

SCALE USED IN PSYCHIATRY



Compiled by-

Dr. Pradeep Yadav

Dr. Rajon Jaishy

Dr. Krishna Yadav

Department of Psychiatry I.M.S. BHU

SN	Topic	Page
1	Progress Report (proforma)	3
2	DASS21	4
3	Hamilton Anxiety Rating Scale (HAM-A)	6
4	GAD-7 Anxiety	8
5	THE HAMILTON RATING SCALE FOR DEPRESSION	9
6	HAMILTON DEPRESSION RATING SCALE (HAM-D)	13
7	MADRS	14
8	Beck's Depression Inventory	17
9	YMRS	20
10	Yale Brown OCD Scale YBOCS	22
11	Y-BOCS Symptom Checklist	23
12	BDD-YBOCS	24
13	BRIEF PSYCHIATRIC RATING SCALE (BPRS)	29
14	PANSS	30
15	SANS	43
16	S A P S	46
17	Bush-Francis Catatonia Rating Scale	50
18	AIMS Examination Procedure	54
19	Barnes Akathisia Rating Scale (BARS)	56
20	MODIFIED SIMPSON-ANGUS SCALE (MSAS) Extrapyramidal Side Effects Scale	58
21	ADDENBROOKE'S COGNITIVE EXAMINATION - ACE-III	60
22	Mini-Mental State Examination (MMSE)	66
23	HMSE	68
24	Adult ADHD Self-Report Scale	70
25	Severity of Dependence Scales (SDS)	73
26	Fagerstrom Test for Nicotine Dependence	75
27	Alcohol Use Disorders Identification Test (AUDIT)	76
28	SEVERITY OF ALCOHOL DEPENDENCE QUESTIONNAIRE (SADQ-C)	80
29	Drug Abuse Screening Test, DAST-10	83
30	Alcohol Withdrawal Assessment Scoring Guidelines (CIWA - Ar)	84
31	CAGE Substance Abuse Screening Tool	86
32	Clinical Institute Withdrawal Assessment Scale - Benzodiazepines	87
33	Clinical Opiate Withdrawal Scale (COWS)	90
34	The Cannabis Use Disorder Identification Test - Revised (CUDIT-R)	91

Progress Report (proforma)

Period of Fallow- up (1 week) (From -----to-----)

- 1- **Global:** Improvement / Status quo/ Deterioration/ Others: %
- 2- **Basic activities-**
 - a- Sleep:
 - b- Appetite and feeding behaviours:
 - c- Personal care (bathing, grooming):
- 3- **Problem Behaviour:**
 - a- Violent & assaultive behaviour:
 - b- Suicidal behaviour /risk:
 - c- Absconding tendency/ behaviour:
 - d- Drug compliance:
- 4- **Old Symptoms:** Improvement / Status quo/ Deterioration/ Others (in terms of intensity, frequency, duration, and other parameters)
- 5- **New Symptoms:** (in terms of intensity, frequency, duration, and other parameters)
- 6- **Residual symptoms:**
- 7- **Behaviour in ward:**
 - a- With Relative& visitors
 - b- With neighbouring patients & their relative
 - c- With Doctors:
 - d- With Nursing staff:
- 8- **Visit to OT:**
 - a- Morning/afternoon shift: yes/no
 - b- Duration of stay in each shift:
 - c- Activities in OT:
 - d- Behaviour in OT:
- 9- **Outdoor activities:** (Badminton, walking other)
- 10- **Adherence to Ward rules:**
- 11- **Side effects:**
- 12- **Physical examination:**
- 13- **MSE:** (Changes that have occurred)
- 14- **Assessment on relevant rating scale:**
- 15- **Investigation;**
- 16- **Referrals if any:**
- 17- **Treatment:** (Mention reason for major changes in treatment)

DASS21

Name:

Date:

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week**. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree or a good part of time
- 3 Applied to me very much or most of the time

1 (s)	I found it hard to wind down	0	1	2	3
2 (a)	I was aware of dryness of my mouth	0	1	2	3
3 (d)	I couldn't seem to experience any positive feeling at all	0	1	2	3
4 (a)	I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5 (d)	I found it difficult to work up the initiative to do things	0	1	2	3
6 (s)	I tended to over-react to situations	0	1	2	3
7 (a)	I experienced trembling (e.g. in the hands)	0	1	2	3
8 (s)	I felt that I was using a lot of nervous energy	0	1	2	3
9 (a)	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10 (d)	I felt that I had nothing to look forward to	0	1	2	3
11 (s)	I found myself getting agitated	0	1	2	3
12 (s)	I found it difficult to relax	0	1	2	3
13 (d)	I felt down-hearted and blue	0	1	2	3
14 (s)	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15 (a)	I felt I was close to panic	0	1	2	3
16 (d)	I was unable to become enthusiastic about anything	0	1	2	3
17 (d)	I felt I wasn't worth much as a person	0	1	2	3
18 (s)	I felt that I was rather touchy	0	1	2	3
19 (a)	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
20 (a)	I felt scared without any good reason	0	1	2	3
21 (d)	I felt that life was meaningless	0	1	2	3

DASS-21 Scoring Instructions

The DASS-21 should not be used to replace a face to face clinical interview. If you are experiencing significant emotional difficulties you should contact your GP for a referral to a qualified professional.

Depression, Anxiety and Stress Scale - 21 Items (DASS-21)

The Depression, Anxiety and Stress Scale - 21 Items (DASS-21) is a set of three self-report scales designed to measure the emotional states of depression, anxiety and stress.

Each of the three DASS-21 scales contains 7 items, divided into subscales with similar content. The depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest / involvement, anhedonia and inertia. The anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The stress scale is sensitive to levels of chronic non-specific arousal. It assesses difficulty relaxing, nervous arousal, and being easily upset / agitated, irritable / over-reactive and impatient. Scores for depression, anxiety and stress are calculated by summing the scores for the relevant items.

The DASS-21 is based on a dimensional rather than a categorical conception of psychological disorder. The assumption on which the DASS-21 development was based (and which was confirmed by the research data) is that the differences between the depression, anxiety and the stress experienced by normal subjects and clinical populations are essentially differences of degree. The DASS-21 therefore has no direct implications for the allocation of patients to discrete diagnostic categories postulated in classificatory systems such as the DSM and ICD.

Recommended cut-off scores for conventional severity labels (normal, moderate, severe) are as follows:

NB Scores on the DASS-21 will need to be multiplied by 2 to calculate the final score.

	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely Severe	28+	20+	34+

Hamilton Anxiety Rating Scale (HAM-A)

Reference: Hamilton M. The assessment of anxiety states by rating. *Br J Med Psychol* 1959; 32:50–55.

Rating Clinician-rated

Administration time 10–15 minutes

Main purpose To assess the severity of symptoms of anxiety

Population Adults, adolescents and children

Scoring

Each item is scored on a scale of 0 (not present) to 4 (severe), with a total score range of 0–56, where <17 indicates mild severity, 18–24 mild to moderate severity and 25–30 moderate to severe.

Versions

The scale has been translated into: Cantonese for China, French and Spanish. An IVR version of the scale is available from Healthcare Technology Systems.

Additional references

Maier W, Buller R, Philipp M, Heuser I. The Hamilton Anxiety Scale: reliability, validity and sensitivity to change in anxiety and depressive disorders. *J Affect Disord* 1988;14(1):61–8.

Borkovec T and Costello E. Efficacy of applied relaxation and cognitive behavioral therapy in the treatment of generalized anxiety disorder. *J Clin Consult Psychol* 1993; 61(4):611–19

Address for correspondence

The HAM-A is in the public domain.

Hamilton Anxiety Rating Scale (HAM-A)

Below is a list of phrases that describe certain feelings that people have. Rate the patients by finding the answer which best describes the extent to which he/she has these conditions. Select one of the five responses for each of the fourteen questions.

0 = Not present,

1 = Mild,

2 = Moderate,

3 = Severe,

4 = Very severe.

1 Anxious mood

0 1 2 3 4

Worries, anticipation of the worst, fearful anticipation, irritability.

2 Tension

0 1 2 3 4

Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax.

3 Fears

0 1 2 3 4

Of dark, of strangers, of being left alone, of animals, of traffic, of crowds.

4 Insomnia

0 1 2 3 4

Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors.

5 Intellectual

0 1 2 3 4

Difficulty in concentration, poor memory.

6 Depressed mood

0 1 2 3 4

Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing.

7 Somatic (muscular)

0 1 2 3 4

Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone.

8 Somatic (sensory)

0 1 2 3 4

Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, pricking sensation.

9 Cardiovascular symptoms

0 1 2 3 4

Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat.

10 Respiratory symptoms

0 1 2 3 4

Pressure or constriction in chest, choking feelings, sighing, dyspnea.

11 Gastrointestinal symptoms

0 1 2 3 4

Difficulty in swallowing, wind abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, looseness of bowels, loss of weight, constipation.

12 Genitourinary symptoms

0 1 2 3 4

Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence.

13 Autonomic symptoms

0 1 2 3 4

Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair.

14 Behavior at interview

0 1 2 3 4

Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, etc.

GAD-7 Anxiety

Over the <u>last two weeks</u> , how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult



Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day." GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

THE HAMILTON RATING SCALE FOR DEPRESSION

(to be administered by a health care professional)

Patient's Name _____

Date of Assessment _____

To rate the severity of depression in patients who are already diagnosed as depressed, administer this questionnaire. The higher the score, the more severe the depression.

For each item, write the correct number on the line next to the item. (Only one response per item)

1. DEPRESSED MOOD (Sadness, hopeless, helpless, worthless)

- _____
- 0=** Absent
 - 1=** These feeling states indicated only on questioning
 - 2=** These feeling states spontaneously reported verbally
 - 3=** Communicates feeling states non-verbally—i.e., through facial expression, posture, voice, and tendency to weep
 - 4=** Patient reports VIRTUALLY ONLY these feeling states in his spontaneous verbal and non-verbal communication

2. FEELINGS OF GUILT

- _____
- 0=** Absent
 - 1=** Self reproach, feels he has let people down
 - 2=** Ideas of guilt or rumination over past errors or sinful deeds
 - 3=** Present illness is a punishment. Delusions of guilt
 - 4=** Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations

3. SUICIDE

- _____
- 0=** Absent
 - 1=** Feels life is not worth living
 - 2=** Wishes he were dead or any thoughts of possible death to self
 - 3=** Suicidal ideas or gesture
 - 4=** Attempts at suicide (any serious attempt rates 4)

4. INSOMNIA EARLY

- _____
- 0=** No difficulty falling asleep
 - 1=** Complains of occasional difficulty falling asleep—i.e., more than 1/2 hour
 - 2=** Complains of nightly difficulty falling asleep

5. INSOMNIA MIDDLE

- _____
- 0=** No difficulty
 - 1=** Patient complains of being restless and disturbed during the night
 - 2=** Waking during the night—any getting out of bed rates 2 (except for purposes of voiding)

6. INSOMNIA LATE

- _____
- 0=** No difficulty
 - 1=** Waking in early hours of the morning but goes back to sleep
 - 2=** Unable to fall asleep again if he gets out of bed

7. WORK AND ACTIVITIES

- _____
- 0=** No difficulty
 - 1=** Thoughts and feelings of incapacity, fatigue or weakness related to activities; work or hobbies
 - 2=** Loss of interest in activity; hobbies or work—either directly reported by patient, or indirect in listlessness, indecision and vacillation (feels he has to push self to work or activities)
 - 3=** Decrease in actual time spent in activities or decrease in productivity
 - 4=** Stopped working because of present illness

8. RETARDATION: PSYCHOMOTOR (Slowness of thought and speech; impaired ability to concentrate; decreased motor activity)

- _____
- 0=** Normal speech and thought
 - 1=** Slight retardation at interview
 - 2=** Obvious retardation at interview
 - 3=** Interview difficult
 - 4=** Complete stupor

9. AGITATION

- _____
- 0=** None
 - 1=** Fidgetiness
 - 2=** Playing with hands, hair, etc.
 - 3=** Moving about, can't sit still
 - 4=** Hand wringing, nail biting, hair-pulling, biting of lips

10. ANXIETY (PSYCHOLOGICAL)

- _____
- 0=** No difficulty
 - 1=** Subjective tension and irritability
 - 2=** Worrying about minor matters
 - 3=** Apprehensive attitude apparent in face or speech
 - 4=** Fears expressed without questioning

11. ANXIETY SOMATIC: Physiological concomitants of anxiety, (i.e., effects of autonomic overactivity, "butterflies," indigestion, stomach cramps, belching, diarrhea, palpitations, hyperventilation, paresthesia, sweating, flushing, tremor, headache, urinary frequency). Avoid asking about possible medication side effects (i.e., dry mouth, constipation)

- _____
- 0=** Absent
 - 1=** Mild
 - 2=** Moderate
 - 3=** Severe
 - 4=** Incapacitating
-

12. SOMATIC SYMPTOMS (GASTROINTESTINAL)

- 0=** None
1= Loss of appetite but eating without encouragement from others. Food intake about normal
2= Difficulty eating without urging from others. Marked reduction of appetite and food intake

13. SOMATIC SYMPTOMS GENERAL

- 0=** None
1= Heaviness in limbs, back or head. Backaches, headache, muscle aches. Loss of energy and fatigability
2= Any clear-cut symptom rates 2

14. GENITAL SYMPTOMS (Symptoms such as: loss of libido; impaired sexual performance; menstrual disturbances)

- 0=** Absent
1= Mild
2= Severe

15. HYPOCHONDRIASIS

- 0=** Not present
1= Self-absorption (bodily)
2= Preoccupation with health
3= Frequent complaints, requests for help, etc.
4= Hypochondriacal delusions

16. LOSS OF WEIGHT

- A.** When rating by history:
0= No weight loss
1= Probably weight loss associated with present illness
2= Definite (according to patient) weight loss
3= Not assessed

17. INSIGHT

- 0=** Acknowledges being depressed and ill
1= Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2= Denies being ill at all

18. DIURNAL VARIATION

- A.** Note whether symptoms are worse in morning or evening. If NO diurnal variation, mark none
0= No variation
1= Worse in A.M.
2= Worse in P.M.
B. When present, mark the severity of the variation. Mark "None" if NO variation
0= None
1= Mild
2= Severe
-

19. DEPERSONALIZATION AND DEREALIZATION (Such as: Feelings of unreality;
Nihilistic ideas)

-
- 0=** Absent
1= Mild
2= Moderate
3= Severe
4= Incapacitating

20. PARANOID SYMPTOMS

-
- 0=** None
1= Suspicious
2= Ideas of reference
3= Delusions of reference and persecution

21. OBSESSIVE AND COMPULSIVE SYMPTOMS

-
- 0=** Absent
1= Mild
2= Severe

Total Score _____

Presented as a service by

GlaxoWellcome

Glaxo Wellcome Inc.
Research Triangle Park, NC 27709
Web site: www.glaxowellcome.com

HAMILTON DEPRESSION RATING SCALE (HAM-D)

Instructions for the Clinician:

The Hamilton Depression Rating Scale (HAM-D) has proven useful for many years as a way of determining a patient's level of depression before, during, and after treatment. It should be administered by a clinician experienced in working with psychiatric patients .

Although the HAM-D form lists 21 items, the scoring is based on the first 17. It generally takes 15-20 minutes to complete the interview and score the results. Eight items are scored on a 5-point scale, ranging from 0 = not present to 4 = severe. Nine are scored from 0-2.

Since its development in 1960 by Dr. Max.Hamilton of the University of Leeds, England, the scale has been widely used in clinical practice and become a standard in pharmaceutical trials.

HAM-D Scoring Instructions:

Sum the scores from the first 17 items.

0-7 = Normal

8-13 = Mild Depression

14-18 = Moderate Depression

19-22 = Severe Depression

≥ 23 = Very Severe Depression

MONTGOMERY-ASBERG DEPRESSION RATING SCALE (MADRS)

OVERALL SEVERITY

The rating should be based on a clinical interview moving from broadly phrased questions about symptoms to more detailed ones which allow a precise rating of severity. The rater must decide whether the rating lies on the defined scale steps (0, 2, 4, 6) or between them (1, 3, 5).

It is important to remember that it is only on rare occasions when a depressed patient is encountered who cannot be rated on the items on the scale. If definite answers cannot be elicited from the patient all relevant clues as well as information from other sources should be used as a basis for the rating in line with customary clinical practice.

The scale may be used for any time interval between ratings, be it weekly or otherwise but this must be recorded.

Specify **one** of the reasons listed below by putting appropriate number in adjacent box.

1. APPARENT SADNESS

Representing despondency, gloom, and despair (more than just ordinary transient low spirits) reflected in speech, facial expression, and posture. Rate by depth and inability to brighten up.

- 0 - No sadness
- 1
- 2 - Looks dispirited but does brighten up without difficulty
- 3
- 4 - Appears sad and unhappy most of the time
- 5
- 6 - Looks miserable all the time. Extremely despondent

2. REPORTED SADNESS

Representing reports of depressed mood, regardless of whether it is reflected in appearance or not. Includes low spirits, despondency, or the feeling of being beyond help and without hope. Rate according to intensity, duration, and the extent to which the mood is reported to be influenced by events.

- 0 - Occasional sadness in keeping with the circumstances
- 1
- 2 - Sad or low but brightens up without difficulty
- 3
- 4 - Pervasive feelings of sadness or gloominess. The mood is still influenced by external circumstances
- 5
- 6 - Continuous or unvarying sadness, misery, or despondency

3. INNER TENSION

Representing feelings of ill-defined discomfort, edginess, inner turmoil, mental tension mounting to either panic, dread, or anguish.

Rate according to intensity, frequency, duration, and the extent of reassurance called for.

- 0 - Placid. Only fleeting inner tension
- 1
- 2 - Occasional feelings of edginess and ill-defined discomfort
- 3
- 4 - Continuous feelings of inner tension or intermittent panic which the patient can only master with some difficulty
- 5
- 6 - Unrelenting dread or anguish. Overwhelming panic

4. REDUCED SLEEP

Representing the experience of reduced duration or depth of sleep compared to the patient's own normal pattern when well.

- 0 - Sleeps as usual
 - 1
 - 2 - Slight difficulty dropping off to sleep or slightly reduced, light or fitful sleep
 - 3
 - 4 - Sleep reduced or broken by at least 2 hours
 - 5
 - 6 - Less than 2 or 3 hours sleep
-

5. REDUCED APPETITE

Representing the feeling of a loss of appetite compared with when well. Rate by loss of desire for food or the need to force oneself to eat.

- 0 - Normal or increased appetite
 - 1
 - 2 - Slightly reduced appetite
 - 3
 - 4 - No appetite. Food is tasteless
 - 5
 - 6 - Needs persuasion to eat at all
-

6. CONCENTRATION DIFFICULTIES

Representing difficulties in collecting one's thoughts mounting to incapacitating lack of concentration.

Rate according to intensity, frequency, and degree of incapacity produced.

- 0 - No difficulties in concentrating
 - 1
 - 2 - Occasional difficulties in collecting one's thoughts
 - 3
 - 4 - Difficulties in concentrating and sustaining thought which reduces ability to read or hold a conversation
 - 5
 - 6 - Unable to read or converse without great difficulty
-

7. LASSITUDE

Representing a difficulty getting started or slowness initiating and performing everyday activities.

- 0 - Hardly any difficulty in getting started. No sluggishness
- 1
- 2 - Difficulties in starting activities
- 3
- 4 - Difficulties in starting simple routine activities which are carried out with effort
- 5
- 6 - Complete lassitude. Unable to do anything without help

8. INABILITY TO FEEL

Representing the subjective experience of reduced interest in the surroundings, or activities that normally give pleasure. The ability to react with adequate emotion to circumstances or people is reduced.

- 0 - Normal interest in surroundings and in other people
 - 1
 - 2 - Reduced ability to enjoy usual interests
 - 3
 - 4 - Loss of interest in the surroundings. Loss of feelings for friends and acquaintances
 - 5
 - 6 - The experience of being emotionally paralyzed, inability to feel anger, grief, or pleasure and a complete or even painful failure to feel for close relatives and friends
-

9. PESSIMISTIC THOUGHTS

Representing thoughts of guilt, inferiority, self-reproach, sinfulness, remorse, and ruin.

- 0 - No pessimistic thoughts
 - 1
 - 2 - Fluctuating ideas of failure, self-reproach, or self-depreciation
 - 3
 - 4 - Persistent self-accusations or definite but still rational ideas of guilt or sin. Increasingly pessimistic about the future
 - 5
 - 6 - Delusions of ruin, remorse, or unredeemable sin. Self-accusations which are absurd and unshakable
-

10. SUICIDAL THOUGHTS

Representing the feeling that life is not worth living, that a natural death would be welcome, suicidal thoughts, and preparations for suicide. Suicide attempts should not in themselves influence the rating.

