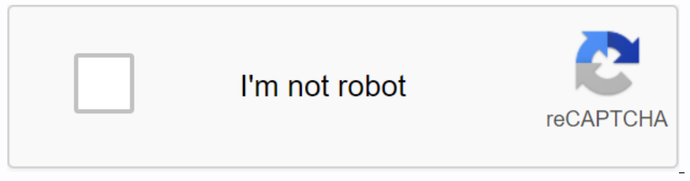

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Beck hopelessness scale bhs pdf

UvodSamo je nekoliko vaga potvr.eno na .panjolskom za procjenu rizika od samoubojstva, a nijedna od njih nije postigla prediktivnu valjanost. Cilj Odrediti valjanost i pouzdanost Beck bezna'a razmjera u bolesnika sa samoubila-kim rizikom poha-anje specijalisti-ke klinike. Metode Beck Ljestvica bezna'a, razlozi za 'ivotni invent i upitnik o samoubojstvu primijenjeni su kod pacijenata s rizikom samoubojstva koji poha-aju psihijatrijsku kliniku i odjel za hitne slu'ajeve. Nova procjena napravljena je 30 dana kasnije kako bi se utvrdila prediktivna valjanost poku-aja samoubojstva ili samoubojstva. Rezultati Evaluacija je obuhvatila ukupno 244 bolesnika, sa srednjom dobi od 30.7±13,2 godine, a vesina su bile'een. Unutarnja konzistentnost bila je .9 (Kuder–Richardson formula 20). Prona-ene su 'etri dimenzije koje su 'inle 50% varijance. To je pozitivno povezano s upitnikom o suicidalnom pona-anju (Spearman .48, P<.001), brojem poku-aja samoubojstva (Spearman .25, P<.001), theinom rizika od samoubojstva (Spearman .23, P<.001). Korelacija s razlozima za'ivotni invent bila je negativna (Spearman .52, P<.001). S ≥12, negativna prediktivna vrijednost bila je 98.4% (95% CI: 94.2–99.8), a pozitivna prediktivna vrijednost 14.8% (95% CI: 6.6–27.1). Zaklju-ak Beck ljestvica bezna'a u kolumbijskih bolesnika sa suicidalno-u pokazuje rezultate sli'ne izvornoj verziji, s odgovaraju-om pouzdano-u i umjerenom istodobnom i prediktivnom valjano-u. Prediktivna vrijednost testovaIntroductionPocas scales have been validated in Spanish for suicidal risk and none of them have found predictive validity. ObjectiveDetermine the validity and reliability of Beck's Scale of Hopelessness in patients with suicidality who attend specialized consultation. Methods Beck's Scale of Hopelessness, the Prayer of Reasons to Live and the Suicide Behavior Questionnaire were prerogated to patients with suicidality who attended external consultation and emergencies. At 30 days a assessment was made to determine the predictive validity of the suicide attempt or suicide. ResultsSevalued 244 patients with an average age of 30.7 years±13.2; Most of them were women. The internal consistency of Beck's Hopelessness Scale is 0.9 (Kuder-Richardson Formula 20). Four dimenzije were found explaining 50% of the variance. It had a positive correlation with the Suicide Behavior Questionnaire (Spearman 0.48, p<0.001), number of suicide attempts (Spearman 0.25, p<0.001), and suicide risk severity (Spearman 0.23, p<0.001). The correlation with the Reasons for Living Field was negative (Spearman 0.52, p<0.001). With a cut-off point ≥12 the negative predictive value was 98.4% (95% CI: 94.2-99.8), and the positive predictive value was 14.8% (95% CI: 6.6-27.1). Conclusion Beck's Scale of Hopelessness in Colombian patients with suicidality has a few dimenzije a la versión original, con adecuada confiabilidad y moderada validez, tanto concurrente como predictiva. In 2013, The New York Times published an email to the U.S. Department of Health and Human Inau who called for the 2013 World Health Organization to be published in the 2014 World Health Organization. Suicide prevention is an integral part of this plan, with the goal of reducing the suicide rate by about 10% in all countries by 2020.1 The annual standardized suicide rate of age was 11.4 per 100,000 inhabitants (15 for men and 8 for women). However, this figure is considered insufficient assessment because suicide is a sensitive topic. It is even illegal in several countries, so do not apply; in addition, in countries where it has been properly reported it is often poorly classified as accidental death or other causes of death.2 For each suicide, there are many people who attempt suicide every year. Suicide attempt is the most important risk factor for suicide in the general population. In Colombia, in 2014, the medical system reported a suicide death rate of 4.33 cases per 100,000 inhabitants, similar to the reported rates in the last nine years. The highest rate per 100,000 residents (6.5) is reported for age groups 20 to 24 years old and 70 to 74 years old.3Suicide is a public health problem that can be prevented by low-cost, evidence-based interventions.2 Therefore it is important to implement tools to detect early patients at risk of suicide. These tools must assess risk factors. A number of risk factors are described in the literature and include hopelessness.2Self-applied scales and instruments have been