Self-rating scales tell you more than the score

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Results of self-rating scales that do not match your clinical impression of a patient can inform your diagnosis

Rating scales give psychiatrists an objective benchmark on which to base critical treatment decisions, but not all clinicians use them because they view scales as time-consuming and offering little clinical yield. However, any depression self-rating scale (***Table***) can yield valuable clinical information if you pay attention to 3 areas.

Table

Commonly used depression self-rating scales

- Beck Depression Inventory, 2nd edition (BDI-II)
- Quick Inventory of Depressive Symptomatology, Self-Report (QIDS-SR)
- Zung Self-Rating Depression Scale

1. Total score

The total score supplies patients with objective feedback on their symptom severity, supports your treatment recommendations, and provides a benchmark for clinical decision-making. This information can help you determine when:

- the patient has shown no or insufficient improvement and treatment should be changed
- the patient has improved enough to stay the course
- antidepressant treatment would not be helpful because the baseline score is within the normal range.

Results that do not match your clinical impression can inform your diagnosis. If the total score is lower than expected, the patient might have a stoic temperament; if it is high, the patient might be histrionic or malingering. An unchanged total score might indicate that the patient has not responded to antidepressant treatment or is feeling demoralized.

2. Individual items

Note items that stand out because the patient rated them very high or endorsed items such as suicidality. An item-by-item analysis can help you focus on symptoms the patient considers problematic and which could be treatment targets, such as severe insomnia or fatigue. Often you can detect a pattern in the results, such as if a patient displays strong somatization or has mostly depressive cognitions.

3. Approach to the scale

Observe the patient while he or she fills out the scale. Obsessive patients might take a long time to complete the scale because they cannot decide which answer is correct and will argue with you about individual items. They may want to answer "2.5" instead of having to choose between 2 or 3. Patients with cognitive problems also might need a long time to complete the questionnaire, but don't forget about possible marginal literacy. Narcissistic patients might refuse to take the test because it is "below" them to fill out a scale that surely cannot capture their specialness.

Used in these 3 ways, scales are not a burden but an opportunity to engage your patient and to practice patient-centered medicine, even during brief clinical encounters.

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›› To read more about rating scales, see **"Every patient, every visit: Routine tests yield clinically useful data."** pages 39-48