



The extent and origin of discordance between self- and observer-rated depression in patients with psychosis

Maike M. Hartmann*, Anja Fritzsche, Tania M. Lincoln

University of Hamburg, Department of Psychology, Von-Melle-Park 5, 20146 Hamburg, Germany

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ABSTRACT

It is assumed that patients with psychosis have difficulties indicating clinical symptoms accurately in self-reported measures. The present study investigated the ability of self-rating scales to detect symptoms of depression in patients with psychosis and aimed at identifying demographic, clinical and neurocognitive factors that predict the discordance between self-ratings and observer ratings. Inpatients and outpatients with psychosis ($n=118$) were assessed for depression by applying two observer rating and two self-rating scales. We found reasonable correlation scores between the ratings by patients and observers (range: $r=0.50-0.57$). In half of the patients (49.2%) the self-ratings corresponded well with the ratings of clinicians. Patients who rated their depressive symptoms as less severe than the clinicians demonstrated more negative symptoms such as blunted affect and poor affective rapport. Patients who rated their depression symptoms as being more severe were characterized by more self-reported general psychopathology. The concordance rates indicate that self-ratings of depression can be a valid additional tool in clinical assessment of patients with psychosis. However, clinicians should be attentive to the fact that some patients might have a general tendency to over-report symptoms and that patients with negative symptoms tend to be rated as more depressed in observer ratings compared with self-assessments.

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1. Introduction

Symptoms of depression are common in patients with psychosis and can occur in every phase of the disorder (Heald et al., 2008). Reported prevalence rates range from 30% (Siris, 1991) to 70% in an acute phase of psychosis (Birchwood et al., 2000). Previous studies have demonstrated that depressive symptoms in patients with psychosis are associated with low subjective quality of life or well-being (Reine et al., 2003; Schennach-Wolff et al., 2011), in higher symptomatology (Chemerinski et al., 2008; Rocca et al., 2005), increased risk of relapse (Johnson, 1988) and increased suicidal ideation (Heilä et al., 1997).

It is therefore important to be able to identify depressive symptoms via a reliable and valid diagnostic procedure. In patients without psychosis, symptoms of depression are typically assessed via self-rating scales (e.g., Beck Depression Inventory (BDI); Beck et al., 1961). However, it is assumed that patients with psychosis have difficulties in describing their symptoms accurately that might be due to denial, shame, poor insight and information processing deficits in attention, concentration, memory, abstraction and

concept formation (Hamera et al., 1996). As a consequence, observer-rated symptom scales are a common method of assessing the severity of depressive symptoms in patients with psychosis and most of the assessment research has focused on observer-rating scales (Addington et al., 1996; Collins et al., 1996; Kontaxakis et al., 2000; El Yazaji et al., 2002). However, observer ratings are time-consuming, require intensive training, are costly as well as prone to socially desirable answers and may be observer-biased. In contrast, self-ratings are efficient and could enhance therapeutic outcome and alliance (Liraud et al., 2004; McCabe et al., 2007) because they provide a means to assess and value the subjective well-being in therapy which might render improvement of depressive symptomatology more likely (Schennach-Wolff et al., 2011).

So far, two studies have compared self-rating with observer-rating scales and found them to correlate moderately to highly (range from $r=0.53$ to $r=0.84$) (Addington et al., 1993; Kim et al., 2006). These studies have not, however, provided answers to the question of which factors might be responsible for the remaining discordance between clinicians' and patients' estimates of symptoms. Such factors have only been investigated in non-psychotic patients with depression (Domken et al., 1994; Enns et al., 2000). Both studies found several patient characteristics such as age, specific personality factors such as high neuroticism, and low self-esteem, to predict the disparities between self-ratings and observer ratings. With regard to patients with psychotic disorders, factors

* Corresponding author. University of Hamburg, Department of Clinical Psychology and Psychotherapy, Von-Melle-Park 5, 20146 Hamburg, Germany.
Tel.: +49 40 42838 7820; fax: +49 40 42838 6170.

