– BEYOND NUMBERS –

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In the currently practice of psychology, it is widely spread the use of questionnaires, test and scales, in order to get more clinical information about the patient. These instruments are composed by several questions related to the symptomatology that is being studied. They can be used in any part of the psychotherapy (assessment, diagnosis, treatment and therapy results). How are these instruments used? Usually, the figures of each question are added up and the final score that is obtained is compared to normative scales proposed by the authors of the instruments. Those normative scales give information about the severity of the symptomatology that the patient present.

As it has been said, it is common for the therapist to only pay attention to the final score obtained in the questionnaire, and the information that it provide but, is this all the information that we can get form them? If so, the therapist would only be paying attention to the quantitative information of the test but, is there any information beyond the figures? Can qualitative information be obtained from these very same tools as well? If it would be possible, very useful information for the understanding of the patient and its problem could be used for the therapist. Should not be forgotten that a fundamental part of any psychological intervention (framed into cognitive-behavioural therapy) is the functional analysis and case formulation. These clinical tools help psychologists to understand and explain the patient problem in an analytical, visual and schematic way. We have considered that the qualitative information given by the questionnaires would be very helpful for filing both clinical tools. Therefore, what we purpose is how can be this task achieved.

Thanks to the collaboration between Universidad Complutense de Madrid (UCM) and the *Terrorism Victims Association* (AVT), we have been able to work with a wide sample of people who, sadly, have experienced a terrorist attack, in a direct (injured and witnesses) or indirect (relatives or partners) way. More accurately, the present collaboration between the two institutions was made with the aim of creating a "*Following of the psychological and social necessities of terrorism victims*". Thanks to it, diagnostic assessment interviews, psychological treatment and results tracing have been carried out in victim's behalf. In those interviews, several questionnaires have been used by the therapists, among which the most relevant ones

are the *Beck Depression Inventory Second Version* (BDI-II), the *Beck Anxiety Inventory* (BAI) and the *Post-traumatic Check List Civil Version* (PCL-C) (Table1). In addition, *Structured Clinical Interview for DSM-IV Axis I Disorders* (SCID-I) was used as a diagnostic interview. Other questionnaires were used in the process, but we have chosen BDI-II, BAI and PCL-C for the present study because they are the ones who assess the symptomatology of the three more frequent diagnoses in our sample (Major Depressive Disorder, Anxiety Disorders and Post-Traumatic Stress Disorder respectively). In the frame of the collaboration, therapists had mainly paid attention to the final scores of the test (to the quantitative information) so far, but recently it has arisen the idea of paying more attention to the information given by the questionnaires' items themselves, in order to have more comprehensive information about the patient and its problems. That information, as explained in the previous paragraph, could be also used in the functional analysis and case formulation. Thus, our aim has been to try to find a common answer pattern in victims with the same diagnosis, looking for a relationship between those diagnosis and the higher scores in the questionnaires' items.

- **Table 1: Questionnaires' description.**

	QUESTIONNAIRE		
	BDI-II	**BAI**	**PCL-C**
AIM	Asses the presence and severity of depressive symptomatology	Asses the presence and severity of anxiety symptomatology	Asses the presence and severity of post-traumatic stress disorder symptomatology
DESIGNED FOR POPULATION...	Clinical and no clinical over 13 years old	Clinical and no clinical over 13 years old	Clinical and no clinical over 18 years old
NUMBER OF ITEMS	21 (scores between 0-3)	21 (scores between 0-3)	17 (scores between 1-5)
SIGNIFICATIVE SCORE	≥14	≥8	≥44

