Qualitative differences in psychiatric symptoms between high risk groups assessed on a screening test (GHQ-30)

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Summary. Scores on five subscales derived from the GHQ-30 have been examined in various groups at risk for psychiatric disorder, to determine whether different patterns of symptoms are found. The subscales are based on a factor analysis of a population sample of over 6,000 adults (Huppert et al. 1989) which identified five robust factors corresponding to symptoms of anxiety, feelings of incompetence, depression, difficulty in coping and social dysfunction. Previous studies have identified certain groups of people who are vulnerable to mental illness and are therefore likely to obtain a high score on the GHQ. These include unemployed men, single women with dependent children, and elderly people in poor health. The results show marked differences in symptom patterns among these three at-risk groups. For example, while scores on anxiety and depression subscales were significantly raised in most at-risk groups, young unemployed men did not show significant anxiety whereas elderly men in poor health did not show significant depressive symptoms. However both these groups showed difficulty in coping, unlike older unemployed men or elderly women in poor health. Single women with dependent children reported the highest rate of psychiatric symptoms, particularly anxiety and depression, but had difficulty in coping only if they were also employed. These findings suggest that this method of analysing data from the GHQ-30 has potential value in yielding qualitative as well as quantitative information about psychiatric symptoms.

The 30-item General Health Questionnaire (GHQ) of Goldberg (1972) is widely used as a unidimensional measure for screening functional psychiatric illness. The typical scoring technique, in which 30 questions are summed to form a single continuous score, provides no indication of the pattern of response. With this in mind, using data collected as part of the Health and Lifestyle Survey (Cox et al. 1987), a series of factor analyses were carried out on a sample of 6,000 questionnaires (Huppert et al. 1989). The reliability of the factor structure was demonstrated by repeating the analysis on ten independent random samples from the population and on each of six age groups for men and women separately. The identification of five robust and independent factors corresponding to different types of psychiatric symptoms (anxiety, feelings of incompetence, depression, difficulty in coping and social dysfunction) suggests that it is possible to look at the data in a more qualitative way. To this end, we have selected three groups of people who are currently receiving attention as being at risk for psychiatric disorders due to their social circumstances. These are unemployed men, single women with dependent children, and elderly people in poor health.

Considerable evidence has accumulated supporting the association of unemployment and psychological distress (Warr 1982). Documentation of this relationship ranges from the finding that unemployed men are more likely to attempt suicide or parasuicide (nonfatal deliberate self-harm) than employed men (Hawton and Rose 1986; Platt and Kreitman 1984), and more likely to report psychiatric morbidity as assessed by the GHQ (Banks & Jackson, 1982). These adverse effects of unemployment may be more severe for men during middle age (Hawton and Rose, 1986). The finding that the unemployed are also more ill physically (e. g. Blaxter 1987) complicates the relationship, making it difficult to ferret out direct from indirect effects, much less determine causality. As the current study is correlational, it will not be possible to evaluate the causal direction. However, by controlling for number of physical symptoms, we can attempt to remove the confounding influence of physical illness from the effect of employment status.

There is also mounting evidence that single women with dependent children are at higher risk of experiencing psychological distress than their counterparts with partners. It is important to highlight the interactive nature of this relationship. The effect of marriage for women seems to depend on a host of other variables, including social class, social support, life events, employment and parental status (Cleary and Mechanic 1983; Parry 1986; Warr and Parry, 1982). As the emphasis of this paper is methodological, we chose to focus on two of these, the effects of

marital status and employment on women with dependent children. Specifically, evidence is emerging that employment may affect single mothers with dependent children in some aspects of psychological functioning, but not in others. By comparing the patterns of responses on the GHQ, it is possible that some subtle, hitherto undetected, relationship between the marital and employment status of women with dependent children may be revealed.

Another group considered to be at risk for psychological morbidity is elderly people who are physically ill. The positive relationship between physical health and mental health is well documented (Costa and McCrae 1980; Linn and Linn 1980; Smith Monson and Ray 1986) and seems to be evident across cultures (Cockeram et al. 1988) and across genders (Costa and McCrae, 1987). Moreover, people generally experience more troubling symptoms as they grow older. Thus, even if elderly people are not necessarily more psychologically distressed as a function of age alone, it seems likely that many of them are ill and, as a result, at risk.

Our own data (Huppert et al. 1987) support these basic findings. By examining responses to the 30-item General Health Questionnaire in a more qualitative way, i.e. by looking at scores on subscales of the GHQ, differences in symptomatology among these at-risk groups may be revealed.

