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European Archives of Psychiatry and Clinical Neuroscience, 25, 612.Article Google Scholar Loading...There has been much discussion in recent years about whether depression is a chronicillness against the modern view that it is typically time-limited.1 Gask dated the growing dominance of thisview to the 1980s and the launch and promotion of a new group of antidepressants, theselective serotonin reuptake inhibitors (SSRIs).2 The traditional view of depressive illness,from melancholia in the nineteenth century to Kraepelins characterisation of manicdepression that dominated twentieth-century psychiatry, was that the illness was recurrent,chronic or both. Sufferers could spend years in mental hospitals, where, from the 1950s,they might receive regular electro-convulsive therapy (ECT). The changes in the last quarterof the twentieth century are well known and recognised as revolutionary at all levels:definitions of depression and the impact of DSM-III; the treatment of choice shifting fromECT to drugs; the closure of long-stay hospitals and the development of community care wheresufferers from depression are mainly treated by general practitioners. The impact of thesechanges on medical views of depression was evident in an Editorial in PsychologicalMedicine in 2012, which had to remind readers of new evidence that amongstpatients diagnosed with depression, only half had a single episode and half had a recurrentand chronic life-long illness.3 The authors argued that more effort should now be given to identifyingrecurrence, with a view to altering the trajectory of depression that is so chronic, severeand disabling for the betterment of so very many.My principal research question is when and how did the view that depression was typicallytime-limited and non-chronic originate? Was it in the 1980s and early 1990s with the arrivalof SSRIs? These drugs were undoubtedly important, but so too were the changes in serviceprovision and a host of other patient, professional and other factors. In this article, Iinvestigate the longer-term origins in ways that depression was framed by psychiatriststhrough the impact of the Hamilton Rating Scale for Depression (HRSD), which from the 1970sbecame, and to a large extent remains, the dominant tool in assessing the severity ofdepression. A key feature of HRSD was that it was used to measure the outcome of treatment,especially drugs, and was applied as a before and after schema, leading to the view thatdepression was event, thereby downplaying seriality. My argument also offers a case study ofthe impact of standard scales in medicine, and the interaction of drug standards andstandard drugs.My methods are those of the social construction of knowledge, explaining how ways ofknowing and practising are formulated in specific social contexts, then circulated andvalidated in contingent settings by a variety of actors. Constructivist historical methodswere applied to articles and books that discussed the application of HRSD to various patientgroups in hospital and community setting from the 1960s to the late 1970s. Sources wereidentified from the standard online databasesPubmed (keyword) and Science Direct (fulltext)and quantitative indicators were derived from Web of Science. Detailed qualitativeanalysis of selected articles was also made, using close reading to identify the assumptionsand modes of analysis of the authors.The 21-item HRSD for assessing the severity of depression was developed by the Englishpsychiatrist Max Hamilton and presented to the psychiatric community in 1960 in the, thensomewhat obscure, Journal of Neurology, Neurosurgery andPsychiatry.4 Interviewed in 1982, Hamilton observed that, after completing a number ofclinical trials on new drugs,I was also interviewing people about my depression scale and trying to see if I couldget some work going on depression. I went around with my scale and it created atremendous wave of apathy. They all thought I was a bit mad. Eventually I got itpublished in the Journal of Neurology, Neurosurgery and Psychiatry. Itwas the only one that would take it.5He took some pleasure in adding that, And now everyone tells me the scale is wonderful, Ialways remember when it had a different reception. This makes sure I don't get a swollenhead. Whether the last point was accurate is open to debate, as Hamilton was quite adomineering figure, but there is no doubt that his rating scale was, and still is, widelyused. It has earned the title of the Gold Standard for the assessment of depression,though its reign may now be limited.6 Given its status and influence, it is surprising that it has not beensubject of historical enquiry and even authors who are critical of modern psychiatry and itsmanufacturing of depression have not subjected it to scrutiny.7There are two explanations of its dominance, both of which have some merit but are not thewhole story. The first, which is common amongst psychiatrists, is that HRSD became the GoldStandard simply by being the earliest scale to enjoy widespread use. However, it was borninto a world of already competing scales, so the key question to answer