The Sleep Condition Indicator:
Reference values derived from a sample of 200,000 adults

Running Head: Reference values for the SCI

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Author contributions: Espie, Luik and Machado designed the study, analyzed and interpreted the data, and wrote the paper. Carl, Kyle and Cape and Siriwardena contributed to the paper. All authors have approved the final version of the paper.

Summary

The Sleep Condition Indicator (SCI) is an 8-item rating scale that was developed to screen for insomnia disorder based on DSM-5 criteria. It has previously been shown to have good psychometric properties across several language translations. We developed age- and sex-referenced values for the SCI to assist the evaluation of insomnia in everyday clinical practice. A random sample of 200,000 persons (58% women, mean age 31 ± 13 years) was selected from those who had completed the SCI via several internet platforms. Descriptive and inferential methods were applied to generate reference data and indices of reliable change for the SCI for men and women across the age deciles 16-25yrs, 26-35yrs, 36-45yrs, 46-55yrs, 56-65yrs and 66-75yrs. The mean SCI score for the full sample was 14.97 ± 5.93. Overall, women scored worse than men [14.29 ± 5.83 vs 15.90 ± 5.94; difference in means = -1.60, η^2 = 0.018, Cohen's d = 0.272] and those of older age scored worse than those younger (-0.057 points per year [95% CI: -0.059 to -0.055] relative to age 16-25 years). The Reliable Change Index was established at 7 scale points. In conclusion, the SCI is a useful instrument for clinicians and researchers that can help them screen for insomnia, compare completers to individuals of similar age and sex, and establish whether a reliable change was achieved following treatment.

Keywords

Insomnia, Sleep Medicine, Psychometrics, Reliable change

Introduction

Insomnia is the most ubiquitous of all mental health complaints, in men and women of all ages, and across ethnic groups (Singleton et al., 2001). Insomnia is also the most prevalent of the classifiable disorders of human sleep (Morgan, 2012, Lichstein et al., 2011). Between 25 and 42% of the adult population has troublesome insomnia symptoms each week (Swanson et al., 2011), and even when using conservative clinical criteria, approximately 10% of adults have clinical insomnia disorder (Morin and Benca, 2012). It has been reported that the prevalence of insomnia is higher in women (18%) than in men (12%) (Lichstein et al., 2011) and that prevalence increases in later life, particularly after the age of 60 years (Morin et al., 2009, Lichstein et al., 2004). This is in part attributable to insomnia being persistent across the life span (Morgan, 2012).

The importance of recognizing insomnia as a problem in its own right has been highlighted in the DSM-5 recommendation that 'Insomnia Disorder' should be coded "whenever diagnostic criteria are met whether or not there is a co-existing physical, mental or sleep disorder" (American Psychiatric Association, 2013). In addition, mounting evidence suggests that chronic insomnia constitutes a risk factor for the development of physical and mental health problems (Pigeon et al., 2017, Khan and Aouad, 2017). Likewise, insomnia is predictive of work disability (Sivertsen et al., 2006), poorer quality of life (Kyle et al., 2010) and higher societal costs (Leger and Bayon, 2010). Despite these facts, insomnia is seldom adequately assessed, and perhaps as one consequence, treatment services remain poor (Falloon et al., 2011, Espie et al., 2014a, Morin and Benca, 2012).

In clinical settings, the general practitioner (GP) is typically the first point of contact. However, GPs are often short of time and may not know how to best

evaluate a sleep complaint (Dyas et al., 2010). One German study suggests that GPs are aware of a patient's sleep problem in only 9% of mild insomnia cases, 22% of moderate insomnia cases and 39% of severe insomnia cases (Hohagen et al., 1993). A more recent Norwegian study suggests that fewer than 8% of doctors assessed sleep problems with sleep questionnaires or sleep diaries (Sivertsen et al., 2010), even though these are recommended assessment tools to diagnose insomnia (Schutte-Rodin et al., 2008). The positive predictive value of clinicians' evaluations of patients sleep disturbance (i.e. the probability that subjects clinically diagnosed truly have insomnia disorder) has been reported to be as low as 53% (Kallestad et al., 2011). Qualitative studies have found that GPs wanted more training and tools to assess and manage insomnia better (Dyas et al., 2010, Davy et al., 2015).

Given this context of a common problem that is poorly managed, brief measures that can screen for insomnia are of considerable potential clinical utility; and perhaps even more so if they are norm-referenced (Anastasi and Urbina, 1997) for the sex and age of the presenting patient. Referent data provide the clinician with specific information on whether their patient is experiencing a problem that is similar to or worse than their peer-group. In addition, defining the magnitude of change that would represent reliable improvement for that population (Jacobson and Truax, 1991, Altman and Bland, 2003) may help clinicians and researchers interpret whether treatment is successful. Such information is complementary to the use of generic 'cut-off' scores that indicate whether or not a patient meets criteria for a given disorder. We suggest that the availability of referent data might promote more informed discussion between the clinician and the patient of the problem at initial presentation, as well as assist the evaluation of outcome associated with any

subsequent sleep intervention. Moreover, references can serve as a comparison group for research purposes.

