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Acknowledgments

The SCAN system has been developed in the framework of the World Health
Organization (WHO) and National Institutes of Health (NIH) Joint Project on Diagnosis and Classification of Mental Disorders, Alcohol and Drug Related Problems (Principal Investigator, N Sartorius, 1993 on Dr. TB Üstün WHO). Development of SCAN was funded by WHO, NIH, and other institutions employing collaborators who took part in the project.

SCAN had its origins in an existing instrument, the Present State Examination (PSE). A brief introduction to the earlier history of the PSE, to the structure of SCAN, and to the development of other instruments in the Joint Project, will be found below.

It is impossible to acknowledge the work of everyone who has participated during the past 16 years. No such enterprise can succeed without the advice, support and collaboration of many researchers, centers and agencies. Some, at least, are listed below.

**Task Force on Diagnostic Instruments:**

JK Wing (chair), M von Cranach, C Pull, L Robins, H-U Wittchen, investigators from Field Trial Centers, and staff of WHO and NIH.


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Print and graphic design: Design Locker (M Locker, J Stevenson), G Der, JK Wing, and others
Social impairment: LG Wing
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An Editorial Committee supervised changes necessary to incorporate the final revision of ICD-10 DCR and DSM-IV: JK Wing (Chair), T Babor, JL Vazquez-Barquero, PE Bebbington, A Bertelsen, TS Brugha, S Chatterji, W Compton III, G Harrison, V Mavreas, AJ Romanoski, N Sartorius, AY Tien and at WHO: TB Üstün, A Janca.

Textual changes were edited by A Bertelsen, T Brugha, S Chatterji, W Compton III, RY Mehta, AJ Romanoski, and AY Tien.

Development of new computer programs for data entry, CAPSE, and ICD-10 and DSM diagnostic algorithms was initiated by S Chatterji, G Der, AY Tien, and TB Üstün. Inventa, Inc. of Bangalore, India (Principal Programmers: R Ashok, CP Hari, and others) undertook the programming. SM Channabasavanna, RS Murthy, and MK Isaac at the National Institute of Mental Health and Neurosciences in Bangalore, India, provided support for editorial and programming work.

Administrative and secretarial assistance: R Barrelet, J Head (London), G Covino, J Wilson (Geneva), M Brugha, I Chenery (Leicester), D Tien, M Tseng (Baltimore).


Errata lists were contributed by TS Brugha, S Chatterji, WM Compton, JL Vazquez-Barquero, A Bertelsen, CG Lyketsos, F Nienhuis, and A Göğüş. Further suggestions for changes were contributed by CG Lyketsos and S Bassett. Textual changes were edited by A Bertelsen, T Brugha, S Chatterji, and AY Tien.

The SCAN Computer Program (I-Shell for SCAN) has been developed at the World Health Organization by Can Çelik with the guidance and supervision of TB Üstün. The
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Computer Program and the Diagnostic Algorithms for were designed & checked by the SCAN Advisory Committee, in particular by FJ Nienhuis, WM Compton, A Bertelsen, L Andrade and TS Brugha.

Administrative and secretarial help: D Eggertsen (Aarhus), G Covino, J Wilson, R. Westermeyer (Geneva), M Brugha, J Chenery (Leicester).

SCAN Training and Reference Centers (*Field Trial Centers)

Complete addresses are listed at the end of the Glossary in the Appendix.

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INTRODUCTION TO SCAN

The Joint Project on Diagnosis (see acknowledgments) set up a Task Force on Diagnostic Instruments in 1980. This group decided to develop further two of the then most widely used instruments in epidemiological research. The NIMH-DIS, version III (with some input from PSE9, see below) formed the basis for the development and field trials of a new instrument, the Composite International Diagnostic Interview (CIDI), which has now been published by WHO. SCAN was the second instrument to be commissioned. The Task Force also commissioned a new instrument, the International Personality Disorder Examination (IPDE).

SCAN (Schedules for Clinical Assessment in Neuropsychiatry) represents the latest stage in a 30-year line of development that began in the late 1950s. PSE9 was the first of the series to be published, following 15 years of work on earlier versions, including two large multicenter international projects – the US-UK Diagnostic Project and the International Pilot Study of Schizophrenia. PSE9 consists of only 140 items, compared to the 500–600 of PSE7 and PSE8. It has been widely used, as evidenced by its translation into 35 or more languages, but many users have regretted that the longer preceding editions were withdrawn; they would have preferred a choice, which is now provided by PSE10.

SCAN is a set of instruments aimed at assessing, measuring and classifying the psychopathology and behavior associated with the major psychiatric syndromes of adult life. It has 4 components: the tenth edition of the Present State Examination (PSE10), the Glossary of Differential Definitions, the Item Group Checklist (IGC) and the Clinical History Schedule (CHS). PSE10 itself has two parts. Part One covers somatoform, dissociative, anxiety, depressive and bipolar disorders, and problems associated with basic bodily functions and use of alcohol and other substance use. There is a screen for Part Two conditions. Part Two covers psychotic and cognitive disorders and observed abnormalities of speech, affect and behavior.

Data from the schedules can be recorded in a variety of ways: in the SCAN Schedules themselves, in Coding Booklets, or by the computer program.

A set of computer algorithms will process data entered from SCAN schedules. Output is presented as a series of options, including a range of profiles of symptom and IGC scores, an Index of Definition, ICD-10, DSM-IV, and possibly ICD-9 and DSM-III-R categories, and a prediagnostic profile of categories. It may be possible to derive SCAN Version 1 items from Version 2.1 of SCAN.

Further details concerning the development of SCAN, instructions as to its use, and results of international trials are in the Glossary, Training Pack and Reference Manual. SCAN is intended for use by clinicians with an adequate
knowledge of psychopathology who have taken a course at a WHO-designated training center. A shortened version of Part One of PSE10 can be used (e.g. in two-stage population surveys, as with the equivalent version of PSE9) by lay interviewers trained in these centers. All interviewers using SCAN should be fully familiar with the Glossary.
12 INTRODUCTION
0 SCAN face sheet

0.001 Version of SCAN

0.002 Project/Center number

0.003 Respondent number

0.004 Rater number

0.005 Key date of first PSE examination [Day Month Year] D M Y

[If no examination, date of completion of first schedule]

SKIP => to 0.016 if non-routine option is chosen.

Only two periods may be rated using the routine option using the paper version of SCAN, e.g. a PSE and/or IGC for each period. If the computer version is used, the onset and offset of individual SCAN items may be dated individually, and as many periods as needed can be rated.

Period(s) rated using PSE(s) - any source of information.

0 PSE not rated.
1 PSE rated for the period stated.

0.006 Present state (PS)

0.007 Representative previous episode (RE)

0.008 Lifetime before PS (LB)

0.009 This PSE completed by

0 PSE not used (IGC used instead).
1 Interviewer rating own interview.
2 Observer rating interview.
3 Rating from videotape.
4 Rating from audiotape.
5 Other, specify ____________________________

SOCIODEMOGRAPHICS 13
0.010  **Source of information used to rate PSE**

[Use left box for PS, right box for RE or LB.]

0  PSE not used [Only IGCs].
1  Respondent only.
2  Respondent and other sources.
3  Case records only.
4  Informant/s only.
5  Case records and informant/s. Specify relative, professional, etc.
6  Prepared abstract.

**Period rated using IGC(s)**

0  IGC not used.
1  IGC used for the period stated.

0.011  **Present state (PS)**

0.012  **Representative previous episode (RE)**

0.013  **Lifetime before (LB)**

0.014  **Source of information used to rate IGC**

[Use left box for PS, right box for RE or LB.]

0  IGC not used.
1  Respondent only [e.g. observed behavior ratings only].
2  Respondent and other sources.
3  Case records only.
4  Informant/s only.
5  Case records and informant/s. Specify relative, professional, etc.
6  Prepared abstract.
1 Beginning the interview

The purpose of Section 1 is to obtain a preliminary overview of the possible problems that the respondent (R) may have. Almost every item recorded in Section 1 can be rated with detail and precision in later Sections. The interviewer should be well informed before starting the interview and be prepared for the following possibilities.

In general

Begin with Section 1 and then proceed to those sections containing items that R most wants to discuss or that are clearly predominant. This will provide more complete coverage on the important topics. If the interview is likely to be incomplete, try to complete sections with highly relevant items first.

Consider the approach and interview strategy likely to be needed.

Prior to beginning, the interviewer should be as well informed as possible. Usually there will be information as to whether R is likely to be able to answer questions and give a fair account of any problems. Several contingencies are outlined below.

If none of the following contingencies apply, begin the interview at next page.

CONTINGENCIES

1 Severe language disorders/or cognitive impairment

- Rate Section 15 for language disorders.
- Rate Section 21 (behavioral and history items).
- Rate Sections 22 - 25.
- Complete Clinical History Schedule.

2 Severe behavior disturbance, uncooperativeness or likelihood of premature termination

Begin with those Sections that are most relevant to R. Keep conversation going while observing speech, affect and behavior (Sections 22 - 25). If necessary complete the examination in stages. All stages can be rated on one schedule if the full SCAN can be is completed within a few days. Be sure to rate adequacy items (13.125 20.113-20.115, and 24.045).

- Re-interview with PSE10 as opportunity affords.
- If interview impossible, rate PS on Item Group Checklist.
- Use all information available to rate Item Group Checklist for previous episode if necessary.
- Complete Clinical History Schedule.

3 **Recent catastrophic trauma or psychosocial stressor**
- Begin with Section 13 and complete required checklist items if needed.
- Use informant records and ascertain details of event.
- Complete the full SCAN as soon as possible, and make attributions of effects of stressors in Section 13, if possible, delaying until precise "causal" influence of any trauma/stressor is clear.

4 **Dissociative symptoms**
- Complete items 2.102 - 2.117.
- Obtain information from informants/records.
- Complete the full PSE10.

5 **Drug or alcohol use**
If the main problem, it is advisable to consider Sections 11 and 12 first, but the whole of PSE10 must be completed. Attributions of cause and effect may be rated in Section 13, preferably after their influence has been clearly established.

