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Family childhood experiences reports in depressed patients: comparison between 2 time points

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Abstract

Research has shown some discrepancies in the reports of experiences from childhood when an individual is depressed, because a depressed mood may have biasing effects on autobiographical memory. The present study sought to clarify this issue by examining whether there is temporal stability in the report of childhood experiences in depressed subjects, or rather, if these experiences are influenced by the mood at the time of report. The study therefore carries implications for the credibility of childhood reports of depressed adults, for the validity of the questionnaire used – Family Background Questionnaire (FBQ), adapted from Melchert (1991) – and for the conclusions it might yield. We hypothesized that the report of the same childhood family experiences across the year would not be influenced by the mood disorder. To test this prediction, we solicited reports of family experiences in 25 depressed subjects (76% women and 24% men) across the course of one year . The diagnosis of Major Depressive Episode at the outset of the study was confirmed in all subjects with the use of Structured Clinical Interview for DSM-IV Axis I and the Beck Depression Inventory (BDI) to quantify level of depressive mood (M = 19.80, SD = 10.68). The report of childhood and family experiences was collected with the FBQ (Melchert, 1991; Melchert & Sayger, 1998), which consists of 124 items comprising 14 subscales. As hypothesized, results demonstrated that the reporting of childhood experiences in dthe family after approximately 1 year was not influenced by mood state of depression, which reinforces the reliability of childhood reports and the adequate reliability of the FBQ. However, there were significant differences between the first and second moment in the mood of the subjects (BDI), with a significant mood improvement after one year. These results are consistent with those of other authors which confirms that the use of questionnaires with more objective and specific items reduce the risk of biased responses on self-reporting childhood experiences.

1. Introduction

When someone reports events experienced throughout his life, it is difficult to know whether individuals are responding to these issues based on their memories when they were children, or are based on current judgments and feelings about the behaviors their parents were with her when she was a child. In that respect, in recent years, the study on the influence of humor, loyalty and stability of reporting the experiences has been the subject of many scientific investigations. Assessment instruments of the care received within the family-of-origin measure memories

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of family experiences, rather than a direct measure of aspects of past events or even provide a measure of the fidelity of these memories (Melchert & Sayger, 1998). However, research on the reliability of childhood memories is directly relevant to assess the validity of the reports obtained with these instruments. Thus, in terms of conceptualization or theoretical research, it is important to know the degree of veracity of autobiographical memories. In a clinical or empirical perspective, the importance of determining the validity of those memories is increased, mainly because the subjective view of the stored memories, even if distorted or wrong, have a very significant impact on psychological functioning and behavior (e.g., Loftus, Feldman, & Dashiell, 1997; Fabiani, Stadler, & Wessels, 2000). Still in this perspective, it is important to stress the complexity involved in the validation of the account of previous experience in the family-of-origin. For discrete events, which are more objective, it is easier to test its validity by examining the recall and other descriptions of the same event (e.g., cross reports of the subject with reports of parents or siblings of the same event). But for many complex interactions between members and family events, this test is virtually impossible until now. On a closer scrutiny, even for discrete events, despite the congruence between the elements found, this does not confirm necessarily the truth of the Genesis experience, there may be a collective distortion of the same event (for peer influence, family, educational, social or cultural).

Retrospective investigations of maltreatment have 3 methodological limitations (cf. Azevedo & Maia, 2006) because includes some risks regarding data interpretation, since it can lead to confusion regarding the precise demarcation between causes and consequences of adverse experiences in development (e.g., changing the child's behavior can trigger episodes of ill-treatment or may be the consequence). A second limitation may be due to the fact that it was investigating the cases from the child social protection services (which limits the generalization of results). And finally, given the conceptual difficulties in the definition of abuse/ maltreatment, there are many investigations dealing with this concept globally, when, in essence, they only worked with cases of physical abuse or other type of abuse.

