# Alcohol Use Disorders Identification Test (AUDIT)

Saunders, J. B., Aasland, O. G., Babor, T. F., De la Fuente, J. R., & Grant, M. (1993). Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption‐II. *Addiction*, *88*(6), 791-804.

1. How often do you have a drink containing alcohol?

Never, Monthly or less, Two to four times a month, Two to three times a week, Four or more times a week

1. How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2, 3 or 4, 5 or 6, 7 to 9, 10 or more

1. How often do you have six or more drinks on one occasion?

Never, Less than monthly, Monthly, Weekly, Daily or almost daily

1. How often during the last year have you found that you were not able to stop drinking once you had started?

Never, Less than monthly, Monthly, Weekly, Daily or almost daily

1. How often during the last year have you failed to do what was normally expected from you because of drinking?

Never, Less than monthly, Monthly, Weekly, Daily or almost daily

1. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

Never, Less than monthly, Monthly, Weekly, Daily or almost daily

1. How often during the last year have you had a feeling of guilt or remorse after drinking?

Never, Less than monthly, Monthly, Weekly, Daily or almost daily

1. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never, Less than monthly, Monthly, Weekly, Daily or almost daily

1. Have you or someone else been injured as a result of your drinking?

No, Yes but not in the last year, Yes during the last year

1. Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No, Yes but not in the last year, Yes during the last year

## Scoring

Questions 1-8 are scored 0, 1, 2, 3 or 4. Questions 9 and 10 are scored 0, 2 or 4 only.

# Apathy Evaluation Scale

Marin, R. S., Biedrzycki, R. C., & Firinciogullari, S. (1991). Reliability and validity of the Apathy Evaluation Scale. *Psychiatry research*, *38*(2), 143-162.

“For each question, circle the answer that best describes your thoughts, feelings, and actions during the past 4 weeks.”

1. I am interested in things. (Q)
2. I get things done during the day. (Q)
3. Getting things started on my own is important to me.
4. I am interested in having new experiences. (Q)
5. I am interested in learning new things. (Q)
6. I put little effort into anything. \*
7. I approach life with intensity.
8. Seeing a job through to the end is important to me.
9. I spend time doing things that interest me.
10. Someone has to tell me what to do each day. \*
11. I am less concerned about her/his problems than I should be. \*
12. I have friends. (Q)
13. Getting together with friends is important to me.
14. When something good happens, I get excited.
15. I has an accurate understanding of my problems.
16. Getting things done during the day is important to me.
17. I have initiative.
18. I have motivation.

## Scoring

All items are coded as follows:

1. Not at all characteristic.

2. Slightly characteristic (trivial, questionable, minimal).

3. Somewhat characteristic (moderate, definite).

4. Very characteristic (a great deal, strongly).

Note: Very characteristic is the level obtained by normal individuals.

The criteria for applying these codes are quantified for several items (#I, #2, #4, #5, #12). These quantifiable items (labelled Q) are rated by counting the number of instances cited by the subject for a particular item (e.g., number of interests, number of friends):

1. Not at all: 0 items

2. Slightly : 1-2 items

3. Somewhat: 2-3 items

4. Very: 3 or more

# Barrat Implusiveness Scale (BIS-11)

Patton, J.H., Stanford, M.S., & Barratt, E.S. (1995). Factor structure of the Barratt Impulsiveness

Scale. Journal of Clinical Psychology, 51, 768–774.

1. I plan tasks carefully.\*
2. I do things without thinking.
3. I make-up my mind quickly.
4. I am happy-go-lucky.
5. I don’t “pay attention”.
6. I have “racing” thoughts.
7. I plan trips well ahead of time.\*
8. I am self controlled.\*
9. I concentrate easily.\*
10. I save regularly.\*
11. I “squirm” at plays or lectures.
12. I am a careful thinker.\*
13. I plan for job security.\*
14. I say things without thinking.
15. I like to think about complex problems.\*
16. I change jobs.
17. I act “on impulse.”
18. I get easily bored when solving thought problems.
19. I act on the spur of the moment.
20. I am a steady thinker.\*
21. I change residences.
22. I buy things on impulse.
23. I can only think about one thing at a time.
24. I change hobbies.
25. I spend or charge more than I earn.
26. I often have extraneous thoughts when thinking.
27. I am more interested in the present than the future.
28. I am restless at the theater or lectures.
29. I like puzzles.\*
30. I am future oriented.\*