6 **Eating disorders**
- If the main problem, begin with Sections 8 - 9.
- Return to Section 1 and complete PSE.
INTRODUCTIONS AND OVERVIEW

The Clinical History Schedule contains a more comprehensive clinical and social history, which may be completed with the additional aid of case-records and informants. There is a reminder in CHS to check all PSE history items in the light of information from case records and informants.

The Glossary notes on rating episodes should be used when completing this section.

Always be as fully informed as possible, e.g. from case-records and/or other informants before starting.

My name is [I am] ... What is your name?
[Offer to shake hands]

Obtain permission to proceed and to use any recording equipment. Explain the purpose of the interview, for example:

We are making a survey in this neighborhood in order to:

Or:

This is part of the routine medical examination of people who come to the hospital, except that we should like to take time to discuss problems in more detail than usual because ...

Or:

We are making a study of ... and would like to ask you about any health problems you have been having

Or:

[Other introduction and explanation]

Is that all right with you?

To begin with, I should like to get a general view of the kind of health problems, physical and mental, that might have troubled you recently. Would you say that you had recently enjoyed good mental and physical health or have you had any problems?

Allow or prompt R to give a narrative account. Ask clarifying questions only, as in the following prompts:

- Could you describe what ... was like?
- Could you give me an example of ...?
- Do you still ...?
- When did ... start?
- Are you taking any medication? (What kind?)
- Are you receiving any other help or therapy?

If R describes no relevant symptoms, ask:

Would you say you had enjoyed excellent physical and mental health recently, with no real problems?

1.001 R's unprompted response to initial questions

0 R does not describe having had psychotic, affective, or neurotic symptoms recently.
1 R spontaneously describes such symptoms.
2 R reluctant to describe symptoms but does so after probing.
8 R's reply is uninformative.

Use all information from other sources to rate whether the following symptom types have ever been present:

[Use colloquial terms. Do not ask questions that R has already answered, but confirm them, e.g. 'So you have had ...']

Were specified symptom groups ever present?

May I mention some problems that many people experience at some time in their lives, and ask whether you have ever been troubled by any of them, and if so how distressing or disabling they were?
For each type of symptom ever present, ask:

- Could you describe what it was like?
- When did it first start?
- How old were you then?
- Has it been continuous or intermittent?
- And how long has this recent period lasted?

0 No evidence that symptom category was ever present.
1 Present, but only mildly distressing or disabling.
2 Present and moderately distressing or disabling.
3 Present and severely distressing or disabling.

1.002 Anxious or panicky feelings, often in particular situations? ☐
1.003 Feeling very low in spirits? ☐
1.004 Feeling the opposite - feeling much too ‘high’ or elated or very irritable without much reason? ☐
1.005 Experiences that are difficult to explain or understand like hearing voices or seeing things? ☐
1.006 Having problems due to alcohol or other substances? ☐

CUT OFF => to 2.001 and begin PS - check if 1.002 - 1.006 are all rated 0.

SELECTION OF EPISODES

Decide provisionally, on the basis of this information, which periods represent the most clinically significant symptoms (of neurotic, affective or psychotic disorders) during the clinical course. See Glossary notes on choice of episodes. Time periods of symptoms that do not fit the pattern established here in Section 1 can be recorded separately at the end of each Section.

1.007 Onset of Present Episode, PE

Onset date must follow 2 months or more without significant clinical symptoms. R must have had clinically significant symptoms (any severity level) within approximately the month before the interview. See notes for full definition. If not ‘in episode’ at interview, leave blank, but complete a PS-check for 4 weeks before examination. September, 1994 is entered 0994.

1.008 Number of days in PS

This period should usually be 28 days and end at the date of examination. See Glossary notes for permissible extensions, e.g. ‘notional month’.
1.009 Dates of representative episode, RE

1.010 Duration of RE, in weeks

Use RE if a single discrete episode, together with PS, adequately represents the course of clinically significant symptoms. See Glossary for full definition. March 1971 to May 1973 is entered as 0371 to 0573, duration 112 weeks. If RE is contiguous with the beginning of PS, PS+RE=PE. Variations in the timing of RE between different syndromes, if necessary, can be recorded separately within each Section.

Skip => to 1.015 if RE used. If RE not used, leave RE dates blank, and consider 1.011 - 1.014. Record the option chosen for PERIOD (PS, RE, LB) at 0.006 - 0.008.

Dates of Lifetime Before, LB

LB is dated from onset of the first episode to the start of PS. LB can represent one continuous episode or contain several discrete episodes. Use LB if PS and RE together do not adequately represent the clinically significant symptoms manifested during the course. It would not usually be sensible to rate more than 2 episodes in LB if R is also in episode at PS. See Glossary for full definition and rating instructions. Leave blank if never present. Sections not referred to here are rated for specific periods referred to above (contingencies), i.e. Sections 2, 9, 11, 12 and 21.

1.011 Episode of Neurotic symptoms

1.012 Episode of Depressive symptoms

1.013 Episode of Manic symptoms

1.014 Episode of Psychotic symptoms

Date approximate age of first onset of symptom types in LB

This estimate should represent the first onset of a clinically significant group of symptoms of the type listed, causing at least moderate distress or disability. 98 = NK. 99 = NA. Further details can be recorded at 1.046 - 1.049 and in CHS.

1.015 Age at first onset of Neurotic symptoms
1.016 Age at first onset of Depressive symptoms

1.017 Age at first onset of Manic symptoms

1.018 Age at first onset of Psychotic symptoms

1.019 Quality of remissions between episodes

If there have been 2 or more episodes, whether similar or dissimilar, consider the persistence of significant clinical symptoms between them.

- 0 No episodes or only one episode, not followed by significant symptoms.
- 1 No or few significant symptoms between episodes.
- 2 Mixed, but intervals more often like (1).
- 3 Mixed, but intervals more often like (4).
- 4 Significant symptoms usually present in intervals.
- 5 Continuous symptomatology

SKIP => to 1.026 if episode(s) have been rated at 1.011 - 1.019.

Special episode list

Use of this episode list entails rating several episodes separately, each with its own face sheet and recording book. Item 0.016 of the face sheet must contain the identifying number of the episode rated. Any other information needed locally should be entered in the ‘spare’ spaces provided in the data entry program. A separate CATEGO output will be provided for each individual episode. Users will make their own analyses of the results. The dates of recurrent episodes of affective disorder may also be recorded in a similar way in Sections 6 and 10.

1.020 Episode 1

1.021 Episode 2

1.022 Episode 3

1.023 Episode 4

1.024 Episode 5

1.025 Episode 6
Rating scales in Part One

GENERAL POINTS

The main rating scale in Part One is Scale I. The rating points are specified below, and are elaborated on in the Glossary.

However, many items (particularly in sections other than 3-6 of Part One) have their own individual rating scales, which are specified within their item blocks. It should be noted that all symptom items can be rated 0, 5, 8, or 9, using the definitions given in Scale I, whether or not these points are specified in the text.

For making etiological attributions, many items have boxes with dashed line below the episode rating boxes. These are optional ratings that are not required, but which may be useful for research purposes, and in certain clinical situations. The purpose is to separate the ratings of phenomenology from any ratable etiological factors; for example Parkinson’s disease, or the effects of alcohol or other drugs. The etiology scale should be used to code any attribution of etiology. Further details are elaborated on page 29.

RATING SEVERITY

The severity of a symptom can be assessed in terms of duration, persistence, degree of interference with other mental functions, distress, impairment of everyday activities, effect on other people, and contact with services of various kinds. In SCAN, the approach is to measure clinical severity by the duration and frequency of the symptom and the degree of interference with mental functions (intensity). Social and occupational performance, other people’s reactions, and help-seeking behavior (all of which can be influenced by many other factors), are assessed separately.

Somewhere between the two lies the respondent’s own reaction, but this may be stoical or distressed according to temperament and circumstances, and is therefore also regarded as adding a degree of ambiguity to the rating. Distress is only mentioned in items which use criteria from a rule-based system that requires it to be present.

These points hold good for ratings throughout SCAN and, in particular, for the four main Rating Scales.

RATING SCALE I

Many items in Sections 2-6 are rated on this standard 4-point scale (0-3). The factors chiefly involved are intensity (intrusiveness and extent of interference with mental functions) and frequency of the symptoms. The
standard definitions are suitable for a period of about 4 to 6 weeks. This is the period of the 'Present State', from which the PSE originally derived its name.

In longer episodes, it is often possible to select (with R) a period of equivalent length during which most of the symptoms characteristic of the episode were present (a 'representative month').

When rating a period longer than a month it may be difficult to specify the proportion of time during which a symptom has been present.

In such cases, rate mainly on clinical intensity rather than duration. Frequency can still, however, be used as appropriate.

Do not be too pedantic when asking about each symptom. It is usually sufficient to establish an overall frequency and intensity for a group of symptoms and then to establish any variation in particular items.

0. This is a positive rating of absence. It does not mean 'not known' or 'uncertain whether present or not'. It can only be used if sufficient information is available to establish its accuracy.

1. This is a positive rating of presence, but presence of such a minor degree that it is not appropriate for use in classification. Like (0), it does not mean 'not known' or 'uncertain'. Ratings of (1) count in scores (but not for diagnostic purposes), which in turn influence the level allocated on the Index of Definition.

2. This rating means that the item is present at a level sufficient to use in classification. For this purpose it is equivalent to 3, but it contributes less to scores. In general, it is used when symptoms are of moderate severity during most of the period being assessed.

3. A rating of (3) is similar to (2) except that the symptom is present in severe form for most of the period under review.

5. The presence of psychotic symptoms can make the rating of Part One items very difficult, because of problems in interpreting the meaning of what R says, or because the symptoms (for example, anxiety or a phobia about leaving one's house) may themselves be based in psychotic experiences. The rating should only be made when there is genuine doubt about the nature of the symptom or the balance is in favor of the symptom being psychotic.

8. If, after an adequate examination, the interviewer is still not sure whether a symptom is present (rated 1-3) or absent (rated 0), the rating is (8). This is the only circumstance in which (8) is used. It should not be used to indicate a mild form of the symptom.
9. This rating is only used if the information needed to rate an item is incomplete in some respect, for example because of language or cognitive disorder, or lack of cooperation, or because the interviewer forgot to probe sufficiently deeply. It is distinguished from (8) because the examination was not, for whatever reason, carried out adequately.

