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Screening for depressive disorders using the MASQ anhedonic depression scale: A receiver-operator characteristic analysis

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Abstract

The present study examined the utility of the anhedonic depression scale from the Mood and Anxiety Symptoms Questionnaire (MASQ-AD) as a way to screen for depressive disorders. Using receiver-operator characteristic analysis, the sensitivity and specificity of the full 22-item MASQ-AD scale, as well as the 8 and 14-item subscales, were examined in relation to both current and lifetime DSM-IV depressive disorder diagnoses in two nonpatient samples. As a means of comparison, the sensitivity and specificity of a measure of a relevant personality dimension, neuroticism, was also examined. Results from both samples support the clinical utility of the MASQ-AD scale as a means of screening for depressive disorders. Findings were strongest for the MASQ-AD 8-item subscale and when predicting current depression status. Furthermore, the MASQ-AD 8-item subscale outperformed the neuroticism measure under certain conditions. The overall usefulness of the MASQ-AD scale as a screening device is discussed, as well as possible cutoff scores for use in research.

Keywords

depressive disorders; anhedonic depression; Mood and Anxiety Symptoms Questionnaire; receiver-operator characteristic analysis; screening

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Introduction

There are a variety of strategies that clinical researchers can use to recruit individuals with specific forms of psychopathology. One strategy is to target individuals seeking treatment for the condition of interest. A key limitation of this strategy is that those individuals seeking treatment can be expected to be unrepresentative of individuals who suffer from that condition (du Fort, Newman, & Bland, 1993). An alternative approach is to use specific advertising techniques to target individuals who report suffering from these conditions, though again there is no way to ensure that those who respond are representative. A third approach is to screen, using diagnostic interviews, a very large number of individuals (with the number of individuals to be screened guided by base rates). This strategy can be very inefficient because of the relatively large amount of time that must be devoted to screening each participant.

A related recruitment approach involves screening a large number of participants with an instrument that can be administered quickly and easily, and then conducting follow-up assessments with a subset of these individuals using more extensive diagnostic procedures. This approach has the advantages of being more efficient than conducting full assessments with a large number of participants, as well as the ability to identify non-treatment seeking individuals with psychopathology. Of course, the feasibility of adopting this approach is premised on two conditions: (1) that sufficiently predictive instruments have been identified which can accurately distinguish individuals who are likely to meet diagnostic criteria from individuals who are likely to not meet diagnostic criteria; and (2) that information is available for determining an appropriate cut-off value that can be used for screening decisions. Both of these conditions can be addressed using receiver-operator characteristic (ROC) analysis (Green & Swets, 1966). In ROC analysis, one obtains a curve in which the sensitivity (i.e., the rate at which the instrument at a given value indicates the presence of a condition when the condition is actually present) is plotted against the specificity (i.e., the rate at which the instrument at a given value indicates the absence of a condition when the condition is not actually present) for the full range of scores on a given measure. The adequacy of a given measure as a screening tool can be determined by calculating the area under the ROC curve (AUC). AUC reflects the probability that a randomly selected “case” will score higher on the test or measure than a randomly selected “control” (Hanley & McNeil, 1983). Furthermore, sensitivity and specificity for specific scores on the measure can be examined to determine an appropriate clinical cut-off. ROC analysis is growing in popularity as a procedure for evaluating the utility of specific self-report instruments as screening tools for use in clinical research (e.g., Behar, Alcaine, Zuellig, & Borkovec, 2003; Chen, Faraone, Biederman, & Tsuang, 1994), in part because test results are robust even when the number of cases and controls is unequal in the sample (Rice & Harris, 1995).

Since the majority of individuals with depressive disorders do not seek professional treatment (Flament, Cohen, Choquet, Jeammet, & Ledoux, 2001; Kendler, 1995), recruiting research participants from clinical settings will likely exclude a very large proportion of the population with depressive disorders. Furthermore, motivational deficits, coupled with the stigma associated with mental disorders, may make depressed individuals less likely to respond to targeted advertisements. Finally, the base rates of depressive disorders, though higher than some other forms of psychopathology, are still low enough that conducting diagnostic procedures with an unselected sample of participants would not be very cost-effective. Thus, there is a clear need for self-report instruments that can be administered quickly and easily and can accurately identify individuals likely to have depressive disorders. Research involving ROC analysis has examined the utility of popular self-report measures of depression, such as the Beck Depressive Inventory (BDI; Beck, Steer, &

