

Inventory of Depressive Symptomatology (IDS) and Quick Inventory of Depressive Symptomatology (QIDS)

Inventory of Depressive Symptomatology (IDS)

Background and Rationale

There are several reasons to measure specific depressive symptoms in clinical practice: to (1) screen for depression; (2) subtype depression (e.g., atypical, melancholic) to guide treatment selection; (3) assess treatment outcome; (4) obtain a consistent measure to decide when to continue a medication, raise the dose, or change treatment strategy (augment or switch); (5) establish that sustained symptom remission (the goal of treatment) has occurred; and (6) teach symptom monitoring/disease management to patients and families. Ideally, the measurements used in clinical studies should also be helpful in daily clinical practice. The 30-item Inventory of Depressive Symptoms (IDS) was developed to serve all 6 of these functions.

The construction of the IDS-C₃₀ and IDS-SR₃₀ was intended to remedy deficits in the Hamilton (HRSD) and Montgomery Asberg (MADRS) depression rating scales by (a) including all nine symptom domains needed to diagnose a DSM-IV major depressive episode in order to assess for symptom remission, (b) including items that assess the symptoms of melancholic and atypical types of depression, (c) scaling items so as to detect milder levels of symptoms than the HRSD since many patients respond to treatment, but do not remit, (d) providing unconfounded items

(e.g., irritability and anxiety are separately rated); and (e) providing equivalent weighting for each item (unlike the HRSD) so the total score reflects a balanced rating of items. The IDS items assess both the pervasiveness and the intensity of symptoms. It excluded by design items that were uncommonly encountered (e.g., depersonalization) and it does not rate psychotic symptoms.

There are two versions of the IDS with identical items: a clinician rating (IDS-C₃₀) and a self-report (IDS-SR₃₀). The self-report was developed to determine if it could be used as an alternative to the IDS-C₃₀ in clinical or research settings, which would provide a low cost, easily used gauge of depressive symptom severity to assist patients and providers in managing the disorder.

Test Structure

For both the IDS-C₃₀ and the IDS-SR₃₀, only 28 of the 30 items are scored (either weight gain OR weight loss is scored; either appetite increase OR decrease is scored). Each item is rated 0-3. The total score ranges from 0-84. The items on each scale were designed to assess (a) all nine Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV) criterion domains of major depressive disorder (MDD): depressed mood, decreased interest, decrease/increase in appetite/weight, sleep disturbance, psychomotor agitation/retardation, decreased energy, worthlessness/guilt, concentration/decision making and suicidal ideation and (b) commonly associated symptoms (e.g., psychic anxiety, sympathetic nervous system arousal, aches and pains, irritability), as well as all DSM-IV melancholic (e.g., distinct quality of mood, mood

reactivity, diurnal variation) and atypical symptom features (e.g., leaden paralysis, hypersomnia, interpersonal rejection sensitivity).

Symptoms are evaluated based on their presence in the past week. The IDS-C and IDS-SR each take 15-20 minutes to complete.

Test Performance

Both the IDS-C₃₀ and IDS-SR₃₀ have very satisfactory psychometric properties and are treatment sensitive measures of symptom severity.

The IDS-C₃₀ and IDS-SR₃₀ have been validated in both public and private sectors in symptomatic outpatients with major depressive disorder (MDD), nonsymptomatic controls, and outpatients with bipolar disorder in studies with 47 to 1442 subjects. The instruments have also been studied in the primary care setting.

Cronbach's alpha ranged from 0.67 to 0.94 for the IDS-C₃₀ and IDS-SR₃₀. In studies where both the IDS₃₀ and the HRSD₁₇ were collected, Cronbach's alpha tended to be numerically higher for both the IDS-C₃₀ and IDS-SR₃₀ than for the HRSD₁₇ (HRSD₁₇ ranged from 0.53 to 0.91).

Interrater reliability for the IDS-C₃₀ (0.96) was slightly numerically higher than for the HRSD₁₇ (0.92).

The IDS-C₃₀ and IDS-SR₃₀ are highly correlated with the HRSD₁₇ (0.88 to 0.95) and with the Beck Depression Inventory (BDI) (0.86 – 0.93). Reductions of $\geq 50\%$ in baseline IDS-C₃₀ or

IDS-SR₃₀ scores are clinically significant and are roughly proportional to reductions of $\geq 50\%$ in baseline HRSD₁₇ scores. Both are moderately correlated with the SF-12 Mental Health scale (-0.46 or more) and SF-12 Physical scale (-0.40 or more). The IDS-C₃₀ is highly correlated with the NIMH Life Chart in bipolar outpatients (-0.78). Neither the IDS-C₃₀ nor the IDS-SR₃₀ are correlated with age, gender, or education. Correlations between the IDS-C₃₀ and IDS-SR₃₀ range from 0.77 to 0.97.

