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INSTRUMENT FOR THE ASSESSMENT OF PRODROMAL SYMPTOMS AND STATES

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ABSTRACT

Certain constellations of prodromal symptoms have recently been shown to predict the onset of psychosis with a high degree of accuracy, thus making treatment intervention in the prodromal phase more feasible scientifically and ethically. Here we present a structured interview, the Structured Interview for Prodromal Symptoms (SIPS) and a severity scale, the Scale of Prodromal Symptoms (SOPS), to identify operationally the presence of these prodromal constellations and to measure their severity over time, including their conversion to actively psychotic states.

T. Miller et al. (eds.), Early Intervention in Psychotic Disorders, 135–149.

Introduction

Recent research in Schizophrenia suggests that early intervention in the prodromal phase of illness may prevent onset or improve the prognosis of any psychosis that develops (reviewed in McGlashan and Johannessen, 1996). The prodromal phase consists of nonspecific attenuated symptoms of psychosis, signs of general distress and varying degrees of functional disability. The nonspecificity of the prodrome has limited early intervention because it renders difficult distinguishing patients who are truly at risk for psychosis (true positives) from those who are not (false positives).

Recently, however, Yung et al (1996) have defined three prodromal states that appear to have predictive validity. The first group presents with very brief psychotic states that fail to meet psychosis duration criteria by most current systems; the second group presents with recently developed attenuated positive psychotic symptoms; the third group presents with genetic risk for psychosis and a recent deterioration of functioning. Following young people with prodromal symptoms so defined, Yung etal (1998) found that 40% became psychotic within one year of baseline evaluation. They replicated this finding in a second and more recent sample (McGorry, Personal Communication, February, 1998). This work renders early identification and treatment more feasible and ethically compelling. Indeed, following upon these findings, experimental trials of prodromal treatment in schizophrenia have been launched recently in Melbourne, Australia, and in New Haven, CT.

These findings have also led to a critical need for operational instrumentation to characterize, quantify, and track prodromal symptoms and states for clinical and research purposes. This report describes such a scale, the Scale of Prodromal Symptoms (SOPS), and a structured interview, The Structured Interview for Prodromal Symptoms (SIPS), their development, content, and initial use with illustrative cases of the prodrome.

Scale Development

Available descriptions of prodromal states were reviewed, including Chapman, et al (1994), Hafner, et al (1993) the German Basic Symptoms School (Klosterkotter, et al, 1997), recent phenomenological descriptions (Moller, in press; Yung and McGorry, 1996; Yung, et al, 1996), and a scale developed in Melbourne to identify prodromal states, the Comprehensive Assessment of At Risk Mental States (Yung, Personal Communication, 1996).

The SOPS and SIPS were developed to accomplish three tasks: 1) to define the presence/absence of psychosis, 2) to define the presence/absence of one or more of the three prodromal states as defined by Yung, et al, 1996), and 3) to measure the severity

of prodromal symptoms cross sectionally and longitudinally. Used together, they are designed to be both a diagnostic instrument and a scale for the quantitative assessment of psychopathology.

Schizophrenic psychosis is defined in DSM IV by the presence of at least one positive "A" symptom of hallucinations, delusions, thought disorder, or bizarre behavior. Consistent with DSM-IV the SOPS and SIPS define psychosis and two out of the three prodromal states with five positive symptoms. At the psychotic level of intensity, the five positive symptoms are delusions, paranoia, grandiosity, hallucinations, and disorganized speech. The corresponding five attenuated or prodromal positive symptoms are unusual thought content, suspiciousness, expansiveness, perceptual abnormalities, and discursive speech that is difficult to follow but not unintelligible.

PSYCHOSIS THRESHOLD

The SOPS, like DSM-IV, defines psychosis as the presence of at least one positive symptom at psychotic intensity for a "sufficient" length of time. The meaning of "sufficient", however, is not clear in DSM IV. For DSM-IV Schizophrenia sufficient is "a significant portion of time during a one month period", but what constitutes a significant portion of time is not further specified. For DSM IV Schizophreniform disorder, sufficient is an episode of disorder, including prodromal, active, and residual phases, that lasts at least one month but less than 6 months. Again, the period of time for active phase symptoms is not specified. For DSM IV Brief Psychosis sufficient length is "at least one day but less than 1 month with full return to premorbid level". Time period is better specified, but it is qualified by a retrospective judgment about remission. For DSM IV Psychosis NOS sufficient length of active psychotic symptoms is not specified. In short, DSM IV does not provide a clear or uniform threshold for the presence, and onset, of psychosis. Accordingly, for the SOPS we defined psychosis threshold as the presence of at least one of the five positive symptoms at psychotic level of intensity at sufficient frequency, duration, or urgency. Frequency/duration is operationalized as at least one hour a day at an average frequency of 4 days per week over one month, i.e., definite presence for more than half the days over one month. Urgency is any positive psychotic symptom that is "seriously disorganizing or dangerous", no matter what the duration.