is, why and how didit see off its rivals? Interestingly, Hamiltons Anxiety Scale, which was actually publishedbefore HRSD and hence was more of a first, did not endure. The second explanation is thatHRSD was ideally suited to measure the effects of drug treatments, especially tricyclicssuch as imipramine, which were somewhat anxiolytic and somewhat sedative ineffect.8 HRSDscored for sleep and for weight gain, which were known to be affected by tricyclics. Inother words and to quote one reviewer of The Antidepressant Era, The earlydrugs defined the very scale that was used to measure their performance.9 One recent critic of thescale wrote that Hamilton fashioned his test to meet the needs of his drug companypatrons.7 Healysays that there is no evidence that Hamilton used his own scale in clinical practice, butthen it was a research rather than clinical tool, designed to quantify changes in apatients condition over time.10 It is unclear whether Hamilton had direct drug company patrons,though he was the founding President of the British Association of Psychopharmacology and anearly member of the International College of Neuro-Psychopharamcology (CINP), which sincehis death in 1988 has awarded an annual prize in his name. On the other hand, Hamilton iswidely described as an iconoclast and seems to have been a socialist; he was certainly astrong defender of the National Health Service in the 1980s when it was under threat fromThatcher era cuts in public spending. What is clear is that in the late 1950s and early1960s Hamilton had many motives and that his abrasive character meant that pleasing anyonewas not high on the list.In this article, I argue that the dominance of HRSD was only slowly achieved and that inits first two decades it had many rivals and that no one was more surprised than Hamiltonhimself that it proved to be so successful. Also, its dominance was largely in clinicalresearch, translating trial findings, quite often, into simple before-and-after scores.There was an inherent bias to consider depression as time-limited and all the more so as aresult of drug treatment. Hamilton created the scale to enable psychiatrists to chartchanges in already diagnosed patients through particular treatment regimes, convertingqualitative judgments into quantitative data on a fine-grained 100-point scale. The scalealso allowed psychiatrists to determine what the most significant changes were in an arrayof symptoms; though as I will show, most early studies used the aggregated scores ratherthan disaggregated data. Indeed, studies in the 1980s demonstrated that the schema wasmodified promiscuously, with psychiatrists adding and subtracting items to assess.11 In 1990, Zitman etal.surveyed five major journals over a year for research papers using the HAM-D and askedauthors of for a copy of the scale they used. Fewer than half the investigators referencedthe correct version of the HAM-D, and only 4 out of 51 responders used versions that werethe same as a published version.HRSD was not designed as a diagnostic schema, though many used it as such and one reasonfor its success was that its approach anticipated the emphasis of symptoms and diseaseentities enshrined in DSM-III in 1980.12 Although invented well before even DSM-II(1968), Hamiltons scale was for a specific condition and proposed standardisation aroundovert symptoms, the features that distinguished the third from the second version of theDSM. Shaped by the assumptions of dominant psychodynamic approaches, DSM-I and -II hadconceived of symptoms as reflections of broad underlying dynamic conditions. that onlybecame meaningful through exploring the personal history of each individual.12 Influenced strongly byKarl Menningers assumption that all mental disorders were reducible to the failure of thesuffering individual to adapt to his or her environment, psychiatrists tended to focus onfinding underlying mental causes and to interpret these as constitutional and likely to bechronic.13DSM-IIIs move towards specific diseases and to focus on symptoms rather than underlyingcauses weakened these imperatives.Max Hamilton was born in Offenbach, near Frankfurt, in 1912, and his parents moved toLondon in 1915.14 Hequalified in medicine at University College Hospital London in 1934 and worked in a numberof posts before settling upon psychiatry in 1946, when he joined the Maudsley Hospital inLondon. He worked at various London hospitals and began an association with Cyril Burt thatled him to develop expertise in, and an almost missionary commitment to, psychometrics,which was fashionable in the psychological sciences in the 1950s. In 1953, he moved to theUniversity of Leeds as lecturer in psychiatry. He found little time for research and in 1957resigned to take up a temporary, 2-year research position in the University. This was fundedby research grants from the Mental Health Research Trust and by a trial that his head ofdepartment, Ronald Hargreaves, was running on chlorpromazine. In this work, Hamiltondeveloped a number of scales, the first in 1957 in a study with Hargreaves on the value ofBenactyzine in the treatment of anxiety, for which drugs and placebos