The Psychotic Depression Assessment Scale (PDAS)

(For instructions and interview see the next page)

1. Somatic symptoms – general

0. Absent.
1. Doubtful or very vague feelings of fatigue or muscle pains/aches.
2. Fatigue or muscle pains/aches more clearly present but without impact on daily activities.
3. Fatigue or muscle pains/aches so marked that they interfere significantly with daily life.
4. Severe fatigue or muscle pains/aches that are highly impairing.

2. Work and activities

0. No difficulty.
1. Slight problems with usual daily activities such as work or hobbies (at home or outside home).
2. Loss of interest in work or hobbies – either reported directly by the patient (pt.), or indirectly as evident in listlessness, indecision and vacillation (has to push himself/herself to complete things).
3. Problems managing routine tasks, which can only be completed with major effort. Clear signs of helplessness.
4. Completely unable to carry out routine tasks without aid. Extreme helplessness.

3. Depressed mood

0. Absent.
1. Slight tendency to despondency or sadness.
2. Clearer indications of lowered mood. The pt. is moderately depressed, but hopelessness is not present.
3. Significantly lowered mood with occasional feelings of hopelessness. There may be non-verbal signs of depressed mood (e.g.,weeping)
4. Severely depressed mood with persistent feelings of hopelessness. There may be depressive delusions (e.g., no hope of recovering).

4. Psychic anxiety

0. Absent.
1. Only mild worrying, tension or fear.
2. Worrying about minor matters. Still able to control anxiety.
3. The anxiety and worrying are so pronounced that it is difficult for the pt. to control. The symptoms have an impact on daily activities.
4. The anxiety and worrying are highly impairing and the pt. is unable to control the symptoms.

5. Guilt feelings

0. Absent
1. Lowered self-esteem in relation to family, friends or colleagues. The pt. may feel that he/she is a burden to others.
2. More pronounced guilt feelings. The pt. is concerned with incidents in the past (minor omissions or failings).
3. More severe guilt feelings that are unreasonable. The pt. may feel that the current depression is a punishment, but is however able to recognize that this is hardly the case.
4. The guilt feelings are delusional as the pt. cannot be convinced to truly believe that they are unreasonable.

6. Psychomotor retardation

0. Absent.
1. The pt's usual level of motor activity is slightly reduced.
2. More pronounced motor retardation, i.e., moderately reduced gesticulation, slowed pace and/or slowed speech.
3. The psychomotor retardation is very obvious and the interview is clearly prolonged due to slowness in answering.
4. The interview can hardly be completed due to psychomotor retardation. Depressive stupor may be present.

HAM-D_6 score = ☐

7. Emotional withdrawal

0. Absent.
1. Lack of emotional involvement shown by noticeable failure to make reciprocal comments, or lacking in warmth, but responds to interviewer when approached.
2. Emotional contact not present for most of the interview because the pt. does not elaborate responses, fails to make eye contact, or does not seem to care whether the interviewer is listening.
3. The pt. actively avoids emotional participation. He/she is frequently unresponsive or responds with yes/no answers and minimal affect (not solely due to persecutory delusions).
4. The pt. consistently avoids emotional participation. He/she is unresponsive or responds with yes/no answers (not solely due to persecutory delusions). May leave during the interview.

8. Suspiciousness

0. Absent.
1. The pt. seems on guard. He/she describes incidents in which others have harmed or wanted to harm him/her (sounds plausible). Feels as if others are watching, laughing at or criticizing him/her in public, but this occurs only rarely. There is little or no preoccupation.
2. The pt. says that other persons are talking about him/her maliciously, have negative intentions or may want to harm him/her (beyond the likelihood of plausibility). The perceived persecution is associated with some preoccupation.
3. The pt. is delusional and speaks of plots against him/her. For instance someone spying on him/her at home/workplace/hospital.
4. Same as 3, but the beliefs are more preoccupying and the pt. tends to disclose or act on the persecutory delusions.

9. Hallucinations

0. Absent.
1. The pt. occasionally has visions, smells odors or hears voices, sounds, or has other sensory perceptions in the absence of external stimulation. Does not cause impairment.
2. Occasional or daily visual, auditory, gustatory, olfactory, tactile, or proprioceptive hallucinations with some functional impairment.
3. The pt. experiences hallucinations several times a day OR some areas of functioning are disrupted by hallucinations.
4. There are persistent hallucinations throughout the day OR most areas of functioning are disrupted by hallucinations.

10. Unusual thought content

0. Absent.
1. Vague ideas of reference (people are staring/laughing at pt.); ideas of persecution; unusual beliefs in spirits, UFOs, etc.; unreasonable ideas about illness, poverty, etc. Not strongly held (not delusional).
2. Delusion(s) are present with some preoccupation or some areas of functioning disrupted by delusional thinking.
3. Delusion(s) are present with much preoccupation or many areas of functioning are disrupted by delusional thinking.
4. Delusion(s) are present with almost total preoccupation or most areas of functioning disrupted by delusional thinking.

11. Blunted affect

0. Absent.
1. Overall emotional range is slightly diminished, subdued or reserved. Voice tone may appear monotonous.
2. Emotional range very diminished. The pt. does not show emotion, or react to distressing topics except minimally. Facial expression does not change very often. Voice tone is monotonous much of the time.
3. 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.
4. Virtually no emotional range, expressions or gestures. Voice tone is very monotonous all of the time.

