



High Beck Depression Inventory 21 scores in adolescents without depression are associated with negative self-image and immature defense style

Emma M. Savilahti^{a,*,1}, Henna Haravuori^{a,b}, Minna Ryttilä-Manninen^{a,c,2}, Nina Lindberg^{d,3},
Kirsi Kettunen^{a,c,2}, Mauri Marttunen^{a,b}

^a Adolescent Psychiatry, University of Helsinki and Helsinki University Hospital, PO BOX 660, 00029 HUS Helsinki, Finland

^b Mental Health Unit, National Institute for Health and Welfare, Helsinki, Finland

^c Hospital District of Helsinki and Uusimaa, Kellokoski Hospital, Kellokoski, Finland

^d Forensic Psychiatry, University of Helsinki and Helsinki University Hospital, Helsinki, Finland

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ABSTRACT

Beck Depression Inventory (BDI) is widely used in assessing adolescents' psychological wellbeing, but occasionally the result diverges from diagnostics. Our aim was to identify factors associated with discrepancies between BDI scores and diagnostic assessment in adolescent psychiatric patients and general population.

The study comprised 206 inpatients (13–17 years old) and 203 age and gender matched non-referred adolescents. Study subjects filled self-reports on depression symptoms (BDI-21), alcohol use (AUDIT), defense styles (DSQ-40) and self-image (OSIQ-R), and on background information and adverse life events. Diagnostics was based on K-SADS-PL interview, and/or clinical interview and clinical records when available.

We compared subjects who scored in BDI-21 either 0–15 points or 16–63 points firstly among subjects without current unipolar depression ($n = 284$), secondly among those with unipolar depression ($n = 105$). High BDI-21 scores in subjects without depression diagnosis ($n = 48$) were associated with female sex, adverse life events, parents' psychiatric problems, higher comorbidity, higher AUDIT scores, worse self-image and more immature defense styles. Low BDI-21 scores among subjects with depression diagnosis ($n = 23$) were associated with male sex, more positive self-image and less immature defense style.

In conclusion, high BDI-21 scores in the absence of depression may reflect a broad range of challenges in an adolescent's psychological development.

1. Introduction

Major depressive disorder (MDD) is one of the most common psychiatric disorders in adolescence with a cumulative prevalence of up to 20% (Avenevoli et al., 2015). It often leads to a decrease in cognitive and social functioning and increases the risk for suicidality. Furthermore, depressive symptoms that do not reach the diagnostic threshold of MDD (prevalence 5–29%) also cause significant impairment (Carrellas et al., 2017). Several screening and diagnostic tools for depression have therefore been developed (Brooks and Kutcher, 2001; Stockings et al., 2015). In clinical practice, self-reported depressive symptoms and clinical diagnostics occasionally diverge raising the question what could explain this discrepancy. To our knowledge, this

issue has not been studied in adolescents.

Research data on the risk factors for depression point to factors worth considering also in subthreshold depression. The three most important risk factors for depression in adolescents are female sex, a family history of depression and exposure to psychosocial stress (Thapar et al., 2012). The intergenerational transmission of depressive symptoms arises from a mix of hereditary and environmental factors (Mason et al., 2017; Weissman et al., 2006). Various psychosocial stress factors can induce depression in adolescents (St Clair et al., 2015; Rice et al., 2017), and susceptibility appears to be higher in females than males (St Clair et al., 2015). Depressive symptoms in adolescents are also associated with psychological factors, in particular negative self-image (Fine et al., 1993; Erkolahti et al., 2003) and immature styles

* Corresponding author.

E-mail addresses: emma.savilahti@hus.fi (E.M. Savilahti), henna.haravuori@hus.fi (H. Haravuori), minna.rytila-manninen@hus.fi (M. Ryttilä-Manninen), nina.lindberg@hus.fi (N. Lindberg), kirsi.kettunen@fimnet.fi (K. Kettunen), mauri.marttunen@hus.fi (M. Marttunen).

¹ Address: Adolescent Psychiatry, Helsinki University Hospital, PO BOX 660, 00029 HUS, Helsinki, Finland.

² Address: Kellokoski Hospital, Ohkolantie 20, 04500 Kellokoski, Finland.

³ Address: Psykiatriakeskus, P O Box 590, 00029 HUS, Helsinki.

(Chan, 1997; Muris et al., 2003; Ruuttu et al., 2006).

For identifying depressive symptoms, one of the most widely used structured self-reports is Beck Depression Inventory (BDI) – 21 (Beck et al., 1961). This 21-item depression scale has been validated for adolescents (Stockings et al., 2015). BDI-21 does not, however, directly screen the DSM depression criteria and stresses cognitive symptoms. For diagnostics in adolescents the gold standard is the semi-structured clinical interview called The Schedule for Affective Disorders and Schizophrenia for School-Age Children–Present and Lifetime version (K-SADS-PL) (Kaufman et al., 1997; Ambrosini, 2000). Studies that compare the results of BDI and clinical diagnostics usually aim at defining the psychometrics of BDI (Kumar et al., 2002; Osman et al., 2008; Dolle et al., 2012). Our aim, in contrast, is to investigate what psychological and background factors explain why the self-report and the diagnostic appraisal may diverge. We compare the BDI-21 scores and psychiatric diagnostics among both psychiatric inpatients and control subjects from general population. Our premise is to consider the clinicians' assessments as the gold standard for psychiatric diagnostics, while acknowledging that the diagnostics in adolescent psychiatry entails uncertainties (Lauth et al., 2010; Youngstrom et al., 2011). Drawing on research on the risk factors for depression, our hypothesis is that divergence between the absence of unipolar depression diagnosis and high BDI-21 scores is associated with immature defense styles and negative self-image.

