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Диагностические шкалы Депрессий

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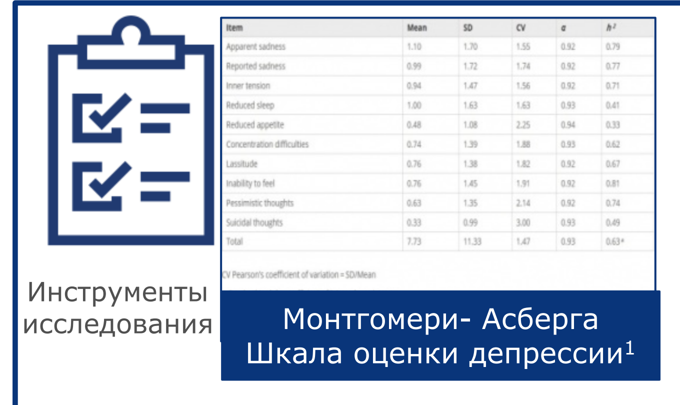
Материал предназначен для медицинских и фармацевтических работников. Материал разработан медицинским отделом ТОО «Johnson&Johnson Kazakhstan»

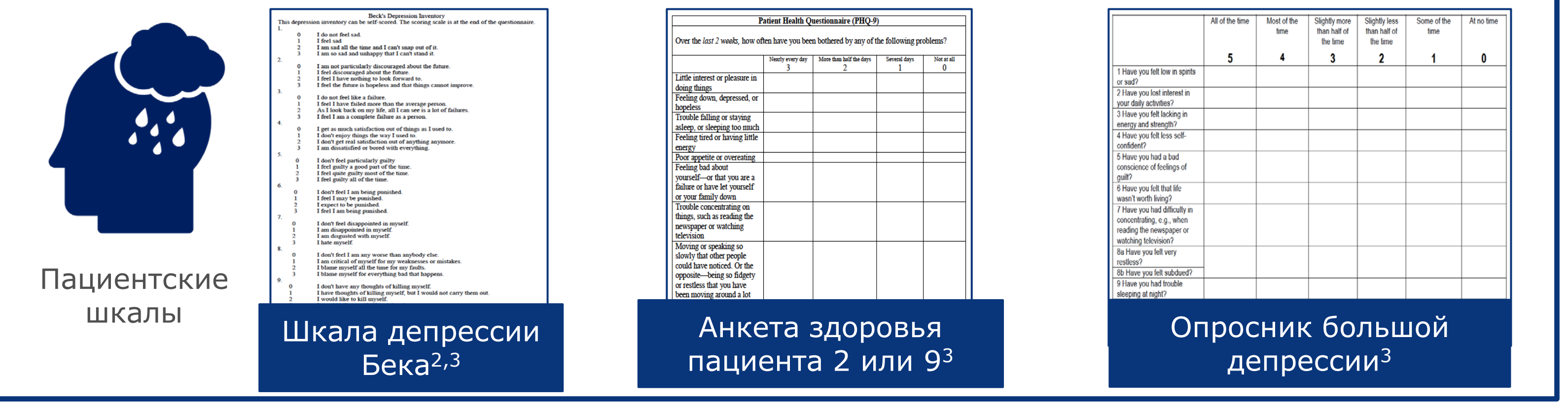
Оценка пациентов на наличие депрессии

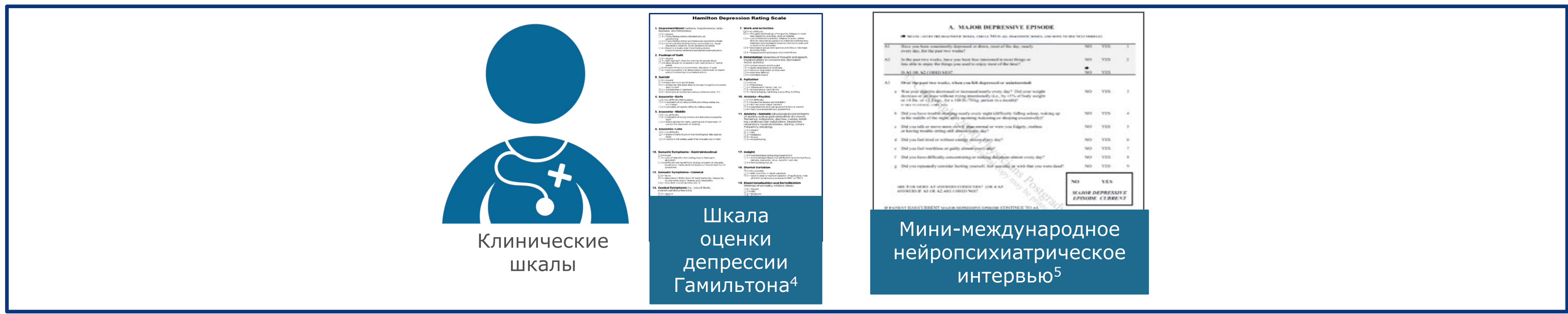
Пациентов можно оценить на предмет депрессии, обратившись к классификациям DSM-5 и МКБ-10.
Однако существует множество проверенных инструментов для помощи в диагностике:



