How to Define the Effect of ECT?

NACT 2023

- Martin Balslev Jørgensen

Depression
HAMD
MADRS and MADRS-S
Beck Depression Inventory (BDI-II)
QIDS-SR16
Mania
Bech-Rafaelsen Mania Scale (MAS)
Schizophrenia
PANSS
BPRS
Catatonia
Bush-Francis catatonia rating scale
General
CGI
MODE
SCL10
Cognition
MMSE
A subset of RAVLT Rey Auditory Visual Learning Test and the RFT Rey Figure Test
SCIP
COPRA
ECCA The ElectroConvulsive therapy Cognitive Assessment and the Montreal Cognitive Assessment (MoCA)
CPRS memory item (Comprehensive Psychopathological Rating Scale)
AMIsf
AMT

Seizure quality as Proxy
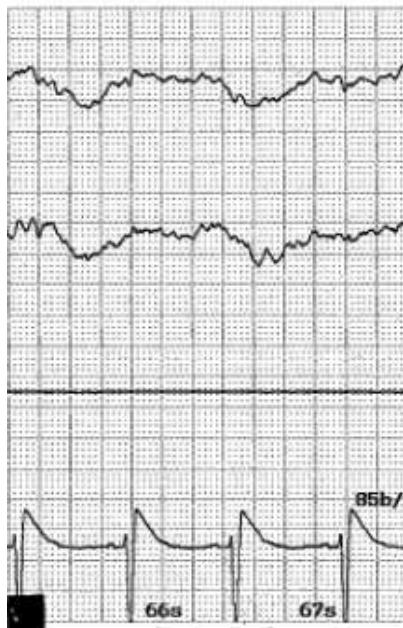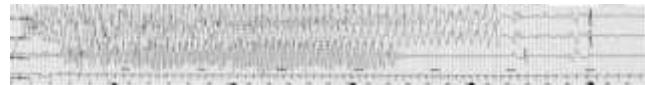

```
Thymatron System IV S/N: 42317
15/10/19 08:50:59
% Energy Set................... 10 %
Charge Delivered.............. 50.4 mC
Current....................... 0.90 A
Stimulus Duration............. 5.6 Sec
Frequency..................... 10 Hz
Pulse Width................... 0.50 mSec
Static Impedance.............. 1710 Ohm
Dynamic Impedance............. 270 Ohm
EEG Endpoint.................. 37 Sec
EMG Activity is not detected
Base Heart Rate............... 98 b/m
Peak Heart Rate............... 171 b/m
Average Seizure Energy Index.. 7078.7 μV2
Postictal Suppression Index... 68.2 %
Maximum Sustained Power....... 10963.4 μV2
Time to Peak Power............ 28 Sec
Maximum Sustained Coherence... 94.8 %
Time to Peak Coherence........ 31 Sec

Program Selected: 2X DOSE
```

Postictal orientation recovery time (Sobin et al. 1995)

Register based studies

BJPsych — The British Journal of Psychiatry (2019)
214, 168–170. doi: 10.1192/bjp.2018.150

Short Report

Electroconvulsive therapy and risk of dementia in patients with affective disorders: a cohort study

Merete Osler, Maarten Pieter Rozing, Gunhild Tidemann Christensen, Per Kragh Andersen, Martin Balslev Jørgensen

Summary
Background Electroconvulsive therapy (ECT) is the most effective treatment for severe episodes of mood disorders. Temporary memory loss is a common side-effect, but ongoing discussions exist regarding potential long-term adverse cognitive outcomes. Only a few studies have examined the frequency of dementia in patients after ECT. The aim of this study was to examine the association between ECT and risk of subsequent dementia in patients with a first-time hospital diagnosis of affective disorder.

Methods We did a cohort study of patients aged 10 years and older in Denmark with a first-time hospital contact for an affective disorder from Jan 1, 2005, through Dec 31, 2015, identified in the Danish National Patient Registry with

Lancet Psychiatry 2018
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March 6, 2018
http://dx.doi.org/10.1016/S2215-0366(18)30056-7
See Online/Comment
http://dx.doi.org/10.1016/S2215-0366(18)30

Electroconvulsive therapy and later stroke in patients with affective disorders

Maarten Pieter Rozing, Martin Balslev Jørgensen and Merete Osler

Summary
The long-term effects of electroconvulsive therapy (ECT) on the risk of stroke are unknown. We examined the association between ECT and risk of incident or recurrent stroke. A cohort of 174 534 patients diagnosed with affective disorder between 2005 and 2016 in the Danish National Patient Registry were followed.

this estimate was likely influenced by competing mortality risk. Of 11 939 patients with a history of stroke, 228 (1.9%) were treated with ECT. During follow-up, 2330 (19.5%) patients had a recurrence, of which 26 were patients treated with ECT. ECT was not associated with risk of a new event (HR = 0.69, 95% CI 0.46–1.01, P = 0.05). ECT is not associated with an elevated risk of

ORIGINAL STUDY

Original Article

Electroconvulsive therapy, depression severity and mortality: Data from the Danish National Patient Registry

Journal of Psychoph
1–7
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DOI: 10.1177/0269881119895518
journals.sagepub.com/home/jop
SAGE

Martin Balslev Jørgensen[1], Maarten Pieter Rozing[1,2,3], Charles H. Kellner[4] and Merete Osler[2,5]

Abstract
Background: The effects of electroconvulsive therapy are usually estimated from changes in depression scales from studies with relatively small patient samples. Larger patient samples can be achieved from epidemiological registers, which provide information on other social and clinical predictors, results and risks.

Aims: To examine whether depression severity predicts the use of electroconvulsive therapy, risk of re-hospitalization, suicidal behaviour and mortality following electroconvulsive therapy in patients with major depression.

