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Contents lists available at ScienceDirect

Geriatric Nursing

journal homepage: www.gnjournal.com



Feature Article

Testing the psychometric properties of the Cognitions Checklist, a measure to differentiate anxiety and depression among older adults

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ARTICLE INFO

Article history:

Received 9 January 2014

Received in revised form

10 May 2014

Accepted 12 May 2014

Available online 06 June 2014

Keywords:

Geriatric

Cognitions Checklist

Content specificity hypothesis

ABSTRACT

Considerable debate has been waged in the field about whether anxiety and depressive cognitions can be discriminated, and whether they can discriminate anxiety and depression symptoms. The current study examined a standard measure of cognitions, the Cognitions Checklist (CCL) that has yielded mixed results when tested in older age samples. A community sample of older adults ($N = 169$; mean age = 75.70; $SD = 8.55$) completed a series of self-report questionnaires, including the CCL as well as measures of anxiety and depression symptoms. The CCL, which yielded a three-factor structure rather than the typical two-factor structure, did not cognitively discriminate anxiety from depression. The results have implications for understanding cognitive factors that differentiate between anxiety and depression symptoms in older adults and suggest the importance of assessing cognitions that are tailored to the concerns of this population.

Published by Elsevier Inc.

Introduction

Because symptoms of anxiety and depression may often manifest in similar ways, it is imperative to use assessments that can reliably and validly differentiate between the two types of symptom presentation. This has historically been done through the evaluation of emotions (i.e., the two-factor model of affect)¹ or cognitions (i.e., the cognitive content-specificity hypothesis).² Advancing our knowledge of the distinct cognitive mechanisms related to anxiety and depression has important implications for prevention and alleviation of these symptoms in late life. One challenge to this, however, is that considerable debate has been waged in the field about whether anxiety and depressive cognitions can be discriminated, and whether they can discriminate the symptoms of anxiety and depressive disorders,³ particularly in

older adults. Attempts to disentangle anxiety cognitions from depression cognitions have had mixed success, in part reflecting the general difficulty in disentangling anxiety and depression symptoms in both older^{4,5} and younger populations.³ An added challenge is the growing evidence that the anxiety and depression symptoms witnessed in younger adults may be different than the symptoms which present in older adults.^{6–8} Cognitions are of particular interest when studying the differentiation of anxiety and depression in older adults because cognitions are less susceptible to age related factors than are somatic or behavioral mechanisms.

According to Beck's cognitive content specificity hypothesis, anxiety has its own unique disorder-specific content that differentiates it from depression.^{2,9} Basic to this model is the assumption that anxiety is concerned with the harm appraisal of potential future threat, whereas depression is concerned with past loss, defeat, and failure.^{2,9,10} Cognitions related to perception of danger are typically associated with anxiety symptoms, whereas cognitions of loss or failure are more characteristic of depression. While these automatic thoughts are not specific symptoms of anxiety or depressive disorders, having automatic thoughts related to danger or failure is associated with the diagnosis of anxiety or depressive disorders, respectively. Beck and colleagues¹¹ developed the Cognition Checklist (CCL) to assess the frequency of automatic thoughts specific to anxiety and depression in order to facilitate the

Role of funding source: The research was supported by a Career Development Award (CSR0-068-10S) from the Clinical Science R & D Program of the Veterans Health Administration. The contents do not reflect the views of the Department of Veterans Affairs or the United States Government.

Declaration of interest: There are no conflicts to report.

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differentiation of anxiety and depressive symptoms and thus the diagnosis of anxiety and depressive disorders.

Across age groups, the ability to discriminate anxiety from depression with the CCL or similar instruments has received mixed support.^{3,12–14} For example, Beck and Perkins³ performed a meta-analysis and found evidence of cognitive content specificity for depression but not for anxiety. In keeping with cognitive content specificity, their meta-analysis confirmed that depression has distinct cognitive content (e.g., hopelessness) that is not as strongly related to anxiety. Their results yielded little evidence for discriminating cognitive features or specific cognitive contents of anxiety (e.g., threat cognitions or worry) that are not equally correlated with depression.

Studies of the CCL in older adult samples have likewise failed to substantiate a clear distinction between anxious and depressive cognitions.^{13,14} In a clinical sample of older adults diagnosed with generalized anxiety disorder (GAD), Beck and colleagues¹³ found the expected two-factor structure of the CCL (anxiety & depression cognitions) but they did not show specificity to symptoms. Results indicated that the CCL-Depression factor correlated with depression and the CCL-Anxiety factor did not uniquely correlate with anxiety. Shapiro et al¹⁴ found three factors (Anxious, Social Loss, & Worthlessness) in the CCL in their work with an older community sample. Taken together, it is clear that gaps remain in our understanding of the disorder-specific cognitions in older adults.

The primary purpose of this investigation was to explore the reliability and validity of a previously established measure by further evaluating the factor structure and discriminant validity of the standard CCL¹¹ in an older adult population. The importance of examining the psychometric properties is twofold. First, this would help to cognitively differentiate anxiety and depression in older adults. Further, this would shed light on the utility of this measure in an older adult psychiatric population. Eventually, these results could lead to further development of accurate measures of anxiety and depressive cognitions in older adults.

