Policy Statement

LA BEST BABIES NETWORK
Healthy Babies. Our Future.

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Screening for Postpartum Depression at Well-Child Visits

Postpartum depression (PPD) is the most common complication of childbirth with an estimated prevalence of 15-20%[1]. PPD has devastating short- and long-term consequences for the mother, her partner, and her newborn. The most severe adverse outcomes of PPD include increased risk for marital discord and divorce, child abuse and neglect, and even maternal suicide or infanticide[2]. Children of depressed mothers are at increased risk for impaired mental and motor development, difficult temperament, poor self-regulation, low self-esteem, and behavior problems[3]. Easy-to-use, reliable, self-administered screening tools for PPD are available, as are effective therapeutic modalities. Nevertheless, PPD often goes unrecognized and therefore untreated. Pediatricians have a unique opportunity to screen for PPD since they see the mother/infant dyad at least 7 times during the first year of life. By incorporating routine screening for PPD into these early well-child visits, pediatricians could help depressed women and their children by identifying and referring women for care.

What is Postpartum Depression?

Perinatal depression is defined as a period of at least 2 weeks during which there is depressed mood or loss of interest or pleasure in nearly all activities, which occurs during pregnancy or within the first 12 months after birth. Postpartum depression usually begins from 3 to 14 days postpartum, but can develop anytime within the first year after delivery.

Symptoms of postpartum depression include:

- Social withdrawal
- Deep sadness, crying spells, hopelessness
- Excessive worrying and fears
- Irritability or short temper
- Mood swings
- Feeling overwhelmed
- Feeling very emotional
- Difficulty making decisions
- Changes of appetite
- Sleep problems
- Mixed emotions about the baby

Major depression typically peaks at approximately 6 weeks postpartum with another peak at 6 months[1]. The average duration of an episode of postpartum depression (without treatment) is seven months.

After one episode of postpartum depression, the risk of recurrence in subsequent pregnancies is 50-

Box 1. Diagnostic Criteria for Depression

For major depression, at least five of the following symptoms must be present for most of the day, nearly every day, for at least 2 weeks. At least one of the first two bolded symptoms must be present.

Symptoms:

- ◊ **Depressed mood, often accompanied or overshadowed by severe anxiety**
- ◊ **Markedly diminished interest or pleasure in usual activities**
- ◊ Sleep disturbance –most often insomnia and fragmented sleep, even when the baby sleeps
- ◊ Fatigue or loss of energy
- ◊ Appetite disturbance – usually loss of appetite with weight loss
- ◊ Physical agitation (most commonly) or psychomotor slowing
- ◊ Feelings of worthlessness or excessive or inappropriate guilt
- ◊ Decreased concentration or ability to make decisions
- ◊ Recurrent thoughts of death or suicide

A diagnosis of major depression also requires a decline from the woman's previous level of functioning, and substantial impairment.

75%. Therefore, women with any previous episode of depression should be promptly referred for treatment.

Another mental disorder that can occur in the perinatal period is **postpartum psychosis**. Unlike postpartum depression, postpartum psychosis is a relatively rare event with an estimated incidence of 1.1-4.0 cases per 1,000 deliveries[4]. The onset of postpartum psychosis is usually acute, within the first 2 weeks of delivery, and is more common in women with a strong family history of bipolar or schizoaffective disorder. It resembles a manic psychosis with agitation, irritability, depressed or elated mood, delusions, and disorganized behavior, and it carries a risk of infanticide and suicide, making it a psychiatric emergency. However, with immediate hospitalization and treatment with mood stabilizers, women with this disorder can do very well. Although it is an important disorder in its own right, it will not be further addressed in this issue brief.

Why Does Depression Matter?

Without intervention, maternal depression can have life-long repercussions for the child, the mother, and their relationship. Here are ways that it may have a negative impact.