Methods: A cohort of 92,895 patients diagnosed with single or recurrent depression between 2005 and 2016 in the Danish National Patient Registry

Electroconvulsive Therapy and Risk of Road Traffic Accidents
A Danish Register–Based Cohort Study

Simon Hjerrild, MD, PhD,*† Martin Balslev Jørgensen, MD, DMSc,‡ Ole Henrik Dam, MD,‡ Elisabeth Tehrani, MD, PhD,§ Poul Videbech, MD, DMSc,‖ and Merete Osler¶#

Brain Stimulation xxx (2017) 1–5

Contents lists available at ScienceDirect

BRAIN

Brain Stimulation

ELSEVIER — journal homepage: http://www.journals.elsevier.com/brain-stimulation

Electroconvulsive therapy and subsequent epilepsy in patients with affective disorders: A register-based Danish cohort study

Fie Krossdal Bøg [a,b], Martin Balslev Jørgensen [c], Zorana Jovanovic Andersen [b], Merete Osler [a,b,*]

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Kirov in Tallin

Cognitive tests in Cardiff

Mini Mental State Examination (MMSE)

Verbal Fluency (N words in 1 min, beginning with F, A, T or S)

Digit Span backwards (0-8)

Recognition of words, shapes and faces, on computer (memory)

Reaction time simple / with distraction, on computer

Trail making A & B

Complex figure drawing

Cognitive Failures Questionnaire

3/12   yearly
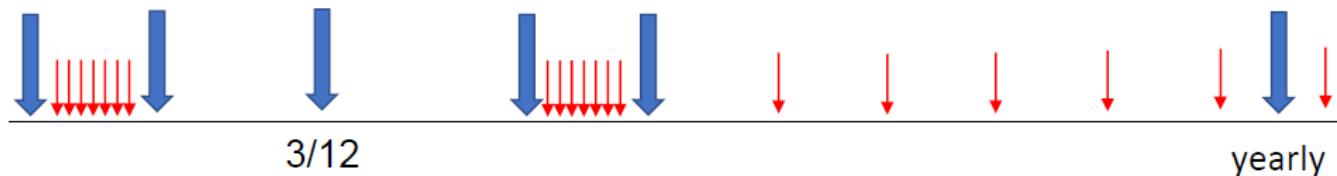
In 2016 published data on 498 tests in 199 patients

Bauer et al. 2009

TABLE 4. Seizure-Related Data

	Thiopental	Propofol	P
Cumulative EEG duration, s	451 ± 247	289 ±106	0.002
EEG duration per treatment, s	36.3 ± 13.2	25.7 ± 8.3	0.001
Visual seizures, cumulative, s	287 ± 182.8	150 ± 68.4	0.000
Visual seizures, per treatment, s	24.5 ± 13.0	13.5 ± 5.9	0.000
Restimulations (mean)	1.43 ± 2.25	2.19 ± 2.85	0.295
Restimulations, patients not receiving anticonvulsants	1	2.1	0.160
Total charge, mC	1300 ± 1641	1483 ±1150	0.099
Mean charge, mC	79.5 ± 50.7	109.8 ± 49.5	0.026

TABLE 6. Clinical Data

	Thiopental	Propofol	P
Remission*	14 (45%)	17 (55%)	0.781
Response*	6 (19.5%)	5 (16%)	
Nonresponder*	6 (19.5%)	4 (13%)	
Noncompleter*	5 (16%)	5 (16%)	
HDRS before ECT (number)†	25 (26)	27 (26)	0.62
BDI before ECT (number)†	21 (24)	21 (22)	0.89
HDRS, 6 treatments (number)†	15 (26)	13 (25)	0.21
BDI, 6 treatments (number)†	14 (23)	9 (24)	0.027
HDRS, end (number)†	11 (26)	9 (26)	0.19
BDI, end (number)†	8 (19)	6 (21)	0.29
MMSE (number)†	28.9 (24)	26.8 (25)	0.014
No. treatments†	13	10.2	0.27

*All patients.
†Completers.

Semkowska og McLoughlin 2010
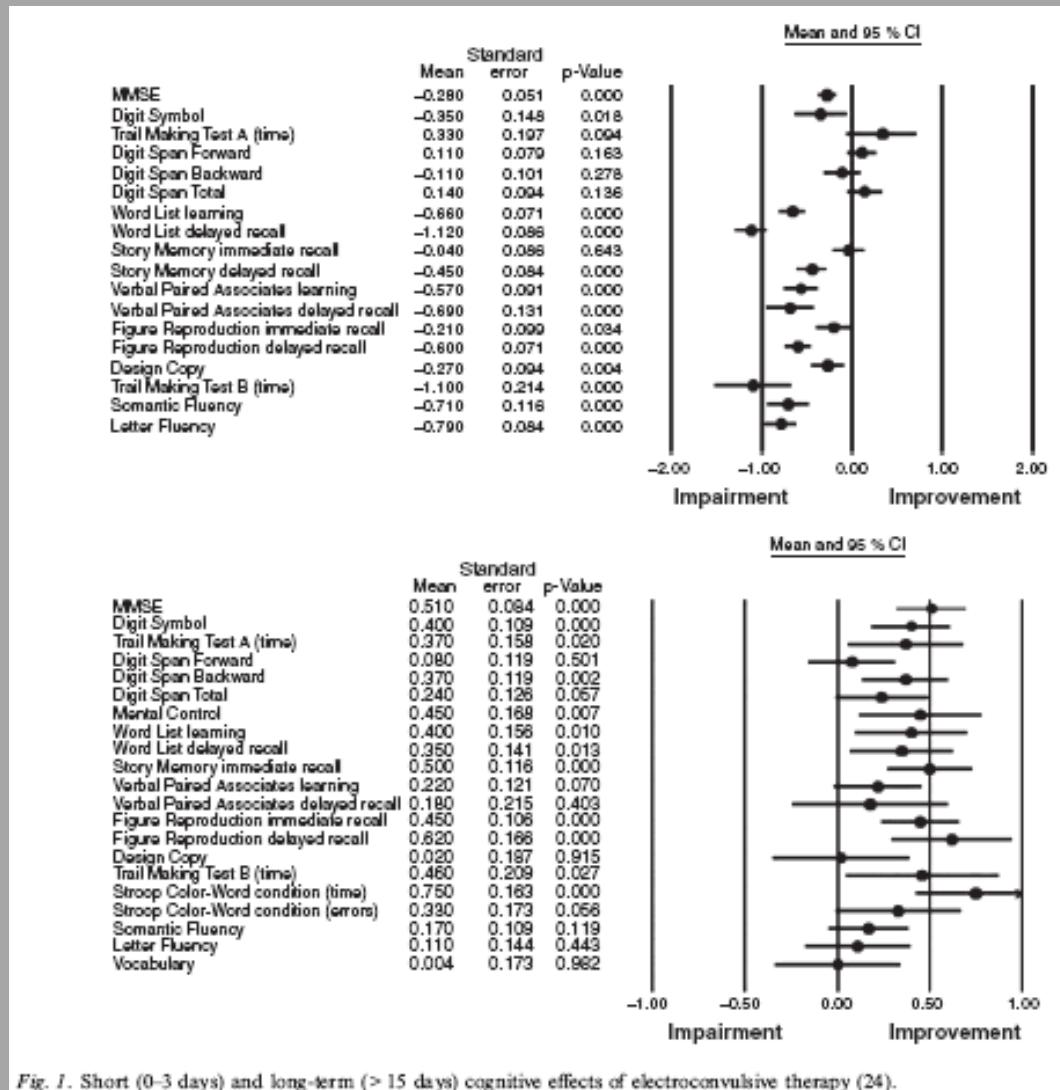
Fig. 1. Short (0–3 days) and long-term (> 15 days) cognitive effects of electroconvulsive therapy (24).

