

KGVM Symptom Scale

Version 7.0

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General guidelines for use of the scale

The purpose of the KGVM is to enable the user to elicit, and to measure the severity of, those psychiatric symptoms that are most commonly experienced by people who have psychotic illnesses such as schizophrenia and bipolar affective disorder. The measure is only reliable when used by an appropriately trained and experienced rater. Potential users of the measure are strongly urged to obtain training that allows them to demonstrate acceptable reliability before employing the measure in clinical or research settings.

The measure comprises 14 items. Ratings for items 1 to 6 are based on information elicited from the patient using semi-structured questioning, and the time frame for the assessment of these items is the month prior to the interview. Ratings for items 7 to 13 are based on systematic observation of the patient's behaviour during the interview. Item 14 is an index of the accuracy and completeness of the assessment and not a psychiatric symptom.

For items 1 to 6, questions are listed to guide the rater when eliciting and rating the severity of these symptoms. Questions in bold typeface should be regarded as mandatory. All these questions should always be asked whenever the measure is used to assess a patient. The rater should never assume that they know how a patient will answer a mandatory question, even if the patient's responses to previous questions seem to suggest what their answer will be. Each mandatory question is followed by supplementary questions in ordinary typeface. The purpose of these supplementary questions is to elicit more detailed information concerning a particular symptom, to help the rater establish whether the symptom was definitely present during the previous month, and if present how severe.

If the patient's response to a mandatory question is clearly and unambiguously negative the rater may pass directly to the next mandatory question. If the patient gives a positive response to a mandatory question, or if their response is unclear or ambiguous, the rater should ask the accompanying supplementary questions in order to clarify the nature of the patient's experiences before making a final judgement about the symptom in question. When necessary, the rater should employ additional questions of their own to help with this process, until they have sufficient information to make a reliable judgement concerning the symptom. This pattern of questioning should be adhered to as far as is possible in every interview. The wording of mandatory questions should not be altered since this may adversely affect the reliability and validity of the assessment. With practice, the rater will become skilled at asking these questions in a fluent and natural manner.

In addition to the specific eliciting questions provided for items 1 to 6, the following generic questions should be employed whenever a symptom is found to have been present in the previous month.

For Anxiety, Depressed Mood, Elevated Mood:

1. Frequency.

How often have you felt in the last month? Have you felt all the time? Have you felt most days or only on a minority of days?

2. Duration.

When you feel how long does it usually last? Does it last for a few minutes or several hours? Does it last all day or only part of the day? Have you never been free of in the last month?

3. Subjective Severity

How strong is the feeling of? Is it an intense feeling that is difficult for you to bear? Does it seem to overwhelm you? Is it usually a mild or moderate feeling?

4. Control

When you start to feel can you control the feeling to an extent? Can you reduce or stop the feeling by turning your attention to other things, such as watching television, or going for a walk, or chatting to someone? Can you put it completely out of your mind?

For Delusions

1. Frequency

How often have you thought about in the last month? Are these thoughts always on your mind? Do you think about most days or only on the minority of days? Do you find that is on your mind a lot recently? How much of the time?

2. Conviction

How sure are you that ? Are you certain, or is there a real possibility that you could be mistaken? Have there been days when you have had your doubts? Is there any other possible explanation for? What is the likelihood that you are mistaken? On a scale of 0 to 100 percent, how convinced are you?

For Hallucinations

1. Frequency

How often have you heard / seen in the last month? Have you heard / seen every day? Has it happened most days or just the odd few days recently?

2. Perceived Origins

What do you think is the cause of the voices/visions? Where do they seem to come from? Do you know who they belong to? Do you know who causes them? Why do think these experiences happen? Could there be any other explanation for these experiences?

For items 7 to 13, observational guidelines are provided which list the particular component behaviours to which the rater must attend when assessing these symptoms. The rater should assess each behavioural component separately before arriving at an overall severity rating for the symptom. There is a tendency for most of the rater's time and attention to be given to the assessment of symptoms 1 to 6, since these symptoms must be actively elicited by detailed questioning. The rater must be aware of this potential bias and ensure that adequate time and attention are also given to the observation and assessment of the behavioural symptoms. In general, it is more difficult to achieve acceptable reliability when rating behavioural symptoms so the amount of care and deliberation given to the assessment of these symptoms should at least equal that given to the rating of the elicited symptoms.

Sometimes, the patient's responses to the eliciting questions may not appear to be consistent with aspects of their observed behaviour. For example, the patient may appear during the interview to be distracted by auditory hallucinations yet give negative answers to all the questions in the Hallucinations section. In such circumstances, the rater should ask further questions in an attempt to resolve the apparent contradiction between elicited and

observed evidence. If the patient continues to deny experiencing a symptom that the rater feels may in fact be present, the rater should record the behavioural evidence for this, using the appropriate behavioural items within the scale, but should rate the suspected elicited symptom as absent. In the present example, the rater should record a zero score for Hallucinations indicating that there is no reported evidence from the patient for the presence of hallucinations, and record a positive score for Abnormal Movements indicating that unusual behaviours were observed. In addition, the apparent inconsistency between the patient's report of their experiences and their observed behaviour would itself be recorded by a positive score for the final item Adequacy of Assessment, where the rater would note their reservations about the patient's responses to questions about hallucinations.

When assessing the severity of a symptom, the rater should not be influenced by possible causes of the symptom. For example, it will sometimes become clear that the patient has developed affective symptoms in response to severe life events, such as bereavement, unemployment or homelessness, or in response to disturbing delusional ideas. However, the fact that a patient has become anxious or depressed following exposure to stressful life experiences, or as a consequence of delusional ideas, does not mean that their symptoms should be ignored or rated less severely than might otherwise be the case. Similarly, some abnormal behaviours may be caused or exacerbated by medication. These should be recorded under the appropriate behavioural items and a rating made based on the observed severity of the behaviour. For example, the presence of tardive dyskinesia or akathisia should be noted under Abnormal Movements and the fact that these abnormal movements may be caused by medication should not lead to them being ignored or rated less severely.

It is essential that the rater uses the KGVM data sheet to make detailed notes during the interview. There are two important reasons for doing this. First, to record the evidence upon which the ratings are based, allowing the rater to check the accuracy of their ratings and to maintain standards of reliability and validity. This would include information on the frequency, duration, subjective severity, content and degree of control over the patient's symptoms. Second, to record clinically useful information that can be drawn upon by the practitioner when planning clinical interventions. This would include information on the cognitive and behavioural antecedents and consequences associated with the symptoms, coping strategies, and the responses of significant people such as family or other carers. It is as important to record this information as it is to record a rating of symptom severity.

A number of aggregate scores can be derived from the measure. A total symptom score is calculated by summing the scores for items 1 to 13. A positive symptom score can be calculated by summing the scores for Delusions, Hallucinations and Abnormal Speech; a negative symptom score by summing the scores for Flattened Affect, Psychomotor Retardation and Poverty of Speech; an affective symptom score by summing the scores for Anxiety, Depression and Elevated Mood.

