A SELF-REPORT QUESTIONNAIRE FOR THE PSYCHOLOGICAL STATE (QSP).

D. SALMASO
D. Marsella, P. Torti, G. Viola.

CNR, Institute of Psychology,
Viale Marx 15, 00137 Roma, ITALY.

SUMMARY

Early detection of disease arising in the elderly is going to be the primary goal for psychological research. However, this goal can only be reached by using methods less expensive and quicker than a complete examination of the subject. A way to achieve this aim has been the development of self_evaluation questionnaires which allow the clinical situation of numerous subjects to be ascertained rapidly. In order to collect information about the psychological state of aging population we have developed a self_report questionnaire (QSP). The QSP includes 38 items exploring cognition, depression, anxiety, emotion and so on. Additional information about marital status, living arrangements and physical health are also required. Subjects provide information by answering each item on a three_point scale (2=often, 1=sometimes, 0=never). A total score (obtained by adding the score for each item and dividing by 2) represents the frequency with which psychological symptoms are supposed to be present in the subject considered. The QSP was administered to 201 subjects (78 M, 123 F; mean age 60.4) living in Rome and attending recreational activities for elderly. For our subjects the mean score was 0.63 (sd 0.29). There were neither sex differences, nor among 4 differently_aged groups, nor among 4 differently_educated groups. On the other hand QSP scores were affected by physical and social distress, according to the suggestions provided by WHO Expert Group (1977). Altogether QSP seems to be useful for the screening of the elderly population and for the early identification of subjects (or groups), who could develop some forms of dementia.

One of the major issues facing psychology and geriatrics is to keep the elderly healthy and at the same time to limit health care costs. On the research side, cost containment drives us to carry out more primary prevention activities (Taylor, 1990). For aging research this means the capacity to identify the factors underlying conditions of health and disorders.

Screening programmes represent one possible strategy for attaining the desired goals (Cooper & Bickel, 1984). The traditional approach to early detection of disease is through repeated periodic medical examination, but the growing elderly population excludes that approach.

Psychological screening could be made in at least four ways: 1) checklists, 2) rating scales, 3) interviews and 4) psychometric tests. The last two are time-consuming and require special skills. They are inappropriate for screening purposes.

There are three general types of checklists and rating scales: 1) to be completed by non-experts, e.g. nurses, 2) to be completed by experts, e.g. psychologists, 3) to be completed by subjects. The first two are more suitable for clinical purposes, like evaluation over time of a demented patient.

The development of symptom checklists to be completed by the subject represents the more recent way to look at psychological screening programmes. They are less expensive and quicker than any other tool. However, they present some methodological difficulties: for instance, people have different degrees of insight into their psychological processes. By contrast they present an incomparable advantage: they provide information directly from the person experiencing the phenomena.

To collect information about the psychological state of the aging population, we have developed a self-report questionnaire (QSP). The QSP includes items exploring cognition, depression, anxiety, emotion and so on, mainly drawn from CAMDEX (Roth et al., 1988), CFQ (Broadbent et al., 1982), EMQ (Sunderland et al., 1982), BSI (Derogatis, 1975).

METHODS

Subjects. The 201-sample included adults (78 M, 123 F; mean age 60.4) aged 19-83. Most of the older subjects were attending public recreational centres in Rome. They were without any apparent neurological and psychological problem. Table 1 summarises the characteristics of the sample, while Table 2 shows the subject distribution as a function of 4 age-groups. There were no age and no education differences between sexes.

TABLE I: CHARACTERISTICS OF THE SAMPLE

SEX	N	AGE	EDUCATION	QSP SCORE
MALES	78	63.0	9.0	0.58
sd		16.0	3.8	0.32
FEMALES	123	59.0	10.0	0.67
sd		13.5	4.0	0.27
ALL	201	60.4	9.7	0.63
sd		14.6	4.0	0.29

TABLE II: SUBJECT DISTRIBUTION AS A FUNCTION OF SEX AND AGE-GROUPS

SEX	AGE-GROUPS			
	<55	54<X<65	64<X<75	>74
MALES	12	17	37	12
Mean	29.8	61	69.3	79.5
sd	11.5	3	2.5	2.4
FEMALES	35	48	28	12
Mean	42.4	60.1	68.6	78.8
sd	11.9	2.6	2.8	2.0
ALL	47	65	65	24
MEAN	39.2	60.4	69.0	79.2
sd	13.0	2.7	2.7	2.2