THE AUTOBIOGRAPHIC MEMORY INTERVIEW SHORT FORM

MANUAL FOR ADMINISTRATION AND SCORING

Martin C. McElhiney
Bobba J. Moody
and
Harold A. Sackeim

Department of Biological Psychiatry
New York State Psychiatric Institute
and
Department of Psychiatry
College of Physicians & Surgeons
Columbia University

VERSION 3, April 20001

AMI S

Sackeim 2007 and 2008

The Cognitive Effects of Electroconvulsive Therapy in Community Settings
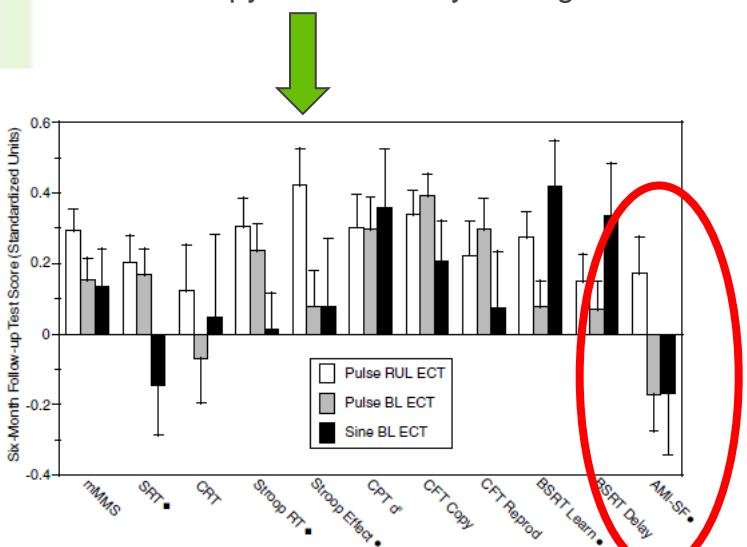
Figure 5 Scores on the 11 cognitive measures 6 months following the ECT course for patients treated with brief pulse right unilateral (RUL), ECT pulse bilateral (BL), ECT, and sine wave BL ECT. Filled boxes indicate a significant effect of waveform in the ANCOVA ($\blacksquare = p < 0.05$). Filled circles indicate a significant effect of electrode placement in the ANCOVA ($\bullet = p < 0.05$).

The Cognitive Effects of Electroconvulsive Therapy in Community Settings
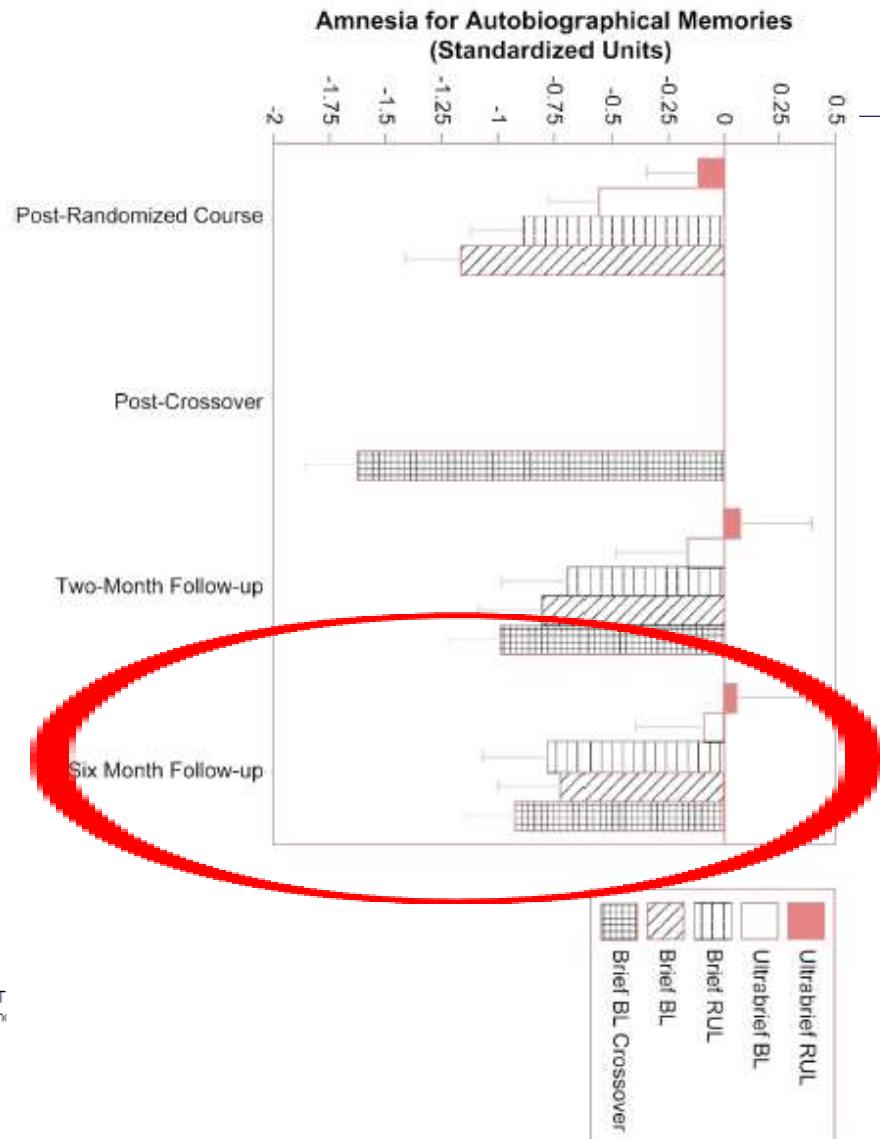
Figure 5.
Scores on the Columbia University Autobiographical Memory Interview. Retrograde amnesia for autographical events was assessed immediately following the end of the randomized and crossover phases and at two- and six-month followup, after completing all ECT. At each time point, Analyses of covariance indicated that each of the ultrabrief ECT conditions resulted in less retrograde amnesia than any of the brief pulse conditions (P's<0.05). Thus, effects of pulse width on extent of retrograde amnesia persisted at least six month following completion of ECT.