- 0 - Enjoys life or takes it as it comes
- 1
- 2 - Weary of life. Only fleeting suicidal thoughts
- 3
- 4 - Probably better off dead. Suicidal thoughts are common, and suicide is considered as a possible solution, but without specific plans or intention
- 5
- 6 - Explicit plans for suicide when there is an opportunity. Active preparations for suicide

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.

- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.

- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.

- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.

- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

5.

- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6.

- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7.

- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

8.

- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.

9.

- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10.

- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now.
- 3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated by things than I ever was.
 1 I am slightly more irritated now than usual.
 2 I am quite annoyed or irritated a good deal of the time.
 3 I feel irritated all the time.
12. 0 I have not lost interest in other people.
 1 I am less interested in other people than I used to be.
 2 I have lost most of my interest in other people.
 3 I have lost all of my interest in other people.
13. 0 I make decisions about as well as I ever could.
 1 I put off making decisions more than I used to.
 2 I have greater difficulty in making decisions more than I used to.
 3 I can't make decisions at all anymore.
14. 0 I don't feel that I look any worse than I used to.
 1 I am worried that I am looking old or unattractive.
 2 I feel there are permanent changes in my appearance that make me look unattractive
 3 I believe that I look ugly.
15. 0 I can work about as well as before.
 1 It takes an extra effort to get started at doing something.
 2 I have to push myself very hard to do anything.
 3 I can't do any work at all.
16. 0 I can sleep as well as usual.
 1 I don't sleep as well as I used to.
 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
 3 I wake up several hours earlier than I used to and cannot get back to sleep.
17. 0 I don't get more tired than usual.
 1 I get tired more easily than I used to.
 2 I get tired from doing almost anything.
 3 I am too tired to do anything.
18. 0 My appetite is no worse than usual.
 1 My appetite is not as good as it used to be.
 2 My appetite is much worse now.
 3 I have no appetite at all anymore.
19. 0 I haven't lost much weight, if any, lately.
 1 I have lost more than five pounds.
 2 I have lost more than ten pounds.
 3 I have lost more than fifteen pounds.

- 20.
- 0 I am no more worried about my health than usual.
 - 1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
 - 2 I am very worried about physical problems and it's hard to think of much else.
 - 3 I am so worried about my physical problems that I cannot think of anything else.
- 21.
- 0 I have not noticed any recent change in my interest in sex.
 - 1 I am less interested in sex than I used to be.
 - 2 I have almost no interest in sex.
 - 3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score _____ Levels of Depression

1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression

YOUNG MANIA RATING SCALE (YMRS)

GUIDE FOR SCORING ITEMS

The purpose of each item is to rate the severity of that abnormality in the patient. When several keys are given for a particular grade of severity, the presence of only one is required to qualify for that rating.

The keys provided are guides. One can ignore the keys if that is necessary to indicate severity, although this should be the exception rather than the rule.

Scoring between the points given (whole or half points) is possible and encouraged after experience with the scale is acquired. This is particularly useful when severity of a particular item in a patient does not follow the progression indicated by the keys.

Specify **one** of the reasons listed below by putting the appropriate number in adjacent box.

1. ELEVATED MOOD

- 0 - Absent
 - 1 - Mildly or possibly increased on questioning
 - 2 - Definite subjective elevation; optimistic, self-confident; cheerful; appropriate to content
 - 3 - Elevated, inappropriate to content; humorous
 - 4 - Euphoric; inappropriate laughter; singing
-

2. INCREASED MOTOR ACTIVITY ENERGY

- 0 - Absent
 - 1 - Subjectively increased
 - 2 - Animated; gestures increased
 - 3 - Excessive energy; hyperactive at times; restless (can be calmed)
 - 4 - Motor excitement; continuous hyperactivity (cannot be calmed)
-

3. SEXUAL INTEREST

- 0 - Normal; not increased
 - 1 - Mildly or possibly increased
 - 2 - Definite subjective increase on questioning
 - 3 - Spontaneous sexual content; elaborates on sexual matters; hypersexual by self-report
 - 4 - Overt sexual acts (toward patients, staff, or interviewer)
-

4. SLEEP

- 0 - Reports no decrease in sleep
 - 1 - Sleeping less than normal amount by up to one hour
 - 2 - Sleeping less than normal by more than one hour
 - 3 - Reports decreased need for sleep
 - 4 - Denies need for sleep
-

5. IRRITABILITY

- 0 - Absent
- 2 - Subjectively increased
- 4 - Irritable at times during interview; recent episodes of anger or annoyance on ward
- 6 - Frequently irritable during interview; short, curt throughout
- 8 - Hostile, uncooperative; interview impossible

6. SPEECH (Rate and Amount)

- 0 - No increase
 - 2 - Feels talkative
 - 4 - Increased rate or amount at times, verbose at times
 - 6 - Push; consistently increased rate and amount; difficult to interrupt
 - 8 - Pressured; uninterruptible, continuous speech
-

7. LANGUAGE - THOUGHT DISORDER

- 0 - Absent
 - 1 - Circumstantial; mild distractibility; quick thoughts
 - 2 - Distractible; loses goal of thought; change topics frequently; racing thoughts
 - 3 - Flight of ideas; tangentiality; difficult to follow; rhyming, echolalia
 - 4 - Incoherent; communication impossible
-

8. CONTENT

- 0 - Normal
 - 2 - Questionable plans, new interests
 - 4 - Special project(s); hyperreligious
 - 6 - Grandiose or paranoid ideas; ideas of reference
 - 8 - Delusions; hallucinations
-

9. DISRUPTIVE - AGGRESSIVE BEHAVIOR

- 0 - Absent, cooperative
 - 2 - Sarcastic; loud at times, guarded
 - 4 - Demanding; threats on ward
 - 6 - Threatens interviewer; shouting; interview difficult
 - 8 - Assaultive; destructive; interview impossible
-

10. APPEARANCE

- 0 - Appropriate dress and grooming
 - 1 - Minimally unkempt
 - 2 - Poorly groomed; moderately dishevelled; overdressed
 - 3 - Dishevelled; partly clothed; garish make-up
 - 4 - Completely unkempt; decorated; bizarre garb
-

11. INSIGHT

- 0 - Present; admits illness; agrees with need for treatment
- 1 - Possibly ill
- 2 - Admits behavior change, but denies illness
- 3 - Admits possible change in behavior, but denies illness
- 4 - Denies any behavior change

YMRS- Total score- 60,

Score- ≤ 12 – Remission, 13-19 – Minimal symptom, 20-25- mild mania
26-37- moderate mania, 38-60 – severe mania

Obsessive-Compulsive Test - Yale Brown OCD Scale YBOCS

	(0)	(1)	(2)	(3)	(4)
Obsessions are frequent, unwelcome, and intrusive thoughts.					
1. How much time do you spend on obsessive thoughts?	None	0-1 hrs/day	1-3 hrs/day	3-8 hrs/day	More than 8 hrs/day
2. How much do your obsessive thoughts interfere with your personal, social, or work life?	None	Mild	Definite but manageable	Substantial interference	Severe
3. How much do your obsessive thoughts distress you?	None	Little	Moderate but manageable	Severe	Nearly constant, Disabling
4. How hard do you try to resist your obsessions?	Always try	Try much of the time	Try some of the time	Rarely try. Often yield	Never try. Completely yield
5. How much control do you have over your obsessive thoughts?	Complete control	Much control	Some control	Little control	No control
Compulsions are repetitive behaviors or mental acts that you have a strong urge to repeat that are aimed at reducing your anxiety or preventing some dreaded event.					
6. How much time do you spend performing compulsive behaviors?	None	0-1 hrs/day	1-3 hrs/day	3-8 hrs/day	More than 8 hrs/day
7. How much do your compulsive behaviors interfere with your personal, social, or work life?	None	Mild	Definite but manageable	Substantial interference	Severe
8. How anxious would you feel if you were prevented from performing your compulsive behaviors?	None	Little	Moderate but manageable	Severe	Nearly constant, Disabling
9. How hard do you try to resist your compulsive behaviors?	Always try	Try much of the time	Try some of the time	Rarely try. Often yield	Never try. Completely yield
10. How much control do you have over your compulsive behaviors?	Complete control	Much control	Some control	Little control	No control

Your Score:

If you have both obsessions and compulsions, and your total score is;

8-15 = Mild OCD; 16-23 = Moderate OCD; 24-31= Severe OCD; 32-40 = Extreme OCD

No single test is completely accurate. You should always consult your physician when making decisions about your health.

References

- Goodman, W. K., Price, L. H., Rasmussen, S. A., Mazure, C., et al., The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability. *Arch Gen Psychiatry*, 1989. **46**(11): p. 1006-11.
- Rapp, A. M., Bergman, R. L., Piacentini, J., & McGuire, J. F., Evidence-Based Assessment of Obsessive-Compulsive Disorder. *J Cent Nerv Syst Dis*, 2016. **8**: p. 13-29. PMC4994744.

Y-BOCS Symptom Checklist

Instructions: Generate a Target Symptoms List from the attached Y-BOCS Symptom Checklist by asking the patient about specific obsessions and compulsions. Check all that apply. Distinguish between current and past symptoms. Mark Principal symptoms with a “p”. These will form the basis of the Target Symptoms List. Items marked “*” may or may not be OCD.

AGGRESSIVE OBSESSIONS

Current Past

- Fear might harm self
- Fear might harm others
- Violent or horrific images
- Fear of blurting out obscenities or insults
- Fear of doing something else embarrassing*
- Fear will act on unwanted impulses (eg, to stab friend)
- Fear will steal things
- Fear will harm others because not careful enough (eg, hit / run motor vehicle accident)
- Fear will be responsible for something else terrible happening (eg, fire, burglary)
- Other _____

CONTAMINATION OBSESSIONS

- Concerns or disgust with bodily waste or secretions (eg, urine, feces, saliva)*
- Concern with dirt or germs
- Excessive concern with environmental contaminants (eg, asbestos, radiation, toxic waste)
- Excessive concern with household items (eg, cleansers, solvents)
- Excessive concern with animals (eg, insects)
- Bothered by sticky substances or residues
- Concerned will get ill because of contaminant
- Concerned will get others ill by spreading contaminant (Aggressive)
- No concern with consequences of contamination other than how it might feel
- Other _____

SEXUAL OBSESSIONS

- Forbidden or perverse sexual thoughts, images, or impulses
- Content involves children or incest
- Content involves homosexuality*
- Sexual behavior towards others (Aggressive)*
- Other _____

HOARDING / SAVING OBSESSIONS

(distinguish from hobbies and concern with objects of monetary or sentimental value)

RELIGIOUS OBSESSIONS (Scrupulosity)

- Concerned with sacrilege and blasphemy
- Excess concern with right / wrong, morality
- Other _____

OBSSESSION WITH NEED FOR SYMMETRY OR EXACTNESS

- Accompanied by magical thinking (eg, concerned that another will have accident unless things are in the right place)
- Not accompanied by magical thinking

MISCELLANEOUS OBSESSIONS

- Need to know or remember
- Fear of saying certain things
- Fear of not saying just the right thing

Current Past

- Fear of losing things
- Intrusive (nonviolent) images
- Intrusive nonsense sounds, words, or music
- Bothered by certain sounds / noises*
- Lucky / unlucky numbers
- Colors with special significance
- Superstitious fears
- Other _____

SOMATIC OBSESSIONS

- Concern with illness or disease*
- Excessive concern with body part or aspect of appearance (eg, dysmorphophobia)*
- Other _____

CLEANING / WASHING COMPULSIONS

- Excessive or ritualized handwashing
- Excessive or ritualized showering, bathing, toothbrushing, grooming, or toilet routine
- Involves cleaning of household items or other inanimate objects
- Other measures to prevent or remove contact with contaminants
- Other _____

CHECKING COMPULSIONS

- Checking locks, stove, appliances, etc.
- Checking that did not / will not harm others
- Checking that did not / will not harm self
- Checking that nothing terrible did / will not happen
- Checking that did not make mistake
- Checking tied to somatic obsessions
- Other _____

REPEATING RITUALS

- Rereading or rewriting
- Need to repeat routine activities (eg, in / out door, up / down from chair)
- Other _____

COUNTING COMPULSIONS

- _____

ORDERING / ARRANGING COMPULSIONS

- _____

HOARDING / COLLECTING COMPULSIONS

(distinguish from hobbies and concern with objects of monetary or sentimental value (eg, carefully reads junk mail, piles up old newspapers, sorts through garbage, collects useless objects))

MISCELLANEOUS COMPULSIONS

- Mental rituals (other than checking / counting)
- Excessive list making
- Need to tell, ask, or confess
- Need to touch, tap, or rub*
- Rituals involving blinking or staring*
- Measures (not checking) to prevent harm to self _____; harm to others _____; terrible consequences _____
- Ritualized eating behaviors*
- Superstitious behaviors
- Trichotillomania*
- Other self-damaging, or self-mutilating behaviors*
- Other _____

**BODY DYSMORPHIC DISORDER MODIFICATION
OF THE Y-BOCS (BDD-YBOCS) FOR ADOLESCENTS[©]**

SUBJECT # _____ DATE: _____

For each item circle the number identifying the response which best characterizes the patient during the **past week**.

**1. TIME OCCUPIED BY THOUGHTS
ABOUT BODY DEFECT**

How much time do you spend thinking about this problem with how you look?

- 0 - None
 - 1 - Mild (less than 1 hr/day)
 - 2 - Moderate (1-3 hrs/day)
 - 3 - Severe (greater than 3 and up to 8 hrs/day)
 - 4 - Extreme (greater than 8 hrs/day)
-

**2. INTERFERENCE DUE TO THOUGHTS
ABOUT BODY DEFECT**

How much do these THOUGHTS about how you look get in the way of school, work, or doing things with family or friends? (Is there anything you don't do because of them?)

- 0 - None
- 1 - Mild, slight interference with social, occupational, or role activities, but overall performance not impaired.
- 2 - Moderate, definite interference with social, occupational, or role performance, but still manageable.
- 3 - Severe, causes substantial impairment in social, occupational, or role performance.
- 4 - Extreme, incapacitating.

Y/N Spending time with friends

Y/N Dating

Y/N Attending social functions

Y/N Doing things w/family in and outside of home

Y/N Going to school/work each day

Y/N Being on time for or missing school/work

Y/N Focusing at school/work

Y/N Productivity at school/work

Y/N Doing homework or maintaining grades

Y/N Daily activities/errands/chores

**3. DISTRESS ASSOCIATED WITH THOUGHTS
ABOUT BODY DEFECT**

How much do these THOUGHTS about how you look bother or upset you?

- 0 - None
 - 1 - Mild, and not too disturbing.
 - 2 - Moderate, and disturbing.
 - 3 - Severe, and very disturbing.
 - 4 - Extreme, and disabling distress
-

Rate "disturbing" feelings or anxiety that seem to be triggered by these thoughts, not general anxiety or anxiety associated with other symptoms.

4. RESISTANCE AGAINST THOUGHTS OF BODY DEFECT

How hard do you try to stop these thoughts or ignore them?

Only rate effort made to resist, NOT success or failure in actually controlling the thoughts.

How much patient resists may or may not correlate with ability to control them.

0 - Makes an effort to always resist, or symptoms so minimal doesn't need to actively resist.

1 - Tries to resist most of time.

2 - Makes some effort to resist.

3 - Yields to all such thoughts without attempting to control them but yields with some reluctance.

4 - Completely and willingly yields to all such thoughts.

5. DEGREE OF CONTROL OVER THOUGHTS ABOUT BODY DEFECT

When you try to fight the thoughts about how you look, can you beat them?

How much control do you have over your thoughts?

0 - Complete control, or no need for control because thoughts are so minimal.

1 - Much control, usually able to stop or divert these thoughts with some effort and concentration.

2 - Moderate control, sometimes able to stop or divert these thoughts.

3 - Little control, rarely successful in stopping thoughts, can only divert attention with difficulty.

4 - No control, experienced as completely involuntary, rarely able to even momentarily divert attention.

6. TIME SPENT DOING COMPULSIVE BEHAVIORS RELATED TO BODY DEFECT

Now I'm going to ask you about the activities/habits you do related to your appearance problem.

Read list of behaviors below to determine which ones the patient engages in.

How much time do you spend doing these things?
Include all behaviors.

0 - None

1 - Mild (spends less than 1 hr/day)

2 - Moderate (1-3 hrs/day)

3 - Severe (spends more than 3 and up to 8 hours/day)

4 - Extreme (spends more than 8 hrs/day in these activities)

READ LIST OF BEHAVIORS

(check all that apply)

- Checking mirrors/other surfaces
- Checking the appearance of the disliked body areas directly
- Grooming activities (e.g., hair combing, styling, shaving)
- Applying makeup
- Excessive exercise (time beyond 1 hr. per day)
- Selecting/changing clothing or other cover-up (rate time spent selecting, changing or fixing clothes or cover-up, not time wearing them)
- Comparing disliked body areas with those body areas on other people
- Questioning others about/discussing your appearance

-
- Picking at skin because it doesn't look right
 - Skin cleansing routines
 - Pulling out hair because it doesn't look right
 - Touching the body areas
 - Tanning
 - Other _____
-

7. **INTERFERENCE DUE TO ACTIVITIES RELATED TO BODY DEFECT**

How much do these activities/habits get in the way of school , work, or doing things with family or friends? (Is there anything you don't do because of them?)

- 0 - None
 - 1 - Mild, slight interference with social, occupational, or role activities, but overall performance not impaired.
 - 2 - Moderate, definite interference with social, occupational, or role performance, but still manageable.
 - 3 - Severe, causes substantial impairment in social, occupational, or role performance.
 - 4 - Extreme, incapacitating.
-

8. **DISTRESS ASSOCIATED WITH ACTIVITIES RELATED TO BODY DEFECT**

How would you feel if you were prevented from doing these activities/habits?

How upset would you become?

Rate degree of distress/frustration patient would experience if performance of the activities were suddenly interrupted. Use a composite rating for all behaviors.

- 0 - None
 - 1 - Mild, only slightly anxious if behavior prevented.
 - 2 - Moderate, reports that anxiety would mount but remain manageable if behavior is prevented.
 - 3 - Severe, prominent and very disturbing increase in anxiety if behavior is interrupted.
 - 4 - Extreme, incapacitating anxiety from any intervention aimed at modifying activity.
-

9. **RESISTANCE AGAINST COMPULSIONS**

How much do you try to fight doing these activities/ habits?

*Only rate effort made to resist, not success or failure in actually controlling the activities. How much the patient resists these behaviors may or may not correlate with his/her ability to control them
Use a composite rating for all behaviors.*

- 0 - Makes an effort to always resist, or symptoms so minimal doesn't need to actively resist.
 - 1 - Tries to resist most of the time.
 - 2 - Makes some effort to resist.
 - 3 - Yields to almost all of these behaviors without attempting to control them, but does so with some reluctance.
 - 4 - Completely and willingly yields to all behaviors related to body defect.
-

10. DEGREE OF CONTROL OVER COMPULSIVE BEHAVIOR

How strong is the feeling that you have to carry out these activities/habits?

When you try to fight them, what happens?

(*For the advanced child ask:* How much control do you have over the activities/habits?)

Use a composite rating for all behaviors.

- 0 - Complete control, or control is unnecessary because symptoms are mild.
- 1 - Much control, experiences pressure to perform the behavior, but usually able to exercise voluntary control over it.
- 2 - Moderate control, strong pressure to perform behavior, can control it only with difficulty.
- 3 - Little control, very strong drive to perform behavior, must be carried to completion, can delay only with difficulty.
- 4 - No control, drive to perform behavior

experienced as completely involuntary and overpowering, rarely able to even momentarily delay activity.

11. INSIGHT

What word would you use to describe how bad your appearance flaws look? *Obtain a “global” description/belief of all perceived defects combined. If necessary, offer words such as “ugly,” “deformed,” “disfigured,” or “unattractive,” and have the patient choose one. Use the same belief when doing subsequent ratings.*

How certain are you that these body areas look [fill in patient’s word(s)]? Are you certain your belief is accurate?

- 0 = Excellent insight: Completely certain belief is false
- 1 = Good insight. Realizes belief is probably not true, or substantial doubt exists
- 2 = Fair insight: Belief may or may not be true, or unable to decide if belief is true or not
- 3 = Poor insight: Fairly convinced that belief is but an element of doubt exists.
- 4 = Lacks insight; delusional. Completely convinced that belief is true (100% certainty)

12. AVOIDANCE

Have you been avoiding doing anything, going any place, or being with anyone because of your thoughts or activities/habits related to your problem with how you look?
If YES, then ask: What do you avoid?

Rate degree to which patient deliberately tries to avoid things such as social interactions or school-related activities. Do not include avoidance of mirrors or avoidance of compulsive behaviors.

