Version 4.0

BRIEF PSYCHIATRIC RATING SCALE (BPRS)

Expanded Version

Scales, Anchor Points, and Administration Manual adapted by

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DESCRIPTION AND ADMINISTRATION OF THE BPRS

The Brief Psychiatric Rating Scale (BPRS) provides a highly efficient, rapid evaluation procedure for assessing symptom change in psychiatric patients. It yields a comprehensive description of major symptom characteristics. Factor analyses of the original 18-item BPRS typically yields four or five factor solutions. The Clinical Research Center's Diagnosis and Psychopathology Unit has developed a 24-item version of the BPRS.

This manual contains interview questions, symptom definitions, specific anchor points for rating symptoms, and a "how to" section for problems that arise in rating psychopathology. The purpose of the manual is to assist clinicians and researchers to sensitively elicit psychiatric symptoms and to reliably rate the severity of symptoms. The expanded BPRS includes six new scales added to the original BPRS (Overall & Gorham, 1962) for the purpose of a more comprehensive assessment of a wider range of individuals with serious mental disorders, especially outpatients living in the community (Lukoff, Nuechterlein, & Ventura, 1986).

This manual will enable the clinician or researcher to conduct a high quality interview adequate to the task of eliciting and rating the severity of symptoms in individuals who are often inarticulate or who deny their illness. The following guidelines are provided to standardize assessment. Please familiarize yourself with these methods for assessing psychopathology.

(1) Using all sources of information on symptoms.

(2) Selecting an appropriate period or interval for rating symptoms.

(3) Integrating frequency and severity in symptom rating: the hierarchical criterion.

(4) Rating the severity of past delusions for which the patient lacks insight.

(5) Rating symptoms when the patient denies them.

(6) Using a standardized reference group in making ratings.

(7) Rating symptoms that overlap two or more categories or scales on the BPRS.

(8) Rating a symptom that has no specified anchor point congruent with its severity level.

(9) "Blending" ratings made in different evaluation situations.

(10) Resolving apparently contradictory symptoms.

1. USING ALL SOURCES OF INFORMATION ON SYMPTOMS

The rating of psychopathology should be made on the basis of all available sources of information about the patient. These sources include behavioral observations and interviews made by treatment staff, family members, or other caregivers in contact with the patient, available medical and psychiatric case records, and the present interview of the patient. The interviewer/rater is encouraged to seek additional sources of information about the patient's psychopathology from others to supplement the present interview--this is particularly important when the patient denies symptoms.

2. SELECTING AN APPROPRIATE PERIOD OR INTERVAL FOR RATING SYMPTOMS

The duration of the time frame for assessment depends upon the purpose for the rating. For example, if the rater is interested in determining the degree of change in psychopathology during a one month period between pharmacotherapy visits, the rating period should be one month. If a research protocol aims to evaluate the emergence of prodromal symptoms or exacerbation of psychotic symptoms, it may be advisable to select a one week interval since longer periods may lose accuracy in retrospective recall. When a study demands completeness in identifying criteria for relapse or exacerbation during a one or two year period, frequent BPRS assessments will be necessary.

Rating periods typically range from one day to one month. Retrospective reporting by patients beyond one month may suffer from response bias, retrospective distortions, and memory problems (which are common in persons with psychotic and affective disorders). When resources and personnel do not permit frequent assessments, important information can still be captured if the frequency of assessments can be temporarily increased when (1) prodromal symptoms or stress are reported; (2) medication titration and dosing questions are paramount; and (3) before and after major changes in treatment programs.

3. INTEGRATING FREQUENCY AND SEVERITY IN SYMPTOM RATING: THE HIERARCHICAL CRITERION

Most of the BPRS scales are scored in terms of the frequency and/or severity of the symptom. It is sometimes the case that the frequency and severity do not match. A hierarchical principle should be followed that requires the rater to select the highest scale level that applies to either frequency or severity. Thus, when the anchor point definitions contain an "OR," the patient should be assigned the highest rating that applies. For example, if a patient has hallucinations persistently throughout the day (a rating of "7"), but the hallucinations only interfere with the patient's functioning to a limited extent (a rating of "5"), the rater should score this scale "7."

The BPRS is suited to making frequent assessments of psychopathology covering short periods of time. If, however, an interviewer intends to cover a relatively long period of time (e.g., 6 weeks), then combining ratings for severity and frequency of symptoms must be carefully thought out depending upon the specific project goals. If the goal of a project is to define periods of relapse or exacerbation, the rating should reflect the period of peak symptomatology. For example, if over a six week period the patient experienced a week of persistent hallucinations, but was free of hallucinations the remaining time, the patient should be rated a "6" on hallucinations, reflecting the "worst" period of symptomatology. Alternatively, if the goal is to obtain a general level

of symptomatology, the rating should reflect a "blended" or average score. For extended rating periods (e.g., 3 months), the interviewer may prefer to make one rating reflecting the worst period of severity/frequency/functioning and another rating reflecting the "average" amount of psychopathology for the entire period.

4. RATING THE SEVERITY OF PAST DELUSIONS FOR WHICH THE SUBJECT LACKS INSIGHT

Patients may often indicate varying degrees of insight or conviction regarding past symptoms, making their symptoms difficult to rate. Experiences that result from psychotic episodes can often appear quite real to patients. For example, the belief that others tried to poison them, or controlled all their thoughts and forced them to walk into traffic, could have created severe anxiety and intense fear. Patients can give vivid accounts of their psychotic experiences that are as real as if the situations actually occurred. It is important in these cases to rate the extent to which these memories of a delusional experience can be separated from current delusions involving the present.

Please note that a patient may be able to describe his or her past or current delusions as part of an illness or even refer to them as "delusions." However, a patient should always be rated as having delusions if he or she has *acted* on the delusional belief during the rating period.

When a patient describes a delusional belief once firmly held, but that is now seen as irrational, then a "1" should be scored for Unusual Thought Content (and also for Grandiosity, Somatic Concern, Guilt, or Suspiciousness if the idea fell into one of these thematic categories). However, if the individual still believes that the past psychotic experience or event was real, despite not currently harboring the concern, it should be rated a "2" or higher depending on the degree of reality distortion associated with the belief.

