CUTLINE OF AN INVESTIGATION
TO CONSTRUCT A RATING SCALE
FOR MENTAL STATUS
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FOR MENTAL STATES

I. INTRODUCTION:

In the course of a rather elaborate investigation of the results of various forms of therapy in schizophrenia it was found that it was extremely difficult to obtain satisfactory judgments as to change in mental state on the basis of the usual psychiatric data. The psychiatrists did not agree on definitions used, had quite different criteria for improvement and deterioration, and in general had no consistent standards -- absolute or individual. The present project outline describes the attempt made at the Worcester State Hospital to meet the problems raised by this situation and presents a project for the development of a rating scale technique which might be of general utility.

II. OBJECT:

1. To develop a technique for the objective rating of symptoms and traits in psychoses, especially schizophrenia.
2. To supply a method for a more quantitative determination of therapeutic results.

III. SIGNIFICANCE:

a. Previous studies:

A number of attempts have been made to meet certain
aspects of the problem in the work of Kempf (Amer. Jour. of
Insanity, 71, 1915, 761-772); Plant, (Amer. Jour. of Psychiat.,
1, 1922, 547-572); and the Boston Psychopathic Hospital
study of the past several years.

E. J. Kempf of the Phipps Clinic following up the work
of Adolf Meyer at Kankakee, Worcester, and in the New York
State Hospitals, completed a pictorial behavior chart for
mental diseases. The plan was for the attendant to chart
daily (in general) the reactions of the patient by checking
the presence or absence of certain traits. Fifty-seven
items were listed, divided into two main groups: spontaneous
and required behavior. Some of the items used were:
"destructive", "angry", "apprehensive", "reading", "entert-
tainment", "spoon-fed". Whether or not a dictionary was
provided for the attendant is not known.

Plant's scheme was organized for use by nurses at the
McLean Hospital. It more nearly approaches the degree
rating scheme method. It consists of 19 types with 10 to 12
subdivisions for each. The subdivisions are statements of
concrete forms of behavior, involving little interpretation.
Some of the fields covered are: attitude toward taking food,
reaction toward nurses, emotional reaction, hallucinations,
recent memory.

At the Boston Psychopathic Hospital a rating scheme
has been worked out, which apparently emphasizes personality
traits. Since it was used as part of a study of the socio-
logical aspects of mental diseases, the emphasis has been
on the collection of that kind of material. Social workers
have primarily done the rating. It is the most carefully worked out of the schemes which have come to our notice. Unfortunately, the work had to be done with historical material for which they had to depend largely on more or less prejudiced observers (relatives, friends, etc.). This was over and above the notorious inability of even unprejudiced individuals to report objectively in the rather complex field of personality.

The mentioned studies are the only attempts with psychotic patients known to us that have reached the stage of formal presentation.

B. Defects of the present system of mental examinations.

An acquaintance with present psychiatric technique in routine and even more elaborately worked-up case studies can not but leave one dissatisfied. An analysis of this dissatisfaction uncovers at least these points:

1. Absence of quantifying possibilities in the methods used:

   a. The attempt to deal with any physiological or other variable in psychiatric cases has always had to contend with the difficulty of being unable to correlate that variable with psychological characteristics of the individual at the time because of the absence of a quantitative determination of these characteristics. The use of type of psychosis or the vaguely and inaccurately defined symptoms for this purpose is obviously unsatisfactory and its common accompaniment by an apology is understandable.

   2. The inexactness of definition of the terms used
even from the qualitative point of view:

a. From the psychological point of view the definitions used are often inadequate and not entirely sound.

b. Different psychiatrists characterize the same behavior differently.

c. Different psychiatrists characterize different types of behavior by similar terms.

C. Possibilities in an adequate method.

An adequate rating method would give (considering the material with which one is dealing) a comparatively satisfactory quantitative technique for certain aspects of psychiatric work. Psychiatrists on the whole have shied at any attempts at quantification. They have argued "mechanization", etc., etc. While recognizing the abstract desirability of accuracy they have passed it by as an impractical "counsel of perfection." There is some justification for a dislike of mechanization and over-emphasis of the quantitative rating. Nevertheless, we must agree with Allport when he says that, "Notwithstanding the dangers and difficulties encountered in devising and employing rating scales, we are forced to recognize this method as the only available objective criterion of personality. The sources of error must be gradually overcome by the improvement of the technic of rating."

(Psychol. Bull. 10, 1921, 449).

Some of the specific advantages of a workable mental status rating scale would be these:
1. Fair quantitative material on the psychiatric side is obtained which is suitable for correlation with other studies made of the individual.

a. For a single patient, one may use the ratings of one psychiatrist, or one may use the composite (average) ratings of a group of psychiatrists (which has been found from a technical point of view the more reliable).

2. Fair qualitative material for following up the same cases.

3. The elimination of the personal factor to a much greater extent than in the present system.

   a. "Personality" is important in therapy but a handicap on the investigatory side.

4. It offers more dependable material which can be used for the determination of syndromes, and even diagnostic types.

5. It offers a method for judging psychiatrists.

   a. One of the primary qualities of a good psychiatrist is the ability to use accurately the special language.