Item	Mean	SD	CV	α	h^2
Apparent sadness	1.10	1.70	1.55	0.92	0.79
Reported sadness	0.99	1.72	1.74	0.92	0.77
Inner tension	0.94	1.47	1.56	0.92	0.71
Reduced sleep	1.00	1.63	1.63	0.93	0.41
Reduced appetite	0.48	1.08	2.25	0.94	0.33
Concentration difficulties	0.74	1.39	1.88	0.93	0.62
Lassitude	0.76	1.38	1.82	0.92	0.67
Inability to feel	0.76	1.45	1.91	0.92	0.81
Pessimistic thoughts	0.63	1.35	2.14	0.92	0.74
Suicidal thoughts	0.33	0.99	3.00	0.93	0.49
Total	7.73	11.33	1.47	0.93	0.63*

CV Pearson's coefficient of variation = SD/Mean

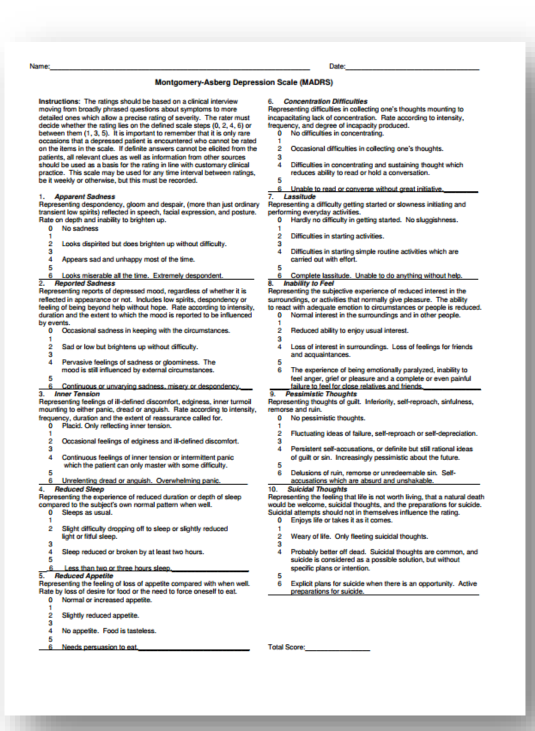




DSM - Диагностическое и статистическое руководство по психическим расстройствам; МКБ-10 - Международная классификация болезней.

1. Williams J &Kobak KA. Dr J Psychiatr 2008; 192: 52-58; 2. Beck AT, et al. *Arch Gen Psychiatry* 1961; 5: 561-571; 3. Bienenfeld D. Screening tests for depression. Available at: https://emedicine.medscape.com/article/1859039-overview#showall (last accessed January 2019); 4. Hamilton M. *J Neurol Neurosurg Psychiatry* 1960; 23: 56-62; 5. Sheehan DV, et al. *J Clin Psychiatry* 1998; 59: 22-33.

Шкала оценки депрессии Монтгомери – Асберга (MADRS)



Name:____________________ Date:____________________

Montgomery-Asberg Depression Scale (MADRS)

Instructions: The ratings should be based on a clinical interview moving from broadly phrased questions about symptoms to more detailed ones which allow a precise rating of severity. The rater must decide whether the rating lies on the defined scale steps (0, 2, 4, 6) or between them (1, 3, 5). It is important to remember that it is only rare occasions that a depressed patient is encountered who cannot be rated on the items in the scale. If definite answers cannot be elicited from the patients, all relevant clues as well as information from other sources should be used as a basis for the rating in line with customary clinical practice. This scale may be used for any time interval between ratings, be it weekly or otherwise, but this must be recorded.

1. ***Apparent Sadness***
Representing despondency, gloom and despair, (more than just ordinary transient low spirits) reflected in speech, facial expression, and posture. Rate on depth and inability to brighten up.
0 No sadness
1
2 Looks dispirited but does brighten up without difficulty.
3
4 Appears sad and unhappy most of the time.
5
6 Looks miserable all the time. Extremely despondent.