For Mother:

- Impaired care-taking of self and others
- Altered appetite/weight
- Sleep disturbance
- Increased risk of substance abuse
- Increased risk of smoking
- Suicidal thoughts or actions
- Long-term depression or anxiety

For Infant:

- Increased crying and irritability
- Poor attachment to mother
- Increased risk of abuse or neglect
- Decreased duration of breastfeeding
- Increased risk of failure to thrive
- Poor weight gain
- Physical dysregulation

For Family:

- Marital friction and divorce
- Contributes to father's feelings of helplessness and depression
- Effects on older children (emotional, behavioral)
- Causes feelings of loss and grief in family

For Children:

- Developmental delays:
  - Late walking and talking
  - Delayed readiness for school
  - Learning difficulties and problems with school work
  - Attention and focus impairment
- Emotional problems:
  - Low self-esteem
  - Anxiety and fearfulness
  - Increased risk for developing major depression early in life
- Behavioral and sleep problems:
  - Increased aggression
  - Acting out in destructive ways
- Social difficulty:
  - Problems with establishing secure relationships
  - Difficulty making friends in school
  - Social withdrawal

Impact on Early Parenting Practices[5]:

- Safety Practices:
  - Decreased use of car seats and electrical outlet covers
  - Decreased use of smoke detector
  - Less likely to place baby on back to sleep
  - Increased use of corporal punishment during first year of life
  - Increased risk for accidents necessitating ED visits
- Feeding Practices:
  - Less likely to breastfeed or breastfeed for shorter duration
  - More likely to give water, juice or cereal before age of 4 months
- Behaviors that promote early development:
  - Less likely to talk daily while in the home
  - Less likely to play daily with infant
  - Less likely to show books daily to infant
  - Less likely to be affectionate with infant
  - Less likely to follow 2 or more routines at meals, naptime and bedtime
  - Less likely to make pediatric appointments and follow through on pediatric guidelines

- More likely to display anger and disengagement

The interaction between parent and infant is central to the infant's physical, cognitive, social, and emotional development, as well as to his self-regulation abilities[6]. Maternal depression interferes with the mother's capacity to bond with her infant and can seriously impair the baby's emotional and even physical well-being because of neglect of the infant's needs and lack of reinforcement of the infant's engagement cues. Maternal depression can also result in insecure attachment that increases the risk for subsequent externalizing and internalizing behaviors in the developing child. Thus, it is critical to detect and treat maternal depression as early as possible in the life of the infant.

Box 2. Signs of Possible Problems with Emotional Well-Being in Infants of Depressed Mothers[8]

- Excessive crying and irritability, with difficulty calming
- Dysregulation in sleep
- Physical dysregulation (e.g. vomiting or diarrhea)
- Poor weight gain
- Poor eye contact
- Lack of brightening on seeing parent
- Not turning to sound of parent's voice
- Lack of vocalizations
- Extremely low activity level or tone
- Lack of mouthing to explore objects
- Sad or somber facial expression (evident by 3 months of age)
- Wariness (evident by 4 months of age)

Who is at risk for Postpartum Depression?

No woman is immune to the development of postpartum depression, but some new mothers are at increased risk[8].

Medical or psychiatric risk factors:

- Family or personal history of mood disorders or other mental illness, history of depression, or depression or anxiety during pregnancy.
- Prior history of trauma or loss, especially loss of one's mother.
- Stressful life events–separation, divorce, job loss, move, etc.
- Unplanned and/or unwanted pregnancy.
- Difficult or high risk pregnancy.
- Birth trauma or complications.
- Multiple birth.
- History of infertility.
- Chronic medical disorder.
- Substance abuse.
- Perinatal loss: miscarriage, stillbirth, neonatal death, infant death.
- Baby in NICU.
- Baby with birth defect or disability.
- "Fussy baby" or baby with difficult temperament.
- Adopted baby.

Social risk factors:

- Poverty or financial hardship.
- Poor or inadequate social support.
- Relationship dissatisfaction and/or stress.
- Domestic violence.
- High levels of child care stress.
- Teen motherhood.
- Single motherhood.
- Immigrant status.
- Military service.

Why Pediatricians?

According to the American Academy of Pediatrics, pediatricians have unique opportunities "to prevent future mental health problems through…timely interventions for common behavioral, emotional, and social problems encountered in the typical course of infancy, childhood, and adolescence."[9] The family-centeredness of the child's medical home and the pediatrician's longitudinal, trusting, and empowering therapeutic relationship with the family represent the perfect framework for implementing routine screening for maternal depression. Moreover, pediatricians, unlike obstetricians or midwives, have the opportunity to see the mother/infant dyad continually during the first year of life[10]. Obstetricians and midwives typically only have one postpartum visit with the new mother and rarely see her beyond 6 to 8 weeks

postpartum, at the point when many low-income mothers lose their insurance coverage. Since most depressed mothers do not recognize their symptoms as depression, they are unlikely to be under psychiatric care. Thus, the pediatrician may be the only provider the mother sees on a regular basis during the first year of a child's life.