   1. The reliability of his use can be checked in successive ratings on the same patient.

   2. The validity can be checked against the ratings of a group of other psychiatrists of known ability on the same patient.

6. It offers a method for training psychiatrists.

   a. It would be valuable in emphasizing the need for accuracy of description more than do the present
methods.

b. One could check one's self on the use of terms during the training period against the ratings of a competent observer on the same patient.

c. It keeps before the psychiatrist the particular items which he must obtain during the mental status examination.

It is to be understood, of course, that the present scheme is not intended to take the place of the usual mental examination and interpretative study. It is to be filled out after the usual examinations are made and after a definite period of observation.

III. METHOD:

It is proposed to evolve an empirical rating scale based on multiple studies of a fixed (standard) group of subjects. Considerable preliminary work has already been done at the Worcester State Hospital on a quantitative Rating Scale. It might be best to discuss the method by stating the steps already taken and those contemplated for which support is desired.

A. First preliminary study:

1. A list of 104 traits, symptoms, and response patterns of all types of psychoses was gathered.

a. This was taken from leading psychiatric texts, and from the periodical literature. Bleuler, White, Assmoff, Henderson & Gilmore, Strecker & Laugh, and others were consulted.

b. The experience of the psychiatric and psycho-
logical groups at the hospital was also called upon to a considerable extent.

2. Preliminary definitions were set for these traits.
   a. These were taken from text books, dictionaries (psychiatric and psychological), and similar sources.

3. A scale of degrees of presence or absence of the different traits was established.
   a. In general an attempt was made to fit them into a 5-point scale with descriptive characterizations for the various degrees wherever possible.
   b. In order to eliminate any tendency towards marking one of the extremes, the "most marked" presence of a trait was sometimes set at 1, sometimes at 5, -- approximately half and half.

4. Rating forms for the traits and instructions for the use of the scale were organized, together with a trait dictionary which contained the definitions both of the traits and the degrees. (See Appendix A).

5. Approximately 76 patients were rated by the scale once, some 25 of these having two studies 3 months apart.

6. The comments and criticisms of the psychiatrists and others using the scale were collected for each of the traits.

7. A preliminary statistical analysis was made of the ratings to determine items difficult to rate, items on which there was considerable disagreement, etc.

On the basis of the results of testing with the first preliminary form, it was felt that the definitions of
the traits was the most unsatisfactory part. It was therefore thought necessary to make modifications in this aspect of the scheme first.

B. Second preliminary study:

With the material collected and the comments and criticisms organized, the four Psychiatrists, the Psychologist, the Statistician and the Resident Director of Research held a series of conferences on the project. As a result of these conferences, a second preliminary rating scale was organized, with the following modifications:

1. After detailed discussion on each characteristic the definitions were modified to meet the consensus of opinion of the group, with however considerable weight being given to the consensus of opinion of authorities.

2. Many new items were added and a few omitted as a result of the discussions, finally ending up with 183.

3. For the present the descriptive characterization of the degree of presence of traits, except on a normal distribution basis of "very marked"; "marked"; "considerable"; "some"; "none", was eliminated. It was felt that this part of the scale should depend on a large accumulated body of experience, and that for the present, while this was being collected, it was desirable to leave the matter free.

4. To obtain the aid just mentioned each person working with the scale was supplied with a notebook. As examples, comments, or criticisms occur to him while using the scale, they are entered. It is hoped to be able to work out for each of the degrees a characterization of a
detailed descriptive and exemplificatory nature, with a view to reducing the element of personal judgment in what is probably the most difficult part of the scheme.

5. New forms, a new set of instructions, and a new dictionary were organized. (See Appendix B).

a. It will be noted that a special place is left in the new form for sources of information. It is hoped that after a time the sources of information for each of the traits will be capable of specification, and the ratings weighted according to source.

6. The scale is at present in use but only very preliminary analyses of the data have been made.

IV. PLENARY COURSE OF ADMINISTRATION AND JUDGMENT:

A. General Techniques:

1. Approximately 110 patients are to be studied.

a. Characteristics of the group:

1. Male Dementia Praecox subjects of an elaborate research made from various angles.

a. There are three distinct groups:

1. Forty (40) patients receiving no medication.

2. Forty (40) patients receiving medication of various kinds.

3. Thirty (30) patients receiving placebos.

b. Although largely chronic cases there are a certain number of acute cases.

1. The chart showing the distribution of hospital stay.
2. These are to be divided equally among the eight psychiatrists.

a. Our experience has been that the expenditure of full time on rating scales for any length of time is unsatisfactory and repugnant to the examiners. We therefore propose that the equivalent of four full-time psychiatrists be used in the study but that the four psychiatrists already on the service and the four requested each give half-time to this particular project. The balance of their time is to be spent in individual work with patients, research, etc. -- what is ordinarily expected of a psychiatrist on a specialized service such as the one under consideration.