2. ***Reported Sadness***
Representing reports of depressed mood, regardless of whether it is reflected in appearance or not. Includes low spirits, despondency or feeling of being beyond help without hope. Rate according to intensity, duration and the extent to which the mood is reported to be influenced by events.
0 Occasional sadness in keeping with the circumstances.
1
2 Sad or low but brightens up without difficulty.
3
4 Pervasive feelings of sadness or gloominess. The mood is still influenced by external circumstances.
5
6 Continuous or unvarying sadness, misery or despondency.

3. ***Inner Tension***
Representing feelings of ill-defined discomfort, edginess, inner turmoil mounting to either panic, dread or anguish. Rate according to intensity, frequency, duration and the extent of reassurance called for.
0 Placid. Only reflecting inner tension.
1
2 Occasional feelings of edginess and ill-defined discomfort.
3
4 Continuous feelings of inner tension or intermittent panic which the patient can only master with some difficulty.
5
6 Unrelenting dread or anguish. Overwhelming panic.

4. ***Reduced Sleep***
Representing the experience of reduced duration or depth of sleep compared to the subject's own normal pattern when well.
0 Sleeps as usual.
1
2 Slight difficulty dropping off to sleep or slightly reduced light or fitful sleep.
3
4 Sleep reduced or broken by at least two hours.
5
6 Less than two or three hours sleep.

5. ***Reduced Appetite***
Representing the feeling of loss of appetite compared with when well. Rate by loss of desire for food or the need to force oneself to eat.
0 Normal or increased appetite.
1
2 Slightly reduced appetite.
3
4 No appetite. Food is tasteless.
5
6 Needs persuasion to eat.

6. ***Concentration Difficulties***
Representing difficulties in collecting one's thoughts mounting to incapacitating lack of concentration. Rate according to intensity, frequency, and degree of incapacity produced.
0 No difficulties in concentrating.
1
2 Occasional difficulties in collecting one's thoughts.
3
4 Difficulties in concentrating and sustaining thought which reduces ability to read or hold a conversation.
5
6 Unable to read or converse without great initiative.

7. ***Lassitude***
Representing a difficulty getting started or slowness initiating and performing everyday activities.
0 Hardly no difficulty in getting started. No sluggishness.
1
2 Difficulties in starting activities.
3
4 Difficulties in starting simple routine activities which are carried out with effort.
5
6 Complete lassitude. Unable to do anything without help.

8. ***Inability to Feel***
Representing the subjective experience of reduced interest in the surroundings, or activities that normally give pleasure. The ability to react with adequate emotion to circumstances or people is reduced.
0 Normal interest in the surroundings and in other people.
1
2 Reduced ability to enjoy usual interest.
3
4 Loss of interest in surroundings. Loss of feelings for friends and acquaintances.
5
6 The experience of being emotionally paralyzed, inability to feel anger, grief or pleasure and a complete or even painful failure to feel for close relatives and friends.

9. ***Pessimistic Thoughts***
Representing thoughts of guilt. Inferiority, self-reproach, sinfulness, remorse and ruin.
0 No pessimistic thoughts.
1
2 Fluctuating ideas of failure, self-reproach or self-depreciation.
3
4 Persistent self-accusations, or definite but still rational ideas of guilt or sin. Increasingly pessimistic about the future.
5
6 Delusions of ruin, remorse or unredeemable sin. Self-accusations which are absurd and unshakable.

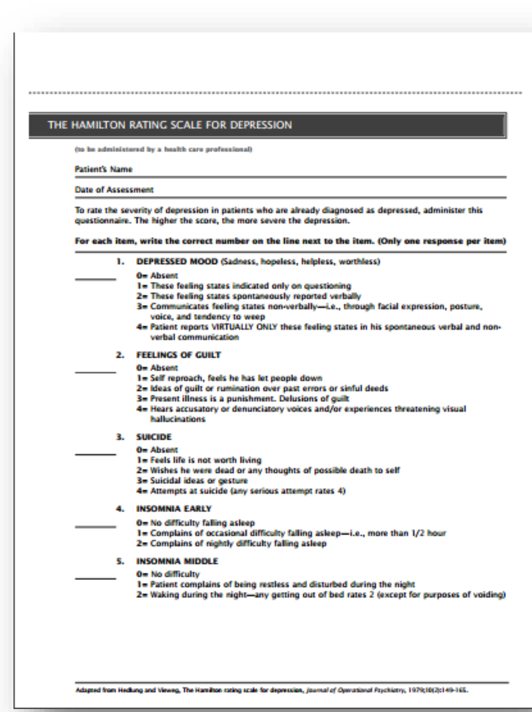
10. ***Suicidal Thoughts***
Representing the feeling that life is not worth living, that a natural death would be welcome, suicidal thoughts, and the preparations for suicide. Suicidal attempts should not in themselves influence the rating.
0 Enjoys life or takes it as it comes.
1
2 Weary of life. Only fleeting suicidal thoughts.
3
4 Probably better off dead. Suicidal thoughts are common, and suicide is considered as a possible solution, but without specific plans or intention.
5
6 Explicit plans for suicide when there is an opportunity. Active preparations for suicide.

