Swiss Psychedelic Side Effects Inventory – Clinician's Instructions

Introduction and purpose

The Swiss Psychedelic Side Effects Inventory (SPSI) is designed to assess the presence and impact of clinically relevant side effects related to psychedelics, including classic psychedelics, MDMA, and similar substances. It can be completed in 10-15 minutes and contains 32 side effects, as well as an option to add additional ones.

The SPSI is given with reference to a particular psychedelic experience or treatment series and can be used in research studies, clinics, and other contexts in which psychedelics are administered. It is meant to be given either as a clinician-administered interview or as a self-report after patients or study participants have been briefly instructed on how to fill it out. It may also be adapted for online studies.

Instructions for clinicians

Before giving the SPSI as either an interview or self-report form, fill in the information on the top of the SPSI form (page 3). This includes the subject ID, the date(s) of the psychedelic experience(s) in question, and the timeframe participants should consider when answering the questions. Specify the timeframe on the top left according to your needs.

If giving the SPSI as an interview, please read through the instructions on page 2 and mark the subject's answers as they are verbally given. Judgments about treatment-relatedness should consider the perspective of the interviewee as well as the clinician.

If using the SPSI as a self-report tool to be filled out by the subjects themselves, please first show them the form (page 3) and walk them through the instructions on page 2. Participants should be able to keep the instructions for reference as they mark their answers.

Scoring: Calculate total scores for the number of side effects, severity, and impact by adding the relevant columns. Then, calculate the overall score by subtracting total severity from total impact. The overall score represents the burden of side effects for that person within the specified timeframe. If desired, overall scores may be calculated specifically for side effects with a given likelihood of treatment-relatedness and/or only for unresolved side effects.

Reference: Calder, A & Hasler, G. *(2024) Validation of the Swiss Psychedelic Side Effects Inventory: Standardizing reporting of adverse effects in studies of psychedelics and MDMA.*

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Further copies of the SPSI can be found in publications or on the authors' group website:
https://molecularpsychiatry.ch/

SPSI – Participant Instructions

This questionnaire asks about side effects you may have had after taking psychedelics, MDMA, or similar substances. Side effects may be pleasant or unpleasant, and they may be mild or severe. There are no right or wrong answers, so please choose the answers that best match your experiences.

If you answer "yes" to a particular side effect, you will be asked some additional questions about it. Below are instructions for answering these additional questions.

Severity

Please rate whether the severity of the side effect was mild, moderate, or severe.

1	**Mild**	*Example: A headache that you noticed, but that did not bother you much.*
2	**Moderate**	*Example: A headache that bothered you while you went about your day.*
3	**Severe**	*Example: A headache so painful that you couldn't go about your day as usual.*

Impact

Please rate how you feel about the side effect and any overall impact it had on you. It may have had no impact, it may have impacted you in an adverse or negative way, or it may have impacted you in a beneficial or positive way.

-2	This side effect had a **very adverse** impact.
-1	This side effect had a **somewhat adverse** impact.
0	This side effect had **both** adverse and beneficial impacts, or **neither**.
1	This side effect had a **somewhat beneficial** impact.
2	This side effect had a **very beneficial** impact.

Causality

Please rate the likelihood that this side effect was related to the psychedelic substance.

0	**Unknown**	There is not enough information to judge whether it was related.
1	**Unlikely**	It occurred so long after taking the substance that a relationship is improbable, and there are other plausible explanations.
2	**Possibly**	It occurred soon after taking the substance, and there are other possible explanations.
3	**Probably**	It occurred soon after taking the substance, and other explanations are unlikely.
4	**Certainly**	It occurred soon after taking the substance, and it cannot be explained by anything else.

Timing

Please check the box under "During" if the side effect occurred while the psychedelic experience was still ongoing. Check the box under "After" if the side effect occurred after the psychedelic experience had ended (i.e., after the substance's effects had worn off). If both are true, please check both boxes.

Duration

If the side effect is no longer present, please indicate how long it lasted in relation to substance intake. If it is still present, please write "ongoing."

Tolerability

Tolerability refers to how well you were able to cope with side effects from the dose you received. Please rate tolerability according to the corresponding scale.

Additional details

Please add any other important information about any of the side effects you experienced, for example information about how it was treated or details about how it affected you.

