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The Self-Efficacy Questionnaire for Depression in Adolescents (SEQ-DA)
Development and psychometric evaluation

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■ **Abstract** The 12-item clinician or self-administered Self-Efficacy Questionnaire for Depression in Adolescents (SEQ-DA) was developed as a measure of perceived ability to cope with depressive symptomatology. This study examined the reliability and validity of the SEQ-DA in a clinical population of 130 adolescents that were receiving treatment for depression. Psychometric evaluation revealed good internal consistency and test-retest reliability. Results indicated that higher SEQ-DA scores were associated with lower self-rated depression scores (Reynolds Adolescent Depression Scale), which is evidence of good construct validity. Further, higher SEQ-DA scores prior to treatment predicted better outcome at the end of the 3 months of treatment and at 6 months post-treatment. Therefore, the SEQ-DA has a potentially useful role in clinical work and research with depressed young people.

■ **Key words** self-efficacy – adolescents – depression – psychometric properties

Introduction

According to Bandura [6], in order to competently carry out and maintain a particular behaviour, one needs both the belief that a given behaviour will lead to the desired outcome (high outcome expectancy) and the belief that one can successfully execute the behaviour to produce the outcome (high self-efficacy expectancy). High self-efficacy has been found to be a good predictor of health promotion behaviours, such as smoking cessation [15, 30, 32], weight reduction [10, 11, 31] and pain management [3, 8, 20]. Perceived self-efficacy is also crucial to perceived personal control and successful adaptation to life events [5]. Further, it has been suggested that it may act as an important buffer against depression [5]. Depression is a disabling condition that has been estimated to have been the third highest cause of disease burden for Australian adolescents in 1996 [21].

Bandura [4] proposed that when individuals have high outcome expectancy, but relative to others they have low self-efficacy expectancy, the result is a lack of behavioural initiative and persistence, self-devaluation and depressed mood. Under conditions of low outcome expectancy, individuals may experience lack of behavioural initiative and persistence, but not depressive symptoms such as self-devaluation and despondency, because they do not view themselves as flawed relative to others. Bandura et al. [7] suggested that a low sense of efficacy to exercise control in one's life can lead to depression through unfulfilled aspirations. Furthermore, the authors posited that a low sense of social efficacy may impair the gain of social supports that could act as a buffer against depression, and that a low sense of efficacy to control depressing ruminative thoughts may

help to convert depressive mood to a more pervasive depressive disorder.

This theory of self-efficacy is consistent with other prominent cognitive theories of depression such as the learned helplessness theory [1] and Beck's cognitive theory of depression [9]. Learned helplessness theory argues that one of the key factors in depression is attributional or explanatory style, by which an individual tends to explain positive and negative life events. Individuals who tend to explain negative events using internal, stable and global factors are likely to be prone to depression following the occurrence of a negative event [1]. Beck [9] proposed that individuals suffering from depression have negative beliefs about themselves, the world, and the future. In terms of self-efficacy theory, individuals who according to Beck [9] generally view themselves as incompetent and incapable, or according to Abramson et al. [1] attribute the cause of bad outcomes to stable internal flaws, are probably expressing low self-efficacy expectancy.

Thus far, some studies have found a relationship between depressive symptoms and perceived self-efficacy. For example, a cross-sectional study of high school students revealed a negative correlation between self-efficacy and depression [13]. The domain of self-efficacy expectancy might predict depression because specific measures of self-efficacy, such as academic and emotional self-efficacy, have been found to be more strongly associated with depression than physical or social self-efficacy [13, 24, 25].

Longitudinal research findings have shown that low levels of academic and social self-efficacy in a sample of school children were predictive of long-term depression at 1- and 2-year follow-up [7]. A study with clinically depressed adults showed that improvements in depression after group cognitive therapy treatment were closely associated with higher post-treatment levels of self-efficacy regarding control of mood and with self-monitored levels of negative cognition [18]. Further, remission in the following year was predicted by initial response to treatment, shorter duration of the depressive episode prior to treatment, and by post-treatment self-efficacy regarding control of negative cognition.