Total Score:____________

- MADRS - это рейтинговая шкала из 10 пунктов, предназначенная для оценки степени тяжести симптомов депрессивного заболевания и определения чувствительности к эффектам лечения.
- Симптомы оцениваются по 7-балльной шкале от 0 (нет симптома) до 6 (тяжелый симптом). Определение степени серьезности дается с интервалом в два пункта. Общий балл по десяти пунктам варьируется от 0 до 60.
- На администрирование и оценку MADRS уходит примерно 15-20 минут.

(1) Montgomery & Åsberg Brit J Psychiatry 1979; 134: 382-389

Шкала Гамильтона для оценки депрессии (HDRS)



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

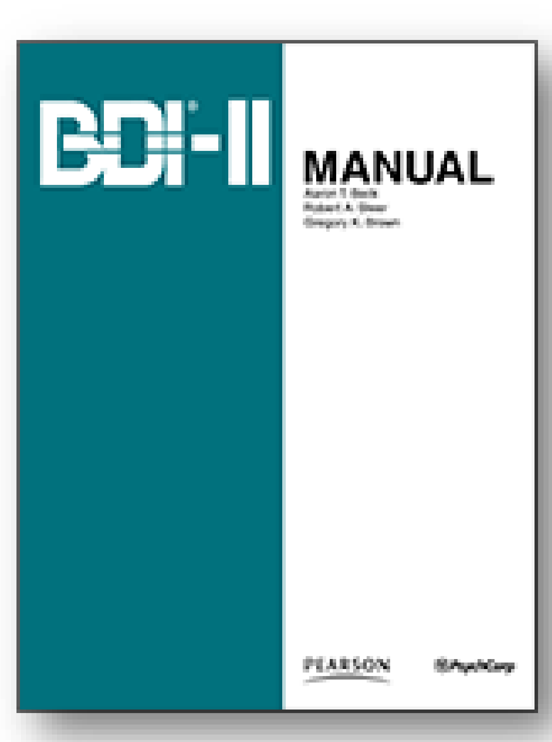
______
- 0= No difficulty
- 1= Patient complains of being restless and disturbed during the night
- 2= Waking during the night—any getting out of bed rates 2 (except for purposes of voiding)

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

- Шкала оценки депрессии Гамильтона - это наиболее широко используемая шкала интервью, разработанная в 1960 году для измерения тяжести депрессии у стационарных пациентов.
- В исходной шкале, устанавливаемой клиницистом, первые 17 пунктов подсчитываются для получения общего балла, а пункты 18–21 используются для дальнейшей оценки депрессии.
- Баллы от 0 до 7 считаются нормальными, а баллы больше или равные 20 указывают на умеренно тяжелую депрессию. Каждый пункт оценивается либо по 5-балльной шкале, представляющей отсутствующие, легкие, умеренные или тяжелые симптомы, либо по 3-балльной шкале, представляющей отсутствующие, незначительные или сомнительные и четко присутствующие симптомы.
- HDRS содержит относительно большое количество соматических симптомов и относительно небольшое количество когнитивных или аффективных симптомов.
- На заполнение HDRS уходит от 20 до 30 минут.

(1) Williams JW. Eur Arch Psychiatry Clin Neurosci. 2001. 251 (suppl 2):116. (2) Hamilton M. J Neurol Neurosurg Psychiatry. 1960,23:56-62.

Шкала **депрессии Бека (BDI-II)**



- BDI-II - это шкала самооценки, состоящая из 21 пункта, предназначенная для оценки наличия и тяжести симптомов депрессии у подростков и взрослых.
- Каждый из 21 симптома оценивается по 4-балльной шкале от 0 (нет симптома) до 3 (тяжелый симптом). Два пункта включают 7 вариантов ответа, указывающих на увеличение или уменьшение (аппетит и сон).
- Заполнение BDI-II занимает примерно от 5 до 10 минут.

