The Manchester Scale
A Standardised Psychiatric Assessment for Rating Chronic Psychotic Patients

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The Manchester Scale (Krawiecka et al, 1977) was developed as a short, easy to administer instrument, sensitive to change, for screening patients with chronic psychosis. It consists of eight 5-point rating scales which cover three areas of psychopathology. Positive symptoms consist of coherently expressed delusions, hallucinations, incoherence and irrelevance of speech; negative symptoms include flattened/incongruous affect, psychomotor retardation or lack of spontaneity and poverty of speech. Affective symptoms cover both anxiety and depression.

The instrument’s predecessors include a simple interview described by Wing (1961) using a 5-point scale which allowed reliable classification of patients with chronic schizophrenia and the Clinical Interview Schedule (Goldberg et al, 1970) which used 22 5-point scales to allow a clinical diagnosis in the community.

The methodology involved initially producing videotapes of ten psychotic patients by two trained psychiatrists. Secondly, a full training interview was made with explanations and a detailed manual. Thirdly, this allowed new raters to train and compare their ratings with the other ten tapes. Hence it would be a relatively easy matter for new raters or centres to become skilled.

The scale is not intended to be used blindly; a working familiarity with the patients’ notes is desirable. The first four ratings are based on the patient’s replies to questions, the next four on clinical observations during the interview.

A reliability study has been performed. The two interview psychiatrists independently rated all ten tapes, three other psychiatrists trained on the example tapes and then rated the ten criterion tapes. The overall agreement between psychiatrists was established using Kendall’s Coefficient of Concordance W, for the groups of five (all psychiatrists) and three (tape trained psychiatrists) raters.

Friedman’s Two-Way Analysis of Variance by ranks was carried out for the groups of five and three psychiatrists. There were no differences between the psychiatrists in their mean severity ratings except on flatness of affect where one psychiatrist gave consistently lower ratings resulting in a significant difference ($P<0.01$) for both the three- and five-psychiatrist groups.

Suggested uses of the Manchester Scale include assessing large chronic populations, drug trials (when a simple side-effect rating is also available), and rehabilitation studies. It would also be suitable for multicentre population comparisons with the advantages of easy training and rapidity of use. Other developments have been suggested, including the incorporation of two further 5-point scales, ‘Cooperation with the Social Situation of Interview’ and ‘Abnormal Movements’ in the ratings by observation (Eve Johnstone personal communication). These have not been fully investigated yet.

Further work is at the moment being carried out at Manchester updating and clarifying the scale and videotapes using our experience of the last 10 years.

Reference
The Manchester Scale*

Ratings

All ratings are on a 5-point scale:

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

Ratings made by replies to questions

- Depressed
- Anxious
- Coherently expressed delusions
- Hallucinations

Ratings made by observation

- Incoherence and irrelevance of speech
- Poverty of speech, mute
- Flattened affect
- Incongruous affect
- Psychomotor retardation

Side-effects
(Rate as: 0. Absent; 1. Mild; 2. Marked)

- Tremor
- Rigidity
- Dystonic reactions
- Akathisia
- Difficulties with vision
- Other (specify)

Guide lines for the use of the five-point scales

In making these ratings the psychiatrist is expected to use his clinical judgement to make overall assessments about the patients in each particular area. For example, in making the rating for depression the rater should be expressing his own clinical assessment of the severity of depression, based on both the patient's demeanour and behaviour during the interview, and the history that the patient has given concerning depression. It should be emphasised that a morbid rating (2, 3, or 4) for depression does not imply that the principal diagnosis made will necessarily be an affective illness.

General rules for the five-point scale

0. Mild. The item is for all practical purposes absent.

1. Mild. Although there is some evidence for the item in question, it is not considered pathological.
2. Moderate. The item is present in a degree just sufficient to be regarded as pathological.
3. Marked. See individual definitions.
4. Severe. See individual definitions.

Depression

This does not only include the actual behaviour observed at interview — dejected pose, sad appearance, despondent manner — but should be a clinical rating which expresses the overall assessment of depression, and the contribution that this abnormality of affect is making to the abnormal mental state being rated. Whether there is a discrepancy between depression observed at interview and depressed mood reported as having been experienced in the past week, the rating made should be the greater of the two ratings.