Care must be exercised when interpreting these aggregate scores. All the symptom severity scales are structured in such a way that a score of 1 represents phenomena that lie within the range of normal experience and are not definitely indicative of psychiatric illness. It is useful to be able to detect and record these relatively minor phenomena, since their presence may provide early warning signs of the onset of more severe psychiatric problems. But as a result it is possible for a patient to achieve a substantial aggregate score in the absence of any definite mental illness. It is therefore essential that when assessing the

clinical significance of a patient's results, attention is paid to the individual symptom scores, in order to identify those scores that indicate definite psychiatric morbidity.

References

The symptom definitions and many of the eliciting questions contained in this measure were drawn from the following sources.

1. GELDER, M., GATH, D., MAYOU, R. & COWAN, P. (1996) *Oxford Textbook of Psychiatry: Third Edition*. Oxford: Oxford University Press.
2. KRAWIECKA, M., GOLDBERG, D. & VAUGHN, M. (1977) A standardised psychiatric assessment scale for chronic psychiatric patients. *Acta Psychiatrica Scandinavica*, **55**, 299-308.
3. LEFF, J. P. & ISAACS, A. D. (1990) *Psychiatric Examination in Clinical Practice: Third Edition*. Oxford: Blackwell Scientific Publications.
4. WING, J. K., COOPER, J. E. & SARTORIUS, N. (1974) *The Description and Classification of Psychiatric Symptoms: An Instruction Manual for the PSE and Catego System*. London: Cambridge University Press.

1. ANXIETY - eliciting questions

WORRYING: **Have you worried a lot in the last month?** What do you worry about? What is it like when you worry? Do unpleasant thoughts constantly go round and round in your mind? Can you stop them by turning your attention to something else?

TENSION PAINS: **Have you had headaches or other aches or pains in the last month?** What kind? e.g. a band around the head, tightness in the scalp, ache in the back of the neck or shoulders?

TIREDDNESS OR EXHAUSTION: **Have you been getting exhausted or worn out during the day or evening, even when you have not been working very hard?** Do you feel tired all the time for no apparent reason? Is it a feeling of tiredness or exhaustion? Do you have to take a rest during the day?

MUSCULAR TENSION: **Have you had difficulty relaxing in the last month?** Do your muscles feel tensed up? Is it hard to get rid of the tension?

RESTLESSNESS: **Have you been so fidgety and restless that you couldn't sit still?** Do you have to keep pacing up and down?

HYPOCHONDRIASIS: **Do you tend to worry over your physical health?** What does your doctor say is wrong? What do you think may be wrong with you?

SUBJECTIVE NERVOUS TENSION: **Do you often feel on edge, or keyed up, or mentally tense?** Do you generally suffer from your nerves? Do you suffer from nervous exhaustion?

FREE FLOATING ANXIETY: **Have there been times lately when you have been very anxious or frightened?** What was this like? Did you experience unpleasant bodily sensations, like blushing, butterflies, choking, difficulty getting breath, dizziness, dry mouth, palpitations, sweating, tingling sensations, trembling? How often in the last month?

ANXIOUS FOREBODING: **Have you had the feeling that something terrible might happen?** A feeling that some disaster might occur but you are not sure what? Have you been anxious about getting up in the morning because you are afraid to face the day? What did this feel like? Did you experience unpleasant bodily sensations?

PANIC ATTACKS: **Have you had times when you felt shaky, or your heart pounded, or you felt sweaty, and you simply had to do something about it?** What was it like? What did you do in order to try and resolve the feeling of panic? How often in the last month?

SITUATIONAL ANXIETY: **Have you tended to get anxious in certain situations, such as travelling, or in crowds, or being alone, or being in enclosed spaces?** What situations? Did you experience unpleasant bodily sensations? How often in the past month?

ANXIETY ON MEETING PEOPLE: **What about meeting people, e.g. going into a crowded room, making conversation?**

SPECIFIC PHOBIAS: **Do you have any special fears, like some people are scared of feathers, or cats, or spiders, or birds?**

AVOIDANCE: **Do you avoid any of these situations (specify as appropriate) because you know you will get anxious?** How often have you found yourself doing this in the last month? How much does this affect your day to day life?

OBSESSIONAL AND COMPULSIVE IDEAS: **Do you ever find that you check or repeat**

things that you have already done? What sorts of things? How many times do you have to check or repeat them before you feel satisfied that they have been done correctly? If you resist the desire to check or repeat these things do you become very anxious? **Do you ever find that you have to wash yourself over and over even though you know you are clean?** How many times do you have to do this? If you resist the desire to do this do you become very anxious? **Do you ever find that unpleasant or frightening thoughts come into your mind even though you try not to think about them?** Do they seem like they are your own thoughts or that they belong to someone else?

1. ANXIETY - rating scale

- 0 = The patient reports no anxiety in the past month.
- 1 = The patient reports mild anxiety. The patient can easily and quickly stop their anxious thoughts and feelings by turning their attention to other things, or, these thoughts and feelings quickly come and go of their own accord. No signs of motor tension or autonomic hyperactivity are present.
- 2 = The patient reports moderate anxiety. The patient is able to exercise some control over their anxiety, and can reduce or put a stop to the anxiety by turning their attention to other things, but this requires a distinct and sustained effort. If signs of motor tension or autonomic hyperactivity are present these are very mild or of very brief duration.
- 3 = The patient reports marked anxiety. The patient has no control over the anxiety when it occurs and cannot turn their attention to other things, even when a distinct and sustained effort is made. At least one marked and persistent sign of motor tension or autonomic hyperactivity should accompany the anxiety. The anxiety has been present in this form on the minority of days in the last month.
- 4 = The patient reports severe anxiety. The patient has no control over their anxiety when it occurs and cannot turn their attention to other things, even when a distinct and sustained effort is made. At least one marked and persistent sign of motor tension or autonomic hyperactivity should accompany the anxiety. The anxiety has been present in this form on the majority of days in the last month.

Notes

(1) Signs of motor tension include: physical restlessness, trembling, involuntarily tensed muscles, tension pains affecting neck, back or legs, and tension headaches. Signs of autonomic hyperactivity include: gastro-intestinal dry mouth, difficulty swallowing, epigastric discomfort, frequent loose motions; respiratory feeling of constriction in the chest, difficulty inhaling, hyperventilation; cardiovascular discomfort over the heart, palpitations, missed heartbeats, throbbing in the neck; genitourinary frequency and urgency of micturition, failure of erection, lack of libido, increased menstrual discomfort; nervous system tinnitus, blurring of vision, dizziness, prickling sensations, sweating, blushing.

