The Hamilton Anxiety Rating Scale: Uses and Criticism

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INTRODUCTION

The Hamilton Anxiety Rating Scale (HAM-A) was created by Max Hamilton and first introduced in 1959. Since then, the HAM-A has been regularly used in clinical settings to help determine the severity of a client's anxiety. It is still widely used today, though its availability at no cost through the public domain may be at least partially responsible for the level of current usage. In this presentation, the use cases and limitations of use for the HAM-A will be explored.

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DISCUSSION

Since its introduction shortly after WWII, the HAM-A has been a useful tool in aiding clinicians as they examine the degree of severity of their client's anxiety symptoms, both psychological and somatic. With just 14 brief questions, the HAM-A offers a 0-4 rating scale that is simple to administer and quite possibly, just as simple to inaccurately complete if one doesn't have a clear picture already of a client's full background. The main complication at first glance lies in the inability of the scales to discern between symptoms of anxiety and side effects of anxiety medications (including antidepressants). Per Zimmerman et al (2017), over half of the HAM-A rates items that could easily be mistaken for anxiety symptoms when they may, in fact, be symptoms of antidepressants. Another issue that Zimmerman saw, which is easy to spot at a glance, is that the items frequently cover multiple symptoms. It would be possible to rate a group of symptoms high, yet not have one or more of the symptoms listed. Zimmerman posits that a way to correct his would to have scales for each of the individual symptoms to avoid any confusion. However, Bech (2009) came to the conclusion that Hamilton's goal was not to get measurements that were specific to just anxiety or just medication side effects, but were instead indicative of the individual's overall load. The weight that their anxiety and any associated medications left them to carry every day. While this is certainly a valid way to measure an individual's overall state of wellness, Zimmerman et al (2020) noted that the wording of the HAM-A does tend to allow symptoms associated with depression to overlap with those of anxiety, thus contributing to possible confusion around the individual's actual presenting symptoms. It is possible that such a situation might be the result of medication side effects and not actual depression, but that is not something the HAM-A would specifically call out for the clinician. In that manner, the HAM-A is most certainly a starting point for discussion with the client.

CONCLUSIONS

While the HAM-A does have some obvious weak points, there is no denying that it most definitely has staying power. Any assessment that is still being used since 1959 and per Thompson (2015), has been translated into three languages (Cantonese, French, and Spanish) from the original English, yet still is utilized and considered a valid tool has to have some very strong positives to outweigh the negative aspects of the assessment. In 1988, Meier et al suggested the same limitations that their peers are still discussing now, more than 30 years later. Yet, the HAM-A is still widely used. If that's not a measure of validity, what else is?

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