shown to be a good alternative to this assessment on emergency and out-of-patient departments, as they are easily and quickly applied.4.5 They need to be validated in each community in order for healthcare personnel to have useful tools that allow them to be more effective in treating patients of this type. Although several scales are used, the oldest and one of those assessed for predictive validity is the Beck's Hopelessness Scale (BHS).5 Hopelessness is defined as pessimism or negative expectations about the future, and is associated with suicide.6 More specifically, hopelessness is associated with suicidal ideation, suicide attempts and suicidal behavior in the adolescent community and mental health patients; also associated with past and future suicide attempts.7.8 The main goal of the scale is to measure hopelessness, although several studies have shown that it is a good predictor of attempted and consumed suicide.9.10 This scale was selected because it was the first designed solely to assess hopelessness, which is correlated with a higher risk of suicide. The aim of this study is to determine the validity and reliability of BHS in patients at risk of suicide attending a specialized operation in the city of Bucaramanga, Colombia.MethodsA test has been subjected to a validation test. The study was approved by the Commission for Research Ethics of the Faculty of Health Sciences of The Bucaramanga Universidad Autónoma. All participants were asked to give their informed consent before starting the

study. They gave their consent after they received an explanation and understanding of the research goals. They participated voluntarily and with the guarantee of confidentiality in accordance with Colombian regulations governing health research and the Helsion Declaration.11,12 In the case of minors, an adolescent and a family member or tutor had to give their consent. Instruments BHS is prepared by Aaron T. Beck et al. At the Center for Cognitive Therapy at the University of Pennsylvania School of Medicine, to assess pessimism in patients at risk of suicide.6 Beck and his colleagues constructed an instrument based on pessimistic forward-looking statements selected from the descriptions mentioned by patients. The 20 selected proposals were known as the General Expectation Scale (GES). The scale consists of 20 propositions that can be defined as true or false, and assess the extent of negative expectations about the immediate and long-term future.6 It is added that the answers are given a score of 0 to 20, with a point of intersecting to 9 or 10, depending on the population for which it has been confirmed. Items that indicate a nod have 1 point, while those that do not indicate it have 0 points. The number of points measures the severity of hopelessness: 0-3 is minimal or normal, 4-8 is mild, 9-14 moderate, and 15-20 hard.5 BHS is validated with a good internal consistency that varies from .82 to .93; the reliability of the test varies from .60 to .69; its convergent validity with Beck Depression Inventory (BD) is 0.63. BHS discriminates against patients with depression (M=11,3; SD=5.2) and generalised anxiety (M=7.9; SD=4.9).6,9,13,14 The main purpose of the scale is to measure hopelessness, although several studies show that it is a good predictor of attempted and consumed suicide.10.15 Suicide Questionnaire – Revised (SBQ-R) is an instrument composed of 4 items. It contains questions about suicidal thoughts and behavior in the past and the future. SBQ-R is a Likert-type questionnaire, consisting of questions about the frequency of occurrence of suicidal ideation, communication of suicidal thoughts towards others, attitudes and expectations regarding the current suicide attempt. The maximum rating is 18, and the scale takes about 5min to complete. It has adequate internal consistency, reliability of the test and concurrent validity.16 Reasons for Life Inventory (RFL) is a questionnaire containing 48 items achieved on the Likert 6 points scale. This scale evaluates adaptive (positive) and the expectation that he wouldn't commit suicide. The factors analysed are divided into dimensions and point to 6 main reasons for life: a) beliefs about survival and dealing with things (24 items); b) family responsibility (7 items); c) concerns about children (3 items); d) fear of suicide (7 cases); e) fear of social disapproval (3 items) and f) moral objections (4 items).17 The study and sample study of the universe consisted of all patients who visited either the emergency department or the Ambulance Instituto del Sistema Nervioso de