TABLE III: QSP STRUCTURE

AREA	NUMBER OF ITEMS
A. COGNITIVE	(12)
A1. ATTENTION/CONCENTRATION	(3)
A2. ORIENTATION	(2)
A3. MEMORY	(7)
B. EMOTIONAL	(26)
B1. DEPRESSION	(7)
B2. HYPOCHONDRIA	(2)
B3. ANXIETY	(3)
B4. OBSESSIVE/COMPULSIVE	(2)
B5. EMOTIONAL LABILITY	(2)
B6. SOMATIZATION	(3)
B7. LONELINESS	(2)
B8. PARANOID IDEATION	(3)
B9. SLEEP DISORDERS	(2)

   Procedure. The Questionnaire of the Psychological State (QSP) is a 38-item self-report questionnaire designed to assess the psychological conditions of elderly people. The items were selected to obtain information about cognitive and emotional functions. Items belong to the main areas illustrated in the Table 3. The primary consideration in item development was to obtain phrases worded in simple language. All items were rated on a 3-point scale (often=2, sometimes=1, never=0). A total score (obtained by adding the score for each item and dividing by 2) represents the frequency with which psychological symptoms appear to be present in the subject considered. Point 2 represents the maximum frequency of symptoms.

   Information was also available from each participant relatively to: 1) physical health, 2) diseases, 3) medical treatments, 4) alcohol use, 5) living conditions, 6) marital status.

TABLE 3b: EXAMPLES OF ITEMS
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A1. Forgetting what you have just read.
A2. Failing to recognize places you know well
A3. Forgetting where you have put something.
    Finding that a word is 'on the tip of your tongue'.
    Forgetting something you were told yesterday.
B1. Finding it more difficult to decide something.
    Feeling no interest in doing things.
B2. Worrying about your health.
B3. Worrying about novelties.
    Feeling fearful.
B4. Feeling obsessed by some thought.
B5. Crying for trivial reasons.
B6. Experiencing difficulties in breathing.
B7. Preferring to be alone.
B8. Feeling that you are being watched.
    Hearing things other people do not hear.
B9. Finding difficulties in falling asleep.

_____

RESULTS

   Figure 1 summarises mean values for each item. We can observe that items with a lower mean value are items belonging to the clinical evaluation of dementia, that is sensitive indicators of organicity. This means that they cannot be considered good items for assessing normal aging. Higher values are scored for memory, depression and anxiety.

   Different statistical analyses were performed on QSP scores. They were carried out to test the following factors: 1) area (cognitive vs emotional); 2) sex; 3) age; 4) education; 5) marital status; 6) physical health.

   Results can be summarised as follows:

1) no difference between emotional and cognitive areas (0.65 vs 0.61).
2) no difference for sex (males=0.59, females=0.67).
3) no difference among age groups (n=4) and no correlation between age and QSP score (see figure 2).
4) No difference among education groups (n=4), and a negative correlation between education and emotional score (QSPe, p<.025).
5) Widowed people show higher QSP scores than any other subject (F=3.6; df=2,189; p<.025). (see table IV).
6) Self-report of physical health produces groups with different QSP scores (F=8.5; df=2,195; p<.001): QSP scores increase moving from good-health subjects to poor-health subjects (see table IV). This effect is more marked in the emotional area (F=10.1; df=2,195; p<.001). The effect of self-reported physical health does not change across age groups. Finally, there were significant correlations between physical health and diseases and drugs. People with diseases or on treatment show higher QSP scores.

TABLE IV: MEAN VALUES AS A FUNCTION OF THE MARITAL STATUS AND PHYSICAL HEALTH

	MARRIED	SINGLE	WIDOWED
N	112	39	44
MEAN	0.59	0.66	0.74

	GOOD	MEAN	POOR
N	75	104	22
MEAN	0.52	0.68	0.80

FIGURE 1

FIGURE 1

MEAN VALUES FOR EACH ITEM
N=201

COGNITIVE (A)

MEAN VALUES FOR EACH ITEM
N=201

EMOTIONAL (B)