PRODROMAL GROUP DEFINITIONS

According to Yung, etal (1996) positive symptoms define two out of the three prodromal states or groups. The first group is defined as patients with positive psychotic symptoms that are brief and do not meet the frequency, duration, or urgency criteria specified above for the presence of psychosis. Such patients may meet criteria for DSM IV Brief Psychosis or Psychosis NOS, but they do not meet criteria for DSM IV Schizophreniform Disorder. The second group is defined by the onset within the past year of non psychotic, attenuated positive symptoms that occur at least once a week in the past month. The third group is not characterized by positive symptoms but by genetic risk and recent deterioration of functioning. Genetic risk for psychosis

means these patients either meet DSM IV criteria for Schizotypal Personality Disorder or have a first degree relative with a diagnosed psychotic disorder, be it in the schizophrenic, bipolar, or psychotic affective spectrum. They must also experience a significant loss of functioning in the past year, i.e., 30 or more GAF (APA, 1987) points for at least one month. The first group are called Brief Intermittent Psychosis Prodromal States. The second group are called Attenuated Positive Symptom Prodromal States and the third group are called Genetic Risk and Deterioration Prodromal States.

Other Prodromal Dimensions

The Scale of Prodromal Symptoms (SOPS) was also designed to be a dimensional instrument capable of quantifying severity. This includes more than the positive symptoms used to define states. It includes Negative, Disorganized, and General Psychopathology symptom domains. Six symptoms make up the Negative domain: 1) Social Isolation or Withdrawal, 2) Avolition, 3) Decreased Expression of Emotions and Self, 5) Decreased Ideational Richness, and 6) Deterioration in Role Functioning. Four symptoms make up the Disorganized domain: 1) Odd Behavior or Appearance; 2) Bizarre Thinking, 3) Trouble with Focus and Attention, and 4) Impairment in Personal Hygiene/Social Attentiveness. The General cluster or domain includes 4 symptoms: 1) Sleep Disturbance, 2) Dysphoric Mood, 3) Motor Disturbances, and 4) Impaired Tolerance to Normal Stress.

SOPS

The complete SOPS can be found in the Appendix. It consists of 19 items: 5 Positive symptoms, 6 Negative symptoms, 4 Disorganization Symptoms, and 4 General Symptoms. For the Negative Disorganized, and General domains, each item is rated on a 6 point scale ranging from 0, meaning absent, to 6, meaning daily and continuous or extremely severe. The Positive domain items are also rated on a six point scale but with the difference that level 6 stands for psychotic level of severity. Defining it this way allows the SOPS to be used as a diagnostic as well as an ordinal instrument.

Other dimensional scales of psychotic psychopathology such as the BPRS (Overall and Gorham, 1962) or the PANSS(Kay, etal, 1987), measure the full range of severity of established, frankly psychotic symptoms. Not so the SOPS which measures positive psychotic symptoms only to the threshold of psychotic intensity. Research protocols that must capture the full range of prodromal and psychotic intensities need to use the SOPS and a measure of psychosis such as the PANSS or BPRS.

THE SIPS

The definition of prodromal states involves positive symptoms but also includes Family History, a rating of Schizotypal Personality Disorder, and the GAF measure of functional capacity. These and the SOPS are incorporated in a structured interview called the Structured Interview for Prodromal Symptoms (SIPS). The interview includes 29 questions to probe for each positive symptom item in the SOPS. During

the interview patients are also rated on the other SOPS domains, on GAF, Family History, and Schizotypal PD. The SIPS is used to determine the presence or absence of a psychotic state, of a prodromal state, and of which prodromal states. The SOPS is used to determine the severity of the prodromal state once it has been diagnosed.

Case Illustrations

The following patients represent (disguised) case examples of each prodromal state. They were recruited to participate in an ongoing clinical trial of early intervention in the prodrome. They were evaluated with the SIPS at baseline, found to meet prodromal criteria, consented to the study, and were followed on a weekly to monthly basis with SOPS ratings.