Consider the following scenarios:

Scenario No. 1: The patient gives an account of delusional and/or hallucinatory experience and realizes in retrospect that he was ill. He indicates that he has a chemical imbalance in his brain, or that he has a mental condition.

≅ Rate "1" on Unusual Thought Content.

Scenario No. 2: The patient gives indications that his past psychotic experiences were due to a chemical imbalance and/or an illness, but entertains some degree of doubt. He claims it is possible that people were trying to kill him, but he is doubtful. The memories of what happened are not bizarre and he indicates that currently he is certain no one is trying to hurt him.

≅ Rate "2" or "3" on Unusual Thought Content depending on degree of reality retained.

Scenario No. 3: The patient describes previous psychotic experiences as if they actually occurred. He can give examples of what occurred, e.g., co-workers put drugs in his coffee, or that machines read his thoughts. However, the patient says those circumstances no longer occur. The patient is not currently concerned about co-workers or machines, but he is convinced that the circumstances on which the delusions are based actually occurred in the past.

≅ Rate "3" or "4" on Unusual Thought Content depending on the degree of reality distortion, and a "1" on Suspiciousness.

<u>Scenario No. 4</u>: The patient holds bizarre beliefs regarding the circumstances that occurred in the past and/or his current behavior is influenced by delusional beliefs. For example, the patient believes that thoughts were at one time beamed into his mind from aliens OR the patient will not watch T.V. for fear that the messages will again be directed to him OR that the mafia is located in shopping malls that he should avoid.

≅ Rate "4" or higher on Unusual Thought Content depending on the degree of preoccupation and impairment associated with the belief. Consider rating suspiciousness.

<u>Scenario No. 5</u>: The patient believes that previous psychotic experiences were real and previous delusional beliefs are currently influencing most aspects of daily life causing preoccupation and impairment.

≅ Rate "6" or "7" on Unusual Thought Content depending on the degree of preoccupation and impairment associated with the belief.

5. RATING SYMPTOMS WHEN THE PATIENT DENIES THEM

An all too common phenomenon in clinical practice or research is the denial or minimization of symptoms by patients. Patients deny, hide, dissemble or minimize their symptoms for a variety of reasons, including fear of being committed, restricted to a hospital, or having medication increased. Simply recording a patient's negative response to BPRS symptom items, if denial or distortion is present, will result in invalid and unreliable data. When an interviewer suspects that a patient may be denying symptoms, it is absolutely essential that other sources of information be solicited and utilized in the ratings.

Several situations might suggest that a patient is not entirely forthcoming in reporting his/her symptom experiences. Patients may deny hearing voices, yet be observed whispering under their breath as if in response to a voice. The phrasing that a patient uses in response to a direct question about a delusion or hallucination can alert the interviewer to the potential denial of symptoms. For example, if a patient responds to an inquiry regarding the presence of persecutory ideas by saying, "Not really," this is not the same as saying "No." Subtleties in patient responses communicate a great deal and must be followed-up before the interviewer concludes that the symptom is absent.

There are several ways for the interviewer to obtain more reliable information from a patient who may be denying or minimizing symptoms. In all these approaches, interviewing skills, interpersonal rapport, and sensitivity to the patient are of paramount importance. If the patient is experiencing difficulty disclosing information about psychotic symptoms, the interviewer can shift to inquire about less threatening material such as anxiety/depression or neutral topics. The interviewer should then return to sensitive topics after the patient feels more comfortable and concerns about disclosure have been addressed.

The use of empathy is critical in helping a patient express difficult and possibly

embarrassing experiences. A interviewer may say, "I understand that recalling what happened may be unpleasant, but I am very interested in exactly what you experienced." It is advisable to let patients know what you may be sensing clinically; "I have the impression that you are reluctant to tell me more about what happened. Could that be because you are concerned about what I might think or write down about you?" The interviewer should actively engage the patient in discussing any apparent reasons for denying symptoms. The interviewer can discuss openly in an inviting and noncritical fashion any discrepancies noted between the patient's self-report of symptoms and observations of speech and behavior. For example, "You have said that you are not depressed, yet you seem very sad and you have been moving very slowly." When denial occurs, the BPRS interview becomes a dynamic interplay between the interviewer's desire for accurate symptom information and determining the reasons underlying the patient's reluctance to disclose.

Occasionally, at the time of the interview, the interviewer will have information about the symptoms that the patient is denying. It is permissible to use a mild confrontation technique in an attempt to encourage a patient to disclose accurate symptom information. For example, a BPRS interviewer may learn from the patient's therapist or relatives of the presence of auditory hallucinations. The interviewer may state, "I understand from talking with your therapist (or relative) that you have been hearing voices. Could you tell me about that?" Letting the patient know in a sensitive and gentle manner that information about his symptoms are already known may aid willingness to disclose. This approach is most effective when a policy of sharing patient information in a treatment team situation is explained to all entering patients. In may be necessary to inform the patient that not all clinical material is shared, but that symptom information needed to manage treatment cannot in all cases be confidential.

When you cannot resolve conflicts or contradictions between patient's self-report and the report of others, you must use your clinical judgment regarding the most reliable informants. Be sure to make notes on the BPRS rating sheet regarding any conflicting sources of information and specify how the final decision was made.

6. USING A STANDARDIZED REFERENCE GROUP IN MAKING RATINGS

The proper reference group for conducting assessments is a group of normal individuals who are <u>not</u> psychiatric patients who are living and working in the community free of symptoms. BPRS interviewers should have in mind a group of individuals who are able to function either at work/school, socially, or as a homemaker, at levels appropriate to the patient's age and socioeconomic status. Research has shown that normal controls score at "2" or below on most psychotic items of the BPRS. BPRS interviewers should not use other patients previously interviewed, especially those with severe symptoms, as the reference standard, since this will systematically bias ratings toward lower scores.

7. RATING SYMPTOMS THAT OVERLAP TWO OR MORE CATEGORIES OR SCALES ON THE BPRS

Systematized or multiple delusions can be rated on more than one symptom item or scale on the BPRS. depending on the theme of the delusional belief. For example, if a

patient has a delusion that certain body parts have been surgically removed against his/her will and replaced with broken mechanical parts, he or she would be rated at the level of "6" or "7" on both Somatic Concern and at the level of "4" to "7" on Unusual Thought Content depending on the frequency and preoccupation with the delusion. Furthermore, if the patient felt guilty because he believed the metal in his body interfered with radio transmissions between air traffic controllers and pilots resulting in several plane crashes, the BPRS item Guilt should also be rated.

