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# Assessing Anhedonia in Major Depressive Disorder: A Focused Review of Measurement Tools and Patient-Centered Care

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## Abstract

**Objective:** Anhedonia is a core symptom of major depressive disorder (MDD) that may persist despite improvement in overall depressive symptom scores. This mini review describes the use and characteristics of selected anhedonia instruments and considers their potential relevance to patient-centered assessment.

**Methods:** Google Scholar, PubMed, and ClinicalTrials.gov were searched for publications and registered studies from January 2016 through July 2026. Searches included the Snaith-Hamilton Pleasure Scale (SHAPS), Chapman Physical and Social Anhedonia Scales (CPAS/CSAS), Fawcett-Clark Pleasure Capacity Scale (FCPS), Dimensional Anhedonia Rating Scale (DARS), Temporal Experience of Pleasure Scale (TEPS), and Anticipatory and Consummatory Interpersonal Pleasure Scale (ACIPS), combined with terms for MDD. Records were cross-referenced and duplicates removed. Eligible records involved adults with MDD and reported use of at least one selected instrument.

**Results:** The search identified 14,161 records meeting the prespecified search criteria; however, because this number represents a bibliometric search yield rather than a systematically screened set of eligible studies, the search result should be interpreted as a search yield rather than a definitive estimate of eligible studies. The search yielded a precision estimate of 80%, and the scale-name search yield was 39%. Among records retained for instrument-use analysis, second-generation instruments accounted for approximately 93% of identified scale use. TEPS represented 71% and DARS 28% of second-generation instrument use. These findings describe observed use within the selected data sources and search strategy, not comparative clinical effectiveness.

**Conclusion:** Available instruments differ in the dimensions of anhedonia assessed, including hedonic tone, social and physical pleasure, anticipatory pleasure, consummatory pleasure, motivation, and effort. More multidimensional instruments may provide a fuller description of anhedonia than general depression scales alone. Whether use of these instruments improves shared decision-making, adherence, satisfaction, or clinical outcomes requires direct study.

## Introduction

Anhedonia is defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) as markedly diminished interest or pleasure in nearly all activities. It is a core symptom of MDD and is also observed across other psychiatric conditions. In MDD, anhedonia may involve reduced pleasure, diminished anticipation of rewarding experiences, lower motivation, reduced effort expenditure, and impaired social engagement. These domains may not be fully captured by global depression rating scales[1,2].

Anhedonia has clinical relevance because improvement in

depressed mood or total depression scores may not always correspond to recovery in pleasure, motivation, functioning, or engagement in meaningful activities. Patients with MDD and anhedonia may report lower satisfaction with progress toward treatment goals than patients without anhedonia, while patient and physician priorities can differ. For example, patients may prioritize sleep, functioning, motivation, and return to valued activities, whereas clinicians may place greater emphasis on symptom severity or safety-related outcomes[3,4,5].

Shared decision-making (SDM) provides a useful framework for discussing these potentially different priorities. However, although anhedonia-specific measures may make relevant symptoms more visible during clinical assessment, evidence is currently insufficient to conclude that their use itself improves SDM, treatment adherence, patient satisfaction, or clinical outcomes. Their role should therefore be viewed as a potentially useful component of patient-centered assessment rather than an established intervention.

Rizvi and colleagues reviewed the strengths and limitations of established anhedonia measures in 2016, including SHAPS, FCPS, CPAS, and CSAS. Since then, multidimensional measures such as DARS, TEPS, and ACIPS have received increasing attention. This mini review describes selected first- and second-generation instruments, summarizes their observed use in an MDD-focused search, and considers how they may support more individualized discussions of treatment goals.

## Methods

### Search strategy

The purpose of this targeted literature search was for a bibliometric count of how many times the scales were discussed or used was conducted in Google Scholar, PubMed, and ClinicalTrials.gov for the period from January 2016 through July 2026. Google Scholar was included because of its broad indexing of peer-reviewed articles, theses, conference materials, preprints, and other scholarly sources; PubMed was included as a biomedical database; and ClinicalTrials.gov was searched to identify registered research involving anhedonia measures.