Parker Schwab 2021
Bipolar Geriatric pt.
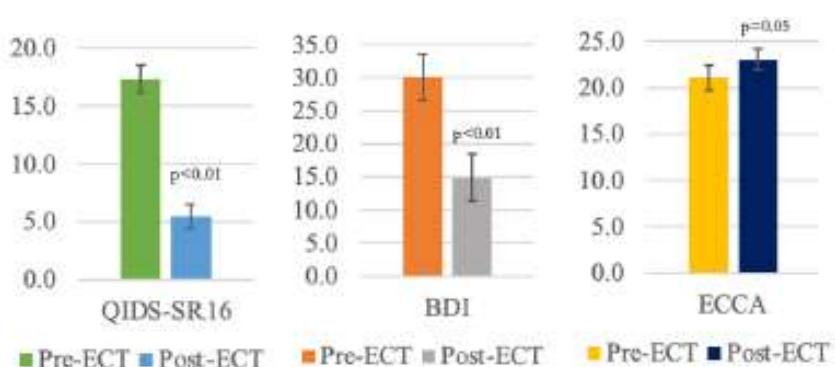
Fig. 1. Change in average pre- and post-ECT scores for mood and cognitive status metrics for patients with late-life biploar depression undergoing UBRULECT.

Table 2

Response and Remission Rates in Mood, Clinical Status, and Cognitive Scores for Patients with Late-Life Bipolar Depression Undergoing UBRUL ECT.

	n =	% Total
QIDS-SR16	20	
Response (> 50% reduction)	16	80.0%
Remission (<5)	13	65.0%
BDI	7	
Response (> 50% reduction)	4	57.1%
Remission (<12)	3	42.9%
CGI-I	27	
Remission (<2)	23	85.2%
ECCA	14	
No Change or Improved Score	12	85.7%

Response and remission rates in Quick Inventory of Depressive Symptomatology (QIDS-SR16), Beck Depression Inventory (BDI), Clinical Global Impression-Improvement (CGI-I), and ElectroConvulsive Cognitive Assessment (ECCA) scales throughout treatment for patients receiving UBRUL ECT for treatment of Late-Life Bipolar Depression.

SCIP and COBRA

Gómez-Benito *et al. BMC Psychiatry* 2013, **13**:127
http://www.biomedcentral.com/1471-244X/13/127

BMC Psychiatry

RESEARCH ARTICLE **Open Access**

The screen for cognitive impairment in psychiatry: diagnostic-specific standardization in psychiatric ill patients

Juana Gómez-Benito[1,2], Georgina Guilera[1,2*], Óscar Pino[3,1], Emilio Rojo[3], Rafael Tabarés-Seisdedos[4], Gemma Safont[5], Anabel Martínez-Arán[6], Manuel Franco[7], Manuel J Cuesta[8], Benedicto Crespo-Facorro[9], Miguel Bernardo[5], Eduard Vieta[6], Scot E Purdon[10], Francisco Mesa[11], Javier Rejas[12] and for the Spanish Working Group in Cognitive Function

Abstract

Background: The Screen for Cognitive Impairment in Psychiatry (SCIP) is a simple and easy to administer scale developed for screening cognitive deficits. This study presents the diagnostic-specific standardization data for this scale in a sample of schizophrenia and bipolar I disorder patients.

Methods: Patients between 18 and 55 years who are in a stable phase of the disease, diagnosed with schizophrenia, schizoaffective disorder, schizophreniform disorder, or bipolar I disorder were enrolled in this study.

Results: The SCIP-S was administered to 514 patients (57.9% male), divided into two age groups (18–39 and 40–55 years) and two educational level groups (less than and secondary or higher education). The performance of the patients on the SCIP-S is described and the transformed scores for each SCIP-S subtest, as well as the total score on the instrument, are presented as a percentile, z-score, T-scores, and IQ quotient.

Conclusions: We present the first jointly developed benchmarks for a cognitive screening test exploring functional psychosis (schizophrenia and bipolar disorder), which provide increased information about patient's cognitive abilities. Having guidelines for interpreting SCIP-S scores represents a step forward in the clinical utility of this instrument and adds valuable information for its use.

Keywords: SCIP-S, Standardization data, Norms, Schizophrenia, Bipolar I disorder

ORIGINAL STUDY

Cognitive Adverse Effects of Electroconvulsive Therapy
A Discrepancy Between Subjective and Objective Measures?

Lisa G. Hammershøj, BSc, Jeff Z. Petersen, PhD,*† Hans M. Jensen, MD,‡*
Martin B. Jørgensen, MD, DMSc,§|| and Kamilla W. Miskowiak, DMSc, DPhil†*

Key Words: depression, ECT, cognition, neuropsychology

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Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

ELSEVIER

Research report

Validity and reliability of a rating scale on subjective cognitive deficits in bipolar disorder (COBRA)

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[e] *Centro Universitário Unilasalle Rua Victor Barreto 2288, Canoas, RS, Brazil*

SCREEN FOR COGNITIVE IMPAIRMENT IN PSYCHIATRY (SCIP)
Scot E. Purdon, Ph.D., Clinical Professor of Psychiatry, University of Alberta; spurdon@ualberta.ca
© 2005 Purdon Neuropsychological Labs Inc., Edmonton, Alberta, Canada

Verbal learning Imediate

1. **List learning test:** Read the list of 10 words at 3 seconds per word. Test free recall. Repeat 2 more times. At the end of trial 3 let participant know they will be asked to recall the list again later.