were supplied byGlaxo.15 Theanxiety scale, later termed HAMA, anticipated many of the features of HRSD.We therefore classified all the symptoms likely to be found in our patients under thefollowing headings: (1) anxious mood; (2) tension; (3) specific fears and phobias; (4)sleep disturbance; (5) intellectual disturbance; (6) depressive features; (7) somaticdisturbances (muscular and sensory); (8) cardiovascular disturbance; (9) respiratorydisturbances; (10) gastro-intestinal disturbances; (11) genitourinary disturbances; (12)autonomic disturbances and (13) manifestations of anxiety in the behaviour at theinterview. A gloss was prepared listing the features to be taken into account in makingan assessment under any of these headings. At the interview we rated each of thesethirteen items on a five-point scale as follows: 0, none; 1, mild; 2, moderate; 3,severe; 4, grossly disabling. This rating scale yields a variety of different types ofinformation for each patient, including a profile of his symptomatology and, bysumming the ratings for all headings, a gross symptom score.15One conclusion of this study was that impressionistic global judgments of a patient'scondition alone are of little value in assessing the effect upon him of a particularregime. Hamilton had previously spoken on the use of scales in this work on anxiety at theBritish Psychological Society in 1956.16 In what became a feature of hispublications of scales, he devoted much of the paper to sophisticated statistical testing ofreliability and reproducibility. As noted already, HAMA was further elaborated in the 1960sbut did not have the success of HRSD, but that is a topic for another paper.The first iteration of the HRSD scale was actually published in 1959, in an articleco-authored with Jack White, a consultant psychiatrist at the Stanley Royd Hospital,Wakefield.17 Thefamous 1960 paper was already in press and mentioned, though without a citation. The scalein the 1959 paper offered a different and more finely grained classification of patientsymptoms, moving away from the three accepted dichotomies: Reactive Endogenous; Agitated Retarded; Neurotic Psychotic. Hamilton and White subjected patients scores on theirschema to factor analysis and identified four groups of patients and types of depression:Endogenous, Doubtful Endogenous, Doubtful Reactive and Reactive. In other words, they wereusing the scores for the classification of different types of depression. In conclusion,they argued that, with the range of therapeutic options increasing as new drugs were addedto ECT and psychotherapy, it was important for psychiatrists to be better able todifferentiate forms of depression and their response to treatments. The study was of 64 malepatients at Stanley Royd and included an Appendix of case histories of 20 patients, whichshowed that they had received a variety of treatments. Of the 20, 16 had received ECT, sothe origins of HRSD lie in charting the dominant therapeutic regimes of the era and were notonly developed for pharmaceutical treatment.What became known as HRSD was proposed by Hamilton in his now famous and much cited 1960paper? His stated aim was to improve upon existing scales, which he criticised for beinginappropriate, unreliable or using ill-defined symptoms.4 His new scale was to be used in interviewsconducted by psychiatrists and was intended for patients already diagnosed with depression.It relied mostly on the observations of bodily (somatic) and behavioural features bypsychiatrists, which were also weighted more heavily than the few symptoms that relied onpatients reports of their feelings (Figure1). Hamilton's now famous paper on rating scales for depression waspublished in a little known journal.4The empirical basis of the paper was drawn from 49 of the 64 patients discussed in the 1959paper. There were 17 variables in the new scale, each rated on either a four- or two-pointrange, which produced a potential maximum of 50 points for extremely severe illness. Therecommendation was that two psychiatrists interview the patient separately and their scoresbe added together to give a rating out of 100 (Figure 2). The correlation between the scores of thetwo scorers (presumably Hamilton and White) was found to be high and to improve withexperience. The first published iteration of what became HAM-D orHRSD.4In discussing individual patients, Hamilton did not use their overall rating score; insteadhe gave their pattern of factor measures in terms of the four diagnostic groups identifiedin the 1959 paper with White: Factor 1: Endogenous, Factor 2: Doubtful Endogenous, Factor 3:Doubtful Reactive and Factor 4: Reactive.17Figure 3 presents the description ofone of the patients whose profile was predominantly Factor 1 and this ends with theclassification of his illness as endogenous and seemingly chronic and likely to relapse. Anexample of the case histories and commentaries included in Hamilton's 1960paper.4Hamilton made clear the importance of factor scores and their value over the classicalclinical categories. In summary, he wrote:A rating scale is described for use in assessing the symptoms of patients diagnosed assuffering from