Oriente (ISNOR) with suicidal tendencies. To ensure that the sample was collected, a psychiatrist ticked a predetermined box in electronic clinical history after a patient with suicidal tendencies was discovered. This sign informed a group of researchers about the presence of a patient with suicidal tendencies so they could be included in the study. A sum of 20 items in BHS was used to calculate the sample size. The recommendation for the recruitment of 10 patients per item was taken into account in order to enable the validation of the construct (in this case at least 200 patients).18 Predictive validation took into account the incidence of 10% of attempted or consumed suicides, with a negative predictive value of .95 and a positive predictive value of .2; of .05 and a strength of .8 for a minimum number of 480 patients. Patients with suicidal tendencies were defined as all those with suicidal thoughts, ideas or plans and behaviors or suicide attempts.19ProcedureAll patients who voluntarily agreed to participate in the study and who had suicidal tendencies toward their doctor were included in the study. Those with psychosis were excluded, as were those with cognitive functioning that would prevent them from answering an interview or those who were unable to understand the issues scale because of their educational level. All patients were interviewed by one of the researchers with prior training in assessing the risk of suicide. The training was carried out by the director of a group of researchers, a psychiatrist with 14 years of experience and 3 years of research into suicide risk. They conducted a semi-standing interview in which they were asked about demographic characteristics, major risk factors such as alcohol consumption, family problems or partner problems, as well as protective factors such as children and the elderly.20 They finally classified the severity of suicide risk as low, medium, high or very high and immediate, depending on the presence or absence of factors. After the interview, one of the researchers gave the patient instructions on how to respond to BHS, RFL and SBQ-R. The researcher interviewed the patient 30 days later to determine whether there had been an attempted or consummated suicide, and BHS was re-administered. The why the 30-day follow-up was selected is that in the first 2 weeks the highest number of attempts or suicides was observed in patients with suicidal tendencies.21,22 Although of course it is possible to make further attempts or suicide after 30 days, the likelihood of this is far lower. A maximum of 3 appointments were made for this monitoring, and if the patient did not keep an appointment, it was declared that he had given up the test. Statistical analysis Based on the fact that BHS is a dichotomy scale, the internal consistency was determined using the Kuder-Richardson 20.23 coefficient before identifying possible factors on the Bartletts sphericity scale was administered together with the Kaiser-Meyer-Olkin sample suitability index (KMO). Defining the best intersecting point according to the ROC curve.27 Spearman or Pearson correlation coefficient was used to convergence. 258 patients were examined, 14 of whom were excluded from the study because they met exclusion criteria; 244 agreed to participate voluntarily in the study; 67 patients did not conclude the study as they could not be contacted. Fig. 1 shows a sample of the study. Most of the patients were women, which can be expected because these are the most consulted populations; the average age was 30.65 years±13.2, with an educational level ending at 11 years±3.4 years. Table 1 shows the sociodemographic characteristics of the population. Table 2 presents protective or risk factors of suicide that were clinically evaluated using a semi-staircase interview. Table 3 presents the main diagnoses of the studied population. There were no suicides and there were 10 suicide attempts in the 30-day follow-up. The average rating on BHS was 7.8±5.3. The minimum score was 0 and the maximum was 20. The overall average for women was 7.9±5, and for men 7.8±5.8,analysis of factors. Bartlett's spherical test was significant (δ2=1419.01, gl=190, P<.001). The Kmo sample suitability test showed that it was appropriate (0.90). An analysis of oblique research factors (Promax) found 4 dimensions that explained 50% variance. These dimensions are denominated: (1) expectations for the future (self-rated 6.34; explanation 31.7 % of deviations); (2) motivation (self-rated 1.54; explaining 7.7% deviation); (3) future pessimism (self-rated 