CASE 1: BRIEF INTERMITTENT PSYCHOSIS PRODROMAL STATE

Adam was a 17 year old junior in high school who lived with his parents and younger brother. Parents were first generation immigrants who met and married in the U.S. There was no family history of mental illness. Adam's problems began in 9th grade with other students calling him "queer". He became depressed, withdrawn and had difficulties concentrating and sleeping for two months. The same problems resurfaced in his junior year. Adam complained he was being teased about his sexuality. He also claimed his wrestling coach tried to convince him he was homosexual. Again he became depressed and had problems concentrating and sleeping. His grades suffered and he refused to go to school to avoid teasing. This prompted his referral to the study.

In his initial evaluation Adam was guarded and affectively constricted. He said there were people who held grudges against him and wanted to beat him up. He also said he could be very critical of others and had a knack of getting people angry with him. The week prior to his evaluation he avoided two classmates because he heard them calling him queer and felt he was in danger of being attacked. When questioned in detail, he acknowledged they probably did not call him queer but he had been sure of it at that moment. Adam had similar experiences four to five other times over the past 3 months, never lasting more than a few minutes and never leading to confrontation. Adam had mild conceptual disorganization as occasional circumstantial thinking but no other unusual thought content or grandiosity. He described limited perceptual changes, e.g., hearing his cat meowing outside. It was convincing enough that he went looking but the cat was not around. He reported this happening a "few times" in the past 3 - 4 months. Functionally his grades had slipped from B's to D's and he was in danger of repeating his junior year.

Adam was judged to meet the Brief Intermittent Psychotic Prodromal State criteria. On the SOPS he scored 6 or psychotic on suspiciousness/ paranoia He had moments of paranoia that were of delusional intensity but not acutely disorganizing or dangerous and too short lived to meet duration criteria for the presence of psychosis. He also

remained the same, and her psychotic symptom was not considered disorganizing or dangerous. Beatrice was judged to have converted to psychosis when this symptom remained prominent over the next two weekly assessments. Double-blind mediation was stopped, and she continued to be followed on open label antipsychotic medication.

CASE 3: GENETIC RISK AND DETERIORATION PRODROMAL STATE

Charlie was a 16 year old white, male, junior in high school, the youngest of three children, having two older sisters, one of whom had been under treatment for schizophrenia for 3 years. Charlie felt depressed about 6 months prior to referral and was treated with antidepressant medication with moderate success. Nevertheless, he continued to feel tired, to sleep a great deal, to have trouble concentrating, and to have fleeting thoughts about hurting himself. He developed the feeling that his friends were only making believe they were his friends and that they really wanted him to be dead. Once in the month prior to evaluation when riding in the car with his mother he became acutely worried that they were being followed by the car behind them. One month prior to referral Charlie thought he heard the TV playing when it was off. Most striking and problematic were several negative symptoms. Charlie felt unmotivated to do anything and spent hours on his computer. This indifference included school work and he was failing four out of 5 classes and attending school only about 60% of the time. He felt uncomfortable around friends and preferred to be alone. He complained of not having feelings when it was normal to have them. Charlie was brought for evaluation by his mother who was concerned he was showing symptoms she had seen in her daughter prior to her psychotic break.

Charlie participated passively in the evaluation. He acknowledged depression and negative symptoms. His mother indicated that he seemed to have "two minds about these". On the one hand he was concerned and kept promising to start to do x or y "tomorrow". On the other hand he never did. Charlie discounted his concerns about being followed or the genuineness of his friends as products of his imagination. He indicated that he was always doubtful of their reality even when he was experiencing them, which was rarely. He treated the reality of his recent auditory or visual experiences with the same skepticism.

Charlie was judged to meet the Genetic Risk and Deterioration Prodromal State criteria. His attenuated positive symptoms of unusual thought content (friends not really friends), paranoia (cars following) and perceptual abnormalities (TV playing) were too infrequent, fleeting and minimally "real" to be rated as more than 3 or moderate on the SOPS positive symptoms scales. Most striking were the number and strength of Charlie's negative symptoms (such as an avolition score of 5 or severe) and his concomitant deterioration in functioning both academically and socially. He was judged to have suffered a drop in his GAF of 40 points in the past year. This plus the positive history of schizophrenia in a first degree relative made the prodromal diagnosis of Genetic Risk and Deterioration.

Comment

These cases illustrate the use of the SOPS and its accompanying structured interview for the identification of symptom states that appear to be prodromal to psychosis. The interview includes probes for the 19 SOPS symptoms and additional questions that measure other defining features of the prodrome such as family history, functional capacity, and the presence or absence of schizotypy. Once characterized, the severity of the prodromal state(s) can be followed longitudinally with the SOPS, as illustrated by the second case where one of the patient's attenuated positive symptoms became severe enough for long enough that she was judged to have converted from prodrome to psychosis.

