Measuring anxiety in depressed patients: A comparison of the Hamilton anxiety rating scale and the DSM-5 Anxious Distress Specifier Interview

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ABSTRACT

DSM-5 included criteria for an anxious distress specifier for major depressive disorder (MDD). In the present report from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project we examined whether a measure of the specifier, the DSM-5 Anxious Distress Specifier Interview (DADSI), was as valid as the Hamilton Anxiety Scale (HAMA) as a measure of the severity of anxiety in depressed patients. Two hundred three psychiatric patients with MDD were interviewed by trained diagnostic raters who administered the Structured Clinical Interview for DSM-IV (SCID) supplemented with questions to rate the DADSI, HAMA, and Hamilton Depression Rating Scale (HAMD). The patients completed self-report measures of depression, anxiety, and irritability. Sensitivity to change was examined in 30 patients. The DADSI and HAMA were significantly correlated \( r = 0.60, p < 0.001 \). Both the DADSI and HAMA were more highly correlated with measures of anxiety than with measures of the other symptom domains. The HAMD was significantly more highly correlated with the HAMA than with the DADSI. For each anxiety disorder, patients with the disorder scored significantly higher on both the DADSI and HAMA than did patients with no current anxiety disorder. A large effect size of treatment was found for both measures (DADSI: \( d = 1.48 \); HAMA: \( d = 1.37 \)). Both the DADSI and HAMA were valid measures of anxiety severity in depressed patients, though the HAMA was more highly confounded with measures of depression than the DADSI. The DADSI is briefer than the HAMA, and may be more feasible to use in clinical practice.

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1. Introduction

The Hamilton Rating Scale for Anxiety (HAMA) (Hamilton, 1959) is the most commonly used clinician-rated measure of anxiety in treatment studies of depression (Ionescu et al., 2014). The HAMA was published more than 50 years ago. As one of the first reliable and valid interviewer-administered instruments assessing the severity of anxiety, it is not surprising that it has become the standard in the field.

The 14 items of the HAMA are rated from 0 to 4 with general guidelines provided for distinguishing the gradations of severity (0 = absent, no symptoms; 1 = mild, occurs irregularly and for short periods of time; 2 = moderate, occurs more constantly and of longer duration, requiring considerable effort on part of patient to cope with it; 3 = severe, continuous and dominates patient's life; 4 = very severe, incapacitating.) The items incorporate groups of symptoms (e.g., autonomic symptoms; respiratory symptoms, fears) rather than specific, single, symptoms.

Although the HAMA is a reliable and valid measure of the severity of anxiety in depressed patients, at least 5 problems with the scale have been described through the years. First, the scale includes items assessing depression. One of the items on the scale is labeled depressed mood, which includes an assessment of low mood, loss of pleasure or interest in activities, early morning awakening, and diurnal variation of mood. The components of other HAMA items also incorporate features of depression (e.g., loss of libido as part of the genitourinary symptoms item; easily moved...
to tears as part of the tension item). It is therefore not surprising that the HAMA has been criticized for failing to adequately distinguish depression and anxiety (Maier et al., 1988; Porter et al., 2017; Riskind et al., 1987). The inclusion of symptoms of depression on the HAMA confounds the interpretation of studies examining the efficacy of treatments for depression on anxiety.

A second problem with the HAMA is that each of the items on the scale includes multiple symptoms. For example, the tension item incorporates the assessment of feelings of tension, fatigability, startle response, being moved to tears easily, trembling, feelings of restlessness, and inability to relax. The anxious mood item includes worries, anticipation of the worst, fearful anticipation, and irritability. To examine a treatment’s effects on each of these individual constructs, it would be necessary to have separate ratings of them.

Because the HAMA item ratings are complex, covering multiple symptoms, a third potential problem with the scale is that some symptoms can be rated on multiple items. For example, Hamilton’s description for rating the depression item includes early waking, which could also be rated on the insomnia item. It is likely that there is variability amongst raters, particularly raters at different sites, in how insomnia is rated (i.e., on both items, only on the insomnia item, or only on the depression item). The same could be said for the rating of fatigue and restlessness, both of which are listed on multiple items.

Because half of the items on the HAMA assess somatic symptoms of anxiety, a fourth criticism of the scale has been that it is sometimes difficult to determine if the ratings reflect symptoms of anxiety or side effects of medication (Bruss et al., 1994; Maier et al., 1988).

And fifth, the general guidelines in rating the graded levels of severity have been criticized as being open to interpretation and rating variance (Bruss et al., 1994). To improve reliability and facilitate standardization of measurement across studies, semi-structured interviews and rating manuals have been developed (Bech, 2011; Bruss et al., 1994; Shear et al., 2001). However, these guidelines differ in the ways they define the severity levels.

