

## SECTION 10: EMOTIONAL AND SEXUAL HEALTH CARE

Concern	Care/Test	Frequency
Emotional/Sexual Health Care	◆ Assess emotional health; screen for depression .....	Each focused visit
	◆ Assess sexual health concerns .....	Each focused visit

Main topics included in this section:

- ◆ Depression and Other Psychological Disorders
- ◆ Postpartum Depression
- ◆ Depression Screening
- ◆ Treatment for Depression
- ◆ Encouraging Self-Help
- ◆ Other Psychological Disorders
- ◆ Psychosocial Factors Associated with Diabetes
- ◆ Sexual Health Concerns
- ◆ Essential Education
- ◆ Additional Resources
- ◆ References

Tools included in this section:

- ◆ Patient Health Questionnaire (PHQ-9) (1 page)
- ◆ PHQ-9 Quick Depression Assessment – Instructions for Use (1 page)

## ***Depression and Other Psychological Disorders***

Depression is highly prevalent among people with diabetes and is the most frequently cited psychological disorder associated with diabetes. It is roughly three times more prevalent in those with diabetes (15-20% of people) than in those without diabetes. People with both diabetes and depression have poorer clinical outcomes. The cause of increased instances of depression in people with diabetes is unknown; there is ***no evidence that diabetes, itself, causes depression.*** In addition to the normally cited psychological complications leading to depression, the challenge of adopting the wide-ranging medical regimens and lifestyle changes required for good diabetes self-management may aggravate depression in people with diabetes. A sense of loss frequently accompanies depression and can aggravate good diabetes self-management.

Evidence linking depression to both Type 1 and Type 2 diabetes complications continues to accumulate. Women have a higher prevalence of major depression than men. There are also differences in the prevalence of major depression among racial and ethnic subgroups. The lowest prevalence is seen among Asian Americans (1%) and the highest prevalence is found among American Indians and Alaskan Natives (28%). The prevalence of major depression is higher among people with Type 2 diabetes who use insulin than both those with Type 1 diabetes and those with Type 2 diabetes who are not using insulin.

People with diabetes are at an increased risk of depression; primary care providers should routinely screen for, diagnose, and treat depression in people with diabetes, which may assist in optimizing self-management goals and overall outcomes. Like many others, people with diabetes frequently may not want to admit they are depressed. Primary care providers must be sensitive and assist with decreasing the stigmatization often associated with depression.

Depression is directly associated with poor glycemic control and can also contribute to poor lifestyle choices (e.g., overweight, obesity, physical inactivity, substance abuse, tobacco use), which further increase the risk for poor health.

Major depression is a disorder characterized by a cluster of mental and physical changes, all of which may persist and worsen over an extended period of time. People with diabetes experiencing major depression are usually unable to adhere to meal plans, testing schedules, and activity recommendations, leading to high blood sugar levels, increasing the risk of long-term complications. Typical symptoms of depression are:

- Decreased ability to cope with changes or challenges in life,
- Crying spells for no apparent reason,
- Changes in sleep patterns,
- Changes in weight or appetite,
- Fatigue or loss of energy,
- Changes in ability to concentrate,
- Changes in sexual desire,
- Increased pessimism,
- Loss of interest in normal daily activities or things once enjoyed,
- Feeling sad and down,
- Feeling guilt, hopelessness, or worthlessness,

- Thoughts of death or suicide.

Depression can be mild, moderate, or severe. Mild depression is present when a person has some symptoms and extra effort is needed to complete normal daily activities. Moderate depression is present when a person has many symptoms, often keeping the person from doing normal daily activities. Severe depression is present when a person has nearly all the symptoms, preventing them from doing normal daily activities. Depression is different for everyone.

It is important for providers in clinical practice to be aware of the potential for depression. Providers may mislabel lack of attention to diabetes self-care as non-compliant behavior when, in fact, it may indicate the need to screen for depression. Early recognition of depression symptoms, prompt treatment, and referral may lead to improved diabetes self-care and quality of life. Since people with diabetes may also have recurrent periods of depression, ongoing assessment or reassessment is essential.

### ***Postpartum Depression***

Postpartum depression (PPD) affects 10-15% of mothers within the first year after giving birth. Given the prevalence of depression in people with diabetes, it is prudent to address PPD in women who have either pre-existing diabetes or gestational diabetes. It is recommended that women with diabetes be screened for PPD at the 4- to 6-week postpartum visit. Women exhibit the same symptoms listed earlier, as well as these additional characteristics:

- Worried/concerned about ability to care for baby,
- Not feeling close to or having difficult bonding with baby,
- Thoughts of harming self or baby.