Screening for Postpartum Depression

Studies exploring the feasibility of screening for maternal postpartum depression using a standardized tool[11-13] have found that the introduction of screening during well-child visits is well received, with few patients declining. Since the standardized tools are self-administered, they can be completed by the mother while she is in the waiting room, and then scored by the nurse or medical assistant. Clinician time demands are modest, with most screenings requiring no additional discussion, 20-30% requiring brief discussions (less than 3 minutes), and only 4-5% requiring a longer discussion[13].

The two most widely used, validated screening tools are the Patient Health Questionnaire (PHQ-2 or PHQ-9) and the Edinburgh Postpartum Depression Scale (EPDS-10).[1] Both are available at no cost.[14,15] The PHQ-2 asks about the two fundamental symptoms of depression, diminished mood and anhedonia, and requests simple yes/no responses. Most clinicians start by administering the PHQ-2 and if the respondent answers "yes" to either or both questions, the PHQ-9 is then administered.[16] The PHQ-9 has been validated for measuring depression severity and can be self-administered, administered telephonically, or read to the patient. In addition, it has been validated in African American, Chinese American, Latino, and non-Hispanic white patient groups and is available in English, Spanish, and Chinese.

The EPDS-10, a 10-item, self-administered questionnaire specifically developed for the assessment of postpartum depression, focuses on the psychological rather than the somatic aspects of depression. Patients respond to items on a 4-point Likert scale. **Anxiety is a more prominent feature of postpartum depression**[17] than of depression that occurs at other times in life, and for some mothers with PPD, anxiety will be the only symptom. *Therefore, if the pediatrician elects to use the PHQ-9 screening tool over the EPDS-10, we strongly recommend that the* ***EPDS-3*** *(the 3-item anxiety subscale of the Edinburgh Postpartum Depression Scale*[18]*) be used concurrently (See Box 6.)*

Box 3. Screening Protocol for Postpartum Depression at Well-Child Visits

◊	Who	All mothers
◊	When	At each well-child visit the first year of life
◊	Where	Waiting room (self-administered) or in private room if patient has low health literacy and needs MA to read it to her
◊	Who scores	Nurse or medical assistant
◊	How	PHQ-2, followed by PHQ-9 if answer "yes" to either question, PLUS EPDS-3
◊	Why	Early detection

Box 4. Scoring the PHQ-9 Depression Assessment[14]

For initial diagnosis

1. Patient completes the PHQ-9 Quick Depression Assessment
2. Questions #1 and #2 are answered as either 2 or 3.
3. If there are at least 5✔s in the two right columns (including Questions #1 and #2), consider a **major depressive disorder**. Add score to determine severity.
4. **Functional impairment** is answered as "somewhat difficult" or greater.

Severity Determination

Total Score	Depression Severity
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately severe
20-27	Severe

Box 5. PHQ-9: Guide to Diagnosis and Treatment Options[14]

PHQ-9 Score	Provisional Diagnosis	Treatment Options
5-9	Minimal symptoms	Support, educate to call if worse, return in one month
10-14	Minor depression* Dysthymia** Major depression, mild	Support, watchful waiting Antidepressant or psychotherapy Antidepressant or psychotherapy
15-19	Major depression, moderately severe	Antidepressant or psychotherapy
>20	Major depression, severe	Antidepressant and psychotherapy (especially if not improved on monotherapy)

*If symptoms present > 1 month or severe functional impairment, consider therapy.
** If symptoms present ≥2 years, probable chronic depression, warrants therapy.

Box 6. 3-Item Anxiety Subscale of Edinburgh Postpartum Depression Scale[18]

Please underline the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

1 I have blamed myself unnecessarily when things went wrong.

Yes, most of the time
Yes, some of the time
Not very often
No, never

2 I have been anxious or worried for no good reason.

Yes, very often
Yes, sometimes
Hardly ever
No, not at all

3 I have felt scared or panicky for no very good reason.

Yes, most of the time
Yes, sometimes
Hardly ever
No, not at all

Is the Patient Unsafe to Self or Others?

