**抑郁问卷的异质性：基于对27个抑郁测量问卷的内容分析**

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**Assessing the heterogeneity of 27 scales for measuring depression**

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**CrediT Author Statement**

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摘要

关键词

# 1. 引言

按照总分总方式写主旨句

[第一段的主旨句]

抑郁障碍的严重性（患病率、社会成本等），青少年期和成年早期是关键的时间。

[第二段的主旨句]

自评量表在抑郁症的研究中广泛使用，也是各类关于青少年与学生政策的基础（中国、世界范围内大规范调查的的数据）

[第三段的主旨句]

但抑郁自评量表数量繁多，被广泛使用的量表也不在少数，有潜在的重大影响（如影响到心理健康问题的检出率）。

[第四段的主旨句]

当前研究发现不同抑郁问题可能在测量不同的内容。Fried（2017年）的研究表明，不同的抑郁量表不能互相替代使用，这给抑郁研究带来了挑战。

[第五段的主旨句]

上述问题可能也延伸到发展中国家，但目前没有实证的数据进行评估，本研究将对用于学生的抑郁自评量表进行分析。

还可以补充一些非常广泛的调查，只用了某一个问卷。可以用大规模调查用的问卷来举例。例如中国国民心理健康发展报告，心理所的调查只用了ces-d简版和中国心理健康量表简版广泛焦虑。

# 2. Methods

We took three steps to extract symptoms from all scales that measure depressions among students population (see Fig 1 for the flowchart). Firstly, we identified all scales that has been used for screening depression among students and screen the scales for completedness of their items information. Secondly, we identified unique symptoms of each scale. Thirdly, we compared the symptoms between different scales. The latter two steps followed Fried (2017) but with modifications (see details below).

## 2.1 Identify and screen scales

We identified scales that measure depression from four recent meta-analyses which synthesized the prevalence of different mental health problems among four students populations: elementary school, middle school, high school, and college (于晓琪等, 2022; 黄潇潇等, 2022; 张亚利等, 2022; 陈雨濛等, 2022). We extracted all papers included in these meta-analyses and selected scales that were used for screening depression. In total, we identified 34 scales from 470 articles included in these four meta-analysis.

We then evaluated multiple versions of scales (if exist) and identified the most valid version for later analysis (See supplementary material for details). The rationale behind this examination lies in the fact that even for the same scale, meta-analytic data may provide multiple versions. When confronted with multiple versions of a scale, we adhered to the following inclusion criteria: (1) If the scales cited in the meta-analytic data are available only in English, we search for the Chinese versions ourselves; (2) If the citations in the meta-analytic data provide both English and Chinese versions, we prioritize selecting the Chinese version ; (3) If there were multiple Chinese versions, where one included symptom names and the other did not, we preferred the version that included symptom names; (4) If no reviews are available for versions that do not present symptoms, select the most frequently used one. If there are reviews, base the selection on them. For instance, CES-D was first translated by 汪向东等(1999), which was used by 39/470 papers. However, 章婕等(2010) revised the 20th item, "I could not get going", of this scale because the meaning of original translation, “我走路很慢” ("I walk very slowly" as directly back translated into English), diverge from the original English meaning. Instead, 章婕等(2010) translated this item as “我提不起劲儿来做事” ("I lack the motivation to do things" as directly back translated into English). Thus we chose the revised version by 章婕等(2010).