It is also known that humor has a significant influence on the account of the experiences or the self-responses of an individual (e.g., Hardt & Rutter, 2004). On the psychopathology of depression, in addition to the emotional changes, there is a change in mood (e.g., Soares, 2000), so that, while emotions are based on the information from the environment, the different types of humor are bound to inner person (Williams, Watts, Macleod, & Mathews, 2000). Many variables in research on depressive symptoms uses tools for self-reporting, which assesses the individual's perception of their ability to see and deal with problems, or to describe the self or the perceptions of their interpersonal relationships. In this regard, several researchers have expressed concerne that the scores on the instruments of self-response could be influenced by the presence of depressed mood (e.g., Enns, Cox, & Larsen, 2000). A state of depressed mood may be associated with biased autobiographical memory, which can enhance the individual to have a sense of self and interpersonal relationships perspective in a more critical and negative (Williams et al., 2000). In this concern, the results of the instruments of self-response could be a consequence of depressive symptoms (Enns, Cox, & Larsen, 2000). Therefore, one could think that the current mood is a key factor in how subjects give their answers in relation to their experiences. However, in two literature reviews (e.g., Enns, Cox, & Larsen, 2000; Heene, Raedt, Buysse, & Oost, 2008), investigations tend to indicate that the mood does not influence the self-responses for questions or items on autobiographical memories and past experiences. In this regard, Heene and his colleagues (2008) developed an experimental study to test the influence of negative mood in the materials for self-response assessment of depressive symptoms. By using procedures of mood induction into two groups (experimental and control), the results showed that responses did not differ in the measures evaluated, although the mood manipulation was effective. This shows that the evaluation of these measures of self-assessment, such as depression, are generally insensitive to the influence of mood state, which contributes to the reliability of the results in the materials for self-reporting.

Regarding the methods used in investigations (whether retrospective or longitudinal), the research does not provide advantage to the interview in relation to the questionnaires or vice versa, but evidence the priority for specific questions and objectives that include the definition of what is to assess (Hardt & Rutter, 2004). These are the focus strategies, preferably using a number of issues to cover a set of experiences that increase the reliability of reporting of past experiences. Certainly, all these results shown in retrospective studies can and should be supplemented with longitudinal studies, which will reduce the subjectivity of individual perception and increase knowledge of the events and real life experiences that gives access to valuable information, in order to clarify, more robustly, the degree of reliability of the instruments of self-reporting. The higher correlation between the responses over time the better for reliability of the report of the individual (Henry, Moffitt, Caspi, Langley, & Silva, 1994). Other strategies could be the use of other sources of information to confirm the information collected with the evaluated individual, although it is also dependent on the subjective perception of each person. The laboratory and

empirical investigation on autobiographical memory suggests that after a certain age (generally from 18 years), previous and most striking experience are remembered, and that the amount of sensory and contextual details accompanying the report of these experiments favors real memory, making it more reliable (Brewin, Andrews, & Gotlib, 1993; Henry et al., 1994). Although we know that with interviews or questionnaires, the more objective and detailed questions in relation to autobiographical memories, the lower the degree of bias and the greater the accuracy of the report, there are some discrepancies when investigating a report of experiences in development when an individual is depressed, as a state of depressed mood may be associated with biased autobiographical memory (e.g., Williams et al., 2000).

Thus, this study aims to investigate, in a sample of depressed subjects with confirmed diagnosis of depression, in two different times (about 12 months apart), if there is temporal stability in the account of experiences in development, or rather, if these experiences are influenced by the mood at the time of reporting. To this end we place the following hypothesis (H1): The report in two different time points for the same interpersonal experiences of development is not influenced by the mood disorder.

2. Method

2.1. Participants

This study was conducted with a sample of 25 depressed subjects, 76% female (n = 19) and 24% (n = 6) male. The average age of this sample is 36.84 (SD = 11.63) years old, within a range between 19 and 56 years old. In terms of the total number of major depressive episodes, 76% (n = 19) subjects have a history of one or more past major depressive episodes and 24% (n = 6) with no history of depression (other than the diagnosis made at the first moment of evaluation). With regard to marital status, 44% (n = 11) living with a partner (married or living together) and 56% (n = 14) without a partner (single and divorced). The number of children, 60% (n = 15) have between one and two children and 40% (n = 10) have no children. As regards the socio-economic class, 80% (n = 20) belong to the middle class and 20% for lower middle class.

