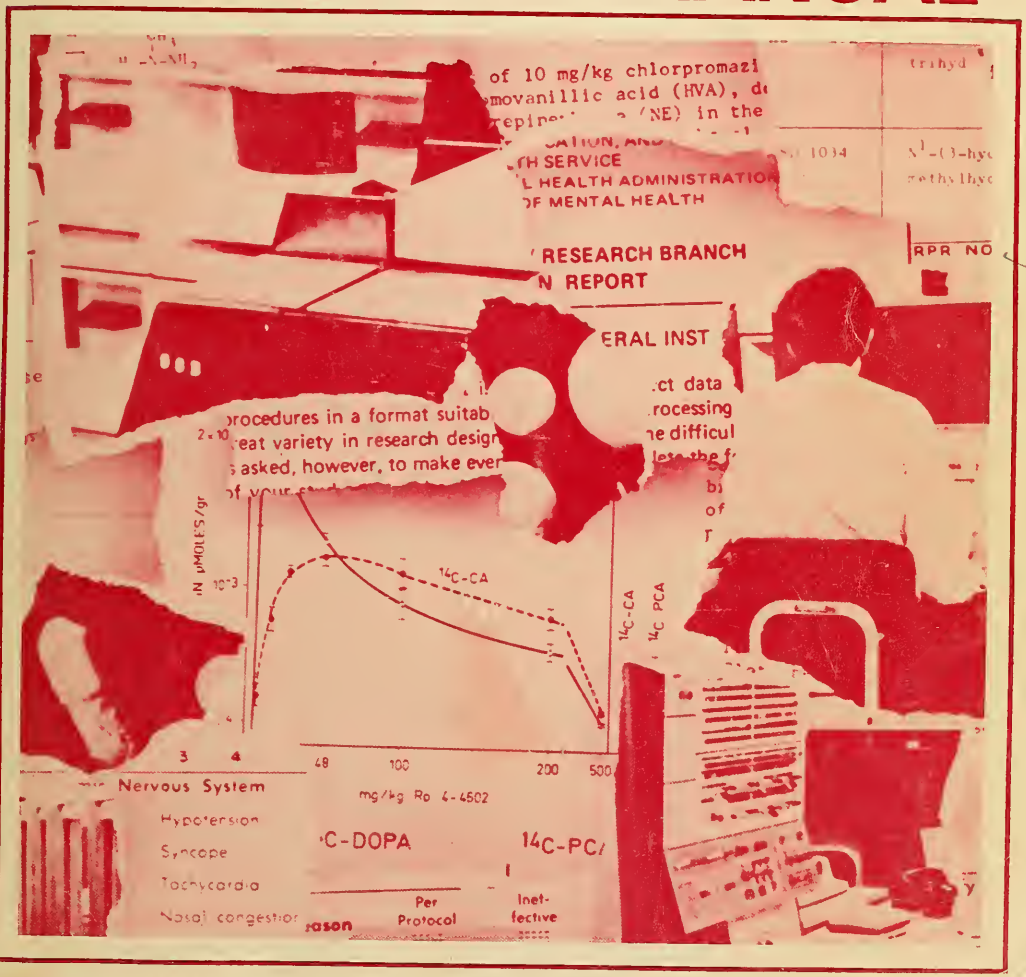
ECDEU ASSESSMENT MANUAL



U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE • Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

ECDEU ASSESSMENT MANUAL FOR PSYCHOPHARMACOLOGY Revised, 1976

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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HAMILTON PSYCHIATRIC RATING SCALE FOR DEPRESSION

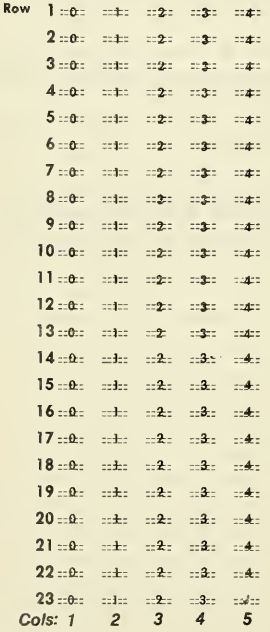
HAM D

INSTRUCTIONS: *Code 01 under Sheet Number on GSS.*

For each item select the one "cue" which best characterizes the patient.

Be sure to record your answers in the appropriate spaces (positions 0 through 4), Columns 1 – 5, on the left half of the General Scoring Sheet.

See *Special Instructions* in Manual for Items 7, 16, 18, and 20.