(2) Some patients utilise avoidance strategies as a means of coping with their anxiety. They may report experiencing little or no anxiety in the previous month because they have avoided those situations that would have provoked anxiety. For example, a person who experiences severe anxiety in public situations may have avoided this by stopping at home

all the time, relying on a relative or other carer to carry out essential tasks like shopping or going to work. In these circumstances it is recommended that the score for anxiety should be based on the level of reported anxiety experienced by the patient, but the presence of avoidance strategies, the frequency with which they are employed, and the disruption they cause to the person's social functioning should also be noted.

DEPRESSION - eliciting questions

POOR CONCENTRATION: What has your concentration been like recently? Can you read an article in the paper, or watch a TV programme right through? Do your thoughts drift so that you don't take things in?

NEGLECT DUE TO BROODING: Do you tend to brood on things? So much that you neglect things, like your work, or eating, or housework, or looking after yourself?

LOSS OF INTEREST: What about your interests, have they changed at all? Have you lost interest in work, or hobbies, or recreations? Have you let your appearance go?

DEPRESSED MOOD: Do you keep reasonably cheerful, or have you been very depressed or low spirited recently? Have you cried at all, or wanted to cry? When did you last really enjoy doing anything?

HOPELESSNESS: How do you see the future? Has life seemed quite hopeless? Can you see any future? Have you given up, or does there still seem some reason for trying?

MORNING DEPRESSION: Is the depression worse at any particular time of day?

SOCIAL WITHDRAWAL: Have you wanted to stay away from other people? Why?

Have you been suspicious of their intentions? Afraid of actual harm?

SELF-DEPRECIATION: What is your opinion of yourself compared to other people?

Do you feel better, or not as good, or about the same as most? Do you feel inferior or even worthless?

LACK OF SELF CONFIDENCE: How confident do you feel in yourself? For example when talking to others, or in managing your relations with other people?

IDEAS OF REFERENCE: Are you self-conscious in public? Do you get the feeling that other people are taking notice of you in the street, or a bus, or restaurant? Do they ever seem to laugh at you or talk about you critically? Are people really looking at you or is it perhaps the way you feel about it?

GUILTY IDEAS OF REFERENCE: Do you have the feeling you are being blamed for something, or even accused? What about?

PATHOLOGICAL GUILT: Do you tend to blame yourself at all? If people are critical at all, do you think you deserve it?

LOSS OF WEIGHT DUE TO POOR APPETITE: What has your appetite been like recently? Have you lost any weight during the last three months? Have you been trying to lose weight?

DELAYED SLEEP: Have you had any trouble getting off to sleep recently? How long do you lie awake? What happens if you take sleeping tablets? How often does it happen?

SUBJECTIVE ANERGIA AND RETARDATION: Do you seem to be slowed down in your movements, or to have too little energy recently? How much has it affected you?

EARLY WAKING: Do you wake early in the morning? What time do you wake? Can you get back to sleep quickly, or do you lie awake? How often has this happened recently?

LOSS OF LIBIDO: Has there been any change in your interest in sex?

DELUSIONS OF GUILT: Do you feel as if you have committed a crime, or sinned

greatly, or deserve punishment? Have you felt that your presence might contaminate or ruin other people?

HYPOCHONDRIACAL DELUSIONS: Is anything the matter with your body? Do you think you have some kind of serious physical illness? Is your body unhealthy or diseased or rotten? Is part of it no longer working? Do you ever think that your body has ceased to exist?

LOSS OF EMOTIONS: Do you ever feel that you have lost your emotions in some way? That you are empty of all feeling? That you are incapable of reaction emotionally? Is this a definite change or have you always been like that?

2. DEPRESSION - rating scale

- 0 = The patient reports no depression in the past month.
- 1 = The patient reports mild depression. The patient can easily and quickly stop their depressive thoughts and feelings by turning their attention to other things, or, these thoughts and feelings quickly come and go of their own accord. No biological symptoms of depression are present.
- 2 = The patient reports moderate depression. The patient is still able to exercise some control over their depression, and can reduce or put a stop to the depression by turning their attention to other things, but this requires a distinct and sustained effort. If biological symptoms are present these are very mild or of low frequency.
- 3 = The patient reports marked depression. The patient has no control over their depression when it occurs and cannot turn their attention to other things, even when a distinct and sustained effort is made. At least one marked and persistent biological symptom of depression should be present. The depression has been present in this form for the minority of days in the last month.
- 4 = The patient reports severe depression. The patient has no control over their depression when it occurs and cannot turn their attention to other things, even when a distinct and sustained effort is made. At least one of the biological symptoms of depression and at least one indicator of severe depression should be present. The depression has been present in this form for the majority of days in the last month.

Notes

- (1) Biological symptoms of depression include: psychomotor retardation, sleep disturbance, diurnal variation in mood, loss of appetite, unintentional loss of weight, constipation, loss of libido, amenorrhoea.
- (2) Indicators of severe depression include: a conviction of worthlessness or hopelessness; mood congruent delusions concerning guilt, ill health, impoverishment, nihilism, punishment and persecution; mood congruent hallucinations with a critical, threatening or catastrophic content; uncontrollable weeping; a complete loss of the ability to feel emotion; specific plans for committing suicide, or active preparations for suicide, or attempts at suicide with serious intent to die.

3. SUICIDAL THOUGHTS AND BEHAVIOURS - eliciting questions

NEGATIVE EVALUATION OF LIFE: **In the last month, have there been times when you felt that life wasn't worth living?** How often have you felt like this recently?

ADVANTAGES FOR SELF: **Have you thought that you might be better off dead?** Do you feel that it would be a relief from your problems? Does it seem like the only solution to your problems, or could things still be put right by other means? Are you sure of this? How often have you thought like this recently?

ADVANTAGES FOR OTHERS: **Have you thought that other people would be better off if you were dead?** In what way would they be better off? Would they be happier if you were gone? Are you sure of this? How often have you thought like this recently?

ACTIVE DESIRE FOR DEATH: **Have you found yourself actually wishing you were dead and away from it all?** How often have felt like this?

SUICIDAL THOUGHTS: **Have you had any thoughts about taking your own life?** Have you thought seriously about this? Has the idea of taking your life kept coming into your mind? How much of the time has this been in your mind in the last month?

PLANS FOR SUICIDE: Have you made any plans for taking your life? What did you think you might do? Have you decided on how and where you could do this? Have you decided on a time?

What prevents you from carrying out your plans? Does the thought of dying make you feel afraid?

Does it make you feel relieved? Are you resigned to the fact?

PREPARATIONS FOR SUICIDE: Have you made any preparations for taking your life? What have you done? Have you got the means to do it? Have you written a letter saying why you want to do this?

RECENT ATTEMPTS: Have you actually tried to take your life recently? What did you do? Did you expect to die? Do you intend to try again? When might you do this?