Brown, 1996; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). Findings from these studies have generally been encouraging (e.g., Kumar, Steer, Teitelman, & Villacis, 2002; Lasa, Ayuso-Mateos, Vázquez-Barquero, Díez-Manrique, & Dowrick, 2000). Nevertheless, many of these popular measures have been criticized as having poor discriminant validity, since they primarily measure general distress or negative affect, which is not unique to depression (see Watson & Clark, 1984). One possible implication of this criticism is that these instruments are likely to have high sensitivity but low specificity (see Sloan et al., 2002). According to the tripartite model of depression and anxiety, low levels of positive affect (anhedonia) are unique to depressive disorders, whereas elevated levels of negative affect are shared by both depressive and anxiety disorders (Clark & Watson, 1991). Self-report instruments have been developed to measure this unique component of depression, perhaps the most popular being the Mood and Anxiety Symptoms Questionnaire (MASQ; Watson, Clark, et al., 1995; Watson, Weber, et al., 1995). The MASQ includes an anhedonic depression scale, which was designed to measure the low levels of positive affect unique to depression (along with other symptoms that are thought to differentiate depressive disorders from anxiety disorders, such as lack of motivation).

Three studies have used ROC procedures to examine the utility of the MASQ anhedonic depression scale in clinical settings as a means of identifying individuals with depressive disorders (Boschen & Oei, 2007; Buckby, Yung, Cosgrave, & Cotton, 2007; Buckby, Yung, Cosgrave, & Killackey, 2007). Though all three studies showed that scores on the scale predict depressive disorder diagnoses, some disagreement still exists regarding the ultimate utility of this scale for clinical applications. Importantly, one of these studies (Buckby, Yung, Cosgrave, & Killackey, 2007) showed that the MASQ anhedonic depression scale outperformed a popular measure of depression (the Center for Epidemiologic Studies-Depression Scale) in predicting depressive disorder diagnoses. To date, no research has examined the utility of the MASQ anhedonic depression scale as a means for screening for depressive disorders in nonclinical settings. Such work is critical to exploring the potential utility of the MASQ anhedonic depression scale for research applications, or for initial screening for depressive disorders in primary health care settings.

Research has shown that items on the anhedonic depression scale of the MASQ load onto two separate factors, one of which consists of 8 items regarding depressed mood, lack of motivation, and other symptoms of depressive disorders (e.g., “felt really slowed down”), and another which consists of 14 reverse-scored items related to experiencing pleasant emotions (e.g., “felt like nothing was very enjoyable”; Nitschke, Heller, Imig, McDonald, & Miller, 2001; Watson, Clark, et al., 1995; Watson, Weber, et al., 1995). Existing ROC research examining the MASQ anhedonic depression scale has not examined these subscales separately to determine whether one of these subscales outperforms the other and/or the total scale.

The present project examined the utility of the MASQ anhedonic depression scale (MASQ-AD) as a screening tool for depressive disorders using ROC analysis. The utility of the MASQ-AD 22-item scale, as well as that of the 8- and 14-item subscales, was examined in a sample of college students in Study 1 and in a sample of community members in Study 2. The present study also went beyond past research by comparing the MASQ anhedonic depression scales with a measure of neuroticism, which is a personality trait shown to confer risk for a broad range of psychopathology, including but not limited to depression (Ormel et al., 2004).

Study 1

Method

Participants—Participants were 108 university students (60% female) ages 18–22 (*M* = 19.0; *SD* = 1.0) who were recruited to participate in a large scale neuroimaging study. All participants passed exclusion criteria related to a neuroimaging study: left-handedness, history of serious brain injury, abnormal hearing or vision, metal in their body, pregnancy, or non-native English speaker. For reasons associated with the primary goals of the neuroimaging study, efforts were made to oversample individuals with symptoms of anxiety and/or depression. To achieve this goal, a large number of individuals (n = 2,637) were initially assessed using self-report measures of anhedonic depression, anxious arousal, and worry. This screening session occurred one to six months prior to the collection of the data reported in this paper. Questionnaire scores from this session were used to determine who would participate in the next stage of the research; they were not used in the analyses presented in this paper. Based on their scores on these questionnaires, five groups of participants were recruited. Specifically, three groups scored above the 80th percentile (percentile levels determined from previous testing; Nitschke, Heller, Imig, McDonald, & Miller, 2001) on either the 8-item MASQ anhedonic depression subscale (*n* = 17), the MASQ anxious arousal scale (*n* = 18), or the Penn State Worry Questionnaire (*n* = 14; Meyer et al., 1990), and below the 50th percentile on the other two scales. A fourth group scored above the 80th percentile on all three measures (*n* = 29), and the final group scored below the 50th percentile on all three measures (*n* = 29)[1]. All participants received monetary compensation for participating in the study.