	Desert	Face	Letter	Bed	Machine	Milk	Helmet	Sailor	Horse	Nail	Σ/10
Tr. 1											
Tr. 2											
Tr. 3											Σ/30 =

Working memory

2. **Consonant repetition test** (Read each set of three letters. Have the subject count backwards from the start # for the seconds under delay for each item, and then recall letters. Any order is fine):

Stimulus	Start #	Delay	Response	Stimulus	Start #	Delay	Response
D-L-H				Z-Q-M	49	3	
M-S-R				B-X-K	67	18	
P-H-Q	39	9		N-F-P	128	9	
X-C-D	177	18		C-T-J	40	3	Σ/24 =

Verbal fluency

3. **Verbal fluency test.** Allow 30 seconds to generate words beginning with each letter.

Stimulus	Response	
F		
R		Σ =

Verbal learning-delayed

4. **Delayed list learning:** Ask the subject to recall the earlier words; do not repeat the list.

	Desert	Face	Letter	Bed	Machine	Milk	Helmet	Sailor	Horse	Nail	Σ /10	t4/t3 * 100
Tr. 4												

---FOLD HERE---

Processing speed

5. **Visuomotor tracking test:** After practice items, allow 30 seconds to complete left to right and top to bottom.

M	F	X	D	W	J
- -	. . - .	- . . -	- . .	. - -	. - - -

Practice						Test		
W	D	X	J	M	F	X	M	W
F	J	D	W	D	M	J	X	F
M	X	J	W	D	F	X	J	F
D	W	M	F	X	W	M	F	J	Σ/30=

SCORING SUMMARY: For each sub-test, divide the difference between observed from predicted scores and divide by the standard deviation (n=185, 1st year college sample, IQ approx. 110): Z-Scores=((Score-Mean)/SD). M+SD for VLT_I=23.59+2.87, WMT=20.66+2.45, VFT=17.44-4.74, VLT_D=7.65+1.90, PST=14.26+2.25.

Subject Name (First, Last):_____ Gender: ____ Examiner::_____
DOB (d/m/y):_____ Test Date (d/m/y):_____ Time of test:_____
IQ estimate (indicate PPVT, NART, WAIS):_____ Education (years):_____ Handedness:____

COBRA
Cognitive complaints in bipolar disorder rating assessment

Navn: _____ CPR: _____ Dato: _____

Besvar venligst alle spørgsmålene ved at sætte **en ring** om det **korrekte svar**, eller det sv
som du synes, passer bedst på dig.

1. Har du svært ved at huske folks navne?

0	1	2	3
Aldrig	Af og til	Ofte	Altid

2. Har du problemer med at finde dagligdags brugsgenstande (nøgler, briller, armbåndsur...)?

0	1	2	3
Aldrig	Af og til	Ofte	Altid

3. Synes du det er svært at huske situationer, der er vigtige for dig?

0	1	2	3
Aldrig	Af og til	Ofte	Altid

4. Er det svært for dig at placere vigtige begivenheder tidsmæssigt?

0	1	2	3
Aldrig	Af og til	Ofte	Altid

5. Synes du det er svært at koncentrere dig når du læser en bog eller avis?

0	1	2	3
Aldrig	Af og til	Ofte	Altid

6. Har du problemer med at huske, hvad du har læst eller har fået fortalt på det seneste?

0	1	2	3
Aldrig	Af og til	Ofte	Altid

7. Har du vanskeligt ved at færdiggøre, det du har startet?

0	1	2	3
Aldrig	Af og til	Ofte	Altid

8. Tager det dig længere end normalt at udføre de daglige opgaver?

0	1	2	3
Aldrig	Af og til	Ofte	Altid

9. Har du nogen sinde følt dig desorienteret på gaden?

0	1	2	3
Aldrig	Af og til	Ofte	Altid

10. Når folk minder dig om en samtale eller en kommentar, du har hørt, har du indtryk af at det er første gang, du hører det?

0	1	2	3
Aldrig	Af og til	Ofte	Altid

11. Er det af og til svært for dig at finde de rette ord?

0	1	2	3
Aldrig	Af og til	Ofte	Altid

12. Bliver du let distraheret?

0	1	2	3
Aldrig	Af og til	Ofte	Altid

13. Har du det svært ved simple udregninger i hovedet?

0	1	2	3
Aldrig	Af og til	Ofte	Altid

14. Har du indtryk af, at du ikke kan følge med i en samtale (at du taber tråden)?

0	1	2	3
Aldrig	Af og til	Ofte	Altid

15. Har du lagt mærke til, at det er svært for dig at lære ny viden / information?

0	1	2	3
Aldrig	Af og til	Ofte	Altid

16. Har du besvær med at holde fokus på en bestemt opgave i længere tid ad gangen?

| 0	1	2	3
Aldrig	Af og til	Ofte	Altid

Swedish National Quality Register for ECT (Q-ECT)