1.19; explanation of 6.0% deviation) and (4) individual perception of the future (self-evaluated 1.0; explanation of 5.0% deviation) (Table 4). Internal consistency. The Kuder-Richardson 20 coefficient was .88 for total BHS. Kuder-Richardson values for each of the dimensions were as follows: 0.81 for the first factor; .70 for the second factor; .65 3 el factor and .64 for the fourth factor. Simultaneous validity. A positive correlation with SBQ (Spearman .48, P<.001) was found; number of suicide attempts (Spearman .25, P<.001) and the severity of the risk of suicide classified by researchers (Spearman .23, P<.001). The correlation with RFL inventory was negative (Spearman −.52, P<.001). Predictive validity. The area below the ROC curve was 0.78 (CI 95%: 0.64–0.92) (Fig. 2). In this population, the best cut-off point was ≥12. At this point of reduction, the negative predictive value was 98.4% (CI 95%: 94.2–99.8) and positive predictive value was 14.8% (CI 95%: 6.6–27.1). RR patients with suicidal tendencies with ≥12 results were 9.1 (CI 95%: 2–41.5). Discussion This study shows that in the Colombian population BHS has similar dimensions as the original version, with adequate reliability and good simultaneous validity. However, the usefulness of the scale can be affected by low positive predictive value. Although similar to the original, the factor structure of BHS in the Colombian population has an additional factor. In the original validation of Beck et al. In 1974, 3 factors were found: feelings about the future, loss of motivation and expectations for the future, which is similar to validation in Argentina.10:14 In this validation, feelings about the future factor were divided on pessimism and individual perception of the future. In subsequent validation by Steer et al. in 199728 2 factors were found: pessimism about the future, which is similar to ours, and resignation, which would correspond to expectations for the future and in this work. In addition, the validation carried out in 2006 in Lima, Peru, identified 6 factors, although 2 of them contained only one item.9 The observed differences can be explained by the type of population in question, since Beck included the general population and patients at risk of suicide or simply with depression.14,28 On the other hand, differences in the interpretation of the issue may be due to cultural factors. This would lead to dimensions being different from the population, although in any case they would still follow relevant and representative intrinsic logic regarding the concept of hopelessness. Despite the difference in the construct, BHS worked properly in our population as the overall internal consistency of the scale was excellent and each of the factors had an internal consistency that was from good to very good. This indicates that there are no redundant issues on the scale and that neither subject is missing in every factor. As expected, BHS had a different correlation with the RFL, as the latter was constructed using positive statements about life, children, family or religion. It is also logical that there is a convergence with SBQ-R and the number of suicide attempts, since hopelessness is associated with such behavior. The With the number of suicide attempts previously identified.29 The positive correlation with SBQ-R has also been documented.30 However, this is the first time that a correlation of this scale has been documented with the severity of suicide risk assessed by the researcher. Given predictive validity, a high negative predictive value was found, which would make the scale useful in wards where a quick assessment of a psychiatrist would be difficult. This is because the scale guarantees with a low margin of error that those who score less than 12 will be less likely to attempt suicide. However, its positive predictive value was very low, leading to a high percentage of false positive results. The result of this chart characteristics is that when the score is 12 or higher it is impossible to determine whether there is really a high risk of suicide. Therefore, it is impossible to use the scale itself as the only tool in assessing the risk of suicide. This must be assessed by a psychiatrist or an expert to assess this risk. These predictive values are similar to those found in previous studies, so the APA recommended that these scales not be used in clinical practice to assess suicide risk.31 However, the APA likely excluded the usefulness of scale in countries where it would be difficult to find the necessary specialised human resources, and did not take into