THE UNIVERSITY OF CALGARY

THE USE OF MEASUREMENT INSTRUMENTS IN ASSESSING DEPRESSION : A SOCIAL WORK PERSPECTIVE

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ABSTRACT

In spite of the prevalence and long history of depression, consensus and clarity as to its etiology, definition and classification have never been attained.

So far, the assessment of depression has relied- in the main- on the discernment and evaluation of related signs and symptoms. To date, numerous measurement instruments have been designed to assist the clinician in this task.

By investigating the present practice of assessing depression among a sample of clinical social workers in Calgary, this project aims at discovering the current utilization of measurement instruments the measures used, the perceived effectiveness of the methods used and the level of interest in learning to use and using measurement instruments among those who have not used standardized measures.

The analysis of data- illuminated by an overview of the historical development and basic characteristics and requirements of depression measurement instruments- shows, among other things, that the majority of respondents never use measurement instruments in assessing depression. They are generally satisfied with their current methods which they consider to be quite effective. However, their interest in learning and using these instruments remains high. Even among those who use these tools, the range of mastery over the popular instruments appears to be limited if not fragmentary.

Accordingly, recommendations have been formulated with a view to promote the appropriate and necessary use of measurement instruments in clinical social work practice.

THE USE OF MEASUREMENT INSTRUMENTS

IN

ASSESSING DEPRESSION : A SOCIAL WORK PERSPECTIVE

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I. INTRODUCTION

I. Depression as a widespread problem

Depression, as human distress, has been recognized at least 3,000 years ago (Erickson, 1975). Literary description of this condition can be traced back to Homer and the Book of Job (Mendels & Stern, 1980). Melancholia-as it was called and described by Hippocrates-was due, according to the father of Medicine, to the presence of balck bile and phlegm in the brain.

Since that time, efforts to differentiate it from related affective disorders (mania, bipolar affective disorder, anxiety state...) and to classify it according to various proposed distinctions (endogenous vs reactive, primary vs secondary, bipolar vs unipolar...) have never diminished. This may be due to the pervasiveness of this human condition as well as its varied manifestations.

Accoding to the American Institute of Mental Health, 15% of adults between the ages of 18 and 74 may suffer, in any given year, from serious depressive symptoms (Brodie & Kolb, 1982). A number of other authors (such as Brown, Holzer, Schwab and Sokolof, 1963 ; Lee and Lewinsohn, 1981...) estimate the percentage of adult population suffering from depression sufficiently to warrant clinical treatment to vary from 4% to 25%. In Canada, according to Erickson (1975) the actual incidence of depressive disorders requiring hospitalization in 1970 was 40% of all psychiatric patients. In addition, the incidence of depressive disorders in the males and females was respectively 26.7% and 55.4% in the same year.

Boyd and Weissman (I982) report that estimates of the point of prevalence of depressive symptoms range between I3 and 20 per cent of the population and that risk factors associated with these symptoms are young and female, old and male, lower economic class and being divorced or separated. They also point out that the point prevalence of non-bipolar depression in industrialised nations is found to be 3.2 per cent of the adult female population. The incidence figures are : 82 to 20I cases per I00,000 females per year. Risk factors for this condition include : being female, particularly in the age 35 to 45 years; having a family history of depression or alcoholism; having childhood experiences in a disruptive, hostile and generally negative environment ; having had recent negative life events, particularly exits ; lacking an intimate confiding relationship ; having a baby in the preceding six months. The morbidity risk of bipolar disorder for both females and males is found to range from 0.6% to 0.88% in industrialised nations. The incidence of bipolar disorder for men is 9 to I5.2 new cases per I00 000 per year and for woment, 7.4 to 32 new cases per I00 000 per year. Risk factors are : being female; and, having a family history of bipolar disorder. People under the age of 50 are at higher risk of a first attack and, as the sufferer grows older, he or she will face an increasing risk of reccurrent manic or depressive episode. Bipolar disorder seems to be associated with upper socioeconomic class.

In spite of the prevalence and long history of depression, there is little clarity or consensus on its definition or etiology. As Lewinsohn (I974) has pointed out " It is sometimes used to refer to a normal mood state, an abnormal mood state, a symptom, a symptom syndrome as well as a disease process and possibly to a series of disease

processes."

In the absence of a commonly accepted definition and conceptualization of this state. One may have to look at the signs and symptoms of depression as well as other related as pects of the construct in order to have a better picture of it.

The signs and symptoms of depression can be divided into four groups : affective, cognitive, somatic, and behavioral . The following table summarizes the main components of these four groups.

Table I.I

Signs and symptoms of depression

Affective	Cognitive	Somatic	Behavioral
Sadness	Impaired concentration	Sleep disturbance	Suicidal behavior
Apathy	Indecisiveness	Loss of appetite & weight	Thoughts
Anhedonia	Self-blame	Constipation	Threats
Anxiety	Low self-esteem	Decreased energy	Attempts
Guilt	Hopelessness	Loss of libido	Other behavioral aspects
		Menstrual changes	Neglect of personal appearance
		Aches and pains	Social withdrawal
			Psychomotor retardation
			Agitation

Source : Mendels and Stern Affective Disorders. In A.E.Kazdin, A.S.Bellack and M.Hersen (Eds) New Perpectives in Abnormal Psychplogy. New York/ Oxford : Oxford University Press. I980.

The classification of different types of depression is far from unitary and consensus is still lacking as evidenced in different diagnostic systems (DSM III, Research Diagnostic Criteria, International Classification of Diseases...)

In view of the breadth and depth of depression phenomena as well as its elusive nature, it is not surprising to find a wealth of literature touching on different aspects of this intriguing human distress.

A cursory perusal of the " Social Work Research and Abstracts" journal since 1965 to date reveals nearly 100 articles related to depression included because of their relevance to social work and especially to clinical practice.

