WHO Psychiatric Disability Assessment Schedule (WHO/DAS)

with a guide to its use

WORLD HEALTH ORGANIZATION
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Preface

Much past research on mental disorders has been focused on hospital populations, and few attempts have been made to disentangle the clinical characteristics of the disorders, such as the symptoms and their course over time, from the disturbances in social adjustment and behaviour. Even less is known about the "natural history" and evolution of the different components of these complex conditions, and about the extent to which some of their manifestations could in fact represent maladaptive responses to particular aspects of the social environment.

One of the obstacles to progress has been the lack of easily applicable and standardized methods for assessing disabilities in psychiatric patients. Another has been the absence of agreed concepts and a general framework to which epidemiological, clinical, and social observations can be related.

In an attempt to overcome these obstacles, WHO initiated a pilot study in 1976 in seven countries, to explore the applicability, reliability, and validity of a set of instruments and procedures for the evaluation of functional impairments and disabilities in a population of patients with potentially severe psychiatric disorders. Through consecutive follow-up assessments, data were also collected on the "natural history" of such impairments and disabilities in different sociocultural environments with a view to identifying predictors of disease outcome at levels of social functioning. Details of the study are given in Annex 1.

One of the principal instruments of the collaborative study was the WHO Psychiatric Disability Assessment Schedule (WHO/DAS). This schedule was used to record information about the patients' functioning and some of the factors that might influence it. The version presented here was finalized by the collaborating investigators in 1984, after the completion of the field studies. The instrument has also been used in other studies, both within and outside the framework of the WHO mental health programme, in over 20 countries.

In addition to English, the schedule is available in Arabic, Bulgarian, Chinese, Danish, French, German, Hindi, Japanese, Russian, Serbo-Croat, Spanish, and Urdu. Anyone wishing further information on the use of the schedule, including details of training material, should contact the Division of Mental Health, World Health Organization, 1211 Geneva 27, Switzerland.

The collaborating investigators in the study for which the WHO/DAS was developed were: Dr I. Temkov, Dr T. Tomov, Dr M. Boyadjieva, Dr Z. Ivanov, Dr C. Todorov, Dr C. Popov, and Dr L. Zhivkov, Institute of Neurology, Psychiatry, and Neurosurgery, Sofia, Bulgaria; Dr R. Schwarz, Mr K. Maurer, Dr H. Biehl, Mrs C. Schubart, Dr G. Badelt, Dr J. Michael, and Dr A. Schwarz, Central Institute for Mental Health, Mannheim, Federal Republic of Germany; Dr R. Giel, Dr D. Wiersma, Dr A. de Jong, Dr H. C. Sauer, and
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The study was coordinated at WHO Headquarters in Geneva by Dr. A. Jablensky (principal investigator), Mrs. G. Ernberg, Dr. H. Hugler, Miss K. Canavan, and Miss J. Sikkens.
Introduction

The WHO Psychiatric Disability Assessment Schedule is designed to assess the social functioning of patients with a mental disorder; it is applicable in a variety of cultural settings. The schedule consists of five parts: 1. Overall behaviour (pp. 4–7); 2. Social role performance (pp. 8–18); 3. Patient in hospital (for hospitalized patients only) (pp. 19–24); 4. Modifying factors (pp. 25–30); and 5. Global evaluation (p. 31).

Who should fill in the schedule?

The patient's behaviour and functioning should be rated, and the schedule filled in, by one of the following: a psychiatrist, a psychologist, a sociologist, or a social worker. Whatever the professional qualification of the rater, previous experience in rating behaviour, and a period of training in the use of this schedule, are required.

Sources of information

The schedule is not a questionnaire and the rating of the items included presupposes an ability to make a judgement on the basis of the information available. The sources of information are: (a) a key informant about the patient (usually a family member); (b) the patient; and (c) any written records, or data from other informants (e.g., workmates, colleagues). To obtain relevant information, the rater should be thoroughly familiar with the content of the items of the schedule; in the course of the interviews, he or she should ask appropriate questions and cross-examine informants and/or the patient. Although a key informant would be, in most instances, the main source of information, it is always advisable for the rater to have at least a brief interview with the patient, especially as regards the items marked with an asterisk in the schedule, which require corroborating information from the patient.

Making a rating

Under each heading in Sections 1 and 2, the guidelines given refer to the areas of functioning or behaviour that should be considered. Guidelines are also provided for choosing the appropriate step of the scale ranging from "no dysfunction" to "maximum dysfunction". In case of doubt, the general rule is that the rater should select the numerically lower step. In every instance, when a rating of 1, 2, 3, 4, or 5 is made, it is desirable to make a brief narrative note of the specific facts that justify the particular rating. Unless otherwise specified, the rater's criteria for selecting a particular step of the scale should take into consideration: (a) the severity (or intensity) of the particular behaviour that is being rated; and (b) the proportion of time in the past month during which the behaviour was manifest. If a manifestation occurring during thepast month was severe but of brief duration, it can be rated at the
Introduction

same level as a less severe manifestation occupying a greater proportion of the month.

Baseline for evaluation

For most of the items, the patient’s behaviour or functioning (in the previous month, unless specified otherwise) should be evaluated against the presumed “average” or “normal” functioning of a person of the same sex and of comparable age and sociocultural background (general guidelines given under “no dysfunction”).

Hospitalized patients

For patients who have been in hospital for more than two weeks before the evaluation, Section 3 should be rated in addition to Sections 1 and 2. For patients currently in hospital (admitted not more than 2–3 months ago) the ratings in Section 2 should refer to the month before admission. If the patient has been in hospital for more than 3 months, Section 2 should not be rated.
The WHO
Psychiatric Disability
Assessment Schedule
The WHO/DAS Identification Form

Name of facility

Patient's first name or initials

Identification number of patient in the facility

Card 1
Column

Project identification Card no.

1–8

Field research centre

01 = 06 =
02 = 07 =
03 = 08 =
04 = 09 =
05 = 10 =

Investigator who filled in this schedule

9–10

11–13

Name

Was this schedule filled in as part of a training exercise or for purposes of inter-observer comparison?

0 = No

1 = Yes, the person who filled in this schedule was present during the interview but did not interview the informant himself/herself (name of person who interviewed the informant: )

14

Patient's project identification no.

Sex Date of birth

Day Month Year

15–17

18–24

Date when this form was filled in

Day Month Year

25–30

Source of information used to fill in this schedule

31–33
1. Overall behaviour

1.1 Patient's self-care during past month

Inquire about: (i) personal hygiene—washing; shaving; keeping clothes, hair, fingernails, etc., clean and tidy; toilet habits; (ii) feeding habits; (iii) keeping living space (e.g., own room) tidy

Rate 9 if no assessment possible

No dysfunction: level and pattern of self-care normal within patient's sociocultural context; patient takes a reasonable interest in his/her appearance.

Minimum dysfunction: patient maintains reasonable standards of (i), (ii) and (iii) with some (occasional) supervision; or standards are somewhat lowered when no supervision is available; some loss of interest in own appearance.

Obvious dysfunction: lack of self-care beyond minimum dysfunction is clearly established; patient likely to make an unfavourable impression; mild deterioration in appearance.

Serious dysfunction: marked decline in all aspects of self-care; evidence of neglect, e.g., vagrant or tramp-like appearance.

Very serious dysfunction: to the extent of exposing the patient to hazards such as malnutrition, dehydration, or infection, and of a severity likely to necessitate social intervention.

Maximum dysfunction: patient totally uninterested in own appearance, unable to care for self; constant supervision is necessary for (i), (ii) and (iii); gross self-neglect when supervision is less intensive. Use this code only in extreme cases, e.g., when patient wets or soils himself/herself if left unattended.
1.2 Underactivity during past month

Inquire about: time during the day spent in what the culture considers to be doing nothing; e.g., lying awake in bed; or sitting still and unoccupied; not talking with others. Make an estimate on the basis of typical behaviour during the past one month. (Do not include time spent watching television and other passive but culturally sanctioned behaviours.)

Rate 9 if no assessment possible

No dysfunction: patient reasonably active and occupied during the day (taking into consideration cultural norms and expectations), without supervision or encouragement.

Minimum dysfunction: on a typical day during the last month patient spent between 2 and 4 hours doing nothing.

Obvious dysfunction: lack of activity for an average of 4–6 hours during the day.

Serious dysfunction: lack of activity for 6–8 hours on the average; needs occasional prompting for the execution of simple tasks during the day.

Very serious dysfunction: spends about 8 hours a day doing nothing; requires almost continuous supervision to keep going.

Maximum dysfunction: patient does nothing during most of the day; would not carry out most elementary tasks without constant encouragement and supervision; nearly total lack of initiative for most of the time in the past month.
### 1.3 Slowness

Inquire about: overall speed of movement and agility in carrying out daily activities during past one month.

**Rate 9 if no assessment possible**

- **No dysfunction:** normal speed of movement and of carrying out ordinary daily activities.

- **Minimum dysfunction:** takes longer than normal to carry out ordinary tasks, but can manage once started; or shows periods of extreme slowness but at other times is normal.

- **Obvious dysfunction:** slowness of movement definitely present most of the time but does not interfere severely with the patient's daily routine.

- **Serious dysfunction:** slowness definitely present most of the time and interferes with most of patient's activities.

- **Very serious dysfunction:** slowness very marked and persists throughout the day; activities performed with great difficulty.

- **Maximum dysfunction:** all or most of the time during the past month patient has been extremely slow to move and carry out ordinary tasks like dressing, eating, etc. Slowness may amount to absence of movement for hours or longer at a stretch.
1.4 Social withdrawal during past month

Inquire about: (a) active avoidance of interacting (verbally or non-verbally) with people, e.g., avoiding talking to people present; (b) active avoidance of being in the physical presence of other people. The latter includes avoidance of normally expected social activities outside the home, such as visiting relatives or friends, going out with friends, or participating in games.

Since behaviour of type (b) must be absent in order for behaviour of type (a) above to be manifested, (b) should be regarded as a more severe degree of disturbance than (a). Other manifestations of withdrawal, e.g., interacting with people via the telephone while avoiding their presence, should be rated (1) or (2).

Rate 9 if no assessment possible

No dysfunction: patient mixes, talks, and generally interacts with people in accordance with the expectations of his/her sociocultural context; no evidence of avoiding people.

Minimum dysfunction: somewhat socially withdrawn and solitary but mixes with people if encouraged.

Obvious dysfunction: maintains a very restricted range of social contacts; avoids being with other people.

Serious dysfunction: clear tendency to self-isolation, but still responds to encouragement.

Very serious dysfunction: marked tendency to self-isolation; not responsive to encouragement.

Maximum dysfunction: during the past one month, has practically never mixed socially with anyone; is inaccessible; actively avoids both company and conversation; may frequently lock himself/herself up in a room; or wander aimlessly without attempting to make contact with people for most of the day.
2. Social role performance

In filling in Section 2, please remember: (a) whenever possible, this section should also be rated if the patient has been admitted to hospital recently (not more than 2–3 months ago) and is currently in hospital; in such instances the ratings should refer to the month before admission; (b) the concepts underlying the ratings in this section refer to the performance of specific social roles and not to the more generalized disturbances rated in the previous section. This section should be rated also for patients currently in day-care facilities (select a suitable informant).
2. Social role performance

2.1 Participation in household activities during past month

Inquire about: (i) patient's participation in common activities of the household, such as having meals together, doing domestic chores, going out or visiting together, playing games, watching television, etc.; (ii) patient's participation in decision-making concerning the household, e.g., decisions about the children, money, etc. For housewives, consider the household jobs that a housewife usually has to do. Make a rating without regard to whether patient is asked to participate, left on his/her own or rejected in some way.

Rate 8 if information not available and 9 if item not applicable

No dysfunction: patient participates in household activities about as much as is expected for his/her age, sex, position in the household, and sociocultural context.

Minimum dysfunction: patient participates less than would be expected and has little interest in (ii), although such participation would normally be expected for someone in similar circumstances.

Obvious dysfunction: household participation is reduced to a narrow range of family functions, performed somewhat incompetently.

Serious dysfunction: lack of participation and of competence in household matters, to the extent of being excluded from decision-making by other members.

Very serious dysfunction: takes no part in any common activities; is alienated from daily routine; exists alongside the household as a unit.

Maximum dysfunction: patient totally excludes himself/herself, or is excluded, from participation in any common household activities; disrupts the functioning of the household as a unit.
WHO Psychiatric Disability Assessment Schedule

2.2 Marital role: affective relationship to spouse during past month*  
(Here "spouse" means a steady heterosexual partner regardless of legal status)

Inquire about: (i) patient's communication with spouse (e.g., talking to spouse about ordinary events, news, the children, etc.) (ii) patient's ability to show affection and warmth towards spouse (occasional outbursts of anger or irritability should be evaluated against the cultural norm); (iii) spouse's feeling that patient is a source of support to whom spouse can turn. Ask for examples.

Rate 8 if information not available and 9 if item not applicable  
(e.g., if patient unmarried or not living with spouse or partner during past month)

<table>
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<tr>
<th>Dysfunction</th>
<th>Rating</th>
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<tr>
<td>No dysfunction</td>
<td>0</td>
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<tr>
<td>Minimum dysfunction</td>
<td>1</td>
</tr>
<tr>
<td>Obvious dysfunction</td>
<td>2</td>
</tr>
<tr>
<td>Serious dysfunction</td>
<td>3</td>
</tr>
<tr>
<td>Very serious dysfunction</td>
<td>4</td>
</tr>
<tr>
<td>Maximum dysfunction</td>
<td>5</td>
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* This item requires corroborating information from the patient.
2.3 Marital role: sexual relations with spouse during past month*

Consider: (i) occurrence of sexual intercourse in past month, (ii) whether patient experiences sexual relations as satisfactory, (iii) whether spouse experiences sexual relationships as satisfactory.

Rate 8 if information unobtainable and 9 if item not applicable

No dysfunction: sexual intercourse has taken place during the past month; neither patient nor spouse finds their sexual relations unsatisfactory.

Minimum dysfunction: sexual intercourse has taken place but either patient or spouse finds their sexual relations not satisfactory (e.g., less pleasurable, or spouse "overdemanding"). If sexual intercourse has not taken place (although there were opportunities) and the patient’s interest in sex has diminished, rate between 2 and 4, depending on estimated severity. Degree of loss of interest and initiative as regards sex should be considered in choosing a rating.

Obvious dysfunction: patient’s sexual interest and initiative have declined, or his/her involvement in the sexual relationship now deviates from the previously established pattern (e.g., more frequent demands for intercourse, to a degree unacceptable to the spouse, disregard for spouse’s feelings and pleasure).

Serious dysfunction: a more severe degree of disturbance than 2; no sexual initiative; or advances towards marital partner grossly inappropriate and inconsiderate, in comparison with previous pattern.

Very serious dysfunction: more severe degree than 3; avoidance of any cues to intimacy, or definite aversion towards spouse.

Maximum dysfunction: persistent and total lack of sexual interest in spouse.

* This item requires corroborating information from the patient.
WHO Psychiatric Disability Assessment Schedule

2.4 Parental role: interest and care of child (children) during past month*

Consider: (i) undertaking and performance of child care tasks appropriate to patient's position in household (e.g., feeding, putting to bed, taking to school—for small children; looking after child's needs—for older children); (ii) interest in child (e.g., playing, reading to, taking interest in his/her problems, school work, etc.). If children are not living with patient, consider and rate only (ii).

Rate 8 if information not available and 9 if item not applicable

No dysfunction: patient participates in child care to the extent that is expected in his/her sociocultural context for his/her parental role (father/mother) and shows interest in the child (children).

Minimum dysfunction: patient unable to perform without aid or some supervision child care tasks that are normally considered his/hers, or has less interest in child (children) than would be expected.

Obvious dysfunction: competence in performing routine parental duties as prescribed by culture is significantly reduced; spouse must take over increasing number of child care tasks and responsibilities.

Serious dysfunction: as above, but practically all child care is taken over by spouse.

Very serious dysfunction: parental functions completely taken over by spouse or relatives (friends); in addition, external agencies (e.g., social, medical, legal) have been called to intervene; patient not trusted to be alone with the children.

Maximum dysfunction: patient totally unable to look after child (children) and can be a risk because of carelessness, lack of interest, or overt hostility to child (children).

* This item requires corroborating information from the patient.
2.5 Sexual role: relationships with persons other than marital partner during past month
(unmarried patient or patient not living with spouse)*

Consider: (i) heterosexual (or homosexual) interests and emotional responsiveness shown by patient; (ii) actual relationship or contacts sought by patient (regardless of whether sexual relations involved or not).

