Part 2. Scalification

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Once a complaint (eg, depression, anxiety, loneliness) has been "goalified"[1] (eg, happiness, calmness, community), the next step is "scalification."

Scalification is most easily defined with an example:

> **Pt:** Doc, I'm so depressed [elaborates].
> **Dr:** [Accurate empathic statement, then goalifying] It sounds like your goal is to make yourself happier. Have I got that right?
> **Pt:** [Responding rapidly] Yes, I guess you could say that.
> **Dr:** [Scalifying] OK, well let's imagine a 0-to-10 scale of happiness, where 0 was your most depressed, and 10 was your happiest. Where are you along that scale today?

Accountability is the primary purpose of scalifying (eg, patient-to-self, patient-to-doctor, and doctor-to-patient). The main application of scalification is for those psychological interventions with a medium level of formality—not likely to be a "one-off," but not likely to be full-on "psychotherapy" either. One-offs don't need scales, and formal psychotherapy lacks credibility without more formal psychometry (eg, Beck Depression Inventory, Beck Anxiety Inventory).

Scalification continues with a "why-not-worse" question to reinforce the patient's locus of control:

> **Dr:** [Empathy, then ...] You say 3. What are some of things you're doing to keep it from being a 2?

The final component in scalifying is a "how-make-better" question:

> **Dr:** What are you willing to commit to [or experiment with] doing to try to make it a 4 between now and our next appointment?

The "how-make-better" question might have to be repeated: it's not uncommon for the patient to slip back into "complaint mode" at this time. Sometimes even re-goalifying is required:

> **Dr:** Sorry to interrupt, but when you say you're so depressed, you're also saying that happiness is your goal, right?

The doctor ends with a behavioural prescription—which is ideally recorded in the chart.

An excellent opening question on follow-up is as follows:

> **Dr:** Last time we agreed that you have a goal of happiness, and you said you were 3 on a 0-to-10 scale. You were doing A and B to keep it from getting worse, and said you'd try doing C and D to try to make it better. Where are you on our happiness scale today?

If there was good adherence and a good outcome, make sure you point out the correlation. If the link seems causal, say so. Many chronic patients have erroneously concluded that mood is randomly determined. To us causal connections are obvious, but to those with "learned helplessness" they are not.

In the common scenario of poor adherence and a poor outcome, linger awhile. It's vitally important that patients learn from natural consequences. Consider asking a question like "What do you make of that?" and pausing. Diving in too early with anesthetizing empathy can impair learning, and in the long run can be iatrogenic (this issue will be addressed in greater depth in a future article).

In the unfortunate scenario of good adherence and poor outcome, begin with a good dose of empathy. Emphasize that efforts are essential even without a 100% guarantee of mood improvement. Discuss lag effects (if appropriate). Collaboratively explore whether another experiment with the same behavioural prescription is warranted, and tweak as required.

Scalification is both a measurement tool and an intervention with an important role in psychological situations with medium formality.

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Reference
1. Dubord G. Part 1. Goalification. *Can Fam Physician* 2010;56:1312.

Next month: **The Reward Chart**