The prodromal states defined by Yung, etal (1990) are heterogeneous and can be achieved via different paths. The SOPS and SIPS provide for this categorical heterogeneity and at the same time offer a prodromal symptom severity scale that can track these states longitudinally for studies of natural history, prevention or treatment.

The SIPS and SOPS have been in use for a little more than a year. They have been translated into Norwegian (Larsen, Personal Communication, 1998) and Finnish (Salokangas and Heinimaa, Personal Communication, 1998) for use in prodromal studies in those countries. The SIPS takes approximately one hour to administer. Baseline SOPS scores are generated using the SIPS, repeat SOPS measures require 15 - 30 minutes to collect. The instruments have been modified twice based on experience with prodromal populations. Modifications largely involved refining scale anchor points in order to achieve current consensus and future reliability. Efforts are underway to establish inter-rater reliability.

In summary the SOPS and SIPS aim to diagnose psychosis and prodromal states, to chart the course of prodromal patients at any stage, and to offer a standardized measure of the prodrome for patients participating in clinical trials. Thus far they appear to serve these goals and to possess face validity. Further work will assess whether the SOPS can be used reliably, whether it will be a sensitive measure of change, and whether it will prove to be a valid predictor of conversion to psychosis.

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Appendix

SCALE OF PRODROMAL SYMPTOMS (SOPS)

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Patients Name: _____
Date: _____
Date of first treatment contact: _____/_____/_____
DD MM YY

Check ***all*** sources of information used in completing this form.

1._____Patient
2._____Family Member/Friend
3._____Medical Records
4._____Health Care Provider
5._____Other (specify)_____

Scaling Instructions

The SOPS rates four domains of symptoms

A. Positive Symptoms
B. Negative Symptoms
C. Disorganization Symptoms
D. General Symptoms

Because psychosis is defined exclusively by positive symptoms, the scale for domain A, Positive Symptoms, is constructed differently from the scale for domains B,C, and D. The scale for domain A is based on symptom intensity and it includes a rating for psychotic level of intensity, as follows:

Positive Symptom Scale

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe but Not Psychotic	6 Severe and Psychotic

The scales for domains B, C, and D are also based on symptom intensity but do not include a rating for psychotic level of intensity, as follows:

Negative, Disorganized, General Symptom Scale

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe	6 Extreme

A. POSITIVE SYMPTOMS

1. **Unusual Thought Content/Delusional Ideas**

One or more of the following:

a. Perplexity and Delusional mood. Something odd going on. Puzzlement. Confusion about what is real or imaginary. The familiar feels strange, confusing, ominous, threatening, or has special meaning. Sense that self, others, the world has changed. Changes in perception of time. Deja vu.

b. Non persecutory ideas of reference (including unstable delusions of reference).

c. Disturbance of receptive, expressive language. Thought pressure, preservation, insertion, interference, withdrawal, broadcasting, telepathy.

d. Over valued beliefs. Preoccupation with unusually valued ideas (religion, meditation, philosophy, existential themes). Magical thinking that influences behavior and is inconsistent with subculture norms (e.g., superstitiousness, belief in clairvoyance, "sixth sense", uncommon religious beliefs).

e. Delusional ideas about the body, guilt, nihilism, jealousy, religion, external control, radio and TV messages. Delusions may be present but are not well organized and not tenaciously held.

Severity Scale (circle one)

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe but not Psychotic	6 Severe and Psychotic
	Unexpected thought, feeling, movement, experience. Surprising but easily dismissed.	Mind "tricks" that are puzzling. Sense that something is different.	Unanticipated mental events/beliefs that cannot be dismissed and are also irritating and/or worrisome. A sense that unexpected experiences are somehow meaningful because they won't go away	Notion that experiences are coming from outside the self or that ideas / beliefs are real, but skepticism remains intact.	Belief of external control more compelling but doubt can be induced by contrary evidence and others' opinions. May affect functioning	Delusional conviction (with no doubt) at least intermittently. Usually interferes with thinking, social relations, or behavior.

2. **Suspiciousness/Persecutory Ideas**

One or more of the following:

a. Excessive concern about the motivations of others; distrustful;
b. Suspiciousness or paranoid thinking;
c. Presents a guarded or even openly distrustful attitude that may reflect delusional conviction and intrude on the interview and/or behavior.