In this paper, we will first assess the psychometric properties of the Sleep Condition Indicator (SCI) to confirm the SCI as a suitable instrument in a large self-referred population of 200,000 people. The SCI is a brief, 8-item scale, first published in 2014 and the first questionnaire to be modeled upon DSM-5 insomnia criteria (SCI: (Espie et al., 2014b). The SCI has subsequently been translated, and further validated in Italian, Romanian, Chinese and French (Palagini et al., 2015, Voinescu and Szentagotai, 2013, Bayard et al., 2017, Wong et al., 2017). The SCI has previously demonstrated sound psychometric properties including internal consistency (published range of α = 0.71 to 0.89), convergent validity with the Pittsburgh Sleep Quality Index (r=0.73) and the Insomnia Severity Index (r=0.79), predictive validity in relation to Insomnia Disorder when diagnosed by expert clinical interview (Bayard et al., 2017, Wong et al., 2017, Palagini et al., 2015), and has proven sensitive to change in several clinical trials (Barnes et al., 2016, Bostock et al., 2016, McGrath et al., 2016, Espie et al., 2012). Second, we will present sex and age-referent data on a sample of 200,000 people to facilitate the use in clinical and research settings. Lastly, to facilitate the use of the SCI as an outcome measure, we report data on the Reliable Change Index (RCI) (Jacobson and Truax, 1991, Altman and Bland, 2003) to facilitate the determination of meaningful changes following treatment.

Methods

Sample characteristics

A sample of 200,000 persons who completed the SCI online and on whom we had information about sex and age was randomly extracted from three platforms, namely: www.sleepio.com which is an online (web/ mobile) cognitive behavioural therapy (CBT) programme for people with persistent insomnia; www.greatbritishsleepsurvey.com (GBSS) which is an online survey instrument and research tool, targeted toward UK completers; and www.worldsleepsurvey.com (WSS) which is very similar to the GBSS but with greater international exposure. It is important to recognise that participants did not comprise a true general population sample. Rather, they were likely to already have some concern about their sleep, especially those enrolling for the Sleepio programme, or at least to have sufficient curiosity about their sleep to complete the online GBSS or WSS surveys. By completing the measures online participants agreed that their data could be used anonymously for research, as specified in terms and condition statements for each of the platforms on their respective websites. As the current evaluation was not formally designed as a research study, no additional ethical approval was obtained.

Insert Table 1

Measurements

The SCI is an 8-item scale, comprising 2 quantitative items on sleep continuity [item 1: getting to sleep; item 2: remaining asleep], two qualitative items on sleep satisfaction/dissatisfaction [item 4: sleep quality; item 7: troubled or not], two quantitative items on severity [item 3: nights per week; item 8: duration of problem], and two qualitative items on attributed daytime consequences of poor sleep [item 5: effects on mood, energy, or relationships (personal functioning); item 6: effects on

concentration, productivity, or ability to stay awake (daytime performance)]. Validated quantitative criteria indicative of insomnia disorder (e.g. 31 – 45 minutes to fall asleep) serve as responses for sleep continuity items 1 and 2. Items 5 and 6 on daytime effects were derived by Principal Components Analysis as described in the initial validation report (Espie et al., 2014b). The SCI is presented in Table 1.

As can be seen, each item is scored on a 5-point scale (0 – 4), with lower scores, in the 0 – 2 range, reflecting putative DSM-5 threshold criteria for Insomnia Disorder (shaded area in Table 1). The clinician can then see at a glance the profile of possible concerns. Possible total score ranges from 0 – 32, with higher values indicative of better sleep. To facilitate interpretation for clinicians and patients, total scores can be converted to a 0 – 10 scale, by dividing the total by 3.2; where 10 represents the best possible sleep. In this paper however, we concentrate on reporting the scale in the 0 – 32 point format.

A minimal additional dataset was extracted comprising birth-year from which age could be estimated, and sex, in order to create age- and sex-referenced values for the SCI.

Analyses

Analysis was performed on IPython (Perez et al., 2011) and Jupyter Notebooks (Kluyver et al., 2016), using Python 2.7 (Python Software Foundation) and the python libraries numpy (Van Der Walt et al., 2011) and pandas (McKinney, 2010). The means of sex and age were compared via two-sided t-tests using the scipy library (Van Der Walt et al., 2011); due to our large sample size, we report on effect size for the tests, using Cohen's d and η2, instead of the associated t-statistic and p-value. Test-retest reliability was assessed via Pearson's r and the intraclass

correlation coefficient (ICC). The regression modelling of SCI score vs. age and sex was performed via a Bayesian Generalized Linear Model, using the pymc3 library (Salvatier et al., 2016); age and sex were modelled as continuous and categorical variables, respectively; parameters were estimated using Automatic Differentiation Variational Inference (Kucukelbir et al., 2016) and the No-U-Turn Sampler (Hoffman and Gelman, 2014). Plots were produced using the matplotlib library (Hunter, 2007).

