Hamilton Depression Scale

Definition

The Hamilton Depression Scale (HDS or HAMD) is a test measuring the severity of depressive symptoms in individuals, often those who have already been diagnosed as having a depressive disorder. It is sometimes known as the Hamilton Rating Scale for Depression (HRSD) or the Hamilton Depression Rating Scale (HDRS).

Purpose

The HDS is used to assess the severity of depressive symptoms present in both children and adults. It is often used as an outcome measure of depression in evaluations of antidepressant psychotropic medications and is a standard measure of depression used in research of the effectiveness of depression therapies and treatments. It can be administered prior to the start of medication and then again during follow-up visits, so that medication dosage can be changed in part based on the patient's test score. The HDS often used as the standard against which other measures of depression are validated.

The HDS was developed by Max Hamilton in 1960 as a measure of depressive symptoms that could be used in conjunction with clinical interviews with depressed patients. It was later revised in 1967. Hamilton also designed the Hamilton Depression Inventory (HDI), a self-report measure consistent with his theoretical formulation of depression in the HDS, and the **Hamilton Anxiety Scale** (HAS), an interviewer-rated test measuring the severity of anxiety symptoms.

Precautions

Some symptoms related to depression, such as self-esteem and self-deprecation, are not explicitly included in the HDS items. Also, because anxiety is specifically

asked about on the HDS, it is not always possible to separate symptoms related to anxiety from symptoms related to depression.

Because the HDS is an interviewer-administered and rated measure, there is some subjectivity when it comes to interpretation and scoring. Interviewer bias can impact the results. For this reason, some people prefer self-report measures where scores are completely based on the interviewee's responses.

Description

Depending on the version used, there are either 17 or 21 items for which an interviewer provides ratings. Besides the interview with the depressed patient, other information can be utilized in formulating ratings, such as information gathered from family, friends, and patient records. Hamilton stressed that the interview process be easygoing and informal and that there are no specific questions that must be asked.

The 17-item version of the HDS is more commonly used than the 21-item version, which contains four additional items measuring symptoms related to depression, such as **paranoia** and **obsession**, rather than the severity of depressive symptoms themselves.

Examples of items for which interviewers must give ratings include overall depression, guilt, **suicide**, **insomnia**, problems related to work, psychomotor retardation, agitation, anxiety, gastrointestinal and other physical symptoms, loss of libido (sex drive), **hypochondriasis**, loss of insight, and loss of weight. For the overall rating of depression, for example, Hamilton believed one should look for feelings of hopelessness and gloominess, pessimism regarding the future, and a tendency to cry. For the rating of suicide, an interviewer should look for suicidal ideas and thoughts, as well as information regarding suicide attempts.

Results

In the 17-item version, nine of the items are scored on a five-point scale, ranging from zero to four. A score of zero represents an absence of the depressive symptom being measured, a score of one indicates doubt concerning the presence of the symptom, a score of two indicates mild symptoms, a score of three indicates moderate symptoms, and a score of four represents the presence of severe symptoms. The remaining eight items are scored on a three-point scale, from zero to two, with zero representing absence of symptom, one indicating doubt that the symptom is present, and two representing clear presence of symptoms.

For the 17-item version, scores can range from 0 to 54. One formulation suggests that scores between 0 and 6 indicate a normal person with regard to depression, scores between 7 and 17 indicate mild depression, scores between 18 and 24 indicate moderate depression, and scores over 24 indicate severe depression.

There has been evidence to support the reliability and validity of the HDS. The scale correlates highly with other clinician-rated and self-report measures of depression.

Resources

BOOKS

Edelstein, Barry. *Comprehensive Clinical Psychology Volume 7: Clinical Geropsychology*. Amsterdam: Elsevier, 1998.

Maruish, Mark R. *The Use of Psychological Testing for Treatment Planning and Outcomes Assessment*. Mahwah, NJ: Lawrence Erlbaum Associates, 1999.

Ollendick, Thomas. *Comprehensive Clinical Psychology Volume 5: Children and Adolescents: Clinical Formulation and Treatment*. Amsterdam: Elsevier, 1998.

Schutte, Nicola S., and John M. Malouff. *Sourcebook of Adult Assessment Strategies.* New York: Plenum Press, 1995.

THE HAMILTON RATING SCALE FOR DEPRESSION

(to be administered by a health care professional)

Patient's Name

Date of Assessment

To rate the severity of depression in patients who are already diagnosed as depressed, administer this questionnaire. The higher the score, the more severe the depression.

