

REVIEW ARTICLE

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SUMMARY

Anxiety disorders are characterized by fear and anxiety disproportionate to the situation that triggers and persists beyond what is foreseen for the event. They cause harm to the individual due to the suffering produced, worsen the quality of life and impose social restrictions. Psychological assessment techniques can help an investigation and improve understanding of these disorders. This study aimed to investigate the instruments for anxiety assessment used in Brazil. Thus, a literature review was carried out, searching specialized textbooks, journals and indexed articles (in capes, lilacs, pubmed, mediline, scielo and academic Google) in order to describe the most used ones. At the end of this study, it was found that the instruments for assessing anxiety disorders can be divided into seven categories: The first includes instruments that assess anxiety as a global construct; the second evaluates psychiatric disorders; the third comprises instruments that assess specific anxiety disorders, taking into account symptomatic behaviors and thoughts or feelings; the fourth category covers instruments related to specific contexts, such as hospital or sports; the fifth category includes instruments for assessing specific characteristics related to anxiety, such as concern, irritability, among others; the sixth category, covers instruments for mental health assessment in general as complaints related to anxiety seen as screening and need for psychiatric care and; finally, the seventh category comprises the other instruments that did not fall into the previous categories. It was also verified that the most used tests in Brazil from 2000 to 2015 were: Anxiety Inventory (BAI), Hospital Anxiety and Depression Scale (HADS); State Trait Anxiety Inventory (IDATE); Hamilton Anxiety Scale; Social Phobia Inventory (SPIN). These instruments are adaptations of international instruments for use in Brazil.

Keywords: Anxiety disorders, instruments, psychological evaluation.

1. INTRODUCTION

Psychological evaluation is understood as a technical-scientific process, usually complex, where data collection is performed, and the information provided by patients is interpreted as resulting from interactions of various natures between individuals and the social environment. Thus, methods, techniques and psychological instruments of standardized

measurement are used and based on a scientific theory, being necessary to meet the requirements of validity and accuracy (CFP, Resolution No. 6, of March 29, 2019).

Psychological assessment should produce hypotheses, or diagnoses, about a person or group of people. Hypotheses or diagnoses concern intellectual functioning, personality characteristics, ability to perform one, or more tasks, among other possibilities (HUTZ, 2015).

The expression psychological testing is sometimes used as a synonym for psychological evaluation, but it is necessary to be careful with this linkage, because testing is often part of the evaluation, but it is not necessarily psychological evaluation. Although it is a fact that psychological evaluation can be done, in certain specific cases, using only psychological tests, this does not occur as a rule (HUTZ, 2015).

When it comes to the broad term, psychological evaluation, one must first distinguish it from the assessment instruments. Evaluation is a more complex activity and constitutes a systematic search for knowledge about the psychological functioning of individuals, so that it can guide future actions and decisions. On the other hand, evaluation instruments are systematically organized procedures for collecting useful and reliable information in order to serve as the basis for a broader and deeper process of psychological evaluation, in ways that the instruments are part of the broader process of psychological assessment (PRIMI et al., 2004). Testing can be interpreted as part of the psychological evaluation process in many situations.

Instruments in general are standardized means to obtain behavioral samples and indicators in order to reveal individual differences in constructs, latent traits or implicit psychic resources. Thus, the covert traits are the causative variables of the behaviors that manifest themselves during testing. Therefore, the comprehensive processes of measures, implying in directly, through the observation of indicators, allows interference on the construct to be evaluated (GOTTFREDSON and SAKLOFSKE, 2009). Validity studies seek to prove the causal relationship between variations in the underlying construct and changes in behavioral indicators analyzed by the instrument, thus confirming the meanings associated with construct-related scores (PRIMI, 2010).

It is important to mention that psychological evaluation is one of the oldest areas of

psychology (ANASTASI and URBINA, 2000; PRIMI, 2010). Large-scale testing only at the end of the 19th century, when modern psychological testing began in France (HUTZ, 2015).

In Brazil, this area was included in federal law no. 4,119 (1962), which regulated the profession of psychologist in the country and, among other things, created only one function as a private of the psychologist: the use of psychological methods and techniques for the purposes of psychological diagnosis, guidance and professional selection, psychopedagogical guidance and solution of adjustment problems (BUENO and PEIXOTO, 2018).

At the beginning of the 20th century, there were already laboratories conducting research in psychological evaluation. In 1907 was founded the first Brazilian laboratory of psychological evaluation and in 1924, José Joaquim de Campos da Costa de Medeiros and Albuquerque (1867-1934) published the book entitled "Tests", with the subtitle "Introduction to the study of scientific means of judging the intelligence and application of students", this was the first book on psychological tests in Brazil (GOMES, 2009; HUTZ and BANDEIRA, 2003).

Hutz, (2015) still describes the following text on the importance of psychological evaluation:

It is also important to understand that psychological evaluation is a complex area with interfaces and applications in all areas of psychology. In principle, one should not start a procedure, with people or groups, in any area of psychology without a diagnosis or an initial evaluation of that person or group. After the procedure (or even during its performance), it is necessary to evaluate the results. It is, therefore, fundamental a basic training in this area to work efficiently and quality as a psychologist in any other area of application of psychology. How this training should be done is still the subject of discussion. The Brazilian Institute of Psychological Assessment (IBAP) has promoted this debate and published some documents about it. It is clear that the training does not end in graduation. The psychologist, although legally able to use psychological tests and make psychological assessments in all areas, should follow his training through specialization or postgraduate courses (master's degree, doctorate) and systematic reading of specialized literature in the area [...] (HUTZ, 2015).

