MENTAL WELLNESS AND POSTGRADUATE STUDIES
精神健康與研究及學習

Wellness and Counselling Centre
Office of Student Affairs, The Chinese University of Hong Kong
香港中文大學學生事務處 心理健康及輔導中心

27 August 2021 (Friday)
Sapphire Li, Student Counsellor
MENTAL WELLNESS
MENTAL HEALTH

1. It matters to you
2. Self-understanding
   • Quiz: MHC; PHQ; GAD
3. CU’s Support
MENTAL WELLNESS MENTAL HEALTH

It matters to You!!
Grad School New Year's Resolutions:
- Eat better
- Sleep more
- Get more exercise
- See friends

pick one

or Graduate.

Mental Health Issues Among Graduate Students

By Nash Turley // October 7, 2013

mental health issues may be the biggest barriers to grad student success.
This is your mind on grad school

By Denia Djokic and Sebastian Leutis

April 28, 2014
Under pressure: Report on graduate student mental health at UC Berkeley

Stress, anxiety, and depression are the most common reasons graduate students seek mental health services.

Percentage of graduate students expressing the following emotions “frequently” or “all the time”:
- Suicidal: 0.7%
- Depressed: 8.5%
- Hopeless: 13%
- Sad: 18%
- Exhausted: 40%
- Overwhelmed: 46%

Women are up to 2x as likely as men to report these stressors.

45% of graduate students report having an emotional or stress related problem over the past year.

Percentage of graduate students citing the following reasons for seeking mental health services:
- Financial: 10%
- Career: 25%
- Academic: 23%
- Mental: 26%
- Emotional: 40%

50% of self-reported suicide attempts are made by STEM graduate students.

In 2012, Campus Psychological Services say a record increase in graduate students seeking mental health support.
MENTAL HEALTH MATTERS TO UNIVERSITIES

Well-being/ Wellness as a Common Focus
University Mental Health Day 2019

# UniMentalHealthDay
March 7th

How are you going to use your voice to improve student mental health?

https://www.unimentalhealthday.co.uk/
Mental Health
心理健康

= Absence of Mental Illness??
Grad School
New Year’s Resolutions:

- Eat better
- Sleep more
- Get more exercise
- See friends

both Graduate.

MY RESOLUTIONS NEED A BETTER SOLUTION.
“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”
MENTAL HEALTH
精神健康

• a state of well-being in which every individual
  一種健康狀態，包括能夠
  realizes his or her own potential,
    發揮到自己的潛能
• can cope with the normal stresses of life,
    應付日常的生活壓力
• can work productively and fruitfully,
    有效率地做事
• and is able to make a contribution to her or his community.
    及對自己的社群作出貢獻

-- World Health Organization
世界衛生組織
“My research centers on illuminating the “two continua” model of health and illness, showing how the absence of mental illness does not translate into the presence of mental health, and revealing that the causes of true health are often distinct processes from those now understood as the risks for mental illness."
Mental Health

With Mental Illness

Flourishing with mental illness
心盛及有精神病

Languishing with mental illness
心衰及有精神病

No Mental Illness

Flourishing without mental illness
心盛而沒有精神病

Languishing without mental illness
心衰而沒有精神病

Poor Mental Health
心理健康欠佳
Flourishing 心盛

happy and satisfied 愉快和滿足

see life as having a purpose 視生活為有意義和目的

feel some degree of mastery and accept all parts of self 對生活有掌控感，並接受自己的全部

have a sense of personal growth 有個人成長

have a sense of autonomy and an internal locus of control 對生活有自主及承擔
Languishing 心衰

sad and unsatisfied 不愉快和不滿足
not seeing life as having a purpose 視生活為沒有意義和目的
no sense of mastery and do not accept yourself 對生活沒有掌控感，並不接受自己的全部
no sense of personal growth 沒有個人成長
no sense of autonomy and an external locus of control 對生活沒有自主及承擔
Mental Health Check-up!
精神健康檢測

