A. Cordero Villafáfila[1]
J. A. Ramos Brieva[2]
R. Gutiérrez Labrador[1]

The Axial Diagnostic and Sensitive-to-Change for Depression Index: Diagnostic utility and use in studies of therapeutic evaluation

[1] Mental Health Service "Miraflores" Alcobendas (Madrid)

[2] Psychiatry Department Hospital Universitario Ramon y Cajal Universidad de Alcalá de Henares. Madrid.

Introduction. The authors develop a new rating scale for to measure its sensibility to the change of the intensity of the depressive symptoms under the effects of antidepressants drugs, and for to analyze the predictive validity of its total score. Designate it: The Axial Diagnostic and Sensitive-to-Change for Depression Index (ADSCDI). For this, use only seven nuclear items for the depression diagnosis (mood, interest, impulse/drive, pleasure, energy, daily job and different quality) without vegetative symptoms or anxious.

Methodology. The authors interview to 111 psychiatric outpatients attended consecutively in a Mental Health Center. Sixty were fulfilling the criteria for depressive episode of the ICD-10 and fifty and one were forming part of the group of control: psychiatric outpatients not depressed. They use for this a protocol of collection of data that contains the ADSCDI, where the patients indicate how are found on a Visual Analogical Scale in the one which quantify their answers in each item, the Hamilton Rating Scale for Depression of 17 articles (HRSD-17) and an Global Clinical Impression scale (GCI). Each depressed patient receipt the antidepressant treatment that better were adjusted to his clinical profile according to the psychiatrist that was trying to him. The depressed patients were evaluated a second time after thirty days of treatment.

Results. All the items of the ADSCDI perceive a change statistically significant in the intensity of the depressive symptoms (p=0.00). The total score of the ADSCDI, also, at same level of statistical significance that the total scores of the HRSD-17 and of the GCI (p=0.000). The ADSCDI interrelates high and significatively with the HRSD-17 as with the GCI (r=0.77 and r=0.73 respectively; p=0.00). Equally makes it with the average of the "proportion of improvement" that evaluates, with the one evaluated by the HRSD-17 and the GCI (r=0.74 and r=0.68 respectively; p=0.000). A cut-off of 39 offers the best predictive values for the ADSCDI respect to the clinical and the ICD-10 criteria for depression. With a sensibility of 0.97, a specificity of 0.76 (of 0.88 with psychiatric patients free of symptoms), a total probability of guessing right of 93% and a *kappa* reliability of 0.74. The results improve when the ADSCDI is used as external criterion. For this new operative diagnostic criteria (ADCD), a cut-off of 40 offers a sensibility of 1.00, a specificity of 0.96 a probability of guessing right of 99% and a *kappa* reliability of 0.96.

Conclusions. The ADSCDI offers sufficient concurrent validity with the HRSD-17 and the GCI. It can be considered a sensitive instrument to the change, with the advantage of containing, only, items that have shown be frequent, discriminant and predictives. The ADSCDI also is a good instrument to establish diagnostic of depression in the system ADCD/ADSCDI or in the ICD-10 one.

Key words:
Depression. Scales. Predictive validity. Evaluation. Measure. Therapeutic efficiency.

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El Índice Diagnóstico Axial y de Seguimiento para la Depresión. Su utilidad diagnóstica y en estudios de evaluación terapéutica.

Introducción. Los autores desarrollan una nueva escala para medir el cambio de la intensidad de los síntomas depresivos bajo los efectos de fármacos antidepresivos y analizar la validez predictiva de su puntuación total. La denominan: Índice Diagnóstico y de Seguimiento para la Depresión (IDASD). Para ello, utilizan solamente siete ítems nucleares para el diagnóstico de depresión (ánimo, interés, impulso, gusto/placer, energía, trabajo y distinta cualidad) sin síntomas vegetativos o ansiosos.

Metodología. Los autores entrevistan a 111 pacientes psiquiátricos atendidos consecutivamente en régimen ambulatorio. Sesenta cumplían los criterios para episodio depresivo de la CIE-10 y 51 formaban parte del grupo de

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Correspondence:
JA Ramos Brieva
Servicio de Psiquiatria.
Hospital Universitario Ramon y Cajal
Ctra Colmenar km 9,100
E-28034 Madrid (Spain)
E-mail: jramosb.hrc@salud.madrid.org

control: enfermos psiquiátricos no deprimidos. Utilizan para ello un protocolo de recogida de datos que contiene el IDASD, donde los pacientes señalan cómo se encuentran sobre una Escala Analógico-Visual en la que cuantifican sus respuestas en cada ítem, la Escala de Hamilton para la Depresión de 17 ítems (EHD-17) y una Impresión Clínica Global (ICG). Cada paciente deprimido recibía el tratamiento antidepresivo que mejor se ajustaba a su perfil clínico según el psiquiatra que le trataba. Los pacientes deprimidos fueron evaluados una segunda vez tras 30 días de tratamiento.

