



Development and validation of the 48-item Symptom Questionnaire (SQ-48) in patients with depressive, anxiety and somatoform disorders

Ingrid Carlier^{a,*}, Yvonne Schulte-Van Maaren^a, Klaas Wardenaar^b, Erik Giltay^a, Martijn Van Noorden^a, Peter Vergeer^c, Frans Zitman^a

^a Department of Psychiatry, Leiden University Medical Centre, Albinusdreef 2, 2300 RC Leiden, The Netherlands

^b Department of Psychiatry, University Medical Centre Groningen, Interdisciplinary Centre Psychopathology and Emotion Regulation, PO Box 30.001, Hospital Mail Address CC7, 9700 RB Groningen, The Netherlands

^c Dutch Forensic Institute, Laan van Ypenburg 6, 2497 GB Den Haag, The Netherlands

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ABSTRACT

Self-report measures of psychological distress or psychopathology are widely used and can be easily implemented as psychiatric screening tools. Positive psychological constructs such as vitality/optimism and work functioning have scarcely been incorporated. We aimed to develop and validate a psychological distress instrument, including measures of vitality and work functioning. A patient sample with suspected depressive, anxiety, and somatoform disorders ($N=242$) and a reference sample of the general population ($N=516$) filled in the 48-item Symptom Questionnaire (SQ-48) plus a battery of observer-rated and self-report scales (MINI Plus, MADR, BAS, INH, BSI), using a web-based ROM programme. The resulting SQ-48 is multidimensional and includes the following nine subscales: Depression (MOOD, six items), Anxiety (ANXI, six items), Somatization (SOMA, seven items), Agoraphobia (AGOR, four items), Aggression (AGGR, four items), Cognitive problems (COGN, five items), Social Phobia (SOPH, five items), Work functioning (WORK, five items), and Vitality (VITA, six items). The results showed good internal consistency as well as good convergent and divergent validity. The SQ-48 is meant to be available in the public domain for Routine Outcome Monitoring (ROM) and can be used as a screening/ monitoring tool in clinical settings (psychiatric and non-psychiatric), as a benchmark tool, or for research purposes.

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1. Introduction

The measurement of self-reported psychological distress is prominently represented in both the psychological and psychiatric literature. Historically, assessment of the general psychological status of individuals by means of self-report dates back to the First World War, and the development of the so called Personal Data Sheet by Woodworth (1918). Woodworth's scale provided a means for each man to "interview himself" and created a historical benchmark for a new modality of psychological measurement (Derogatis and Melisaratos, 1983). Nowadays, self-report measures of psychological distress or psychopathology are widely used as psychiatric screening tool in clinical settings and epidemiological studies.

Many validated self-report questionnaires for measuring psychological distress or psychopathology have been developed (see

Dohrenwend et al., 1980; Ritsner and Ponizovsky, 1998; Ritsner et al., 2002; Luckett et al., 2010). For instance, Symptom Checklist-90 (SCL-90; Derogatis et al., 1973) and its short-form Brief Symptom Inventory (BSI, BSI-18; Derogatis and Melisaratos, 1983; Derogatis, 2001); General Health Questionnaire (GHQ; Fichter et al., 1988); 50-Item Brief Symptom Rating Scale (BSRS-50; Lee et al., 1990); Talbier Brief Distress Inventory (TBDI; Ritsner et al., 1995); Mood and Anxiety Symptoms Questionnaire (MASQ; Watson et al., 1995a,b) and its short-form MASQ-D30 (Wardenaar et al., 2010).

Studies concerning the above-mentioned instruments often used multiple related concepts interchangeably: concepts such as psychological distress, emotional distress, affective distress, mental distress, global distress, symptom distress, psychiatric distress, general psychopathology. Notably, however, these instruments have been useful for assessing the aggregate level of nonspecific psychological distress, and not for diagnosing particular psychiatric disorders (Dohrenwend et al., 1980; Coyne, 1994; Ritsner and Ponizovsky, 1998). Elevated scores on the scales are an indicator of possible psychopathology and could assist the clinician to predict the probability of individuals meeting criteria for disorder

* Correspondence to: Department of Psychiatry, Leiden University Medical Centre, Albinusdreef 2, Postzone B1-P, 2300 RC Leiden, The Netherlands. Tel.: +31 71 5265237; fax: +31 71 5248156.