Self-Report Questionnaires

Anhedonic Depression: Participants completed the anhedonic depression scale from the Mood and Anxiety Symptoms Questionnaire a second time, after being recruited to participate in the neuroimaging study. Scores from this second administration were used in the analyses reported below. On the MASQ-AD, individuals indicate how frequently they have experienced a variety of different symptoms during the past week. This scale is composed of 22 items such as “felt like nothing was very enjoyable” and “felt really slowed down.” Research has indicated that this scale has good convergent and discriminant validity in undergraduate and community samples (Nitschke, Heller, Palmieri, & Miller, 1999; Nitschke et al., 2001; Watson, Clark, et al., 1995; Watson, Weber, et al., 1995). Since past research has shown that the items of anhedonic depression scale of the MASQ load onto two separate factors (Nitschke et al., 2001; Watson, Clark, et al., 1995; Watson, Weber, et al., 1995), analyses were conducted with the full 22-item scale as well as the 8- and 14-item subscales. In Study 1, alphas for the 22-, 8-, and 14-item scales were .94, .94, and .86, respectively.

Neuroticism: Participants also completed the 60-item NEO-Five Factor Inventory (Costa & McCrae, 1992) after being recruited to participate in the study. The 12-item Neuroticism scale is composed of items such as “I often feel inferior to others” and “I often feel tense and jittery”. Participants rated how characteristic each statement is of them. Research has indicated that this scale has good reliability and convergent validity in a variety of samples (Costa & McCrae, 1992). In the present sample, alpha for the neuroticism scale was .93.

Diagnostic Interview—Within approximately two weeks of completing the questionnaires described above, each participant was interviewed by an advanced doctoral

[1]One participant did not meet criteria for any of the five groups. Since group membership was not directly relevant to the present project, data from this individual was included in the analyses.

student in clinical psychology using the Structured Clinical Interview for DSM-IV Disorders, Nonpatient Edition (SCID-NP; First, Spitzer, Gibbon, & Williams, 2002) to assess for symptoms of Axis I pathology. All final diagnostic decisions were determined through consensus of the interviewers in consultation with one of the authors (GM), a licensed clinical psychologist who has supervised over 2000 SCID cases. Interviewers were blind to participants' scores on the self-report questionnaires.

For the current study, we used information gathered during the SCID-NP to classify all participants on four variables related to current and lifetime depressive disorder diagnoses. The first variable was based on whether the participant met DSM-IV diagnostic criteria for a current Major Depressive Episode (MDE) at the time of the interview. The second variable was based on whether the participant met diagnostic criteria for any current DSM-IV depressive disorder at the time of the interview. This included individuals who met full diagnostic criteria for a current MDE, as well as individuals who met full diagnostic criteria for Dysthymic Disorder, Substance Induced Mood Disorder with Depressive Features, Mood Disorder due to a General Medical Condition with Depressive Features, or Depressive Disorder, Not Otherwise Specified at the time of the interview. The third variable was based on whether the participant met DSM-IV diagnostic criteria for lifetime Major Depressive Disorder (MDD). The fourth variable was based on whether the participant had ever met diagnostic criteria for any DSM-IV depressive disorder, or a bipolar disorder (Bipolar I, II, or Cyclothymic Disorder) with a history of clinically significant depressive symptoms[2]. These diagnostic variables were not treated as mutually exclusive; thus, participants who qualified for current MDE also qualified for current depressive disorders, those who qualified for current MDE also qualified for lifetime MDD, and those who qualified for current depressive disorders also qualified for lifetime depressive disorders.

To examine interrater reliability, a secondary rater (blind to the original diagnoses) listened to audiotaped SCID-NP interviews of 20 participants (10 randomly selected cases who, according to the original diagnostician, met diagnostic criteria for lifetime MDD, and 10 randomly selected cases who did not) and provided ratings for the four diagnostic variables. Kappa was 1.00 for current MDE, 1.00 for current depressive disorders, .70 for lifetime MDD, and .90 for lifetime depressive disorders.