2.2. Materials

Family Background Questionnaire (Melchert, 1991) – this instrument consists of 179 items, divided by twenty-two subscales (check table 1). Its punctuation gives rise to a total value of measuring the functioning of the family of origin in general, which is calculated by the addition of several items of almost all subscales. It is also possible to calculate the total of each subscale. The application is directed to adults and does questions about their memories of experiences in the family home until eighteen years of age. A Lickert-type scale of one to five points is used for all items of the instrument. All scores are listed so that the highest level indicates better family functioning. Thus, it varies in a *continuum* from 1 to 5, and the more closer to 5 the better family functioning. The temporal stability of the Family Background Questionniare (FBQ) was examined by retesting 79 undergraduate college students after a 2-week period (Melchert & Sayger, 1998). The Pearson correlation coefficient between the two test administrations was .96 for the Total Scale, and ranged from .59 for the Sexual Abuse scale to .93 for the Father Acceptance scale. Over one-half of the scales (52.2%) had stability coefficients of at least .85, but there were 3 subscales with coefficients less than .70 (i.e., Sexual Abuse, Mother Substance Abuse, and Child Social Support).

Beck Depression Inventory (BDI) - this is an inventory of auto-response which was designed to assess the severity of depressive symptoms, resulting in a value of depressive mood (BDI, Beck, Ward, Mendelsohn, Mock & Erbaugh, 1961 / portuguese version by Vaz-Serra & Pio Abreu, 1973a, 1973b). It is constituted with 21 items spread over 21 different manifestations of depression and it's organized according to 6 parameters of depressive symptoms assessment like emotional, cognitive, motivational, delusional, and physical functioning (sleep, appetite, libido and weight). Each of the items consists of 4 or 5 statements ranked according to severity of symptoms. Given these items, the individual should choose the one statement that is closest to its current state, varying the value of the alternatives between 0 and 3. The internal consistency of this instrument is good, with a test-retest high fidelity (Vaz-Serra & Pio Abreu, 1973a, 1973b).

3. Design and Procedure

This research had as participants' adult subjects, which is an advantage, since "there is less likelihood of development and maturation over time, when we evaluate two or more stages of evaluation" (Almeida & Freire, 2000, p.84). In order to investigate the impact of mood on participants' responses, the study was planned for 2 times of assessment, which the first time was between 2005 and 2006 and the second moment occurred about one year after the first time (with a variation of plus or minus 3 months), which gathered data from depressed participants from the first time available to work again in the study (n = 25). Since there is no manipulation of variables, all are dependent and the subject and we used a intra-subject planning. About the design of research, this study is a longitudinal one year. It was assured for both times the confidentiality and privacy of all responses. The second stage of evaluation was equivalent in terms of the content of the protocol applied, but with a different procedure. In this second phase, participants in both groups were contacted by telephone, about 1 year after of applying the first time. In order to standardize the call for collaboration in the second phase of the study, we followed a written text, by telephone contact. In this second time a protocol was sent with all materials applied in the first time. The materials submitted included an envelope printed with the recipient (workplace of the researcher) already included with stamp, safeguarding the identity of the participant, so that in case of loss, if maintained confidentiality and privacy of each subject.

4. Results

With regard to depressive mood, assessed with the BDI, the average score in time 1 is 19.80 (SD = 10.68) and 12.68 (SD = 13.30) in time 2. In time 1, four subjects have BDI scores below 10 points, six subjects with scores between 11 and 19 points (mild depression) and eleven subjects with scores between 20 and 30 (moderate depression) and four subjects with more than 30 points (severe depression), varying the score in time 1 between 2 and 40 points. Thus, the depressive mood that prevails in most time 1 is *moderate*. In time 2, fifteen subjects have in the BDI scores below 10 points, five subjects with scores between 11 and 20 (mild depression), two subjects with scores between 20 and 30 (moderate depression) and four subjects with more than 30 points (depression severe), scores ranging from 0 (no depression) and 48 points (severe depression). Comparing the two moments, we note statistically significant differences ($F_{(1,24)} = 4,357$, $p < .05$), with lower values in time 1 (M = 19.80, SD = 10.68) compared with time 2 (M = 12.68, SD =. 13.30). Be noted that in time 2 fifteen subjects had scores below 10 points in the BDI and 6 subjects with scores of depressive mood classified as moderate and severe (BDI scores greater than 20). This results in a standard deviation above average, which shows that the scores of depressed mood are quite pronounced in some subjects. However, overall, most subjects show significant improvements in their state of depressed mood in time 2, a year after having been evaluated. For all variables of family history, we note that positive correlations between the two times of assessment, varying from those .520 ("depressed mood") and .924 ("index of maternal care"). The total correlation of the general family care index between the two moments is considered strong ($r = .844$, $p < .01$).