Resultados. Todos los ítems de la IDASD perciben un cambio en la intensidad de la sintomatología estadísticamente significativo (p = 0,00). La puntuación total del IDASD, también, al mismo nivel de significación estadística que las puntuaciones totales de la EHD-17 y de la ICG (p = 0,000). El IDASD correlaciona alto y significativo tanto con la EHD-17 como con la ICG (r = 0,77 y r = 0,73, respectivamente; p = 0,00). Igualmente lo hace el promedio de la «proporción de mejoría» que evalúa, con la evaluada por la EHD-17 y la ICG (r = 0,74 y r = 0,68 respectivamente; p = 0,000). Un punto de corte de 39 ofrece las mejores prestaciones predictivas del IDASD respecto al criterio clínico y al criterio diagnóstico de depresión de la CIE-10. Con una sensibilidad de 0,97, una especificidad de 0,76 (de 0,88 con pacientes psiquiátricos asintomáticos), una probabilidad total de acertar de 93% y una fiabilidad *kappa* de 0,74. Los resultados mejoran cuando se utiliza como criterio externo el CDAD. Para ese nuevo criterio diagnóstico operativo (CDAD), un punto de corte de 40 ofrece una sensibilidad de 1,00, una especificidad de 0,96 una probabilidad de acertar del 99% y una fiabilidad *kappa* de 0,96.

Conclusiones. El IDASD ofrece suficiente validez concurrente con la EHD-17 y la ICG. Puede considerarse un instrumento sensible al cambio, con la ventaja de contener, tan sólo, ítems que han mostrado ser frecuentes, discriminantes y predictivos. El IDASD también es un buen instrumento para establecer diagnósticos de depresión en el sistema CDAD/IDASD o en el de la CIE-10.

Palabras clave:
Depresión. Escalas. Validez predictiva. Evaluación. Medida. Eficacia terapéutica.

INTRODUCTION

The Axial Diagnostic Criteria for Depression (ADCD) and the Axial Diagnostic and sensitive-to change for Depression Index (ADSCDI) were recently developed. Both tools make up the ADCD/ ADSCDI diagnostic system.

The ADCD is an operational diagnostic criterion (ODC) for depression constructed with 7-core symptoms to establish the diagnosis and that is devoid of those items that have been demonstrated to be less frequent, predictive and discriminatory.

The ADSCDI is a self-applied scale designed in parallel with the ADCD to detect the presence of each symptom and establish the diagnosis based on the patients' responses and in accordance with the requirements of the ADCD.

The ADCD/ADSCDI system has good predictive or diagnostic capacity, with a 0.93 sensitivity and 0.82 specificity with 0.76 *kappa* reliability and a proportion of total correctly predicted cases of 88 to 93%. When the control group is made up exclusively of asymptomatic psychiatric patients, specificity increases up to 0.92. The ADCD/ADSCDI system also has good construct validity (0.69) and good alpha reliability (α = 0.92). Its internal consistency is also acceptable: elevated two halves of the test (R= 0.91), high test-retest correlation (r=0.67), with all the item/total correlations above r= 0.79.1

Up to now, the ADSCDI has been used as a mere tool to detect the presence/absence of symptoms and to make the diagnosis based on these data. However, its construction allows the patients to make their answers flexible as in any scale with discrete variables, since each item has an associated Visual Analogue Scale (V AS) that makes it possible to express the patient's status flexibly in regards to the previous two weeks (see Annex). This has suggested to the authors that the ADSCDI may be used as a scale to measure depressive symptoms intensity, as the Hamilton Depression Rating Scale (HDRS),[2] which could be useful to make therapeutic follow-ups.

For decades, the HDRS was the gold standard with which 80% of the antidepressant drugs coming onto the market were evaluated.[3] However, its success did not prevent it from being criticized due to the overrepresentation of the vegetative and anxiety-dependent symptoms on this scale.[4] Up to 53-60% of the total score of the different HDRS versions could be attributed to these symptoms.