Rate 8 if information not available and 9 if item not applicable
(e.g., if patient married, or circumstances rule out possibility of sexual contacts; or cultural norms preclude such contact)

No dysfunction: patient currently has a relationship with, or is showing emotional/sexual interest in, a person as appropriate for his/her age and sociocultural context.

Minimum dysfunction: patient has shown sexual interest or has had casual contacts but no established relationship in spite of existing opportunities.

Obvious dysfunction: evidence of diminished sexual interest, or even if some interest shown, no approach to the other person made.

Serious dysfunction: patient either shows no sexual interest at all or only interests and initiatives that are clearly unrealistic or inappropriate.

Very serious dysfunction: complete indifference to sexual stimuli; or manifests bizarre attitudes to sexually eligible persons.

Maximum dysfunction: patient fears and avoids and/or shows hostility to persons of opposite sex; risk of violence may be considered.

* This item requires corroborating information from the patient.
2.6 Social contacts: friction in interpersonal relationships outside the household in past month*

Consider: overt conflictive behaviour on the part of the patient involving inappropriate arguments, annoyance, anger or marked irritability arising in social situations outside own home, e.g., (i) with supervisors, colleagues, customers, etc., if patient is working; (ii) with neighbours, other people in the community, etc., if patient is a housewife or not working; (iii) with teachers, administrators, other students, etc., if patient is a student. For patients living in hostels or other communal accommodation, include frictions arising with other boarders.

Rate 8 if information not available and 9 if item not applicable

No dysfunction: no undue friction in interpersonal relationships; gets along reasonably well with other people; is liked and generally well accepted in group activities.

Minimum dysfunction: some friction has occurred on isolated occasions during past month but no serious conflict or arguments; tolerated by other people.

Obvious dysfunction: patient's response to people tends to be belligerent or argumentative; this is noticed by others and leads to some ostracism.

Serious dysfunction: conspicuous friction with at least one person markedly affects the patient's acceptance and integration in his/her social or occupational group and environment.

Very serious dysfunction: more generalized or more severe friction causing serious problems in daily living and/or work; external agencies may be called upon to mediate.

Maximum dysfunction: patient is in a serious and lasting conflict with one or more individuals in one of the categories (i), (ii), or (iii). Very severe tension, hostility, anger, or violence shown towards one particular individual should be rated (5), even if relations with other people are unexceptional. On the other hand, a rating of (5) should also be made when a generalized, though not exceptionally severe, conflict is present between the patient and many other people, leading to virtual exclusion from social activities and/or sanctions, especially if external agencies have been involved in getting the situation under control.

* This item requires corroborating information from the patient.
2.7 Occupational role: work performance during past month (including students and persons in sheltered employment)*

Inquire about: (i) whether patient conforms to the work routine—going to work regularly and on time, observing the rules, etc.; (ii) quality of performance and output. Household work is excluded (rate in 2.1). If key informant unable to provide information, make a rating after consulting alternative sources.

*This item requires corroborating information from the patient.

Rate 8 if information not available and 9 if item not applicable (e.g., patient is not employed or is a housewife)

No dysfunction: patient goes to work or study regularly; output and quality of performance within acceptable levels for the job.

Minimum dysfunction: compared with the average employee (or student) in the same type of job or in the same school, class, etc., the patient has been absent from work more often during the past month; or there has been a noticeable decline in his/her output and quality of performance; or patient complains that work is too heavy for him/her. If the above description applies to a sheltered job, rate 2.

Obvious dysfunction: as above, but aggravated by conspicuous lack of concern on the part of the patient.

Serious dysfunction: marked decline of performance or output; this is perceived by key figures at work (or school) as disruptive.

Very serious dysfunction: deterioration in performance has reached a critical point; patient is facing risk of administrative sanction.

Maximum dysfunction: patient has been absent from work most of the time; or has shown gross or dangerous neglect at work more than once; or performance has been extremely poor; for any of these reasons, administrative sanctions (e.g., dismissal from job) have actually been taken.
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2.8 Occupational role: interest in getting a job or in going back to work or studies

(To be rated for patients of employable age but currently not employed or not working; students are included. If the patient is a housewife, use judgement about local expectations concerning housewives seeking employment outside the home.)

Consider: (i) interest in obtaining or returning to a job or studies; (ii) actual steps undertaken to get a job or start studies.

Rate 8 if information not available and 9 if item not applicable

No dysfunction: patient talks about his/her interest in obtaining a job or studying; evidence that during the past month he/she has actively taken steps to get a job or continue studies.

Minimum dysfunction: patient declares interest in taking a job (study); however, has made only half-hearted attempts to get a job or continue studies; or attempts that are insufficiently realistic.

Obvious dysfunction: patient shows hesitation; might consider taking a job (study) if pushed; no initiative of his/her own.

Serious dysfunction: patient no longer entertains the idea of working or studying; offers various unrealistic excuses for this; unresponsive to persuasion.

Very serious dysfunction: total lack of interest in working (studying) and no concern about prospects of remaining without any occupation.

Maximum dysfunction: patient resists the idea of obtaining a job (or continuing studies); has avoided or rejected actual opportunities to get a job or enrol for study; or has revealed totally unrealistic fantasies in these respects.
2.9 Interests and information during past month*

Consider: (i) interest shown by patient in local or world events or in other matters, as commensurate with his/her social background, education, and level of intelligence; (ii) efforts to obtain such information.

Rate 8 if information not available and 9 if item not applicable

No dysfunction: patient is showing an interest in local or world events and is seeking information (e.g., by reading newspapers, books, or other literature, listening to news broadcasts, watching television programmes, or talking to other people), as appropriate to his/her sociocultural context.

Minimum dysfunction: patient shows less than average interest in local or world events and is not making any special efforts to obtain information; occasionally reads newspapers or other literature, or listens to news broadcasts, or watches television programmes.

Obvious dysfunction: patient not concerned about information; does not read; may occasionally listen to radio broadcasts or watch television, has only superficial or inaccurate ideas about current local and world events.

Serious dysfunction: patient shows gross and obvious gaps in information about current events that most other people would know about.

Very serious dysfunction: patient reveals an almost total lack of information in spite of superficial claims to the contrary in answering the question.

Maximum dysfunction: patient totally uninterested in local and world events; never reads anything; does not listen to radio or watch news on television.

* This item requires corroborating information from the patient.
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2.10 Patient’s behaviour in emergencies or in out-of-the-ordinary situations that have occurred in the past six months

Consider: patient’s response to events such as: (i) sickness or accident affecting a family member; (ii) sickness, accident or incident involving other people; (iii) minor emergencies (e.g., breakdown of equipment); (iv) any other situation out of the routine for the patient, normally requiring action (e.g., patient left to baby-sit, requested to pass on a message, etc.).

Rate 8 if information not available and 9 if nothing of the sort has happened in the past six months or not known

No dysfunction: patient has responded in an adequate and reasonably efficient way to the unusual situation.

Minimum dysfunction: patient has shown some response and concern but no initiative of his/her own and little efficiency, if instructed how to act.

Obvious dysfunction: inefficient or inadequate response to a situation in which most other people would have found a proper course of action without difficulty.

Serious dysfunction: patient has shown incompetence (but not indifference) in situations with potentially hazardous consequences.

Very serious dysfunction: patient has shown indifference, in addition to incompetence, in situations with potentially hazardous consequences.

Maximum dysfunction: patient has shown total apathy and indifference in situations calling for relatively simple, feasible action; this has had adverse consequences.
3. Patient in hospital

(This section should be rated if the patient has been in hospital for at least 2 weeks during the past month.)

3.1 Ward behaviour

Information for rating this section should be obtained from the nursing staff on the ward.

Please consider the patient’s behaviour during the past week only, even if it was not typical of his or her usual condition.

There are three ratings under each item. If one of the ratings describes the patient’s behaviour in the past week, write the corresponding code in the box on the right.

3.1.1 Slowness of movement

0 = Speed of movement normal.
1 = Showed substantial periods of marked slowness of movement, but moved at normal speed part of the time.
2 = Usually extremely slow to move, e.g., took very much longer over a meal, or dressing, or walking across the ward, than other patients.

3.1.2 Underactivity

0 = Showed no underactivity.
1 = Showed substantial periods of marked underactivity, but at other times was not underactive.
2 = Stood or sat in one place all the time, with little movement. Even with encouragement was very difficult to get moving.

3.1.3 Overactivity (consider also over-talkativeness)

0 = Showed no overactivity or over-talkativeness.
1 = Showed substantial periods of overactivity, or over-talkativeness, but at other times was not overactive or over-talkative.
2 = Usually extremely overactive, over-talkative or restless, e.g., paced rapidly up and down, became excited, talked or sang loudly or wildly.
3.1.4 Conversation
0 = Ordinary amount of conversation.
1 = Speech very restricted, e.g., said a few words in reply to a question or to make wants known, but was otherwise silent.
2 = Was mute or almost mute.

3.1.5 Social withdrawal
0 = Normal social mixing.
1 = Was socially withdrawn and solitary, but would mix passively with others if encouraged to do so.
2 = Never mixed socially with anyone, even when encouraged to do so.

3.1.6 Leisure interests
0 = Showed normal spontaneous interests.
1 = Showed very little interest, but could be persuaded to watch television, read newspapers, join in games, etc., for a while.
2 = Showed no interest in anything. Did not watch television, read newspapers, play games, etc., even when encouraged to do so.

3.1.7 Irrelevant or incomprehensible talk
0 = No such instance noted.
1 = Occasional instances of talking about irrelevant things, or in an incomprehensible manner, but these did not occur every day.
2 = Frequent instances (once a day or more often) of talking irrelevantly or incomprehensibly.

3.1.8 Posturing and mannerisms
0 = No such behaviour seen.
1 = Behaved as in (2), but less often than every day.
2 = Adopted odd or uncomfortable postures, or made bizarre movements, every day.

3.1.9 Threatening or violent behaviour
0 = No such behaviour seen.
1 = Was threatening in manner, or verbally abusive, but did not strike anyone.
2 = Struck someone, or destroyed some articles (e.g., clothing, window, crockery).
3. Patient in hospital

3.1.10 Tendency to remain in or return to bed
0 = Stays in bed not more than normally expected on the ward.
1 = Tends to remain in bed, or to return to bed, but responds to encouragement not to do so.
2 = Persists in tendency to remain in bed or to return to bed despite encouragement not to do so.

3.1.11 Personal appearance
0 = Maintained reasonably neat appearance without prompting or supervision.
1 = Could shave (if male), dress and wash, but needed reminding or supervision or would be slovenly in appearance.
2 = Needed to be shaved, washed, or dressed fully at least once during the week.

3.1.12 Behaviour at mealtime
0 = Normal behaviour at mealtime.
1 = Needed some supervision because of faulty table manners.
2 = Needed assistance in eating at least once during the week.

3.2 Nurses' opinions

Ratings should reflect the opinion of the nursing staff or other persons, e.g., relatives, about the patient's present potential for the behaviours specified below.

0 = yes  1 = no  9 = not applicable

3.2.1 Could this patient do useful work in the hospital such as laundry, typing, or domestic work, if it were available? 

3.2.2 Could this patient be allowed to possess matches?

3.2.3 Could this patient be quite free to visit relatives or friends at weekends?

3.2.4 Could this patient be allowed to go out with patients of the opposite sex (e.g., to the local cinema or bar/pub)?

3.2.5 Could this patient be allowed to possess scissors or razor blades?

3.2.6 Could this patient look after the money he/she might earn?

3.2.7 Could this patient manage to do some kind of work outside while living in the hospital?
3.2.8 Could this patient be discharged now, if a job was found and he/she had a suitable place to live?  

3.2.9 Could this patient be accommodated in an open ward or room?

3.3 Patient’s occupations  
(rate peak performance only)

3.3.1 Housekeeping activities on the ward or premises

0 = None.
1 = Contributes very little towards ward housekeeping (e.g., a little polishing or dusting).
2 = Contributes to ward housekeeping daily at a fair level.
3 = Contributes to ward housekeeping above normal expectations.
9 = Not applicable.

3.3.2 Work therapy outside the ward

0 = None.
1 = Member of a supervised working party (e.g., on grounds or drives).
2 = Work in sewing room, kitchens, laundry, cafeteria, other wards.
3 = Work in service departments (e.g., stores, bakehouse, shoemaker).
4 = Individual work on farm or gardens (not a member of a working party).
5 = Work outside hospital.
9 = Not applicable.

3.3.3 Occupational and industrial therapy activities

0 = None.
1 = One or two hours daily, in ward.
2 = Three or four hours daily, in ward.
3 = Occasional visit to Occupational Therapy (O.T.) Department.
4 = Goes to O.T. Department every day.
5 = Does industrial contract work or equivalent.
9 = Not applicable (e.g., O.T. not available).
3.4 Contact with outside world

3.4.1 Being visited during past three months
0 = Not visited during the past three months.
1 = Visited less often than once a week.
2 = Visited about once a week or more often.
8 = Patient in hospital for less than a week.
9 = Not applicable.

3.4.2 Visits home during past three months
0 = No visit home during past three months.
1 = Visited home once.
2 = Visited home more than once.
8 = Patient in hospital for less than a week.
9 = Not applicable.

3.4.3 Need for supervision for security reasons
0 = Not allowed outside ward unless under escort.
1 = Only allowed out of ward when supervised.
2 = Can use the hospital grounds without asking permission.
3 = Can go outside hospital but has to ask permission.
4 = Can go outside the hospital without asking permission.
9 = Not applicable.
WHO Psychiatric Disability Assessment Schedule

3.4.4 If intensive supervision is needed, please state reason

0 = No constant supervision needed.
1 = May try to escape.
2 = May wander away.
3 = May be aggressive or threatening.
4 = May be destructive (to property).
5 = Appearance may be frightening to others.
6 = Risk of suicide.
7 = Any other reason. Give details below.
9 = Not applicable.
4. Modifying factors

4.1 Specific assets

4.1.1 During most of the last six months, did the patient have any regular activity with the explicit aim of increasing his/her knowledge or of obtaining/improving skills in a particular area (e.g., sewing classes, cooking, mechanics, carpentry, plumbing, other do-it-yourself activities, reading for a degree, examination, or other goal, learning a foreign language, learning a trade)? Make a rating on the basis of actual sustained effort, regardless of whether the patient is a student, attends any local courses, or just studies on his/her own; do not consider here reading for entertainment.

0 = no
1 = yes (specify) ____________________________

9 = not known or did not inquire

4.1.2 During most of the time in the last six months, did the patient have any special interests, or pursue regularly special activities, in any area? (Include here hobbies, sports, playing musical instruments, other artistic activities, etc.)

0 = no
1 = yes (specify) ____________________________

9 = not known or did not inquire

4.1.3 In the interviewer's judgement, does the patient have above-average ability or assets in any area (e.g., superior intelligence, special talents, special skills or achievements that are highly valued in the patient's community, markedly attractive appearance)?

0 = no
1 = yes (specify) ____________________________

8 = impossible to make a judgement
9 = not known or did not inquire
4.1.4 Are there any other characteristics of the patient’s environment and current circumstances that, in the interviewer’s judgment, can favorably influence the patient’s level of functioning (e.g., participation in a supportive social group, being financially privileged, comfortable housing, or any other—even minor ones like keeping a pet)? Consider local culture and socioeconomic circumstances in making a judgement.

0 = no
1 = yes (specify) ___________________________________________________________

8 = impossible to make a judgement
9 = not applicable or did not inquire

4.1.5 Does the patient have a stable confiding relationship with any person, other than parent or spouse (i.e., a person with whom the patient discusses personal problems, shares specific interests, asks advice, etc.)? Note that rating on this item cannot be 1 if a rating of 5 has been made on item 1.4.

0 = no
1 = yes (specify) ___________________________________________________________

8 = impossible to make a judgement
9 = not known

4.2 Specific liabilities

4.2.1 Are there any characteristics of the patient’s current environment that put him/her at a specific disadvantage? (Examples: belonging to an underprivileged group; not speaking the local language fluently; very inadequate housing; serious financial difficulties or poverty; severely disturbed home environment unrelated to patient’s illness; severely ill or disabled members of the family.)

0 = no
1 = yes (specify) ___________________________________________________________

8 = impossible to make a judgement
9 = not known
4.2.2 Does the patient suffer from a physical, neurological, or sensory disability or handicap?