Analyses—The four diagnostic variables (current MDE, current depressive disorders, lifetime MDD, and lifetime depressive disorders) were used as the criteria for evaluating the absolute and relative effectiveness of the self-report questionnaires as a means of screening for depressive disorders, using ROC procedures. In each of these analyses, all participants in the sample who did not qualify as positive cases for that variable were treated as negative cases. For example, for analyses conducted with the current MDE variable, all participants in the sample who did not meet full criteria for a current Major Depressive Disorder (including remaining participants who qualified as positive cases for the other diagnostic variables, such as lifetime Major Depressive Disorder) were treated as negative cases. Areas under the ROC curves (AUCs) were calculated for each instrument to quantify the general utility of each scale as a means of screening for current and lifetime depressive disorder. Statistical significance of AUC estimates (i.e., whether these estimates are significantly above chance, which is .50) was determined using nonparametric tests (Hanley & McNeil, 1983). Since these tests are nonparametric, they do not require any statistical assumptions about the distributions of questionnaire scores and/or the base rates on the diagnostic variables. Although no specific guidelines for interpreting the size of AUC estimates are currently available, the following have been employed across a wide range of disciplines

[2]All analyses for the lifetime depressive disorders variable were rerun excluding individuals who qualified for bipolar disorders, and the results were virtually identical in both samples.

(e.g., Luna-Herrera et al., 2003; Starr et al., 2004; Thuiller et al., 2003): 0.50–0.60 = fail, 0.60–0.70 = poor, 0.70–0.80 = fair, 0.80–0.90 = good, 0.90–1.0 = excellent. All analyses were conducted using SPSS, Version 16.0.

To compare the relative effectiveness of each of the scales, AUCs for the different self-report scales were contrasted using the procedures for comparing correlated ROC curves described by DeLong and colleagues (DeLong, DeLong, & Clarke-Pearson, 1988). These analyses were conducted using locally written Matlab programs (Matlab R2007a, Natick, MA). Also, planned follow-up analyses for the MASQ-AD scales were conducted by calculating sensitivity, specificity, positive predictive power, and negative predictive power for specific scale values[3], which in turn were used to explore optimal clinical cutoffs. In order to determine optimal cutoff scores, the Youden (1950) Index was computed, which has been shown to yield lower misclassification rates than other commonly used methods (Perkins & Schisterman, 2006).

Results and Discussion

Table 1 provides means, standard deviations, and ranges for the self-report measures. The descriptive statistics for this sample closely resemble those reported from past studies involving unselected student samples (e.g., Watson, Clark, et al., 1995). Based on the SCID-NP, three participants (2.7%) met criteria for a current MDE and six participants (5.6%) met criteria for current depressive disorders. Seventeen participants (15.7%) met criteria for lifetime MDD, and 28 (25.9%) participants met criteria for lifetime depressive disorders. The rates in this sample, whose mean age was 19.0, are comparable to rates reported in epidemiological studies of depressive disorders in older adolescents (e.g., Lewinsohn, Rohde, & Seeley, 1998).

Table 2 contains AUCs for the four criterion variables: current MDE, current depressive disorders, lifetime MDD, and lifetime depressive disorders. As can be seen in Table 2, the self-report scales effectively predicted depressive disorder diagnoses, particularly for current MDE and depressive disorders. Specifically, the MASQ-AD 8-item scale and the neuroticism scale reliably predicted whether participants met criteria for a current MDE. The AUCs for both scales were in the good range, with the neuroticism scale bordering on the excellent range. The MASQ-AD 8-item subscale and the neuroticism scale also predicted lifetime MDD, with AUCs in the fair range. In addition, the full 22-item MASQ-AD scale predicted lifetime MDD, although the AUC for this scale bordered on the poor range. All of the scales predicted current depressive disorders, with all of the AUCs for the MASQ-AD scales in the good range, and the AUC for the neuroticism scale bordering on the excellent range. In addition, all of the scales predicted lifetime depressive disorders, with the AUCs for the full 22-item MASQ-AD scale, the 8-item subscale, and the neuroticism scale in the fair range, and the AUC for the 14-item subscale in the poor range.