The specific ratings for each of the overlapping symptom dimensions may differ depending on the anchor points of the BPRS item(s). Thus, a patient with a clear-cut persecutory delusion involving the neighbors should be rated a "6" on Suspiciousness. Whereas, the same delusion could be rated a "4" on Unusual Thought Content if it is encapsulated and not associated with impairment.

8. RATING A SYMPTOM THAT HAS NO SPECIFIC ANCHOR POINT CONGRUENT WITH ITS SEVERITY LEVEL

The anchor points for a given BPRS item are critical in achieving good reliability across raters and across research settings. However, there are occasions when a particular symptom may not fit any of the anchor point definitions. Anchor point definitions could not be written to cover all possible symptoms exhibited by patients. In general, ratings of 2 or 3 represent nonpathological but observable mild symptomatology; 4 or 5 represents clinically significant moderate symptomatology; and 6 or 7 represents clinically significant and severe symptomatology.

The anchor points in this manual are guidelines to aid in the process of defining the character, frequency, and impairment associated with various types of psychiatric symptoms. When faced with a complicated rating, the interviewer may find it useful to first classify the symptom as mild (2 or 3), moderate (4 or 5), or severe (6 or 7), and second to consult the anchor point definitions to pinpoint the rating.

BPRS symptoms that are classified in the severe range usually represent pathological phenomena. However, it is possible for a patient to report or be observed to exhibit examples of mild psychopathology that should be rated at much higher levels. For example, on the item Tension, if hand wringing is observed on 2-3 occasions, the interviewer would rate a "2" or "3." However, if the patient is observed to be hand wringing constantly, then consider a higher rating such as "5" or "6" on Tension. Similarly, instances of severe psychopathology that are brief, transient, and non-impairing in nature should be rated in the mild range.

9. "BLENDING" RATINGS MADE IN DIFFERENT EVALUATION SITUATIONS

A psychiatric patient can exhibit different levels of the same symptom depending on the setting in which the patient is observed or the time period involved. Consider the patient who is talkative during a rating session with the BPRS interviewer, but is very withdrawn and blunted with other patients. In the interview session the patient may rate a "3" on blunted affect and "2" on emotional withdrawal, but rate "5" on those symptoms when interacting with other patients. The interviewer can consider integrating the two sources of information and make an averaged or "blended" rating.

10. RESOLVING APPARENTLY CONTRADICTORY SYMPTOMS

It is possible to rate two or more symptoms on the BPRS that represent seemingly contradictory dimensions of phenomenology. For example, a patient can exhibit blunted affect and elevated mood in the same interview period. A patient may laugh and joke with the interviewer, but then shift to a blunted, slowed, and emotionally withdrawn state during the same interview. In this case, rating the presence of both elevated mood and negative symptoms may be appropriate reflecting that both mood states were present. Although the simultaneous presence of apparently contradictory symptoms is rare, if such combinations do appear, the rater should consider rating each symptom lower than if just one had appeared. This conservative approach to rating reflects a cautious orientation to the rating process when there is ambiguity regarding the symptomatology being assessed.

CLINICAL APPLICATIONS OF THE BPRS: GRAPHING SYMPTOMS

A graph is printed at the end of this administration manual to help raters plot and monitor symptoms from the BPRS. Because psychotic and other symptoms often fluctuate over time, graphing them enables the clinician to identify exacerbations, periods of remission, and prodromal periods that precede a relapse. Monitoring and graphing can be the key to early intervention to reduce morbidity, relapses, and rehospitalizations.

Graphing of symptomatology can provide vivid representations of the relationships between specific types of symptoms (e.g., hallucinations) and other variables of interest, such as (1) medication type and dose, (2) changes in psychosocial treatment and rehabilitation programs, (3) the use of "street" drugs or alcohol, (4) life events, and (5) other environmental or familial stressors. The preprinted graph shown at the end of this manual provides space to write significant life events or treatment changes and permits the "eyeballing" of the influence of these variables on symptoms. Repeated measurement and graphing of symptoms over time can be done for individual items (e.g., anxiety or hallucinations), or for clusters of symptoms (e.g., psychotic index). Such clusters can be chosen from factor analyses of earlier versions of the BPRS (Guy, 1976; Overall, Hollister, and Pichot, 1967; Overall and Porterfield, 1963). The blank graph in this manual allows raters to select and write in specific symptoms of the BPRS based on the needs of individual patients.

REFERENCES

Guy W: *ECDEU Assessment Manual for Psychopharmacology.* DHEW Pub. No. (ADM) 76-338. Rockville, MD: National Institute of Mental Health, 1976.

Lukoff D, Nuechterlein KH, and Ventura J: Manual for the Expanded Brief Psychiatric Rating Scale. *Schizophrenia Bulletin, 12:* 594-602, 1986.

Overall JE and Gorham DR, The Brief Psychiatric Rating Scale. *Psychological Reports, 10:* 799-812, 1962.

Overall JE, Hollister LE, Pichot P: Major psychiatric disorders: A four-dimensional model. *Archives of General Psychiatry, 1*6: 146-151, 1967.

Overall JE and Porterfield, JL. Powered vector method of factor analysis. *Psychometrika, 28:* 415-422, 1963

SCALE ITEMS AND ANCHOR POINTS

Rate items 1-14 on the basis of patient's self-report. Note items 7, 12, and 13 are also rated on the basis of observed behavior. Items 15-24 are rated on the basis of observed behavior and speech.

1. SOMATIC CONCERN: Degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the patient, whether complaints have realistic bases or not. Somatic delusions should be rated in the severe range with or without somatic concern. Note: Be sure to assess the degree of impairment due to somatic concerns only and not other symptoms, e.g., depression. In addition, if the subject rates a "6" or "7" due to somatic delusions, then you must rate Unusual Thought Content at least a "4" or above.

Have you been concerned about your physical health? Have you had any physical illness or seen a medical doctor lately? (What does your doctor say is wrong? How serious is it?
Has anything changed regarding your appearance?
Has it interfered with your ability to perform your usual activities and/or work?
Did you ever feel that parts of your body had changed or stopped working?