3. Each patient is to be examined in a Cosell room by one psychiatrist, three of the others observing and noting from outside. A sufficient number of examination sessions is to be held until the necessary information for a mental examination has been obtained.

a. As many combinations of the eight psychiatrists are to be taken four at a time as is possible, each psychiatrist being in charge of an equal number of patients.

1. There will thus be a check on the differences due to the unavoidable more intensive work with a patient.

4. All information on each patient from outside sources is to go to each psychiatrist involved.

5. After two weeks observation of the patient, each psychiatrist is to fill out a rating blank independently. This is to be done for each patient on the Service by the four psychiatrists involved.
6. Each patient is to be re-examined at least every three months by his psychiatric group in the usual way.

B. Cautions (Sources of Error) and Controls:

1. Differences in length and depth of acquaintance of psychiatrists with patients which usually is present.
   a. This will be controlled to some extent by statistical study of the effect of being the psychiatrist-in-charge of a patient rather than an observing psychiatrist.

2. Inadequacy of a 5-point "very-marked-to-none" scale for dependable description.
   a. A more satisfactory detailed descriptive scale is being developed, with examples from text books, experience, etc.

3. Differences in the difficulty of rating traits.
   a. Traits are to be defined and refined, and if agreement is apparently impossible, the given trait is finally to be eliminated.

4. Differences in sex of observers.
   a. At present there is no difficulty of this kind. It would be desirable not to introduce the sex variable. If this is necessary, however, statistical checks should be made on sex differences.

5. "Halo" effect in rating.
   a. Traits are to be defined as exactly as possible.
   b. The insidiousness of this is to be stressed in training of observers.

6. Use of "expected" performance as criterion for rating.
a. Emphasis is to be placed on actual performance being used in rating.

b. It is planned to have each psychiatrist rationalize his particular check for each trait to determine the bases on which judgments are made.

7. Differences in standards which may exist.
   a. Distribution curves for each trait are to be made for each observer.
   b. Emphasis in training on the need for constancy of standards.
   c. Recheck of previous ratings at regular intervals.
   d. Use of average as standard.

8. In order to avoid the influence of raters on each other, ratings are always to be made independently.

9. In order to avoid the influence of previous results as such as possible successive rating forms are always to be made out without consulting previous forms.

10. The problem raised by variability in the patient.
    a. All examinations are to be made in the concealed presence of the three other observers. Other extended observations are to be avoided.
    b. All reports are to go to all psychiatrists.

11. General errors.
    a. Frequent conferences on procedure.
    b. Frequent training conferences.

C. Statistical Treatment:

The material is to be treated statistically in as elaborate a manner as is necessary or deemed advisable. The
following points are a few of those to be kept in mind:

1. Which items lend themselves to a rating scale technic?
   a. Items which give zero ratings (i.e., "cannot be determined") consistently and after attempts at redefinition will be eliminated.
   b. Discrepancies amongst psychiatrists would perhaps indicate that some had a superior technic for getting at the items in question and would necessitate redefinition or discussion to get at the differences.

2. Reliability of ratings.
   a. The variation of the individual psychiatrist.
   b. The variation amongst psychiatrists.
   c. Study of differences in successive examinations carefully analyzed to make sure that they are not due to shifts in scoring standards.

3. Personal ties.
   a. Self-ratings of observers are to be compared with ratings by other psychiatrists and others in organization not doing the psychiatric work.

4. Statistical determination of syndromes.
   a. Inter-correlation of the various traits, etc.

B. Results of statistical treatment:
   1. Traits are to be again re-defined and degrees descriptively stated.

2. Weighting of Traits.
   a. Judicial and cost of experts on importance.
   b. By reliability.
   c. Combination of both.
E. Records and Reports.

1. See the forms to which reference has already been made, copies of which will be found in the appendices.

2. See the forms used by various assistants - C.T., nurses, etc. in appendices.

V. PERSONNEL AND DURATION OF PROJECT:

A. Personnel.

1. The additional personnel should consist of four psychiatrists, 1 part-time psychologist, 1 part-time statistician, 1 psychological assistant, 1 statistical assistant, 2 clerks and a consultant. The duties of the various members should be as follows:

Psychiatrists - Psychiatric examinations, analysis of the reports from various sources and filling out of rating forms.

Psychologist (part-time) - Continue the general direction of the project.

Statistician (part-time) - Direct the statistical treatment of the material as it comes in.

Assistant psychologist - Organize the material as it comes in, make up the new forms, etc. under the direction of the psychologist.

Assistant statistician - Statistical work connected with the project under the direction of the statistician.

Clerks - Necessary typing, filing, etc.

Consultant - Expert in the field for special consultations on various aspects of work.
Regular

Psychiatrists  4 @ $4,000  $16,000
Psychologist - part time  1 @ $1,500  $1,500
Statistician - part time  1 @ $1,250  $1,250
Psychological Assistant  1 @ $2,500  $2,500
Statistical Assistant  1 @ $2,000  $2,000
Clerks  2 @ $960  $1,920
Expenses (stationery, etc.)  2,000
Building Gesell Room  250

Advisory

Consultants  $1,500

Total  $28,920

B. Duration of Project:

1. It is felt that with the progress that has already been made on the project and the fact that the organization is already largely built up that a period of two years would be sufficient to obtain the ends sought.