Method

During the first stage of the Health and Lifestyle Survey, 9003 community residents aged 18 and over took part in an extensive home-based initial interview. These subjects comprised a representative sample of the adult population of England, Scotland, and Wales. Considerable information relevant to the current study was gathered at this point in the data collection process including the demographic data (gender, age, household status, marital status, parental status, and employment) as well as an illness score (sum of number of physical symptoms endorsed from a 16-item check list). Of the original participants, 7414 (82.4%) agreed to the second stage of the study, a nurse's visit involving a series of physiological measurements and simple tests of cognitive function (see Cox et al. 1987; Huppert et al. 1987). The 30-item General Health Questionnaire was introduced to the respondents at the conclusion of this second visit. Of those accepting the questionnaires, 6572 (88.6%) returned them by mail in pre-paid envelopes. Analyses were conducted on the 6317 completed questionnaires.

In the GHQ-30, the four response categories to the positively worded items are labelled 'better than usual/more so than usual', 'same as usual', 'less than usual', and 'much less than usual', whereas the response categories for the negatively worded items are 'not at all', 'no more than usual', 'more than usual', and 'much more than usual'. Two scoring techniques were employed for this report. First, a conventional uni-dimensional GHQ score was calculated, where responses were simply dichotomized into essentially asymptomatic (two lower categories) or symptomatic (two higher categories), resulting in a final score ranging from 0 to 30 (i.e. from no symptoms present to all 30 symptoms

present). For a general population sample the recommended cutoff when the GHQ is used as a screening test is 4/5 (Tarnopolsky et al. 1979) i.e. any respondent scoring 5 or more is considered to be a potential case of psychiatric disorder. Alternatively, the GHQ items can be scored with a Likert format where subjects' responses to each of the thirty items can take on a value from 0 to 3. The subscale scores were based on the latter scoring technique.

As we reported previously (Huppert et al. 1989), factor analysis of the GHQ responses (Likert scoring) for this sample identified five independent factors corresponding to anxiety, feelings of incompetence, depression, difficulty in coping and social dysfunction. Five subscales were then derived by summing an individual's scores on each of the items that contributed substantially to a particular factor (Appendix A). The number of items making a sizable contribution to each factor varied from eight items for the anxiety factor to only three items on the social dysfunction factor. In order to standardise the scores obtained on different subscales, each score was divided by the number of items in the subscale and then expressed as a score from 0 to 100.

Group selection

The first group we identified to be at risk was unemployed males between the ages of 18 and 64. As the proportion of nonmanual men who were unemployed was small (3%), we confined our analyses to manual workers. The comparison group was limited to full-time employees since less than 2% of the manual workers were employed part-time. Within this analysis we compared younger (18–39 years of age) with older subjects (40–64 years of age). Although in selecting this sample we ruled out men who were unemployed due to poor health, there could still be some variance in symptomatology, perhaps related to age, that could confound the analysis. We employed the illness score described above to control for this effect.

The second group identified to be at risk was single women (aged 18–44) with dependent children; they were compared to "married" women with dependent children. The married women category included all women who lived with a partner, regardless of their marital status. In fact, only 2% of the couples were not married. For convenience we will refer to this group as married for the remainder of the paper. Employment status, also a potentially critical factor in the psychological health of women with dependent children, was also included in the analysis. Slightly over half of this sample of women were employed; twice as many of the women were employed part-time (fewer than 30 hours) as full-time (30 hours or more).

Lastly, the third group perceived to be at risk was elderly people (65+) who were physically ill. The number of physical illness symptoms reported in the initial interview was dichotomized into high (four through six symptoms) and low (fewer than four symptoms). We chose six as the cutoff because the distribution of scores is larger for women, with fewer men falling in the tail. As men and women are typically found to differ in terms of both psychological distress and illness scores (e.g., Nathanson, 1975), gender was included in the analysis.