[If patient reports any somatic concerns/delusions, ask the following]:

How often are you concerned about [use patient's description]?
Have you expressed any of these concerns to others?

2 Very Mild
Occasional somatic concerns that tend to be kept to self.

3 Mild
Occasional somatic concerns that tend to be voiced to others (e.g., family, physician).

4 Moderate
Frequent expressions of somatic concern or exaggerations of existing ills OR some preoccupation, but no impairment in functioning. Not delusional.

5 Moderately Severe
Frequent expressions of somatic concern or exaggeration of existing ills OR some preoccupation and moderate impairment of functioning. Not delusional

6 Severe
Preoccupation with somatic complaints with much impairment in functioning OR somatic delusions without acting on them or disclosing to others.

7 Extremely Severe
Preoccupation with somatic complaints with severe impairment in functioning OR somatic delusions that tend to be acted on or disclosed to others.

2. ANXIETY: Reported apprehension, tension, fear, panic or worry. Rate only the patient's statements, not observed anxiety which is rated under TENSION.

Have you been worried a lot during [mention time frame]? Have you been nervous or apprehensive? (What do you worry about?) Are you concerned about anything? How about finances or the future? When you are feeling nervous, do your palms sweat or does your heart beat fast (or shortness of breath, trembling, choking)?

[If patient reports anxiety or autonomic accompaniment, ask the following]:

How much of the time have you been [use patient's description]?
Has it interfered with your ability to perform your usual activities/work?

2 Very Mild
Reports some discomfort due to worry OR infrequent worries that occur more than usual for most normal individuals.

3 Mild
Worried frequently but can readily turn attention to other things.

4 Moderate
Worried most of the time and cannot turn attention to other things easily but no impairment in functioning OR occasional anxiety with autonomic accompaniment but no impairment in functioning.

5 Moderately Severe
Frequent, but not daily, periods of anxiety with autonomic accompaniment OR some areas of functioning are disrupted by anxiety or worry.

6 Severe
Anxiety with autonomic accompaniment daily but not persisting throughout the day OR many areas of functioning are disrupted by anxiety or constant worry.

7 Extremely Severe
Anxiety with autonomic accompaniment persisting throughout the day OR most areas of functioning are disrupted by anxiety or constant worry.

3. DEPRESSION: Include sadness, unhappiness, anhedonia, and preoccupation with depressing topics (can't attend to TV or conversations due to depression), hopelessness, loss of self-esteem (dissatisfied or disgusted with self or feelings of worthlessness). Do not include vegetative symptoms, e.g., motor retardation, early waking, or the amotivation that accompanies the deficit syndrome.

How has your mood been recently? Have you felt depressed (sad, down, unhappy as if you didn't care)? Are you able to switch your attention to more

pleasant topics when you want to? Do you find that you have lost interest in or get less pleasure from things you used to enjoy, like family, friends, hobbies, watching TV, eating?

[If subject reports feelings of depression, ask the following]:

How long do these feelings last? Has it interfered with your ability to perform your usual activities/work?

2 Very Mild
Occasionally feels sad, unhappy or depressed.

3 Mild
Frequently feels sad or unhappy but can readily turn attention to other things.

4 Moderate
Frequent periods of feeling very sad, unhappy, moderately depressed, but able to function with extra effort.

5 Moderately Severe
Frequent, but not daily, periods of deep depression OR some areas of functioning are disrupted by depression.

6 Severe
Deeply depressed daily but not persisting throughout the day OR many areas of functioning are disrupted by depression.

7 Extremely Severe
Deeply depressed daily OR most areas of functioning are disrupted by depression.

4. SUICIDALITY: Expressed desire, intent or actions to harm or kill self.

Have you felt that life wasn't worth living? Have you thought about harming or killing yourself? Have you felt tired of living or as though you would be better off dead? Have you ever felt like ending it all?

[If patient reports suicidal ideation, ask the following]:

How often have you thought about [use patient's description]?
Did you (Do you) have a specific plan?

2 Very Mild
Occasional feelings of being tired of living. No overt suicidal thoughts.

3 Mild
Occasional suicidal thoughts without intent or specific plan OR he/she feels they would be better off dead.

4 Moderate
Suicidal thoughts frequent without intent or plan.

5 Moderately Severe
Many fantasies of suicide by various methods. May seriously consider making an attempt with specific time and plan OR impulsive suicide attempt using non-lethal method or in full view of potential saviors.

6 Severe
Clearly wants to kill self. Searches for appropriate means and time, OR potentially serious suicide attempt with patient knowledge of possible rescue.

7 Extremely Severe
Specific suicidal plan and intent (e.g., "as soon as _____ I will do it by doing X"), OR suicide attempt characterized by plan patient thought was lethal or attempt in secluded environment.

5. GUILT: Over concern or remorse for past behavior. Rate only patient's statements, do not infer guilt feelings from depression, anxiety, or neurotic defenses. Note: If the subject rates a "6" or "7" due to delusions of guilt, then you must rate Unusual Thought Content at least a "4" or above depending on level of preoccupation and impairment.

Is there anything you feel guilty about? Have you been thinking about past problems? Do you tend to blame yourself for things that have happened? Have you done anything you're still ashamed of?

[If patient reports guilt/remorse/delusions, ask the following]:

How often have you been thinking about [use patient's description]? Have you disclosed your feelings of guilt to others?

2 Very Mild
Concerned about having failed someone or at something but not preoccupied. Can shift thoughts to other matters easily.

3 Mild
Concerned about having failed someone or at something with some preoccupation. Tends to voice guilt to others.

4 Moderate
Disproportionate preoccupation with guilt, having done wrong, injured others by doing or failing to do something, but can readily turn attention to other things.

5 Moderately Severe
Preoccupation with guilt, having failed someone or at something, can turn attention to other things, but only with great effort. Not delusional.

6 Severe
Delusional guilt OR unreasonable self-reproach very out of proportion to circumstances. Moderate preoccupation present.

7 Extremely Severe
Delusional guilt OR unreasonable self-reproach grossly out of proportion to circumstances. Subject is very preoccupied with guilt and is likely to disclose to others or act on delusions.

6. HOSTILITY: Animosity, contempt, belligerence, threats, arguments, tantrums, property destruction, fights and any other expression of hostile attitudes or actions. Do not infer hostility from neurotic defenses, anxiety or somatic complaints. Do not include incidents of appropriate anger or obvious self-defense.