ROW NO.	Mark each item on left half of scoring sheet on row specified Use marking positions 0 – 4, columns 1 – 5
1	1. **DEPRESSED MOOD** *(Sadness, hopeless, helpless, worthless)* 0 = Absent 1 = These feeling states indicated only on questioning 2 = These feeling states spontaneously reported verbally 3 = Communicates feeling states non-verbally – i.e., through facial expression, posture, voice, and tendency to weep 4 = Patient reports VIRTUALLY ONLY these feeling states in his spontaneous verbal and non-verbal communication
2	2. **FEELINGS OF GUILT** 0 = Absent 1 = Self reproach, feels he has let people down 2 = Ideas of guilt or rumination over past errors or sinful deeds 3 = Present illness is a punishment. Delusions of guilt 4 = Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations
3	3. **SUICIDE** 0 = Absent 1 = Feels life is not worth living 2 = Wishes he were dead or any thoughts of possible death to self 3 = Suicide ideas or gesture 4 = Attempts at suicide *(any serious attempt rates 4)*
4	4. **INSOMNIA EARLY** 0 = No difficulty falling asleep 1 = Complains of occasional difficulty falling asleep – i.e., more than ½ hour 2 = Complains of nightly difficulty falling asleep
5	5. **INSOMNIA MIDDLE** 0 = No difficulty 1 = Patient complains of being restless and disturbed during the night 2 = Waking during the night – any getting out of bed rates 2 *(except for purposes of voiding)*
6	6. **INSOMNIA LATE** 0 = No difficulty 1 = Waking in early hours of the morning but goes back to sleep 2 = Unable to fall asleep again if he gets out of bed
7	7. **WORK AND ACTIVITIES** 0 = No difficulty 1 = Thoughts and feelings of incapacity, fatigue or weakness related to activities; work or hobbies 2 = Loss of interest in activity; hobbies or work – either directly reported by patient, or indirect in listlessness, indecision and vacillation *(feels he has to push self to work or activities)* 3 = Decrease in actual time spent in activities or decrease in productivity. In hospital, rate 3 if patient does not spend at least three hours a day in activities *(hospital job or hobbies)* exclusive of ward chores 4 = Stopped working because of present illness. In hospital, rate 4 if patient engages in no activities except ward chores, or if patient fails to perform ward chores unassisted

HAMILTON PSYCHIATRIC RATING SCALE FOR DEPRESSION

ROW NO.	Continue marking on left half of scoring sheet on row specified
8	**8. RETARDATION** *(Slowness of thought and speech; impaired ability to concentrate; decreased motor activity)* 0 = Normal speech and thought 1 = Slight retardation at interview 2 = Obvious retardation at interview 3 = Interview difficult 4 = Complete stupor
9	**9. AGITATION** 0 = None 1 = Fidgetiness 2 = Playing with hands, hair, etc. 3 = Moving about, can't sit still 4 = Hand wringing, nail biting, hair-pulling, biting of lips
10	**10. ANXIETY PSYCHIC** 0 = No difficulty 1 = Subjective tension and irritability 2 = Worrying about minor matters 3 = Apprehensive attitude apparent in face or speech 4 = Fears expressed without questioning
11	**11. ANXIETY SOMATIC** 0 = Absent 1 = Mild 2 = Moderate 3 = Severe 4 = Incapacitating Physiological concomitants of anxiety, such as: Gastro-intestinal — *dry mouth, wind, indigestion, diarrhea, cramps, belching* Cardio-vascular — *palpitations, headaches* Respiratory — *hyperventilation, sighing* Urinary frequency Sweating
12	**12. SOMATIC SYMPTOMS GASTROINTESTINAL** 0 = None 1 = Loss of appetite but eating without staff encouragement. Heavy feelings in abdomen 2 = Difficulty eating without staff urging. Requests or requires laxatives or medication for bowels or medication for G.I. symptoms
13	**13. SOMATIC SYMPTOMS GENERAL** 0 = None 1 = Heaviness in limbs, back or head. Backaches, headache, muscle aches. Loss of energy and fatigability 2 = Any clear-cut symptom rates 2
14	**14. GENITAL SYMPTOMS** 0 = Absent 1 = Mild 2 = Severe Symptoms such as: *Loss of libido* *Menstrual disturbances*
15	**15. HYPOCHONDRIASIS** 0 = Not present 1 = Self-absorption (bodily) 2 = Preoccupation with health 3 = Frequent complaints, requests for help, etc. 4 = Hypochondriacal delusions

