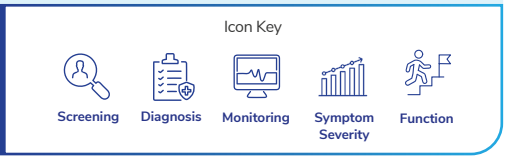
Common Scales in Major Depressive Disorder and Bipolar I Disorder

Introduction Standardized psychiatric rating scales are useful tools for healthcare providers to collect information needed to help address symptoms of mental disorders, including major depressive disorder (MDD) and bipolar I disorder (BP-1).[1] They can also be used to assess the efficacy of interventions used throughout the patient's treatment journey and evaluate progress over time. As recommended by the American Psychiatric Association, the use of objective assessment tools, including validated and standardized rating scales, is an important component of measurement-based care (MBC). Along with careful clinical assessment, a thorough patient interview, and input from family or caretakers (with a patient's consent), standardized psychiatric rating scales can help healthcare providers (HCPs) monitor patients' treatment responses and make necessary treatment changes to help improve patient outcomes.[2]

Key Considerations for Choosing a Rating Scale Different scales are designed to measure specific aspects of mental health conditions, such as symptom severity, treatment response or non-response, or quality of life/functional impairment. The following tables provide information on rating scales commonly used in clinical practice for MDD, BP, and overall functioning.



Scales Used to Assess Symptoms of Depression

	PHQ-9	ATRQ
Disease State	MDD	MDD
Description	Brief, self-rated questionnaire used to screen for symptoms of depression evident over the past 2-week period.[3]	Scale used to assess treatment response or nonresponse to adequate antidepressant trials among patients with MDD.[5]
Time to Administer	Less than 5 minutes[4]	N/A
Items/Symptoms Assessed	The PHQ-9 consists of 9 items derived from the diagnostic criteria for a depressive episode defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-4)*.[3]	The ATRQ examines a patient's antidepressant treatment history, using specific criteria to define the adequacy of both dose and duration of each antidepressant trial, and the degree of symptomatic improvement obtained with each trial.[6]
Scoring	PHQ-9 items are rated according to frequency on a scale from 0 to 3, then summed to create a total score ranging between 0 and 27.[3] A diagnosis of depression can be made based on the total score, with a cutoff threshold of greater than or equal to 10.[3]	The degree of improvement is rated on a scale from 0% (not improved at all) to 100% (completely improved).[6]
Score Interpretation	None/Normal = 1 to 4 Mild = 5 to 9 Moderate = 10 to 14 Moderately severe = 15 to 19 Severe = 20 to 27[3]	The ATRQ defines 6 weeks on an adequate dose of antidepressant medication as adequate treatment duration except for augmentation or combination treatments, for which at least 3 weeks is required. An increase in dose for at least 4 weeks is considered optimization unless the patient achieves remission followed by a relapse, for which the dose increase will be regarded as a new treatment trial.[6]

ATRQ = Antidepressant Treatment Response Questionnaire, PHQ-9 = Patient Health Questionnaire Depression Scale

Bipolar Disorder (BP) Screening Tools

	RMS	MDQ
Disease State	BP-1, MDD	BP
Description	Patient-reported tool developed to help screen for BP-1 in patients with depressive symptoms who have been diagnosed with MDD.[7]	Brief, self-rated questionnaire that can be used to screen patients at risk for BP.[8]
Time to Administer	Less than 5 minutes[7]	Less than 5 minutes[9]
Items/Symptoms Assessed	Includes 6 yes/no items, with 3 items for depressive characteristics that are more likely to indicate BP-1 than MDD and 3 items that screen for manic symptoms.[7]	Includes 13 manic symptom-specific yes/no items (question 1) and 2 additional items assessing the co-occurrence of symptoms (question 2) and functional impairment (question 3).[8]
Scoring	6 items are scored as a "yes" or "no."[7]	The 13 symptom-specific items and 1 co-occurrence of symptoms item are scored as a "yes" or "no." The item on functional impairment is rated on a 4-point scale.[8]
Score Interpretation	A "yes" response on 4 or more items is considered a positive screen, indicating a very high likelihood of BP-1. A positive screen should be followed up with a comprehensive diagnostic evaluation.[7]	A positive screen requires a "yes" to 7 or more of the 13 items in question 1, a "yes" to question 2, and "moderate problem" or "serious problem" in response to question 3.[9]

MDQ = Mood Disorder Questionnaire, RMS = Rapid Mood Screener.

