Cross-cultural adaptation of the depression coping self-efficacy scale for use in Brazil

Adaptação transcultural do instrumento depression coping self-efficacy scale para uso no Brasil

Adaptación transcultural de la depression coping self-eficacy scale para uso en Brasil

RESUMO

Objetivo: Adaptar transculturalmente a Depression Coping Self-Efficacy Scale (DCSES) no contexto brasileiro. Método: Adaptação envolvendo cinco etapas:tradução, síntese, back-translation, revisão e pré-teste. Para a revisão de conteúdo, selecionou-se um comitê de cinco especialistas e um pré-teste de 40 participantes com diagnóstico de depressão. Resultados: O comitê de especialistas resultou num coeficiente de validade de conteúdo >0,8 para todos os itens do instrumento, exceto no consumo de frutas e verduras. A população do pré-teste, 90% gênero feminino, parda(55%), escolaridade entre 9 e 11 anos de estudo(55%), vínculo empregatício(52,5%) e renda de um salário mínimo(30%). A média de autoeficácia de 55,56, Alfa de Cronbach de 0,82 para o instrumento em geral reforça a consistência da escala. Conclusão: Pressupõe-se a adequação da escala para o contexto brasileiro. Ressalta-se a importância de instrumentos válidos para nortear práticas clínicas e melhor prognóstico da depressão.

DESCRITORES: Autoeficácia; Depressão; Estudo de Validação; Tradução.

ABSTRACT

Objective: To cross-culturally adapt the Depression Coping Self-Efficacy Scale (DCSES) in the Brazilian context. Method: Adaptation involving five steps: translation, synthesis, back-translation, review and pre-test. For the content review, a committee of five experts and a pre-test of 40 participants with a diagnosis of depression were selected. Results: The expert committee resulted in a content validity coefficient >0.8 for all items in the instrument, except for the consumption of fruits and vegetables. The pre-test population, 90% female, mixed race (55%), schooling between 9 and 11 years of study (55%), employment relationship (52.5%) and income of one minimum wage (30%). The average self-efficacy of 55.56, Cronbach's Alpha of 0.82 for the instrument in general reinforces the consistency of the scale. Conclusion: The adequacy of the scale for the Brazilian context is assumed. We emphasize the importance of valid instruments to guide clinical practices and better prognosis of depression.

DESCRIPTORS: Self-efficacy; Depression; Translating; Validation study.

RESUMEN

Objetivo: Adaptar transculturalmente la Depression Coping Self-Efficacy Scale (DCSES) en el contexto brasileño. Método: Adaptación que involucra cinco pasos: traducción, síntesis, retrotraducción, revisión y pre-test. Para la revisión de contenido se seleccionó un comité de cinco expertos y un pretest de 40 participantes con diagnóstico de depresión. Resultados: El comité de expertos arrojó un coeficiente de validez de contenido >0,8 para todos los ítems del instrumento, excepto para el consumo de frutas y verduras. La población pretest, 90% femenina, mestiza (55%), escolaridad entre 9 y 11 años de estudio (55%), relación laboral (52,5%) e ingreso de un salario mínimo (30%). La autoeficacia media de 55,56, Alfa de Cronbach de 0,82 para el instrumento en general refuerza la consistencia de la escala. Conclusión: Se asume la adecuación de la escala para el contexto brasileño. Destacamos la importancia de contar con instrumentos válidos para orientar las prácticas clínicas y un mejor pronóstico de la depresión.

DESCRIPTORES: Autoeficacia; Depresión; Estudio de Validación; Traducción.

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INTRODUCTION

Depression is a mood disorder that causes a loss in the individual's quality of life, affecting their relationships and causing great psychological distress. [1] It is characterized by a set of psychological and physical symptoms (depressed mood, loss of interest in daily activities, apathy, lack of confidence, changes in weight, appetite, sleep and psychomotor activity) associated with various comorbidities, disabilities and suicide. [2]

In 2011, the Brazilian Ministry of Health established the Psychosocial Care Network (RAPS), whose purpose is the creation, expansion and articulation of health care points for people with suffering or mental disorders and with needs arising from the use of crack, alcohol and other drugs, within the scope of the Unified Health System (SUS). In this service network, several health and assistance professionals are expected to work in different areas, from primary care to care in highly complex health equipment. [2]

Health professionals must be able to identify the symptoms of depression to lead or refer the individual to resume their life and lead it within their capabilities and limitations. In order to guide an evidence-based practice, the use of a theoretical framework is indicated that makes it possible to obtain objective data in order to compare the information collected before and after the interventions carried out [3], as psychometric instruments for measuring phenomena.

