Anxiety-Depression-Assessment (ADA)

Inventory of Scientific Findings

Behavior Data Systems
PO Box 44256
Phoenix, AZ 85064-4256
(800) 231-6401
www.bdsltd.com
www.online-testing.com
www.suicide-risk-assessment.com

Table of Contents

Introduction

Anxiety can occur as a symptom of depression and depression can be caused by an anxiety disorder. Anxiety and depression frequently coexist. Grohol (2008) emphasized it is important that both anxiety and depression (anxious-depression) be assessed (evaluated or tested) and as warranted, treated. The World Health Organization ICD-10 describes mixed anxiety and depression disorders (Wikipedia). The symptoms of anxiety and depression disorders resemble those presented in DSM-5 (2013). This emphasized the importance of screening both anxiety and depression when clinically screening patients.

Brady & Sinha (2005) noted "The high rate of co-occurrence of psychiatric disorders is well established." The importance of adequately assessing both anxiety and depression is very important. Anxiety can occur as a symptom of depression, and depression can be triggered by an anxiety disorder. Consequently, many individuals have both diagnoses concurrently, i.e., anxiety and depression (Hall-Flavin, D., n.d.). Anxiety and depression frequently coexist. At least 85% of people with major depression also have significant anxiety symptoms (Clayton, P.J., n.d.). Continuing, about 33% of people with depression have panic attacks during their depressive episodes.

Grohol (2008) demonstrated that it is important for healthcare professionals to assess anxiety during the initial diagnosis of major depression. Such co-existing anxiety can negatively affect treatment outcome if not taken into consideration and also treated. Grohol used the term "anxious-depression."

Mixed anxiety-depression is the term that defines patients who suffer from both anxiety and depression. The World Health Organization's ICD-10 describes mixed anxiety and depressive disorder (Wikipedia). The symptoms of mixed anxiety and depressive disorder resemble those presented in DSM-5 (2013) for depression and anxiety disorders. Brady & Sinha (2005) noted, "The high rate of co-occurrence of psychiatric disorders is well established." The implications of adequate assessment and treatment of co-occurring anxiety and depression disorders is challenging but cannot be ignored.

Anxiety-Depression-Assessment

The Anxiety-Depression Assessment (ADA) is an evidence based self-report test. The ADA is used to assess clients (patients) that have anxiety and/or depression problems. The ADA is used by clinicians, psychologists, counselors, treatment staff, probation officers and mental health professionals. The ADA is a patient-related anxiety and depression risk assessment instrument or test.

The Anxiety-Depression Assessment (ADA) facilitates early problem identification, which simplifies prompt problem identification, intervention as warranted and treatment when necessary. The ADA enables accurate matching of problem severity with treatment intensity.

The Anxiety-Depression Assessment (ADA) consists of 151 true-false and multiple choice questions. The ADA takes on average 30 minutes to administer, and from data (answers) entry, three (3) minutes to computer score and print three page ADA reports. ADA scales (domains) include:

1. Truthfulness
2. Generalized Anxiety Disorder
3. Social Anxiety
4. Agoraphobia
5. Panic Disorder
6. Specific Phobia
7. Self-Esteem
8. Depression

Early detection of problem severity facilitates prompt interventions which contributes greatly to successful interventions and outcomes. By measuring problem severity evaluators are able to match severity with treatment or intervention intensity. We know this is a successful requirement to reduce recidivism and allocate limited staff resources effectively.

Scale Descriptions

In order to facilitate proper treatment and severity match, clinicians must have an understanding of the scales in order to facilitate accurate interpretation. Along with individual scale interpretation, clinicians must understand possible scale interactions. To that end, ADA scales (measures or domains) are described below:

1. Truthfulness Scale is an important feature of the Anxiety-Depression Assessment (ADA). Socially desirable responding (answers) can significantly impact assessment results (Stoeber, 2001; McBurney, 1994; 1993; Paulhus, 1991). Denial and problem minimization has been show to exacerbate lack of treatment progress (Marshall, Thornton, Marshall, Fernandez, & Mann, 2001; Brake & Shannon, 1997), and increased probability of treatment dropout (Daly & Peloski, 2000); while increasing the probability of recidivism (Kropp, Hart, Webster & Eaves, 1995; Grann & Wedin, 2002).

One of the first major psychological tests to use a truthfulness scale and truth-corrected scores was the Minnesota Multiphasic Personality Inventory (MMPI) which is the most widely used personality test in the U.S. and arguably the world. The ADA Truthfulness Scale's truth-correction equation is similar to that used in the MMPI, and converts raw scores to truth-corrected scores. Truth-corrected scores are more accurate than raw scores. It is important to establish a client's (patient's) truthfulness at the time of ADA testing, and this is accomplished with the ADA Truthfulness Scale.

