In addition, three summary indexes can be calculated: the General Severity Index, a weighted frequency based on the sum of the ratings the patient has assigned to each symptom; the Positive Symptom Total, a count of the number of the subjects' symptoms; and the Positive</p>	<p>Derogatis & Spencer (1982) report that in a sample of psychiatric out-patients (n=1002), alpha ranged from 0.71 (for psychotics) to 0.85 (for depression), and that the test-retest correlation ranged from 0.68 (for somatization) to .91 (for phobic anxiety). Among psychiatric out-patients (n=565), the correlation between each corresponding dimension of the BSI and the SCL-90-R ranged from 0.92 (for psychotics) to 0.99 (for hostility). In addition, there was a high convergence for the dimensions of the BSI with MMPI scales.</p>

ASSESSMENT INSTRUMENTS THAT EXAMINE HEALTH

		<p>Symptom Distress Index, a score reflecting the intensity of distress, corrected for the number of symptoms (Source: Boulet & Boss, 1991).</p> <p>It is available in English, Spanish, and French.</p>	
<p>3. Clinician Administered PTSD Scale (CAPS)</p> <p>Blake, Weathers, Nagy, Kaloupek, Gusman, Charney & Keane (1995)</p> <p>Can be ordered: http://www.ncptsd.va.gov/ncmain/assessment/assessmt_request_form.html</p>	<p>Petrak & Campbell (1999) and Roy-Byrne, Russo, Michelson, Zatzick, Pitman & Berliner (2004)</p>	<p>The CAPS is a clinical interview designed to assess adults for the 17 symptoms of Posttraumatic Stress Disorder (PTSD) outlined in Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV), along with five associated features (guilt, dissociation, derealization, depersonalization, and reduction in awareness of surroundings). It includes standardized prompt questions, supplementary follow-up (probe) questions, and behaviorally anchored 5-point rating scales corresponding to the frequency and intensity of each symptom assessed. The 30 items take 40-60 minutes to administer. The CAPS scoring provides information concerning self-reports of exposure to potential Criterion A events, a current and/or lifetime DSM-IV diagnosis of PTSD, the frequency and intensity of each symptom, the impact of the 17 PTSD symptoms on social and occupational functioning, and the overall severity of PTSD.</p> <p>It is available in English.</p>	<p>Blake, Weathers, Nagy, Kaloupek, Gusman, Charney & Keane (1995) reported that test-retest diagnostic reliability ranged from 0.90 to 0.98, and internal consistency was 0.94. Using the Structured Clinical Interview for DSM (SCID) as criterion reference, CAPS achieved acceptable sensitivity (0.84), high specificity (0.95), and good agreement ($\kappa=0.78$).</p>
<p>4. General Health Questionnaire (GHQ-12)</p> <p>Goldberg & Williams (1988)</p> <p>http://www.webpoll.org/psych/GHQ12.htm</p>	<p>Petrak & Campbell (1999)</p>	<p>The GHQ-12 is a self-administered instrument designed to assess adults' mental health. Each of the 12 items asks respondents to rate the severity of a mental health problem over the past few weeks using a 4-point scale. It takes approximately 5 minutes to administer. Ratings for items are summed to generate a total score ranging from 0 to 36, with higher scores indicating worse conditions.</p> <p>It is available in English and Spanish.</p>	<p>Roy-Byrne, Russo, Michelson, Zatzick, Pitman & Berliner (2004) reported split half reliability of 0.95. Internal consistency, assessed via Cronbach's alpha, for the GHQ-12 ranged from 0.82 to 0.93. Depending on the type of patient, scores six months apart correlated between 0.51 and 0.90. Content validity was demonstrated by showing that each test item highly discriminated between groups with and without mental illness.</p>
<p>5. Hospital Anxiety and</p>	<p>Petrak & Campbell (1999)</p>	<p>The HADS is a self-administered instrument designed to measure adults' anxiety and depression. It consists</p>	<p>Zigmond & Sniath (1983) reported that the internal consistency of the anxiety subscale (HADS-A) ranged</p>