Self-efficacy is a topic widely discussed for the acquisition of healthy behaviors and as a strategy for coping with stressful situations, including depression. To Bandura [4], Self-efficacy is personal belief or confidence in one's ability to perform a specific action necessary to obtain a certain result. A person's adherence to a certain activity or behavior is related to their confidence that they will be able to successfully develop it. [5]

We chose to use the Depression Coping Self-Efficacy Scale (DCSES) for this research, due to the rigorous methodological process of its development, the psychometric properties and its objective of measuring self-efficacy in coping with depressive symptoms.[4] However, instruments that measure a health phenomenon need to undergo a process of translation and cross-cultural adaptation, considering the local reality of the target population, for use in different care settings. [3]

In view of the problem addressed, the objective of the present study is to cross-culturally adapt the Depression Coping Self-Efficacy Scale (DCSES) to the Brazilian context, considering that depression has a significant prevalence and incidence in the Brazilian population and that self-efficacy strategies can help guide the actions of professionals in the health care network.

METHOD

The present study is the result of a doctoral research that took place from March 2018 to March 2021, with a time frame for data collection from April to September 2019. Beaton, et al. [6] descri-

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bed a method considered by the scientific community to be the most complete and for this reason it was chosen as a methodological reference in the cross-cultural adaptation of this study. The steps consist of: 1. Initial Translation; 2. Synthesis of translations; 3. Translation back to the original language (Back-translation); 4. Review by an expert committee; 5. Pre-test. Considering the ethical procedures in relation to the adaptation of instruments, Pasquali [7] guides that a request for authorization be made with the author of the scale to use the instrument in Brazil. Authorization for translation, adaptation and application of the instrument was obtained through electronic contact with Suzanne Perraud, author of DCSES, who authorized the procedure.

Participants took part in two of the five stages of the cross-cultural adaptation process, namely: Expert Committee (EC) and pre-test. As for the EC, five specialists in the area of health were selected, all professors from Federal Institutions of Higher Education, with a doctorate degree and expertise in the area of mental health. The following inclusion criteria were adopted: having an updated Lattes curriculum within 12 months prior to data collection and obtaining at least five points from the adapted Fehring(8), adapted. In relation to the pre-test, 20 participants were selected who were people registered in Family Health Units (USF) or who were directly referred by health, education and/or social assistance professionals, to ensure good sample variability, as recommended by Lobiondo-Wood. [9]

Inclusion criteria were applied: people aged 18 years or older, both sexes, diagnosed with depression (indicated by a medical professional and/or self-report of previous diagnosis), with a minimum of seven years of schooling (incomplete elementary school), a minimum score of 24 points on the Mini-Mental State Examination (MMSE) and who have already undergone or are undergoing drug treatment or not for depression. People who had clinical conditions (physical and/or cognitive) that made it difficult to understand the research instruments and those who obtained a score greater than or equal to 16 on the Alcohol Use Disorder Identification Test (AUDIT) were excluded.

Regarding Resolution 510/16 of the National Health Council, Brazil, the research was approved by the Research Ethics Committee of the Health Sciences Center of the Federal University of Pernambuco, Brazil (CAAE: 81639417.7.0000.5208 and opinion 2,532,294). All participants gave consent by reading and signing the Free and Informed Consent Form (FICT).

Self-efficacy is a topic widely discussed for the acquisition of healthy behaviors and as a strategy for coping with stressful situations, including depression.

In step 4, the specialists answered instruments for the analysis of semantic, idiomatic, functional and conceptual equivalences; language clarity, practical relevance, theoretical relevance and degree of relevance [10] of each DCSES item. For step 5, a questionnaire was used with socioeconomic, demographic and clinical questions, prepared by the research team, in addition to the instruments: Beck Depression Inventory (BDI), Mini Mental State Examination (MMSE), Alcohol Use Disorders Identification Test (AUDIT) and the Depression Coping Self-Efficacy Scale (DCSES).