Among the articles cited, however, less than ten had been published in social work journals (Social Casework, Social Service Review, Child Welfare...). Others had been published in journals of other disciplines such as psychiatry and abnormal psychology .Does this means that depression is less relevant, less frequently encountered in social work practice ? This is far from the case. In daily practice (whether it be hospital, mental health clinic or institution) the clinical social worker frequently observes depression in clients in its various forms. Consequently, the ability to detect early depressive symptoms and/or depressive syndrome would be beneficial to both client and worker.

In order to do so, the clinical social worker would have to be conversant with basic categories and distinctions of affective disorders and with the popular tools for assessing them.

2. Assessment of depression and use of instruments

There are two clinical activities that the clinical social worker should distinguish : Assessment and diagnosis.

Assessment, according to Klerman (1982), is the collection of information relevant to the client's clinical condition and useful for other clinical activities (diagnosis, management and treatment).

Diagnosis is a clinical process by which a specific nosologic class or disorder is assigned to a given client using information gathered during assesment.

History taking, signs and symptoms review, current social situation assessment, suicidal potential evaluation, physical check- up ... are major parts of an overall assessment task. These components are specified in Table I.2 below.

Table I.2

Assesment of Client with Affective Disorder

I. History :

A. Family : psychiatric ilness, drug use, response to medication, suicide.

B. Social history : family background; education, occupation.

C. Previous psychiatric history : hospitalization, suicidal ideation mood changes, response to ECT, medication.

II. Current psychopathology: preferably along the lines of some standarized fromat (inventory, scale...)

III. Assessment of current social situation : stresses, social support, social performance

IV. Physical examination : for differential diagnosis and for ascertainment of conditions that may contraindicate or influence treatment.

V. Laboratory test *: Liver battery, EEG.

VI. Interview with significant other(s) : usually spouse and/or other family menber(s).

(over please)

VII. Information from hospital records, social agencies, employment.

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* When necessary

Source : Adapted from Practical issues in the treatment of depression and mania by G.L Klerman in E.S.Paykel (Ed) Handbook of Affective Disorders .New York : the Guilford Press, I982.

A broader knowledge of affective disorders would certainly provide a wider perspective for the interview.Between depressive state (which may not necessarily reflect an abnormal clinical state) and clinical depression, there exists a wide range of signs and symptoms , and the clustering patterns and boundaries are still a matter of controversy.A familiarity with these clusters of signs and symptoms is a sine qua non for the clinical social worker in carrying out the assessment task.

From an epidemiological point of view, one can differentiate three main categories of affective disorders- depressive state, non-bipolar depression and bipolar disorder.In depressive state, signs and symptoms listed in Table I.I are in a nascent state, emerging with affective manifestations.Feeling of sadness and disappointment are part of everyday life.The boundary between normal mood and abnormal symptoms has never been clearly defined.

Non-bipolar depression has been referred to as neurotic depression, endogenous depression, involutional depression, psychotic depression unipolar depression, the depressed type of manic depressive illness, and depression not otherwise specified.(Boyd & Weissman, I982).In non-polar depression, signs and symptoms take on more serious nuances.Depressed mood, loss of interest, anxiety, feelings of guilt, suicidal thought,

difficulty in falling asleep...become intense, pervasive, persistent and interfere with the individual functioning .

Bipolar disorder invloves both depression and mania, although persons with mania only would also be included. The criterion for bipolar disorder is relatively clear : evidence of present or past manic episode. There is evidence that a small percentage of persons with bipolar disorder experience experience only manic episode.

Lee and Lewinsohn (I98I) proposed three different goals for clinical assessment of depression, namely :

a. Differential diagnosis : is the process by which a clinical depression condition is confirmed. Diagnostic assessment* must include the evaluation of the severity and duration of the presenting symptoms in order to differentiate between different subtypes of depression and establish a baseline for evaluating treatment progress and outcome.

b. Functional diagnosis : Assessment should also identify events and behavior patterns which are functionally related to the clent's depression. Such information will also be useful in the formulation of the treatment plan.

c. Evaluation : Evaluation involves periodic assessment of changes in depression level and concomitant changes in other factors in the functional relationship .

Generally speaking, the number and variety of instruments designed to assist the assessment of depression are quite numerous. Included are scales, inventories, checklists and questionnaires. Generally, they can be subsumed under two main categories : Those based on the client's statements; and Those based on the judgment of the interviewer or the observer.

*Lee and Lewinsohn do not follow the distinction between assessment and diagnosis described above

The clinical social worker would not make use of all these assessing devices. This may be due to the work setting or other limiting factors such as the client's literacy or availability of a skilled observer. For example, in a hospital or mental health setting, the clinical social worker does not operate alone but rather as a menber of a professional team. In this context, the social worker's responsibility is for initial assessment rather than final diagnosis. Even in private practice, the social worker seldom operates without consultation with other professionals. Concerning limitations on the part of the client, one can readily see that many of these devices can not be used when dealing with illiterate clients. With semi-literate clients difficulties in understanding of words used in these instruments or in making accurate judgments ... are common.

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By investigating the current practice of assessing depression among a sample of clinical social worker in Calgary, this project aims at discovering the current utilization of measurement instruments, the measures used, the perceived effectiveness of the methods used and the level of interest in learning to use and using measurement instruments among those who have not used standardized measures.

Before presenting the results of the study and the recommendations derived from the findings, an overview of the issue of quantifying the symptomatology of depression will provide the reader with a broader perpective on the various aspects of the problem under study.