## Scoring

1. Do not agree at all
2. Agree slightly
3. Agree a lot
4. Agree completely

First order factors: 1) attention, 2) motor impulsiveness, 3) self-control, 4) cognitive complexity, 5) perseverance, 6) cognitive instability  
Second order factor structure: 1) attentional impulsiveness = 1) attention + 6) cognitive instability, 2) motor impulsiveness = 2) motor impulsiveness + 5) perseverance, 3) non-planning impulsiveness = 3) self-control + 4) cognitive complexity

|  |  |
| --- | --- |
| Attention | 11, 28, 5, 9, 20 |
| Motor Impulsiveness | 17, 19. 22, 3, 2, 25, 4 |
| Self-control | 12, 1, 8, 7, 13, 14 |
| Cognitive Complexity | 15, 29, 10, 27, 18 |
| Perseverance | 21, 16, 30, 23 |
| Cognitive Instability | 26, 6, 24 |

# Eating Attitudes Test (EAT-26)

Garner, D. M., Olmsted, M. P., Bohr, Y., & Garfinkel, P. E. (1982). The eating attitudes test: psychometric features and clinical correlates. *Psychological medicine*, *12*(04), 871-878.

1. I am terrified about being overweight.
2. I avoid eating when I am hungry.
3. I find myself preoccupied with food.
4. I have gone on eating binges where I feel that I may not be able to stop.
5. I cut my food into small pieces.
6. I am aware of the calorie content of foods I eat.
7. I particularly avoid foods with high carbohydrate content.
8. I feel that others would prefer if I ate more.
9. I vomit after I have eaten.
10. I feel extremely guilty after eating.
11. I am preoccupied with a desire to be thinner.
12. I think about burning up calories when I exercise.
13. Other people think that I am too thin.
14. I am preoccupied with the thought of having fat on my body.
15. I take longer than others to eat meals.
16. I avoid foods with sugar in them.
17. I eat diet foods.
18. I feel that food controls my life.
19. I display self-control around food.
20. I feel that others pressure me to eat.
21. I give too much time and thought to food.
22. I feel uncomfortable after eating sweets.
23. I engage in dieting behaviour.
24. I like my stomach to be empty.
25. I enjoy trying new rich foods.\*
26. I have the impulse to vomit after meals.

## Scoring

1. Always
2. Usually
3. Often
4. Sometimes
5. Rarely
6. Never

Three subscales: 1) Dieting, 2) Bulimia and Food Preoccupation and 3) Oral Control   
Dieting scale items: 1, 6, 7, 10, 11, 12, 14, 16, 17, 22, 23, 24, 25

Bulimia and Food Preoccupation scale items: 3, 4, 9, 18, 21, 26

Oral Control scale items: 2, 5, 8, 13, 15, 19 20

Score for questions 1-24, 26: 3, 2, 1, 0, 0, 0

Score for question 25: 0, 0, 0, 1, 2, 3

A score at or above 20 on the EAT-26 indicates a high level of concern about dieting, body weight or problematic eating behaviours.

# Obsessive-Compulsive Inventory – Revised (OCI-R)

Foa, E.B., Huppert, J.D., Leiberg, S., Hajcak, G., Langner, R., et al. (2002). The ObsessiveCompulsive Inventory: Development and validation of a short version. Psychological Assessment, 14, 485-496.

1. I have saved up so many things that they get in the way.
2. I check things more often than necessary.
3. I get upset if objects are not arranged properly.
4. I feel compelled to count while I am doing things.
5. I find it difficult to touch an object when I know it has been touched by strangers or certain people.
6. I find it difficult to control my own thoughts.
7. I collect things I don’t need.
8. I repeatedly check doors, windows, drawers, etc.
9. I get upset if others change the way I have arranged things.
10. I feel I have to repeat certain numbers.
11. I sometimes have to wash or clean myself simply because I feel contaminated.
12. I am upset by unpleasant thoughts that come into my mind against my will.
13. I avoid throwing things away because I am afraid I might need them later.
14. I repeatedly check gas and water taps and light switches after turning them off.
15. I need things to be arranged in a particular way.
16. I feel that there are good and bad numbers.
17. I wash my hands more often and longer than necessary.
18. I frequently get nasty thoughts and have difficulty in getting rid of them.