- 0 - No deliberate avoidance.
- 1 - Mild, minimal avoidance.
- 2 - Moderate, some avoidance clearly present.
- 3 - Severe, much avoidance; avoidance prominent.
- 4 - Extreme, very extensive avoidance; patient avoids almost all activities.

Brackets [] indicate material that should be read.

Parentheses () indicate optional material that may be read.

Italicized items are instructions to the interviewer.

Phillips KA, Hollander E, Rasmussen SA, Aronowitz BR, DeCaria C, Goodman WK. A severity rating scale for body dysmorphic disorder: development, reliability, and validity of a modified version of the Yale-Brown Obsessive Compulsive Scale. Psychopharmacol Bull 1997;33:17-22.

This scale is based on the BDD-YBOCS for adults and the Children's Yale-Brown Obsessive-Compulsive Scale; it was modified by R.S. Albertini and K.A. Phillips and subsequently by K.A. Phillips

©1999, Katharine A. Phillips, M.D.

BRIEF PSYCHIATRIC RATING SCALE (BPRS)

Please enter the score for the term which best describes the patient's condition.

0 = not assessed, 1 = not present, 2 = very mild, 3 = mild, 4 = moderate, 5 = moderately severe, 6 = severe, 7 = extremely severe

1. SOMATIC CONCERN Degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the patient, whether complaints have a realistic basis or not. <input style="width: 100px; height: 20px; margin-top: 10px;" type="text"/>	10. HOSTILITY Animosity, contempt, belligerence, disdain for other people outside the interview situation. Rate solely on the basis of the verbal report of feelings and actions of the patient toward others; do not infer hostility from neurotic defenses, anxiety, nor somatic complaints. (<i>Rate attitude toward interviewer under "uncooperativeness".</i>) SCORE <input style="width: 100px; height: 20px; margin-top: 10px;" type="text"/>
2. ANXIETY Worry, fear, or over-concern for present or future. Rate solely on the basis of verbal report of patient's own subjective experiences. Do not infer anxiety from physical signs or from neurotic defense mechanisms. <input style="width: 100px; height: 20px; margin-top: 10px;" type="text"/>	11. SUSPICIOUSNESS Brief (<i>delusional or otherwise</i>) that others have now, or have had in the past, malicious or discriminatory intent toward the patient. On the basis of verbal report, rate only those suspicions which are currently held whether they concern past or present circumstances. SCORE <input style="width: 100px; height: 20px; margin-top: 10px;" type="text"/>
3. EMOTIONAL WITHDRAWAL Deficiency in relating to the interviewer and to the interviewer situation. Rate only the degree to which the patient gives the impression of failing to be in emotional contact with other people in the interview situation. <input style="width: 100px; height: 20px; margin-top: 10px;" type="text"/>	12. HALLUCINATORY BEHAVIOR Perceptions without normal external stimulus correspondence. Rate only those experiences which are reported to have occurred within the last week and which are described as distinctly different from the thought and imagery processes of normal people. SCORE <input style="width: 100px; height: 20px; margin-top: 10px;" type="text"/>
4. CONCEPTUAL DISORGANIZATION Degree to which the thought processes are confused, disconnected, or disorganized. Rate on the basis of integration of the verbal products of the patient; do not rate on the basis of patient's subjective impression of his own level of functioning. <input style="width: 100px; height: 20px; margin-top: 10px;" type="text"/>	13. MOTOR RETARDATION Reduction in energy level evidenced in slowed movements. Rate on the basis of observed behavior of the patient only; do not rate on the basis of patient's subjective impression of own energy level. SCORE <input style="width: 100px; height: 20px; margin-top: 10px;" type="text"/>
5. GUILT FEELINGS Over-concern or remorse for past behavior. Rate on the basis of the patient's subjective experiences of guilt as evidenced by verbal report with appropriate affect; do not infer guilt feelings from depression, anxiety or neurotic defenses. <input style="width: 100px; height: 20px; margin-top: 10px;" type="text"/>	14. UNCOOPERATIVENESS Evidence of resistance, unfriendliness, resentment, and lack of readiness to cooperate with the interviewer. Rate only on the basis of the patient's attitude and responses to the interviewer and the interview situation; do not rate on basis of reported resentment or uncooperativeness outside the interview situation. SCORE <input style="width: 100px; height: 20px; margin-top: 10px;" type="text"/>
6. TENSION Physical and motor manifestations of tension "nervousness", and heightened activation level. Tension should be rated solely on the basis of physical signs and motor behavior and not on the basis of subjective experiences of tension reported by the patient. SCORE <input style="width: 100px; height: 20px; margin-top: 10px;" type="text"/>	15. UNUSUAL THOUGHT CONTENT Unusual, odd, strange or bizarre thought content. Rate here the degree of unusualness, not the degree of disorganization of thought processes. SCORE <input style="width: 100px; height: 20px; margin-top: 10px;" type="text"/>
7. MANNERISMS AND POSTURING Unusual and unnatural motor behavior, the type of motor behavior which causes certain mental patients to stand out in a crowd of normal people. Rate only abnormality of movements; do not rate simple heightened motor activity here. <input style="width: 100px; height: 20px; margin-top: 10px;" type="text"/>	16. BLUNTED AFFECT Reduced emotional tone, apparent lack of normal feeling or involvement. SCORE <input style="width: 100px; height: 20px; margin-top: 10px;" type="text"/>
8. GRANDIOSITY Exaggerated self-opinion, conviction of unusual ability or powers. Rate only on the basis of patient's statements about himself or self-in-relation-to-others, not on the basis of his demeanor in the interview situation. <input style="width: 100px; height: 20px; margin-top: 10px;" type="text"/>	17. EXCITEMENT Heightened emotional tone, agitation, increased reactivity. SCORE <input style="width: 100px; height: 20px; margin-top: 10px;" type="text"/>
9. DEPRESSIVE MOOD Despondency in mood, sadness. Rate only degree of despondency; do not rate on the basis of inferences concerning depression based upon general retardation and somatic complaints. <input style="width: 100px; height: 20px; margin-top: 10px;" type="text"/>	18. DISORIENTATION Confusion or lack of proper association for person, place or time. SCORE <input style="width: 100px; height: 20px; margin-top: 10px;" type="text"/>

POSITIVE AND NEGATIVE SYNDROME SCALE (PANSS) RATING CRITERIA

GENERAL RATING INSTRUCTIONS

Data gathered from this assessment procedure are applied to the PANSS ratings. Each of the 30 items is accompanied by a specific definition as well as detailed anchoring criteria for all seven rating points. These seven points represent increasing levels of psychopathology, as follows:

- 1- absent
- 2- minimal
- 3- mild
- 4- moderate
- 5- moderate severe
- 6- severe
- 7- extreme

In assigning ratings, one first considers whether an item is at all present, as judging by its definition. If the item is absent, it is scored 1, whereas if it is present one must determine its severity by reference to the particular criteria from the anchoring points. The highest applicable rating point is always assigned, even if the patient meets criteria for lower points as well. In judging the level of severity, the rater must utilise a holistic perspective in deciding which anchoring point best characterises the patient's functioning and rate accordingly, whether or not all elements of the description are observed.

The rating points of 2 to 7 correspond to incremental levels of symptom severity:

- A rating of 2 (minimal) denotes questionable or subtle or suspected pathology, or it also may allude to the extreme end of the normal range.
- A rating of 3 (mild) is indicative of a symptom whose presence is clearly established but not pronounced and interferes little in day-to-day functioning.
- A rating of 4 (moderate) characterises a symptom which, though representing a serious problem, either occurs only occasionally or intrudes on daily life only to a moderate extent.
- A rating of 5 (moderate severe) indicates marked manifestations that distinctly impact on one's functioning but are not all-consuming and usually can be contained at will.
- A rating of 6 (severe) represents gross pathology that is present very frequently, proves highly disruptive to one's life, and often calls for direct supervision.
- A rating of 7 (extreme) refers to the most serious level of psychopathology, whereby the manifestations drastically interfere in most or all major life functions, typically necessitating close supervision and assistance in many areas.

Each item is rated in consultation with the definitions and criteria provided in this manual. The ratings are rendered on the PANSS rating form overleaf by encircling the appropriate number following each dimension.

PANSS RATING FORM

		<u>absent</u>	<u>minimal</u>	<u>mild</u>	<u>moderate</u>	<u>moderate severe</u>	<u>severe</u>	<u>extreme</u>
P1	Delusions	1	2	3	4	5	6	7
P2	Conceptual disorganisation	1	2	3	4	5	6	7
P3	Hallucinatory behaviour	1	2	3	4	5	6	7
P4	Excitement	1	2	3	4	5	6	7
P5	Grandiosity	1	2	3	4	5	6	7
P6	Suspiciousness/persecution	1	2	3	4	5	6	7
P7	Hostility	1	2	3	4	5	6	7
N1	Blunted affect	1	2	3	4	5	6	7
N2	Emotional withdrawal	1	2	3	4	5	6	7
N3	Poor rapport	1	2	3	4	5	6	7
N4	Passive/apathetic social withdrawal	1	2	3	4	5	6	7
N5	Difficulty in abstract thinking	1	2	3	4	5	6	7
N6	Lack of spontaneity & flow of conversation	1	2	3	4	5	6	7
N7	Stereotyped thinking	1	2	3	4	5	6	7
G1	Somatic concern	1	2	3	4	5	6	7
G2	Anxiety	1	2	3	4	5	6	7
G3	Guilt feelings	1	2	3	4	5	6	7
G4	Tension	1	2	3	4	5	6	7
G5	Mannerisms & posturing	1	2	3	4	5	6	7
G6	Depression	1	2	3	4	5	6	7
G7	Motor retardation	1	2	3	4	5	6	7
G8	Uncooperativeness	1	2	3	4	5	6	7
G9	Unusual thought content	1	2	3	4	5	6	7
G10	Disorientation	1	2	3	4	5	6	7
G11	Poor attention	1	2	3	4	5	6	7
G12	Lack of judgement & insight	1	2	3	4	5	6	7
G13	Disturbance of volition	1	2	3	4	5	6	7
G14	Poor impulse control	1	2	3	4	5	6	7
G15	Preoccupation	1	2	3	4	5	6	7
G16	Active social avoidance	1	2	3	4	5	6	7

SCORING INSTRUCTIONS

Of the 30 items included in the PANSS, 7 constitute a **Positive Scale**, 7 a **Negative Scale**, and the remaining 16 a **General Psychopathology Scale**. The scores for these scales are arrived at by summation of ratings across component items. Therefore, the potential ranges are 7 to 49 for the Positive and Negative Scales, and 16 to 112 for the General Psychopathology Scale. In addition to these measures, a Composite Scale is scored by subtracting the negative score from the positive score. This yields a bipolar index that ranges from -42 to +42, which is essentially a difference score reflecting the degree of predominance of one syndrome in relation to the other.

POSITIVE SCALE (P)

P1. **DELUSIONS** - Beliefs which are unfounded, unrealistic and idiosyncratic.

Basis for rating - Thought content expressed in the interview and its influence on social relations and behaviour.

- 1** **Absent** - Definition does not apply
- 2** **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3** **Mild** - Presence of one or two delusions which are vague, uncrystallised and not tenaciously held. Delusions do not interfere with thinking, social relations or behaviour.
- 4** **Moderate** - Presence of either a kaleidoscopic array of poorly formed, unstable delusions or a few well-formed delusions that occasionally interfere with thinking, social relations or behaviour.
- 5** **Moderate Severe** - Presence of numerous well-formed delusions that are tenaciously held and occasionally interfere with thinking, social relations and behaviour.
- 6** **Severe** - Presence of a stable set of delusions which are crystallised, possibly systematised, tenaciously held and clearly interfere with thinking, social relations and behaviour.
- 7** **Extreme** - Presence of a stable set of delusions which are either highly systematised or very numerous, and which dominate major facets of the patient's life. This frequently results in inappropriate and irresponsible action, which may even jeopardise the safety of the patient or others.

P2. **CONCEPTUAL DISORGANISATION** - Disorganised process of thinking characterised by disruption of goal-directed sequencing, e.g. circumstantiality, loose associations, tangentiality, gross illogicality or thought block.

Basis for rating - Cognitive-verbal processes observed during the course of interview.

- 1** **Absent** - Definition does not apply
- 2** **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3** **Mild** - Thinking is circumstantial, tangential or paralogical. There is some difficulty in directing thoughts towards a goal, and some loosening of associations may be evidenced under pressure.
- 4** **Moderate** - Able to focus thoughts when communications are brief and structured, but becomes loose or irrelevant when dealing with more complex communications or when under minimal pressure.
- 5** **Moderate Severe** - Generally has difficulty in organising thoughts, as evidenced by frequent irrelevancies, disconnectedness or loosening of associations even when not under pressure.
- 6** **Severe** - Thinking is seriously derailed and internally inconsistent, resulting in gross irrelevancies and disruption of thought processes, which occur almost constantly.
- 7** **Extreme** - Thoughts are disrupted to the point where the patient is incoherent. There is marked loosening of associations, which result in total failure of communication, e.g. "word salad" or mutism.

P3. **HALLUCINATORY BEHAVIOUR** - Verbal report or behaviour indicating perceptions which are not generated by external stimuli. These may occur in the auditory, visual, olfactory or somatic realms.

Basis for rating - Verbal report and physical manifestations during the course of interview as well as reports of behaviour by primary care workers or family.

- 1** **Absent** - Definition does not apply
- 2** **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3** **Mild** - One or two clearly formed but infrequent hallucinations, or else a number of vague abnormal perceptions which do not result in distortions of thinking or behaviour.
- 4** **Moderate** - Hallucinations occur frequently but not continuously, and the patient's thinking and behaviour are only affected to a minor extent.
- 5** **Moderate Severe** - Hallucinations occur frequently, may involve more than one sensory modality, and tend to distort thinking and/or disrupt behaviour. Patient may have a delusional interpretation of these experiences and respond to them emotionally and, on occasion, verbally as well.
- 6** **Severe** - Hallucinations are present almost continuously, causing major disruption of thinking and behaviour. Patient treats these as real perceptions, and functioning is impeded by frequent emotional and verbal responses to them.
- 7** **Extreme** - Patient is almost totally preoccupied with hallucinations, which virtually dominate thinking and behaviour. Hallucinations are provided a rigid delusional interpretation and provoke verbal and behavioural responses, including obedience to command hallucinations.

P4.	<p>EXCITEMENT - Hyperactivity as reflected in accelerated motor behaviour, heightened responsivity to stimuli, hypervigilance or excessive mood lability.</p> <p>Basis for rating - Behavioural manifestations during the course of interview as well as reports of behaviour by primary care workers or family.</p> <ul style="list-style-type: none"> 1 Absent - Definition does not apply 2 Minimal - Questionable pathology; may be at the upper extreme of normal limits 3 Mild - Tends to be slightly agitated, hypervigilant or mildly overaroused throughout the interview, but without distinct episodes of excitement or marked mood lability. Speech may be slightly pressured. 4 Moderate - Agitation or overarousal is clearly evident throughout the interview, affecting speech and general mobility, or episodic outbursts occur sporadically. 5 Moderate Severe - Significant hyperactivity or frequent outbursts of motor activity are observed, making it difficult for the patient to sit still for longer than several minutes at any given time. 6 Severe - Marked excitement dominates the interview, delimits attention, and to some extent affects personal functions such as eating or sleeping. 7 Extreme - marked excitement seriously interferes in eating and sleeping and makes interpersonal interactions virtually impossible. Acceleration of speech and motor activity may result in incoherence and exhaustion.
------------	---

P5.	<p>GRANDIOSITY - Exaggerated self-opinion and unrealistic convictions of superiority, including delusions of extraordinary abilities, wealth, knowledge, fame, power and moral righteousness.</p> <p>Basis for rating - Thought content expressed in the interview and its influence on behaviour.</p> <ul style="list-style-type: none"> 1 Absent - Definition does not apply 2 Minimal - Questionable pathology; may be at the upper extreme of normal limits 3 Mild - Some expansiveness or boastfulness is evident, but without clear-cut grandiose delusions. 4 Moderate - Feels distinctly and unrealistically superior to others. Some poorly formed delusions about special status or abilities may be present but are not acted upon. 5 Moderate Severe - Clear-cut delusions concerning remarkable abilities, status or power are expressed and influence attitude but not behaviour. 6 Severe - Clear-cut delusions of remarkable superiority involving more than one parameter (wealth, knowledge, fame, etc) are expressed, notably influence interactions and may be acted upon. 7 Extreme - Thinking, interactions and behaviour are dominated by multiple delusions of amazing ability, wealth, knowledge, fame, power and/or moral stature, which may take on a bizarre quality.
------------	---

P6.	<p>SUSPICIOUSNESS/PERSECUTION - Unrealistic or exaggerated ideas of persecution, as reflected in guardedness, ad distrustful attitude, suspicious hypervigilance or frank delusions that others mean harm.</p> <p>Basis for rating – Thought content expressed in the interview and its influence on behaviour.</p> <ul style="list-style-type: none"> 1 Absent - Definition does not apply 2 Minimal - Questionable pathology; may be at the upper extreme of normal limits 3 Mild - Presents a guarded or even openly distrustful attitude, but thoughts, interactions and behaviour are minimally affected. 4 Moderate - Distrustfulness is clearly evident and intrudes on the interview and/or behaviour, but there is no evidence of persecutory delusions. Alternatively, there may be indication of loosely formed persecutory delusions, but these do not seem to affect the patient's attitude or interpersonal relations. 5 Moderate Severe - Patient shows marked distrustfulness, leading to major disruption of interpersonal relations, or else there are clear-cut persecutory delusions that have limited impact on interpersonal relations and behaviour. 6 Severe - Clear-cut pervasive delusions of persecution which may be systematised and significantly interfere in interpersonal relations. 7 Extreme - A network of systematised persecutory delusions dominates the patient's thinking, social relations and behaviour.
------------	---

P7. HOSTILITY - Verbal and nonverbal expressions of anger and resentment, including sarcasm, passive-aggressive behaviour, verbal abuse and assualtiveness.

Basis for rating - Interpersonal behaviour observed during the interview and reports by primary care workers or family.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - Indirect or restrained communication of anger, such as sarcasm, disrespect, hostile expressions and occasional irritability.
- 4 **Moderate** - Presents an overtly hostile attitude, showing frequent irritability and direct expression of anger or resentment.
- 5 **Moderate Severe** - Patient is highly irritable and occasionally verbally abusive or threatening.
- 6 **Severe** - Uncooperativeness and verbal abuse or threats notably influence the interview and seriously impact upon social relations. Patient may be violent and destructive but is not physically assualtive towards others.
- 7 **Extreme** - Marked anger results in extreme uncooperativeness, precluding other interactions, or in episode(s) of physical assault towards others.

NEGATIVE SCALE (N)

N1. BLUNTED AFFECT - Diminished emotional responsiveness as characterised by a reduction in facial expression, modulation of feelings and communicative gestures.

Basis for rating - Observation of physical manifestations of affective tone and emotional responsiveness during the course of the interview.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - Changes in facial expression and communicative gestures seem to be stilted, forced, artificial or lacking in modulation.
- 4 **Moderate** - Reduced range of facial expression and few expressive gestures result in a dull appearance
- 5 **Moderate Severe** - Affect is generally 'flat' with only occasional changes in facial expression and a paucity of communicative gestures.
- 6 **Severe** - Marked flatness and deficiency of emotions exhibited most of the time. There may be unmodulated extreme affective discharges, such as excitement, rage or inappropriate uncontrolled laughter.
- 7 **Extreme** - Changes in facial expression and evidence of communicative gestures are virtually absent. Patient seems constantly to show a barren or 'wooden' expression.

N2. EMOTIONAL WITHDRAWAL - Lack of interest in, involvement with, and affective commitment to life's events.

Basis for rating - Reports of functioning from primary care workers or family and observation of interpersonal behaviour during the course of the interview.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - Usually lack initiative and occasionally may show deficient interest in surrounding events.
- 4 **Moderate** - Patient is generally distanced emotionally from the milieu and its challenges but, with encouragement, can be engaged.
- 5 **Moderate Severe** - Patient is clearly detached emotionally from persons and events in the milieu, resisting all efforts at engagement. Patient appears distant, docile and purposeless but can be involved in communication at least briefly and tends to personal needs, sometimes with assistance.
- 6 **Severe** - Marked deficiency of interest and emotional commitment results in limited conversation with others and frequent neglect of personal functions, for which the patient requires supervision.
- 7 **Extreme** - Patient is almost totally withdrawn, uncommunicative and neglectful of personal needs as a result of profound lack of interest and emotional commitment.

