**PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)**

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

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>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</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**FOR OFFICE CODING**

\[
\text{Total Score: } 0 + \_\_\_ + \_\_\_ + \_\_\_ + \_\_\_ = \_\_\_\_\_\_\]

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?

<table>
<thead>
<tr>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

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GAD-7

Over the **last 2 weeks**, how often have you been bothered by the following problems?

*(Use "✓" to indicate your answer)*

<table>
<thead>
<tr>
<th>Problems</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling nervous, anxious or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Being so restless that it is hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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

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INSTRUCTION MANUAL
Instructions for Patient Health Questionnaire (PHQ) and GAD-7 Measures

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>PAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>1</td>
</tr>
<tr>
<td>Coding and Scoring</td>
<td>2, 4, 5</td>
</tr>
<tr>
<td>Versions</td>
<td>3</td>
</tr>
<tr>
<td>Use as Severity and Outcome Measures</td>
<td>6-7</td>
</tr>
<tr>
<td>Translations</td>
<td>7</td>
</tr>
<tr>
<td>Website and Other Issues</td>
<td>8</td>
</tr>
<tr>
<td>Selected References</td>
<td>9</td>
</tr>
</tbody>
</table>

BACKGROUND

The Primary Care Evaluation of Mental Disorders (PRIME-MD) was an instrument developed and validated in the early 1990s to efficiently diagnose five of the most common types of mental disorders presenting in medical populations: depressive, anxiety, somatoform, alcohol, and eating disorders.[1] Patients first completed a one-page 27-item screener and, for those disorders for which they screened positive, were asked additional questions by the clinician using a structured interview guide. However, this 2-stage process took an average of 5-6 minutes of clinician time in patients without a mental disorder diagnosis and 11-12 minutes in patients with a diagnosis. This proved to be a barrier to use given the competing demands in busy clinical practice settings.

Therefore, in two large studies enrolling 8000 patients (3000 from general internal medicine and family practice clinics and 3000 from obstetrics-gynecology clinics), a self-administered version of the PRIME-MD called the Patient Health Questionnaire (PHQ) was developed and validated.[2,3] In the past decade, the PHQ in general and the PHQ-9 depression scale in particular [4-6] have gained increasing use in both research and practice. The original PRIME-MD is now largely of historical interest and seldom used except in a few types of research studies.

Given the popularity of the PHQ-9 for assessing and monitoring depression severity, a new 7-item anxiety scale using a response set similar to the PHQ-9 was initially developed to diagnose generalized anxiety disorder (hence its name, the GAD-7) and validated in 2740 primary care patients.[7] Though originally developed to diagnose generalized anxiety disorder, the GAD-7 also proved to have good sensitivity and specificity as a screener for panic, social anxiety, and post-traumatic stress disorder.[8] Finally, the PHQ-15 was derived from the original PHQ studies and is increasingly used to assess somatic symptom severity and the potential presence of somatization and somatoform disorders.[9]
Each PHQ module can be used alone (e.g. the PHQ-9 if depression is the condition of interest), together with other modules, or as part of the full PHQ. Also, alternative or abbreviated versions of the PHQ-9 and GAD-7 are sometimes used in certain screening or research settings [10-14]. Although the PHQ was originally developed to detect five disorders, the depression, anxiety, and somatoform modules (in that order) have turned out to be the most popular.[10] Also, most primary care patients with depressive or anxiety disorders present with somatic complaints and co-occurrence of somatic, anxiety, and depressive symptoms (the SAD triad) is exceptionally common. This is the rationale behind the PHQ-SADS screener.[15] The most commonly used versions of the PHQ scales are summarized in Table 1, page 3.

CODING AND SCORING

The full PHQ, Brief PHQ, and PHQ for Adolescents (PHQ-A) can be used to establish provisional diagnoses for selected DSM-IV disorders. The diagnostic algorithm for the PHQ modules are included in footers at the bottom of each page of the PHQ, and also reiterated in Table 2, page 4. The other measures are principally used to derive severity scores (PHQ-9 and PHQ-8 for depressive symptom severity; GAD-7 for anxiety symptom severity; PHQ-15 for somatic symptom severity) or as ultra-brief screeners (PHQ-2, GAD-2, PHQ-4). An example in which the PHQ depression module can be used as both a diagnostic module as well as a depression severity score (PHQ-9 score) is shown in Table 3, page 5.

Over time, the severity scores have been a particularly popular use of the measures, and are now used much more commonly than the provisional diagnoses. For example, cutpoints of 5, 10, and 15 represent mild, moderate, and severe levels of depressive, anxiety, and somatic symptoms, on the PHQ-9, GAD-7, and PHQ-15 respectively. Also, a cutpoint of 10 or greater is considered a "yellow flag" on all 3 measures (i.e., drawing attention to a possible clinically significant condition), while a cutpoint of 15 is a "red flag" on all 3 measures (i.e., targeting individuals in whom active treatment is probably warranted). For the ultra-brief measures (PHQ-2 and GAD-2), a score of 3 or greater should prompt administration of the full PHQ-9 and/or GAD-7, as well as a clinical interview to determine whether a mental disorder is present.

The final question on the PHQ (and some of its abbreviated versions) asks the patients to report "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?" This single patient-rated difficulty item is not used in calculating any PHQ score or diagnosis but rather represents the patient's global impression of symptom-related impairment. It may be useful in decisions regarding initiation of or adjustments to treatment since it is strongly associated with both psychiatric symptom severity as well as multiple measures of impairment and health-related quality of life.