### ***Depression Screening***

Depression screening tools (examples are provided in Table 17) can assist primary care providers in identifying depression symptoms and determining whether treatment is necessary. The simplest, most direct and sensitive screening measure is asking the following two questions:

- 1) “Over the past two weeks, have you ever felt down, depressed, or hopeless?” and
- 2) “Have you felt little interest or pleasure in doing things?”

**Table 17: Depression Screening Tools**

Name of Test	Contact Information	Other Information
Beck Depression Inventory (BDI): <i>Fast Screen for Medical Patients</i> (for adolescents and adults)	Psychological Corporation Harcourt Assessment P.O. Box 839954 San Antonio, TX 78283-3954 (800) 211-8378 <a href="http://www.psychcorp.com">http://www.psychcorp.com</a> (type “Beck Depression Inventory” into search box)	Complete kit (including manual and 25 record forms), \$99
HANDS® Harvard National Depression Screening Day Scale	Harvard Department of Psychiatry National Depression Screening Day Scale One Washington Street, Suite 304 Wellesley Hills, MA 02481-1706 (781) 239-0071 or (781) 431-7447 <a href="http://www.nmisp.org">http://www.nmisp.org</a>	Contact them by phone or email for additional information.
Patient Health Questionnaire-9 (PHQ-9), adapted from <i>PRIME-MD Today</i> , developed by Spitzer, Williams, Kroenke, and colleagues	For a copy of the PHQ-9, contact your local Pfizer pharmaceutical representative	No charge; reproduction permitted for the purposes of clinical care and research only.
Postpartum Depression Screening Scale by Cheryl Beck at the University of Connecticut	Western Psychological Services 12031 Wilshire Boulevard Los Angeles, CA 90025-1251 (310) 478-2061 <a href="http://www.wpspublish.com">http://www.wpspublish.com</a> (type “Postpartum depression screening scale” into search box)	Complete kit (including 25 auto-score test forms and manual), \$79.75
Several depression assessment tools are available (English, Spanish, and Hmong) at the Wisconsin Association of Perinatal Care website	<a href="http://www.perinatalweb.org/index.php?option=content&amp;task=view&amp;id=86">http://www.perinatalweb.org/index.php?option=content&amp;task=view&amp;id=86</a>	No charge.

Note: These are only a few of the many depression screening tools available.

### ***Treatment for Depression***

While there is little information linking treatment of depression in people with diabetes to a faster recovery, outcomes are clearly enhanced by treatment. In fact, there is evidence that increased understanding of depression and its treatment modalities directly correlates with an increased adherence to provider recommendations. Treatment of depression in the primary care setting includes medication, psychotherapy, or combined treatment of medication and psychotherapy.

Treatment with pharmacological agents and/or other therapeutic approaches can lead to improvements in self-management, glycemic control, adherence to recommendations, functionality, and quality of life. The choice of treatment is based on the history of illness and the severity of the depressive episode. Some people may benefit from a combination of both pharmacological agents and short-term psychotherapy. Scientific evidence indicates that several

forms of short-term psychotherapy (cognitive, interpersonal, or behavioral) are effective in treating most cases of mild and moderate depression.

Two newer atypical antipsychotic medications – aripiprazole (Abilify) and ziprasidone (Geodon) – do not tend to have adverse metabolic effects. Others such as clozapine (Clozaril) and olanzapine (Zyprexa) are very likely to have metabolic adverse effects (e.g. weight gain, diabetes risk, dyslipidemia) and compromise glycemic control due to a potential side effect of weight gain. Mental health professionals, particularly those familiar with diabetes, can offer appropriate education, support, and treatment for depression. Assess all people with depression for suicide risk by direct questioning about suicidal thinking, impulses, and personal history of suicide attempts.

### ***Encouraging Self-Help***

Depression makes some people feel hopeless, helpless, and worthless. The person who has such feelings should recognize that negative thinking is a symptom of the illness and will fade as depression responds to treatment. In the meantime, encourage the depressed person to follow these self-help tips:

- Set realistic expectations;
- Try to be with other people;
- Participate in activities (e.g., physical activity, social gatherings) that may make them feel better;
- Avoid alcohol, drugs, or excessive food;
- Delay making major life decisions, such as changing jobs, getting married, or getting divorced;
- Do not blame him/herself, as depression can happen to anyone.

