PHN-PREP
Public Health Nursing Practice, Research & Education Program

Professional Resource

Administration, Scoring & Interpretation of the Patient Health Questionnaire-9 (PHQ-9)

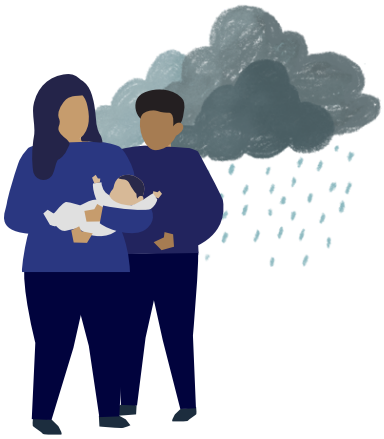
When a client presents with signs of depression, the recommendation within the *Public Health Nursing Care Plans for Supporting Perinatal Clients at Risk of Depression* is that either the Edinburgh Postnatal Depression Scale (EPDS) or the PHQ-9 tool is administered to screen for risk of perinatal depression. This Practice Guidance Resource provides information on how to introduce, administer, score and interpret the **PHQ-9** screening tool during the postpartum period.

What is Depression?

Depression is more than just feeling sad or experiencing temporary "blues." Clinical depression, sometimes called major depressive disorder, is a complex mood disorder caused by various factors, including genetic predisposition, personality, stress and brain chemistry.[1]

Perinatal Depression

Perinatal depression refers to depressive symptoms that occur during pregnancy or within the first year postpartum. It can affect any parent, including biological parents, adoptive parents, and partners.[2]



For additional information on how to recognize, assess, and respond to perinatal mental health concerns in practice, refer to the Public Health Nursing Care Plans for Supporting Perinatal Mental Health Practice Guidance document.

Signs and Symptoms of Depression & Perinatal Depression

Depression[3]	Perinatal Depression[2]
For both depression and perinatal depression, a person must present with five (or more) symptoms that have been present nearly every day during the same 2-week period, and at least one of the symptoms is either: **Depressed mood (e.g., feels sad, empty, hopeless)** OR **Loss of interest in activities that would have previously been pleasurable**	
Other symptoms: • Changes in appetite (increase or decrease) or unintended weight loss/gain • Sleep disturbances (difficulty sleeping or excessive sleep) • Fatigue or loss of energy	**Symptoms of perinatal depression include all of those identified with depression, as well as:** • Lack of interest in the baby, not feeling bonded to the baby, or feeling very anxious about/around the baby • Feelings of being a bad mother/caregiver • Fear of harming the baby or oneself

- Increase in purposeless physical activity (e.g., inability to sit still, pacing, handwringing) or slowed movements or speech [these actions must be severe enough to be observable by others]
- Feelings of worthlessness, excessive or inappropriate guilt
- Trouble thinking or concentrating, and difficulty making decisions
- Recurrent thoughts of death/suicide

- Early cessation of breastfeeding*[4]

**The relationship between breastfeeding and postpartum depression has been found to be bidirectional. While early cessation of breastfeeding has been identified as a symptom of postpartum depression, breastfeeding appears to reduce the incidence of postpartum depression.[4]*

Depression occurs on a **spectrum** from mild to severe. At the "severe" end of the spectrum, individuals may develop suicidal thoughts or intent (e.g., plans) and/or psychotic symptoms.[3]

Screening for Risk of Depression

If signs of depression are observed during the client interaction or the client shares their experiences of symptoms that may be suggestive of depression, begin to ask open-ended questions that invite the client to further elaborate on their experiences.

Can you tell me about any changes in your mood or emotions since your baby arrived?

How has your energy level / sleep patterns / appetite been lately?

I heard you mention that things are really hard / overwhelming. Can you tell me more about that?

I've noticed that you seem to be tearing up when we talk. Can you tell me more about what is going on for you right now? What are some of your feelings or thoughts?