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<tbody>
<tr>
<td>0</td>
<td>no</td>
</tr>
<tr>
<td>1</td>
<td>yes (specify)</td>
</tr>
<tr>
<td>9</td>
<td>not known or did not inquire</td>
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4.2.3 Are there any other characteristics of the patient (e.g., personality disorder, appearance, habits) that, in the interviewer's judgement, unfavourably influence the patient's level of functioning?

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<tr>
<td>1</td>
<td>yes (specify)</td>
</tr>
<tr>
<td>8</td>
<td>impossible to make a judgement</td>
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<tr>
<td>9</td>
<td>not known or did not inquire</td>
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4.3 Home atmosphere

4.3.1 In the interviewer's judgement, who has been the key figure in the patient's home environment during the past six months? (The key figure is the person spending most time with the patient.)

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<table>
<thead>
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<tbody>
<tr>
<td>0</td>
<td>no key figure identifiable</td>
</tr>
<tr>
<td>1</td>
<td>mother</td>
</tr>
<tr>
<td>2</td>
<td>father</td>
</tr>
<tr>
<td>3</td>
<td>spouse</td>
</tr>
<tr>
<td>4</td>
<td>other relative (specify)</td>
</tr>
<tr>
<td>5</td>
<td>other person, not relative (specify)</td>
</tr>
<tr>
<td>9</td>
<td>impossible to make a judgement</td>
</tr>
</tbody>
</table>

4.3.2 Estimate how many hours (waking time) of direct face-to-face contact the patient had with the key figure indicated above during an average week in the past month (write in 99 if not applicable). Face-to-face contact implies the physical presence of the key person.

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<tbody>
<tr>
<td>27</td>
<td>28</td>
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</tbody>
</table>

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*The items in this section have been included to permit a pilot exploration of the feasibility of making judgements, in the course of a flexibly structured interview, of constructs such as "expressed emotion", which may modify the course of the disorder and have been shown to be of predictive value.*
WHO Psychiatric Disability Assessment Schedule

4.3.3 On the basis of all available information and impressions, assess the level of emotional involvement with the patient shown by the key figure indicated above over the past month. Note that what is rated here is the intensity of the emotional involvement with little regard to its quality (which may be positive or negative). There are no "normal" or "abnormal" ratings—the scale refers only to the "emotional temperature" of the interaction.

0 = No emotional involvement shown; key figure is strikingly reserved and "flat" in daily interaction with patient.
1 = Some emotional involvement shown, but key figure remains somewhat aloof in relation to patient.
2 = Considerable emotional involvement; manifestations may include among other things: key figure shows realistic concern, has had to adapt to patient's behaviour, has done specific things to meet patient's needs.
3 = Very strong emotional involvement; manifestations may include among other things: key figure excessively and constantly preoccupied with the patient, and responds emotionally to his/her problems; daily life of the key person entirely dominated by patient's problems.
8 = Impossible to make a judgement.
9 = Not applicable, no key figure identified, or did not inquire.

4.3.4 Assess the degree to which, in the past month, the key figure indicated above has been exercising control (in the sense of organizing the patient's daily routine) and has been demanding in relation to the patient. Consider: (i) control exercised over execution of daily tasks; (ii) demands, pressures, and expectations of activities to be undertaken by patient above his/her spontaneous level of performance.

0 = No undue pressure.
1 = Undue pressure exercised on specific occasions, e.g., patient forced to socialize to gratify key figure.
2 = Undue pressure exerted on the patient constantly, e.g., key figure insists on the patient's total obedience.
8 = Impossible to make a judgement.
9 = Not applicable, no key figure identified, or did not inquire.
4.3.5 Rate any evidence emerging during the interview, as well as the overall impression, of any attitudes of rejection of patient by the key figure in the family or household. Consider the tone of voice, overt criticisms, abusive remarks, expressions of dislike, etc., made about the patient.

0 = No rejection at all.
1 = Occasional critical remarks, always addressed at specific behaviours of the patient.
2 = Occasional expressions of general dislike of the patient as a person.
3 = Both 1 and 2 present and frequent.
8 = Impossible to make a judgement.
9 = Not applicable, no key figure identified, or did not inquire.

4.3.6 Rate the patient’s access to privacy in his/her home environment. Consider: (i) opportunities to withdraw physically from the company of others; (ii) the acceptability of such behaviour in the home. Assess the potential access to privacy, and not the actual use of such opportunities.

0 = Patient has access to privacy and his/her withdrawal would be acceptable to the other household members.
1 = Patient has opportunities for privacy but withdrawal would be unacceptable.
2 = No opportunity for privacy.
8 = Impossible to make a judgement.
9 = Not applicable or did not inquire.

4.4 Outside support

4.4.1 In the past month, has the patient or his/her family sought, but not actually received, outside help or assistance for any problem? Consider: (i) financial assistance or material help in kind; (ii) help in running the household, looking after the children; (iii) assistance in any activities of the family or household.

— From relatives
— From neighbours, friends or other members of the local community
— From community agencies (e.g., doctors, social workers, rehabilitation schemes, local administration)

Specify: ___________________________________________________________________
WHO Psychiatric Disability Assessment Schedule

— From other sources (e.g., voluntary organizations, religious bodies)
Specify: ________________________________

0 = no, 1 = yes, 8 = not known, 9 = not applicable.

4.4.2 In the past month, has the patient or his/her family actually received outside help or assistance of the kind specified in 4.4.1.
— From relatives
— From neighbours, friends or other members of the local community
— From community agencies (e.g., doctors, social workers, local administration)
Specify: ________________________________

— From other sources (e.g., voluntary organizations, religious bodies)
Specify: ________________________________

0 = no, 1 = yes, 8 = not known, 9 = not applicable.

4.4.3 On the basis of an overall assessment of the current socioeconomic situation how easy would it be, in the interviewer’s judgement, for an individual of the same age, sex, and educational level as the patient, but not having a history of mental illness, to get a paid job at present?

0 = Very easy, job readily available.
1 = Some difficulty in finding the right job, but no serious obstacles.
2 = Very difficult, few appropriate jobs available.
3 = Almost impossible to get any job due to current economic circumstances.
8 = Impossible to make a judgement.
9 = Not applicable.
5. Global evaluation

Considering all the information recorded and rated in this schedule, what is your overall assessment of this patient’s current social adjustment? Please note that this global evaluation of social adjustment should not mechanically reflect the specific disabilities recorded in sections dealing with particular behaviours and roles; it must be based on a judgement of the patient’s total social functioning in relation to the standards appropriate to his/her socioeconomic background in the particular culture.

0 = excellent or very good adjustment.
1 = good adjustment.
2 = fair adjustment.
3 = poor adjustment.
4 = very poor adjustment.
5 = severe maladjustment.
8 = impossible to make a rating.
WHO Psychiatric Disability Assessment Schedule

Thumbnail sketch

Please write a concise "portrait" of this patient as a whole person, and of the environment in which he/she lives. If the patient belongs to a social group with certain special characteristics, describe these as well.
### Summary of ratings and scoring

#### Dysfunctional overall behaviour

<table>
<thead>
<tr>
<th></th>
<th>Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Self-care</td>
</tr>
<tr>
<td>1.2</td>
<td>Underactivity</td>
</tr>
<tr>
<td>1.3</td>
<td>Slowness</td>
</tr>
<tr>
<td>1.4</td>
<td>Social withdrawal</td>
</tr>
</tbody>
</table>

To obtain a raw score, add up all ratings different from 9.

Raw score:

To obtain an adjusted score, divide the raw score by the number of items in this section rated other than 9.

Adjusted score:

#### Dysfunction in social roles

<table>
<thead>
<tr>
<th></th>
<th>Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Participation</td>
</tr>
<tr>
<td>2.2</td>
<td>Marital/affective</td>
</tr>
<tr>
<td>2.3</td>
<td>Marital/sexual</td>
</tr>
<tr>
<td>2.4</td>
<td>Parental</td>
</tr>
<tr>
<td>2.5</td>
<td>Sexual</td>
</tr>
<tr>
<td>2.6</td>
<td>Social contacts</td>
</tr>
<tr>
<td>2.7</td>
<td>Work performance</td>
</tr>
<tr>
<td>2.8</td>
<td>Interest in job</td>
</tr>
<tr>
<td>2.9</td>
<td>Information</td>
</tr>
<tr>
<td>2.10</td>
<td>Emergencies</td>
</tr>
</tbody>
</table>

To obtain a raw score, add up all ratings different from 9.

Raw score:

To obtain an adjusted score, divide the raw score by the number of items in this section rated other than 9.

Adjusted score:
WHO Psychiatric Disability Assessment Schedule

Behaviour in hospital

3.1 Disturbed ward behaviour  Score:  
(add up ratings)

3.2 Nurses’ opinion about patient’s capacity for independence  Score:  
(add up all ‘1s’ and divide by the number of items rated other than 9)

3.3 Occupation  Score:  
(add up all ratings different from 9 and divide by the number of items rated other than 9)

3.4 Contact with outside world  Score:  
(add up all ratings on 3.4.1, 3.4.2, and 3.4.3 that are different from 8 or 9, and divide by the number of items rated other than 8 or 9)

Assets and liabilities

4.1 Assets  Score:  
(add up all ratings different from 8 or 9)

4.2 Liabilities  Score:  
(add up all ratings different from 8 or 9)

Home atmosphere

4.3.3–4.3.6 Adverse effects of home atmosphere  Score:  
(add up ratings on:  
4.3.3 (only if 3)  
4.3.4 (only if 1 or 2)  
4.3.5 (if 1, 2 or 3)  
4.3.6 (if 1 or 2))

Social support

4.4.1 Seeking support  Score:  

4.4.2 Receiving support  Score:  
(add up all ratings different from 8 or 9)

Global Evaluation Score:  

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Guide to the use of the WHO Psychiatric Disability Assessment Schedule
Introduction

This interviewer’s guide to the WHO Psychiatric Disability Assessment Schedule (DAS) is intended:

(a) to provide an outline of the concept of psychiatric disability on which the DAS is based;

(b) to clarify and extend the descriptions of the social behaviours and roles that have been included in Sections 1 and 2 of the DAS for the assessment of dysfunction;

(c) to draw attention to those topics of conversation with the informant that are most likely to elicit information on the specific disabilities being rated and to suggest probing and guiding questions appropriate to this purpose;

(d) to spell out the general principles to be used in rating the severity of any dysfunction and to offer examples of manifestations of disturbed behaviour typically present at specific levels of dysfunction.

Outline of the concept of psychiatric disability

The DAS is designed specifically for the assessment of the patient’s behaviour and social functioning in his particular social and cultural context. ‘Disability’ in the sense adopted in the DAS means dysfunctional social behaviour and disturbance in the performance of social roles, resulting from mental disorder. Disability should be distinguished from psychiatric symptoms and the specific psychological impairments associated with mental disease. Although arising as a consequence of psychiatric symptoms and impairments, disability in the individual patient may not correspond in degree to their severity and will often be found to depend on various extraneous and personality-related factors, some of which antedate and some follow the development of psychiatric disorder.

Since disability can be manifest only in a social context, the baseline against which the patient’s behaviour should be measured is provided by the existing social norms. A social norm, however, is always relative; there is no single norm valid for all ages, for both sexes, and for each social and cultural setting. Furthermore, there is no inventory of such norms, which should be objective, reliable, and flexible enough to allow the assessment of the individual cases. Therefore, the approach adopted in the DAS is to base the assessment on a trained interviewer’s clinical judgement, assuming that his background and experience will allow him to compare his observations with the presumed “average” or “normal” functioning of a person of the same sex.

1 For the sake of convenience, unless the context requires otherwise, the masculine gender has been used throughout this guide for pronouns referring to either the patient or the interviewer.
Guide to the use of the WHO/DAS

and of comparable age and sociocultural environment. The instructions in this guide, and the “anchor points” provided in the DAS for rating various degrees of dysfunction, should aid him in this task, but they cannot replace training and the use of disciplined judgement.

Contents of the WHO/DAS

The schedule permits the recording of information about the patient’s current functioning and some of the factors that might influence it. It consists of six parts:

1. Overall behaviour
2. Social role performance
3. Patient in hospital
4. Modifying factors
5. Global evaluation
6. Summary of ratings and scoring

The time period for which behaviour is rated in Sections 1 and 2 is approximately one month. For non-hospitalized patients this one-month period is immediately prior to the date of interview. For patients who have been in hospital for less than three months before the date of interview, this one-month period is immediately prior to hospitalization. For patients who have been in hospital for more than two weeks before the evaluation, Section 3 should be rated in addition to Section 2; for patients who have been in hospital for more than three months, Section 3 should be rated instead of Section 2. Ratings in Section 3 should be based on the patient’s behaviour during the past week only, even if it was not considered typical of his usual condition. Ratings of “modifying factors” in Section 4 should be related in general to a period of at least six months.

Sources of information

Key figure: someone who has been in daily face-to-face contact with the patient, e.g., a parent, husband/wife, or other family member, preferably living in the same household.

Other informant: someone who knows the patient well, e.g., friend, nurse, social worker, family member, work colleague.

Written sources: e.g., case notes, work reports, discharge letters.

The patient: if possible, an interview with the patient should also take place, in order to obtain information concerning social behaviour from the patient’s point of view (items requiring corroborating information from the patient are marked with an asterisk in the schedule).

Suggestions for topics of inquiry

Since the DAS is an interviewing schedule rather than a questionnaire, the actual format of the interview is that of a “conversation” between interviewer and informant.
Introduction

The interviewer must make use of the informant’s knowledge of the patient and his insight into the patient’s behaviour and life-style, by guiding the conversation into the areas that need to be explored in order to make a judgement. Under each item in Sections 1 and 2, therefore, the guide lists suggested topics of inquiry and probes. They are given as formulations that should assist the interviewer in keeping the “conversation” on the right lines.

Principles of rating

The DAS contains various rating scales of aggregate nature, in the sense that several variables are considered in only one score. Each such global rating of severity represents a combination of two judgements: one on the intensity of the dysfunction (i.e., the degree of deviation from the norm) and another on the duration or persistence of that particular dysfunctional behaviour.

For each item in Sections 1 and 2, mentioned under the heading “consider” or “inquire about”, the rater must take into account both dimensions—intensity and persistence.

The more intensive each behavioural dysfunction and the longer the duration of the disturbed behaviour, the higher should be the rating of severity. For example, the patient’s self-care (item 1.1) is assessed by inquiring about (1) personal hygiene, (2) eating habits, and (3) keeping the living space tidy. A dysfunction limited to one of these areas should be given a lower rating than dysfunction in all three of them. A severe dysfunction of personal hygiene should be given a higher rating than minor dysfunctions in one or two of the areas mentioned. A severe dysfunction present for a short period of time, e.g., only a couple of days, should be given a rating equal to or less than a rating of minor disturbance persisting all the time.

A general definition of the various steps of the scale is given below. It is essential to keep the intervals between the various steps of one scale (0–1, 1–2, 2–3, etc.) as equal as possible.

No dysfunction (0): The patient’s functioning conforms to the norms of his/her reference group or sociocultural context.

Minimum dysfunction (1): Deviation from the norm in one or more areas is present. The disturbances are minor but persist over the greater part of the time period. More conspicuous dysfunctions may appear for very short periods, e.g., one or two days.

Obvious dysfunction (2): The deviation from the norm is conspicuous and dysfunctions interfere with social adjustment. Dysfunction in at least one area persists nearly all the time. More severe dysfunction may appear only for a few days.

Serious dysfunction (3): Deviations from the norm are marked in most areas and persist more than half of the time.
Guide to the use of the WHO/DAS

Very serious dysfunction (4): Deviations in all areas are very severe and persist nearly all the time. Action by others to remedy or control the dysfunction might be required (according to the rater’s judgement), but it does not need to have taken place in order to make this rating.

Maximum dysfunction (5): Deviation from the norm has reached a crisis point. A clear element of danger to the patient’s own existence or social life and/or to the lives of others may be present. Some form of action or social intervention is necessary.
Instructions for the use of Section 1 of the WHO/DAS

1.1 Self-care

Self-care here should be regarded as an activity guided by social norms and conventions. Failure to maintain acceptable standards of personal hygiene, physical fitness, and appearance is likely to interfere with the patient’s social participation. To disclose this, the inquiry should cover:

(a) the patient’s activities concerned with the maintenance of personal hygiene and physical health, including washing, shaving, keeping clothes, hair, and fingernails clean, toilet habits, etc., as well as the observance of normal social proprieties;

(b) eating habits, e.g., regular meals, quantity of food intake, whether the patient is maintaining/losing/putting on weight, and ability to prepare at least a simple meal;

(c) the patient’s maintenance of personal belongings and living space;

(d) the family’s feelings and reactions to the patient’s inadequate self-care.