ROW NO.	Continue marking on left half of scoring sheet on row specified
16	**16. LOSS OF WEIGHT** *Rate either A or B* **A. When Rating By History:** 0 = No weight loss 1 = Probable weight loss associated with present illness 2 = Definite (according to patient) weight loss 3 = Not assessed
17	**B. On Weekly Ratings By Ward Psychiatrist, When Actual Weight Changes Are Measured:** 0 = Less than 1 lb. weight loss in week 1 = Greater than 1 lb. weight loss in week 2 = Greater than 2 lb. weight loss in week 3 = Not assessed
18	**17. INSIGHT** 0 = Acknowledges being depressed and ill 1 = Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc. 2 = Denies being ill at all
19	**18. DIURNAL VARIATION** **A. Note whether symptoms are worse in morning or evening. If NO diurnal variation, mark none** 0 = No variation 1 = Worse in A.M. 2 = Worse in P.M.
20	**B. When present, mark the severity of the variation. Mark "None" if NO variation** 0 = None 1 = Mild 2 = Severe
21	**19. DEPERSONALIZATION AND DEREALIZATION** 0 = Absent 1 = Mild 2 = Moderate 3 = Severe 4 = Incapacitating Such as: *Feelings of unreality* *Nihilistic ideas*
22	**20. PARANOID SYMPTOMS** 0 = None 1 = Suspicious 2 = Ideas of reference 3 = Delusions of reference and persecution
23	**21. OBSESSIONAL AND COMPULSIVE SYMPTOMS** 0 = Absent 1 = Mild 2 = Severe

Hamilton's Depression Scale (HAMD) is a 23-item (including two 2-part items) scale formatted for use with the General Scoring Sheet. The scale points vary from 3 to 5. The HAMD is one of the most widely used instruments for the clinical assessment of depressive states. Unfortunately, the scale has been employed in a number of different versions - creating considerable difficulty when attempting to compare published findings. The present version is, we believe, the author's version.

REFERENCE — Hamilton, M., Development of a Rating Scale for Primary Depressive Illness, Brit. J. Soc. Clin. Psychol., 1967, 6, 278-296.

APPLICABILITY — Adults with depressive symptomatology

UTILIZATION — Once at pretreatment; at least one posttreatment rating. Additional ratings are at the discretion of the investigator.

TIME SPAN RATED — Now or within the last week

CARD FORMAT - ITEMS (19x, 2311)

	Item	Column		Item	Column
1	Depressed Mood	20	13	Somatic-General	32
2	Guilt	21	14	Genital Symptoms	33
3	Suicide	22	15	Hypochondriasis	34
4	Insomnia - early	23	16A	Weight-History	35
5	Insomnia - middle	24	16B	Weight-Actual	36
6	Insomnia - late	25	17	Insight	37
7	Work	26	18A	Diurnal Variation-time	38
8	Retardation	27	18B	Diurnal Variation-severity	39
9	Agitation	28	19	Depersonalization	40
10	Anxiety-Psychic	29	20	Paranoid	41
11	Anxiety-Somatic	30	21	Obsess/Comp	42
12	Somatic-GI	31			

CARD FORMAT - FACTORS CARD 51 = (19x, 6F6.2, F4.0)
Code "5" in Col. 18 indicates card which contains factor, cluster or derived scores.

Factor	Columns	Factor	Columns
1	20-25	5	44-49
2	26-31	6	50-55
3	32-37	Total Score	56-59
4	38-43		

$$\text{Factor score} = \frac{\text{Sum of composite items}}{\text{No. of composite items}}$$ Factor Score Range = 0 - 4

Total Score = Sum of all items.* Total Score Range = 0 - 62.

* In calculating Total Score, Only Item 18B - not 18A - is included.

FACTOR COMPOSITION

This factor structure based on a 1975 analysis of the pretreatment ratings of 480 subjects with diagnoses of neurotic depression. (Table 10).

Factor I - Anxiety/Somatization

10. Anxiety, Psychic
11. Anxiety, Somatic
12. Somatic Symptoms, Gastro-Intestinal
13. Somatic Symptoms, General
15. Hypochondriasis
17. Insight

Factor II - Weight

16A. Loss of Weight (History)
16B. Loss of Weight (Actual

Factor III - Cognitive Disturbance

2. Feelings of Guilt
3. Suicide
9. Agitation
19. Depersonalization and Derealization
20. Paranoid Symptoms
21. Obsessional and Compulsive Symptoms

Factor IV - Diurnal Variation

18A. Diurnal Variation (Time)
B. Diurnal Variation (Severity)

Factor V - Retardation

1. Depressed Mood
7. Work and Activities
8. Retardation
14. Genital Symptoms

Factor VI - Sleep Disturbance

4. Insomnia, Early
5. Insomnia, Middle
6. Insomnia, Late

SPECIAL INSTRUCTIONS

Item 7. Work and Activities - Rater may seek information from relatives or ward personnel.

Item 9. Agitation - This item - printed in the packet as a 3-point scale - should be rated on a 5-point scale as follows:

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

Item 16. Loss of Weight - This is an "either/or" item requiring a response to only part of the item, i.e., 16A or 16B. Actual Weight Changes (16B) is the preferred choice - particularly during the course of a study. It is suggested that Weight by History (16A) be used only at the pretreatment rating.