## 2.2 Identify symptoms within scales

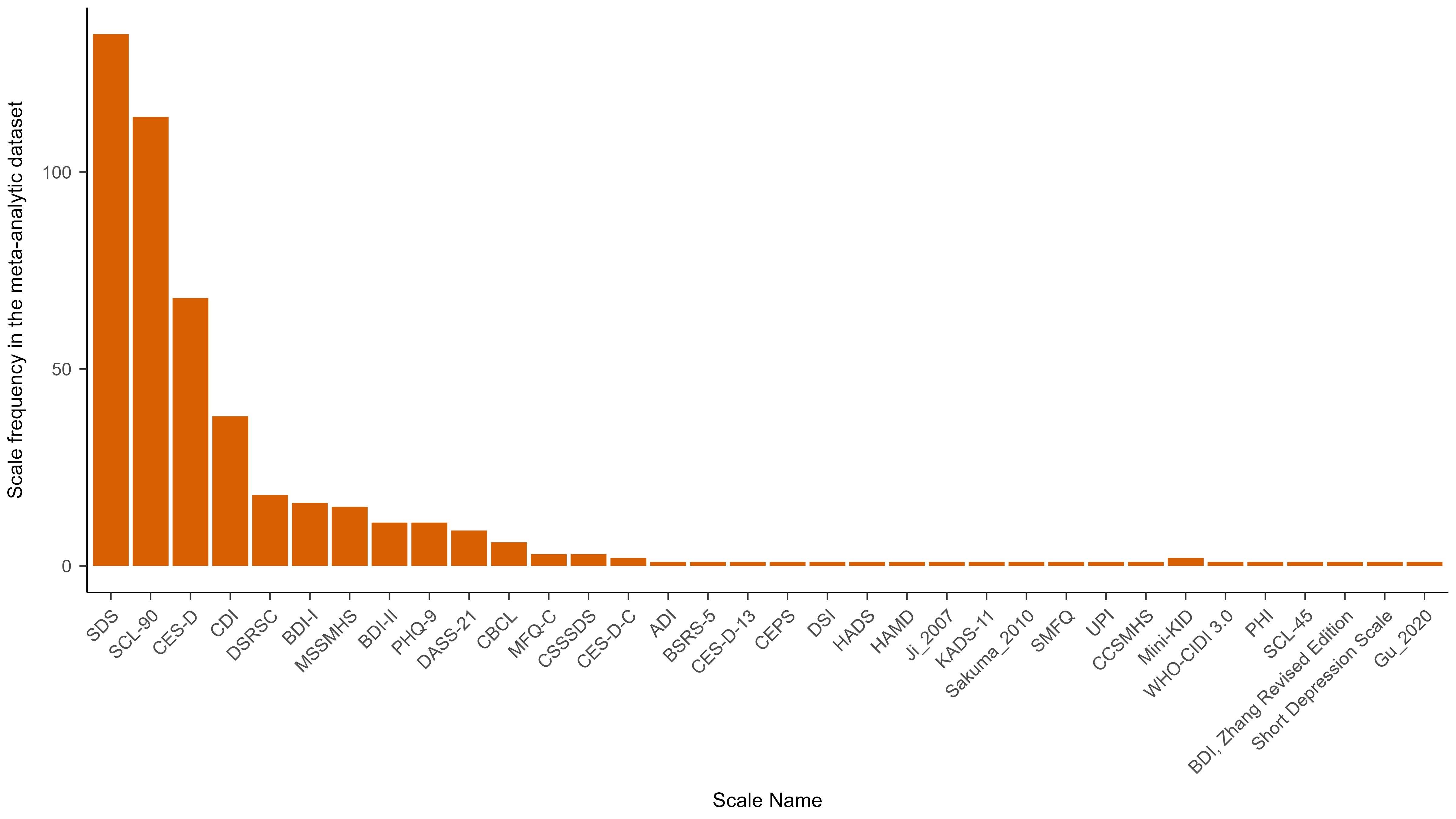
In this phase of our study, four trained coders focused on identifying items that assessed identical or similar symptoms within each scale. The process proceeded as follows: First, the four coders independently identified and consolidated items within each scale. Then, they formed two pairs, with each pair reviewing their results and resolving any discrepancies. Subsequently, the two pairs of coders cross-checked their findings and collaboratively addressed any remaining inconsistencies, seeking guidance from the corresponding author when necessary. The final, consolidated version of the results underwent independent verification by a clinically certified doctor (co-author \*\*\*), who made necessary revisions to ensure accuracy.

## 2.3 Compare symptoms across different scales

In this step, the same four coders compared symptoms across all scales. The procedure was the same as the identification of symptoms within scales: indepenedent individual coding, discussion by pairs, cross-checking between pairs, discussion with the corresponding author, and verification by a clinically certificated doctor.

The coding processes were as follow. We first pooled symptoms from all scales together and identified unique symptoms. In this step, we retained both compound symptoms and specific symptoms, as in Fried (2017). Compound symptoms are symptoms that include a range of related symptoms, whereas specific symptoms are more concrete and describe specific patterns. For example, “appetite changes” is a compound symptom, it includes two specific symptoms: “appetite increased” and “appetite decreased”. And all three symptoms were treated as unique symptoms. We employed an approach that maximize the amount of different symptoms. More specifically, if the items describe similar symptom using different words and that the words have significantly different meanings under the Chinese context, we treat them as belonging to the same compound symptom but are different specific symptoms. For instance, there are many different words for describe depressed mood in different scales, we used 'depressed moods' as the compound symptom but distinguish different specific symptoms such as: 'blue', 'low mood', 'sad', and 'anhedonia'. This approach is slightly different from Fried (2017), where he coded all these item as a specific symptom 'Sad moods'.