- Level of flourishing 心盛程度
- Depressive symptoms 抑鬱徵狀
- Anxiety symptoms 焦慮徵狀
Thank you for completing this questionnaire. Please find below your scores and our recommendations.
MEASURE YOUR MENTAL HEALTH, SCREEN FOR DEPRESSION & ANXIETY

**Scale 1**: (2nd page of Questionnaire) Measure for **Mental Wellness** (adapted from the Mental Health Continuum-Short Form [MHC-SF])

**Scale 2**: (3rd page of Questionnaire) Measure for **Depression** (adapted from the Patient Health Questionnaire – 9 [PHQ-9])

**Scale 3**: (4th/ last page of Questionnaire) Measure for **Anxiety** (adapted from the generalized anxiety disorder 7-item scale [GAD-7])
Thank you for completing this questionnaire. Please find below your scores and our recommendations.

---

**Scale 1: MHC-SF**

**Flourishing**

Congratulations for having a flourishing mental health! You generally have positive emotion, good social and psychological well-being. Keep it up!

---

**Scale 2: PHQ-9**

Scores: 27

Your score lies in the severe range of major depression.

And your answer shows that you have thoughts of hurting yourself in some way in these 2 weeks. You are recommended to seek medical and psychological help.

Note: your score does not reflect fully if you are having depression. Please seek help from psychiatrist, clinical psychologist or medical doctor for proper assessment.

---

**Scale 3: GAD-7**

Scores: 21

Your score lies on the severe range of anxiety disorder. You may be distressed by the persistent anxiety. You can consider reaching us or reading our self-help materials.

Note: your score does not reflect fully if you are having anxiety disorder. Please seek help from psychiatrist, clinical psychologist or medical doctor for proper assessment.

---

多謝你完成本問卷，你的得分及我們的建議如下：

---

**心理測驗一：心理健康量表**

**心裏**

你的得分表示你有「心裏」的心理健康狀況，你可能在正面情緒、社交或個人心理狀態上有所匱乏。歡迎瀏覽自助資源庫的資料來改善你的心理健康，你亦可參與學生事務處所舉辦的活動（學生事務處網頁），以找尋幫助自己「心裏」的方法。

---

**心理測驗二：抑鬱量表**

得分: 0

你沒有明顯的抑鬱症徵狀，可能你目前擅於調節自己的情緒。如果你日後感到情緒困擾，歡迎瀏覽自助資源庫的資料，或與本組聯絡。

注：你的得分不能完全反映你是否有抑鬱症。請聯絡精神科醫生、臨床心理學家或普通科醫生以作出專業評估。

---

**心理測驗三：焦慮量表**

得分: 0

你沒有明顯的焦慮症徵狀，可能你應對焦慮的方法甚為有效。如果你日後感到情緒困擾，歡迎瀏覽自助資源庫的資料，或與本組聯絡。

注：你的得分不能完全反映你是否有焦慮症。請聯絡精神科醫生、臨床心理學家或普通科醫生以作出專業評估。
Level of flourishing 心盛程度

- Social growth
- Social integration
- Social acceptance
- Social contribution
- Social coherence

Social wellbeing 社會層面的幸福
- Interest in life
- Satisfaction
- Happiness

Emotional wellbeing 情緒層面的幸福
- Purpose in life
- Self-acceptance
- Positive relations with others

Psychological wellbeing 心理層面的幸福
- Autonomy
- Environmental mastery
- Personal growth
Depression 抑鬱

- **Add the scores from Q1 to 9**
  計算第一至九題總分
- **At least 5 questions scored “2” or “3”, Q1 and/or Q2 must be included**
  五題或以上在填「2」或「3」, 第一及/或第二題必需包括在內
- **Q10 scored “1” to “3”**
  第十題有填「1」至「3」

