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Anxiety scale questionnaire

Generalized anxiety disorder (GAD) screening tool measures symptoms on a scale from 0 to 21, with 5-9 being mild, 10-14 moderate, and 15+ severe. The GAD-7 score is calculated by adding individual scores for the 7 questions, with 0-3 assigned to each response category of 'not at all', 'several days', 'more than half the days', or 'nearly every day'. Scores above 10 suggest mild to severe anxiety, warranting further evaluation. The tool has a sensitivity of 89% and specificity of 82% for GAD diagnosis. It also detects three other common anxiety disorders: panic disorder, social anxiety disorder, and post-traumatic stress disorder, with moderate accuracy. Pfizer originally held the copyright but made both PHQ-9 and GAD-7 available without restriction in 2010. Each response category is assigned a score of 0, 1, 2, or 3, and the total score is calculated by adding individual scores for the 7 questions. Anxiety symptoms appear in various domains such as physical, emotional, cognitive, and behavioral. Physical manifestations typically involve autonomic arousal like rapid breathing, chest discomfort, racing heartbeat, stomach upset, dizziness, trembling, or numbness/tingling. Emotional symptoms range from nervousness to terror and panic. Cognitive symptoms include worry, apprehension, difficulty concentrating, and negative thoughts about potential threats. Behavioral symptoms often aim to avoid or escape perceived threats or distress through avoidance and safety-seeking behaviors. Over the past 20 years, research has advanced treatment options for anxiety disorders, but assessing anxiety remains a challenge. Currently, assessments are often disorder-based, neglecting the dimensional approach suggested by nosological research. The most commonly used measure is the Hamilton Anxiety Scale (HAM-A), which is valid but clinician-administered, time-consuming, and focuses heavily on somatic symptoms. The HAM-A has been criticized for not adequately measuring central GAD symptoms or capturing associated symptoms listed in the DSM-IV-TR and DSM-5. As a result, it lacks sensitivity to symptom change. The scale also fails to provide guidance on balancing severity/intensity and frequency/duration when rating symptoms, limiting its reliability. Furthermore, the HAM-A has moderate discriminant validity between anxiety and depression symptoms. Alternatives to the HAM-A include self-report measures like the Beck Anxiety Inventory (BAI). While the BAI is widely used, research suggests it's not a broad measure of anxiety. Of specific interest is the physical manifestation of anxiety rather than its overall effects. Interestingly, individuals with panic disorder tend to score higher on the Brief Anxiety Inventory (BAI) compared to those with other anxiety disorders. The GAD-7, a commonly used ultra-brief self-report measure, primarily assesses frequency but not intensity of symptoms and has limited adoption in research settings. Our team at Massachusetts General Hospital developed an alternative measure, the Anxiety Symptoms Questionnaire (ASQ), designed to evaluate the severity of anxiety symptoms over the past week. The ASQ is a brief and practical 17-item self-report assessment that measures both frequency and intensity of anxiety symptoms on a 0-10 scale. It assesses various symptoms such as nervousness, worrying, and somatic symptoms, yielding two subscales: frequency and intensity, with a total score obtained by summing the scores. The ASQ takes approximately 2-3 minutes to complete, making it more efficient than the BAI. This analysis examines the reliability and validity of the ASQ in both clinical and college student samples, as well as its ability to detect symptoms independent of depression. We also investigated demographic predictors of the total ASQ score. A total of 240 outpatients with various anxiety disorders and 111 non-clinical controls completed the ASQ and additional questionnaires measuring depression and anxiety. A total of 487 college students from two local colleges in Boston participated in an on-campus mental health screening. All participants provided informed consent and a detailed description of the parent study can be found in Farabaugh et al.'s study. The clinical analyses were based on the responses of 240 patients and 111 controls to various questionnaires, including the ASQ, HAM-A, MADRS, and CGI-S. The college analyses involved 487 students who responded to the ASQ, BAI, and BDI. However, instead of diagnostic assessments, their ASQ results were examined based on the presence or absence of high anxiety symptoms (n=71) and/or high depressive symptoms (n=74). The study applied a square root transformation to improve normality for measures such as the ASQ, HAM-A, BAI, and MADRS total scores. All analyses were conducted using SAS V.9.3 with a two-sided $\alpha=0.05$ significance level. Internal consistency of the ASQ was examined through Cronbach's α calculations for the entire scale and separately for intensity and frequency subscales