3. SUICIDAL THOUGHTS AND BEHAVIOURS - rating scale

- 0 = No thoughts that life is pointless or not worth living. No hopelessness about the future. No thoughts that self or others would be better off if patient were dead. No thoughts about possibility of taking own life. No active desire to die, or preparations for suicide, or attempts at suicide.
- 1 = Occasional brief thoughts that life has no point or is not worth living, and/or that the future is hopeless, and/or that self or others would be better off if patient were dead. No thoughts about possibility of taking own life. No active desire to die, or preparations for suicide, or attempts at suicide.
- 2 = Frequent or prolonged thoughts that life has no point or is not worth living, and/or that the future is hopeless, and/or that self or others would be better off if patient were dead. Thoughts about possibility of taking own life, but no thoughts about specific methods of doing this. No preparations for suicide or attempts at suicide.
- 3 = Frequent or prolonged thoughts that life has no point or is not worth living, and/or that the future is hopeless, and/or that self or others would be better off if patient were dead. Thoughts about committing suicide that include consideration of specific methods. No preparations for suicide or attempts at suicide.
- 4 = Firm belief that life has no point or is not worth living, and/or that the future is hopeless, and/or that self or others would be better off if patient were dead. Has formed desire to kill self. Has a plan for committing suicide by a specific method and has made preparations for implementing this plan, or has made an attempt at suicide in the last month using a method that the patient thought could be lethal.

Notes

- (1) Record a positive rating if the patient satisfied the relevant criteria at any time in the last month.
- (2) If the patient is given a positive score, a more detailed assessment of suicidal risk is recommended, using valid and reliable instruments e.g. Beck Suicide Inventory, Beck Hopelessness Scale, Beck Suicide Intent Scale.

4. ELEVATED MOOD - eliciting questions

EXPANSIVE MOOD: Have you sometimes felt particularly cheerful and on top of the world, without any reason? How would you describe the feeling? Was it a feeling of ordinary happiness or something unusually intense? How long did the feeling last? Could you control the feeling? Was it a pleasant feeling or did it seem too cheerful to be healthy? How often have you felt like this in the last month?

SUBJECTIVE IDEOMOTOR PRESSURE: Have you felt particularly full of energy lately, or full of exciting ideas? Do things seem to go too slowly for you? Do ideas or images seem to pass through your mind at a faster rate than normal? Do you need less sleep than usual? Do you find yourself extremely active but not getting tired? Did you stay up all night because you felt too full of energy to sleep? Have you developed any new interests recently?

GRANDIOSE IDEAS AND ACTIONS: Have you seemed super efficient, or felt as though you had special powers or talents quite out of the ordinary? Have you felt especially healthy? Have you been buying any interesting things recently? Have you told other people about how you were feeling, or about your ideas and plans? Did you feel that you had to tell everyone about it?

4. ELEVATED MOOD - rating scale

- 0 = The patient reports no instances of elevated mood in the past month.
- 1 = The patient reports mildly elevated mood. The patient experiences a distinct feeling of happiness, excitement or wellbeing. The feeling quickly subsides, either spontaneously or when the patient's attention is turned to other things. The patient experiences no increase in the rate of mental processes or physical activity.
- 2 = The patient reports moderately elevated mood. The patient experiences a feeling of exceptional happiness, or excitement, or enhanced wellbeing. The feeling persists for several hours or longer and is not affected by attending to other things. The patient may also experience a slight increase in the rate of mental processes or physical activity.
- 3 = The patient reports markedly elevated mood. The patient experiences a feeling of intense happiness, or excitement, or wellbeing. The feeling persists for several hours or longer and is not affected by attending to other things. The feeling is accompanied by a marked increase in the rate of mental processes or physical activity, or a reduced need for sleep. Elevated mood was present in this form on a minority of days in the last month.
- 4 = The patient reports severely elevated mood. The patient experiences a feeling of intense happiness, or excitement, or wellbeing. The feeling persists for several hours or longer, and is not affected by attending to other things. The feeling is accompanied by a marked increase in the rate of mental processes or physical activity, or a reduced need for sleep. Elevated mood was present in this form on a majority of days in the last month.

Notes

- (1) Include drug induced mood states and note the cause.

5. HALLUCINATIONS - eliciting questions

AUDITORY HALLUCINATIONS: **Do you ever seem to hear noises or to hear voices when there is no one about and nothing else to explain it?**

NON-VERBAL AUDITORY HALLUCINATIONS: **Do you ever hear noises like tapping or music? Do you ever hear muttering or whispering?** Can you make out the words?

VERBAL HALLUCINATIONS: What does the voice say? (If critical or accusatory) Do you think that it is justified? Do you deserve it? Do you hear your name being called?

VOICES DISCUSSING PATIENT IN THIRD PERSON OR COMMENTING ON THOUGHTS OR ACTIONS: Do you ever hear several voices talking about you? Do they refer to you as he (she)? What do they say? Do they seem to comment on what you are thinking or doing?

VOICES SPEAKING TO PATIENT: Do they speak directly to you? Are they threatening or unpleasant? Do they call you names? Do they give you orders?

DISSOCIATIVE HALLUCINATIONS: Can you carry on a two way conversation with ----? Do you see anything or smell anything at the same time as you hear the voice? Who is it you are talking to? What is the explanation? Do you know anyone else who has this kind of experience?

LOCATION OF AUDITORY HALLUCINATIONS: Do you hear these voices inside your head or can you hear them through your ears? Where do they seem to be coming from? Do they seem to come from somewhere in the room, or from somewhere else?

QUALITY OF AUDITORY HALLUCINATIONS: Do they sound like there is someone in the room is talking to you? If the voices are inside your head do they sound like voices that belong to someone else or do they sound like your own thoughts spoken aloud in your head? How long do the voices last for? Were you half asleep at the time, or does it occur when you were fully awake? How do you explain them?

VISUAL HALLUCINATIONS: **Have you seen things that other people cannot see?** What did you see?

FORMLESS VISUAL HALLUCINATIONS: **Have you seen shadows or flashes of light?** What did you see?

LOCATION OF VISUAL HALLUCINATIONS: Did you see these things with your eyes or in your mind?

QUALITY OF VISUAL HALLUCINATIONS: How real did they look? Were they solid or could you see through them? Were they three dimensional or flat, like a photograph? Were they coloured or black and white? How long did the image last for? Were you half asleep at the

time, or does it occur when you were fully awake? Did the vision seem to arise out of a pattern on the wallpaper or shadows in the room? How do you explain it?

OLFACTORY HALLUCINATIONS: Do you sometimes notice strange smells that other people don't notice? What sort of smell is it? How do you explain it? **Do you seem to think that you yourself give off a strange smell?** What sort of smell is it? How do you explain it?

SOMATIC HALLUCINATIONS: Do you ever feel that someone is touching you, but when you look there is nobody there? How do you explain this? **Do you sometimes notice strange feelings inside your body?** How do you explain this?

GUSTATORY HALLUCINATIONS: Have you noticed that food or drink seems to have an unusual taste recently? How do you explain this?