Table 1. Mean and standard error GHQ scores and percentage scoring over threshold in groups at risk for psychiatric illness and comparison groups

	n	Mean (SE)	Percentage over threshold
Manual workers			
Age 18–39			
Employed	525	3.12 (0.18)	24
Unemployed	95	4.78 (0.50)	45
Age 40–64			
Employed	472	2.75 (0.19)	18
Unemployed	67	6.21 (0.77)	51
All ages			
Employed	997	2.94 (0.13)	21
Unemployed	162	5.37 (0.43)	47
Women with dependent children			
Housewives			
Married	504	4.25 (0.25)	32
Single	60	6.87 (0.76)	57
Employed			
Married	531	3.41 (0.20)	27
Single	64	7.14 (0.98)	48
Both groups			
Married	1035	3.82 (0.16)	29
Single	124	7.01 (0.62)	52
Elderly (65 +)			
Men			
< 4 Illness Symptoms	337	2.96 (0.22)	22
4–6 Illness Symptoms	103	5.13 (0.53)	41
Women			
< 4 Illness Symptoms	316	3.16 (0.25)	22
4–6 Illness Symptoms	147	6.46 (0.52)	51
Both sexes			
< 4 Illness Symptoms	653	3.06 (0.17)	22
4–6 Illness Symptoms	250	5.91 (0.38)	47

Analytic methods

The GHQ scors were analyzed in two ways, both as categorical variables and as continuous variables. χ^2 tests were used to compare subjects scoring above and below the GHQ threshold, while analyses of variance were used on the uncategorised data. ANOVA is a very economical and informative means of investigating multiple classifications, but in order to apply the ANOVA validly to the positively skewed data obtained on the GHQ, we employed a log transformation prior to analysis. In the tables, however, we present untransformed means for ease of interpretation.

Results

GHQ scores

Before examining the pattern of subscale scores for the groups at risk, we assessed the overall differences in GHQ scores. Beginning with the male manual workers, we partialled out the effect of physical illness and then performed a two-way analysis of variance. The main effect of

employment was significant ($F = 39.17$, $P < 0.001$) as was age ($F = 5.05$, $P = 0.025$). The interaction was not significant. Perhaps of more clinical relevance is the comparison of the percentage of unemployed men as compared to employed men who score over the GHQ-30 threshold (4/5). Separate χ^2 were performed for the younger men and the older men. Both were significant at $P < 0.001$, and subsequently φ coefficients were calculated to determine the strength of these associations. The difference in the size of the effect of employment for the younger men ($\varphi = 0.17$) versus the older men ($\varphi = 0.26$) approached significance ($P = 0.06$, one-tailed test).

For the second at-risk group, single women with dependent children, another 2×2 (single versus married and employed versus housewives) analysis of variance was conducted. Both the main effect of marital status and employment status were significant ($F = 30.32$, $P < 0.001$ and $F = 5.13$, $P = 0.05$ respectively). As can be seen in Table 1, marital status in particular exerted a profound effect with single women scoring considerably higher on the GHQ (mean = 7.01) than their counterparts (mean = 3.82). Turning to employment status, housewives scored higher on the GHQ (mean = 4.53) than employed women (mean = 3.81). Although the interaction did not reach statistical significance, it should be noted that this main effect is due to the difference in scores for the married women who comprise the majority (89%) of the sample. The single women's scores are, in fact, in the opposite direction. χ^2 were calculated, separately for house-wives and for employed women, examining the percentage of single and married women who cross the GHQ threshold. For each of these groups, a greater proportion of single women scored above the GHQ threshold than married women ($P < 0.001$). The strength of these associations was not meaningfully different for housewives ($\varphi = 0.16$) as compared to employed women ($\varphi = 0.15$). For single employed women, the lack of correspondence between their very high GHQ mean score (7.14) and the percentage of them who fall above threshold reflects the large variability in their scores.

For the elderly subsample, there was a main effect of illness ($F = 67.54$, $P < 0.001$) but neither the main effect of gender nor the interaction proved significant. A χ^2 analysis demonstrates the clinical relevance of the relationship. For both men and women, the proportion of elderly people who crossed the GHQ threshold was greater for the group with the higher number of physical symptoms. This association was significantly stronger ($P = 0.04$, one-tailed test) for women than for men ($\varphi = 0.29$ and 0.18 respectively).

GHQ subscale patterns within groups

In the analyses reported below, 2×2 ANOVAS were conducted for each of the three at-risk groups for each of the GHQ subscales: anxiety, feelings of incompetence, depression, difficulty in coping, and social dysfunction. To accommodate the number of analyses (5) conducted for each subsample, a Bonferroni (1936) adjustment was applied. As a result of this decision, for the remainder of the analyses, a Type I error of 0.01 was used as the criterion of

statistical significance rather than the traditional 0.05. For all three groups at risk, we looked more closely at the main effects and the interaction effects by calculating the simple effect of the identified risk factor for each level of the controlling variable (e. g. effect of employment status for older men only). Although all the analyses are included in the following discussion, it should be noted that Tables 2–4 depict the significance of the simple effects only, rather than the ANOVAS per se.