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-9</td>
<td>Minimal</td>
</tr>
</tbody>
</table>
| 10-14       | Minor depression | 輕度抑鬱 
<p>| 15-19       | Major depression, moderately severe | 中度嚴重抑鬱 |
| 20 or above | Major depression, severe | 嚴重抑鬱 |</p>
<table>
<thead>
<tr>
<th>Depressive symptoms</th>
<th>抑鬱徵狀</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling sad or depressed</td>
<td>情緒低落</td>
</tr>
<tr>
<td>Loss of interest or pleasure in activities once enjoyed</td>
<td>對以往喜愛的活動失去興趣</td>
</tr>
<tr>
<td>Trouble sleeping or sleeping too much</td>
<td>很難入睡 / 潮睡</td>
</tr>
<tr>
<td>Changes in appetite</td>
<td>食慾不振或暴食</td>
</tr>
<tr>
<td>A slowing down of thought and a reduction of physical movement</td>
<td>思想緩慢/行動遲滯</td>
</tr>
<tr>
<td>Loss of energy or increased fatigue</td>
<td>感到疲累乏力</td>
</tr>
<tr>
<td>Difficulty thinking, concentrating or making decisions</td>
<td>思考能力、專注力下降</td>
</tr>
<tr>
<td>Feeling worthless or guilty</td>
<td>內疚、自責</td>
</tr>
<tr>
<td>Recurrent thoughts of death or suicide</td>
<td>反覆有死亡、自殺念頭</td>
</tr>
</tbody>
</table>
Anxiety 焦慮

- Add the scores of Q1 – 7
  計算第一至七題的總分

  5-9
  Mild
  輕度焦慮

  10-14
  Moderate
  中度焦慮

  15 or above
  Severe
  嚴重焦慮
Anxiety symptoms 焦慮徵狀

excessive anxiety and worry which is hard to control
過份焦慮和擔心，並且難以控制

- Restless 坐立不安
- Easily fatigued 容易疲累
- Difficulty concentrating 難以專注
- Irritable 暴躁
- Muscle tension 肌肉緊張
- Sleep disturbance 睡眠問題
Explore the social network around you
探索新的社交圈子

Try out different new things with an open mind
用開放的心去嘗試新事物

Find out what you enjoy and fulfil your own potential
發掘你喜歡的事物，並發揮潛能
Help seeking is not a weakness, but a strength
尋求協助是一個優勢，而非弱點

Seek help if you need to!
如果你需要，請盡快尋求協助！
Wellness and Counselling Centre (WACC)
心理健康及輔導中心

• Serves full-time CUHK undergraduate and postgraduate students
  服務香港中文大學全日制本科生及研究生
• Staffed by Psychologists and professional counsellors
  有心理學家以及專業輔導員
• Free of charge 費用全免
• Tel 電話: 3943 7208 / 3943 3493
• Office hour:
  辨公時間:
  | Mon - Thu | 8.45 am - 1.00 pm |
  |           | 2.00 pm - 5.30 pm |
  | Fri       | 8.45 am - 1.00 pm |
  |           | 2.00 pm - 5.45 pm |
2/F Pommerenke Student Centre
龐萬倫學生中心二樓
Next to Chung Chi College student canteen
崇基學院眾志堂旁
Pommerenke Student Centre (PSC) is the largest student amenities centre in CUHK. The Centre offers various student facilities, including Multi-purpose Hall, Fitness Room, Piano Rooms, Meeting Rooms, Band Room and Snooker Room, etc. The OSA Service Counter on 1/F PSC, provides loan of facilities services.
心靈健康書刊歡迎取閱
An open shelf with mental wellness books and leaflets

心理健康及輔導中心休憩閣
Our cosy waiting area
面談室
A cosy, sound-proofed interview room

活動室
Group Counselling Room for workshops and mental health activities
More about our service and mental health related information
知道更多心理健康的資訊及我們的服務
TPg students are also supported by various CUHK service units, such as the **Office of Student Affairs (OSA)**.

The following diagram describes in general the relationships and interactions among various stakeholders.

---

**Key to relationships in general:**
- Solid line: Teaching, learning and academic advice
- Dashed line: Administrative governance and policies
- Dotted line: Progress and assessment
- Dotted-dashed line: Non-academic advice, services and support
The hotline service is operated by trained counsellors from Christian Family Service Centre which offers telephone counselling and crisis interventions. Our service would follow up on the students in need of psychological counselling.

