The Center for Epidemiologic Studies-Depression (CES-D) scale measures a continuum from well-being to depression: Testing two key predictions of positive clinical psychology

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ABSTRACT

Background: Two core but untested predictions of Positive Clinical Psychology (PCP) are that (1) Many psychiatric problems can be understood as one end of bipolar continua with well-being, and (2) that reducing psychiatric symptoms will provide an equal (near linear) decrease in risk for several other psychiatric variables, irrespective of position on continua.

Aims: We test these predictions in relation to a purported well-being/depression continuum, as measured by the Center for Epidemiologic Studies-Depression (CES-D), a popular measure of depressive experiences in research and clinical practice.

Method: A large (N=4138), diverse sample completed the CES-D, which contains a mixture of negatively worded and positively worded items (e.g., “I felt sad,” “I enjoyed life”). The latter are conventionally reverse scored to compute a total score. We first examined whether purportedly separate well-being and depression CES-D factors can be reconceptualised as a bipolar well-being/depression continuum. We then characterised the (linear or nonlinear) form of the relationship between this continuum and other psychiatric variables.

Results: Both predictions were supported. When controlling for shared method bias amongst positively worded items, a single factor well-being/depression continuum underlies the CES-D. Baseline levels on this continuum are found to have near linear relationships with changes in anxiety symptoms, aggression, and substance misuse over time, demonstrating that moving from depression to well-being on the CES-D provides an equal decrease in risk for several other psychological problems irrespective of position on the continuum.

Limitations: The CES-D does not measure well-being as comprehensively as established scales of well-being.

Conclusions: Results support calls for mental health services to jointly focus on increasing well-being and reducing distress, and point to the value of early intervention and instilling resilience in order to prevent people moving away from high levels of well-being.

Well-being is becoming an increasingly central focus of international policy (e.g., Department of Health, 2009; Mental Health Commission of Canada, 2009). The positive psychology movement was proposed in order to raise awareness of the importance of researching psychological traits and constructs that promote well-being (Gable and Haidt, 2005; Seligman and Csikszentmihalyi, 2000). This literature has burgeoned and recent years have seen an increasing shift towards a broader position that jointly focuses on alleviating psychological problems and promoting well-being (e.g., Ivtzan et al., 2015; Joseph and Wood, 2010; McNulty and Fincham, 2012; Peterson, 2006; Wood and Tarrier, 2010), which some have labeled the “second wave” of positive psychology (Ivtzan et al., 2015; Wong, 2011).

One prominent component of this shifting zeitgeist has been the inception of Positive Clinical Psychology (PCP), which has called for positive psychology research to be integrated with the voluminous evidence base concerned with understanding and treating psychological problems (Wood and Tarrier, 2010, as clarified in Johnson and Wood, in press). Numerous articles (e.g., Johnson and Wood, in press; Lomas, 2015; Joseph and Wood, 2010; Wood and Tarrier, 2010; Wong, 2011) and at least three books (Ivtzan et al., 2015; Peterson, 2006; Wood and Johnson, 2016) have now summarized evidence which supports this integration. These demonstrate, for example, that: (i) constructs studied by positive psychology researchers can independently predict psychological problems over and above clinical con-
that depression forms a bipolar continuum with well-being, and the continuum (Wood & Johnson, in press; Wood and Tarrier, 2010) towards well-being will provide an equal decrease in risk that moving along the well-being/depression continuum (total score on adolescents.

This study explores this issue by testing two core predictions made by PCP using the example of depressive experiences. The first prediction to be tested here is the idea that many psychological problems in fact form continua with well-being. A well-being/psychological problem continuum would indicate that research on either area has implications for the opposite pole (Joseph and Wood, 2010; Wood and Tarrier, 2010) and would suggest that the language of “positive” and “negative” is arbitrary and dependent on one’s perspective and context (Johnson and Wood, in press; McNulty and Fincham, 2012; Wood and Johnson, 2016). This conceptualization would align with the substantial research base demonstrating that psychological problems are best-viewed as continuous constructs rather than discrete categories (e.g., see Bentall, 2003; Haslam et al., 2012; Markon et al., 2011) and which has examined continuously distributed transdiagnostic constructs and mechanisms (e.g., see Harvey et al., 2004).

We test this key prediction in relation to a hypothesized depression/well-being continuum using the Center for Epidemiologic Studies-Depression (CES-D) scale (Radloff, 1977). The CES-D is one of the most frequently used self-report measures of depressive experiences (Santor et al., 2006) and there is extensive support for its psychometric properties (Ensel, 1986; Radloff, 1977; Roberts, 1980; Shean and Baldwin, 2008). The fact that the CES-D contains a mixture of negatively worded items (e.g., “I felt sad;” “I thought my life had been a failure”) and positively worded items (e.g., “I felt happy;” “I enjoyed life”) led to the proposal that it could be re-conceptualized as a depression/well-being continuum (Joseph, 2006, 2007). It was argued that for a score of zero to occur on the CES-D, a person would have to give all of the negatively worded items (“e.g., “I felt sad”) the lowest possible score (“rarely of none of the time”) and all of the positively worded items (“e.g., “I enjoyed life”) the highest possible score (“most or all of the time”). For such a person it would be misleading to state that they have merely indicated an absence of depressive experiences; such an individual has also clearly indicated the presence of well-being (Joseph, 2006, 2007; Joseph and Wood, 2010).