A particularly important question is how to assess suicide risk in individuals who answer positively to the 9th question of the PHQ-9. A four-item screener has been developed that may assist in positive responses to this 9th question [16], although a final decision about the actual risk of self-harm requires a clinical interview.
### Table 1. Versions: Patient Health Questionnaire (PHQ) Family of Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Scoring</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRIME-MD</td>
<td>Predecessor of PHQ, now mainly of historical interest.</td>
<td>Combined self-administered patient screener with clinician follow-up questions.</td>
<td>1</td>
</tr>
<tr>
<td>PHQ</td>
<td>Five modules covering 5 common types of mental disorders: depression, anxiety, somatoform, alcohol, and eating.</td>
<td>Selected (but provisional) DSM-IV diagnoses for all types of disorders except somatoform.</td>
<td>2, 3</td>
</tr>
<tr>
<td>PHQ-9</td>
<td>Depression scale from PHQ.</td>
<td>Nine items, each of which is scored 0 to 3, providing a 0 to 27 severity score.</td>
<td>1, 4, 5, 6, 10</td>
</tr>
<tr>
<td>GAD-7</td>
<td>Anxiety measure developed after PHQ but incorporated into PHQ-SADS.</td>
<td>Seven items, each of which is scored 0 to 3, providing a 0 to 21 severity score.</td>
<td>7, 8, 10</td>
</tr>
<tr>
<td>PHQ-15</td>
<td>Somatic symptom scale from PHQ.</td>
<td>Fifteen items, each of which is scored 0 to 2, providing a 0 to 30 severity score.</td>
<td>9, 10</td>
</tr>
<tr>
<td>PHQ-SADS</td>
<td>PHQ-9, GAD-7, and PHQ-15 measures, plus panic measure from original PHQ.</td>
<td>See scoring for these scales above.</td>
<td>10</td>
</tr>
<tr>
<td><strong>Variants</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief PHQ</td>
<td>PHQ-9 and panic measures from original PHQ plus items on stressors and women’s health.</td>
<td>See scoring for PHQ above. Stressor and women’s health items are not diagnostic or scored.</td>
<td>3</td>
</tr>
<tr>
<td>PHQ-A</td>
<td>Substantially modified version of PHQ developed for use in adolescents. Moderate data exists for validity but much less than for original PHQ.</td>
<td>Diagnostic scoring described in manual, available upon request.</td>
<td>11</td>
</tr>
<tr>
<td>PHQ-2</td>
<td>First 2 items of PHQ-9. Ultra-brief depression screener.</td>
<td>Two items scored 0 to 3 (total score of 0-6)</td>
<td>10, 12</td>
</tr>
<tr>
<td>GAD-2</td>
<td>First 2 items of GAD-7. Ultra-brief anxiety screener.</td>
<td>Two items scored 0 to 3 (total score of 0-6)</td>
<td>8, 10, 12</td>
</tr>
<tr>
<td>PHQ-4</td>
<td>PHQ-2 and GAD-2.</td>
<td>See PHQ-2 and GAD-2 above.</td>
<td>10, 12, 13</td>
</tr>
<tr>
<td>PHQ-8</td>
<td>All items of PHQ-9 except the 9th item on self-harm. Mainly used in non-depression research studies.</td>
<td>Eight items, each of which is scored 0 to 3, providing a 0 to 24 severity score.</td>
<td>5, 10, 14</td>
</tr>
</tbody>
</table>
### Table 2. Diagnostic Algorithms for the PHQ

<table>
<thead>
<tr>
<th>Page 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Somatoform Disorder</strong> if at least 3 of #1a-m bother the patient “a lot” and lack an adequate biological explanation.</td>
</tr>
<tr>
<td><strong>Major Depressive Syndrome</strong> 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).</td>
</tr>
<tr>
<td><strong>Other Depressive Syndrome</strong> 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).</td>
</tr>
<tr>
<td><strong>Note:</strong> the diagnosis of Major Depressive Disorder and Other Depressive Disorder requires ruling out normal bereavement (mild symptoms, duration less than 2 months), a history of a manic episode (Bipolar Disorder) and a physical disorder, medication or other drug as the biological cause of the depressive symptoms.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Page 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Panic Syndrome</strong> if #3a-d are all ‘YES’ and 4 or more of #4a-k are ‘YES’.</td>
</tr>
<tr>
<td><strong>Other Anxiety Syndrome</strong> if #5a and answers to three or more of #5b-g are “More than half the days”.</td>
</tr>
<tr>
<td><strong>Note:</strong> The diagnosis of Panic Disorder and Other Anxiety Disorder require ruling out a physical disorder, medication or other drug as the biological cause of the anxiety symptoms.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Page 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bulimia Nervosa</strong> if #6a,b, and c and #8 are ‘YES’;</td>
</tr>
<tr>
<td><strong>Binge Eating Disorder</strong> the same but #8 is either ‘NO’ or left blank.</td>
</tr>
<tr>
<td><strong>Alcohol abuse</strong> if any of #10a-e are “YES”.</td>
</tr>
</tbody>
</table>

### 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 impairing 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?
Table 3. Example of PHQ Depression Module for both Diagnostic and Severity Purposes

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

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

**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 cutoffs for mild, moderate, moderately severe and severe depression, respectively. Sensitivity to change has also been confirmed.
USE OF SOME SCREENERS AS SEVERITY AND OUTCOME MEASURES

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 (see table 3, page 5), 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. The PHQ-8 is scored just like the PHQ-9 and its total score ranges from 0 to 24. Cutpoints on the PHQ-8 are identical to the PHQ-9.

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 anxiety disorders, a recommended cutpoint for further evaluation is a score of 10 or greater.

PHQ-2 and GAD-2 Severity. These consist of the first two items of the PHQ-9 and GAD-7 respectively, and constitute the two core DSM-IV items for major depressive disorder and generalized anxiety disorder, respectively. Each ranges from a score of 0 to 6. The operating characteristics of these ultra-brief measures are quite good; the recommended cutpoints for each when used as screeners is a score of 3 or greater. When used together, they are referred to as the PHQ-4 a 4-item screening measure which ranges from a score of 0 to 12, and serves as a good measure of “caseness” (i.e., the higher the score, the more likely there is an underlying depressive or anxiety disorder). In particular, the PHQ-2 and GAD-2 subscores of the PHQ-4 provide separate depressive and anxiety scores, and can be used as screeners for depression and anxiety.

PHQ-15 Somatic Symptom Severity. This is calculated by assigning scores of 0, 1, and 2 to the response categories of “not at all”, “bothered a little”, and “bothered a lot”, for the 13 somatic symptoms of the PHQ (items 1a-1m). Also, 2 items from the depression module (sleep and tired) are scored 0 (“not at all”), 1 (“several days”) or 2 (“more than half the days” or “nearly every day”). Thus, a PHQ-15 score can be derived from page 1 of the PHQ, or from separate administration of the PHQ-15 scale or the PHQ-SADS. PHQ-15 scores of 5, 10, and 15 represent cutpoints for low, medium, and high somatic symptom severity, respectively.

