

DEPRESSION RECOGNITION TOOLS

Physician Memory Aids

Two-Question Screen

A quick way of screening patients you think may be depressed requires asking patients these two questions:

During the past month, have you been bothered by:

- | | | |
|---|------------------------------|-----------------------------|
| 1. little interest or pleasure in doing things? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. feeling down, depressed or hopeless? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

- ⇒ If the patient's response to *both* questions is "NO," the screen is negative.
- ⇒ If the patient responded "YES" to *either* question, consider asking more detailed questions or using the PHQ-9 questionnaire.

The Interview Approach

As an alternative or enhancement to the two-question screen, the medical interview is a powerful tool for recognizing depression. Using open-ended questions, addressing emotional issues in some way at each visit ("How are things at home?") and having a high index of suspicion for depression when patients present with certain complaints (e.g., headache, fatigue, nonspecific aches) are all effective. Consider also asking these questions during your interview with patients whom you suspect are depressed.

Depressed mood

How's your mood been lately?

Anhedonia

What have you enjoyed doing lately?

Effects of Symptoms on Function

How are things at home/work?
How have (the symptoms) affected your home or work life?

Physical Symptoms

How have you been sleeping?
What about your appetite?
How's your energy?

Psychological Symptoms/Suicidal Ideation

How's your concentration?
Have you been feeling down on yourself?
How does the future look to you?

Do you ever feel like life is not worth living?
Do you have plans to hurt yourself?

Instructions – How to Score PHQ-9

For initial diagnosis:

Consider Major Depressive Disorder

- If there are 5 or more ✓'s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- If there are 2-4 ✓'s in the shaded section (one of which corresponds to Question #1 or #2)

To monitor severity over time:

Patients may complete questionnaires at baseline and at regular intervals (e.g. every 2 weeks) at home and bring them in at their next appointment for scoring or complete the questionnaire during each scheduled appointment.

PHQ-9 Scoring Card for Severity Determination

For health professional use only

Scoring – add up all checked boxes on PHQ-9

For every ✓ : Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3.

Interpretation of Total Score

Total score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Introduction

Improving primary care depression treatment requires increasing the systematic recognition of patients with depression and monitoring treatment progress over time. There are a variety of self-report depression measures that have been used for either case finding or for monitoring treatment response. A valid and reliable self-report measure does not require specific mental health clinical expertise to administer. With periodic re-administration, a self-report measure provides relatively objective information to determine whether changes in the treatment plan are indicated.

In general, the available measures have been designed for use as screening instruments in specialty populations and not for use as diagnostic tools or treatment monitoring measures for primary care. The depression scale of the Patient Health Questionnaire (PHQ) is a major advance in that it was developed in and for primary care, its items come directly from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria for diagnosing major depression, and in that it provides a severity measure which can be repeated to guide treatment decisions. The items on the questionnaire are the nine signs and symptoms of depression in the DSM-IV with a question on functional impairment from the symptoms (as also required in the DSM-IV). Because of the direct relationship to the nine DSM-IV depression signs and symptoms it is called the PHQ-9. The PHQ-9 is thus a dual-purpose instrument that, with the same items, can establish a provisional depressive disorder diagnosis as well as provide a symptom severity score. The sensitivity and specificity of the PHQ-9, using a mental health clinician's diagnosis as the standard, compare favorably with structured psychiatric interviews. A recent review of case-finding measures for depression gave the PHQ-9 a high rating for both operating characteristics and utility.

Spitzer R, Kroenke K, Williams J. Validation and utility of a self-report version of PRIME-MD: the PHQ Primary Care Study. *Journal of the American Medical Association* 1999; 282: 1737-1744. [Abstract](#)

Kroenke K, Spitzer R L, Williams J B. The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine* 2001; 16: 606-613 [Abstract](#)

Rost K, Smith J. Retooling multiple levels to improve primary care depression treatment. *Journal of General Internal Medicine* 16: 644-645, 2001 [PubMed Citation](#)

Kroenke K, Spitzer RL. The PHQ-9: A new depression and diagnostic severity measure. *Psychiatric Annals* 2002; 32: 509-521.