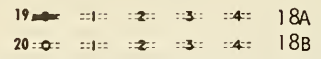
TABLE 10

6 - FACTOR VARIMAX SOLUTION OF 23-ITEM HAMILTON DEPRESSION SCALE

Cleary, P. and Guy, W., Factor Analyses of the Hamilton Depression Scale, presented at the International Symposium on the Evaluation of New Drugs in Clinical Psychopharmacology, Pisa, September, 1975.

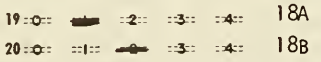
		F1	F2	F3	F4	F5	F6	Communalities
Depressed Mood	1	077	052	-213	043	709	100	57
Feelings of Guilt	2	012	006	-678	-068	152	090	50
Suicide	3	009	237	-429	163	366	157	43
Insomnia (Early)	4	091	367	-065	052	105	585	50
Insomnia (Middle)	5	058	109	-194	104	223	709	62
Insomnia (Late)	6	105	084	-102	119	244	708	60
Work & Activities	7	184	103	-167	-032	602	261	50
Retardation	8	167	000	-065	074	645	222	50
Agitation	9	420	144	-465	-196	-021	295	54
Anxiety Psychic	10	448	233	-393	117	201	030	46
Anxiety Somatic	11	720	155	-158	-030	156	109	60
Somatic Symptoms G.I.	12	462	293	-139	048	224	326	48
Somatic Symptoms - General	13	601	002	-211	116	338	284	61
Genital Symptoms	14	340	083	-117	325	531	004	52
Hypochondriasis	15	731	076	-070	048	167	-097	58
Loss of Weight A	16	086	746	025	167	136	269	68
Loss of Weight B	17	262	898	-101	054	-040	174	92
Insight	18	513	-417	054	094	-252	323	62
Diurnal A.M.	19	-015	109	-121	731	229	078	62
Diurnal P.M.	20	084	064	-082	814	-030	134	70
Depersonalization & Dualization	21	119	235	-556	140	223	146	47
Paranoid	22	173	-139	-678	229	-083	163	59
Obsessional-Compulsive Symptoms	23	162	-022	-626	076	205	-051	47
Contribution of factor (V_p)		2.63	2.05	2.45	1.56	2.33	2.09	13.11
% of Total Variance		11.43	8.91	10.65	6.78	10.13	9.08	56.9
% of Common Variance		20.06	15.63	18.68	11.89	17.77	15.94	

Item 18. Diurnal Variation - When no variation is present, encode "0" for Item A (Row 19) and leave 18B (Row 20) blank as follows:



When diurnal variation is present, encode the time of day when the symptoms are worse in 18A and indicate the severity of variation; i.e., the degree or amount of variation, in 18B. "Mild" should be interpreted as doubtful or slight variation: "Severe" as clear or marked variation.

Example: The patient's symptoms are clearly worse in the morning. Encode 1 in Row 19 and 2 in Row 20.



DOCUMENTATION

a. Raw score printout
b. Factor score printout
c. Means and standard deviations of factor scores
d. Crosstabulations
e. Variance analyses

COMMENTS OF THE AUTHOR - Adapted from "Development of a Rating Scale for Primary Depressive Illness"; Brit. J. of Soc. Clin. Psychol., 1967, 6, 278-296

Max Hamilton, M.D.

The scale provides a simple way of assessing the severity of a patient's condition quantitatively, and for showing changes in that condition. It should not be used as a diagnostic instrument. A set of items to be so used should include not only those which will show the presence of the symptoms that the patient has, but also those which the patient has not, for a diagnosis not only includes the patient within a certain category but also excludes him from others. It is possible that the scale may have other uses, e.g.: predicting outcome and selection of treatment, but these have not yet been worked out.

Ratings can be done in a number of ways, depending on the purpose, but whatever this may be it must never be forgotten that the scores are merely a particular way of recording the rater's judgment. Other things being equal, the value of the ratings therefore depends entirely on the skill and experience of the rater and on how adequate is the information available to him. This scale was devised for recording the severity of symptoms of a patient (apart from minor and temporary fluctuations) and therefore questioning should be directed to his condition in the last few days or week. It is desirable to obtain additional information from relatives, friends, nurses etc. and this should always be done whenever there is doubt about the accuracy of the patient's answers. A question frequently asked concerns the length of time required to make a rating, i.e. for how long should the patient be interviewed in order to obtain sufficient information on which to base a judgment. This will obviously depend on the skill of the rater and the condition of the patient. Sick patients cannot think quickly and they should never be hurried. An adequate interview will surely be not less than half an hour, for that gives an average time of about two minutes per item, which is not really sufficient.