How have you been getting along with people (family, co-workers, etc.)? Have you been irritable or grumpy lately? (How do you show it? Do you keep it to yourself?) Were you ever so irritable that you would shout at people or start fights or arguments? (Have you found yourself yelling at people you didn't know?) Have you hit anyone recently?

2 Very Mild
Irritable or grumpy, but not overtly expressed.

3 Mild
Argumentative or sarcastic.

4 Moderate
Overtly angry on several occasions OR yelled at others excessively.

5 Moderately Severe
Has threatened, slammed about or thrown things.

6 Severe
Has assaulted others but with no harm likely, e.g., slapped or pushed, OR destroyed property, e.g., knocked over furniture, broken windows.

7 Extremely Severe
Has attacked others with definite possibility of harming them or with actual harm, e.g., assault with hammer or weapon.

7. ELEVATED MOOD: A pervasive, sustained and exaggerated feeling of well-being, cheerfulness, euphoria (implying a pathological mood), optimism that is out of proportion to the circumstances. Do not infer elation from increased activity or from grandiose statements alone.

Have you felt so good or high that other people thought that you were not your

normal self? Have you been feeling cheerful and "on top of the world" without any reason?

[If patient reports elevated mood/euphoria, ask the following]:

Did it seem like more than just feeling good? How long did that last?

2 Very Mild
Seems to be very happy, cheerful without much reason.

3 Mild
Some unaccountable feelings of well-being that persist.

4 Moderate
Reports excessive or unrealistic feelings of well-being, cheerfulness, confidence or optimism inappropriate to circumstances, some of the time. May frequently joke, smile, be giddy or overly enthusiastic OR few instances of marked elevated mood with euphoria.

5 Moderately Severe
Reports excessive or unrealistic feelings of well-being, confidence or optimism inappropriate to circumstances much of the time. May describe feeling on top of the world," "like everything is falling into place," or "better than ever before," OR several instances of marked elevated mood with euphoria.

6 Severe
Reports many instances of marked elevated mood with euphoria OR mood definitely elevated almost constantly throughout interview and inappropriate to content

7 Extremely Severe
Patient reports being elated or appears almost intoxicated, laughing, joking, giggling, constantly euphoric, feeling invulnerable, all inappropriate to immediate circumstances.

8. GRANDIOSITY: Exaggerated self-opinion, self-enhancing conviction of special abilities or powers or identity as someone rich or famous. Rate only patient's statements about himself, not his demeanor. Note: If the subject rates a "6" or "7" due to grandiose delusions, you must rate Unusual Thought Content at least a "4" or above.

Is there anything special about you? Do you have any special abilities or powers? Have you thought that you might be somebody rich or famous?

[If the patient reports any grandiose ideas/delusions, ask the following]:

How often have you been thinking about [use patient's description]? Have you told anyone about what you have been thinking? Have you acted on any of these ideas?

2 Very Mild
Feels great and denies obvious problems, but not unrealistic.

3 Mild
Exaggerated self-opinion beyond abilities and training.

4 Moderate
Inappropriate boastfulness claims to be brilliant, insightful, or gifted beyond realistic proportions, but rarely self-discloses or acts on these inflated self-concepts. Does not claim that grandiose accomplishments have actually occurred.

5 Moderately Severe
Same as 4 but often self-discloses and acts on these grandiose ideas. May have doubts about the reality of the grandiose ideas. Not delusional.

6 Severe
Delusional--claims to have special powers like ESP, to have millions of dollars, invented new machines, worked at jobs when it is known that he was never employed in these capacities, be Jesus Christ, or the President. Patient may not be very preoccupied.

7 Extremely Severe
Delusional--Same as 6 but subject seems very preoccupied and tends to disclose or act on grandiose delusions.

9. SUSPICIOUSNESS: Expressed or apparent belief that other persons have acted maliciously or with discriminatory intent. Include persecution by supernatural or other nonhuman agencies (e.g., the devil). Note: Ratings of "3" or above should also be rated under Unusual Thought Content.

Do you ever feel uncomfortable in public? Does it seem as though others are watching you? Are you concerned about anyone's intentions toward you? Is anyone going out of their way to give you a hard time, or trying to hurt you? Do you feel in any danger?

[If patient reports any persecutory ideas/delusions, ask the following]:

How often have you been concerned that [use patient's description]? Have you told anyone about these experiences?

2 Very Mild
Seems on guard. Reluctant to respond to some "personal" questions. Reports being overly self-conscious in public.

3 Mild
Describes incidents in which others have harmed or wanted to

harm him/her that sound plausible. Patient feels as if others are watching, laughing, or criticizing him/her in public, but this occurs only occasionally or rarely. Little or no preoccupation.

4 Moderate
Says others are talking about him/her maliciously, have negative intentions, or may harm him/her. Beyond the likelihood of plausibility, but not delusional. Incidents of suspected persecution occur occasionally (less than once per week) with some preoccupation.

5 Moderately Severe
Same as 4, but incidents occur frequently, such as more than once per week. Patient is moderately preoccupied with ideas of persecution OR patient reports persecutory delusions expressed with much doubt (e.g., partial delusion).

6 Severe
Delusional -- speaks of Mafia plots, the FBI, or others poisoning his/her food, persecution by supernatural forces.

7 Extremely Severe
Same as 6, but the beliefs are bizarre or more preoccupying. Patient tends to disclose or act on persecutory delusions.

10. HALLUCINATIONS: Reports of perceptual experiences in the absence of relevant external stimuli. When rating degree to which functioning is disrupted by hallucinations, include preoccupation with the content and experience of the hallucinations, as well as functioning disrupted by acting out on the hallucinatory content (e.g., engaging in deviant behavior due to command hallucinations). Include thoughts aloud ("gedankenlautwerden") or pseudohallucinations (e.g., hears a voice inside head) if a voice quality is present.

Do you ever seem to hear your name being called? Have you heard any sounds or people talking to you or about you when there has been nobody around? [If hears voices]: What does the voice/voices say? Did it have a voice quality? Do you ever have visions or see things that others do not see? What about smell odors that others do not smell?