N3. POOR RAPPORT - Lack of interpersonal empathy, openness in conversation and sense of closeness, interest or involvement with the interviewer. This is evidenced by interpersonal distancing and reduced verbal and nonverbal communication.

Basis for rating - Interpersonal behaviour during the course of the interview.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - Conversation is characterised by a stilted, strained or artificial tone. It may lack emotional depth or tend to remain on an impersonal, intellectual plane.
- 4 **Moderate** - Patient typically is aloof, with interpersonal distance quite evident. Patient may answer questions mechanically, act bored, or express disinterest.
- 5 **Moderate Severe** - Disinvolvement is obvious and clearly impedes the productivity of the interview. Patient may tend to avoid eye or face contact.
- 6 **Severe** - Patient is highly indifferent, with marked interpersonal distance. Answers are perfunctory, and there is little nonverbal evidence of involvement. Eye and face contact are frequently avoided.
- 7 **Extreme** - Patient is totally unininvolved with the interviewer. Patient appears to be completely indifferent and consistently avoids verbal and nonverbal interactions during the interview.

N4. PASSIVE/APATHETIC SOCIAL WITHDRAWAL - Diminished interest and initiative in social interactions due to passivity, apathy, anergy or avolition. This leads to reduced interpersonal involvements and neglect of activities of daily living.

Basis for rating – Reports on social behaviour from primary care workers or family.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - Shows occasional interest in social activities but poor initiative. Usually engages with others only when approached first by them.
- 4 **Moderate** – Passively goes along with most social activities but in a disinterested or mechanical way. Tends to recede into the background.
- 5 **Moderate Severe** - Passively participates in only a minority of activities and shows virtually no interest or initiative. Generally spends little time with others.
- 6 **Severe** - Tends to be apathetic and isolated, participating very rarely in social activities and occasionally neglecting personal needs. Has very few spontaneous social contacts.
- 7 **Extreme** – Profoundly apathetic, socially isolated and personally neglectful.

N5. DIFFICULTY IN ABSTRACT THINKING - Impairment in the use of the abstract-symbolic mode of thinking, as evidenced by difficulty in classification, forming generalisations and proceeding beyond concrete or egocentric thinking in problem-solving tasks.

Basis for rating - Responses to questions on similarities and proverb interpretation, and use of concrete vs. abstract mode during the course of the interview.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - Tends to give literal or personalised interpretations to the more difficult proverbs and may have some problems with concepts that are fairly abstract or remotely related.
- 4 **Moderate** - Often utilises a concrete mode. Has difficulty with most proverbs and some categories. Tends to be distracted by functional aspects and salient features.
- 5 **Moderate Severe** - Deals primarily in a concrete mode, exhibiting difficulty with most proverbs and many categories.
- 6 **Severe** - Unable to grasp the abstract meaning of any proverbs or figurative expressions and can formulate classifications for only the most simple of similarities. Thinking is either vacuous or locked into functional aspects, salient features and idiosyncratic interpretations.
- 7 **Extreme** - Can use only concrete modes of thinking. Shows no comprehension of proverbs, common metaphors or similes, and simple categories. Even salient and functional attributes do not serve as a basis for classification. This rating may apply to those who cannot interact even minimally with the examiner due to marked cognitive impairment.

- N6. LACK OF SPONTANEITY AND FLOW OF CONVERSATION** - Reduction in the normal flow of communication associated with apathy, avolition, defensiveness or cognitive deficit. This is manifested by diminished fluidity and productivity of the verbal interactional process.

Basis for rating - Cognitive-verbal processes observed during the course of interview.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - Conversation shows little initiative. Patient's answers tend to be brief and unembellished, requiring direct and leading questions by the interviewer.
- 4 **Moderate** - Conversation lacks free flow and appears uneven or halting. Leading questions are frequently needed to elicit adequate responses and proceed with conversation.
- 5 **Moderate Severe** - Patient shows a marked lack of spontaneity and openness, replying to the interviewer's questions with only one or two brief sentences.
- 6 **Severe** - Patient's responses are limited mainly to a few words or short phrases intended to avoid or curtail communication. (e.g. "I don't know", "I'm not at liberty to say"). Conversation is seriously impaired as a result and the interview is highly unproductive.
- 7 **Extreme** - Verbal output is restricted to, at most, an occasional utterance, making conversation not possible.

- N7. STEREOTYPED THINKING** - Decreased fluidity, spontaneity and flexibility of thinking, as evidenced in rigid, repetitious or barren thought content.

Basis for rating - Cognitive-verbal processes observed during the interview.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - Some rigidity shown in attitude or beliefs. Patient may refuse to consider alternative positions or have difficulty in shifting from one idea to another.
- 4 **Moderate** - Conversation revolves around a recurrent theme, resulting in difficulty in shifting to a new topic.
- 5 **Moderate Severe** - Thinking is rigid and repetitious to the point that, despite the interviewer's efforts, conversation is limited to only two or three dominating topics.
- 6 **Severe** - Uncontrolled repetition of demands, statements, ideas or questions which severely impairs conversation.
- 7 **Extreme** - Thinking, behaviour and conversation are dominated by constant repetition of fixed ideas or limited phrases, leading to gross rigidity, inappropriateness and restrictiveness of patient's communication.

GENERAL PSYCHOPATHOLOGY SCALE (G)

- G1. SOMATIC CONCERN** - Physical complaints or beliefs about bodily illness or malfunctions. This may range from a vague sense of ill being to clear-cut delusions of catastrophic physical disease.

Basis for rating - Thought content expressed in the interview.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - Distinctly concerned about health or bodily malfunction, but there is no delusional conviction and overconcern can be allayed by reassurance.
- 4 **Moderate** - Complains about poor health or bodily malfunction, but there is no delusional conviction, and overconcern can be allayed by reassurance.
- 5 **Moderate Severe** - Patient expresses numerous or frequent complaints about physical illness or bodily malfunction, or else patient reveals one or two clear-cut delusions involving these themes but is not preoccupied by them.
- 6 **Severe** - Patient is preoccupied by one or a few clear-cut delusions about physical disease or organic malfunction, but affect is not fully immersed in these themes, and thoughts can be diverted by the interviewer with some effort.
- 7 **Extreme** - Numerous and frequently reported somatic delusions, or only a few somatic delusions of a catastrophic nature, which totally dominate the patient's affect or thinking.

G2.	ANXIETY - Subjective experience of nervousness, worry, apprehension or restlessness, ranging from excessive concern about the present or future to feelings of panic. Basis for rating - Verbal report during the course of interview and corresponding physical manifestations.
	<ol style="list-style-type: none"> 1 Absent - Definition does not apply 2 Minimal - Questionable pathology; may be at the upper extreme of normal limits 3 Mild - Expresses some worry, overconcern or subjective restlessness, but no somatic and behavioural consequences are reported or evidenced. 4 Moderate - Patient reports distinct symptoms of nervousness, which are reflected in mild physical manifestations such as fine hand tremor and excessive perspiration. 5 Moderate Severe - Patient reports serious problems of anxiety which have significant physical and behavioural consequences, such as marked tension, poor concentration, palpitations or impaired sleep. 6 Severe - Subjective state of almost constant fear associated with phobias, marked restlessness or numerous somatic manifestations. 7 Extreme - Patient's life is seriously disrupted by anxiety, which is present almost constantly and at times reaches panic proportion or is manifested in actual panic attacks.

G3.	GUILT FEELINGS - Sense of remorse or self-blame for real or imagined misdeeds in the past. Basis for rating - Verbal report of guilt feelings during the course of interview and the influence on attitudes and thoughts.
	<ol style="list-style-type: none"> 1 Absent - Definition does not apply 2 Minimal - Questionable pathology; may be at the upper extreme of normal limits 3 Mild - Questioning elicits a vague sense of guilt or self-blame for a minor incident, but the patient clearly is not overly concerned. 4 Moderate - Patient expresses distinct concern over his responsibility for a real incident in his life but is not pre-occupied with it and attitude and behaviour are essentially unaffected. 5 Moderate Severe - Patient expresses a strong sense of guilt associated with self-deprecation or the belief that he deserves punishment. The guilt feelings may have a delusional basis, may be volunteered spontaneously, may be a source of preoccupation and/or depressed mood, and cannot be allayed readily by the interviewer. 6 Severe - Strong ideas of guilt take on a delusional quality and lead to an attitude of hopelessness or worthlessness. The patient believes he should receive harsh sanctions as such punishment. 7 Extreme - Patient's life is dominated by unshakable delusions of guilt, for which he feels deserving of drastic punishment, such as life imprisonment, torture, or death. There may be associated suicidal thoughts or attribution of others' problems to one's own past misdeeds.

G4.	TENSION -Overt physical manifestations of fear, anxiety, and agitation, such as stiffness, tremor, profuse sweating and restlessness. Basis for rating - Verbal report attesting to anxiety and thereupon the severity of physical manifestations of tension observed during the interview.
	<ol style="list-style-type: none"> 1 Absent - Definition does not apply 2 Minimal - Questionable pathology; may be at the upper extreme of normal limits 3 Mild - Posture and movements indicate slight apprehensiveness, such as minor rigidity, occasional restlessness, shifting of position, or fine rapid hand tremor. 4 Moderate - A clearly nervous appearance emerges from various manifestations, such as fidgety behaviour, obvious hand tremor, excessive perspiration, or nervous mannerisms. 5 Moderate Severe - Pronounced tension is evidenced by numerous manifestations, such as nervous shaking, profuse sweating and restlessness, but can conduct in the interview is not significantly affected. 6 Severe - Pronounced tension to the point that interpersonal interactions are disrupted. The patient, for example, may be constantly fidgeting, unable to sit still for long, or show hyperventilation. 7 Extreme - Marked tension is manifested by signs of panic or gross motor acceleration, such as rapid restless pacing and inability to remain seated for longer than a minute, which makes sustained conversation not possible.

G5. **MANNERISMS AND POSTURING** – Unnatural movements or posture as characterised by an awkward, stilted, disorganised, or bizarre appearance.

Basis for rating - Observation of physical manifestations during the course of interview as well as reports from primary care workers or family.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - Slight awkwardness in movements or minor rigidity of posture
- 4 **Moderate** – Movements are notably awkward or disjointed, or an unnatural posture is maintained for brief periods.
- 5 **Moderate Severe** - Occasional bizarre rituals or contorted posture are observed, or an abnormal position is sustained for extended periods.
- 6 **Severe** - Frequent repetition of bizarre rituals, mannerisms or stereotyped movements, or a contorted posture is sustained for extended periods.
- 7 **Extreme** - Functioning is seriously impaired by virtually constant involvement in ritualistic, manneristic, or stereotyped movements or by an unnatural fixed posture which is sustained most of the time.

G6. **DEPRESSION** - Feelings of sadness, discouragement, helplessness and pessimism.

Basis for rating - Verbal report of depressed mood during the course of interview and its observed influence on attitude and behaviour.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - Expresses some sadness or discouragement only on questioning, but there is no evidence of depression in general attitude or demeanor.
- 4 **Moderate** - Distinct feelings of sadness or hopelessness, which may be spontaneously divulged, but depressed mood has no major impact on behaviour or social functioning and the patient usually can be cheered up.
- 5 **Moderate Severe** - Distinctly depressed mood is associated with obvious sadness, pessimism, loss of social interest, psychomotor retardation and some interference in appetite and sleep. The patient cannot be easily cheered up.
- 6 **Severe** - Markedly depressed mood is associated with sustained feelings of misery, occasional crying, hopelessness and worthlessness. In addition, there is major interference in appetite and or sleep as well as in normal motor and social functions, with possible signs of self-neglect.
- 7 **Extreme** - Depressive feelings seriously interfere in most major functions. The manifestations include frequent crying, pronounced somatic symptoms, impaired concentration, psychomotor retardation, social disinterest, self neglect, possible depressive or nihilistic delusions and/or possible suicidal thoughts or action.

G7. **MOTOR RETARDATION** – Reduction in motor activity as reflected in slowing or lessening of movements and speech, diminished responsiveness of stimuli, and reduced body tone.

Basis for rating - Manifestations during the course of interview as well as reports by primary care workers as well as family.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - Slight but noticeable diminution in rate of movements and speech. Patient may be somewhat underproductive in conversation and gestures.
- 4 **Moderate** - Patient is clearly slow in movements, and speech may be characterised by poor productivity including long response latency, extended pauses or slow pace.
- 5 **Moderate Severe** – A marked reduction in motor activity renders communication highly unproductive or delimits functioning in social and occupational situations. Patient can usually be found sitting or lying down.
- 6 **Severe** - Movements are extremely slow, resulting in a minimum of activity and speech. Essentially the day is spent sitting idly or lying down.
- 7 **Extreme** - Patient is almost completely immobile and virtually unresponsive to external stimuli.

G8. **UNCOOPERATIVENESS** - Active refusal to comply with the will of significant others, including the interviewer, hospital staff or family, which may be associated with distrust, defensiveness, stubbornness, negativism, rejection of authority, hostility or belligerence.

Basis for rating - Interpersonal behaviour observed during the course of the interview as well as reports by primary care workers or family.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - Complies with an attitude of resentment, impatience, or sarcasm. May inoffensively object to sensitive probing during the interview.
- 4 **Moderate** - Occasional outright refusal to comply with normal social demands, such as making own bed, attending scheduled programmes, etc. The patient may project a hostile, defensive or negative attitude but usually can be worked with.
- 5 **Moderate Severe** - Patient frequently is incompliant with the demands of his milieu and may be characterised by others as an "outcast" or having "a serious attitude problem". Uncooperativeness is reflected in obvious defensiveness or irritability with the interviewer and possible unwillingness to address many questions.
- 6 **Severe** - Patient is highly uncooperative, negativistic and possibly also belligerent. Refuses to comply with the most social demands and may be unwilling to initiate or conclude the full interview.
- 7 **Extreme** - Active resistance seriously impact on virtually all major areas of functioning. Patient may refuse to join in any social activities, tend to personal hygiene, converse with family or staff and participate even briefly in an interview.

G9. **UNUSUAL THOUGHT CONTENT** - Thinking characterised by strange, fantastic or bizarre ideas, ranging from those which are remote or atypical to those which are distorted, illogical and patently absurd.

Basis for rating - Thought content expressed during the course of interview.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - Thought content is somewhat peculiar, or idiosyncratic, or familiar ideas are framed in an odd context.
- 4 **Moderate** - Ideas are frequently distorted and occasionally seem quite bizarre.
- 5 **Moderate Severe** - Patient expresses many strange and fantastic thoughts, (e.g. Being the adopted son of a king, being an escapee from death row), or some which are patently absurd (e.g. Having hundreds of children, receiving radio messages from outer space from a tooth filling).
- 6 **Severe** - Patient expresses many illogical or absurd ideas or some which have a distinctly bizarre quality (e.g. having three heads, being a visitor from another planet).
- 7 **Extreme** - Thinking is replete with absurd, bizarre and grotesque ideas.

G10. **DISORIENTATION** - Lack of awareness of one's relationship to the milieu, including persons, place and time, which may be due to confusion or withdrawal.

Basis for rating - Responses to interview questions on orientation.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - General orientation is adequate but there is some difficulty with specifics. For example, patient knows his location but not the street address, knows hospital staff names but not their functions, knows the month but confuses the day of the week with an adjacent day, or errs in the date by more than two days. There may be narrowing of interest evidenced by familiarity with the immediate but not extended milieu, such as ability to identify staff but not the mayor, governor, or president.
- 4 **Moderate** - Only partial success in recognising persons, places and time. For example, patient knows he is in a hospital but not its name, knows the name of the city but not the borough or district, knows the name of his primary therapist but not many other direct care workers, knows the year or season but not sure of the month.
- 5 **Moderate Severe** - Considerable failure in recognising persons, place and time. Patient has only a vague notion of where he is and seems unfamiliar with most people in his milieu. He may identify the year correctly or nearly but not know the current month, day of week or even the season.
- 6 **Severe** - Marked failure in recognising persons, place and time. For example, patient has no knowledge of his whereabouts, confuses the date by more than one year, can name only one or two individuals in his current life.
- 7 **Extreme** - Patient appears completely disorientated with regard to persons, place and time. There is gross confusion or total ignorance about one's location, the current year and even the most familiar people, such as parents, spouse, friends and primary therapist.

G11. POOR ATTENTION - Failure in focused alertness manifested by poor concentration, distractibility from internal and external stimuli, and difficulty in harnessing, sustaining or shifting focus to new stimuli.

Basis for rating – Manifestations during the course of interview.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - Limited concentration evidenced by occasional vulnerability to distraction and faltering attention toward the end of the interview.
- 4 **Moderate** - Conversation is affected by the tendency to be easily distracted, difficulty in long sustaining concentration on a given topic, or problems in shifting attention to new topics.
- 5 **Moderate Severe** - Conversation is seriously hampered by poor concentration, distractibility, and difficulty in shifting focus appropriately..
- 6 **Severe** - Patient's attention can be harnessed for only brief moments or with great effort, due to marked distraction by internal or external stimuli.
- 7 **Extreme** - Attention is so disrupted that even brief conversation is not possible.

G12. LACK OF JUDGEMENT AND INSIGHT - Impaired awareness or understanding of one's own psychiatric condition and life situation. This is evidenced by failure to recognise past or present psychiatric illness or symptoms, denial of need for psychiatric hospitalisation or treatment, decisions characterised by poor anticipation or consequences, and unrealistic short-term and long-range planning.

Basis for rating – Thought content expressed during the interview.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - Recognises having a psychiatric disorder but clearly underestimates its seriousness, the implications for treatment, or the importance of taking measures to avoid relapse. Future planning may be poorly conceived.
- 4 **Moderate** - Patient shows only a vague or shallow recognition of illness. There may be fluctuations in acknowledgement of being ill or little awareness of major symptoms which are present, such as delusions, disorganised thinking, suspiciousness and social withdrawal. The patient may rationalise the need for treatment in terms of its relieving lesser symptoms, such as anxiety, tension and sleep difficulty.
- 5 **Moderate Severe** - Acknowledges past but not present psychiatric disorder. If challenged, the patient may concede the presence of some unrelated or insignificant symptoms, which tend to be explained away by gross misinterpretation or delusional thinking. The need for psychiatric treatment similarly goes unrecognised.
- 6 **Severe** - Patient denies ever having had a psychiatric disorder. He disavows the presence of any psychiatric symptoms in the past or present and, though compliant, denies the need for treatment and hospitalisation.
- 7 **Extreme** - Emphatic denial of past and present psychiatric illness. Current hospitalisation and treatment are given a delusional interpretation (e.g. as punishment for misdeeds, as persecution by tormentors, etc), and the patient thus refuse to cooperate with therapists, medication or other aspects of treatment.

G13. DISTURBANCE OF VOLITION – Disturbance in the wilful initiation, sustenance and control of one's thoughts, behaviour, movements and speech.

Basis for rating - Thought content and behaviour manifested in the course of interview.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - There is evidence of some indecisiveness in conversation and thinking, which may impede verbal and cognitive processes to a minor extent.
- 4 **Moderate** - Patient is often ambivalent and shows clear difficulty in reaching decisions. Conversation may be marred by alteration in thinking, and in consequence, verbal and cognitive functioning are clearly impaired.
- 5 **Moderate Severe** - Disturbance of volition interferes in thinking as well as behaviour. Patient shows pronounced indecision that impedes the initiation and continuation of social and motor activities, and which also may be evidence in halting speech.
- 6 **Severe** - Disturbance of volition interferes in the execution of simple automatic motor functions, such as dressing or grooming, and markedly affects speech.
- 7 **Extreme** – Almost complete failure of volition is manifested by gross inhibition of movement and speech resulting in immobility and/or mutism.

G14. POOR IMPULSE CONTROL - Disordered regulation and control of action on inner urges, resulting in sudden, unmodulated, arbitrary or misdirected discharge of tension and emotions without concern about consequences.

Basis for rating - Behaviour during the course of interview and reported by primary care workers or family.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - Patient tends to be easily angered and frustrated when facing stress or denied gratification but rarely acts on impulse.
- 4 **Moderate** - Patient gets angered and verbally abusive with minimal provocation. May be occasionally threatening, destructive, or have one or two episodes involving physical confrontation or a minor brawl.
- 5 **Moderate Severe** - Patient exhibits repeated impulsive episodes involving verbal abuse, destruction of property, or physical threats. There may be one or two episodes involving serious assault, for which the patient requires isolation, physical restraint, or p.r.n. sedation.
- 6 **Severe** - Patient frequently is impulsive aggressive, threatening, demanding, and destructive, without any apparent consideration of consequences. Shows assultive behaviour and may also be sexually offensive and possibly respond behaviourally to hallucinatory commands.
- 7 **Extreme** - Patient exhibits homicidal, sexual assaults, repeated brutality, or self-destructive behaviour. Requires constant direct supervision or external constraints because of inability to control dangerous impulses.

