

## Assessment of beliefs about psychotropic medication and psychotherapy: development of a measure for patients with anxiety disorders<sup>☆</sup>

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### Abstract

**Objective:** This study presents the psychometric properties of a brief measure to assess beliefs about psychotropic medications and psychotherapy among patients with anxiety disorders.

**Method:** Data were collected on a large sample of primary care patients with a range of anxiety disorders, as part of the Collaborative Care for Anxiety and Panic study. Factor analyses using principal axis factoring with Varimax rotations were used to determine the factor structure of the beliefs scale. Internal consistency, concurrent validity and predictive validity of the resulting subscales were examined.

**Results:** Two subscales emerged, one reflecting beliefs about psychotropic medications and the other assessing beliefs about psychotherapy. Both showed strong internal consistency and concurrent validity. The beliefs about psychotropic medication demonstrated strong predictive validity.

**Conclusions:** This measure may be a useful tool for assessing treatment beliefs among patients with anxiety disorders toward the provision of more quality treatment for this population. Its brevity may make it particularly useful in primary health care settings.

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### 1. Introduction

Anxiety disorders are extremely common, with 12-month prevalence estimates of 19% for the general population [1]. Rates are substantially higher among patients in primary care settings [2–8]. Nonetheless, the vast majority of patients with anxiety disorders do not receive adequate treatment. For example, in a recent national survey, only 20% of adults with anxiety disorders reported receiving appropriate pharmaco-

therapy and only 10% reported receiving appropriate counseling [9]. Although a range of factors likely contribute to inadequate treatment, there is evidence from other diagnostic groups that patients' belief systems about treatment may be particularly relevant.

Researchers in health psychology have demonstrated that the beliefs patients hold about treatment medication strongly predict adherence to medication for a range of health problems [10]. Similar findings are emerging for patients treated for mood disorders. Specifically, among patients with depression and mixed depression and anxiety, greater treatment compliance has been found for patients matched to treatments they prefer compared to patients randomly assigned to treatment [11,12]. Further, degree of belief in the rationale for treatment has been associated with more rapid

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and enhanced treatment outcomes [13–16]. As such, the Institute of Medicine has stressed the importance of taking patient needs and preferences into account in order to provide high-quality health care [17]. However, no measures currently exist to measure beliefs about treatment among patients with anxiety disorders, specifically. This is striking, given recent evidence that beliefs about treatment may influence treatment seeking more among patients with anxiety disorders than patients with depression [18].

The current study aimed to develop and provide an initial assessment of the psychometric properties of a measure to assess beliefs about psychotropic medication and psychotherapy among patients with anxiety disorders. Given the prevalence of anxiety disorders in primary care settings, the aim was to develop a brief measure that could be usable in this context. This article will describe the selection of items and the process used to determine scale structure, and present data on the internal consistency, concurrent validity and predictive validity of the measure. It was predicted that items assessing beliefs about medication would factor distinctly from items assessing beliefs about psychotherapy. It was further predicted that more favorable attitudes about psychotherapy and psychotropic medication would be associated with a greater likelihood of receiving psychotherapy and medication, respectively.

## 2. Method

### 2.1. Setting and participants

Data are from the Collaborative Care for Anxiety and Panic (CCAP) study, a randomized, controlled trial of evidence-based treatment (including both pharmacotherapy and cognitive-behavioral therapy) for panic disorder in primary health care settings [19]. Patients were screened and recruited from six university-affiliated primary care clinics in Seattle, San Diego and Los Angeles.

