ISSN Print: 2664-8962
ISSN Online: 2664-8970
Impact Factor: RJIF 5.44
IJPR 2024; 6(1): 16-20
www.psychiatryjournal.in
Received: 14-11-2023
Accepted: 19-12-2023

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Maternal filicide and extended suicidal attempt: A case report from rural south India

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DOI: https://doi.org/10.33545/26648962.2024.v6.i1a.61

Abstract
This case report discusses the tragic phenomena of maternal filicide and extended suicidal attempt, which garner significant concern for researchers, legal professionals and clinicians. The case involves a 25-year-old woman from rural South India who experienced peripartum depression following the birth of her daughter, leading to feelings of hopelessness and suicidal ideation. The report highlights the factors associated with these acts such as psychiatric disorders, a history of suicidal behavior, psychosocial stressors and the role of the Hypothalamic-Pituitary-Adrenal (HPA) axis in peripartum depression and its connection to hormonal changes during pregnancy and childbirth. The case underscores the importance of early detection, comprehensive psychiatric evaluation and appropriate interventions to prevent such devastating outcomes and the need for increased awareness and support for maternal mental health, as well as collaborative efforts among healthcare professionals, social services and law enforcement agencies to ensure the safety and well-being of individuals at risk and potential victims. Addressing the complex psychopathology and social factors associated with maternal filicide and extended suicide can help prevent future cases and promote the well-being of mothers and their children.

Keywords: Maternal filicide, extended suicide, peripartum depression

1. Introduction
Filicide, the intentional act of killing one's own child, is a subject of great concern and interest among researchers, legal professionals and clinicians due to its complex medico-legal aspects. Various psychiatric disorders including schizophrenia, delusional disorders, mood disorders (with or without psychosis), substance use disorders and personality disorders have been associated with filicide [1]. Women convicted of filicide have frequently been diagnosed with depressive disorders, psychotic illnesses and have a history of psychiatric treatment and suicidal behavior [2]. These women often face multiple psychosocial stressors such as financial constraints, social isolation, primary caregiver roles, domestic violence, conflicts with family members, persistent abusive relationships and lack of social support. Notably, a significant proportion of women who commit filicide eventually die by suicide themselves [3]. The most common methods used in filicide cases include strangulation, beating, asphyxiation, drowning, defenestration and throat-slitting [4]. Women are identified as perpetrators in 16-29% of filicide cases while men account for 40-60%. Filicides make up 2% of all homicides and constitute 7.6% of homicide-suicides according to one study [5]. Furthermore, 42% of offenders have criminal records and 50% have a history of domestic issues [6].
Extended suicide holds significant importance from the perspectives of forensic psychology and psychiatry. This type of suicide involves an "initiator" also known as the inducer who takes the lead in the act and other individuals referred to as the "induced", who either willingly or under coercion participate in the suicide. Psychopathologically motivated extended suicides are commonly observed among patients with endogenous depression. These individuals influenced by delusions, make the decision to end not only their own suffering but also the lives of their loved ones. The dynamics of extended suicide typically involve an active relationship between the inducer and the induced. The inducer articulates the reasons behind the act based on a well-defined suicidal ideology. Initially, the induced may resist the suggestion, but succumb to the inducer's pressure over time.

Various categories of extended suicide exist, including double suicide involving couples or family members, group suicide in relatively small numbers (such as family suicides, suicide clubs, or religious sects) and mass (epidemic) suicide that affects larger groups of people [7].

Peripartum depression (PPD) is a mood disorder that affects 10-30% of mothers worldwide, with a prevalence of 22% in India [8]. Peripartum depression may affect 15% of women during the first year after giving birth [9]. It occurs after childbirth and is characterized by significant hormonal, physical, emotional and psychological changes in women. While it is common for mothers to experience a range of emotions known as "baby blues" within the first two weeks after delivery, PPD is different as it can persist for a longer duration and significantly impacts a woman's functioning. PPD not only affects the mother but also her relationship with her infant, compromising maternal brain response and behavior. Unfortunately, many cases of PPD go undiagnosed due to privacy issues and the stigma surrounding the condition.