The IDS-C₃₀ and IDS-SR₃₀ differentiate between MDD, euthymic, manic, and mixed bipolar patients; MDD and euthymic patients; patients with endogenous and nonendogenous depression; MDD and dysthymic patients; depressed and nondepressed radiation oncology patients; and depressed and nondepressed cocaine dependent inmates. The IDS-SR₃₀ also predicts the diagnosis of MDD in postpartum women on the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I).

Both the IDS-C₃₀ and the IDS-SR₃₀ are sensitive to symptom change associated with medications or psychotherapy.

The IDS-SR₃₀ is as sensitive as the HRSD₂₄ and the Patient Global Impression-Improvement (PGI-I) in detecting between group differences in comparisons among medication vs. psychotherapy, medication vs. the combination of medication and psychotherapy, and psychotherapy vs. the combination of psychotherapy and medication in 602 adult outpatients with nonpsychotic chronic MDD (Rush, A.J. et al manuscript submitted).

The HRSD₂₄, PGI-I and IDS-SR₃₀ were obtained at baseline and weeks 0-4, 6, 8, 10, and 12 by a rater blinded to treatment assignment. Changes in scores on the IDS-SR₃₀ at each measurement point were very similar to changes on the HRSD₂₄. The same significant between group differences were found using the IDS-SR₃₀, PGI-I and HRSD₂₄ over the first four week period of the trial. In the next, eight week period, the IDS-SR₃₀ and PGI-I identified group differences between 2 out of 3 groups while the HRSD₂₄ identified differences among all 3 groups.

The sensitivity of the IDS-SR₃₀ and in detecting response and remission was compared to the HRSD₂₄. Response was defined a priori as a $\geq 50\%$ reduction in baseline total score for each scale, and remission was established as ≤ 8 on the HRSD₂₄, and ≤ 14 on the IDS-SR₃₀.

Substantial agreement (kappas of 0.67 or more) was found between responders vs. nonresponders and remitters vs nonremitters as classified by the HRSD₂₄ and IDS-SR₃₀.

In a small trial of 26 depressed outpatients, the IDS-SR₃₀ was also found to be sensitive to change and comparable to the HRSD₁₇.

Studies are ongoing that evaluate the performance of the IDS-C₃₀ in assessing response to antidepressant treatment in depressed outpatients with substantial concurrent general medical conditions. In this group of patients (n = 1442) with MDD, there were slight but not clinically significant differences in the IDS-C₃₀ total scores of these groups. (Yates, W.R., et al manuscript submitted)

Severity Thresholds for the IDS-C₃₀/IDS-SR₃₀

Optimal thresholds for depression screening depend on the intent of the screen (to avoid false negatives vs. to minimize false positives), and on the prevalence of MDD in the population. The following thresholds are recommended for depression screening with the IDS-C₃₀ or IDS-SR₃₀.

The HRSD₁₇ thresholds are included for comparison.

Severity Thresholds			
	HRSD₁₇	IDS-C₃₀	IDS-SR₃₀
No depression	≤ 7	≤ 11	≤ 13
Mild	8-14	12-23	14-25
Moderate	15-19	24-36	26-38
Moderate to Severe	20-24	37-46	39-48
Severe	≥ 25	≥ 47	≥ 49

Conversion of IDS-SR Scores into HRSD Scores

A table to convert IDS-SR₃₀ total scores into HRSD₁₇, 21, or 24 total scores is below. It is based on Item Response Theory analysis for a group of 578 outpatients with chronic MDD.

**Conversion Between IDS-SR₃₀ Total Scores and HRSD₂₄, HRSD₂₁ and
HRSD₁₇ Total Scores using IRT Analysis**

IDS-SR ₃₀	HRSD ₂₄	HRSD ₂₁	HRSD ₁₇
0-3	0-1	0-1	0
4-5	2	2	1-2
6	3-4	3	3
7-8	5	4	4
9-11	6-7	5-6	5-6
12-13	8-9	7-8	7
14-16	10-11	9	8
17-18	12	10	9-10
19-21	13-14	11-12	11
22-23	15-16	13	12
24-25	17-18	14-15	13
26-28	19	16	14-15
29-30	20-21	17	16
31-33	22-23	18-19	17
34-36	24-25	20-21	18-19
37-38	26	22	18-19
39-40	27-28	23	20
41-43	29-30	24-25	21-22
44-45	31-32	26	23
46-47	33	27	24
48	34	28	25
49-53	35-38	29-31	26-27
54-55	39	32	28
56-58	40-41	33-34	29
59-61	42-44	35-36	30-31
62-64	45-46	37-38	32
65-67	47-49	39-41	33-35
68-84	50-75	42-64	36-52

The only valid comparisons that can be made from this table are between 1) IDS-SR₃₀ and HRSD₂₄; 2) IDS-SR₃₀ and HRSD₂₁; and 3) IDS-SR₃₀ and HRSD₁₇.