Participants were screened in clinic waiting rooms using a brief self-report questionnaire that assessed demographics, chronic medical illness, and anxiety and depression symptoms. The anxiety and depression items have demonstrated predictive validity for panic disorder, social phobia, post-traumatic stress disorder, generalized anxiety disorder and major depressive disorder [20,21]. A total of 8315 patients were initially screened. Those who screened positive for any anxiety disorder and a random sample of patients screening positive for no disorder were next invited to participate in a telephone diagnostic interview ( $n=1319$ ). Sixty-one percent of this group participated in the telephone interview ( $n=801$ ), which included a diagnostic assessment. Questions assessing beliefs about psychotherapy and psychotropic medication, as well as recent psychiatric treatment utilization, were asked during the telephone interview. Patients participating in the telephone interview had agreed during the consent procedure to consider using medications to manage their symptoms and to consider meeting with

someone to discuss their problems. All individuals meeting diagnostic criteria for panic disorder were initially administered the beliefs items. In order to assess beliefs across diagnostic groups, the beliefs items were administered to all individuals completing the telephone interview beginning approximately one third-way through the study (therefore, although a higher percentage of individuals with panic disorder completed these items, all those completing the items are viewed as representative of their diagnostic groups). Participants were randomized to treatment groups after the telephone interview; thus, all belief items were administered prior to treatment.

In the current study, the factor structure, internal reliability and concurrent validity analyses of the beliefs measure were conducted on those patients who met *DSM-IV* criteria for panic disorder, social phobia, posttraumatic stress disorder, generalized anxiety disorder or no disorder who completed the beliefs items. Due to some missing data on the beliefs items, the final sample sizes were 388 for beliefs about psychotropic medication and 374 for beliefs about psychotherapy. Concurrent and predictive validity were analyzed on the patients with panic disorder who were randomized to the intervention ( $n=232$ ) in the larger study.

### 2.2. Measures

The diagnostic interview included relevant sections from the Composite Diagnostic Interview (CIDI) by the World Health Organization [22]. The generalized anxiety disorder module was added mid-way through the study ( $n=130$ ). The CIDI has strong psychometric properties and has been validated for administration over the telephone; we slightly modified the interview to enhance its ability to distinguish between panic disorder and social phobia. Following the CIDI, participants were asked more detailed questions, including questions about demographics and recent treatment utilization.

Recent psychiatric treatment utilization was assessed with questions about CBT and anti-panic medication specifically. For the current study, two recent treatment utilization variables were created: recent psychotropic medication was defined as taking an appropriate anti-panic medication for at least 6 weeks in the 3 months prior to assessment [23]; recent CBT was defined as receiving at least three sessions of counseling that had at least four out of seven cognitive-behavioral psychotherapy components (including psychoeducation, relaxation training, skill acquisition, identification of cognitive distortions, cognitive restructuring, exposure and homework assignments of these techniques).

Items used in the development of the beliefs scale included the following. Ten items that assess beliefs about psychotropic medication were adapted from those used previously in studies of treatment of depression in primary care [24]. Fifteen items regarding beliefs about psychotherapy were derived from a beliefs about psychotherapy scale, previously validated on undergraduate students and primary health care patients [25]. All items are rated on a 5-point

Likert scale (1=*strongly disagree*; 5=*strongly agree*); some items are reverse-scored.

### 2.3. Intervention

The CCAP intervention is described in detail elsewhere [19]. In brief, a collaborative care model was used to deliver evidence-based psychotherapy (CBT) and pharmacotherapy in the primary health care setting. Behavioral health specialists were trained to deliver a shortened version of CBT for panic. Patients were offered six sessions (the last three of which could be delivered over the phone) and up to six additional brief follow-up phone contacts. Pharmacotherapy was administered by the primary care physicians following a 1-h didactic on recognizing and treating panic disorder using a medication algorithm (which detailed medication types and dosing strategies). Usual care patients received pharmacotherapy from their PCP without psychiatric consultation and possible referral to specialty mental health providers. Patients were assessed at 3, 6, 9 and 12 months post-entry into the study.