HEIGHTENED PERCEPTION: Have there been times recently when sounds have seemed unnaturally clear or loud, or things have looked vividly coloured or detailed?

DULLED PERCEPTION: Have things seemed dark, or grey, or colourless?

CHANGED PERCEPTION: Does the appearance of things or people change in a puzzling way: e.g. in shape, size, or colour?

5. HALLUCINATIONS - rating scale

- 0 = The patient reports no unusual sensory experiences in the last month.
- 1 = The patient reports any of the following: illusions; intense mental imagery; brief hypnagogic and hypnopompic hallucinations.
- 2 = The patient reports any of the following: intensified or dulled perceptions; distorted perceptions; elementary hallucinations while fully awake; own thoughts spoken aloud inside their head.
- 3 = The patient reports hallucinations occurring on a minority of days in the last month.
- 4 = The patient reports hallucinations occurring on a majority of days in the last month.

Notes

(1) Illusions are misperceptions of real stimuli.

(2) Hypnagogic hallucinations occur at the point of falling asleep and hypnopompic hallucinations occur at the point of waking up.

(3) Elementary hallucinations comprise experiences such as brief noises, flashes of light, sensations of movement at the edge of the visual field.

(4) The hallucinations rating scale no longer requires the rater to distinguish between true and pseudo auditory hallucinations. If the patient hears a voice that appears to be located inside their head, then this phenomenon is classed as an auditory hallucination, and is rated in the same way as a voice that appears to be externally located.

(5) When the patient reports hearing voices located inside their head it is important to distinguish between those patients experiencing internal auditory hallucinations and those

experiencing their own thoughts spoken aloud in their head. To make this distinction, the rater should try to obtain a precise description of the experience from the patient, in order to establish whether the voice sounds like the patient's own internal mental voice or like someone else's voice. If the patient hears their thoughts spoken aloud in their head by their own mental voice, this should be assigned a rating of 2 on the severity scale. If the patient hears their own thoughts spoken aloud by someone else's voice, this should be classed as an auditory hallucination and assigned a rating of 3 or 4, depending on the frequency of the phenomenon.

6. DELUSIONS - eliciting questions

INTERFERENCE WITH THINKING: **Can you think clearly or is there any interference with your thoughts?** What kind of interference? **Are you in full control of your thoughts?**

THOUGHT INSERTION: **Are thoughts put into your head which you know are not your own?** How do you know they are not your own? Where do they come from?

THOUGHT BROADCAST: **Do you ever seem to hear your own thoughts spoken aloud in your head, so that someone standing near might be able to hear them?** How do you explain this? Are your thoughts broadcast so that other people know what you are thinking?

THOUGHT ECHO OR COMMENTARY: **Do you ever seem to hear your own thoughts repeated or echoed?** What is that like? How do you explain it? Where does it come from?

THOUGHT BLOCK OR WITHDRAWAL: **Do you ever experience your thoughts stopping quite suddenly so that there are none left in your mind, even though your thoughts were flowing freely before?** What is that like? How does it occur? What is it due to? **Do your thoughts ever seem to be taken out of your head, as though some external person or force were removing them?** Can you give an example? How do you explain it?

DELUSION OF THOUGHTS BEING READ: **Can anyone read your thoughts?** How do you know? How do you explain it?

DELUSIONS OF CONTROL: **Do you ever feel under the control of some force or power other than yourself?** As though you were a robot without a will of your own? As though you were possessed by someone or something else? What is that like?

DELUSIONS OF REFERENCE: **Do people seem to drop hints about you, or say things with a double meaning, or do things in a special way so as to convey a meaning?** Can you give an example of what do they do? **Does everyone seem to gossip about you?** What do they say? **Do people follow you about, or check up on you, or record your movements?** Why are they doing this?

DELUSIONAL MISINTERPRETATION AND MISIDENTIFICATION: **Do things seem to be specially arranged?** Is an experiment going on, to test you out? Do you see any reference to yourself on TV or in the papers? Do you ever see special meanings in advertisements?

DELUSIONS OF PERSECUTION: **Is anyone deliberately trying to harm you, e.g. trying to poison or kill you?** How? Is there any kind of organisation behind it? Is there any other kind of persecution?

DELUSIONS OF ASSISTANCE: **Do you think people are organising things specially to help you?** What are they doing?

DELUSIONS OF GRANDIOSE ABILITIES: **Is there anything special about you? Do you have any special abilities or powers?** Can you read people's thoughts? Is there a special purpose or mission to your life? Are you especially clever or inventive?

DELUSIONS OF GRANDIOSE IDENTITY: **Are you a very prominent person or related to someone prominent like royalty?** Are you very rich or famous? How do you explain this?

RELIGIOUS DELUSIONS: **Are you a very religious person?** Specially close to God? Can God communicate with you? Are you yourself a saint?

DELUSIONS CONCERNING APPEARANCE: **Do you think your appearance is normal?**

DELUSIONS OF DEPERSONALISATION: **Is anything the matter with your brain?**

DELUSIONAL EXPLANATIONS: How do you explain the things that have been happening? Is anything like hypnotism or telepathy going on? Is anything like electricity, or X rays, or radio waves affecting you?

6. DELUSIONS - rating scale

- 0 = The patient reports no unusual ideas in the last month.
- 1 = The patient reports any of the following: overvalued ideas; ideas of reference.
- 2 = The patient reports delusional ideas held with up to 50% conviction present during the last month.
- 3 = The patient reports delusional ideas held with more than 50% conviction present on a minority of days in the last month.
- 4 = The patient reports delusional ideas held with more than 50% conviction present on a majority of days in the last month.

Notes

(1) An overvalued idea is an idiosyncratic belief held on inadequate grounds, which is not delusional or obsessional in nature, and which is not a conventional belief within the patient's culture or religion.

(2) Ideas of reference arise in people who are overly self-conscious. The patient feels that other people are taking notice of him in ordinary public situations but is able to recognise that this feeling originates within himself and is out of proportion to any possible cause.

(3) A delusion is a belief that is held on inadequate grounds, is resistant to rational argument or evidence to the contrary, and is not a conventional belief within the patient's culture or religion. Delusions are usually false beliefs, but may occasionally be true or become true. It is not the falsity of the belief that determines whether it is delusional, but the nature of the reasoning processes that support the belief.

(4) Delusions may be held with varying degrees of conviction or certainty. The rating scale distinguishes between delusional beliefs held with up to 50% conviction and delusional beliefs held with more than 50% conviction. The following questions are suggested to assist the rater in distinguishing between the different degrees of conviction:

- " Do you think that you could be mistaken about (specify the belief)?"
- " Do you have any doubts about (specify the belief)?"
- " On a scale of 0-100% how certain are you that (specify the belief) is true?"