Methodology

Participants

A total of 169 older adult participants were given a series of self-report questionnaires, including measures of anxiety and depression symptoms. Recruitment took place at a local university educational course for retired older adults as well as in a continuing care retirement facility that contained over 300 residents via posted flyers. A total of 110 from the educational course and all residents from the continuing care were invited to participate. To be included in the study, participants had to be over the age of 60. All participants consented to the Institutional Review Board approved project and no participants were found ineligible.

Participants were 113 female (66.9%) and 56 male (33.1%) older adults with an average age of 75.70 ($SD = 8.55$). This sample consisted mainly of Caucasian participants (98.3% Caucasian, 1.1% African American, and 0.6% Other). Ninety-four participants were recruited from a continuing care retirement facility and 75 participants were recruited from community dwelling seniors. Although continuing care residents reported significantly higher numbers of health conditions ($M = 4.74$, $SD = 2.65$) than those from the community ($M = 3.11$, $SD = 2.59$), $F(1,175) = 19.37$, $p < 0.001$, there were no other significant differences found between these two samples. Over one half of the participants were married (56.5%) while 32.8% were widowed, 6.2% were divorced, 3.4% were never married, and 1.1% were separated. Educational levels were high (44.1% received a graduate school degree, 20.3% received a college degree, 15.3% received some college, 8.5% received a high school degree, 1.2% received some high school, and 8.5% gave no response).

Measures

Basic demographic factors including age, gender, and ethnicity were included. Marital status, educational level, and total number of self-reported physician diagnosed medical illnesses were also assessed. There was no formal measurement of health status.

The Adult Manifest Anxiety Scale – Elderly Version (AMAS-E)¹⁵ is a 44-item self-report inventory that measures the level and nature of anxiety in older adults based on the Diagnostic and Statistical Manual – IV-TR (DSM-IV-TR).¹⁶ The AMAS-E includes three subscales focused on Worry/Oversensitivity, Physiological Anxiety, and Fear of Aging. All items are answered dichotomously (yes or no), with affirmative answers corresponding to endorsement of anxiety thoughts, feelings, or actions. The current study looked only at the Total Anxiety score of the AMAS-E, in which higher scores suggest higher levels of anxiety. Internal consistency of the AMAS-E Total Anxiety score is good ($\alpha = 0.90$), as is the test-retest reliability ($r = 0.83$).¹⁵

The Clinical Assessment Scales for the Elderly (CASE-SF)¹⁷ is a self-report measure designed to screen for Axis I disorders in older adults based on the DSM– IV-TR.¹⁶ The clinical scales include: anxiety, cognitive competence, depression, fear of aging, mania, obsessive-compulsive, paranoia, psychoticism, somatization, and substance abuse.

The Cognition Checklist (CCL)¹¹ is a 26-item self-report measure of cognitions typically present in individuals with depressive or anxiety symptoms. The CCL consists of two subscales: Depressive Cognition subscale (CCL-D) and the Anxious Cognition subscale (CCL-A). Both subscales have demonstrated high internal consistency (CCL-D: $\alpha = 0.90$; CCL-A: $\alpha = 0.92$), test-retest reliability over six-weeks (CCL-D: $r = 0.76$, $p < 0.001$; CCL-A: $r = 0.79$, $p < 0.001$).⁷ Scores on the CCL have been found to correlate with depressive and anxiety symptoms in both clinical and non-clinical populations in young and middle-aged adults.

Data analysis

Univariate analyses of variance were conducted on the entire sample to determine the effects of demographic factors (age, ethnicity, sample origin, number of health conditions, and education) on measures of cognitions, anxiety, and depression. Next, exploratory factor analysis was conducted on the CCL. Following the analyses of Shapiro and colleagues,¹⁴ principal-axis factoring with varimax (orthogonal) rotation was utilized to explore the items of the CCL and a scree plot was used to examine the potential factor solution. To determine the number of stable factors present in each measure, factors with eigenvalues over one were examined. Factor Loadings of 0.30 or greater were considered to be stable factors. Internal reliability, concurrent, and discriminant validity were explored. Finally, the relationships between the three observed subscales of the CCL and anxiety and depression were examined with Pearson and partial correlations.

Results

Age and gender differences on the CCL, AMAS-E, and CASE were explored. Although no gender differences were found on the CCL, females were significantly higher than males on both the AMAS-E total anxiety scale (females: $M = 46.52$, $SD = 9.02$; males: $M = 43.04$, $SD = 7.19$), $F(1,167) = 6.26$, $p < 0.05$, and depression on the CASE depression subscale (females: $M = 44.82$, $SD = 5.51$; males: $M = 42.37$, $SD = 3.80$); $F(1,157) = 8.53$, $p < 0.05$. Age significantly predicted number of health conditions ($R^2 = 0.06$, $F(1,168) = 10.74$, $p < 0.01$) but was not related to other variables.

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