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II. The Use of Measurement Instruments in Assessing Depression : Overall Aspects and Results of the Study

I/The problem of quantifying the symptomatology of depression

a/A historical overview :

According to Pichot (I972), the first pioneering work on quantifying the symptomatology of depression was carried out by Moore(I930) who, through factorial analysis, was able to distinguish, in I930, two groups of symptoms related to 'retarded depression' and 'agitated depression' respectively. In the same year, Jasper published his 'depression-elation' questionnaire. The Minnesota Multiphasic Personality Inventory (M.M.P.I) which became available in I943, included a depression scale consisting of items selected to differentiate the normal subjects from those suffering from depression.

However, the above instruments are either purely theoretical (Moore's study), unspecific (The M.M.P.I's depresion scale) or drawn up for investigating normal subjects. More practical instruments are needed.

Since the fifties, with the advent of psychotropic drugs and the increasing recognition of the need for more precise description and measurement of the client's clinical state, more instruments have been developed to evaluate and analyze the sympmatology of the mentally ill in general and of depression in particular, with emphasis on standardization of procedures and replication.

At first, the instruments developed were of a very general type, providing an overall picture of various aspects of the client's behavior. The Psychiatric Rating Scale introduced by Wittenborn in I95I , The Multidimensional Scale for Rating Psychiatric Patients (M.S.R.P.P) The Multidimensional Scale for Rating Psychiatric Patients (M.S.R.P.P), revised and called the In-Patient Multidimensional Psychiatric Scale,

developed by Lorr and his associates, as well as the A.P.M* put to use in Europe at about the same time, belong to this general category.

Later instruments were designed more specifically for the measurement of depressive symptomatology. The first of this type was the Lehmann Scale, introduced in I958. It was criticized for containing an insufficient number of items and scale points to permit the study of specific changes in the client's condition (Wechsler, et al. I963). In I960, Hamilton published his Rating Scale for Depression comprising of I7 items. It is still 'a documentary aid most widely used today in trials of antidepressant drugs' (Pichot, I972). In I96I, Grinker, et al. submitted the symtomatology of depression to statistical analysis and produced the Feelings and Concerns Checklist comprising of III items, and a Current Behavior Checklist of I39 items. Since then, a number of other rating scales have been published such as the Quantification of Depressive Reaction by Cutler & Kurland in I96I, the Depression Rating Scale by Wechsler, et al. in I963, the Montgomery and Asberg Depression Scale (I979).

Depressive syndromes, according to Pichot (I974) are the object of considerable research directed toward both practical and theoretical objectives.

The principal practical purpose is to study the effects of antidepressant drugs. The theoretical research focuses on the analysis of the components of depressive syndromes and the classification of clients into homogeneous subtypes. These syndromes can be evaluated, in most cases, either by an observer using observer rating scales such as those just mentioned above or by the client himself or herself using self-assessment instruments such as those described below.

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* A.P.M stands for Arbeitsgemeinschaft fur Methodik und Documentation in der Psychiatrie.

Since the sixties, self-assessment instruments such as inventories, questionnaires, scales... have become more and more numerous. these instruments are usually designed for a variety of specific purposes such as the detection of change in the client's subjective feelings or depressed mood.

The Depression Inventory developed by Beck in I96I is among the first of this class of instrumeits. It is consisted of 2I items, each having four grades. The Self-Rating Depression Scale (SDS) introduced by Zung in I965 is shorter (20 statements) and more widely used (Hamilton, I982). More recently, the Wakefield Scales (Snaith, et al. I97I) consisting of I2 items, each having four grades and the kindred Leeds Scales (Bridge, Hamilton and Snaith, I976) have been developed to overcome some weaknesses of the Zung Self-Rating Depression Scale and to measure both anxiety and depression.

In addition, there are two adjective checklists currently in use. One is the Depressive Adjective Checklist (DACL) developed by Lubin in I967 and the other is the English version of Von Zerssen's Scale (Von Zerssesn, et al. I97I).

The visual analogue scales in which the client is asked to rate his or her mood on a line representing a continuum from 'best mood' to worst mood' are also useful though fairly crude instruments. They have been found to correlate well with other measurement instruments such as the Hamilton Rating Scale, the Beck Depression Inventory and other global psychiatric ratings (Lee & Lewinsohn, I982).

In social work, the measurement instruments designed specifically for assessing depression appear to be underdeveloped, at least until the introduction of the Hudson's measurement package for clinical social worker in I977. The Heimler Scale of Human Social Functioning (I967)

and the Profile of Moods States (Mc Nair, Lorr and Doppleman, I97I) which have been mentioned from time to time in the profession's literature, are more comprehensive measures covering a wide spectrum of affective states than specific instruments focussing on depressive symptomatology.

The above brief historical overview is admittedly incomplete. It is regrettable that -unlike the case of mental tests- there is no annotated compilation of measurement for depression similar to the series of Mental Measurement Yearbook edited by Buros.

b/Basic characteristics and requirements of depression measurement instruments

The depression measurement instruments, as presented above, differ fundamentally from the personality and other mental tests in that they focus on the ' superficial' symptomatology rather than on the ' structural characteristics of the personality '(Pichot, I974). Although they are not designed for diagnostic purposes, they must be sensitive enough to register not only the present clinical status but also its variations. And, this sensitivety must be greater than the ordinary clinical observations.

In addition, to be useful, these instruments should fulfill the following basic requirements :

Content: The instrument should contain items reflecting major aspects of depression.

Validity : The instrument should be able to differentiate not only between the depressed and non-depressed clients but also different degrees of severity among the depressed group.

Sensitivity: This concept refers to another form of validity which shows the instrument's ability to reflect changes in the intensity of symptoms through the changing scores.

Reliability The instrument must show consistency and stability through repeated uses.

Simplicity :The instrument should not require inordinate time and effort or special training (in case of observer rating scales) to administer.

In principle, those instruments based on the judgment of an interviewer are considered superior to those based on the client's statements because the former cover not only all the symptoms figuring in the client's questionnaire but also those which the latter is incapable of registering. However, this superiority depends largely on how well trained and objective the interviewer may be. In case such qualified observers are not available, the self-assessment instrument is preferable. In practice, the most satisfactory solution seems to be the combination of both types of instruments.