One existing study has tested whether the CES-D can be re-conceptualized as a well-being/depression continuum (Wood et al., 2010). The authors found that when accounting for item wording using structural equation modeling, the CES-D can indeed be understood as measuring a bipolar continuum that ranges from well-being to depression. The authors established these findings using separate adult and older adult samples and presented evidence that the well-being items (e.g., “I felt happy;” “I enjoyed life”) demonstrate convergent validity with the well-validated Scales of Psychological Well-being (Ryff, 1989). Given the potential practical importance of the suggestion that depression forms a bipolar continuum with well-being, and the increasing emphasis on replicating scientific findings to ensure that they are robust and generalizable, our first aim was to replicate the structural analyses of this previous study using a large, diverse sample of adolescents.

The second prediction made by PCP that we test here is the idea that moving along the well-being/depression continuum (total score on the CES-D) towards well-being will provide an equal decrease in risk for several other psychological problems, irrespective of position on the continuum (Wood & Johnson, in press; Wood and Tarrier, 2010). We test this prediction by examining the form of the relationship between the depression/well-being continuum and other psychological problems over time, which Flett et al. (1997) referred to as “phenomenological continuity.” That is, continuity in the relationship between psychological problems and their antecedents, concomitants, or sequela. Accordingly, even if depression is relatively continuous in a psychometric sense, its relationship with associated variables could be relatively discontinuous or nonlinear in form, defining a natural boundary of depressive experiences (Markon, 2010).

The benefit of these analyses is that they make the clinical importance of this topic more apparent and explicit than merely examining whether a well-being/depression continuum exists. One possibility, for example, is that there is no relationship between the well-being/depression continuum and other psychological problems up to a particular point (e.g., throughout the range of the well-being pole), after which the detrimental consequences of depression begin to manifest. Evidence of this relationship would corroborate the current emphasis in mental health services on alleviating and treating psychological problems. This conceptualization of depression (and other mental health) problems underpins psychiatric nomenclature and, as a result, psychiatric and psychological interventions tend to be stopped at the point of problem absence.

An alternative possibility is a linear relationship between the well-being/depression continuum and other psychological problems throughout the range of the continuum. This relationship would be apparent if depressive experiences increase at a constant rate along with other psychological problems, without any threshold defining a change in association. Evidence of this relationship would simultaneously highlight the importance of treating depression (because as depressive experiences increase, so do other psychological problems) and emphasize the usefulness of fostering well-being (because as well-being increases, psychological problems decrease). Such evidence would be consistent with calls from professional bodies (e.g., The British Psychological Society, 2010) and the mental health recovery movement (e.g., Andresen et al., 2003) for mental health services to focus not just on tackling psychological problems but also on fostering well-being and helping people live a valued, meaningful life.

We examine these two key predictions of PCP using a large population-based archival dataset, which, by implication, involved variability in the latent entity, thereby minimizing the likelihood of systematic sampling bias, which could have been introduced had we used a purely community or clinical sample (Waller and Meehl, 1998). For example, using an undergraduate sample could introduce a systematic sampling bias since only those individuals functioning well enough to attend classes would be studied (Hankin et al., 2005). Likewise, focusing entirely on clinical individuals may limit variability in depressive experiences (Hankin et al., 2005) as clinical samples often exhibit more severe symptoms and greater comorbidities than population-based samples (Newman et al., 1998).

1. Method

1.1. Participants

The sample comprised 4138 adolescents and adults aged 13–21 years from Hawai‘i. These individuals took part in the five-year longitudinal Hawaiian High Schools Health Survey (HHSSH) study conducted by the National Center on Indigenous Hawaiian Behavioral Health (NCHHH). This sample provides a broad spread of ages, ethnicities, socioeconomic status,’ and gender (Andrade et al., 2006; Hishinuma et al., 2000). Participants for the HHSSH study were sampled from five high schools which were selected from both urban and rural areas to obtain a representative sample of adolescents residing in Hawaii. Students who provided assent completed the survey in their classrooms under the supervision of their teachers. Parents of students younger than 18 years old were notified of the study by mail and given an opportunity to refuse participation. Data collected during the 1992/1993 (N=4164), 1993/1994 (N=4182), and 1994/1995 (N=1433) school years were used in this study. There was some missing demographic information and incomplete questionnaire re-
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