The following points about interviewing will be obvious to the skilled interviewer, but it does no harm to emphasize them. The patient should not be pressed and should be allowed sufficient time to say what he wants to say; but he should not be allowed to wander too far from the point. The number of direct questions should be kept to a minimum and such questions should be asked in different ways and, in particular, both in positive and negative form, e.g. 'How badly do you sleep?' and 'How well do you sleep?' Questions should be asked in language which the patient understands and ordinary words should never be used in a technical sense. It must not be forgotten that patients sometimes misuse technical words. Patients should be helped and encouraged to admit to symptoms of which they are ashamed. Normal people do not talk freely about themselves to strangers, and this is true of patients; it is therefore helpful to delay a detailed assessment to a second interview.

When ratings are repeated they should be made independently. The interviewer should not have previous ratings in front of him and should use a new form on each occasion; this may seem a trivial matter but experience has shown that it is important. As far as possible he should avoid asking questions relating to changes since the previous interview. In order to increase the reliability of ratings, it is advisable for two interviewers to be present, one of them conducting the interview and the other asking supplementary questions at the end. The two raters should record scores independently and then sum them after the interview to give the rating for the patient. Discussion can take place after this. A discrepancy of one point on any

item is of no consequence, but a difference of two points requires careful consideration. Experience has shown that a preliminary training done on about a dozen patients should produce close agreement. A difference of 4 points on the total score is the maximum allowable, but in practice, the difference is rarely more than 2 points. There is a great practical gain from having two raters: occasionally one of them may not be available and then the other can do the rating (and double his scores). With increasing experience, a rater can learn to give half points, but summed scores from two raters should be converted into integers for each item.

Symptoms are rated finely or coarsely; the former are on a five-point scale (0-4) where the numbers are equivalent to absent, doubtful or trivial, mild, moderate and severe. The latter are on a three-point scale (0-2) equivalent to absent, doubtful or mild, and obvious, distinct or severe.

The Rating of Male Patients

1. Depression (0-4) - Depressed mood is not easy to assess. One looks for a gloomy attitude, pessimism about the future, feelings of hopelessness and a tendency to weep. As a guide, occasional weeping could count as 2, frequent weeping as 3, and severe symptoms alloted 4 points. When patients are severely depressed they may 'go beyond weeping'. It is important to remember that patients interpret the word 'depression' in all sorts of strange ways. A useful common phrase is 'lowering of spirits'.

2. Guilt (0-4) - This is fairly easy to assess but judgment is needed, for the rating is concerned with pathological guilt. From the patient's point of view, some action of his which precipitated a crisis may appear as a 'rational' basis for self-blame, which persists even after recovering from his illness. For example, he may have accepted a promotion, but the increased responsibility precipitated his breakdown. When he 'blames' himself for this, he is ascribing a cause and not necessarily expressing pathological guilt. As a guide to rating, feelings of self-reproach count 1, ideas of guilt 2, belief that the illness might be a punishment 3, and delusions of guilt, with or without hallucinations, 4 points.

3. Suicide (0-4) - The scoring ranges from feeling that life is not worth living 1, wishing he were dead 2, suicidal ideas and half-hearted attempts 3, serious attempts 4. Judgment must be used when the patient is considered to be concealing this symptom, or conversely, when he is using suicidal threats as a weapon, to intimidate others, obtain help and so on.

4, 5, 6 Insomnia (initial, middle and delayed) (0-2) - Mild, trivial and infrequent symptoms are given 1 point, obvious and severe symptoms are rated 2 points; both severity and frequency should be taken into account. Middle insomnia (disturbed sleep during the night) is the most difficult to assess, possibly because it is an artifact of the system of rating. When insomnia is severe, it generally affects all phases. Delayed insomnia (early morning wakening) tends not to be relieved by hypnotic drugs and is not often present without other forms of insomnia.

7. Work and Interests (0-4) - It could be argued that the patient's loss of interest in his work and activities should be rated separately from his decreased performance, but it has been found too difficult to do so in practice. Care should be taken not to include fatiguability and lack of energy here; the rating is concerned with loss of efficiency and the extra effort required to do anything. When the patient has to be

admitted to hospital because his symptoms render him unable to carry on, this should be rated 4 points, but not if he has been admitted for investigation or observation. When the patient improves he will eventually return to work, but when he does so may depend on the nature of his work; judgment must be used here.

8. Retardation (0-4) - Severe forms of this symptom are rare, and the mild forms are difficult to perceive. A slight flattening of affect and fixity of expression rate as 1, a monotonous voice, a delay in answering questions, a tendency to sit motionless count as 2. When retardation makes the interview extremely prolonged and almost impossible, it is rated 3, and 4 is given when an interview is impossible (and symptoms cannot be rated). Although some patients may say that their thinking is slowed or their emotional responsiveness has been diminished, questions about these manifestations usually produce misleading answers.

