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HAMILTON PSYCHIATRIC RATING SCALE FOR DEPRESSION

The following questions refer to thoughts and behaviors exhibited during the week leading up to and including the date of the interview. For each item, select and circle one statement that best describes the patient.

1. DEPRESSED MOOD

Have you felt" Sad, hopeless, helpless, or 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 VITUALLY ONLY these feeling states in his spontaneous verbal and non-verbal communication

2. FEELINGS OF GUILT

Have you experienced feelings of guilt?

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

3. SUICIDE

Have you thought about or have you attempted the act of suicide?

0. Absent
1. Feels life is not worth living
2. Wishes he were dead or <u>any thoughts</u> of possible death to wish
3. Suicide ideas or gesture
4. Attempts at suicide (any serious attempt rates a 4)

4. INSOMNIA (Early)

Have you experienced difficulty falling asleep in the early part of the sleeping process?

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

5. INSOMNIA (Middle)

Have you experienced difficulty sleeping in the middle part of the sleeping process?

0. No difficulty falling asleep
1. Complains of being restless and disturbed during the night
2. Waking during the night- any getting out of bed rates 2 (except for purposes of voiding)

6. INSOMNIA (Late)

Have you experienced difficulty sleeping in the late part of the sleeping process?

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

7. WORK ACIVITIES

Have you experienced difficulties at work, hobbies or 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 indicated in listlessness, indecision and vacillation (feels he has to push self to work or to participate in activities).

8. RETARDATION

Have you experienced "slowness of thought and speech; impaired ability to concentrate; decreased motor activity"?

0. Normal speech and thought
1. Slight retardation at interview
2. Obvious retardation at interview
3. Interview difficult
4. Complete stupor

9. AGITATION

Have you experienced agitation or do you perform the following?

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 lips

10. ANXIETY (Psychic)

Have you experienced the feelings of anxiety?

0. No difficulty
1. Subjective tension and irritability
2. Worry about mild matters
3. Apprehensive attitude apparent in the face or speech
4. Fears expressed without questioning

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11. ANXIETY (Somatic)
Have you experienced physiological concomitants of anxiety, such as:
a) Gastrointestinal symptoms- dry mouth, wind, indigestion, diarrhea, cramps, belching
b) Respiratory symptoms- hyperventilation, sighing
c) Urinary symptoms- frequency of urination
d) Sweating

0. Absent
1. Mild
2. Moderate
3. Severe
4. Incapacitating

12. SOMATIC SYMPTOMS (gastrointestinal)
Have you experienced a loss of appetite or difficulty eating?

0. None
1. Loss of Appetite but eating without encouragement. Heavy feeling in abdomen.
2. Difficulty eating without urging. Requests or requires laxatives or medication for bowels or medication for G.I. symptoms.

13.SOMATIC SYMPTOMS (General)
Have you experienced the following?

0. None.
1. Heaviness in limbs, back or head, backaches, headaches, muscle aches, loss of energy, and tangibility.
2. Any clear cut symptoms rates 2.

14. GENTIAL SYMPTOMS
Have you experienced
Male—loss of libido?
Female—loss of libido and/ or menstrual disturbances?

0. Absent
1. Mild
2. Severe

15. HYPOCHODRIASIS
How much do you think about your body and health?

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

16. LOSS OF WEIGHT
Have you experienced a loss of weight?

0. No weight loss
1. Probably weight loss associated with present illness
2. Definite (according to patient) weight loss

17. INSIGHT
(requires judgment of rater)

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

18. DIURNAL VARIATION
(Rate both A and B but add only 18.B into total score)
A. Note whether symptoms are worse in morning or evening. If NO diurnal variation, mark none.
Have your symptoms been worse during A.M. or P.M.?

0. No variation
1. Worse in A.M.
2. Worse in P.M.

B. How severe were the symptoms during that time?
When present, mark the severity of the variation, Mark "none" if no variation.

0. None
1. Mild
2. Severe

19. DEPERSONALIZATION AND DEREALIZATION
(Such as feelings of unreality)
Have you experienced feelings of depersonalization or unreality?

0. Absent
1. Mild
2. Moderate
3. Sever
4. Incapacitating

20. PARANOID SYMPTOMS
(Requires judgment of rater)

0. None
1. Suspicious
2. Ideas of reference
3. Delusions of reference and persecution

21. OBSESSIONAL AND COMPULSIVE SYMPTOMS
(Requires judgment of rater)

0. Absent
1. Mild
2. Severe

TOTAL SCORE: ITEMS 1 THROUGH 21=