Then, we coded each scale on all unique symptoms. More specifically, a scale was coded as “0” on a symtom if it does not have items that measures this symptom. If a scale has an item that directly measures a symptom, compound or specific, it was coded as 2 on that symptom. Note if a scale has an item measures a compound symptom, then, this scale not only had a score of 2 on that compound symptom but also has a score of 1 on each of the specific symptoms under this compound symptom. For instance, the CDI has no item for 'Depressed mood' , we assigned “0” for CDI on this symptom. For compound symptom “appetite change”, CDI has an item directly measures this symptom and was coded as 2 on this symptom. Importantly, even CDI does not have item for specific symptoms of “appetite changes”, i.e., 'appetite increased' and 'appetite decreased', it was coded as 1 on both two specific symptoms (see Supplementary Materials and Figure 2 for details). However, if the item measures a specific symptom under a compound symptom, this scale was coded “2” on that specific symptom but also coded as “0” on the corresponding compound symptom.



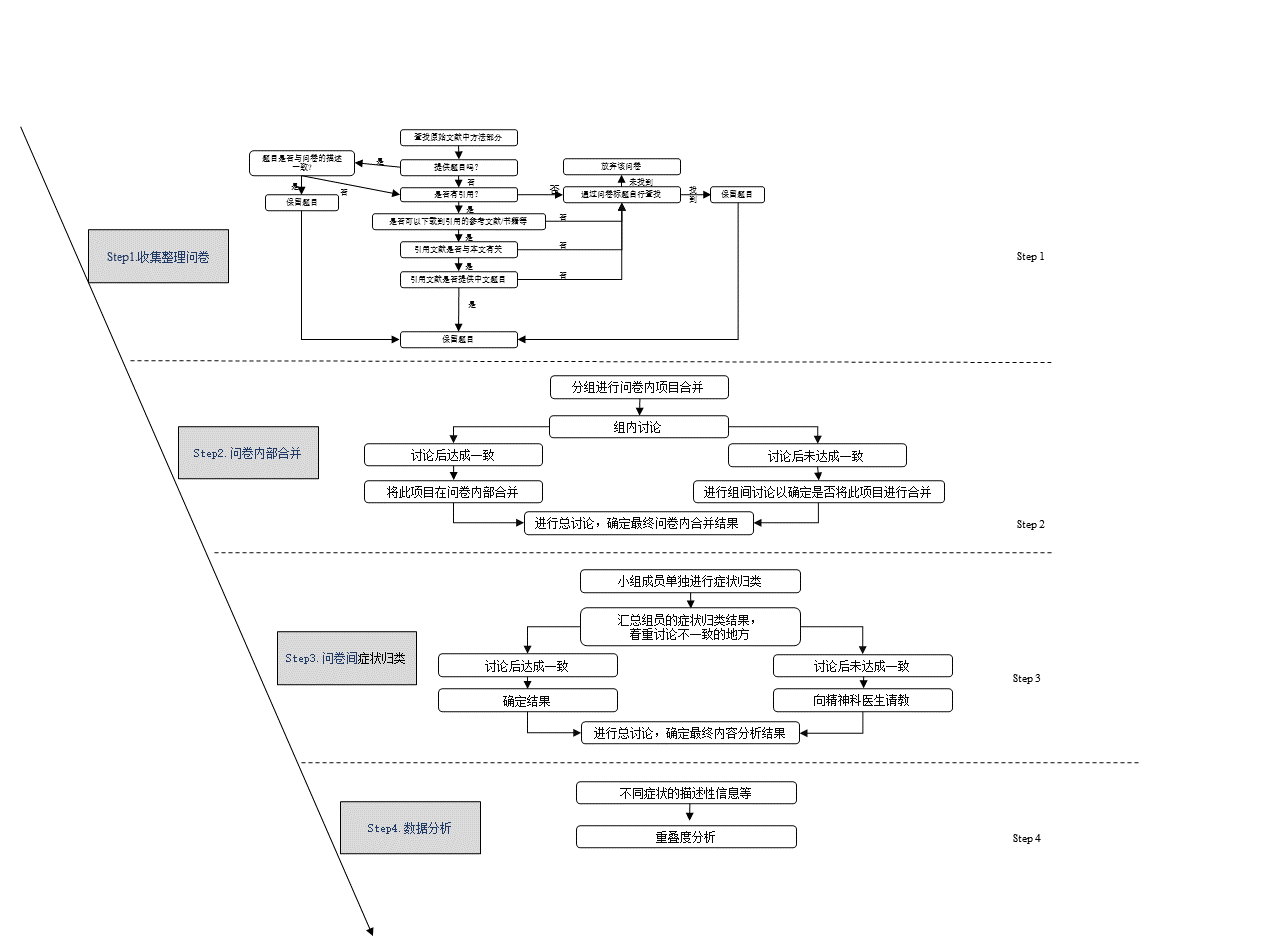
**Figure 2**

*Number of articles that used each scale for screening depression.* Total number of articles were based on those included in four meta-analyses (XXX). Scales with \* were excluded from our analyses.