9. Agitation (0-4) - Severe agitation is extremely rare. Fidgetiness at interview rates as 1, obvious restlessness with picking at hands and clothes should count as 2. If the patient has to get up during the interview he is given 3, and 4 points are given when the interview has to be conducted 'on the run', with the patient pacing up and down, picking at his face and hair and tearing at his clothes. Although agitation and retardation may appear to be opposed forms of behavior, in mild form they can co-exist.

NOTE - The scale points printed on the original Adult packet are 0-2. Dr. Hamilton states that the original range (0-4) was abandoned when severer forms of agitation could not be found. He has since found that more severe cases of agitation do occur - particularly in countries other than Great Britain. The author prefers the 0-4 range, but the packet was printed before this instruction could be inserted. Subsequent editions of the Adult Packet will contain the 5-point scale and raters are urged to employ the 5-point scale for this item.

10. Anxiety (psychic symptoms) (0-4) - Many symptoms are included here, such as tension and difficulty in relaxing, irritability, worrying over trivial matters, apprehension and feelings of panic, fears, difficulty in concentration and forgetfulness, 'feeling jumpy'. The rating should be based on pathological changes that have occurred during the illness and an effort should be made to discount the features of a previous anxious disposition.

11. Anxiety (somatic symptoms) (0-4) - These consist of the well-recognized effects of autonomic over-activity in the respiratory, cardiovascular, gastro-intestinal and urinary systems. Patients may also complain of attacks of giddiness, blurring of vision and tinnitus.

12. Gastro-intestinal symptoms (0-2) - The characteristic symptom in depression is loss of appetite and this occurs very frequently. Constipation also occurs but is relatively uncommon. On rare occasions patients will complain of 'heavy feelings' in the abdomen. Symptoms of indigestion, wind and pain, etc. are rated under Anxiety.

13. General somatic symptoms (0-2) - These fall into two groups: the first is fatiguability, which may reach the point where the patients feel tired all the time. In addition, patients complain of 'loss of energy' which appears to be related to

difficulty in starting up an activity. The other type of symptom consists of diffuse muscular achings, ill-defined and often difficult to locate, but frequently in the back and sometimes in the limbs; these may also feel 'heavy'.

14. Loss of libido (1-2) - This is a common and characteristic symptom of depression, but it is difficult to assess in older men and especially those, e.g. unmarried, whose sexual activity is usually at a low level. The assessment is based on a pathological change, i.e. a deterioration obviously related to the patient's illness. Inadequate or no information should be rated as zero.

15. Hypochondriasis (0-4) - The severe states of this symptom, concerning delusions and hallucinations of rotting and blockages, etc., which are extremely uncommon in men, are rated as 4. Strong convictions of the presence of some organic disease which accounts for the patient's condition are rated 3. Much preoccupation with physical symptoms and with thoughts of organic disease are rated 2. Excessive preoccupation with bodily functions is the essence of a hypochondriacal attitude and trivial or doubtful symptoms count as 1 point.

16. Loss of insight (0-2) - This is not necessarily present when the patient denies that he is suffering from mental disorder. It may be that he is denying that he is insane and may willingly recognize that he has a 'nervous' illness. In case of doubt, enquiries should be directed to the patient's attitude to his symptoms of Guilt and Hypochondriasis.

17. Loss of weight (0-2) - The simplest way to rate this would be to record the amount of loss, but many patients do not know their normal weight. For this reason, an obvious or severe loss is rated as 2 and a slight or doubtful loss as 1 point.

18. Diurnal variation (0-2) - This symptom has been excluded from Hamilton's factors as it indicates the type of illness, rather than presenting an addition to the patient's disabilities. The commonest form consists of an increase of symptoms in the morning, but this is only slightly greater than worsening in the evening. A small number of patients insist that they feel worse in the afternoon. The clear presence of diurnal variation is rated as 2 and the doubtful presence is 1 point.

The following three symptoms were excluded from Hamilton's factors because they occur with insufficient frequency, but they are of interest in research.

19. Derealization and Depersonalization (0-4) - The patient who has this symptom quickly recognizes the questions asked of him; when he has difficulty in understanding the questions it usually signifies that the symptom is absent. When the patient asserts that he has this symptom it is necessary to question him closely; feelings of 'distance' usually mean nothing more than that the patient lacks concentration or interest in his surroundings. It would appear that the severe forms of this symptom are extremely rare in patients diagnosed as depressive.

admitted to hospital because his symptoms render him unable to carry on, this should be rated 4 points, but not if he has been admitted for investigation or observation. When the patient improves he will eventually return to work, but when he does so may depend on the nature of his work; judgment must be used here.

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difficulty in starting up an activity. The other type of symptom consists of diffuse muscular achings, ill-defined and often difficult to locate, but frequently in the back and sometimes in the limbs; these may also feel 'heavy'.