Given that the results of the ROC analyses largely supported the effectiveness of all of the self-report measures as a means of screening for depressive disorders, we proceeded to examine whether the four scales differed from one another by conducting pairwise comparisons of the AUCs. The results revealed one statistically significant difference: the neuroticism scale outperformed the MASQ-AD 14-item subscale as a predictor of lifetime depressive disorders, ($\chi^2 = 4.29$, $p = .04$). No other pairs of scales differed significantly from one another.

[3]Positive and negative predictive power were included because some have argued that these indices are more clinically meaningful than sensitivity and specificity (Kessel & Zimmerman, 1993; Widiger et al., 1984).

Given that one of the primary goals of the project was to explore possible cutoff scores on the MASQ-AD scales that could be used to screen for depressive disorders, sensitivity, specificity, positive predictive power, and negative predictive power were computed for specific scale values. This was done using the 8-item subscale to predict current MDE status[4] because that subscale slightly outperformed the full 22-item scale and the 14-item subscale in the ROC analyses, and the results were stronger for current than for lifetime depressive disorders. The results are presented in Table 3. A cutoff score of 21 on the MASQ-AD 8-item subscale maximized the Youden Index, thus achieving a balance of sensitivity and specificity. At this cutoff, negative predictive power was excellent (1.0), though positive predictive power was fairly low (.13).

Overall, the results from Study 1 support the utility of the MASQ-AD scale as a means of screening for depressive disorders, though the MASQ-AD did not significantly outperform the neuroticism scale in predicting current or lifetime diagnostic status. The results were stronger for all of the self-report measures when predicting current rather than lifetime diagnostic status.

Nevertheless, these findings are qualified by some important limitations. The sample for this study was a sample of convenience consisting of undergraduate participants who were preselected on the basis of their scores on several self-report scales, including one of the MASQ-AD subscales. Consequently, it is possible that certain portions of the population distributions for the self-report measures (in particular, the MASQ-AD scales) were unrepresented, or underrepresented, in this sample. In turn, this may have inflated their discriminative power. Furthermore, the fact that the sample consisted solely of college students raises questions about the generalizability of the results. To address these limitations, Study 2 sought to replicate the findings from Study 1 in a sample of unselected community participants.

Study 2

Method

Participants—Participants were 167 community members (65 % female) ages 19–51 (*M* = 34.7; *SD* = 9.2). Participants were recruited though advertisements targeting adults interested in participating in a neuroimaging study and were screened for the same exclusion criteria as used in Study 1. All participants received monetary compensation for participating.

Self-Report Questionnaires

Anhedonic Depression: Participants completed the MASQ-AD. As in Study 1, analyses examined the 22, 8, and 14-item scales. In the present sample, alphas were 92, .94, and .80, respectively. One participant had missing data on the 22- and 14-item versions of the MASQ scale and was excluded from analyses involving these scales.

Neuroticism: Participants also completed the NEO-FFI. In the present sample, the alpha for the neuroticism scale was .88. Twelve participants had missing data on the NEO-FFI and were excluded from analyses involving this scale.

Diagnostic Interview—Within approximately two weeks of completing the questionnaires described above, each participant was interviewed by a clinical psychology

[4]Statistics for specific values on the other self-report scales that were examined, as well as for the other diagnostic variables, are available from the authors upon request.

graduate student using the SCID-NP, which was used classify participants on the same four variables described in Study 1 (current MDE, current depressive disorders, lifetime MDD, and lifetime depressive disorders). As in Study 1, these diagnostic variables were not treated as mutually exclusive, interviewers were blind to participants' scores on the self-report questionnaires, and all final diagnostic decisions were determined through consensus.

Again, a secondary rater listened to audiotaped SCID-NP interviews of 20 participants (10 randomly selected cases who, according to the original diagnostician, met for lifetime MDD, and 10 randomly selected cases that did not) and provided ratings for the four diagnostic variables. Kappa was 1.00 for current MDE, .77 for current depressive disorders, 1.00 for lifetime MDD, and .76 for lifetime depressive disorders.

Analyses—The same analyses were conducted as in Study 1. Again, all analyses were conducted using SPSS, Version 16.0, and locally written Matlab programs.

Results and Discussion

Table 1 contains means, standard deviations, and ranges for self-report measures. The descriptive statistics for this sample closely resemble those reported from past studies involving unselected adult samples (e.g., Watson, Clark, et al., 1995). Based on the SCID-NP, five participants (3.0%) met criteria for a current MDE, and 11 (6.6%) participants met criteria for current depressive disorders. Fifty-five participants (32.9%) met criteria for lifetime MDD and 81 (48.5%) participants met criteria for lifetime depressive disorders. The rates in this sample for current diagnoses were comparable to rates reported in epidemiological research, though the rates for the two lifetime variables were higher than estimates from past research (e.g., APA, 2000;Kessler et al., 2003).