depressive states. The first four latent vectors of the intercorrelationmatrix obtained from 49 male patients are of interest, as shown by (a) the factorsaturations, (b) the case histories of patients scoring highly in the factors and (c)the correlation between factor scores and outcome after treatment. The general problemof the relationship between clinical syndromes and factors extracted from theintercorrelations of symptoms is discussed.4There is no evidence in the paper that before and after treatment scores were taken, theonly link to treatment seems to be that the initial factor scores were indicative of theoutcome of (mostly ECT) treatment, hence, this first presentation of HRSD can be read asoffering a more refined diagnosis or prognosis. In another paper with Jack White, alsopublished in 1960, Hamilton assessed ratings as an indicator of the outcome of depressiontreated with ECT.18The first published trial to use HRSD was a study of the use of the new drug amitriptylineby CG Burt and colleagues at the Royal Park Hospital in Melbourne, Australia.19 For each patient anaggregate score out of 50 was first used to group patients; there was no factor analysis.After initial evaluation on Hamilton's (1960) scale for quantifying depressiveillnesses, patients were allocated to one of four groups delineated on the basis of twoleading prognostic criteria, age and severity of illness. Mild young depressives wereaged between 30 and 49 and, out of a possible maximum score of 100, had total scalescores below 40; young severe depressives were between 30 and 49 and had total scalescores above 40. Similar criteria of severity were used in the old mild and oldsevere, who were aged between 50 and 70.The same overall rating score was used to assess the outcome after one and then four weekstreatment with amitriptyline compared to imipramine; the latter being the market leader forsevere depression. The Table and Chart below show the range in individual rating scores andaggregates for the old severe group. In fact, this was one of the few studies in theperiod that presented the symptom scores separately, typically the single aggregate scoreout of 50 or 100 was used (Figure4). Burt CG, etal. Amitriptyline in depressive states: a controlledtrial. Br J Psychiatry 1962; 108: 711730.In their discussion, Burt etal. made two key points about the HRSD that were, and arestill, widely stated to account for its widespread use: (1) it was simple to use andrapidly completed and (2) it could map changes that drugs brought in specific symptoms.Burt and his colleagues wrote of target symptoms, which was perhaps an implicit comparisonto the blunderbuss of ECT and its impact on the whole psyche. HRSD could certainly also mapthe temporal and experiential dimensions of treatments that were difficult to collect frompatients after ECT. Fritz Freyhan, Clinical Director, Director of Research, Delaware StateHospital, Farnhurst, Delaware, explained this point in 1960, showing how drug treatmentscould be combined with psychotherapy.The pharmacological treatment of depressions offers this immense psychologicaladvantage: the patient maintains his experiential continuity. The amnestic syndromeassociated with ECT, to which many attributed therapeutic significance, proves to bequite superfluous as is seen in successful pharmacotherapy. The preservation ofexperiential continuity has vast implications for psychotherapy. Until now,psychotherapy either followed ECT or had to be limited to patients who seemed capable ofaffective contact and of self-control over suicidal impulses. With ECT, the patientremains physically and emotionally passive. His recovery comes, as it were, fromwithout. Pharmacotherapy makes him a participating partner. This offers psychotherapyentirely new opportunities to involve the patient in the therapeutic process untilrecovery is seen as coming from within.20The second study to use the scale, albeit casually and with crude aggregate scores, was byAA Robin and J Harris at Runwell Hospital, Essex, in a comparison of imipramine andECT.21 In thisstudy, as in many others at this time, ECT was found to give better outcomes.In 1963, JT Rose published a study of patient responses to ECT using HRSD.22 In measuring the impact oftherapy, he validated HRSD by the fact that a drop in the score corresponded in the greatmajority of cases with improvement as recorded by overall clinical assessments and withfalling scores in the occupational therapy ratings. This is interesting as Hamiltondeveloped his scale because of his dissatisfaction with overall clinical assessments andother scales. Cross reference to, and validation against, overall clinical assessment wascommon in discussions of HRSD throughout the 1960s and 1970s, not least because the scalewas about changing qualitative judgments of clinical outcomes into quantitative values,either in a single score or a matrix of scores.Interestingly, HRSD was not used in 1964-1965 in a major clinical trial on treatments fordepressive illness organised by the Clinical Psychiatry Committee of the Medical ResearchCouncil (MRC), even though Hamilton played a leading role in the scheme.22 The trial