VI. PLACE:

The project is to be carried out at the Forester State Hospital. The reasons for the choice are many:

A. Attitude of the Administration:

1. The Superintendent, Dr. W. A. Bryan, and the other administrative officers are very heartily in sympathy with the project and have done and will do all they can to further the development of the scale.

B. Subjects:
1. By far the most logical place to work on a project of this sort with psychotic patients would seem to be a large State Hospital where the patients remain for a considerable length of time and where there is a variety of material on which to draw.

a. The Worcester State Hospital has a population of 2200 patients, male and female, and an admission rate of approximately 700 yearly. Approximately half the patients are male. The hospital also has the possibility of calling on other hospitals in the state system for patients of any given kind.

2. The choice of subjects for this particular project, the patients who are on the Dementia Praecox Special Study, gives us an opportunity to work out the scale on a comparatively homogeneous group. They are patients who are undergoing different amounts of investigation in various fields and on whom there will therefore be considerable material for correlation of mental and physiological states.

C. Personnel:

A very strong argument for doing the work at the Worcester State Hospital is that there is an existing personnel and organization into which the new members could easily fit. This would save considerable of the usual time necessary for organization purposes. The present organization of the Research Service includes approximately sixty members. Those who would have direct contact with the project are the psychiatric, psychological, and statistical departments. Some of the individuals likely to have more close contact are listed herewith:
R. C. Hockins, M.D. (Johns Hopkins), Ph.D. (Harvard) - Director of Research

F. M. Sleeper, M.D. (B.U.) - Resident Director of Research

J. R. Linton, M.S. (U. of finals.), M.D. (Harvard) - Senior Assistant Physician

M. H. Erickson, M.A. (Wis.), M.D. (Wis.) - Senior Assistant Physician

H. T. Carmichael, M.A. (Minn.), M.D. (Queens) - Senior Assistant Physician

J. C. Rheingold, M.A. (Ill.), M.D. (Ill.) - Assistant Physician

D. Shakow, M.A. (Harvard) - Chief Psychologist

E. H. Jellinek, M.Ed. (Leipzig) - Chief Statistician

Although a certain amount of retrenchment may be necessary, the organization will remain essentially the same. It is important to emphasize that the various members of the organization have already devoted considerable time and thought to rating scale work and have been taught the need for such measures. A large part of this personnel, maintained by the Hospital, automatically become involved in this new project without any expense to the supporters. There is available at the Hospital a well-organized and equipped statistical department, a strong psychological department, special ward observers, and others necessary for a project of this kind.

II. Preliminary work:

1. The fact that all of the preliminary work has been done at the Hospital and with the present staff would make the Hospital the logical place to continue.
MENTAL EXAMINATION

RATING SCALE
1. -The details at the top of each Rating Form should be filled out.

2. -The Rating Forms are to be used in conjunction with the Characteristic Dictionary which supplies the definitions of the characteristic, examples of the characteristic when necessary, comments on related and differential characteristics, and the definition of the degree of presence of the characteristic.

3. -A check is to be placed in the column corresponding to the degree of presence of the characteristic as defined in the Dictionary.

4. -If the presence or absence of the trait cannot be determined a check is to be placed in the "0" column.
   a. This has the purpose of showing that the characteristic was considered and not omitted through oversight.
   b. In cases where only a "wild guess" could be made as to the characteristic, it is desirable to check in the "0" column.

5. -In cases where a trait is marked as absent ("1" or "5" as the case may be), then a check should be placed in the "X" column of all the related traits.
   a. E.g., if "Delusions - number" is checked in column 5 then the balance of the items referring to delusions should be checked in the "X" column.
5a. In cases where trait is marked as indeterminable ("O") then all the related traits should be checked "O".

6. The "Y" column should be used for those instances where a check in any of the other columns would not meet the conditions. For instance, when the patient shows two distinct degrees of a trait during the period of observation so that it is necessary to check both 1 and 4 for instance, then both 1 and 4 should be checked and an additional check placed in the "Y" column. An explanation should be given in the "Remarks, etc." column.

7. In the column referring to "Source of Information" a check should be placed under those numbers which refer to the source from which the information has been obtained. For each characteristic a star will be found in the proper columns under this heading. These stars imply that under ordinary circumstances the starred sources are the sources from which information will be obtained on the particular trait.

   a. The equivalent sources for the numbers listed are as follows:

   1. Psychiatrist's Observation
   2. Patient's Report
   3. Relative's Report
   4. Nurse's Report
   5. C. T. Report
   7. Psychometric Report
   8. Industrial Test Report
   9. Other reports
8. In the "Remarks, etc." column any desired qualifications may be placed.

9. Blank lines are left on each sheet for the addition of characteristics which the examiner thinks should be included in the particular case.