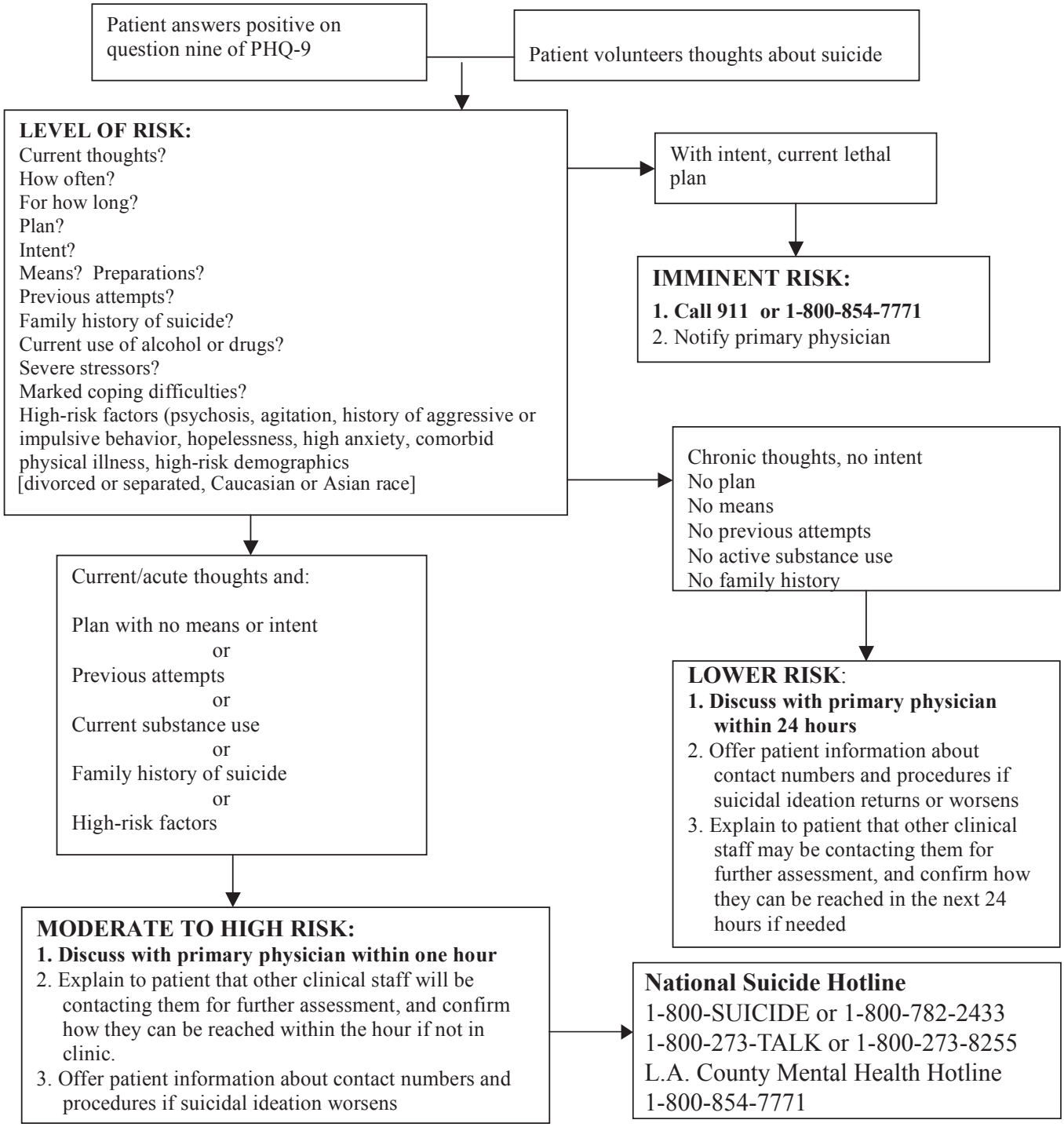
Once you have determined that the mother is depressed, it is critical to assess suicidal tendencies.[14] Asking questions about suicide will NOT make a mother more or less suicidal than she already is. In fact, the opportunity to discuss her suicidal thoughts is often cathartic. The first clue is if the mother answered yes to question #9 on PHQ-9 – "Over the past 2 weeks, how often have you been bothered by thoughts that you would be better off dead, or of hurting yourself in some way?" Consider asking and documenting the following progression of questions:

1. Do you feel that life is worth living?
2. Do you wish you were dead?
3. Have you thought about ending your life?
4. If yes, have you gone so far as to think about how you would do so?
5. Do you have access to a way to carry out your plan?
6. What keeps you from harming yourself?