A summary of the results is presented in Table 1.

Table 1 Means, *Standard Deviations, Correlations and MANOVA for the two time points for the IHF*

Variables	Time 1		Time 2		Correlation 2 times	MANOVA
Father Care Questionnaire	M	SD	M	SD		
1 – Father Acceptance and Expressiveness	2.96	1.05	3.13	.98	r = .662, p=.001**	F (1,22) = .297, p=.588
2 – Father Responsiveness and Dialogue	2.40	1.07	2.45	1.11	r =.753, p=.000***	F (1,22) = .027, p=.870
3 – Father Educational Involvement	3.01	1.04	3.08	.93	r =.736, p=.000***	F (1,22) = .055, p=.816
4 – Father Physical and Emotional Respect	3.51	1.06	3.74	.96	r =.798, p=.000***	F (1,22) = .574, p=.453
Father Care Scale	2.97	.80	3.09	.82	r =.728, p=.000***	F (1,22) = .287, p=.595
Mother Care Questionnaire	M	SD	M	SD		
5 - Mother Acceptance and Expressiveness	3.51	1.07	3.59	1.09	r =.838, p=.000***	F (1,24) = .060, p=.807
6 – Mother Responsiveness and Dialogue	3.12	.90	3.05	1.07	r =.859, p=.000***	F (1,24) = .057, p=.812
7 - Mother Educational Involvement	3.41	1.08	3.59	.81	r =.895, p=.000***	F (1,24) = .404, p=.528
8 - Mother Physical and Emotional Respect	3.60	.99	3.87	1.02	r =.843, p=.000***	F (1,24) = .859, p=.359
Mother Care Scale	3.41	.81	3.52	.84	r =.924, p=.000***	F (1,24) = .231, p=.634
Family Environmental Questionnaire	M	SD	M	SD		
9 – Absence of Parental Substance Abuse	4.60	.74	4.62	.75	rs = .830, p=.000***	F (1,24) = .014, p=.906
10 - Parental Coalition and Psychological Adjustment	3.35	.71	3.48	.74	r =.899, p=.000***	F (1,24) = .454, p=.504
11 – Physical Care and Non-violent Parental Relationship	4.27	.82	4.30	.72	r =.800, p=.000***	F (1,24) = .030, p=.864
12 – Absence of Domestic Chores	3.21	1.33	3.24	1.21	r =.772, p=.000***	F (1,24) = .009, p=.925
13 – Childhood Social Support and Family Emotional Expression	2.60	.83	2.62	.78	r =.765, p=.000***	F (1,24) = .006, p=.941
14 – Parental Control	2.94	.75	3.21	.76	r = .553, p = .004**	F (1,24) = .086, p=.770
Family Environmental Scale	3.50	.42	3.58	.35	r = .776, p = .000***	F (1,24) = .054, p=.818
General Family Care Index	3.33	.49	3.43	.51	r = .844, p = .000***	F (1,24) = .328, p=.569
Depressed Humour	19.80	10.68	12.68	13.30	r =.520, p=.008**	F (1,24) = 4.357, p=.042*

*p<.05, ** p<.01, ***<.001

The Father Care scale, the depressed subjects have an average of 2.97 (SD =. 80) in the time 1 and an average of 3.09 (SD =. 82) in time 2, and these differences are not statistically significant (F (1, 22) = .287, p> .05). The Mother Care scale, the subjects have an average in time 1 of 3.41 (SD =. 81) and in time 2 of 3.52 (SD =. 84), there was also no significant differences between the two time periods (F (24) = .231, p> .05). For the Family Environment scale, the average of time 1 is 3.50 (SD =. 42) and in time 2 is 3.58 (SD =. 35). No significant differences between the two time periods was found (F (1,24) = .054, p> .05). We noted also that the General Family Care Index, the average in time 1 is 3.33 (SD =. 49) and in time 2 of 3.43 (SD =. 51), they did not differ significantly between the two stages of evaluation (F (1,24) = .328, p> .05). In a particular analysis of each subscale, there are no significant differences in any subscale between the two evaluation times. Besides this fact, there is a strong correlation between the two moments on the various subscales, indicating stability of the report, even despite the significant differences in depressive mood between the two times.