E-mail address: maike.hartmann@uni-hamburg.de (M.M. Hartmann).

that explain discrepancies are likely to be found in the specific characteristics of these patients. Patients with psychosis might either under- or overestimate their symptoms due to lack of insight (Lincoln et al., 2007), higher levels of interpersonal distrust (Andreasen and Flaum, 1991), low self-esteem (Kesting et al., 2011), lack of cognitive flexibility (Beck et al., 2004) or cognitive impairment (Heinrichs and Zakzanis, 1998). On the other hand, the discrepancy could also be caused by biases on the side of the clinicians. For example, clinicians might underestimate symptoms of depression in patients with higher levels of positive symptoms, in particular those who appear agitated or aggressive. Similarly, clinicians might incorrectly interpret the diminished emotional expressions that are associated with negative symptoms or medication side effects (e.g., extrapyramidal effects; Müller et al., 2002) as symptoms of depression. However, it needs pointing out that the phenomenological similarity of negative and depressive symptoms makes it difficult to differentiate these syndromes. This makes it difficult to attribute an overlap of self- and observer-reported symptoms entirely to a rating bias (Chemerinski et al., 2008).

The present study therefore aims at identifying the clinical and neurocognitive variables as well as measurement-related factors that are likely to be responsible for self-observer discrepancies in the assessment of depression in patients with psychosis.

2. Methods

2.1. Participants

All included participants ($n=118$) had a diagnosis of acute or remitted delusions according to the criteria of the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV; American Psychiatric Association, 1994). The DSM-IV criteria for schizophrenia were fulfilled by 92 participants (78.0%), for schizoaffective disorder by 11 participants (9.3%), for psychotic depression by 1 participant (0.8%) and 14 participants met the criteria for other psychotic disorders (11.9%). About a quarter of all participants ($n=28$; 23.7%) met the DSM-IV criteria for comorbid depression. All diagnoses were established using the Structured Clinical Interview for DSM-IV (SCID; Wittchen et al., 1997) or the International Diagnostic Checklist for ICD-10 (IDCL; Janca and Hiller, 1996). The majority of patients ($n=79$, 66.9%) participated in an outpatient cognitive behavioral therapy treatment project from January 2006 to August 2008 at the clinical psychology section at the University of Marburg in Germany. The remaining participants ($n=39$, 33.1%) were inpatients in three different inpatient settings nearby Marburg. All but two patients were receiving antipsychotic medication, mostly atypical neuroleptics ($n=103$, 87.3%). The total number of participants was $n=129$ and we had complete data from 118 participants. In the remaining 11 participants one of the self-rating instruments was missing. In one patient both self-ratings were missing because his or her symptomatology deteriorated and he or she had to be rehospitalized. In the other cases no specific reasons were documented. These missing data are therefore likely to be due to lost or unreturned questionnaires.

Socio-demographic, clinical and neurocognitive data of the sample including age, gender, level of education, intelligence quotient (IQ), global functioning, duration of disorder and severity of clinical symptoms are depicted in Table 1. Chlorpromazine equivalents (doses of neuroleptic medication) were calculated based on conversion factors for typical or atypical neuroleptics (Benkert and Hippus, 2004).

2.2. Procedures

Patients were contacted by their mental health professionals who informed them about the study. Assessments took place at the outpatient setting (outpatient sample) attached to the University or in the inpatient settings (inpatient sample). All participants provided informed consent. The study was approved by the ethics committee of the German Society of Psychology.

2.3. Instruments

Symptoms of depression were assessed via two different observer ratings [Calgary Depression Scale of Schizophrenia (CDSS; Addington and Addington, 1990) and the item “depression” (G6) of the Positive and Negative Syndrome Scale of Schizophrenia (PANSS; Kay et al., 1987)] and two different self-rating scales which are widely used in clinical practice [BDI (Beck et al., 1961) and the subscale

“depression” of the Symptom-Checklist Revised (SCL-90-R; Derogatis, 1977)]. All symptoms were assessed with regard to their presence or absence in the previous week. We calculated interrater reliabilities (ICCs) for the observer-rating scales of the outpatients ($n=71$) by videotaping the assessment interviews and obtaining a second rating from an independent rater. All interviewers and raters were trained in the application and rating of the scales.