2. Generalized Anxiety Disorder is characterized by excessive anxiety and worry for several months, about several events or activities. As cited in DSM-5, 2013, the excessive anxiety and worry are associated with three (or more) of the following six symptoms:

1. Restless or on edge
2. Easily fatigues
3. Difficulty concentrating
4. Irritability
5. Muscle tension
6. Sleep disturbance

The client's (patient's) excessive worry and anxieties cause noticeable distress and impairment in the client's social, occupational, interpersonal and recreational functioning. The symptoms of a generalized anxiety disorder tend to be chronic. In summary, the essential feature of a generalized anxiety disorder is excessive anxiety and worry about a number of events or activities (DSM-5, 2013). Common or frequent co-morbidities include other anxiety disorders and depression.

Five common anxiety disorders are included in the Anxiety-Depression Assessment (ADA) and these are: generalized anxiety disorder, social anxiety, agoraphobia, panic disorder and specific phobias. When a person experiences excessive anxiety in normal everyday situations on a regular basis, that person likely has an anxiety disorder.

3. Social Anxiety is characterized by noticeable fear or anxiety in one or more social situations in which the individual may be observed by others. The social situations almost always provoke excessive fear and anxiety. The intense fear, anxiety or avoidance behaviors cause impairment in the individual's social, occupational, interpersonal or recreational activities.

The central features of social anxiety disorders are intense fear and anxiety of social situations in which the client may be observed, scrutinized or evaluated by others. In short, the concern, anxiety or fear is that the individual would be negatively evaluated because of the anxiety symptoms, like excessive sweating, trembling, etc.

4. Panic Attacks are characterized by a sudden unexpected surge of intense fear, discomfort and anxiety that reaches a peak within minutes. Panic symptoms as set forth in the DSM-5, 2013 include: increased heart rate, excessive sweating, trembling or shaking, shortness of breath (like smothering), choking, chest pain, nausea, feeling dizzy/faint, chills or hot flashes, paresthesias (numbness/tingling), depersonalization, fear of losing control (going crazy), and fear of dying.

A panic attack is described as an abrupt surge of intense fear and discomfort that peaks within minutes. The persistent concern and worry about future panic attack symptoms (e.g., losing control, nausea, "going crazy," fear of dying, etc.) are especially debilitating. Panic attacks are typically unexpected. Nevertheless, "expected" panic attacks occur after exposure to an object or situation to which panic attacks have occurred. The frequency and intensity of panic attacks vary widely. And panic attacks are often co-morbid with other anxiety disorders. When agoraphobia is present, a separate diagnosis of agoraphobia is given. Panic disorder is associated with high levels of social, occupational, interpersonal and recreational impairments. That said, panic attack is not a DSM-5 mental disorder.

5. Agoraphobia is a noticeable and intense fear or anxiety triggered by real or imagined exposure to a variety of situations. DSM-5, 2013 sets forth the following common agoraphobia situations: 1. using public transportation, 2. being in open spaces, 3. being in enclosed spaces, 4. standing in line, 5. being in a crowd, and 6. being outside of one's home alone.

Some agoraphobics also experienc panic disorders. It's often the fear of another panic attack that is debilitating. Other common co-morbid disorders include other anxiety disorders (e.g., social anxiety, generalized anxiety disorder, specific phobias, panic disorder) and depression.

In agoraphobia the patient fears and avoids places or situations that might cause panic. Extreme agoraphobia can severely limit one's ability to socialize, work, manage daily tasks or attend recreational activities. Agoraphobia can greatly restrict or limit one's life activities. Some people with severe agoraphobia are not able to leave their home and become housebound. Without treatment, agoraphobia often gets worse.

6. Specific Phobias are characterized by intense fear and anxiety elicited by particular situations or objects. To meet specific phobia criterion the fear and anxiety must be intense or severe. The fear and anxiety may take the form of a panic attack. And the fear and anxiety is elicited every time the individual is exposed (comes into contact with) to the phobic object. The fear and anxiety occurs as soon as the phobic object is encountered. Consequently, the phobic individual actively avoids the phobic situation or object.

Specific phobias frequently occur with other anxiety disorders and depression. Consequently, there may be symptom overlap. However, specific phobias, fear and anxiety is elicited by a specific situation (e.g., flying) or object (e.g., snakes).

7. Self-Esteem Scale assesses a person's explicit valuing and appraisal of self. Self-esteem incorporates an attitude of acceptance-approval versus rejection-disapproval of self. Low self-esteem sufferers often report feelings of inadequacy, being undervalued, incompetence, hypersensitivity, and having difficulty adapting or adjusting to change. Self-esteem attacks are sometimes called "panic attacks" and often lead to feelings of remorse, depression and more anxiety.