The DCSES The pre-final version of the scale was applied, which has already gone through all the previous steps: translation (two independent translations and a combination of both by the research team), back-translation (native translator of the language in which the DCSES was prepared and with proficiency in Brazilian Portuguese), approval by the author of the instrument and evaluation by the committee of experts. It consists of 24 items, scored in percentage values, from 0 to 100, where 0 means not confident and 100 means confident. In addition, participants answered two forms prepared by the research team, which deal with face validity and semantic equivalence. [11].

The statistical analyzes of step 4 were performed using the content validity coefficient (CVC), guided by the formulas suggested by Hernández-Nieto [12] for the assessment of agreement among experts on language clarity, practical relevance and theoretical relevance. The concordance index (CI) was calculated for the semantic, idiomatic, experiential and conceptual equivalences and for the degree of relevance of each item. [13] For stage V, the descriptive statistics of the pre-final sample were first computed. Regarding the calculation of self-efficacy, the score suggested by Mahakittikun, et al. [14] and with p-value related to the Kolmogorov-Smolnikov test to evaluate the normality of the distribution. Face validation and semantic evaluation by the pre-test audience was calculated using

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frequency and percentage. The DCSES reliability was obtained by calculating Cronbach's Alpha and Spearman's correlation. The statistical program Statistical Package for the Social Sciences (SPSS) version 20.0 was used for the calculations.

RESULTS

Translation, synthesis and back-translation

The cross-cultural adaptation process started with the initial translations (T1 and T2) from English to Brazilian Portuguese (step 1), followed by the synthesis of the translations (T12), carried out by the research team (step 2). It should be noted that the name of the instrument was not translated by choice of the research team, in order to ensure visibility and facilitate searches for the scale in databases and articles produced. After the synthesis, the back-translation was performed (step 3), which was duly approved by the author, Suzanne Perraud.

Content validation

Table 1 presents the result of the Content Validity Coefficient (CVC) regarding language clarity, practical relevance and theoretical relevance, according to the EC's answers (step 4). Hernández-Nieto [12] recommends that items that obtained CVC > 0.8 be classified as satisfactory. Only item "8", on the consumption of fruits and vegetables, obtained averages below the indicated value, however, they point out that it is necessary to consider the different views of the specialists, because they have different professional backgrounds and, consequently, have divergent opinions. Therefore, acceptable values were considered with a mean from CVC between 0.7 and 0.8. It should be noted that the mean total and error DCSES were 0.94.

The average values (in percentage) of the Concordance Index (CI), for the equivalences, through the evaluation of the specialists were: semantics, 99.26%, idiomatic, experiential and conceptual,

Tabela 1 - Escores dos coeficientes de validade de conteúdo (CVC). Recife, PE, Brasil, 2021.