Again we turn first to the male manual workers. After partialling out the effect of physical illness, there was a main effect of employment status for three of the subscales: feelings of incompetence, depression, and difficulty in coping. There were no significant differences for any of the subscales between the young and older workers. However, since two of the age differences approached significance ($P < 0.02$), closer examination of the simple effects of unemployment on psychiatric morbidity in younger and older men seemed warranted. As

Table 2. Mean (and standard error) of standardised subscale scores of male manual workers by employment status and age[a]

	Anxiety	Feelings of incompetence	Depression	Difficulty in coping	Social dysfunction
Age 18–39					
Employed (n = 525)	21.82 (0.80)	28.4 (0.54)	12.93 (0.59)	31.12 (0.61)	30.83 (0.55)
Unemployed (n = 95)	25.70 (2.19)	33.07 (1.41)	19.58 (1.66) <0.001	34.95 (1.54) 0.003	31.93 (1.54)
Age 40–64					
Employed (n = 472)	20.60 (0.83)	30.35 (0.58)	13.43 (0.60)	30.89 (0.56)	32.02 (0.50)
Unemployed (n = 67)	31.72 (3.11) 0.008	36.69 (1.94)	24.78 (2.51) <0.001	33.83 (1.51)	35.82 (2.15)

[a] The significance of the differences between employed versus unemployed manual workers are shown for each subscale, separately for the younger and the older men.

Table 3. Mean (and standard error) of standardized subscale scores of women (aged 18–44) with dependent children by marital and employment status[a]

	Anxiety	Feelings of incompetence	Depression	Difficulty in coping	Social dysfunction
Housewife					
Married (n = 504)	28.01 (0.98)	30.65 (0.60)	16.36 (0.75)	33.33 (0.67)	32.84 (0.66)
Single (n = 60)	40.49 (3.10) 0.003	33.75 (1.85)	26.67 (2.52) <0.001	32.89 (1.62)	34.07 (2.14)
Employed					
Married (n = 531)	26.40 (0.86)	29.03 (0.48)	13.47 (0.58)	31.88 (0.56)	30.84 (0.55)
Single (n = 64)	40.69 (2.91) <0.001	32.55 (2.11)	25.00 (2.97) <0.001	39.27 (2.20) 0.001	34.03 (2.46)

[a] The significance of the differences between single versus married women with dependent children are shown for each subscale, separately for the employed women and the housewives.

Table 4. Mean (and standard error) of standardized subscale scores of the elderly (65 +) by illness symptoms and gender[a]

	Anxiety	Feelings of incompetence	Depression	Difficulty in coping	Social dysfunction
Men					
<4 symptoms (n = 337)	16.30 (0.94)	31.33 (0.67)	13.91 (0.70)	31.75 (0.78)	35.38 (0.79)
4–6 symptoms (n = 103)	22.57 (1.97) 0.009	37.46 (1.73)	16.83 (1.50)	36.70 (1.56) 0.003	36.89 (1.69)
Women					
<4 symptoms (n = 316)	20.52 (0.99)	31.62 (0.68)	15.55 (0.75)	31.67 (0.69)	35.27 (0.74)
4–6 symptoms (n = 147)	32.37 (1.91) <0.001	37.36 (1.50)	21.95 (1.53) <0.001	38.28 (1.39)	40.59 (1.50)

[a] The significance of the differences between the elderly with 0–4 symptoms versus the elderly with 4–6 symptoms are shown for each subscale, separately for men and women.

seen in Table 2, for both age groups, unemployment is associated with depression; in addition, there was a significant relationship between unemployment and anxiety for the older group only, and a significant relationship between unemployment and difficulty in coping for the younger group only.

For women with dependent children, the ANOVA showed a significant main effect of marital status on two of the subscales, anxiety and depression. The magnitude of this difference was in the predicted direction, with single women obtaining higher scores than married women (40.59 versus 27.19 for anxiety and 25.18 versus 14.88 for depression). Although the main effect of employment failed to reach statistical significance, the effect of employment status and/or the interaction between marital status and employment approached significance on some of the subscales. We therefore examined the simple effects of marital status on psychiatric morbidity in employed women and housewives. It can be seen from Table 3 that there is a significant effect of marital status on difficulty in coping for employed women but not for housewives. This indicates that the combination of being single with dependent children and employed outside the home is associated with problems in coping.