### 2.4. Analyses

Factor analyses using principal axis factoring with Varimax rotations were used to determine the factor structure of the beliefs scale (SPSS v. 13.0). Cronbach's  $\alpha$  was computed to assess the internal consistency of the derived subscales. Validity with respect to the demographics was examined using linear regression analyses. Key demographic variables were entered as a set to assess their independent associations with the belief subscale scores. To examine concurrent validity, ANCOVAs controlling for the demographic variables that were significant in the preceding analyses were used to determine if the belief subscales discriminated the above-described treatment history groups. Predictive validity was assessed using random-coefficient or mixed-effect ordinal regression analyses. Here, belief scores were used to predict adherence to both psychotropic medication and psychotherapy as defined above, longitudinally during the controlled treatment outcome study at baseline, 3, 6, 9 and 12 after baseline. Four models were constructed, using both sets of outcomes and both subscale types. Each model contained the significant covariates from the demographic analyses, time, time-squared (to account for the curvilinear form of the data over time), intervention status (control or intervention), time by intervention, and a belief subscale. The belief subscales were examined as main effects and in interactions with time and intervention status. A significant main effect of a belief subscale would demonstrate predictive validity. Interactions of beliefs with treatment would indicate that beliefs might modify the intervention effect. After the interactions were tested and found nonsignificant, they were dropped from the model, and the model was recalculated. No statistically significant interactions were observed with the beliefs subscales, so all models presented are main-effect models.

## 3. Results

Demographic and descriptive information about the sample are presented in Table 1. The majority of the sample was Caucasian, female, had at least a college education and lived above the poverty line.

### 3.1. Factor structure of the beliefs measure

Beginning with the original 25 items, several steps were used to determine the final items and factor structure of the measure. First, two items were eliminated before conducting the factor analysis due to lack of variance in the response to the items (i.e., less than 5% of the sampled endorsed "strongly disagreed" or "disagreed" combined). After the initial factor analysis, additional items were eliminated and the factor analysis was repeated for the following conditions: (1) if an item did not have a factor loading greater than or equal to .4 on any factor; (2) if an item was the only one loading on a factor; or (3) if an item loaded on two or more factors. Only factors with eigenvalues greater than 1 were included at any step. The final model was fit to a two-factor solution and accounted for 37% of the item variance. Six items loaded on a factor representing beliefs about psychotropic medications and eight items loaded on a factor representing beliefs about psychotherapy. Cronbach's  $\alpha$ 's for the medication and psychotherapy subscales were .71 and .82, respectively. Table 2 lists the final items for the two subscales.

### 3.2. Association with demographic variables

Six variables were entered into the regression analyses: age, gender, ethnicity (white/nonwhite), poverty (above vs.

Table 1  
Demographic characteristics of the sample

	Entire sample ( <i>n</i> =388)	Intervention sample ( <i>n</i> =232)
	%	%
Sex		
Men	38.7	32.9
Women	61.3	67.1
Education		
High school or less	26.3	23.8
Some college or more	73.6	76.2
Income		
Below poverty line	31.0	34.2
Above poverty line	69.0	65.8
Race		
Caucasian	66.2	65.5
Non-Caucasian	33.8	34.5
Black	15.2	13.8
Hispanic/Latino	11.3	13.4
Other	7.3	7.3
Depression		
Depressed	42.5	55.4
Not depressed	57.5	44.6
Age (years)		
Over 50	31.4	28.1
50 or less	68.6	71.9

below the poverty line, as defined by the 2001 Federal Poverty Guidelines according to family size [26]), education (high school education or lower vs. higher), and study site [California (clinics combined) vs. Washington]. Age [ $t(379)=2.76$ ;  $P<.01$ ] and ethnicity [ $t(379)=5.07$ ;  $P<.001$ ] were significantly associated with the medication beliefs subscale indicating that more positive beliefs about medications were associated with older age and white ethnicity. Ethnicity [ $t(379)=3.29$ ;  $P<.01$ ] and study site [ $t(379)=3.08$ ;  $P<.01$ ] were significantly associated with the psychotherapy beliefs subscale such that more positive attitudes toward psychotherapy were related to white ethnicity and the California site.