No.	ITEM	CVC					
		LC	CLPe	PP	PPPe	RT	RTPe
1	Telling others how I feel in a socially acceptable way.	0,92	0,92	0,92	0,92	0,92	0,92
2	Being aware of my behavior and how it affects others.	0,88	0,88	0,96	0,96	0,96	0,96
3	Refusing requests from others when I don't want to do something someone wants me to do, including authorities and strangers.	0,88	0,88	1,00	1,00	1,00	1,00
4	Going to sleep and waking up at the same time every day.	0,96	0,96	0,84	0,84	0,88	0,88
5	Plan nice things to do during my free time.	1,00	1,00	1,00	1,00	1,00	1,00
6	Limit naps to 20-30 minutes during the day.	1,00	1,00	0,92	0,92	0,96	0,96
7	Asking for help when I have trouble understanding something because I'm not concentrating well (eg income tax, legal documents, etc.).	0,80	0,80	0,92	0,92	0,92	0,92
8	Eat four servings of fruits and vegetables daily.	0,96	0,96	0,76	0,76	0,72	0,72
9	Drink 6 to 8 glasses of water daily.	1,00	1,00	0,92	0,92	0,88	0,88
10	Recognize when I'm blaming myself for my symptoms and try to stop.	0,92	0,92	1,00	1,00	1,00	1,00
11	Engage in some kind of creative activity, such as writing, reading, drawing, playing music, or participating in projects.	1,00	1,00	1,00	1,00	1,00	1,00
12	Being with at least one very close person when I'm feeling lonely.	0,92	0,92	1,00	1,00	1,00	1,00
13	Get up and do something relaxing if you can't sleep before trying to sleep again.	0,84	0,84	0,96	0,96	0,92	0,92
14	Questioning whether it is appropriate to think of myself negatively or to assume that I am not good.	0,84	0,84	0,96	0,96	0,96	0,96
15	Take a shower or do some other calming activity before bed.	1,00	1,00	1,00	1,00	1,00	1,00
16	Take the medication as the doctor has recommended.	0,96	0,96	1,00	1,00	1,00	1,00
17	Exercising or doing some activity every day.	0,96	0,96	1,00	1,00	1,00	1,00
18	Be aware when I'm thinking of myself in a negative way or assuming I'm no good.	0,84	0,84	0,96	0,96	0,96	0,96
19	Laughing and trying to find humor in my situation, despite my problems.	0,84	0,84	0,92	0,92	0,92	0,92
20	Confronting thoughts that suicide is the only way to deal with my problems.	0,96	0,96	1,00	1,00	1,00	1,00

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100%. An acceptable value is understood to be values starting from 90%. [15] It is worth noting that in relation to idiomatic and conceptual equivalences, there were no requests for changes, as all the specialists agreed that the expressions of the original language of the instrument were translated properly. Only 20.83% of the 24 items on the scale were modified based on the experts' observations. In addition to these, the text of the instructions, the initial sentence of the scale and the final sentence were also rewritten, thus forming the DCSES version for the pre-test. The average CI percentage for the degree of relevance of each DCSES item was 94.81%.

21	Trying to understand why I'm anxious.	0,80	0,80	1,00	1,00	1,00	1,00
22	Keeping a journal describing my mood or how I feel emotionally each day	1,00	1,00	0,84	0,84	0,84	0,84
23	Meditate or do relaxation exercises at least once a day.	1,00	1,00	0,92	0,92	0,88	0,88
24	Realizing the feelings that bother me so I can face them and not let them bother me.	0,84	0,84	0,96	0,96	0,96	0,96
	Average per feature	0,92	0,92	0,95	0,95	0,95	0,94
	Full scale average				0,94		
	Full scale average with error calculation				0,94		

Source: Own elaboration adapted by Cassepp-Borges, Balbinotti and Teodoro (2010).
Caption: CVC - content validity coefficient; LC - language clarity; CLPe - clarity of language with error calculation; PP -practical pertinence; PPPe - practical pertinence with error calculation; TR - theoretical relevance; RTPe - theoretical relevance with error calculation.

Sociodemographic characterization and health condition of the pre-final sample

Participants in stage V were mostly female (90%), with a higher frequency of age group from 25 to 59 years (75%), with ethnic aspects of brown color (55%),

education level between 9 and 11 years of study time (55%), formal or informal employment relationship (52.5%) and income of up to one minimum wage (30%) (Table 2).

Only one person had not undergone previous treatment for depression (they would still start the medication). The places with the highest frequency of treatment were the private office (38.48%) and outpatient clinics in polyclinics (33.33%). 87.5% of the interviewees were undergoing treatment at the time of the interview and of these, 40% were in the form of psychotherapy. Regarding the use of specific medication, 87.5% were using it and of these, only 9.09% used more than two daily medications for depression.

The results of the Beck Inventory revealed that 70% of the sample were, at the time of the interview, with mild to moderate depression Table 3.

The mean self-efficacy was 55.56 which, according to the scores suggested by Mahakittikun, et al. [14], corresponds to

Table 2 - Comparison of frequencies and percentages of sociodemographic variables in the sample (n0=40). Recife, PE, Brazil, 2021.