As can be seen in Table 2, for the most part, the self-report scales effectively predicted current MDE and depressive disorders, with the 8-item MASQ-AD scale performing particularly well. Specifically, all four self-report scales predicted whether participants met criteria for a current MDE, with the AUCs for the full 22-item MASQ-AD scale and the 8-item subscale in the good range and the AUCs for neuroticism scale and the 14-item MASQ-AD subscale in the fair range. Likewise, all four self-report scales predicted whether participants met criteria for a current depressive disorder, with the AUCs for each scale falling into these same ranges. Unlike Study 1, the self-report scales did not predict lifetime MDD and depressive disorders very well. Specifically, only the full 22-item MASQ-AD scale and the 14-item subscale significantly predicted lifetime MDD diagnosis, although the AUCs were both in the poor range. The full 22-item MASQ-AD scale, the 8-item subscale, and the neuroticism scale predicted lifetime depressive disorders, although again the AUCs for all of these scales were in the poor range.

Again, the results of comparisons of the AUCs for the self-report measures revealed very few significant differences. In this sample, the MASQ-AD 8-item subscale outperformed the neuroticism scale ($\chi^2 = 3.71$, $p = .05$) and the MASQ-AD 22 item scale outperformed the 14-item subscale ($\chi^2 = 3.77$, $p = .05$) as a means of predicting current depressive disorders. Also, the neuroticism scale outperformed the MASQ-AD 14-item subscale ($\chi^2 = 4.83$, $p = .03$) as a means of predicting lifetime depressive disorders.

Table 3 presents sensitivity, specificity, positive predictive power, and negative predictive power for the 8-item scale when predicting current MDE status[4]. A cutoff score of 23 on the MASQ-AD 8-item subscale maximized the Youden Index, thus achieving a balance of sensitivity and specificity. At this cutoff, negative predictive power was once again excellent (.99). Positive predictive power, though low, was better than in Study 1 (.25).

The results of Study 2 provide additional support for the utility of the MASQ-AD scales as a means of screening for depressive disorders, thus replicating the main finding from Study 1 without its limitations. Furthermore, unlike in Study 1, the MASQ-AD 8-item subscale outperformed the neuroticism measure when predicting current depressive disorders. This is consistent with the notion that anhedonia is specific to depressive disorders (relative to anxiety disorders) (Clark & Watson, 1991), and thus measures that specifically developed to tap this dimension of depression are likely to have higher specificity.

The results for all of the self-report measures were again stronger when predicting current rather than lifetime clinical diagnostic status. Unlike Study 1, only the full 22-item MASQ-AD scale and the 14-item subscale predicted lifetime MDD at a level above chance, and the AUCs were not very strong in either case. Furthermore, although the full 22-item MASQ-AD scale, the 8-item subscale, and the neuroticism scale predicted lifetime depressive disorders at a level above chance, again none of the AUCs were very strong. This suggests that screening for lifetime history of depressive disorders is difficult in an unselected sample of participants with a broader age range.

General Discussion

In both evaluations of the MASQ-AD scale as a means of screening for depressive disorders, all of the self-report scales that were examined predicted current depressive disorders. In Study 1, all four self-report scales also predicted lifetime depressive disorders, and the MASQ-AD 8-item subscale and the neuroticism scale predicted current MDE and lifetime MDD. In Study 2, all four self-report scales also predicted current MDE. Furthermore, the 8-item scale significantly outperformed the neuroticism scale when predicting current depressive disorders.

Overall, these findings support the usefulness of the MASQ-AD scale as a means of screening for depressive disorders in nonclinical settings, and suggest that the 8-item subscale may be the best means of screening for depressive disorders (amongst the scales that were examined). Results were stronger for this subscale in several analyses compared to the 14-item subscale and the full 22-item scale. More importantly, this subscale requires less time to administer. The MASQ-AD scales appear to be more effective as a means of screening for current than for lifetime depressive disorders. Though the MASQ-AD scales predicted lifetime MDD and lifetime depressive disorders in Study 1, the results were much less impressive for these two variables in Study 2. This discrepancy could be due to systematic differences between the two samples (e.g., the larger age range of participants in Study 2 relative to Study 1). It is important to note that our results are applicable to categorically defined diagnostic entities (such as those in the DSM-IV) and not to dimensional definitions of psychopathology.