Because the objective was a bibliometric enumeration of publications that explicitly discussed or reported use of prespecified scales, we used a targeted, precision-oriented retrieval strategy based on full scale names, abbreviations, and known naming variants. We assessed the final screening yield as precision: the proportion of retrieved records meeting the predefined eligibility criteria[6]. Following Garritty et al, these data were calculated as :

Precision = final yield/screened yield;

Full scale names=final yield/initial yield;

Because of the high number of papers identified with the initial broad based count, digital tools (VOS Viewer) was used to generate the exact count.

The following instrument-specific search strings were used to extract records from the broad based count:

- (“Snaith-Hamilton Pleasure Scale” OR SHAPS) AND (“major depressive disorder” OR MDD)
- (“Fawcett-Clark Pleasure Capacity Scale” OR FCPS) AND (“major depressive disorder” OR MDD)
- (“Chapman Physical Anhedonia Scale” OR CPAS OR “Chapman Social Anhedonia Scale” OR CSAS) AND (“major depressive disorder” OR MDD)
- (“Dimensional Anhedonia Rating Scale” OR DARS) AND (“major depressive disorder” OR MDD)
- (“Temporal Experience of Pleasure Scale” OR TEPS) AND (“major depressive disorder” OR MDD)
- (“Anticipatory and Consummatory Interpersonal Pleasure Scale” OR ACIPS) AND (“major depressive disorder” OR MDD)

### Eligibility criteria

Records were considered for inclusion if they:

- Included adults aged 18 years or older with MDD.
- Reported use of at least one prespecified anhedonia measure.
- Were indexed or registered between January 2016 and July 2026.
- Were available in English.

Records were cross-referenced across databases and duplicates were removed before tallying instrument use. Because this work was conducted as a mini review, it did not include dual independent screening, formal risk-of-bias assessment, or meta-analysis. Consequently, results should be interpreted as a descriptive overview rather than a systematic estimate of instrument utilization.

### Instrument classification

For descriptive purposes, instruments were grouped according to their primary measurement focus:

- **First-generation measures:** SHAPS, CPAS/CSAS, and FCPS. These measures primarily assess hedonic tone, physical pleasure, social pleasure, or generalized pleasure capacity.
- **Second-generation measures:** DARS, TEPS, and ACIPS. These measures assess multiple components of reward processing, including anticipatory pleasure, consummatory pleasure, interest, motivation, effort, and interpersonal pleasure.

This classification is conceptual rather than definitive. Individual measures differ in recall period, item format, psychometric properties, and suitability for state versus trait assessment.

## Results

A total of 35,873 records were retrieved across all databases. After removal of 18,172 duplicate records—primarily reflecting overlap between Google Scholar and PubMed—17,701 unique records remained for screening. Of these, 3,540 did not meet the prespecified study inclusion criteria, leaving 14,161 records for the final bibliometric count. The final yield represented a screening precision of 80%, while the scale-name search yield was 39%. This relatively high precision was expected because the search strategy explicitly incorporated the full names, abbreviations, and variants of the prespecified scales and was designed to identify records with explicit scale-related mentions, rather than to capture the broader conceptual literature.

Among the records included in the descriptive instrument-use analysis, approximately 93% used second-generation instruments. TEPS accounted for approximately 71% of second-generation instrument use, and DARS accounted for approximately 28%. The remaining use involved ACIPS and first-generation instruments.

These descriptive findings suggest growing use of measures that distinguish among components of pleasure and reward processing. They do not establish that second-generation measures are superior for diagnosis, treatment selection, monitoring, or patient-centered outcomes.