Symtomskattning och symtomfrihet

Bedömning med MADRS eller MADRS-S efter ECT vid depression

Andelen patienter med depression som utvärderats med MADRS eller MADRS-S efter index-ECT var 66 % i riket. I Örebro, Stockholm och Dalarna har över 80 % av patienterna utvärderats med depressionsskattningskala.
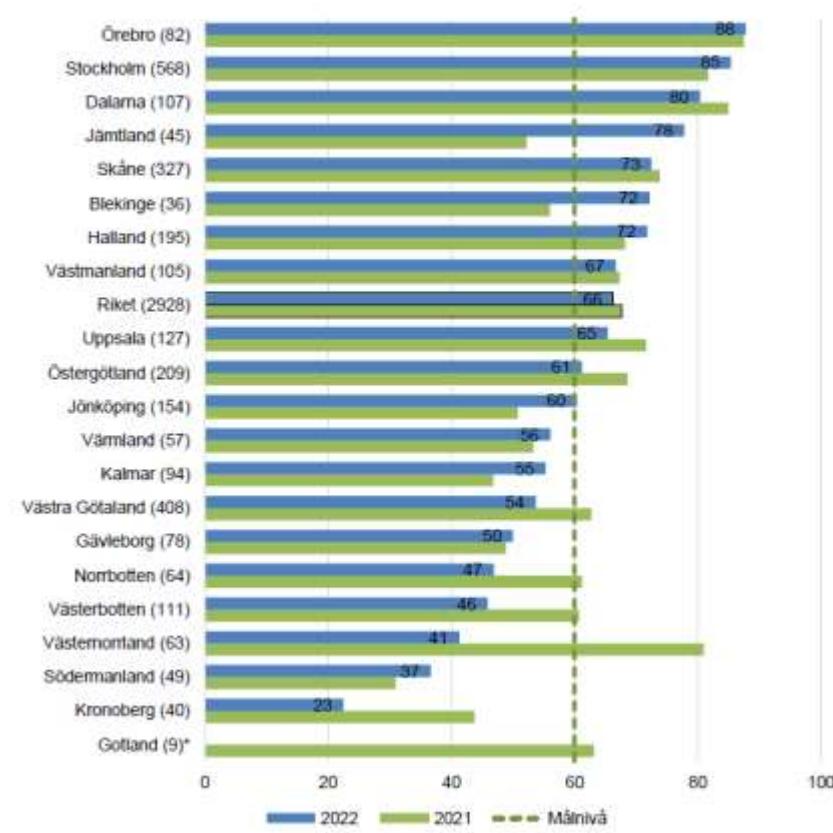
## Klinisk bedömning och förändring efter ECT

Bedömning med Clinical Global Impression-Improvement (CGI-I)

I riket bedömdes 91 % av patienterna med CGI-I efter ECT. Andelen bedömda varierade från 52 % i Uppsala till 100 % i Jämtland, Värmland och Östergötland.
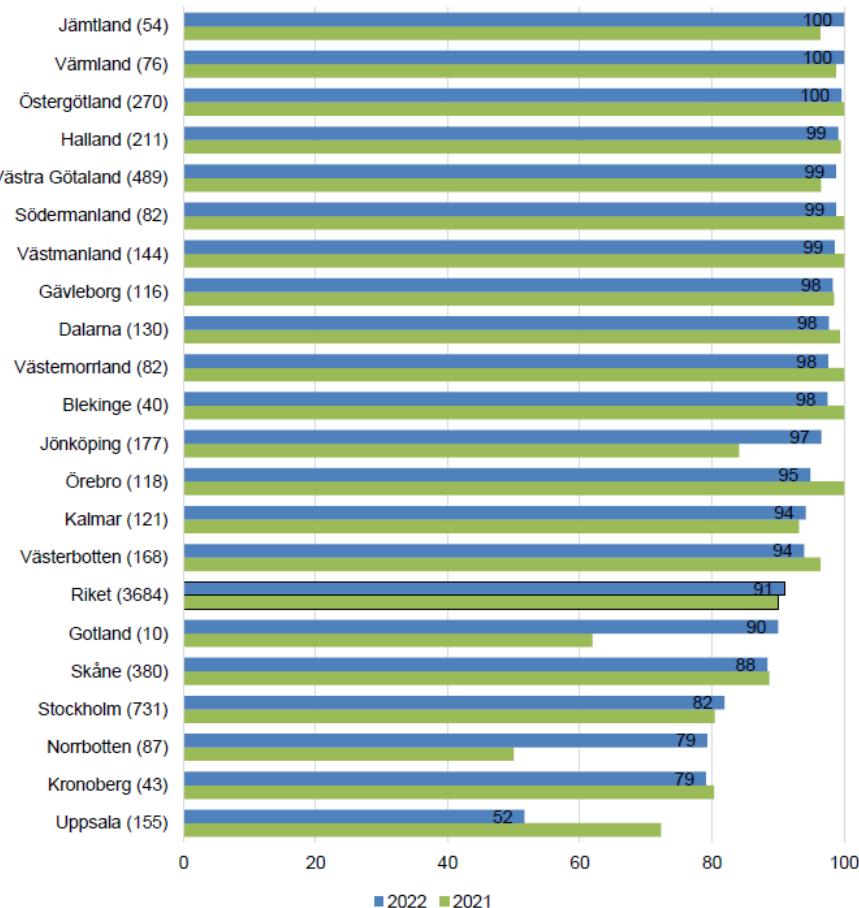
CPRS memory item

Comprehensive Psychopathological Rating Scale (Åsberg et al 1978)

CPRS memory item on a scale from 0–6. Ratings 0–1 indicate no memory impairment and 6 indicates complete inability to remember