## 2.4 Data analyses

We reported the following information: descriptive details of different symptoms and the performance and characteristics of scales on various symptoms. Additionally, we provided the proportions of idiosyncratic symptoms (symptoms appeared in only one scale), the respective proportions of compound and specific symptoms, and the proportions of DSM-5 depressive symptoms included.

We used Jaccard index for the degree of overlap between different scales (Fried, 2017). The formal of Jaccard index is s/(u1 + u2 + s), where "s" represents the number of items shared by two scales, and "u1" and "u2" denote the number of items that are exclusively present in each of the two scales. Jaccard index ranges from 0 (no overlap among scales) to 1 (complete overlap). We interpreted Jaccard index as in Fried (2017) guidelines: very weak 0.00–0.19, weak 0.20–0.39, moderate 0.40–0.59, strong 0.60–0.79, and very strong 0.80–1.0.



**Figure 1**

*Research flowchart*

# 3 Result

# 3.1 A summary of scales

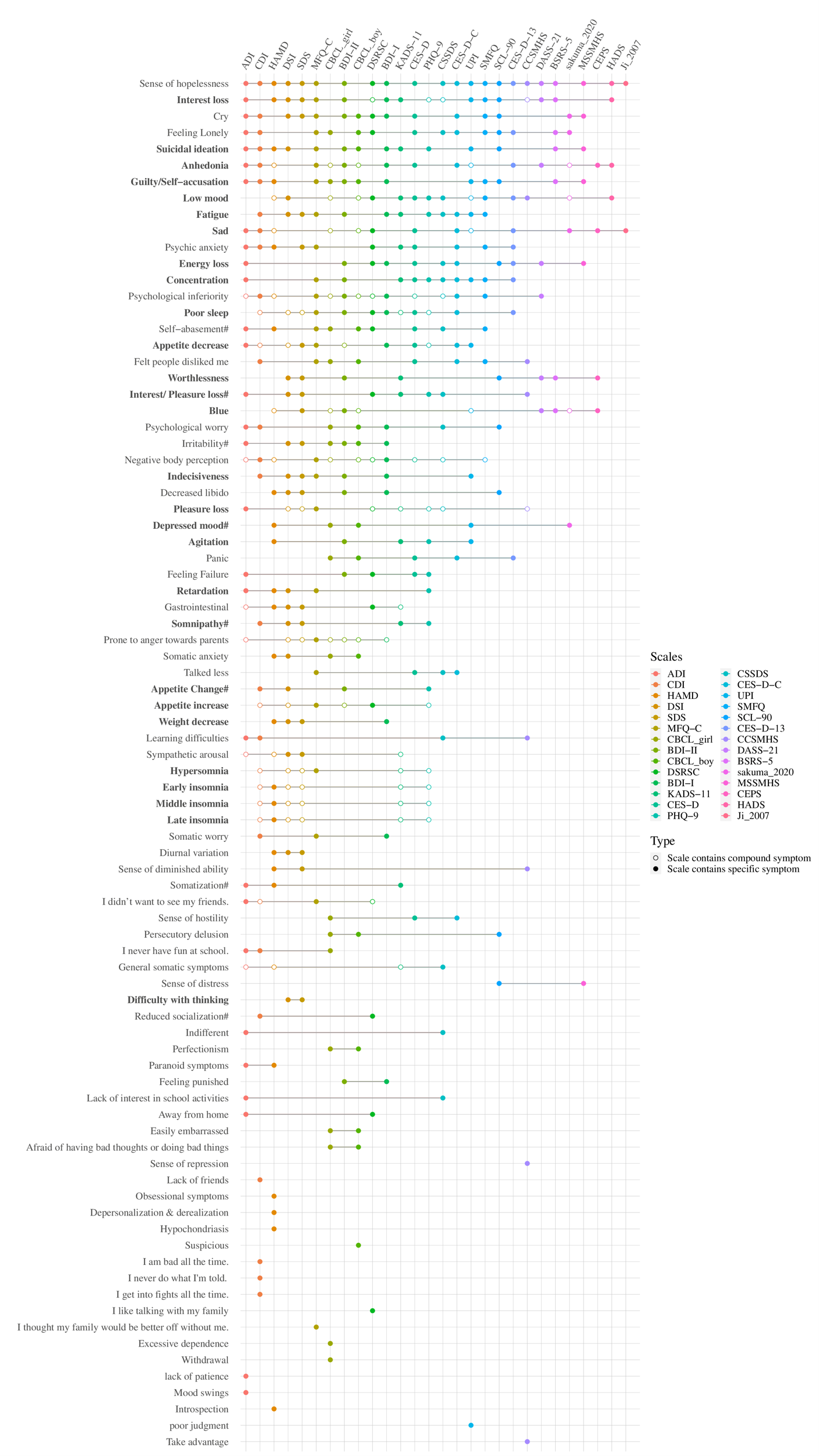
In four meta-analyses, 470 papers were related to depression and 34 unique scales were identified. Among all these scales, the items of four scales, the Mini International Neuropsychiatric Interview for children and adolescents (Mini-KID), WHO-CIDI 3.0, Psychological Health Inventory (PHI), and the Symptom Checklist 45, were not available. The items of the other two scales, the Beck Depression Inventory (Zhang Yuxin Revised Edition) and Short Depression Scale, were not available either because of unidentifiable citations. These six scales were excluded from furthere analyses. The items used in 'Gu & Chen (2020) 'and 'Ji (2007)' were identifical but in different languages, thus we regarded these two studies used the same scale referred them as 'Ji (2007)'. Also, the boys’ and girls’ version of the Child Behavior Checklist (CBCL) were treated as one scale, CBCL. In short, 27 scales were included in the analysis. See figure 2 for the number of usages of these scales among all 470 empirical papers in the meta-analyes (CITATIONS). The seven most frequently used scales in this study are SDS, SCL-90, CES-D, CDI, DSRSC, BDI-I, and MSSMHS, among which CES-D and SDS are consistent with the scales selected by Fried (2017).