Due to this, other instruments having similar characteristics have been developed with a specific design to evaluate changes in symptom intensity and less presence of anxious or anxious-dependent symptoms. The Montgomery-Asberg Depression Rating Scale (MADRS) was one of those attempts.[5]

Since the death of Max Hamilton at 76 years of age, on August 6, 1988, the MADRS has progressively replaced the HDRS as the gold standard in the evaluation of the changes of intensity of depressive symptoms in the clinical trials.

In spite of the efforts of their authors, the MADRS, however, is also not exempt of anxious-dependent symptoms

("inner tension," "insomnia," decreased appetite"), although these exist to a lesser degree than in the HDRS (30%). This makes it possible to support the fact that the problem which was initially attributed to the HDRS has still not been completely solved with the MADRS.

The presence of anxious-dependent symptoms is important in this type of instrument when analyzing the drug efficacy of the antidepressants. This is mainly because it is precisely the anxious symptoms that improve the earliest,[6] even when only under the "placebo" effect of the medical act itself. This makes it possible to attribute an antidepressant efficacy to drugs which may not have as much of an effect or one that is not as early. When the score of the anxious symptoms decreases, these scales provide unreal early improvements, since the clearly depressive symptoms remain active.[8]

Research objectives

In this context, an instrument that is really void of this type of item would be more useful in the true therapeutic evaluation of the antidepressant drugs. That is why the authors have proposed determining the follow-up capacity and sensitivity to change of the ADSCDI.

Furthermore, it is aimed to determine the predictive or diagnostic capacity of the total score when the ADSCDI is used as a common scale, along the same line which, for example, the predictive capacity of the HDRS was studied.[9]

MATERIAL AND METHODS

Subjects

A total of 111 patients over 18 years of age consecutively attended as outpatients in the Mental Health Care Center "Miraflores" of Alcobendas (Madrid) were included in the study. Sixty of them were assigned to the depressed patient group according to the clinical opinion the psychiatrists evaluating them. After, it was assured that they also met the diagnostic criteria for depressive episode of the international classification of diseases-I0 (ICD-10) (mild [n= 5], middle [n= 13] or severe [n= 40]). The rest of the patients introduced into the investigation made up the control group, also according to clinical criteria in the first place and then the ICD-IO. None of the control subjects met the clinical criteria or the ICD-10 for depressive episode.

The sociodemographic data of the probands and other characteristics of the sample have already been specified in another part.[1]

Procedure

The patients were informed of the type of study that it was aimed to carry out during a common psychiatric interview. After obtaining their informed consent to be enrolled in the study, the evaluation was done. To do so, a protocol was filled out. This protocol contained, besides the ICD-IO diagnostic criteria and sociodemographic variables, the ADSCDI, 17-item HDRS validated in Spanish[10] and a 7-item Clinical Global Impression (CGI) scale applied to the depressive symptoms.[11] The ADSCDI was completed by the patient, although the patient could be helped by his/her physician, if he/she requested it. The HDRS and CGI were filled out by the psychiatric investigator. The depressed patients received the antidepressant treatment that each psychiatrist considered to be effective in each case and the evaluation was repeated 30 days later with the same initial protocol (excluding the sociodemographic and ICD-10 diagnostic data).

The ADSCDI is a self-applied instrument developed parallelly to the ADCD proposed by the authors.[1] Its use makes it possible to express the ADCD in a measurable way and facilitates psychometric analyses. Although the Visual Analogue Scales (VAS) of each item are really discrete-type variables, the combination generates an instrument that can be used as a continual variable that can be managed with parametric statistics,[12] as is generally done with the HDRS.

Given that the anxious and non-anxious symptoms of the HDRS do not behave similarly in the evaluation of the symptoms,[8] this scale was subdivided into two parts. One part was made up of the symptoms related most with a melancholic factor found in a previous investigation (depressive mood, guilt, suicide, inhibition, work and interests).[13] The total score of this subscale was called HDRS-Melancholy. The rest of the items of the HDRS were included under the name of HDRS-Anxiety, although it may have been more appropriate, and longer, to have called it anxious-vegetative or vegetative-anxious.