In determining the intensity of the dysfunction consider any evidence of:
— hazards to the patient’s physical health,
— adverse effects on the patient’s adjustment in other fields, and
— adverse effects on other persons.

Guiding questions (use others as appropriate)

• What has the patient’s personal hygiene been like in the past month? (Does he change his clothes regularly? Does he wash and shave regularly? What about bathing and cleaning teeth?)

• Is the patient having regular meals? (What about his diet? Is he putting on weight? Would he cook a meal or set the table for himself?)

• How does the patient behave in public? (What are his manners like? What about his table manners?)

• How much pride does the patient take in his appearance? (Does he seem to have let himself go? What does he look like when he goes out? Are his clothes usually washed, ironed, mended when he wears them? Is the patient fashion-conscious?)
Guide to the use of the WHO/DAS

- What is the patient's room like compared with the rest of the house? (Are his personal belongings well looked after? Are his things in a reasonable standard of cleanliness, maintenance, orderliness?)

- How do you feel about the patient's standards of self-care? (Do you try to supervise him? How hard do you have to push him?)

- Is the patient like this all the time?

Rate no dysfunction if the patient's level and pattern of self-care are normal within the sociocultural context, i.e., reasonable interest shown, reasonable amount of time and energy spent. Disregard of the prevalent social conventions concerning hygiene and appearance is not necessarily a dysfunction if the patient lives in a subculture that shares such attitudes.

To rate minimum dysfunction, factual evidence should be provided of a decline in self-care and appearance, e.g., the patient does not bath, shave, change clothes, or dress for the occasion as readily as expected. The decline in self-care should have occurred more than once, but without producing any adverse consequences, such as hazards to the patient's physical health, embarrassment to other people, or concern within the family.

To rate obvious dysfunction, evidence for lack of concern for self-care on the part of the patient; beyond the level of minimum dysfunction, should be clearly established. Such evidence of dysfunction may include: mild deterioration of physical health and fitness, e.g., obesity, tooth decay; awareness that the patient makes an unfavourable impression on others (e.g., because of bad table manners). Family members or other persons might be only emotionally involved (e.g., express complaints), or they might have developed a strategy to cope (e.g., family member puts out patient's clothing each day).

To rate serious dysfunction the decline in the patient's self-care should be marked in all areas and should have persisted over more than half of the time period. The consequences should be such as to be detrimental to the patient's social adjustment (e.g., the patient wears torn clothes, washes only if made to, eats only if told to). There might be evidence of serious hazards to physical health (e.g., malnutrition, infection, lice) and of social ostracism.

To rate maximum dysfunction, total or nearly total lack of self-care on the part of the patient should be present (e.g., patient soils himself). There would be considerable risk to physical survival if the patient were not cared for (e.g., needs feeding, washing, putting on toilet). Constant supervision is necessary. This rating should be made also in cases where such a degree of self-neglect has been present for a part of the period under consideration.

1.2 Underactivity

An interest in daily activities other than work, school, and housekeeping should be considered here, e.g., reading books, watching television, visiting, hobbies, sports, and other forms of social life. Having established the range
of the patient's spare-time activities, the interviewer should try to assess:

(a) their \textit{meaningfulness} in terms of whether they have a socially acceptable function (including recreation);

(b) their \textit{spontaneity} in terms of the drive and energy displayed by the patient in their pursuit;

(c) the patient's \textit{involvement} in terms of the emotional gratification he derives from these activities; and

(d) their \textit{appropriateness} in terms of the patient's ability to subordinate, delay, and interrelate his activities.

The interviewer should specifically inquire about the proportion of time during the day spent in doing nothing (lying awake in bed, sitting still, being unoccupied, not talking with others), any persistent "wasting" of time.

It should be remembered that different cultures allow varying amounts of socially approved "time doing nothing"; dysfunction therefore is present only if the "wastage" of time by the patient significantly exceeds the culturally tolerable limits.

\textbf{Guiding questions} (use others as appropriate)

\begin{itemize}
  \item \textit{Has the patient kept himself reasonably occupied during the past month?} (Does he have a lot to do? Could you list the things he does out of his own interest?—for the other members of the family?—for other people outside the family?—for entertainment?)
  
  \item \textit{Does the patient ever sit around doing nothing at all?} (Does he ever get bored? What happens if you suggest something he could do? Can you describe what he is like when he is doing nothing at all? How many hours a day is he like this?)
  
  \item \textit{How do you feel about the way the patient spends his time?} (Do you try to encourage him to do things? How hard do you have to push him? What happens if you push him? Is he like that all the time? To what extent does he affect your usual routine?)
\end{itemize}

Rate \textit{no dysfunction} if the patient keeps himself reasonably occupied and active during the day without supervision and encouragement.

To rate \textit{minimum dysfunction}, factual evidence should be provided for slightly aimless or futile activity or underactivity during spare time, e.g., the patient is reported as idling away an average of two hours a day. The patient's way of spending his time is, however, acceptable to the family, i.e., no particular concern is expressed, no adverse consequences are pointed out, and no special steps to control him are undertaken.

To rate \textit{obvious dysfunction}, evidence should be provided of an inadequately narrow range of activities and of \textit{loss of spontaneity} (e.g., the patient idles away about four hours a day). The patient's inactivity causes concern in the
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family, e.g., family members may have to adjust to the patient's ways and have to encourage and supervise him.

To rate serious dysfunction, a markedly reduced range of activities should be reported (e.g., the patient does little beyond the daily routine of eating, sleeping, dressing; activities are void of content (e.g., walking aimlessly in the streets, sitting in a tea-bar, sitting in front of the television, irrespective of what programme is on) and the patient spends on the average six hours a day doing nothing. Despite efforts on the part of the family, it is no longer possible to integrate the patient into the family life.

Rate very serious dysfunction if the patient spends about eight hours doing nothing. General level of activity is extremely restricted. The patient has no spare-time interests, and no involvement or interest in any sort of daily activity.

To rate maximum dysfunction, evidence should be provided that the patient does nothing during most of the day, and has to be forced to carry out the most elementary tasks; there is a total lack of initiative.

1.3 Slowness

Slowness may be reported as being characteristic of the patient's body movements and verbal (mental) responses, or it may be described in terms of the patient's inefficiency in performing tasks or in responding to social stimuli. Also, it might appear only at certain times or it might be a constant feature. Slowness, by itself (in the absence of other impairments), usually interferes with the patient's social adjustment.

Consider reduction of rate, speed, and extent of voluntary movements, and delay in initiating tasks or movements requested of the patient. (Acceleration of movement might also be reported, and might contribute to dysfunction in various fields of behaviour and social roles. In the present schedule, however, acceleration of movement is not seen as an independent dimension implying social disability and worthy of graded ratings on its own.)

The interviewer should enquire about:

(a) the presence of slowness of the patient's body movements in carrying out daily activities;

(b) the patient's speed and consistency of performance, mental vigour, and vitality.

In rating the intensity of the dysfunction due to slowness, the interviewer should consider if there is evidence of:

—slowness preventing to any degree the autonomous functioning of the patient;

—adverse effects on the patient's social participation;

—effects on others.
**Guiding questions** (use others as appropriate)

- **Can you describe the patient's speed of movement?**
  (Does it take him a long time to carry out daily activities such as washing, dressing, getting ready for work, having his meals? Is his speed of movement predictable and consistent?)

- **How quick-thinking is the patient?**
  (Can he easily make up his mind? Is he quick to answer a simple question? How long does it take him to make a decision or express an opinion? How perceptive and quick is he to grasp another person's meaning?)

- **Does the patient usually finish what he starts or does he leave things halfway through?**
  (How eagerly does he do things? Does he tend to slow down once he has started? What about things done together with someone else? Can he keep up with other people?)

- **How do you feel about the patient's slowness?**
  (Do you have to tell him to hurry up? How hard do you have to push him? Do you have to take over and finish what he is doing? Is he like that all the time?)

Rate *no dysfunction* if the patient's speed of movement, of mental processes, and of carrying out daily activities is normal or accelerated.

To rate *minimum dysfunction*, evidence should be provided that the patient is somewhat slow in movement, thinking, or responding to others. Descriptions such as "slow to start" or "lacking in vigour" should not be considered enough. A specific example should be recorded, e.g., "it took him two hours to get dressed the other day" or "it took him half the day to make up his mind whether he was coming with us". At this level of dysfunction, slowness does not prevent the patient from performing a normal range of activities and roles.

To rate *obvious dysfunction*, the patient's speed of movement, thinking, or performing should be reported as being definitely slowed down to a degree that renders him incapable of coping with a full range of daily activities (e.g., someone else has to clean patient's room because it takes him a long time). Although this degree of slowness may not be present all the time.

To rate *serious dysfunction*, evidence must be provided that the patient's slowness interferes with most of his daily routines (e.g., has to be pushed to get dressed, is no longer expected to join the family at mealtimes, or to help with household tasks) and that such slowness is present at least half of the time.

Rate *very serious dysfunction* if slowness is both very marked (as above) and present nearly all the time.

Rate *maximum dysfunction* if patient is extremely slow to move. Slowness amounts to absence of movement for hours at a time on most days and is severe enough to be incompatible with any but basic everyday functions.
1.4 Social withdrawal

Social withdrawal implies avoidance of people, lack of communication skills, and a narrow range of social contacts, failings that presumably reinforce one another. For the assessment of social withdrawal, therefore, evidence of a willingness to communicate and the actual amount of the patient’s social contacts should be considered. The interviewer should restrict himself to taking the facts of the patient’s communication at their face value (i.e., as observed behaviour) rather than in terms of the patient’s inner experience. Apart from establishing the amount of contact, it is important to inquire if the patient actively avoids interaction (verbal or non-verbal) with people present and if he actively avoids being in the physical presence of other people. Such behaviour includes avoidance of normally expected social activities outside the home (e.g., visiting or going out) and should be regarded as a more severe degree of disturbance. To rate the degree of social withdrawal of the patient, accurate knowledge of his communication skills would be helpful.

The interviewer should inquire about:

(a) the amount of verbal contact that the patient has with the family, with his friends, and with casual acquaintances;

(b) the patient’s avoidance of being in the physical presence of people;

(c) the patient’s conversational skills, initiation, maintenance, completion of conversation, asking questions, showing interest in others, etc.;

(d) the reactions of the family with regard to the patient’s social withdrawal.

In determining the severity of the dysfunction the interviewer should consider if there is evidence of:

— social withdrawal affecting the autonomous functioning of the patient in other fields, including his social role;

— any adverse consequences affecting the patient’s access to social participation;

— any effects on the family.

Guiding questions (use others as appropriate)

• What is the patient like when he is with other people? (Does he avoid talking to members of the family?—his own friends and colleagues?—family visitors?—casual acquaintances, e.g., postmen, neighbours, people in shops, in the street, on buses? Has he always been like this?)

• In the last month, has the patient avoided being in the presence of certain people? (Does he stay in the same room as the rest of the family? What happens when friends and relatives come? Does he ever visit them? Will he answer the door?—pick up the telephone?—go to the shops?)
- How good is the patient at making conversation?
(Will he start a conversation? If you start a conversation will he carry on
talking to you? Does he show interest in what you are saying? Does he make
comments? Does he ask questions?)

- How do you feel about the patient's social withdrawal?
(Do you try to encourage him to be more sociable? Do you ever insist that
he mixes more? If so, how?)

Rate no dysfunction if the patient mixes, talks, and generally interacts with
people as much as can be expected within his sociocultural context. There
should be no evidence of avoiding people.

To rate minimum dysfunction, the patient should be described as taciturn and
solitary in social situations, e.g., when meeting strangers or friends. Signs of
social anxiety might be reported, but there should be no conspicuous
consequences in terms of social isolation or family concern.

To rate obvious dysfunction, a narrow range of social contacts should be
reported (e.g., patient has no independent social life apart from the contacts
offered through his family) and evidence of active avoidance of people on
some occasions. Manifestations of social anxiety might be present. Evidence
should also be present that the restriction of social communication interferes
with the performance of other social roles or that it causes embarrassment to
people. The family expresses concern over the patient's social contacts.

To rate serious dysfunction, evidence of more generalized, active avoidance
of contact with people should be reported (e.g., patient leaves the room
when visitors arrive, never approaches anybody, will not answer the door).
Social participation greatly reduced.

Rate very serious dysfunction if the patient hardly has any contacts and
actively avoids people nearly all the time, e.g., may often lock himself in a
room. The patient's verbal communication with people when contacts are
unavoidable is restricted to the bare minimum.

To rate maximum dysfunction, the patient should be reported as inaccessible
(e.g., does not even look up when asked a question). May lock himself in his
room every day, or walk aimlessly without responding to any attempts at
contact.
2.1 Participation in household activities

An account should be obtained of the life of the patient’s family (or the household that is the family surrogate) and how the patient fits into it. First, the patient’s functions and duties as a family member should be considered. Though role-specific (i.e., wife, father, son, etc.) they are likely to vary between families, depending on the established pattern. Whether the patient conforms to this pattern is the important issue here and is disclosed in his participation in domestic chores and decision-making. Information on visiting together, doing domestic chores, having meals together, and playing games or sharing other leisure activities is necessary.

A second aspect of the patient’s participation in family life concerns his ability to occupy more subtle positions in the family group, such as “the comforter”, “the entertainer”, “the adviser”, “the confider”, etc. Decline in these abilities should be particularly relevant in patients with milder degrees of dysfunction.

The interviewer should inquire about:

(a) the functions and duties of the patient in maintaining the family as a viable social group (i.e., formal social roles occupied and more subtle positions as a group member);

(b) the manner in which the patient carries out his roles in the family (e.g., father, mother, child) and fulfills the family expectations.

In determining the severity of the dysfunction the interviewer should consider if there is evidence of:

— any reduction in the patient’s modes of participation in family life;

— any threat to the viability of the family as a group because of the burden experienced by the family members.

Guiding questions (use others as appropriate)

• Is the patient a good wife, father, etc?
  (What kind of things does he do for the family? How does he take part in household activities?)

• When you think about the family or the household as a whole where exactly does the patient fit in?
  (Ask how well he performs the behaviours set out above.)
Section 2

What do you think the patient gets out of family life?
(Is he pleased and proud if someone achieves something? Is he worried if you have any problems? Does he ask your advice? Does he confide in you? Is he a source of comfort to you? Do you confide in him? Can you share a joke with him? Can you ask his advice in personal matters?)

How do you feel about the patient's lack of interest in the family?
(Do you try to encourage him to take more part in family matters? Have you given up hope of his taking an interest in you? Is his behaviour upsetting to you all? How have things changed in the family since he became like this? Is he like this all the time?)

Rate no dysfunction if the patient participates in family life as much as can be expected for his age, sex, position in the household, and sociocultural context.

To rate minimum dysfunction, factual evidence should be provided that the patient is somewhat detached from family life (e.g., does not contribute ideas on family matters; is last to hear when visitors are expected; does not participate in planning). A specific example should always be recorded. The patient conforms to the family routine but is somewhat emotionally aloof (e.g., would not share personal problems, is not good at expressing sympathy).

To rate obvious dysfunction, evidence should be provided of an inadequately narrow range of family functions performed somewhat incompetently by the patient, e.g., does not contribute constructively to family decisions; causes irritation by aloofness or tendency to contradict. It might be reported that the patient is incompetent in giving advice, in expressing concern or affection, and family members avoid involving him in their personal matters. Some complaints and irritation on the part of the family are expressed.

To rate serious dysfunction, evidence should be provided that the patient's participation in family life does not conform at all to the established family pattern and disrupts the family life. It might be reported that he requires the family to accept behaviour that they find intolerable (e.g., drinking, upsetting younger children, unconventional sex life). Such behaviour should have been present for more than half of the time during the period under consideration.

Rate very serious dysfunction if the patient takes no part in any common activity or is disruptive nearly all the time.

Rate maximum dysfunction if the patient is totally alienated from every routine of his family, i.e., exists alongside rather than within the family.

2.2 Marital role: affective relationship

The interviewer should try to obtain a fairly complete account of the marital bond by utilizing all sources of information available. In considering the patient's performance of his marital role, the interviewer should be aware that recent stressful events may cause the spouse to exaggerate marital problems; the interviewer should, therefore, rely as much as possible on reported facts and actual behaviour, rather than on people's judgements, which might be
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biased. Further, the interviewer should be aware of the cultural and social variation in "norms" of marital relationship, as well as of the difference between the husband's and wife's roles within the particular culture.