Evaluated factor	N	%	p-value
Gender			
Male	4	10	0,000
Female	36	90	
Age1			
18 to 24 years	6	15	
25 to 39 years	15	37,5	0,000
40 to 59 years	15	37,5	
60 years or more	4	10	
Color1,2			
White	15	37,5	0,001
Black	3	7,5	
Brown	22	55	
Marital status 2			
Single	21	52,5	0,000
Married / Stable Union	15	37,5	
Divorced	4	10	
Education			
7 to 8 years	6	15	0,000
9 to 11 years	22	55	
12 or more	12	30	

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moderate. As in the original scale, the BDI scores were negatively correlated with those of the pre-final DCSES, since the lower the BDI score, the higher the DCSES. The group with the highest confidence (80%) had a "minimal depression" score on the BDI and the group with the lowest confidence (57.14%) had "severe depression" on the BDI. When "moderate" confidence was considered, the group with the highest percentages were classified as having mild (81.82%) to moderate (70.59%) depression.

Face validation, semantic evaluation and reliability of the DCSES obtained in the pre-final sample

For face validation, respondents were asked about their understanding of what was being measured and whether the instrument presented was measuring what was proposed. Respondents (90%) responded that the DCSES was understandable and that it was measuring what it proposes. As for the response scale, 80% said it was easy to understand, 15% regular and 5% difficult.

The semantic evaluation of each item was evaluated by the pre-final sample and items: 5, 11, 16 and 21 were not suggested to change and items 1, 8 and 9 had a frequency of requests for changes from 20%. We emphasize that only one person suggested reducing the text of the initial instructions and everyone agreed with the final sentence.

DCSES reliability was obtained by calculating Cronbach's Alpha, which resulted in 0.82 for the instrument in general, reflecting that it is considered good for measuring self-efficacy in coping with depression. When considering the exclusion of each item, Cronbach's alpha varied between 0.79 and 0.82, revealing the maintenance of good reliability of the DCSES.

Spearman's correlation revealed a weak magnitude in 58.33% of the items, indicating a good relationship between them. For this interpretation of intensity, we considered: < 0.3 (weak); > 0.3 to < 0.59 (moderate) and > 0.6 to 0.99

Occupation			
Worker (formal)	15	37,5	0,000
Worker (informal)	6	15	
Retired	3	7,5	
Unemployed	7	17,5	
Houseworker	1	2,5	
Student	5	12,50	
Others	3	7,5	
Income			
Up to 1 Minimum wage (MW)	12	30	0,002
From 1 MW and 2 MW	8	20	
From 2 MW and 3 MW	4	10	
From 4 MW and 5 MW	5	12,50	
More than 5 MW	5	12,50	
No income	3	7,5	
Not Declared	3	7,5	

Source: own elaboration. N, sample; %, percentage value; p-value, distribution; 1 Stratification, according to criteria of the Brazilian Institute of Geography and Statistics (IBGE); 2 Only options in which there were respondents are shown.

Table 3 - Sample health condition (n0=40). Recife, PE, Brazil, 2021.

Evaluated factor	N	%
Among them:*		
Diabetes	1	5
Hypertension	8	40
Other heart diseases	0	0
Rheumatological diseases	8	40
Other diseases	8	40
Physical activity		
Yes	14	35
No	26	65
Diagnosis - life cycle		
Adolescence	5	12,5
Adult	35	87,5
Prior treatment for depression		
Yes	39	97,5
No	1	2,50
Where did the treatment take place 1		
Psychosocial Care Center	5	12,82
UPA	3	7,69
Outpatient Polyclinic	13	33,33
Private office	15	38,46

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(strong) and 1 (perfect). [31] Detailed information can be found in Table 5.

DISCUSSION

In view of the results, it was observed that the cross-cultural adaptation of the DCSES obtained a satisfactory level of semantic, idiomatic, experiential and conceptual equivalence and, the pre-test indicated that the instrument is understandable and that it measures what it proposes, indicating the DCSES as adapted to the Brazilian context.