Sensitivity to Change for Monitoring Treatment Outcomes. A particularly important use of a measure is its responsiveness to changes of condition severity over time. This is well-established for the PHQ-9 which is increasingly used as a measure to assess the level of depression severity (for initial treatment decisions) as well as an outcome tool (to determine treatment response).[6,10] An example of how different PHQ-9 severity levels might guide treatment is shown in Table 4, page 7. There is preliminary evidence that the PHQ-15 may be responsive to changes as individuals with somatoform disorders or high somatization are treated.[10] The GAD-7 has demonstrated change as a secondary anxiety outcome in several depression trials, but has not yet been studied as a primary outcome in anxiety trials. Also, since there is more diagnostic splitting for anxiety than for depressive disorders, it remains to be determined whether a single anxiety measure can suffice as an outcome measure. It is likely the GAD-7 will be useful but not yet certain it will be sufficient.
Psychometrics. The psychometrics of the PHQ and its component scales are described in the validation articles for specific measures (see Selected References on page 9) and are summarized in a review article on the PHQ-9, GAD-7, and PHQ-15.[10]

Table 4. PHQ-9 Scores and Proposed Treatment Actions *

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Depression Severity</th>
<th>Proposed Treatment Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 4</td>
<td>None-minimal</td>
<td>None</td>
</tr>
<tr>
<td>5 – 9</td>
<td>Mild</td>
<td>Watchful waiting; repeat PHQ-9 at follow-up</td>
</tr>
<tr>
<td>10 – 14</td>
<td>Moderate</td>
<td>Treatment plan, considering counseling, follow-up and/or pharmacotherapy</td>
</tr>
<tr>
<td>15 – 19</td>
<td>Moderately Severe</td>
<td>Active treatment with pharmacotherapy and/or psychotherapy</td>
</tr>
<tr>
<td>20 – 27</td>
<td>Severe</td>
<td>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</td>
</tr>
</tbody>
</table>

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

TRANSLATIONS

There are numerous translations of the PHQ as well as the PHQ-9 and GAD-7 available in many languages, which are freely downloadable on the PHQ website (www.phqscreeners.com). The abbreviated versions of these measures – PHQ-8, PHQ-2, GAD-2, and PHQ-4 – can simply be derived from the translations by selecting the relevant items (see Table 1, page 3). The PHQ-15 can also be simply derived by selecting the 13 somatic items (1a-1m), plus the sleep and tired items (2c and 2c) from the PHQ translations.

Many of the translations have been developed by the MAPI Research Institute using an internationally accepted translation methodology. Thus, most of the translations are linguistically valid. However, unlike the English versions of the PHQ and GAD-7, few of the translations have been psychometrically validated against an independent structured psychiatric interview.

If a translation is not available for a language you are interested in using, and you have the interest and resources to develop a linguistically valid translation, please send an e-mail to questions@phqscreeners.com for instructions on how to proceed. One requirement is that we are provided a copy of the final translation as well as a description of the translation methodology.
WEBSITE
Copies of the PHQ family of measures, including the GAD-7, are available at the website:

www.phqscreeners.com

Also, translations, a bibliography, an instruction manual, and other information is provided on this website.

QUESTIONS NOT ADDRESSED IN THIS INSTRUCTION DOCUMENT
For further questions, please send an e-mail to questions@phqscreeners.com

QUESTIONS REGARDING DEVELOPMENT, ACKNOWLEDGMENTS AND USE
The PHQ family of measures (see Table 1, page 3), including abbreviated and alternative versions as well as the GAD-7, were developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

All of the measures included in Table 1 are in the public domain. No permission is required to reproduce, translate, display or distribute.
SELECTED REFERENCES


Modified Mini Screen (MMS)

Patient Name: ___________________________ Date: ___________________________

Section A – Please circle "yes" or "no" for each question.

1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks? ................................................................. Yes No

2. In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time? ............................................. Yes No

3. Have you felt sad, low, or depressed most of the time for the last two years? ................................................................. Yes No

4. In the past month, did you think that you would be better off dead or wish you were dead? ........ Yes No

5. Have you ever had a period of time when you were feeling up, hypor, or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.) ......................... Yes No

6. Have you ever been so irritable, grouchy, or annoyed for several days, that you had arguments, had verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way? ................................................................. Yes No

Section B – Please circle "yes" or "no" for each question.

7. Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable, or uneasy, even when most people would not feel that way? Did these intense feelings get to be their worst within ten minutes? (If the answer to both questions is "yes," circle "yes"; otherwise circle "no.") ................................................................. Yes No

8. Do you feel anxious or uneasy in places or situations where you might have the panic-like symptoms we just spoke about? Or do you feel anxious or uneasy in situations where help might not be available or escape might be difficult? Examples: ○ being in a crowd, ○ standing in a line, ○ being alone away from home or alone at home, ○ crossing a bridge, ○ traveling in a bus, train, or car? ............................................................................................................................................................................................................................................................................. Yes No

9. Have you worried excessively or been anxious about several things over the past six months? (If you answer "no" to this question, answer "no" to Question 10 and proceed to Question 11.) ... Yes No

10. Are these worries present most days? ............................................................................................................................................................................................................................................................................. Yes No

11. In the past month, were you afraid or embarrassed when others were watching you or when you were the focus of attention? Were you afraid of being humiliated? Examples: ○ speaking in public, ○ eating in public or with others, ○ writing while someone watches, ○ being in social situations. ................................................................. Yes No

continued on other side
12. In the past month, have you been bothered by thoughts, impulses, or images that you couldn't get rid of that were unwanted, distasteful, inappropriate, intrusive, or distressing? Examples: ○ being afraid that you would act on some impulse that would be really shocking, ○ worrying a lot about being dirty, contaminated, or having germs, ○ worrying a lot about contaminating others, or that you would harm someone even though you didn't want to, ○ having fears or superstitions that you would be responsible for things going wrong, ○ being obsessed with sexual thoughts, images, or impulses, ○ hoarding or collecting lots of things, ○ having religious obsessions. ................................................................. Yes  No

13. In the past month, did you do something repeatedly without being able to resist doing it? Examples: ○ washing or cleaning excessively, ○ counting or checking things over and over, ○ repeating, collecting, or arranging things, ○ other superstitious rituals. ................................................................. Yes  No

14. Have you ever experienced, witnessed, or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples: ○ serious accidents, ○ sexual or physical assault, ○ terrorist attack, ○ being held hostage, ○ kidnapping, ○ fire, ○ discovering a body, ○ sudden death of someone close to you, ○ war, ○ natural disaster. ................................................................. Yes  No

15. Have you re-experienced the awful event in a distressing way in the past month? Examples: ○ dreams, ○ intense recollections, ○ flashbacks, ○ physical reactions. ................................................................. Yes  No

Section C – Please circle “yes” or “no” for each question.

16. Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you? ................................................................. Yes  No

17. Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking? ................................................................. Yes  No

18. Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Or, have you ever felt that you were possessed? ................................................................. Yes  No

19. Have you ever believed that you were being sent special messages through the TV, radio, or newspaper? Did you believe that someone you did not personally know was particularly interested in you? ................................................................. Yes  No

20. Have your relatives or friends ever considered any of your beliefs strange or unusual? ................................................................. Yes  No

21. Have you ever heard things other people couldn't hear, such as voices? ................................................................. Yes  No

22. Have you ever had visions when you were awake or have you ever seen things other people couldn't see? ................................................................. Yes  No
SCREENING FOR CO-OCCURRING DISORDERS USING THE MODIFIED MINI SCREEN (MMS)

USER'S GUIDE

(Rev. 6/05)
ACKNOWLEDGEMENTS

This user guide was developed by the NYS Practice Improvement Collaborative (PIC) under a grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. It was compiled by PIC Project Director Susan Brandau, in collaboration with the NKI Research team, specifically Mary Jane Alexander and Gary Haugland. We are grateful for suggestions received from pilot trainees that were ultimately incorporated into the document. Some of the content for this manual was adapted from the following sources:

Summary of the California Board of Corrections Mentally Ill Offender Crime Reduction Grant Project Manager’s Meeting presentation conducted by Roger H. Peters, PhD and Richard K. Sherman, MS, October 4, 2001.

The Modified Mini Screen (MMS) is a 22 item scale designed to identify persons in need of an assessment in the domains of Mood Disorders, Anxiety Disorders and Psychotic Disorders. The questions are based on gateway questions and threshold criteria found in the Diagnostic and Statistical Manual IV (DSM-IV)$^1$, the Structured Clinical Interview for Diagnosis (SCID)$^2$ and the Mini International Neuropsychiatric Interview (M.I.N.I.)$^3$. 
WHAT ARE CO-OCCURRING DISORDERS?

A person who has alcohol or drug abuse/dependence and emotional/psychiatric problems is said to have co-occurring disorders. To recover fully, treatment is required for both problems.

HOW PREVALENT ARE CO-OCCURRING DISORDERS?

- According to a face-to-face survey of people in randomly sampled households across the U.S., thirty-seven percent of alcohol abusers and fifty-three percent of drug abusers also have at least one mental disorder.
- According to the National Household Survey on Drug Abuse, within the diagnosed mentally ill population, twenty percent currently abuse either alcohol or drugs and sixty percent will have abused either substance during their lifetime.
- Individuals with mental disorders are at increased risk for developing a substance abuse disorder and conversely, people with substance abuse disorders are at increased risk for developing a mental disorder.

WHAT TYPES OF MENTAL OR EMOTIONAL PROBLEMS ARE SEEN WITH PEOPLE WITH CO-OCCURRING DISORDERS?

Psychiatric problems commonly found in persons with co-occurring disorders can be arranged under four main categories:

- **Mood Disorders** are characterized by extreme emotions such as major depression, bipolar disorder (formerly called manic-depression) and dysthymia (a milder but chronic form of depression).
- **Anxiety Disorders** are characterized by powerful fears and avoidance behaviors. They include Post Traumatic Stress Disorder; Obsessive-Compulsive Disorder (obsession are unavoidable thoughts and compulsions are unavoidable behaviors); Social Phobias (e.g., excessive shyness); Agoraphobia (fear of being in crowds or places with no easy exit); Panic Attacks; and generalized, non-specific anxieties.
- *Psychotic Disorders* include severe illnesses such as schizophrenia. These disorders are characterized by unusual thoughts and beliefs, often at odds with evidence apparent to others and the behaviors that result from acting on those ideas. Visual or auditory hallucinations, extreme paranoia and delusional thoughts may be present.

- *Personality Disorders* are characterized by enduring and inflexible patterns of experience and behavior, across a broad range of personal and social situations, that markedly differ from the expectations of a person’s culture, and that lead to either significant distress or impaired function in important life domains. (Personality disorder items are not included in the Modified Mini Screen.)

**WHAT ARE THE GENERAL CHARACTERISTICS OF PATIENTS WITH CO-OCCURRING DISORDERS?**

- Substance abuse and mental disorders have biological, psychological, and social components, so people with co-occurring disorders have disabilities, disadvantages, and psychosocial problems that interact with each other.
- Co-occurring disorders occur across the lifespan in both men and women.
- When one or both disorders are severe, consequences include inability to maintain stable housing or to stay employed, repeated cycles through treatment, probation, jail, or prison.
- Use of even small amounts of alcohol or drugs may trigger recurrence of mental health symptoms.

**WHAT ARE THE TREATMENT RELATED CHARACTERISTICS OF A PATIENT WITH CO-OCCURRING DISORDERS?**

Patients with one or more severe co-occurring disorders are likely to use services only when in crisis, to be minimally engaged in treatment, and to be involved with the criminal justice system.

Some specific characteristics are:

- More rapid progression from initial use to substance dependence
- Poor adherence to medication
- Decreased likelihood of treatment compliance
- Greater rates of hospitalization
- More frequent suicidal behavior especially for clients with schizophrenia spectrum, major depressive or bipolar disorders. Fifteen to 25% of suicides
are committed by persons who abuse alcohol. Suicide may also be associated with intoxication or withdrawal from addictive substances.

- Difficulties in social functioning
- Shorter time in remission of symptoms

In addition, individuals with severe disorders are:

- More sensitive to substance effects
- Unlikely to develop dependence or medical signs of sustained, heavy use
- More likely to encounter substances and pressure to use
- More likely to experience negative outcomes

WHAT ARE THE BEHAVIORAL CHARACTERISTICS OF PATIENTS WITH CO-OCCURRING DISORDERS?

People with mental disorders will have the characteristics of the disorder they suffer from. Those with severe mental illness may have:

- Difficulty comprehending or remembering important information
- Inability to recognize the consequences of behavior, thereby affecting the ability to plan
- Poor judgment
- Disorganization
- Limited attention span
- Poor response to confrontation

They are likely to use substances to:

- Combat loneliness, social anxiety, boredom, insomnia
- Deal with stress or strong emotions like anger, pain, shame, guilt
- Relieve specific symptoms of mental illness or medication side effects

WHAT BENEFITS ARE ASSOCIATED WITH RECOVERY FOR PATIENTS WITH CO-OCCURRING DISORDERS?

- Regular engagement in enjoyable activity
- Decent, stable housing
- Loving relationships with someone sober who accepts person’s mental illness
- Positive, valued relationship with treatment professional
- When actively engaged in treatment, clients with co-occurring disorders are actually more likely to attend outpatient groups
WHAT IS THE PURPOSE OF SCREENING FOR CO-OCCURRING DISORDERS?