## Scoring

1. Not at all
2. A little
3. Moderately
4. A lot
5. Extremely

Scores are generated by adding the item scores (0 to 4). The possible range of scores is 0-72. Mean score for persons with OCD is 28.0 (SD = 13.53). Recommended cutoff score is 21, with scores at or above this level indicating the likely presence of OCD.

# Schizotypy

Mason, O., Linney, Y., & Claridge, G. (2005). Short scales for measuring schizotypy. *Schizophrenia research*, *78*(2), 293-296.

1. When in the dark do you often see shapes and forms even though there is nothing there?
2. Are your thoughts sometimes so strong that you can almost hear them?
3. Have you ever thought that you had special, almost magical powers?
4. Have you sometimes sensed an evil presence around you, even though you could not see it?
5. Do you think that you could learn to read other's minds if you wanted to?
6. When you look in the mirror does your face sometimes seem quite different from usual?
7. Do ideas and insights sometimes come to you so fast that you cannot express them all?
8. Can some people make you aware of them just by thinking about you?
9. Does a passing thought ever seem so real it frightens you?
10. Do you feel that your accidents are caused by mysterious forces?
11. Do you ever have a sense of vague danger or sudden dread for reasons that you do not understand?
12. Does your sense of smell sometimes become unusually strong?
13. Are you easily confused if too much happens at the same time?
14. Do you frequently have difficulty in starting to do things?
15. Are you a person whose mood goes up and down easily?
16. Do you dread going into a room by yourself where other people have already gathered and are talking?
17. Do you find it difficult to keep interested in the same thing for a long time?
18. Do you often have difficulties in controlling your thoughts?
19. Are you easily distracted from work by daydreams?
20. Do you ever feel that your speech is difficult to understand because the words are all mixed up and don't make sense?
21. Are you easily distracted when you read or talk to someone?
22. Is it hard for you to make decisions?
23. When in a crowded room, do you often have difficulty in following a conversation?'
24. Are there very few things that you have ever enjoyed doing?
25. Are you much too independent to get involved with other people?
26. Do you love having your back massaged?
27. Do you find the bright lights of a city exciting to look at?
28. Do you feel very close to your friends?
29. Has dancing or the idea of it always seemed dull to you?
30. Do you like mixing with people?
31. Is trying new foods something you have always enjoyed?
32. Have you often felt uncomfortable when your friends touch you?
33. Do you prefer watching television to going out with people?
34. Do you consider yourself to be pretty much an average sort of person?
35. Would you like other people to be afraid of you?
36. Do you often feel the impulse to spend money which you know you can't afford?
37. Are you usually in an average kind of mood, not too high and not too low?
38. Do you at times have an urge to do something harmful or shocking?
39. Do you stop to think things over before doing anything?
40. Do you often overindulge in alcohol or food?
41. Do you ever have the urge to break or smash things?
42. Have you ever felt the urge to injure yourself?
43. Do you often feel like doing the opposite of what other people suggest even though you know they are right?

## Scoring

1. No
2. Yes

No = 0, Yes = 1. Unusual experiences = 12 items, Cognitive Disorganisation = 11 items, Introvertive Anhedonia = 10 items, Impulsive Nonconformity = 10 items.

Reversed scoring for 26, 27, 28, 30, 31, 34, 37, 39.

# State Trait Anxiety Inventory (STAI) Form Y-2

Spielberger, C. D., Gorsuch, R., & Lushene, R. E. (1970). State-trait anxiety inventory. *Mind Garden*.