14. Loss of libido (1-2) - This is a common and characteristic symptom of depression, but it is difficult to assess in older men and especially those, e.g. unmarried, whose sexual activity is usually at a low level. The assessment is based on a pathological change, i.e. a deterioration obviously related to the patient's illness. Inadequate or no information should be rated as zero.

15. Hypochondriasis (0-4) - The severe states of this symptom, concerning delusions and hallucinations of rotting and blockages, etc., which are extremely uncommon in men, are rated as 4. Strong convictions of the presence of some organic disease which accounts for the patient's condition are rated 3. Much preoccupation with physical symptoms and with thoughts of organic disease are rated 2. Excessive preoccupation with bodily functions is the essence of a hypochondriacal attitude and trivial or doubtful symptoms count as 1 point.

16. Loss of insight (0-2) - This is not necessarily present when the patient denies that he is suffering from mental disorder. It may be that he is denying that he is insane and may willingly recognize that he has a 'nervous' illness. In case of doubt, enquiries should be directed to the patient's attitude to his symptoms of Guilt and Hypochondriasis.

17. Loss of weight (0-2) - The simplest way to rate this would be to record the amount of loss, but many patients do not know their normal weight. For this reason, an obvious or severe loss is rated as 2 and a slight or doubtful loss as 1 point.

18. Diurnal variation (0-2) - This symptom has been excluded from Hamilton's factors as it indicates the type of illness, rather than presenting an addition to the patient's disabilities. The commonest form consists of an increase of symptoms in the morning, but this is only slightly greater than worsening in the evening. A small number of patients insist that they feel worse in the afternoon. The clear presence of diurnal variation is rated as 2 and the doubtful presence is 1 point.

The following three symptoms were excluded from Hamilton's factors because they occur with insufficient frequency, but they are of interest in research.

19. Derealization and Depersonalization (0-4) - The patient who has this symptom quickly recognizes the questions asked of him; when he has difficulty in understanding the questions it usually signifies that the symptom is absent. When the patient asserts that he has this symptom it is necessary to question him closely; feelings of 'distance' usually mean nothing more than that the patient lacks concentration or interest in his surroundings. It would appear that the severe forms of this symptom are extremely rare in patients diagnosed as depressive.

20. Paranoid symptoms (0-4) - These are uncommon, and affirmative answers should always be checked carefully. It is of no significance if the patient says that others talk about him, since this is usually true. What is important in the mild symptom is the patient's attitude of suspicion, and the malevolence imputed to others. Doubtful or trivial suspicion rates as 1, thoughts that others wish him harm rates as 2, delusions that others wish him harm or are trying to do so rates as 3, and hallucinations are given 4 points. Care should be taken not to confuse this symptom with that of guilt, e.g. 'people are saying that I am wicked'.

21. Obsessional symptoms (0-2) - These should be differentiated from preoccupations with depressive thoughts, ideas of guilt, hypochondriacal preoccupations and paranoid thinking. Patients usually have to be encouraged to admit to these symptoms, but their statements should be checked carefully. True obsessional thoughts are recognized by the patient as coming from his own mind, as being alien to his normal outlook and feelings, and as causing great anxiety; he always struggles against them.

The Rating of Female Patients

The same general principles apply to the rating of women as of men, but there are special problems which need to be considered in detail.

1. Depression (0-4) - It is generally believed that women weep more readily than men, but there is little evidence that this is true in the case of depressive illness. There is no reason to believe, at the moment, that an assessment of the frequency of weeping could be misleading when rating the intensity of depression in women.

7. Work and interests (0-4) - Most women are housewives and therefore their work can be varied, both in quantity and intensity, to suit themselves. Women do not often complain of work being an effort, but they say they have to take things easily, or neglect some of their work. Other members of the family may have to increase the help they give. It is rare for a housewife to stop looking after her home completely. If she has an additional job outside the home she may have to change it to part-time, or reduce her hours of work or even give it up completely. Women engage in hobbies less frequently than men. Loss of interest, therefore, may not be as obvious. Patients may complain of inability to feel affection for their families. This could be rated here, but it could be rated under other symptoms, depending upon its meaning and setting. Care should be taken not to rate it in two places. It is a very valuable and important symptom if the patient mentions it spontaneously but could be very misleading as a reply to a question.

11. Anxiety (somatic) (0-4) - These last three symptoms appear to be more common in women than in men.

13. Somatic symptoms (general) (0-2) - It is not uncommon for women to complain of backache and to ascribe it to a pelvic disorder. This symptom requires careful questioning.