account that a large number of false positives are inevitable for rare occurrences such as suicide. Beck et al. they performed a study in which they observed the link between hopelessness and suicide, analyzing each patient's outcome for death by suicide. They took a sample of 1,958 patients with affective disorders and suicidal ideation from September 1978. Every patient had to finish BHS. The follow-up included those patients who had completed treatment at the hospital by 1982. To document whether the proportion of participants committed suicide, a 43-month follow-up of death certificates registered at local Philadelphia and national offices was carried out; 31 participants (1.6 per cent) of 17 committed suicide (0.86 per cent). They found that patients who committed suicide had a higher score on the scale than patients who died of natural causes. They found a point of intersecting for BHS of 9, in contrast to this study, in which the point of cutting BHS was found at 12. Sensitivity was 94.1% and specificity was 41%. While these values may seem good, they represent the intrinsic properties of the scale and do not in themselves have practical value. Positive predictive value in beck et al's study. was 2.28% and negative predictive value was 96.6%. This data is not presented in the study, but can be found based on sensitivity and specificity. When seen in that light of the study Beck et al. has conclusions that are similar to those of this study.32The main limitation of this the sample is too small to achieve predictive validity. However, the confidence interval for negative predictive value is appropriate. This is one of the few studies assessing the predictive validity of BHS, and is the first to do so in the Latin American population. In addition, although RR was significant, it has a wide confidence interval for the same reason: insufficient sample. However, the sample was large enough to find the simultaneous validity and validity of the structure. Another weakness was the time of follow-up; Although a higher proportion of suicide suicides or suicide attempts were expected in the first month after the detection of suicide risk, this is also the time when the highest number of therapeutic alternatives is offered, and it cannot be excluded that suicide occurred subsequently. The findings of this study could be used by clinicians without sufficient training to assess patients at risk of suicide on primary care wards and in situations where rapid access to a psychiatrist is hampered by geographic factors or deficiencies in the healthcare system. Taking into account the fact that BHS is the most famous tool for assessing hopelessness and is one of the most important risk factors in assessing the risk of suicide, this paper offers a valid scale for assessing hopelessness in Latin America. However, it is recommended that these results be repeated in similar populations with longer follow-up. Conclusions1.A high level of negative predictive validity has been found, which makes this scale useful in outpatient and emergency departments, since there is a high likelihood that patients who score less than 12 will not attempt suicide in the next 30 days.2.Finding low positive predictive validity, and therefore a higher likelihood of false positive results, means that a professional assessment is needed before taking any action with the patient. However, this does not mean that the scale is not useful as the initial method of assessing the risk of suicide.3.In Colombian patients with suicidal tendencies BHS has similar dimensions as the original version, with an appropriate level of reliability and moderate concurrent, as well as predictive validity. Ethical responsibilitiesProtection of persons and animals Authors declare that in this study there were no experiments with human beings or animals. Confidentiality of data Authors declare that they have followed the protocols of their work center on the publication of patient data. Right to privacy and informed consent The authors have received informed consent from patients and/or subjects from this paper. This document is held by the corresponding author. Conflict of interest Authors do not have a conflict of interest for the statement. We thank Dr. Maria Teresa López, Dr. Kelly Guzmán and Dr. Alexander Blanc for their assistance in this work. Please list this article as: Rueda-Jaimes GE, Castro-Rueda VA, AM, Moreno-Quijano C, Martinez-Salazar GA, Camacho PA. Confirming Beck's hopelessness scale in patients with suicidal risk. Rev Psychiatrist Health Ment (Barc.). 2018;11:86–93.