Using Plain Language in Client Conversations

When discussing depression with a client, it's important to use clear, supportive language and define potentially unfamiliar terms. Some individuals may not identify with the term "depression" but may relate more to:

- Feeling down or stuck
- Having a hard time enjoying things
- Feeling exhausted all the time or struggling to find energy
- Struggling with motivation or focus
- Feeling disconnected from their baby
- Having negative thoughts about themselves

When a client is presenting with **signs of depression or perinatal depression**, it is recommended in the Public Health Nursing Care Plans for Supporting Perinatal Clients at Risk for Depression that a nurse consider administering one of two tools to screen for risk of depression, the PHQ-9 or the EPDS.

CRITICAL PRACTICE NOTE:

If a client is around two weeks postpartum, they may be experiencing a normal transition to parenting, even possibly in the form of the "baby blues."* It is important not to pathologize normal maternal adjustment. Use nursing judgement based on your client's history to determine whether or not to utilize screening tools at this time. Explore with your client if further assessment is warranted during follow-up appointment.

* For more information, refer to the ***Understanding and Supporting Emotional Changes in the Early Postpartum Period ("The Baby Blues")*** practice guidance resource.

What is the PHQ-9?

The PHQ-9 is a validated screening tool designed to assess the symptoms and severity of depression.[5] It is not a diagnostic tool however information gained from completion of the tool helps guide further assessment and intervention. It is brief, easy to administer, and suitable for use in the perinatal period. The tool is available in over 90 languages, and translated versions can be accessed through a public database created to to provide health care workers unrestricted access to the tool.[6]

Features of the PHQ-9

- 9 questions assessing depressive symptoms over the **past two weeks**
- Questions focus on mood, sleep, energy levels, concentration, and thoughts of self-harm
- 4-point Likert scale responses:

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

Introducing the PHQ-9 to the Client

When a public health nurse introduces a mental health screening tool like the PHQ-9 to a client, it is important to do so utilizing a trauma- and violence-informed (TVIC) approach to care.

Key Principle	Why It Matters	How to Apply It in Practice
Create a safe and supportive environment	Clients experiencing depression may feel isolated, vulnerable, or ashamed of their feelings. A safe space fosters trust and openness.	Choose a **private, quiet space** where the client feels comfortable. Use **open body language** and a **calm, supportive tone** to reduce distress.
Normalize and validate the experience	Many parents struggle with guilt or shame around feeling low, exhausted, or disconnected from their baby. Validating their feelings reduces stigma.	Use **non-pathologizing language.** *"Many parents feel overwhelmed, exhausted, or disconnected in the postpartum period. You're not alone in this."*

Key Principle	Why It Matters	How to Apply It in Practice
Explain the purpose clearly	If the tool feels like a test, clients may **minimize their responses** out of fear of judgement. Explaining its purpose reassures them.	Introduce the PHQ-9 as a **way to explore emotions**, not a diagnosis. *"This tool helps guide our conversation so we can understand what support might be helpful for you."*
Give the client choice and control	Trauma survivors and individuals experiencing perinatal depression may feel **powerless**. Offering choice promotes a sense of control.	Always **ask permission** before administering the PHQ-9. *"Would you be open to going through these questions together?"* Allow the client to **opt out** or **take breaks.** Ensure the client knows they can skip questions or ask for clarification.
Use plain language and avoid jargon	Clients may not identify with the term **"depression"**, but may relate to feeling **drained, hopeless, or disconnected**.	Frame questions in **everyday language.** *"Some people describe feeling numb or like they're just going through the motions. Have you felt that way?"*
Frame it as a collaborative conversation	Builds **trust and partnership**, making the client more likely to engage meaningfully.	Reinforce that **the client is the expert** on their experience. *"This tool helps me understand what you've been feeling so we can explore what might be most helpful for you."*
Acknowledge strengths and offer reassurance	Clients with depression often experience **self-doubt** or **guilt about not feeling happy**. Reassurance helps counter these feelings.	Normalize their experience and **highlight resilience**. *"You're doing a lot right now, and it's okay to ask for support."*
Discuss next steps together	A rigid or prescriptive approach can make clients feel powerless or dismissed.	After completing the PHQ-9, **ask how they feel about their responses and explore next steps collaboratively.** *"Is there anything from these questions that stood out to you?"*

Options for Administering the PHQ-9

The PHQ-9 can be administered in different ways. It is essential to provide the client with a choice.