Several factors contribute to the development of PPD. Psychological factors include a history of depression and anxiety, premenstrual syndrome, negative attitudes towards the baby, reluctance regarding the baby's gender and a history of sexual abuse. Obstetric risk factors include risky pregnancies, complications during childbirth and low hemoglobin levels. Social factors such as lack of social support, domestic violence and smoking during pregnancy also increase the risk. Lifestyle factors like eating habits, sleep patterns, physical activity and exercise can influence PPD.

PPD is diagnosed when at least five depressive symptoms persist for a minimum of 2 weeks. The DSM-5 considers it a major depressive episode with peripartum onset, while the ICD-10 defines it as postpartum depression, onset within 6 weeks after delivery. The symptoms including depressed mood, loss of interest, insomnia or hypersomnia, psychomotor retardation or agitation, worthlessness or guilt, loss of energy or fatigue, suicidal ideation or attempt, impaired concentration or indecisiveness and change in weight or appetite must be present nearly every day and cause distress or impairment. PPD can range from mild to severe and shares symptoms with non-puerperal depression but is characterized by a history of childbirth. It can have detrimental effects on maternal-infant bonding, breastfeeding, parenting practices, marital relationships and the child's development.

Remission of symptoms is important to reduce the risk of behavioral and psychiatric problems in the child and a history of PPD increases the likelihood of future episodes and the development of other mood disorders. Personal and family histories of peripartum depression and psychosis should be considered when evaluating a woman for PPD.

2. Case presentation

2.1 Sociodemographic and Clinical Details: Our patient was a 25-year-old female, unemployed graduate, housewife from middle socioeconomic status and rural background.

2.2 History of present illness: She had conceived spontaneously after four years of marriage and delivered a female baby via cesarean section. After delivery, she developed mood swings, weeping spells, depressed mood and suicidal ideas. She felt that her family members on both sides were not happy with the birth of a female baby and she could not cope with expectations of family members on both sides, compounded by pain from stitches, low milk supply, unable to feed the baby properly and lack of sleep. On multiple occasions, she expressed to her mother and husband that she was feeling restless and wanted to end her life. They convinced and counseled her each time. On the 42nd day of delivery, her newborn daughter developed a minor nasal bleed and she was admitted to an area hospital. On that day, when no one was around patient escaped from the hospital along with the baby and tried to jump into the river. However, the guards and others prevented her from doing so, the baby fell into the river. The patient fainted after the incident and upon regaining consciousness, she was overwhelmed with guilt regarding the baby's death. Her husband had registered an FIR (First information report) in the police station against her for the death of the baby. She presented with complaints of sad mood, weeping spells, expressing death wishes and suicidal ideas from six weeks after delivery and expressed ongoing death wishes and was initially taken to a private clinic. From there, she was referred to a tertiary care hospital in South India and was brought by her mother and elder brother due to her continued expression of death wishes. The patient had a family history of similar complaints where her mother and maternal aunt had experienced similar issues in the past.

2.3 Physical examination: Physical examination showed she was conscious, general condition was fair, mild pallor present, vitals found to be stable and physical examination did not reveal any abnormalities. Upon further assessment, the patient appeared moderately built and nourished with intact orientation. Systemic examination, including a detailed neurological assessment was unremarkable.

2.4 Mental status examination: She came and sat upon a chair anxiously, exhibiting signs of anxiety, including crying during the interview. She was kempt, psychomotor activity was normal, eye to eye contact was present and rapport was established. Her speech was in low tone, normal volume, normal tempo, normal reaction time, relevant to the questions and coherent. She expressed suicidal ideas at the time of admission and reported occasional perceptual disturbances, such as auditory hallucinations of the baby crying.