10. The grades: Very marked, marked, considerable, some, none, and very many, many, considerable, some, none are meant to include approximately the following percentages of the general population:

   a. Very marked — upper 5%
      Marked — next 20%
      Considerable — middle 50%
      Some — next 20%
      None — lowest 5%

   E.g., if the examiner thinks that the patient has reasoning ability equivalent to an individual in the upper quartile of the population but not quite in the upper 5% then he should check number 4, or number 2 as the case may be.

   b. In a few traits, however, specific qualifications are made for the various grades which do not follow the above classification.

11. The attention of examiners is called to the fact that the "most marked" presence of the characteristic is not necessarily number 1. In approximately half the cases the scoring is reversed.

12. Objectivity is to be aimed at insofar as possible — performance rather than opinion should be used as a criterion wherever possible.

13. It is recognized that in many instances classification is difficult. One can only do one's best.
14. It is not expected that the Rating Scale will take the place of the usual Mental Examination. There will be a number of items which will be included in the Mental Examination which are not included in the Rating Scale because they do not lend themselves to quantitative treatment.

15. An attempt has been made to define all of the characteristics. In some cases the definitions are very short since their meaning is generally agreed upon.

16. It is expected that detailed descriptions will come out in the usual Mental Examination, therefore details should not go into the column provided for "Remarks, etc."

17. Ratings should be done after acquaintance with the patient for two weeks and should cover characteristics of the patient for that period. It is desirable to keep to this, insofar as it is possible.

18. In those cases where a differential determination of traits is to be made on the basis of whether the response is voluntary or non-voluntary, assume a non-voluntary response unless there is good evidence to point to the voluntariness of the response.

a. Examples: "Stubbornness" vs. "negativism"
   "Rutism" vs. "stubbornness."

19. In the case of "hallucinations" of the various kinds, an "L" will be found in the Remarks column. This is to remind Examiner that a note is to be made in the column on the localization of the hallucination in question, when it is marked present.

20. In the case of mute and inaccessible patients all traits which cannot be determined should be marked "0", rather than not checked.

21. When the Rating Forms are completed there should be a check in at least one of the columns for each trait.
I. ATTITUDE AND GENERAL BEHAVIOR

A. Under-activity. (Abnormal reduction of voluntary motor responses.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

B. Over-activity. (Abnormally facile release of voluntary motor responses.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

C. Purposefulness of Activity. (Degree with which activity is directed towards a goal.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

D. Solitariness. (Tendency to withdraw into solitude.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

E. Playfulness. (Tendency to busy one's self for diversion, sport or frolic.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked
F. Initial Psychomotor Retardation. (Slowness or delay in initiation of acts of psychomotor nature.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

G. Executive Psychomotor Retardation. (Slowness in the execution of acts of psychomotor nature once initiated.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

H. Reduction in Volitional Control. (Apparent reduction of ability to carry out a preferred activity not due to physical disability.)

(Ex.: 1. Inability to choose food from menu, 2. Inability to put on overcoat, 3. Auto patient who tries to talk.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

I. Stereotypy of Posture. (Maintenance of mechanical and apparently unmotivated position. The muscles usually become tense and the patient resists attempts to alter his position. Then the posture is disturbed, patient shows tendency to return to it as soon as opportunity offers.)

(Ex.: 1. Standing in either ear are raised, 2. Lying in bed with head hanging over side.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None
J. Movement Stereotypy.  
(Mechanical and apparently unmotivated repetition of a movement. To be distinguished from a mannerism in that it is maintained long after fatigue would under ordinary circumstances have caused relaxation.) (Ex.: 1. Swinging back and forth. 2. Nodding. 3. Wrinkling forehead.)

1. None  
2. Some  
3. Considerable  
4. Marked  
5. Very marked

K. Motor Perseveration - Amount.  
(The tendency for a motor response once given to be repeated as a response to succeeding stimuli, despite individual's effort to produce a new one. The response is almost always irrelevant.)

1. Very marked  
2. Marked  
3. Considerable  
4. Some  
5. None

L. Mannerisms.  
(Habitual automatic oddities of attitude or general behavior. To be distinguished from stereotypy in that not so monotonously repeated and more in keeping with personality. Usually modifications of ordinary movements.) (Ex.: 1. Sliding right foot backwards and forward before beginning to walk. 2. Holding foot in peculiar way. 3. Leaking close to wall.)

1. None  
2. Some  
3. Considerable  
4. Marked  
5. Very marked

M. Tic, Habit Stares, etc. - Severity.  
(Tic = Sudden little involuntary movement of short duration.) (Ex.: 1. Raising and lowering eyebrows. 2. Winking. 3. Sudden throwing back of head.) (Habit Stare = Sudden violent, involuntary, rigid contraction due to muscular action. Patient is aware of them and they are usually a cause of annoyance.)

1. None  
2. Some  
3. Considerable  
4. Marked  
5. Very marked
N. Compulsive Behavior. (Irresistible impulse to perform some apparently unreasonable act. It is usually against patient's desire and better judgment.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

O. Impulsive Behavior. (Acts without reflection, choice or voluntary direction. Appear without cause but considered as originating within personality.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

P. Automatism. (Performance of acts normally requiring attention without the apparent supervision or even the knowledge of the performer.) (Ex.: Automatic writing.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

Q. Automatic Obedience. (Extreme form of suggestibility.)

(See Suggestibility.)