The standardized character of the measurement instrument will bring about such advantages as the enhancement of completeness in information-taking, the decrease in the variability of the information available about clients, the facilitation of later information analysis ...(Hamilton, I972).

The actual use of both types of instrument seems to depend on a number of factors such as : length, the level of training required as in case of observer rating instruments, the client's ability, literacy and cooperation. For instance, in case of self-assessment scale, the client may be too ill to answer properly or he or she may have difficulty interpreting such adjectives as very, mild, frequent. In addition, the client may not be able to complete items such as loss of insight (Hamilton, I982).

In social work, the use of measurement instrumens in practice

appears to be a neglected area. Recently, for clinicians to apply single system designs to their practice, which involves the use of more precise measurement of practice, the probability of the use of these instruments by social workers seems less remote. There has been no effort discovered by the writer to document developments in this area.

The present study has been undertaken to shed some light on the use of measurement instruments in a particular area : assessment of depression. The study also has two limitations : one geographical and the other, professional. Stated more specifically, the study is limited to a number of selected clinical social workers presently operating in a number of settings in Calgary, who chose to respond to a questionnaire.

2/Report on the Study

a/ The Study

The main focus of the study- as stated earlier- was to discover, through the investigation of the current practices of assessing depression among the respondents, the current state-of-affairs concerning the use or non-use of measurement instruments as well as such related aspects as the effectiveness of the methods used, the level of interest in learning and using measurement instruments, ...

Eight agencies were chosen (see Appendix I). Three of them were social services departments of general hospitals; one was a mental health agency, and four were family service agencies.

The subjects selected were those clinical social workers presently employed by the above agencies who met the following criteria:

--holder of at least a bachelor's degree in social work

-a front line worker, dealing directly with the agency's clientele in daily practice.

A questionnaire (see Appendix 2) was designed to explore the

relevant aspects of the current practice of assessing depression, contrasting users and non-users of measurement instruments.

The dimensions explored with each of these two groups of respondents encompass the following :

Non-user :

-Current method(s) of assessing depression;

-Dimensions of depression and their order of importance within the scope of the method(s) used;

-Chosen purposes and their importance when assessing depression;

-Effectiveness of the respondent's method(s);

-Respondent's satisfaction and dissatisfaction with the method(s) used;

-Reasons for non-use of measurement instruments;

-Level of interest in learning and using measurement instruments.

User :

-Measurement instruments currently used, known but not used, and those considered most suitable for social work practice;

-Effectiveness of the method(s) used

-How respondents gained familiarity with the instruments known;

-Instruments' features most desirable for social work practice;

-Training needs for use of those instruments familiar to respondent.

-Estimates of the proportions of adult clients suffering from depresion and of those with whom measurement instruments are used.

-With regard to the dimensions assessed and the purposes of such assessments the questions were identical to those asked of the non-user group.

In addition, information was obtained from all respondents.

concerning the presenting problem areas most frequently encountered, the respondent seniority in social work, professional credential(s) and opinion on the possible impact of the use of measurement instruments on the credibility and accountability of social workers.

The questionnaire consisted of 2I items, encompassing all the dimensions mentioned above. During the first week of February, all the questionnaires were distributed after an introductory letter (see Appendix 3) had been sent to the directors of the sampled agencies. A reminder was also sent out three weeks after the distribution to boost the response rate. By March 9, the last day for the returned questionnaires to be included in the analysis, the response rate was 50.46 %.

The results-as analyzed and presented below-reveal a fairly clear picture of the current practices of assessing depression and of the extent of knowledge and use of measurement instruments on the part of the user group. Generally speaking, users are a small minority, but the level of interest among non-users in learning and using measurement instruments seems justify better access to training in their use.

b/<u>The Results</u> :

The respondents were divided into two groups : users and non-users. Their answers were analyzed separately. In order to facilitate the analysis and presentation of data, the questionnaire items have been regrouped into 4 tables namely, Responses to non-unique items, Assessment dimensions and purposes : Comparison of responses of users and non-users, Responses of non-users to unique items, and Responses of users to unique items.

Table 2.I shows the responses to items which are not unique to either the user or non-user group. As can be seen from the table, 9I percent of the respondents are non-users and the users account for only 9 percent of all the respondents.

The use of measurement instruments would, in the opinion of 4I percent of the respondents, enhance the credibility and accountability of social workers. Those who oppose the idea account for 26 percent as compared to 22 percent of the respondents who are not sure about their stand.

Concerning the year of the respondent's first social work position, the data obtained can be spread through nearly 30 years with two dense clusters around the (year) bracket 7I-80 (59%) and 6I-70 (22%). There is one who started his or her position in I957 (with a Master degree), and at the other end of the time continuum are 7 (I3%) newcomers. These general trends still hold with each group (users or non-users).

There are 37 respondents with a bachelor degree of social work 38 (70%) with a master degree of social work and 22 (or4I% of the total respondents) having both degrees. In other words, there are I5 respondents possessing a bachelor degree of social work only and I6 with master degree only. One respondent did not answer to this inquiry.

With regard to the clientele's presenting problems most frequently encountered in practice, the respondents seem to face more family, children problems and sexual abuse (48%) or other problems(52%) (such as psychosis, adjustment reactions, interpersonal relationship problems...) than affective disorders (39%). This state of affairs probably help explain the complacency of the majority of respondents about their present method(s) of assessing depression since the latter in particular and affective disorders in general were not as frequently encountered as originally surmised.