# 3.2 Items and symptoms within scales

For the 27 scales included, there are 425 items in total. We merged 73 items into 31 symptoms when coding items within scales. Alos, there were two cases where one item measured two symptoms. The item from Ji (2007), "During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing your usual activities?" meausres both 'sad' and 'Sense of hopelessness'. And the 8th item from PHQ-9, "Actions or speech slowed down to a noticeable extent, or conversely—feeling restless or agitated, being unable to sit still, more than usual", measures both 'Agitation' and 'Retardation'. Thus, a total of 385 symptoms were identified across different scales (See supplementary materials for number of items and symptoms of each included scale).

The comparison of 385 symptoms across 27 scales resulted in unique 84 symptoms (see Figure 3). Among these, eight are compound symptoms, including *Depressive mood, Irritability*, *Self-abasement*, *Interest/pleasure loss*, *Somatization*, *Appetite changes*, *Somnipathy*, and *Reduced socialization* (See supplementary material for details).

We comprehensively reported the number of symptoms included in each scale, the adjusted scale length, the number of idiosyncratic symptoms and the ratios of compound and specific symptoms. Furthermore, it outlines the prevalence of DSM-5 depressive symptoms within each scale. Among the scales analyzed, 19 did not include any idiosyncratic symptoms. The CSSMHS exhibited the highest percentage of idiosyncratic symptoms, with a prevalence of 22.22%, while the remaining scales showed varying rates of idiosyncratic symptom inclusion, ranging from 3.85% to 12.5%. Ten scales did not incorporate compound symptoms, with proportions for the remaining scales varying from 7.69% to 47.37%. The DSI exhibited the highest prevalence of DSM-5 depression symptoms, encompassing 71.42% of the total nine DSM-5 depression symptoms. Conversely, the Ji\_2005 scale demonstrated the lowest representation, comprising only 3.57% of the nine DSM-5 depression symptoms. It is also the least number of items among the scales included in this study. The supplementary materials provide detailed information.