For the third at-risk group, the physically ill elderly, illness scores were strongly associated with psychological distress, showing a positive relationship for four of the five subscales (all except social dysfunction). The main effect of gender was significant only for anxiety ($P < 0.001$), falling just short of significance for depression ($P = 0.02$). As illustrated in Table 4, there was a simple main effect of illness for women on the depression subscales but there was no effect for men ($P > 0.1$). In contrast, there was a simple main effect for men on difficulty in coping, but no significant effect for women.

Comparison of subscale patterns across at-risk groups

In Table 5, we display the pattern of differences that were statistically significant for the at-risk groups as compared to their counterparts. In these comparisons, we are only

Table 5. Comparison of at-risk groups on the five subscales and overall GHQ score[a].

	Anxiety	Feelings of incompetence	Depression	Difficulty in coping	Social dysfunction	GHQ
Unemployed manual workers		*	**	**		5.37
Single women with dependent children	**		**			7.01
Elderly (65 +) with 4–6 illness symptoms	**	*	**	**		5.91

[a] The asterisks indicate the significance (* ≤ 0.01, ** ≤ 0.001) of the differences between each at-risk group and their counterpart.

considering the effect of the identified risk factors. All three at-risk groups obtain higher scores on the depression subscale than their counterparts, and none differs from their counterpart on the social dysfunction subscale. Interestingly however, different patterns emerge for the three at-risk groups in terms of the remaining three subscales. Unlike unemployed men, both single women with dependent children and the elderly in poor health obtained higher scores than their counterparts on the anxiety subscale. On the feelings of incompetence and difficulty in coping subscales, unemployed men and the elderly in poor health scored higher than their counterparts, but single women with dependent children did not.

Discussion

Because of its wide use in psychiatric research, we have attempted to refine the scoring of the GHQ-30 to yield information about the nature of the symptoms reported. Groups which obtain high total GHQ scores would be expected to differ from their counterparts on some or all of the GHQ subscales which we have derived. The focus of this paper has been to determine whether there are different subscale profiles for different groups with a high risk of psychiatric disorder. The high-risk groups which we selected from a large population sample were: unemployed men, single women with dependent children and elderly people in poor health.

Comparisons of subscale patterns across at-risk groups

We confirmed that each group had high total scores on the GHQ-30 (Table 1) and indeed about half of each group scored above the standard threshold employed for screening psychiatric disorder. Before deciding whether the high risk groups show different profiles of psychiatric symptoms, we need to address the issue of severity of symptoms. In general, the higher a group's score on the GHQ, the greater the probability that the group will score high on any given subscale. It is interesting, therefore, that the group with the highest GHQ score (single women with dependent children) shows the greatest selectivity with respect to symptoms (Table 5). Compared

with their married counterparts, single women with dependent children differ on the anxiety and depression subscales. By contrast, unemployed men differ from their employed counterparts on three subscales (feelings of incompetence, as well as depression and difficulty in coping), despite having lower total GHQ scores than the single women (5.37 versus 7.01). The elderly in poor health also have lower total GHQ scores than the single women with dependent children (5.91 versus 7.01), yet differ from their counterparts on four of the five subscales. In general, this documentation that symptom profiles are not simply related to overall severity of psychiatric symptoms suggests that different at-risk groups may indeed vary in the nature of the symptoms which they present.

Comparison within groups

More detailed analysis (Tables 2–4) shows additional differences within each at-risk group. As described above, unemployed men of all ages scored higher than their counterparts in terms of depression. However, the older men were characterized by high anxiety scores and the younger men by difficulty in coping. Although this analysis took account of possible confounding variables such as social class and physical illness (which is higher among the older unemployed men), age differences may simply reflect the difference in total GHQ scores (4.78 versus 6.20 for younger and older unemployed men respectively). In order to generalize safely about specific psychiatric problems associated with unemployment, independent of the effect of age, problems with depression and difficulty in coping (Table 5) probably warrant the most attention.

For the single women with dependent children, anxiety and depression emerge as the main contributors to differences in overall GHQ scores. For employed women, being a single mother is also associated with difficulty in coping, presumably due to adding an additional stress to an already burdened state. Interestingly, for housewives, one's status as a single mother does not seem to heighten difficulty in coping scores. Indeed, the scores for single versus married housewives, albeit not statistically different, are reversed, with married women faring slightly worse. It should be noted that although several of the differences presented within at-risk groups for the five subscales did not reach statistical significance, this is the only comparison that was not in the predicted direction. Upon closer examination, we discovered that whereas for married women with dependent children, employment was typically part-time (69 % of the employed married women wokred less than 30 hours), for the single mothers, employment was more likely to be full-time (56 % of the employed single women worked 30 hours or more). Further analyses (Garcia and Huppert, unpublished manuscript) have shown that part-time workers report significantly fewer psychiatric symptoms than either housewives or full-time workers. This effect is particularly strong for single women with dependent children; those working part-time do not differ from their married counterparts. The effect of working full-time if a woman is unmarried

and has dependent children, is extremely deleterious in terms of her mental health.