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Scales Used to Assess Function and Quality of Life

	FAST	SF-12v2
Disease State	BP	General
Description	24-item clinician-administered instrument to assess 6 areas of functional impairment or disability over the last 15 days before assessment, particularly in patients with BP.[10]	12-item self-reported questionnaire, a shortened version of the SF-36, is used as a quality of life measure.[12]
Time to Administer	5 to 10 minutes[10]	Less than 5 minutes[12]
Items/Symptoms Assessed	The FAST consists of 24 items that include 6 specific areas of functioning: autonomy, occupational functioning, cognitive functioning, financial issues, interpersonal relationships, and leisure time.[10]	The SF-12 includes 8 health domains categorized under two component scores, the Physical Component Summary (PCS) and Mental Component Summary (MCS). The PCS consists of physical functioning, role-physical, bodily pain, and general health. The MCS consists of consists of vitality, social functioning, role-emotional, and mental health.[12]
Scoring	All items are rated on a 4-point scale from 0 to 3. The total FAST score is the sum of each item. Lower scores indicate better functioning, while higher scores indicate increased disability and specific areas of impairment.[10]	The SF-12 score is calculated from 2 summary scores, PCS and MCS, using norm-based methods. The PCS and MCS scores are calculated using regression coefficients and a constant derived from the general US population. They are transformed to have a mean of 50 and a standard deviation of 10 in the general US population, with higher scores indicating better health. This allows the PCS and MCS scores to be meaningfully compared with those in the general US population.[12]
Score Interpretation	No impairment = 0 to 11 Mild = 12 to 20 Moderate = 21 to 40 Severe = 41 to 71[11]	Above average in the general US population = scores above 50 Below average in the general US population = scores below 50[12]

FAST = Functional Assessment Short Test, SF-12v2 = 12-item Short Form Survey.

Importance of Incorporating Rating Scales in Clinical Practice

Four Benefits of Measurement Based Care

- Informed Clinical Decisions
- Enhanced Patient Relationship With HCPs
- Help Improve Adherence
- Increased Patient Engagement

Implementing MBC by utilizing standardized and validated rating scales in clinical practice enables HCPs to more accurately measure and monitor patients' symptoms and treatment responses. By regularly collecting quantitative data from these scales, HCPs may be better able to assess patients' progress to help inform their clinical decision-making and help improve patient outcomes.[2]

Research indicates that implementing MBC can have a significant impact on the outcomes of patients undergoing treatment for mood disorders. A meta-analysis of 7 randomized clinical trials examining pharmacotherapy in over 2,000 patients with depressive disorders found that patients treated under MBC conditions, which utilize standardized rating scales, achieved remission at a significantly higher rate and experienced lower symptom severity compared to those who received standard treatment. In addition, medication adherence was notably higher in the MBC group than in the standard treatment group.[13]

In a study of 120 MDD patients receiving pharmacotherapy, those treated under MBC conditions, characterized by guideline- and rating scale-based treatment decisions, achieved treatment response at a significantly higher rate than those under standard treatment conditions, which relied on their clinicians' choices for treatment (86.9% vs 62.7%, p=0.002). Similarly, the remission rate in the MBC group was significantly higher at 73.8% compared to 28.8% in the standard treatment group (p<0.001). Patients receiving MBC also achieved response and remission significantly earlier than those receiving standard treatment (5.6 weeks vs 11.6 weeks for response, and 10.2 weeks vs 19.2 weeks for remission). Further, the improvement in symptom severity was significantly greater in patients who received MBC compared to those who received standard treatment.[14]

It is important to remember that scales should be used in combination with a comprehensive clinical evaluation and the provider's clinical judgment.[1]

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