Results

Sample characteristics

A sample of 200,000 adults who had completed the SCI online was extracted, comprising n = 116,185 females (58.0%) and n = 83,815 males (42.0%). The mean age of the total sample was 31 ± 13 yrs, with females being on average 30 ± 13 yrs and males 32 ± 12 yrs. Six age-group sub-samples: 16 – 25 yrs (n = 87,576), 26 – 35 yrs (n = 52,135), 36 – 45 yrs (n = 29,253), 46 – 55 yrs (n = 18,109), 56 – 65 yrs (n = 9,876) and 66 – 75 yrs (n = 3,051), were also derived. Because the data is extracted from commercially used platforms, we were not able to use the full sample for these analyses, however the sample was representative of the larger population with a similar distribution of age [mean 31 ± 13 yrs, difference with sample mean = 0.003, $\eta^2 < 0.001$, $p = 0.94$] and gender [58.0% females and 42.0% males]. Differences in SCI between the full population and the sample, for each of the gender/age subgroups, were assessed via t-tests and found to be negligible (absolute difference in means for all groups < 0.02, η^2 for all groups < 0.001, p for all groups > 0.88].

Psychometric properties of SCI

As can be seen in Figure 1, SCI data formed a slightly right skewed distribution with a mean value of 14.97 (Fisher-Pearson coefficient of skewness: 0.283). Psychometric properties can be found in Table 2.

Internal consistency

Cronbach's α for the entire sample was acceptable at 0.733 (range of α-if-item-deleted 0.671 to 0.744). Mean corrected item-total correlation was moderate (r=0.454) indicating substantial unique variance per item (6% to 41.6%; with shared variance = 20.6%). Suppl. Table 1 summarizes data on these parameters by sex and age-group, from which it can be seen that internal consistency is uniformly acceptable (range of α = 0.704 to 0.775) and the mean item-total correlation ranges from r = 0.424 to 0.505.

Test-retest reliability

In order to estimate test-retest reliability, we identified a small sample of SCI completions (*n* = 180, 71% females, mean age 44 ± 14 yrs) by the same user within an interval of no less than 12 hrs and no greater than 7 days. The resulting test-retest reliability and intraclass correlation coefficients were r = 0.85 and ICC = 0.84 respectively.

Insert Figure 1 and Table 2

Reference values for the SCI

Mean score on the SCI for the whole sample was 14.97 ± 5.93. Figure 2 and Table 3 provide detailed data on the SCI by sex and age. It can be seen that women had somewhat poorer (lower) SCI scores than men [14.29 ± 5.83 vs 15.90 ± 5.94; difference in means = -1.60, η^2 = 0.018, Cohen's d = 0.272]. Indeed, women's sleep was poorer than men's sleep consistently across the six age-groups [range of difference in means -2.24 to -1.38; range of η^2 0.013 to 0.032]. SCI score differences between the sexes were greater in absolute terms from the 36 – 45 year range upwards (where women's sleep remained at least 2 scale points poorer).

Visual inspection of Figure 2 illustrates that progressively poorer sleep with increasing age was the norm for both men and women. We investigated this relation by performing a linear regression of SCI versus age and gender. Our results are consistent with a decrease in the total SCI of -0.057 points per year [95% CI: -0.059 to -0.055] relative to baseline age. Suppl. Fig 1 depicts distribution curves of SCI scores by sex and age.

Table 3 provides a summary of SCI descriptives, interquartile ranges may be useful to assess at which quartile a patient scores. Suppl. Fig 1 can be used to assess where a given patient fits within the overall distribution of scores at a particular stage in life.

Insert Figure 2 and Table 3

Reliable Change Index (RCI) for the SCI

Rather than relying on an anchor-based approach, we followed Jacobson & Truax's [Reliable Change Index (RCI), 1991] and Bland & Altman's (2003) approach to determine a reliable unit of change, representing 95% of the standard error of the

mean (SEM). Utilizing our full SCI distribution dataset, and taking into account our observed test-retest coefficient, we arrived at a mean RCI = 6.54. This reliable change index appears stable across the age-groups (see Suppl. Table 1), both for women (range of RCI = 6.07 to 6.64) and men (range of RCI = 6.24 to 6.82).

Given that the SCI is always scored in whole integers, we suggest that RCI = 7 is the most parsimonious value for use in clinical and research practice, and that it is applicable for men and women of all ages.