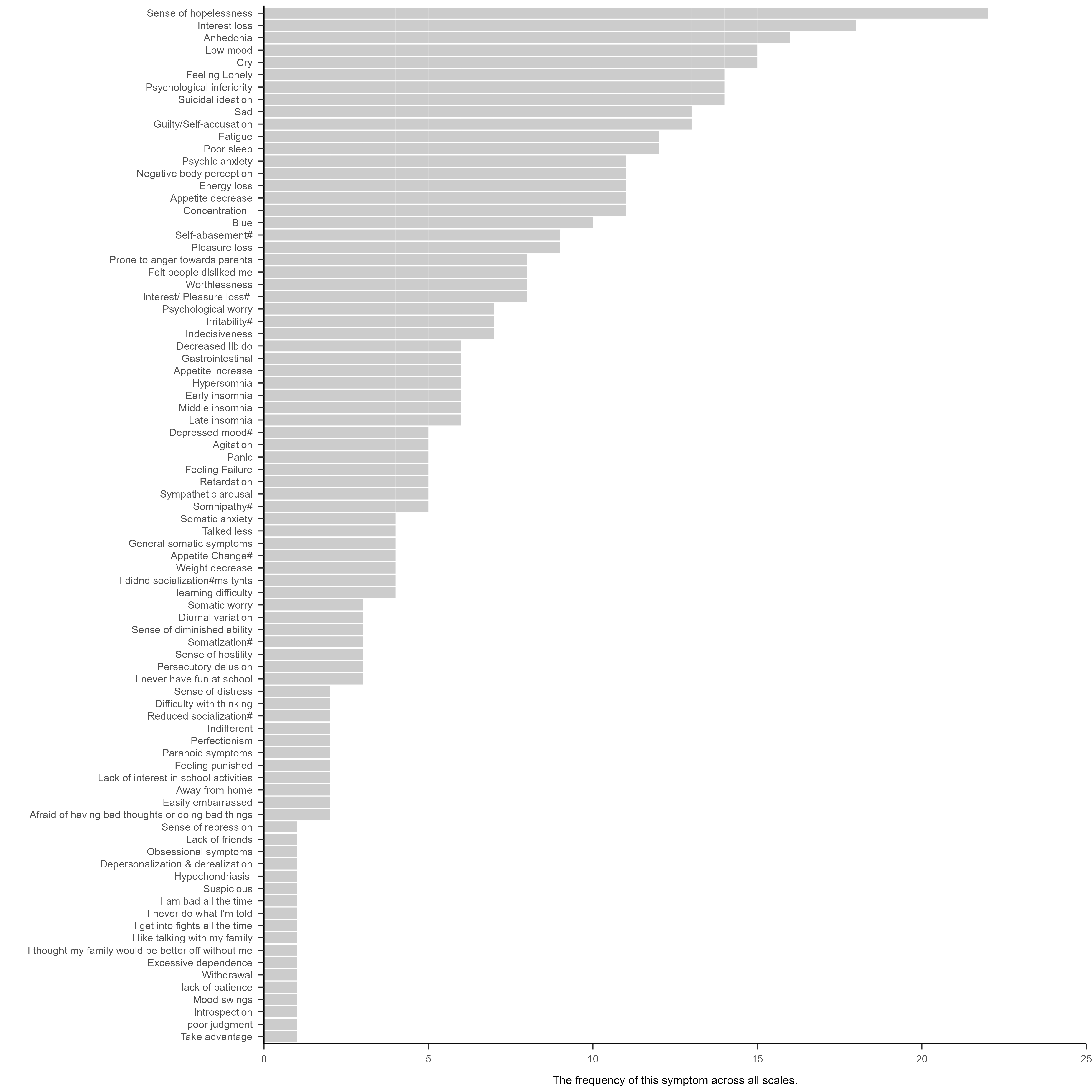
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**Figure 3***. Content Overlap Across* *Twenty-seven Depression Scales.* Each row represents a symptom, each column represents a scale.If a scale measures a symptom, then there is a dot or a circle on that row. The former represent compound symptoms and the latter represent specific symptoms. Symptoms in bold font are from DSM-5. ADI: Adolescent Depression Inventory, CDI: Children's Depression Inventory, HAMD: Hamilton Depression Rating Scale for Depression, DSI: Depression Status Inventory, SDS: Self- Rating Depression Scale, MFQ-C: Mood and Feelings Questionnaire, CBCL: Child Behavior Checklist, BDI-II：Beck Depression Inventory-II, DSRSC: Depression Self-rating Scale for Children, BDI-I: Beck Depression Inventory, KADS-11: Kutcher Adolescent Depression Scale, CES-D: The Center for Epidemiological Studies Depression Scale, PHQ-9: Patient Health Questionnaire-9 items, CSSDS: China Middle school students' depression scale, CES-D-C: Center for Epidemiologic Studies Depression Scale for Children, UPI: University Personality Inventory, SMFQ: Short Mood and Feelings Questionnaire, SCL-90: Symptom Checklist 90, CES-D-13: Short version of Center for Epidemiologic Studies Depression Scale, CCSMHS: Chinese College Student Mental Health Scale, DASS-21: The Depression Anxiety Stress Scale, BSRS-5: Brief Symptom Rating Scale, Sakuma\_2010: Sakuma et al.(2010) self-designed questionnaire, MSSMHS: Middle-school students Mental Health Scale, CEPS: China Education Panel Survey, HADS: Hospital Anxiety and Depression Scale, Ji\_2007: Comprehensive Survey Report on Health-Related/Risk Behaviors among Chinese Adolescents.