In the SCAN text, an instruction to 'use Scale I' simply means that it is not necessary to point out any individual rating characteristics for that item. Any point on Scale I can be selected, according to clinical judgement.

For duration ratings, duration less than 1 week/month should be rated 1. A rating of 0 thus means that the phenomenon has been totally absent.
2  Somatoform and dissociative symptoms

Adapt questions about disorders and treatments to local usage. Use information from informants and case records. Note that Section 2 generally defines episodes based on a much longer duration than other Sections.

2.001  Physical fitness

Now I should like to ask you some questions about your physical health. During the past month or so would you say your physical health has been excellent, good, fair or poor? How about before the past month? [Rate two standard periods].

1  Excellent.  3  Fair.
2  Good.       4  Poor.

If fair:  What makes you say 'fair' rather than 'good'?

Continue with 2.002 if poor; otherwise, go to 2.003.

If poor:

2.002  Length of unfitness

For how long has your physical health been poor?

Specify in years and months. One year and 6 months is entered '01 06'. Leave blank if physical health has been at least fair.

2.003  Change in weight, past year

Have you lost or gained any weight during the past year? [1 kg = 2.2 lb].

- Over what period of time?

0  Virtually no change.
1  Less than 2 kg (<5 lb) change.
2  Lost 2+kg (5+lb) within 6 week period.
3  Gained 2+kg (5+lb) within 6 week period.
4  Weight has fluctuated, outside 2+kg (5+lb) loss or gain.

Items 8.006 and 8.007 deal with weight change in more detail.
2.004  **Physical illnesses or disabilities, past year**

*In the past year, have you had any bodily aches or pains, or weakness, or physical illnesses or injuries, or disabilities that limited your activities in any way?*

- What sort of problems have you had?
- Did the doctor/specialist tell you what was the matter?

0  None.
1  Describes somatic symptoms or disorder without clear diagnosis.

**SKIP => to 2.007 or 2.008**

2  Has clear physical diagnosis.

**DIAGNOSABLE PHYSICAL ILLNESS OR DISABILITY**

Conditions associated with mental retardation and/or autism, e.g. Down's Syndrome, fetal rubella, etc., should be checked in CHS. The first box should contain a letter indicating the ICD-10 chapter, followed by up to 3 digits. If none leave blank.

2.005 Diagnosis 1

2.006 Diagnosis 2

Women only:  [Show a card if it would be helpful.]

2.007  **Pre-menstrual symptoms, past year**

*Have you had any symptoms before menstruation which stop as soon as the period starts? Such as:*

- Irritability, depression;
- Feeling of being bloated or gaining weight;
- Tenderness or swelling of the breasts;
- Muscular tension;
- Aches and pains such as headaches, backache, etc.;
- Poor concentration;
- Cravings.

Enter number positive; if 7 or 8 rate 7 as 8 = NK. Ideally this rating should be based on a concurrent diary using a systematic inventory covering at least two cycles.
2.008  **Limitations on physical activities, past year**

*Have any of these problems (2.001 - 2.007) limited your well-being or activities in the past year?*

- *How severe has the limitation on your physical activities been?*
  
  0  None.
  1  Mild.
  2  Moderate.
  3  Severe to incapacitating.

2.009  **Satisfaction with care, past year**

*Have you had expert advice about ... (physical problems)?*

- *How much contact have you had with doctors [healers, etc.]?*
- *What did the doctor say was wrong?*
- *Are you reasonably satisfied that the problem has been thoroughly investigated and you have received good advice?*
- *Have you any more appointments with a doctor?*

  0  R is satisfied that the problem has been investigated and treated with reasonable care, is reasonably dissatisfied, or had no expert advice.
  1  R is unreasonably dissatisfied with medical care.
  8  Unclear whether dissatisfaction is due to R's overconcern or to reasonable grievance.

**CUT OFF => to 3.001**  
if there is no evidence from interview, records, or informants of somatoform or dissociative symptoms.

Always continue if symptoms have no convincing medical explanation.
RATING SCALE I

0. This is a positive rating of absence. It does not mean 'not known' or 'uncertain whether present or not'. It can only be used if sufficient information is available to establish its accuracy.

1. This is a positive rating of presence, but presence of such a minor degree that it is not appropriate for use in classification. Like (0), it does not mean 'not known' or 'uncertain'. Ratings of (1) count in scores (but not for diagnostic purposes), which in turn influence the level allocated on the Index of Definition.

2. This rating means that the item is present at a level sufficient to use in classification. For this purpose it is equivalent to 3, but it contributes less to scores. In general, it is used when symptoms are of moderate severity during most of the period being assessed.

3. A rating of (3) is similar to (2) except that the symptom is present in severe form for most of the period under review.

5. The presence of psychotic symptoms can make the rating of Part One items very difficult, because of problems in interpreting the meaning of what R says, or because the symptoms (for example, anxiety or a phobia about leaving one's house) may themselves be based in psychotic experiences. The rating should only be made when there is genuine doubt about the nature of the symptom or the balance is in favor of the symptom being psychotic.

8. If, after an adequate examination, the interviewer is still not sure whether a symptom is present (rated 1-3) or absent (rated 0), the rating is (8). This is the only circumstance in which (8) is used. It should not be used to indicate a mild form of the symptom.

9. This rating is only used if the information needed to rate an item is incomplete in some respect, for example because of language or cognitive disorder, or lack of cooperation, or because the interviewer forgot to probe sufficiently deeply. It is distinguished from (8) because the examination was not, for whatever reason, carried out adequately.
54 SOMATOFORM AND DISSOCIATIVE SYMPTOMS
3  Worrying, tension, etc.

Before rating any item that might be present, always establish whether there has been a period of 'normality' before onset. Symptom ratings require there to have been a definite deviation from a previous state when the symptom was absent.

Use Scale I to rate all Section 3 items except 3.004.

First I should like to ask about some very common experiences and see whether you have had any of them recently.

3.001  Worrying

Have you worried a great deal during [PERIOD]?  
- What is it like when you worry?
- Do unpleasant thoughts go round and round in your mind?
- Do you worry more than is necessary, given the problem?
- What happens when you try to turn your attention to something else?
- Can you stop worrying by looking at TV or reading or thinking about something you usually enjoy?

A round of painful thought which cannot be stopped and is out of proportion to the topic of worry. Worries 'too much' but only in relation to real problems = mild.

3.002  Feeling of nervous tension

Have you often felt on edge or keyed up or mentally strained?  
- What is that like?
- How severe is it?
- Do everyday problems get on top of you?
- Do you tend to startle too easily?

There is no need for autonomic accompaniments for this symptom to be rated present though they usually are. Include exaggerated startle response. Feels strain only in relation to real problems = mild. If R says she or he is anxious but does not describe autonomic symptoms, consider rating here.
56 WORRYING, TENSION, ETC.
3.003 General muscular tension

Have you had difficulty in relaxing during [PERIOD]?

- Do your muscles feel tensed up?
- Where do you feel it?
- Can you relieve it by relaxing?

Tension only in relation to real problems = mild.

If 3.001 - 3.003 are rated 0 ask 3.004.

3.004 Calmness in the face of problems

These questions have been about nervous problems. Could I ask you the opposite kind of question? Would you say you were more calm and collected, less prone to irritability, restlessness, self-consciousness or nervous fatigue than most people during [PERIOD]?

- That you would only get upset if something really serious happened to cause it?

Probe for items 3.001 - 3.013 as appropriate.

1 Less prone to Section 3 problems than most.
2 About average.
3 More nervous than average.
4 Severe nervousness.

CUT OFF => to 4.001 if 3.001 - 3.003 rated 0 and 3.004 rated 1 or 2

3.005 Localized tension pains

Have you had aches and pains, like headaches, neckache, backache, aching muscles, during the [PERIOD]?

- What is it like?

'Band round head', 'pressure', 'tightness in scalp', 'ache in back of neck', etc., but not migraine or other specific syndrome. If probable physical cause, use etiology option with dashed boxes or at 13.035.
3.006  Subjectively described restlessness

Have you been so fidgety and restless that you couldn’t sit still?

   - Did you have to keep pacing up and down?


3.007  Fatiguability and exhaustion

Have you been getting exhausted and worn out during the day, even when you haven’t been working very hard?


3.008  Sensitivity to noise

Have you found that noise upsets you?

   - Do noises that other people find tolerable seem to penetrate or go through your head?
   - More than ordinary dislike of loud noises?
   - Do you have to put up with a lot of noise?
   - Are you able to work or think in noisy places?

Exclude ordinary dislike of loud noise. Sensitive but copes = mild.

3.009  Irritability

Have you been very much more impatient or irritable than usual during [PERIOD]?

   - How has that shown itself?
   - Do you keep it to yourself or raise your voice or flare up without reason?
   - Have you really lost your temper or your control?

1 Mild irritability, unusual for R, or brief domestic quarrels out of the ordinary.
2 Raised voice, anger, shouting, more frequently picking quarrels.
3 Pushing, hitting, lost control.
3.010  **Simple ideas of reference**

Are you self-conscious in public?

- Do you get the feeling that other people are taking particular notice of you, for example in the street or in a restaurant?
- Are they really taking a special interest in you or are you sensitive?

R must recognize that the feelings originate from within but nevertheless cannot help thinking people talk, laugh, criticism, notice etc. Delusions of reference = 5.

3.011  **Suspiciousness**

Have you tended to be more suspicious than usual?

3.012  **Depersonalization and derealization**

Have you felt that things around you, or other people, or you yourself were unreal? [see 16.006 - 16.009]

Exclude if solely in context of anxiety; see 4.026. If any evidence for depersonalization, complete Section 16.

3.013  **Non-delusional jealousy**

Have you been more inclined to be jealous? [check at 19.015]

3.014  **Timing of PERIOD/s of Section 3 symptoms**

It is necessary to record only if dates of symptoms in this Section are different from PERIOD rated in Section 1 (items 1.007-1.014).

Date of onset in PS or PE (DD MM YY) 

Duration in PS or PE in days

Date of onset in RE or LB 

Duration in RE or LE in weeks
3.015  **Interference with activities due to Section 3 symptoms**

You have mentioned [summarize symptoms] during PERIOD. Overall, how much interference has there been with your everyday activities because of these problems?