The knowledge of psychological evaluation comes against the current concept of health, and the causes of diseases. Health is not only as an absence of symptoms, since an individual may be severely ill without presenting symptomatology. Diseases, in the current view, do not have a single determination, but on the contrary, they are multidetermined. There are no two psychos, one of health and one related to the disease. In reality, the expression psychology in health involves the experience of a person and also in their process of illness. Thus, every disease has psychological aspects and involves multiple factors to be evaluated, such as lifestyle, habits, culture and family myths (STRAUB, 2005).

Speaking particularly of anxiety disorders, they substantially affect people's lives, compromises everyday activities, social relationships and other aspects of their lives. These disorders have low rates of spontaneous regression and a strong tendency to chronicor even unfold in other psychiatric disorders if not treated (PINE, 1997; VIANNA, 2009). Thus, it is necessary that the diagnosis occurs as soon as possible, taking into account the appropriate evaluations and treatments, so the patients will have better prognoses and lower will be the harms for the individual.

The correct diagnosis of an anxiety disorder, both due to severity and comorbidities, generates expectation of a good prognosis because it provides adequate information about course, prevalence and possibilities of treatment, in addition to other factors. Therefore, it is important that clinicians have at their disposal appropriate instruments for the assessment of anxiety, both for symptom measurements and for screening and diagnosis. Good instruments provide standardized and safe instruments for obtaining indicators for construct evaluation, a latent trait or underlying psychological process (PRIMI, 2010), for example anxiety and fear – constructs that hide symptoms of anxiety disorders (CRASKE et al., 2009). The use of appropriate instruments for the assessment of anxiety ensure reliable and coherent data for the research and treatment of anxiety disorders, reflecting to the benefit of people suffering from the damage caused by this category of disorder. For this, investigations are necessary to seek increasingly appropriate instruments for the evaluation of anxiety disorders. In this sense, the aim of this study was to conduct a review of the Brazilian scientific literature aiming at the identification of psychological instruments used for anxiety assessment in Brazil.

2. METHOD

A literature review was conducted seeking specialized textbooks, journals and indexed scientific articles (in CAPES journals, Lilacs PubMed, Mediline, Scielo), in order to obtain the information and reports of the authors about the instruments used in psychological evaluation in anxiety disorders, in order to describe the most used ones.

3. DEVELOPMENT

3.1 ANXIETY

Anxiety is a normal, essential and natural emotion to human life, functioning as a defense mechanism, adaptive in nature and having the role of mediating the interaction of the individual with the environment and preparing for situations of common threat and danger of human experience (RAMOS, 2011). In general, anxiety acts as a warning sign, as it warns of imminent dangers and encourages the individual to take measures to face threats (VASCONCELOS et al., 2008).

Anxiety involves cognitive, behavioral, affective, physiological and neurological factors that modulate the individual's perception of the environment and provoke specific responses by stimulating some kind of action (CLARK and BECK, 2012; CRASKE et al., 2009). In the face of stimuli or stressful situations, the body's responses arise, such as increased blood pressure, increased frequency of heartbeat, increased sweating and motor activity, agitation, skeletal muscle stiffness and respiratory changes, superficial and rapid type and insomnia, in addition to other physiological changes (LUNDIN, 1977).

According to Tess (1996) anxiety is a warning sign, a warning about immediate dangers, preparing you to create and take measures to face a vague threat, where the situation of danger is not concrete, however it leads to a behavioral and physiological repertoire in a response and has the direction facing the future.

Anxiety is not necessarily a pathological condition, but a natural condition of the organism,

which allows preparing for a response, defense or attack, in the best possible way, in new or unknown situations, or situations already known but interpreted as eminently dangerous (SILVA, 2010). This condition only becomes pathological when it reaches very high and continuous levels, starting to impair performance in daily activities and generate physical and/or emotional imbalance and thus will configure in a state of constant alertness, characterizing the pathologies designated as anxiety disorders (ARAÚJO, 2011).

According to DSM 5, (2014), anxiety disorders include disorders that share excessive fear and anxiety characteristics and related behavioral disorders. Fear is the emotional response to real or perceived imminent threat, while anxiety is anticipating future threat. Obviously, these two states overlap, but also differ, with fear being more often associated with periods of increased autonomic excitability, necessary for fight or flight, thoughts of immediate danger and escape behaviors, and anxiety being more often associated with muscle tension and vigilance in preparation for future danger and behaviors of caution or elusiveness. Sometimes the level of fear or anxiety is reduced by constant antics behaviors. Panic attacks stand out within anxiety disorders as a particular type of response to fear. They are not limited to anxiety disorders and can also be seen in other mental disorders [...].

According to Antai-Otong (2003), the manifestations of anxiety disorders are the most prevalent and disabling of psychiatric disorders, and lead their patients to health services over and over again to seek different medical specialties, and cause damage to the functioning and quality of life of patients. Anxiety disorders are different from both fear and adaptive anxiety, since their manifestations are excessive and lasting, and go far beyond what is expected for the event or triggering situation. Often these disorders develop in childhood and can persist throughout adulthood if left untreated (APA, 2014). These disorders are clinical conditions in which symptoms are primary, not originating from other psychiatric circumstances such as depression, psychosis, developmental disorders, hyperkinetic disorder, and others (CASTILLO, 2000). According to the revised text of the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM 5), the criteria for the diagnosis of anxiety disorder should take into account the frequency and intensity of occurrences of different physical symptoms (increased heart rate, palpitations, dyspnea sialosquesis and sweating), behavioral (agitation, insomnia, exaggerated reaction to (stimuli and fears) or

cognitive (nervousness, apprehension, concern, irritability and distractability) (DSM 5, 2014).