(1) Beck et al Manual for the Beck Depression Inventory-II. San Antonio, Tex: Psychological Corporation; 1996. (2) Beck et al Arch Gen Psychiatry. 1961 Jun. 4:561-71

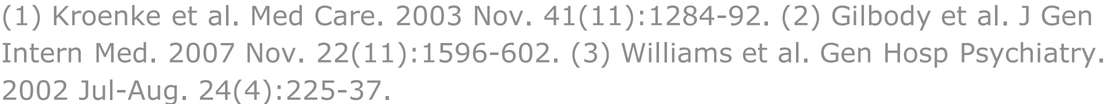
Анкеты состояния здоровья (PHQ2 or PHQ9)

Patient Health Questionnaire (PHQ-9)

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

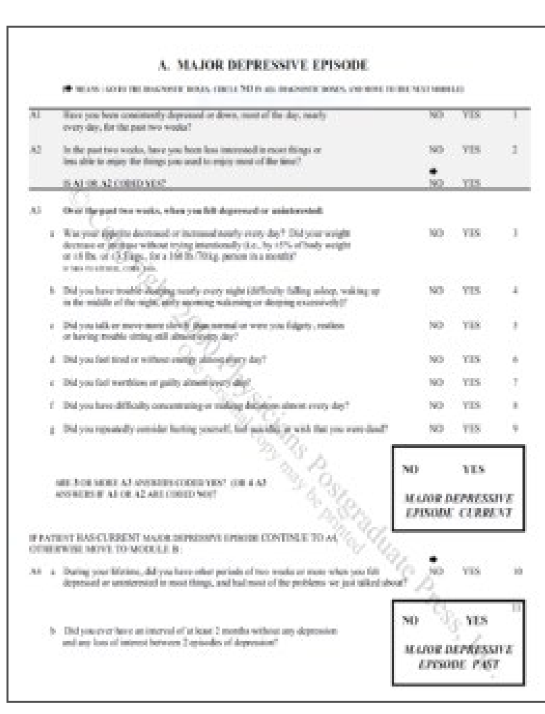
	Nearly every day 3	More than half the days 2	Several days 1	Not at all 0
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself—or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				

- Анкета о состоянии здоровья пациента - это инструмент для самостоятельного заполнения, состоящий из 2 (PHQ2) или 9 (PHQ9) пунктов. [1,2,3]
- PHQ-2 - это инструмент для выявления депрессии, который оценивает частоту депрессивного настроения и ангедонии за последние 2 недели, оценивая каждую из них от 0 («совсем нет») до 3 («почти каждый день»).[1]
- PHQ 9 устанавливает клинический диагноз депрессии и может дополнительно использоваться для отслеживания степени тяжести симптомов с течением времени.[2,3]
- По шкале PHQ-9 5, 10, 15 и 20 баллы соответствуют легкой, средней, умеренно тяжелой и тяжелой депрессии.[2,3]



(1) Kroenke et al. Med Care. 2003 Nov. 41(11):1284-92. (2) Gilbody et al. J Gen Intern Med. 2007 Nov. 22(11):1596-602. (3) Williams et al. Gen Hosp Psychiatry. 2002 Jul-Aug. 24(4):225-37.

Мини-международное нейропсихиатрическое интервью (**MINI**)[1,2]



A. MAJOR DEPRESSIVE EPISODE

NO YES

MAJOR DEPRESSIVE EPISODE CURRENT

NO YES

MAJOR DEPRESSIVE EPISODE PAST

- Занимает примерно 45 минут, если вы не знакомы с процессом, и от 15 до 25 минут, когда вы знакомы.
- Позволяет исследователям ставить диагноз психических расстройств в соответствии с DSM-IV или МКБ-10[1].
- В MINI доступно 19 диагнозов расстройств, первый из которых - БДР[1].
- MINI состоит из серии вопросов с ответами «да» или «нет», которые указывают на наличие депрессии в настоящее время или в прошлом[1].
- Первые два вопроса, используемые для скрининга БДР, относятся к основным симптомам депрессии в критериях DSM[1].
- Также доступен экран MINI, который представляет собой короткую версию, в которой используются только контрольные вопросы от MINI[2].

БДР- большое депрессивное расстройство

1. Sheehan DV, et al. J Clin Psychiatry 1998; 59: 22-33. 2. Harm Research Institute. MINI. Available from http://harmresearch.org/index.php/mini-international-neuropsychiatric-interview-mini/ (last accessed January 2019).