2.5 Other Details: Our patient was premorbidly well adjusted. There was no history of medical (including hypertension and other cardiovascular disorders) or neurological disorders, or substance abuse.

2.6 Investigations: Laboratory studies, including complete blood picture, renal functions, blood sugars, liver and thyroid functions, urine analysis, chest X ray, and electro-cardiogram did not reveal any abnormalities.

2.7 Diagnosis

She was diagnosed to have "Peri-partum depression" as per Diagnostic and Statistical Manual of Mental disorders (DSM V criteria).

2.8 Assessments

At various time points, different instruments were applied to assess the illness severity and treatment response (Table 1). PHQ-9 (Patient Health Questionnaire-9) is a questionnaire assessing depression symptoms with nine questions. EPDS (Edinburgh Postnatal Depression Scale) is a screening tool for postpartum depression risk in new mothers, consisting of ten questions focused on emotional well-being during the postpartum period.

Table 1: (Annexure 1)

Scales	At the time of admission	At the time of discharge
EPDS	23	7
PHQ-9	13	5

2.9 Treatment Details and Course in the Hospital: During the patient's hospitalization, a comprehensive course of treatment was implemented to address her complex mental health challenges. Upon admission, she exhibited symptoms of profound sadness, weeping spells and expressed both thoughts of death and suicidal ideation. Initial treatment included T. Escitalopram 10mg/day, Cap. Fluoxetine 20 mg/day and Inj. Haloperidol 2 amp + Promethazine 1 amp i/m twice a day yet noticeable improvement was limited (Further treatment details discussed in Table 2). Unfortunately, her suicidal ideation persisted as the patient's husband was not in talking terms with her and abandoned her underscoring the severity of her condition.

In response to her ongoing struggle, the treatment approach evolved to incorporate Modified Electroconvulsive Therapy (MECT). The patient underwent four MECT sessions on Days 20, 22, 26, and 30 of her hospitalization. Psychological intervention including psychoeducation, crisis intervention and basic psychotherapy was given to patient. While the comprehensive treatment regimen showed varying degrees of effectiveness, it is evident that the patient's case highlights the intricate nature of mental health challenges and the need for multifaceted interventions tailored to each individual's unique circumstances.

Table 2: Treatment Details and Course in the Hospital

	Complaints	Medications	Improvement
Day 1	sad mood, weeping spells, expressing death wishes and suicidal ideas	T. Escitalopram 10 mg/day, Cap. Fluoxetine 20mg/day, Inj. Haloperidol 2 amp + Promethazine 1 amp i/m twice a day	No change
Day 7	Crying spells, marital conflicts, expressing suicidal ideas and perceptual disturbances	T. Escitalopram 20 mg/day, Cap. Fluoxetine 20mg/day, T. Lorazepam 2 mg/day once a day and T. Olanzapine 5mg once a day	No change
Day 14	Expressing suicidal ideas	T. Escitalopram 20 mg/day, Cap. Fluoxetine 20mg/day, T. Lorazepam 2 mg/day once a day and T. Olanzapine 5mg twice a day	No change
Day 17	Ideas of worthlessness and hopelessness	T. Escitalopram 20 mg/day, Cap. Fluoxetine 20mg/day, T. Lorazepam 2 mg/day once a day and T. Olanzapine 5mg twice a day	No change, planned for MECT
Day 20	Ongoing death wishes	1st MECT given	No change
Day 22	Ongoing death wishes	2nd MECT given	20% improvement
Day 26	Reduced suicidal ideation	3rd MECT given	50% improvement
Day 30	Reduced suicidal ideation	4th MECT given	70-80% improvement

3. Discussion

The case report presented here highlights the complex nature of maternal filicide and extended suicide. Maternal filicide refers to the intentional act of a mother killing her own child or children, while extended suicide involves the initiator (or inducer) leading others to participate in the act of suicide. Both phenomena have profound implications from forensic-psychological and psychiatric perspectives.