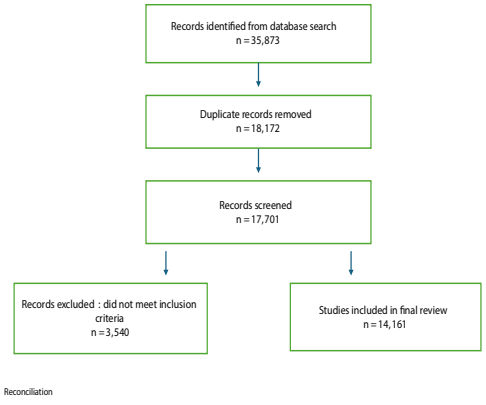


**Figure 1:** Simple Study Flow Chart

### Selected Anhedonia Instruments

SHAPS remains one of the most widely recognized measures of hedonic tone. It assesses pleasure in common domains such as hobbies, sensory experiences, food and drink, and social interaction. However, it does not comprehensively assess motivation, effort, or anticipatory reward processing[8].

The Chapman scales provide more extensive coverage of physical and social anhedonia but were developed largely as trait-oriented measures and may be more practical in research than in time-limited clinical settings. FCPS assesses anticipated pleasure in hypothetical situations and may be useful when trait-like pleasure capacity is of interest, although its relevance to momentary or state-dependent anhedonia may be limited[9,10].

DARS is a 17-item measure designed to assess desire, motivation, effort, and consummatory pleasure in four domains: hobbies and pastimes, food and drink, social activities, and sensory experiences. It has shown favorable reliability and validity in several settings and may provide a more granular description of anhedonia than measures focused only on consummatory pleasure[1,3].

TEPS distinguishes between anticipatory and consummatory pleasure. This distinction may be clinically useful when a patient reports, for example, being unable to look forward to an activity despite retaining some capacity to enjoy it once engaged. ACIPS focuses more specifically on interpersonal reward and social pleasure[11-13].

### Clinical Example

The following example and its recommendations should be interpreted as a conceptual / practical framework rather than evidence based conclusions derived directly from the bibliometric search, as discussed above. The search strategy primarily addressed the use of selected

**Table 1:** First-generation instruments

| Instrument | Primary construct | Format and clinical utility | Key limitations |
|---|---|---|---|
| SHAPS | Current hedonic tone and capacity for pleasure | Fourteen-item self-report measure that evaluates pleasure across activities, sensory experiences, food and drink, hobbies, and social interaction. It is brief and widely used in depression research. | Focuses mainly on consummatory pleasure and may not capture motivation, effort, or reward anticipation. |
| CPAS/CSAS | Physical and social anhedonia | Longer self-report measures designed to assess trait-like deficits in physical and social pleasure. Their detailed assessment may be useful in research settings. | Length and binary response format may limit feasibility and sensitivity in routine clinical practice. |
| FCPS | Generalized pleasure capacity | Self-report measure using hypothetical pleasurable scenarios across several domains. It may be useful for trait-level assessment of hedonic capacity. | Responses may depend on imagination, cognition, and hypothetical judgment rather than current real-world functioning. |

**Table 2:** Second-generation instruments

| Instrument | Primary construct | Format and potential use | Key limitations |
|---|---|---|---|
| DARS | Desire, motivation, effort, and consummatory pleasure | Seventeen-item self-report measure covering hobbies, food and drink, social activities, and sensory experiences. It may support multidomain assessment of state anhedonia. | Evidence for performance across all MDD populations, languages, and comorbidity profiles remains incomplete. |
| TEPS | Anticipatory and consummatory pleasure | Eighteen-item self-report scale with anticipatory and consummatory pleasure subscales. It can help distinguish whether difficulty lies in looking forward to reward or experiencing reward. | May not capture the full range of social, motivational, and effort-related aspects of anhedonia. |
| ACIPS | Interpersonal anticipatory and consummatory pleasure | Seventeen-item self-report measure focused on social and interpersonal pleasure. It may be particularly relevant when social withdrawal or loss of interpersonal reward is prominent. | Narrower focus on social reward may not capture non-social reward processing. |

anhedonia instruments, while the following discussion provides a potentially useful clinical framework for shared decision making.

## Strategic Approach

A patient with MDD reports improved mood after treatment but continues to say, "I do not look forward to anything and I have stopped seeing friends." A global depression scale may show partial improvement, yet it may not distinguish reduced reward anticipation from reduced pleasure during activities.