Roughly, $HRSD_{17} \times 9/5 = IDS-C_{30}$ or $IDS-SR_{30}$
 $IDS-C_{30}$ or $IDS-SR_{30} \times 5/9 = HRSD_{17}$

Generally, $IDS-C_{30}$ scores are about one to two points lower than $IDS-SR_{30}$ scores.

Disorders/Populations Evaluated

Both versions of the IDS have been used in nonpsychotic and psychotic MDD, postpartum depression, premenstrual dysphoric disorder, dysthymic disorder, minor depression, bipolar disorder, as well as in cancer and asthma populations. The performance of the IDS in the elderly is being investigated. The IDS has been and is currently being used in efficacy and effectiveness trials.

Limitations of the IDS

The IDS is not a diagnostic measure, since varying levels of depressive symptoms can be due to general medical conditions, and nonmood Axis I disorders, Axis II disorders, substance abuse/dependence or withdrawal, or to selected prescribed medications.

The IDS does not measure neurocognitive or memory disturbances in depression, nor does it measure insight or psychotic (hallucinations/delusions) features. It also does not include less commonly encountered symptoms (e.g., paranoid ideation, depersonalizing/derealization).

The Quick Inventory of Depressive Symptoms (QIDS)

Background and Rationale

Following the development of the IDS-C₃₀ and IDS-SR₃₀, it was decided to provide a shorter, time-efficient, 16-item version for use in clinical research and daily practice, which focuses only on the nine DSM-IV criterion symptom domains. The resulting scales are called the Quick Inventory of Depressive Symptomatology – Clinician Rating (QIDS-C₁₆) and the Quick Inventory of Depressive Symptomatology – Self Report (QIDS-SR₁₆).

Test Structure

Sixteen items from the IDS-C₃₀/IDS-SR₃₀ were identified that were needed to rate the nine criterion domains of major depression: 4 items were needed to rate sleep disturbance (early, middle, and late insomnia plus hypersomnia); 2 items were needed to rate psychomotor disturbance (agitation and retardation); 4 items were needed to rate appetite/weight disturbance (appetite increase or decrease and weight increase or decrease); and 1 item each was needed to rate the remaining 6 domains (depressed mood, decreased interest, decreased energy, worthlessness/guilt, concentration/decision making, and suicidal ideation).

Each item is rated 0-3. To measure the domains that require more than one item, the highest score of the item relevant for each domain is taken. For example, if early insomnia is 0, middle

insomnia is 1, late insomnia is 3, and hypersomnia is 0, the sleep disturbance domain is rated 3.

The total score ranges from 0-27.

The QIDS-C₁₆ and QIDS-SR₁₆ each take 5-7 minutes to complete.

Test Performance

Both the QIDS-C₁₆ and QIDS-SR₁₆ also have very satisfactory psychometric properties and are treatment sensitive measures of symptom severity.

Both scales have been validated in both public and private sectors in outpatients with MDD and in the public sector with outpatients with bipolar disorder in studies with 122 to 1442 subjects.

Cronbach's alpha ranged from 0.81 to 0.90 for the QIDS-C₁₆ and was 0.86 for the QIDS-SR₁₆. In a study where both the QIDS-SR₁₆ and HRSD₁₇ were collected, Cronbach's alpha was numerically higher for the QIDS-SR₁₆ than for the HRSD₁₇.

The QIDS-C₁₆ and QIDS-SR₁₆ are highly correlated (0.72 or more) with the HRSD₁₇.

Reductions $\geq 50\%$ in baseline QIDS-C₁₆ or QIDS-SR₁₆ scores are clinically significant and are roughly proportional to reductions of $\geq 50\%$ in baseline HRSD₁₇ score. Higher QIDS-C₁₆ and QIDS-SR₁₆ scores are associated with lower SF-12 Mental Health scores.

The QIDS-C₁₆ is highly correlated with the IDS-C₃₀ (0.82 or more) and the QIDS-SR₁₆ is highly correlated with the IDS-SR₃₀ (0.83 or more). The QIDS-C₁₆ is as sensitive to change as

the IDS-C₃₀, and the QIDS-SR₁₆ is as sensitive to change as the IDS-SR₃₀. There is good agreement between QIDS-C₁₆ and IDS-C₃₀ and between the QIDS-SR₁₆ and the IDS-SR₃₀ in the assessment of response (kappas of 0.66 or more) and remission (kappas 0.75 or more). There is also good agreement between the QIDS-C₁₆ and QIDS-SR₁₆ for response (kappa of .68) and remission (kappa of .79).

The QIDS-SR₁₆ is almost as sensitive as the HRSD₂₄ and PGI-I in detecting between group differences in comparisons among medication vs. psychotherapy, medication vs. the combination of medication and psychotherapy, and psychotherapy vs. the combination of psychotherapy and medication in 602 adult outpatients with nonpsychotic chronic MDD (Rush, A.J. et al manuscript submitted).