used both anoverall clinical rating of severity and its own scale of 15 symptoms: depressed mood,psychomotor retardation, suicidal ideas, ideas of bodily change, ideas of reference,self-reproach, anxiety, insomnia (early, middle, late) anorexia and fatigue. This scale borea close relation to HRSD in both the symptoms monitored and the range of scoring, givingtacit endorsement to Hamiltons approach if not his particular scale. In fact, the Committeeinvented its own so-called MRC Scale, which was used quite widely for a number of years,but fell away as HRSD took centre stage.That the uptake of HRSD was relatively slow is borne out by the number of publications inwhich it was cited in its first 20 years, see Figure 5, which is presented with all the usual caveatsabout citations and what they mean. Two sets of data are given: the number of articles eachyear citing Hamiltons 1960 paper and the number of papers cited with depression in thetitle. There is steady growth in the number of papers citing HRSD, but this is slower thanthe overall growth of citations on depression, bearing in mind that both were influenced bythe increase in the number of medical journals and the drive to publish more and often.Also, there were many publications, particularly at the end of the 1970s, in which HRSD wasused without citing the 1960 paper. Perhaps it was too well known to need citing? Perhapsthe absence of citation indicated that it was being used only casually? And, of course,citation did not mean that authors followed Hamiltons protocols, in fact psychiatrists usedHRSD selectively and flexibly. Writing in 2001, Jane Williams observed that over time,Several versions of the scale had come into use, with differences in their total numberof items, their anchor descriptions, their item interpretations and their scoringconventions. By 1990 there were so many versions of the HAM-D that researchers andclinicians had lost track of what was available, and what were the characteristics ofeach one. No single version of the HAM-D or single set of conventions has beenuniversally accepted.11 Number of articles each year citing Hamilton M, A ratingscale for depression, J Neurol Neurosurg Psychiatry 1960; 23:5662; and number of articles cited with depression in the title. Source: Web ofScience.Williams noted that by this time, in different publications the number of items scored asHRSD had risen from 17 to 59.11For much of the 1960s, HRSD was discussed as just another rating scale. For example in1965, Gerald Klerman and Jonathan Coles review of imipramine and related antidepressantsmentions HRSD three times in different contexts and always in relation to otherscales.23Phenomenological differentiations of depressed patients have been developed, usingsymptom patterns and clusters derived by multivariate statistical techniques. Grinkeretal., Friedman etal., Hamilton and Wittenborn etal. have published promisingfindings.For example, in studying hospitalized patients, especially severely depressed orschizophrenic patients, well validated scales, particularly by Lorr, Wittenborn,Hamilton and others are widely used. Instruments for nursing observations and forpatients self-ratings also have been developed.Drug-placebo differences were revealed by global estimates of degree of depression andby ratings of specific symptoms like anxiety, insomnia, weight gain and guilt.Hamiltons rating scale, Lorrs Inpatient Multidimensional Psychiatric Scale and theWittenborn Psychiatric Scale were sensitive to differences in most studies in which theywere employed.23This illustrates Martin Roths statement in his brief biography of Max Hamilton that Ittook more than a decade before the HRSD scale was recognised as a major contribution toknowledge and clinical practice.24Healy suggests that one reason HRSD was widely used is that it gave particular weight toanxiety symptoms, and thus was good at charting the positive effects of drugs, likeimipramine, that were anxiolytic. Alan Broadhurst, a pharmacologist, who was in the group atGeigy that discovered imipramine told David Healy that, Max Hamilton was excited aboutimipramine and it certainly did fit in beautifully with his rating scale. Years later hestill referred to it as a happy coincidence.8 However, therapeutic regimes change for somany reasons that it is difficult to tease out the relative importance of HRSD relative toother factors and, although I do not have the data, it is likely that the uptake ofimipramine was more rapid than that of HRSD.25An alternative approach to assessing the rise of HRSD is to look at when and how it wascriticised, and why these objections did not impede its progress to becoming the GoldStandard. In the 1960s, HRSD had a competitor, the Inventory for Measuring Depression (thenID and now Beck depression inventory (BDI)), proposed by Aaron T Beck at the University ofPennsylvania.26BDI has proved similarly enduring and also had the advantage of being a first and the oneagainst which other scales were calibrated and validated. Beck was a pioneer of cognitivetherapy and his scale was quite different to HRSD in being based on a patients self-rating.In its original form the