An anhedonia-specific measure such as DARS, TEPS, or ACIPS could help clarify whether the patient's residual symptoms involve motivation, anticipation of reward, consummatory pleasure, or social reward. This information may support a more focused conversation about the patient's goals, such as returning to work, resuming hobbies, or reconnecting socially. It should not be assumed, however, that using the measure alone will improve treatment adherence or outcomes.

Now consider patients with treatment-resistant anhedonia where a care plan that targets both depression severity and the patient's specific reward-related goals is needed—such as reconnecting socially, returning to work, or regaining interest in meaningful activities. A patient-centered approach uses shared decisions, repeated symptom measurement, and treatment adjustments based on the particular component of anhedonia that persists.

## Tactical Approach

### Start With a Precise Assessment

Avoid treating anhedonia as a single symptom. Clarify whether the predominant problem is:

- Reduced anticipatory pleasure: "I cannot look forward to anything."
- Reduced consummatory pleasure: "Even when I do it, I do not enjoy it."
- Low motivation or initiation: "I want to care, but cannot get started."
- Low effort expenditure or persistence: "Everything feels like too much work."
- Social anhedonia: "I no longer feel connected to people."
- Loss of meaning, role function, or engagement in valued activities.

We recommend to use a general depression scale alongside a targeted measure when feasible—for example, SHAPS for hedonic tone, TEPS for anticipatory versus consummatory pleasure, DARS for desire, motivation, effort, and pleasure across domains, or ACIPS when social reward is a major concern. Measurement-based care involves regularly collecting validated patient-reported outcomes and using them to guide treatment adjustments.

### Co-Create Recovery Goals

Move beyond "reduce the depression score" to define outcomes that matter to the person. Ask:

- "What would you be doing more of if treatment were working?"
- "Which loss is most distressing: interest, energy, motivation, enjoyment, or connection?"
- "What is one activity or relationship you would want back first?"
- "What trade-offs are unacceptable—for example, emotional blunting, sedation, sexual adverse effects, cost, visit frequency, or treatment burden?"

Translate responses into small, observable targets. For example: "Attend a 30-minute coffee visit twice this month," "resume woodworking for 10 minutes weekly," or "take one walk with a family member." These goals give the team a meaningful measure of progress even when symptom scales change slowly.

**Table 3.** Match Interventions to the Pattern

| Predominant Barrier | Patient-Centered Strategy | Practical Focus |
|---|---|---|
| Avoidance, inactivity, or loss of routine | Behavioral activation | Schedule small, values-linked activities; review barriers and reward experiences rather than waiting for motivation to return. |
| Difficulty anticipating positive experiences | Anticipatory-reward work | Use concrete planning, positive future imagery, and graded re-engagement with previously valued activities. |
| Limited enjoyment during activities | Mindfulness or savoring-based strategies | Help the patient notice sensory, emotional, and interpersonal aspects of positive experiences in real time. |
| Social withdrawal or reduced connection | Social-reward focus | Identify low-pressure social contact, address interpersonal barriers, and track anticipated versus actual reward from interactions. |
| Persistent symptoms after adequate treatment trials | Collaborative TRD reassessment | Confirm diagnosis, treatment adequacy, adherence barriers, comorbidity, substance use, sleep disturbance, medical contributors, and patient preferences before changing strategy. |
| Interest in device-based or specialty care | Shared decision-making about specialty options | Discuss evidence, adverse effects, access, cost, visit burden, and the patient's priorities regarding approaches such as rTMS, ketamine/esketamine where appropriate, or other guideline-concordant TRD options. |

Behavioral activation, mindfulness-based strategies, and savoring approaches are among the interventions with potential relevance to reward-related symptoms, although the evidence base specifically for treatment-resistant anhedonia remains heterogeneous. For patients with treatment-resistant depression, neuromodulation options such as repetitive transcranial magnetic stimulation may be considered within an individualized, evidence-based treatment plan rather than presented as an anhedonia-specific cure[14-17].