本熱線由基督教家庭服務中心專業輔導員接聽，並提供即時情緒支援及危機處理。本組隨後會主動跟進有需要支援的同學。
Multicultural Counselling Service

- Individual counselling services by native Putonghua speaking counsellors and native English speaking counsellors. Counselling sessions could be conducted in languages include Putonghua, English and other languages such as Dutch, French, Spanish, Japanese, Korean, Hindi and Sindhi.

- Details:
  - For all CUHK full-time non-local students
  - 6 counselling sessions (might be extended to max of 12 according to service needs)

- Period:
  - from September 2021 to May 2022

- Service location:
  - St John’s Cathedral Counselling Service in Central
  - Address: 7/F, Wings Building, 110-116 Queen’s Road Central, Central, Hong Kong
  - Easy access from Central MTR Station (exit A1)

- Opening hours:
  - 9am to 9pm (Monday to Saturday, except public holiday)

- Enrolment & enquiries:
  - 3943 7208 / 3943 3493 (WACC general line)
  - St John’s Cathedral Counselling Service office enquiry no: 2525 7207
SUNSHINE@CUHK
A one-stop online platform for students to access handy self-help mental health information

- Mental Health materials include:
  - Mindfulness videos
  - Self-help tips and articles
  - Indepth mental health information
  - Self assessment tools
  - Online community resources, etc.
Sunshine At CUHK at-a-glance

01 WEBSITE
https://www.sunshine.cuhk.edu.hk

02 MOBILE APP
- Phase I: to be launched in **early Oct 21**
- Phase II: to be launched in **Jun 22**

03 FB
https://www.facebook.com/SunshineatCUHK

04 IG
https://www.instagram.com/sunshineatcuhk/

05 Campus Wide Events
Lamp Post Revamp
Exercise / Welcoming Events / Moving Wellness Project, etc.

06 Inhouse Workshops
Mini Planter DIY Workshop / Mindful cooking & eating / Mindful Yoga, etc.

PLEASE STAY TUNED!!
uBuddies Peer Counselling Network

Workshops

Facebook page

Service projects

Dr Dog @CU

Hiking
Wellness Promotion Team
To build a supportive, fun & caring campus

Service Projects
uPals Instagram
World Mental Health Day
Workshops/ Activities to raise awareness on mental wellness
**uShine SEN Service**

**Service details**

- **Assist SEN students in adaptation of university life and study**
  - 製作點字筆記 Prepare braille lecture notes
  - 學科交流 Exchange study tips
  - 小組學習支援 Small-group learning support

- **Organize activities to promote SEN awareness to CUHK community**
  - 體驗式工作坊 Experimental Workshops
  - 機構探訪 Organization Visits
  - 攤位展覽等 Booth Exhibition, etc.

**You can…**

- **Receive training on various types of SEN**
- **Learn about learning aids and equipment**
- **Complete 12-hours Mental Health First Aid Course**
- **Make friends with uShiners and SEN students from different fields of study**
- **Service hours will be recorded in the Student Development Portfolio (SDP) (for undergraduate students only)**

**SEN = Special Educational Needs**

**Support for students with special educational needs**
Join uShine & Enjoy university life with SEN students!

VR Experience – Get to know Mental Illnesses

Braille Printing

Learning Sign Language

Dialogue in the Dark

Dark Experience

Visit Hong Kong Seeing Eye Dog Services Centre

加入uShine，與 SEN 同學一同度過充實的大學生活！

uShine. Do small things with great love
Support in CUHK 校園支援

- Graduate School
  研究院
- Professors / Academic Advisors
  教職員
- Hostel Warden & Tutors
  宿舍舍監及樓導師
- University Health Service
  大學保健處
- Office of Student Affairs
  學生事務處

And your friends and family!
還有你的朋友！
Thank You
Promoting and Protecting Mental Health as Flourishing

A Complementary Strategy for Improving National Mental Health

Corey L. M. Keyes
Emory University

This article summarizes the conception and diagnosis of the mental health continuum, the findings supporting the two continua of mental health and illness, and the benefits of flourishing in individuals and society. Completely mentally healthy adults—individuals free of a 12-month mental disorder and flourishing—reported the fewest missed days of work, the fewest self-harm or greater work cutbacks, the healthiest psychosocial functioning (i.e., low helplessness, clear goals in life, high resilience, and high intimacy), the lowest risk of cardiovascular disease, the fewest number of chronic physical diseases with age, the fewest health limitations of activities of daily living, and lower health care utilization. However, the prevalence of flourishing is barely 20% in the adult population, indicating the need for a national program on mental health promotion to complement ongoing efforts to prevent and treat mental illness. Findings reveal a black advantage in mental health and flourishing and no gender disparity in flourishing among Whites.