Self-efficacy theory has been criticised for failing to acknowledge that self-efficacy may not be an independent variable, but rather an epiphenomenon of performance (see [16, 17]). While self-efficacy has been acknowledged as having utility in predicting behaviour such as smoking cessation and management of pain, it has been criticised when referred to as a cause of behaviour [17]. Kirsch [19] argues that behavioural change linked to self-efficacy is not so much a belief in one's ability to accomplish something, but rather a willingness to undertake these tasks. Similarly, a low sense of self-efficacy may merely be an epiphenomenon of having a depressive disorder. It could be argued that studies show-

ing the predictive value of self-efficacy for depression indicate that self-efficacy is not simply an effect of depression because it occurs prior to the depression. However, this ignores the possibility that the level of self-efficacy has been determined already by prior (unmeasured) events [16, 17]. However, even the greatest critics acknowledge that self-efficacy has "certain utility in terms of predicting behaviour" (p. 252 [17]), and is of clinical interest in terms of planning and evaluating treatment. As pointed out by Muris [24], the value of a self-efficacy instrument may be to provide information on the extent to which treatment has been effective in the client's acquisition of effective coping skills for negative emotions.

◾ Aim

In adults with depressive disorders, it has been found that those with greater self-efficacy regarding their ability to cope with their depression had fewer depressive symptoms and were functioning better after treatment [33]. In the light of this finding, it would be of potential value to extend the investigation of self-efficacy of coping with depression to adolescents. The first step in this process is the development of a reliable and valid instrument for assessing self-efficacy expectations about coping with depressive symptoms in adolescents. The current study reports the development and psychometric evaluation of such a questionnaire, the self-administered Self-Efficacy Questionnaire for Depression in Adolescents (SEQ-DA).

Subjects and methods

◾ Sample

The 12-item SEQ-DA was trialled in a sample of 57 adolescents that were treated in the *Berriga House* [14] and 73 adolescents that were treated in the *Time for a Future* [22] adolescent depression projects. These projects treated 12- to 18-year-old adolescents (mean age = 15.05 years, SD = 1.51) living in the community, that were suffering from depression. The adolescents were randomly assigned to treatment with cognitive behaviour therapy (CBT), supportive therapy, a selective serotonin re-uptake inhibitor (sertraline), or a combination of sertraline and CBT. Of these adolescents, 68 were diagnosed with DSM-IV criteria [2] major depressive disorder, 30 with dysthymic disorder, 31 with depression not otherwise specified, and one with an adjustment disorder with depressed mood. The ratio of females to males was nearly 2:1 (85 females and 45 males). The sample comprised six 12-year-olds, fourteen 13-year-olds, thirty-two 14-year-olds, twenty-one 15-year-olds, thirty-four

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16-year-olds, eighteen 17-year-olds, and five 18-year-olds. Over 60 % of the sample was also diagnosed with other comorbid disorders. The most frequently diagnosed comorbid problems were generalised anxiety disorder (11 %), dysthymic disorder (5.4 %), oppositional defiant disorder (3.8 %), post-traumatic stress disorder (3.1 %), and DSM-IV [2] v-coded family relational problems (23.8 %). Participants were excluded from these projects if they suffered from bipolar disorder, psychosis, chronic illness, intellectual disability precluding participation in CBT, or if they were actively suicidal requiring hospitalisation.

The stability of the scale over time was tested in 35 of these adolescents, first at the initial assessment session, then 1–2 weeks later, prior to the start of treatment. While this interval is somewhat short and, thus, a methodological limitation, this procedure ensured that participants did not have altered self-efficacy at retest due to treatment effects. The test-retest sample comprised 13 males and 22 females ranging from 12 to 17 years of age (mean age = 15.3 years, SD = 1.4). One participant was 12 years old, three were 13, nine were 14, three were 15, ten were 16 and nine were 17 years old.