Statistical analysis of the data

To analyze the *diagnostic capacity* of the ADSCDI, the responses of the initial evaluation of all the patients were analyzed (N= III). The predictive validity of the ADSCDI in regards to the external criterion, its sensitivity and specificity, were calculated following the method described by Reid.[14] The search for the optimum cutoff point with the best likelihood to correctly diagnose all the cases, as well as the positive and negative cases, supposing a 50%-base rate, was performed with the methodology of Meehl and Rosen.[15] Their methodology applies the Bayes Theorem principles or that of conditioned likelihood, to the screening questionnaires. The predictive efficacy was calculated using the con-

cordance coefficient and *kappa* reliability (K of Cohen[16]), pi (π) overall probability of being correct7 and the Youden Index (ϑ).[18]

For the evaluation of *sensitivity to change* in the symptom intensity, Pearson's r correlation coefficient was used to establish the level of association between the total scores of the different instruments used in the study. To check if the differences between the means of these total scores are statistically significant, the Student's t test for cases of small samples[12] was calculated. In every case, the minimum level of statistical significant demanded was always 0.01.

RESULTS AND DISCUSSION

Regarding its diagnostic capacity, Table 1 shows the predictive and predictive efficacy indicators of the ADSCDI for different cutoffs of its total score. It is not difficult to see that the most balanced cutoff is ≥39. This value includes the best balanced proportions of sensitivity and specificity. It is true that the cutoff of ≥38 has a perfectly correct sensitivity and proportion of negative cases (1.00). However, the specificity is somewhat reduced regarding that of 39. If the other indicators are added to the latter, such as the proportion of total and positive cases correctly found, the Youden Index (the closer to the unit, the better the predictive capacity), the pi likelihood of being correct and the *kappa* reliability are similar in both cases, it seems to be correct to prefer the cutoff of ≥39.

It can be stated that the specificity of this cutoff (≥39) increases to 0.88 when this deals with detecting depressions in the face of asymptomatic psychiatric subjects. The effect of having active psychopathology reduces the specificity of the ADSCDI system as has already been indicated in another part. However, this significantly decreases the efficacy of the instrument.[1]

In any event, the predictive indicators of ADSCDI are reasonably good. On the other hand, they are similar or superior to those found by other instruments greatly used for this effect. This is, for example, the case of the HDRS, whose sensitivity for the different versions of this scale, and its heterogeneous cutoffs, range from 0.54 and 0.84, with a specificity that ranges from 0.75 to 0.95 and *kappa* reliability fluctuating from 0.22 and 0.70.[19] These values are below those found for the ADSCDI. Another example would be the Montgomery-Asberg Depression Rating Scale, which reaches a sensitivity of 0.94 and specificity of 0.83 with a 31 cutoff.[20]

If instead of using as external criterion the clinical criterion and that of the ICD-1 0, as in the previous case, we focus on our ADCD, the predictive validity indicators of the ADSCDI improve considerably (Table II). Although it is complex to choose between the different cutoffs analyzed, because all have excellent predictive values, it seems that the best balanced would be ≥40. This has the best indicators of predictive efficacy and the greatest likelihood of accurately finding the total, negative and positive cases. Its sensitivity is perfect (1.00) and its specificity is 0.96. Although its capacity to detect the non-depressed is similar at the cutoff of ≥41, it has slightly worse performance for the depressed cases. This is a reason to prefer ≥40.

Such indicators of predictive validity can be interpreted in two ways. One of them is that its excellence does not reflect more than a tautology, since the ADSCDI and the ADCD form a part of the same diagnostic system. The other, which in spite of everything, given the constructive solidity, internal consistence and diagnostic reliability of the ADCD regarding the clinical criteria and those of the ICD-101 (which makes it a diagnostic criteria for depression that is effective, valid and safe), the total score of the ADSCDI (≥ 40) would be an excellent representative of it, making it an instrument to use when an attempt is being made to establish diagno-

Table 1 Predictive validity of the ADSCDI*

			Likelihood of being correct for			Predictive efficacy		
			total	positive	negative	Youden Index	Likelihood of being correct	reliability
Cutoff (≥)	*sen*	*esp*				ϑ	π	κ
40	0.93	0.76	0.84	0.79	0.92	0.68	0.92	0.71
39	**0.76**	**0.76**	**0.87**	**0.80**	**0.96**	**0.73**	**0.93**	**0.74**
38	1.00	0.73	0.87	0.79	1.00	0.73	0.93	0.74
37	1.00	0.71	0.86	0.78	1.00	0.71	0.92	0.72
36	1.00	0.69	0.85	0.78	1.00	0.69	0.92	0.70

sen: sensitivity; *esp*: specificity
*External criterion: clinical and that of the ICD-10