ASSESSMENT INSTRUMENTS THAT EXAMINE HEALTH

<p>Depression Scale (HADS)</p> <p>Zigmond & Snaith (1983)</p> <p>http://dop.hawaii.edu/resources/Hospital%20Anxiety%20and%20Depression%20Scale.doc</p>		<p>of 14 items (7 concerning anxiety [HADS-A] and 7 concerning depression [HADS-D]) which respondents rate on a 4-point scale, from 0 (not present) to 3 (considerable). It takes 10-15 minutes to administer. The item ratings are summed creating subscale scores for HADS-A and HADS-D that range from 0 to 21.</p> <p>It is available in English.</p>	<p>from 0.41 to 0.76, and that the internal consistency of the depression subscale (HADS-D) ranged from 0.30 to 0.60. Scale reliability for HADS-A was $r=0.74$ and scale reliability for HADS-D was $r=0.70$.</p>
<p>6. Impact of Events Scale (IES)</p> <p>Horowitz, Wilner, & Alvarez (1979)</p> <p>http://www.swin.edu.au/victims/resources/assessment/ptsd/ies.html</p>	<p>Harrison & Murphy (1999)</p>	<p>The self-administered IES is designed to assess adults' subjective distress for any specific life event. Of the 15 items, 7 assess intrusive symptoms (intrusive thoughts, nightmares, etc.) and 8 assess avoidance symptoms (numbing of responsiveness, avoidance of feelings, etc.). Respondents rate each item on a scale to denote how often the symptom has occurred in the past 7 days, from 0 (not at all) to 4 (often). Administration takes 10-15 minutes. Ratings are summed to create an intrusive subscale, an avoidance subscale, and a total subjective stress score.</p> <p>It is available in English.</p>	<p>Corcoran & Fischer (1994) found that the subscales of the IES demonstrated internal consistency based on 2 separate samples. The coefficients ranged from 0.79 to 0.92, with an average of .86 for the intrusive subscale and 0.90 for the avoidance subscale. In Horowitz's original study (Horowitz, Wilner & Alvarez, 1979), the split-half reliability of the IES was high ($r=0.86$). Internal consistency of the subscales, calculated using Cronbach's alpha, was also high (intrusion = 0.78, avoidance = 0.82). A correlation of 0.42 ($p<0.0002$) between the intrusion and avoidance subscales indicates that the two subscales are associated, but do not measure identical dimensions. Test-retest reliability over a one week period was 0.87 for the total stress scores, 0.89 for the intrusion subscale, and 0.79 for the avoidance subscale. The IES is sensitive to change in symptoms over time.</p>
<p>7. Impact of Events Scale – Revised (IES-R)</p> <p>Weiss & Marmar (1997)</p> <p>http://www.swin.edu.au/victims/resources/assessment/ptsd/ies-r.html</p>	<p>Petrak & Campbell (1999)</p>	<p>The self-administered IES-R is designed to assess persons' subjective distress for any specific life event. Of the 22 items, 6 assess hyperarousal symptoms (anger and irritability, etc.), 8 assess intrusion (intrusive thoughts, etc.), and 8 assess avoidance (numbing of responsiveness, etc.). Respondents rate each item on a scale from 0 (not at all) to 4 (extremely). Administration takes 5-10 minutes. Scores are summed to create the 3 subscale scores and a total subjective stress score. The hyperarousal,</p>	<p>Weiss & Marmar (1997) reported that the internal consistency of the 3 subscales was high, with intrusion alphas ranging from 0.87 to 0.92, avoidance alphas ranging from 0.84 to 0.86, and hyperarousal alphas ranging from 0.79 to 0.90 (Briere, 1997). Test-retest data were available for 2 of the samples in the Weiss & Marmar (1997) study. Data from sample 1 ($n = 429$) yielded the following test-retest correlation coefficients for the subscales: intrusion = 0.57, avoidance = 0.51, hyperarousal =</p>