Instruments

The 12 items of the SEQ-DA were developed by the authors to measure specific self-efficacy expectancies related to coping with depressive symptomatology. Scale item selection was informed by DSM-IV [2] diagnostic criteria for depressive disorders, a review of the adolescent depression literature, the clinical experience of the authors, and consideration of age-related developmental features of depression. The items measured the ability to cope with managing activities, sad mood, over- or under-eating, sleep difficulties, tiredness, concentration difficulties, irritability and anger, a difficult day, negative thoughts, holding a conversation with unfamiliar people, life events and self-harm impulses. While many items pertain to diagnostic criteria for a depressive episode, no items refer to psychomotor changes, because these are relatively uncommon in adolescent depression [27]. Perceived coping is evaluated on a five-point scale, ranging from "really sure I couldn't (1)", "probably couldn't (2)", "maybe (3)", "probably could (4)", and "really sure I could (5)". Scoring is conducted by summing the responses, yielding a possible total score between 12 and 60. Higher scores reflect greater self-efficacy expectations.

The 30-item Reynolds Adolescent Depression Scale (RADS) [28] was chosen as a test of concurrent validity for the SEQ-DA. The RADS is also self-administered and takes 5–10 min to complete. Scores on this scale range from 30 to 120, and a score above 76 is considered to indicate clinical levels of depression. The scale has been shown to have good reliability and validity, with an internal consistency reliability of 0.91 and test-retest reliability of 0.87 [29]. The RADS has also been found to correlate highly (r > 0.72) with other measures of depression including the Hamilton Depression Rating Scale [29] and the Children's Depression Inventory [28], indicating good construct validity.

Procedure

The SEQ-DA and the RADS were included as part of the assessment process for *Berriga House* and *Time for a Future* study participants [14]. The SEQ-DA data from those adolescents that were diagnosed with a depressive disorder and undertook treatment in these projects were included in this study. Of those participants, 35 were retested 1–2 weeks after the first assessment session, prior to starting treatment.

Results

Scale analysis

Exploratory factor analyses provide insight as to the underlying factor structure of a scale. Testing the factor structure of the SEQ-DA aims to examine the integrity of the instrument for use in evaluating adolescents' perceived ability to cope with depressive symptomatology. Exploratory factor analysis using principal components with varimax rotation was performed on the 12 items of the SEQ-DA for 123 participants who did not have any missing data from a total of 130. A two-factor solution (with loadings of 0.4 or more) and a three-factor solution (with loadings of 0.5 or more) emerged that explained 39 % and 48 % of the variance, respectively. The two-factor solution depicted in Table 1 indicated that the

Table 1 Factor loading of items from the SEQ-DA for the two-factor solution

Item	Factor loading
Factor 1	
Coping with sad mood	0.67
Managing doing favourite activity	0.65
Coping with sleep difficulties	0.63
Coping with stopping negative thoughts	0.57
Coping with over- or under-eating	0.57
Coping with concentration difficulties	0.52
Coping with a difficult day	0.50
Coping with tiredness	0.44
Factor 2	
Coping with a future big life event	0.70
Cope with self-harming impulses	0.68
Coping with irritable/angry mood	0.54
Coping with having a conversation with unfamiliar people	0.48

first factor comprised eight items, which measured perceived confidence in coping with somatic and psychological symptoms of depression. The remaining four items that constituted factor 2 did not appear to measure a common underlying construct. The items on factor 2 consisted of both confidence in coping with external events (such as life events and holding a conversation with unfamiliar people), and coping with irritable or angry mood and self-harm impulses.

The three-factor solution depicted in Table 2 also did not suggest three meaningful constructs. Although the first factor appeared to measure perceived confidence in coping with somatic and psychological symptoms of depression, the second and third factors did not appear to reflect any clear underlying constructs. The second factor measured perceived ability to cope with negative thoughts, hold a conversation with unfamiliar people and to cope with self-harm impulses. The third factor measured the perceived ability to cope with irritability or anger, future life events and sleep difficulties. In view of the lack of meaningful constructs evident in both the two- and three-factor solutions, it was concluded that the SEQ-DA best reflects a single dimension, although a single-factor solution explains only 28% of the total variance. A single-factor solution is conceptually consistent with the aim of designing an instrument to measure the construct of perceived ability to cope with depressive symptomatology.

