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## Psychiatry Research

journal homepage: [www.elsevier.com/locate/psychres](http://www.elsevier.com/locate/psychres)

# Unipolar and bipolar patient responses to a new scale measuring the consequences of depression



Gordon Parker\*, Stacey McCraw, Dusan Hadzi-Pavlovic

School of Psychiatry, University of New South Wales, Sydney, Australia and Black Dog Institute, Sydney, Australia

## ARTICLE INFO

### Article history:

Received 12 July 2015

Received in revised form

12 October 2015

Accepted 20 October 2015

Available online 28 October 2015

### Keywords:

Depression

Bipolar disorder

Economic impact

Consequences

Functional impairment

## ABSTRACT

There are generic measures available to assess functional impairment associated with clinical conditions, but no measure has been developed to specifically evaluate consequences of differing mood disorders, our current objective. In this study, 208 participants took part in a research interview which aimed to differentiate clinical depression from non-clinical mood states. The 126 participants who met diagnostic criteria for clinical depression (i.e., bipolar disorder, melancholic depression or non-melancholic depression) were asked to judge whether they had experienced any of 24 consequences of their depressive episodes with the measure focusing on occupational, personal and interpersonal functioning. Such consequences were affirmed by 100% of participants diagnosed with bipolar disorder, 84% of those experiencing melancholic depression and 74% of those who had experienced a non-melancholic depressive episode. Results from a three-factor solution were consistent with the expected domains (i.e. work and relationships; self-care and daily functioning; intimate relationships and coping), and had sound goodness of fit properties. Participants with bipolar disorder were more likely to affirm each item compared to participants with unipolar depression, and participants with melancholic depression affirmed each item at a higher rate than participants who had experienced non-melancholic episodes. The new measure (the Consequences of Depression Scale; CODS) could be utilised in research and clinical activities seeking to identify and quantify the personal and economic burden of mood disorders, and provides an additional perspective for evaluating the impact of mood disorders on interpersonal, personal and occupational functioning.

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## 1. Introduction

It is widely recognised that both the unipolar and bipolar mood disorders are highly impairing and disabling and that their toll is both a consequence of the mood state itself and its impact on social functioning and on work performance (e.g., Goodwin and Jamison, 1990; Simon, 2003). The primary aim of most therapies is symptom remission but, as complete and persisting remission is relatively uncommon, there is increasing recognition that functional recovery should be a priority (Lam et al., 2015).

A mood disorder can – by its consequences – be a cause of ongoing or new episodes of depression and other psychological symptoms and social problems. The bipolar disorders are widely recognised as risking considerable ‘collateral damage’ across interpersonal, social and occupational domains (McCraw et al., 2014; Parker et al., 2013). Relationships and work functioning are at

particular risk of jeopardy and, if compromised or irreclaimable, contribute to ongoing depression or become the source of loss-induced depression (e.g., Gitlin et al., 1995).

While there are many scales that measure impairment associated with psychiatric conditions, such as the Social and Occupational Functioning Assessment Scale (SOFAS; Goldman et al., 1992), the Global Assessment of Functioning (GAF; DSM-IV) and the World Health Organisation Health and Work Performance Scale (Kessler et al., 2003), there are few measures that specifically allow the impact of mood-related consequences to be evaluated and quantified. As summarised by Lam et al. (2015), there are two depression-specific outcome scales which assess occupational functioning (the Lam Employment Absence and productivity Scale; Lam et al., 2009) and social functioning (the Social Adaptation Self-evaluation Scale; Bosc et al., 1997), while all others are ‘generic’. Judging there to be no multi-faceted measure of the consequences of a depressive disorder we sought to design and evaluate such a measure. The development study reported here also sought to determine if differing mood disorders (i.e. bipolar, melancholic and non-melancholic) disorders might evidence

\* Correspondence to: Black Dog Institute, Prince of Wales Hospital, Randwick 2031, Sydney, Australia.

E-mail address: [g.parker@unsw.edu.au](mailto:g.parker@unsw.edu.au) (G. Parker).

differential consequences.

The bipolar disorders are generally viewed as more severe and impairing than the unipolar disorders (Borkowska and Rybakowski, 2001; Goldberg et al., 1995), while the melancholic disorders might be presumed to be generally more impairing and risk greater adverse consequences due to their key feature of psychomotor disturbance compromising cognitive and functional performance (Austin et al., 1999; Malhi et al., 2007). Hence, we hypothesised that consequences of depression would vary in prevalence and in breadth across the principal mood disorders in a way that reflects their differing clinical features. If confirmed, such findings would support the utility of the proposed measure (i.e., the Consequences of Depression Scale; CODS).

## 2. Methods

### 2.1. Sample

The study objective was embedded in a broader enquiry seeking to differentiate 'clinical' from 'normal' mood disorders and, as its design and characteristics have been detailed (Parker et al., 2015), will only be briefly overviewed here. A total of 208 participants were initially recruited, primarily from the community via newspaper and web advertisements (93%), or from out-patients and associates attending the Black Dog Institute. Inclusion criteria required participants to be aged between 18 and 70 years, fluent in spoken English and willing to take part in a research interview lasting approximately 60 min. Exclusion criteria included memory or cognitive deficits (e.g., diagnosis of dementia or traumatic brain injury), and any history or current non-affective psychotic disorder, and with these features screened for by the interviewer. Written informed consent was provided by each participant and the study was approved by the University of New South Wales Ethics Committee.