Keywords: mental health, flourishing, mental illness, subjective well-being, race and ethnicity

The National Institute of Mental Health (NIMH) recently declared that a positive psychology, as a goal of research (Nolen-Hoeksema, 2000). The assumption is that by reducing the number of cases of mental illness, either by preventing those at risk or by successfully treating more cases of mental illness, the American population will be mentally healthier. This is truly an assumption, because it rests on one of the most simple and empirically untested empirical hypotheses: The absence of mental illness is the presence of mental health. Put in psychoanalytic terms, the success of the current approach to mental health hinges on the hypothesis that measures of mental illness and measures of mental health belong to a single bipolar latent continuum. There is mounting empirical evidence that the paradigm of mental health research and services in the United States must change. In the 21st century, first, measures of mental illness and measures of mental health form two distinct continua in the U.S. population (Keyes, 2005). Second, measures of disability, chronic physical illness, psychosocial functioning, and health care utilization reveal that anything less than flourishing is associated with increased impairment and burden to self and society. Third, only a small proportion of these otherwise healthy people are mentally healthy (i.e., flourishing). Put simply, the absence of mental illness is not the presence of mental health; flourishing individuals function markedly better than all others, but barely one fifth of the U.S. adult population is flourishing (Keyes, 2002, 2003, 2004, 2005, 2006).

The two continua model (see also Taylor, 1996) calls for the adoption of a second, complementary national strategy: the promotion and maintenance of genuine mental health as flourishing. Curing or ameliorating mental illness will not guarantee a mentally healthy population. Because mental health belongs to a separate continuum, and the absence of mental health—a condition described earlier as "flourishing in life"—is as bad as major depressive disorder (MDE), the current national strategy of focusing solely on mental illness can, at best, reduce mental illness but not promote mental health. This U.S. strategy for mental health must simultaneously continue to seek to prevent and treat cases of mental illness and (b) seek to understand how to promote flourishing in individuals otherwise free of mental illness but not mentally healthy. To paraphrase the famous Johnny Mercer song (Mercer & Arlen, 1944), if mental health is truly society's national objective—and I would like to make a case in this article that it must be—then it has to be: "To accentuate the positive (i.e., flourishing), eliminate the negative (i.e., mental illness)... and don't mess with mister in-between (i.e., languishing)."

Stuck in the Past: The Meanings of Health

The U.S. national vision of health is rooted in a bygone era: recognizing this is the first step toward adopting a complementary approach. The U.S. national vision of health, which has been the dominant Western understanding of human history, has been three conceptions of health.

This article is derived from my invited presidential plenary address at the 113th Annual Convention of the American Psychological Association, Washington, DC, August 2005. Correspondence concerning the article should be addressed to Corey L. M. Keyes, Department of Sociology and Department of Behavioral Sciences and Health Education, Emory University, 1555 Dekalb Drive, Atlanta, GA 30322. E-mail: corey.keyes@emory.edu

February-March 2007 • American Psychologist

95

The pathogenic approach is the first, most historically dominant vision, derived from the Greek word pathos, meaning suffering or an emotion evoking sympathy. The pathogenic approach views health as the absence of disability, disease, and premature death. The second approach is the salutogenic approach, which can be found in early Greek writings and was popularized by Antonovsky (1979) and humanistic societies (e.g., Carl Rogers and Abraham Maslow). Derived from the word salus, meaning health, the salutogenic approach views health as the presence of positive states of human capacities and functioning in maintaining feeling, and behavior (Stirnberg, 1995). The third approach is the complete state model, which derives from the ancient word for health as being haur, meaning whole and strong. This approach is exemplified in the World Health Organization's (1984) definition of health as a complete state, consisting of the presence of a positive state of human capacities and functioning as well as the absence of disease or disability. By submitting the pathogenic and salutogenic paradigms, the whole states approach is, in my opinion, the only paradigm that can achieve true population health.