### 3.3. Concurrent validity of the beliefs measure

Medication beliefs [ $F(1,226)=12.5$ ;  $P<.001$ ] significantly discriminated the medication usage group such that those subjects with recent medication use had more favorable attitudes about medications [mean (S.D.)=23.3 (2.6) vs. 21.8 (2.8)] after controlling for age and ethnicity. The ANCOVA for beliefs about psychotherapy showed that there was a trend for the psychotherapy beliefs subscale to discriminate the psychotherapy utilization groups [ $F(1,227)=3.36$ ;  $P=.07$ ]; those who reported recent CBT demonstrated more positive beliefs about psychotherapy [mean (S.D.)=33.1 (5.0) vs. 31.2 (3.9)]. This analysis controlled for ethnicity and site. Both of the preceding analyses were repeated without controlling for demographic variables and the results were virtually the same.

Table 2  
Beliefs scale items and factor loadings

Scale items	Factor loadings
<i>Beliefs about medications</i>	
1. Medications for panic and anxiety do not help a person cope better. <sup>a</sup>	.65
2. People with anxiety should avoid taking medications to help their anxious problems. <sup>a</sup>	.61
3. Medications are an important part of the treatment of anxiety and panic.	.54
4. Panic and anxiety symptoms can usually be improved with medication.	.52
5. Medications for panic and anxiety can help a person feel better physically.	.52
6. Most medications for anxiety or panic are highly addictive. <sup>a</sup>	.40
<i>Beliefs about psychotherapy</i>	
7. Therapy patients are wasting money. <sup>a</sup>	.76
8. Therapy often harms the patient's relationships with other people. <sup>a</sup>	.70
9. Therapy can help individuals overcome stressful life events.	.68
10. Therapy often offers patients new and beneficial perspectives.	.67
11. Therapy can be a healthy experience for anyone.	.61
12. Therapy is ineffective for most people. <sup>a</sup>	.50
13. Therapy is unhealthy because patients usually become dependent on their relationships with the therapist. <sup>a</sup>	.45
14. Being in therapy is a sign of weakness. <sup>a</sup>	.40

<sup>a</sup> These items are reverse-scored.

Table 3

Estimated means and standard deviations for medication beliefs according to those who were ("yes") and were not ("no") taking appropriate psychotropic medications over time

Time period	Mean (S.D.)	F <sup>a</sup>	P
Month 3			
Yes	22.86 (2.56)	$F(1,175)=9.77$	.002
No	21.63 (2.70)		
Month 6			
Yes	22.92 (2.69)	$F(1,172)=7.92$	.005
No	21.76 (2.80)		
Month 9			
Yes	22.97 (2.76)	$F(1,160)=7.72$	.006
No	21.76 (2.68)		
Month 12			
Yes	22.87 (2.60)	$F(1,174)=11.88$	.001
No	21.47 (2.73)		

<sup>a</sup> Sample size varied over time due to missing data.

### 3.4. Predictive validity

Predictive validity of the medication subscale was shown by the results of the random-coefficient analyses. The medication subscale was significantly related to the pattern of appropriate anti-panic medication usage for six or more weeks over the course of the study ( $z=4.73$ ;  $P<.001$ ). At each assessment point, those who were using the medications had higher belief scores (see Table 3). As expected, this same analysis replicated using the psychotherapy beliefs subscale showed no significant effect ( $z=1.24$ ).

The longitudinal random-coefficient analyses examining adherence to *psychotherapy* (receiving at least three sessions of counseling that had at least four out of seven cognitive-behavioral psychotherapy components) showed that neither the psychotherapy ( $z=0.01$ ) or medication belief ( $z=0.62$ ) subscale was related to the pattern of psychotherapy over time. Thus, predictive validity could not be demonstrated using this outcome.

## 4. Discussion

This article presents data on the psychometric properties of a brief measure to assess beliefs about psychiatric treatment among a sample of patients with anxiety disorder diagnoses. Consistent with our prediction, two distinct subscales emerged, one assessing beliefs about psychotropic medication and one assessing beliefs about psychotherapy. Internal consistency for these subscales was moderately strong for this sample. Evidence for concurrent validity was also provided. The beliefs about medication subscale demonstrated predictive validity, while the beliefs about psychotherapy subscale did not.