(5) Care should be taken when asking questions concerning thought insertion, thought broadcast, thought echo or commentary, thought block, and thought withdrawal. The basic experiences enquired about under these headings are not in themselves sufficient to justify a positive rating for delusions. To allow a positive rating for delusions, the rater must also establish that the patient has acquired delusional beliefs concerning these experiences. For example, the basic experience enquired about under the heading Thought Broadcast is that of hearing one's own thoughts spoken aloud in one's head. This should be taken as a simple description of the patient's experience and should not be classed as a delusional belief. If, in addition, the patient believes that their thoughts are so loud that other people can share their thoughts at a distance, this could be classed as a delusional belief concerning their experience of loud thoughts.

7. FLATTENED AFFECT - observational guidelines

Emotion is normally conveyed by variations in facial expression, vocal pitch and volume, hand and arm gestures, and body posture. When flatness of affect is present the patient shows a reduction in the range and frequency of these variations in expression, voice, gesture and posture. The resulting impression is that the patient finds it difficult, or in extreme cases impossible, to convey their emotional reactions during the interview. This does not necessarily mean that they lack emotional feelings, only that they may have difficulty conveying their feelings to others. When assessing flatness of affect, consider the following factors:

1. Variation in facial expression. There may be a reduction in the movement of some or all of the facial muscles that are normally used to form facial expressions. The patient may show no sign of a smile when talking about amusing or pleasant events, or may form a limited, partial smile with the mouth, while the muscles around the eyes fail to move. Similarly, when discussing sad or distressing topics the patient's face may show little sign of distress.

2. Variation in vocal pitch and volume. The patient's voice may show little or no variation in pitch or volume, regardless of the emotional content of the interview, and may have a monotonous quality. Alternatively, the same pattern of rising and falling pitch may be repeated throughout the interview, but the inflections do not correspond to changes in the emotional content of the interview and are not present to give emphasis to particular words or feelings.

3. Gesture and posture. Hand and arm gestures, together with changes in body posture, are also used to help convey emotion. The patient who feels happy or excited may use frequent, rapid hand gestures to add emphasis to their description of pleasant events. An angry patient may lean forwards towards the interviewer to give emphasis to the strength of their angry feelings. These gestures and changes in body posture may be reduced or entirely

absent in the patient with flattened affect.

4. Depressed patients. Depressed patients may show a diminution in their range of facial expression, vocal range, and their range of movement and gesture. These patients may have an unvaryingly sad expression, their speech may exhibit repeated patterns of descending pitch, and they may maintain a "closed posture" with limited use of gesture, little change in posture, and reduced eye contact. When this pattern of behaviour is observed in a depressed patient, it should not be rated as flattened affect, since the patient's face, voice and posture accurately reflect their depressed affect. When flattened affect is present, the patient conveys an inappropriately reduced emotional response, or no response at all.

5. Some patients show a normal range of emotional expression during most of the interview, but appear calmly indifferent to emotive topics. For example, the patient may describe disturbing hallucinations or bizarre delusions in a matter of fact way, with little or no signs of concern or emotional distress. This should be rated as flattened affect.

7. FLATTENED AFFECT - rating scale

- 0 = The patient exhibits no evidence of flattened affect during the interview.
- 1 = The patient's emotional responses appear mildly flattened. Emotive topics evoke an emotional response from the patient but this is slightly less than might normally be expected.
- 2 = The patient's emotional responses appear moderately flattened. Emotive topics evoke an emotional response from the patient but this is distinctly less than might normally be expected.
- 3 = The patient's emotional responses appear markedly flattened. Very little emotion is shown, even when discussing emotionally highly charged topics. The patient cannot convey the impact of distressing symptoms and events, and shows little sign of concern when discussing current problems and future plans.
- 4 = The patient's emotional responses appear severely flattened. No emotional expression whatever regardless of the topic discussed. The patient's face is expressionless, their voice unvaryingly monotonous or confined to a repetitive pattern of inflection which is unrelated to the content of their speech. There is no expressive use of gesture or posture.

8. INCONGRUOUS AFFECT- observational guidelines

In patients with incongruous affect, the expressed emotion is not in keeping with the situation, or with the topic of conversation, or with the patient's own feelings. By contrast, patients with flattened affect either exhibit no emotional response, or responses that are appropriate but less intense than might normally be expected. When rating incongruity, consider the following factors:

1. Inappropriate jocularity. The patient makes jokes or laughs when discussing unpleasant or distressing topics, or smiles or giggles repeatedly during the interview for no apparent reason.
2. Unprovoked tearfulness. The patient becomes tearful when discussing neutral or pleasant topics. The rater should ensure that the tearfulness is not due to an underlying depressive state.

8. INCONGRUOUS AFFECT - rating scale

- 0 = The patient exhibits no evidence of incongruous affect during the interview.
- 1 = The patient's emotional responses appear mildly incongruous. Slightly inappropriate or odd emotional responses occur during the interview.
- 2 = The patient's emotional responses appear moderately incongruous. Distinctly inappropriate emotional responses occur occasionally during the interview. The majority of emotional responses are not incongruous.
- 3 = The patient's emotional responses appear markedly incongruous. Distinctly inappropriate emotional responses occur frequently during the interview. The majority of emotional responses are incongruous.
- 4 = The patient's emotional responses appear severely incongruous. Distinctly inappropriate emotional responses occur constantly during the interview. All of the patient's emotional responses are incongruous.

9. OVERACTIVITY - observational guidelines

When overactivity is present there is an increase in the frequency, and/or speed, and/or extent of bodily movements. When rating overactivity, consider the following factors:

1. Generalised restlessness. During the course of an interview, healthy patients will change their posture and position from time to time to avoid physical discomfort. The overactive patient changes posture and position more frequently than is normally required to maintain physical comfort and may engage in repetitive, unnecessary movements of the limbs. In mild form, the patient appears fidgety and restless but is able to remain seated. In more extreme form, the patient may find it impossible to remain seated and gets up from the chair to pace about the room.
2. Increased speed of movements. The patient performs movements more rapidly than is normal, walks or paces abnormally quickly, makes rapid shifts in posture and position, gestures rapidly.
3. Gross excitement. The patient runs about, jumps around, waves their arms wildly, shouts or screams, and may throw things.

9. OVERACTIVITY - rating scale

- 0 = The patient exhibits no evidence of overactivity during the interview.
- 1 = The patient appears mildly overactive. They are occasionally fidgety or restless but are able to remain still for substantial periods of time. The patient is never so restless that they get up from their chair and pace about the room.
- 2 = The patient appears moderately overactive. They are fidgety or restless for the majority of the interview and are able to remain still for only short periods of time. They may rise from their chair and pace about the room on one or two brief occasions, but it is always possible for the patient to return to their seat and complete the interview.
- 3 = The patient appears markedly overactive. They are constantly fidgety or restless and unable to remain still for more than a few seconds. They may rise from their chair frequently and pace about the room. It may not be possible to complete the interview in a single session because the patient spends a substantial part of the time pacing.
- 4 = The patient appears severely overactive. The patient is grossly excited, remains seated for only brief periods, and spends most of the time pacing rapidly about the room or even running around. The patient cannot be interviewed.