Brazil has very high rates of anxiety disorders, and factors such as socioeconomic, poverty, unemployment, environmental factors, lifestyles in large cities favor this scenario (GONÇALVES and KAPCZINSKI, 2008). On the other hand, Anxiety Disorders are among the most prevalent mental disorders in children and adolescents. According to Asbahr, (2004) loses only to Attention Deficit Hyperactivity Disorder (TDAH) and Conduct Disorder.

Epidemiological studies in American populations indicated that childhood anxiety disorders have an estimated prevalence of 8 to 12% (COSTELLO, 1989; SPENCE, 2001). In Brazil, a population study showed a prevalence rate of 4.6% in children and 5.8% in adolescents (FLEITLICH-BIL and GOODMAN, 2004). Ford et al., (2003) in studies in England, morbidity rates were similar to those found in Brazil, indicating a prevalence of 3.4% in children, and 5.04% in adolescents (FORD et al., 2003).

According to the World Health Organization (WHO) the worldwide prevalence of anxiety disorder (TA) is 3.6% of the population. However, in the American continent, this disorder reaches 5.6%, and in Brazil, TA reaches 9.3% of the population, with the highest number of cases of anxiety among the countries of the world (WHO, 2017).

Anxiety disorders are pointed out as one of the most relevant mental health problems in Brazil and are among the most recurrent psychiatric disorders. It is emotional dysfunction that probably most affects and most interferes with quality of life and are considered the most disabling disorders (RAMOS, 2009). These data point to anxiety disorder as a public health problem, and suggest that further studies be conducted in this regard.

3.2 ANXIETY DISORDERS ACCORDING TO DSM 5

The reformulation of the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) removed from the chapter referring to anxiety disorders, the disorders “obsessive compulsive”, “acute stress” and “posttraumatic stress”, reselecting them in new chapters. Phobic conditions (agoraphobia, specific phobia and social anxiety disorder) no longer require the minimum age of eighteen years for the recognition of their excessive or irrational fear. Finally, the minimum duration for diagnosis also became six months without age distinction

(ARAÚJO and LOTUFO NETO, 2014).

Panic disorder and agoraphobia are now separated into independent diagnoses, thus recognizing the existence of cases of agoraphobia in the absence of panic symptoms. Moreover, panic attack can occur in comorbidity with mental disorders other than anxiety this led DSM 5 to include panic attack as specifier for other disorders (ARAÚJO and LOTUFO NETO, 2014).

Selective mutism and separation anxiety disorder began to make up the chapter of anxiety disorders. Finally, the diagnostic criteria for separation anxiety disorder are in accordance with the previous manual, but accept the possibility that symptoms started at the age of eighteen years. On the other hand, the criteria for diagnosing selective mutism were practically unchanged (ARAÚJO and LOTUFO NETO, 2014). The topics below will describe the anxiety subtypes.

3.2.1 SEPARATION ANXIETY DISORDER

This disorder is characterized by excessive anxiety regarding the removal from home or attachment figures, anxiety exceeds what is expected in relation to the stage of development of the individual, and persists for at least one month, causes intense suffering and expressive damage, in different areas of life (DSM 5, 2014).

Children or adolescents fear that something might happen to themselves or their caregivers, as long as they are removed from them. Thus, they assume excessive attachment behavior to their caregivers, preventing the removal or even systematically phoning them. They need company to sleep and can resist sleep for fear of separation or loss of control. They refer to nightmares, about the fears of separation is common secondary school refusal in these patients (CASTILLO, 2000).

It is enough for a child to imagine that his/her parents will be absent so that somatic manifestations of anxiety (abdominal pain, headache, nausea and vomiting) may arise. Some have palpitations, dizziness and an impression of fainting. Retrospective studies have raised the hypothesis that separation anxiety in childhood may constitute a risk factor for the onset of anxiety disorders in adults (CASTILLO, 2000).

3.2.2 GENERALIZED ANXIETY DISORDER (TAG)

The essential characteristics of generalized anxiety disorder are excessive anxiety and concern (apprehensive expectation) about various events or activities. The intensity, duration, or frequency of anxiety and worry is disproportionate to the actual probability or impact of the anticipated event. The individual has difficulty controlling the concern and preventing worrying thoughts from intervening in the attention to the tasks in question. Adults with generalized anxiety disorder often worry about daily life routine circumstances, such as possible responsibilities at work, health and finances, the health of family members, misfortunes with their children, or minor issues (e.g., performing household chores or being late for appointments). Children with the disorder tend to worry excessively about their competence or the quality of their performance. During the course of the disorder, the focus of concern may shift from one concern to another. [...] (DSM 5, 2014, p.222).

TAG is the anxiety disorder most commonly found in clinical practice, being considered a chronic disease, associated with high morbidity and high individual and social costs, with great demand for outpatient medical services, since the symptoms of TAG are often confused with other clinical conditions (RAMOS, 2009). Depression often coexists in patients with TAG (MACKINNON, 2008). Symptomatology associated with TAG includes agitation, fatigue, difficulty concentrating, nervousness, muscle tension, sleep disorder, excess concern (KINRYS and WYGANT, 2005).

3.2.3 SPECIFIC PHOBIA

Specific phobia presents fear or anxiety associated with the presence of a particular object or situation (phobic stimulus). For the diagnosis of specific phobia, fear or anxiety are exaggerated in relation to the real danger manifested by the object or situation. The suffering caused adds damage to social, professional or other important areas of life (DSM 5, 2014).