This measure of treatment beliefs adds to existing measures by combining beliefs about medication and psychotherapy into one measure, and assessing beliefs about medication in relation to anxiety disorders, specifically. It is also brief and easy to administer, making it appropriate for quick assessment of beliefs, such is often needed in primary

health care settings. This study adds to existing research by assessing beliefs among a sample of general adult outpatients, most of whom had diagnosable anxiety disorders. Notably, and consistent with research on depression, this study also demonstrated that psychotropic treatment beliefs predicted adherence to treatment among the subsample of patients with panic disorder.

It is noteworthy that predictive validity was not found for the psychotherapy beliefs subscale, and the predictive validity for the medication subscale, although significant, was not incredibly strong. This may be due to the fact that the subsample was preselected for their willingness to consider treatment, thus, restricting the range of belief scores. Further, the subsample used for these analyses was offered and/or received the two treatment options and the consent process as well as the intervention itself may have influenced beliefs (indeed, a rationale for treatment is an integral component of CBT); as beliefs were only assessed at the initial phone interview, this possibility cannot be examined. Finally, the psychotherapy beliefs items referred generically to “therapy” which may have been viewed as more akin to “counseling” and “support” by patients than more educational and behavioral procedures provided in CBT. It may also be the case, of course, that this subscale does not have strong predictive validity.

Strengths of this study include a moderate sample size; use of a clinical population, most of whom met diagnostic criteria for a range of anxiety disorders; and the fact that all patients were given the option of both pharmacotherapy and psychotherapy, which allowed for the ability to examine predictive validity without the need to control for other confounding factors such as access to treatments. A number of limitations of this study should be noted. First, this was a convenience sample, and patients were preselected based on their willingness to consider both medications and psychotherapy for treatment; therefore, the sample was likely skewed away from patients who may have more negative beliefs about either type of treatment. Second, the items assessing beliefs about psychotherapy were not specific to anxiety disorders, but instead reflected beliefs more generally. These items were derived from those used in a previous study to allow for comparability between studies (Story et al., under review); however, this does create difficulty in comparing scores between the two subscales in the current measure, as the items assessing beliefs about psychotropic medications are specific to anxiety symptoms. Third, the same sample was used to assess the factor structure and concurrent validity of the current measure, and a subsample was used to assess predictive validity—this may have led to an overestimate of the association between the measure and treatment adherence.

Additional research is needed to determine the predictive validity of this measure, including other samples of anxiety disordered patients. In particular, the current sample was predominantly Caucasian and highly educated and it is unclear whether the results would generalize to other patient

populations (caution should be used in utilizing this measure among ethnic minority populations for whom words such as “anxiety” and “psychotherapy” may have different meanings). Further, this measure would be strengthened by studies examining test–retest reliability and discriminant validity with similar but distinct measures (e.g., measuring beliefs about help seeking more generally).

Nonetheless, this study suggests that this brief measure of psychotropic medication and psychotherapy beliefs is psychometrically sound and may be useful for predicting adherence to treatment, particularly psychotropic medication. Treatment adherence and outcome among patients with anxiety-related problems may therefore be facilitated by using this measure to assess beliefs. For example, this measure could be used to individualize education about treatment options toward optimizing treatment matching. This may provide one means of increasing the likelihood that patients with anxiety disorders receive and adhere to quality treatment. This study therefore represents an initial step toward improving care for this prevalent and undertreated population.