### ***Other Psychological Disorders***

People with diabetes can also experience a variety of psychological disorders including:

- Anxiety (e.g., generalized anxiety disorder, obsessive-compulsive disorder),
- Stress and stress-related disorders (e.g., adjustment disorder, eating disorder),
- Other mental disorders (e.g., personality disorders, schizophrenia, and other psychoses).

Special attention is needed to differentiate psychological problems from diabetes-related symptoms. Symptoms of psychological disorders can frequently mimic symptoms of diabetes or typical diabetes care (i.e., hyperglycemia symptoms can be similar to symptoms of depression or anxiety disorders, and a focus on eating can be either healthy, attentive self-care or an early sign of an eating disorder).

#### **→ Anxiety**

Clinical anxiety is another problem common to people with diabetes that can interfere with effective diabetes management. Symptoms of clinical anxiety include restlessness, feeling on edge, fatigue, difficulty concentrating, irritability, muscle tension, and sleep disturbance. People experiencing anxiety may also describe an intense fear of hypoglycemia, or may not take the required amount of medication or insulin to adequately control blood sugar levels.

Other fears or anxieties may focus on injections and testing blood glucose levels. Anxiety can compromise glycemic control.

→ **Stress**

People with diabetes must deal with the challenges of diabetes in addition to the stresses that are a part of everyday life in our culture. Because of the 24/7 nature of self-care, feelings of frustration are common. In addition, newly diagnosed individuals can be fearful or concerned about the impact of the disease on an already difficult job or family situation. Emotional, physiological, and behavioral reactions to stress can lead to a deterioration of glycemic control. When stress hormones are released, the liver produces more glucose, blood pressure elevates, heart rate elevates, cortisol increases, and the immune system is compromised. Increased education in diabetes self-management, as well as training in problem-solving and coping skills, can help people with diabetes reduce stress. Severe cases may require intensive treatment such as psychotherapy or anti-anxiety medications.

→ **Eating Disorders**

Anorexia nervosa and bulimia nervosa can affect people with diabetes. Problems with food can begin when people use it to cope with painful situations and feelings, or to relieve stress. This can happen without the person realizing it. Eating disorders appear most frequently in young women with Type 1 diabetes. Anorexia nervosa involves a severe, self-imposed restriction of food coupled with high levels of physical activity. Bulimia nervosa involves binge eating followed by purging (vomiting). Bulimia also frequently involves the use of diuretics and laxatives. Many persons with eating disorders will manipulate their insulin or purposefully not take it in an attempt to lose and control weight. This varied food intake, along with inconsistent insulin use, can increase the risk of poor glycemic control. Early detection and referral to a specialist for assistance with an eating disorder is essential.

### ***Psychosocial Factors Associated with Diabetes***

There are other psychosocial factors crucial to understanding a person's reaction to a diagnosis of diabetes, as well as his or her ability to self-manage and adhere to recommendations. Psychosocial factors (e.g., feelings of anger, grief, fear, frustration, guilt, and embarrassment) may contribute to a lack of energy or motivation or an inability to attain or maintain optimal blood glucose control. Understanding these psychosocial factors and other reactions to diabetes (e.g., denial and obsession) can play a significant role in treating the underlying issues that negatively impact the treatment and management of diabetes. Providers can encourage discussion and ask questions that assess coping ability. Maximizing effective self-help opportunities, positive coping strategies, and various therapies may help people address their negative emotions and reactions more effectively.

People with Type 1 diabetes bring with them a history shaped in part by the following: various circumstances surrounding their diagnosis and treatment; the reaction of family, friends, teachers, and coaches to their diagnosis; and, the kind of supportive education received about diabetes. A child who was taught to be secretive and ashamed of his/her diagnosis may carry those feelings into adulthood, just as a child who never learned self-management may feel helpless as an adult.

Similarly, people with Type 2 diabetes may feel angry or responsible for “causing” their diabetes. They may feel that family members act as the “diabetes police” and food is now a battleground. How they learned of their diagnosis, their misconceptions, and their experience with others who have diabetes may form or alter their ability to cope, learn, and self-manage.

### ***Sexual Health Concerns***

Sexual dysfunction for people with diabetes is commonly caused by autonomic neuropathy. Sexual problems are common, and can affect approximately 75% of men and 35% of women with diabetes. The most common sexual problem for men is impotence and retrograde ejaculation. Impotence is an impairment or loss of erectile ability sufficient for intercourse with normal libido. Retrograde ejaculation is less common and results in damage to the efferent sympathetic nerves that normally coordinate the closure and relaxation of the internal and external vesicle sphincters. Men with diabetes are more than twice as likely to suffer from hypogonadism, also known as low testosterone, compared to other men. The most common sexual difficulties for a woman with diabetes involve problems with arousal, decreased vaginal lubrication during stimulation, and anorgasmia (i.e., the inability to have an orgasm) despite normal libido. Women can also experience more frequent yeast infections or other vaginal infections with diabetes, which can contribute to sexual difficulties.

It is important for providers to inquire about the possibility of sexual concerns for both men and women, offer referrals to a specialist for diagnosis and counseling, and review therapeutic options. Sexual difficulties may be related to autonomic neuropathy (e.g., loss of libido), but can also be related to depression.

### ***Essential Education***

Because there are still many myths about depression and sexual health, it is important to help people understand that both depression and problems with sexual health are treatable conditions. Use culturally appropriate approaches and materials as needed. An assessment of literacy level/skill can determine the best educational strategy or learning style to use. Education should include, but is not limited to:

- Explaining that depression is often associated with low energy levels, low motivation, and low self-esteem, all of which are factors contributing to diminished self-care.
- Providing emotional support and counter self-blame, especially when the person is unable to adequately self-manage or control blood sugars during a major depressive episode.
- Encouraging people to take medication routinely and as prescribed (i.e., not stopping without first speaking to health care provider). Encouraging treatment follow-up to assess responsiveness, check side-effect profile, titrate medications as needed, and provide continued support.
- Assessing social support system (e.g., family, friends, church, and support groups) and the level of practical and emotional support they are providing.
- Discussing and offering ideas for community resources (e.g., a local support group).
- Advising additional self-management support and/or education as emotional health improves.
- Inquiring about sexual health concerns, as people find it difficult to initiate this type of conversation.

## ***Additional Resources***

- 1) Surwit, RS, Bauman, A. *The Mind Body Diabetes Revolution: A Proven New Program for Better Blood Sugar Control*. New York, NY: Free Press; 2004.
- 2) Rubin, RL, Biermann J, Toohey B. *Psyching Out Diabetes: A Positive Approach to Your Negative Emotions*. 3<sup>rd</sup> ed. Lincolnwood, IL: Lowell House; 1999.
- 3) National Institute of Mental Health. Phone (301) 443-4513 or search NIMH's home page: <http://www.nimh.nih.gov>.
- 4) American Association of Diabetes Educators. *Take Charge. Talk T. What men with diabetes need to know about low testosterone*: <http://www.talklowt.org/>.

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## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

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

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

add columns:  +  +

(Health care professional: for interpretation of TOTAL, please refer to accompanying score card.)

**TOTAL:**

<b>10.</b> If you checked off <i>any</i> problems, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?	<b>Not difficult at all</b> _____ <b>Somewhat difficult</b> _____ <b>Very difficult</b> _____ <b>Extremely difficult</b> _____
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Provided as a service by Pfizer Neuroscience

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

## **PHQ-9 QUICK DEPRESSION ASSESSMENT – INSTRUCTIONS FOR USE**

*for doctor or health care professional use only*

### **For initial diagnosis:**

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1. Person completes PHQ-9 Quick Depression Assessment
2. If there are at least 4 ✓s in the gray highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.
3. Consider Major Depressive Disorder
  - ◆ if there are at least 5 ✓s in the gray highlighted section (one of which corresponds to Question #1 or #2)Consider Other Depressive Disorder
  - ◆ if there are 2-4 ✓s in the gray highlighted section (one of which corresponds to Question #1 or #2)

**Note:** Since the questionnaire relies on individuals self-reporting, the clinician should verify all responses and make a definitive diagnosis on clinical grounds, taking into account how well the individual understood the questionnaire, as well as other relevant information from the individual. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

### **To monitor severity over time for newly diagnosed individuals or individuals in current treatment for depression:**

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1. Individual may complete questionnaires at baseline and at regular intervals (e.g., every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: “Several days” = 1, “More than half the days” = 2, “Nearly every day” = 3.
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in individual’s file to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

#### **PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION**

*for health care professional use only*

#### **Scoring – add up all checked boxes on PHQ-9**

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

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#### **Interpretation of Total Score**

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