Individuals with specific phobia use avoidance to solve the problem. His life is related to unreal and distressing fears. They rationally explain their fears, but at the same time

recognize the objects or situations are only partially responsible for their feelings. Although they often perceive their fear as inadequate, they believe that avoiding the situation is the only possible choice due to their intense fear (MACKINNON, 2008).

3.2.4 SOCIAL ANXIETY DISORDER (TAS)

Intense fear and anxiety characterize ASD in social situations in which the individual can be judged by others. The possibility of negative evaluation causes intense anxiety, causing the subject to avoid these moments. Anxiety and fear are compared to the real threat manifested by the social situation and the sociocultural context, which end up causing persistent dodges that usually last over six months. Causing clinically significant suffering and impairment in social, professional or other areas of life (DSM 5, 2014).

In clinical samples, TAS has a prevalence of 12.1% during life. Patients with TAS are 10 to 20% of individuals with anxiety disorder (MULULO et al., 2009). According to Ramos (2009), symptoms of TAS can arise in adolescence and evolve in chronic course.

3.2.5 PANIC DISORDER (TP)

In panic disorder there is an abrupt outbreak of fear, or intense discomfort that reaches a peak in minutes and during this time the most common symptoms presented are: palpitations, acceleration of heart rate, sweating, feeling short of breath, or being suffocated, feeling dizzy, fear of losing control or dying, depersonalization, disrealization, in addition to other symptoms. The start is always sudden and the duration of 10 to 30 minutes on average (DSM 5, 2014).

Panic attacks can happen to anyone, but only those who have frequent attacks, three or more for one month, are diagnosed as TP (RAMOS, 2009). This disorder reaches approximately 3% of the population and causes much suffering to the person and damage in his life (SHINOHARA, 2005). This chronic disorder influences the quality of life of patients, since its repercussion affects several social, physical, family and occupational contexts (CARVALHO et al., 2008).

3.2.6 AGORAPHOBIA

Agoraphobia is characterized by the marked or intense fear or anxiety triggered by the exposure, real or predicted, to various situations. To make the diagnosis it is necessary that symptoms occur in at least two of the five situations such as: use of public transport; stay in open space; stay indoors; staying in a line or in the crowd; departure from home alone (DSM 5, 2014).

When anxiety or fear is triggered in these situations, individuals generally experience thoughts that something terrible might happen. They believe that escaping these situations would be very difficult, or that there is no help available when symptoms of panic occur, or other disabling and embarrassing symptoms. Anxiety is evoked almost every time the person comes into contact with the dhimed situation (DSM 5, 2014). These individuals develop a series of strategies to deal with fear, such as leaving home accompanied, or always carrying a tranquilizer with you. Anticipatory anxiety is also part of the picture (RAMOS, 2009).

3.2.7 SELECTIVE MUTISM

DSM 5 (2014) provides the description that children with selective mutism when they meet other people in social interactions, do not start the discourse or do not respond when others speak to them. The lack of speech occurs in social interactions with both adults and other children.

Children with this disorder speak at home in the presence of family members, but often do not talk to close friends or second-degree family members. The disorder is often marked by high social anxiety. At school, these children often refuse to speak, and have repercussions on school performance.

As for the development and course of this disorder, in general, its onset occurs before the age of 5, but may not be clinically detected until entering the school, where there is an increase in social interaction (DSM 5, 2014).

Risk factors for selective mutism are not well identified. Negative affectivity (neuroticism) or

behavioral inhibition may play a role, as well as parental history of shyness, social isolation and social anxiety. At the environmental level, parents of children with selective mutism were described as overprotective and more controlling than parents of children with other anxiety disorder or without disturbances. Due to the significant overlap between selective mutism and social phobia, there may be genetic factors common to both conditions (DSM 5, 2014).

4. RESULT AND DISCUSSION

Araújo (2013), conducted a systematic review in search of psychological assessment instruments available in Brazil, with relevance for diagnoses of anxiety disorders and divided the instruments into seven categories. The first category includes instruments that analyze anxiety as a global construct, in this category is the Inventory of State-Trait Anxiety - STAI). The second category involves instruments to assess psychiatric disorders, such as the Screen for Child Anxiety Related Emotional Disorders (SCARED) or instruments for the evaluation of anxiety disorders and disorders of other psychiatric categories (e.g., Composite International Diagnostic Interview - CIDI).

The third comprises instruments for assessing specific anxiety disorders through behaviors, thoughts and/or feelings symptomatic of the disorder in question (e.g., Social Phobia Inventory - SPIN). The fourth includes instruments for assessing anxiety related to specific contexts (e.g., hospital, where it applies to anxiety and depression scales - HADS); Competitive State Anxiety Inventory-2 - CSAI-2). The fifth category includes instruments for assessing a peculiarity related to anxiety, such as the concern: Penn State Worry Questionnaire - PSWQ; anxiety sensitivity index-3 - ASI-3). The sixth category, involving instruments that assess mental health in general - such as anxiety-related complaints - has value as an indicative screening of the need for psychiatric care, among them is the Self-Reporting Questionnaire-20 - SRQ-20). The seventh category comprises the other instruments included that did not fall into the previous categories.

The studies by Obelar (2016) in a systematic review of the psychological evaluation of anxiety disorders in adults, including all studies published from 2000 to 2015, and presenting psychological anxiety assessment instruments that include the Brazilian population, showed that the most cited instruments for assessing anxiety disorders in Brazil were: Beck Anxiety

Inventory (BAI); Hospital Anxiety and Depression Scale (HADS); Inventory of Trait and State Anxiety (STAI); Social Phobia Inventory (SPIN) and the Hamilton Anxiety Scale. These instruments will be described below.