## References

- [1] Kessler RC, McGonagle KA, Zhao S, et al. Lifetime and 12-month prevalence of psychiatric disorders in the United States: results from the National Comorbidity Survey. *Arch Gen Psychiatry* 1994;51:8–19.
- [2] Nisenson LG, Pepper CM, Schwenk TL, Coyne JC. The nature and prevalence of anxiety disorders in primary care. *Gen Hosp Psychiatry* 1998;20:21–8.
- [3] Olsson M, Fireman B, Weissman MM, et al. Mental disorders and disability among patients in a primary care group practice. *Am J Psychiatry* 1997;154:1734–40.
- [4] Olsson M, Shea S, Feder A, et al. Prevalence of anxiety, depression, and substance use disorders in an urban general medicine practice. *Arch Fam Med* 2000;9:876–83.
- [5] Ormel J, Vonkorff M, Ustun B, et al. Common mental disorders and disability across cultures: results from the WHO collaborative study on psychological problems in general health care. *JAMA* 1994;272:1741–8.
- [6] Sherbourne CD, Jackson CA, Meredith LS, Camp P, Wells KB. Prevalence of comorbid anxiety disorders in primary care outpatients. *Arch Fam Med* 1996;5:27–34.
- [7] Stein MB, McQuaid JR, Pedrelli P, Lenox R, McCahill ME. Posttraumatic stress disorder in the primary care medical setting. *Gen Hosp Psychiatry* 2000;22:261–9.
- [8] Weiller E, Bisslerbe JC, Boyer P, Lepine JP, Lecrubier Y. Social phobia in general health care: an unrecognized undertreated disabling disorder. *Br J Psychiatry* 1996;168:169–74.
- [9] Young AS, Klap R, Sherbourne CD, Wells KB. The quality of care for depressive and anxiety disorders in the United States. *Arch Gen Psychiatry* 2001;58:55–61.
- [10] Horne R, Weinman J. Patients’ beliefs about prescribed medicines and their role in adherence to treatment in chronic physical illness. *J Psychosom Res* 1999;6:555–67.
- [11] Chilvers C, Dewey M, Fielding K, et al. Antidepressant drugs and generic counseling for treatment of major depression in primary care: randomized trial with patient preference arms. *BMJ* 2001;322:772–5.
- [12] Eisenthal S, Emery R, Lazare A, Udin H. Adherence and the negotiated approach to patienthood. *Arch Gen Psychiatry* 1979;36:393–8.
- [13] Addis ME, Jacobson NS. Reason-giving and the process and outcome of cognitive-behavioral psychotherapies. *J Consult Clin Psychol* 1996; 64:1417–24.

- [14] Addis ME, Jacobson NS. A closer look at the treatment rationale and homework compliance in cognitive-behavioral therapy for depression. *Cogn Ther Res* 2000;24:313–26.
- [15] Fennell MJV, Teasdale JD. Cognitive therapy for depression: individual differences and the process of change. *Cog Ther Res* 1987;11:253–71.
- [16] Ilardi SS, Craighead WE. The role of nonspecific factors in cognitive-behavior therapy for depression. *Clin Psychol Sci Pract* 1994;1:138–56.
- [17] Medicine Io. Envisioning the national health care quality report. Washington (DC): National Academy Press; 2001.
- [18] Mojtabai R, Olfson M, Mechanic D. Perceived need and help-seeking in adults with mood, anxiety, or substance use disorders. *Arch Gen Psychiatry* 2002;59:77–84.
- [19] Roy-Byrne PP, Craske MG, Stein MB, et al. A randomized controlled trial of cognitive behavior therapy and medication for primary care panic disorder. *Arch Gen Psychiatry* 2005;62(3):290–8.
- [20] Connor KM, Kobak KA, Churchill E, et al. Mini-SPIN: a brief screening assessment for generalized social anxiety disorder. *Depress Anxiety* 2001;14:137–40.
- [21] Stein MB, Roy-Byrne PP, McQuaid JR, et al. Screening for panic disorder in primary care. *Psychosom Med* 1999;61:359–64.
- [22] World Health Organization. Composite International Diagnostic Interview (CIDI) 2.1. Geneva (Switzerland): World Health Organization; 1997.
- [23] Roy-Byrne PP, Stein M, Bystritsky A, Katon W. Pharmacotherapy of panic disorder: proposed guidelines for the family physician. *J Am Board Fam Pract* 1998;11:282–90.
- [24] Lin E.H.B, Von Korff M, Ludman EJ, et al. Enhancing adherence to prevent depression relapse in primary care. *Gen Hosp Psychiatry* 2003;25:303–10.
- [25] Story TJ, Craske MG, Conner BT, et al. Beliefs about psychotherapy: scale construction [under review].
- [26] US Department of Health and Human Services, Institute for Research on Poverty. The 2001 HHS poverty guidelines. *Fed Regist* 2001;66:10695–7.