[If the patient reports hallucinations, ask the following]:

Have these experiences interfered with your ability to perform your usual activities/work? How do you explain them? How often do they occur?

2 Very Mild
While resting or going to sleep, sees visions, smells odors, or hears voices, sounds or whispers in the absence of external stimulation, but no impairment in functioning.

3 Mild

While in a clear state of consciousness, hears a voice calling the subjects name, experiences non-verbal auditory hallucinations (e.g., sounds or whispers), formless visual hallucinations, or has sensory experiences in the presence of a modality-relevant stimulus (e.g., visual illusions) infrequently (e.g., 1-2 times per week) and with no functional impairment.

4 Moderate
Occasional verbal, visual, gustatory, olfactory, or tactile hallucinations with no functional impairment OR non-verbal auditory hallucinations/visual illusions more than infrequently or with impairment.

5 Moderately Severe
Experiences daily hallucinations OR some areas of functioning are disrupted by hallucinations.

6 Severe
Experiences verbal or visual hallucinations several times a day OR many areas of functioning are disrupted by these hallucinations.

7 Extremely Severe
Persistent verbal or visual hallucinations throughout the day OR most areas of functioning are disrupted by these hallucinations.

11. UNUSUAL THOUGHT CONTENT: Unusual, odd, strange or bizarre thought content. Rate the degree of unusualness, not the degree of disorganization of speech. Delusions are patently absurd, clearly false or bizarre ideas that are expressed with full conviction. Consider the patient to have full conviction if he/she has acted as though the delusional belief were true. Ideas of reference/persecution can be differentiated from delusions in that ideas are expressed with much doubt and contain more elements of reality. Include thought insertion, withdrawal and broadcast. Include grandiose, somatic and persecutory delusions even if rated elsewhere. Note: if Somatic Concern, Guilt, Suspiciousness, or Grandiosity are rated "6" or "7" due to delusions, then Unusual Thought Content must be rated a "4" or above.

Have you been receiving any special messages from people or from the way things are arranged around you? Have you seen any references to yourself on TV or in the newspapers? Can anyone read your mind? Do you have a special relationship with God? Is anything like electricity, X-rays, or radio waves affecting you? Are thoughts put into your head that are not your own? Have you felt that you were under the control of another person or force?

[If patient reports any odd ideas/delusions, ask the following]:

How often do you think about [use patient's description]? Have you told anyone about these experiences? How do you explain the things that have

been happening [specify]?

2 Very Mild
Ideas of reference (people may stare or may laugh at him), ideas of persecution (people may mistreat him). Unusual beliefs in psychic powers, spirits, UFO's, or unrealistic beliefs in one's own abilities. Not strongly held. Some doubt.

3 Mild
Same as 2, but degree of reality distortion is more severe as indicated by highly unusual ideas or greater conviction. Content may be typical of delusions (even bizarre), but without full conviction. The delusion does not seem to have fully formed, but is considered as one possible explanation for an unusual experience.

4 Moderate
Delusion present but no preoccupation or functional impairment. May be an encapsulated delusion or a firmly endorsed absurd belief about past delusional circumstances.

5 Moderately Severe
Full delusion(s) present with some preoccupation OR some areas of functioning disrupted by delusional thinking.

6 Severe
Full delusion(s) present with much preoccupation OR many areas of functioning are disrupted by delusional thinking.

7 Extremely Severe
Full delusions present with almost total preoccupation OR most areas of functioning are disrupted by delusional thinking.

Rate items 12-13 on the basis of patient's self-report and observed behavior.

12. BIZARRE BEHAVIOR: Reports of behaviors which are odd, unusual, or psychotically criminal. Not limited to interview period. Include inappropriate sexual behavior and inappropriate affect.

Have you done anything that has attracted the attention of others? Have you done anything that could have gotten you into trouble with the police? Have you done anything that seemed unusual or disturbing to others?

2 Very Mild
Slightly odd or eccentric public behavior, e.g., occasionally giggles to self, fails to make appropriate eye contact, that does not seem to attract the attention of others OR unusual behavior conducted in private, e.g., innocuous rituals, that would not attract the attention of others.

3 Mild
Noticeably peculiar public behavior, e.g., inappropriately loud talking, makes inappropriate eye contact, OR private behavior that occasionally, but not always, attracts the attention of others, e.g., hoards food, conducts unusual rituals, wears gloves indoors.

4 Moderate
Clearly bizarre behavior that attracts or would attract (if done privately) the attention or concern of others, but with no corrective intervention necessary. Behavior occurs occasionally, e.g., fixated staring into space for several minutes, talks back to voices once, in appropriate giggling/laughter on 1-2 occasions, talking loudly to self.

5 Moderately Severe
Clearly bizarre behavior that attracts or would attract (if done privately) the attention of others or the authorities, e.g., fixated staring in a socially disruptive way, frequent inappropriate giggling/laughter, occasionally responds to voices, or eats non-foods.

6 Severe
Bizarre behavior that attracts attention of others and intervention by authorities, e.g., directing traffic, public nudity, staring into space for long periods, carrying on a conversation with hallucinations, frequent inappropriate giggling/laughter.

7 Extremely Severe
Serious crimes committed in a bizarre way that attracts the attention of others and the control of authorities e.g., sets fires and stares at flames OR almost constant bizarre behavior, e.g., inappropriate giggling/laughter, responds only to hallucinations and cannot be engaged in interaction.

13. SELF-NEGLECT: Hygiene, appearance, or eating behavior below usual expectations, below socially acceptable standards, or life-threatening.

How has your grooming been lately? How often do you change your clothes? How often do you take showers? Has anyone (parents/staff) complained about your grooming or dress? Do you eat regular meals?

2 Very Mild
Hygiene/appearance slightly below usual community standards, e.g., shirt out of pants, buttons unbuttoned, shoelaces untied, but no social or medical consequences.

3 Mild

Hygiene/appearance occasionally below usual community standards, e.g., irregular bathing, clothing is stained, hair uncombed, occasionally skips an important meal. No social or medical consequences

4 Moderate
Hygiene/appearance is noticeably below usual community standards, e.g., fails to bathe or change clothes, clothing very soiled, hair unkempt, needs prompting, noticeable by others OR irregular eating and drinking with minimal medical concerns and consequences.