R. Suggestibility. (Readiness with which behavior is altered by suggestion from without.) (Ex.: 1. Extravert forms, echolalia, echopraxia, cornea flexibilitas - automatic obedience.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None
S. Negativism—Active. (Patient impulsively does opposite of what he is requested to do. Not to be confused with voluntary resistance or stubbornness.) (Ex.: Request to stick tongue out results in pressing teeth tightly together.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

T. Negativism—Passive. (Patient non-voluntarily does not do what is expected of him or what is normally done or called for in a given situation. Not to be confused with voluntary resistance or stubbornness.) (Ex.: 1. Offer of hand for shaking not accepted. 2. Request to do something elicits no response—perception and attention not being involved apparently.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

U. Retention. (Persistent keeping within the body of material ordinarily excreted or keeping in mouth material ordinarily swallowed.) (Ex.: 1. Feces. 2. Urine. 3. Saliva. 4. Food.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

V. Resistiveness. (Voluntary opposition to suggested course of action despite fact that under the circumstances it is reasonable.) (Stubbornness.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None
W. Inaccessibility. (Difficulty of making contact with patient.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

X. Self-mutilation. (Mutilation of own body by patient in any way.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

Y. Destructiveness. (Causing the breaking up of objects, etc.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

Z. Assaultiveness - Gesture. (Gestures of striking others with or without weapons.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

AA. Assaultiveness - Attack. (Violent attacks by means of blows, weapons, etc.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

BB. Suicide - Attempts. (Attempts at self-destruction.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked
CC. Homicide - Attempts. (Attempts at destruction of others.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

DD. Silliness. (Foolish conduct.) (Ex.: 1. Inappropriate giggles.
2. Extreme coyness. 3. Grimaces.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

EE. Agitation. (Condition in which activity cannot be repressed and
in which a certain degree of worry is involved.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

FF. Fatiguability. (Degree with which efficiency is diminished due
to activity.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

GG. Productions - Written. ( Anything of written nature brought forth
or originated by patient.) (Ex.: 1. Poetry. 2. Prose.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

II. Productions - Other. (Anything of other nature brought forth or originated by patient.) (Ex.: 1. Mechanical, 2. Business.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

JJ. Letters Written - Number. (Number of letters written by patient weekly.)

1. None
2. Some - less than one a week
3. Considerable - one to two a week
4. Marked - three to six a week
5. Very marked - over six a week

KK. Cooperativeness - General. (Degree with which individual works with others on the ward and contributes to the general welfare.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

LL. Cooperativeness - Examination. (Degree with which individual enters into examination in order to help examiner to attain aims.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None
II. STREAM OF TALK

A. Over-productivity of Speech - Spontaneous. (Copiousness and spontaneously aroused.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

B. Over-productivity of Speech - Stimulated. (Copiousness and ease of utterance following intended stimulation.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

C. Under-productivity of Speech. (Stagnation and insufficiency of utterance.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

D. Thinking Difficulty. (Slowness in the elaboration of ideas.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

E. Confusion. (Lack of lucidity of thought.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked
I. Speech Retardation — Initial. (Slowness in the initiation of speech)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

G. Speech Retardation — Executive. (Slowness in the execution of speech once initiated.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

H. Mutism — No Utterance at all. (Non-voluntary inhibition of speech not even in response to repeated questions.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

I. Mutism — No Spontaneous Utterance. (Non-voluntary inhibition of speech. Speech only in response to direct questions. No spontaneous utterance when opportunity offered by environment for comment and remarks.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

J. Blocking. (Sudden obstruction of flow of speech, apparently due to uncomfortable thought which is revived, for which patient is usually unable to account. Distinguish from retardation by fact that blocked patient reacts with normal speed when obstruction removes or under other circumstances.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None
K. Speech Stereotypy. (Mechanical and apparently unmotivated repetition of word(s) or phrase(s). Synonymous with verbiage.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

L. Circumstantiality. (Type of speech where goal idea is reached only after relating many irrelevant and inconsequential details.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

M. Flight of Ideas. (Type of speech where the goal idea as a narrative is not reached due to frequent digressions to more or less related subjects. Distinguish from circumsstantiality where goal idea is reached in time.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

N. Irrelevance. (Lack of harmony of answers with questions.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

O. Disconnection. (A sequence of associations which have no apparent relationship.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked
P. Perscveration of Speech. (The tendency for a verbal response once given to be repeated as a response to succeeding questions and therefore almost always irrelevant.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

Q. Neologisms. (Newly coined words.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

R. Peculiarities of Speech. (Singular or queer ways of speaking.)

(Ex.: 1. Eliminative endings. 2. Whisperings. 3. Peculiar timbre. 4. etc.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

S. Peculiarities of Phrasology. (Novel combinations of words.) (Ex.: 1. "Purposive blending of entomologic complexities"

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

T. Evasion. (Avoidance of direct answers.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

U. Homicide-Talk. (Talk or threats of destruction of others.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked
III. AFFECTIVE AND EMOTIONAL REACTIONS.