4.1 BECK ANXIETY INVENTORY (BAI)

The Beck Scales are inventories originally developed by Beck, Epstein, Brown and Steer in 1988 and adapted by Jurema Alcides Cunha in 2001, has good reliability and validity coefficients. The first sample of reliability and validity of this inventory was reported by Cronbach's alpha in samples of psychiatric, non-clinical and clinical lycemium patients. The coefficients for non-clinical samples ranged from 0.71 to 0.72. In addition, the one-week interval between tests led to a correlation between applications in a sample of the general population of 0.99 ($p < 0.001$) its Manual evidences content validity, convergent, discriminant and factorial (CUNHA, 2001).

The Beck Scales are composed of four measures: a) Depression Inventory (BDI) that measures the intensity of depression; b) Anxiety Inventory (BAI), which assesses anxiety intensity; c) Hopelessness Scale (BHS) is known as a measure of pessimism and is capable of presenting evidence suggestive of suicide risk in depressed individuals or individuals with a history of suicide attempts; and d) Suicide Ideation Scale (BSI) that detects the presence of suicidal ideation, assessing the extent of motivation and planning of suicidal behavior. This instrument is suitable for people aged 17 to 80 years. In Brazil only supervised psychology professionals and students are allowed to post this test. Scales can be applied separately or not. Its joint use is more indicated, as it makes the diagnosis more accurate since the phenomena investigated are often associated. The result is not influenced by the order of presentation (CUNHA, 2001).

Bai was adapted and standardized for the Brazilian population by Cunha (2001). It assesses anxiety symptoms on a scale from zero to four points, and identifies increasing severity levels of each symptom (TAVARES et al., 2012).

4.2 HOSPITAL SCALE OF ANXIETY AND DEPRESSION (HADS)

There are several instruments already described in order to assess anxiety and depression (Hamilton Anxiety Scale, IDATE Anxiety Inventory I and II, Beck Anxiety and Depression Inventories and Hospital Anxiety and Depression Scale (HADS). Most of them were created to be used in patients with psychiatric disorders. However, HADS was initially created to verify symptoms of anxiety and depression in patients in hospitals and non-psychiatric clinics, later started to be used in non-hospitalized patients and in theotically disorder-free individuals.

HADS was limited to 14 items, divided into anxiety and depression subscales. Zigmond and Snaith (1983) recommended two cutoff points in both subscales as follows: possible cases with scores greater than 8 and probable cases, greater than 11 points. They also suggested a third cut-off point: in relation to severe disorders, which received more than 15 points.

This instrument has already been translated into several languages. Botega et al., (1995) produced a hads validation study in Portuguese. HADS differs from other scales by excluding the interference of somatic disorders, so they are not present in the score of this scale, symptoms of anxiety or depression associated with physical diseases.

Therefore, items such as weight loss, anorexia, insomnia, fatigue, pessimism about the future, headache and dizziness, etc. are not included.

4.3 TRACE-STATE ANXIETY INVENTORY (IDATE)

This Inventory is one of the most used instruments to quantify subjective components of anxiety (KEEDWELL and SNAITH, 1996). It was prepared by Spielberger; Gorsuch and Lushene (1970) and in Brazil was translated and adapted by Biaggio and Natalício (1979). IDATE has a scale to assess anxiety as a state (IDATE -E) and another that checks anxiety as a trait (IDATE -T).

The anxious state portrays a transient response related to a situation of adversity that presents itself at a given moment, while the trait refers to a more stable aspect, the propensity of the individual to deal with greater or lesser anxiety throughout life (CATTELL

and SCHEIER, 1961).

The IDATE was initially developed with the purpose of measuring specific latent structures, in which each scale would correspond to a single factor (SPIELBERGER et al., 1970). However, studies were conducted in the 1970s-80s with technical and statistical foundations of factor analysis, which indicated the existence of two factors for IDATE -E and IDATE -T (BARKER; BARKER and WADSWORTH, 1977; GAUDRY and POOLE, 1975; LOO, 1979; SPIELBERGER et al., 1980). This pattern of results generated discussion about the true potential structure of these scales, especially in relation to the IDATE -T that demonstrated a greater problem of interpretation regarding the nature of its factors.

Spielberger et al., (1980) showed that the best classification of items related to these two factors was the one that contained contents that manifested the presence or absence of anxiety.

In Brazil, the factorial structure of the IDATE-T has been little studied. Among the studies are those of Pasquali et al., (1994) as well as those of Andrade et al., (2001), who found different factorial structures in relation to IDATE-T. For example, Pasquali and et al. (1994), verified a solution that helped the interpretation of the two factors of IDATE-T in “present anxiety” and “absent anxiety”. On the other hand, Andrade and et al. (2001) reported the presence of two factors related to anxiety and depression.

The assessments on the factorial structure of the IDATE found a high consistency index in both scales, and Cronbach’s alpha in three samples ranged from 0.82 to 0.89 (LORICCHIO, 2012).

4.4 SOCIAL PHOBIA INVENTORY (SPIN)

The Mini-SPIN is composed of three items, which assess the fear of embarrassment and avoidance. For each item in the inventory, the individual is asked to indicate how much the situations bothered him in the last week, and should mark one of the five existing options, which range from “Nothing to extremely”. The score for each option ranges from 0 to 4, and the total score of the instrument ranges from 0 to 12. Scores of 6 points or more suggest that the clinician should investigate the presence of generalized social phobia. The original

English version of this instrument has good sensitivity (88.7%), specificity (90.0%) and diagnostic efficiency (89.9%). This instrument is a good tool for tracking generalized social phobia (CONNOR et al., 2001).