Minnesskattning och minnesförändring

Minnesskattning (CPRS-minne) före och efter ECT

I lite drygt hälften av de täta serierna efterfrågades och dokumenterades patientens minnesfunktion inom en vecka före och efter ECT. Andelen varierade från 16 % i Kronoberg till 80 % i Örebro. Nio regioner nådde upp till målnivån på minst 60 %.
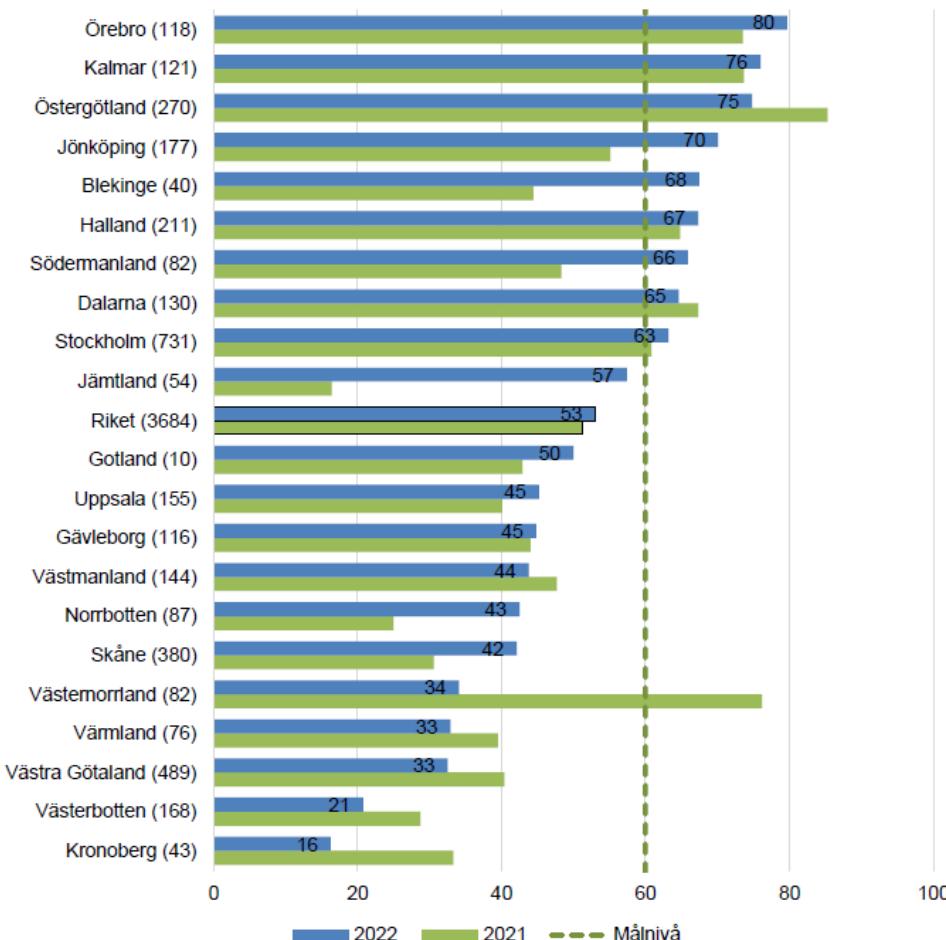
Region	2022
Örebro (118)	80
Kalmar (121)	76
Östergötland (270)	75
Jönköping (177)	70
Blekinge (40)	68
Halland (211)	67
Södermanland (82)	66
Dalarna (130)	65
Stockholm (731)	63
Jämtland (54)	57
Riket (3684)	53
Gotland (10)	50
Uppsala (155)	45
Gävleborg (116)	45
Västmanland (144)	44
Norrbotten (87)	43
Skåne (380)	42
Västernorrland (82)	34
Värmland (76)	33
Västra Götaland (489)	33
Västerbotten (168)	21
Kronoberg (43)	16

2022 2021 Målnivå
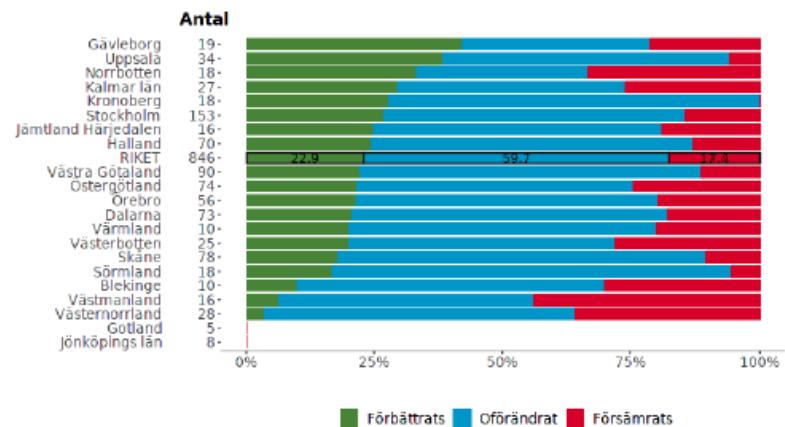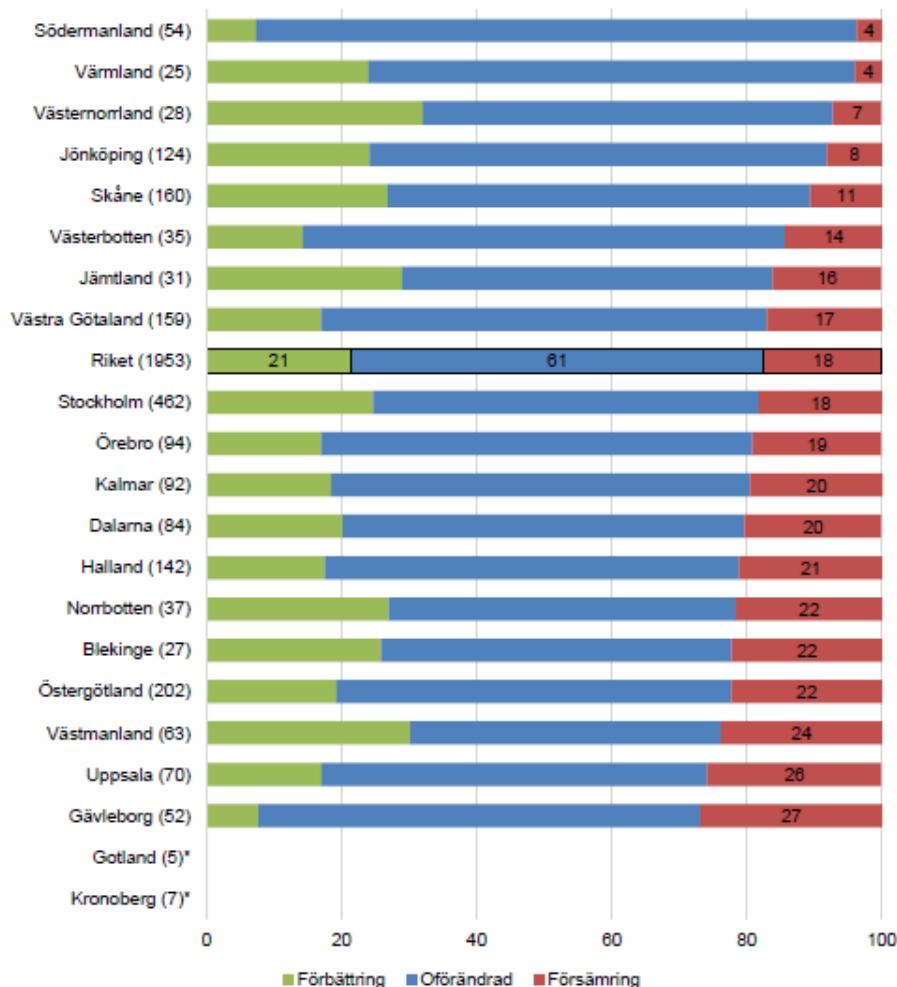
MODE
Mårtensson Odeberg Dimensionell Evaluering