Williams JW, Noel PH, Cordes J A, Ramirez G, Pignone M. Is this patient clinically depressed? *Journal of the American Medical Association* 2002; 287: 1160-1170. [Abstract](#)

The PHQ-9 is adapted from PRIMEMDTODAY, developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr. Spitzer at rls8@columbia.edu. The names PRIME-MD® and PRIMEMDTODAY™ are trademarks of Pfizer Inc.

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Patient Health Questionnaire (PHQ-9)

NAME: **John Q Sample**

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at All	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	✓ 1	2	3
2. Feeling down, depressed, or hopeless	0	1	✓ 2	3
3. Trouble falling or staying asleep, Or sleeping too much	0	1	2	✓ 3
4. Feeling tired or having little energy	0	1	2	✓ 3
5. Poor appetite or overeating	0	✓ 1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	✓ 2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	✓ 2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	✓ 2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	✓ 0	1	2	3

add columns: **2** + **8** + **6**

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: 16

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

	Not difficult at all	_____
	Somewhat difficult	_____ ✓
	Very difficult	_____
	Extremely difficult	_____

Patient Health Questionnaire (PHQ-9)

NAME: _____

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at All	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself -- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite -- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns: + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

<p>10. If you checked off <i>any</i> problems, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p>	<p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>
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1: J Gen Intern Med. 2001 Sep;16(9):606-13.

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The PHQ-9: validity of a brief depression severity measure.

[Kroenke K](#), [Spitzer RL](#), [Williams JB](#).

Regenstrief Institute for Health Care and Department of Medicine, Indiana University, Indianapolis 46202, USA. kkroenke@regenstrief.org

OBJECTIVE: While considerable attention has focused on improving the detection of depression, assessment of severity is also important in guiding treatment decisions. Therefore, we examined the validity of a brief, new measure of depression severity. **MEASUREMENTS:** The Patient Health Questionnaire (PHQ) is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders. The PHQ-9 is the depression module, which scores each of the 9 DSM-IV criteria as "0" (not at all) to "3" (nearly every day). The PHQ-9 was completed by 6,000 patients in 8 primary care clinics and 7 obstetrics-gynecology clinics. Construct validity was assessed using the 20-item Short-Form General Health Survey, self-reported sick days and clinic visits, and symptom-related difficulty. Criterion validity was assessed against an independent structured mental health professional (MHP) interview in a sample of 580 patients. **RESULTS:** As PHQ-9 depression severity increased, there was a substantial decrease in functional status on all 6 SF-20 subscales. Also, symptom-related difficulty, sick days, and health care utilization increased. Using the MHP reinterview as the criterion standard, a PHQ-9 score ≥ 10 had a sensitivity of 88% and a specificity of 88% for major depression. PHQ-9 scores of 5, 10, 15, and 20 represented mild, moderate, moderately severe, and severe depression, respectively. Results were similar in the primary care and obstetrics-gynecology samples. **CONCLUSION:** In addition to making criteria-based diagnoses of depressive disorders, the PHQ-9 is also a reliable and valid measure of depression severity. These characteristics plus its brevity make the PHQ-9 a useful clinical and research tool.

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- [Validation Studies](#)

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1: J Gen Intern Med. 2001 Sep;16(9):644-5.

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Retooling multiple levels to improve primary care depression treatment.

[Rost K.](#) [Smith J.](#)

Publication Types:

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1: JAMA. 2002 Mar 6;287(9):1160-70.

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- [ACP J Club. 2002 Sep-Oct;137\(2\):74.](#)
- [J Fam Pract. 2002 Jun;51\(6\):511.](#)



Is this patient clinically depressed?

[Williams JW Jr](#), [Noel PH](#), [Cordes JA](#), [Ramirez G](#), [Pignone M](#).