A perusal of table 2.2 would reveal both similarities and differences in responses of the user and non-user group concerning the dimensions of depression assessed and the assessment purposes. For example,

TABLE 2. I

Responses to Non- unique Items

(N = 54)

Questionnaire Items	Users (% if applicable)	Non- Users (% if applicable)	All respondents (% if applicable)
I. Use or Non-use of measurement Instruments	5 (9)	49 (9I)	54 (I00)
I8. Enhancement of social workers' credibility & accountability through the use of measurement instruments			
Yes	3	I9	22 (4I)
No	I	I3	I4 (26)
Not sure	I	II	I2 (22)
I9. Year of first social work position			
57 - 60		I	I
6I - 70	I	II	I2 (22)
7I - 80	4	28	32 (59)
8I - 84		7	7 (I3)
No answer			I
2I. Social work degree(s) and year(s) obtained	BSW / MSW	BSW / MSW	BSW / MSW
59 - 70	I	I / 4	2 / 4

TABLE 2.I (cont'd)

	BSW	MSW	BSW	MSW	BSW	MSW
7I - 80	3	I	26	24	29	25
8I - 84		3	6	6	6	9
20. Clientele's presenting problem areas						
Affective disorders			2I		2I (39)	
Family (marital, parent-child...) children problems, sexual abuse		3	23		26 (48)	
Others			28		28 (52)	
Not applicable *		2	4		6 (II)	

* These respondents listed their own problems at work instead of those of the clientele.

TABLE 2.2

Assessment dimensions & purposes : comparative analysis of responses of users and non-users

Questionnaire Items	Users (N = 5)				Non - Users (N = 49)			
	N° of respondents (% if applicable)	Ranking			N° of respondents (% if applicable)	Ranking		
3(or I6).Dimensions assessed		I st	2nd	3rd		I st	2nd	3rd
-Severity	5	3	2		48 (98)	34 (69)	I4 (29)	I
-Changes in symptomatology	4	2	I	I	46 (94)	6 (I2)	7 (I4)	25 (5I)
-Types	5		2	3	39 (80)	I4 (29)	22 (45)	I0 (20)
4(or I7) Assessment purposes								
-To make treatment plan and other decisions	5 (I00)	5			49 (I00)	40 (82)	7 (I4)	I (2)
-To make referral decisions	3		I	2	44 (90)	8 (I6)	I5 (3I)	20 (4I)
-To measure client changes & evaluate effectiveness of treatment	5	I	3	I	44 (90)	2 (4)	24 (49)	I7 (35)

both groups agree that the severity dimension deserves the highest attention and importance (respective percentages are I00%,60% for users and 98%,69% for non-users).Similar conclusion can be drawn for the dimension of making treatment plan and other decisions (respective percentages are I00%,I00% for users and I00%,80% for non-users.Referral decision making is considered by both group as the least important purpose but receives unequal amount of attention (60% for users vs 90% for non-users).The measurement of client change and evaluation of treatment dimension receives similar amount of attention and ranking for both groups.

The sharpest differences between the two groups concern the dimension of changes in symptomatology and types of depression.The user group pay less attention to the former dimension but rank it second in importance while the contrary holds true with the non-user group.(respective percentages are 80%,40% for users vs 94% and I2% for non-users).Interestingly enough,the reverse conclusion is true with the latter dimension ,that is the differentiation of types of depression. (percentages concerning attention are I00% for users vs 80% for non-users;ranking is third for users and second for non-users).

Table 2.3 presents the analysis of responses of non-users to items unique to them.As can be seen from the table,the non-users' assessment methods include observation (82%),interview (I00%) and consultation (8%).These methods are usually used in combination,especially with regard to the first two methods.

It is clear-from the perusal of the respondents' effectiveness ratings- that the majority of non-users rate their methods to be highly effective (scale ratings from point I to 4 included : 7I%).Only

4 per cent of non-users consider their method(s) as next to ineffective. The rest give moderate ratings.

The meaning of the above ratings becomes somewhat clearer when one examines the satisfied and dissatisfied aspects of the assessment method(s) used. From the table, one can see that the majority of non-users are satisfied with their method(s) because the latter are accepted by clients (92%), meet the agency's requirements (86%), are easily administered (82%), sensitive (76%), not time-consuming (69%), facilitate the communication of results to colleagues (69%) and the recording (65%). However, when one comes to such aspects as validity, reliability and comprehensiveness, it is clear that those who express satisfaction are fewer (less than 55%) and those expressing dissatisfaction are more numerous as compared to other dissatisfied aspects (from 35% to 45%). In addition, dissatisfaction is also considerable with the other three aspects namely speed of application, easy recording and ease of communication of results to others (respective percentages are I8%, I8% and I6%). Thus, attention seems to have been given more to administrative and client considerations than to the basic requirements (among which reliability and validity are the most important) of a good assessment method.

Among the reasons offered for being non-users, lack of training and access and availability of psychologist figure as the most often mentioned ones, accounting for 53 percent, 43 percent and 4I percent of non-users, respectively. Other reasons include limited derived information from the use of depression measurement instruments (3I%), lack of confidence (20%), client's unacceptance (I8%), time-consuming (I4%) and lack of qualification (4%). Among the other (unlisted), specified reasons, there are some interesting ones such as testing and measuring are

TABLE 2.3

Responses of non-users to unique items
(N = 49)

Questionnaire Items	Number of respondents (% if applicable)	
2. Assessment methods		
Observation	48 (82)	
Interview	49 (100)	
Consultation	4 (8)	
5. Effectiveness rating of method(s) used		
I - 2	II (22)	
3 - 4	24 (49)	
5 - 6	II (22)	
7 - 8	2 (4)	
9 - 10		
6. Satisfied & dissatisfied aspects of methods used	Satisfied	Dissatisfied
Comprehensiveness	22 (45)	22 (45)
Sensitivity	37 (76)	II (22)
Validity	25 (51)	17 (35)
Reliability	26 (53)	19 (39)
Accepted by clients	45 (92)	I (2)
Meets agency requirements	42 (86)	I (2)
Ease of application	40 (82)	I (2)
Speed of application	34 (69)	9 (18)
Easily recorded	32 (65)	9 (18)
Results easily communicated to colleagues	34 (69)	8 (16)
Others*	I (2)	I (2)