### Use Measurement-Based Follow-Up

At each follow-up, review three types of outcomes:

- Symptoms: depression severity, anhedonia dimensions, anxiety, sleep, cognition, suicidality, adverse effects.
- Function: work or school participation, self-care, physical activity, relationships, and daily routines.
- Patient-defined goals: whether the person is moving toward the activities, roles, and relationships they identified as meaningful.

A useful approach is to review both anticipated and experienced rewards. For example, a patient may predict that a social visit will be unrewarding but later report modest enjoyment. That discrepancy can become a concrete therapeutic target: not forcing pleasure, but testing predictions and building opportunities for engagement.

The VA/DoD guideline frames measurement-based care as the routine use of reliable, clinically appropriate patient-reported measures to monitor progress and inform treatment changes; it also emphasizes shared decision-making in individualized depression treatment planning[14].

### Protect Autonomy and Safety

Patient-centered care does not mean asking patients to carry responsibility for "trying harder." Anhedonia itself can impair initiative, anticipation, and effort. Make care accessible by reducing practical barriers, offering choice about format and intensity of treatment, involving supportive others only with permission, and addressing transportation, cost, work schedules, stigma, and digital access.

Continue structured safety assessment, particularly when anhedonia coexists with hopelessness, social isolation, severe functional decline, or suicidal thinking. The clinical plan should clearly identify who to contact, what to do if risk escalates, and how treatment decisions will be revisited.

There are currently no FDA-approved treatments specifically indicated for anhedonia, and contemporary depression guidelines do not yet offer highly specific anhedonia-targeted algorithms. This makes careful phenotype-based assessment, collaborative goal setting, and repeated reassessment especially important[15].

## Discussion

This review highlights the conceptual diversity of anhedonia measures used in MDD research. First-generation instruments primarily assess hedonic tone or physical and social pleasure. In contrast, second-generation instruments assess additional domains that may be clinically relevant, including anticipation of reward, motivation, effort, and interpersonal pleasure.

The descriptive finding that second-generation measures were frequently represented in the selected search does not establish their clinical superiority. Selection of an instrument should instead depend on the purpose of assessment, the patient's symptoms, respondent burden, recall period, psychometric performance in the relevant population, and the intended use of results.

In clinical practice, general depression scales such as the Hamilton Depression Rating Scale, Montgomery-Åsberg Depression Rating Scale, and Patient Health Questionnaire-9

include items related to interest or pleasure but are not designed to provide a detailed profile of anhedonia. An anhedonia-specific measure may therefore be useful when a patient identifies loss of pleasure, motivation, social engagement, or reward anticipation as a primary concern.

A practical approach is to select a measure based on the following questions:

1. Is the purpose to assess current symptoms, monitor change over time, or characterize a more stable trait?
2. Which domains are most relevant to the patient: social engagement, hobbies, food and sensory experience, reward anticipation, motivation, or effort?
3. Is a brief measure necessary for routine practice, or is a more detailed multidimensional assessment feasible?
4. Does the tool have acceptable validity, reliability, cultural appropriateness, and sensitivity to change for the intended clinical population?

Second-generation measures may be helpful when a broader description of reward-related symptoms is needed. However, their use should complement—not replace—clinical interview, safety assessment, functional evaluation, and collaborative goal setting.

## Limitations

This article has several limitations. It is a targeted mini review rather than a systematic review. The search was limited to three sources, English-language records, a defined set of instruments, and adult MDD populations. The broad search yield of 14,161 records was not derived from a fully reported PRISMA-style screening process with independent reviewers, detailed exclusion criteria, or risk-of-bias assessment.

The reported proportions of instrument use are therefore descriptive and may be influenced by database coverage, search syntax, duplicate handling, publication type, and the inclusion of records not directly comparable at the study level. The review also did not assess whether use of individual anhedonia measures changes treatment decisions, improves shared decision-making, increases adherence, or improves patient outcomes.

Future work should use systematic search and screening methods, report a study-selection flow diagram, assess the quality of included evidence, and directly evaluate whether specific anhedonia measures improve patient-centered care.