The purpose of a screening instrument—such as the Modified Mini Screen—in chemical dependency treatment settings is to identify patients with a high likelihood of having a mental illness that could compromise successful treatment outcomes. A high screen score will prompt a referral for a more thorough psychiatric assessment. Screening should be completed in a timely manner to assist in developing a comprehensive treatment plan, as required by OASAS Chemical Dependency Regulations. It should be noted that screening is a process for evaluating the possible presence of a problem while assessment is a process for defining the nature of that problem and developing specific treatment recommendations to address that problem. While screening can be conducted by any trained clinician, assessments can only be conducted by licensed practitioners.

High prevalence, low treatment and low engagement rates, as well as the under identification of co-occurring disorders in treatment settings highlight the need for better detection and assessment procedures. Treatment outcomes have been poor for chemical dependency clients who have mental disorders. The absence of assessment of co-occurring disorders has been identified as a major barrier to effective treatment and prevention. The screening process allows a clinician to assess whether there are signs that a patient with a substance abuse disorder has a mental disorder as well. If a problem is identified, the patient should be referred for a more detailed assessment and an appropriate referral. Adequate assessment of the full picture of a patient’s co-occurring disorder occurs over time in an established trusting relationship with a skilled clinician.

Screening for mental disorders is the first step in good clinical practice for patients with co-occurring disorders. Screening demonstrates to the patient that the program is committed to identifying and addressing the full range of their problems. The therapeutic relationship is initiated when these problems are brought out into the open and treatment options and limits are discussed in a context of respect and acceptance.

WHEN SHOULD SCREENING OCCUR?

Alcohol and substance abuse greatly influence symptoms of mental illness, and vice versa. Abuse of addictive substances like alcohol, opiates, and cocaine may precipitate mental disorders like depression and psychotic disorders are
sometimes secondary to use of crack cocaine, hallucinogens, alcohol, and ecstasy. On the other hand, withdrawal from substances may exacerbate symptoms of mental disorders when substance use has been a way for the person to cope with depression, loneliness, boredom, or anxiety. When both disorders are identified, they should be considered as primary and should be treated. In addition, HIV and Hep-C positive patients may exhibit symptoms, such as dementia, due to the disease itself or the medication regimen. Substance related affective symptoms (depression, mania) usually clear within two weeks of abstinence; psychotic symptoms usually clear within days to a week of abstinence while symptoms of anxiety may take up to six months to clear. Administration of the Modified Mini Screen after two weeks of abstinence is recommended. The goal is to screen the patient when their sensorium is not clouded by alcohol or other drugs and/or the withdrawal of substances—at a minimum, the patient should be stabilized prior to screening. Thereafter, a clinician may conduct subsequent screens as appropriate based upon their clinical judgment and as per the program’s policies and procedures. CLINICAL OBSERVATIONS BY STAFF SHOULD NEVER BE REPLACED BY ANY SCREENING TOOL.

It is the program’s responsibility to develop a written implementation plan that identifies the specific screening procedures that the provider will adhere to. A suggested implementation guide has been developed to assist in this process which identifies a range of issues relative to implementation.

HOW ACCURATE IS SCREENING?

Screens are first line identifiers and as such, are imperfect. They may either under identify or over identify the condition they are designed to detect. Standard screens help avoid these problems, and follow up assessments are key to adequately identifying and incorporating co-occurring disorders into a comprehensive treatment plan.

When an effective screen like the Modified Mini Screen is implemented properly, staff is more likely to identify someone who truly has mental illness but will incorrectly identify some others as exhibiting signs or symptoms of mental illness when a mental illness is not present. Screening increases the likelihood of discovering high-risk cases; only a relatively small percentage of mental health assessments are conducted when they are not needed.
WHAT IS THE MODIFIED MINI SCREEN (MMS)?

The Modified Mini Screen is a 22 item questionnaire that may be administered by a clinician in about 15 minutes. The tool uses a set of “gateway” questions that relate to signs of distress that may be attributed to a diagnosable psychiatric disorder; however, NO SPECIFIC DIAGNOSIS SHOULD BE INFERRRED. The screen is divided into 3 sections to capture the three major categories of mental illness as follows:

Section A – Mood Disorders
Section B – Anxiety Disorders
Section C – Psychotic Disorders

HOW SHOULD THE MODIFIED MINI SCREEN BE SCORED?

Scoring of the Modified Mini Screen is straightforward and additive—each YES in the screen counts as 1. The clinician adds all the positive responses for a total score which ranges from 1 to 22. Remember, if a patient answers YES to questions, that does not mean they are mentally ill; it simply means that they are reporting distress. It is the responsibility of each program to determine, based upon their patient population, the “score” that will trigger a referral for a complete psychiatric assessment based upon the continuum on the next page. Once a patient has been screened, the results should be utilized to inform the development of the patient’s individualized treatment plan. Follow up may be required to ensure that a patient receives an assessment in a timely manner. In addition, a program may need to utilize resources such as primary care physicians if access to standard mental health services is limited.
WHAT SCORE SHOULD TRIGGER A REFERRAL FOR A MENTAL HEALTH ASSESSMENT?

It is useful to view a Modified Mini Screen score as having three distinct zones as follows:

ZONE 1  ZONE 2  ZONE 3
1  2  3  4  5  6  7  8  9  10  11  12.

Low likelihood of MI  Moderate likelihood of MI  High likelihood of MI

Zone 1 GREEN—no further action is indicated, based only on the screen
Zone 2 YELLOW—the patient should be seriously considered for referral for a
detailed diagnostic assessment
Zone 3 RED—the patient should definitely be referred for a diagnostic assessment

In addition, question 4 relates to suicidality. Any patient who answers YES to
this should be referred for further evaluation regardless of the total score.
Questions 14 and 15 refer to Post-Traumatic Stress Disorder (PTSD). PTSD
is not only combat related, but also related to experiences of physical and
sexual abuse, as well as other trauma. If BOTH questions 14 and 15 are
answered YES, the client should be referred for further evaluation regardless
of the patient’s total score.

WHAT IF THE PATIENT SCORES WITHIN ZONE 2?

Any patient score within Zone 2 requires some clinical judgment as to
whether or not the patient should be referred for a detailed diagnostic
assessment. Each agency has its own policies and procedures that should be
followed. At the low end of Zone 2, more patients without a disorder will be
identified while scores at the high end will result in more patients with mental
health disorders being missed.
References


**The Mood Disorder Questionnaire**

**Instructions:** Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and...
   - ...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?
   - ...you were so irritable that you shouted at people or started fights or arguments?
   - ...you felt much more self-confident than usual?
   - ...you got much less sleep than usual and found you didn't really miss it?
   - ...you were much more talkative or spoke much faster than usual?
   - ...thoughts raced through your head or you couldn't slow your mind down?
   - ...you were so easily distracted by things around you that you had trouble concentrating or staying on track?
   - ...you had much more energy than usual?
   - ...you were much more active or did many more things than usual?
   - ...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?
   - ...you were much more interested in sex than usual?
   - ...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?
   - ...spending money got you or your family into trouble?