TABLE 2.3 (Cont'd)

Questionnaire Items	Number of respondents (% if applicable)
7. Reasons for non-use of measurement instruments	
Never learned	26 (53)
No access	2I (43)
No confidence	I0 (20)
Too limited information	I5 (3I)
Unaccepted by clients	9 (I8)
Time-consuming	7 (I4)
Lack of qualification	2 (4)
Disapproval of agency and/or supervisor	
Disapproval of colleagues	
Availability of psychologist	20 (40)
Others	9 (I8)
8. Level of interest in learning and using measurement Instruments	
I - 2	9 (I8)
3 - 4	I0 (20)
5 - 6	I3 (27)
7 - 8	8 (I6)
9 - I0	6 (I2)

* One respondent mentioned acceptance by psychiatrist; the other, the 'equivocalness' of the item and marked dissatisfied.

antitherapeutic, the measurement instruments are limited both in scope and depth of exploration, the present methods are more than sufficient for the worker's assessment purposes...

It is interesting to note that those reasons which are explicitly against the use of measurement instruments (such as lack of confidence, limited information, client's unacceptance...) remain relatively weaker in terms of non-users ' support as compared to those arising out of the absence of resources or the presence of an alternative recourse.

If one also notes that nearly 47 percent of non-users did not give any reasons , one can readily see why over 65 percent of non-users show their interest in learning and using measurement instruments. Only I2 percent of them say that they have no interest at all.

The user group which accounts for only 9 percent of the total respondents, provides scanty but telling information about their experiences with the use of measurement instruments in assessing depression, an area where- as revealed by Table 2.4- those who have ventured in it appear to be more an explorer than an expert.

The measurement instruments, used, known but do not use include- in order of frequency- the Hudson Scale (the General Contentment scale) the Beck Inventory, the Heimler Scale, the Hamilton Scale, the POMS and the MMPI. DSM III (which, to the writer, is not a standardized measurement instrument) and another instrument (which the writer is unable to decipher the user's handwriting) are also mentioned.

The instrument considered the most suitable for social work practice is the Hudson Scale (the General Contentment Scale). Next come the other three of same standing which are the Beck Inventory,

TABLE 2.4

Responses of users to unique items

(N = 5)

Questionnaire Items	Number of respondent (% if applicable)		
9. Measures currently used, known or suitable for social work practice	9. Currently used	Known but not used	Suitable for SW practice
Hudson Scale (the GCS)	3		2
Beck Inventory	2	2	I
Heimler Scale		2 (40)	
Hamilton Scale	I		I
Profile of Mood States	I (20)		I
M.M.P.I		I	
IO. Effectiveness rating of methods used	IO.		
I - 2		I	
3 - 4		I	
5 - 6			
7 - 8		3 (60)	
9 - IO			
II. Ways to become familiar with the instruments	II.		
Social work degree program		I	
Continuing education course			
Agency in-service course		2	
Professional literature & own practice		5 (IOO)	
Colleagues		4	
Others			
I2. Instrument features most desirable for social work practice	I2.		
Reliability		2	
Validity		4	

TABLE 2.4 (Cont' d)

Questionnaire Items	Number of respondents (% if applicable)			
Ease of administration & scoring	2			
Complementariness to clinical observation	2			
Comprehensiveness	I			
Comparability of results	I			
Economy (efficient&time-saving)	I			
I3. Required training levels for use of selected instruments	Hudson Scale	Beck Inventory		Heimler Scale
Essential	I	I		I
Desirable but not essential	I			
Little or no training	I	I		
I4. Percentage of adult clients assessed with instrument(s)	I%	5%	20%	50%
	I	I	I	2
I5. Estimated percentages of adult clients affected by depression	I0%	20%	30%	50%
	I	I	2	I

the Hamilton Scale, and the POMS.

Interestingly enough, three out of five users rate the effectiveness of their method very low. Only two users consider their method as effective.

The users rely mostly on the professional literature and colleagues to gain familiarity with the instruments used (80 to 100 per cent of users). Less frequent avenues include agency in-service course and social work degree program.

Instrument's features most desirable for social work practice are- in order of frequency -firstly, validity; secondly, reliability, ease of administration and scoring, and complementariness to clinical observations; and, thirdly, comprehensiveness, comparability and economy.

With regard to the required training for the use of the instruments mentioned, the users' answers show a diffuse and at times, contradictory picture (as in the case of the Hudson Scale and the Beck Inventory), as can be seen in Table 2.4.

Concerning the estimates (in percentage) of adult clients affected by depression and of those with whom measurement instruments are used, the response pattern is again diffuse, with a range spanning from one to fifty percent.

III. Conclusions and Recommendations

From the above analysis, what has emerged, generally speaking, is the following :

-The majority of respondents never use measurement instruments in assessing depression. They are generally satisfied with their current methods which they consider to be quite effective. Measurement instruments seem to belong more to other disciplines (such as psychology, psychiatry, psychopharmacology...) than social work. However, their interest in learning and using these instrument remains high.

-There is an obvious lack of a basic knowledge base of measurement instruments.This is true with both the user and non-user group.

-There is virtually no systematic training in the use of measurement instruments,for the respondents.As a result, the latter tend to rely on colleagues or self-study to gain some familiarity with these instruments.

-Apparently, there is no concern on the part of the agencies as to whether or not its clinical social workers are familiar with measurement instruments.This probably help explain the non-users' complacency about their present methods of assessing depression although most of them do show keen interest in learning and using the measurement instruments.