The DCSES translation, synthesis and back-translation process proved to be satisfactory, as the back-translation version was approved by Suzanne Perraud. This access by the author of the scale to this version, as well as knowledge about the steps taken, allows for greater methodological rigor, since the original author of the instrument can state whether the items are maintaining the idealized conceptual line. [16]

As for content validation by the expert committee, the items language clarity, practical relevance and theoretical relevance had a CVC of 0.94, representing good acceptability. The item with a coefficient lower than 0.8 (recommended) raises questions about fruit and vegetable consumption, indicating quan-

USF	2	5,12
Other types of treatment	6	15,38
In treatment for depression		
Yes	35	87,5
No	5	12,5
Where/What treatment do you perform 1		
Psychosocial Care Center	3	8,57
Psychotherapy	15	42,86
Occupational therapy	2	5,71
Integrative Practices	3	8,57
Psychiatrist	7	20
Other types of treatment	7	20
Specific medication for depression		
Yes	35	87,5
No	5	12,5
How many medications 1		
1 or 2	33	90.90
3 or 4	2	9.09
Beck's Inventory 2		
Minimal depression	5	12,5
Mild depression	11	27,5
Moderate depression	17	42,5
Severe depression	7	17,5

Source: own elaboration. N, sample; %, percentage value; 1 Relative percentage value; 2 Classification according to Gorenstein et al. (2011).

Tabela 4- Relação entre os escores do Inventário de Beck e da autoeficácia, segundo a DCSES. Recife, PE, Brasil, 2021.

Beck's Inventory 1	DCSES 2						Total group		p-value3	r4
	Not Confident		Moderately Confident		Confident					
	N	%	N	%	N	%	N	%		
Minimal depression	1	20	-	-	4	80	5	12,5	0,002	0,48
Mild depression	-	-	9	81,82	2	18,18	11	27,5		
Moderate Depression	4	23,52	12	70,59	1	5,9	17	42,5		
Severe Depression	4	57,14	3	42,86	-	-	7	17,5		

Source: own elaboration. N, sample; 1 Classification according to Gorenstein et al.; 2 DCSES reference values, according to the author's proposal; 3 p-value relative to Pearson's Correlation; 4 r, correlation.

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tity. In Brazil, especially in economically disadvantaged regions, the use of these foods is related to the cost and the habit of consuming other types of groceries. [17]

The idiomatic and conceptual equivalences were considered totally satisfactory by the expert committee, with no suggestions for changes. Considering all the equivalences evaluated, the CI percentage was satisfactory, providing a better quality product. [18]

The sociodemographic characteristics of the pre-test respondents revealed a larger audience of women and this data is in accordance with the study by Zavaschi, et al. [19], whose data reveal that depression has a higher incidence in women, ranging from 10 to 25%, compared to men, with percentages from 5 to 12%. As for age, 75% were between 25 and 59 years old, which corroborates the data found in the study by Barros, et al. [20], which revealed a high prevalence of depressive disorders in Brazilian adults.

Regarding ethnicity, income and educational level, studies that investigated the association between depression and skin color found that brown-black skinned individuals have a higher prevalence of depression compared to white skinned people, in addition to underdeveloped countries having a higher prevalence of cases of depression and requiring greater attention in terms of public policies for prevention and treatment. [21-22]

Low adherence to physical exercise was observed, with 65% of respondents stating that they did not perform any type of activity of this nature. It is worth noting that evidence in the scientific literature of the relationship between physical exercise and improvement in mental health, in addition, it was observed that more active people had lower risks of presenting depressive symptoms. [23-24]

Considering the scores obtained with the BDI, 87.5% of respondents had some degree of depression (from mild to severe), with the highest percentage being moderate. This data may explain the average self-efficacy, according to the pre-final DCSES, found in the pre-test

Table 5- Pre-test results against DCSES items. Recife, PE, Brazil, 2021.