The AUCs obtained for the MASQ-AD scales predicting current MDE and depressive disorders were strong in both samples and were comparable to those reported for some common biomedical tests (Swets et al., 1979) as well as other self-report measures used to screen for psychopathology (e.g., the Penn State Worry Questionnaire as a means of screening for Generalized Anxiety Disorder; Fresco et al., 2003; the Beck Depression Inventory as a means of screening for Major Depressive Disorder; Kumar et al., 2002). Thus, the MASQ-AD appears to be a potentially useful tool for researchers who wish to screen for current depressive disorders. In recent years, increased attention has been devoted to identifying untreated depressed individuals in primary-care settings (e.g., Zich, Attkisson, & Greenfield, 1990). The results of the present study indicate that the MASQ-AD, and in particular the 8-item subscale, may also be quite useful for depression screening in primary-care settings.

In order to explore what might be an appropriate clinical cutoff score on the MASQ-AD when screening for depressive disorders, sensitivity, specificity, positive predictive power, and negative predictive power were examined for specific values in both samples. Results were consistently strongest for the MASQ-AD 8-item scale and when predicting current diagnostic status, so analyses focused on the 8-item scale predicting current MDE. Results from Study 1 showed that the optimal cutoff score (based on the Youden Index) was 21; in Study 2, the optimal cutoff score was 23. Of course, the most appropriate cutoff score to use for any specific application will depend on the nature of the sample, as well as the relative importance of sensitivity and specificity.

To concretize the implications of present findings for research on depressive disorders, a table of results for a hypothetical sample of 500 unselected community participants was constructed, using data from Study 2 to estimate how participants would be classified as meeting criteria for a current Major Depressive Episode based on a cutoff score of 23 on the MASQ-AD 8-item subscale. Table 4 shows that, of 48 individuals at or above that cutoff, 12 (71%) of the 17 individuals who would meet diagnostic criteria for a current MDE would be correctly identified. The remaining 36 would be judged false positives. Perhaps more importantly, 447 individuals who would not qualify for a current MDE would be correctly screened out. Clearly, this approach would be much more efficient than conducting full diagnostic assessments with all 500 participants.

The participants in Study 1 were college students selected on the basis on their scores on several questionnaires, including the MASQ-AD scale. Though the mean and standard deviations for the MASQ-AD from this sample were comparable to those from past research involving unselected student samples (e.g., Watson, Clark, et al., 1995), concerns could be raised about whether the results from Study 1 would generalize to an unselected sample. To address this concern, in Study 2 we replicated the findings using an unselected sample of community participants.

As expected, the rates of current depressive disorder diagnoses in both samples were comparable to estimates for the general population. Though the absolute rates of current depressive disorders were low (6.5% in Study 1 and 6.6% in Study 2), this sort of sample is appropriate for examining the utility of screening for depressive disorders in research and primary-care settings. The rates of lifetime depressive disorder diagnoses in Study 1 were comparable to the rates reported in previous research examining older adolescents, though the rates of lifetime depressive disorder diagnoses in Study 2 were higher than usually found in the general population. As previously noted, one of the major strengths of ROC methodology is that test results are robust even when the number of cases and controls is unequal in the sample (Rice & Harris, 1995). The fact that our results were very comparable to results from past studies on the MASQ-AD scale using ROC methods (Boschen & Oei, 2007; Buckby, Yung, Cosgrave, & Cotton, 2007; Buckby, Yung, Cosgrave, & Killackey, 2007) serves to bolster confidence in applicability of our findings. Nonetheless, to be confident that the MASQ anhedonic depression scale can be used to successfully select individuals with depressive disorders, whether for research purposes or in primary-care settings, additional replication is needed.

The present comparison of the MASQ-AD scales to a self-report measure of neuroticism indicated that the MASQ-AD 8-item subscale outperformed the neuroticism scale under certain circumstances (i.e., when predicting current depressive disorders in an unselected sample). Thus, the MASQ-AD scale may be more appropriate as a means of screening for current depressive disorders than a measure of neuroticism in unselected participants from a wide range of age groups. Coupled with results from research showing that the MASQ-AD scale can outperform other popular measures of depression (Buckby, Yung, Cosgrave, &

Killackey, 2007), these findings also suggest that the MASQ-AD scale may be more appropriate to use for such purposes than scales that primarily gauges high levels of general distress or negative affect. Future research should directly compare the effectiveness of MASQ-AD scales and other popular measures of depression (e.g., the Beck Depression Inventory) when screening for depressive disorders in nonclinical settings.