Assuming H1 placed for this study, namely that " The report in two different time points for the same interpersonal experiences of development is not influenced by the mood disorder", the results confirms that there are no differences in reporting family childhood experiences, despite significant variation in depressive mood. Thus, the hypothesis H1 is confirmed..

5. Discussion

The average value of depressive mood at time 1 is classified as moderate (with 19.80 points) but the in time 2 is just classified as mild (with 12.68). This improvement may have been due to the fact that the subjects begun psychotherapy since after time 1 evaluation.

Assuming the hypothesis H1 under discussion in this study ("the report at two different times of the same family experiences during childhood is not influenced by depressed mood "), it appears that despite the significant decrease in depressive mood from time 1 to time 2, no difference in any of the subscales of the Instrument of Family History (IHF) between the two times. In addition to this evidence, the strong correlation between the two moments of the report (which ranges from .553 in the "Parental Control" and .924 in "Maternal Care scale") suggests the stability of the report. Considering the arguments of Henry and his colleagues (1994), who argue that the correlation between responses over time, when high, indicates the reliability of the individual's report, one can conclude that there is stability of the reports of childhood experiences, mainly confirming the significant differences in depressive mood and the long period of time between the two evaluation times. Consequently, overall, the results indicate the validity and temporal stability of retrospective evaluation of experiences during development, regardless of the mood disorder. It is confirmed, therefore, the hypothesis H1.

There are several investigations that show that memory is often distorted and inaccurate (e.g., Schacter, 1995) and, often, memory, as a reconstructive process experience is influenced by mood (e.g., Fernandez & Díez, 2001). In addition, the evaluation of memories of family experiences with tools of self-reporting does not directly measure aspects of past events or give a measure of the accuracy of such memories (Melchert & Sayger, 1998). After all, our findings go against what many authors consisted in several literature reviews on the account of experiences from self-responses (Brewin, Andrews, & Gotlib, 1993; Enns, Cox, & Larsen, 2000, Hardt & Rutter, 2004, Heene et al., 2008). Yet, these authors concluded that although there is some influence of mood on self-reported experiences, the more specific and objective are the questions or items under consideration, the lower the risk of biased answers. The fact that our results show on the Instrument of Family History (IHF) is that the answers do not appear to be affected by depressed mood, suggesting the reliability and temporal stability in the assessment report of family experiences, since, even with the difference in the intensity of depressive mood between the two times of assessment, the childhood reports tends to be the same in the self-response questionnaire.

Our results also meet the work of Richter and Eisemann (2001) on the assessment of the report of depressed subjects for parental care, who found a strong stability of the report in a questionnaire of self-assessment, despite the significant variations in the degree of depression. This evidence gives reason to what many researchers claim, namely that the assessment based on the autobiographical memory is feasible (e.g., Neisser, 1994) and that the use of questionnaires of self-reporting, which are founded on specific questions and objective (Hardt & Rutter, 2004), encompassing sensory details and contextual (Brewin, Andrews, & Gotlib, 1993) is an appropriate way to assess the degree of reliability of family experiences in the past (Henry et al., 2004).

In the future, despite the results obtained in the individual report of each subject, it is important to resort to other sources of information, such as a real-time monitoring of participants throughout life (in longitudinal studies), with assessments more based on present reality and not only based on the memory of past experience (as in retrospective studies), which may be influenced by perceptions, cognitive schemata and mood of the subject at the time of recall (eg, Fabiani, Stadler, & Wessels, 2000, Lindsay & Read, 1994; Schacter, 1995).

In conclusion, our results suggest that depressed mood does not seem to have enough significant impact to change the reporting of family experiences on self-responses using the Portuguese version of the Instrument of Family History (IHF), which contributes to the reliability of this instrument in the research, as well as to strengthen the evidence found in other studies with this same material.

Aknowledges

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