The interviewer should inquire about:

(a) the patient's communication with the spouse (e.g., the areas of the patient's life that he discusses or shares with his spouse);

(b) the patient's ability to show affection and concern;

(c) the extent to which the patient is felt by the spouse to be a source of support.

In determining the severity of the dysfunction the interviewer should consider if there is evidence of:

—any reduction in the areas of communication between the patient and the spouse;

—any reduction in mutual affection and support;

—any threat to the viability of the marriage.

Guiding questions (use others as appropriate)

• How would you describe your marriage?
  (Is your spouse a good husband/wife? How often do you talk to each other? What sorts of things do you talk about? Does he confide in you? Is he aware of your problems? Why not?)

• Is he affectionate?
  (Do you feel he cares about you? How does he show how he feels? Would he remember your birthday? Does he compliment your cooking/clothes/appearance? Is he proud of you? Is he considerate towards you? Does he share your problems?)

• Can you confide in him?
  (Is he reliable? Does he support you? Is he a problem to you? In what way?)

• What kind of things do you argue about?
  (What are your arguments like? How long do disagreements last? Who usually wins the argument? Is he ever violent? Are you ever afraid of him? Have you ever considered divorce?)

Rate no dysfunction if the patient's relationship with his spouse does not deviate from what could be considered "normal" for his age and sociocultural context (occasional conflicts, outbursts of anger, etc., should be evaluated against the cultural norm).

To rate minimum dysfunction, factual evidence should be provided that the patient is somewhat remote or uncaring (e.g., does not share everyday "gossip" with spouse, has fewer conversations with spouse, gives shorter
answers, does not display affection and concern about spouse as readily as before). The spouse does not see the change as cause for serious concern.

To rate obvious dysfunction, evidence should be provided that on a substantial number of topics there is no communication between spouses (e.g., patient sees no point in informing spouse, asking his opinion or expressing affection). Frequent bursts of anger or quarrels might be reported as occurring for no reason whatsoever or caused by spouse's insistence on close and intimate relationship. Evidence might be presented that the patient can no longer be seen as a source of support. Concern for the future of the marriage might be reported.

To rate serious dysfunction, evidence should be provided that the patient's participation in the marital relationship is grossly inadequate for more than half of the time; there are no shared areas of communication, and the patient has regular outbursts of violence or hostility. The marriage is described as void of content.

Rate very serious dysfunction if the patient's participation in the marital relationship is grossly inadequate nearly all the time; not even fleeting feelings of affection and warmth towards spouse are shown. Communication between the two partners is extremely restricted or non-existent.

Rate maximum dysfunction when evidence is presented that the patient is hostile and could become dangerous. The spouse is afraid of the patient, talks of need for separation (e.g., hospitalization, removal from home, etc.) and has undertaken action in this direction. Actual separation, for shorter or longer periods, may have taken place.

2.3 Marital role: sexual relationship

The interest that the patient shows in his spouse as a sexual partner is disclosed mainly by the frequency of his sexual demands and his response to the demands of the spouse. Any judgement here should be made against the established pattern of the couple. The assessment of the patient's involvement in the sexual relationship should be based on information as to both how he enjoys it and how eager he is to please his partner. The spouse's satisfaction and concern about the patient's sexual performance should be a major guide here.

The interviewer should inquire about the occurrence of sexual intercourse and how satisfactory the experience has been to the partners.

In determining the severity of the dysfunction the interviewer should consider if there is evidence of any adverse consequences for the viability of the marriage and for other aspects of the patient's social functioning.

Guiding questions (use others as appropriate)

- Have you any problems with your sex life?
  (Have you made love in the past month? Is your sex life satisfactory to you? Is it satisfactory to your husband/wife?)
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If there is evidence of sexual problems:

• How do you cope with them?
  (Do you do what the patient wants? Does it bother you?)

• Have you ever thought of leaving the patient?

• Are you afraid of him?

• Is he like that all the time?

Rate no dysfunction if sexual intercourse has taken place during the past month or if no change in the patient's interest and involvement in the sexual relationship is reported; neither patient nor spouse finds their sexual relationship unsatisfactory.

To rate minimum dysfunction, factual evidence should be reported of psychosexual problems encountered by the couple (e.g., decline in the patient's sexual demands leading to less frequent or less pleasurable sexual practice; premature ejaculation, frigidity, or occasional impotence on the part of the patient might be reported). The spouse, however, although experiencing the sexual relationship as less satisfactory, does not see it as a cause for concern.

To rate obvious dysfunction, evidence should be provided either that the patient's sexual interest and initiative has markedly declined or that his involvement in the sexual relationship has deviated from the established pattern of the couple (e.g., more frequent demands to a degree unacceptable to the spouse, disregard for spouse's feelings and pleasure). The spouse may express concern about the patient's lack of interest in sex or his sexual whims.

To rate serious dysfunction, evidence should be provided that the inadequate sexual relationship causes marital strain. It might be reported that no sexual initiative has been shown by the patient, or that grossly inappropriate and inconsiderate demands have been made.

Rate very serious dysfunction if the sexual relationship is very inadequate. Total lack of sexual interest on the part of the patient is reported and there may be evidence of definite aversion towards the spouse.

Rate maximum dysfunction if the patient presents a persistent and total lack of sexual interest in the spouse.

2.4 Parental role

An account of the patient's actual performance of child-care tasks should be obtained. The patient's position in the household, the children's ages, and the family pattern of child care should be taken into consideration in making a judgement here.

The patient's involvement in the upbringing and the lives of his children is usually reflected in the amount of time he devotes to them and the number of
specific activities he undertakes with the explicit objective of contributing to his children's lives.

A third aspect of the parental role is concerned with the patient's competence in approaching and relating to his children. Note that high involvement does not necessarily mean high competence. Any judgement here should be substantiated with factual evidence (e.g., children avoid patient or are emotionally disturbed by him).

The interviewer should inquire about:

(a) the basic tasks and activities undertaken by the patient to ensure the health and security of the children;

(b) the closeness of their relationship and the depth of affection and interest shown for the children's wellbeing and future;

(c) any abuse of the parental role or possibility of adverse affects on the children;

(d) the feelings and reactions of the spouse to the way the patient performs his parental role.

In determining the severity of the dysfunction the interviewer should consider if there is evidence of:

—any inadequacy in the patient's performance of the parental role;

—any jeopardy to the physical and mental wellbeing of the children;

—any involvement of external agencies (relatives, welfare office) in order to alleviate the possibility of hazard to the children and the burden experienced by the spouse or other members of the family.

Guiding questions (use others as appropriate)

● How good a parent is the patient?
(What does he do for the children? Who gets them up in the morning? Who gives them their meals? Who looks after them if they are sick? Who buys their food and clothes?)

● How close is the patient to the children?
(Does he buy them birthday presents? Does he play with them? Does he take an interest in their school work? Does he take them out? Do they confide in him? Does he listen to them? Does he discipline them when necessary? Does he take an interest in their future?)

● Do you approve of the patient's attitude to his children?
(What don't you like in the way he behaves towards them? Do you think he should be, e.g., more involved?—kinder?—stricter?)

● Do you feel there could be any danger to the children?
(Has he ever been unduly violent? Are the children afraid of him?)
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* How do you cope with the patient's lack of interest? (Does it lead to arguments? What additional workload does it involve for you? Do you feel you need help? How often is he like that?)

Rate *no dysfunction* if the patient participates in child care to the extent that is expected in his sociocultural context and shows involvement and competence.

To rate *minimum dysfunction*, factual evidence should be provided that the patient is experiencing problems in coping with the day-to-day tasks of child care. Such findings are very likely to be reported in relation to younger children (e.g., episodes of carelessness and forgetfulness or episodes of unwarranted tension might be described). When older children are concerned (from school age onwards) the patient might be described as emotionally aloof, although he makes adequate provision for their physical wellbeing. These changes, however, are not perceived by the spouse as a cause for particular concern.

To rate *obvious dysfunction*, a marked reduction in the patient's participation in day-to-day child care should be reported. This might be a result of low involvement, e.g., patient routinely sends children to the other parent to attend to their needs, or of low competence, e.g., patient is unable to perform certain tasks and the other parent takes over. Where older children are concerned, the patient's approach to disciplining them or to providing for their needs as individuals might be reported as disturbing and causing concern to the spouse.

Rate *serious dysfunction* if the patient is reported as performing hardly any activities concerned with child care. Participation in the upbringing of the children is markedly reduced. Most of the parental functions are taken over by the spouse, and relatives or friends might also be involved.

To rate *very serious dysfunction*, the patient should be reported as performing no activities whatsoever concerned with child care and in no way participating in the upbringing of the children. The parental functions are taken over by the spouse, friends or relatives, or external agencies. Where younger children are concerned it might be reported that the patient is not trusted alone with them. In the case of older children, evidence might be provided that the patient is "an outsider" in the family, i.e., he is not expected to respond to their needs.

Rate *maximum dysfunction* when the very coexistence under the same roof of the patient and his children is found to have detrimental effects on the latter or to be a hazard to them. This might be due either to the patient's lack of concern about exhibiting abnormal behaviour in their presence or to overt hostility and violence displayed towards them.

2.5 Sexual role: relationships with persons other than marital partner during past month

(This section should be rated if the patient is not married or is not living with his spouse.)
In cultures where premarital or extramarital relationships are not tolerated, this section may be inapplicable. What should be assessed here is not only the patient’s sexual activity, but also his involvement in an affective relationship. If the patient is homosexual, this should be recorded in a narrative note.

An account should be obtained of the patient’s interest and involvement in intimate (affective and sexual) relationships. It should be based on the patient’s behaviour and expressed needs rather than on his statements and declarations. Any judgement should be made in the context of the relevant sociocultural norms and conventions. Secondly, the patient’s competence in performing the affective-sexual role should be considered, as shown by his ability to present and assert himself and to utilize his own assets and interpersonal skills for appropriate purposes.

The interviewer should inquire about:

(a) the interest shown by the patient in the opposite sex;

(b) the range of the patient’s heterosexual activities;

(c) the patient’s plans and potential prospects for future marriage.

In determining the severity of dysfunction the interviewer should consider if there is evidence of:

— any insufficiency in the patient’s involvement and/or competence with the opposite sex;

— any adverse consequences, i.e., poor prospects for future marriage, possibility of social censorship for deviant acts.

**Guiding questions** (use others as appropriate)

- **Has the patient a girl-friend?**
  (Does he go anywhere to meet girls? Does he ever take girls out? How much time and energy does he spend on this?)

- **Can the patient ask a girl out?**
  (Do girls seem to like him? Does he seem shy with girls? Have you ever seen him with a girl? What is he like? How long do his relationships last?)

- **Do you think the patient will ever get married?**
  (Does he want to get married? Are you worried that he will not get married? Why? Do you even arrange for him to meet people? How does he react when you do?)

- **Is his private life something the patient shares with you?**
  (To what extent? Does his lack of a proper girl-friend cause you any problems?)

Rate no dysfunction if the patient has an affective/sexual relationship with a person of the opposite sex or is showing emotional/sexual interest in such a person, as would be expected for his age and sociocultural context.
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To rate minimum dysfunction, factual evidence should be provided that the patient has shown interest in the opposite sex with the intention of developing an intimate (affective and sexual) relationship but is lacking the necessary confidence and social skills. It might be reported that the patient has had only casual contacts and has failed to develop a relationship although opportunities have been present. On the whole, however, the family considers the patient’s interest or involvement realistic enough.

To rate obvious dysfunction, evidence should be provided that the patient’s interest in establishing a sexual relationship is diminished or that he resorts to unrealistic strategies, e.g., writes to film stars or to girls he does not know. No contacts have really occurred. It might be reported that the patient “rationalizes” his failure to establish an intimate relationship, e.g., finds an unconvincing excuse for not going out when an opportunity arises, says others’ interest in him is not “genuine”, puts up an attitude of resentment towards sexual matters, expects family to interfere to an unacceptable degree in supplying him with a partner.

To rate serious dysfunction, evidence should be provided that the patient’s sexual interest has not been socialized to the appropriate cultural expectations. Patient’s total alienation from the idea of establishing an affective-sexual relationship might be reported. The patient’s behaviour with persons of the opposite sex is characteristically void of any elements that might suggest intimacy. In other cases, the patient’s sexual intentions might be clearly unrealistic or inappropriate, e.g., he might be writing to film stars, or proposing sexual intimacy to persons and under circumstances that are culturally “taboo”.

Rate very serious dysfunction if the patient is completely indifferent to sexual stimuli, or manifests bizarre attitudes to sexually eligible persons.

Rate maximum dysfunction when evidence of grossly inadequate patterns of sexual behaviour is provided, e.g., patient fears and avoids persons of the opposite sex altogether, shows marked hostility towards them, or engages in deviant antisocial acts. Risk of violence may be a distinct possibility.

2.6 Social contacts: friction in interpersonal relationships outside the household in past month

Style of adaptation to others outside the household and flexibility in mixing with people should be considered here. What is important is the patient’s pattern of approaching and responding to everyday relationships. The most characteristic element of the pattern concerns overt behaviour on the part of the patient involving arguments, annoyance, anger, irritability, in social situations outside own home, e.g., in work situation, contacts with neighbours, student-teacher relationship, or relationship with other boarders. The overall theme is how far the patient causes friction in contacts with other people. If the patient has no contacts outside the household, rate “9”.

The interviewer should inquire about:

(a) the way in which the patient responds to the questions, requests, and demands of people outside the household:
(b) his readiness for coexistence on an "impersonal" level (e.g., colleagues, people in the bus, people in shops, fellow-students);

(c) his manner with people outside the household whom he dislikes.

In determining the severity of the dysfunction consider if there is evidence of:
—any lack of cooperation in social situations on the part of the patient;
—any adverse consequences for the patient's social functioning, i.e., restricted social integration.

**Guiding questions** (use others as appropriate)

- **What is the patient's behaviour like with strangers?**
  (Is he polite to them? Supposing someone was to ask him the time or for directions? Is he polite in public? Does he wait his turn in shops?)

- **How does the patient get on with people at work?—school?—college?—with neighbours?**
  (Do they seem to like him? Does he ever tell you about arguments he has had? Does he ever get into fights?)

- **How does the patient behave with people he dislikes?**
  (Can he control himself in public?)

- **What effect does the patient's behaviour have on the rest of the family?**
  (Has he ever embarrassed you? Have you ever had to make up for what he has done? Is he like this all the time?)

Rate *no dysfunction* if the patient gets along reasonably well with other people and causes no undue friction in his interpersonal relationships.

Rate *minimum dysfunction* if some friction has occurred on isolated occasions during the past month but no serious conflicts or arguments have erupted; the patient is known to be "nervous", "irritable", or "quick to fly off the handle", but is generally tolerated by other people.

To rate *obvious dysfunction*, factual evidence should be provided that the patient's initial pattern of response to people tends to be belligerent and argumentative. This is noted by other people and there may be a tendency for them to avoid the patient. There should be no evidence of major undesirable social consequences.

Rate *serious dysfunction* if conspicuous friction with at least one person has occurred and has markedly affected the patient's acceptance and integration in his social or occupational group.

To rate *very serious dysfunction*, evidence should be provided that the patient's belligerence and hostility in social situations are generalized, unpredictable, and self-perpetuating, to the point of causing serious problems in daily living and/or work. The patient is socially ostracised (e.g., avoided by everybody, banned from the local pub) and external agencies
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(e.g., police) may have been called upon for help. He is not, however, seen as threatening anybody’s life.

Rate maximum dysfunction if the patient is in a serious and lasting conflict and may be a serious danger to one or more individuals (e.g., threatens their lives) to the extent that some form of social constraint (e.g., police, compulsory hospitalization) is deemed necessary. The family are fearful of potential consequences. Very severe tension, hostility, anger, or violence is shown towards one or more particular individuals, even though relations with other people may be unexceptional.

2.7 Occupational role: work performance

It should be noted that:

1. This item is not applicable to persons who have never been employed or who have left their jobs (prior to or during the past month) for reasons other than mental illness, e.g., physical disability, redundancy, private income. Household work should be rated under item 2.1.) A rating of 9 should be given in such cases. The only exception to this rule is people of employable age who are currently students. Their school performance should be assessed here as an occupational role and rated accordingly. Persons in sheltered employment should be rated here but cannot be given a rating of “0” (no dysfunction).