Severity Scale (circle one)

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe but not Psychotic	6 Severe and Psychotic
	Wariness	Doubts about safety, Hyper-vigilance without clear source of	Notions that people are hostile, untrustworthy, and/or harbor ill will easily. Perplexed and	Loosely organized beliefs of being watched, singled out. Beliefs easily	Loosely organized beliefs about danger or hostile attention. At times openly distrustful	Delusional paranoid conviction (with no doubt) at least intermittently. Likely
		danger	mistrustful	dismissed. Irritable and suspicious.	but behavior and interactions minimally affected. Skepticism and perspective can be elicited with non confirming evidence or opinion.	to affect functioning.

3. **Grandiosity**

One or more of the following:

a. Exaggerated self-opinion and unrealistic sense of superiority.
b. Some expansiveness or boastfulness.
c. Occasional clear-cut grandiose delusions that can influence behavior

Severity Scale (circle one)

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe but not Psychotic	6 Severe and Psychotic
	Private thoughts of superiority	Ideas of being highly talented, under - standing, etc. Keeps ideas private.	Notions of being unusually special, powerful. Occasionally expansive.	Loosely organized belief of power, wealth. Easily distracted from beliefs.	Preoccupation with having unnatural intellect, attractiveness, power, fame. Skepticism about belief can be elicited. Usually not acted upon.	Delusional grandiose conviction (with no doubt) at least intermittently. Usually influences behavior to some extent.

4. **Perceptual Abnormalities/Hallucinations**

One or more of the following in one or more perceptual domains (auditory, visual, somatic, tactile, olfactory, gustatory)

a. Unusual perceptual experiences. Heightened or dulled perceptions, vivid sensory images, distortions, illusions.
b. Pseudo-hallucinations or hallucinations into which the subject has insight (i.e., is aware of their abnormal nature at the time);
c. Occasional frank hallucinations which may minimally influence thinking or behavior.

Severity Scale (circle one)

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe but not Psychotic	6 Severe and Psychotic
	Change in perceptual sensitivity, heightened, dulled.	Unexpected, unformed perceptual changes, noises, lights, etc. Worrisome	Unanticipated, formed, perceptual changes, e.g., designs, geometrical figures, identifiable noises. Puzzling, irritating.	Perceptual distortions, illusions, pseudo-hallucinations (faces, bodies, voices) that are recognized as not real yet can be frightening or captivating.	Clearly formed but brief hallucinations, or else a number of vague abnormal perceptions. Usually do not result in distortions of thinking or behavior.	Hallucinations occur intermittently. Visions, voices, other sensory events are experienced as real and influence thinking, feeling, and behavior quite clearly.

5. **Conceptual Disorganization**

One or more of the following difficulties in thought process.

a. Odd thinking and speaking process. Vague, metaphorical, overelaborate, stereotyped;
b. Confused or muddled thinking, racing thoughts or slowed down thoughts, using the wrong words for things sometimes, talking about things irrelevant to context or going off the track;
c. Thinking is circumstantial, tangential, or paralogical. There is some difficulty in directing thoughts toward a goal.
d. Loosening of associations may be present making speech unintelligible.

Severity Scale (circle one)

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe but not Psychotic	6 Severe and Psychotic
	Sudden word or phrase that doesn't make sense.	Vague, confused, muddled, inconsistent thoughts.	Wrong words, irrelevant topics. Frequently off track. Meta - phorical, stereotyped, over- elaborate.	Thinking is circum -stantial or paralogical. There is some difficulty in directing thoughts toward a goal. No loosening of associations. Sporadically impossible to follow and understand.	Thinking is circumstantial or paralogical or, tangential. There is some difficulty in directing thoughts toward a goal, and some loosening of associations may be evidenced under pressure. Occasionally impossible to follow and understand. Responds to structuring, especially with questions.	Communication loose or irrelevant and unintelligible when under minimal pressure or when the content of the communication is complex. Not responsive to structuring the conversation.

B. NEGATIVE SYMPTOMS

1. **Social Isolation or Withdrawal**

One or more of the following:

a. Lack of close friends or confidants other than first degree relatives;
b. Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self;
c. Ill at ease in the presence of others and prefers to spend time alone, although he/she participates in social functions when required. Does not initiate contact;
d. Passively goes along with most social activities but in a disinterested or mechanical way. Tends to recede into the background.