E-mail address: I.V.E.Carlier@lumc.nl (I. Carlier).

(Dohrenwend et al., 1980; Boulet and Boss, 1991; Oakley Browne et al., 2010).

More specifically, “psychological distress” can be described as a reaction of an individual to external and internal stresses, characterized by a mixture of psychological symptoms, such as sadness, anxiety, confused thinking, hopelessness, helplessness, dread, and poor self-esteem (Ritsner et al., 2002). In addition, some instruments, such as the BSI, include somatic distress. Psychological distress was originally considered as a uni-dimensional construct. However, more recent research suggested a multidimensional structure of psychological distress. For instance, Schwannauer and Chetwynd (2007) found a three-factor model of depression, anxiety, and general psychological distress.

The assessment of psychological distress is important both in health care and mental health care, because of its relevance for compliance, quality of life, prediction of treatment outcome and planning of treatment (Kalman, 1993; Buchanan, 1996; Awad et al., 1996; Ritsner et al., 2002). Research has shown that pervasive distress may affect the course of illness, symptom expression, as well as levels of social relationships and adaptation (Feldman et al., 1995; Laatsch and Shahani, 1996; Barker and Orrell, 1999; Ritsner et al., 2002).

More recently, there is a growing awareness that, in addition to distress-based measures, attention must also be paid to more positive constructs such as vitality/optimism (van Fenema et al., 2012; Giltay et al., 2004) and work functioning (Burdick et al., 2010; Verboom et al., 2011). The importance of both constructs has already been demonstrated. For instance, Burdick et al. (2010) showed that poor work functioning was significantly related to subsyndromal depression and course of illness. Emotional vitality, on the other hand, seems to be a critical positive psychological factor (related to but separate from optimism) that may promote psychological health as well as physical health (Wyshak, 2003; Giltay et al., 2004; Rozansky and Kubzansky, 2005; Kubzansky and Thurston, 2007). In addition (lack of) vitality/optimism has been shown to be an important defining feature of depression, with distinct implications for prognosis (Giltay et al., 2006).

To date, there is no psychological distress instrument available that also measures vitality and work functioning. Another shortcoming is that most self-report instruments are usually not free of charge, which particularly in Routine Outcome Monitoring (ROM) with repeated assessment is a costly matter. In line with these shortcomings, the purpose of this study was to develop and validate a brief psychological distress instrument (SQ-48), which also includes measures of vitality and work functioning (or study). In addition, the SQ-48 is developed as a public domain questionnaire, freely available to clinicians and researchers. This practical advantage is in line with growing efforts in other scientific areas to develop instruments that are free of charge (Moessner et al., 2010).

The SQ-48 is meant as a screening tool to improve diagnostic recognition in clinical and nonclinical settings. Therefore, the present study used both clinical and nonclinical samples: a patient sample with suspected depressive, anxiety, and somatoform disorders, and a reference sample of the general population. In this way, the SQ-48 could be useful as a monitoring tool in the context of ROM (Luckett et al., 2010; Moessner et al., 2010; Carlier et al., 2012), for benchmark purposes (Hermann et al., 2006; Minami et al., 2008; Cleary et al., 2010), or as a research tool in for instance epidemiological studies.

2. Methods

The present study was conducted with patients and non-patients, and consisted of two phases: (1) instrument development of the SQ-48 and (2) its psychometric evaluation.

2.1. Participants and procedures

The total sample among which the SQ-48 was developed and evaluated consisted of participants from two large studies: a Routine Outcome Monitoring (ROM) sample of psychiatric outpatients and a ROM reference sample of the general population.

The Medical Research Ethics Committee at the Leiden University Medical Centre (LUMC) approved the general study protocol and documents presented to participants in both phases. A comprehensive protocol safeguards anonymity of ROM-participants and ensures proper handling of the data. This protocol (Psychiatric Academic Registration Leiden database) is available on request for participants, and informed consent is not required for patients. Non-patients provided written and informed consent.