ASSESSMENT INSTRUMENTS THAT EXAMINE HEALTH

		<p>intrusion and avoidance subscales parallel the DSM-IV criteria for posttraumatic stress disorder (PTSD).</p> <p>It is available in English.</p>	<p>0.59. From sample 2 (n = 197) the correlation coefficients were considerably higher: intrusion = .94, avoidance = .89, hyperarousal = .92. The hyperarousal subscale has good predictive validity with regard to trauma (Briere, 1997). The intrusion and avoidance subscales have been shown to detect change in respondents' clinical status over time and to detect relevant differences in the response to traumatic events of varying severity (Weiss & Marmar, 1997; Horowitz, Wilner, & Alvarez, 1979).</p>
<p>8. Pennebaker Inventory of Limbic Languidness (PILL)</p> <p>Pennebaker (1982)</p> <p>http://homepage.psy.utexas.edu/homepage/faculty/Pennebaker/questionnaires/PILL.pdf</p>	<p>Resnick, Acierno, Holmes, Kilpatrick & Jager (1999)</p> <p>and</p> <p>Resnick, Acierno, Kilpatrick & Holmes (2005)</p>	<p>The self-administered PILL is designed to assess adults' frequency of common physical symptoms and sensations experienced as a result of rape. In addition, the PILL includes potential somatic reactions to rape and the effects of the intervention on these reactions. The 54-items are rated in a 5-point Likert scale to indicate the frequency of experiencing the system from "have never or have almost never experienced the symptom" to "more than once a week." The time it takes to administer the PILL was not reported. Scores are summed with higher scores indicating greater symptomatology.</p> <p>It is available in English.</p>	<p>Resnick, Acierno, Kilpatrick & Holmes (2005) report Cronbach's alphas ranging from 0.88 to 0.91. Two-month test-retest reliability ranged from 0.79 to 0.83.</p>
<p>9. Post-traumatic Stress Disorder Interview (PTSD-I)</p> <p>Davidson, Kudler & Smith (1990)</p> <p>Can be ordered online at:</p> <p>http://www.ncptsd.va.gov/ncmain/assessment/</p>	<p>Petrak & Campbell (1999)</p>	<p>The PTSD-I is a semi-structured, clinical interview designed to assess adults for PTSD. It closely corresponds to the Diagnostic and Statistical Manual of Mental Disorders Third Edition - Revised (DSM-III-R) criteria for PTSD. The 17 items corresponding to PTSD criteria, including trauma re-experiencing (4 items), avoidance of stimuli-associated trauma (7 items), and increased arousal (6 items). The interviewer asks the client to rate the severity/frequency of each of the items using a 7-point Likert response scale. More detailed information on scoring was not located. It takes 20-30 minutes to administer.</p>	<p>Watson, Juba, Manifold, Kucala & Anderson (1991) reported high internal consistency (alpha=0.92) and test-retest reliability (total score r= 0.95) and diagnostic agreement (87%).</p>

ASSESSMENT INSTRUMENTS THAT EXAMINE HEALTH

		It is available in English.	
<p>10. Post-Traumatic Stress Symptom Scale (PSS-SR)</p> <p>Foa, Riggs, Dancu & Rothbaum (1993)</p> <p>Not located online, but can be ordered by contacting: Edna Foa, PhD, Department of Psychiatry, University of Pennsylvania, 3535 Market Street, Philadelphia, PA 19104-3309</p>	<p>Resnick, Acierno, Holmes, Kilpatrick & Jager (1999)</p> <p>Resnick, Acierno, Kilpatrick & Holmes (2005)</p>	<p>The PSS-SR may be used as a clinical interview or self-administered questionnaire to assess adults' symptoms of PTSD as defined in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition - Revised (DSM III-R). Each of the 17 items describe symptoms which respondents rate in terms of their frequency or severity using a Likert scale ranging from 0 (not at all or only one time) to 3 (almost always or five or more times per week). Administration takes 20-30 minutes. Ratings on items are summed to create three subscales, including re-experiencing, avoidance, and arousal, as well as a total score (that ranges from 0 to 51).</p> <p>It is available in English.</p>	<p>Foa, Riggs, Dancu & Rothbaum (1993) reported on the administration of the PSS-SR to 118 recent rape and non-sexual assault victims and found that it obtained a total score alpha of 0.91 and subscale alphas (for re-experiencing, avoidance, and arousal) ranging from 0.78 to 0.82. In addition, one-month test-retest reliability for the total score was 0.74, while test-retest reliability for subscales ranged from 0.56 to 0.71. Convergent validity of the PSS-SR, with the Impact of Events Scale and State-Trait Anxiety Inventory was also demonstrated, with correlations ranging from 0.52 to 0.81. In addition, using the Structured Clinical Interview for DSM-IV Disorders (SCID) as the criterion reference, PSS-SR diagnostic sensitivity was 62%, specificity was 100%, positive predictive power equaled 100%, negative predictive power was 82%, and the total hit rate was 86%.</p>
<p>11. PTSD Check List – Civilian Version (PCL-C)</p> <p>Weathers, Litz, Huska & Keane (1994)</p> <p>http://www.isu.edu/~bhstamm/tests.htm and http://www.isu.edu/~bhstamm/tests/pclc.htm</p>	<p>Roy-Byrne, Russo, Michelson, Zatzick, Pitman & Berliner (2004)</p>	<p>The PCL-C is a self-administered questionnaire used to assess adults for PTSD. It uses diagnostic criteria B, C, and D for PTSD of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). There are three associated PTSD symptom clusters. They are re-experiencing, numbing/avoidance, and hyperarousal. Respondents rate the 17 items using a Likert response scale that ranges from 1 to 5 based on how they felt over the last month. The time that it takes to administer the instrument was not reported. The PCL-C may be scored to create a total score (that can range from 17 to 85).</p> <p>It is available in English.</p>	<p>Blanchard, Jones-Alexander, Buckley & Forneris (1996) examined the psychometric properties of the PCL-C on a population of 40 motor vehicle accident victims and sexual assault victims using diagnoses and scores from the CAPS (Clinician Administered PTSD Scale) as the criteria. For the PCL-C as a whole, the correlation with the CAPS was 0.929 and diagnostic efficiency was 0.900 versus CAPS. Examination of the individual items showed wide ranging values of individual item correlations ranging from 0.386 to 0.788, and with diagnostic efficiencies of 0.700 or better for symptoms.</p>
<p>12. Severity Grade of Sexual Assault and</p>	<p>Garcia, Figueiredo, Moretti,</p>	<p>The overall goal of this assessment tool used by clinical examiners is to classify persons by their type of sexual assault experiences to determine whether or</p>	<p>Not reported</p>