14. Loss of libido (0-2) - In women whose sexual experience is satisfactory, this symptom will appear as increasing frigidity, progressing to active dislike of sexual intercourse. Women who are partially or completely frigid find that their customary toleration of sex also changes to active dislike. It is difficult to rate this symptom in women who have had no sexual experience or, indeed, in widows since loss of libido in women tends to appear not so much as a loss of drive but as a loss of responsiveness. In the absence of adequate information of a pathological change a zero rating should be given. Disturbed menstruation and amenorrhea have been described in women suffering from severe depression, but they are very rare. Despite the difficulties in rating, it has been found that the mean score for women is negligibly less than men.

REFERENCES

Robin, A. A., and Langley, G. E. A Controlled Trial of Imipramine. Brit. J. Psychiat. 110: 419-422, May, 1964

Doig, R. J., et al, Plasma Control Levels in Depression. Brit. J. Psychiat. 112: 1263-1267, Dec. 1966

Davison, K., et al, Genetic Polymorphism in Metabolism of Phenelzine. Brit. J. Psychiat. 112: 105, Jan. 1966

Sutherland, S. S., et al. The Response to Treatment of Individual Patients in a Drug Trial. Brit. J. Psychiat. 115: 1383-1385, Dec. 1969

Martin, I. C. A., and Leahy, M. R. Prediction in Anti-Depressant Therapy. Brit. J. Psychiat. 114: 749-754, June 1968

McDowell, R. W. T., et al, Subsequent Suicide in Depressed In-Patients. Brit. J. Psychiat. 114: 749-754, June 1968

Mendels, J., Electroconvulsive Therapy & Depression in the Prognostic Significance of Clinical Factors. Brit. J. Psychiat. 111: 675-681, Aug. 1965

Fernando, S. J. M. Depressive Illness in Jews and Non-Jews. Brit. J. Psychiat. 112: 991-996, Oct. 1966

Lascelles, R. G. Atypical Facial Pain and Depression. Brit. J. Psychiat. 112: 651-659, July 1966

Halliday, A. M., et al, A Comparison of the Effects on Depression & Memory of Bilat. E. C. T. & Unilat. E. C. T. to the Dominant & Non-Dominant Hemispheres. Brit. J. Psychiat. 114: 997-1012, Aug. 1968

Schwab, J. J. et al, Hamilton Rating Scale for Depression and Medical In-Patients. Brit. J. Psychiat. 113: 83-88. Jan. 1967

Sandifer, M. G. et al, The Influence of Case Selection & Dosage in an Anti-Depression Drug Trial. Brit. J. Psychiat. 111: 142-148, Feb. 1965

Mendels, J., Comparative Trial of Nortriptyline and Amitriptyline in 100 Depressed Patients. Am. J. Psychiat. 124, No. 8, Suppl. 59 - 1968

Paykel, E. S. et al. A Comparative Trial of Imipramine and Chlorpromazine in Depressed Patients. Brit. J. Psychiat. 114: 1287, Oct. 1968

Stewart, J. A. and Mitchell, P. H. A Comparative Trial of Desipramine and Nortriptyline in Depression. Brit. J. Psychiat. 114: 469-471, Apr. 1968

Leahy, M. R. and Martin, I. C. A. Double-Blind Comparison of Nortriptyline and Amitriptyline in Depressive Illness. Brit. J. Psychiat. 113: 1433-1434, Dec. 1967

Rose, J. T. et al. A Comparison of Nortriptyline and Amitriptyline in Depression. Brit. J. Psychiat. 111: 1101-1103, Nov. 1965

Waldron, J., and Bates, T. J. N. The Management of Depression in Hospital. A Comparative Trial of Desipramine and Imipramine. Brit. J. Psychiat. 111: 511-516, June 1965

Richmond, P. W. and Roberts, A. H. A Comparative Trial of Imipramine, Amitriptyline, Isocarboxazid, & Tranylcypromine in O-P Depressive Illness. Brit. J. Psychiat. 110: 846-850, Nov. 1964

Valentine, M., et al. A Comparison of Techniques in Electro-Convulsive Therapy, Brit. J. Psychiat. 114: 989-996, Aug. 1968

Lewis, A., and Hoghughi, M. An Evaluation of Depression as a Side Effect of Oral Contraceptives, Brit. J. Psychiat. 115: 697-701, June 1969

Munro, A. Parental Deprivation in Depressive Patients, Brit. J. Psychiat. 112: 443-457, May 1966

Hamilton, M., A Rating Scale for Depression, J. Neurol. Neurosurg. Psychiat., 23, 56-62, 1960

Hamilton, M., Comparison of Factors by Ahmavaara's Method, Brit. J. Math. Stat. Psychol., 20, 1, 107. May 1967

Hamilton, M. Standardized Assessment and Recording of Depressive Symptoms. Psychiat. Neurol. Neurochir., 72, 201-205, 1969