The high internal consistency of the instrument (Cronbach's $\alpha = 0.73$) further supports the decision to regard the SEQ-DA as reflecting one single dimension. In addition, confirmatory factor analysis was conducted to determine how well a single factor fits the data. Results indicated that there was a reasonable fit [comparative fit index (CFI) = 0.78, root mean square error approximation (RMSEA) = 0.086]. Out of the 12 items, only

inclusion of item 7 (coping with irritable or angry mood) was questionable. The weight for item 7 was not significant, suggesting that the fit may be improved with removal of this item. However, results were inconclusive, with CFI scores improving (0.80) with deletion of item 7 and RMSEA scores deteriorating (0.091). Cronbach's α improved from 0.73 to 0.75 with the removal of item 7.

■ Reliability analysis

Test-retest reliability for the SEQ-DA was established by comparing initial scores of 33 adolescents (2 adolescents were excluded due to missing data) with scores obtained 1–2 weeks after the first assessment, prior to start of treatment. The instrument was found to have very good stability with both Pearson's r and intra-class correlations equalling 0.85. The SEQ-DA also has good internal consistency with a Cronbach's α reliability coefficient of 0.73.

■ Validity

Construct validity was determined by examining the association of SEQ-DA total scores and total depression scores measured by the RADS. As higher scores on the SEQ-DA reflect better functioning, and higher scores on the RADS indicate poorer functioning, an inverse relationship was expected. The SEQ-DA scores were significantly negatively correlated with total RADS scores (Pearson's $r = -0.67$, $p < 0.001$).

■ Relationship between SEQ-DA and post-treatment depression scores

The possibility that pre-treatment self-efficacy might be a predictor of response to treatment was investigated by testing the relationship between pre-treatment SEQ-DA scores and post-treatment RADS scores, and with 6-months post-treatment RADS scores. Missing post-treatment data were analysed using an intent-to-treat procedure, which is designed to avoid any possible overestimation of treatment outcomes due to the non-inclusion of participants who discontinued treatment. Nelson's [26] 'last observation carried forward' technique was used. This involved substituting outcome measures from the previous assessment for missing post treatment or 6-months post-treatment assessment data. This technique thus assumes that the outcome does not change with time, and provides a conservative estimate of outcome. Partial correlations controlling for treatment type revealed a significant inverse relationship between pre-treatment SEQ-DA scores and post-treatment

Table 2 Factor loading of items from the SEQ-DA for the three-factor solution

Item	Factor loading
Factor 1	
Coping with concentration difficulties	0.67
Coping with sad mood	0.67
Coping with tiredness	0.61
Managing doing favourite activity	0.60
Coping with over- or under-eating	0.55
Coping with a difficult day	0.51
Factor 2	
Coping with having a conversation with unfamiliar people	0.73
Coping with stopping negative thoughts	0.70
Cope with self-harming impulses	0.64
Factor 3	
Coping with irritable/angry mood	0.70
Coping with a future big life event	0.56
Coping with sleep difficulties	−0.51

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RADS scores ($r = -0.37$, $p = 0.001$), and between pre-treatment SEQ-DA scores and 6-months post-treatment RADS scores ($r = -0.43$, $p < 0.001$).

Discussion

The results confirm that the SEQ-DA has satisfactory reliability and validity. Analyses suggested that a single-factor solution best explains the SEQ-DA, which is consistent with the aim of designing an instrument to measure the construct of perceived ability to cope with depressive symptomatology. While one item pertaining to coping with irritable or angry mood did not load on the single-factor solution, removal of this item did not reveal conclusive evidence for improved fit. In addition, irritability is an alternate marker of adolescent depression and is, therefore, of upmost clinical importance. Thus, while results cast some doubt on the inclusion of this item, its clinical utility suggests that, until further validity data are available, this item should be retained.

Both test-retest reliability and internal consistency of the instrument were satisfactory. Higher pre-treatment RADS depression scores were associated with lower SEQ-DA scores, providing evidence of construct validity. Further, lower pre-treatment SEQ-DA scores were also associated with higher RADS depression scores after completion of treatment and 6 months post-treatment. This is consistent with findings from a study of depressed adults, where higher self-efficacy regarding the ability to cope with depressive symptoms was related to fewer depressive symptoms and better functioning at the completion of treatment [33].