Many patients will not answer #4 directly or will add, "But I'd never do it." Give them positive feedback (e.g., "I'm glad to hear that") but do not drop the subject until she has told you the specific methods considered (e.g., gun, medication overdose, motor vehicle accident).

It is important for each healthcare office or clinic

Example Suicidality Screening Flow*



***Note: A clear chain of responsibility within the clinic system needs to be established and distributed to all parties who may identify a suicidal patient. Well-defined follow-up procedures for contacting the patient for further evaluation need to be established. Events need to be well documented in the patient's medical record.**

to develop its own suicide protocol. The office should develop a clear process for risk assessment, including when to involve a mental health specialist, use of local or national hotlines, next steps, etc. See algorithm for **Suicidality Screening Flow** on page 6.

A mother deemed to be at imminent risk for suicide should not be left alone for even a short period of time (not even when she goes to the bathroom); someone should stay with her until the Los Angeles County Psychiatric Mobile Response Team (PMRT) arrives to evaluate her, and if necessary, involuntarily detain her. PMRT responds to requests for mobile psychiatric services within 60 minutes of the initial call to 800-854-7771.

Educating and Engaging the Depressed Mother

Successful care of major depression as a medical illness requires active engagement of each patient and her family, and ongoing education, beginning at the time of diagnosis. The National Research Council and Institute of Medicine's 2009 report[19] recommends that a focus on positive parenting and child development be paired with treatment of parental depression to prevent adverse outcomes in the child, enhance the parent's interactions with the child, and help engage the parent in treatment. Key messages[14] include:

- *You are not alone.* Maternal depression is common medical illness and can affect any woman regardless of age, income, culture, or education.
- *You did nothing to cause this.* This is not your fault.
- *Help is available.* The sooner you get treatment, the better.
- *Recovery is the rule, not the exception.*
- *Treatment is effective for most patients.* The aim of treatment is complete remission, not just getting better, but staying well.

Referring the Depressed Mother for Treatment

Pediatricians can refer the depressed mother to her primary care provider, or directly to a mental health specialist, for initiation of treatment, depending on the mother's preference. Ideally, the pediatrician has a social worker co-located at his office or clinic. Alternatively, the pediatrician has a working relationship with a mental health professional (MSW, MFT, PsyD, PhD, psychiatrist) in the community to whom patients can be easily referred. However, if the pediatrician needs to find a therapist for a depressed mother in Los Angeles County, he can call 2-1-1 and/or Postpartum Support International (PSI) at 1-800-944-4PPD (www.postpartum.net).

To the greatest extent possible, it is important for there to be a "warm hand-off" whereby the primary care provider directly introduces the client to the mental health provider. The reason for this is both to establish an initial face-to-face contact between the client and the mental health counselor and to confer on the counselor the trust and rapport the client has developed with the provider. Many clinicians report that this face-to-face introduction helps ensure that the counseling appointment will be kept. Nevertheless, support and education in the primary care setting, i.e., the pediatrician's office, are critical and contribute to the likelihood of good follow-through on treatment.

The impact of the mother's depression on her older children and family as a whole should also be taken into consideration when making referrals. For example, if the mother's depression has been chronic, older children might need a comprehensive mental health evaluation and/or referral for early intervention.

Patient Self-Management

All depressed women need psychosocial support and should be encouraged to identify family members and friends with whom they can talk. If none can be identified, it is important to refer them to a postpartum support group.[20] Activity scheduling is a straightforward behavioral intervention in which patients are taught to increase their daily involvement in pleasant activities and to increase their positive interactions with their environment[21]. Physical activity, at a dose consistent with public health recommendations (i.e., 30 minutes of moderate-intensity aerobic exercise, 3 to 5 days a week, for otherwise healthy adults), can also be helpful in easing the symptoms of major depression.

Treatment Options

Pharmacologic and/or psychotherapy interventions are also effective in treating depression. Factors to consider in making treatment recommendations are symptom severity, presence of psychosocial stressors, presence of co-morbid conditions, chronicity of symptoms, and patient preferences. *If the mother has mild to moderate depression, either an antidepressant or psychotherapy is indicated, or possibly both.* On the other

hand, if the presenting symptoms of depression are severe or chronic, a combination of an antidepressant and psychotherapy is often necessary.