BDI consisted of 21 questions, each with four possible answers thatthe patient had to rate 0-3. This gave a theoretical maximum score of 63. A score above 30indicated severe illness, 1929 moderate, 1018 mild and below 10 minimal. A common way ofcontrasting BID with HRSD was to say that it was subjective: it relied upon patientsthoughts and feelings, while HRSD was objective, because it was mainly based on clinicianobservations of bodily and behavioural symptoms.In 1965, Maryse Metcalfe and Ellen Goldmann compared HRSD favourably with BDI, though theyacknowledged that it depended on the skill of the rater and their clinical bias, which, theycautioned, made it somewhat difficult to compare meaningfully results obtained in differentinvestigations.27In their view, the advantages of BDI were that it was simple, quick and easy to administer,and independent of doctors and nurses bias, seemingly relying on the constant of thepatient. In 1967, John Schwab and colleagues, at the University of Florida College ofMedicine, published a comparison of HRSD and BDI amongst ordinary and, one must assume,mostly non-depressed medical inpatients.28,29 They found a good correlation(rz=0.75) in scores, but argued that the two scales werecomplementary because they measured different components of the depressive complex.Hamilton assessed and offered a further elaboration of his own scale in 1967.30 The second paper waslargely methodological, though it did consider a larger patient group and females as well asmales. He also added four extra symptoms to score. However, the article was not easy readingfor his peers. It was highly mathematical, as the Abstract illustrates.This is an account of further work on a rating scale for depressive states, includinga detailed discussion of the general problems of comparing successive samples from apopulation, the meaning of the factor scores, and the other results obtained. Theintercorrelation matrix of the times of the scale has been factor-analysed by the methodof principal components, which were then given a Varimax rotation. Weights are given forcalculating factor scores, both for rotated as well as unrotated factors.30The data to the end of 1990 (Figure6) shows that, if citations in any way indicate the resources used by psychiatristsin their work, that they stuck with the 1960 paper, for the later elaboration was citedless, even allowing for lags. Number of article each year citing Hamilton M, A rating scale fordepression. J Neurol Neurosurg Psychiatry 1960; 23: 5662 andHamilton M, Development of a rating scale for primary depressive illness. Br JSoc Clin Psychol 1967; 6: 278296. Source: Web ofScience.In his 1967 paper, Hamilton noted, in a very revealing statement, that this study had beendifficult because of the time taken to accumulate a sufficient number of patients withdepression. What he actually meant was the difficulty in findingappropriate patients, that is, those with treatable illness, as hecontrasted this difficulty with the ease of earlier studies with patients in mentalhospitals where there were large numbers of chronic cases.30 It seems that within a decade, whatcounted as depression, along with who and how they suffered, had changed.I now want to jump another ten years and consider the ways that HRSD was being used intherapeutic trials at the end of the 1970s.31 By this time almost all trials were withpsychopharmaceuticals, though ECT was still being used for patients diagnosed with severedepression. In fact, prior treatment with ECT often excluded patients from participation indrug trials. However, HRSD was still being used in assessments of ECT, as well aspsychotherapy.32And in 1977, it was even used by Aaron Beck to compare pharmacotherapy and cognitivetherapy, see Figure 7.33 Anexample of the reporting outcomes of the use of HRSD with another scale and fordifferent treatments.33To sample the uses of HRSD, I surveyed all of the clinical trials for depression publishedin the medical journals listed in Web of Science for 1979. It was impossible to producereliable quantitative data of the series, because of the different drugs, protocols andcitation practices, so I have chosen to discuss articles that are representative. In mosttrials HRSD was used with another scale and sometimes with multiple scales, as in the reportof a controlled trial of trimipramine and monoamine oxidase inhibitors at St ThomassHospital, London, published in 1979. The authors stated:The patients completed the Beck scale for depression and the Middlesex HospitalQuestionnaire (MHQ), and were rated blindly by an independent assessor on the Hamiltonrating scale for depression, the MRC depression scales, and an overall six-point ratingof the severity of depression. A standard rating of side effects was completed by thepsychiatrist who regulated drug dosage to prevent knowledge of any such effects biasingthe clinical ratings of the other assessor.34,35The graphs below show how the results of the different scales were mapped for the six weeksof the trial (Figure 8). An exampleof HRSD scores reported against many other scales.34The same pattern was evident in a study of Limbitrol in California.The