2. People who have never been employed because of mental illness (i.e., their disability developed before they reached employable age or while they were still attending school), people who have lost their employment (prior to or during the past month) because of mental illness, and people who have been on sick leave because of mental illness on more than half the days during the past month should be rated “5” (maximum dysfunction for more than half the time during the past month).

3. Students of employable age who have given up their studies (prior to or during the past month) because of mental illness and have not started work or who have discontinued their studies because of mental illness upon medical advice for a defined period including the past month, and students who have not attended school because of mental illness on more than half the days during the past month should be rated “5” (maximum dysfunction present for more than half the time during the past month).

All persons in the categories described in paragraphs 2 and 3 above (i.e., rated (5)) should also be rated with reference to item 2.8.

Persons in the category described in paragraph 1 above should be rated with reference to item 2.8 if this is relevant.

The interviewer should inquire about:

(a) the patient’s conformity to the work discipline;

(b) the quality of his performance and output;

(c) his motivation in maintaining the occupational role.
In determining the severity of the dysfunction the interviewer should consider if there is evidence of:

— any decline in the patient’s work performance;
— any adverse social consequences for the patient (e.g., decline in social status, social isolation).

**Guiding questions** (use others as appropriate)

● *Does the patient go to work regularly?*  
  (Do you have any problems getting him to go to work? How many days has he been off in the past month?)

● *Does the patient like his job?*  
  (How do you know? Does he talk about work to you? Does he take a pride in what he does?)

● *Can the patient cope with his job?*  
  (Does he ever complain that it is too much for him? Does he seem exhausted when he comes home? Has he always been like that?)

● *Can you rely on the patient financially?*  
  (Does his attitude cause you any financial problems? Can you cope financially?)

● *How do you feel about the patient’s work situation?*  
  (Do you worry about his future? How does it affect the rest of the family?)

*Rate no dysfunction* if the patient goes to work regularly and his output and quality of performance are within acceptable levels for the job.

To rate *minimum dysfunction*, factual evidence should be provided of a noticeable decline in the patient’s ability to cope with the work routine and in his adherence to the discipline of the day-to-day demands of a job. It might be reported that the patient complains that he cannot cope, or that he is fed up with the job, or that he is dissatisfied with his performance at work. Evidence might be provided that he looks exhausted and overworked and concern might be expressed on the part of the family about his fitness for work, though not about his determination to maintain the occupational role.

To rate *obvious dysfunction*, evidence should be provided of lack of concern on the part of the patient for his occupational role and declining work performance. It might be reported that the patient is late for work, that he has missed a day or two for no apparent reason, that he leaves work early, that he is no longer perceived as a trustworthy employee (e.g., he has been criticized at work or his spouse has been contacted). The family might now be involved in a number of ways (e.g., make him go to work in the mornings, have frequent discussions with him, financial difficulties are foreseen).

To rate *serious dysfunction*, evidence should be provided of a marked decline in the patient’s work performance, output, and attitude to work. It might be reported that he is disruptive at work (virtually unproductive and interfering
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with the work of his colleagues) or that he is unwilling to adhere to the
discipline of going to work daily. It should be evident that the patient does
not share the minimum expectations of others (at work or at home) with
regard to his performance of the occupational role.

Rate very serious dysfunction if the patient has been absent from work a
great deal of the time or if the decline in work performance and attitude to
work have reached a critical point. Termination of employment might be
imminent, or other administrative sanctions might already have been applied.

Rate maximum dysfunction if the patient has been absent from work most of
the time or has shown more than once gross or dangerous neglect at work;
or if the deterioration in the patient’s work performance has led to
termination of employment or sick leave during the past month.

2.8 Occupational role: interest in getting a job or
in going back to work or studies

Being gainfully employed (or self-employed) is often regarded in modern
societies as an important measure of the standard of one’s social
participation. In most cases, a person who is unemployed is actively looking
for a job (unless he or she is a student, housewife, etc.). The attitudes, skills,
and activities involved in the patient’s performance of the “looking-for-a-
job” role should be considered here.

The interviewer should enquire about:

(a) the patient’s plans and strategies in relation to obtaining a job or
returning to work;

(b) the practical steps undertaken by the patient to get a job or get back to
work;

(c) the patient’s efficiency and competence in assessing his own potential
vis-à-vis the specific work situation.

In determining the severity of the dysfunction, the interviewer should
consider if there is evidence of:

— any inadequacy in the patient’s performance of the “looking-for-a-job”
role;

— the impact of unemployment in terms of adverse social consequences, i.e.,
loss of opportunities, decline in other roles.

Guiding questions (use others as appropriate)

● Does the patient want to get back to work?
(How do you know? Does he look for jobs? When? How? Has he applied
for any jobs?)

● Has the patient been offered any jobs?
(If so, what happened?)


- *Does the patient talk about going back to work?*
  (Has he asked his doctor's advice? What did the doctor say?)

- *How do you feel about the fact that the patient is not working?*
  (What sort of worries does he cause to you? Do you worry about his future?)

- *Has the fact of the patient being out of work caused you financial problems?*
  (What have you done about it?)

Rate *no dysfunction* if the patient's attitudes and plans to obtain or return to a job are realistic, and if, active, practical steps have been taken during the past month.

To rate *minimum dysfunction*, factual evidence should be provided that the patient declares interest in getting a job and makes plans for doing so; however, his practical steps are half-hearted and not very satisfactory or reasonable. Typically, the patient might be reported as not being prepared to compromise by accepting a lower status job for the time being, or that he tends to postpone his returning to work while planning it.

To rate *obvious dysfunction*, evidence should be provided of diminished initiative in looking for a job or going back to work. Typically, the patient is reported as showing hesitation about going back to work and not initiating any steps. He might go to a job centre if sent by the family but would not consider returning to work if he were not pushed to do so. Evidence is often presented of adverse consequences for the patient (e.g., losing touch with society and contacts with previous work environment).

To rate *serious dysfunction*, evidence of loss of interest and/or inadequacy in approaching the problem should be provided. It might be reported that the patient no longer considers the idea of going back to work, or pays lip service to it but has no real intention of doing so. A loss of social credibility is now present, e.g., in spite of what the patient says or plans the informants express disbelief in his going to work. Usually a decline in social status is present.

Rate *very serious dysfunction* if total lack of interest and/or inadequacy in approaching the problem is present and if the patient shows no concern about the prospect of remaining without an occupation.

Rate *maximum dysfunction* if the patient resists the idea of working (e.g., is hostile to suggestions that he should work) and has avoided or rejected opportunities to get a job (or enrol for study). Totally unrealistic fantasies in respect of work may be revealed.

### 2.9 Interests and information

Being well informed about local and world events should be regarded here as having important implications for the individual's social participation. The acquisition of general knowledge about what is happening around him
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enables the individual to relate his own activity to a social framework of conventions and expectations.

The interviewer should inquire about:

(a) the amount of effort that the patient makes to keep in touch with events around him and the activities he engages in for this purpose;

(b) the involvement he shows in these activities and the amount of new information he brings into the home.

In determining the severity of the dysfunction the interviewer should consider if there is evidence of:

—any loss of interest in events around him and diminishing desire to be informed about them;

—any adverse consequences, i.e., curtailment and limitation of the patient’s personality and outlook.

Guiding questions (use others as appropriate)

• Does the patient show any interest in what is going on around him?
  (What sort of things is he interested in? What does he do to show his interest? Does he buy magazines, newspapers? Does he support a football team? Does he buy new records?)

• Is he interested in people around him?
  (Does he talk about what other people are doing? With whom?)

• How involved does the patient get in things that interest him?
  (Does he tell you of things he has learned about?)

• Can you rely on the patient to know when to pay the rent? — the telephone bill? — other outgoings?

• Does the patient’s lack of interest worry you?
  (Do you try to stimulate his interests?)

Rate no dysfunction if the patient shows interest in both local and world events and seeks information in a manner consistent with his sociocultural context.

To rate minimum dysfunction, factual evidence should be provided of a decline in the patient’s efforts to obtain information. He is typically reported as having become less interested in local and world events, only occasionally reading newspapers or other literature, listening to news broadcasts, or watching television programmes.

To rate obvious dysfunction, evidence should be provided of the patient’s lack of spontaneous interest in what is going on in his immediate social sphere and the world in general. It might be reported that the patient is not aware when the rent is due or what to do about his social security benefits, etc., or that he never talks about relatives, news, or neighbours, or that he
never brings home any news. The family is aware that the patient’s aloofness from the outside world has adverse consequences, i.e., some of his judgements are lacking in common sense.

To rate serious dysfunction, the patient’s interest should have declined severely, i.e., he makes little effort to acquire information and does not react when information is offered. It might be reported that the patient’s awareness and knowledge of local and world events shows gross and obvious gaps.

Rate very serious dysfunction if the patient’s loss of interest is almost total and he does not make any effort to acquire information. He is hardly aware of what is going on in his immediate social sphere or in the world in general.

Rate maximum dysfunction if the patient is uninterested to the extent that he is totally unaware of anything apart from his own immediate needs (e.g., does not know the date). He never reads anything and does not listen to the radio or watch TV. The patient might be a social outcast.

2.10 Patient’s behaviour in emergencies or in out-of-the-ordinary situations that have occurred in the past six months

Consider how well the patient copes with emergencies, unforeseen events, and other non-routine circumstances that require immediate action, problem-solving, and initiative. Try to obtain an account of what the family thinks of the patient’s reliability, trustworthiness, and sense of responsibility.

Inquire about situations such as: contacting the doctor in case of accident or sickness at home, turning off an unlit gas burner or a running water tap; delivering a message, etc. Ask whether the patient reacts at all to such situations and, if so, try to make a judgement as to the speed, appropriateness, and efficiency of his reaction.

In determining the severity of the dysfunction, consider if there is evidence of:

— any threat to the patient’s safety (and that of the family and home) arising from the way he copes with emergencies;

— any adverse social consequences for the patient, e.g., not trusted, in need of supervision.

**Guiding questions** (use others as appropriate)

- **Has the patient a sense of initiative?** For example, will he pick up a burning match?

- **Would you trust the patient in charge of a young child?**

- **Can you rely on the patient to pass on a message?**

- **What problems does the patient’s unreliability cause for you?** (Do you need to supervise him? Can you leave him alone in the house?)
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Rate *no dysfunction* if the patient has responded in an adequate and reasonably efficient way to unusual situations.

To rate *minimum dysfunction*, evidence should be provided that although the patient may be slow to react (e.g., hesitates slightly) he has shown some response and concern, but no initiative and little efficiency, even if instructed how to act in a non-routine situation.

To rate *obvious dysfunction*, evidence should be provided that the patient reacts in an inefficient manner (e.g., only when told what to do) or inadequately (e.g., is clumsy) in a situation that would have caused little difficulty to most people. It might be reported that the family has adopted specific strategies to avoid possible incidents, e.g., not leaving him alone with a boiling saucepan.

To rate *very serious dysfunction*, evidence should be provided that the patient is strikingly indifferent to hazardous situations, e.g., incapable of telephoning a doctor in case of emergency. The patient is considered not to have a sense of responsibility (e.g., is treated as a child).

Rate *maximum dysfunction* if the patient shows total apathy and indifference to hazardous situations. Only swift intervention from another would prevent serious consequences to the patient (e.g., stands in the midst of heavy traffic; remains in a gas-filled room).
Instructions for the use of Sections 3, 4, and 5 of the WHO/DAS

Section 3 applies only to patients who have been in hospital for two weeks or more during the past month. The use of this section is explained in the instructions laid down in the interview schedule itself.

Section 4 is designed to assess the presence, in the immediate social environment of the patient, of certain characteristics that previous research has suggested might have adverse or beneficial effects on the course of psychiatric illness, and possibly on the social disability connected with the illness.

What should be assessed here is not the specific response to the illness, which will have been taken into account in previous sections, but the more general and constant aspects of the patient's environment, which exist irrespective of any deviant behaviour by the patient.

The interviewer will by now have an overall picture of the position of the patient in the family system and will have made some assessment of the quality of information available from the relatives. He should therefore not take answers to this section at their face value, but should use his judgement in assessing the actual situation, on the basis of his previous professional experience.

Instructions for the use of Section 5 of the WHO/DAS are given under the specific item of that section of the interview schedule.
Explanation of certain key terms used in the WHO/DAS and in the accompanying guide
Explanation of key terms

Activity, social. Includes the performance of actions and participation in events as prescribed by the codes and beliefs of a social group, which may be formal, e.g., a club, voluntary organization, or political party, or informal, e.g., a circle of friends, a kinship network, or a neighbourhood.

Activity, spare time. In the DAS context, includes any kind of purposeful occupation during the day that is not directly governed by the necessities of survival and gratification of the basic physiological needs. Examples are: hobbies, sports, reading, participation in social activities, and visiting friends or relatives. Behaviour that qualifies as a spare-time activity involves some amount of attention, involvement, and conscious effort; in this it differs from passive relaxation. The behaviours that count as spare-time activities are sanctioned by social convention (q.v.) and show both cultural and social class variation.

Adjustment, social. A state in which the needs of the individual and the requirements of the social environment, as reflected in the social norm (q.v.), are both satisfied and in harmony with each other.

Asset. Any quality inherent in the person or conferred on him/her by the environment that is socially advantageous and can serve to offset the effects of adverse qualities or circumstances (cf. Liability).

Behaviour, social. The observable activities of an individual directed to, or in response to, other individuals, groups, social situations, and symbols used in social communication (verbal or non-verbal).

Burden, psychological. The subjective experience of discomfort accompanying the awareness of a lasting situation that interferes with one’s emotional gratification and sense of personal autonomy, and at the same time cannot be readily evaded for ethical, emotional, social, or economic reasons.

Burden, social. Objectively observable disturbance in the functioning of a social group resulting from the presence of a person, or persons, who persistently deviate from its norms and cause others to adjust to the deviation, but who cannot be readily dismissed or banished for ethical, emotional, social, or economic reasons.

Communication. All observable behaviour involving the transmission and receiving of signals, verbal or non-verbal, and signs. In the DAS context, it includes the spoken and written word, facial expression, and gesture, and any other form of exchange of messages between at least two persons. Inner speech, and reading and writing not involving interpersonal interaction, are excluded.
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**Competence, social.** The individual’s degree of internalization of social values and his mastery of social skills and of codes of conduct that enable him to perform social roles within a specified social and cultural context.

**Confidant(s).** A person trusted with information about private, intimate, or sensitive affairs.

**Confiding relationship.** Relationship between two or more persons in which at least one discloses voluntarily to the other(s) his intimate thoughts and feelings and derives satisfaction from doing so.

**Convention, social.** The accepted way of behaving in a specific situation, dealing with a specific problem, etc. A social convention usually evolves spontaneously by informal consent among individuals and groups, in contrast to laws and contracts.

**Conversational skills.** Verbal and non-verbal abilities that are prerequisite for engaging in the social act of conversation. They include: transmitting and decoding verbal messages, timing and synchronizing one’s utterances with those of one’s conversational partner(s), acknowledging or requesting information, emitting non-verbal commentary by mimicry and gesture, observing the conventions concerning choice and sequence of topics, and many other abilities determined by custom and tradition. While the formal characteristics of conversational skills, such as those listed above, are universal, their concrete expression is highly culture-specific.

**Cooperation.** Preparedness to act together with other person(s) to achieve a particular end, as inferred from observable behaviour. Cooperation presupposes an active and willing attitude, in contrast to passive compliance.

**Coping.** The acts of organizing and guiding one’s own behaviour so as to deal successfully with adversities or difficulties.

**Disability, social.** As used in the DAS, social disability is any temporary or persistent restriction, resulting from mental disorder or impairment, of the individual’s capacity to perform the social roles that are considered normal for someone of his/her sex, age, and social and cultural context. It should be noted that, according to the *International Classification of Impairments, Disabilities, and Handicaps*, disability is “any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being”, while

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1 Published by the World Health Organization, Geneva, 1980.
the "disadvantage ... resulting from an impairment or a disability, that limits or prevents the fulfilment of a role that is normal ... for that individual" is termed handicap. The DAS concept of social disability, therefore, contains elements of both these definitions.

**Dysfunction, social.** Any observable deviation from the social norm in the individual's performance of activities that may affect others.

**Expectations, social.** The anticipation, shared by the members of a social group, that individual behaviour in various situations is predictable within certain limits and will conform to known patterns or stereotypes.

**Family surrogates.** A social group that, for a certain individual, performs some of the functions of the family and, to that extent, replaces it.