Among elderly people in poor health, both men and women reported heightened anxiety, but the women also showed symptoms of depression while the men reported difficulty in coping. Of all the at-risk groups and sub-groups which we examined, the only one which did not show increased depression scores was the elderly men in poor health. This is not simply due to their relatively low total GHQ scores (5.13) because the young unemployed men obtained a lower total score (4.78) but nevertheless had significantly raised depression scores.

Two issues surrounding this last set of analyses should be addressed at this time. First, there are certain limitations in our use of illness symptoms as our measure of physical health. There was not a perfect match of men and women within the two physcial illness categories, as women scored higher on average within each category. However, by confining our analysis to people with a maximum of six physical symptoms, thereby avoiding the part of the distribution where the gender difference is greatest, we attempted to minimize such differences. Questions might also arise concerning the validity of self-reported symptoms as an overall measure of health. Admittedly, a simple count of symptoms does not reflect their frequency or severity, much less provide information concerning any underlying disorders. Notwithstanding this qualification, as has been reported elsewhere (Blaxter 1985), illness symptoms did seem to perform as an adequate surrogate health measure, given their ability to differentiate among the elderly in terms of psychiatric functioning on the different subscales. Whether the common variance is primarily a function of reporting style remains to be teased apart.

A second issue that deserves attention as we consider the results for the elderly subsample is the finding that there is a strong gender effect for the overall GHQ score. Interestingly, however, when the GHQ is broken into the five subscales, we only found a significant difference between men and women, collapsed across illness categories, for anxiety. Thus, at least in terms of the four other subscales, any differences in pattern (e. g., the apparently stronger deleterious effect of physical illness on difficulty in coping for men as opposed to women) is not simply a reflection of overall gender differences.

Given the differences that were revealed in the subscale patterns, both between and within the at-risk groups, even after taking into account overall severity, our data suggest that qualitative differences for certain at-risk groups can be detected through application of the subscale scoring technique which we have devised for the General Health Questionnaire. To the degree that this alternative scoring technique provides valid and reliable information concerning qualitative differences in psychiatric functioning, a scale that has hitherto been limited to its function as a screening instrument may yield additional information that could have both diagnostic and prognostic implications. With this in mind, we have two recommendations concerning future research efforts. First, it would be useful for investigators employing the GHQ-30 to apply the subscale scoring technique and validate their results against standardized instruments designed to tap the relevant characteristic. It is conceivable that existing data bases that include the GHQ could be re-evaluated with this suggestion in mind. The second recommendation is in response to the limitations of survey data for addressing questions of causal direction. Future investigations involving the GHQ as a method for identifying groups at risk for psychiatric disorder would be most useful if they were longitudinal in design.

Appendix A

Factor A – Anxiety

2 Lost much sleep over worry?
14 Felt constantly under strain?
15 Felt you couldn't overcome your difficulties?
18 Been taking things hard?
21 Found everything getting on top of you?
22 Been feeling unhappy and depressed?
23 Been losing confidence in yourself?
28 Been feeling nervous and strung-up?

Factor B – Feelings of incompetence

4 Been managing to keep yourself busy and occupied?
6 Been managing as well as most people would in your shoes?
7 Felt on the whole you were doing things well?
8 Been satisfied with the way you've carried out your task?

Factor C – Depression

24 Been thinking of yourself as a worthless person?
25 Felt that life is entirely hopeless?
26 been feeling hopeful about your own future?
29 Felt that life isn't worth living?
30 Found at times you couldn't do anything because your nerves were too bad?

Factor D – Difficulty in coping

13 Felt capable of making decisions about things?
16 Been finding life a struggle all the time?
17 Been able to enjoy your normal day-to-day activities?
19 Been getting scared or panicky for no good reason?
27 Been feeling reasonably happy, all things considered?

Factor E – Social dysfunction

5 Been getting out of the house as much as usual?
10 Been finding it easy to get on with other people?
11 Spent much time chatting with people?

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