Changes in scores on the QIDS-SR₁₆ at each measurement point (weeks 0-4, 6, 8, 10, and 12) were very similar to changes on the HRSD₂₄ and PGI-I. The same significant between group differences were found using the QIDS-SR₁₆, HRSD₂₄, and PGI-I over the first four week period of the trial. In the next, eight week period, the QIDS-SR₁₆ and PGI-I identified group differences between 2 out of 3 groups, whereas the HRSD₂₄ identified differences among all 3 groups.

Response was defined a priori as a $\geq 50\%$ reduction in baseline total scores for each scale, and remission was established as ≤ 8 on the HRSD₂₄ and ≤ 6 on the QIDS-SR₁₆. Good agreement (kappas of 0.61) was found between response based on the HRSD₂₄ and QIDS-SR₁₆, and moderate agreement (kappas of 0.53) was found between remission based on the HRSD₂₄ and the QIDS-SR₁₆ using the above definitions.

Studies are ongoing that evaluate the performance of the QIDS-SR₁₆ in assessing response to antidepressant treatment in depressed outpatients with substantial concurrent general medical conditions. In this group of patients (n = 1442) with MDD, there was no difference in QIDS-SR₁₆ ratings by subjects with or without significant general medical comorbidities. (Yates, W.R., et al manuscript submitted)

Severity Thresholds for the QIDS-C₁₆/QIDS-SR₁₆

The following thresholds are recommended for major depression screening with the QIDS:

	Severity Thresholds	
	QIDS-C₁₆	QIDS-SR₁₆
No depression	≤ 5	≤ 5
Mild	6-10	6-10
Moderate	11-15	11-15
Severe	16-20	16-20
Very Severe (check)	≥ 21	≥ 21

Conversion of QIDS-SR₁₆ Scores into HRSD_{17, 21, 24} Scores

A table to convert QIDS-SR₁₆ total scores into HRSD_{17, 21, or 24} total scores is below. It is based on Item Response Theory analysis for a group of 578 outpatients with chronic MDD.

**Conversion Between QIDS-SR₁₆ Total Scores and HRSD₂₄, HRSD₂₁,
and HRSD₁₇ Total Scores Using IRT Analysis**

QIDS-SR₁₆	HRSD₂₄	HRSD₂₁	HRSD₁₇
0	0–1	0–1	0
1	2	2	1–2
2	3–4	3	3
3	5	4	4
4	6–7	5–6	5–6
5	8–9	7–8	7
6	10–11	9	8
7	12	10	9–10
8	13–14	11–12	11
9	15–16	13	12
10	17–18	14–15	13
11	19	16	14–15
12	20–21	17	16
13	22–23	18–19	17
14	24–25	20–21	18–19
15	26	22	18–19
16	27–28	23	20
17	29–30	24–25	21–22
18	31–32	26	23
19	33	27	24
20	34	28	25
21	35–38	29–31	26–27
22	39	32	28
23	40–41	33–34	29
24	42–44	35–36	30–31
25	45–46	37–38	32
26	47–49	39–41	33–35
27	50–75	42–64	36–52

The only valid conversions that can be made from this table are between
1) QIDS-SR₁₆ and HRSD₂₄; 2) QIDS-SR₁₆ and HRSD₂₁; and 3) QIDS-SR₁₆
and HRSD₁₇.

Roughly, QIDS-C_{16} or $\text{QIDS-SR}_{16} = 4/5 \text{ HRSD}_{17}$
 $5/4 \text{ QIDS-C}_{16}$ or $\text{QIDS-SR}_{16} = \text{HRSD}_{17}$

Generally, QIDS-C_{16} scores are about the same as QIDS-SR_{16} scores.

Conversion of QIDS Scores into IDS Scores

Tables, derived from Item Response Theory analyses, to convert QIDS-C_{16} into IDS-C_{30} and QIDS-SR_{16} into IDS-SR_{30} , are below. They are based on 544 public sector outpatients (nonpsychotic and psychotic) with MDD.

**Conversion Between QIDS-SR₁₆ and IDS-SR₃₀ Total Scores and
QIDS-C₁₆ and IDS-C₃₀ Total Scores Using IRT Analysis**

IDS-C ₃₀	QIDS-C ₁₆	IDS-SR ₃₀	QIDS-SR ₁₆
0-3	0	0-3	0
4-5	1	4-5	1
6	1	6	2
7	2	7	2
8	2	8	3
9	3	9	3
10	3	10	4
11	4	11	4
12	4	12	5
13	4	13	5
14	5	14	5
15	5	15	6
16-17	6	16-17	6
18	6	18	7
19	7	19	7
20	7	20	7
21	8	21	8
22	8	22	8
23-24	9	23-24	9
25	9	25	9
26	10	26	10
27	10	27	10
28-29	11	28-29	11
30	11	30	11
31	12	31	12
32	12	32	12
33-34	13	33-34	13
35	13	35	13
36	14	36	14
37	14	37	14

Roughly, $\text{QIDS-SR}_{16} \times 2.7 = \text{IDS-SR}_{30}$
 $\text{QIDS-C}_{16} \times 2.7 = \text{IDS-C}_{30}$

Disorders/Populations Evaluated

Both versions of the QIDS have been used in psychotic and nonpsychotic MDD and bipolar disorder. Benchmarks from epidemiologic studies with the QIDS-SR₁₆ are being acquired. The QIDS-SR₁₆ has been successfully completed by 13–18-year-olds. The performance of the QIDS in the elderly is under investigation.

