Quick Guide to PRIME-MD Patient Health Questionnaire (PHQ) PHQ9 and GAD7

Purpose

The Patient Health Questionnaire (PHQ) is designed to facilitate the recognition and diagnosis of the most common mental disorders in primary care patients. For patients with a depressive disorder, a PHQ Depression Severity Index score can be calculated and repeated over time to monitor change.

Who Should Take the PHQ

Ideally, the PHQ should be used with all new patients, all patients who have not completed the questionnaire in the last year, and all patients suspected of having a mental disorder.

Making a Diagnosis

Since the questionnaire relies on patient self-report, definitive diagnoses must be verified by the clinician, taking into account how well the patient understood the questions in the questionnaire, as well as other relevant information from the patient, his or her family or other sources.

Interpreting the PHQ

To facilitate interpretation of patient responses, all clinically significant responses are found in the column farthest to the right. (The only exception is for suicidal ideation when diagnosing a depressive syndrome.) At the bottom of each page, beginning with "FOR OFFICE CODING", in small type, are criteria for diagnostic judgments for summarizing the responses on that page. The names of the categories are abbreviated, e.g., Major Depressive Syndrome is Maj Dep Syn..

Additional Clinical Considerations

After making a provisional diagnosis with the PHQ, there are additional clinical considerations that may affect decisions about management and treatment.

- *Have current symptoms been triggered by psychosocial **stressor(s**)?*
- *What is the **duration** of the current disturbance and has the patient received any **treatment** for it?*
- *To what extent are the patient's symptoms i**mpairing** his or her usual work and activities?*
- *Is there a **history** of similar episodes, and were they **treated**?*
- *Is there a **family history** of similar conditions?*

Sourcing Further Information

All PRIME-MD and PHQ materials were developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

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Website to obtain PHQ-9, including permission for clinical/research use: www.pfizer.com/phq-9

Example of Diagnosing Major Depressive Disorder & Calculating PHQ-9 Depression Severity

Patient: A 43-year-old woman who looks sad and complains of fatigue for the past month.

2. Over the last 2 weeks, how often have you been bothered by any of the following:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
	(0)	(1)	(2)	(3)
a. Little interest or pleasure in doing things?……..	☐	☐	☐	☒
b. Feeling down, depressed, or hopeless?……..….	☐	☒	☐	☐
c. Trouble falling or staying asleep, or sleeping too much?	☐	☐	☒	☐
d. Feeling tired or having little energy?.....……...……..	☐	☐	☐	☒
e. Poor appetite or overeating?.....……	☐	☒	☐	☐
f. Feeling bad about yourself—or that you are a failure or have let yourself or your family down?……..	☐	☐	☒	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television? ……..	☐	☐	☐	☒
h. 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?.....……..	☒	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way? ……	☐	☒	☐	☐

FOR OFFICE CODING: Maj Dep Syn if #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all) . Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).

Major Depressive Disorder Diagnosis

The criteria for Major Depressive Syndrome are met since she checked #2a "nearly every day" and five of items #2a to i were checked "'more than half the days" or "nearly every day". Note that #2i, suicidal ideation, is counted whenever it is present.

In this case, the diagnosis of Major Depressive Disorder (not Syndrome) was made since questioning by the physician indicated no history of a manic episode; no evidence that a physical disorder, medication, or other drug caused the depression; and no indication that the depressive symptoms were normal bereavement. Questioning about the suicidal ideation indicated no significant suicidal potential.

PHQ-9 Depression Severity

This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. PHQ-9 total score for the nine items ranges from 0 to 27. In the above case, the PHQ-9 depression severity score is 16 (3 items scored 1, 2 items scored 2, and 3 items scored 3). Scores of 5, 10, 15, and 20 represent cutpoints for mild, moderate, moderately severe and severe depression, respectively. Sensitivity to change has also been confirmed.

GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of “not at all,” “several days,” “more than half the days,” and “nearly every day,” respectively. GAD-7 total score for the seven items ranges from 0 to 21. Scores of 5, 10, and 15 represent cutpoints for mild, moderate, and severe anxiety, respectively. Though designed primarily as a screening and severity measure for generalized anxiety disorder, the GAD-7 also has moderately good operating characteristics for three other common anxiety disorders – panic disorder, social anxiety disorder, and post-traumatic stress disorder. When screening for individual or any anxiety disorder, a recommended cutpoint for further evaluation is a score of 10 or greater.

References

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PHQ-9 Scores and Proposed Treatment Actions *

PHQ-9 Score	Depression Severity	Proposed Treatment Actions
0 – 4	None	None
5 – 9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10 – 14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15 – 19	Moderately Severe	Immediate initiation of pharmacotherapy and/or psychotherapy
20 – 27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

* From Kroenke K, Spitzer RL, Psychiatric Annals 2002;32:509-521

PHQ-9 and PHQ-2 Operating Characteristics in 580 Primary Care Patients

Cutpoint	Major Depressive Disorder N = 41 (7.1%)	Any Depressive Disorder N = 106 (18.3%)
PHQ-9 (0-27 range)		
8		
Sensitivity	.95	.77
Specificity	.81	.86
9		.
Sensitivity	.95	.75
Specificity	.84	.90
10		
Sensitivity	.88	.66
Specificity	.88	.93
11		
Sensitivity	.83	.61
Specificity	.89	.95
12		
Sensitivity	.83	.56
Specificity	.92	.96
PHQ-2 (0-6 range)		
2		
Sensitivity	.93	.82
Specificity	.74	.80
3		
Sensitivity	.83	.62
Specificity	.90	.95

GAD-7 and GAD-2 Operating Characteristics in 965 Primary Care Patients

Cutpoint	Generalized Anxiety Disorder N = 72 (7.5%)	Panic Disorder N = 66 (6.8%)	Social Anxiety Disorder N = 60 (6.2%)	Posttraumatic Stress Disorder (N = 83) (8.6%)	Any Anxiety Disorder N = 188 (19.5%)
GAD-7 (0-21 range)					
8					
Sensitivity	.92	.82	.78	.76	.77
Specificity	.76	.75	.74	.75	.83
9					
Sensitivity	.90	.79	.77	.74	.73
Specificity	.79	.78	.77	.78	.85
10					
Sensitivity	.89	.74	.72	.66	.68
Specificity	.82	.81	.80	.81	.88
GAD-2 (0-6 range)					
2					
Sensitivity	.96	.91	.85	.86	.86
Specificity	.64	.63	.62	.63	.70
3					
Sensitivity	.88	.76	.70	.59	.65
Specificity	.83	.81	.81	.81	.86

On the following pages are the

- PHQ-9 depression scale
- GAD-7 anxiety scale

PHQ-9

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

(*For office coding: Total Score* _____ = ___ + ___ + ___)

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**
☐	☐	☐	☐

GAD-7

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3