### 2.2. Materials and procedure

Participant interviews were conducted face-to-face by one of four research assistants (psychology graduates and postgraduates) trained in administering standardised interview schedules. Participants were asked whether they had ever experienced – for two weeks or longer – any of 46 depressive symptoms, with all DSM-IV major depression criteria incorporated (including melancholia and psychosis specifier criteria) and with such questioning being in relation to their most severe depressive episode. All participants were screened for bipolar disorder (I or II) or a major depressive episode (with or without melancholic features) using DSM-IV criteria. Such assessment components allowed us to allocate lifetime bipolar, unipolar melancholia and unipolar non-melancholic diagnoses to those whose most severe episode met diagnostic criteria for such a 'clinical' mood disorder ( $n=126$ ) and who form the current sample. During the interview, participants who affirmed experiencing a depressed mood state were asked "Did you experience any of the following problems as consequences of your depression", with our 24-item measure designed to focus on occupational and relationship functioning as well as on self-care. Items are listed in Table 1. Only 'yes' or 'no' responses were allowed for each question, and with the entire scale taking approximately 2 minutes to complete.

The 74 omitted cases were not eligible for the analysis either because they reported that they had never experienced any depressive mood state throughout their life and therefore could not answer questions about such a mood state ( $n=50$ ), or reported subthreshold and transient depressive mood states which the participants generally judged as not resulting in any consequences

**Table 1**

Factor loadings and inter-factor correlations for the imposed 3-factor solution.

	Rotated loadings <sup>a</sup>		
	1	2	3
1. Finding it a real struggle to get to work	<b>0.582</b>	<b>0.642</b>	–0.225
2. Not being able to get to work	<b>0.534</b>	<b>0.716</b>	–0.028
3. Quitting a job you would otherwise have kept	<b>0.452</b>	0.319	–0.143
4. Risking losing your job	<b>0.603</b>	0.222	0.105
5. Actually losing your job	<b>0.556</b>	0.327	0.226
6. Risking being demoted	<b>0.723</b>	–0.118	0.324
7. Actually being demoted	<b>1.125</b>	– <b>0.469</b>	0.000
8. Difficulty in studying or taking in information	–0.196	<b>0.786</b>	0.154
9. Having to drop out of school or other education	0.264	<b>0.641</b>	0.166
10. Finding it difficult to keep up your normal exercise or health routine	0.047	<b>0.847</b>	–0.171
11. Not being able to keep up your normal exercise or health routine	–0.024	<b>1.045</b>	–0.241
12. Problems in your relationship with your partner	–0.114	0.278	<b>0.790</b>
13. Risking losing the relationship with your partner	0.004	0.241	<b>0.952</b>
14. Actually losing your partner	0.046	0.003	<b>0.935</b>
15. Problems in relationships with family	<b>0.475</b>	0.083	0.285
16. Actually losing relationships with family	<b>0.461</b>	0.005	0.281
17. Problems in relationships with others	<b>0.716</b>	0.022	<b>0.527</b>
18. Actually losing relationships with others	<b>0.636</b>	–0.034	<b>0.575</b>
19. Finding it difficult to get out of bed	0.272	<b>0.635</b>	0.058
20. Physically not being able to get out of bed	<b>0.404</b>	<b>0.632</b>	0.096
21. Not being able to shower or keep up self care	0.004	<b>0.719</b>	0.264
22. Using alcohol as a coping mechanism	–0.004	–0.058	<b>0.549</b>
23. Using cigarettes as a coping mechanism	–0.279	0.235	0.169
24. Using drugs other than those prescribed by your doctor	0.044	0.164	<b>0.607</b>
	Inter-factor correlations		
	1.000		
	0.218	1.000	
	0.197	0.268	1.000

<sup>a</sup> All loadings in bold (which identify the factors) plus those in italics are significant at 5% level.

or functional impairments and were 'normal' reactions given the life event ( $n=20$ ). The remaining 8 cases were judged as providing unreliable information (for instance, giving inconsistent or contradictory responses, or refusing to endorse the term 'depression' despite acknowledging the experience of significant symptoms of depression).

Our study design allowed us to examine the prevalence of items but not their severity of impact. As the items capture consequences likely to have quite varying magnitudes, we undertook a supplementary study, asking eleven researchers at our institute to rate the theoretical impact of each consequence on a 0–100 scale. Mean estimations for each item were used to determine the relative weight of each consequence of depression. The average impact of items affirmed by each subgroup was then calculated ('mean impact'), as well as the average accumulative impact of items affirmed by each subgroup ('total impact').

### 2.3. Data analysis

Data were analysed using the Statistical Package for Social Sciences (SPSS; Version 22.0). Descriptive statistics were employed to analyse the demographic variables, while chi square tests were undertaken to determine any differential frequency of questionnaire items affirmed across the three diagnostic sub-groups. For each item, two between-group contrasts (bipolar disorder versus the two unipolar groups; and, within the unipolar

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