1. I feel pleasant.
2. I feel nervous and restless.
3. I feel satisfied with myself.
4. I wish I could be as happy as others seem to be.
5. I feel like a failure.
6. I feel rested.
7. I am "calm, cool, and collected".
8. I feel that difficulties are piling up so that I cannot overcome them.
9. I worry too much over something that really doesn't matter.
10. I am happy.
11. I have disturbing thoughts.
12. I lack self-confidence.
13. I feel secure.
14. I make decisions easily.
15. I feel inadequate.
16. I am content.
17. Some unimportant thought runs through my mind and bothers me.
18. I take disappointments so keenly that I can't put them out of my mind.
19. I am a steady person.
20. I get in a state of tension or turmoil as I think over my recent concerns and interests.'

## Scoring

1. Almost never
2. Sometimes
3. Often
4. Almost always

1 to 4, but reserved scoring for 1, 3, 6, 7, 10, 13, 14, 16, 19.

Scores range from 20 to 80, with higher scores suggesting greater levels of anxiety. Low scores suggest mild anxiety, median scores suggest moderate anxiety, while high scores suggest severe anxiety.

# Zung Depression Scale

Zung, W. W. (1965). A self-rating depression scale. *Archives of general psychiatry*, *12*(1), 63-70.

1. I feel down-hearted and blue.
2. Morning is when I feel the best.
3. I have crying spells or feel like it.
4. I have trouble sleeping at night.
5. I eat as much as I used to.
6. I still enjoy sex.
7. I notice that I am losing weight.
8. I have trouble with constipation.
9. My heart beats faster than normal.
10. I get tired for no reason.
11. My mind is as clear as it used to be.
12. I find it easy to do the things I used to do.
13. I am restless and can't keep still.
14. I feel hopeful about the future.
15. I am more irritable than usual.
16. I find it easy to make decisions.
17. I feel that I am useful and needed.
18. My life is pretty full.
19. I feel that others would be better off if I were dead.
20. I still enjoy the things I used to do.

## Scoring

1. A little of the time
2. Some of the time
3. Good part of the time
4. Most of the time

1 to 4. Reversed scoring for 2, 5, 6, 11, 12, 14, 16, 17, 18, 20.

20-44 Normal Range

45-59 Mildly Depressed

60-69 Moderately Depressed

70 and above Severely Depressed

# liebowitz Social Anxiety Scale

Liebowitz, M. R. (1987). Social phobia. Modern Problems of Pharmacopsychiatry 22, 141–173.

1. Telephoning in public.

2. Participating in small groups.

3. Eating in public places.

4. Drinking with others in public places.

5. Talking to people in authority.

6. Acting, performing or giving a talk in front of an audience.

7. Going to a party.

8. Working while being observed.

9. Writing while being observed.

10. Calling someone you don’t know very well.

11. Talking with people you don’t know very well.

12. Meeting strangers.

13. Urinating in a public bathroom.

14. Entering a room when others are already seated.

15. Being the center of attention.

16. Speaking up at a meeting.

17. Taking a test.

18. Expressing a disagreement or disapproval to people you don't know very well.

19. Looking at people you don’t know very well in the eyes.

20. Giving a report to a group.

21. Trying to pick up someone.

22. Returning goods to a store.

23. Giving a party.

24. Resisting a high pressure salesperson.

## Scoring

Fear or Anxiety:

0 = None

1 = Mild

2 = Moderate

3 = Severe

Avoidance:

0 = Never (0%)

1 = Occasionally (1—33%)

2 = Often (33—67%)

3 = Usually (67—100%)

The 24 items are first rated on a [Likert Scale](https://en.wikipedia.org/wiki/Likert_scale) from 0 to 3 on fear felt during the situations, and then the same items are rated regarding avoidance of the situation.

Usually, the sum of the total fear and total avoidance scores are used in determining the final score (thus, essentially it uses the same numbers as the self-administered test). Research supports a cut-off point of 30, in which SAD is unlikely. The next cut-off point is at 60, at which SAD is probable. Scores in this range are typical of persons entering treatment for the non-generalized type of SAD. Scores between 60 and 90 indicate that SAD is very probable. Scores in this range are typical of persons entering treatment for the generalized type of SAD. Scores higher than 90 indicate that SAD is highly probable.