It should be noted, however, that item 8 ("how long have you had a problem with your sleep") could be omitted from some calculations of change, because duration of sleep problems, while relevant for screening and diagnosis, is not necessarily appropriate for measuring change. Therefore we also calculated the RCI for the SCI omitting item 8. For the remaining 7 SCI items we calculated mean RCI = 5.79, and again the RCI appeared stable across the age-groups (see Suppl. Table 1), both for women (range of RCI = 5.39 to 6.16) and men (range of RCI = 5.39 to 6.22). Consequently we recommend that when the SCI is used in 7-item format for pre=post evaluation RCI = 6 is the most suitable index value.

Previous research has supported the use of a cut-off of 16 for Possible Insomnia Disorder (Espie et al., 2014b, Wong et al., 2017, Ballesio et al., 2017, Bayard et al., 2017, Palagini et al., 2015). In the present sample we applied criteria based on the DSM-5 to our dataset to distinguish those with possible insomnia from 'normal' sleepers. Criteria included were (A) difficulty initiating or maintaining sleep: SCI item 1 or SCI item 2 above 30 min and SCI item 4 'Average' or worse (B) significant distress: SCI item 7 'Somewhat' or worse and SCI item 5 or SCI item 6 'Somewhat' or worse, (C) frequency: SCI item 3 equal or above 3 nights per week,

(D) duration: SCI item 8 equal or above 3 months. This created two distributions, one of 'normal' sleepers (N = 93,293, 54% female, mean age 29.78 ± 12.23 yrs and one of those with possible insomnia (N = 106,707, 61% female, mean age 32.59 ± 13.12 yrs. As can be seen in Suppl. Figure 2, the difference between these groups exceeds the RCI of 6.5 points, providing further support for the RCI.

Insert Figure 3

Discussion

The Sleep Condition Indicator was developed as a brief, DSM-5 compliant screening tool to assist in population and clinical evaluation of insomnia, and this study confirms previous reports that the SCI has sound psychometric properties across the adult age range. Indeed, it was the availability of a very large dataset of this brief measure that led us to evaluate the properties of the SCI by sex and age-group.

Such referent data provide the individual and the clinician with useful information on whether a presenting problem is similar to or worse than that of the comparator peer-group. This is how we suggest that the data tables and figures, including supplemental ones, may be useful in practice. The SCI score can also be completed and compared to the current reference values via www.sleepio.com/sleep-condition-indicator. It is both interesting and important to compare scores in any clinical domain with 'norms', but often reference values reported in the insomnia literature are not detailed in relation to such characteristics, and the validation samples are relatively small. These SCI data permit consideration of how an individual is sleeping, not just in relation to a clinical cut-off, but also in relation to large samples of other people of their sex and age. The results

demonstrate for example that women's sleep is generally poorer than men's; women score consistently at least 2 SCI scale points lower than men from the 36 – 45 year range upwards. In addition, progressively poorer sleep with increasing age is the norm for both men and women.

With regard to treatment effects, our results suggest that the magnitude of change that would represent reliable improvement on the SCI is 7 scale points when all 8 items of the SCI are included, a change of 6 scale points is needed to indicate reliable improvement when the duration item (Item 8) is excluded of the SCI. This value (RCI = 7) seems appropriate for men and women across the age deciles, although variability again can be interrogated from the tables. At the clinical level (or in research), therefore, improvement for a given patient may be interpreted in several ways using the SCI. A change in status may be inferred from: a) an SCI score reduction from below the clinical cut-off of 16 to a score that is now above that cut-off; or b) by a reliable change increase in SCI score of 7 points or greater.

There are important limitations that need to be taken into account. In particular, the data presented here are not true population norm-referenced values. What these data represent is simply a randomly selected convenience sample of people who had completed the SCI online. Thus, although the sample is large, it is not representative of the general population. We did not sample based upon sex and age demographics. It is evident for example that younger age groups are considerably over-represented. Moreover, we do not have information on other population characteristics, such as socioeconomic or civil status, which one would expect to find using normative sampling methods. Also, there is a sampling bias in favour of those who have an interest in sleep, by virtue of their self-selection to complete an online test, and a bias towards those with a sleep problem. For

example, more than half of the sample screened positive for possible insomnia. In addition, we were unable to analyze the full pool of data that formed the base of the extracted sample of 200,000. Commercial platforms were used to extract the data, usage numbers, such as a total N, are typically viewed as commercially sensitive. Our extracted sample was however representative of the full pool of data.