A. Depression. (State of gloomy thought and dejection.)
   1. Very marked
   2. Marked
   3. Considerable
   4. Some
   5. None

B. Elation. (Joyful feelings, disproportionate to the circumstances.)
   1. Very marked - exaltation
   2. Marked
   3. Considerable
   4. Some - euphoria
   5. None

C. Ecstasy. (Happiness with marked mystical coloring.)
   1. None
   2. Some
   3. Considerable
   4. Marked
   5. Very marked

D. Anxiety. (Emotional state arising when a continuing desire seems likely to miss its goal.)
   1. Very marked
   2. Marked
   3. Considerable
   4. Some
   5. None

E. Apprehension - Sense of Peril. (Disquieting anticipation of external dangers.)
   1. Very marked
   2. Marked
   3. Considerable
   4. Some
   5. None

F. Irritability. (Abnormal responsiveness to stimuli.)
   1. None
   2. Some
   3. Considerable
   4. Marked
   5. Very marked
C. Pathological Anger. (Excessive anger.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

H. Suspicion. (Apprehension of something wrong without proof or with very slight evidence.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

I. Emotional Control. (Ability to restrain outward expression of emotions. Patient acts accordingly when affect is present.) (Ex.: 1. Poor poker players.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

J. Lability. (Flexibility and fluctuations of emotions and feelings.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

K. Reduction of Affect - Amount. (Emotional indifference; lack of manifestation of interest or feeling.)

1. Very marked - apathy
2. Marked
3. Considerable
4. Some
5. None
L. Reduction of Affect - Spread. (Number of things about which there is a lack of manifestation of interest or feeling, about which patient would under ordinary circumstances be expected to react affectively.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

M. Pathological Duration of Affect. (Persistence of affective response longer than normally expected.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

N. Ambivalence - Emotional. (Tension of feeling - ideas, situations, objects have two apparently opposite affective values.) (Ex.: 1. Both attachment and antagonism to father.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

O. Incongruity of Affect. (Inappropriateness of emotional expression to thought content or situation.) (Ex.: 1. Joy expressed on relating calamity to self or family.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

P. Emotional Deterioration. (Impairment - usually progressive - of ability to show normal emotional responses)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked
Q. Egotism. (Conceit - entertainment of high value of one's self.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None
IV. MENTAL CONTENT

A. Illusions. (Mistaken perception of an actual object having some possible similarity to the perception.)

   1. None
   2. Some
   3. Considerable
   4. Marked
   5. Very marked

B. Hallucinations - Number. (Amount of time taken up by perceptions without apparent stimuli.)

   1. Very marked
   2. Marked
   3. Considerable
   4. Some
   5. None

C. Hallucinations - Auditory. (Number of auditory hallucinations.)

   1. Very marked
   2. Marked
   3. Considerable
   4. Some
   5. None

D. Hallucinations - Visual. (Number of visual hallucinations.)

   1. None
   2. Some
   3. Considerable
   4. Marked
   5. Very marked

E. Hallucinations - Tactile. (Number of tactile hallucinations.)

   1. Very marked
   2. Marked
   3. Considerable
   4. Some
   5. None
F. Hallucinations - Olfactory. (Number of olfactory hallucinations.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

G. Hallucinations - Gustatory. (Number of gustatory hallucinations.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

H. Hallucinations - Somatic. (Number of somatic hallucinations.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

I. Hallucinations - Other. (Number of other hallucinations.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

J. Hallucinations - Fixity. (Temporal duration of the hallucinations.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

K. Hallucinations - Effect on Conduct. (Degree to which patient's conduct is affected by the hallucinations. (Ex.: 1. Talks back to them. 2. Attempts to strike, etc.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked
L. **Hallucinations** - Degree of acceptance. (Degree with which hallucinations reality is accepted.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

M. **Obsessive Thoughts**. (Oblivious, unwelcome but uncontrollable ideas which tend to dominate thinking. Often fully comprehended by individual, and always partially comprehended.) (Ex.: 1. That patient does not exist. 2. Fear of cancer, syphilis, etc.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

N. **Autochthonous Thoughts**. (Imaginative ideas attributed to some outside influence, usually benevolent. Patient disclaims responsibility for thoughts - they are foreign and not connected with personality.) (Ex.: 1. Patient believes that enemy forces on him the idea of killing his father.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

O. **Deprivation of Thought**. (Patient reports that thoughts are read or stolen. Patient's report.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

P. **Autistic Thinking**. (Derivative Thinking.) (Preoccupation with dreams and fantasies at expense of interest in external events.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None
Q. Preoccupation. (Reflection on one topic or field of thought to exclusion of practically everything else.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

R. Delusions - Number. (Amount of time taken up by false beliefs not true to facts, which cannot be corrected by appeal to reason and which are out of harmony with individual's education and surroundings.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

S. Delusions - Persecution. (False beliefs of a persecutory nature.) (Ex.: 1. Ganga after subject.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