MEAN VALUES FOR EACH ITEM
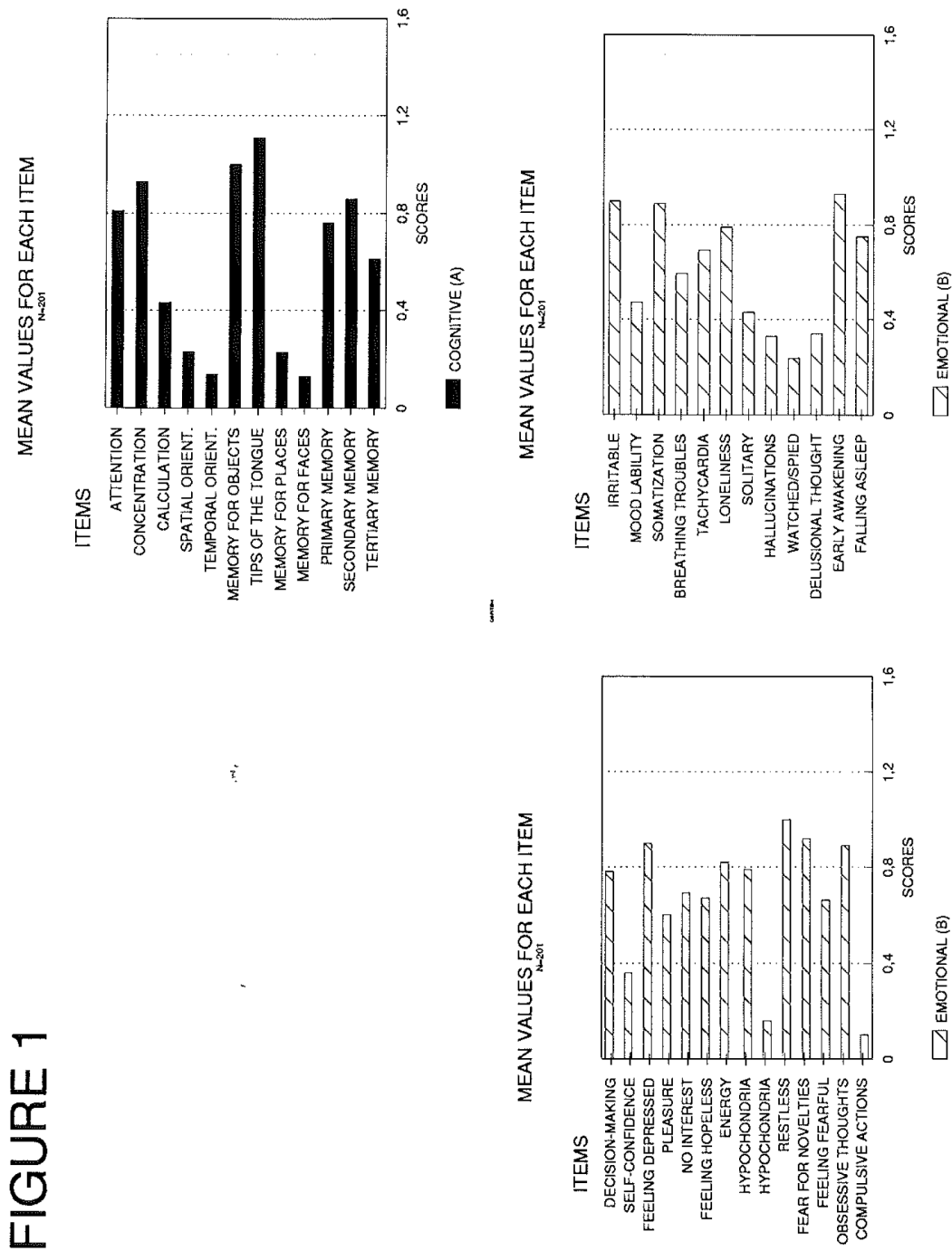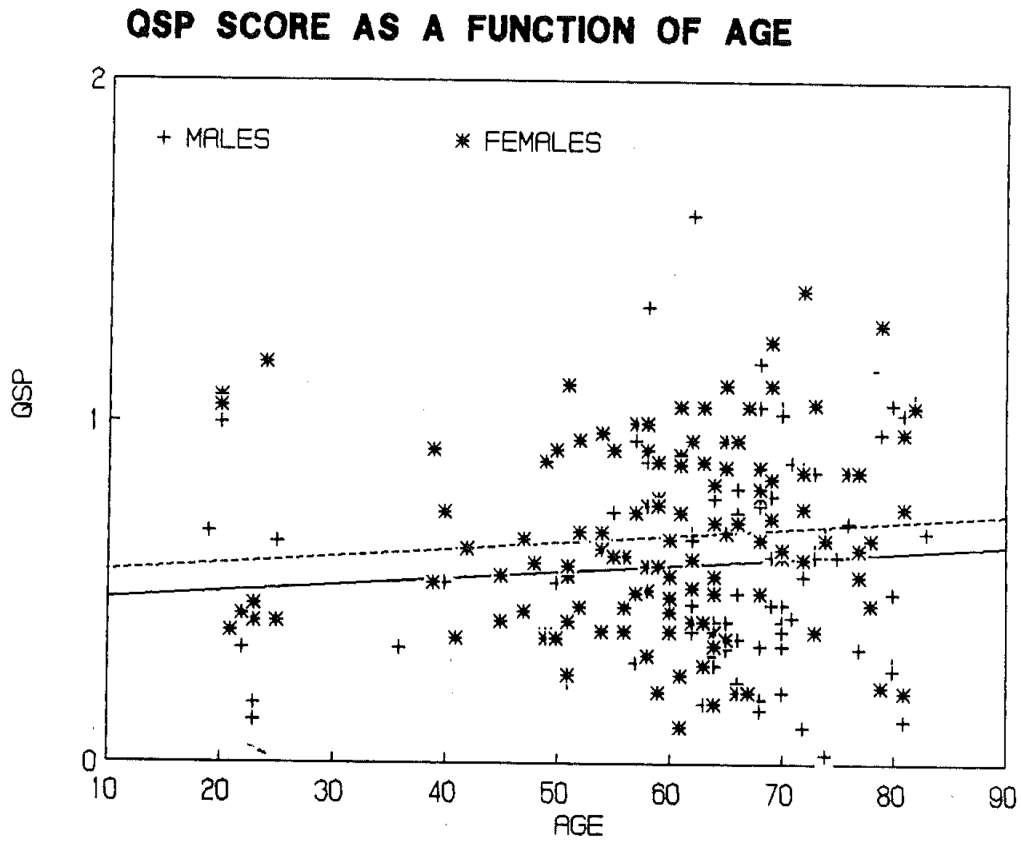N=201