Notes

(1) The abnormal movements which are typical of medication induced akathisia should be rated under Abnormal Movements and Postures and not under this section of the measure.

(2) The abnormal movements which are typical of medication induced tardive dyskinesia should also be rated under Abnormal Movements and Postures and not under this section of the measure.

10. PSYCHOMOTOR RETARDATION - observational guidelines

When psychomotor retardation is present there is a reduction in the frequency, speed and extent of voluntary movements, leading to delays in initiating tasks or movements requested of the patient. This physical retardation is accompanied by a slowing of thought which is reflected in the patient's speech, with delays before answering questions and pauses in conversation.

When assessing psychomotor retardation consider the following factors:

1. Slowness of voluntary movements: delays in performing movements, performing movements and gestures slowly, a low frequency of movements.
2. Slow speech: long pauses before answering questions, a reduced rate of speech, long pauses between phrases.
3. Catatonic stupor: a total absence of voluntary movement, accompanied by muteness, but with evidence of continuing conscious awareness.

10. PSYCHOMOTOR RETARDATION - rating scale

- 0 = The patient exhibits no evidence of psychomotor retardation during the interview.
- 1 = The patient exhibits mild psychomotor retardation. There is slight slowness in movement accompanied by short delays in responding to questions and slight slowness of speech when answering questions.
- 2 = The patient exhibits moderate psychomotor retardation. There is distinct slowness in movements accompanied by definite delays before responding to questions and distinct slowness of speech when answering questions.
- 3 = The patient exhibits marked psychomotor retardation. There is very pronounced slowness of movements accompanied by long delays before responding to questions and pronounced slowness of speech when answering questions.
- 4 = The patient exhibits severe psychomotor retardation. There is extreme slowness of movements or the patient is immobile, long delays before responding even to very simple questions, and speech is restricted to brief answers or the patient is mute.

Notes

(1) The patient must show evidence of slowed thought processes to justify a positive rating for Psychomotor Retardation: for example, by a reduced rate of speech, or pauses between phrases, or pauses before answering questions.

11. ABNORMAL SPEECH - observational guidelines

When rating abnormal speech consider the following factors:

1. Flight of ideas: The patient's conversation moves abruptly from one topic to another, so that a new train of thought appears before the previous one is completed. There is some discernible connection between one idea and the next which makes the change in topic understandable. This connection may be words that rhyme (clang association), words that have a similar sound (assonance), words with more than one meaning (punning), or words that have an association.
2. Knight's move thinking or derailment of thought: The patient's conversation moves abruptly from one topic to another so that a new train of thought appears before the previous one is completed. However, there is no discernible connection between one idea and the next and the change in topic is not understandable.
3. Incoherence: The patient utters strings of unrelated words or phrases. The speech lacks any logical or grammatical structure, suggesting that the structure and coherence of

thinking has been completely lost.

4. Vagueness and talking past the point: The patient's speech fails to focus on the topic under discussion. Although the patient speaks grammatically, little or no relevant information is conveyed to the listener. This kind of speech may be described as exhibiting poverty of content.

5. Neologisms: The patient invents new words. Neologisms must be distinguished from incorrect pronunciation, the wrong use of words by people with limited education, and obscure technical and literary terms.

6. Perseveration and verbigeration: The patient engages in the repeated and inappropriate expression of the same sounds, words or phrases.

11. ABNORMAL SPEECH - rating scale

0 = The patient exhibits no evidence of abnormal speech during the interview.

1 = Mild abnormality of speech observed. The train of speech is occasionally disjointed but it is always possible to discern a logical connection between the ideas expressed by the patient. Or, occasional instances of vagueness or irrelevance but the patient always returns to the point without prompting. No neologisms, perseveration or verbigeration occur.

2 = Moderate abnormality of speech observed. There are occasional breaks in the train of speech where it is impossible to discern a logical connection between the ideas expressed by the patient, but the majority of the patient's speech is normal. Or, occasional instances of vagueness or irrelevance during which the patient needs prompting to return to the point of the question, but most replies are relevant. Or, occasional neologisms, perseveration or verbigeration against a background of predominantly normal speech.

- 3 = Marked abnormality of speech observed. Frequent breaks in the train of speech where it is impossible to discern a logical connection between the ideas expressed by the patient, only a minority of the patient's speech is normal. Or, frequent instances of vagueness or irrelevance during which the patient needs prompting to return to the point, only a minority of replies are relevant. Or, frequent neologisms, perseveration or verbigeration repeatedly disrupt the flow of speech, but some meaningful communication is still possible.
- 4 = Severe abnormality of speech observed. Continual breaks in the train of speech where it is impossible to discern a logical connection between the ideas expressed by the patient, so no meaningful communication is possible. Or, the entire patient's speech is markedly vague or irrelevant, with no relation between the interviewer's questions and the patient's answers. Or, speech consists entirely of neologisms, perseveration or verbigeration.

Notes

(1) Speech that is difficult to understand solely because it is spoken quietly or is mumbled should not be rated under this item. If the patient's speech is difficult to discern for either of these reasons the interviewer must attend closely to what is said and attempt to establish whether the logical and grammatical structure is intact or shows signs of breaking down.

12. POVERTY OF SPEECH - observational guidelines

This item refers to restricted quantity of speech occurring in the absence of psychomotor retardation. In reply to questions the patient gives brief responses which impart the minimum of information, shows a reluctance to elaborate on their responses, but shows no evidence of slowed thought processes. Replies may be brief or monosyllabic, the patient may fail to volunteer information and need repeated encouragement to expand on their initial brief responses to questions, questions may be answered with a shrug or shake of the head, or not answered at all.

When assessing poverty of speech consider the following factors:

1. Reluctance to elaborate on replies to questions: The patient gives brief replies to questions and is reluctant to say more even when asked to do so by the interviewer.
2. Tendency to give brief or monosyllabic answers to questions without regard to their content: Patient confines their answers to 'Yes', 'No', 'Don't know', 'Not sure' etc.

3. Abnormal lack of spontaneous comments: The patient fails to volunteer information or to make comments of any kind.
4. Non-social speech: The patient seems reluctant to reply to the interviewer's questions, but murmurs inaudibly or unintelligibly during the interview.

12. POVERTY OF SPEECH - rating scale

- 0 = No lack of speech. Patient gives full and informative replies to questions and voluntarily provides additional relevant information.
- 1 = Occasional difficulties or silences but patient gives full and informative replies to most questions without repeated prompting or encouragement from the interviewer,.
- 2 = Patient only speaks when spoken to and tends to give brief replies. Does not volunteer additional information without repeated prompting or encouragement from the interviewer.
- 3 = Most replies are monosyllabic despite prompting or encouragement from the interviewer. Frequently fails to answer at all.
- 4 = Speaks only two or three words. Or, murmurs constantly but says nothing intelligible

to the interviewer.