Rate interference due to symptoms in Section 3.

- 0 No Section 3 symptoms present in significant degree.
- 1 Symptom/s present but little interference.
- 2 Moderate or intermittent interference.
- 3 Severe to incapacitating interference.

Although rating attribution of physical (including alcohol, drugs, medical condition etc.) cause is possible using the optional attributional scale with the dashed boxes or in Section 13, items 3.016 and 3.017 allow the user to rate organic cause at the section or syndrome level. For example, consider effects of amphetamines and if present whether these provide a sufficient reason for the items rated.

3.016  **Organic cause of symptoms in Section 3**

Use the four criteria listed in Glossary.

- 0 Absent.
- 1 Probable organic cause; not fully confirmed.
- 2 Definite; confirmed by expert investigation.
- 8 Uncertain whether organic or not.

3.017  **Identify organic cause of Section 3 symptoms**

For identifiable causes, enter ICD-10 chapter letter and up to 4 digits. If two periods are rated, use top row boxes for the first period (PS) and the bottom row for the second period (RE or LB). If none leave blank. Organic cause may also be rated with the attributional scale at the item level.
4  Panic, Anxiety and Phobias

If present but judged to be due to physical cause, e.g. hyperthyroidism, cardiothoracic disease, stimulants, withdrawal from drugs (e.g. benzodiazepines), etc., users may rate individual items with the optional attribution scale or rate entire section at end of Section 4 or in Section 13. Consider stress reaction in Section 13. If R says he or she is anxious but does not describe autonomic symptoms, consider rating elsewhere, e.g., Section 3.

4.001  General rating of anxiety

Now I should like to ask about feelings of anxiety or attacks of panic during PERIOD.

When people get anxious or panicky they often feel very fearful. They may feel their heart beating fast, or they may start shaking or sweating, or feel they can’t get their breath. Have you had feelings like that? (Can you describe it?)

0  Anxiety and panic attacks absent.
1  Anxiety and/or panic attacks present.

4.002  General rating of phobias

Some people have phobias. They feel anxious, or panicky or scared in certain situations, like being afraid of heights, or open spaces, or certain animals or insects, or in some social situations. They try to avoid them or avoid even thinking about them.

Would that be true of your experience?

0  Phobias absent.
1  Phobias present.

How long have you noticed this? When did it first start?

Check ages at 4.056 and record duration of period at 4.059 unless same as in item 1.007.

Symptoms of anxiety or panic are listed in items 4.003 - 4.019. Those marked + are autonomic arousal symptoms specified in ICD-10 as especially important for panic states. The computer program sums them separately.
The list may be presented by the interviewer one item at a time, or as prompt card, to R directly. In either case, the terminology used should be appropriate for local circumstances and culture. For example, ‘butterflies’ will only be understood in a few parts of the world. Other examples should be found for the same symptom.

Some respondents may attest to these symptoms in addition to other somatic complaints but attribute them to a disabling physical cause for which they have sought medical help, or if that is not available have engaged in self treatment with physical remedies. Use somatoform checklists in Section 2 and rate 2.127 if panic attacks (4.020) are also rated present in this Section.

When rating these items, ask first the presence of each item, making a tick mark. Then determine the temporal relationships between items and rate 1, 2 or 3 as appropriate.

Do not rate anxiety if due to appropriate environmental circumstances.

*I should like to ask about a list of symptoms that some people get when they are anxious or have attacks of panic. Do you have any of these?*

Rate items 4.003 - 4.019.

0 Absent.
1 Symptoms present at different times (in isolation).
2 Symptoms rated as occurring together (e.g. during an attack of panic).
3 Both situations present.

4.003 *Can’t get breath and smothering feeling*

4.004+ *Heart pounding, missing beats, faster*

4.005 *Dizzy, light-headed, faint, unsteady*

4.006 *Tingling, numbness in face/fingers*
4.007  Tightness, discomfort or pain in chest

4.008+  Dry mouth not due to medication or dehydration

4.009  Difficulty in swallowing, lump in throat

4.010+  Sweating, e.g. palms

4.011+  Trembling or shaking, e.g. of hands or limbs

4.012  Hot or cold sweats or flushes

4.013  Unreality, 'not really here’. Like an actor

4.014  Churning stomach, nausea, butterflies

4.015  Fear of dying

4.016  Feeling of choking

4.017  Fear of going crazy, or fear of losing emotional control or passing out
4.018  **Apprehension, jumpiness, or increased startle response**

4.019  **Other, e.g. urinary frequency, etc**

**CUT OFF => to 5.001** if 4.001 and 4.002 are rated 0, and no anxiety symptoms are present.

If some evidence of past anxiety symptoms, ask:

*You suggested that you did have problems with [anxiety and/or phobias] but you have not had any of these anxiety symptoms during PERIOD. Is that because you have not been in situations that provoke them?*

**SKIP => to 4.027** if no anxiety symptoms occur because of avoidance.

4.020  **Frequency of panic attacks with autonomic symptoms**

*Have you had any attacks of panic, or sudden attacks of anxiety, with unpleasant feelings like these (4.003 - 4.019), which very quickly became intolerable?*

- Can you describe a typical recent attack?
- How often did these attacks occur, say in a 4 week PERIOD?
- Did you only get them in certain situations?
- What situations?

Include if they occur out of the blue, or in phobic situations, or apparently triggered by alarming thoughts or internal sensations. There is usually a sudden onset with a rapid crescendo to maximum. Consider the possible contribution of a cardiothoracic or other physical disease and if an attributable cause, consider using the etiology options. Record approximate number in a 4 week period up to 40. If there is doubt about this occurrence of panic attacks, rate 88.

- 00  No attacks.
- 40  40 or more.
- 55  Psychotic symptoms make rating difficult.
- 88  NK.
5 Obsessional symptoms

The ideas and impulses are experienced as entering the mind against conscious resistance. R tries to resist them but fails. They are unpleasantly repetitive. They are acknowledged as excessive or unreasonable and recognized as part of R’s own thoughts and much distress is caused by this, since the thoughts may be embarrassing or blasphemous. Thoughts (obsessions) and actions (compulsions) are closely connected and can be rated together under each item. In very chronic conditions, the resistance may lose force; therefore take history into account.

1 This rating is not appropriate in the case of obsessions and should not be used.
2 Most days for at least 2 weeks, moderate severity.
3 As 2 but severe.
5 Difficult to differentiate from psychotic symptoms.

Ask these general probes:

Some people find that they have to keep on checking things that they know they have done; like gas taps, light switches, whether the front door is locked, and so on. Do you have problems like that?

Another problem with some people is that they have to keep things round them in a special order, far beyond ordinary tidiness. Is that true of you?

And what about keeping things clean? Do you have to spend a lot of time washing things repeatedly that are already clean?

- There are other difficulties of a similar kind, like unpleasant and unwanted thoughts or images coming into the mind, which can’t be resisted. Has that been a problem?

If any evidence that there might be section 5 symptoms, probe further:

- Can you describe what it is like?
- Where do these ideas or impulses come from?
- Do you try to resist them - for example, to stop yourself from ...?
  (What happens?)
- Do you get very upset or distressed when you can’t control it?
- How severe has it been?
- How often has it occurred during PERIOD? Most days? For as long as a fortnight? Longer?

5.001 Evidence for obsessional and compulsive symptoms

0 No evidence.
1 Sufficient to proceed below cut off.
6 Depressed mood and ideation

Remember that Sections do not always have to be taken in strict numerical order. If it is more appropriate to take items in Section 7 or 8 relevant to depressed mood first, that is the optimal order.

Symptoms of Depression

Before rating any item that might be present, always establish whether there has been a period of 'normality' before onset. Symptom ratings require there to have been a definite deviation from a previous state when the symptom was absent. Use Scale 1 for rating unless otherwise specified.

Dysthymia

This is a condition of persistent despondency or gloom lasting for 2 years or more; with poor sleep, low energy, tedium vitae and a feeling of insufficiency. There can be periods of normal mood and basic coping is not impaired. If answers to the first items suggest a chronic condition, complete Section 6, and items 6.044 - 6.071.

Recurrent Brief Depressive Disorder

Complete Section 6. Then rate items 6.072 - 6.077.

May I ask some questions about feelings of sadness or depression?

6.001 Depressed mood

Have you been feeling low in spirits recently?[PERIOD]?

- Would you describe your mood as sad, downcast, gloomy, despairing or deeply depressed?
- Has it been mild, moderate or severe?
- How much of the time were you in reasonable spirits?
- And how much of the time were you really low?
- When did you last feel your usual self?

When rating clinical severity of depression, remember that deeply depressed people may not necessarily cry, and that retardation may produce an impression of apathy and empty mood (see 6.007). Irritability (item 3.009) may also mask depression. Rate mood on subjective description of peak period. Manifestations at interview are rated at 23.001. Consult Glossary.
6.002  ‘Masked’ depression

If 6.001 is rated 0 or 1, but the interviewer considers that a depressed mood is masked by other symptoms (e.g. irritability), or difficulty in introspecting (e.g. cognitive impairment from any cause, or educational problem), or a cultural tendency to manifest depression in other forms than mood, e.g. in somatic symptoms, rate here. If uncertain, rate 8. See Glossary.

1 Circumstances suggest that depressed mood might be present but a definite rating cannot be made [continue beyond cut-off].
2 Masked depression of mood very probably present.

6.003  Tearfulness and crying

Do you often feel like crying?

- Do you actually cry?
- How often does that happen?
- For how long has it been going on?
- What starts you off?

Mild = tears in eyes;
Moderate = tearfulness;
Severe = long periods of weeping, nearly every day, much of the day.

If > 2 years, consider dysthymia.
6.004 Anhedonia

Have you been able to positively enjoy things like taking a walk, working at your hobbies or interests, having a nice meal with friends, winning a game or receiving a compliment?

Or do you seem unable to find pleasure even in things you used to enjoy?

- How much of the time were you unable to enjoy things as much as usual?
- When did you last really enjoy something? What?
- Do you keep up the appearance of enjoyment?