The pathogenic approach to health has dominated human history, not only because only a few illnesses have recently undergone the epidemiological transition. This transition refers to a historical change in the cause of death and disease from acute and infectious to chronic and more pervasive lifestyle causes (see, e.g., Graham & Preston, 1993). Before this transition, life was, to paraphrase Thomas Hobbes (1651), "nasty, brutish, and short" because of acute and infectious diseases and illnesses. The United States and other industrialized nations underwent the epidemiological transition in the 20th century, during which life expectancy at birth increased by an average of 30 years for Americans, which amounted to adding more years of life during the past 100 years than all prior centuries combined.

Clearly, Americans have shown themselves capable of molding the conditions of life that hasten death and acute disease. Believing that reducing premature mortality is, increasing longevity is, the gold standard of population health, America has been sobered by the rise in the rate of health-related problems (e.g., a threat of increase in teen suicide, more adults with anxiety and depression, and more lifestyle and stress-related chronic physical health conditions; see, e.g., Silove, 2003). Increased life expectancy has increased the number of years spent living with chronic physical diseases and mental disorders rather than greater health.

This epidemiological paradox has happened for at least three reasons. First, with age, biological, cellular (e.g., free radicals and oxidative stress), and genetic (e.g., telomere shortening) stresses to respond to and the normal adaptations of life's demands produces a down-regulation and wear on organ systems (see, e.g., Epel et al., 2004; McEwen, 1998). Thus, with time, all individuals will experience some physical, psychological, or neurological disorder or disease. Second, although risk of physical disease is rather low in youth and younger adults, some chronic problems such as diabetes, asthma, and even cardiovascular disease (CVD) are now occurring at younger ages (Nussel, van der Velden, von Stumm, Lehmann, & van den Bos, 1996; Ohnhsan, Rudolph, Cars, Cassel, & Brody, 1991). Modifiable lifestyle factors that do not necessarily influence the overall population's life expectancy now affect individuals' levels of physical and mental health. Third, increased life expectancy has not ushered in a paradigm shift toward a salutogenic approach to complement the health care system that was built to address the pathogenic crisis when life was "nasty, brutish, and short."

Before the epidemiological transition, biomedical and public health practices of promoting health by creating and implementing prevention and panacea for illness and disease have been ineffective and costly in its pursuit of life expectancy. The continued attempt to improve population health solely by disease and illness prevention and panaceae after the epidemiological transition has proven extremely costly and largely ineffective. The United States is among the nations worldwide that now spends 15% of its gross domestic product on health care (Reinhardt, Hussey, & Anderson, 2004), and health care consumes the largest percentage of the U.S. gross domestic product, more than twice the global spending (BlueCross & BlueShield, 2006). For the average American family, health care in the 21st century is the fifth largest expense to rival the purchase of a home, which historically has been a family's largest expenditure (Lamers & Morenig, 2001). In 1999, diabetes, for example, resulted in a combined cost (i.e., direct costs due to health care and indirect costs due to...
Although copyrighted, the MHC-SF may be used as long as proper credit is given. Proper citation of this document: Keyes, C. L. M. (2009). Atlanta: Brief description of the mental health continuum short form (MHC-SF). Available: http://www.sociology.emory.edu/ckeyes/.
MEASURE FOR DEPRESSION
(ADAPTED FROM THE PATIENT HEALTH QUESTIONNAIRE – 9 [PHQ-9])

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 √s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder
- if there are at least 5 √s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder
- if there are 2-4 √s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
MEASURE FOR ANXIETY (ADAPTED FROM THE GENERALIZED ANXIETY DISORDER 7-ITEM SCALE [GAD-7])

The GAD-7 was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

This easy to use self-administered patient questionnaire is used as a screening tool and severity measure for generalized anxiety disorder.