G15. PREOCCUPATION - Absorption with internally generated thoughts and feelings and with autistic experiences to the detriment of reality orientation and adaptive behaviour.

Basis for rating - Interpersonal behaviour observed during the course of interview.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - Excessive involvement with personal needs or problems, such that conversation veers back to egocentric themes and there is diminished concerned exhibited toward others.
- 4 **Moderate** - Patient occasionally appears self-absorbed, as if daydreaming or involved with internal experiences, which interferes with communication to a minor extent.
- 5 **Moderate Severe** - Patient often appears to be engaged in autistic experiences, as evidenced by behaviours that significantly intrude on social and communicational functions, such as the presence of a vacant stare, muttering or talking to oneself, or involvement with stereotyped motor patterns.
- 6 **Severe** - Marked preoccupation with autistic experiences, which seriously delimits concentration, ability to converse, and orientation to the milieu. The patient frequently may be observed smiling, laughing, muttering, talking, or shouting to himself.
- 7 **Extreme** - Gross absorption with autistic experiences, which profoundly affects all major realms of behaviour. The patient constantly may be responding verbally or behaviourally to hallucinations and show little awareness of other people or the external milieu.

G16. ACTIVE SOCIAL AVOIDANCE - Diminished social involvement associated with unwarranted fear, hostility, or distrust.

Basis for rating - Reports of social functioning primary care workers or family.

- 1 **Absent** - Definition does not apply
- 2 **Minimal** - Questionable pathology; may be at the upper extreme of normal limits
- 3 **Mild** - Patient seems ill at ease in the presence of others and prefers to spend time alone, although he participates in social functions when required.
- 4 **Moderate** - Patient begrudgingly attends all or most social activities but may need to be persuaded or may terminate prematurely on account of anxiety, suspiciousness, or hostility.
- 5 **Moderate Severe** - Patient fearfully or angrily keeps away from many social interactions despite others' efforts to engage him. Tends to spend unstructured time alone.
- 6 **Severe** - Patient participates in very few social activities because of fear, hostility, or distrust. When approached, the patient shows a strong tendency to break off interactions, and generally he tends to isolate himself from others.
- 7 **Extreme** - Patient cannot be engaged in social activities because of pronounced fears, hostility, or persecutory delusions. To the extent possible, he avoids all interactions and remains isolated from others.

See SANS Manual for detailed coding definitions (N. Andreasen, 1984).

INTERVIEWER: Ratings are to be based on the last 30 days.

NONE → SEVERE UNK

AFFECTIVE FLATTENING OR BLUNTING

1. **Unchanging Facial Expression**

The patient's face appears wooden--changes less than expected as emotional content of discourse changes.

0 1 2 3 4 5 U

2. **Decreased Spontaneous Movements**

The patient shows few or no spontaneous movements, does not shift position, move extremities, etc.

0 1 2 3 4 5 U

3. **Paucity of Expressive Gestures**

The patient does not use hand gestures or body position as an aid in expressing his ideas.

0 1 2 3 4 5 U

4. **Poor Eye Contact**

The patient avoids eye contact or "stares through" interviewer even when speaking.

0 1 2 3 4 5 U

5. **Affective Nonresponsivity**

The patient fails to laugh or smile when prompted.

0 1 2 3 4 5 U

6. **Inappropriate Affect**

The patient's affect is inappropriate or incongruous, not simply flat or blunted.

0 1 2 3 4 5 U

7. **Lack of Vocal Inflections**

The patient fails to show normal vocal emphasis patterns, is often monotonic.

0 1 2 3 4 5 U

8. **Global Rating of Affective Flattening**

This rating should focus on overall severity of symptoms, especially unresponsiveness, inappropriateness and an overall decrease in emotional intensity.

0 1 2 3 4 5 U

ALOGIA

9. **Poverty of Speech**

The patient's replies to questions are restricted in amount, tend to be brief, concrete, unelaborated.

0 1 2 3 4 5 U

10. **Poverty of Content of Speech**

The patient's replies are adequate in amount but tend to be vague, over concrete or over generalized, and convey little in information.

0 1 2 3 4 5 U

SANS CODES

0 = None/Not at All
1 = Questionable
2 = Mild

3 = Moderate
4 = Marked
5 = Severe

U = Unknown/
Cannot Be Assessed/
Not Assessed

NONE → SEVERE UNK

- | | | | | | | | | |
|-----|--|---|---|---|---|---|---|---|
| 11. | Blocking
The patient indicates, either spontaneously or with prompting, that his train of thought was interrupted. | 0 | 1 | 2 | 3 | 4 | 5 | U |
| 12. | Increased Latency of Response
The patient takes a long time to reply to questions, prompting indicates the patient is aware of the question. | 0 | 1 | 2 | 3 | 4 | 5 | U |
| 13. | Global Rating of Alogia
The core features of alogia are poverty of speech and poverty of content. | 0 | 1 | 2 | 3 | 4 | 5 | U |

AVOLITION/APATHY

- | | | | | | | | | |
|-----|---|---|---|---|---|---|---|---|
| 14. | Grooming and Hygiene
The patient's clothes may be sloppy or soiled, and he may have greasy hair, body odor, etc. | 0 | 1 | 2 | 3 | 4 | 5 | U |
| 15. | Inpersistence at Work or School
The patient has difficulty seeking or maintaining employment, completing school work, keeping house, etc. If an inpatient, cannot persist at ward activities, such as OT, playing cards, etc. | 0 | 1 | 2 | 3 | 4 | 5 | U |
| 16. | Physical Anergia
The patient tends to be physically inert. He may sit for hours and not initiate spontaneous activity. | 0 | 1 | 2 | 3 | 4 | 5 | U |
| 17. | Global Rating of Avolition/Apathy
Strong weight may be given to one or two prominent symptoms if particularly striking. | 0 | 1 | 2 | 3 | 4 | 5 | U |

ANHEDONIA/ASOCIALITY

18. **Recreational Interests and Activities** 0 1 2 3 4 5 U
The patient may have few or no interests.
Both the quality and quantity of
interests should be taken into account.

SANS CODES		
0 = None/Not at All	3 = Moderate	U = Unknown/
1 = Questionable	4 = Marked	Cannot Be Assessed/
2 = Mild	5 = Severe	Not Assessed

NONE —————→ SEVERE UNK

19. Sexual Activity

The patient may show decrease in sexual interest and activity, or no enjoyment when active.

0 1 2 3 4 5 U

20. Ability to Feel Intimacy and Closeness

The patient may display an inability to form close or intimate relationships, especially with opposite sex and family.

0 1 2 3 4 5 U

21. Relationships with Friends and Peers

The patient may have few or no friends and may prefer to spend all his time isolated.

0 1 2 3 4 5 U

22. Global Rating of Anhedonia/Asociality

This rating should reflect overall severity, taking into account the patient's age, family status, etc.

0 1 2 3 4 5 U

ATTENTION

23. Social Inattentiveness

The patient appears unininvolved or unengaged. He may seem "spacey".

0 1 2 3 4 5 U

24. Inattentiveness During Mental Status Testing

Refer to tests of "serial 7s" (at least five subtractions) and spelling "world" backwards.

0 1 2 3 4 5 U

25. Global Rating of Attention

This rating should assess the patient's overall concentration, both clinically and on tests.

0 1 2 3 4 5 U

SANS CODES

0 = None/Not at All	3 = Moderate	U = Unknown/
1 = Questionable	4 = Marked	Cannot Be Assessed/
2 = Mild	5 = Severe	Not Assessed

Psychiatric University Hospital Zurich, Division of Clinical Psychiatry**SCALE FOR THE ASSESSMENT OF POSITIVE SYMPTOMS****S A P S****Nancy C. Andreasen**

STUDY	[____]	1-4
GROUP	[____]	5-6
PATIENT	[____]	7-9
RATING DAY	[____]	10-12
CARD NUMBER	[____]	13-14
Sex (1=male, 2=female)	[____]	15
Birthday (dd.mm.yyyy)	[____ : ____ : ____]	16-23
Date of hospitalization (dd.mm.yyyy)	[____ : ____ : ____]	24-31
First diagnosis	[____ · ____]	32-36
Second diagnosis	[____ · ____]	37-41
Diagnostic system (1=ICD9, 2=ICD10, 3=DSM3-R, 4=DSM4)	[____]	42
Age at onset	[____]	43-44
Course (1=first manifestation, 2=intermittent, 3=progradient, 4=chronic)	[____]	45
Duration of Current Episode Prior to Hospitalization (days)	[____]	46-48
Medication Prior to Hospitalization (0=none, 1=antidepr., 2=neuroleptics, 3=other)	[____]	49
Current Medication (cf. list of codes)	[____]	50-52
Educational level (1=remedial, 2=junior high, 3=high, 4=college)	[____]	53
DATE (dd.mm.yyyy)	[____ : ____ : ____]	54-61
INTERVIEWER	[____]	62-64
HOSPITAL	[____]	65-66
PATIENT ID (the hospital's internal PID)	[_____]	67-78



0=None	1=Questionable	2=Mild	3=Moderate	4=Marked	5=Severe
---------------	-----------------------	---------------	-------------------	-----------------	-----------------

1-12 dupl

0. CARD NUMBER

[___] 13-14

1. HALLUCINATIONS

- 1 Auditory Hallucinations** [___] 15
The patient reports voices, noises, or other sounds that no one else hears.
- 2 Voices commenting** [___] 16
The patient reports a voice which makes a running commentary on his behavior or thoughts.
- 3 Voices Conversing** [___] 17
The patient reports hearing two or more voices conversing.
- 4 Somatic or Tactile Hallucinations** [___] 18
The patient reports experiencing peculiar physical sensations in the body.
- 5 Olfactory Hallucinations** [___] 19
The patient reports experiencing unusual smells which no one else notices.
- 6 Visual Hallucinations** [___] 20
The patient sees shapes or people that are not actually present.
- 7 Global Rating of Hallucinations** [___] 21
This rating should be based on the duration and severity of the hallucinations and their effects on the patient's life.

2. DELUSIONS

- 8 Persecutory Delusions** [___] 22
The patient believes he is being conspired against or persecuted in some way.
- 9 Delusions of Jealousy** [___] 23
The patient believes his spouse is having an affair with someone.
- 10 Delusions of Guilt or Sin** [___] 24
The patient believes that he has committed some terrible sin or done something unforgivable.
- 11 Grandiose Delusions** [___] 25
The patient believes he has special powers or abilities.

0=None	1=Questionable	2=Mild	3=Moderate	4=Marked	5=Severe
---------------	-----------------------	---------------	-------------------	-----------------	-----------------

- 12 Religious Delusions** [__] 26
The patient is preoccupied with false beliefs of a religious nature.
- 13 Somatic Delusions** [__] 27
The patient believes that somehow his body is diseased, abnormal, or changed.
- 14 Delusions of Reference** [__] 28
The patient believes that insignificant remarks or events refer to him or have special meaning.
- 15 Delusions of Being Controlled** [__] 29
The patient feels that his feelings or actions are controlled by some outside force.
- 16 Delusions of Mind Reading** [__] 30
The patient feels that people can read his mind or know his thoughts.
- 17 Thought Broadcasting** [__] 31
The patient believes that his thoughts are broadcast so that he himself or others can hear them.
- 18 Thought Insertion** [__] 32
The patient believes that thoughts that are not his own have been inserted into his mind.
- 19 Thought Withdrawal** [__] 33
The patient believes that thoughts have been taken away from his mind.
- 20 Global Rating of Delusions** [__] 34
This rating should be based on the duration and persistence of the delusions and their effect on the patient's life.

3. BIZARRE BEHAVIOR

- 21 Clothing and Appearance** [__] 35
The patient dresses in an unusual manner or does other strange things to alter his appearance.
- 22 Social and Sexual Behavior** [__] 36
The patient may do things considered inappropriate according to usual social norms (e.g., masturbating in public).
- 23 Aggressive and Agitated Behavior** [__] 37
The patient may behave in an aggressive, agitated manner, often unpredictably.

0=None	1=Questionable	2=Mild	3=Moderate	4=Marked	5=Severe
---------------	-----------------------	---------------	-------------------	-----------------	-----------------

- 24 Repetitive or Stereotyped Behavior** [__] 38
 The patient develops a set of repetitive actions or rituals that he must perform over and over.

- 25 Global Rating of Bizarre Behavior** [__] 39
 This rating should reflect the type of behavior and the extent to which it deviates from social norms.

4. POSITIVE FORMAL THOUGHT DISORDER

- 26 Derailment** [__] 40
 A pattern of speech in which ideas slip off track onto ideas obliquely related or unrelated.
- 27 Tangentiality** [__] 41
 The patient replies to a question in an oblique or irrelevant manner.
- 28 Incoherence** [__] 42
 A pattern of speech that is essentially incomprehensible at times.
- 29 Illogicality** [__] 43
 A pattern of speech in which conclusions are reached that do not follow logically.
- 30 Circumstantiality** [__] 44
 A pattern of speech that is very indirect and delayed in reaching its goal idea.
- 31 Pressure of Speech** [__] 45
 The patient's speech is rapid and difficult to interrupt; the amount of speech produced is greater than that considered normal.
- 32 Distractable Speech** [__] 46
 The patient is distracted by nearby stimuli which interrupt his flow of speech.
- 33 Changing** [__] 47
 A pattern of speech in which sounds rather than meaningful relationships govern word choice.
- 34 Global Rating of Positive Formal Thought Disorder** [__] 48
 This rating should reflect the frequency of abnormality and the extent to which this affects the patient's ability to communicate.

Bush-Francis Catatonia Rating Scale

Severity Score (Number of points for items 1 -23) _____

Screening Score (Presence or absence of items 1 – 14) _____

Number of items 1-23 _____

Patient: _____ Date: _____ Time: _____ Examiner: _____

1. Immobility/stupor: Extreme hypoactivity, immobile, minimally responsive to stimuli.

- 0 - Absent.
- 1 - Sits abnormally still, may interact briefly.
- 2 - Virtually no interaction with external world.
- 3 - Stuporous, non-reactive to painful stimuli.

2. Mutism: Verbally unresponsive or minimally responsive.

- 0 = Absent.
- 1 = Verbally unresponsive to majority of questions; incomprehensible whisper.
- 2 = Speaks less than 20 words/5mins.
- 3 = No speech.

3. = Staring: Fixed gaze, little or no visual scanning of environment, decreased blinking.

- 0 = Absent.
- 1 = Poor eye contact, repeatedly gazes less than 20 s between shifting of attention; decreased blinking.
- 2 = Gaze held longer than 20 s, occasionally shifts attention.
- 3 = Fixed gaze, non-reactive.

4. Posturing/catalepsy: Spontaneous maintenance of posture (s), including mundane (e.g. sitting or standing for long periods without reacting).

- 0 = Absent.
- 1 = Less than 1 min.
- 2 Greater than one minute, less than 15 min.
- 3 Bizarre posture, or mundane maintained more than 15 min.

5. Grimacing: Maintenance of odd facial expressions.

- 0 = Absent.
- 1 = Less than 10seconds.
- 2 = Less than 1 min.
- 3 = Bizarre expression(s) or maintained more than 1 min.

6. Echopraxia/echolalia: Mimicking of examiner's movements (echopraxia) or speech (echolalia).

- 0 = Absent
- 1 = Occasional.
- 2 = Frequent.
- 3 = Constant

7. Stereotypy: Repetitive, non-goal-directed motor activity (e.g. finger-play, repeatedly touching, patting or rubbing self); abnormality not inherent in act but in its frequency.

- 0 - Absent
- 1 - Occasional.
- 2 - Frequent.

3 - Constant.

8. Mannerisms: Odd, purposeful movements (hopping or walking tiptoe, saluting passers-by or exaggerated caricatures of mundane movements); abnormality inherent in act itself.

0 - Absent

1 - Occasional.

2 - Frequent.

3 - Constant.

9. Stereotyped & meaningless repetition of words & phrases (verbigeration): Repetition of phrases or sentences (like a scratched records).

0 - Absent.

1 - Occasional.

2 - Frequent, difficult to interrupt.

3 - Constant.

10. Rigidity: Maintenance of a rigid position despite efforts to be moved (exclude if cog-wheeling or tremor present)

0 = Absent.

1 = Mild resistance.

2 = Moderate.

3 = Severe, cannot be repositioned.

11. Negativism: Apparently motiveless resistance to instructions or attempts to move/examine patients. Contrary behavior, does exact opposite of instruction.

0 - Absent

1 - Mild resistance and/or occasionally contrary.

2 - Moderate resistance and/or frequently contrary.

3 - Severe resistance and/or continually contrary.

12. Waxy flexibility: During repositioning of patient, patient offers initial resistance before allowing him/herself to be repositioned, similar to that of a bending candle. (also defined as slow resistance to movement as the patient allows the examiner to place his/her extremities in unusual positions. The limb may remain in the position in which they are placed or not)

0 - Absent

3 - Present.

13. Withdrawal: Refusal to eat, drink and/or make eye contact.

0 = Absent.

1 = Minimal oral intake/interaction for less than 1 day.

2 = Minimal oral intake/interaction for more than 1 day.

3 = No oral intake/interaction for 1 day or more.

14. Excitement: Extreme hyperactivity, constant motor unrest which is apparently non-purposeful.

Not to be attributed to akathisia or goal-directed agitation.

1 - Excessive motion, intermittent.

2 - Constant motion, hyperkinetic without rest periods.

3 - Full-blown catatonic excitement, endless frenzied motor activity.

15. Impulsivity: Patient suddenly engages in inappropriate behavior (e.g. runs down hallway, starts screaming or takes off clothes) without provocation. Afterwards can give no, or only a facile explanation.

0 - Absent.
1 - Occasional.
2 - Frequent.
3 - Constant or not redirectable.

16. Automatic obedience: Exaggerated cooperation with examiner's request or spontaneous continuation of movement requested.

0 = Absent.
1 = Occasional
2 = Frequent
3 = Constant.

17. Passive Obedience (mitgehen): Patient raises arm in response to light pressure of finger, despite instructions to the contrary.

0 = Absent.
3 = Present.

18. Muscle Resistance (gegenhalten): Involuntary resistance to passive movement of a limb to a new position. Resistance increases with the speed of the movement.

0 - Absent
3 - Present.

19. Motorically Stuck (ambitendency): Patient appears stuck in indecisive, hesitant motor movements.

0 - Absent.
3 = Present.

20. Grasp reflex: Striking the patient's open palm with two extended fingers of the examiner's hand results in automatic closure of patients hand.

0 = Absent
3 = Present

21. Perseveration: Repeatedly returns to same topic or persists with the same movements.

0 = Absent.
3 = Present.

22. Combativeness: Belligerence or aggression, Usually in an undirected manner, without explanation.

0 = Absent
1 = Occasionally strikes out, low potential for injury.
2 = Frequently strikes out, moderate potential for injury.
3 = Serious danger to others.

23. Autonomic abnormality: Abnormality of body temperature (fever), blood pressure, pulse, respiratory rate, inappropriate sweating, flushing.

0 = Absent
1 = Abnormality of one parameter (exclude pre-existing hypertension).
2 = Abnormality of two parameters.
3 = Abnormality of three or more parameters.

Appendix I - Standardized examination for catatonia. The method described here is used to complete the 23-item Bush-Francis Catatonia Rating Scale (CRS) and the 14-item Catatonia Screening Instrument (CSI). Item definitions on the two scales are the same. The CRS measures the severity of 23 signs on a 0- 3 scale, while the CSI measures only the presence or absence of the first 14 signs.

Ratings are to be made solely on the basis of observed behaviour during the examination with the exception of completion of the items for 'withdrawal' and 'autonomic abnormality', which may be based on directly observed behaviour and for chart documentation. As a general rule, only rate items which are clearly present. If uncertain as to the presence of an item, rate the item as '0'.

	Procedure	Examines
1	Observe patient while trying to engage in a conversation	Activity level, Abn movements Abn speech
2	Examiner scratches head in exaggerated manner	Echopraxia
3	Examine arm for cogwheeling. Attempt to reposture, instructing patient to "keep your arm loose" - move arm with alternating lighter & heavier force.	Negativism, Waxy flexibility
4	Ask patient to extend arm. Place one finger beneath hand and try to raise slowly after stating, "Do NOT let me raise your arm".	Passive obedience
5	Extend hand stating "Do NOT shake my hand". Gets stuck trying to do both.	Motorically stuck
6	Reach into pocket and state, "Stick out your tongue, I want to stick a pin in it".	Automatic obedience
7	Check for grasp reflex.	Grasp reflex
8	Check chart for reports of previous 24-hour period. In particular check for oral intake, vital signs, and any incidents.	
9	Observe patient indirectly, at least for a brief period, each day.	
	Fink, 1996, c/o David Healy, Modified by Miles, 2013	

References:

Bush G, Fink M, Petrides G, Dowling F, Francis A. Catatonia. I. Rating scale and standardized examination. *Acta Psychiatr Scand.* 1996;93(2):129–136.