This should be a definite loss compared with the normal state but the loss need not have begun during PERIOD.

If > 2 years, consider dysthymia

6.005 Duration of depressed mood or anhedonia

How long have you been feeling like this?
When was the last time you usually felt free of this feeling?

Enter number of weeks up to 80 (88 = unsure, but always try to rate approximate duration conservatively, i.e. if it is at least a month, rate 04 and not 88):

If > 2 years, consider dysthymia.

If 6.001 is rated from 1 - 3, ask:

What do you think is the cause?

Note the answers for items in section 13.

CUT OFF => to 7.001 if no evidence of depressed mood or other Section 6 symptoms.

If Section 6 symptoms may be present without a context of depression, complete the relevant items.

If depressed for more than two years, continue but consider dysthymia 6.044 - 6.071 throughout the section unless clearly severe and episodic.
6.006 Loss of hope for the future

How do you see the future?

- Do you think there are some good days still to come?
- How much of the time does everything seem quite hopeless?
- When did you last feel you could see a reasonable future? What were you looking forward to?

This should be a definite loss compared with the normal state but the loss need not have begun during PERIOD.

Consider dysthymia if > 2 years.

6.007 Feeling of loss of feeling

Sometimes people don’t describe sadness or depression as such but say they have lost the ability to feel any emotion at all. They can’t feel sad and can’t cry. Have you actually experienced that lack?

- What is it like compared with your ordinary mood?
- How severe or continuous was it during the PERIOD?
- Have you been free of it at all?

This should be a definite loss compared with the normal state but the loss need not have begun during PERIOD. 'The loss of feeling is felt, the numbness perceived, the lifelessness experienced' (E Bleuler). See Glossary definition. Constricted affect but not as a positive feeling = 1.

6.008 Loss of reactivity

Does the depressed mood come and go, or does it seem to be always there, even if only in the background?

- Does it get better or worse with circumstances or is it always much the same?

0 Depressed mood absent.
1 Depressed mood reactive to circumstances on most days.
2 Depressed mood variable but not event-reactive.
3 Depressed mood persistent through most of period; not reactive.
6.009 **Morning depression**

What time of day does the depression feel worst?

- Is there any time when it is less severe?

0 No depression, or not worst early.
1 Regularly feels worst early in the day.

6.010 **Preoccupation with death or catastrophe**

Do you tend to brood over possible disasters, like death or ruin or some catastrophe that could occur to you or others?

- How much of the time have you been free of this?
- How often was the brooding really intense and continuous?

If delusional, rate at 6.019.

If \( > 2 \) years consider dysthymia.

6.011 **Suicide or self-harm**

Have you thought about harming yourself or even made an attempt at suicide, during [PERIOD]?

- What happened?

Include whether thought due to depression or not:

0 Absent.
1 Deliberately considered suicide or self-injury (intrusive thoughts) but made no attempt.
2 Injured self or made an attempt but no serious harm resulted.
3 As 2 but with serious self-harm.
4 Made an attempt at suicide designed to result in death.

If 6.011 is rated 0, ask 6.012.
6.012  *Tedium vitae*

Have you felt, during the [PERIOD], that life was not worth living or that you would not care if you didn’t wake in the morning?

- Would you even wish to have some fatal disease or accident?
- How much of the time did the feeling last?
- Recurrent thoughts of death, death-wish?

6.013  *Pathological guilt*

Do you tend to blame yourself for something you have done or thought; to feel guilty or ashamed of yourself?

- What is it that you think you have done wrong?
- How much of the time, in [PERIOD], have you been free of it?
- How often did you feel guilty?

Rate only if guilt is not realistic; not if actions have been blameworthy and guilt proportional. 6.013 and 6.014 can co-exist. If so, rate both.

If delusional, rate at 6.018.

6.014  *Guilty ideas of reference*

Do you have the feeling that you are being blamed or accused by others because of some action or lapse or deficiency that you yourself feel was blameworthy?

- How much of the time, in the [PERIOD] have you been free of the feeling?
- How often have you had the feeling that you were being blamed for something really serious?

Rate only if guilt is not realistic. Omit if actions have been blameworthy and reference could be just. If delusional, rate at 19.010. Check 3.010.
SELF ATTITUDES

6.015 Loss of self-confidence with other people

How confident do you feel in yourself? For example, in talking to others or in managing your relationships with other people?

- When could you last feel confident in that way?
- Was there any change or has it always been like that?

This should be a definite loss compared with the normal state but it need not have begun during Period.

If 6.015 is traitlike consider rating of 27.034. If > 2 years consider dysthymia.

6.016 Social withdrawal

Have you wanted to stay away from other people? Do you answer the door bell or the telephone? Do you try to avoid the company of other people?

Check item 3.011.

If 6.016 is prolonged or life-long consider rating of 27.033.

6.017 Loss of self-esteem

What is your opinion of yourself compared to other people?

- Do you seem to feel less competent than they are?
- In what way?
- Do you feel inferior, or worthless?
- Is that new or have you always felt that way?

This should be a definite change compared with the normal state but the change need not have begun during PERIOD. Worthless = 3.

If 6.017 is prolonged or life-long consider rating of 27.034.

If > 2 years consider dysthymia.
PSYCHOTIC AFFECTIVE SYMPTOMS

Part II of PSE10, from which the following 4 items are taken, should always be completed if any psychotic symptom is present. Rate as below.

1 Rare.
2 Occasional. (Scale II, p. 211).
3 Frequent.

6.018 Delusions of guilt or worthlessness in context of depression

Unshakeable conviction, in context of depression, of guilt, crime, evil, harm to others, worthlessness, etc., for which R feels culpable and deserving of punishment. [19.025].

6.019 Delusions of catastrophe in context of depression

Unshakeable conviction, in context of depression, that the world is about to end, the country is evil and will be destroyed, that R or family will be ruined, etc. R feels responsible. [19.026].

6.020 Hypochondriacal delusions in context of depression

Unshakeable conviction that bowels are stopped up, insides are rotting, etc., in context of depressed mood. [19.027].

6.021 Congruence of auditory hallucinations with affective state

Rate congruence if, for example, content based on guilt: 'You deserve to die you sinner' etc., or on delusions of grandeur: 'Go to the palace. You are the King'; etc. If unsure, rate 8. Include if content was congruent earlier but mood has improved before AH disappeared. [Check at 17.010]

0 No auditory hallucinations (AH).
1 Virtually all content congruent with affective state.
2 More congruent than not.
3 Congruent and incongruent AH equally.
4 More incongruent than congruent.
5 Virtually all content incongruent.
GENERAL RATINGS OF DEPRESSION

To rate the following items it is not necessary to make a firm diagnosis of depression. The items should be rated if there is any possibility of the diagnosis. If both depression and anxiety, somatoform or obsessional symptoms present:

6.022 Depression or anxiety primary

You have mentioned that you have felt both anxious and depressed [in PERIOD]. You mentioned ...

- Some people say they are depressed because they have phobias or anxiety; they are miserable because of that. If the phobias or anxiety cleared up they would not be depressed any more.
- Other people say that if only the depression would go, they would stop being anxious.
- Can you decide if one or the other is more important for you or is there little to choose between them?

Probe further. Use examples below if appropriate.

Anxiety and depression must both be rated present for this item to be meaningful.

0 Absent, or symptoms of one type only.
1 Anxiety is primary. Depression appears to be entirely explicable in terms of the limitations placed on the subject by the symptoms of anxiety, e.g. being unable to leave the house, travel, meet people, etc., or being afraid of heart disease because of palpitations.
2 Anxiety and depression both present but seem independent of each other, or fluctuating in predominance; e.g. onset of depression makes any preceding anxiety more severe, or vice versa.
3 Depression is primary. Anxiety is either a result of the depression (e.g. subject is frightened because of morbid or suicidal ideas) or it takes the form of fears of catastrophe, forebodings about illness or death, dread of having to face the day when first waking in the morning, preoccupation that something awful is going to happen. Panic attacks and situational anxiety, if present, are secondary to depression.
8 Uncertain, e.g. because of lack of information.

In Section 13 reconsider clinical judgement of relationship of depressive syndrome to other syndromes.
6.023  **Relation of somatoform to depressive symptoms**

Respondents with somatoform symptoms may deny depressive symptoms. Information from informants and records may be required. Review, if necessary, ratings of 6.002 and 6.004. If symptoms of depression have been present at the same time as somatoform symptoms, which were most severe or started first?

0  Absent, or symptoms of one type only.
1  Depressive symptoms more severe or started first.
2  Symptoms occurring together.
3  Somatoform symptoms more severe or started first.
8  Uncertain.

6.024  **Relation of obsessional to depressive symptoms**

If symptoms of depression have been present at the same time as obsessional symptoms, which were most severe or started first? [Check 5.009].

0  Absent, or symptoms of one type present only.
1  Depressive symptoms more severe or started first.
2  Symptoms occurring together.
3  Obsessional symptoms more severe or started first.
8  Unsure.

6.025  **Age of first onset of depressive symptoms**

*How old were you when these feelings of depression first started?*

*When did you first feel really distressed by them or they first started to limit your daily activities?*

Check dates of LB and first onset at 1.012 and 1.016 and duration current depressive symptoms PE at 6.026. If PE represents a relapse or recurrence, record dates of most recent episodes at 6.038 - 6.043.
### 6.026 Timing of PERIOD/s of Section 6 depressive symptoms

For short depressive episodes it is important to rate time in detail in order to decide whether the duration has been 14 days or longer.

- **Date of onset in PS or PE (DD MM YY)**
- **Duration in PS or PE in days**
- **Date of onset in RE or LB**
- **Duration in RE or LB in weeks**

### 6.027 Interference with activities due to depression

How much interference has there been with your everyday activities because of depression?

- **What sort of problem is it?**

If an in-patient, consider period up to admission. Check at 13.006.

- 0 No significant depression present.
- 1 Symptoms present but little interference.
- 2 Moderate or intermittent interference.
- 3 Severe to incapacitating.

Although rating attribution of physical (including alcohol, drug, medical condition, ect.) cause is possible using the optional attributional scale with the dashed boxes or in section 13, items below allow rating of organic cause at the section or syndrom level.