Negative Symptom Scale

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe	6 Extreme
	Slightly socially awkward or anxious but socially active.	Ill at ease with others. Disinterested or anxious in most social situations but socially present.	Participates socially only reluctantly due to anxiety or disinterest.	Few friends outside of extended family. Is mistrustful of others or socially apathetic.	Prefers to be alone. Spends most time alone or with first degree relatives.	No close friends. Spends most time alone, including first degree relatives.

2. **Avolition**

One or more of the following:

a. Impairment in the initiation, persistence, and control of goal-directed activities;
b. Loss of drive, energy, productivity
c. Feeling uninterested, things are an effort and/or take longer to do.

0 Never, Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe	6 Extreme
	Less interested in every day activities or long term goals, but normally productive.	Waning interest in pleasurable activities. Tasks require more effort and take longer though productivity maintained.	Diminished interest and productivity. Impairment in task initiation and/or persistence. Initiation requires prodding.	Avoiding many everyday tasks and/or long-standing activities. Prodding needed regularly.	Relinquishing most goal-directed activities. Significant reduction in achievement. Prodding needed all the time.	Abandoning virtually all goal-directed activities. Prodding unsuccessful.

3. **Decreased Expression of Emotion**

One or more of the following:

a. Flat, constricted, diminished emotional responsiveness, as characterized by a decrease in facial expression, modulation of feelings (monotone speech) and communication gestures (dull appearance);
b. Lack of spontaneity and flow of conversation. Reduction in the normal flow of communication. Conversation shows little initiative. Patient's answers tend to be brief and unembellished, requiring direct and sustained questions by interviewer.
c. Poor rapport. Lack of interpersonal empathy, openness in conversation, sense of closeness, interest, or involvement with the interviewer. This is evidenced by interpersonal distancing and reduced verbal and non-verbal communication.

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe	6 Extreme
	Emotional responsiveness slightly delayed or blunted.	Speech lacking character. Emotional expression minimal.	Commun-ications brief, un-engaging. Conversation lacks liveliness, feels stilted.	Difficulty in maintaining spontaneity and flow of conversation. Minimal interpersonal empathy. Speech mostly monotone, May avoid eye contact.	Starting and maintaining conversation requires direct and sustained questioning by the interviewer. Affect constricted. Lack of gestures.	Flat affect, monotone speech. Unable to become involved with interviewer or maintain conversation despite active questioning by the interviewer.

4. **Decreased Experience of Emotions and Self**

One or more of the following:

a. Emotional experiences and feelings less recognizable, genuine, appropriate.
b. Sense of distance when talking to others, no longer feeling rapport with others.
c. Emotions disappearing, difficulty feeling happy or sad.
d. Sense of having no feelings: Anhedonia, apathy, loss of interest, boredom.
e. Feeling profoundly changed, unreal, or strange.
f. Feeling depersonalized, at a distance from self.
g. Loss of sense of self.

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe	6 Extreme
	Feeling distant from others. Everyday feelings muted. Lack of strong emotions.	Difficulty recognizing differentiated feelings, aware of shifts between numbness and displeasure.	Emotions feel like they are disappearing. Perplexing sense of something wrong "inside"	Emotionally blank, even when feelings are appropriate. Sense of deadness.	Feeling a loss of sense of self. Feeling depersonalized, unreal or strange. May feel disconnected from body, from world, from time.	Feeling profoundly changed and possibly alien to self. No feelings most of the time.

5. **Decreased Ideational Richness**

One or more of the following:

a. Difficulty in abstract thinking. Impairment in the use of the abstract-symbolic mode of thinking, as evidenced by difficulty in classification, forming generalizations, and proceeding beyond concrete or egocentric thinking in problem-solving tasks; often utilizes a concrete mode.
b. Simple words and sentence structure; paucity of dependent clauses;
c. Stereotyped thinking. Decreased fluidity, spontaneity, and flexibility of thinking, as evidenced in rigid, repetitious, or barren thought content. Some rigidity in attitudes or beliefs. May refuse to consider alternative positions or have difficulty in shifting from one idea to another.
d. As a listener unable to make sense of familiar phrases or to grasp the "gist" of a conversation or to follow everyday discourse.

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe	6 Extreme
	Some rigidity in thought, attitudes, and beliefs. Difficulty switching topics or ideas.	Difficulty with abstract conceptualizations or under-standing the "gist" of conversations.	Conversation remains on simple plane, abstract comments missed or mis-interpreted.	Thought content is barren or monotonous. Thinking is stereotyped, repetitive, concrete.	Difficulty following and/or understanding everyday discourse. Uses simple words and sentence structure without modifiers.	Simple yes, no answers without elaboration, sometimes without understanding.