Limitations of the QIDS

The QIDS has several additional limitations, beyond those already noted for the IDS. The QIDS-SR₁₆ and QIDS-C₁₆ do not measure all of the melancholic or atypical symptom features, although these are measured by the IDS-C₃₀ and IDS-SR₃₀. The performance of the QIDS in premenstrual dysphoric disorder and in postpartum depression is only now being investigated.

Additional Applications of the IDS/QIDS

Long-Term Disease Management

It is well known that, even in treated patients, depressive symptoms will wax and wane. Sometimes, the worsening of symptoms are brief "blips" requiring only reassurance, while for others they may lead to relapses or recurrences. Arming patients with a way to communicate accurately the symptom status of their depression will assist both patients and clinicians in implementing timely and appropriate interventions.

Medication Management Using Symptom Ratings

In managing treatment, most guidelines recommend a change in dose or type of medication after some period of time sufficient to establish (a) that the treatment will not work or (b) that while effective, it will not result in full symptom remission. These critical decision points may be informed by global clinical ratings or by more specific itemized symptom ratings (such as the IDS or QIDS). To date, data indicate that itemized self-report symptom ratings are closer to the "gold standard" - itemized clinician symptom ratings -than are global clinical judgments.

Further, several studies indicate a reduced probability of ultimate response if, at 4-6 weeks, at least a 20% reduction in baseline symptoms has not occurred with medication provided at therapeutic doses. As well, remission follows response by 2-8 weeks, and in more chronically depressed patients, by 1-3 months. These findings indicate that the measurement of symptoms at critical decision points should assist clinicians in making treatment decisions.

Interactive Voice Response Presentations of the IDS/QIDS

Interactive voice response (IVR) technology can be used to collect data directly from study patients. IVR describes a computer's ability to interpret Touch- Tone or speech input and respond with prerecorded voice over a standard telephone line. IVR systems branch to the next question based on the patient's previous input. The QIDS and IDS have been converted to IVR technology.

In addition to interacting with a caller in a personalized, customized manner through sophisticated branching that models an expert clinician, IVR systems have many optional features: transfer to live operator; outbound paging; immediate faxing or e-mailing of custom

information following the call; report generation; and interactive scripts written in multiple languages and presented in both genders.

Computer interviews have been used to collect data directly from patients for almost 40 years and have a number of advantages over clinician interviews. Computer interview questions and the sequence of those questions are identical from patient to patient; interviews proceed at the patient's pace and are relatively cheap; sensitive subject matter can be easily disclosed to the computer; and data are stored in a computer database where they can be immediately available for clinical care or research analyses. Patients like computer interviews, at times preferring them to interviews with clinicians. Touchtone telephones are easily used by almost everyone, and they overcome functional illiteracy for most of the 23% of the U.S. population who cannot understand what is written in newspapers.

Patient self-reports collected by computer interview appear at least as accurate as those collected by clinicians. For these reasons, the government and pharmaceutical industry sponsors of clinical trials are moving rapidly to employ computer interviews to collect many kinds of medical data directly from patients.

To learn more about Healthcare Technology Systems, which provides IVR technology, visit www.healthtechsys.com. You may also contact Ms. Christine Lys, Vice President, Business Development, Healthcare Technology Systems, Inc., 7617 Mineral Point Road, Suite 300, Madison, Wisconsin, 53717; telephone number: 608-827-2419 or 800-316-2414; email: clys@healthtechsys.com.

Scales Available in English and Translations

The following are available in English:

English IDS-C₃₀
 English IDS-SR₃₀
 English IDS-C₃₀ with interview questions
 English QIDS-C₁₆
 English QIDS-SR₁₆
 English QIDS-C₁₆ with interview questions (STAR*D)

Scoring Instructions for the IDS-C₃₀/IDS-SR₃₀ and QIDS-C₁₆/QIDS-SR₁₆

English Combined HRSD₁₇/IDS-C₃₀ (STAR*D)
 English Combined HRSD₁₇/QIDS-C₁₆ (STAR*D)

English (Australia) IDS-C₃₀*
 English (Australia) IDS-SR₃₀*
 English (Canada) IDS-SR₃₀*
 English (Singapore) IDS-C₃₀*
 English (Singapore) IDS-SR₃₀*
 English (Taiwan) IDS-C₃₀*
 English (Taiwan) IDS-SR₃₀*

The following translations are available:

Chinese (Singapore) IDS-C₃₀*
 Chinese (Singapore) IDS-SR₃₀*
 Chinese (Taiwan) IDS-C₃₀*
 Chinese (Taiwan) IDS-SR₃₀*

Danish IDS-C₃₀
 Danish IDS-SR₃₀

Dutch IDS-C₃₀
 Dutch IDS-SR₃₀

French IDS-C₃₀*
 French IDS-SR₃₀*

German IDS-C₃₀*
 German IDS-SR₃₀*

Italian IDS-SR₃₀

Norwegian IDS-C₃₀*
 Norwegian IDS-SR₃₀*

Portuguese (Brazil) IDS-C₃₀*
 Portuguese (Brazil) IDS-SR₃₀*

Spanish (Mexico) IDS-C₃₀*
 Spanish (Mexico) IDS-SR₃₀*
 Spanish (Chile, Colombia, Peru, Venezuela) IDS-C₃₀*
 Spanish (Chile, Colombia, Peru, Venezuela) IDS-SR₃₀*

Spanish IDS-C₃₀ with interview questions
 Spanish QIDS-C₁₆ (STAR*D)
 Spanish QIDS-SR₁₆ (STAR*D)
 Spanish QIDS-C₁₆ with interview questions (STAR*D)

Spanish Combined IDS-C₃₀/HRSD₁₇ (STAR*D)
 Spanish Combined QIDS-C₁₆/HRSD₁₇ (STAR*D)

Turkish IDS-C₃₀
 Turkish IDS-SR₃₀
 Turkish QIDS-C₁₆
 Turkish QIDS-SR₁₆

*Merck & Co. translations

Industry Use

The following companies have used the IDS or QIDS in a self-report, clinician-rated, or IVR format: Bristol-Myers Squibb, Cyberonics, Inc., Forest Laboratories, GlaxoSmithKline, Merck, Inc., and Organon, Pfizer, Inc.

Copyright/Use Issues

All versions of the IDS (except for the IVR) are available at no cost to clinicians and researchers. Copies may be downloaded from this site and used without permission. For those wishing to place the IDS into a computer-administered or automated telephone-administered format, please contact the author for permission: *A. John Rush, MD., Department of Psychiatry, University of*

Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, Dallas, TX 75390-9086. Tel. 214-648-4600; fax 214-648-4612; E-mail address john.rush@utsouthwestern.edu.

CITATIONS

1. Biggs, M.M., Shores-Wilson, K., Rush, A.J., Carmody, T.J., Trivedi, M.H., Crismon, M.L., Toprac, M.G. and Mason, M. A comparison of alternative assessments of depressive symptom severity: A pilot study. Psychiatry Research, 96:269-279, 2000.
2. Boyer, P., Tassin, J.P., Falissart, B., and Troy, S. Sequential improvement of anxiety, depression and anhedonia with sertraline treatment in patients with major depression. Journal of Clinical Pharmacy and Therapeutics, 25(5):363-371, 2000.
3. Brown, E.S., Khan, DA., Nejtek, V.A., Thomas, N.R. and Mahadi, S.F. Depressive symptoms and functioning in asthma patients. Primary Care Psychiatry, 6(4):155-161, 2001.
4. Carpenter, L.L., Yasmin, S., Price, L.H. A double-blind, placebo-controlled study of antidepressant augmentation with mirtazapine. Biological Psychiatry, 51:183-188, 2002.
5. Corruble, E., Legrand, J.M., Duret, C., Charles, G. and Guelfi, J.D. IDS-C and IDS-SR: Psychometric properties in depressed in-patients. Journal of Affective Disorders, 56:95-101, 1999.
6. Corruble, E., Legrand, J.M., Zvenigorowski, H., Duret, C. and Guelfi, J.D. Concordance between self-report and clinician's assessment of depression. Journal of Psychiatric Research, 33:457-465, 1999.
7. Denicoff, K.D., Leverich, G.S., Nolen, W.A., Rush, A.J., McElroy, S.L., Keck, P.E., Suppes, T., Altshuler, L.L., Kupka, R., Frye, M.A., Hatef, J., Brotman, M.A. and Post, R.M. Validation of the prospective NIMH-Life-Chart Method (NIMH-LCM-p) for longitudinal assessment of bipolar illness. Psychological Medicine, 30(6):1391-1397, 2000.
8. Depression Guideline Panel. Clinical Practice Guideline. Number 5. Depression in Primary Care: Volume 2. Treatment of Major Depression. Rockville, MD: US Dept. of Health and Human Services, Agency for Health Care Policy and Research. AHCPR Publication No. 93-0551, 1993.
9. Domkin, M., Scott, J. and Kelly, P. What factors predict discrepancies between self and observer ratings of depression? Journal of Affective Disorders, 31:253-259, 1994.
10. Dunn, A.L., Trivedi, M.H., Kampert, J.B., Clark, C.G. and Chambliss, H.O. The DOSE study: a clinical trial to examine efficacy and dose response of exercise as treatment for depression. Controlled Clinical Trials, 23(5):584-603, 2002.