### 6.028 Organic cause of depressive symptoms

Use the four criteria listed in Section 13.

- 0 Absent.
- 1 Probable organic cause; not fully confirmed.
- 2 Definite; confirmed by expert investigation.
- 8 Uncertain whether organic or not.
6.029  Identify organic cause of depressive symptoms

For identifiable causes, enter ICD-10 chapter letter and up to 4 digits. If none leave blank. If two periods are rated, use top row boxes for the first period (PS) and the bottom row for the second period (RE or LB). Cause may also be rated with the attributional scale at the item level.

SKIP => to 6.044 if R now in first ever episode or if never depressed.

HISTORY ITEMS

It is essential to rate 6.030-6.036, if there is any possibility that a depressive syndrome is present. For recurrent episodes (i.e. seasonal, rapid cycling) rate 6.037 and 6.072 - 6.077. The actual classification will be made by the computer program.

Rate the whole course if information is available.

6.030  Episodes of major affective disorder

There have been at least two episodes of major affective (manic, mixed and/or depressive) disorder during the course (including PS), demarcated by a switch to an episode of opposite or mixed polarity, or separated by a period of normal mood of at least 2 months.

0  Not rated.
1  Only one affective episode in whole course.
2  At least 2 affective episodes.
3  3 + episodes.
4  4 + episodes within a 12-month period.
5  Most recent 4 episodes within a 12-month period.
8  Uncertain.
9  Not applicable. No affective episode during course.

6.031  Personality prior to depression onset

0  Within normal range.
1  Significant personality disturbance before first major depressive episode.
6.032  Severity of affective episodes

How severe have episodes been, in general?

0  Not rated.
1  Mild episodes predominant.
2  Moderate episodes predominant.
3  Severe episodes predominant.
8  Uncertain which were predominant.
9  No episodes/ not applicable.

6.033  Two or more depressive episodes with recovery

Have there been at least two major depressive episodes, each followed by recovery for 2 months or more? Consider the whole clinical course.

0  Not rated.
1  Only one such episode.
2  At least 2 such episodes.
3  Complete remission occurred between 2 most recent episodes.
8  Uncertain.
9  NA.

6.034  Response to adequate antidepressive therapy

Have symptoms in the Major Depressive Disorders shown a good response to adequate antidepressive therapy?

0  Not rated.
1  Response has not been satisfactory.
2  Response has been satisfactory.
8  Uncertain.
9  NA.

6.035  One or more manic or mixed episodes during the course

Has there been at least one manic, hypomanic or mixed episode during the course (including PS/PE)?

0  Not rated.
1  There have been no hypo/manic or mixed episodes.
2  At least one manic or hypomanic or mixed episode.
8  Uncertain.
9  NA.
6.036 **Mixed episodes during the course**

Rate if mixed episodes present currently or in the past (see Glossary for definition of mixed episode).

0  Not rated.
1  There have been no mixed episodes.
2  One or more mixed episodes in the past of at least 1 week’s duration.
3  One or more mixed episodes in the past of at least 2 week’s duration.
4  Current episode mixed of at least 1 week’s duration.
5  Current episode mixed of at least 2 week’s duration.
8  Uncertain.

6.037 **Dates of 6 most recent episodes of depressive disorders before PE**

This rating is required for classification of seasonal, rapid cycling and other recurrent episodes involving clinically significant symptoms from Sections 6, 7, 8.

0  Depressive episode list not required to date episodes of affective disorder.
1  Dates of up to 6 (most) recent depressive episodes prior to PE recorded or PS recorded.
2  As 1, but separate SCAN ratings made of previous episode/s.
3  A subset of previous episodes recorded only.
8  Uncertain: respondent does not give satisfactory account of past episodes of depression.
9  Not applicable: reasons.........................

6.038 **Previous depressive episode 1 dates**

6.039 **Previous depressive episode 2 dates**

6.040 **Previous depressive episode 3 dates**

6.041 **Previous depressive episode 4 dates**

6.042 **Previous depressive episode 5 dates**

6.043 **Previous depressive episode 6 dates**

CHECKLISTS (items 6.044 - 6.077)
PERSISTENT DEPRESSIVE STATES, DYSTHYMIA

Dysthymia consists of persistent despondency or gloom lasting for at least 2 years; with poor sleep, low energy, tedium vitae, and brooding. However, there is basic coping (though a feeling of insufficiency), and occasional brief periods of normal mood. Most items in the checklist have been covered in Section 6 or elsewhere in the PSE, and the interviewer will have noted which have occurred frequently over a two year period.

It will be useful to consult case records and/or an informant.

Rate only for period of 2 years before interview. Do not record dates in optional depressive episode lists 6.038 - 6.043, 1.020 - 1.025.

[6.044 and at least three of the features 6.045 - 6.059 should be present during at least some of the episodes during the two years.]

6.044 2+ years depression; remissions for few weeks only

(0 = no, 1 = yes, 8 = uncertain).

Skip => to 6.072 if 6.044 = 0

Rate items 6.045 - 6.061:

0 No.
1 Yes, but isolated occurrence. (Checklist items covered elsewhere in the PSE fulfil the designated severity criteria)
2 Present at same time as all other items rated 2 (6.045 - 6.061).
9 NA.

6.045 A reduction in energy or activity (7.006, see 22.003, 22.005)

6.046 Insomnia (8.009 and 8.011 - 8.015)

6.047 Hypersomnia (8.016)

6.048 Loss of self-confidence, feelings of inadequacy or low self-esteem (6.015, 6.017)

6.049 Difficulty in concentrating or making decisions (7.002, 7.003)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.050</td>
<td>Frequent tearfulness (6.003)</td>
</tr>
<tr>
<td>6.051</td>
<td>Generalized loss of interest or enjoyment in pleasurable activities (6.004)</td>
</tr>
<tr>
<td>6.052</td>
<td>Loss of interest or enjoyment in sex (8.024 and 8.025)</td>
</tr>
<tr>
<td>6.053</td>
<td>Feeling of hopelessness or despair (6.006)</td>
</tr>
<tr>
<td>6.054</td>
<td>Decreased productivity, effectiveness, or perceived inability to cope with the routine responsibilities of everyday life (7.007)</td>
</tr>
<tr>
<td>6.055</td>
<td>Pessimism about the future or brooding over the past</td>
</tr>
<tr>
<td>6.056</td>
<td>Social withdrawal (6.016)</td>
</tr>
<tr>
<td>6.057</td>
<td>Reduced talkativeness</td>
</tr>
<tr>
<td>6.058</td>
<td>Poor appetite or over-eating (8.005, 8.006, 8.007)</td>
</tr>
<tr>
<td>6.059</td>
<td>Chronic fatigue or tiredness (3.007)</td>
</tr>
<tr>
<td>6.060</td>
<td>Feelings of guilt (6.013)</td>
</tr>
<tr>
<td>6.061</td>
<td>Subjective feelings of irritability or excessive anger (3.009)</td>
</tr>
<tr>
<td>6.062</td>
<td>Interference with activities due to symptoms rated at 6.044 - 6.061</td>
</tr>
</tbody>
</table>

You have mentioned [summarize symptoms] during PERIOD. Overall, how much interference has there been with your everyday activities because of these problems?

Rate interference:

0  No dysthymic symptoms present in significant degree.
1  Symptom/s present but little interference.
2  Moderate or intermittent interference.
3  Severe to incapacitating interference.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.063</td>
<td>Age when present episode of dysthymia began.</td>
</tr>
</tbody>
</table>
Rate items 6.064 - 6.066 and 6.068 - 6.069:

0  No.
1  Yes.

6.064  Did an episode of major depression precede the present episode of dysthymia?

6.065  If 6.064 = 1, did a period of full remission, lasting 6 months or more, intervene between the two episodes?

6.066  Did a major depressive syndrome begin during the first 2 years of the present episode of dysthymia? Rate even if unsure whether full criteria for major depressive episode have been met.

6.067  Age at first onset of any episode of dysthymia

6.068  Did an episode of major depression precede the first episode of dysthymia?

6.069  If 6.068 = 1, did a period of full remission, lasting 6 months or more, intervene between the previous two episodes?

Rate attribution of physical cause (including alcohol, drugs, medical condition, etc.) of dysthymia symptoms using etiology option for individual items or below at syndrome level.

6.070  Organic cause of dysthymia symptoms

Use the four criteria listed in Section 13.

0  Absent.
1  Probable organic cause; not fully confirmed.
2  Definite; confirmed by expert investigation.
8  Not known whether organic or not.

6.071  Identify organic cause of dysthymia symptoms

For identifiable causes, enter ICD-10 chapter letter and up to 4 digits. If none leave blank. Organic cause may also be rated with the attributional scale at the item level.

Consider cyclothymia at 10.031 - 10.057.
RECURRENT BRIEF DEPRESSIVE DISORDER

Rate the following items.

0 Absent.
1 Present.
8 NK.

6.072 Recurrent brief depressive phase

There must have been a brief depressive phase recurring at least once a month over the past year.

6.073 Short duration of depressive phase

The phases of depression must have lasted less than two weeks, and usually only 2-3 days, during the past year.

6.074 Not solely in relation to the menstrual cycle

The phases of depression must not have occurred solely in relation to the menstrual cycle, i.e., during the last week of the luteal phase with remission within a few days of the onset of menses.

6.075 Interference with activities due to brief recurrent depressive disorder

0 Syndrome absent or not rated.
1 Syndrome present, but little interference.
2 Moderate or intermittent interference.
3 Severe to incapacitating interference.
Although rating attribution of physical (including alcohol, drugs, medical condition, etc.) cause is possible using the optional attributional scale with the dashed boxes or in Section 13, items below allow re-rating of organic cause at the section or syndrome level.

6.076 Organic cause of brief depressive phase

Use the four criteria listed in Section 13.

0 Absent.
1 Probable organic cause; not fully confirmed.
2 Definite; confirmed by expert investigation.
8 Uncertain whether organic or not.

6.077 Identify organic cause of brief depressive phase

For identifiable causes, enter ICD-10 chapter letter and up to 4 digits. If none leave blank. If two periods are rated, use top row boxes for the first period (PS) and the bottom row for the second period (RE or LB). Organic cause may also be rated with the attributional scale at the item level.
14 Screen for items in Part Two

SKIP => to Section 15 if Part Two is used. This screen is optional.