6. **Deterioration in Role Functioning**

One or more of the following:

a. Difficulty performing role functions (e.g., wage earner, student, homemaker) that were previously performed without problems.
b. Having difficulty in productive, instrumental relationships with colleagues at work or school.

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe	6 Extreme
	More effort and focus required to maintain same level of performance at work, school, relationships.	Difficulty in functioning at work, school, relationships, that is evident to others.	Definite problems in accomplishing work tasks or a drop in Grade Point Average. Strained social interactions.	Failing one or more courses. Receiving notice or being on probation at work. Limited social interaction.	Failing out of school. Significant absence from work. Social withdrawal.	Failed or left school, left employment or was fired. Socially isolated, interacting with few or no friends.

C. **DISORGANIZATION SYMPTOMS**

1. **Odd Behavior or Appearance**

One or more of the following:

a. Behavior that is odd, eccentric, or peculiar (e.g., collecting garbage, talking to self in public, hoarding food), Preoccupied with apparent internal stimuli);
b. Inappropriate affect.
c. Mannerisms and posturing. Unnatural movements or posture characterized by an awkward, stilted, disorganized or bizarre appearance.

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe	6 Extreme
	Minor eccentricities that are not characteristic and seem out of place.	Occasional odd interests, appearance, or hobbies. Clumsy.	Persistent odd interests, appearance or hobbies. Stilted conversation.Physic ally awkward.	Clearly un-conventional. Distracted by apparent internal stimuli. Disengaging, off putting. Unusual movements.	Strange looking and acting. Disengaged by apparent internal stimuli. Inappropriate affect. May provide noncontextual responses. Stereotyped movements.	Grossly bizarre appearance, or behavior (e.g. talking to self in public, or collecting garbage). Disconnection of affect and speech. Disorganized movements, mannerisms, or posturing.

2. **Bizarre Thinking**

Thinking characterized by strange, fantastic or bizarre ideas that are distorted, illogical or patently absurd.

0	1	2	3	4	5	6
				trouble getting up for school or work). Is difficult to awaken for appointments.	reversal.	

2. **Dysphoric Mood**

One or more of the following for depression:

a. Diminished interest in pleasurable activities
b. Sleeping problems
c. Poor or increased appetite
d. Feelings of loss of energy
e. Difficulty concentrating
f. Suicidal thoughts
g. Feelings of worthlessness and/or guilt

And/or one or more of the following:

a. Anxiety, panic, multiple fears and phobias
b. Irritability, hostility, rage
c. Restlessness, agitation, tensi
d. Unstable mood

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe	6 Extreme
	Feeling "down" or "edgy" more often.	Feeling like the "blues" or other discontents have "settled in".	Occasional "bad" feelings that may be a mixture of depression, irritability, or anxiety.	Frequent unstable and unpredictable periods of "bad or dark feelings".	Persistent unpleasant mixtures of depression, irritability or anxiety that trigger avoidance behaviors such as substance use or sleep.	Painfully unpleasant mixtures of depression, irritability, or anxiety that trigger highly destructive behaviors like suicide or self mutilation.

3. **Motor Disturbances**
One or more of the following:
   a. Reported or observed clumsiness, lack of coordination, difficulty performing activities that were performed without problems in the past.
   b. The development of a new movements such as a nervous habit, stereotypes, characteristic ways of doing something, postures, or copying other peoples' movements.
   c. Motor blockages
   d. Loss of automatic skills
   e. Compulsive motor rituals

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe	6 Extreme
	Awkward.	Reported or observed clumsiness.	Poor coordinationDifficulty performing fine motor movements.	Stereotyped, often inappropriate movements.	Nervous habits, tics, grimacing. Posturing.	Loss of automatic skills. Motor blockages. Echopraxia. Catatonia.

4. **Impaired Tolerance to Normal Stress**
One or more of the following:
   a. Avoids or exhausted by stressful situations that were previously dealt with easily.
   b. Marked symptoms of anxiety in response to everyday stressors.
   c. Increasingly affected by experiences that are easily handled in the past. More difficulty habituating.

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe	6 Extreme
	More tired at end of usual day.	Daily stress brings on symptoms of anxiety beyond what might be expected.	Thrown off by unexpected happenings in the usual day.	Increasingly "challenged" by expected daily experiences that were easily handled in the past.	Avoids or is overwhelmed by situations that previously were dealt with easily.	Disorganization, panic or withdrawal to everyday stress.