2.3.1. Observer-rating scales for depression

The CDSS is a semi-structured interview specially designed to assess levels of depression in patients with psychosis (Addington and Addington, 1990). Nine symptoms are rated on 4-point Likert scales, ranging from 0 to 3. The questions refer to depressed mood, sense of hopelessness, self-depreciation, guilty ideas of reference, pathological guilt, heightened severity of depression in the morning, early wakening and suicide. The German version of the CDSS (Müller et al., 1999) showed a high ICC of 0.97. In our study the ICC was 0.90 for the sum score of the CDSS.

The PANSS (Kay et al., 1987) is composed of three subscales: a 7-item scale which assesses positive symptoms, a 7-item scale which assesses negative symptoms and a 16-item scale which assesses general psychopathology. Item ratings are based on a semi-structured interview. The items are scored with 1, in case of absence, and with 2 (mild) to 7 (extreme). The item “depression” (G6) is a part of the general psychopathology subscale. In this study the intraclass correlation coefficient for the depression item (G6) was 0.83.

2.3.2. Self-rating scales for depression

The BDI (Beck et al., 1961) is a 21-item self-report inventory designed to assess the severity of current depressive symptomatology in the areas of affect, cognition, behavior and vegetative functioning. Item scores range from 0 to 3. The German version of the BDI shows good psychometric properties with Cronbach's alphas of 0.88 or higher (Hautzinger et al., 1994).

The SCL-90-R (Derogatis, 1977) assesses the subjective perceived impairment due to physical and psychological symptoms. It includes 90 items divided into nine subscales. Each item is rated on a 5-point scale ranging from “not at all” to “extremely”. Depression was assessed by the “depression” subscale. Cronbach's alphas of the German version of the SCL-90-R range from 0.79 to 0.89 in different clinical samples (Franke, 1995).

2.3.3. Scales to assess potential predictors of rating discrepancies

Negative and positive symptoms, general psychopathology, neurocognitive functioning, global functioning, DSM-IV diagnosis of depression, medication doses and global self-esteem were analyzed as potential predictors.

To assess positive and negative syndromes, we used the factors derived from the PANSS by van der Gaag et al. (2006). The positive factor includes the following PANSS items: Delusions (P1)+Hallucinations (P3)+Unusual thought content (G9)+Suspiciousness (P6)+Grandiosity (P5)+Somatic concern (G1)+Lack of judgment and insight (G12)+Active social avoidance (G16) – Difficulty in abstraction (N5). The negative factor includes: Lack of spontaneity (N6)+Blunted affect (N1)+Emotional withdrawal (N2)+Apathetic social withdrawal (N4)+Motor retardation (G7)+Poor rapport (N3)+Active social avoidance (G16)+Uncooperativeness (G8)+Disturbance of volition (G13)–Conceptual disorganization (P2).

We used the Global Severity Index (GSI) of the SCL-90-R to assess self-reported general psychopathology. The GSI is the average of the scores of all items in the nine subscales (somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism), and thereby provides the global perceived intensity of psychological distress. In addition, we examined the impact of each SCL-90 subscale. However, for the purpose of this study we excluded the subscale “depression” from the calculation of the GSI and the subscale analyses.

The German version of the Wechsler Adult Intelligence Scale Revised (WAIS-R; Wechsler, 1991) was used as an estimate of the pre-morbid intelligence. To evaluate memory capacity, we used the subtest Logical Memory I of the Wechsler Memory Scale Revised (WMS-R; Wechsler, 1987), which requires recall of short prose passages as an indicator of immediate episodic memory capacity.

The completion times in seconds of the Trail Making Test (TMT) Part A were used to assess information processing speed and the score of Part B as an indicator of cognitive flexibility (e.g., Reitan, 1992).

To assess global self-esteem, we applied the Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965). The RSES is a 10-item self-rating questionnaire in which five negative and five positive self-related statements are rated from 1 to 4. The German version shows good internal consistencies of $\alpha = 0.84$ (Ferring and Filipp, 1996).

2.4. Operationalization and statistical analysis

SPSS for Windows (Version 19.0) was used for statistical analyses. To classify concordance of self- and observer ratings of depression, we defined optimal concordance by the regression equation ($y=1x+0$). The area of acceptable

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