EMOTIONAL (B)

FIGURE 2

QSP SCORE AS A FUNCTION OF AGE

CONCLUSIONS

The two variables, age and education, that are most commonly indicated as relevant in the studies of aging causes show practically no effect, thus confirming more recent data (Perlmutter et al, 1990; Rabbitt et al., 1990; Salmaso et al., 1988).

The QSP appears to be sensitive to both physical and psychological distress, as for instance health conditions and marital status: poor health conditions and being widowed influence negatively people's psychological state and the QSP is able to detect it, thus providing useful suggestions for the identification of groups at risk (see WHO Expert Group, 1977).

As stated in the introduction, these tools are not used for diagnosis, rather for carrying out screenings that allow us to identify the most significant variables in the psychological processes, thus making increasingly more efficient and effective the actions undertaken by society in favour of aging.

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A QUESTIONNAIRE FOR THE PSYCHOLOGICAL ASSESSMENT IN AGING RESEARCH.

SALMASO, D.

CNR, Institute of Psychology,
Viale Marx 15,
00137 Roma, ITALY.

Summary

One of the major aim facing psychology and aging is to keep elderly healthy and at the same time to contain health care costs. On the research side, cost containment push us to do more on primary prevention activities. For aging research this means the capacity to identify the factors underlying conditions of health and disorders.

A way to achieve this purpose has been the development of self_evaluation questionnaires which allow the clinical situation of numerous subjects to be ascertained rapidly. In order to collect information about the psychological state of aging population we have developed a self_report questionnaire (QSP). The QSP includes items exploring cognition, depression, anxiety, emotion and so on. Additional information about marital status, living arrangements and physical health are also required. Subjects provide information by answering each item on a three_point scale (2=often, 1=sometimes, 0=never). A total score (obtained by adding the score for each item and dividing by 2) represents the frequency with which psychological symptoms are supposed to be present in the subject considered. The QSP was administered to 201 subjects (78 M, 123 F; mean age 60.4) living in Rome and attending recreational activities for elderly. For our subjects the mean score was 0.63 (sd 0.29). There were neither sex differences, nor among 4 differently_aged groups, nor among 4 differently_educated groups. On the other hand QSP scores were affected by physical and social distress, according to the suggestions provided by WHO Expert Group (1977). Altogether QSP seems to be useful for the screening of the elderly population and for the early identification of subjects (or groups), who could develop some forms of dementia.