This screen is composed of items relevant to items in Part Two, which is a separate schedule and not to be included with Part One, except when the purposes of the investigator require it. The screen may be useful also when both parts are to be used, but then any positive screen items should be rated on the full scale in the appropriate section. It is essential to record R's description of any positive symptoms.

14.001 Change in appearance of things

Some people occasionally get a feeling that the appearance of things, or people, or even themselves, has changed. That things look or sound or smell unusual or that time has become distorted. Have you had such feelings in [PERIOD]?

Probe as necessary then rate.

0 No.
1 Yes.

14.002 Delusional mood and perplexity

Have you had the feeling that something odd is going on that you can't explain?

- What is it like?
- Do you feel puzzled by strange happenings that are difficult to account for?

R feels that the familiar environment has changed in a way that puzzles her or him and which she or he may not be able to describe clearly. The feeling often accompanies delusion formation.

0 No.
1 Yes.
14.003  Interference with thoughts

Can you think quite clearly, or does there seem to be some kind of interference with your thoughts?

- What is that like?
- Are you fully in control of your thoughts and actions?

Probe as necessary then rate. Exclude slowness or muddled thinking, e.g. in depressive states.

0  No.
1  Yes.

14.004  Second sight, strange presences

What about other unusual experiences that some people have, such as seeing things that others cannot see, having second sight, or being aware of strange presences?

- Can you describe such an experience?

Probe as necessary then rate:

0  No.
1  Yes.

14.005  Hearing voices

We ask this question of everyone and would like to ask you. Do you ever seem to hear noises or voices when there is nobody about and no ordinary explanation seems possible?

- What is that like?

0  No.
1  Yes.
14.006 People too interested in R

Have you had a feeling that people were too interested in you?

- Or that things were arranged so as to have a special meaning for you,
  or even that harm might come to you?
- Can you describe that?

Probe as necessary then rate:

0 No.
1 Yes.

14.007 Odd or unpleasant experiences

Have there been any other odd or unpleasant experiences of any kind recently?

- What happened?

Probe as necessary then rate:

0 No.
1 Yes.

14.008 Subjectively described memory problems

Have you had any difficulty with your memory?

- Is it more difficult to remember things than it used to be?
- Can you give me an example?
- When did the problem start?

Do not include trait inattention or ‘absent-mindedness’. There must be a
definite loss of memory function, though not necessarily with onset in
[PERIOD].

0 None.
1 Mild difficulty such as 'forgetfulness' that might be due to impaired
  concentration, worry, etc.
2 Serious memory loss, unlikely to be due solely to inattention, worry, etc.

Record examples.
14.009 **Compensation for memory impairment**

*Do you have to keep notes to remind you of things to be done?*

There must be a definite change, though not necessarily with onset in [PERIOD].

0 None or rare.
1 Mild difficulty that might be due to inattention, worry, etc.
2 Partial use of reminders to compensate for difficulty possibly due to inattention, worry, etc.
3 Substantial compensation behavior for serious memory loss, unlikely to be due solely to inattention, worry, etc.

*Thank you very much for your help. I hope the questions did not worry you. Most people are quite interested to answer them. Have you any comments or questions?*

Rate the following items from Sections 22 - 24 but rate the full sections if this selection does not cover all the signs present.

0 Symptoms did not occur during period of observation.
1 Definitely present in moderate degree.
2 Present in severe degree.

14.010 **Slowness**

Very slow to move. Unusual for age and physical condition. Motor retardation.

14.011 **Restlessness**

1 Noticeably restless, not amounting to 2.
2 Constantly fiddling, changing position, standing or sitting down, etc.

14.012 **Odd or inappropriate appearance**

Odd clothes, ornaments etc. Would look odd due to posture, gait etc.

14.013 **Self neglect**

Clothes inadequate for warmth and protection. Irrespective of whether odd or embarrassing. Unshaved, unkempt, dirty.
14.014 Observed anxiety

Fearful apprehensive look, frightened tone of voice, tremor in voice or hands, autonomic signs.

14.015 Observed depression

Sad, mournful look, tears, gloomy tone of voice, deep sighing, voice chokes on distressing topic.

14.016 Blunting or flattening of affect

Decrease in emotional responsiveness shown in facial expression, tone of voice, use of gesture, etc.

1  Blunting. Quantitative decrease compared with expectation.
2  Severe and uniform flatness of affect.

14.017 Incoherence of speech

The subject’s meaning is obscured by distorted grammar, lack of logical connection between one part of a sentence and another or between sentences, sudden irrelevancies or ‘Knight’s move’, incomprehensible associations, etc.

Do not rate this symptom present unless examples are written down.

14.018 Magical or markedly illogical thinking

See Glossary for examples.

14.019 Rate restricted quantity of speech

Subject frequently fails to answer, questions have to be repeated, restricted to minimum necessary, no extra sentences, no additional comments.

14.020 Poor use of non-verbal communication during interview

Lack or under-use of normal non-verbal gestures, facial expressions, changes of tone and pitch and loudness, eye-contact, etc., during conversation.

CUT OFF => to Clinical History Schedule (Section 27) if Part Two and IGC are not used.
19 Delusions

It will usually be evident by this stage in the interview whether delusions are present or not. Use judgement to how to word questions.

Use Scale II for rating, but note that Scale II is anchored on frequency or duration, which may not directly reflect on the clinical status of delusional beliefs.

Record descriptions of items when present.

19.001 Probe for delusions of reference

Have you felt that people are unduly interested in you?
Or that things were arranged so as to have a special meaning?
Or even that harm might come to you?

- Can you describe that?

0 No.
1 Yes.

19.002 Probe for other delusions

What about other unusual abilities or talents that some people have, such as having second sight, or being aware of strange powers or presences?

- Are you superstitious?
- Do you have any special powers that most people lack?
- What is that like?
- Do you belong to a group of people who also have these experiences or powers?

Include odd beliefs, magical powers, marked superstitions, clairvoyance, telepathy, etc. The experiences are not psychotic and may be normal within R’s culture, religion or sect. However, they may also be indicators for individual psychopathology, in which case Sections 16 - 19 should be completed. Consider also dissociative symptoms rated at items 2.102 - 2.117.

0 Absent.
1 Present.

CUT OFF => to 20.001 if no evidence of delusions.
**Delusions of Misinterpretation, Misidentification, and Reference**

19.003 **Delusions of being spied upon**

Do people seem to talk about you, check up on you to find out where you are, or follow you about, or record your movements?

- Do they take a special interest or try to photograph you?
- How do you know this?

19.004 **Delusions of reference**

Do people seem to drop hints meant for you, or say things with double meanings?

- Do you see messages for yourself in the newspapers or on TV or radio?
- Can you describe an example?

19.005 **Delusional misinterpretation**

Do you sometimes see coded messages or a special significance in the way objects are arranged, or in colors, or in the way things happen?

- Can you describe it?

19.006 **Quotation of ideas**

Do you find that something you have previously thought or discussed is quoted on TV or in the newspapers or used in some other way to indicate a reference to you?

19.007 **Delusional misidentification**

Are there people about who are not what they seem? Who are perhaps in disguise?

- Do you see people around whom you recognise from earlier in life?
- Can you give an example?
19.008  **Familiar people impersonated**

*Do you feel that the appearance of any people you know well has changed in ways that suggest that someone might be impersonating them?*

This symptom may occur in a variety of clinical pictures. Rate all varieties of the delusion under this item.

19.009  **Delusional perception**

Take examples of delusions rated above. Remind R of the interpretation given.

*When you [saw ... this event] how did you know what it meant?*

- Are you quite sure, or could you be mistaken?
- Is there no natural explanation?
- Have you had any previous experience that made you suspect something like this would happen?
- Did it come out of the blue?

Intrusive, often sudden knowledge of a radically transformed meaning of a common perception. See definition for examples. Exclude if apparently based on abnormal mood, except delusional perplexity, or is part of a culture bound religious experience.

19.010  **Delusional ideas of reference based on guilt**

Must be understandable to some extent in terms of recent depressed mood, though the ideas may persist for a time after mood has improved: e.g. R has become depressed and guilty and now believes that when people shake their heads it means that she or he is to be executed for some nameless crime.

- 0 No such experience present.
- 1 Definite description of such an experience but frequency rare.
- 2 Such experiences have occurred frequently.
- 8 Uncertain whether present, even after adequate examination.
19.011 Delusional ideas of reference based on expansive mood

Must be understandable to some extent in terms of recent expansive mood, although the ideas may persist for a time after mood has improved; e.g. during a post-partum episode of elation and heightened sexuality, R thinks that the way doctors act means that they are in love with him or her and are making him or her feel sexy.

NB: This is not a delusion of control.

0 No such experience present.
1 Definite description of such an experience but frequency rare.
2 Such experiences occurred frequently.
8 Uncertain whether present, after adequate examination.

Delusions of Persecution

19.012 Delusions of persecution

Does anyone seem to be trying to harm you (trying to poison you or kill you)?

- Are they particularly singling you out?
- How do you experience this?

Record description. Include explanations of other psychotic experiences in terms of persecution.

19.013 Delusions of conspiracy

Does there seem to be a plot or a conspiracy behind it?

- How do you recognise it?

Include explanations of other psychotic experiences in terms of conspiracy.

Rate insight into delusions at 19.039. Rate acting on delusions at 19.040.
SEXUAL DELUSIONS

Sexual delusions based on hallucinations have been rated in Section 17.
Rate here only delusions without evidence of hallucinations.

19.014 Delusional jealousy

Do people say you are the jealous type?
- Is it true? Are you jealous of your spouse/friend?
- What do you do to convince yourself that nothing is going on?

Spies on actions. Smells clothes. Misinterprets, etc.

19.015 Non-delusional jealousy (check at item 3.013.)

19.016 Delusions of pregnancy

19.017 Delusional lover

Are you loved by someone who does not publicly acknowledge it?
- Who is it?
- Was she or he the first to try to begin an affair?
- What evidence have you had of these advances?
- Do you try to make contact? In what way?