The limitations mentioned above are likely to have some effect on the reliability of the reference values themselves, and further research is required to confirm their representative nature. On the other hand, the RCI may be more robust because the clinical population was in fact over-represented. There is also need for further validation of the SCI when routinely used in primary care looking at feasibility of use, acceptability and comparison with other insomnia measures. Lastly, with regards to the psychometrics, we were only able to test the test-retest reliability in a small sample that might not necessarily be representable of the larger sample. Unfortunately, we do not have any in-depth knowledge on why people completed the SCI more than once and how this influenced the representability of this sample, on all platforms the SCI can be taken multiple times without stating any reasons. With regards to the internal consistency of the SCI it is important to keep in mind that the SCI is created to follow DSM-5 criteria for insomnia disorder, hence measuring a variety of constructs such as sleep onset latency but also daytime effects. This may make the internal consistency values less conceptually meaningful for the SCI then traditional questionnaires. However, one could equally argue that because of the variable nature of the response format of the items in the SCI the internal consistency range of 0.70 to 0.78 is therefore better than to be expected.

Conclusion

The SCI is reliable, simple and valid tool for potential wider use in general practice and secondary care settings. It can be routinely used for screening of insomnia, to assist diagnosis, and for the clinical (and/or self-) monitoring of treatment-related change. An SCI improvement of 7 points represents reliable change. The availability of sex and age-referenced values adds to the practical utility at the clinical interface as well as strengthening credentials as a research tool.

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Tables

Table 1 Sleep Condition Indicator (SCI)

	Score				
Item	4	3	2	1	0
Thinking about a typical night in the last month …					
1. … how long does it take you to fall asleep?	0 – 15 min	16 – 30 min	31 – 45 min	46 – 60 min	≥ 61 min
2. … if you then wake up during the night … how long are you awake for in total? (add all the wakenings up)	0 – 15 min	16 – 30 min	31 – 45 min	46 – 60 min	≥ 61 min
3. … how many nights a week do you have a problem with your sleep?	0 - 1	2	3	4	5 - 7
4. … how would you rate your sleep quality?	Very good	Good	Average	Poor	Very poor
Thinking about the past month, to what extent has poor sleep …					
5. … affected your mood, energy, or relationships?	Not at all	A little	Somewhat	Much	Very much
6. … affected your concentration, productivity, or ability to stay awake	Not at all	A little	Somewhat	Much	Very much
7. … troubled you in general	Not at all	A little	Somewhat	Much	Very much
Finally …					
8. … how long have you had a problem with your sleep?	I don't have a problem / < 1 mo	1 – 2 mo	3 – 6 mo	7 – 12 mo	> 1 yr

Scoring instructions:

a. Add the item scores to obtain the SCI total (minimum 0, maximum 32)
b. A higher score means better sleep
c. Scores can be converted to 0 – 10 format (minimum 0, maximum 10) by dividing total by 3.2
d. Item scores in grey area represent threshold criteria for DSM-5 Insomnia Disorder

Table 2 Psychometric properties of the Sleep Condition Indicator (SCI) scores (n = 200,000)

Psychometric property	**Statistic**
Internal consistency	α = 0.733 (0.671 - 0.744)
Mean corrected item-total correlation	0.454
Test-retest reliability	*r* = 0.840 *ICC* = 0.841
Reliable Change Index	*RCI* = 6.54 (range 6.07 – 6.82)

Table 3 Sleep Condition Indicator (SCI) sex and age-related reference values, N=200,000

Age group (years)	Sex	N	Mean (SD)	Median (IQR)
16 – 25	F	58,199	14.98 (5.60)	15 (11-19)
	M	29,377	16.36 (5.66)	16 (12-20)
26 – 35	F	26,206	14.30 (5.92)	14 (10-19)
	M	25,929	16.06 (5.96)	16 (12-20)
36 – 45	F	14,077	13.40 (6.02)	13 (9-17)
	M	15,176	15.60 (6.18)	15 (11-19)
46 – 55	F	10,042	12.88 (5.91)	12 (9-16)
	M	8,067	15.01 (6.14)	14 (11-19)
56 – 65	F	5,944	12.64 (5.89)	12 (9-16)
	M	3,932	14.89 (6.13)	14 (11-18)
66 – 75	F	1,717	12.18 (5.50)	12 (8-15)
	M	1,334	14.09 (5.66)	14 (10-17)
All ages	F	116,185	14.29 (5.83)	14 (10-18)
	M	83,815	15.90 (5.94)	16 (12-20)
	All	200,000	14.97 (5.93)	15 (11-19)

F: female; M: male; SD: standard deviation; IQR: interquartile range.
Range SCI 0-32 with 32 indicating better sleep.