Self-esteem refers to a person's appraisal of self. The concept of self-esteem is often addressed in clinical settings because, according to many clinicians, as individuals actions or behaviors can be viewed as a reflection of their self-esteem. When needed, counseling and psychotherapy can be helpful in developing healthy self-esteem. Self-esteem underlies and reflects depression and anxiety disorders.

8. Depression is a major mental health disorder. DSM-5 (2013) sets forth symptoms of depression as:

1. Depressed mood
2. Diminished interest and pleasure in almost all daily activities
3. Significant weight loss (or gain)
4. Insomnia,
5. Psychomotor agitation or retardation

6. Fatigue
7. Feeling worthless
8. Diminished ability to think
9. Suicidal ideation (thoughts)

Depression has been linked to impaired social, occupational, interpersonal and recreational activities. Major depression disorders are associated with high mortality, some of which is accounted for by suicide. Depression frequently co-occurs with (co-morbid) anxiety disorder and poor self-esteem.

An extreme or persistent depression disorder (dysthymia) involves a depressed mood for at least two years. During this two year period the individual has not been without symptoms for more than two months at a time. In other words, the depressive symptoms have persisted for at least two years. Dysthymia and anxiety disorders are common co-morbid conditions (Corcoran & Walsh, 2006). Anxiety is defined as heightened worry, uneasiness, or apprehension (Bjornlund, 2010). Anxiety is characterized by feelings of powerlessness and an inability to cope with threatening imaginary and real events (McIntosh & Livingston, 2008). Depression is characterized by feelings of hopelessness, lack of energy and feelings of helplessness (Bjornlund, 2010).

Unique Test Features

Truthfulness Scale

There are many terms that address the notion of truthfulness within the context of assessment, treatment and rehabilitation, including: D*enial*, *problem minimization*, *misrepresentation* and *equivocation*. The prevalence of denial among patients and offenders is extensively discussed in the psychological literature (Marshall, Thornton, Marshall, Fernandez, & Mann, 2001; Brake & Shannon, 1997; Barbaree, 1991; Schlank & Shaw, 1996). The impact the Truthfulness Scale score has on other scale or test scores is contingent upon the severity of denial or untruthfulness. In assessment, socially-desirable responding impacts assessment results when respondents attempt to portray themselves in an overly favorable light (Blanchett, Robinson, Alksnis & Sarin, 1997).

Truthfulness Scale awareness increased with the release of the Minnesota Multiphasic Personality Inventory (MMPI) many years ago. Soon thereafter, socially-desirable responding was demonstrated to impact assessment results (Stoeber, 2001; McBurney, 1994; Alexander, Somerfield & Ensminger, 1993; Paulhus, 1991). Truthfulness Scale conceptualization began in earnest with the idea of self-response accuracy. Test users want to be sure that respondents' self-report answers were truthful. Evaluators and assessors need to know if they can rely upon the test data being accurate. In other words, can the respondent's self-report answers be trusted? Research also shows that truthfulness is a factor in diagnosis, treatment effectiveness and recidivism with all patients.

Client (patient or offender) truthfulness has been associated with more positive treatment outcomes (Barber, et. al., 2001). Denial often accompanied lack of accountability, lack of motivation to change, resistance and general uncooperativeness (Simpson 2004). Problem minimization has also been linked to lack of treatment progress (Murphy & Baxter, 1997); treatment dropout (Daly & Peloski, 2000; Evans, Libo & Hser, 2009); and offender recidivism (Nunes, Hanson, Firestone, Moulden, Greenberg & Bradford, 2007; Kropp, Hart, Webster & Eaves, 1995; Grann & Wedin, 2002). Some researchers have suggested that client denial should be eliminated prior to commencing treatment. Denial reduction methods include use of survivor reports, directed group work, or addressing cognitive distortions that may cause denial (Schneider & Wright, 2004).

As multidimensional as denial is (Barrett, Sykes, & Byrnes, 1986; Brake & Shannon, 1997; Happel & Auffrey, 1995; Laflen & Sturm, 1994; Langevin, 1988; Orlando, 1998; Salter, 1988; Trepper & Barrett, 1989), truthfulness is equally multifaceted. Yet, client truthfulness (and denial) are integral to accurate assessment, testing and evaluation. Consequently, truthfulness will continue to be studied in the future.

ADA Database

Every time an ADA is scored the test data is automatically stored on the diskette for inclusion in the ADA database. This applies to ADA diskettes used anywhere in the United States and Canada. When the preset number of tests are administered (or used up) on a ADA diskette, the diskette is returned for replacement and the test data contained on these used diskettes is input, in a confidential (no names) manner, into the ADA database for later analysis. This database is statistically analyzed annually, at which time future ADA diskettes are adjusted to reflect demographic changes or trends that might have occurred. This unique and proprietary database also enables the formulation of annual summary reports that are descriptive of the populations tested. Summary reports provide important testing information, for budgeting, planning, management and program description.