The Social Phobia Inventory (SPIN) was validated for the Brazilian context by Osório et al., (2005), being organized into 17 items that analyze symptoms related to social anxiety disorder. Studies have shown reliable validity and reliability indicators for SPIN in Brazilian samples (ALVES, 2012). It is a brief, self-applicable and easy-to-administer instrument, capable of detecting symptoms of fear, avoidance and physiological (ANGÉLICO, 2012).

4.5 HAMILTON ANXIETY SCALE

The Hamilton Anxiety Scale is composed of 14 items divided into two groups, with 7 items: the first group comprises the symptoms of anxious mood, while the second comprises physical symptoms of anxiety. The items are evaluated using a 5-point Likert scale that it considers from absence (0) to high intensity of symptoms (4) (OBELAR, 2016).

4.6 OTHER USEFUL TOOLS IN THE ASSESSMENT OF ANXIETY DISORDER

In addition to the instruments described above because they were found to be the most used over 15 years (2000 to 2015) in the Obelar review (2016), many other tests are used to assess anxiety disorders and due to the psychological importance of each one. Brief psychiatric evaluation scale (BPRS); Zung Anxiety Scale; Symptom Checklist Anxiety Subscale (SCL-90); Clinical Anxiety Scale (CAS); Brief Anxiety Scale (BAS); POMS (Profile of Mood States (POMS).

5. FINAL CONSIDERATIONS

Anxiety is a normal emotion, a warning sign, which warns of imminent dangers and has the function of mediating man's interaction with the environment; being then a natural and necessary reaction for self-preservation. Anxiety symptoms are expected in appropriate situations. Anxiety is considered pathological, when, disproportionate in relation to the

triggering stimulus. Anxiety Disorder is usually identified by repeated and intense occurrence of various physical (aquicardia, sialosquesis, pulmonary hyperventilation and excessive sweating), behavioral (agitation, insomnia, exacerbation of reactions to stimuli and fears) or cognitive (agitation, distress, worry, nervousness and attention deficit) (LOUZÃ et al., 2011).

In the Brazilian population, anxiety disorders have a high prevalence and are very disabling, causing significant functional and social impairment, and high financial cost for the public service. The realization of a more accurate and effective diagnosis is necessary so that the treatment can be performed correctly. (MARCULINO et al., 2007). Psychological evaluation, when performed with valid, reliable and up-to-date instruments can be of great help to diagnostic improvement and treatment guidance and planning.

A psychological assessment instrument must be adequate, and have well-based theoretical bases on empirical evidence, to generate safe diagnoses and prognoses (CUNHA, 2001; PRIMI, 2010).

The Instruments that assess anxiety should ensure confidence to clinicians and researchers to perform screening and diagnosis processes safely, supporting clinical and academic practices in the planning and efficacy of interventions. It is important that professionals know the qualities of the instruments available in Brazil for the evaluation of anxiety disorders and the qualities of the instruments in order to be able to select the best and most appropriate instrument to measure what is desired, according to the objectives in question.

Psychological assessment should be understood as more than simply a field applied to the use of measures and techniques. The evaluation, in general, and the development of instruments, serve to objectiveize and operationalize theories and constructs (PRIMI, 2010). They involve the relationship of theoretical concepts with observable elements and require the application of the scientific method. Seeking evidence of adequacy of the evaluation instruments, the studies help the development of the constructs evaluated (PRIMI, 2010). Thus, the advances of studies on anxiety assessment offer theoretical and empirical bases for the development and knowledge of this construct and for the prevention and treatment of anxiety disorders.

6. REFERENCES

ALVES, Nelson Torro et al. Ansiedade social e atribuição de emoções a faces neutras. Estudos de Psicologia (Natal), v. 17, n. 1, p. 129-134, 2012.

AMERICAN PSYCHIATRIC ASSOCIATION et al. DSM-5: Manual diagnóstico e estatístico de transtornos mentais. Artmed Editora, 2014.

ANDRADE, L. et al. Psychometric properties of the Portuguese version of the State-Trait Anxiety Inventory applied to college students: factor analysis and relation to the Beck Depression Inventory. Brazilian Journal of Medical and Biological Research, v. 34, n. 3, p. 367-374, 2001.

ANGÉLICO, Antonio Paulo; CRIPPA, José Alexandre S.; LOUREIRO, Sonia Regina. Utilização do Inventário de Habilidades sociais no diagnóstico do transtorno de ansiedade social. Psicologia: Reflexão e Crítica, v. 25, n. 3, p. 467-476, 2012.

ANTAI-OTONG, Deborah. Anxiety disorders: treatment considerations. Nursing clinics of North America, v. 38, n. 1, p. 35-44, 2003.

ARAÚJO, Álvaro Cabral; LOTUFO NETO, Francisco. A nova classificação americana para os transtornos mentais: o DSM-5. Revista brasileira de terapia comportamental e cognitiva, v. 16, n. 1, p. 67-82, 2014.

ARAÚJO Desousa, Diogo et al. Revisão sistemática de instrumentos para avaliação de ansiedade na população brasileira. Avaliação Psicológica, v. 12, n. 3, 2013.

ARAUJO, Neuraci Gonçalves de. Fobia específica: passo a passo de uma intervenção bem-sucedida. Revista Brasileira de Terapias Cognitivas, v. 7, n. 2, p. 37-45, 2011.

ASBAHR, Fernando R. Transtornos ansiosos na infância e adolescência: aspectos clínicos e neurobiológicos. Jornal de Pediatria, v. 80, n. 2, p. 28-34, 2004.