0. Absent. Normal manner and behaviour at interview. No depressive phenomena elicited.
1. Mild. Although there may be some evidence of depression — occasional gloominess, lack of verve, etc. — the rater does not consider that it is pathological, or takes it to be a habitual trait not amounting to clinically significant depression.
2. Moderate. The patient is thought to be clinically depressed, but to a mild degree; or occasional depressed feelings which either cause significant distress or are looked upon by the patient as a significant departure from his usual self, in the past week.
3. Marked. The patient is thought to be clinically depressed, in marked degree; or frequent depressed feelings as described in No. 2 in the past week, or occasional extreme distress caused by depression.
4. Severe. The patient is thought to be clinically depressed in extreme degree. Major depressive phenomena should be present, strongly held suicidal ideas, uncontrollable weeping, etc.; or depression has caused extreme distress frequently in the past week.

Anxious

In addition to direct evidence of anxiety observed by the rater at interview, this rating should express the rater's view of the contribution which morbid anxiety is making to the mental state under consideration. (There may be some physiological signs of sympathetic over-activity, moist palms, mild tremor, blotchy patches in skin, etc.). Where anxiety is of such a degree that there is associated motor agitation, this will be rated on this key as not less than No. 3. Where there is a discrepancy between anxiety as observed at interview and anxiety expressed in the previous week the rating made should be the greater of the two ratings.

0. Absent. Normal mood at interview.
1. Mild. Such tenseness as the patient displays is thought either to be an habitual trait not amounting to pathological proportions or is thought to be a reasonable response to the interview situation.
2. Moderate. The patient is thought to display a mild degree of clinically significant anxiety or tension; or anxiety sufficient to cause significant distress has occurred occasionally in the past week.
3. Marked. The patient is thought to display a marked degree of clinically significant anxiety or tension. He may be apprehensive about the interview and need reassurance, but there are only minor disruptions of the interview due to anxiety. There may be associated motor agitation of marked degree; or anxiety sufficient to cause significant distress has occurred frequently in the past week, or anxiety has caused extreme distress for the individual concerned occasionally in the past week.
4. Severe. The patient is thought to display an extreme degree of clinically significant anxiety or tension. He may be unable to relax, or there may be major disruptions of the interview due to anxiety. There may be associated motor agitation of marked degree, or a fearful pre-occupation with impending events, or anxiety has caused extreme distress for the individual concerned frequently in the past week.

Flattened, incongruous affect

Flatness refers to an impairment in the range of available emotional responses; the patient is unable to convey the impact of events while relating his history, and cannot convey warmth or affection while speaking about those near to him.

0. Absent. Normal affect at interview.
1. Mild. The patient may be laconic, taciturn or unresponsive in discussing emotionally charged topics, but the rater considers that this is an habitual trait rather than a sign of illness.
2. Moderate. Clinically significant impairment of emotional response of mild degree. Definite lack of emotional tone discussing important topics; or occasional but undoubted incongruous emotional responses during the interview.
3. Marked. Clinically significant impairment of emotional response of marked degree. No warmth or affection shown. Cannot convey impact of events when giving history, no concern expressed about future; or frequent incongruous responses of mild degree or occasional gross incongruity.
4. Severe. Clinically significant impairment of emotional response of extreme degree: no emotional response whatever elicited; or gross frequent incongruity; fatuous, supercilious, giggling, etc., in such a way as to disturb interview.

Psychomotor retardation

0. Absent. Normal manner and speech during interview. Questions answered fairly promptly; air of spontaneity and changes of expression.
1. Mild. Although there may be evidence of slowness or poor spontaneity the rater considers that this is either an habitual trait or that it does not amount to clearly pathological proportions.
2. Moderate. The rater detects slowness, or lack of spontaneity at interview and attributes this to psychiatric illness; it is just clinically detectable. Delays in answering questions would merit this rating providing that the rater considers that it is part of a morbid mental state rather than an habitual trait of the patient.
3. Marked. Psychomotor retardation attributable to psychiatric illness is easily detectable at interview and is thought to make a material contribution to the abnormalities of the patient's present mental state.
4. Severe. Psychomotor retardation is present in extreme degree for the individual concerned.