## Conclusion

Anhedonia in MDD includes more than reduced pleasure; it may involve altered anticipation, motivation, effort, consummatory experience, and social reward. Available instruments vary substantially in the dimensions assessed and their likely suitability for research or clinical practice.

Anhedonia-specific measures, particularly multidimensional instruments, may help clinicians identify residual reward-related symptoms that are not fully represented in global depression scores. They may also provide a structured basis for discussing patient priorities and functional goals. However, evidence that these measures directly improve shared decision-making, satisfaction, adherence, or clinical outcomes remains limited. Their role in patient-centered MDD with Anhedonia care should therefore be considered promising but not yet established.

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## Supplemental Tables

**Supplemental Table 1 :** Selected Characteristics of First Generation Instruments

| Characteristics | SHAPS | CPAS & CSAS | FCPS |
|---|---|---|---|
| Scale Description | Measures ability to experience pleasure (hedonic tone) and its absence (anhedonia) | Captures facets of reward associated with physical anhedonia and social anhedonia | The Fawcett-Clark Pleasure Capacity Scale (FCPS) is designed to assess an individual's capacity to experience pleasure, particularly targeting patients with depression. |
| Patient population | Adolescents and Adults diagnosed with a psychiatric disorder (MDD, Schizophrenia and Substance abuse) | Adults diagnosed with MDD; Schizophrenia; and other psychiatric disorders (personality disorder and substance abuse) | Adults with MDD |
| Structure | Self Report;<br>Has 14 times<br>Four-point likert scale anchored with 1=strongly disagree, 2=disagree, 3= agree, and 4= strongly agree<br>Recall period is "in the last few days"<br>Scores range from 0-14, with higher scores indicating higher anhedonia | Self-report;<br>Has 61 (CPAS) and 40 (CSAS) items<br>Binary response choice: "true=1" or "false=0"<br>No specific recall period specified;<br>Reverse code of items where necessary and sum. Higher scores indicate more severe anhedonia | Self report: 36-items. The items cover various domains of pleasurable experience, including physical sensations, social interactions, and achievement or mastery activities (for example, physical joy, social pleasure, and satisfaction from accomplishing challenging tasks).<br>Each item on the FCPS is rated using a 5-point Likert scale, with options ranging from 1 ("No pleasure at all") to 5 ("Extreme and lasting pleasure"). Higher scores on the total scale indicate greater hedonic capacity. |
| Concepts Covered | Social Interactions; Sensory Experience; Enjoyment of Food and Drink, and Past Enjoyments | Social Interactions; Sensory Experience; Enjoyment of Food and Drink, and Past Enjoyments | overall pleasure capacity. |
| Strengths | The most frequently used PRO to measure Anhedonia;<br>Short assessment;<br>Developed to be culturally diverse;<br>Demonstrated good divergent/convergent validity, particularly in MDD population. Can effectively differentiate patients with MDD and without MDD which is useful in clinical practice | Ability to measure distinct components of anhedonia, captures both physical and social pleasure deficits;<br>Good psychometric properties (face validity, internal consistency, and predictive validity); with a focus on consummatory pleasure;<br>Measures hedonic experiences over lifetime vs recent experience | Provides a broad assessment of hedonic capacity across multiple life areas; reduces confounding effects of memory bias or recent mood fluctuations by asking patients to rate hypothetical scenarios; has good measurement properties |
| Limitations | Only measures consummatory pleasure; may not capture motivation or effort; lack of standardize scoring<br>Does not probe the other facets of reward processing ;<br>Potential cultural bias/outdated items;<br>Despite generalized nature, the questionnaire may not be specific enough to elicit a strong hedonic reaction; potential difficulty identifying varying levels of severity | Questionable factor structure; Lack of severity measurement; limited scope;<br>Overlapping concepts; Potential cultural bias/outdated items;<br>Binary response can lead to oversimplification of complex issues leading to potential misinterpretation, and loss of nuance;<br>Length of instrument can be burdensome for some respondents<br>More useful within research settings relative to clinical practice. | The FCPS may not reflect patient's real world hedonic functioning as cognitive bias and imagination capacity may affect patient response.<br>Has not been fully validated within a pediatric patient population; Id suited for trait-level assessment rather than capturing changes in "here and now" pleasure; Patients with cognitive deficits/severe depression, or lack imagination, may not be able to complete the assessment; may have not be applicable across all cultures. |