Figures

Figure 1 *Distribution of Sleep Condition Indicator (SCI) scores (n = 200,000)*

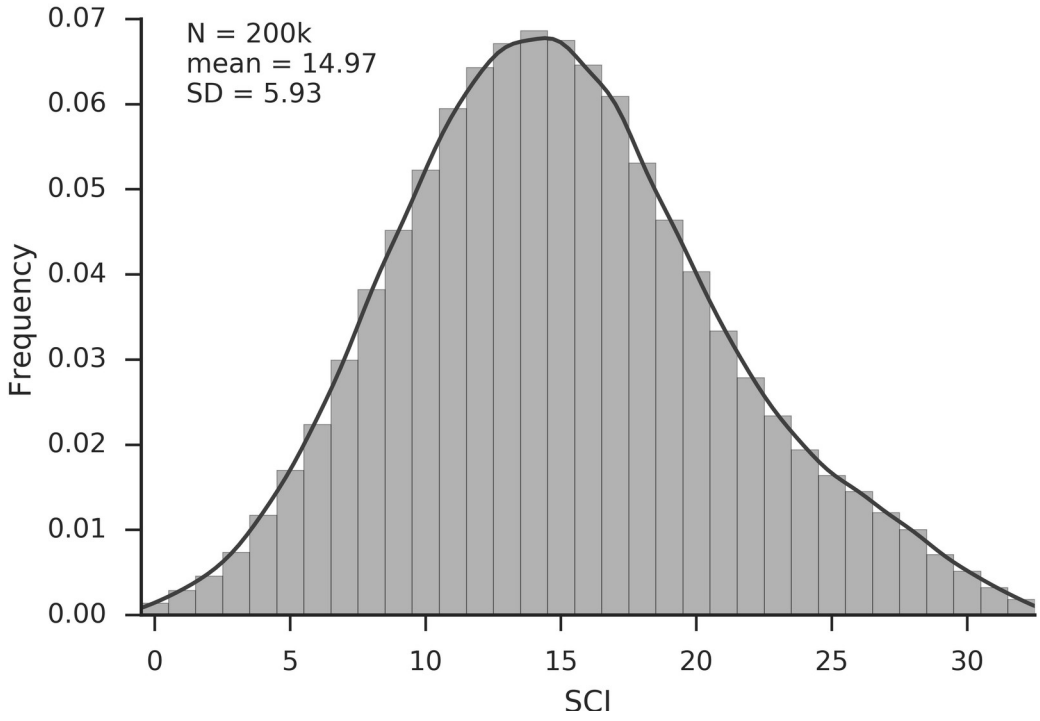
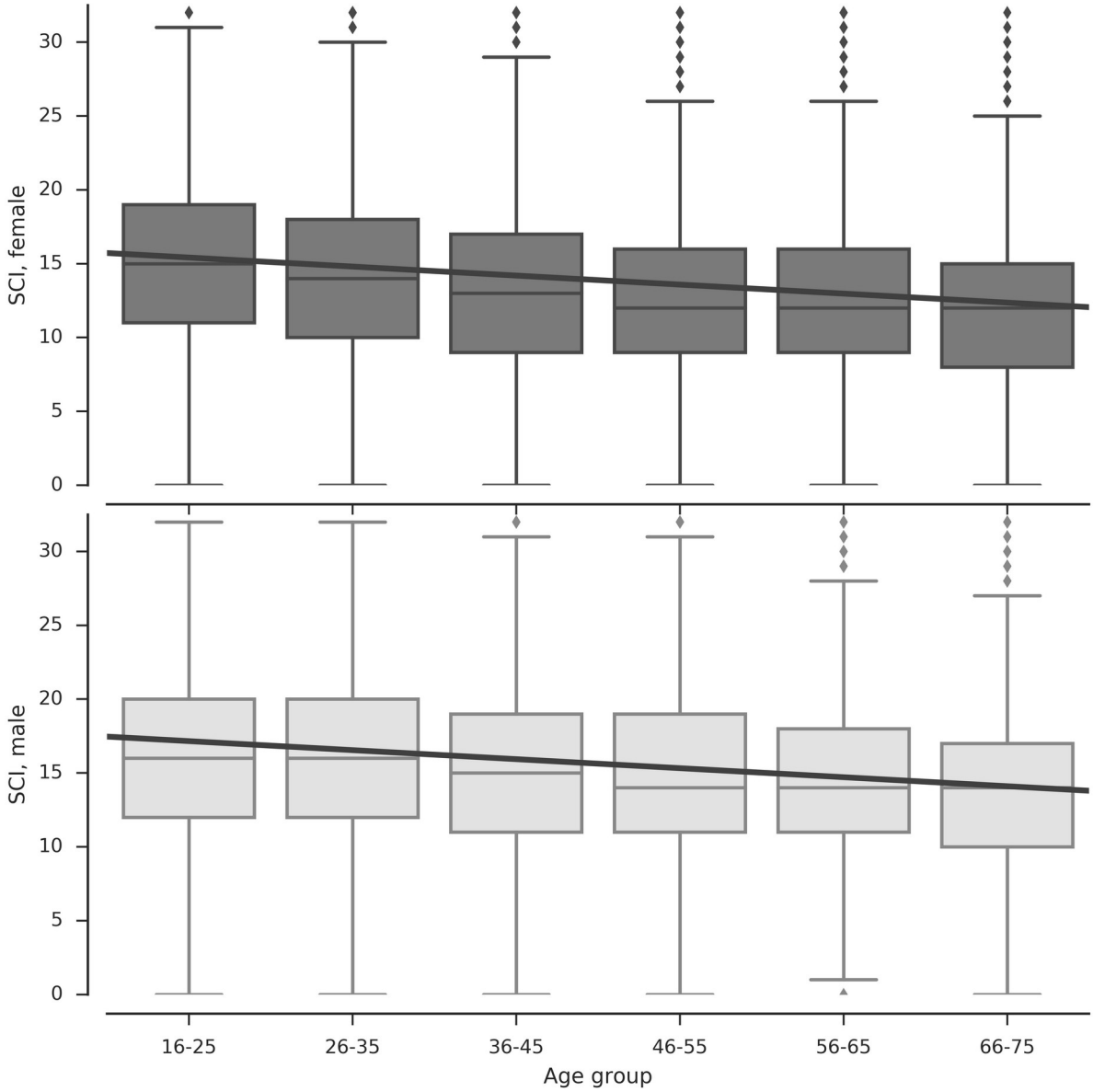
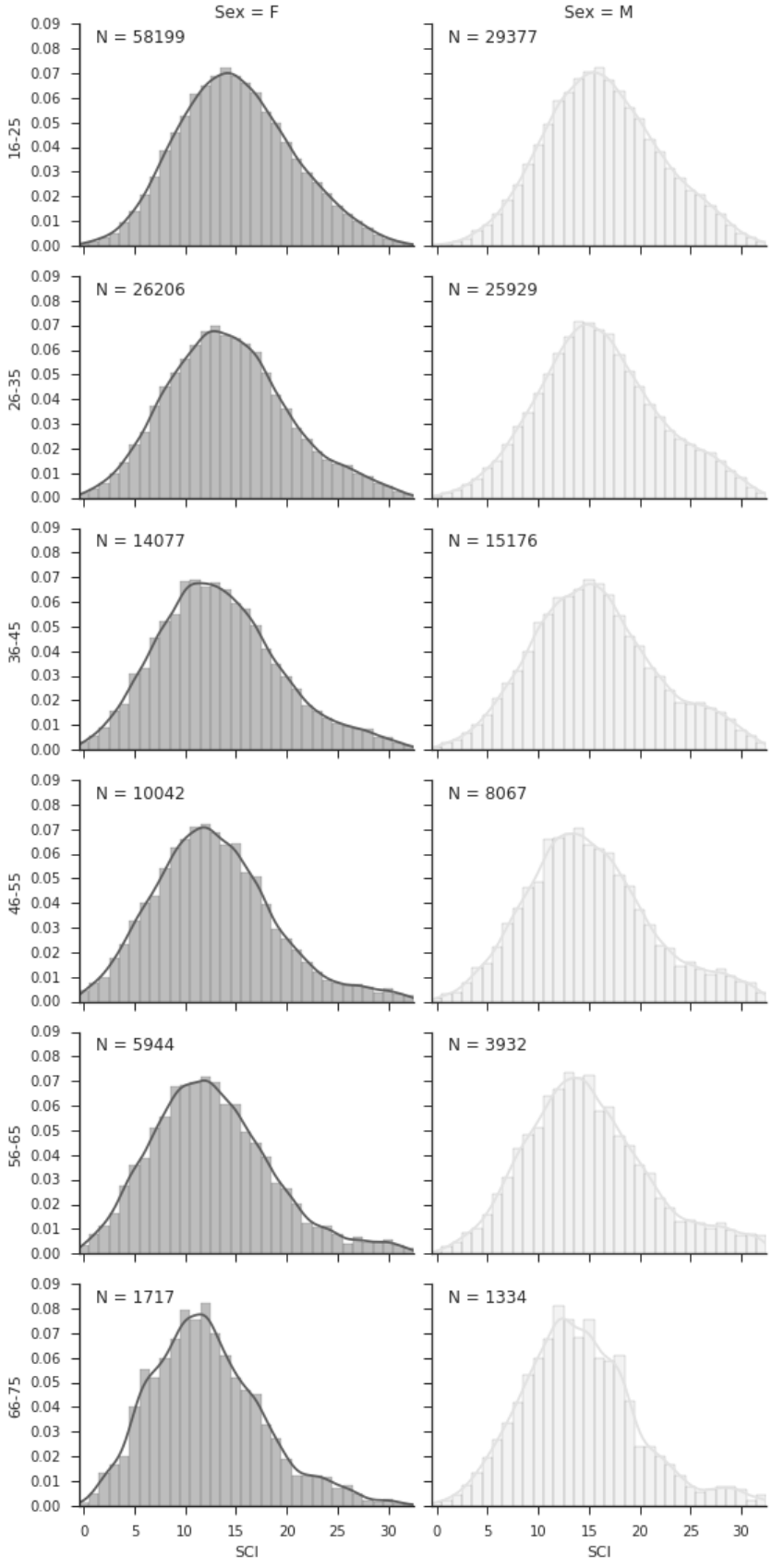