5 Moderately Severe
Several areas of hygiene/appearance are below usual community standards OR poor grooming draws criticism by others, and requires regular prompting. Eating or hydration is irregular and poor, causing some medical problems.

6 Severe
Many areas of hygiene/appearance are below usual community standards, does not always bathe or change clothes even if prompted. Poor grooming has caused social ostracism at school/residence/work, or required intervention. Eating erratic and poor, may require medical intervention.

7 Extremely Severe
Most areas of hygiene/appearance/nutrition are extremely poor and easily noticed as below usual community standards OR hygiene/appearance/nutrition requires urgent and immediate medical intervention.

14. DISORIENTATION: Does not comprehend situations or communications, such as questions asked during the entire BPRS interview. Confusion regarding person, place, or time. Do not rate if incorrect responses are due to delusions.

May I ask you some standard questions we ask everybody?
How old are you? What is the date (allow + or - 2 days)? What is this place called? What year were you born? Who is the president?

2 Very Mild
Seems muddled or mildly confused 1-2 times during interview. Oriented to person, place, and time.

3 Mild
Occasionally muddled or mildly confused 3-4 times during interview. Minor inaccuracies in person, place, or time, e.g., date off by more than + or - 2 days, or gives wrong division of hospital.

4 Moderate
Frequently confused during interview. Minor inaccuracies in person, place, or time are noted, as in "3" above. In addition, may have difficulty remembering general information, e.g., name of president.

5 Moderately Severe
Markedly confused during interview, or to person, place, or time. Significant inaccuracies are noted, e.g., date off by more than one week, or cannot give correct name of hospital. Has difficulty remembering personal information, e.g., where he/she was born, or recognizing familiar people.

6 Severe
Disoriented to person, place, or time, e.g., cannot give correct month and year. Disoriented in 2 out of 3 spheres.

7 Extremely Severe
Grossly disoriented to person, place, or time, e.g., cannot give name or age. Disoriented in all 3 spheres.

Rate items 15-24 on the basis of observed behavior and speech.

15. CONCEPTUAL DISORGANIZATION: Degree to which speech is confused, disconnected, vague or disorganized. Rate tangentiality, circumstantiality, sudden topic shifts, incoherence, derailment, blocking, neologisms, and other speech disorders. Do not rate content of speech.

2 Very Mild
Peculiar use of words or rambling but speech is comprehensible.

3 Mild
Speech a bit hard to understand or make sense of due to tangentiality, circumstantiality or sudden topic shifts.

4 Moderate
Speech difficult to understand due to tangentiality, circumstantiality, idiosyncratic speech, or topic shifts on many occasions OR 1-2 in stances of incoherent phrases.

5 Moderately Severe
Speech difficult to understand due to circumstantiality, tangentiality, neologisms, blocking, or topic shifts most of the time OR 3-5 instances of incoherent phrases.

6 Severe
Speech is incomprehensible due to severe impairments most of the time. Many BPRS items cannot be rated by self-report alone.

7 Extremely Severe

Speech is incomprehensible throughout interview.

16. BLUNTED AFFECT: Restricted range in emotional expressiveness of face, voice, and gestures. Marked indifference or flatness even when discussing distressing topics. In the case of euphoric or dysphoric patients, rate Blunted Affect if a flat quality is also clearly present.

Use the following probes at end of interview to assess emotional responsivity:

Have you heard any good jokes lately? Would you like to hear a joke?

2 Very Mild
Emotional range is slightly subdued or reserved but displays appropriate facial expressions and tone of voice that are within normal limits.

3 Mild
Emotional range overall is diminished, subdued, or reserved, without many spontaneous and appropriate emotional responses. Voice tone is slightly monotonous.

4 Moderate
Emotional range is noticeably diminished, patient doesn't show emotion, smile, or react to distressing topics except infrequently. Voice tone is monotonous or there is noticeable decrease in spontaneous movements. Displays of emotion or gestures are usually followed by a return to flattened affect.

5 Moderately Severe
Emotional range very diminished, patient doesn't show emotion, smile or react to distressing topics except minimally, few gestures, facial expression does not change very often. Voice tone is monotonous much of the time.

6 Severe
Very little emotional range or expression. Mechanical in speech and gestures most of the time. Unchanging facial expression. Voice tone is monotonous most of the time.

7 Extremely Severe
Virtually no emotional range or expressiveness, stiff movements. Voice tone is monotonous all of the time.

17. EMOTIONAL WITHDRAWAL: Deficiency in patient's ability to relate emotionally during interview situation. Use your own feeling as to the presence of an "invisible barrier" between patient and interviewer. Include withdrawal apparently due to psychotic processes.

2 Very Mild

Lack of emotional involvement shown by occasional failure to make reciprocal comments, occasionally appearing preoccupied, or smiling in a stilted manner, but spontaneously engages the interviewer most of the time.

3 Mild
Lack of emotional involvement shown by noticeable failure to make reciprocal comments, appearing preoccupied, or lacking in warmth, but responds to interviewer when approached.

4 Moderate
Emotional contact not present much of the interview because subject does not elaborate responses, fails to make eye contact, doesn't seem to care if interviewer is listening, or may be preoccupied with psychotic material.

5 Moderately Severe
Same as "4" but emotional contact not present most of the interview.

6 Severe
Actively avoids emotional participation. Frequently unresponsive or responds with yes/no answers (not solely due to persecutory delusions). Responds with only minimal affect.

7 Extremely Severe
Consistently avoids emotional participation. Unresponsive or responds with yes/no answers (not solely due to persecutory delusions). May leave during interview or just not respond at all.

18. MOTOR RETARDATION: Reduction in energy level evidenced by slowed movements and speech, reduced body tone, decreased number of spontaneous body movements. Rate on the basis of observed behavior of the patient only. Do not rate on the basis of patient's subjective impression of his own energy level. Rate regardless of the medication effects.

2 Very Mild
Slightly slowed or reduced movements or speech compared to most people.

3 Mild
Noticeably slowed or reduced movements or speech compared to most people.

4 Moderate
Large reduction or slowness in movements or speech.

5 Moderately Severe
Seldom moves or speaks spontaneously OR very mechanical or

stiff movements.