Notes

(1) Poverty of speech should be distinguished from poverty of content of speech. Speech which is vague and imparts little or no information to the listener exhibits poverty of content. With poverty of content the patient may be very talkative and yet be so vague as to convey no useful information at all. Poverty of content should be rated under the item Abnormal Speech.

13. ABNORMAL MOVEMENTS - observational guidelines

This section includes all movements, postures and facial expressions that appear to the interviewer to be abnormal or unusual. When assessing abnormal movements or postures consider the following:

1. Involuntary movements: Tics, tremors, dyskinesia, akathisia, dystonia, choreoathetoid movements. Include all such movements even if thought to be caused by medication.
2. Mannerisms: Odd, stylised movements or acts, usually idiosyncratic to the patient, sometimes suggestive of a special meaning e.g. the patient repeatedly salutes or uses elaborate hand gestures.
3. Stereotypes: Persistent repetition of movements or postures e.g. rocking to and fro in a chair, rubbing head round and round with the hand, nodding head. These movements do

not seem to have a special meaning to the patient.

4. Catatonic movements: Negativism (doing the opposite of what is asked), ambitendence (fluctuating between two alternatives), echopraxia (imitation of body movements), echolalia (imitation of words or phrases), mitgehen and waxy flexibility (excessive co-operation in passive movements).
5. Unusual postures: Voluntarily adopting strange postures, possibly with a special meaning to the patient, or holding uncomfortable postures for long periods.
6. Persistently rigid posture: The patient may sit rigidly in chair or even stand upright for most of the interview. Include rigid posture that may be due to anxiety provided this persists throughout most of the interview.
7. Persistently withdrawn postures: The patient adopts a closed posture, with head down and eyes averted from the interviewer. Include withdrawn posture that may be due to depression, provided that this persists throughout most of the interview.
8. Abnormal staring: Prolonged periods of eye fixation with the interviewer to a degree that is culturally inappropriate, or prolonged staring into space.
9. Facial mannerisms or stereotypes: Distinct idiosyncratic or repetitive movements of unclear meaning e.g. grimacing.
10. Involuntary facial movements: Facial tics, chewing movements.
11. Behaviours apparently resulting from hallucinations: Include unusual behaviour that appears to be a response to hallucinations e.g. breaks off conversation in order to listen to voices, talks aloud or silently in response to voices, looks around at visual hallucinations.

13. ABNORMAL MOVEMENTS - rating scale

- 0 = No evidence of abnormal movements or postures.
- 1 = Slightly unusual movements or postures, which are inconspicuous and are not likely to attract attention of others in social situations.
- 2 = Moderately unusual movements or postures, which are conspicuous and likely to attract attention of others in social situations, but occur infrequently and are not sustained over long periods.
- 3 = Markedly unusual movements or postures, which are conspicuous and likely to

attract attention from others in social situations, and occur frequently or are sustained over long periods.

- 4 = Extremely unusual movements or postures, which are conspicuous and likely to attract attention from others in social situations, and occur almost continuously throughout the interview.

Notes:

(1) When evaluating the degree of conspicuousness of an abnormal movement or posture, the rater should make a judgement about how noticeable it would be to other people if it were to occur in an ordinary, day to day social context. For example, if the patient behaved in that way in a shop, or on a bus, or in a public space, what is the likelihood that other people would notice the behaviour? If it seems likely that others would notice it, would they attend to it briefly or persistently? Behaviour which might draw little attention in a ward or day hospital setting might be highly conspicuous in ordinary social situations.

14. ACCURACY OF ASSESSMENT - observational guidelines

At the outset, all patients must be given a clear explanation of the nature and purpose of the interview, and their co-operation should then be requested. If the patient is extremely reluctant to be interviewed, or if their ability to answer questions is grossly impaired by symptoms, it may be better to postpone the full interview until they are more willing or able to talk. However, if this is done, the scale's behavioural items should still be rated. Some degree of unease or reticence is common amongst patients, particularly at the start of the interview. During the interview, the interviewer should always be prepared to explain the reason for asking any particular question if requested to do so by the patient, and should offer reassurance and further explanation when difficult topics are being discussed. When assessing the accuracy of the assessment, consider the following factors:

1. Suspiciousness: The patient may feel that a deliberate attempt is being made to harm or to annoy. If persecutory delusions are present the patient may believe that the interviewer is involved in a wider conspiracy.
2. Hostility: The patient may be overtly angry and hostile, criticising the interviewer and refusing to answer questions, or cutting off the interviewer by saying no before the question is finished.
3. Misleading answers: The patient may give replies that avoid answering the question, or may frequently contradict himself, or may deny that symptoms are present although there is evidence to the contrary.
4. Verbal over-compliance: This is the tendency to agree passively with the interviewer's questions without seeming to have any regard to their content. The patient repeatedly says 'Yes' or 'I suppose so', without seeming to give proper thought to the questions. He may be trying to please the interviewer, or may be unable to concentrate sufficiently to give a considered response.
5. Resentment or apathy: The patient seems unwilling to co-operate, talks very reluctantly, seems apathetic or listless, or repeatedly says 'No' without seeming to give proper thought to the questions.
6. Interviewing technique: The interviewer should always try to obtain sufficient information to enable an accurate rating to be made. If the patient provides insufficient or ambiguous or contradictory information, the interviewer should attempt to resolve these deficiencies by careful additional questioning, sensitively conducted.
7. In certain circumstances, e.g. following compulsory admission to hospital, the interviewer may feel that a lack of co-operation from the patient is understandable and to some degree justified. This should be recorded on the data sheet as a possible reason for the perceived lack of co-operation, but should not influence the rating itself which should be based solely on the adequacy of the information obtained during the interview.

14. ACCURACY OF ASSESSMENT - rating scale

- 0 = All elicited symptoms rated. All ratings based on complete and consistent information. Any contradictions, ambiguities and uncertainties fully resolved by further questioning of the patient.
- 1 = All elicited symptoms rated. All ratings based on adequate information. Minor unresolved contradictions, ambiguities or uncertainties remain after further questioning of the patient.
- 2 = A minority of elicited symptoms left unrated due to major unresolved contradictions,

ambiguities or uncertainties.

- 3 = A majority of elicited symptoms left unrated due to major unresolved contradictions, ambiguities or uncertainties.
- 4 = All elicited symptoms left unrated due to major unresolved contradictions, ambiguities or uncertainties. Only observed behaviours rated.

Notes

(1) If any rating is thought to be of doubtful accuracy, use this section of the data sheet to record in detail which particular ratings are suspect and why they are judged to be suspect.

(2) Remember that the score for this section should **not** be included when calculating the patient's total symptom score.

Additional Notes:

