

Preface

Patients treated for mental disorders by their family doctor or a clinical psychologist constitute approximately 80 % of the patients seeking treatment for mental disorders. These patients treated in primary care are typically those diagnosed as suffering from personality disorders, anxiety, or depression. The remaining patients are treated by psychiatrists, typically with a diagnosis of severe depression, mania, or schizophrenia.

With the release of DSM-5, it became evident that in all these categories of mental disorder, we still have no biological markers, implying that our ordinary mental disorders (personality disorders, anxiety, depression, mania, and schizophrenia) are defined in DSM-5 by their respective symptomatic algorithms. It was expected, however, that the measurement-related rating scales by which the symptom severity of the ordinary mental disorders are scored would be included in DSM-5. This quantitative approach in which rating scales are used is based on mathematical models where a comparison of a state before and after treatment is possible.

In fact, the editors of the DSM-5 looked at several rating scales. Among the patient-reported symptom questionnaires, the Symptom Checklist (SCL-90) was considered, as it is one of the most widely used scales for measuring the severity of anxiety, depression, mania, and schizophrenia. Among the clinician-administered scales, the Hamilton Anxiety Scale (HAM-A), the Hamilton Depression Scale (HAM-D), and the Brief Psychiatric Rating Scale (BPRS) were considered, because together they, like the SCL-90, measure the severity of anxiety, depression, mania, and schizophrenia, but also because they were in use long before DSM-III or DSM-IV were released, and most clinicians the world over are so familiar with them that nobody wants to give them up. However, these rating scales or questionnaires were not included in DSM-5.

Measurement-based care of patients with mental disorders should be viewed as an attempt to include symptom rating scales or questionnaires to measure the balance between the desired clinical outcome of a treatment and the undesirable side effects of the treatment, using patient-reported quality-of-life scales to evaluate to what extent the patient has returned to his or her usual state of well-being.

The treatment element in measurement-based care is often referred to as evidence-based medicine, which has been established to encourage clinicians to rely more on conclusions from systematic treatment-orientated meta-analyses than on their own clinical experience. The treatment guidelines from the evidence-based medicine approach, however, have not as yet been tested for their efficacy in comparison to conventional clinical experience.

The objective of this book is to select rating scales and questionnaires for measurement-based care of the ordinary mental disorders where the main requirements are that they should be easy to administer, acceptable for both patients and clinicians, short and valid, and that they can differentiate between the wanted and unwanted clinical effects of treatment. Essentially, measurement-based care is intended to increase the dialogue between the patient and his or her therapist in a collaborative treatment situation where the patient's own self-reported well-being is the ultimate goal of therapy.

Because I have worked psychometrically with both the SCL-90 and the clinician-rated HAM-A, HAM-D, and BPRS for approximately four decades, my approach has been to consider the individual items in these questionnaires and rating scales as item banks from which brief scales consisting of five to ten items are derived. Likewise, I have worked psychometrically over the past decades with side-effect scales and scales measuring quality of life. From these item banks, I have selected brief scales to measure side effects and quality of life.

As a first step, all these scales have been used in randomized controlled clinical trials, but as an essential factor in measurement-based care, the scales should also be valid when making a practical outcome evaluation plan in daily clinical routine. As such, measurement-based care, as used in other fields of medicine, should also be applicable in mental disorders.

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Measurement-Based Care in Mental Disorders

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2016, XVI, 93 p. 13 illus. in color., Softcover

ISBN: 978-3-319-46650-7