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please circle one response only.
   - No problem
   - Minor problem
   - Moderate problem
   - Serious problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?

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The MDQ was developed by a team of psychiatrists, researchers and consumer advocates to address a critical need for timely and accurate diagnosis of bipolar disorder, which can be fatal if left untreated. The questionnaire takes about five minutes to complete, and can provide important insights into diagnosis and treatment. Clinical trials have indicated that the MDQ has a high rate of accuracy; it is able to identify seven out of ten people who have bipolar disorder and screen out nine out of ten people who do not.

A recent National DMDA survey revealed that nearly 70% of people with bipolar disorder had received at least one misdiagnosis and many had waited more than 10 years from the onset of their symptoms before receiving a correct diagnosis. National DMDA hopes that the MDQ will shorten this delay and help more people to get the treatment they need, when they need it.

The MDQ screens for Bipolar Spectrum Disorder; (which includes Bipolar I, Bipolar II and Bipolar NOS).

If the patient answers:

1. "Yes" to seven or more of the 13 items in question number 1;
   AND

2. "Yes" to question number 2;
   AND

3. "Moderate" or "Serious" to question number 3;

you have a positive screen. All three of the criteria above should be met. A positive screen should be followed by a comprehensive medical evaluation for Bipolar Spectrum Disorder.

ACKNOWLEDGEMENT: This instrument was developed by a committee composed of the following individuals: Chairman, Robert M.A. Hirschfeld, MD – University of Texas Medical Branch; Joseph R. Calabrese, MD – Case Western Reserve School of Medicine; Laurie Flynn – National Alliance for the Mentally Ill; Paul E. Keck, Jr., MD – University of Cincinnati College of Medicine; Lydia Lewis – National Depressive and Manic-Depressive Association; Robert M. Post, MD – National Institute of Mental Health; Gary S. Sachs, MD – Harvard University School of Medicine; Robert L. Spitzer, MD – Columbia University; Janet Williams, DSW – Columbia University and John M. Zajecka, MD – Rush Presbyterian-St. Luke’s Medical Center.

Primary Care PTSD Screen (PC-PTSD)

Prins, Ouimette, Kimerling et al., 2003

Description
The PC-PTSD is a 4-Item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.

Scale

Instructions
In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?

   YES / NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

   YES / NO

3. Were constantly on guard, watchful, or easily startled?

   YES / NO

4. Felt numb or detached from others, activities, or your surroundings?

   YES / NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.

References

primary care PTSD screen (PC-PTSD): Corrigendum. *Primary Care Psychiatry*, 9, 151

**Additional Reviews**

**Orsillo (2001) p. 299**


**Norris and Hamblen (2004) p. 71**


**To obtain scale:**

See above where scale is made available on this page.

Standardised Assessment of Personality – Abbreviated Scale (SAPAS): preliminary validation of a brief screen for personality disorder
PAUL MORAN, MORVEN LEESE, TENNYSON LEE, PAUL WALTERS, GRAHAM THORNicroft and ANTHONY MANN
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Standardised Assessment of Personality – Abbreviated Scale (SAPAS): preliminary validation of a brief screen for personality disorder

PAUL MORAN, MORVEN LEES, TENNYSON LEE, PAUL WALTERS, GRAHAM THORNCROFT and ANTHONY MANN

Background There is a need for a brief and simple screen for personality disorders that can be used in routine psychiatric assessments.

Aims To test the concurrent validity and test—retest reliability of a brief screen for personality disorder.

Method Sixty psychiatric patients were administered a brief screening interview for personality disorder. On the same day, they were interviewed with an established assessment for DSM—IV personality disorder. Three weeks later, the brief screening interview was repeated in order to examine test—retest reliability.

Results A score of 3 on the screening interview correctly identified the presence of DSM—IV personality disorder in 90% of participants. The sensitivity and specificity were 0.94 and 0.85 respectively.

Conclusions The study provides preliminary evidence of the usefulness of the screen in routine clinical settings.

Declaration of interest None.

Personality disorder can significantly affect the management and outcome of associated mental illness (Patience et al., 1995; Yonkers et al., 2000). An assessment of personality status should therefore ideally form part of the routine assessments conducted by psychiatric teams (Moran et al., 2003; Tyrer & Simmons, 2003). However, too often the assessment of personality disorder remains one of clinical judgement. Unfortunately, clinical diagnoses are unreliable (Mellasp & et al., 1982), and although reliability can be improved by the use of standardised assessments, these assessments are lengthy and require training. Self-report questionnaires are useful research tools, but they can be tiring for patients because they require the ability to concentrate on written questions. A brief structured interview with the patient would overcome some of these problems provided it could be easily incorporated into a standard psychiatric interview. This paper reports on the preliminary validation of a brief structured interview for personality disorders that is feasible for use in routine clinical assessment.

METHOD

Participants A non-random sample of 60 adult patients was recruited from out-patient clinics (n=24), in-patient units (n=24) and day units (n=12) within the South London and Maudsley National Health Service (NHS) Trust. No special attempt was made to select patients with known or suspected personality disorder; however, the sample was chosen to represent patients with a range of psychiatric problems. Patients were also chosen on the basis that they were stable and cooperative with being interviewed. None of the patients was acutely unwell at the time of recruitment. Out-patients and day patients were recruited directly at the time of clinic or day hospital attendance, and in-patients were interviewed on the hospital ward. The sample consisted of 34 women and 26 men, with an mean age of 43 years (s.d.=15.9). The clinical diagnoses of the sample were as follows: affective disorder (n=25), anxiety disorder (n=11), eating disorder (n=9), schizophrenia (n=9) and drug or alcohol dependence (n=6).

Measures Screening questionnaire

The screening questionnaire consisted of eight dichotomously rated items taken from the opening section of an informant-based interview, the Standardised Assessment of Personality (SAP) (Mann et al., 1981; Pilgrim & Mann, 1990; Pilgrim et al., 1993). The SAP allows an ICD-10 or DSM-IV diagnosis of personality disorder to be made (World Health Organization, 1992; American Psychiatric Association, 1994). Each of the eight questions from the opening section of the SAP corresponds to a descriptive statement about the person and can be scored 0 or 1 (see Appendix). The scores on the eight items can be added together to produce a total score between 0 and 8.