SPSI

Subject ID: _____

Date(s) of substance intake: _____

Date of assessment: _____

Please indicate whether you have had any of the side effects below **in the following time period** after taking a psychedelic: _____

For each question, **if you have *not* had that side effect, check "No"** and move on to the next question.

If you *have* had that side effect, check "Yes" and complete that row of follow-up questions according to the instructions on the previous page.
For each question, please check or circle the answer that best matches your experience.

	Please indicate which of these you have experienced:	**No**	→ **Yes**	**Severity** 1 = Mild 2 = Moderate 3 = Severe			**Impact** -2 = Very adverse -1 = Somewhat adverse 0 = Both or neutral +1 = Somewhat beneficial +2 = Very beneficial					**Causality** 0 = Unknown 1 = Unlikely 2 = Possible 3 = Probable 4 = Certain					**Timing**		**Duration** *Specify hours, days, weeks, months, etc or "ongoing"*
																	During	**After**	
1	Headache	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
2	Nausea or vomiting	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
3	Bloating or diarrhea	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
4	Muscle shaking, tightness, or paralysis	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
5	A racing or irregular heartbeat, or pressure or pain in your chest	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
6	Fatigue, tiredness	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
7	Dizziness or feeling faint	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
8	Feeling unusually hot, cold, or sweaty	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
9	Appetite changes	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
10	Memory problems or blackouts	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
11	Confusion or disorientation	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
12	Difficulty concentrating or thinking clearly	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	

	Please indicate which of these you have experienced:	No	→ Yes	Severity 1 = Mild 2 = Moderate 3 = Severe			Impact -2 = Very adverse -1 = Somewhat adverse 0 = Both or neutral +1 = Somewhat beneficial +2 = Very beneficial					Causality 0 = Unknown 1 = Unlikely 2 = Possible 3 = Probable 4 = Certain					Timing		Duration *Specify hours, days, weeks, months, etc or "ongoing"*
																	During	After	
13	Distressing thoughts or memories that come to mind against your will	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
14	Feeling anxious, fearful, or panicked	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
15	Feeling restless or irritable	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
16	Feeling sad, mournful, or depressed	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
17	Feeling apathetic or empty inside	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
18	Feeling lonely, isolated, or alienated from others	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
19	Negative thoughts about yourself	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
20	Thoughts of wanting to go to sleep and not wake up, or of taking your own life	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
21	Paranoia, or feeling like others are watching you or want to harm you	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
22	Fear of losing your mind or going insane	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
23	Feeling detached from your surroundings, or as if they are unreal, flat, or part of a dream	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
24	Feeling detached from your body, voice, memories, or thoughts, or as if you are not real	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
25	Distress related to your understanding of reality or the meaning of life	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
26	Changes in vision (e.g. seeing lights, movement, or things others cannot see)	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
27	Changes in hearing (e.g. tinnitus or hearing sounds that others cannot hear)	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
28	Sleep difficulties (e.g. trouble falling or staying asleep, nightmares)	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	

	Please indicate which of these you have experienced:	No	→ Yes	Severity 1 = Mild 2 = Moderate 3 = Severe			Impact -2 = Very adverse -1 = Somewhat adverse 0 = Both or neutral +1 = Somewhat beneficial +2 = Very beneficial					Causality 0 = Unknown 1 = Unlikely 2 = Possible 3 = Probable 4 = Certain					Timing		Duration *Specify hours, days, weeks, months, etc or "ongoing"*
																	During	After	
29	Feeling like some substance effects have returned without taking the substance again	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	N/A	☐	
30	Desire to take the substance again soon	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
31	Feeling so elated, overjoyed, excitable, or impulsive that others became concerned	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
32	Feeling like your thoughts are being interfered with or controlled	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
33	Have you experienced any other side effects? *Specify :* _____	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
34	*Specify :* _____	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
35	*Specify :* _____	☐	☐	1	2	3	-2	-1	0	+1	+2	0	1	2	3	4	☐	☐	
	Total scores *(Sum of each column, checked boxes = 1)*											N/A							*Total unresolved:* _____
	Overall score *(Score = severity – impact)*											N/A					N/A		N/A

Tolerability *(check one)*	☐ **Good** Could tolerate higher dose	☐ **Moderate** Could tolerate same dose again, but no more	☐ **Poor** Could **not** tolerate this dose (dose was too high)

Please add any additional details here: _____

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