For details about the web-based ROM programme of the LUMC, Department of Psychiatry, we refer to some relevant publications (de Beurs et al., 2010; van Fenema et al., 2012; van Noorden et al., 2010; Carlier et al., 2012; see also <www.lumc.nl/psychiatry/ROM-instruments>).

2.1.1. The ROM patient-group

A total of 242 psychiatric outpatients was included (61.2% females; mean age=38.8 years; S.D.=14.0), referred with suspected (not necessarily diagnosed) mood, anxiety or somatoform disorders to the LUMC Department of Psychiatry or to Rivierduinen specialized mental healthcare centres. Data were collected during a 2–3 h ROM baseline assessment in the LUMC or at the home of the participant. The assessment consisted of a face-to-face psychiatric interview by a trained psychiatric research nurse and the administration of observer-rated and self-report questionnaires, including the SQ-48.

2.1.2. The ROM reference-group

A total of 516 participants (67.2% females; mean age=38.8 years; S.D.=12.8) was included in the reference-group, as part of the ‘Leiden Routine Outcome Monitoring Study’ (Schulte-van Maanen et al., 2012; van Noorden et al., 2010). These participants were randomly selected from the registration systems of general practitioners (GPs) in the Leiden region, in order to recruit a representative general population sample (all Dutchmen are registered with a GP). Because the group was aimed to be used as a healthy reference-group, participants that received treatment for psychiatric problems and/or dependence on alcohol or drugs within six months prior to the assessment were excluded. The inclusion for the ROM reference-group was stratified for gender (62.6% women), age (mean 40.2 years; S.D. 12.5) and urbanization-level (62.3% urban), to make the group demographically comparable to the ROM patient-group. The participants in the reference-group completed the same assessments as the patient-group.

2.2. Instruments

2.2.1. Development of the SQ-48

The SQ-48 was developed to include separate subscales concerning several psychopathological domains matching diagnostic categories in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000). Three main goals were set to achieve during the SQ-48 item-writing and item-selection procedure. First, the items should be easy and unequivocal to be understandable for everyone, irrespective of the level-of-education. Second, the instrument should include measures of functioning which can judge the actual impact of psychiatric problems in daily life. Third, the instrument should cover (lack of) vitality/optimism.

The initial item development followed commonly accepted methods for the creation of patient-reported instruments (Lee et al., 2003; Mohr et al., 2005; Ando et al., 2006; Morlock et al., 2008; Johnson et al., 2009; Diamond et al., 2010). The questionnaire was drafted by a multidisciplinary team of psychologists and psychiatrists through a comprehensive review of existing screening tools, relevant literature, as well as psychiatric diagnostic criteria for mood, anxiety, and somatoform disorders on the basis of the DSM-IV.

Existing screening tools reviewed in this context were for instance: MASQ (-D30); Dimensional Assessment of Personality Pathology-Short Form (van Kampen et al., 2008); BSI; Short-Form 36 (Razavi and Gandek, 1998); Outcome Questionnaire 45 (Lambert et al., 1996); Fear Questionnaire (van Zuuren, 1988); Aggression Questionnaire (Buss and Perry, 1992); Mental Vitality Scale (Richman et al., 2009); Work Home and Leisure Activities Scale (Mundt et al., 2002); MIRECC Version of the Global Assessment of Functioning Scale (Niv et al., 2007); Physical Symptom Checklist (de Waal et al., 2009); Life Orientation Test-revised concerning optimism (Scheier et al., 1994).

The SQ-48 development was based on consensus within the aforementioned multidisciplinary team. It was decided to create a questionnaire covering nine domains or categories: depression, anxiety, somatization, cognitive problems, social phobia, agoraphobia, aggression, work (or study) functioning, and vitality/optimism. Except work functioning and vitality, these general domains cover the most common psychopathological symptoms. So, items were arranged in subscales according to this organization and chosen from a large pool of items. Each

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