For each item, write the correct number on the line next to the item. (Only one response per item)

1. **DEPRESSED MOOD** (Sadness, hopeless, helpless, worthless)
   - **0=** Absent
   - **1=** These feeling states indicated only on questioning
   - **2=** These feeling states spontaneously reported verbally
   - **3=** Communicates feeling states non-verbally—i.e., through facial expression, posture, voice, and tendency to weep
   - **4=** Patient reports VIRTUALLY ONLY these feeling states in his spontaneous verbal and non-verbal communication

2. **FEELINGS OF GUILT**
   - **0=** Absent
   - **1=** Self reproach, feels he has let people down
   - **2=** Ideas of guilt or rumination over past errors or sinful deeds
   - **3=** Present illness is a punishment. Delusions of guilt
   - **4=** Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations

3. **SUICIDE**
   - **0=** Absent
   - **1=** Feels life is not worth living
   - **2=** Wishes he were dead or any thoughts of possible death to self
   - **3=** Suicidal ideas or gesture
   - **4=** Attempts at suicide (any serious attempt rates 4)

4. **INSOMNIA EARLY**
   - **0=** No difficulty falling asleep
   - **1=** Complains of occasional difficulty falling asleep—i.e., more than 1/2 hour
   - **2=** Complains of nightly difficulty falling asleep

5. **INSOMNIA MIDDLE**
   - **0=** No difficulty
   - **1=** Patient complains of being restless and disturbed during the night
   - **2=** Waking during the night—any getting out of bed rates 2 (except for purposes of voiding

6. **INSOMNIA LATE**

0= No difficulty
1= Waking in early hours of the morning but goes back to sleep
2= Unable to fall asleep again if he gets out of bed

7. **WORK AND ACTIVITIES**

0= No difficulty
1= Thoughts and feelings of incapacity, fatigue or weakness related to activities; work or hobbies
2= Loss of interest in activity; hobbies or work—either directly reported by patient, or indirect in listlessness, indecision and vacillation (feels he has to push self to work or activities)
3= Decrease in actual time spent in activities or decrease in productivity
4= Stopped working because of present illness

8. **RETARDATION: PSYCHOMOTOR** (Slowness of thought and speech; impaired ability to concentrate; decreased motor activity)

0= Normal speech and thought
1= Slight retardation at interview
2= Obvious retardation at interview
3= Interview difficult
4= Complete stupor

9. **AGITATION**

0= None
1= Fidgetiness
2= Playing with hands, hair, etc.
3= Moving about, can't sit still
4= Hand wringing, nail biting, hair-pulling, biting of lips

10. **ANXIETY (PSYCHOLOGICAL)**

0= No difficulty
1= Subjective tension and irritability
2= Worrying about minor matters
3= Apprehensive attitude apparent in face or speech
4= Fears expressed without questioning

11. **ANXIETY SOMATIC:** Physiological concomitants of anxiety, (i.e., effects of autonomic overactivity, "butter? ies," indigestion, stomach cramps, belching, diarrhea, palpitations, hyperventilation, paresthesia, sweating, ? ushing, tremor, headache, urinary frequency). Avoid asking about possible medication side effects (i.e., dry mouth, constipation)

0= Absent
1= Mild
2= Moderate
3= Severe
4= Incapacitating

12. **SOMATIC SYMPTOMS (GASTROINTESTINAL)**

0= None
1= Loss of appetite but eating without encouragement from others. Food intake about normal
2= Difficulty eating without urging from others. Marked reduction of appetite and food intake

13. **SOMATIC SYMPTOMS GENERAL**

0= None
1= Heaviness in limbs, back or head. Backaches, headache, muscle aches. Loss of energy and fatigability
2= Any clear-cut symptom rates 2

14. GENITAL SYMPTOMS (Symptoms such as: loss of libido; impaired sexual performance; menstrual disturbances)

0= Absent
1= Mild
2= Severe

15. HYPOCHONDRIASIS

0= Not present
1= Self-absorption (bodily)
2= Preoccupation with health
3= Frequent complaints, requests for help, etc.
4= Hypochondriacal delusions

16. LOSS OF WEIGHT

A. When rating by history:
0= No weight loss
1= Probably weight loss associated with present illness
2= De? nite (according to patient) weight loss
3= Not assessed

17. INSIGHT

0= Acknowledges being depressed and ill
1= Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2= Denies being ill at all

18. DIURNAL VARIATION

A. Note whether symptoms are worse in morning or evening. If NO diurnal variation, mark none
0= No variation
1= Worse in A.M.
2= Worse in P.M.
B. When present, mark the severity of the variation. Mark “None” if NO variation
0= None
1= Mild
2= Severe

19. DEPERSONALIZATION AND DEREALIZATION (Such as: Feelings of unreality; Nihilistic ideas)

0= Absent
1= Mild
2= Moderate
3= Severe
4= Incapacitating

20. PARANOID SYMPTOMS

0= None
1= Suspicious
2= Ideas of reference
3= Delusions of reference and persecution

21. OBSESSIONAL AND COMPULSIVE SYMPTOMS

0= Absent
1= Mild
2= Severe

Total Score _____

Adapted from Hedlung and Vieweg, The Hamilton rating scale for depression Journal of Operational Psychiat, 1979;10(2):149-165.