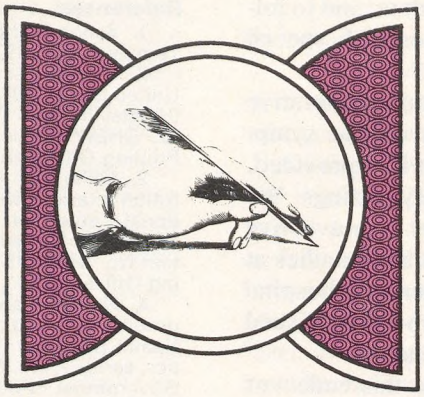
Letters to the Editor



The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Use of Depression Inventories

To the Editor:

We have become increasingly alarmed at the inappropriate usage of the Beck Depression Inventory, as well as other depression inventories, in medical settings. "Influence of Stereotypes in the Diagnosis of Depression by Family Practice Residents" *(J Fam Pract 12:849, 1981)* provides a good example of the lack of understanding of the proper use of psychometric instruments. The Beck Depression Inventory (like the Zung,[1] MMPI Depression Scale,[2] and Multiscore Depression Inventory[3]) has been appropriately used to measure severity of depression by primary care physicians. Severity, however, is not to be confused with diagnosis. This is an error we have seen not only in hasty clinical practice but also in the aforementioned article *(p 849)*. A high score on the Beck Depression Inventory does not necessarily indicate a diagnosis of depression, since one often finds patients with anxiety disorders, terminal cancer, and schizophrenia scoring well above the cutoffs listed in the article. A thorough clinical interview, such as the SADS (Schedule for Affective Disorders and Schizophrenia) is typically used for reliable diagnosis of depression in research and clinical work.

Furthermore, we were surprised once again to see the 21-item version of the Beck Depression Inventory used in a family practice setting. The much shorter 13-item version was introduced specifically for primary care populations, yet has been overlooked by the researchers, although they referenced it in the article as if it were synonymous with the 21-item version. We agree with the authors that residents too frequently misdiagnose patients with both false positives and false negatives; however, their data provide no evidence supporting this conclusion because of the mistaken idea that severity of depression and its diagnosis are interchangeable.

We do hope readers will note, however, the authors' results in Table 5, which indicate that nearly one half of the chart diagnoses of depression were given to patients whose severity of depression, as measured by the Beck, was less than mild. The authors' point about sex stereotyping is also well taken. It is hoped that in future research

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authors will refrain from implying that any self-report measure provides a DSM-III diagnosis, and recognize instead the uses and limitations of these instruments.

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1. Zung WWK: A self-rating depression scale. Arch Gen Psychiatry 12:63, 1965

2. Hathaway SR, McKinley JC: A multiphasic personality schedule (Minnesota III: The measurement of symptomatic depression). J Psychol 14:74, 1942

3. Berndt DJ, Patzel T, Berndt SM: Development and initial evaluation of a multiscore depression inventory. J Pers Assess 44:396, 1980

The preceding letter was referred to Dr. Seller, Dr. Blascovich, and Ms. Lenkei, who respond as follows:

We were rather dismayed with the Berndts' criticism of our recent article regarding the appropriateness of the use of the Beck Depression Index (BDI) in our research. Their argument seems to rest mainly on the contention that the BDI measures "severity" rather than diagnosis of depression.

We base our defense of our use of the BDI on two approaches: logic and relevant literature. First of all, it seems illogical to argue that one can measure the severity of depression without acknowledging its existence. In addition, it is our contention that one can rationally and practically define the existence of depression on the basis of severity. In our research, we defined a patient as "objectively" diagnosed as depressed if he or she had a fairly high BDI score. We chose a high score to minimize the chance of a false positive diagnosis. The Berndts' additional argument that "one often finds patients with anxiety disorders, terminal cancer, and schizophrenia scoring well above the cutoffs listed in the article" does not necessarily mean, as they imply, that the BDI might assess disorders other than depression, but rather it means that patients suffering from these other disorders might also be depressed.

We also feel the literature justifies the use of the BDI in studies such as our own. For example, Salkind[1] concluded that

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the Beck Depression Inventory provides a self-rating measurement of the behavioural manifestations of depression (Beck et al) and consequently promises to be a useful and accurate research instrument, especially valuable in multicentre trials since it bypasses the clinician's subjective bias. For use in general practice a method requires to be easily answered, easily applied by a clinician, easily and rapidly scored; it should be accurate and reliable. The BDI fulfills these requirements more closely than other existing scales.

More recently Nielsen and Williams[2] demonstrated the "BDI to be superior to primary physicians in identifying depressed patients" and suggested its use as a screening test for depression. Finally, we quote the Berndts themselves from an article detailing the development of a multiscore depression inventory: "Evidence for concurrent validity of the Full Scale MDI was obtained from two established measures of depression. The MDI correlated highly with the BDI, $r = .69$, $p < .001$."[3]

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