BARKER, Barbara M.; BARKER JR, Harry R.; WADSWORTH JR, Allen P. Factor analysis of the

items of the state-trait anxiety inventory. *Journal of Clinical Psychology*, v. 33, n. 2, p. 450-455, 1977.

BIAGGIO, Angela, Maria B.; NATALÍCIO, Luiz. Manual para o inventário de ansiedade Traço-Estado (IDATE). Rio de Janeiro: CEPA, v. 15, 1979.

BOTEGA, Neury J. et al. Transtornos do humor em enfermagem de clínica médica e validação de escala de medida (HAD) de ansiedade e depressão. *Revista de saúde pública*, v. 29, p. 359-363, 1995.

BOWMAN, Marilyn L. Testing individual differences in ancient China. *American Psychologist*, v. 44, n. 3, p. 576b, 1989.

BUENO, José Maurício Haas; PEIXOTO, Evandro Moraes. Avaliação psicológica no Brasil e no mundo. *Psicologia: Ciência e Profissão*, v. 38, n. SPE, p. 108-121, 2018.

CARVALHO, Marcele Regine de; NARDI, Antonio Egidio; RANGÉ, Bernard. Comparação entre os enfoques cognitivo, comportamental e cognitivo-comportamental no tratamento do transtorno de pânico. *Archives of Clinical Psychiatry (São Paulo)*, v. 35, n. 2, p. 66-73, 2008.

CASTILLO, Ana Regina GL et al. Transtornos de ansiedade. *Revista Brasileira de Psiquiatria*, v. 22, p. 20-23, 2000.

CATTELL, Raymond B.; SCHEIER, Ivan H. The meaning and measurement of neuroticism and anxiety. Ronald Press, New York. 1961.

CLARK, David. A.; BECK, Aron, T. Terapia cognitiva para os transtornos de ansiedade: ciência e prática. Porto Alegre: Artmed. 2012.

CONNOR, Kathryn M. et al. Mini-SPIN: A brief screening assessment for generalized social anxiety disorder. *Depression and anxiety*, v. 14, n. 2, p. 137-140, 2001.

CONSELHO FEDERAL DE PSICOLOGIA. Resolução CFP, Resolução nº 6, de 29 de março de 2019. Brasília: Conselho Federal de Psicologia, 2019.

COSTELLO, Elizabeth. E. Developments in child psychiatric epidemiology. Journal of the American Academy of Child and Adolescent Psychiatry, v.28, p.836-841,1989.

CRASKE, Michelle G. et al. What is an anxiety disorder?. Depression and anxiety, v. 26, n. 12, p. 1066-1085, 2009.

CUNHA, Jurema Alcides et al. Manual da versão em português das Escalas Beck. São Paulo: Casa do Psicólogo, p. 11-13, 2001.

FLEITLICH-BILYK, Bacy; GOODMAN, Robert. Prevalence of child and adolescent psychiatric disorders insoutheast Brazil. Journal of the American Academy of Child & Adolescent Psychiatry, v. 43, n. 6, p. 727-734, 2004.

FORD, Tamsin; GOODMAN, Robert; MELTZER, Howard. The British child and adolescent mental health survey 1999: the prevalence of DSM-IV disorders. Journal of the American academy of child & adolescent psychiatry, v. 42, n. 10, p. 1203-1211, 2003.

GAUDRY, Eric; VAGG, Peter; SPIELBERGER, Charles D. Validation of the state-trait distinction in anxiety research. Multivariate Behavioral Research, v. 10, n. 3, p. 331-341, 1975.

GIL, Antonio Carlos. Métodos e técnicas de pesquisa social. 6. ed. Editora Atlas SA, 2008.

GOMES, W. B. A tradição em avaliação psicológica no Rio Grande do Sul: a liderança e a referencia de Jurema Alcides Cunha. Avanços e polemicas em avaliação psicológica: em homenagem a Jurema Alcides Cunha, 1ª Ed., São Paulo: casa do psicólogo, p. 7, 2009.

GONÇALVES, Daniel Maffasioli; KAPCZINSKI, Flávio Pereira. Prevalência de transtornos mentais em indivíduos de uma unidade de referência para Programa Saúde da Família em Santa Cruz do Sul, Rio Grande do Sul, Brasil. Cadernos de saúde pública. Rio de Janeiro. V. 24, n. 9. p.2043-2053, 2008.

GOTTFREDSON, Linda; SAKLOFSKE, Donald H. Intelligence: Foundations and issues in assessment. Canadian Psychology/Psychologie canadienne, v. 50, n. 3, p. 183, 2009.

HUTZ, Claudio Simons; BANDEIRA, Denise Ruschel. Avaliação psicológica no Brasil: situação

atual e desafios para o futuro. Construindo a psicologia brasileira: desafios da ciência e prática psicológica. São Paulo: Casa do Psicólogo, p. 261-275, 2003.

HUTZ, Claudio Simon. O que é avaliação psicológica: métodos, técnicas e testes. Psicometria. Cap, v. 1, p. 11-21, 2015

KEEDWELL, Paul; SNAITH, R. P. What do anxiety scales measure?. Acta Psychiatrica Scandinavica, v. 93, n. 3, p. 177-180, 1996.

KINRYS, Gustavo; WYGANT, Lisa E. Transtornos de ansiedade em mulheres: gênero influencia o tratamento?. Revista Brasileira de Psiquiatria, v. 27, supl. II, p. 43 – 45, 2005.

LOO, Robert. The State-Trait Anxiety Inventory A-Trait scale: Dimensions and their generalization. Journal of personality assessment, 1979.

LORICCHIO, Tânia Mara Brito; LEITE, José Roberto. Estresse, ansiedade, crenças de autoeficácia e o desempenho dos bacharéis em Direito. Avaliação Psicológica, v. 11, n. 1, p. 37-47, 2012.