Figure 2 *Box plots of Sleep Condition Indicator (SCI) scores for men and women by age*

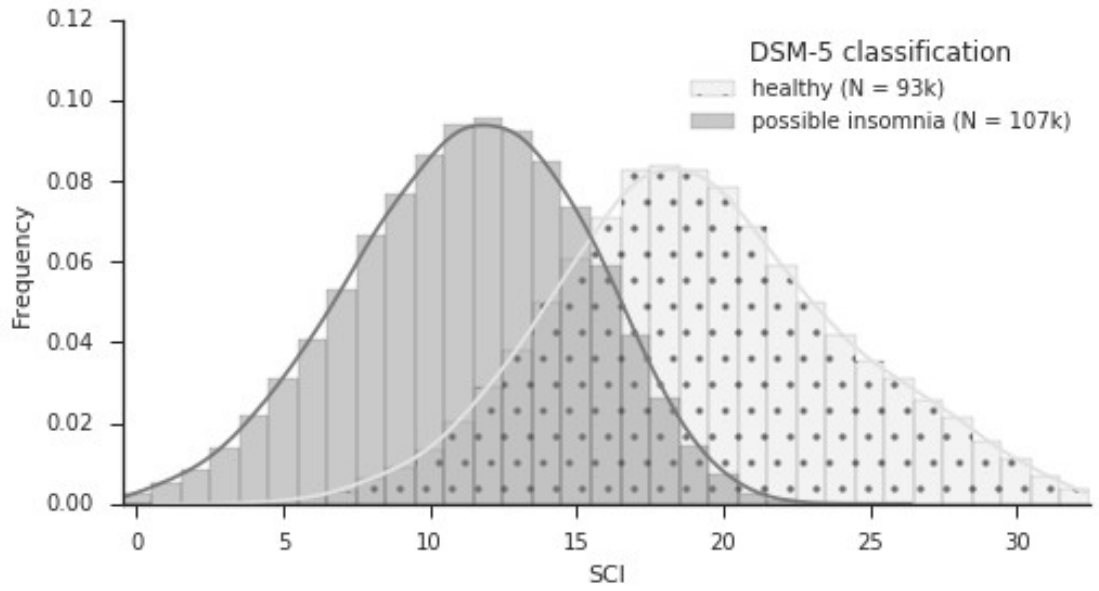


Supplement

Supplemental Figure 1 *Sleep Condition Indicator (SCI) distribution curves by sex and age decile*



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Supplemental Figure 2 *Comparison of participants meeting minimal criteria for DSM-5 Insomnia Disorder (n=106,707) and healthy controls (n=93,293) on the SCI, demonstrating the reliability of the Sleep Condition Indicator (SCI) cut-off score of 16*

Supplemental Table 1 Psychometric properties of and Reliable Change Index (RCI) for the Sleep Condition Indicator (SCI)

Age group (years)	Sex	Cronbach's *α* (range of *α-if-item-deleted)*	Mean corrected item-total correlation (*r*)	*RCI: 8 items*	*RCI: 7 items*
16 – 25	F	0.714 (0.655 - 0.727)	0.427	6.19	5.39
	M	0.713 (0.655 - 0.728)	0.424	6.24	5.39
26 – 35	F	0.750 (0.690 - 0.764)	0.473	6.54	5.87
	M	0.756 (0.700 - 0.769)	0.476	6.58	5.73
36 – 45	F	0.746 (0.682 - 0.765)	0.473	6.64	6.06
	M	0.770 (0.712 - 0.784)	0.496	6.82	6.04
46 – 55	F	0.748 (0.685 - 0.769)	0.477	6.53	6.09
	M	0.770 (0.712 - 0.784)	0.498	6.77	6.11
56 – 65	F	0.750 (0.689 - 0.767)	0.480	6.50	6.16
	M	0.775 (0.717 - 0.791)	0.505	6.76	6.22
66 – 75	F	0.704 (0.632 - 0.730)	0.428	6.07	5.87
	M	0.725 (0.656 - 0.746)	0.449	6.24	5.85
All ages	F	0.722 (0.657 - 0.734)	0.443	6.43	5.71
	M	0.738 (0.677 - 0.750)	0.458	6.56	5.74
	All	0.733 (0.671 - 0.744)	0.454	6.54	5.79

F: female; M: male; RCI: reliable change index.