Consider how clients might be given a choice in how they complete the PHQ-9 to promote comfort and autonomy. Use clinical judgement to determine client literacy level, comfort etc.

"Would you prefer that I ask these questions aloud, or would you rather fill them out yourself?"

- **Self-completion:** the client is handed the PHQ-9 and completes the screening tool on paper or electronically. This offers them privacy in responding to the questions. If the client is unable to answer all questions independently, offer assistance to aid in its completion. Ensure a non-judgemental tone and space when reviewing responses with the client.
- **Side-by-side administration (collaborative approach):** sit beside the client and read each question aloud while the client marks their own response. This approach reinforces that the client is in control of their responses provided.
- **Verbal administration:** ask each question verbally and record response as client responds.
    - If administered verbally, sit side-by-side with the client and read each question and the subsequent responses exactly as written to maintain tool validity and reliability. For verbal administration, the tool could be introduced as follows:

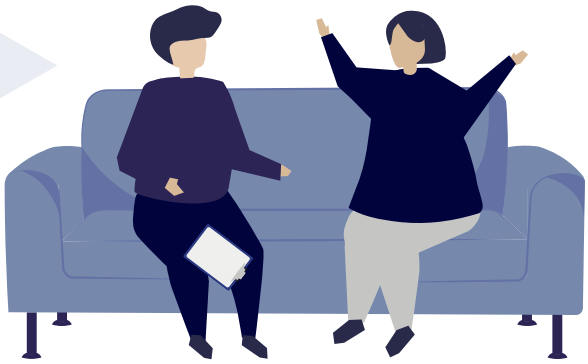
"I'm going to go through a short set of questions called the Patient Health Questionnaire, or PHQ-9. This is a tool I use with many of my clients during visits. These questions explore how often over the last two weeks you have experienced different symptoms, with response options ranging from 0 (not at all) to 3 (nearly every day). I'll read them exactly as written."

How the PHQ-9 Can Be Introduced to a Client

"You've shared that things have felt really overwhelming lately, and I want to acknowledge that those feelings are completely understandable. Many new parents experience changes in their mood, energy, and emotions during this time. To better understand how you've been feeling, I'd like to go through a short set of questions with you called the PHQ-9. These questions won't give a diagnosis, but they can help us explore whether additional support might be helpful for you. There's no pressure, and you can skip any questions you don't feel comfortable answering. Would you be open to going through them together?"

"Becoming a parent comes with a lot of changes, and it's completely normal to have ups and downs, or even feel disconnected, exhausted, or unlike yourself at times. Some parents feel a loss of joy in things they used to enjoy, while others find themselves worrying more or struggling to feel present. You're not alone in this. We have a simple tool called the PHQ-9 that helps us check in on how you've been feeling. It's not a test or a diagnosis, just a way for us to explore what's going on and see if there's any support that might be helpful for you. If you're comfortable, we can go through it together and talk about anything that stands out for you."

"I really appreciate you sharing how you've been feeling. What you're experiencing is valid, and it's okay to need support during this time. One thing that can help us understand how your mood has been lately is a short set of questions called the PHQ-9. This tool is just a way to guide our conversation—it's not about right or wrong answers, but about getting a clearer picture of what's been going on for you. After we go through it, we can talk about next steps together. There's no pressure, and you're in control of what you feel comfortable sharing. How does that sound?"