Table 2 Predictive validity of the ADSCDI*

			Likelihood of being correct for			Predictive efficacy		
			total	positive	negative	Youden Index	Likelihood of being correct	reliability
Cutoff (≥)	*sen*	*esp*				ϑ	π	κ
44	0.88	0.98	0.93	0.98	0.89	0.86	0.96	0.84
43	0.94	0.96	0.95	0.96	0.94	0.90	0.97	0.89
42	0.97	0.96	0.97	0.96	0.97	0.93	0.98	0.93
41	0.98	0.96	0.97	0.96	0.98	0.94	0.99	0.94
40	**1.00**	**0.96**	**0.98**	**0.96**	**1.00**	**0.96**	**0.99**	**0.96**
39	1.00	0.91	0.96	0.92	1.00	0.91	0.98	0.92

sen: sensitivity; esp: specificity
*External criterion: clinical and that of the ICD-10

Table 3 Difference between the means of the ADSCDI items

	Day 0		Day 30			
Item	$\bar{x}$	σ	$\bar{x}$	σ	gl	t*
Mood	7.83	1.84	6.12	2.45	118	4.29
Interest	7.35	2.31	5.75	2.51	118	3.60
Impulse	7.95	1.67	6.20	2.52	118	4.45
Enjoyment/pleasure	7.00	2.64	5.77	2.44	118	2.65
Energy	8.18	1.63	6.55	2.59	118	4.09
Work	7.60	2.10	6.23	2.55	118	3.19
Quality	8.10	2.27	5.87	2.81	118	4.74

$\bar{x}$: mean; σ: standard deviation; * all, p = 0.00

ses of depression using the ADCD and not another external criterion.

Regarding its sensitivity to change, Table III shows the behavior of the different items of the ADSCDI in the follow-up period and Table IV that of its total score. In the latter Table, the behavior of the rest of the instruments used as external or convergent criterion is also shown. As can be seen in Table IV, all the instruments capture statistically significant differences in the symptom intensity of the depressed, including the ADSCDI. This is a first step to state that the ADSCDI behaves in this sense as any other scale designed to measure the change.

Such data, however, does not say much about whether the behavior of the ADSCDI is similar to that of the other instruments used. For this, the scores need to be compared. Table V reflects the correlation of the total score of the ADSCDI with that of the other scales. A strong, statistically significant, correlation can be observed between all of them with the sole exception of HDRS-Anxiety on Day 0. This is not surprising, since the ADSCDI is not made up of the items related with anxiety.[1] The statistically significant correlation of the ADSCDI and HDRS-Anxiety on Day 30 could be due to the fact that the overall improvement of the patients forces all the scores downwards.

It can be seen in Table V that the correlation is more solid with all the instruments on day 30 than in the initial evaluation. In this regards, the ADSCDI does not behave differently regarding the other self-applied scales, that correlate more with those hetero-applied ones in the final stages of the evaluation (when the scores are generally forced down towards zero) than in the initial ones.[21] In any event, correlating all of the scores of both evaluations together, which makes it possible to collect all the variety of the

Table 4 Difference between the means of the respective total scores

	Day 0		Day 30			
Item	$\bar{x}$	σ	$\bar{x}$	σ	gl	t*
ADSCDI	54.02	9.13	42.48	14.02	118	5.29
GCI	4.93	0.84	3.68	1.42	117	5.83
HDRS-Total	22.77	4.91	13.73	7.73	117	7.56
HDRS-Melancholy	9.95	2.42	5.54	3.78	117	7.51
HDRS-Anxiety	12.82	3.74	8.19	4.48	117	6.07

* all, p= 0.00
ADSCDI: Axial Diagnostic an Sensitive-to-Change for Depression Index; GCI: Global Clinic Impresion; HDRS: Hamilton Depression Revised Scale.

Table 5 Correlations (r)* between the total score of the ADSCDI with the other instruments

Instruments	GCI	HDRS-Total	HDRS-Melancholy	HDRS-Anxiety
ADSCDI:				
Day 0	0.46	0.41	0.48	0.23**
Day 30	0.74	0.82	0.84	0.70
Both evaluated together	0.73	0.77	0.80	0.63

* all, p= 0.00; **n.s.
ADSCDI: Axial Diagnostic an Sensitive-to-Change for Depression Index; GCI: Global Clinic Impresion; HDRS: Hamilton Depression Revised Scale.