Coherently expressed delusions

0. Absent. No abnormality detected at interview.
1. Mild. Eccentric beliefs and trivial misinterpretations: that bad weather is caused by nuclear tests; superstitions, religious sects, etc.
3. Marked. Undoubted delusions or delusional perception are described as having occurred in the past month but the patient denies that he still holds the beliefs at present; or delusional ideas are expressed but they are not strongly held or incorrigible.
4. Severe. Undoubted delusions are present and are still held by the patient.

HALLUCINATIONS

The rater must therefore decide whether hallucinations have occurred in the past week; if so, whether they are true — or pseudo-hallucinations, and how frequently they have occurred.

0. Absent. No evidence of hallucinations.
1. Mild. The hallucinatory experiences reported to the rater are not definitely morbid, hypnagogic hallucinations, eidetic images and illusions.
2. Moderate. Pseudo-hallucinations of hearing and vision; hallucinations associated with insight — e.g. those following bereavement.
3. Marked. True hallucinations have been present in the past week but have occurred infrequently.
4. Severe. True hallucinations have occurred frequently in the past week.

Incoherence and irrelevance of speech

0. Absent. No evidence of thought disorder.
1. Mild. Although replies are sometimes odd the abnormalities fall short of those required for thought disorder: it is always possible to understand the connection between ideas.
2. Moderate. Occasional evidence of thought disorder elicited, but patient is otherwise coherent.
3. Marked. Frequent evidence of thought disorder but meaningful communication is possible with the
patient; or several episodes of incoherent speech occur.
4. Severe. Replies difficult to follow owing to lack of
directing associations. Speech frequently incoherent,
without a discernible thread of meaning.

Poverty of speech, mute
0. Absent. Speech normal in quantity and form.
1. Mild. Patient only speaks when spoken to; tends to
give brief replies.
2. Moderate. Occasional difficulties or silences but most
of interview proceeds smoothly; or conversation
impeded by vagueness, hesitancy or brevity of replies.
3. Marked. Monosyllabic replies; often long pauses or
failure to answer at all; or reasonable amount of
speech, but answers slow and hesitant, lacking in
content, or repetitions and wandering; that meaningful
conversation was almost impossible.
4. Severe. Mute throughout interview, or speaks only
two or three words; or constantly murmuring under
breath.
A standardized psychiatric assessment scale for rating chronic psychotic patients

M. Krawiecka, D. Goldberg and M. Vaughan

Simple 5-point scales are described together with the method used to study their reliability, the results of which are shown. The scales are short, easy to administer and sensitive to change, therefore particularly applicable where there is the need for screening chronic psychotic populations. Some uses for the scales are suggested.

Key words: 5-point rating scales – screening – reliability – chronic psychotic populations.

The objective rating of mental state has always been of considerable interest and the assessment and measurement of clinical therapeutic progress has increased the need for a scale suitable for the purpose. It would be necessary for such a scale to be short and yet to allow a reliable assessment of chronic patients in particular and to be sensitive to change in their status. So far no scale fulfills all these criteria. Of the existing scales the Wittenborn (Wittenborn (1955)), the Mental Schedule (Spitzer et al. (1964)), the In-Patient Multi-dimensional Psychiatric Scale (IMPS) (Lorr et al. (1963)), Present State Examination (Wing et al. (1967)) and the Clinical Interview Schedule (Goldberg et al. (1970)) are lengthy. Only Overall & Graham’s (1962) shortened version of IMPS is more manageable from that point of view, but unfortunately it suffers from comparative insensitivity to change.

Although the Present State Examination (Kendell et al. (1968)) yields very reliable ratings for diagnostic purposes it was not designed primarily for measuring change and its length (140 items) makes it difficult to use in this setting. Wing (1961) in an early paper described a simple interview using 5-point scales allowing a reliable classification of schizophrenic patients; the main symptom areas were: flatness and incongruity of affect, poverty of speech, incoherence of speech and coherent delusions. The Clinical Interview Schedule of Goldberg et al. (1970) also uses 5-point scales including most of those described by Wing (1961) but enables the research worker to make a total of 22 ratings, thus making it possible to make a diagnosis in community settings.

There are obvious advantages in scales which can be used for the assessment of therapeutic change but also allow researchers to classify patients according to Wing’s Scale. The aim of the present study was to produce a short set of rating scales which would provide a reliable clinical assessment of chronic psychotic patients and which would be sensitive to changes in their conditions.

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