Scoring and Interpreting the PHQ-9

The PHQ-9 is scored by summing the scores of all 9 items, with a total score range of 0 to 27.

After administering the PHQ-9, tabulate the score and share the score and interpretation with the client using therapeutic language.

Score	Interpretation	Say...
0 - 4	Low Risk	*"You may be at low risk or have minimal depressive symptoms."*
5 - 14	Moderate Risk	*"You may be experiencing some depressive symptoms. Many parents feel this way, and it's okay to ask for support."*
15 or higher	Severe Risk	*"It looks like you may be experiencing significant depressive symptoms. There are supports available to help you through this."*
Positive response to Question 9* (self-harm thoughts.	Immediate Further Assessment	*"I noticed you indicated that thoughts of harming yourself have occurred to you. I'd like to talk about this further to ensure you have the right support in place."* Inquire if the client has thoughts or intentions of harming themselves, children or someone else. Additional assessments to consider: • Suicide risk assessment** • Assess for signs of perinatal psychosis • Assess for signs of homicide (including infanticide) and intention.

***Positive response is defined as an answer of **Several days; More than half the days; Nearly every day.** Adapted from PAR Staff[7]
****Refer to the **Nursing Care Plans for Supporting Perinatal Mental Health for Suicidal Ideation**

After scoring the PHQ-9, refer to the **Public Health Nursing Care Plan for Supporting Perinatal Clients at Risk of Depression** for guidance on next steps for tailoring care to the client's level of risk.

NOTE

It is important to use clinical judgement when interpreting the score of the PHQ-9. For instance, there may be situations where the "score" from an assessment tool reflects "low risk" – yet the client and their partner urgently express significant concern about the mother's safety and mental well-being. In this situation, the public health nurse would use all the assessment information available to them and perhaps interpret that the client is actually at higher risk than what was indicated following completion of the assessment tool alone. The nurse would then choose to respond with interventions appropriate for a higher level of risk.

Communicating Scores to the Client

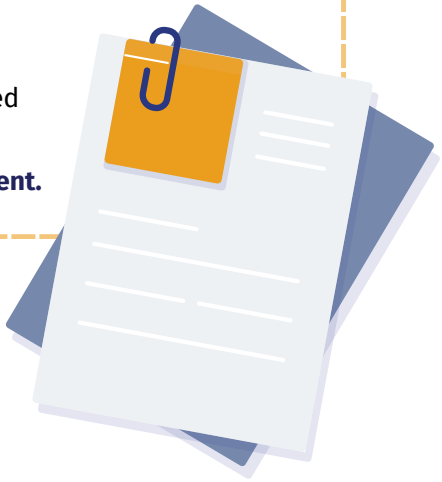
Remember, it's important to normalize, validate and provide reassurance.

"Your responses suggest you may be experiencing some depressive symptoms. It's completely understandable—many parents feel this way. I'd like to talk about how this has been affecting you and explore what kind of support might feel helpful. There are different resources available, and I'm here to guide you through them if that feels right for you. How does that sound?"

An Important Note About Mental Health Screening Tools

Screening tools, like the PHQ-9:

- Support nursing assessment and intervention by providing structured insight into a client's symptoms.
- Are to be used alongside other tools (e.g., care plans, educational resources, clinical observations).
- Help to identify and monitor symptoms of depression over time.
- Aid in client education by increasing awareness of symptoms and available support.
- Provide an opportunity to strengthen the therapeutic relationship when administered in a supportive, trauma-informed manner.
- **Are to be used in a manner that complements, but does not replace, clinical judgement.**



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Citation: Bradley, C., Olarte-Godoy, J., Moisey, L., Strohm, S., Weatherby, J. & Jack, S.M on behalf of the PHN-PREP Project Team [2025]. Administration, Scoring & Interpretation of the Patient Health Questionnaire-9 (PHQ-9) [Professional Resource]. School of Nursing, McMaster University.