**Friction.** A relation between two or more individuals characterized by lack of cooperation, tensions, and negative feelings that can amount to overt irritability, hostility, or aggression.

**Functioning, autonomous (independent).** An individual's capacity to perform socially expected activities of daily life with minimum support or help from others.

**Impairment.** As used in the DAS, any objectively manifest diminution, or loss, of normal psychological functions, behaviour patterns, or social skills (q.v.) that results from mental disorder, character anomaly, or organic lesion of the central nervous system. According to the *International Classification of Impairments, Disabilities, and Handicaps*, an impairment is "any loss or abnormality of psychological, physiological, or anatomical structure or function".

**Inadequacy, social.** An individual's manifest and persisting failure to conform to social expectations.

**Intimate relationship.** A confiding relationship involving also physical closeness.

**Involvement.** The degree of emotional investment in an activity or an interpersonal relationship.

**Key informant.** In the DAS context, a person, usually living in the same household, with whom an individual has frequent and regular face-to-face contact and an emotional bond.

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1 Published by the World Health Organization, Geneva, 1980.
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Liability. Any quality of a person or of his/her environment that can augment the effects on that person of adverse qualities or circumstances (cf. Asset).

Modifying factor. Any attribute of an individual, or any feature of his/her immediate environment, that can either compensate for or augment psychological impairments and social disabilities. Modifying factors include assets and liabilities.

Norm, social. In the DAS context, the range within which patterns of social behaviour (q.v.) and performance of social roles (q.v.) are accepted as desirable by the social convention in a defined reference group or culture. Since social convention (q.v.) usually reflects an implicit, informal group consensus, most social norms correspond closely to the average or modal level of performance of specific roles in that group.

Participation, social. An individual's characteristic level (i.e., frequency and involvement) of partaking in social activities (q.v.).

Pattern of behaviour. An observable, distinctive sequence of behavioural acts, characteristic of a given individual or of any number of individuals, that tend to recur if particular stimuli or circumstances are present.

Performance, social. The exercise of social roles and skills (q.v.).

Role, heterosexual. In the DAS context, includes the social roles of "boyfriend", "girlfriend", "fiancé(e)" and the like (excludes the marital role). It is characterized by patterns of behaviour ranging from indications of interest in a person of the opposite sex to an intimate relationship with a heterosexual partner. Certain roles (e.g., extramartial "affairs"), although acknowledged, may be negatively sanctioned by the social group because they lead to role conflict. The opportunities for engaging in a heterosexual role are more restricted in some cultures than in others.

Role, marital. Generic designation for the respective social roles of a husband and a wife. Each of these roles includes a nurturant (i.e., providing, caring) and an affective component, and each is usually interlocked with the closely related role of father or mother. The attributes of the marital roles vary considerably between social groups and cultures, but the essential elements are present regardless of such variation.
Explanation of key terms

**Role, occupational.** Generic designation for a great variety of social roles having work as their common core. Occupational roles are usually defined in terms of specified tasks and duties, requisite skills and knowledge, and standards of performance and output. The performance of an occupational role is normally expected to result in material goods, services, or other (including intellectual and artistic) products and to be rewarded in exchange for such output.

**Role, parental.** Generic designation for the respective social roles of father and mother. Like marital roles (q.v.), each of these has a nurturant and an affective component manifest in typical, expected patterns of behaviour. In most cultures, the mother is expected to display more nurturant behaviour in the home than the father. The patterns of behaviour expected of the parental role change with time, depending on the age of the children, and as with any other social role, show sociocultural variation.

**Role, social.** Functionally organized pattern of behaviour (q.v.) shared by most individuals occupying a defined social position, considered essential for the maintenance of such a position, and expected in accordance with the social norm (q.v.).

**Satisfaction.** In the DAS context, an individual’s expressed opinion that a particular need, or feeling, has been gratified.

**Self-care.** Activities and behaviour patterns required for the maintenance of physiological equilibrium and survival (feeding, excretion, personal hygiene, avoidance of physical danger) and for social self-presentation (dressing, grooming), normally performed by non-impaired adults with minimum assistance from other people.

**Self-reliance.** The capacity for autonomous functioning (q.v.).

**Skills, social.** Behavioural acts that occur during social interaction and are prerequisite to, or supportive of, communication, social activity, and social role performance. They include perceptual and expressive elements, comprise verbal and non-verbal components, and may appear in complex hierarchical and temporal configurations.

**Sociocultural context.** The matrix of social ”macro”-structure and elements of culture in which each individual’s social position and each social group (”micro”-structure) are embedded.

**Status, social.** The place of any one of the social positions (e.g., marital, occupational) occupied by an individual in the internal hierarchy of the group of which he or she is a member.
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Withdrawal, social. Pattern of behaviour characterized by a persisting tendency to retract from social interaction and communication. Social convention in many cultures recognizes certain motivations, circumstances, and social roles that make withdrawal acceptable and that do not lead to social dysfunction. When such factors are lacking, social withdrawal is usually regarded as deviance, signalling the presence of mental disorder or abnormal personality traits.
Annex 1

The WHO Collaborative Study on the Assessment and Reduction of Psychiatric Disability
Annex 1

The WHO Collaborative Study on the Assessment and Reduction of Psychiatric Disability

The WHO Psychiatric Disability Assessment Schedule was originally designed for use in a collaborative study of patients with potentially severe psychiatric disorders. In order, therefore, to place the instrument in its proper context, it is useful to describe this study, which involved research centres in seven countries: Bulgaria (Sofia), Federal Republic of Germany (Mannheim), the Netherlands (Groningen), Sudan (Khartoum), Switzerland (Zurich), Turkey (Ankara), and Yugoslavia (Zagreb).

Goals of the study

The principal objective of the study was to develop a methodology and a set of instruments for a multi-axial assessment of psychiatric patients that would allow independent, standardized evaluation of clinical and social history, present mental state, psychological impairments, and social disability. The aim was to produce an assessment method that would enable at least some gross comparisons to be made reliably across different social and cultural settings, in a manner that would be acceptable to patients, clinicians, and other mental health personnel, such as social workers.

Another equally important objective was to collect data on the early manifestations of symptoms, impairments, and disabilities in samples of patients with severe mental disorders of relatively recent onset, and to follow their course over a period of time.

Underlying concepts

The distinctions between symptoms of illness, impairments and disabilities are fundamental to the design of the study. Although the boundaries between these concepts are not sharply delineated, the differentiation has been shown to be useful in both physical rehabilitation (1) and social psychiatric work (2).

The concept of illness refers generally to physical or mental states and processes that are perceived as deviations from the normal state of health (in being distressing or threatening), involve some lesion or physiological dysfunction (demonstrable or presumed), and can be described in terms of symptoms and signs. According to the International classification of impairments, disabilities and handicaps (3), an impairment is "any loss or abnormality of psychological, physiological or anatomical structure or function". A particular impairment can also be a symptom or sign of an

1 This report was prepared by Dr A. Jablensky, formerly Senior Medical Officer, Division of Mental Health, World Health Organization.
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illness, but it always points to a function that is disturbed, rather than to a specific nosological diagnosis. For example, cognitive deficit is clearly an impairment but is not disease-specific. Disability is defined as "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being". In the context of this study, disability is more specifically defined as a loss or restriction of the capacity to perform particular social roles, normally expected of the individual in his or her habitual environment.

Assessment instruments
Five different instruments were employed in the study.

Psychiatric history and sociodemographic description
This schedule was drafted at WHO Headquarters on the basis of experience in earlier WHO studies, e.g. the International Pilot Study of Schizophrenia (4, 5). An important part of this instrument is an inventory of past episodes of mental disorder and symptom-free intervals, in which the investigator records data on the clinical characteristics of past episodes, the treatments received, and recent life events.

Present State Examination (PSE)
The ninth edition of the Present State Examination (6) was adopted as an instrument for the clinical assessment of mental state. The PSE is a semi-structured psychiatric interview guide for standardized assessment of symptomatology. Aspects of its reliability, cross-cultural applicability, the appropriate training procedures and methods of data processing have been extensively described elsewhere (4, 5).

Psychological Impairments Rating Schedule (PIRS)
This instrument was designed especially for the purposes of the present study, to serve as a supplement to the PSE that would allow a more detailed recording of the patient's observed behaviour during the interview. Its content is an expansion and elaboration of the section "Behaviour, affect and speech" of the ninth edition of the PSE. The concept of impairment underlying the selection of PIRS items focuses on the interaction skills of the individual that are essential for day-to-day social behaviour and are likely to be present, with some variations, in most cultures. The actual selection of items was made after screening some of the recent literature on interactive and communicative behaviour (e.g., 7, 8).

The schedule contains 97 items in 10 sections: psychic tempo, attention, fatiguability, initiative, communication by facial expression, communication by body language, affect display, conversation skills, self-presentation and cooperation. A brief descriptive note is provided with each item, and a rating key allows the recording of the absence, presence, presence in a severe degree, or lack of certainty about the item of behaviour. In addition, a six-point scale for "overall impression" permits the investigator to make a global judgement about the degree of disturbance in each of the 10 sections regardless of the ratings made for the specific items. After the completion of the 10 behavioural sections, the interviewer records his or her subjective impressions of the patient's personality.
Disability Assessment Schedule (DAS)

Like the impairments rating instrument, this schedule was developed specially for this study. A first draft was prepared at WHO Headquarters and extensively discussed at meetings of investigators who provided various amendments. A pilot version was tested in several field research centres and further adjustments were made until a working version was adopted. The accompanying guide to its use was drafted by Dr T. Tomov (Sofia, Bulgaria) and Mrs J. Korer (Nottingham, England) with the assistance of Dr J. E. Cooper (Nottingham, England), and subsequently amended by the collaborating investigators. The DAS was designed to fill a gap in the existing range of instruments for the assessment of social behaviour in psychiatric patients. Although many scales and inventories are available for the rating of interpersonal behaviour in clinical or psychotherapeutic settings (9), few appropriate tools have been developed for the evaluation of social functioning of patients with severe illnesses. Those that have been proposed are difficult to apply in a cross-cultural context because of the culture-bound content of many of the items. The goal in developing the DAS was to produce a simple instrument, compatible with the PSE (in the sense of covering the same one-month period preceding the assessment), and applicable in different cultural settings.

The instrument contains four sections which include a total of 97 items. Section 1 deals with overall behaviour (self-care, level of activity, social withdrawal). Section 2 is an inventory of social roles that can be found in most cultures (e.g., participation in household activities, marriage, care of children, interests and information, behaviour in emergencies or crises). Each of the role domains is rated first for its applicability with regard to the patient and then for current (i.e., in last four weeks) and past performance. In view of the variation in cultural norms, anchor-point definitions are given for each level in the six-point scale, and the interviewer is required to make a rating on the basis of clinical judgement and experience, taking as his point of reference the "average" performance of a given individual or an individual of a particular social and cultural background. Since there is little systematic knowledge about actual "norms" and "average" performances of specific activities in different cultures, the investigators are required to supplement each rating with a descriptive narrative note. In this way, narrative material is being accumulated, which will be analysed and used to develop further the instrument. Section 3 is filled in if the patient has been hospitalized for most of the time in the last month. This section is a modification of the questionnaire used in the "three-hospital study" by Wing & Brown (10). Section 4, "modifying factors", includes items designed to describe specific assets (e.g., above-average abilities, supportive relationships) and specific liabilities (e.g., membership of an underprivileged group) of the patient, as well as salient features of his home environment. At the end of the schedule, a global judgement about the level of disability of the patient is made and a check-list for rating impressions about the key informants is filled in.

The DAS is rated on the basis of information obtained in an interview with a "key" informant (normally a member of the patient's household), but a brief interview with the patient is also required in order to make a valid judgement about certain specified items. In this study, the DAS assessment was performed independently of the PSE and PIRS assessments, by different members of the project team.
Annex 1

**Diagnostic and Prognostic Assessment (DPA)**

This schedule is a modification of a diagnosis recording form used in the WHO International Pilot Study of Schizophrenia. In addition to sections for recording the diagnosis made by the project team (in terms of the International Classification of Diseases, Ninth Revision (11), and in the terminology current in the centre), and a number of prognostic statements, the schedule includes a check-list of treatment and management modalities which are rated as to “need” and “feasibility” with regard to the particular patient. In this study, the diagnostic and prognostic assessment was finalized only after a full discussion of the case by the team.

**Reliability of the assessments**

All the interviewers in the project using the PSE had received prior training from experienced users of the instrument. With regard to the PIRS and DAS, training sessions were held during meetings of investigators and/or exchanges of visits by investigators. Detailed rules on the application of the instruments were developed during these sessions and subsequently incorporated in the guides to their use.

The intra- and inter-centre reliability of the assessments made with each of the instruments were monitored regularly, both before and during the data collection phase of the project. The material used for evaluation of reliability comprised video and audio recordings of interviews, transcripts of recorded interviews, and live interviews with patients and informants.

The reliability of the DAS is of special interest, since it is a new instrument for the assessment of complex aspects of social behaviour, which are known to show considerable cultural and social class variation. As shown in Table 1, acceptable or high levels of inter-rater agreement on the rating of the major social roles covered in the DAS were achieved within individual centres (a value of kappa equal to, or greater than 0.6, is usually considered to be an indication of good agreement) (12). Table 2, which presents data from an inter-centre reliability exercise, shows that acceptable agreement could also be attained by raters from different sociocultural settings evaluating the same material.

As regards the validity of the DAS ratings, one test is the capacity of the instrument to distinguish between patients and controls, the latter being

<table>
<thead>
<tr>
<th>Centre</th>
<th>Self-care</th>
<th>Interests and information</th>
<th>Participation in household</th>
<th>Under-activity</th>
<th>Social withdrawal</th>
<th>Work role</th>
<th>Sexual relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groningen</td>
<td>0.74</td>
<td>0.73</td>
<td>0.73</td>
<td>0.86</td>
<td>0.85</td>
<td>0.93</td>
<td>1.00</td>
</tr>
<tr>
<td>Mannheim</td>
<td>1.00</td>
<td>0.81</td>
<td>0.70</td>
<td>0.89</td>
<td>1.00</td>
<td>0.91</td>
<td>1.00</td>
</tr>
<tr>
<td>Nottingham</td>
<td>1.00</td>
<td>0.69</td>
<td>0.79</td>
<td>0.90</td>
<td>1.00</td>
<td>0.63</td>
<td>0.24</td>
</tr>
</tbody>
</table>

Table 1. Inter-rater reliability of assessment of social roles (kappa statistic) using the DAS.
Table 2. Inter-centre reliability of assessment of social roles (pairwise agreement rates on two interview transcripts, rated by 14 investigators in 7 research centres) (kappa statistic)

<table>
<thead>
<tr>
<th>Social roles</th>
<th>Self-care</th>
<th>Interests and information</th>
<th>Participation in household</th>
<th>Underactivity</th>
<th>Social withdrawal</th>
<th>Work role</th>
<th>Sexual relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 1</td>
<td>0.85</td>
<td>0.68</td>
<td>1.00</td>
<td>1.00</td>
<td>0.69</td>
<td>0.74</td>
<td>1.00</td>
</tr>
<tr>
<td>Case 2</td>
<td>1.00</td>
<td>1.00</td>
<td>0.52</td>
<td>0.85</td>
<td>0.89</td>
<td>0.72</td>
<td>0.76</td>
</tr>
<tr>
<td>Both cases</td>
<td>0.93</td>
<td>0.84</td>
<td>0.76</td>
<td>0.93</td>
<td>0.79</td>
<td>0.73</td>
<td>0.88</td>
</tr>
</tbody>
</table>

expected to score lower on most or all items. Fig. 1 summarizes data from one centre (Mannheim) where a group of schizophrenic patients was compared with a group of controls. The figure indicates a clear difference between the two groups on most role items, with a much higher proportion of the schizophrenic patients having dysfunction scores on most social roles.

![Graph showing comparison of DAS profiles](image)

**Fig. 1.** Comparison of DAS profiles of schizophrenic patients and controls (N = 56). Mannheim
Design of the study

For the data collection, each of the research teams in the seven centres selected and assessed a series of patients who met specified criteria for functional psychoses of non-affective type and of relatively recent onset. The criteria for inclusion of a patient were:

(1) age 15–44 years;
(2) residence in a defined catchment area;
(3) absence of organic brain disease (including epilepsy), severe mental retardation, severe sensory defects, alcohol or drug dependence;
(4) presence of either (a) at least one of the following: hallucinations, delusions of non-affective type, change to a bizarre or grossly inappropriate behaviour, thought and speech disorder other than retardation or acceleration; or (b) at least two of the following: psychomotor disorder other than simple retardation or over-activity, overwhelming fear or anxiety, marked social withdrawal, marked self-neglect. In one centre (Mannheim) a more restrictive screening procedure was adopted and type (b) criteria were not applied;
(5) onset of psychotic illness not more than 24 months prior to the screening (up to 24 months in two centres, up to 18 months in three centres, and up to 12 months in two centres);
(6) clinical diagnosis of either schizophrenia (ICD 295), paranoid state (ICD 297) or other non-organic psychosis, paranoid or unspecified (ICD 298.3, 298.4, 298.8, and 298.9).