Francis A. Catatonia: diagnosis, classification and treatment. *Curr Psychiatry Rep.* 2010;12:180-185.

Dhossche DM. Decalogue of catatonia in autism spectrum disorder. *Front Psychiatry.* 2014;5:1-4.

SANTA CLARA COUNTY MENTAL HEALTH

AIMS Examination Procedure

Instructions:

- Should be completed before entering the ratings on the AIMS form.
 - Either before or after completing the Examination Procedure, observe the patient unobtrusively at rest (i.e., in waiting room).
 - The chair to used in this examination should be a hard, firm one without arms
-

1. Ask patient whether there is anything in his/her mouth (i.e., gum, candy, etc) and if there is, to remove it.
2. Ask patient about the current condition of his/her teeth. Ask patient if he/she wears dentures. Do teeth or dentures bother patient now?
3. Ask patient whether he/she notices any movements in mouth, face, hands, or feet. If yes, ask to describe and to what extent they currently bother patient or interfere with his/her activities.
4. Have patient sit in chair with hands on knees, legs slightly apart, and feet flat on floor. (Look at entire body for movements while in this position).
5. Ask patient to sit with hands hanging unsupported. If male, between legs, if female, and wearing a dress, hanging over knees. (Observe hands and other body areas.)
6. Ask patient to open mouth. (Observe tongue at rest within mouth.) Do this twice.
7. Ask patient to protrude tongue. (Observe abnormalities of tongue movement.)
8. **Ask patient to tap thumb, with each finger, as rapidly as possible for 10-15 seconds: separately with right hand, then with left hand. (Observe facial and leg movements.)
9. Flex and extend patient's left and right arms, one at a time. (Note any rigidity and rate it.)
10. Ask patient to stand up. (Observe in profile. Observe all body areas again, hips included.)
11. **Ask patient to extend both arms outstretched in front with palms down. (Observe trunk, legs, and mouth.)
12. **Have patient walk a few paces, turn, and walk back to chair. (Observe hands and gait.) Do this twice.

**Activated movements.

SANTA CLARA COUNTY MENTAL HEALTH

Confidential Patient Information
See Welfare & Institution Code 5328

Patient Name _____
(Last, First, MI)
Unicare #_____
Provider _____

ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

Instructions: Complete Examination Procedure before making ratings.

Code: 0=None, 1=Minimal, may be extreme normal, 2=Mild, 3=Moderate, 4=Severe

MOVEMENT RATINGS: Rate highest severity observed. Rate movements that occur upon activation one less than those observed spontaneously. Circle movement as well as code number that applies.		
Facial and oral movements	1. Muscles of Facial Expression e.g. Movements of forehead, eyebrows, periorbital area, cheeks, including frowning, blinking, smiling, and grimacing.	0 1 2 3 4
	2. Lips and Perioral Area e.g. puckering, pouting, smacking	0 1 2 3 4
	3. Jaw e.g. biting, clenching, chewing, mouth opening, lateral movement	0 1 2 3 4
	4. Tongue Rate only increases in movement both in and out of mouth. NOT inability to sustain movement. Darting in and out of mouth.	0 1 2 3 4
Extremity Movements	5. Upper (arms, wrists, hands, fingers) Include choreic movements (e.g. rapid, objectively purposeless, irregular, complex, serpentine). DO NOT INCLUDE TREMOR (e.g. repetitive, regular, rhythmic)	0 1 2 3 4
	6. Lower (legs, knees, ankles, toes) e.g. lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot.	0 1 2 3 4
Trunk Movements	7. Neck, shoulders, hip e.g. rocking, twisting, squirming, pelvic gyrations	0 1 2 3 4
Global Judgments	8. Severity of abnormal movements overall	0 1 2 3 4
	9. Incapacitation due to abnormal movements	0 1 2 3 4
	10. Patient's awareness of abnormal movements 0=No awareness, 1=Aware, no distress, 2=Aware, mild distress, 3=Aware, moderate distress, 4=Aware, severe distress	0 1 2 3 4
Dental Status	11. Current problems with teeth and/or dentures	No Yes
	12. Are dentures usually worn?	No Yes
	13. Edentia?	No Yes
	14. If known, do movements disappear in sleep?	No Yes NA

Doctor Signature: _____

Date: _____

2 of 2

10.07 XC

Name: _____

Date: _____

Barnes Akathisia Rating Scale (BARS)

Instructions: Patient should be observed while they are seated, and then standing while engaged in neutral conversation (for a minimum of two minutes in each position). Symptoms observed in other situations, for example while engaged in activity on the ward, may also be rated. Subsequently, the subjective phenomena should be elicited by direct questioning.

Objective

- 0 Normal, occasional fidgety movements of the limbs
- 1 Presence of characteristic restless movements: shuffling or tramping movements of the legs/feet, or swinging of one leg while sitting, *and/or* rocking from foot to foot or “walking on the spot” when standing, but movements present for less than half the time observed
- 2 Observed phenomena, as described in (1) above, which are present for at least half the observation period
- 3 Patient is constantly engaged in characteristic restless movements, *and/or* has the inability to remain seated or standing without walking or pacing, during the time observed

Subjective

Awareness of restlessness

- 0 Absence of inner restlessness
- 1 Non-specific sense of inner restlessness
- 2 The patient is aware of an inability to keep the legs still, or a desire to move the legs, *and/or* complains of inner restlessness aggravated specifically by being required to stand still
- 3 Awareness of intense compulsion to move most of the time *and/or* reports strong desire to walk or pace most of the time

Distress related to restlessness

- 0 No distress
- 1 Mild
- 2 Moderate
- 3 Severe

Global Clinical Assessment of Akathisia

- 0 *Absent.* No evidence of awareness of restlessness. Observation of characteristic movements of akathisia in the absence of a subjective report of inner restlessness or compulsive desire to move the legs should be classified as pseudoakathisia
- 1 *Questionable.* Non-specific inner tension and fidgety movements
- 2 *Mild akathisia.* Awareness of restlessness in the legs *and/or* inner restlessness worse when required to stand still. Fidgety movements present, but characteristic restless movements of akathisia not necessarily observed. Condition causes little or no distress.
- 3 *Moderate akathisia.* Awareness of restlessness as described for mild akathisia above, combined with characteristic restless movements such as rocking from foot to foot when standing. Patient finds the condition distressing
- 4 *Marked akathisia.* Subjective experience of restlessness includes a compulsive desire to walk or pace. However, the patient is able to remain seated for at least five minutes. The condition is obviously distressing.
- 5 *Severe akathisia.* The patient reports a strong compulsion to pace up and down most of the time. Unable to sit or lie down for more than a few minutes. Constant restlessness which is associated with intense distress and insomnia.

Scoring the Barnes Akathisia Rating Scale (BARS)

The Barnes Akathisia Rating Scale is scored as follows:

Objective Akathisia, Subjective Awareness of Restlessness and Subjective Distress Related to Restlessness are rated on a 4-point scale from 0 – 3 and are summed yielding a total score ranging from 0 to 9.

The Global Clinical Assessment of Akathisia uses a 5-point scale ranging from 0 – 4.

Citation: Barnes TR. A rating scale for drug-induced akathisia. British Journal of Psychiatry 1989;154(5):672-676.
This scale can be reproduced freely.

Patient Name: _____ Rater Name and Date: _____

MODIFIED SIMPSON-ANGUS SCALE (MSAS) Extrapyramidal Side Effects Scale

Each item is rated on a 5-point scale of severity (0 = normal; 4 = most severe; NR = not rated). Circle the rating that best describes the subject's present condition (3 is upper limit for patients without EPS).

1. Gait: The patient is examined as he walks into the examining room: his gait, the swing of his arms, his general posture all form the basis for an overall score for this item. This is rated as follows:

*0 = Normal
1 = Diminution in swing while the subject is walking
2 = Marked diminution in swing with obvious rigidity in the arm
3 = Stiff gait with arms held rigidly before the abdomen
4 = Stooped, shuffling gait with propulsion and retropulsion
NR = Not ratable*

2. Arm Dropping: The patient and the examiner both raise their arms to shoulder height and let them fall to their sides. In a normal subject, a stout slap is heard as the arms hit the sides. In the patient with extreme Parkinson's Syndrome, the arms fall very slowly.

*0 = Normal, free fall with loud slap and rebound
1 = Fall slowed slightly with less audible contact and little rebound
2 = Fall slowed, no rebound
3 = Marked slowing, no slap at all
4 = Arms fall as though against resistance, as though through glue
NR = Not ratable*

3. Shoulder Shaking: The subject's arms are bent at a right angle at the elbow and are taken one at a time by the examiner, who also grasps one hand and also clasps the other around the subject's elbow. The subject's upper arm is pushed to and fro, and the humerus is externally rotated. The degree of resistance from normal to extreme rigidity is scored as follows:

*0 = Normal
1 = Slight stiffness and resistance
2 = Moderate stiffness and resistance
3 = Marked rigidity with difficulty in passive movement
4 = Extreme stiffness and rigidity with almost a frozen joint
NR = Not ratable*

4. Elbow Rigidity: The elbow joints are separately bent at right angles and passively extended and flexed, with the subject's biceps observed and simultaneously palpated. The resistance to this procedure is rated. (The presence of cogwheel rigidity is noted overall but not rated as a separate item.)

*0 = Normal
1 = Slight stiffness and resistance
2 = Moderate stiffness and resistance
3 = Marked rigidity with difficulty in passive movement
4 = Extreme stiffness and rigidity with almost a frozen joint
NR = Not ratable*

5. Wrist Rigidity or Fixation of Position: The wrist is held in one hand and the fingers held by the examiner's other hand, with the wrist moved to extension, flexion, and ulnar and radial deviation, or the extended wrist is allowed to fall under its own weight, or the arm can be grasped above the wrist and shaken to and fro. A "1" score would be a hand that extends easily, falls loosely, or flaps easily upwards and downwards.

*0 = Normal
1 = Slight stiffness and resistance
2 = Moderate stiffness and resistance
3 = Marked rigidity with difficulty in passive movement
4 = Extreme stiffness and rigidity with almost a frozen joint
NR = Not ratable*

6. Head Rotation: The subject sits or stands and is told that the examiner will move his head from side to side, that it will not hurt, and that he should try and relax. (Questions about pain in the cervical area or difficulty in moving his head should be obtained to avoid causing any pain.) Clasp the subject's head between the two hands with the fingers on the back of the neck. Gently rotate the head in a circular motion 3 times and evaluate the muscular resistance to this movement.

*0 = Loose, no resistance
1 = Slight resistance to movement
2 = Resistance is apparent and the time of rotation is shortened
3 = Resistance is obvious and rotation is slowed
4 = Head appears stiff and rotation is difficult to carry out
NR = Not ratable*

Patient Name: _____

Rater Name and Date: _____

7. Glabella Tap: The subject is told to open his eyes and not to blink. The glabella region is tapped at a steady, rapid speed. Note the number of times that the subject blinks in succession. Take care to stand behind the subject so that he does not observe the movement of the tapping finger. A full blink need not be observed; there may be a contraction of the infraorbital muscle producing a twitch each time a stimulus is delivered. Vary the speed of tapping to assure that the muscle contraction is related to the tap.

0 = 0 to 5 blinks
1 = 6 to 10 blinks
2 = 11 to 15 blinks
3 = 16 to 20 blinks
4 = 21 or more blinks
NR = Not ratable

8. Tremor: The subject is observed walking into the examining room and then is re-examined for this item with his arms extended at right angles to the body and the fingers spread out as far as possible.

0 = Normal
1 = Mild finger tremor, obvious to sight and touch
2 = Tremor of hand or arm occurring spasmodically
3 = Persistent tremor of one or more limbs
4 = Whole body tremor
NR = Not ratable

9. Salivation: The subject is observed while talking and then asked to open his mouth to elevate his tongue.

0 = Normal
1 = Excess salivation so that drooling takes place if mouth is opened and tongue is raised
2 = Excess salivation is present and might occasionally result in difficulty in speaking
3 = Speaking with difficulty because of excess drooling
4 = Frank drooling
NR = Not ratable

10. Akathisia: The subject is observed for restlessness. If restlessness is noted, ask, "Do you feel restless or jittery inside; is it difficult to sit still?" Subjective response is not necessary for scoring, but subject report can help make the assessment.

0 = No restlessness reported or observed
1 = Mild restlessness observed, e.g., occasional jiggling of the foot occurs when the subject is seated
2 = Moderate restlessness observed, e.g., on several occasions, the subject jiggles his foot, crosses and uncrosses his legs, or twists a part of the body
3 = Restlessness is frequently observed, e.g., the subject's foot or legs are moving most of the time
4 = Restlessness persistently observed, e.g., the subject cannot sit still, might get up and walk
NR = Not ratable

TOTAL SCORE: _____

Total Score Severity:

Less than 3 = normal

3 to 5 = minimal degree of movement disorder

6 to 11 = clinically significant degree of movement disorder

12 to 17 = severe degree of movement disorder is present

References:

Simpson GM, Angus JWS. A rating scale for extrapyramidal side effects. Acta Psychiatrica Scandinavica 1970;212(Suppl 44): 11-19.

Hawley CJ, Finneberg N, Roberts AG, Baldwin D, Sahadevan A, Sharman V. The use of the Simpson Angus Scale for the assessment of movement disorder: A training guide. Int J Psych Clin Pract 2003; 7: 249-257.

Rush J (2000) Handbook of Psychiatric Measures. Washington: American Psychiatric Publishing.

ADDENBROOKE'S COGNITIVE EXAMINATION - ACE-III

Indian English

Name:	Date of testing: _____ / _____ / _____
Date of Birth:	Tester's name: _____
Hospital No. or Address:	Age at leaving full-time education: _____
Languages Known:	Occupation: _____
Native Language:	Handedness: _____

ATTENTION

<ul style="list-style-type: none"> ➤ Ask: What is the Day _____ ➤ Ask: Which No./Floor _____ Street/Hospital _____ City _____ 	Month _____ Year _____ Season _____	State _____ Country _____	Attention [Score 0-5] <input type="checkbox"/>
---	-------------------------------------	---------------------------	---

ATTENTION

<ul style="list-style-type: none"> ➤ Tell: "I'm going to give you three words and I'd like you to repeat them after me: lemon, key and ball." After subject repeats, say "Try to remember them because I'm going to ask you later". ➤ Score <i>only</i> the first trial (repeat 3 times if necessary). ➤ Register number of trials: _____ 	Attention [Score 0-3] <input type="checkbox"/>
--	---

ATTENTION

<ul style="list-style-type: none"> ➤ Ask the subject: "Could you take 7 away from 100? I'd like you to keep taking 7 away from each new number until I tell you to stop." ➤ If subject makes a mistake, do not stop them. Let the subject carry on and check subsequent answers (e.g., 93, 84, 77, 70, 63 - score 4). ➤ Stop after five subtractions (93, 86, 79, 72, 65): _____ 	Attention [Score 0-5] <input type="checkbox"/>
---	---

MEMORY

<ul style="list-style-type: none"> ➤ Ask: 'Which 3 words did I ask you to repeat and remember?' _____ 	Memory [Score 0-3] <input type="checkbox"/>
--	--

FLUENCY

<ul style="list-style-type: none"> ➤ Letters Say: "I'm going to give you a letter of the alphabet and I'd like you to generate as many words as you can beginning with that letter, but not names of people or places. For example, if I give you the letter "C", you could give me words like "cat, cry, clock" and so on. But, you can't give me words like Catherine or Canada. Do you understand? Are you ready? You have one minute. The letter I want you to use is the letter "P". 	Fluency [Score 0 - 7] <input type="checkbox"/>
---	---

>14	7
11-14	6
8-10	5
6-7	4
3-5	3
2	2
1	1
0	0
Total	Correct

<ul style="list-style-type: none"> ➤ Animals Say: "Now can you name as many animals as possible. It can begin with any letter." 	Fluency [Score 0 - 7] <input type="checkbox"/>
---	---

>16	7
14-16	6
11-13	5
8-10	4
6-7	3
3-5	2
1-2	1
0	0
Total	Correct

MEMORY

- Tell: "I'm going to give you a name and address and I'd like you to repeat the name and address after me. So you have a chance to learn, we'll be doing that 3 times. I'll ask you the name and address later."

Score only the third trial.

Memory
[Score 0 - 7]

	<i>1st Trial</i>	<i>2nd Trial</i>	<i>3rd Trial</i>
Sunil Kumar Singh 52, Station Road, Gandhinagar, Allahabad.	_____	_____	_____

MEMORY

- Name the current Chief Minister.....
 ➤ Name the Prime Minister of India
- Name the actor who was hero in the film 'Mera Naam Joker'.....
 ➤ Name the Father of our Nation.....

Memory
[Score 0 - 4]

LANGUAGE

- Place a pencil and a piece of paper in front of the subject. As a practice trial, ask the subject to "**Pick up the pencil and then the paper.**" If incorrect, score 0 and do not continue further.
- If the subject is correct on the practice trial, continue with the following three commands below.
- Ask the subject to "**Place the paper on top of the pencil**"
 - Ask the subject to "**Pick up the pencil but not the paper**"
 - Ask the subject to "**Pass me the pencil after touching the paper**"
- Note: Place the pencil and paper in front of the subject before each command.

Language
[Score 0-3]

LANGUAGE

- Ask the subject to write two (or more) complete sentences about his/her last holiday/weekend/festival. Write in complete sentences and do not use abbreviations.
 Give 1 point if there are two (or more) complete sentences about the one topic; and give another 1 point if grammar and spelling are correct.

Language
[Score 0-2]

LANGUAGE

- Ask the subject to repeat: '**caterpillar**'; '**eccentricity**'; '**unintelligible**'; '**statistician**'
 Score 2 if all are correct; score 1 if 3 are correct; and score 0 if 2 or less are correct.

Language
[Score 0-2]

LANGUAGE

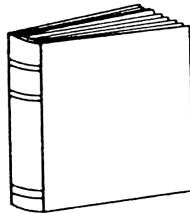
- Ask the subject to repeat: '**All that glitters is not gold**'

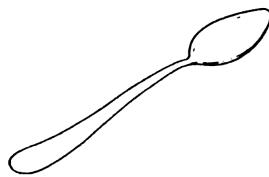
Language
[Score 0-1]

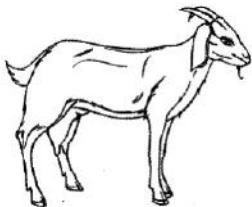
- Ask the subject to repeat: '**A stitch in time saves nine**'

Language
[Score 0-1]
LANGUAGE

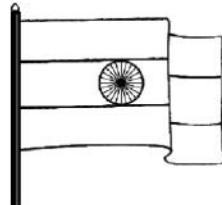
- Ask the subject to name the following pictures:

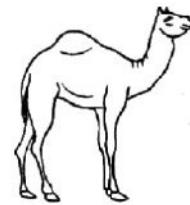






















**LANGUAGE**

- Using the pictures above, ask the subject to:

- Point to the one which is used in rain
- Point to the one which emits light
- Point to the one which is associated with farming
- Point to the one which is found in desserts

.....
.....
.....
.....

Language
[Score 0-4]

LANGUAGE

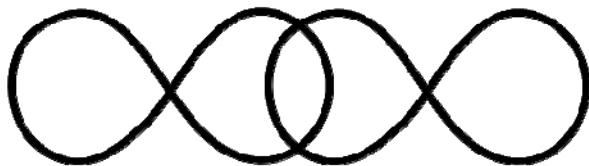
- Ask the subject to read the following words: (Score 1 only if all correct)

**sew
pint
soot
dough
height**

Language
[Score 0-1]

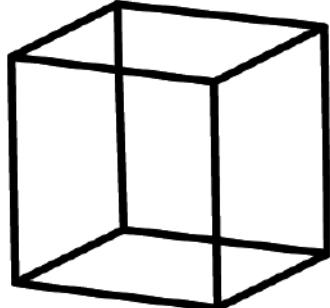
VISUOSPATIAL ABILITIES

- Infinity Diagram: Ask the subject to copy this diagram.



Visuospatial
[Score 0-1]

- Wire cube: Ask the subject to copy this drawing (for scoring, see instructions guide).