# 3.3 Symptoms across scales

Figure 4 lists in how many scales each of the symptoms are listed; for instance, 11 of the 84 symptoms (13.10%) appear across a subset of 2 scales. Among the 84 symptoms, 18 (21.43%) were idiosyncratic symptoms and only appeared in one scale. None of the symptoms were present on all scales.

The most frequently measured symptom, appeared in 22 out of 27, was *Sense of hopelessness*. The second most measured symptom, 18 out of 27, was *Interest loss*. Note that anhedonia, a key symptom of major depression, is separated into two symptoms, loss of interest and loss of pleasure, in DSM-5. We found *Pleasure loss* was observed less frequently than *Interest loss*, being measured in 9 out of 27 scales. The compound symptom *Depressed mood* was measured by 5 scales, the specific symptom *blue* was measured by 10 scales, *low mood* by 15 scales, *sad* by 13 scales, *anhedonia by 16 scales.* If these symptoms were combined with *depressed mood*, this symptom would be the most frequent symptom among the 25 scales.

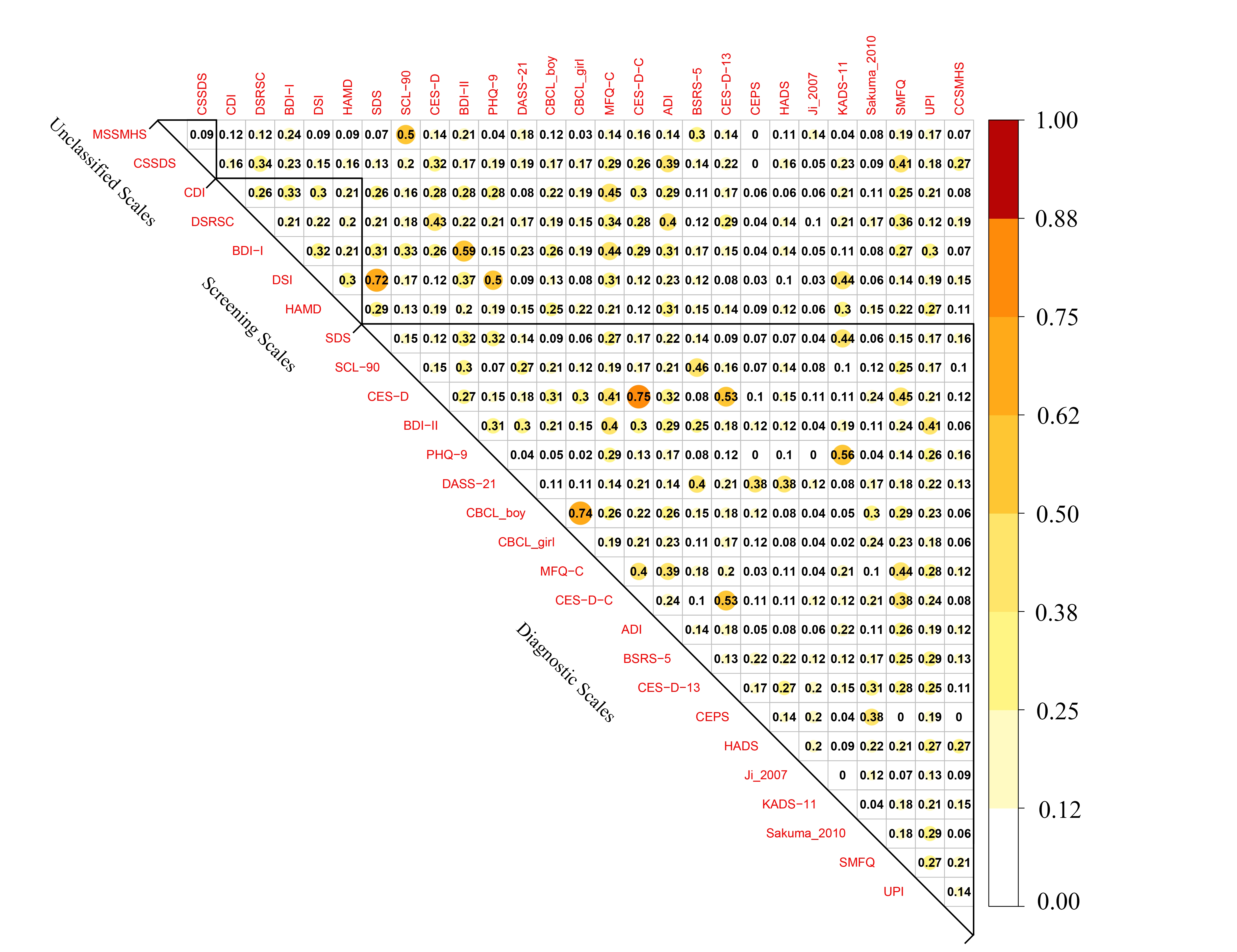


**Figure 4**

*Number of symptoms that appear across combinations of scales.* There are 18 symptoms that appear only in one scale; these symptoms are referred to as idiosyncratic symptoms.