The HPA (Hypothalamo- pituitary- adrenal) axis, which controls the release of glucocorticoids including cortisol, plays a crucial role in regulating various physiological processes and response to stress. During pregnancy, childbirth and lactation, the HPA axis undergoes significant modifications. Placental CRH (pCRH) plays a key role in pregnancy-related phases such as nursing, pregnancy and birthing, leading to elevated cortisol levels. The placenta, in addition to estrogen and progesterone, produces pCRH (placental corticotropin releasing hormone) stimulating cortisol production and creating a positive feedback loop. The placenta is primarily responsible for the higher basal cortisol concentrations during pregnancy. While cortisol levels rise significantly in the final weeks of pregnancy, they decline following delivery, leading to changes in HPA axis regulation. Reduced cortisol stress responses have been

observed in women with significant depression and dysregulation of the HPA axis is often associated with mental illness. Depression after childbirth may be characterized by low cortisol levels, while pregnancy depression may involve high cortisol levels. Prenatal HPA axis dysregulation, indicated by elevated pCRH trajectories, has been linked to an enhanced postpartum decline in cortisol and a potential predictor of postpartum depression. Reproductive hormones and markers are linked to Postpartum Depression (PPD). Progesterone levels, ALLO (Allopregnanolone) and oxytocin fluctuations are associated with PPD. Thyroid hormone abnormalities, inflammatory markers and biochemical indicators like zinc, vitamin D and CRP also predict PPD risk. These findings emphasize the complex interplay between hormones and PPD risk. Understanding the intricate interplay between the HPA axis, cortisol and mental health during pregnancy and the postpartum period is vital for identifying biomarkers and developing effective interventions for conditions such as prenatal and postnatal depression [10].

This case highlights several important factors associated with maternal filicide and extended suicidal attempt. Psychiatric disorders such as depression, schizophrenia, delusional disorders and mood disorders (with or without psychosis) are commonly observed in individuals involved in these acts. Additionally, psychosocial stressors including financial problems, social isolation, caregiver status, domestic violence, conflict with family members, and lack of social support, play significant roles in the development of these behaviors.

Understanding the underlying psychopathology and social factors associated with these acts is crucial for prevention and intervention. Early identification of at-risk individuals, comprehensive psychiatric evaluations, and providing appropriate mental health support and resources are essential in mitigating the risk of maternal filicide and extended suicide. Collaborative efforts among healthcare professionals, social services, and law enforcement agencies are necessary to ensure the safety and well-being of both the individuals at risk and their potential victims.

4. Conclusion

The presented case report highlights the tragic and distressing phenomenon of maternal filicide and extended suicidal attempt. The case underscores the importance of recognizing and addressing the complex psychosocial factors that contribute to such acts of violence and self-harm. The patient's experience of depression, anxiety and feelings of hopelessness following the birth of her female baby demonstrates the profound impact that societal and familial attitudes towards gender can have on maternal mental health. The case also highlights the need for increased awareness, early detection and appropriate interventions for postpartum depression to prevent such devastating outcomes. Healthcare professionals including psychiatrists, obstetricians, psychologists and social workers, play a crucial role in identifying and providing comprehensive care for women at risk for maternal filicide and extended suicide. Collaborative efforts are necessary to promote a supportive and empathetic environment for new mothers, ensure access to mental health services, and address the underlying societal factors that contribute to maternal mental health challenges. By addressing these complex issues, we can strive to prevent future cases of maternal filicide and extended suicide, promoting the well-being of both mothers and their children.

5. Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient (s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

6. Financial support and sponsorship: Nil.

7. Conflicts of interest: There are no conflicts of interest.

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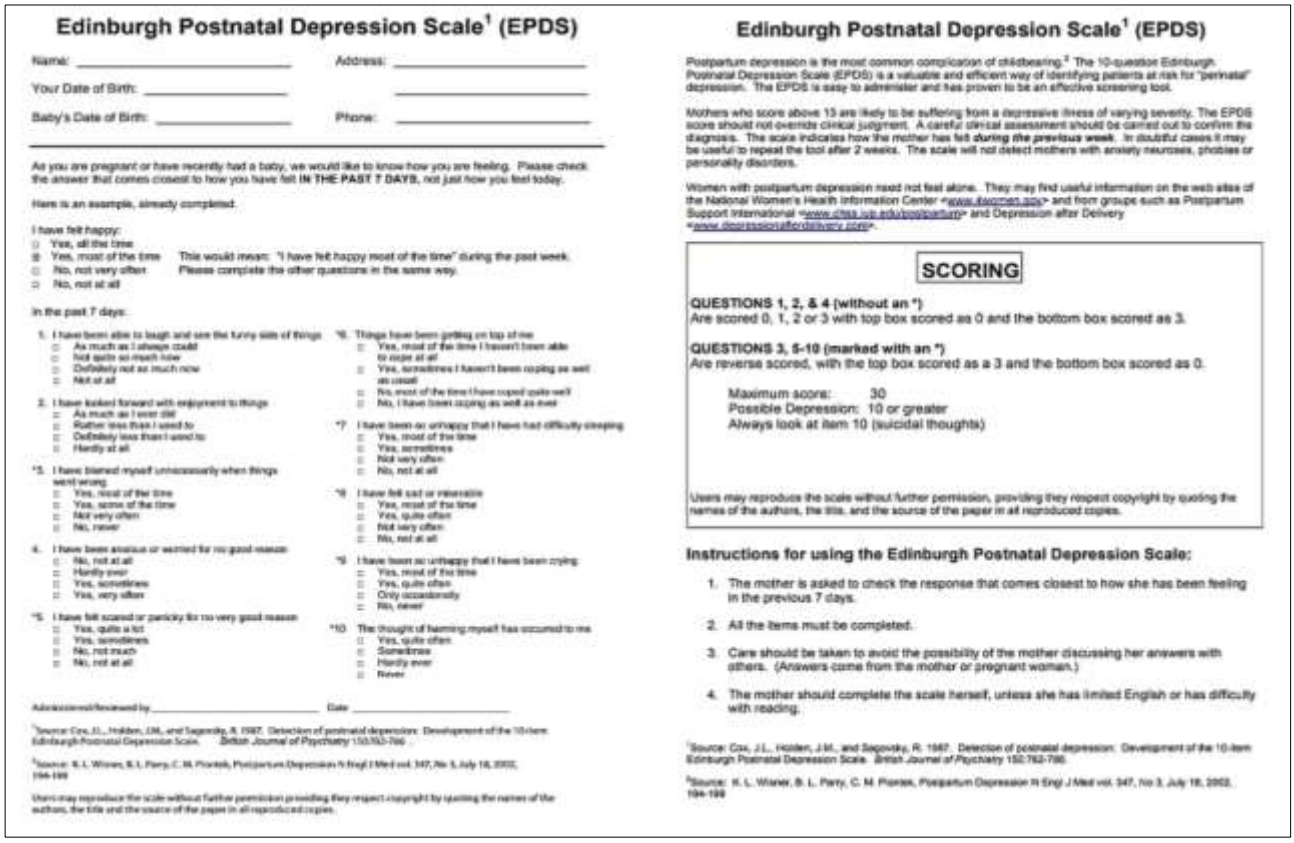
Annexure 1



Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ◉ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not as much now
   - ☐ Not at all
2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

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

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

*5. I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7. I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8. I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9. I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10. The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No. 3, July 18, 2002, 194-199

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Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