These criteria were designed to ensure that sufficiently large numbers of patients with potentially disabling psychotic conditions were available for intensive study at a relatively early point after disease onset, when many of the impairments and disabilities are incipient or possibly reversible.

The study population comprised a total of 520 patients (277 men and 243 women) (Table 3). All patients were assessed with the instruments described above on at least three occasions: on entry into the study, and after one and two years. Some of the centres also carried out a five-year follow-up, and one centre (Mannheim) carried out six-monthly examinations over the first two years of follow-up.

Table 3. Study population at initial examination

<table>
<thead>
<tr>
<th>Centre</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ankara</td>
<td>44</td>
<td>26</td>
<td>70</td>
</tr>
<tr>
<td>Groningen</td>
<td>43</td>
<td>40</td>
<td>83</td>
</tr>
<tr>
<td>Khartoum</td>
<td>55</td>
<td>16</td>
<td>71</td>
</tr>
<tr>
<td>Mannheim</td>
<td>41</td>
<td>29</td>
<td>70</td>
</tr>
<tr>
<td>Sofia</td>
<td>55</td>
<td>65</td>
<td>120*</td>
</tr>
<tr>
<td>Zagreb</td>
<td>7</td>
<td>29</td>
<td>36</td>
</tr>
<tr>
<td>Zurich</td>
<td>32</td>
<td>38</td>
<td>70</td>
</tr>
<tr>
<td>All centres</td>
<td>277</td>
<td>243</td>
<td>520</td>
</tr>
</tbody>
</table>

* Of these, 82 (23 males and 39 females) formed a recent onset series, with duration of illness less than one year, and 58 (32 males and 26 females) formed a comparison series with duration of illness between one and five years.
Diagnostic description of the study sample

The diagnostic classification of the cases was a two-stage process. In the first stage, each team of investigators concluded their assessment of the patient with the formulation of a clinical diagnosis, taking into account all the information available. At the second stage, a computer diagnostic classification program, CATEGO (6), was used to allocate each patient to one of 20 possible diagnostic classes, thus eliminating variation that could be due to differing interpretations of the clinical data. Although the CATEGO classes are not strictly equivalent to clinical diagnoses (because, for this study, only information about recent and current symptoms was used as input), the computer program allows an objective evaluation of the degree to which patients in the different settings have similar symptoms, and of the extent to which they present explicitly defined and generally recognized psychiatric syndromes.

The distribution of patients according to clinical diagnoses made at the centre is shown in Table 4. The majority of the patients (81.5%) had a clinical diagnosis of schizophrenia, mostly of the paranoid subtype. The only other significant diagnostic group was that of the reactive or psychogenic psychoses, and the majority of the patients assigned this diagnosis were in Groningen.

The distribution according to computer-assigned CATEGO class is shown in Table 5. Class S+ comprises cases manifesting the so-called central or nuclear syndrome of schizophrenia, characterized by presence of “first-rank” symptoms (13), such as experience of thought insertion, broadcast, or echo; thought blocking; delusions of passivity and control; and characteristic auditory hallucinations of voices discussing the patient as “he” or “she” or commenting on his or her thoughts and actions. The broader group of classes S, P and O includes a variety of psychotic syndromes commonly encountered in schizophrenia (e.g., other delusions and hallucinations, catatonic disturbances) and can be regarded as being close to the clinical boundaries of schizophrenia, as the disorder is defined in most countries.

The nuclear syndrome (S+) was present in a high proportion of patients in all centres, regardless of cultural setting. The proportion of patients with

Table 4. Distribution of study population by main diagnosis of the centre at initial examination

<table>
<thead>
<tr>
<th>Centre</th>
<th>Schizophrenia</th>
<th>Affective psychosis</th>
<th>Paranoid state</th>
<th>Reactive or psychogenic psychosis</th>
<th>Other</th>
<th>Total*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ankara</td>
<td>59</td>
<td>2</td>
<td>0</td>
<td>9</td>
<td>0</td>
<td>70</td>
</tr>
<tr>
<td>Groningen</td>
<td>24</td>
<td>0</td>
<td>2</td>
<td>54</td>
<td>1</td>
<td>81</td>
</tr>
<tr>
<td>Khartoum</td>
<td>67</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>70</td>
</tr>
<tr>
<td>Mannheim</td>
<td>68</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>70</td>
</tr>
<tr>
<td>Sofia</td>
<td>105</td>
<td>1</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>116</td>
</tr>
<tr>
<td>Zagreb</td>
<td>35</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>35</td>
</tr>
<tr>
<td>Zurich</td>
<td>68</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>70</td>
</tr>
<tr>
<td>All centres</td>
<td>424</td>
<td>4</td>
<td>6</td>
<td>72</td>
<td>6</td>
<td>512</td>
</tr>
</tbody>
</table>

* No diagnosis was made in 8 cases.
**Table 5. Distribution of study population at initial examination by computer-assigned diagnostic class (CATEGO)**

<table>
<thead>
<tr>
<th>Centre</th>
<th>&quot;Central&quot; schizophrenic (S+)</th>
<th>S, P, O</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ankara</td>
<td>43 (62.3)</td>
<td>16 (23.2)</td>
<td>10 (14.5)</td>
<td>69</td>
</tr>
<tr>
<td>Groningen</td>
<td>24 (28.3)</td>
<td>29 (35.4)</td>
<td>29 (35.4)</td>
<td>82</td>
</tr>
<tr>
<td>Khartoum</td>
<td>44 (62.0)</td>
<td>22 (31.0)</td>
<td>5 (7.0)</td>
<td>71</td>
</tr>
<tr>
<td>Mannheim</td>
<td>42 (60.0)</td>
<td>21 (30.0)</td>
<td>7 (10.0)</td>
<td>70</td>
</tr>
<tr>
<td>Sofia</td>
<td>51 (42.1)</td>
<td>28 (23.1)</td>
<td>42 (34.7)</td>
<td>121</td>
</tr>
<tr>
<td>Zagreb</td>
<td>20 (57.1)</td>
<td>8 (22.9)</td>
<td>7 (20.0)</td>
<td>35</td>
</tr>
<tr>
<td>Zurich</td>
<td>32 (45.7)</td>
<td>26 (37.1)</td>
<td>12 (17.1)</td>
<td>70</td>
</tr>
</tbody>
</table>

All centres 256 (48.4) 150 (29.0) 112 (21.6) 518

* Figures in parentheses give percentages.
* S—Schizophrenic psychoses (chief symptoms: thought intrusion, broadcast or withdrawal; delusions of control; voices discussing the patient; other auditory hallucinations; other delusions. If any of the first three symptoms is present, or if other hallucinations and delusions are simultaneously present, the patient is allocated to class S+. the central schizophrenic condition.
* P—paranoid psychoses (chief symptoms: delusions, other than first-rank; hallucinations, other than auditory).
* O—other psychoses (chief symptoms: catatonia; behaviour indicating hallucinations).

Symptom pictures corresponding to the broader concept of schizophrenia (i.e., S+, S, P, and O) is 78.4% for the total study population. Notably, while 66.7% of the Groningen patients had a clinical diagnosis of reactive psychosis, 64.7% of the patients in this centre had a CATEGO class describing schizophrenia. This indicates that the high frequency of reactive psychosis in Groningen is partly a reflection of a diagnostic convention that is different from those prevailing in the other centres. Another part of the explanation is that in Groningen (and in Sofia, the other centre with a high proportion of patients allocated to "other" CATEGO classes), patients with longer duration of previous illness and less florid psychotic symptoms had been over-sampled.

The overall conclusion, however, is that the study population represented a fairly homogeneous and typical cross-section of the type of schizophrenic patients using the psychiatric services in the different settings.

**Social role performance and disability**

The DAS ratings permit the determination of several scores that condense the information into more manageable and comparable units. One of these is the social role repertoire score, representing the number of social roles defined in the DAS on which any rating was made, divided by the total number of possible roles for the particular subject. For example, the role "participation in household" would not be applicable to a patient who does not share a household with other people and, hence, this particular role would be excluded from the denominator.

The average social role repertoire scores are given in Table 6. Five of the patient samples (Mannheim, Sofia-recent onset, Sofia-earlier onset, Zagreb...
Table 6. Mean social role repertoire scores at initial examination (both sexes)

<table>
<thead>
<tr>
<th>Centre</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ankara</td>
<td>2.93</td>
</tr>
<tr>
<td>Groningen</td>
<td>2.58</td>
</tr>
<tr>
<td>Khartoum</td>
<td>3.83</td>
</tr>
<tr>
<td>Mannheim</td>
<td>5.66</td>
</tr>
<tr>
<td>Sofia</td>
<td></td>
</tr>
<tr>
<td>recent onset</td>
<td>5.67</td>
</tr>
<tr>
<td>earlier onset</td>
<td>5.90</td>
</tr>
<tr>
<td>Zagreb</td>
<td>5.47</td>
</tr>
<tr>
<td>Zurich</td>
<td>5.06</td>
</tr>
</tbody>
</table>

and Zurich) had very similar social repertoire scores of five or more, and the remaining three samples (Ankara, Groningen and Khartoum) had somewhat lower scores.

The second score (Table 7) represents the average rating for all social roles performed by the patient and is, therefore, an index of severity of social role dysfunction. With the exception of Khartoum, where the scores for social role dysfunction were higher than in all the other centres, the levels of dysfunction as measured by this particular index were remarkably similar across the centres.

More important than the global scores for role dysfunction was the distribution of the types and numbers of social roles rated as dysfunctional. Table 8 shows the pooled data for 267 patients in all the centres who had complete sets of ratings for all the items in Section 2 of the DAS. The data suggest a pattern in increasing severity of role dysfunction, in the sense that certain roles are likely to be affected before others. For example, among the 33 patients in whom only one social role was affected, this role was "sexual relationship" in 14 of the patients. If two or three roles were affected, "sexual relationship" retained its first rank, followed closely by the work role. In contrast, the role of "self-care" seems to be more refractory to disturbance and becomes dysfunctional only after most of the other social roles are already affected.

Table 7. Mean social role performance scores at initial examination (both sexes)

<table>
<thead>
<tr>
<th>Centre</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ankara</td>
<td>1.31</td>
</tr>
<tr>
<td>Groningen</td>
<td>1.15</td>
</tr>
<tr>
<td>Khartoum</td>
<td>2.46</td>
</tr>
<tr>
<td>Mannheim</td>
<td>1.81</td>
</tr>
<tr>
<td>Sofia</td>
<td></td>
</tr>
<tr>
<td>recent onset</td>
<td>1.61</td>
</tr>
<tr>
<td>earlier onset</td>
<td>1.33</td>
</tr>
<tr>
<td>Zagreb</td>
<td>1.28</td>
</tr>
<tr>
<td>Zurich</td>
<td>1.32</td>
</tr>
</tbody>
</table>
Table 8. Number of patients with social role dysfunctions, in up to 7 roles, by type of social role

<table>
<thead>
<tr>
<th>No. of roles in which dysfunction was manifest</th>
<th>No. of patients</th>
<th>Self-care</th>
<th>Interests and information</th>
<th>Participation in household</th>
<th>Under-activity</th>
<th>Social withdrawal</th>
<th>Work role</th>
<th>Sexual relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>19</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>33</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>2</td>
<td>23</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>10</td>
<td>10</td>
<td>15</td>
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<tr>
<td>3</td>
<td>32</td>
<td>6</td>
<td>17</td>
<td>13</td>
<td>14</td>
<td>9</td>
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<tr>
<td>4</td>
<td>41</td>
<td>11</td>
<td>20</td>
<td>20</td>
<td>22</td>
<td>27</td>
<td>29</td>
<td>35</td>
</tr>
<tr>
<td>5</td>
<td>35</td>
<td>8</td>
<td>21</td>
<td>30</td>
<td>30</td>
<td>27</td>
<td>27</td>
<td>32</td>
</tr>
<tr>
<td>6</td>
<td>42</td>
<td>23</td>
<td>33</td>
<td>29</td>
<td>39</td>
<td>40</td>
<td>39</td>
<td>39</td>
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<tr>
<td>7</td>
<td>42</td>
<td>42</td>
<td>42</td>
<td>42</td>
<td>42</td>
<td>42</td>
<td>42</td>
<td>42</td>
</tr>
<tr>
<td>Total no. of patients</td>
<td>267</td>
<td>93</td>
<td>136</td>
<td>138</td>
<td>156</td>
<td>158</td>
<td>171</td>
<td>198</td>
</tr>
<tr>
<td>Percentage</td>
<td>100</td>
<td>35</td>
<td>51</td>
<td>52</td>
<td>58</td>
<td>58</td>
<td>58</td>
<td>74</td>
</tr>
</tbody>
</table>
This interpretation of the findings was confirmed by analyses applying the so-called Guttman scalogram method (14) to the data. This approach postulates the existence of a hidden hierarchy in a set of variables and aims to present it in the form of a linear scale where each step implies that a positive score should be present in every other step lower in the hierarchy.

Although the requirements for a 'perfect' Guttman scale were not fully met by the data, such a hierarchy was found to be present. This means that the determination of a dysfunction in the performance of any single social role should allow a prediction to be made about the performance of other social roles, if the hierarchy is known. For example, while the finding of a role dysfunction affecting a sexual relationship does not predict whether the subject would also show disturbances in self-care or in general interests and information, the reverse would be possible, i.e., a patient showing disturbances in self-care or in general interests and information would be very likely also to have disturbances in the sphere of sexual relations or work.

The microsocial environment of the patients

Several of the variables rated in the DAS were designed to determine what environmental factors might have a modifying effect (positive or negative) on the impairments and disabilities of the patients. In particular, certain aspects of the day-to-day interaction between the patient and a "key" relative (i.e., the person spending most time in face-to-face contact with the patient) were expected to be important and to show variation from centre to centre. The "home atmosphere", comprising items like degree of emotional involvement of the relative, extent of control and demands, rejecting or critical attitudes towards the patient, and the patient's access to privacy as an escape from emotional tension, was thought to be a highly culture-dependent variable and therefore likely to show marked differences across the centres. That this was not the case is shown clearly in Table 9, where the scores on "home atmosphere" are seen to be very similar. Although further analyses are needed to elaborate on these findings, the data suggest that the microsocial environment of schizophrenic patients living with a close relative is very similar in the different settings.

Table 9. Mean scores for home atmosphere at initial examination

<table>
<thead>
<tr>
<th>Centre</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ankara</td>
<td>2.85</td>
</tr>
<tr>
<td>Groningen</td>
<td>2.13</td>
</tr>
<tr>
<td>Khartoum</td>
<td>2.37</td>
</tr>
<tr>
<td>Mannheim</td>
<td>2.19</td>
</tr>
<tr>
<td>Sofia</td>
<td></td>
</tr>
<tr>
<td>recent onset</td>
<td>3.62</td>
</tr>
<tr>
<td>earlier onset</td>
<td>3.08</td>
</tr>
<tr>
<td>Zagreb</td>
<td>3.73</td>
</tr>
<tr>
<td>Zurich</td>
<td>3.33</td>
</tr>
</tbody>
</table>
Annex 1

Conclusion

The preliminary results from the WHO collaborative study on impairments and disabilities in schizophrenic and other psychotic patients indicate that many similarities exist in the clinical, behavioural, and social characteristics of these people, in spite of the cultural differences. The similarities concern the presenting symptoms, the frequency of diagnostically important clinical syndromes, the nature and severity of psychological and behavioural impairments ("negative" disturbances), and the pattern of development of social role dysfunctions. This finding underscores the belief that schizophrenia is a universal and deep-rooted disorder which, although responsive to influences in the social environment in the individual case, shows little variation in the ways in which this responsiveness is manifested in different cultures. One implication of this finding is that mental health workers in different cultures can reliably compare observations and learn from each other when faced with this complex and sometimes devastating disorder which continues to be a challenge to psychiatric research and mental health care.

References