An exploratory analysis of the SAP ratings of a sample of 303 primary care attenders (Moran et al., 2001; Renda et al., 2002) showed that the total score on these eight official probe items satisfactorily predicted the final SAP Diagnosis of personality disorder obtained after more detailed questioning of the informant: area under the curve (AUC)=0.79, 95% CI 0.74–0.84. The performance of these eight items suggested that they might also act as a patient-based screen for a diagnosis of personality disorder. However, the SAP is an informant-based interview and it was unclear how well the probe items would perform when given to patients as opposed to informants. The examination of the psychometric properties of the patient-based screen, the Standardised Assessment of Personality – Abbreviated Scale (SAPAS), formed the basis of this study.

SCID—II

The Structured Clinical Interview for DSM—IV Personality Disorders (SCID—II) (First et al., 1997) is a 119-item semi-structured interview with the patient. Each item is scored as 1 (absent), 2 (sub-threshold) or 3 (threshold). Questions may
necessitate further exploration by the interviewer in order to score a particular item. If a threshold is reached on a sufficient number of items, the category of personality disorder is deemed to be present. The SCID-II was designed to generate DSM–III–R (American Psychiatric Association, 1987) diagnoses; however, by eliminating items for passive-aggressive and depressive personality disorders, it can be used to generate DSM–IV personality disorder diagnoses. The instrument demonstrates acceptable test–retest (k=0.68) and interrater reliability (k=0.71) and takes up to 1 h to administer.

Procedure
A member of the clinical team (either a doctor or a nurse) interviewed the patient with the SAPAS, as part of routine clinical work. Shortly afterwards, the patient was interviewed with the SCID–II by one of the authors (P.M.). The majority (83%, n=50) of SCID–II assessments were conducted blind to the results of the screening mini-interview. In the case of 10 patient interviews, no staff member was available to conduct the SAPAS and P.M. therefore conducted both interviews. Approximately 3 weeks later (mean interval 20 days, s.d.=10), each patient was re-interviewed by the same person using the SAPAS.

Analysis
Analyses were performed using STATA version 7 (StataCorp, 1999). The main aim of analysis was to identify an appropriate cut-off score on the SAPAS for predicting a SCID–II (DSM–IV) diagnosis of personality disorder. This was achieved by undertaking an AUC analysis. The performance of the SAPAS at different cut-off scores was assessed by reference to the sensitivity, specificity and predictive values of the screening interview. The internal consistency of the SAPAS was assessed by calculating Cronbach’s α on the total score after omitting each item and also overall. The test–retest reliability of each item was estimated by calculating the κ coefficient, and the overall reliability of the total score was estimated using Lin’s concordance coefficient (Lin, 1989). Interrater reliability is not a major issue since the questions are largely self-explanatory and no interpretation is placed on responses.

**Table 1** Internal consistency and test–retest reliability of the Standardised Assessment of Personality – Abbreviated Scale items. The alpha coefficient for the total score is 0.68 and Lin’s concordance coefficient for the total score is 0.89

<table>
<thead>
<tr>
<th>Item</th>
<th>Alpha coefficient if item omitted</th>
<th>Kappa coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty making and keeping friends</td>
<td>0.59</td>
<td>0.81</td>
</tr>
<tr>
<td>Usually a loner</td>
<td>0.63</td>
<td>0.83</td>
</tr>
<tr>
<td>Trusting others</td>
<td>0.57</td>
<td>0.79</td>
</tr>
<tr>
<td>Normally loses temper easily</td>
<td>0.66</td>
<td>0.83</td>
</tr>
<tr>
<td>Normally impulsive</td>
<td>0.72</td>
<td>0.61</td>
</tr>
<tr>
<td>Normally a worrier</td>
<td>0.62</td>
<td>0.62</td>
</tr>
<tr>
<td>Depends on others a lot</td>
<td>0.68</td>
<td>0.82</td>
</tr>
<tr>
<td>Generally a perfectionist</td>
<td>0.70</td>
<td>0.73</td>
</tr>
</tbody>
</table>

**RESULTS**

A total of 33 out of 60 patients received a SCID–II diagnosis of personality disorder, giving an overall prevalence of 55% (95% CI 42–68). The mean number of personality disorder diagnoses among those with any personality disorder was 2.1 (s.d.=1.2). Table 1 shows the α and κ coefficients of each item from the SAPAS and overall reliability coefficients. This shows that there is a moderate degree of overall internal consistency (0.68). ‘Normally impulsive’ and ‘Generally a perfectionist’ are the items least consistent with the rest. The test–retest reliability is reasonable and individual κ values are also acceptable, although the values for ‘Normally impulsive’ and ‘Normally a worrier’ are less. ‘Normally impulsive’ would seem to be the least satisfactory item, taking both internal consistency and test–retest reliability into account.

To investigate the use of alternative cut-off scores on the SAPAS, a logistic regression was employed with the SAPAS total score as predictor and SCID–II diagnosis as dependent variable. This analysis produced an AUC of 0.94 (95% CI 0.88–0.99). To assess the sensitivity and specificity of the SAPAS for various cut-off scores, a sensitivity–specificity plot was obtained (Fig. 1). This indicates that a probability cut-off of 0.65 for a positive SCID diagnosis (equivalent to a total SAPAS score of between 3 and 4) has approximately equal sensitivity and specificity, with both around 0.8. The performance of the SAPAS at a range of cut-off scores is displayed in Table 2; this shows that a cut-off score of 3 or 4 correctly classified over 80% of the patients. Although both thresholds

![Fig 1 Sensitivity–specificity plot relating Structured Clinical Interview for DSM–IV Personality Disorders positive diagnosis to total score on the Standardised Assessment of Personality — Abbreviated Scale.](image-url)
Table 2  Sensitivity, specificity and power to predict personality disorder at different cut-off scores of the Standardised Assessment of Personality — Abbreviated Scale

<table>
<thead>
<tr>
<th>Cut-off score</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>Positive predictive value</th>
<th>Negative predictive value</th>
<th>Correctly classified (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 or more</td>
<td>0.97</td>
<td>0.44</td>
<td>0.68</td>
<td>0.92</td>
<td>73</td>
</tr>
<tr>
<td>3 or more</td>
<td>0.94</td>
<td>0.85</td>
<td>0.89</td>
<td>0.92</td>
<td>90</td>
</tr>
<tr>
<td>4 or more</td>
<td>0.82</td>
<td>0.89</td>
<td>0.90</td>
<td>0.80</td>
<td>85</td>
</tr>
<tr>
<td>5 or more</td>
<td>0.58</td>
<td>1.0</td>
<td>1.0</td>
<td>0.66</td>
<td>77</td>
</tr>
</tbody>
</table>

Fig. 2  Scatter plot showing the effect of prevalence of personality disorder on the positive predictive value of the Standardised Assessment of Personality — Abbreviated Scale.

performed similarly, arguably the cut-off score of 3 offers the best balance of sensitivity (0.94) and specificity (0.85) and gives the maximum total of these two measures. When the ten non-blind assessments were excluded the AUC was 0.92 (95% CI 0.85–0.99), and at a cut-off of 3 the sensitivity was 92% and the specificity was 84%, indicating that the full sample had not been biased by the inclusion of these cases.