ASSESSMENT INSTRUMENTS THAT EXAMINE HEALTH

<p>Categories of Severity Grades</p> <p>Garcia, Figueiredo, Moretti, Resende, Bedoni & Papaïordanou (2005)</p> <p>Not located on line</p>	<p>Resende, Bedoni & Papaïordanou (2005)</p>	<p>not to prescribe various forms of HIV postexposure prophylaxis. Patients are classified into 1 of 3 categories of sexual assault severity grades: low = vaginal/oral intercourse without ejaculation and without visible trauma; medium = vaginal/oral intercourse with ejaculation but without trauma; or high = anal penetration. The time to administer the tool is not reported.</p> <p>It is available in English.</p>	
<p>13. Short Form – 12 Health Survey (SF-12)</p> <p>Ware, Kosinski, & Keller (1996)</p> <p>http://www.crufad.com/phc/sf-12.htm</p> <p>To interpret results http://health.utah.gov/oph/publications/2001hss/sf12/SF12_Interpreting.pdf</p>	<p>Roy-Byrne, Russo, Michelson, Zatzick, Pitman & Berliner (2004)</p>	<p>The SF-12 is a self-administered instrument for use in the general population of adults to assess physical health and mental health. The 12 questions are all from the longer SF-36 Health Survey (Ware, Kosinski, and Keller, 1996). The SF-12 takes 2 minutes to administer. Responses to the questions are weighted and summed to create 2 subscales: the physical health composite score (PCS) and the mental health composite score (MCS). Scores range from 0 to 100, where a zero score indicates the lowest level of health measured by the scales and 100 indicates the highest level of health.</p> <p>It is available in English and Spanish.</p>	<p>The SF-12 was developed to provide a shorter, yet valid alternative to the SF-36. The data obtained with the SF-12 has been developed, tested and validated by Quality Metric Incorporated. No additional psychometric information was reported.</p>
<p>14. Structured Clinical Interview for DSM-III-R (SCID)</p> <p>Spitzer, Williams & Gibbon (1987)</p> <p>Can be ordered online: http://www.ncptsd.va.gov/ncmain/ncdocs/assmnts/structured_clinical</p>	<p>Roy-Byrne, Russo, Michelson, Zatzick, Pitman & Berliner (2004)</p>	<p>The SCID is a semi-structured clinician-administered interview for making the major axis I DSM-III-R diagnoses. It includes an introductory overview followed by nine modules, seven of which represent the major axis I diagnostic classes. It can be adapted for use in studies in which particular diagnoses are not of interest due to its modular construction. The output of the SCID is a record of the presence or absence of each of the disorders being considered, for current episode (past month) and for lifetime occurrence. The method of scoring and time to administer was not reported.</p>	<p>Boon & Draijer (1993) report that the SCID-D demonstrates good reliability and validity for all five DSM-IV dissociative disorder diagnoses.</p>

ASSESSMENT INSTRUMENTS THAT EXAMINE HEALTH

_interview_for_the_dsmiv_axis_i_disorders_scid_ptsd_module.html		It is available in English, Portuguese, Dutch, and Japanese.	
15. Subjective Units of Distress Scale (SUDS) Wolpe (1973) http://www.emdrhap.org/osCommerce/product_info.php?products_id=40	Resnick, Acierno, Holmes, Kilpatrick & Jager (1999) Resnick, Acierno, Kilpatrick & Holmes (2005)	The SUDS is a self-report instrument used to assess the intensity of adult patients' current disturbance or distress. It consists of a 0-10 scale where 0 represents neutral, no disturbance, to 10, where 10 represents the worst disturbance the client can imagine. It takes approximately 5-10 minutes to administer. No other details were reported. It is available in English.	Not reported

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