In summary, the findings from the present studies support the utility of the MASQ-AD scales as a means of screening for depressive disorders. Results were stronger for current than for lifetime depressive disorders, and suggest that the 8-item subscale offers the best discriminative power. Investigators may be able to maximize efficiency by utilizing this measure as an initial screening tool in clinical research.

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Table 1

Descriptive statistics for the self-report measures from Studies 1 & 2.

	STUDY 1			STUDY 2		
Self-Report Scale	**Mean**	**SD**	**Range**	**Mean**	**SD**	**Range**
MASQ-22-item scale	55.4	13.9	26–101	54.4	13.0	30–92
MASQ-8-item subscale	15.7	5.1	8–35	15.1	4.6	8–32
MASQ-14-item subscale	39.7	10.8	14–66	39.2	10.1	14–67
NEO-FFI Neuroticism	35.3	9.3	12–60	33.2	8.9	14–58

Note. In Study 2, n = 166 for the MASQ-AD 22-item scale and 14-item subscale, n = 167 for the MASQ-AD 8-item subscale, and n = 154 for the NEO-FFI Neuroticism scale.

Table 2

Areas under the ROC curves for the four self-report questionnaires predicting current and lifetime depressive disorders.

Self-Report Scale	CURRENT				LIFETIME			
	MDE		Depressive Disorders		MDD		Depressive Disorders	
	Study 1	Study 2	Study 1	Study 2	Study 1	Study 2	Study 1	Study 2
MASQ-22	.83	.83**	.88**	.84**	.70*	.62*	.70**	.61*
MASQ-8	.87*	.85**	.88**	.88**	.72**	.59	.72**	.61*
MASQ-14	.77	.79**	.86**	.79**	.64	.61*	.66*	.58
Neuroticism	.90*	.78*	.90**	.76**	.79**	.59	.79**	.68**

Asymptotic significance:

* $p < .05$,

** $p < .01$

Table 3

Sensitivity, specificity, positive predictive power (PPP), and negative predictive power (NPP) for specific values from the MASQ-8 predicting current MDE status. Statistics for those values that maximized the Youden Index in each sample are shown in bold.

Cutoff Score	Sensitivity		Specificity		PPP		NPP	
	Study 1	Study 2	Study 1	Study 2	Study 1	Study 2	Study 1	Study 2
11	1.00	1.00	.11	.12	.03	.03	1.00	1.00
12	1.00	1.00	.17	.21	.03	.03	1.00	1.00
13	1.00	1.00	.23	.32	.04	.04	1.00	1.00
14	1.00	.80	.31	.42	.04	.04	1.00	.98
15	1.00	.80	.41	.54	.05	.04	1.00	.98
16	1.00	.80	.53	.62	.06	.05	1.00	.99
17	1.00	.80	.56	.73	.06	.06	1.00	.99
18	1.00	.80	.63	.77	.07	.08	1.00	.99
19	1.00	.80	.68	.85	.08	.10	1.00	.99
20	1.00	.80	.73	.87	.10	.16	1.00	.99
21	**1.00**	.80	**.80**	.90	**.13**	.19	**1.00**	.99
22	.67	.80	.83	.90	.10	.20	.99	.99
23	.33	**.80**	.85	**.93**	.06	**.25**	.99	**.99**
24	.33	.40	.87	.95	.07	.20	.98	.98
25	.33	.40	.89	.96	.08	.22	.98	.98
26	.33	.40	.89	.97	.08	.29	.98	.98
27	.33	.40	.90	.99	.09	.50	.98	.98
28	.33	.20	.93	.99	.13	.50	.98	.98
29	.00	.20	.93	.99	.00	.50	.98	.96

Table 4

Hypothetical breakdown of classification accuracy using the MASQ-8 in an unselected sample of 500 participants to screen for current MDEs.

	Accurate	Inaccurate	Total
Below cutoff (<23)	447	5	452
At or above cutoff (≥23)	12	36	48

* numbers rounded up for inaccurate classifications and down for accurate classifications