-Even among the users, the range of mastery over the popular instruments appears to be limited,if not fragmentary.

-Depression,even with its varied manifestations, seems to be less frequently encountered in the respondents' practice than it was originally surmised.Even when it is present, it is -to many respondents- not the primary focus of the therapeutic effort.

-The present state-of-affairs of depression assessment practice will very likely continue to exist,owing to a number of factors such as (i) no necessity to use measurement instruments(ii) availability of alternative resources (psychologists,psychiatrists...) (iii)the present clinical practice of the majority of respondents probably requires no measurement (iv) Lack of access to and availability of measurement instruments...

In view of the above and in line with the thinking of those respondents who have agreed that the use of measurement instruments would enhance the credibility and accountability of social workers,the following recommendations have been formulated with a view to promote

the appropriate and necessary use of measurement instruments in clinical social work practice. They are :

-Clinical social workers should be equipped with a basic knowledge on measurement instruments in general and those designed for depression in particular.

-Availability of and easy access to the most commonly used depression assessing instruments should be provided along with proper supervision and guidance.

- Upgrading courses (which may be of in-service or continuing education format), seminars... to keep clinical social workers abreast of the latest development in this ares, should be offered when necessary.

-Evaluation of practice through the use of measurement should be encouraged in all practice settings.

*

* *

As previously stated, depression-as a clinical problem- is not easy to assess properly owing to its elusive nature and varied manifestations. To date, many measurement instruments have been devised to assist the clinician in his or her assessment task. These instruments are basically efforts to epitomize in whole or in part the complex and unfinished picture of the depression phenomena.

Unfortunately, as the findings of this study reveal, these measurement instruments seem to be out of sight, if not out of mind of most clinical social workers participating in this study.

Fortunately, however, the respondents' answers and generous disclosures have help the writer paint the present picture of this neglected area of clinical social work practice, within the specified framework.

The painting -in many respects- is not a pleasing picture especially to an enthusiastic clinical social worker. In many ways, it remains an unfinished undertaking. It is hoped that the very unpleasant features portrayed would unleash the briddled potential of many clinical social workers so that changes, not in part, but in the total picture could be realized.

APPENDIX I

List of participating ageneies

I.Alberta Mental Health Services

2.Alberta Children Hospital (Family Program)

3.Calgary General Hospital

4.Calgary Family Services Bureau

5.Calgary Catholic Family Services

6.Holy Cross Hospital

7Jewish Family Services

8.Rockyview Hospital

APPENDIX 2

DEPRESSION ASSESSMENT QUESTIONNAIRE

This questionnaire has been designed to obtain information on how you assess depression in your practice. Depression is a condition that is widely encountered in social work clients, and the ability to assess it accurately and efficiently is an important part of the clinician's repertoire.

I am a graduate student in the Faculty of Social Welfare, University of Calgary. This study is my graduate research project. Its purpose is to shed light on how clinical social workers assess depression, what difficulties they encounter and what seems to work for them. It is hoped that useful reccommendations can be derived from the analysis.

The questionnaire takes about fifteen minutes to complete. It is an anonymous enquiry. Do not give your name or place of work. When you have completed the questionnaire please return it to me in the attached stamped return envelope. Your participation is entirely voluntary. There is no agency requirement that you answer the questionnaire.

Thank you for your time and cooperation. A summary of the study will be sent to you. If you have any questions about the questionnaire or the study, you can telephone or write to:

Pham Tung
Suite 200
1000 Eighth Avenue S.W.
Calgary, Alberta T2P 3M7

Tel: 297-4209

THE FIRST QUESTION APPEARS ON THE OTHER SIDE OF THIS PAGE

1. In assessing depression in your clients, do you use measurement instruments?

   Yes: _____ IF YES, PLEASE SKIP TO QUESTION 9 ON PAGE 4

   No: _____ IF NO, PLEASE CONTINUE

2. If you do not use measurement instruments, describe how you assess depression in your clients?

   _____

   _____

   _____

   _____

3. Which of the following <u>dimensions</u> of depression do you assess in your clients? (CHECK ALL THAT APPLY IN COLUMN A, AND THEN RANK THEM IN ORDER OF IMPORTANCE IN COLUMN B)

	A <u>All that apply</u>	B <u>Importance</u>
The severity of the depression	_____	_____
The type of depression	_____	_____
Changes in symptomatology	_____	_____

4. For which of the following <u>purposes</u> do you assess depression in your clients? (CHECK ALL THAT APPLY IN COLUMN A, AND THEN RANK
7 THEM IN ORDER OF IMPORTANCE IN COLUMN B)

	A <u>All that apply</u>	B <u>Importance</u>
To make referral decisions	_____	_____
To make treatment plans and decisions	_____	_____
To measure client change and evaluate effectiveness of treatment	_____	_____

5. How would you rate the methods you use to assess depression in your clients? (CIRCLE THE NUMBER THAT REPRESENTS YOUR RATING)

1	2	3	4	5	6	7	8	9	10
I	I	I	I	I	I	I	I	I	I

Highly effective — Moderately effective — Not at all effective

6. With what aspects of your method of assessing are you satisfied and dissatisfied? (CHECK "Satisfied" IN COLUMN A AND "Dissatisfied" IN COLUMN B)

	A Satisfied	B Dissatisfied
Comprehensiveness	_____	_____
Sensitivity	_____	_____
Validity	_____	_____
Reliability	_____	_____
Accepted by clients	_____	_____
Meets agency requirements	_____	_____
Ease of application	_____	_____
Speed of application	_____	_____
Easily recorded	_____	_____
Results easily communicated to colleagues	_____	_____
Other: _____	_____	_____

7. What reasons have led you <u>not</u> to use standard depression measurement instruments in your practice? (CHECK ALL THAT APPLY BELOW AND ON THE FOLLOWING PAGE)

I have never learned how to use them _____

I don't have access to them _____

I don't have confidence that they provide valid measures of depression _____

ADDITIONAL REASONS APPEAR ON THE NEXT PAGE . . .