A scatter plot showing the positive predictive value of the screen at different cut-off scores of the SAPAS (Fig. 2) allows the effect of assuming various levels of population prevalence to be judged.

DISCUSSION

Performance of the SAPAS

A score of 3 or 4 on the SAPAS correctly identified the presence of personality disorder in over 80% of participants. The study therefore provides preliminary evidence of the usefulness of the SAPAS as a screen for personality disorder in routine clinical settings. The findings should, however, be treated with caution, taking into account a number of limitations.

First, the study relied on a small, non-random sample of stable and cooperative patients with a high prevalence of personality disorder. Although the screen performed acceptably in this population, if it were to be applied to a population with a lower prevalence of personality disorder, its predictive power would diminish (Fig. 2). Consequently, the screen is probably not suitable for use in general community or primary care settings, where the prevalence of personality disorder is in the range 10–20%. Samuels et al (2002) estimated that the prevalence of DSM-IV personality disorders in a community sample was 9%. Thus, from Fig. 2, based on this prevalence, the positive predictive power of the SAPAS in a community sample would be between 40% and 30%. In addition, although sensitivity and specificity are independent of the prevalence of a disorder in a population, measures may be more or less applicable to different populations. The findings therefore require replication in larger and more diverse populations of psychiatric patients.

Second, our choice of the SCID-II as the criterion for validation of the SAPAS may be questioned. However, the validity of the assessment measures for personality disorder has yet to be firmly established and none has been proved superior to any other (Zimmerman, 1994). The SCID-II was chosen as the gold standard because it has been widely used and its psychometric properties are well established (Zimmerman, 1994).

Third, we did not examine the ability of the SAPAS to discriminate between either sub-categories or clusters of personality disorder. In clinical practice, patients with personality disorders usually fulfill diagnostic criteria for more than one sub-category of disorder (McGlashan et al, 2000) and it therefore makes little sense to screen for individual categories of personality disorder. In addition, the identification of sub-categories and clusters of personality disorder requires a more sophisticated diagnostic approach than that afforded by the SAPAS.

Comparison with existing screening methods for personality disorder

A number of self-report questionnaires are available for the purpose of screening for personality disorder. These include the International Personality Disorder Examination Screen (Lenzenweger et al, 1997), the Personality Diagnostic Questionnaire—Revised (Hyler et al, 1992) and the SCID-II Screen (Ekzellus et al, 1994). Although these instruments are of some value to researchers interested in identifying 'high-risk' populations, when compared with a structured interview their specificity is invariably poor. In addition, they require the ability of the respondent to concentrate on a long set of questions.

To the best of our knowledge, only two other interviewer-administered screens for personality disorder have been published. Langbehn et al (1999) have developed the Iowa Personality Disorder Screen (IPDS) to provide a mini-structured interview that the authors estimate can be completed in 5 min. The IPDS consists of 11 questions that address general personality disorder criteria as well as specific criteria. The instrument has been validated against the Structured Interview for DSM-IV Personality Disorders (SIDP-IV) (Pfohl et al, 1997).
The authors reported excellent sensitivity (92%) and good specificity (79%), although the validation was a somewhat circular exercise, as the IPDS items were derived from the DSM-III-R version of the SIDP. Van Horn et al (2000) have developed a structured patient interview for personality disorders, the Rapid Personality Assessment Schedule (PAS-R). However, the PAS-R requires staff training and performs moderately well as a screen for personality disorder when compared with the full version of the PAS (sensitivity 64%, specificity 82%).

In this preliminary validation exercise, the SAPAS showed superior psychometric performance compared with both the IPDS and the PAS-R. In addition, the SAPAS is short (no interview took longer than 2 min to complete), does not require training, is simple to use, and was acceptable to the respondents in this study. It therefore fulfills many of the criteria for a desirable screening test (Brewin et al, 2002).

**Potential applications of the SAPAS**

The SAPAS could be used to identify individuals who are at potentially high risk of having any type of personality disorder in a general adult psychiatric setting. The screen itself should not be used to make a diagnosis of personality disorder or cluster of personality disorders, and we would advise that a person scoring more than 3 on the SAPAS should be interviewed with a detailed structured assessment of personality. Clinicians and investigators might wish to adopt higher or lower thresholds, depending on the nature of the sample and the relative importance to them of sensitivity and specificity.

We think that the screen could have both clinical and epidemiological applications. It is feasible for use in busy clinical settings and could therefore be used to identify individuals in need of a more detailed personality assessment. Although the assessment of personality soon after presentation might result in inflated estimates of personality disorder, this is often the time when treatment decisions are made, and if personality assessments are to have useful treatment implications, arguably they should be made at an early stage (Zimmerman, 1994). From an epidemiological perspective, the SAPAS could be used as a first-stage screen as part of a two-stage procedure for case identification (Lenzenweger et al, 1997; Mann et al, 1999).

**ACKNOWLEDGEMENTS**

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**APPENDIX**

**Standardised Assessment of Personality – Abbreviated Scale**

Only circle Y (yes) or N (no) in the case of question 3 if the patient thinks that the description applies most of the time in most situations.

1. In general, do you have difficulty making and keeping friends? ............... Y/N (yes=1, no=0)

2. Would you normally describe yourself as a loner? ............... Y/N (yes=1, no=0)

3. In general, do you trust other people? ............... Y/N (yes=0, no=1)

4. Do you normally lose your temper easily? ............... Y/N (yes=1, no=0)

5. Are you normally an impulsive sort of person? ............... Y/N (yes=1, no=0)

6. Are you normally a worrier? ............... Y/N (yes=1, no=0)

7. In general, do you depend on others a lot? ............... Y/N (yes=1, no=0)

8. In general, are you a perfectionist? ............... Y/N (yes=1, no=0)

**REFERENCES**