It is important to also take into account cultural beliefs and the availability of resources such as transportation, finances/insurance, and child care when making the decision to treat with medication and/or psychotherapy. Results from a systematic review[22] showed clinical benefits when racial and ethnic minority women were allowed to choose their treatment and provided with support and outreach services.

Psychotherapy for depression includes individual, family, dyadic (mother and infant), and group therapy. Cognitive-behavioral therapy, interpersonal therapy, short-term psychodynamic psychotherapy, and problem-solving treatment all have documented efficacy. However, just because a mother receives treatment for her PPD does not mean her infant will experience improved outcomes.

Unhealthy dyadic relationship patterns, established during the earlier stages of the postpartum depression, may continue.[23] These are patterns that the infant participated in as a way of coping with or "normalizing" interaction with a depressed caretaker. Thus, many experts recommend infant-mother psychotherapy.[24]

Effectiveness of **antidepressant medications** is generally comparable between, and within, classes of medications. However, there are distinct differences in side-effects caused by the classes of medications and individual agents.[14, 24, 26] Moreover, when treating postpartum women, it is important to consider whether the medication is safe for breast-feeding or pregnant women.[27] Nortriptyline, paroxetine, and sertraline are the preferred choices in breastfeeding women[14]. For a complete list of medications, please see www.otispregnancy.org.

When antidepressant therapy is likely to be prescribed, the following key educational messages should be highlighted:

- Side effects from medication often precede therapeutic benefit and typically recede over time.
- Successful treatment often involves dosage adjustments and/or trial of a different medication at some point, to maximize response and minimize side effects.
- Most people need to be on medication at least 6-12 months after adequate alleviation of symptoms.
- Patients may show improvement within 2 weeks but need a longer period of time to really see response and remission.
- Continue to take the medication as prescribed even after you feel better. Premature discontinuation of antidepressant treatment has been associated with a 77% increase in the risk of relapse/recurrence of symptoms.
- Do not stop taking the medication without first calling your provider. Side effects can often be managed by changes in the dosage or dosage schedule.
- Most importantly, instruct the mother and her adult family members to be alert for the emergence of agitation, irritability, and other symptoms. The emergence of suicidality and worsening depression should be closely monitored and reported immediately to her health care provider or 9-1-1.

Establish Follow-Up Plan

Proactive follow-up contacts (in person, by telephone) significantly lower depression severity[28]. The addition of a care manager can help the busy pediatrician make sure the mother has followed through on his referrals.

Legal and Ethical Considerations

One barrier to screening for PPD has been pediatricians' legal and ethical concerns over screening parents during a pediatric visit, for a condition that can have serious negative effects on the infant.[29] Liability often depends on the "standard of care" in the community. Now that AAP's Task Force on Mental Health (TFOMH) has proposed that pediatricians, as part of their Surveillance of Environment for Risk Factors, "screen for maternal depression in the first year of life of the child and when psychosocial history indicates"[30], the standard of care is likely to shift. With respect to ethical considerations, if clinicians know that a treatable disorder is prevalent in their population and may affect the health of their patient, i.e., the child, they are indeed ethically bound to screen and refer mothers for help. When screening, pediatricians should clarify that screens for PPD are performed for the purpose of enhancing the child's well-being. Moreover, pediatric providers should be cautious about overstepping the bounds of their role, and leave ongoing care and therapy of the adult to qualified professionals.[31]

Coding

The AAP has developed a comprehensive toolkit to help primary care clinicians more effectively identify and manage a variety of mental health issues, including maternal PPD. The toolkit, "Addressing Mental Health Concerns in Primary Care," released in June 2010, includes screening tools, step-by-step care plans, parent handouts, and other resources.

Of note, it includes a guide to help code for the specific steps in the mental health algorithms introduced by the AAP TFOMH.[32, 33] Screening for maternal PPD falls under Algorithm A. The TFOMH provides a variety of options for coding primary care visits, some might reflect the possibility of an extended visit (i.e., multiple steps in the algorithm during one encounter), while others reflect a contact focused on a specific step. The guide also takes into consideration if the pediatrician has a co-located licensed mental health professional in the office to perform or assist with some steps.