T. Delusions - Reference. (False beliefs of reference nature.) (Ex.: 1. People call subject names.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

U. Delusions - Influence. (False beliefs of influence nature.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked
V. Delusions - Grandiose. (False beliefs of a grandiose nature.)
(Ex.: 1. Subject millionaire. 2. Subject Christ.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

W. Delusions - Sin and Poverty, etc. (False beliefs of a sin committed,
or of having become poor.) (Ex.: 1. Patient believes self responsible for earthquake.
2. Patient has no money.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

X. Delusions - Sensitiv. (False beliefs involving the body.) (Ex.: 1. Patient has syphilis.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

Y. Delusions - Other. (False beliefs of other kinds.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

Z. Delusions - Systematization. (Organization of delusion into co-
harent and logical order.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked
AA. Delusions - Bizarreness. (Fantasticality, fancifulness, extravagance of delusions.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

BB. Delusions - Fixity. (Temporal duration of the delusion(s).)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

CC. Delusions - Effect on Conduct. (Amount to which patient carries out in behavior the implications of the delusions.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

DD. Delusions - Degree of Acceptance. (Degree with which false belief is accepted intellectually.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

EE. Delusions - Insight-a. (Appreciation of true nature of false beliefs - both intellectual and emotional.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

EE. Delusions - Insight-b. (Appreciation of true nature of false beliefs - only intellectual.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked
GO. Repression. (Exclusion from consciousness of painful and unpleasant material by conscious effort.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

HH. Ambivalence - Thought. (Contradictory intellectual attitude towards the same subjects without either one interfering with or inhibiting the expression of the other.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

II. Symbolization. (Shift of affect from one item to another because of some common characteristic.) (Ex.: 1. Attachment to red-haired men because of childhood attachment to red-haired teacher. 2. Fetishism.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

JJ. Hidden Meanings. (Seeing significances and meanings in events which are not seen by others or not obvious on the surface.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

KK. Sex Involvement. (Degree to which productions have an expressed sexual coloring.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None
II. Religious Involvement. (Degree to which productions have an expressed religious coloring. "Religious" implies a relationship to some superhuman or over-ruling power, whether God, devil, Christ, Bes, etc.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

III. Condensation. (Paving of a number of ideas, events, and pictures.) (Ex.: i. Characteristics of a number of women known fused into one.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

IV. Conversion. (The process by which a repressed affect becomes converted into a physical symptom - motor or sensory.) (Ex.: i. Desire to call mother obscene names repressed and converted into aphonia.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

CO. Assaultiveness - Talk. (Talk of violent attacks by means of blows, weapons, etc.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

PP. Suicide - Talk. (Talk or threats of self-destruction.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked
**QQ. Approximate Responses.** (Ganzini's Syndrome Phenomena.) (Approximate answers or approximate forms of behavior.) (Ex.: 1. 413 = 36; 2. 6X7 = 43; 3. Holding knife by blade.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

**RR. Quantity of Thought.** (Amount of thinking occurring in patient.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

**SS. Deterioration - Intellectual.** (Impairment - usually progressive - of ability along intellectual lines.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked
V. ORIENTATION.

A. Time - Orientation. (Knowledge of relation of self to temporal aspects of situation and life.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

B. Place - Orientation. (Knowledge of relation of self to spatial aspects of situation and life.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

C. Person - Orientation. (Knowledge of relation of self to personal aspects of situation and life.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

D. Feelings of Unreality. (Difficulty in emotionally accepting the actual orientation.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

E. Double Orientation. (State in which false orientation accompanies the correct orientation. Patient may use one or the other or both simultaneously.) (Ex.: 1. Being in hell and in hospital at same time.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None
VI. MEMORY

A. Immediate Memory. (Memory for events immediately preceding within five minutes.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

B. Recent Memory. (Memory for events within a month but more than five minutes.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

C. Remote Memory. (Memory for past events - over a month.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

D. Amnesia. (Loss or impairment of functions of reviving or reliving past experiences with a more or less definite realization that the present experience is a revival.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

E. Parahamnesia. (Falsification of functions of reviving or reliving past experiences with a more or less definite realization that the present examination is a revival.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

F. Hyperamnesia. (Unusual ability in reviving or reliving past experiences with a more or less definite realization that the present experience is a revival.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked
VII. ATTENTION

A. Blunting of Attention. (Dulling of attention so that it is difficult to arouse it.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

B. Distractibility. (Shift of attention due to external stimuli.) (Ex.: 1. Loud sounds, passing people, etc.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

C. Fluctuations. (Shift of attention due to internal stimuli.) (Ex.: 1. Shifts of interests, etc.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

VIII. JUDGMENT AND INSIGHT

A. Comprehension. (Ability to grasp meaning.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None

B. Quality of Judgment. (Quality of the results obtained from extension of concepts either by bringing to light what was implied in it or by adding to it.)

1. None
2. Some
3. Considerable
4. Marked
5. Very marked

C. Insight into total situation. (Degree of true appreciation of patient's state in actual situation.)

1. Very marked
2. Marked
3. Considerable
4. Some
5. None