LOUZÃ NETO, Mario Rodrigues; CORDÁS, TákiAthanássios. Transtornos da personalidade. Porto Alegre: Livraria do Advogado, 2011.

LUNDIN, R. W. Personalidade: Uma análise do comportamento (RR Kerbauy, Trad.). São Paulo, SP: EPU.(Original publicado em 1969), 1977.

MACIKINNON, Roger A. A entrevista psiquiátrica clínica. 2. ed. Porto Alegre: Artmed. 2008.

MARCOLINO, José Álvaro Marques et al. Escala hospitalar de ansiedade e depressão: estudo da validade de critério e da confiabilidade com pacientes no pré-operatório. Revista Brasileira de Anestesiologia, v. 57, n. 1, p. 52-62, 2007.

MELO, Laiz Alves Guimarães. Avaliação psicológica em crianças e adolescentes em situação de risco. Revista Especialize On-line IPOG, v.1, n. 13, p. 1-13, 2017

MULULO, Sara Costa Cabral et al. Eficácia do tratamento cognitivo e/ou comportamental para

o transtorno de ansiedade social. Revista Psiquiatrica RS, v. 31, n. 3, p. 1-10, 2009.

OBELAR, Rosemeri Marques. Avaliação psicológica nos transtornos de ansiedade. Estudos brasileiros. Monografia (Especialização em Avaliação Psicológica) – Instituto de Psicologia, Universidade Federal do Rio Grande do Sul, Curso de pós-graduação em Psicologia, Estado do Rio Grande do Sul, Porto Alegre, 2016.

ORGANIZAÇÃO MUNDIAL DE SAÚDE-OMS. Depression and other common mental disorders: global health estimates [Internet]. Geneva: WHO; 2017[cited 2017 Nov 04]. Available from: <http://apps.who.int/iris/bitstream/10665/254610/1/WHO-MSD-MER-2017.2-eng.pdf>

OSÓRIO, Flávia de Lima; CRIPPA, José Alexandre de Souza; LOUREIRO, Sonia Regina. Instrumentos de avaliação do transtorno de ansiedade social. Archives of Clinical Psychiatry (São Paulo), v. 32, n. 2, p. 73-83, 2005.

PASQUALI, Luiz; PINELLI JÚNIOR, Balsem; SOLHA, Andréia Carvalho. Contribuição à validação e normalização da escala de ansiedade-traço do IDATE. Psicol. teor. pesqui, v. 10, n. 3, p. 411-20, 1994.

PINE, Daniel S. Childhood anxiety disorders. Current Opinion in Pediatrics, v. 9, n. 4, p. 329-338, 1997.

PRIMI, Ricardo et al. Critérios para avaliação de testes psicológicos. Em Conselho Federal de Psicologia – CFP (Org.), Avaliação dos testes psicológicos: relatório, p. 31-55. Brasília: CFP. 2004

PRIMI, Ricardo. Avaliação psicológica no Brasil: fundamentos, situação atual e direções para o futuro. Psicologia: Teoria e Pesquisa, v. 26, n. 25ANOS, p. 25-36, 2010.

RAMOS, Renato T. Transtornos de Ansiedade. RBM, Revista Brasileira de Medicina, v.66 n.11. p. 365-374, 2009

SHINOHARA, Helene. Transtorno de pânico: da teoria à prática. Revista Brasileira de Terapias Cognitivas, v. 1, n. 2, p. 115-122, 2005.

SILVA, André Luiz Picolli da. O tratamento da ansiedade por intermédio da acupuntura: um estudo de caso. *Psicologia: ciência e profissão*, v. 30, n. 1, p. 200-211, 2010.

SPENCE, Susan H. et al. The structure of anxiety symptoms among preschoolers. *Behaviour research and therapy*, v. 39, n. 11, p. 1293-1316, 2001.

SPIELBERGER Charles Donald, et al. STAI: manual for the State – Trait Anxiety Inventory. Palo Alto, CA: Consulting Psychologists Press. 1970

SPIELBERGER, Charles D. et al. The factor structure of the state-trait anxiety inventory. *Stress and anxiety*, v. 7, p. 95-109, 1980.

STRAUB, Ricardo O. *Psicologia da Saúde*. Porto Alegre: Artmed. 2005

TAVARES, Gislaine Pereira; SCHEFFER, Morgana; ALMEIDA, Rosa Maria Martins de. Drogas, violência e aspectos emocionais em apenados. *Psicologia: Reflexão e Crítica*, v. 25, n. 1, p. 89-95, 2012.

TESS, Vera Lucia Carvalho. Disfunções sexuais em pacientes com transtorno de pânico com e sem agorafobia. 1996. Tese de Doutorado. Dissertação de Mestrado. Faculdade de Medicina da Universidade de São Paulo.

VASCONCELOS, Arilane da Silva; COSTA, Cristina; BARBOSA, Leopoldo Nelson Fernandes. Do transtorno de ansiedade ao câncer. *Revista da SBPH*, v. 11, n. 2, p. 51-71, 2008.

VIANNA, Renata Ribeiro Alves Brarboza. Avaliação dos níveis de ansiedade de uma amostra de escolares no Rio de Janeiro através da Escala Multidimensional de Ansiedade para Crianças (MASC-VB). *Psicologia Clínica*, v. 21, n. 2, p. 500-500, 2009.

ZIGMOND, Anthony S.; SNAITH, R. Philip. The hospital anxiety and depression scale. *Acta psychiatrica scandinavica*, v. 67, n. 6, p. 361-370, 1983.

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