The AAP and the American Academy of Child and Adolescent Psychiatry released a white paper addressing the administrative and financial barriers to accessing mental health services as well as collaboration between pediatric primary care providers and their mental health colleagues.[34] The pediatrician plays a critical role in ongoing communication and co-management to monitor the child's progress, support the child and family, and ensure care coordination. In the context of maternal depression, care coordination becomes even more complex–often bringing in the mother's primary care provider, therapist, and/or psychiatrist, as well as the therapist providing dyadic care.

The Patient Protection and Affordable Care Act requires insurers to cover preventive care and screenings without any cost sharing, including screening for postpartum depression. In 2010 the National Institute for Health Care Management released an important issue brief[35] highlighting what health plans can do to ensure early identification of maternal depression and care coordination. Some health plans such as WellPoint, Inc. and Kaiser Permanente are already addressing this issue, by encouraging obstetricians, pediatricians, and primary care providers to screen for maternal depression, by raising awareness of maternal depression through patient education in maternity programs, and by providing free access to physician education.

Home Visiting

Pediatricians concerned about the well-being of an infant of a severely depressed mother should also consider referring the family to an evidence-based home visiting program in the community, such as Early Head Start, Healthy Families America, Nurse-Family Partnership, Home Instruction for Parents of Preschool Youngsters, or Parents as Teachers. These home visiting programs can improve outcomes for mothers and young children in a variety of areas, including prevention of child abuse and neglect, child health, maternal health, child development and school readiness, family economic self-sufficiency, and positive parenting practices. Unlike a physician, the home visitor has the opportunity to see the mother in her real-life context and the time to sit and listen to her.

> *They come to your home where you are comfortable. Because I'll tell you right now, they don't come out in suits. They come out dressed like whoever. They don't make you feel uncomfortable… It's not going into somebody's office. It's almost like sitting down talking to a friend.*[36]

There are also some home visiting programs specifically designed to meet the needs of parents of infants and toddlers struggling with mental health problems, such as Los Angeles Child Guidance Clinic's *First Steps Program*. This program promotes a strong parent-child attachment using a structured home-based intervention model. This model facilitates understanding and support for parents in ways that lead to a better understanding of how they can improve outcomes for their children, e.g. through talking, singing and reading to infants and toddlers, playing interactive games, and interpreting infant and toddler emotional cues. This approach to treatment increases parents' awareness about their children's needs, improves children's developmental course, and expands safety and stimulation in the home environment.

Resources

AAP Mental Health Toolkit
Pediatrics 2010; Volume 125 Supplement #3
Enhancing Pediatric Mental Health Care

Free online training:
www.step-ppd.com/step-ppd/home.aspx

Medications: www.otispregnancy.org

LA County Perinatal Mental Health Task Force's Perinatal Depression Toolkit:
www.lacountyperinatalmentalhealth.org

Postpartum Support International 1-800-944-4773
http://www.postpartum.net/

Suicide Hotlines:
National 1-800-SUICIDE or 1-800-784-2433
LA County 1-800-854-7771

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Sample Screening Form[16]

Depression is a common but treatable illness that occurs more often among parents. Many people who suffer don't realize they have a medical illness and could benefit from treatment.
The U.S. Preventive Services Task Force recommends that all adults be checked for depression when they see a doctor. Parents of children who are cared for in this practice may see us more often than any other healthcare provider. The Task Force is considered the authority on preventive health care and we believe it is wise to follow their advice. It is our job because, if a parent is depressed, their child is affected. The child does better if the parent gets help.

For this reason, please take a minute to respond to the following questions. We will then take a look at your responses together during this visit.

1. Over the past 2 weeks, you have felt down, depressed, or hopeless? *(True or false)*
   If true, have you felt this way for:
   several days, more than half the days, or nearly every day?

2. Over the past 2 weeks, you have felt little interest or pleasure in doing things? *(True or false)*
   If true, have you felt this way for:
   several days, more than half the days, or nearly every day?

Please underline the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

1. I have blamed myself unnecessarily when things went wrong.
   Yes, most of the time
   Yes, some of the time
   Not very often
   No, never

2. I have been anxious or worried for no good reason.
   Yes, very often
   Yes, sometimes
   Hardly ever
   No, not at all

3. I have felt scared or panicky for no very good reason.
   Yes, most of the time
   Yes, sometimes
   Hardly ever
   No, not at all