2. Methods

2.1. Participants

2.1.1. Patients

The participants and clinical procedures have been described previously (Ryttilä-Manninen et al., 2014). The Kellokoski Hospital Adolescent Inpatient Follow-Up Study (KAIFUS) is a longitudinal, naturalistic study on clinical characteristics, psychometrics and the impact of treatment in adolescents (13–17 years old) who were hospitalized in adolescent psychiatry for the first time in their life between September 2006 and August 2010 ($n = 395$). All participants and their legal guardians received verbal and written information about the study and gave thereafter their written informed consent. The Ethics Committee of the Helsinki University Hospital approved the study protocol, and the institutional authority at the Hyvinkää Hospital Area granted permission to conduct the study. Study participation required sufficient knowledge of the Finnish language and adequate cognitive capacity, as well as a hospital treatment period of at least two weeks. Of 395 adolescent patients, 315 were eligible. In 62 (16.4%) cases, the adolescent or his/her parents/guardians did consent to participation. In 23 cases (6%), patients or their parents/guardians discontinued treatment, and 24 cases (6%) provided incomplete data. The final sample consisted of 206 adolescents: 60 (29.1%) boys and 146 (70.9%) girls. Study non-participation was not related to age ($p = 0.31$), socio-economic status (SES, $p = 0.38$), living situation ($p = 0.58$), or having a primary diagnosis of substance use ($p = 0.59$), mood ($p = 0.92$), anxiety ($p = 0.39$), eating ($p = 0.34$), or conduct disorders ($p = 0.09$). It was, however, associated with male gender ($p = 0.02$) and psychotic disorders ($p = 0.02$) (Ryttilä-Manninen et al., 2014).

2.1.2. Community sample

The comparison group was recruited from the same geographical area as the patient group. It consisted of a random sample of sex- and age-matched students from seven schools (two high/secondary schools, one vocational school and four middle/comprehensive schools). Of the 474 invited students, 43.0% ($n = 203$) completed the interview and the questionnaires, 42.5% ($n = 202$) refused to participate, and 14.5% ($n = 68$) did not complete the questionnaires despite providing consent. The final comparison group consisted of 203 adolescents. There were no significant differences between completers and non-completers in

regards to socioeconomic status ($p = 0.61$) or living situation ($p = 0.49$). For adolescents who completed the K-SADS-PL-interview, a treatment referral was endorsed when appropriate.

2.2. Diagnostics and psychometrics

2.2.1. Psychiatric diagnostics

Medical doctors who specialized in adolescent psychiatry evaluated the psychiatric diagnostics according to DSM-IV and based on clinical records, which were available for patients, and K-SADS-PL which was conducted by experienced psychiatric nurses trained in K-SADS-PL. The K-SADS-PL is a semi-structured diagnostic interview that has good to excellent test-retest reliability and high concurrent validity and inter-rater agreement for the original and translated versions (Kaufman et al., 1997; Ambrosini, 2000). The Finnish translation has been used in studies of adolescent inpatient and outpatient settings (Tuisku et al., 2006; Mustanoja et al., 2011). If a patient did not cooperate sufficiently for conducting K-SADS-PL reliably, psychiatric diagnostics was based on clinical interview, observation in the hospital and clinical records. Diagnostic meetings were held during data collection, and any discrepancies were settled by consensus between three experienced adolescent psychiatrists (H.H., N.L., K.K.).

2.2.2. Socio-demographic factors and adverse life events

Study subjects were interviewed on socio-demographic factors as well as adverse life events and stressors with a structured questionnaire composed for this study and as part of the K-SADS-interview as described in a previous publication (Ryttilä-Manninen et al., 2014). Their answers to questions on adverse life events and stressors were categorized as yes or no. In the K-SADS-PL interview, school bullying was screened in the school adaptation and social relationship section. In the post-traumatic stress disorder screening section of K-SADS-PL, domestic violence, exposure to physical and/or sexual abuse was inquired. In the structured background data questionnaire SES was assessed by asking "What is your father's occupation?", or if an adolescent lived with his/her mother (and stepfather), we recorded mother's occupation. SES was classified as high when the guardian (primarily the father) was a self-employed worker or upper-level employee, middle when the guardian was a lower-level employee or manual worker, and low if the guardian was retired, a student or unemployed. Subjects were also asked about parental divorce and whether he/she knew if his/her mother or father suffered from psychiatric or substance use problems requiring professional help. One question from the Life Events Checklist was used to record parents' criminality (Has your parent ever been arrested, suspected or judged for a legal offense?). In the patient group, clinical records additionally provided information on the family background as supplied by legal guardian(s)/parent(s).

2.2.3. Self-reports on psychiatric symptoms and psychological factors

Study participants, both patients and control subjects, filled in structured self-reports on psychiatric symptoms and psychological factors.

BDI-21 is a 21-item self-report scale of depressive symptoms that has been validated for adolescents (Stockings et al., 2015).

Alcohol Use Disorders Identification Test (AUDIT) is a self-report scale screening for alcohol misuse, and in the extended version used in this study, also enquires about other substance use. It has been shown to be applicable to adolescents (Knight et al., 2003).

Defense Style Questionnaire (DSQ) – 40 a reliable and valid self-report instrument for adolescents. In adolescents, it appears to discriminate better four defense styles (mature, neurotic, image-distorting, and immature) rather than three, which is alternatively used in adult populations (Ruuttu et al., 2006).

Offer Self-Image Questionnaire (OSIQ) is a self-report inventory containing descriptive statements with six-point Likert-type scale. The OSIQ has been widely used to assess the self-image of adolescents, and

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