DCSES (PRE-FINAL VERSION)	%[1]	MEAN [2]	SD[3]	TOTAL ITEM [4]	ALPHA[5]
Telling others how I feel in a socially acceptable way.	25	63	31.6	.34	.81
Being aware of my behavior and how it affects others.	15	70.72	29.8	.27	.82
Refusing requests from others when I don't want to do something someone wants me to do, including authorities and strangers.	10	57.05	36.3	.59	.80
Going to sleep and waking up at the same time every day.	20	44.27	37	.14	.82
Plan nice things to do during my free time.	-	61.4	35.8	.54	.80
Limit naps to 20-30 minutes during the day.	17,5	44.3	40.3	.17	.82
Asking for help when I have trouble understanding something because I'm not concentrating well (eg income tax, legal documents, etc.).	10	78.75	25,4	.30	.81
Eat four servings of fruits and vegetables daily.	27,5	45,02	38,8	.40	.81
Drink 6 to 8 glasses of water daily.	22,5	72.13	35.4	.07	.82
Recognize when I'm blaming myself for my symptoms and try to stop.	10	64,38	31,3	.50	.81
Engage in some kind of creative activity, such as writing, reading, drawing, playing music, or participating in projects.	-	68,63	34.2	.48	.81
Being with at least one very close person when I'm feeling lonely.	5	74.28	29.4	.23	.82
Get up and do something relaxing if you can't sleep before trying to sleep again.	7,5	60.5	37.6	.28	.82
Questioning whether it is appropriate to think of myself negatively or to assume that I am not good.	20	52.88	30.8	.56	.80
Take a shower or do some other calming activity before bed.	5	84.63	21.1	.27	.82
Take the medication as the doctor has recommended.	-	75.5	35.5	.26	.82
Exercising or doing some activity every day.	5	32.3	33.5	.35	.81
Be aware when I'm thinking of myself in a negative way or assuming I'm no good.	17,5	57.25	33.5	.77	.79
Laughing and trying to find humor in my situation, despite my problems.	5	57.1	40.3	.44	.81
Confronting thoughts that suicide is the only way to deal with my problems.	5	54.25	39.5	.45	.81
Trying to understand why I'm anxious.	-	62	32.5	.20	.82
Keeping a journal describing my mood or how I feel emotionally each day	20	23.27	32	.32	.81
Meditate or do relaxation exercises at least once a day.	10	32	35.8	.35	.81

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Realizing the feelings that bother me so I can face them and not let them bother me.	2,5	61	32.3	.44	.81

Source: own elaboration. 1 percentage value of people who suggested some modification to the item. 2 Average of DCSES scores on each item. 3 Standard deviation. 4 Spearman correlation. 5 Cronbach's Alpha if the item is deleted. Note: Cronbach's alpha for the complete instrument was 0.82

sample, which corresponded to "moderate confidence", since, according to Perraud [16], self-efficacy tends to be inversely proportional to the degree of depression, that is, the more effective the individual, the lower the chance of presenting depressive symptoms.

The face validation, by the pre-final sample, was satisfactory, indicating that the methodological path followed is in accordance with that proposed by Beaton, et al. [6] In relation to the semantic evaluation by this group, only four items were not targets of suggestion of changes, however, only three items had a frequency of alterations greater than 20%, which demonstrates a good index. As for the reliability of the DCSES presented in the pre-test, the overall Cronbach's Alpha was 0.82, showing that the version is satisfactorily reliable. [25-26] It is noteworthy that these analyzes are preliminary and are relevant because they indicate how the DCSES can present itself when applied to the target audience.

The limitation of the study can be pointed out by the selection of the sample, which included residents of a Brazilian city. However, as a strong point, the cross-cultural adaptation phase was carried out with the methodological rigor recommended by researchers in the area, involving professionals and target audience representation (through the pre-test) in the judgment of all items. The continuity of the study will allow the DCSES to be used by professionals and to guide actions with the target audience, in addition to promoting scientific evidence on the construct of self-efficacy and its relationship with depression.

CONCLUSION

The choice of DCSES to adapt cross-culturally was based on the characteristics of the instrument, on the construct that it proposes to measure and on originality, since there are no records,

until the present moment, of a validated measure, for the Brazilian reality, that makes the measurement of self-efficacy in coping with depression. Contact with the main author during the stages was extremely important to confirm that the original language terms were properly translated without loss of primary meaning.

The participation of the expert committee made it possible to maintain the assertions without distortions and with a logical sense for the Brazilian context. The pre-test stage was of fundamental importance both to resolve issues of a practical and operational nature, as well as to assess the meaning of the items presented by the DCSES. The present study presents an instrument for measuring self-efficacy in depression adapted to the Brazilian context, providing guidance in decision-making and clinical management of this population.

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