Table 6 Correlations (r)* of the average of the proportion of improvement ** of all the instruments used

Instruments	GCI	HDRS-Total	HDRS-Melancholy	HDRS-Anxiety
ADSCDI:	0.68	0.74	0.78	0.57

* all, p= 0.00;
** proportion of improvement = [1 – (score Day 30 ¸ score Day 0)]
ADSCDI: Axial Diagnostic an Sensitive-to-Change for Depression Index; GCI: Global Clinic Impresion; HDRS: Hamilton Depression Revised Scale.

scores possible of the instruments in the same calculation, a high and statistically significant correlation is found between the behavior of the ADSCDI and the other scales used. This confirms its solid convergent validity.

Analyzing the total gross scores may be a somewhat basic procedure to measure the change and to establish similarities in the evaluation made by the different instrument. It would be better to analyze a more purified value that really reflects the *change* produced in the patient. Such an indicator could be the *"proportion of the improvement"* experienced by the patients between both evaluations. It is an indicator that takes into account both the starting and the final condition in all the patients. Thus, it provides more useful information. The ADSCDI detects these proportional changes in such a way that it has a statistically significant correlation with that captured by the other instruments. That is, it detects these changes in a very similar way to the other scales

analyzed. This similarity is greater with the total score of the HDRS and the HDRS-Melancholy subscale (Table VI). It is a behavior that is consistent with the idea that guided the construction of the ADSCDI: using only core symptoms of depression, without those that are less discriminant, specific and predictive or that are influenced by anxiety or vegetative changes underlying this disease, among others.

CONCLUSIONS

The ADSCDI is an index with reasonable construct and convergent validity, strong internal consistency and high reliability, and *good predictive validity* with a cutoff of ≥ 39 if an attempt is being made to make diagnoses similar to the clinical criterion and that of the ICD-10, or of ≥ 40, if an attempt is being made to establish a diagnosis more in agreement with the new ADCD.

Along general lines, the entire ADCD/ADSCDI system offers an effective and safe procedure to *diagnose depression.*

In the same way, the results of the present investigation seem to support that a few core depression items that are well selected, consistent, valid, reliable and predictive, are capable of informing about the changes experienced by the patient over time with the same efficacy as the other more extensive scales.

Thus, it would be possible to promote the ADSCDI as an instrument sensitive to *change*, capable of evaluating the modifications of intensity of the depressive symptoms over lime, under the action of antidepressant drugs.

Since the ADSCDI represents the core symptoms of depression,[1] it would be possible to state that the changes it detects in depressive symptom intensity refer to this core, and not to other more or less non-specific or secondary symptoms. This, in the opinion of the authors, makes it possible to recommend it for clinical trials in which it is really desired to detect the basic changes in the intensity of depression.

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Appendix 1 — Difference between total scores averages

We need you to help us understand how you feel. To do so, we will show you several lines with a series of numbers. Indicate how you have felt during the last two weeks in each section, marking the number that best represents it with a circle

(ask you doctor for help filling out this questionnaire if you need it).

For Example: Good 1 2 3 4 5 6 7 8 9 10 Bad (it means quite bad to very bad)

MOTIVATION, INTEREST for things:	Lack of interest ... Interested 10 9 8 7 6 5 4 3 2 1	
IMPULSE for the activity:	Active ... Passive 1 2 3 4 5 6 7 8 9 10	
LIKING or PLEASURE for things:	Bored, serius ... Enjoyable, cheerful 10 9 8 7 6 5 4 3 2 1	
DAILY WORK it is...:	Tiring ... Mild 10 9 8 7 6 5 4 3 2 1	
State of MOOD:	Fresch, cherful ... Weak, downhearted 1 2 3 4 5 6 7 8 9 10	
ENERGY in the body:	Strong ... Weak 1 2 3 4 5 6 7 8 9 10	
(QUALITY) What happens is:	Normal ... Rare 1 2 3 4 5 6 7 8 9 10	

Note for the evaluator (do not include on the sheet the patient fills out): Write the value given by the patient regarding his/her condition in each item in each box, *add* the scores and write down the total in the box below.
In this way, you can use the ADSCDI as a scale for the evaluation of the depressive symptom intensity.
If you want to use the ADSCDI to make a diagnosis of depression, remember that:

- a score equal to or greater than 39 provides a diagnosis of depression similar to that of the ICD-10.
- a score equal to or greater than 40 provides a diagnosis of depression in the ADCD/ADSCDI system.