SOPS SUMMARY SHEET

Positive Symptom Scale

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe but Not Psychotic	6 Severe and Psychotic

Positive Symptoms

	Totals						
A1. Unusual Thought Content/Delusional Ideas		0	1	2	3	4	5	6
A2. Suspiciousness/Persecutory Ideas		0	1	2	3	4	5	6
A3. Grandiosity		0	1	2	3	4	5	6
A4. Perceptual Abnormalities/Hallucinations	0	1	2	3	4	5	6	
A5. Conceptual Disorganization		0	1	2	3	4	5	6

Negative, Disorganized, General Symptom Scale

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe	6 Extreme

Negative Symptoms

B1. Social Isolation and Withdrawal	0	1	2	3	4	5	6
B2. Avolition	0	1	2	3	4	5	6
B3. Decreased Expression of Emotion	0	1	2	3	4	5	6
B4. Decreased Experience of Emotions and Self	0	1	2	3	4	5	6
B5. Decreased Ideational Richness	0	1	2	3	4	5	6
B6. Deterioration in Role Functioning	0	1	2	3	4	5	6

Disorganization Symptoms

C1. Odd Behavior or Appearance	0	1	2	3	4	5	6
C2. Bizarre Thinking	0	1	2	3	4	5	6
C3. Trouble with Focus and Attention	0	1	2	3	4	5	6
C4. Personal Hygiene/Social Attentiveness	0	1	2	3	4	5	6

General Symptoms

D1. Sleep Disturbance	0	1	2	3	4	5	6
D2. Dysphoric Mood	0	1	2	3	4	5	6
D3. Motor Disturbances	0	1	2	3	4	5	6
D4. Impaired Tolerance to Normal Stress	0	1	2	3	4	5	6

Absent	Questionably Present	Mild	Moderate	Moderately Severe	Severe	Extreme
	Infrequent, "quirky" ideas that are easily abandoned.	Occasional unusual ideas, illogical or distorted thinking.	Persistent unusual ideas, illogical or distorted thoughts that are held as a belief or philosophical system within the realm of subcultural variation.	Persistent unusual or illogical thinking that is embraced but which violates the boundary of most conventional religious or philosophical thoughts.	Illogical construction of strange and unrealistic ideas that are difficult to follow.	Preoccupied with thoughts that are fantastic patently absurd, fragmented and impossible to follow.

3. **Trouble with Focus and Attention**
   - a Failure in focused alertness, manifested by poor concentration, distractibility from internal and external stimuli.
   - b. Difficulty in harnessing, sustaining, or shifting focus to new stimuli.
   - c. Tendency to be easily distracted.
   - d. Trouble holding conversation in memory.

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe	6 Extreme
	Occasional lapses of focus under pressure.	Loss of focus and concentration more easily than usual.	Persistent problems maintaining focus and attention over time.	Easily distracted and occasionally loses track of conversations.	Unable to maintain attention and needs refocusing.	Unable to maintain attention even with external refocusing.

4. **Impairment in Personal Hygiene/Social Attentiveness**
   One or more of the following:
   - a. Impairment in personal hygiene and grooming. Self neglect.
   - b. Social inattentiveness. Looks away, appears uninvolved or disengaged. "Spacey". "Out of it". Abruptly terminates a conversation for no apparent reason.

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe	6 Extreme
	Less attention to personal hygiene but still concerned with appearances.	Less attention to personal hygiene and less concerned with appearance but still within bounds of convention and/or subculture.	Occasional indifference to conventional and/or subcultural conventions of dress and social "graces".	Persistent neglect of social or subcultural norms of hygiene. Slightly "spacey".	Drifts in and out of interactions. Is no longer bathing regularly. "Out of it".	Poorly groomed and appears not to care or even notice. No bathing and may have developed an odor. Inattentive to social cues and unresponsive even when confronted.

D. **GENERAL SYMPTOMS**

1. **Sleep Disturbance**
   One or more of the following:
   - a. Having difficulty falling asleep.
   - b. Waking earlier than desired and not able to fall back asleep.
   - c. Daytime fatigue and sleeping during the day.
   - d. Day night reversal

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe	6 Extreme
	Sleep more restless than usual.	Some mild difficulty falling asleep or getting back to sleep.	Daytime fatigue resulting from difficulty falling asleep at night or early awakening.	Sleep pattern has been significantly disrupted and has intruded on other aspects of functioning (e.g.	Significant difficulty falling asleep or awakening early on most nights. May have day/night	Unable to sleep at all for one or more entire nights.