$BPRS_5$ score = ☐

PDAS total score = HAM-D_6 score + $BPRS_5$ score = ☐

Instructions and short interview for the PDAS

Background

The Psychotic Depression Assessment Scale (PDAS) is a dedicated rating scale for the measurement of severity of psychotic depression. The scale consists of 6 items ($HAM\text{-}D_6$) from the Hamilton Depression Rating Scale and 5 items ($BPRS_5$) from the Brief Psychiatric Rating Scale. The $HAM\text{-}D_6$ can be considered as a "depression subscale" and the $BPRS_5$ as a "psychosis subscale" of the PDAS. The total score on the PDAS is obtained by adding the total score of the $HAM\text{-}D_6$ to that of the $BPRS_5$, or by adding the 11 individual item scores. Note that "suicidality" is not among the PDAS items. However, as part of the clinical assessment of patients with depression, potential suicidality should always be considered.

Instructions

When using the PDAS it is suggested to conduct the semi-structured interview provided below and to consider the severity of symptoms for the past week. Other time frames (for instance 3 days) can be used as well, but must then be clearly pointed out in the interview. As the interview is semi-structured, the rater must continue the inquiry with questions of his/her own until positive information is elicited or denied and the rater is confident in choosing a score. The rater must always choose the score that best fits and not "rate up" or "rate down". If still in doubt, rate conservatively (i.e., choose the lowest score of two options). If a patient provides information during the questioning for one item that is relevant for a different item, this information should also be considered for the latter. This is particularly relevant for delusions, which are rated under item 10 but may be reported (and scored) in relation to other items as well. When rating the PDAS items, the patient's usual/normal state must be used as reference.

Interview

General: "Before we begin with the specific questions of this interview, perhaps you could tell me a little bit about yourself and your background?"; "Now, I'm going to ask you some questions about the past week. How have you been feeling since last (day of week)?"

Item 1. Somatic symptoms - general: "How has your energy level been this past week?"; "Have you felt tired?" if yes: "How bad has it been?"; "This week, have you had any muscle aches or pains?"; "Have you felt any heaviness or pain in your limbs, back, or head?"; "Have you felt weighted down this past week?"; "Have fatigue/aches prevented you from carrying out your daily routine this past week?" if yes: "please specify"

Item 2. Work and activities: "How have you been spending your time this past week?"; "Have you felt interested in doing things, or do you feel you have to push yourself to do them?"; "This week, have you been able to manage your daily activities at work/home/hospital?"; "Have you required help from others to carry out routine tasks such as getting dressed or making your bed?"; "Have you felt helpless this past week?"

Item 3. Depressed mood: "What has your mood been like this past week?"; "Have you been feeling down, depressed or sad?"; "Have you been crying more easily than usual for the past week?"; "How do you look upon the future?"; "Have you felt hopelessness within the past week?" if yes: "In which situations?", "Have you had thoughts about never recovering?" if yes: "Are these thoughts realistic?"

Item 4. Psychic anxiety: "Have you been feeling tense, anxious or irritable this past week? How about feeling fearful or worried?" if yes: "Is this more than is normal for you?"; "This past week, have you been feeling panicky?" if yes "In which situations?"; If anxiety is reported: "Have these feelings been difficult to control for the past week or kept you from doing things?"

Item 5. Guilt feelings: "Have you been especially critical of yourself this past week, or feeling like you've let others down?"; **"**In the past week, have you been feeling guilty about things you've done or should've done but haven't?" if yes: "Please explain"; " Do you feel that your depression is a punishment for something bad that you've done?"; if yes: "Do you deserve such punishment?"; If guilt is reported: "Do you think that your guilt feelings are reasonable/fair?"

Item 8. Suspiciousness: "For this past week, have you felt as though others are watching you or talking about you behind your back?"; "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?" Have you felt that you were in any danger this past week?" **Note:** If the patient reports any persecutory ideas/delusions, ask the following: "For the past week, how often have you been concerned that [use patient's description of persecutory ideas/delusions]?"; "Have you told anyone about it?"

Item 9. Hallucinations: "For the past week have you: -heard people talking, voices or other sounds when there was nobody around? -had visions or seen things that others couldn't see? -smelled odors or tasted things that others couldn't smell/taste? -felt that someone or something was touching you without actually being touched? -felt that an arm, a leg, or another part of your body was in a position that it actually wasn't in at all? -had any sensations of pain, heat or cold without being exposed to painful, hot or cold things?" **Note:** If the pt. reports any hallucinations, ask the following: "Within the past week, how often have you felt [use the patient's description of hallucinations]?"; "Has this troubled you?"

Item 10. Unusual thought content: "Have you experienced anything unusual for the past week?"; "have you been noticing any unusual things about your body, organs or bodily functions this past week?"; "Would you say that you are in good health at the moment?"; if no: "Why not?"; "If you were to guess right now, how old do you think you will become?"; "Have you been concerned about your financial situation this past week?"; "This past week, have you been concerned about things being out of order in your home or other places you've been staying, such as the water supply, sewerage, electricity or other aspects?"; "In your opinion, what is the meaning of life?"; "Have you felt that you were under the control or influence of another person or force this past week?" **Note:** If the pt. reports unusual ideas / delusions, ask the following: "How often do you think about [describe unusual idea / delusion]?"; "How do you explain the [specify unusual idea / delusion]?"; "Has the [unusual idea / delusion] had any consequences for you for the past week?"; "Have you told other people about [unusual idea / delusion]" if yes: "What do they think about it"; "This past week, have you done something because of [unusual idea / delusion] that you otherwise wouldn't have done?"

Items 6, 7 & 11 (Psychomotor retardation, Emotional withdrawal & Blunted affect): These ratings are based on observations from the interview.