- **Table 2: items per symptomatology manifestation.**

	COGNITIVE	MOTOR	PHYSIOLOGICAL	EMOTIONAL
BDI-II	**Item 2:** Pessimism **Item 6:** Punishment feeling. **Item 8:** Self-criticism. **Item 9:** Suicide thoughts/desire. **Item 13:** Indecision. **Item 19:** Concentration problems. **Item 21:** Decrease in sexual arousal.	**Item 10:** Crying. **Item 11:** Agitation	**Item 15:** Loss of Energy. **Item 16:** Changes in Sleeping Pattern. **Item 18:** Changes in Appetite. **Item 20:** Tiredness or Fatigue.	**Item 1:** Sadness **Item 3:** Past Failure. **Item 4:** Loss of Pleasure **Item 5:** Guilty Feelings. **Item 7:** Self-Dislike. **Item 12:** Loss of Interest. **Item 14:** Worthlessness **Item 17:** Irritability
BAI	**Item 4:** Relaxation incapacity. **Item 5:** Fear of the worst. **Item 14:** Fear of losing control. **Item 16:** Fear of dying.	**Item 3:** Wobbly. **Item 12:** Hands trembling. **Item 13:** Trembling. **Item 15:** Difficulty breathing.	**Item 1:** Numbness **Item 2:** Hot sensation. **Item 6:** Dizziness **Item 7:** Heart pounding or racing. **Item 8:** Restless. **Item 11:** Feeling of suffocation. **Item 18:** Indigestion or discomfort in the abdomen. **Item 19:** Fainting. **Item 20:** Red face. **Item 21:** Sweating (not due to heat).	**Item 9:** Terrified. **Item 10:** Nervous. **Item 17:** Frightened.
PCL-C	**Item 1:** Repeated, disturbing memories, thoughts, or images of a stressful experience from the past? **Item 3:** Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)? **Item 6:** Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it? **Item 8:** Trouble remembering important parts of a stressful experience from the past? **Item 12:** Feeling as if your future will somehow be cut short? **Item 15:** Having difficulty concentrating? **Item 16:** Being “super alert” or watchful on guard?	**Item 7:** Avoid activities or situations because they remind you of a stressful experience from the past?	**Item 2:** Repeated, disturbing dreams of a stressful experience from the past? **Item 5:** Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past? **Item 13:** Trouble falling or staying asleep? **Item 17:** Feeling jumpy or easily startled?	**Item 4:** Feeling very upset when something reminded you of a stressful experience from the past? **Item 9:** Loss of interest in things that you used to enjoy? **Item 10:** Feeling distant or cut off from other people? **Item 11:** Feeling emotionally numb or being unable to have loving feelings for those close to you? **Item 14:** Feeling irritable or having angry outbursts?

Our first step for getting the qualitative information has been to assign each questionnaire item to one of the four main symptomatology expressions: *cognitive, motor, physiological and emotional*. The assignation has been done following the test's instructions and the clinical opinion of the collaboration programme research team (UCM-AVT). This assignation can be seen in Table 2.

As it can be regarded in table 2, almost all the items ask for different symptomatology, either cognitive or motor or physiological or emotional. Very few of them ask for the same symptom, which means that a great deal of information can be obtained for our functional analysis and case formulation from the three questionnaires.

With the information given so far, therapists could have a better frame before treating their patients, but we wanted to go further. Thus, we decided to look for which items scored higher in the more prevalent disorders that our sample presented. For it, we run a statistical analysis which consisted on a partial correlation study between the questionnaire items and its final score and the different diagnosis, using as control variables: *sex, age, civil status, working status, studies level, injured during the attack, physical consequences, and the final score of the questionnaires left.* The sample size was of 644 people, victims directly or indirectly of terrorist attacks. We chose those partial correlations which were statistically significant (sig ≤ 0.05) and with *Pearson correlations* (ρ) over 0.2. The results obtained are shown in Table 3.

First thing we would like to highlight is that those results are merely for helping the therapist when approaching the patient problem, and do not intend to create a sophisticated response pattern of our sample. Therefore, when assessing terrorism victims with questionnaires like PCL-C, BDI-II and BAI, therapist should pay special attention to the responses on the items which appear in the table. In case that the patient score in those items were over the half score, the probabilities of that person of having a certain disorder would be higher, and further assessment in that direction would be recommendable. Finally, the squares highlighted in green mean that the final score of those questionnaires are significantly related with the diagnosis of the disorder. Mention that the results in our sample in that sense are in agreement with the scientific literature about those same questionnaires.

- **Table 3: partial correlations.**

	PCL-C	BDI-II	BAI
PTSD	Ítem 1 (0,24); Ítem 6 (0,26); Ítem 7(0,38); Ítem 11 (0,22); Ítem 12 (0,21); Ítem 14 (0,27)		
MDD	Ítem 6 (0,22)	Ítem 2 (0,27); Ítem 3 (0,25); Ítem 6 (0,25); Ítem 10 (0,23); Ítem 15 (0,24)	
T. ANGUSTIA		Ítem 9 (0,27)	Ítem 7 (0,2)
OCD			Ítem 17 (0,2); Ítem 18 (0,2)
AGORAPHOBY			
SOCIAL PHOBY	Ítem 12 (-0,21)		Ítem 11 (0,21)
GAD			Ítem 15 (-0,26)
NON-SPECIFIED ANXIETY			

In conclusion, we want to remark that questionnaires give therapists a lot of information, not only quantitative but qualitative as well. Any of them should be forgotten, because each one gives very valuable information for different but fundamental parts of the assessment. The final score will surely be used as a support for the diagnosis; meanwhile the items themselves will bring key information for the functional analysis and case formulation. Furthermore, insisting in the idea of the value of the qualitative information, when using different questionnaires together therapist will get a very wide range of information about the manifestations of the patient's problem in its four mean spheres (cognitive, motor, physiological and emotional). Finally, but nonetheless important, it seems that cognitive symptomatology is the most relevant one when distinguishing between one or other disorder, being the other three more common among the different disorders, so more attention should be put in the items related to cognitive symptomatology. After all, Aristotle already said so: "*The whole is bigger than the mere addition of its parts*".

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