6 Severe
Does not move or speak unless prodded or urged.

7 Extremely Severe
Frozen, catatonic.

19 TENSION: Observable physical and motor manifestations of tension, "nervousness," and agitation. Self-reported experiences of tension should be rated under the item on anxiety. Do not rate if restlessness is solely akathisia, but do rate if akathisia is exacerbated by tension.

2 Very Mild
More fidgety than most but within normal range. A few transient signs of tension, e.g., picking at fingernails, foot wagging, scratching scalp several times, or finger tapping.

3 Mild
Same as "2," but with more frequent or exaggerated signs of tension.

4 Moderate
Many and frequent signs of motor tension with one or more signs some times occurring simultaneously, e.g., wagging one's foot while wringing hands together. There are times when no signs of tension are present.

5 Moderately Severe
Many and frequent signs of motor tension with one or more signs often occurring simultaneously. There are still rare times when no signs of tension are present.

6 Severe
Same as "5," but signs of tension are continuous.

7 Extremely Severe
Multiple motor manifestations of tension are continuously present, e.g., continuous pacing and hand wringing.

20. UNCOOPERATIVENESS: Resistance and lack of willingness to cooperate with the interview. The uncooperativeness might result from suspiciousness. Rate only uncooperativeness in relation to the interview, not behaviors involving peers and relatives.

2 Very Mild
Shows nonverbal signs of reluctance, but does not complain or argue.

3 Mild
Gripes or tries to avoid complying, but goes ahead without argu-

ment.

4 Moderate
Verbally resists but eventually complies after questions are rephrased or repeated.

5 Moderately Severe
Same as 4, but some information necessary for accurate ratings is withheld.

6 Severe
Refuses to cooperate with interview, but remains in interview situation.

7 Extremely Severe
Same as 6, with active efforts to escape the interview.

21. EXCITEMENT: Heightened emotional tone, or increased emotional reactivity to interviewer or topics being discussed, as evidenced by increased intensity of facial expressions, voice tone, expressive gestures or increase in speech quantity and speed.

2 Very Mild
Subtle and fleeting or questionable increase in emotional intensity. For example, at times seems keyed-up or overly alert.

3 Mild
Subtle but persistent increase in emotional intensity. For example, lively use of gestures and variation in voice tone.

4 Moderate
Definite but occasional increase in emotional intensity. For example, reacts to interviewer or topics that are discussed with noticeable emotional intensity. Some pressured speech.

5 Moderately Severe
Definite and persistent increase in emotional intensity. For example reacts to many stimuli, whether relevant or not, with considerable emotional intensity. Frequent pressured speech.

6 Severe
Marked increase in emotional intensity. For example reacts to most stimuli with inappropriate emotional intensity. Has difficulty settling down or staying on task. Often restless, impulsive, or speech is often pressured.

7 Extremely Severe
Marked and persistent increase in emotional intensity. Reacts to all stimuli with inappropriate intensity, impulsiveness. Cannot settle down or stay on task. Very restless and impulsive most of

the time. Constant pressured speech.

22 DISTRACTIBILITY: Degree to which observed sequences of speech and actions are interrupted by stimuli unrelated to the interview. Distractibility is rated when the patient shows a change in the focus of attention or a marked shift in gaze. Patient's attention may be drawn to noise in adjoining room, books on shelf, interviewer's clothing, etc. Do not rate circumstantiality, tangentiality, or flight of ideas. Also, do not rate rumination with delusional material. Rate even if the distracting stimulus cannot be identified.

2 Very Mild
Generally can focus on interviewer's questions with only 1 distraction or inappropriate shift of attention of brief duration.

3 Mild
Patient shifts focus of attention to matters unrelated to the interview 2-3 times.

4 Moderate
Often responsive to irrelevant stimuli in the room, e.g., averts gaze from the interviewer.

5 Moderately Severe
Same as above, but now distractibility clearly interferes with the flow of the interview.

6 Severe
Extremely difficult to conduct interview or pursue a topic due to preoccupation with irrelevant stimuli.

7 Extremely Severe
Impossible to conduct interview due to preoccupation with irrelevant stimuli.

23. MOTOR HYPERACTIVITY: Increase in energy level evidenced in more frequent movement and/or rapid speech. Do not rate if restlessness is due to akathisia.

2 Very Mild
Some restlessness, difficulty sitting still, lively facial expressions, or somewhat talkative.

3 Mild
Occasionally very restless, definite increase in motor activity, lively gestures, 1-3 brief instances of pressured speech.

4 Moderate
Very restless, fidgety, excessive facial expressions or nonproductive and repetitious motor movements. Much pressured speech, up to one third of the interview.

5 Moderately Severe

Frequently restless, fidgety. Many instances of excessive non-productive and repetitious motor movements. On the move most of the time. Frequent pressured speech, difficult to interrupt. Rises on 1-2 occasions to pace.

6 Severe
Excessive motor activity, restlessness, fidgety, loud tapping, noisy, etc. throughout most of the interview. Speech can only be interrupted with much effort. Rises on 3-4 occasions to pace.

7 Extremely Severe
Constant excessive motor activity throughout entire interview, e.g., constant pacing, constant pressured speech with no pauses, interviewee can only be interrupted briefly and only small amounts of relevant information can be obtained.

24. MANNERISMS AND POSTURING: Unusual and bizarre behavior, stylized movements or acts, or any postures which are clearly uncomfortable or inappropriate. Exclude obvious manifestations of medication side-effects. Do not include nervous mannerisms that are not odd or unusual.

2 Very Mild
Eccentric or odd mannerisms or activity that ordinary persons would have difficulty explaining, e.g., grimacing, picking. Observed once for a brief period.

3 Mild
Same as "2," but occurring on two occasions of brief duration.

4 Moderate
Mannerisms or posturing, e g., stylized movements or acts, rocking, nodding, rubbing, or grimacing, observed on several occasions for brief periods or infrequently but very odd. For example, uncomfortable posture maintained for 5 seconds more than twice.

5 Moderately Severe
Same as "4," but occurring often, or several examples of very odd mannerisms or posturing that are idiosyncratic to the patient.

6 Severe
Frequent stereotyped behavior, assumes and maintains uncomfortable or inappropriate postures, intense rocking, smearing, strange rituals, or fetal posturing. Subject can interact with people and the environment for brief periods despite these behaviors.

7 Extremely Severe
Same as "6," but subject cannot interact with people or the environment due to these behaviors.