in both clinical and college samples. The reliability within subgroups such as gender, race/ethnicity, and comorbidity was also investigated. Test-retest reliability of the ASQ total score was measured using Pearson's correlation between week 0 and week 4 in a subset of GAD/SAD patients (n=43) who showed no change in global severity over time. The reliability of the Anxiety Symptoms Questionnaire (ASQ) was evaluated in both clinical and college samples. In the clinical sample, patients who received no change or reduced medication between weeks 0 and 4 were included for analysis. A subset of students with longitudinal data from one college (n=27) was used to examine test-retest reliability. The ASQ demonstrated extremely high reliability in both clinical and college samples, with Cronbach's α scores ranging from 0.89 to 0.96. Reliability remained strong across various subgroups, including disorder-specific and comorbid conditions. Each question on the ASQ showed a positive correlation with the total score. In the clinical sample, question 7 (Trouble falling or staying asleep) had the lowest correlation with other questions regarding intensity and frequency. Removing this question did not improve Cronbach's α scores. Similarly, in the college sample, question 10 (Trouble remembering things) had the lowest correlation with the total score, but its removal did not enhance reliability. Test-retest reliability analyses revealed high correlations between week 0 and week 4 ASQ totals in both samples. Pearson's correlation coefficients ranged from 0.72 to 0.80, indicating strong agreement between measurements. Additionally, a multivariate logistic regression model was used to examine the discriminant ability of the ASQ in distinguishing anxiety disorder patients from healthy controls. The results showed that a 10-point increase in ASQ total score was significantly associated with an increased likelihood of anxiety diagnosis. Instead of focusing on diagnoses, we explored how well the Anxiety Sensitivity Questionnaire (ASQ) can distinguish between individuals with and without high levels of anxiety. We also examined whether the ASQ could differentiate between those with high anxiety but low depression and those with high depression but low anxiety. The ASQ total score effectively separated people with an anxiety disorder from healthy controls, both on its own and after accounting for the Hamilton Anxiety Rating Scale (HAM-A). A 10-point increase in ASQ total score roughly doubled the likelihood of being classified as having an anxiety disorder rather than being a control, even when controlling for the HAM-A. Notably, among patients diagnosed with anxiety disorders, about 75% had one or more comorbid conditions, while around 49% of patients diagnosed with major depressive disorder (MDD) had similar comorbidity. When analyzing the ability of the ASQ to differentiate between anxiety and depression in individuals without comorbidity, we found that the ASQ total score was a significant predictor of diagnosis, although the effect size associated with a 10-point increase was relatively small. Once controlling for the HAM-A, the ASQ total was no longer a significant predictor of anxiety only versus depression. In contrast, the ASQ total effectively distinguished between college students with high and low levels of anxiety, and similar results emerged when controlling for the presence of high or low depression. We also found that the ASQ total was a borderline significant predictor of high anxiety/low depression versus high depression/low anxiety. To further investigate how well the ASQ and HAM-A detect depression in clinical samples, we examined partial Pearson correlations between the ASQ/HAM-A and the Montgomery-Asberg Depression Rating Scale (MADRS), controlling for comorbidity and diagnosis separately. As seen in Table 4, the ASQ total was less strongly correlated with the MADRS overall than the HAM-A, although these differences were not statistically significant. Certain psychological conditions, such as generalized anxiety disorder (GAD), can be identified through specific questionnaires like the Anxiety and Depression Scale (ASQ). The tool distinguishes between anxiety and depression, making it a valuable diagnostic aid. Predictors of ASQ scores include factors like diagnosis, gender, age, comorbid medical conditions, race, ethnicity, and other relevant statistics. In the clinical group, diagnosis was considered as a factor in all models; while in the college group, variables such as chronic medical conditions and BDI scores were analyzed. After controlling for certain aspects, patients with higher ASQ scores were typically those suffering from GAD or having female sex, younger age, multiple medical issues, or high levels of depression. Comparatively, HAM-A/BAI questionnaires also provided useful insights into the severity of psychological conditions; however, their results differed from ASQ in several key areas. Given text: total scores (β (SE)=1.7 (0.073), $\chi^2=573.8$, p

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