Overall, the SEQ-DA is brief and easy for clinicians and researchers to administer. With only 12 items, this instrument is short enough to use as a self-report assessment tool in depressed adolescents, where reduced attention span may pose difficulties in assessment. The SEQ-DA may be used to identify an adolescent's self-efficacy before beginning treatment to inform decisions regarding the type of cognitive-behavioural coping strategies the young person may need to develop. During treatment it may also be of use to determine the progress of therapy. Finally, the SEQ-DA has potential as a research tool. For example, it may be used to establish whether coping with depression self-efficacy is a predictor of relapse. This study indicates that higher self-efficacy prior to treatment predicts better outcome at the conclusion of 3 months of treatment, and 6 months post-treatment, regardless of the type of treatment.

The reliance on the exclusive use of self-report measures to establish validity is a possible limitation of this study. However, reliability of child reports have been found to increase with age [12], and, with regard to symptoms of depression, children have been found to be better informants than their parents [23]. It is possible that questionnaire scores might reflect an overall negative response style, which may be an epiphenomenon of the depression (as mentioned in the Introduction) rather than the intensity of the depression or perceived ability to cope per se. Further validation of the SEQ-DA could include an investigation of the effects of comorbid disorders and assessment of the SEQ-DA's psychometric properties in a normal population, where its predictive ability to discriminate depressed and non-depressed adolescents could be established. It could also be useful to determine whether self-efficacy relating to perceived ability to cope with depressive symptoms is more strongly associated with depression and more predictive of treatment outcome than other self-efficacy scales that measure, for example, academic and social self-efficacy.

Appendix

■ **SEQ-DA**

Name: .... Date: ....

1. If you were feeling depressed, how sure are you that you could manage doing your favourite activity or hobby?

1	2	3	4	5
Really sure I couldn't	Probably couldn't	Maybe	Probably could	Really sure I could

2. If you were feeling sad, how sure are you that you could help yourself feel less sad?

1	2	3	4	5
Really sure I couldn't	Probably couldn't	Maybe	Probably could	Really sure I could

3. If you couldn't be bothered eating or if you wanted to eat too much, how sure are you of being able to eat a healthy amount (i. e. not too much and not too little)?

1	2	3	4	5
Really sure I couldn't	Probably couldn't	Maybe	Probably could	Really sure I could

4. If you had difficulty sleeping (i. e. too much or too little), how sure are you that you could bring this under control?

1	2	3	4	5
Really sure I couldn't	Probably couldn't	Maybe	Probably could	Really sure I could

5. If you were feeling really tired for most of the day, how sure are you that you could help yourself get through the day?

1	2	3	4	5
Really sure I couldn't	Probably couldn't	Maybe	Probably could	Really sure I could

6. If you found you were having difficulty concentrating on something you really wanted to do (e. g. reading a book or doing school work), how sure are you that you could keep at it?

1	2	3	4	5
Really sure I couldn't	Probably couldn't	Maybe	Probably could	Really sure I could

7. If you were feeling irritable or angry, how sure are you that you could control your temper?

1	2	3	4	5
Really sure I couldn't	Probably couldn't	Maybe	Probably could	Really sure I could

8. If you were having a difficult day (e. g. slept through your alarm, rejected by your friends, got in trouble from your boss or a teacher), how sure are you that you could cope with the rest of the day?

1	2	3	4	5
Really sure I couldn't	Probably couldn't	Maybe	Probably could	Really sure I could

9. If you were thinking sad or negative thoughts about yourself, how sure are you of being able to stop thinking that way?

1	2	3	4	5
Really sure I couldn't	Probably couldn't	Maybe	Probably could	Really sure I could

10. If you were with a group of people you didn't know very well, how sure are you that you could get involved in a conversation with them?

1	2	3	4	5
Really sure I couldn't	Probably couldn't	Maybe	Probably could	Really sure I could

11. If you were faced with a big life event in the future (e. g. finishing school, getting a job or getting married), how sure are you that you could cope with that event?

1	2	3	4	5
Really sure I couldn't	Probably couldn't	Maybe	Probably could	Really sure I could

12. If you were feeling really sad, how sure are you that you could cope with those feelings without hurting yourself?

1	2	3	4	5
Really sure I couldn't	Probably couldn't	Maybe	Probably could	Really sure I could

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