HUKOMMELSE — MODE

– Vurdering af hukommelsesproblemer
(Brug også mellemtilstande)

| 0: Ingen | 2: Moderat | 4: Væsentlig | 6: Ekstrem |

OBSERVERET — Orientering	RAPOTEREDE OPLEVELSER	Påvirkning af FUNKTIONSEVNEN i hverdagen.
0: Fuld orienteret.	0: Ingen oplevelser af problemer med hukommelsen.	0: Ingen påvirkning af funktionsevnen.
2: En vis usikkerhed i orientering omkring tid og/eller dato men ellers orienteret.	2: Oplever forbigående/ midlertidige hukommelsesforstyrrelser.	2: Midlertidig og mildt påvirket funktionsevne. For eksempel: forbigående vanskelighed at finde vej eller huske en aftale.
4: Påfaldende usikkerhed omkring tid/dato.	4: Besværlig til forstyrrende/irriterende hukommelsesproblemer. For eksempel: svært ved at genkende folk og huske navne og oplysninger. Påvirket af omgivelsernes bemærkninger om forringet hukommelse.	4: Væsentlig påvirket funktion. For eksempel: gentagne vanskeligheder med at finde rundt i kendte omgivelser, huske koder og telefonnumre, buslinjer mv.
6: Klart desorienteret i tid, sted, dato.	6: Har haft oplevelser med total manglende evne til at huske.	6: Svær forringet og har vanskeligt ved at tage vare på sig selv.

Interviewet fokuserer først og fremmest på patientens oplevelse af hukommelsesforstyrrelse, og behandlingens indflydelse hukommelsesproblemerne noteres. Efterfølgende spørges der til de berørte funktioner(funktionsevnen). Orienteringsgrad testes primært i dag og dato, i tilfælde af usikkerhed testes også øvrige orienteringsgrader. Det symptom, der er mest fremtrædende afgøre vurderingen.

DEPRESSION — MODE

– Vurdering af depressionsgraden
(Brug også mellemtilstande)

| 0: Ingen | 2: Moderat | 4: Væsentlig | 6: Ekstrem |

OBSERVERET — Latens, stemmeleje, bevægelsesmønstre, evne til at samarbejde.	RAPORTERET — Deprimeret, svækket interesse og/eller udtryk for pessimistiske tanker.	Indflydelse på FUNKTIONEVNEN til at tage initiativ og aktivitet deltage i hverdagen.
0: Helt normal bevægelsesmønster, normal respons, spontan og passende interaktion. Ingen latens, varieret stemmeleje.	0: Grundlæggende neutralt stemningsleje. Oplever naturligt niveau af tristhed eller glæde. Normal interesse for omgivelserne og andre mennesker. Ingen pessimistiske tanker.	0: Ingen påvirkning. Foretager daglige gøremål, passer sit arbejde/studier.
2: Synes konsekvent deprimeret, men kan skifte til lettere humør og bringes til smil. Deltager i samtale med at vis engagerement. Nogen reduktion af vitalitet i stemme.	2: Overvejende deprimeret, men lettere øjeblikke forekommer. Vanskeligt ved at finde interesseret i ting som normalt vækker interesse. Svingende selvbebrejdelse.	2: Let vanskeligheder med at komme i gang med dagens gøremål. Udfordringer med at færdiggøre opgaver. Reduceret spontanitet.
4: Ses ulykkelig og fremtræder ulykkelig uanset emne eller forsøg på almindelig samtale. Reduceret vitalitet i stemmeleje og bevægelsesmønster. Responderer med latens. Svært ved at opfange vittigheder.	4: Kontinuerlig depression, upåvirket af eksterne forhold. Svigtende interesse i omgivelserne. Selvbebrejdelse. Skyldfølelser. Udtalt pessimistisk fremtidssyn.	4: Selv simple opgaver kræver en stor indsats. Dårlig personlighygiejne. Ingen eller meget begrænsede sociale aktiviteter.
6: Maksimal depression. Udtalt hæmning. Afskærmet, ekstremt urolig. Kan ikke afledes.	6: Maksimal depression. Manglende evnen til at føle interesse for noget eller nogen. Absurde tanker og/eller katastrofetanker.	6: Manglende evne til at håndtere de nemmeste aktiviteter. Tager ikke initiativ til noget på egen hånd. Varetager ikke personlig hygiejne.

Interviewet fokuserer først og fremmest på hvordan patienten oplever hans eller hendes tilstand. Der fokuserer på den stemning, interesse eller pessimisme, der fremstår tydeligst. Derefter spørges til eksempler på hverdagens opgaver, der bliver, eller ikke bliver, foretaget. Patientens evne til at interagere, toneleje og mimik observeres. Det symptom, der er mest fremtrædende afgøre vurderingen.

Worked in Piteå – in Copenhagen?

SCL10: items from SCL90

Extracted for use as treatment effect measures in treatment packages for depression or anxiety in Denmark

	I hvilken grad har du gennem de sidste 2 uger været plaget af:	Slet ikke	Lidt	Noget	En hel del	Særdeles meget
30	Feeling blue					
32	Feeling no interest in things					
14	Feeling low in energy or slowed down					
26	Blaming yourself for things					
71	Feeling everything is an effort					
31	Worrying too much about things					
23	Suddenly scared for no reason					
50	Having to avoid certain things, places, or activities because they frighten you					
45	Having to check and double-check what you do					
73	Feeling uncomfortable about eating or drinking in public					

Udfyldes af personalet:

Total råscore (0-40): _____ x 2,5 = _____

Score SCL10 in mECT patients

Diagnose	N	Mean	S.D.	Median
Schizophreni	3	11,0	3,5	10
Bipolar	4	17,7	5,2	17,3
Unipolar dep	7	18,8	4,3	18
Schif.aff.	1			