11. Fava M, Rush AJ, Trivedi MH, Nierenberg AA, Thase ME, Sackeim HA, Quitkin FM, Wisniewski S, Lavori PW, Rosenbaum JF, Kupfer DJ, for the STAR*D Investigators Group. Background and rationale for the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study. In Dunner DL, Rosenbaum JF, eds., Psychiatric Clinics of North America. Volume 26. Philadelphia, PA: W.B. Saunders Company, pp. 1-38, 2003.
12. First, M., Spitzer, R., Gibbon, M., Williams, J. Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I), Clinical Version. Washington, DC: American Psychiatric Association, 1997.
13. Gullion, C.M. and Rush, A.J. Toward a generalizable model of symptoms in major depressive disorder. Biological Psychiatry, 44:959-972, 1998.
14. Hulin, C.L., Drasgow, F., Parsons, C.K. Item Response Theory: Applications to Psychological Measurement. Homewood, IL: Dow Jones Irwin, 1983.
15. Jenkins, C., Carmody, T.J., III and Rush, A.J. Depression in radiation oncology patients: A preliminary evaluation. Journal of Affective Disorders, 50:17-21, 1998.
16. Kalpakjian, C.Z., Lam, C.S., and Leahy, B.J. Conceptualization and identification of depression in adults with brain damage by clients and rehabilitation clinical staff. Brain Injury, 16(6):501-507, 2002.
17. Kashner, T.M., Carmody, T.J., Suppes, T., Rush, A.J., Crismon, M.L., Miller, A.L., Toprac, M., and Trivedi, M. Catching up on health outcomes: the Texas Medication Algorithm Project. Health Services Research, 38(1 Pt 1):311-331, 2003.
18. Keller, M.B., McCullough, J.P., Klein, D.N., Arnow, B., Dunner, D.L., Gelenberg, A.J., et al. A comparison of nefazodone, the cognitive-behavioral analysis system of psychotherapy, and their combination for the treatment of chronic depression. New England Journal of Medicine, 342:1462-1470, 2000.
19. Kessler, R.C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K.R., Rush, A.J., Walters, E.E., and Wang, P.S.; National Comorbidity Survey Replication. The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). Journal of the American Medical Association, 289(23):3095-3105, 2003.
20. Koran LM, Gelenberg AJ, Kornstein SG, Howland RH, Friedman RA, DeBattista C, Klein D, Kocsis JH, Schatzberg AF, Thase ME, Rush AJ, Hirschfeld RMA, LaVange LM, Keller MB. Sertraline versus imipramine to prevent relapse in chronic depression. J Affect Disord, 65:27-36, 2001.
21. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression measure. J Gen Intern Med, 16:603-613, 2001.
22. Leon AC, Ofson M, Portera L, Farber L, Sheehan DV. Assessing psychiatric impairment in primary care with the Sheehan Disability Scale. In J Psychiatry Med, 27:93-105, 1997.