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CONTEXT: Depressive disorders are highly prevalent in the general population, but recognition and accurate diagnosis are made difficult by the lack of a simple confirmatory test. **OBJECTIVE:** To review the accuracy and precision of depression questionnaires and the clinical examination for diagnosing clinical depression. **DATA SOURCES:** We searched the English-language literature from 1970 through July 2000 using MEDLINE, a specialized registry of depression trials, and bibliographies of selected articles. **STUDY SELECTION:** Case-finding studies were included if they used depression questionnaires with easy to average literacy requirements, evaluated at least 100 primary care patients, and compared questionnaire results with accepted diagnostic criteria for major depression. Eleven questionnaires, ranging in length from 1 to 30 questions, were assessed in 28 published studies. Reliability studies for the clinical examination required criterion-based diagnoses made by at least 2 clinicians who interviewed the patient or reviewed a taped examination. Fourteen studies evaluated interrater reliability. **DATA EXTRACTION:** Pairs of authors independently reviewed articles. For case-finding studies, quality assessment addressed sample size and whether patients were selected consecutively or randomly, the criterion standard was administered and interpreted independently of and blind to the results of the case-finding instrument, and the proportion of persons receiving the criterion standard assessment was less than or more than 50% of those approached for criterion standard assessment. For reliability studies, quality assessment addressed whether key patient characteristics were described, the interviewers collected clinical history independently, and diagnoses were made blinded to other clinicians' evaluations. **DATA SYNTHESIS:** In case-finding

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studies, average questionnaire administration times ranged from less than 1 minute to 5 minutes. The median likelihood ratio positive for major depression was 3.3 (range, 2.3-12.2) and the median likelihood ratio negative was 0.19 (range, 0.14-0.35). No significant differences between questionnaires were found. For mental health care professionals using a semistructured interview, agreement was substantial to almost perfect for major depression (kappa = 0.64-0.93). Nonstandardized interviews yielded somewhat lower agreement (kappa = 0.55-0.74). A single study showed that primary care clinicians using a semistructured interview have high agreement with mental health care professionals (kappa = 0.71). **CONCLUSIONS:** Multiple, practical questionnaires with reasonable performance characteristics are available to help clinicians identify and diagnose patients with major depression. Diagnostic confirmation by mental health care professionals using a clinical interview or by primary care physicians using a semistructured interview can be made with high reliability.

Publication Types:

- [Meta-Analysis](#)

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1: JAMA. 1999 Nov 10;282(18):1737-44.

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Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. Primary Care Evaluation of Mental Disorders. Patient Health Questionnaire.

[Spitzer RL](#), [Kroenke K](#), [Williams JB](#).

Biometrics Research Department, New York State Psychiatric Institute, and Columbia University, New York 10032, USA. rls8@columbia.edu

CONTEXT: The Primary Care Evaluation of Mental Disorders (PRIME-MD) was developed as a screening instrument but its administration time has limited its clinical usefulness. **OBJECTIVE:** To determine if the self-administered PRIME-MD Patient Health Questionnaire (PHQ) has validity and utility for diagnosing mental disorders in primary care comparable to the original clinician-administered PRIME-MD. **DESIGN:** Criterion standard study undertaken between May 1997 and November 1998. **SETTING:** Eight primary care clinics in the United States. **PARTICIPANTS:** Of a total of 3000 adult patients (selected by site-specific methods to avoid sampling bias) assessed by 62 primary care physicians (21 general internal medicine, 41 family practice), 585 patients had an interview with a mental health professional within 48 hours of completing the PHQ. **MAIN OUTCOME MEASURES:** Patient Health Questionnaire diagnoses compared with independent diagnoses made by mental health professionals; functional status measures; disability days; health care use; and treatment/referral decisions. **RESULTS:** A total of 825 (28%) of the 3000 individuals and 170 (29%) of the 585 had a PHQ diagnosis. There was good agreement between PHQ diagnoses and those of independent mental health professionals (for the diagnosis of any 1 or more PHQ disorder, kappa = 0.65; overall accuracy, 85%; sensitivity, 75%; specificity, 90%), similar to the original PRIME-MD. Patients with PHQ diagnoses had more functional impairment, disability days, and health care use than did patients without PHQ diagnoses (for all group main effects, P<.001). The average time required of the physician to review the PHQ was far less than to administer the original PRIME-MD (<3 minutes for 85% vs 16% of the cases). Although 80% of the physicians reported that routine use of the PHQ would be useful, new management actions were initiated or planned for only

117 (32%) of the 363 patients with 1 or more PHQ diagnoses not previously recognized.
CONCLUSION: Our study suggests that the PHQ has diagnostic validity comparable to the original clinician-administered PRIME-MD, and is more efficient to use.

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