In recognition of the clinical significance of anxiogenic features in depressed patients, DSM-5 included criteria for an anxiety distress specifier for major depressive disorder (MDD) (American Psychiatric Association, 2013). A measure of anxiety severity based on the DSM-5 specifier offers several potential advantages over the HAMA. First is its brevity—the DSM-5 specifier includes only 5 items versus the 14 items of the HAMA. It would therefore take much less time (and thus less cost) to administer. In fact, perhaps a measure of the DSM-5 criteria would be considered brief enough to administer in routine clinical practice.

Second, the DSM-5 criteria reflect single symptoms whereas each HAMA item represents a group of symptoms. Thus, the simpler structure of the DSM-5 criteria could improve reliability, reduce rater variability across settings, and reduce administration effort. And third, a measure of the DSM-5 specifier would not be confounded by symptoms of depression.

We recently validated a semi-structured interview to assess the criteria of the DSM-5 anxious distress specifier—the DSM-5 Anxious Distress Interview (DADSI) (Zimmerman et al., 2017). In our initial validation study, we found that the DADSI was significantly, albeit moderately, correlated with the HAMA. While the DADSI was initially developed as a measure of the MDD anxious distress specifier subtyping, the goal of the present study was to determine whether the DADSI was equivalent to the HAMA as a measure of general anxiety severity in patients with MDD. Accordingly, in the present report from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project, we tested the hypothesis that the DADSI was as valid as the HAMA as a general anxiety severity measure in depressed patients. Because of the inclusion of depressive symptoms on the HAMA, we further hypothesized that the DADSI would be less highly correlated with measures of depression than the HAMA.

2. Methods

The study was conducted in the Rhode Island Hospital Department of Psychiatry partial hospital program, a 5-day per week intensive treatment program. Patients meet with a psychiatrist and therapist daily, and attend 4 groups per day. The average length of stay is 7.5 days (SD = 4.8).

Two hundred and three patients with current DSM-IV/DSM-5 MDD presenting for an intake evaluation at the Rhode Island Hospital Department of Psychiatry partial hospital program were interviewed by a trained diagnostic rater who administered the Structured Clinical Interview for DSM-IV (SCID) (First et al., 1997). The SCID was supplemented with questions from the Schedule for Affective Disorders and Schizophrenia (SADS) (Endicott and Spitzer, 1978) assessing the severity of symptoms and psychosocial functioning during the week prior to the evaluation as well as a lifetime history of suicide attempts. Of relevance to the current study, all patients were evaluated on the SADS items assessing psychic anxiety, depressed mood, and irritability. Additional questions were included to rate the items on the 17-item Hamilton Depression Rating Scale (HAM-D) (Hamilton, 1960) and the HAMA (Hamilton, 1959). A subsample was re-interviewed on the day of discharge. Details regarding interviewer training and diagnostic reliability are available in other publications from the MIDAS project, which have documented high reliability in diagnosing anxiety and mood disorders (Zimmerman and Mattia, 1999). The Rhode Island Hospital institutional review committee approved the research protocol, and all patients provided informed, written consent.

The DADSI assesses the 5 symptoms of the anxious distress specifier (feeling keyed up or tense, feeling restless, difficulty concentrating because of worry, fear that something awful might happen, and feeling that one might lose control). The probes of the DADSI inquire about symptom presence and severity for the past week and also determine if the symptom is present for the majority of the depressive episode. Item severity for the past week is rated from 0 to 4. Total scale scores range from 0 to 20. The DADSI interview was integrated into the SCID and completed immediately after the MDD section.

The patients completed the Clinically Useful Depression Outcome Scale (CUDOS) (Zimmerman et al., 2008a), the Clinically Useful Anxiety Outcome Scale (CUXOS) (Zimmerman et al., 2010), the Clinically Useful Anger Outcome Scale (CUANGOS) (Zimmerman, in preparation) and the Remission from Depression Questionnaire (Zimmerman et al., 2013). The self-report scales were usually completed prior to the diagnostic interview. The ratings on the DADSI were made blind to the results of the self-report scales.

The CUDOS contains items assessing all of the DSM-IV inclusion criteria for MDD (Zimmerman et al., 2008a). The respondent is instructed to rate the 16 symptom items on a 5-point ordinal scale indicating “how well the item describes you during the past week, including today” (0 = not at all true/0 days; 1 = rarely true/1–2 days; 2 = sometimes true/3–4 days; 3 = usually true/5–6 days; 4 = almost always true/every day). Compound DSM-IV symptom criteria referring to more than one construct (e.g. problems concentrating or making decisions; insomnia or hypersomnia) were subdivided into their respective components and a CUDOS item was written for each component. Total scores range from 0 to 64. In the present study the internal consistency of the CUDOS was 0.75.
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