The degree of overlap between scales was calculated using the Jaccard coefficient. The mean overlap across all scales was 0.19 (0.09 ~ 0.25), indicating a very low level of similarity between these scales. For the specific degree of overlap between each pair of scales and the average overlap with other scales, refer to Figure 5. CES-D has the highest average degree of overlap with other scale, at 0.25. The two scales with the highest overlap were CES-D and CES-D-C at 0.75, followed by DSI and SDS at 0.72. Many scales that have no overlap with each other. For example, there was no overlap between China Education Panel Survey with Middle-school students Mental Health Scale, PHQ-9, CSSDS, SMFQ, CSSMHS. Note that because Ji\_2005 has only one item that measures two symptoms, it has no overlap with PHQ-9, KADS-11.

We found a correlation between the mean overlap of scales and the scale length, *r* = 0.57, 95% CI [0.29-0.74]. Similarly, the correlation between mean overlap of scales and the number of captured symptoms is *r* = 0.69, 95% CI [0.48-0.82]. These findings suggests that longer scales exhibit increased overlap with other scales, thus demonstrating enhanced representativeness.



**Figure 5**

*Overlap of item content of 27 depression scales.* ADI: Adolescent Depression Inventory, CDI: Children's Depression Inventory, HAMD: Hamilton Depression Rating Scale for Depression, DSI: Depression Status Inventory, SDS: Self- Rating Depression Scale, MFQ-C: Mood and Feelings Questionnaire, CBCL: Child Behavior Checklist, BDI-II：Beck Depression Inventory-II, DSRSC: Depression Self-rating Scale for Children, BDI-I: Beck Depression Inventory, KADS-11: Kutcher Adolescent Depression Scale, CES-D: The Center for Epidemiological Studies Depression Scale, PHQ-9: Patient Health Questionnaire-9 items, CSSDS: China Middle school students' depression scale, CES-D-C: Center for Epidemiologic Studies Depression Scale for Children, UPI: University Personality Inventory, SMFQ: Short Mood and Feelings Questionnaire, SCL-90: Symptom Checklist 90, CES-D-13: Short version of Center for Epidemiologic Studies Depression Scale, CCSMHS: Chinese College Student Mental Health Scale, DASS-21: The Depression Anxiety Stress Scale, BSRS-5: Brief Symptom Rating Scale, Sakuma\_2010: Sakuma et al.(2010) self-designed questionnaire, MSSMHS: Middle-school students Mental Health Scale, CEPS: China Education Panel Survey, HADS: Hospital Anxiety and Depression Scale, Ji\_2007: Comprehensive Survey Report on Health-Related/Risk Behaviors among Chinese Adolescents. Mean overlap is detailed in the supplementary materials.

# 4 讨论

[第一段的主旨句]

研究分析了多个常用的抑郁量表，并发现它们在捕捉抑郁症状方面存在较大的异质性。这些量表之间的项目内容重叠度较低。这对于使用和解释相关数据有重要的启示作用。

[第二段的主旨句]

Fried (2017).的研究中Ces-d与其他量表有着最差的平均重叠率（0.27），而Ces-d在本研究中表现出最高的平均重叠率（0.25），可能是由于：1、本研究中除Ces-d以外还纳入了Ces-d简版以及Ces-d儿童版。2、在他的研究中Ces-d有33%的独特症状，而本研究中，随着纳入的量表增加，Ces-d的独特症状为0。

[第三段的主旨句]

抑郁量表的异质性来源可能是由于构念的不清晰，因此，在合并来自不同量表的研究结果时（例如元分析），特别是那些几乎没有重叠的量表时，可能不明智。

[第四段的主旨句]

不能认为低重叠就是糟糕的量表，高重叠就是好的量表。选择测量工具时应考虑多种因素，并根据评估的目的和目标进行选择。

[第五段的主旨句]

目前仍普遍认为量表可以互相替代，研究结果表明量表之间异质性非常强。因此在推广结果中应该强调这是某个量表的结果。

[第六段的主旨句]

确定哪些量表是合适的量表非常重要，我们团队正在使用cosmin系统对本次研究中涉及的量表进行评估。

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