They provide too limited information about the client's depression _____

Many client's would find them unacceptable _____

Administration, scoring and interpretation is too time consuming _____

Only psychologists are qualified to use them _____

My agency and/or supervisor would disapprove _____

My colleagues would disapprove _____

The agency psychologist(s) can administer these instruments for me if I want these measures _____

Other: _____ _____

8. How interested are you in learning about and using such instruments? (CIRCLE THE NUMBER THAT INDICATES YOUR LEVEL OF INTEREST)

1 2 3 4 5 6 7 8 9 10

Very highly interested — Moderately interested — Not at all interested

PLEASE SKIP TO QUESTION 18 ON PAGE 7

9. Please list the standard depression measurement instruments that you know about or use in your clinical practice.

What ones are you presently using?

1. _____

2. _____

3. _____

What others do you know about but don't use?

1. _____

2. _____

3. _____

QUESTION 9 IS CONTINUED ON THE NEXT PAGE . . .

QUESTION 9 CONTINUED FROM THE PREVIOUS PAGE

What standard measures of depression do you consider to be most suitable for social work practice?

1. _____

2. _____

3. _____

10. How would you rate the methods you use to assess depression in your clients? (CIRCLE THE NUMBER THAT REPRESENTS YOUR RATING)

1	2	3	4	5	6	7	8	9	10
I	I	I	I	I	I	I	I	I	I

Highly effective — Moderately effective — Not at all effective

11. How did you become familiar with the instrument(s) that you listedin Question 9? (CHECK ALL THAT APPLY)

In my social work degree program _____

In a continuing education course _____

Through an agency in-service course _____

Professional literature and own practice _____

From professional colleagues _____

Other: _____ _____

12. What features of a standardized measure of depression make it a suitable instrument for clinical social work practice? (LIST THE THREE MOST IMPORTANT)

1. _____

2. _____

3. _____

13. Indicate for the depression measurements with which you are familiar the special training required to use them?

Instruments for which special training is essential

_____

_____

Instruments for which special training is desirable but not essential:

_____

_____

Instruments requiring little or no special training:

_____

_____

14. With what percentage of your adult clients do you use a standard depression measurement?

_____ %

15. With what percentage of your adult clients do you estimate that depression is significantly affecting their functioning?

_____ %

16. Which of the following <u>dimensions</u> of depression do you assess in your clients? (CHECK ALL THAT APPLY IN COLUMN A, AND THEN RANK THEM IN ORDER OF IMPORTANCE IN COLUMN B)

	A <u>All that apply</u>	B <u>Importance</u>
The severity of the depression	_____	_____
The type of depression	_____	_____
Changes in symptomatology	_____	_____

17. For which of the following purposes do you assess dpression in your clients? (CHECK ALL THAT APPLY IN COLUMN A, AND THEN RANK THEM IN ORDER OF IMPORTANCE IN COLUMN B)

	A All that apply	B Importance
To make referral decisions	_____	_____
To make treatment plans and decisions	_____	_____
To measure client change and evaluate effectiveness of treatment	_____	_____

18. Do you think that the more extensive use of standard psychological and social measurements in clinical practice would enhance the credibility and accountability of social workers?

Yes: _____ No: _____ Not sure: _____

19. In what year did you begin your first social work position?

Year: _____

20. What are the three presenting problem areas you most frequently encounter in your practice?

1. _____

2. _____

3. _____

21. Indicate what social work degrees you have and when obtained.

B.S.W. Yes: _____ No: _____ IF YES, WHEN? _____

M.S.W. Yes: _____ No: _____ IF YES, WHEN? _____

THANK YOU VERY MUCH FOR COMPLETING THIS QUESTIONNAIRE. PLEASE MAIL IT IN THE ATTACHED STAMPED RETURN ENVELOPE.

IF YOU HAVE ANY COMMENTS, PLEASE MAKE THEM ON THE OTHER SIDE OF THIS PAGE. INDICATE TO WHICH QUESTION A COMMENT REFERS.

PLEASE MAKE ANY COMMENTS ON THIS PAGE. INDICATE TO WHICH QUESTION A COMMENT REFERS.

APPENDIX 3

THE UNIVERSITY OF CALGARY

Faculty of SOCIAL WELFARE

2500 University Drive N.W., Calgary, Alberta, Canada T2N 1N4

Telephone (403) 284-5943

January 23, 1983

Mr. Norm Karst
Executive Director
Calgary Family Service Bureau
120-13th Avenue S.E.
Calgary, Alberta T2G 1B3

Dear Mr. Karst:

I am writing to ask your cooperation in assisting Mr. Pham Tung in carrying out a study of how client depression is assessed by clinical social workers. He is a graduate student in the Faculty of Social Welfare, and this study is his graduate research project.

The request is that you distribute a copy of the enclosed questionnaire to each member of your staff who meets the following criteria:

1. Holds an M.S.W. or B.S.W. degree.

2. Is currently providing clinical services to clients.

The participation of your staff would be entirely voluntary, and would be anonymous. Neither the respondent nor the agency would be reported on the questionnaire. Questionnaires can be completed in about fifteen minutes, and would be returned in a self-addressed stamped envelope. Copies of a summary of the survey report for you and your staff will be sent to you when the study is completed.

Mr. Pham Tung will be telephoning you early this week to ask if your staff can participate in the study and, if so, how many questionnaires you would require. He will deliver the questionnaires to your office himself.

Your assistance to Mr. Pham Tung in completing his study will be greatly appreciated. If you have questions about this request, please call me at 284-5942, or Mr. Pham Tung at 297-4209.

Sincerely yours,

James Gripton, D.S.W.
Professor

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