Confidentiality (Delete Client Names)

Client privacy and security is of the utmost importance. When using the ADA you can rest assured, knowing that your client's privacy and confidentiality are safe. Any identifying information (name, ID numbers, etc.) is encrypted, before being stored in our database. A secure algorithm, built into the ADA software, unencrypts this information, before displaying it to you over the web. This ensures that only you can access the data and reports for your clients. This encryption method is HIPAA (federal regulation 45 C.F.R. 164.501) compliant.

Additional Benefits and Services

A host of other, complimentary, benefits and features are included with test purchase. For example, these benefits include:

- Support Services
- Test Upgrades
- Annual Summary Reports (Program Summary)
- Human Voice Audio
- Scanner scoring for high volume testing
- Data Input Verification Feature
- Available in English and Spanish (translation into other languages can be available upon request)

Summary

This document is not intended to be an exhaustive compilation of Anxiety-Depression-Assessment (ADA) research; however, it does summarize many research studies supporting the reliability, validity, and accuracy of the ADA. Moreover, ongoing ADA database research ensures an increasingly comprehensive profile of patients' anxiety, depression and overall distress.

Citations

Bjornlund, L. (2010). Depression. *Detroit: GALE CENGAGE Learning*. Retrieved October 8, 2014, from: http://www.healthguideinfo.com/major-depression/p113174.

Blanchette, K. Robinson, D., Alksnis, C., Serin, R. (1997). *Assessing Treatment Outcome Among Family Violence Offenders: Reliability and Validity of a Domestic Violence Treatment Assessment Battery*. Ottawa: Research Branch, Correctional Service Canada.

Brady, T., Sinha, R. (2005). Co-occurring mental and substance use disorders: the neurobiological effects of chronic stress. *American Journal of Psychiatry*. 162: 1483-1493.

Brake, S. & Shannon, D. (1997). Using pretreatment to increase admission in sex offenders. In B. K. Schwartz& H. R. Cellini (Eds.), *The sex offender: New insights, treatment innovations and legal developments, Volume 2* (pp.5-1–5-16). Kingston, NJ: Civic Research Institute.

Clayton, P.J. (n.d.). Co-existing Mood and Anxiety Disorders. *Depression and Bipolar Support Alliance*. Retrieved October 8, 2014, from: http://www.dbsalliance.org/site/PageServer?pagename=education_anxiety_coexisting .

Corcoran, J., & Walsh, J. (2006). Motivational interviewing. In *Theories for Direct Social Work Practice* (pp. 229-248). Pacific Grove, CA: Brooks/Cole.

Daly, J. & Pelowski, S. (2000). Predictors of dropout among men who batter: A review of studies with implications for research and practice. *Violence and Victims, 15,* 137-160. [Abstract].

Grann, M. & Wedin, I. (2002). Risk factors for recidivism among spousal assault and spousal homicide offenders. *Psychology, Crime, and Law, 8,* 5-23.

Grohol, J.M. (2008). Anxious Depression Predicts Poorer Treatment Results . *PsychCentral.com*. Retrieved October 8, 2014, from: http://psychcentral.com/news/2008/01/03/anxious-depression-predicts-poorer-treatment-results/1733.html .

Hall-Flavin, D. (n.d.). Is it possible to have depression and anxiety at the same time? *Mayo Clinic*. Retrieved October 8, 2014, from: http://www.mayoclinic.org/diseases-conditions/depression/expert-answers/depression-and-anxiety/faq-20057989 .

Kropp, P.R., Hart, S.D., Webster, C.D., & Eaves, D. (1995). *Manual for the Spousal Assault Risk Assessment Guide* (2nd ed.). Vancouver, Canada: B.C. Institute on Family Violence.

Marshall, W., Thornton, D., Marshall, L., Fernandez, Y., & Mann, R. (2001). Treatment of sexual offenders who are in categorical denial: A pilot project. *Sexual Abuse: A Journal of Research and Treatment, 13*(3), 205-215.

McBurney D., (1994) *Research Methods*. Brooks/Cole, Pacific Grove, California

McIntosh, K., & Livingston, P. (2008). Youth with conduct disorder: *In trouble with the world.* New York: Mason Crest Publishers.

Mixed anxiety-depressive disorder (n.d.). In *Wikipedia*. Retrieved October 8, 2014, from: http://en.wikipedia.org/wiki/Mixed_anxiety-depressive_disorder.

Murphy, C. & Baxter, V. (1997). Motivating batterers to change in the treatment context. *Journal of Interpersonal Violence, 12*, 607-619.

Paulhus, D.(1991). Measurement and control of response biases. In J.P. Robinson et al. (Eds.), *Measures of personality and social psychological attitudes*. San Diego: Academic Press

Stoeber, J. (2001). The social desirability scale-17 (SD-17). *European Journal of Psychological Assessment, 17*, 222-232