An idealised love, usually with someone of higher status (de Clérambault syndrome) but not necessarily. May persistently follow and pester the supposed lover. Fully delusional. For sexual delusions associated with sexual hallucinations, see 17.027.

19.018 Delusion that others accuse R of homosexuality

Do people seem to suggest that you are homosexual?
OTHER DELUSIONS AND DELUSIONAL EXPLANATIONS

19.019  Delusional memories and fantastic delusions

English’s coast melting. Has lived for 100 years. Came down to earth on a silver star, is from the planet Pluto, etc.

19.020  Preoccupation with previous delusions

19.021  Religious delusions

What is the explanation for these experiences? Do you think there is a religious explanation?

Include only other psychotic experiences or delusional religious beliefs that are explanations of delusions and are themselves delusional. Be careful not to rate well accepted religious or spiritual beliefs, which may colour R’s reaction to psychotic symptoms, as themselves delusional.

Scale II

19.022  Delusional paranormal explanations

Is anything like hypnotism or telepathy going on?

- What is it like?

Occult influences, hypnotism, telepathy, ESP, etc.

Scale II

19.023  Delusional physical explanations

Are you influenced or affected by X-rays, radio waves, neutrons, electrons, or machines or anything like that?

Radio waves, X-rays, laser beams, electricity, computers, television, machines etc.

Scale II

Rate insight into delusions at 19.039. E.g. mental or physical illness. Unconscious thoughts, etc. Rate tendency to act on at 19.040.
19.024  Specifically named local syndrome

Annex 2 of ICD-10 DCR contains a proposed classification of Culture Specific Disorders. Most suggested ICD-10 codes are in F4, and occasionally F3 or F68.8. Examiners should be particularly cautious before making ratings in Part Two of SCAN on respondents who appear to exhibit features similar to those specified in Annex 2. The examiner should consider carefully ratings in Part One, Section 2 (dissociative and somatoform disorders), Sections 3 and 4 (anxiety disorders) and Section 6. The clinical history schedule (Section 27) should also be completed (i.e. 27.053 - 27.069). Examiners who are not members of R’s culture should carefully reconsider whether it is possible to complete, unaided, a reliable SCAN assessment (item 20.114).

Include Koro, Latah, Witigo, or other such specified condition. The item should be rated 1 only if a full PSE10 interview has been completed, and ICD-10 DCR Annex 2 used to match clinical presentation with description in DCR.

0 Absent.
1 A full description of the state is obtained and PSE10 completed including Part One and Clinical History Schedule.

Specify the name of the state, and the main features shown: ....

Delusions Reviewed Elsewhere

These ratings will have been considered in the appropriate sections but should be reviewed here on the basis of the complete interview, particularly sections dealing with other psychotic symptoms. Also check delusions with hallucinations: 17.023, 17.025, 17.027 and 17.029.

Rate using Scale II unless otherwise specified.

19.025  Delusions of guilt or worthlessness in context of depression

Unshakeable conviction, in context of depression, of guilt, crime, evil, harm to others, worthlessness, etc., for which R feels culpable and deserving of punishment. Check 6.018.
19.026  Delusions of catastrophe in context of depression

Unshakeable conviction, in context of depression that the world is about
to end, the country is evil and will be destroyed, etc. R feels responsible.
Check 6.019.

19.027  Hypochondriacal delusions in context of depression

Unshakeable conviction that bowels are stopped up, insides are rotting,
etc. in context of depressed mood. Check 6.020.

19.028  Hypochondriacal delusions not in the context of depression

Rate delusional preoccupation with disease, which may involve the same
symptoms as 19.027 but not the mood. Distinguish from delusions about
appearance rated 16.012; delusional explanations of somatic hallucinations rated
at 17.029. Check 2.086.

19.029  Delusions of grandiose abilities

Check 10.016.

19.030  Delusions of grandiose identity

Check 10.017.

19.031  Delusions concerning appearance

Include dysmorphophobic delusions. Check 16.012.

19.032  Delusion of depersonalization or derealization

Delusion that some part of the body is missing; e.g. no head or no brain,
no thoughts or no mind (symptom of Cotard). Some part of the external world
may be missing. Check 16.013.
GENERAL RATINGS

19.033  Duration of any delusion(s)

Rate in number of weeks.

87 = 87 weeks or more.

19.034  Monothematic delusions

Only one type of delusion is present though it may be predominant in the clinical picture and dominate the behaviour of R. Any development of delusions on other topics should be rated 1 here. Delusions that others think R smells, or is homosexual; delusions that R is pregnant, or has misshaped teeth; delusion of jealousy, etc. Direct elaboration of the central delusion e.g. when a jealous R interprets a light being switched on as a signal to a lover, is acceptable.

0  No delusions.
1  Delusions are not monothematic.
2  Monothematic delusion (plus accessories) only.

19.035  Systematization of delusions

Base the rating on the extent to which all the delusions have a common theme or development.

0  No delusions.
1  No systematization present. Delusions unrelated.
2  Some systematization.
3  Close systematization. Most delusions are related to one ‘scenario’ though this may undergo elaborations or modifications from time to time.
4  Completely systematized delusions.

19.036  Prominence of delusions

0  No delusions.
1  Delusions present but not a central feature of the clinical picture.
2  Delusions are a prominent feature of the clinical picture compared to other symptoms.
19.037  Congruence of delusions with affective state

Take into account all delusions present.

0  No delusions.
1  Most delusions are congruent with mood.
2  Mixed congruent and incongruent.
3  Most delusions are mood-incongruent.

19.038  Mood rated congruent with delusions

0  No or very little congruence.
1  Congruence mainly with depressed mood
2  Congruence with both depressed and elated mood
3  Congruence mainly with elated mood.

19.039  Conviction about delusions or hallucinations [insight]

Include all symptoms in Sections 17 - 19 rated positively. Consider explanations in terms of natural causes as well as those rated at items 19.021 - 19.024.

0  No delusions or hallucinations.
1  Aware of delusions or hallucinations during period but also aware of their abnormal delusional nature.
2  Brief periods of doubt but generally convinced.
3  Unshakeably convinced.

19.040  Actions based on delusions or hallucinations

0  No delusions or hallucinations or no acting on.
1  Actions without serious social or family effects.
2  Some seriously embarrassing or distressing effect.
3  Aggressive or violent consequences.

19.041  Bizarreness of delusions

Rate bizarreness of delusions according to the definition given in the Glossary.

0  Absent.
1  Present.

19.042  Age at first ever onset of delusions

Check 1.018.
19.043  **Timing of PERIOD/s of Section 19 symptoms**

It is necessary to record only if dates of symptoms in this Section are different from PERIOD rated in Section 1 (items 1.007-1.014), or to record duration in number of days.

- **Date of onset in PS or PE (DD MM YY)**
- **Duration in PS or PE in days**
- **Date of onset in RE or LB**
- **Duration in RE or LB in weeks**

19.044  **Interference with activities due to Section 19 symptoms**

You have mentioned [summarize symptoms] during PERIOD. Overall, how much interference has there been with your everyday activities because of these problems?

Interference due to symptoms is also rated in Section 20.

- 0  No section 19 symptoms present in significant degree.
- 1  Symptom/s present but little interference.
- 2  Moderate or intermittent interference.
- 3  Severe to incapacitating interference.

Although opportunity to rate attribution of physical (including alcohol, drugs, medical condition, etc.) cause is present using the optional attributional scale and the dashed boxes, items 19.044 and 19.045 allow rating of organic cause at the section or syndrome level.

19.045  **Organic cause of Section 19 symptoms**

- 0  Absent.
- 1  Probable organic cause; not fully confirmed.
- 2  Definite; confirmed by expert investigation.
- 8  Uncertain whether organic or not.

19.046  **Identify the organic cause of Section 19 symptoms**

For identifiable causes, enter ICD-10 chapter letter and up to 4 digits. If none leave blank. Cause may also be rated with the attributional scale at the item level.

Remember to complete course items for psychotic and affective disorders [20.001 - 20.013] if relevant.
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**Rating scale III Behavior, speech and affect**

NB: Consider behavioral items for cognitive impairment also.

Most items in Sections 22 – 24 are rated on a 3-point scale (0–2) on the basis of severity and frequency during the past month. Information from records for the period should be used as well.

The examination should be supplemented by taking into account any other observations of relevance, e.g. is case records or information from professionals or relatives. Severe behavioral abnormalities may not be observed at examination because of the short time sample, but when they are present skilled direct observations are of great importance. The items listed are also worth rating because of their possible juxtaposition with other symptoms. The time period rated is the month before examination.

Many behavioral items are also included in Item Groups and can be rated in the Checklist.

0 Behavior not present during past month.
1 Unequivocally present during past month, moderate severity only. Use all information available.
2 Present in severe form during past month or at examination.
8 Unsure whether present or not after adequate examination.
9 Not appropriate to make a rating because examination or records are incomplete, or behavior is due to a physical factor.

**Rating scale II**

0 Symptom did not occur during PERIOD.
1 Symptom definitely occurred during the period but was probably uncommon or transitory.
2 Symptom was definitely present, on multiple occasions or for part of the time, during the period.
3 Symptom was present more or less continuously throughout the period.
5 Language difficulty, rated as present in Section 15, makes replies difficult to interpret.
8 Rater is unsure whether the phenomenon is present or absent, even after adequate examination
9 Not appropriate to make a rating because examination incomplete, e.g. because of refusal, omission, etc.
Rating Scale I

0  Symptom absent after adequate examination (PSE9 = 0).
1  Symptom has been present during the period but only in mild degree. Below threshold for diagnosis but counts in scores. It is not the same as 8 (PSE9 = 0).
2  Symptom definitely present but of moderately severe intensity or, if severe, present for less than half the time. If unsure whether 1 or 2, rate 1 (PSE9 = 1).
3  Severe for more than half the period. If unsure whether 2 or 3, rate 2 (PSE9 = 2).
5  Psychotic symptoms make rating of subjective symptoms difficult.
8  Not known whether the phenomenon is present or absent, even after adequate examination. This rating should not be confused with 1 (= mild).
9  Not appropriate to make a rating because examination is incomplete in some relevant respect, e.g. because of language disorder, refusal, omission, irrelevance. Examination either not possible or not necessary.