**Supplemental Table2 :** Selected Characteristics of Second Generation Instruments

| Characteristics | DARS | TEPS | ACIPS |
|---|---|---|---|
| Scale Description | Measures desire, motivation, effort and consummatory pleasure across hedonic categories | Measures individual trait dispositions in both anticipatory and consummatory experiences of pleasure | Measures anticipatory pleasure and consummatory social pleasure |
| Patient population | Adults with psychiatric disorder (MDD, psychotic and anxiety disorder; Schizophrenia, Substance abuse) | >13 year old with diagnosis for Schizophrenia, bipolar, opioid-dependence | >13 year old diagnosed with bsessive-compulsive disorder (OCD), schizophrenia, and depression. The scale is widely used to assess hedonic (pleasure-related) capacity for social and interpersonal pleasure, particularly focusing on social anhedonia across diverse groups. |
| Structure | Self Report; Has 17-items ;<br>Domains based on results from the factor analysis of focus group data obtained during the SHAPS development<br>Administration;<br>5-point scale Likert scale anchored at 0= not at all, 1=slightl, 2=moderately, 3=mostly, 4=very much;<br>Recall period: "right now"<br>Total score is the sum of all domain or score for each domain, lower scores indicate more severe anhedonia | Self Report;<br>Has items: 18 items with two subscales (10 items for anticipatory pleasure, 8 for consummatory pleasure)<br>6-point Likert scale (1= very false for me to 6= very true for me)<br>Recall period: Not reported<br>The scale is scored by summing the item scores for each subscale. Lower scores indicate more anhedonia. | Self Report; 17 items with two subscales (7 items for anticipatory pleasure, 10 for consummatory pleasure)<br>Response scale: 6-point Likert scale (1= very false for me to 6= very true for me)<br>Recall period: Not reported |
| Concepts Covered | Hobbies; Food & Drink; Social Activities and sensory experience | Symptoms, traits and Physical pleasure | Anticipatory and Consummatory |
| Strengths | Combination of open and closed ended items; DARS has demonstrated good reliability, and validity in different settings and across different cultural contexts and populations; provides comprehensive assessment of Anhedonia; has its utility in clinical and research settings;<br>Better predictive power is identifying different subtypes of depression relative to the SHAPS | Measure two domains which helps to characterize anhedonia subtypes across psychiatric disorders; Is short and can be used in research and clinical settings; The scale has demonstrated good reliability and internal consistency; is useful in distinguishing symptoms across psychiatric conditions has schizophrenia, major depressive disorder, and obsessive-compulsive disorder; a robust tool for assessing pleasure experience temporally and dimensionally, providing insights into both psychological well-being and psychiatric symptomatology | Brief questionnaire; convenient for use in both clinical and nonclinical contexts; The scale demonstrates high internal consistency; shown reliability across diverse population; permits meaningful comparisons between men, women, healthy individuals, and those with mental health conditions; Strong convergent and discriminant validity; A robust instrument for researching and assessing social and interpersonal pleasure. |
| Limitations | Problematic generalizability to populations with comorbidities; inherent difficulty in accurately measuring subjective notion of enjoyment; and not fully capture state anhedonia for certain populations. | The scale may not capture the full spectrum of anhedonia; Its factor structure can differ across cultures; Has been criticized for scant item coverage of social anhedonia; Test-retest reliability: greater temporal stability for the anticipatory domain than the consummatory domain; Not generalized enough to be applicable for all patient population; Exclude many aspects of experience of pleasure such as approach to motivation & satiation, approach behavior, memory formation; Assessed in very limited capacities in MDD pop. | Instrument may not capture all facets of social pleasure; less well established psychometric properties in broader or more diverse clinical populations (or across age ranges) are less well established; |