Visuospatial
[Score 0-2]

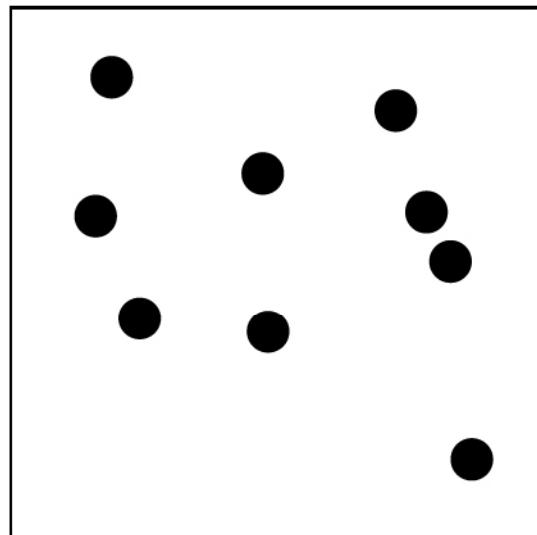
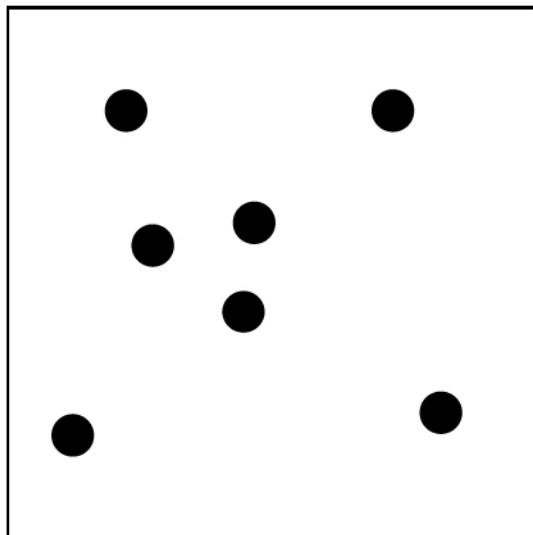
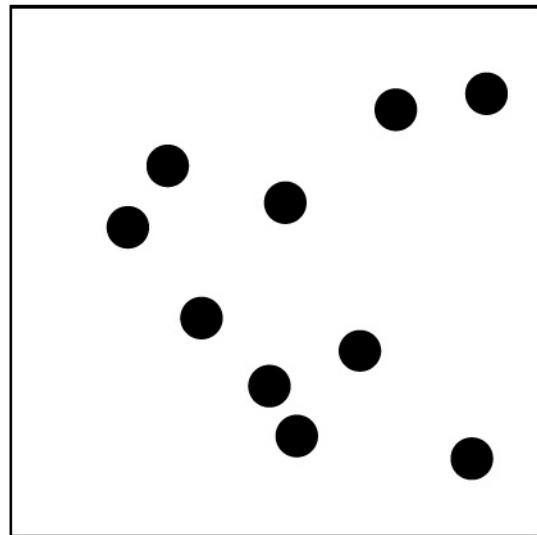
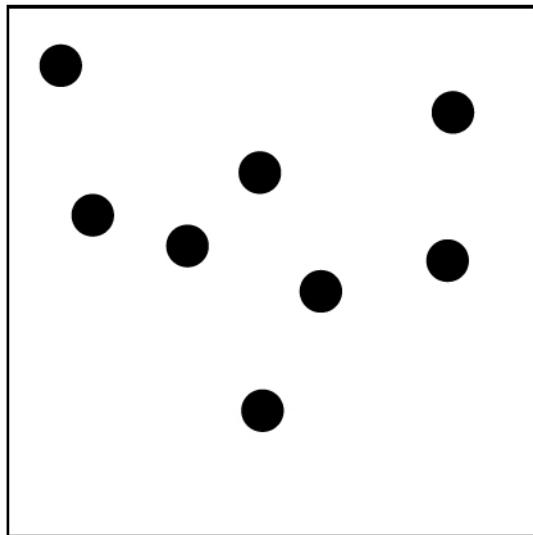
- Clock: Ask the subject to draw a clock face with numbers and the hands at ten past five. (For scoring see instruction guide: circle = 1, numbers = 2, hands = 2 if all correct).

Visuospatial
[Score 0-5]

VISUOSPATIAL ABILITIES

- Ask the subject to count the dots without pointing to them

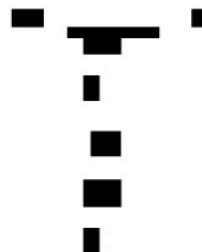
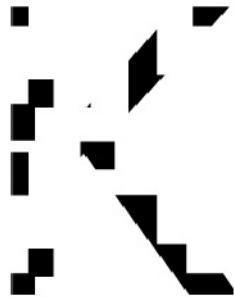
Visuospatial
[Score 0-4]



VISUOSPATIAL ABILITIES

- Ask the subject to identify the letters

Visuospatial
[Score 0-4]

**MEMORY**

- Ask "Now tell me what you remember about that name and address we were repeating at the beginning"

Sunil Kumar Singh
52, Station Road,
Gandhinagar,
Allahabad.

Memory
[Score 0-7]

MEMORY

- This test should be done if the subject failed to recall one or more items above. If all items were recalled, skip the test and score 5. If only part was recalled start by ticking items recalled in the shadowed column on the right hand side; and then test not recalled items by telling the subject "ok, I'll give you some hints: was the name X, Y or Z?" and so on. Each recognised item scores one point, which is added to the point gained by recalling.

Memory
[Score 0-5]

Sunil Kumar Sharma	Sunil kumar Singh	Rakesh Yadav	recalled
25	52	37	recalled
Market Road	Sastri Marg	Station Road	recalled
Prakash Nagar	Gandhi Nagar	Patel Nagar	recalled
Allahabad	Gwalior	Indore	recalled

SCORES

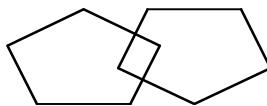
TOTAL ACE-III SCORE	/100
Attention	/18
Memory	/26
Fluency	/14
Language	/26
Visuospatial	/16

Mini-Mental State Examination (MMSE)

Patient's Name: _____ Date: _____

Instructions: Score one point for each correct response within each question or activity.

Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day? Month?"
5		"Where are we now? State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then the instructor asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible.
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, ...) Alternative: "Spell WORLD backwards." (D-L-R-O-W)
3		"Earlier I told you the names of three things. Can you tell me what those were?"
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: 'No ifs, ands, or buts.'"
3		"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.)
30		TOTAL



Interpretation of the MMSE:

Method	Score	Interpretation
Single Cutoff	<24	Abnormal
Range	<21	Increased odds of dementia
	>25	Decreased odds of dementia
Education	21	Abnormal for 8 th grade education
	<23	Abnormal for high school education
	<24	Abnormal for college education
Severity	24-30	No cognitive impairment
	18-23	Mild cognitive impairment
	0-17	Severe cognitive impairment

Interpretation of MMSE Scores:

Score	Degree of Impairment	Formal Psychometric Assessment	Day-to-Day Functioning
25-30	Questionably significant	If clinical signs of cognitive impairment are present, formal assessment of cognition may be valuable.	May have clinically significant but mild deficits. Likely to affect only most demanding activities of daily living.
20-25	Mild	Formal assessment may be helpful to better determine pattern and extent of deficits.	Significant effect. May require some supervision, support and assistance.
10-20	Moderate	Formal assessment may be helpful if there are specific clinical indications.	Clear impairment. May require 24-hour supervision.
0-10	Severe	Patient not likely to be testable.	Marked impairment. Likely to require 24-hour supervision and assistance with ADL.

Source:

- Folstein MF, Folstein SE, McHugh PR: "Mini-mental state: A practical method for grading the cognitive state of patients for the clinician." *J Psychiatr Res* 1975;12:189-198.

HINDI MENTAL STATE EXAMINATION (HMSE)

अनुदेश- अब मैं आपसे कुछ ऐसे सवाल पूछूँगा जिससे कि हम आपकी याददास्त देखना चाहते हैं। कुछ सवाल आसान होंगे और कुछ मुश्किल।

1. अब सुबह या दोपहर या शाम है?

Clarification

अब क्या है?

2. आज हफ्ते का कौन सा दिन/बार है?

Clarification

1- आप एक दिन चुनिये जो आप को लगता है सही है।

2- यदि वह कहे कि हफ्ते का दूसरा दिन तब कहिए हाँ, लेकिन इस दिन का क्या नाम है?

3. आज कौन सी तारीख है?

Clarification

आप एक तारीख बताइये जो आपको लगता है कि सही है।

4. यह कौन सा महीना चल रहा है? आप देसी 'हिन्दी' या 'अंग्रेजी' महीना बता सकते हैं।

Clarification

आप एक महीना बताइये जो आपको लगता है कि सही है।

5. ये साल का कौन सा मौसम है?

Rephrase

आप मुझे पिछले दो दिनों का मौसम मत बताइये साल का मौसम बताइये।

6. यह गांव कौन से डाकखाने में आता है?

7. यह गांव किस जिले में है?

अब कौन से जिले में है?

यह गांव अब कौन से जिले में आता है?

8. यह कौन सा गांव है?

9. इंटरव्यू शुरू करने से पहले चैक कीजिये कि गांव कोई ब्लाक है या कई छोटे-छोटे क्षेत्र।

यह कौन सा मोहल्ला है?

If it has numbered areas only ask: यह कौन सा थोक है?

If it has both block & numbered areas ask: यह कौन सा मोहल्ला है?

10. यह कौन सी जगह है?

यह किसका घर है?

11. मैं दिल्ली गया था और वहां से तीन चीजें लाया, वे हैं - आम-----, कुर्सी-----, पैसा-----।

अब क्या आप बता सकते हैं कि वे तीन चीजें जो मैंने दिल्ली से लाई हैं, वे क्या हैं?

When you repeat the question say: जो तीन चीजें मैं दिल्ली से लाया वे हैं आम-----, कुर्सी-----, पैसा-----। अब क्या आप बता सकते हैं वे क्या हैं?

इन तीन चीजों को जो मैं दिल्ली से लाया याद रखियेगा, कुछ देर बाद मैं फिर पूछूँगा।

Non specific encouragement: कोई बात नहीं, शायद आपको बाद में याद आयेगा।

12. अब आप हफ्ते के दिनों के नाम बताइये। शुरू इतवार से कीजिये?

अब इन्हीं दिनों के नाम उल्टा बताइये? जैसे की इतवार के पहले शनिवार, शनिवार के पहले-----, उसके पहले-----, उसके पहले-----, उसके पहले-----।

13-15. वह तीन चीजें क्या हैं जो मैंने आपको बताया कि मैं दिल्ली से लाया था।

16. Take out a watch and ask :

यह क्या है?

17. Take out a pen and ask :

यह क्या है?

18. *Instruction* : अब मैं आपको एक बात सुनाऊंगा, उसे ध्यान से सुनिये और मेरे कहने के बाद मुझे बिलकुल वैसा ही कहकर सुनाइयेगा।

Phrase ना ये, ना वे

Clarification

1- जो मैंने कहा था बिलकुल वैसा ही कहकर सुनाइये।

2- कोई बात नहीं जो भी आपने सुना था वह बताइये।

Do not repeat the phrase

19. अब मैं आपसे एक अलग तरह का प्रश्न पूछनेवाला हूँ।

अब आप मेरे चेहरे की तरफ देखिये - जैसा मैं कर रहा हूँ, वैसा ही करके दिखायें।

Clarification : नहीं इस बार आपने दोहराना नहीं है। मेरे चेहरे की तरफ देखिये - जैसा मैं कर रहा हूँ, वैसा ही कर के दिखायें।

For subject with poor vision : ध्यान से सुनिये और जैसा मैं बताऊं वैसा ही करिये। अपनी आंखे बंद कीजिये।

20. मैं आपको एक कागज दू़गा, उसके साथ जो मैं बताऊं वैसा ही करिये। कागज को सीधे हाथ में लीजिए फिर इस कागज को दोनों हाथों से एक बार आधा मोड़ लीजिए। फिर इस कागज को मुझे वापस दे दीजिए।

Repetition : Repeat the first part of the instruction as follows :

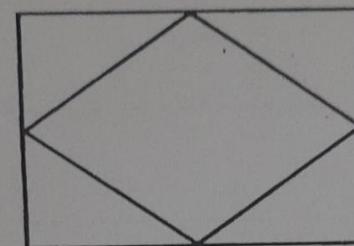
जो कागज मैंने आपको दिया था उसके साथ बिलकुल वैसा ही करिये जैसे मैंने बताया था।

Non specific encouragement जो कुछ भी याद है वही करिये।

21. अब आप अपने घर/मकान के बारे में एक बात कह कर सुनाइये।

Cue : कुछ भी बात अपने घर के बारे में।

22. यह एक तस्वीर है। आप इसको बिलकुल ऐसा ही इस कागज पर बनाइये।



Non specific encouragement : जैसा भी बन सकें, बनाने की कोशिश करिये। कोशिश करिये कि ऐसा ही बनें। मैं आपकी कलाकारी नहीं देख रहा हूँ, जितनी अच्छी तरह कर सकते हो, करिये।

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist Instructions

The questions on the back page are designed to stimulate dialogue between you and your patients and to help confirm if they may be suffering from the symptoms of attention-deficit/hyperactivity disorder (ADHD).

Description: The Symptom Checklist is an instrument consisting of the eighteen DSM-IV-TR criteria. Six of the eighteen questions were found to be the most predictive of symptoms consistent with ADHD. These six questions are the basis for the ASRS v1.1 Screener and are also Part A of the Symptom Checklist. Part B of the Symptom Checklist contains the remaining twelve questions.

Instructions:

Symptoms

1. Ask the patient to complete both Part A and Part B of the Symptom Checklist by marking an X in the box that most closely represents the frequency of occurrence of each of the symptoms.
2. Score Part A. If four or more marks appear in the darkly shaded boxes within Part A then the patient has symptoms highly consistent with ADHD in adults and further investigation is warranted.
3. The frequency scores on Part B provide additional cues and can serve as further probes into the patient's symptoms. Pay particular attention to marks appearing in the dark shaded boxes. The frequency-based response is more sensitive with certain questions. No total score or diagnostic likelihood is utilized for the twelve questions. It has been found that the six questions in Part A are the most predictive of the disorder and are best for use as a screening instrument.

Impairments

1. Review the entire Symptom Checklist with your patients and evaluate the level of impairment associated with the symptom.
2. Consider work/school, social and family settings.
3. Symptom frequency is often associated with symptom severity, therefore the Symptom Checklist may also aid in the assessment of impairments. If your patients have frequent symptoms, you may want to ask them to describe how these problems have affected the ability to work, take care of things at home, or get along with other people such as their spouse/significant other.

History

1. Assess the presence of these symptoms or similar symptoms in childhood. Adults who have ADHD need not have been formally diagnosed in childhood. In evaluating a patient's history, look for evidence of early-appearing and long-standing problems with attention or self-control. Some significant symptoms should have been present in childhood, but full symptomatology is not necessary.

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name	Today's Date					
<p>Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.</p>		Never	Rarely	Sometimes	Often	Very Often
<p>1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?</p>						
<p>2. How often do you have difficulty getting things in order when you have to do a task that requires organization?</p>						
<p>3. How often do you have problems remembering appointments or obligations?</p>						
<p>4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?</p>						
<p>5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?</p>						
<p>6. How often do you feel overly active and compelled to do things, like you were driven by a motor?</p>						
Part A						
<p>7. How often do you make careless mistakes when you have to work on a boring or difficult project?</p>						
<p>8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?</p>						
<p>9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?</p>						
<p>10. How often do you misplace or have difficulty finding things at home or at work?</p>						
<p>11. How often are you distracted by activity or noise around you?</p>						
<p>12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?</p>						
<p>13. How often do you feel restless or fidgety?</p>						
<p>14. How often do you have difficulty unwinding and relaxing when you have time to yourself?</p>						
<p>15. How often do you find yourself talking too much when you are in social situations?</p>						
<p>16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?</p>						
<p>17. How often do you have difficulty waiting your turn in situations when turn taking is required?</p>						
<p>18. How often do you interrupt others when they are busy?</p>						
Part B						

The Value of Screening for Adults With ADHD

Research suggests that the symptoms of ADHD can persist into adulthood, having a significant impact on the relationships, careers, and even the personal safety of your patients who may suffer from it.¹⁻⁴ Because this disorder is often misunderstood, many people who have it do not receive appropriate treatment and, as a result, may never reach their full potential. Part of the problem is that it can be difficult to diagnose, particularly in adults.

The Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist was developed in conjunction with the World Health Organization (WHO), and the Workgroup on Adult ADHD that included the following team of psychiatrists and researchers:

- **Lenard Adler, MD**
Associate Professor of Psychiatry and Neurology
New York University Medical School
- **Ronald C. Kessler, PhD**
Professor, Department of Health Care Policy
Harvard Medical School
- **Thomas Spencer, MD**
Associate Professor of Psychiatry
Harvard Medical School

As a healthcare professional, you can use the ASRS v1.1 as a tool to help screen for ADHD in adult patients. Insights gained through this screening may suggest the need for a more in-depth clinician interview. The questions in the ASRS v1.1 are consistent with DSM-IV criteria and address the manifestations of ADHD symptoms in adults. Content of the questionnaire also reflects the importance that DSM-IV places on symptoms, impairments, and history for a correct diagnosis.⁴

The checklist takes about 5 minutes to complete and can provide information that is critical to supplement the diagnostic process.

References:

1. Schweitzer JB, et al. Med Clin North Am. 2001;85(3):10-11, 757-777.
2. Barkley RA. Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment. 2nd ed. 1998.
3. Biederman J, et al. Am J Psychiatry. 1993;150:1792-1798.
4. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association. 2000: 85-93.

OFFICE USE ONLY

Name: _____

Date: _____

SDS Score: _____

B3: 1 Early Recognition
and Screening HO2

Severity of Dependence Scales (SDS)

This questionnaire will assist your GP to identify ways of meeting your needs about a drug which may be causing you some concern.

Circle the answer that best applies to how you have felt about your use of over the last twelve months.

1. Did you ever think your use of(drug) was out of control?

<i>Never or almost never</i>	0
<i>Sometimes</i>	1
<i>Often</i>	2
<i>Always</i>	3

2. Did the prospect of missing a shot/snort make you very anxious or worried?

<i>Never or almost never</i>	0
<i>Sometimes</i>	1
<i>Often</i>	2
<i>Always</i>	3

3. How much did you worry about your use of the drug?

<i>Not at all</i>	0
<i>A little</i>	1
<i>Often</i>	2
<i>Always or nearly always</i>	3

4. Did you wish you could stop?

<i>Never or almost never</i>	0
<i>Sometimes</i>	1
<i>Often</i>	2
<i>Always</i>	3

5. How difficult would you find it to stop or go without(drug)?

<i>Not difficult at all</i>	0
<i>Quite difficult</i>	1
<i>Very difficult</i>	2
<i>Impossible</i>	3

SCORE_____

SDS: Interpretation of Scores

Originally developed for assessing psychological dependence on heroin, studies have indicated that the SDS is a valuable tool for assessing psychological dependence on other illicit drugs. The research to date, has suggested cut-offs for measuring psychological dependence on various illicit drugs, as indicated below.

	≥ 5	≥ 7
Amphetamines		
Heroin		
Cannabis & Benzodiazepines		

For further information on the development and interpretation of the SDS see:

Gossop, M., Darke, S., Griffiths, P., Hando, J., Powis, B., Hall, W. & Strang, J. 1995, 'The Severity of Dependence Scale (SDS): Psychometric Properties of the SDS in English and Australian Samples of Heroin, Cocaine and Amphetamine Users', *Addiction*, vol. 90, pp. 607–614, and,
Dawe, S., Loxton, N., Hides, L., Kavanagh, D., & Mattick, R. 2002, *Review of diagnostic screening instruments for alcohol and other drug use and other psychiatric disorders* 2nd Edition Commonwealth Department of Health and Ageing, Canberra

Readiness and Confidence to Change Scales

The scores obtained from the questions below may be incorporated into the overall history, and may provide some indication of the patient's willingness and confidence to change.

Readiness to Change

Do you want to change your use of (drug) right now?

No	0
Probably not	1
Unsure	2
Possibly	3
Definitely	4

Confidence to Change

Do you think you could change your use of (drug) now if you wanted to?

Definitely could not	0
Probably could not	1
Unsure	2
Probably could	3
Definitely could	4

Source: Alcohol and Drug Training and Research Unit (ADTRU), Queensland Divisions of General Practice and Department of Psychiatry, University of Queensland, 2002, *Training package for medical practitioners in the effective identification and treatment of pharmaceutical and illicit drug problems*. ADTRU, Brisbane.