patients were evaluated at baseline using the Hamilton rating scale for primarydepressive illness (HDS) and the Covi anxiety scale. In addition, the patients completedthe short form of the BDI and the Hopkins symptom checklist (SCL-58). Efficacy wasassessed at follow-up visits after 1, 2, and 4 weeks of treatment by the physician,using the HDS and a global evaluation, and by the patient using the BDI, the SCL-58, anda global evaluation. In most instances, the BDI and the SCL-5g were completed by thepatient prior to his seeing the psychiatrist.36In a trial of Lithium, HRSD was set against a 5-point nurse rating scale (Figure 9).37 Anexample of reporting HRSD in comparison with a nurse ratingscale.37There are very few publications where the score was disaggregated and the differentcomponents mapped to identify specific changes, one exception was a study comparingamineptine and amitriptyline at Hpital de St. Germain-en-Laye.38 The changes in the total scores were firstpresented (Figure 10) and when thecomponent scores were set out it was difficult to see the wood for the trees (Figure 11), and then only 14 out the 26items scored had statistical significance. A typical use of HRSD charting the effects of twodrugs over time.38 Reporting disaggregated HRSD scores, as illustrated above,became less common.38In this paper, I have made two main claims, first that HRSD was applied by clinicians toconstruct depression as a time-limited illness, and second, that this influential framing ofthe condition was used alongside other scales and only rose to dominance gradually. Theassumption of the time-limited illness supports the claim of Healy and others that anHRSD-structured characterisation of depression was suited to drug therapy and the interestsof pharmaceutical companies in the 1960s and 1970s. The view of psychiatrists in the firsthalf of the twentieth century was that depressive mental illness was chronic, either becauseof patient susceptibilities rooted in somatic factors, such as hereditary or physicaldisease, or in psychic variables influenced by upbringing, interpersonal relationships orpersonality. There was however some turnover in mental hospital patients and moves to treatmany sufferers as out-patients. The patient population peaked in Britain in 1954 at 140,000,when there were 121,000 beds, suggesting that turnover was not great and that most patientshad chronic conditions. The rundown in the number of beds and the move to community care sawdepression move out of the hospital and into the community, as an out-patient or generalpractitioner managed condition. In this setting, and due to new framings and new treatments,it was approached as a mild and short-lived condition, at least compared to the illnessthat had previously required hospitalisation.39 HRSD was used to frame this newdepression and its sufferers, normalising it to the ways of seeing and treating illness asa treatable episode or episodes, rather than a life course condition. As such, HRSD servedthe interests of psychiatrists and psychiatry in the new era of treating specific illnessesoutside of mental hospitals.HRSD rose to dominance from below. When it was sanctioned from above in the 1980s, bythe World Health Organisation, Food and Drugs Administration, and other medicine licensingagencies, this was acknowledging its widespread use, not creating it top down.Paradoxically, the eventual dominance of HRSD was in large part due to its successfulvalidation against the holistic clinician assessments, the very thing Hamilton designed itagainst. However, HRSD was a clinician scoring instrument and proved simple to use becauseclinicians made it so, choosing overall scores rather than disaggregated or factor scores.In many ways, the S in HRSD stood for Score not Scale, but either way it was aquantitative datum on a relatively large and finely grained scale of 100, at least whencompared to the previous clinician scales. Overall, HRSD was a strange kind of standard,being quite non-standard in the flexible and widely varying ways it was used, the number andtype of items in the scale and the meanings given to its findings. Immunological and Neurometabolite Changes Associated With Switch From Efavirenz to an Integrase Inhibitor. Asundi A, Robles Y, Starr T, Landay A, Kinslow J, Ladner J, White L, Plank RM, Melbourne K, Weisholtz D, Bennett M, Pan H, Stern E, Lin A, Kuritzkes DR, Lin NH. Asundi A, et al. J Acquir Immune Defic Syndr. 2019 Aug 15;81(5):585-593. doi: 10.1097/QAI.0000000000002079. J Acquir Immune Defic Syndr. 2019. PMID: 31045650 Free PMC article. Loading...Bagby RM, Ryder AG, Schuller DR, Marshall MB (2004) The Hamilton depression rating scale: has the gold standard become a lead weight? Am J Psychiatry 161:21632177. Google Scholar Beck AT, Ward CH, Mendelson M et al (1961) An inventory for measuring depression. Arch Gen Psychiatry 4:561571. 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**Hamilton depression rating scale 24 item. Hamilton depression rating scale. Hamilton depression rating scale nederlands. Hamilton depression rating scale test. Hamilton depression scale citation. Hamilton depression rating scale range.**