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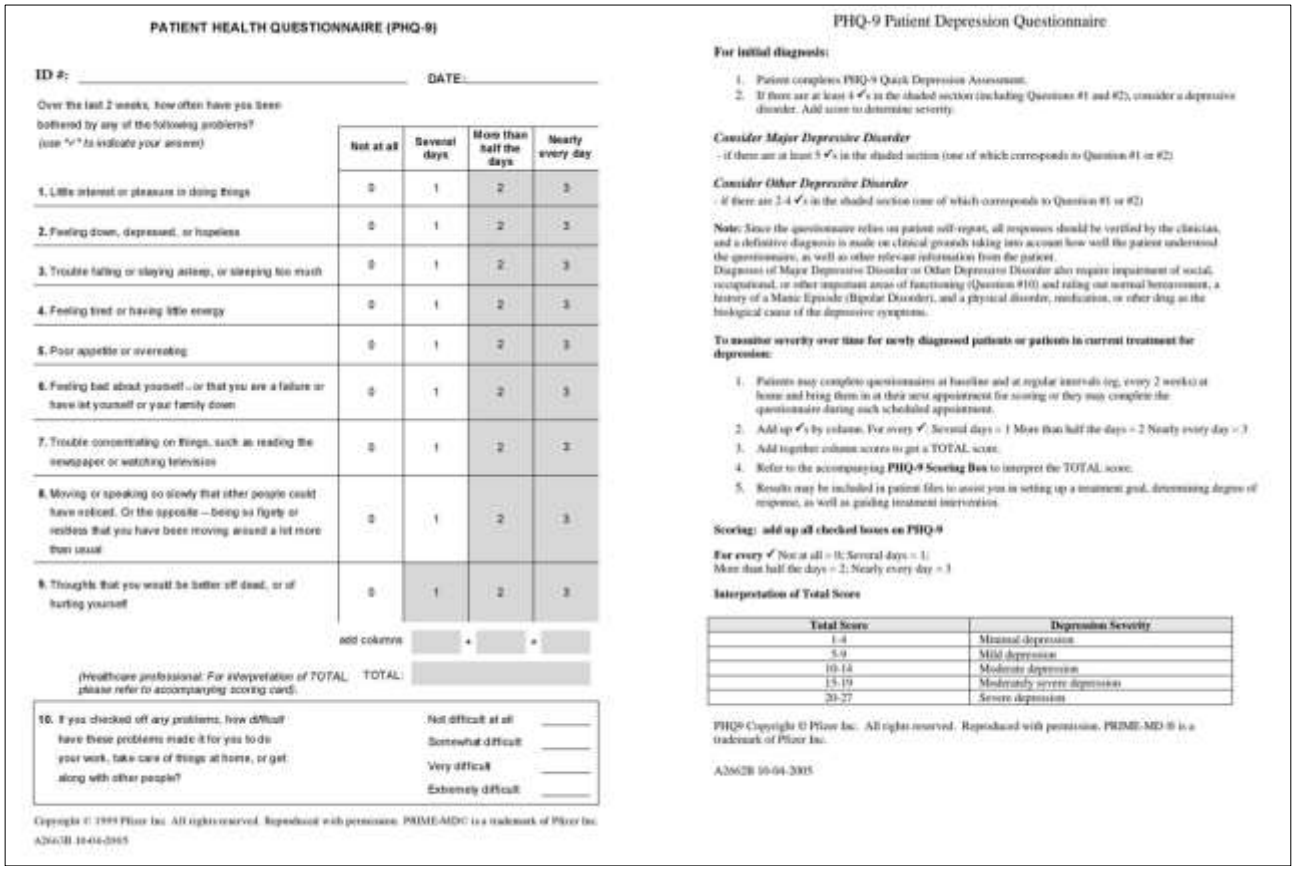
Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ DATE: _____

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

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety 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	0	1	2	3
add columns		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
   - Not difficult at all _____
   - Somewhat difficult _____
   - Very difficult _____
   - Extremely difficult _____

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PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓'s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder
- if there are at least 5 ✓'s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder
- if there are 2-4 ✓'s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. 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 patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, 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 Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

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

Interpretation of Total Score

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

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