Fagerstrom Test for Nicotine Dependence

Score 8+ = high dependence

Score 5-7 = moderate dependence

Score 3-4 = low to moderate dependence

Score 0-2 = low dependence

QUESTION	RESPONSE	SCORE
1. How soon after you wake up do you smoke your first cigarette?	After 60 minutes	0
	31-60 minutes	1
	6-30 minutes	2
	Within 5 minutes	3
2. Do you find it difficult to refrain from smoking in places where it is forbidden?	No	0
	Yes	1
3. Which cigarette would you hate most to give up?	The first in the morning	1
	Any other	0
4. How many cigarettes do you smoke per day?	10 or less	0
	11-20	1
	21-30	2
	31 or more	3
5. Do you smoke more frequently during the first hours after waking, than during the rest of the day?	No	0
	Yes	1
6. Do you smoke even if you are so ill that you are in bed most of the day?	No	0
	Yes	1
Total		

Adapted from Heatherton TF, Kozlowski LT, Frecker RC, Fagerstrom KO. The Fagerstrom Test for Nicotine Dependence: A revision of the Fagerstrom Tolerance Questionnaire. British Journal of Addictions 1991; 86:1119-27.

The most distinctive indicators of nicotine dependence are:

- Time to first cigarette after waking
- The number of cigarettes smoked per day

AUDIT

Introduction

The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item screening tool developed by the World Health Organization (WHO) to assess alcohol consumption, drinking behaviors, and alcohol-related problems. Both a clinician-administered version (page 1) and a self-report version of the AUDIT (page 2) are provided. Patients should be encouraged to answer the AUDIT questions in terms of standard drinks. A chart illustrating the approximate number of standard drinks in different alcohol beverages is included for reference. A score of 8 or more is considered to indicate hazardous or harmful alcohol use. The AUDIT has been validated across genders and in a wide range of racial/ethnic groups and is well-suited for use in primary care settings. Detailed guidelines about use of the AUDIT have been published by the WHO and are available online: http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf

The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol? (0) Never [Skip to Qs 9-10] (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week	<input type="checkbox"/>	6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	<input type="checkbox"/>
2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more	<input type="checkbox"/>	7. How often during the last year have you had a feeling of guilt or remorse after drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	<input type="checkbox"/>
3. How often do you have six or more drinks on one occasion? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily <i>Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0</i>	<input type="checkbox"/>	8. How often during the last year have you been unable to remember what happened the night before because you had been drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	<input type="checkbox"/>
4. How often during the last year have you found that you were not able to stop drinking once you had started? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	<input type="checkbox"/>	9. Have you or someone else been injured as a result of your drinking? (0) No (2) Yes, but not in the last year (4) Yes, during the last year	<input type="checkbox"/>
5. How often during the last year have you failed to do what was normally expected from you because of drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	<input type="checkbox"/>	10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down? (0) No (2) Yes, but not in the last year (4) Yes, during the last year	<input type="checkbox"/>
Record total of specific items here <i>If total is greater than recommended cut-off, consult User's Manual.</i> <input type="checkbox"/>			

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

STANDARD DRINK EQUIVALENTS	APPROXIMATE NUMBER OF STANDARD DRINKS IN:
BEER or COOLER	
12 oz.  ~5% alcohol	12 oz. = 1 16 oz. = 1.3 22 oz. = 2 40 oz. = 3.3
MALT LIQUOR	
8-9 oz.  ~7% alcohol	12 oz. = 1.5 16 oz. = 2 22 oz. = 2.5 40 oz. = 4.5
TABLE WINE	
5 oz.  ~12% alcohol	a 750 mL (25 oz.) bottle = 5
80-proof SPIRITS (hard liquor)	
1.5 oz.  ~40% alcohol	a mixed drink = 1 or more* a pint (16 oz.) = 11 a fifth (25 oz.) = 17 1.75 L (59 oz.) = 39
	*Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

SEVERITY OF ALCOHOL DEPENDENCE QUESTIONNAIRE (SADQ-C)¹

NAME _____ AGE _____ No. _____

DATE:

Please recall a typical period of heavy drinking in the last 6 months.

When was this? Month:..... Year:.....

Please answer all the following questions about your drinking by circling your most appropriate response.

During that period of heavy drinking

1. The day after drinking alcohol, I woke up feeling sweaty.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

2. The day after drinking alcohol, my hands shook first thing in the morning.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

3. The day after drinking alcohol, my whole body shook violently first thing in the morning if I didn't have a drink.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

4. The day after drinking alcohol, I woke up absolutely drenched in sweat.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

5. The day after drinking alcohol, I dread waking up in the morning.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

6. The day after drinking alcohol, I was frightened of meeting people first thing in the morning.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

7. The day after drinking alcohol, I felt at the edge of despair when I awoke.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

8. The day after drinking alcohol, I felt very frightened when I awoke.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

9. The day after drinking alcohol, I liked to have an alcoholic drink in the morning.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

10. The day after drinking alcohol, I always gulped my first few alcoholic drinks down as quickly as possible.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

11. The day after drinking alcohol, I drank more alcohol to get rid of the shakes.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

¹ Stockwell, T., Sitharan, T., McGrath, D.& Lang, . (1994). The measurement of alcohol dependence and impaired control in community samples. *Addiction*, 89, 167-174.

12. The day after drinking alcohol, I had a very strong craving for a drink when I awoke.
ALMOST NEVER SOMETIMES OFTEN ALMOST ALWAYS
13. I drank more than a quarter of a bottle of spirits in a day (OR 1 bottle of wine OR 7 beers).
ALMOST NEVER SOMETIMES OFTEN ALMOST ALWAYS
14. I drank more than half a bottle of spirits per day (OR 2 bottles of wine OR 15 beers).
ALMOST NEVER SOMETIMES OFTEN ALMOST ALWAYS
15. I drank more than one bottle of spirits per day (OR 4 bottles of wine OR 30 beers).
ALMOST NEVER SOMETIMES OFTEN ALMOST ALWAYS
16. I drank more than two bottles of spirits per day (OR 8 bottles of wine OR 60 beers)
ALMOST NEVER SOMETIMES OFTEN ALMOST ALWAYS

Imagine the following situation:

1. You have been **completely off drink for a few weeks**
2. You then drink **very heavily for two days**

How would you feel the **morning after** those two days of drinking?

17. I would start to sweat.
NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT
18. My hands would shake.
NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT
19. My body would shake.
NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT
20. I would be craving for a drink.
NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT

SCORE

CHECKED BY:

ALCOHOL DETOX PRESCRIBED: YES/NO

NOTES ON THE USE OF THE SADQ

The Severity of Alcohol Dependence Questionnaire was developed by the Addiction Research Unit at the Maudsley Hospital. It is a measure of the severity of dependence. The AUDIT questionnaire, by contrast, is used to assess whether or not there is a problem with dependence.

The SADQ questions cover the following aspects of dependency syndrome:

- physical withdrawal symptoms
- affective withdrawal symptoms
- relief drinking
- frequency of alcohol consumption
- speed of onset of withdrawal symptoms.

Scoring

Answers to each question are rated on a four-point scale:

Almost never - 0

Sometimes 1

Often 2

Nearly always 3

A score of 31 or higher indicates "severe alcohol dependence".

A score of 16 -30 indicates "moderate dependence"

A score of below 16 usually indicates only a mild physical dependency.

A chlordiazepoxide detoxification regime is usually indicated for someone who scores 16 or over.

It is essential to take account of the amount of alcohol that the patient reports drinking prior to admission as well as the result of the SADQ.

There is no correlation between the SADQ and such parameters as the MCV or GGT.

Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

In the past 12 months...		Circle	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop abusing drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No
Scoring: Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.		Score:	

Interpretation of Score		
Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Alcohol Withdrawal Assessment Scoring Guidelines (CIWA - Ar)

Nausea/Vomiting - Rate on scale 0 - 7

- 0 - None
1 - Mild nausea with no vomiting
2
3
4 - Intermittent nausea
5
6
7 - Constant nausea and frequent dry heaves and vomiting

Tremors - have patient extend arms & spread fingers. Rate on scale 0 - 7.

- 0 - No tremor
1 - Not visible, but can be felt fingertip to fingertip
2
3
4 - Moderate, with patient's arms extended
5
6
7 - severe, even w/ arms not extended

Anxiety - Rate on scale 0 - 7

- 0 - no anxiety, patient at ease
1 - mildly anxious
2
3
4 - moderately anxious or guarded, so anxiety is inferred
5
6
7 - equivalent to acute panic states seen in severe delirium or acute schizophrenic reactions.

Agitation - Rate on scale 0 - 7

- 0 - normal activity
1 - somewhat normal activity
2
3
4 - moderately fidgety and restless
5
6
7 - paces back and forth, or constantly thrashes about

Paroxysmal Sweats - Rate on Scale 0 - 7.

- 0 - no sweats
1 - barely perceptible sweating, palms moist
2
3
4 - beads of sweat obvious on forehead
5
6
7 - drenching sweats

Orientation and clouding of sensorium - Ask, "What day is this? Where are you? Who am I?" Rate scale 0 - 4

- 0 - Oriented
1 - cannot do serial additions or is uncertain about date
2 - disoriented to date by no more than 2 calendar days
3 - disoriented to date by more than 2 calendar days
4 - Disoriented to place and / or person

Tactile disturbances - Ask, "Have you experienced any itching, pins & needles sensation, burning or numbness, or a feeling of bugs crawling on or under your skin?"

- 0 - none
1 - very mild itching, pins & needles, burning, or numbness
2 - mild itching, pins & needles, burning, or numbness
3 - moderate itching, pins & needles, burning, or numbness
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

Auditory Disturbances - Ask, "Are you more aware of sounds around you? Are they harsh? Do they startle you? Do you hear anything that disturbs you or that you know isn't there?"

- 0 - not present
1 - Very mild harshness or ability to startle
2 - mild harshness or ability to startle
3 - moderate harshness or ability to startle
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

Visual disturbances - Ask, "Does the light appear to be too bright? Is its color different than normal? Does it hurt your eyes? Are you seeing anything that disturbs you or that you know isn't there?"

- 0 - not present
1 - very mild sensitivity
2 - mild sensitivity
3 - moderate sensitivity
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

Headache - Ask, "Does your head feel different than usual? Does it feel like there is a band around your head?" Do not rate dizziness or lightheadedness.

- 0 - not present
1 - very mild
2 - mild
3 - moderate
4 - moderately severe
5 - severe
6 - very severe
7 - extremely severe

Procedure:

1. Assess and rate each of the 10 criteria of the CIWA scale. Each criterion is rated on a scale from 0 to 7, except for "Orientation and clouding of sensorium" which is rated on scale 0 to 4. Add up the scores for all ten criteria. This is the total CIWA-Ar score for the patient at that time. Prophylactic medication should be started for any patient with a total CIWA-Ar score of 8 or greater (ie. start on withdrawal medication). If started on scheduled medication, additional PRN medication should be given for a total CIWA-Ar score of 15 or greater.
2. Document vitals and CIWA-Ar assessment on the Withdrawal Assessment Sheet. Document administration of PRN medications on the assessment sheet as well.
3. The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is vitally important. Early intervention for CIWA-Ar score of 8 or greater provides the best means to prevent the progression of withdrawal.

Assessment Protocol a. Vitals, Assessment Now. b. If initial score ≥ 8 repeat q1h x 8 hrs, then if stable q2h x 8 hrs, then if stable q4h. c. If initial score < 8, assess q4h x 72 hrs. If score < 8 for 72 hrs, d/c assessment. If score ≥ 8 at any time, go to (b) above. d. If indicated, (see indications below) administer prn medications as ordered and record on MAR and below.	Date										
	Time										
	Pulse										
	RR										
	O₂ sat										
	BP										
Assess and rate each of the following (CIWA-Ar Scale): Refer to reverse for detailed instructions in use of the CIWA-Ar scale.											
Nausea/vomiting (0 - 7) 0 - none; 1 - mild nausea, no vomiting; 4 - intermittent nausea; 7 - constant nausea, frequent dry heaves & vomiting.											
Tremors (0 - 7) 0 - no tremor; 1 - not visible but can be felt; 4 - moderate w/ arms extended; 7 - severe, even w/ arms not extended.											
Anxiety (0 - 7) 0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute panic state											
Agitation (0 - 7) 0 - normal activity; 1 - somewhat normal activity; 4 - moderately fidgety/restless; 7 - paces or constantly thrashes about											
Paroxysmal Sweats (0 - 7) 0 - no sweats; 1 - barely perceptible sweating, palms moist; 4 - beads of sweat obvious on forehead; 7 - drenching sweat											
Orientation (0 - 4) 0 - oriented; 1 - uncertain about date; 2 - disoriented to date by no more than 2 days; 3 - disoriented to date by > 2 days; 4 - disoriented to place and / or person											
Tactile Disturbances (0 - 7) 0 - none; 1 - very mild itch, P&N, numbness; 2-mild itch, P&N, burning, numbness; 3 - moderate itch, P&N, burning, numbness; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations											
Auditory Disturbances (0 - 7) 0 - not present; 1 - very mild harshness/ ability to startle; 2 - mild harshness, ability to startle; 3 - moderate harshness, ability to startle; 4 - moderate hallucinations; 5 severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations											
Visual Disturbances (0 - 7) 0 - not present; 1 - very mild sensitivity; 2 - mild sensitivity; 3 - moderate sensitivity; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations											
Headache (0 - 7) 0 - not present; 1 - very mild; 2 - mild; 3 - moderate; 4 - moderately severe; 5 - severe; 6 - very severe; 7 - extremely severe											
Total CIWA-Ar score:											
PRN Med: (circle one) Diazepam Lorazepam	Dose given (mg):										
	Route:										
Time of PRN medication administration:											
Assessment of response (CIWA-Ar score 30-60 minutes after medication administered)											
RN Initials											

Scale for Scoring: Total Score = 0 – 9: absent or minimal withdrawal 10 – 19: mild to moderate withdrawal more than 20: severe withdrawal	Indications for PRN medication: a. Total CIWA-AR score 8 or higher if ordered PRN only (Symptom-triggered method). b. Total CIWA-Ar score 15 or higher if on Scheduled medication. (Scheduled + prn method) Consider transfer to ICU for any of the following: Total score above 35, q1h assess. x more than 8hrs required, more than 4 mg/hr lorazepam x 3hr or 20 mg/hr diazepam x 3hr required, or resp. distress.
--	---

Patient Identification (Addressograph)

Signature/ Title	Initials	Signature / Title	Initials



CAGE Substance Abuse Screening Tool

Directions: Ask your patients these four questions and use the scoring method described below to determine if substance abuse exists and needs to be addressed.

CAGE Questions

1. Have you ever felt you should cut down on your drinking?
 2. Have people annoyed you by criticizing your drinking?
 3. Have you ever felt bad or guilty about your drinking?
 4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?
-

CAGE Questions Adapted to Include Drug Use (CAGE-AID)

1. Have you ever felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Scoring: Item responses on the CAGE questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol problems. A total score of two or greater is considered clinically significant.

The normal cutoff for the CAGE is two positive answers, however, the Consensus Panel recommends that the primary care clinicians lower the threshold to one positive answer to cast a wider net and identify more patients who may have substance abuse disorders. A number of other screening tools are available.

CAGE is derived from the four questions of the tool: Cut down, Annoyed, Guilty, and Eye-opener

CAGE Source: Ewing 1984

Clinical Institute Withdrawal Assessment Scale - Benzodiazepines

Guide to the Use of the Clinical Withdrawal Assessment Scale for Benzodiazepines

Person Report:

For each of the following items, circle the number that best describes how you feel.

Do you feel irritable?	0 Not at all	1	2	3	4 Very much so
Do you feel fatigued?	0 Not at all	1	2	3	4 Unable to function
Do you feel tense?	0 Not at all	1	2	3	4 Very much so
Do you have difficulties concentrating?	0 Not at all	1	2	3	4 Unable to concentrate
Do you have any loss of appetite?	0 Not at all	1	2	3	4 No appetite, unable to eat
Have you any numbness or burning on your face, hands or feet?	0 No numbness	1	2	3	4 Intense burning/numbness
Do you feel your heart racing? (palpitations)	0 No disturbance	1	2	3	4 Constant racing
Does your head feel full or achy?	0 Not at all	1	2	3	4 Severe headache

Do you feel muscle aches or stiffness?	0 Not at all	1	2	3	4 Severe stiffness or pain
Do you feel anxious, nervous or jittery?	0 Not at all	1	2	3	4 Very much so
Do you feel upset?	0 Not at all	1	2	3	4 Very much so
How restful was your sleep last night?	0 Very restful	1	2	3	4 Not at all
Do you feel weak?	0 Not at all	1	2	3	4 Very much so
Do you think you didn't have enough sleep last night?	0 Very much so	1	2	3	4 Not at all
Do you have any visual disturbances? (sensitivity to light, blurred vision)	0 Not at all	1	2	3	4 Very sensitive to light, blurred vision
Are you fearful?	0 Not at all	1	2	3	4 Very much so
Have you been worrying about possible misfortunes lately?	0 Not at all	1	2	3	4 Very much so

Clinician Observations

Observe behaviour for sweating, restlessness and agitation		Observe tremor		Observe feel palms	
0	None, normal activity	0	No tremor	0	No sweating visible
1		1	Not visible, can be felt in fingers	1	Barely perceptible sweating, palms moist
2	Restless	2	Visible but mild	2	Palms and forehead moist, reports armpit sweating
3		3	Moderate with arms extended	3	Beads of sweat on forehead
4	Paces back and forth, unable to sit still	4	Severe, with arms not extended	4	Severe drenching sweats

Total Score Items 1 – 20

1–20 = mild withdrawal

41–60 = severe withdrawal

21–40 =moderate withdrawal

61–80 = very severe withdrawal

Source: Adapted from Busto, U.E., Sykora, K. & Sellers, E.M. (1989). A clinical scale to assess benzodiazepine withdrawal. *Journal of Clinical Psychopharmacology*, 9 (6), 412–416.

Clinical Opiate Withdrawal Scale

Introduction

The Clinical Opiate Withdrawal Scale (COWS) is an 11-item scale designed to be administered by a clinician. This tool can be used in both inpatient and outpatient settings to reproducibly rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time. The summed score for the complete scale can be used to help clinicians determine the stage or severity of opiate withdrawal and assess the level of physical dependence on opioids. Practitioners sometimes express concern about the objectivity of the items in the COWS; however, the symptoms of opioid withdrawal have been likened to a severe influenza infection (e.g., nausea, vomiting, sweating, joint aches, agitation, tremor), and patients should not exceed the lowest score in most categories without exhibiting some observable sign or symptom of withdrawal.

APPENDIX 1

Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name: _____ Date and Time _____ / _____ / _____ : _____	
Reason for this assessment: _____	
Resting Pulse Rate: _____ beats/minute <i>Measured after patient is sitting or lying for one minute</i> 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	GI Upset: over last 1/2 hour 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: over past 1/2 hour not accounted for by room temperature or patient activity. 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	Tremor observation of outstretched hands 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness Observation during assessment 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	Yawning Observation during assessment 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	Anxiety or Irritability 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	Gooseflesh skin 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection
Runny nose or tearing Not accounted for by cold symptoms or allergies 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

This version may be copied and used clinically.

The Cannabis Use Disorder Identification Test - Revised (CUDIT-R)

Have you used any cannabis over the past six months? YES / NO

If YES, please answer the following questions about your cannabis use. Circle the response that is most correct for you in relation to your cannabis use *over the past six months*

1. How often do you use cannabis?

Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
0	1	2	3	4

2. How many hours were you "stoned" on a typical day when you had been using cannabis?

Less than 1	1 or 2	3 or 4	5 or 6	7 or more
0	1	2	3	4

3. How often during the past 6 months did you find that you were not able to stop using cannabis once you had started?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
0	1	2	3	4

4. How often during the past 6 months did you fail to do what was normally expected from you because of using cannabis?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
0	1	2	3	4

5. How often in the past 6 months have you devoted a great deal of your time to getting, using, or recovering from cannabis?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
0	1	2	3	4

6. How often in the past 6 months have you had a problem with your memory or concentration after using cannabis?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
0	1	2	3	4

7. How often do you use cannabis in situations that could be physically hazardous, such as driving, operating machinery, or caring for children:

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
0	1	2	3	4

8. Have you ever thought about cutting down, or stopping, your use of cannabis?

Never	Yes, but not in the past 6 months	Yes, during the past 6 months
0	2	4

This scale is in the public domain and is free to use with appropriate citation:

Adamson SJ, Kay-Lambkin FJ, Baker AL, Lewin TJ, Thornton L, Kelly BJ, and Sellman JD. (2010). An Improved Brief Measure of Cannabis Misuse: The Cannabis Use Disorders Identification Test – Revised (CUDIT-R). *Drug and Alcohol Dependence* 110:137-143.

This questionnaire was designed for self administration and is scored by adding each of the 8 items:

- Question 1-7 are scored on a 0-4 scale
- Question 8 is scored 0, 2 or 4.

Scores of 8 or more indicate hazardous cannabis use, while scores of 12 or more indicate a possible cannabis use disorder for which further intervention may be required.