23. Leverich, G.S., Nolen, W.A., Rush, A.J., McElroy, S.L., Keck, P.E., Denicoff, K.D., Suppes, T., Altshuler, L.L., Kupka, R., Kramlinger, K.G. and Post R.M. The Stanley Foundation Bipolar Treatment Outcome Network. I. Longitudinal methodology. Journal of Affective Disorders, 67(1-3):33-44, 2001.
24. Manber, R., Rush, A.J., Thase, M.E., Amow, B., Klein, D., Trivedi, M.H., Kornstein, S.G., Markowitz, J.C., Dunner, D.L., Munsaka, M., Borian, F.E., and Keller, M.B. The effects of psychotherapy, nefazodone, and their combination on subjective assessment of disturbed sleep in chronic depression. Sleep, 26(2):130-136, 2003.
25. Nierenberg AA, McLean NE, Alpert JE, Worthington JJ, Rosenbaum JF, Fava M. Early nonresponse to fluoxetine as a predictor of poor 8-week outcome. Am J Psychiatry;152:1500-1503, 1995.
26. Ninan, P.T., Rush, A.J., Crits-Christoph, P., Kornstein, S.G., Manber, R., Thase, M.E., Trivedi, M.H., Rothbaum, B.O., Zajecka, J., Borian, F.E., and Keller, M.B. Symptomatic and syndromal anxiety in chronic forms of major depression: effect of nefazodone, cognitive behavioral analysis system of psychotherapy, and their combination. Journal of Clinical Psychiatry, 63(5):434-441, 2002.
27. Quitkin FM, Petkova E, McGrath PJ, Taylor B, Beasley C, Stewart J, Amsterdam J, Fava M, Rosenbaum J, Reimherr F, Fawcett J, Chen Y, Klein D. When should a trial of fluoxetine for major depression be declared failed? Am J Psychiatry;160:734-740, 2003.
28. Rush, A.J., Carmody, T.J., Ibrahim, H.M., Trivedi, M.H., Biggs, M.M., Shores-Wilson, K., Crismon, M.L., Kashner, T.M. and Toprac, M.G. How do clinician and self-report ratings of depression compare in public sector patients? In preparation for submission to the Journal of Clinical Psychopharmacology.
29. Rush AJ, Fava M, Wisniewski SR, Lavori PW, Trivedi MH, Sackeim HA, Thase ME, Nierenberg AA, Quitkin FM, Kashner TM, Kupfer DJ, Rosenbaum JF, Alpert J, Stewart J, McGrath PJ, Biggs MM, Shores-Wilson K, O'Neal BL, Lebowitz BD, Ritz L, Niederehe G, for the STAR*D Investigators Group. Sequenced Treatment Alternatives to Relieve Depression (STAR*D): Rationale and design. Control Clin Trials, in press.
30. Rush AJ, Trivedi MH, Ibrahim HM, Carmody TJ, Arnow B, Klein DN, Markowitz JC, Ninan PT, Kornstein S, Manber R, Thase ME, Kocsis JH, Keller MB. The 16-item Quick Inventory of Depressive Symptomatology (QIDS) Clinician Rating (QIDS-C) and Self-Report (QIDS-SR): A psychometric evaluation in patients with chronic major depression. Biol Psychiatry, in press.
31. Rush, A.J., Carmody, T. and Reimtz, P-E. The Inventory of Depressive Symptomatology (IDS): Clinician (IDS-C) and self-report (IDS-SR) ratings of depressive symptoms. International Journal of Methods in Psychiatric Research, 9:45-59, 2000.
32. Rush, A.J., Giles, D.E., Schlessner, M.A., Fulton, C.L., Weissenburger, J.E. and Burns, C.T. The Inventory of Depressive Symptomatology (IDS): Preliminary findings. Psychiatry Research, 18:65-87, 1986.

33. Rush, A.J., Gullion, C.M., Basco, M.R., Jarrett, R.B. and Trivedi, M.H. The Inventory of Depressive Symptomatology (IDS): Psychometric properties. Psychological Medicine, 26:477-486, 1996.
34. Rush, A.J., Hiser, W. and Giles, D.E. A comparison of self-reported versus clinician-rated symptoms in depression. Journal of Clinical Psychiatry, 48:246-248, 1987.
35. Rush, A.J., Trivedi, M.H., Carmody, T.J., et al. Self-Reported Depressive Symptom Measures: Sensitivity to Detecting Change in a Randomized, Controlled Trial of Chronically Depressed, Nonpsychotic Outpatients. Neuropsychopharmacology, submitted.
36. Rush, A.J., Trivedi, M.H., Ibrahim, H.M., et al. The 16-item Quick Inventory of Depressive Symptomatology (QIDS) Clinician Rating (QIDS-C) and Self-Report (QIDS-SR): A psychometric evaluation in patients with chronic major depression. Biological Psychiatry, in press.
37. Schulberg HC, Katon W, Simon GE, Rush AJ. Treating major depression in primary care practice: An update of the Agency for Health Care Policy and Research practice guidelines. Arch Gen Psychiatry, 55:1121-1127, 1998.
38. Surís, A., Kashner, T.M., Gillaspay, J.A., Jr., Biggs, M. and Rush, A.J. Validation of the Inventory of Depressive Symptomatology (IDS) in cocaine dependent inmates. Journal of Offender Rehabilitation, 32:15-30, 2001.
39. Tondo, L., Burrai, C., Scamonatti, L., Weissenburger, J.E. and Rush, A.J. A comparison between clinician-rated and self-reported depressive symptoms in Italian psychiatric patients. Neuropsychobiology, 19:1-5, 1988.
40. Trivedi, M.H., Rush, A.J., Ibrahim, H.M., et al. The Inventory of Depressive Symptomatology, Clinician Rating (IDS-C) and Self-Report (IDS-SR), the Quick Inventory of Depressive Symptomatology, Clinician Rating (QIDS-C) and Self-Report (QIDS-SR) in public sector patients with mood disorders: A psychometric evaluation. Psychological Medicine, in press.
41. Trivedi, M.H., Rush, A.J., Pan, J.Y and Carmody, T.J. Which depressed patients respond to nefazodone and when? Journal of Clinical Psychiatry, 62(3):158-163, 2001.
42. Tsevat, J., Keck, P.E., Hornung, R.W., and McElroy, S.L. Health values of patients with bipolar disorder. Quality of Life Research, 9(5):579-586, 2000.
43. Yonkers, K.A., Ramin, S.M., Rush, A.J., Navarrete, C.A., Carmody, T., March, D., Heartwell, S.F. and Leveno, K.J. Onset and persistence of postpartum depression in an inter-city maternal health clinical system. American Journal of Psychiatry, 158(11):1856-1863, 2001.