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Original article

Presence in head and neck cancer multidisciplinary team meeting: The patient's experience and satisfaction

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ABSTRACT

Background: In oncology, multi-disciplinary team meetings improve overall survival and reduce time to treatment in head and neck cancer. Interestingly, no study has examined the experience of patients attending an MTM. The present study addressed two questions: Does the MTM cause anxiety/depression for patients who are present? Are patients satisfied at the end of the meeting?
Patients and methods: The study included all patients attending an MTM, who agreed to participate in the study and who fully completed two questionnaires. The Hospital Anxiety and Depression Scale (HADS) and a satisfaction questionnaire were filled out at three time-points: T0 before MTM, T1 at end of MTM, and T2 1 month after MTM for the HADS; and T1 and T2 for the satisfaction questionnaire.
Results: There were no significant differences in the number of patients experiencing anxiety between T0 and T1 ($P = 0.6085$), T0 and T2 ($P = 1$) or T1 and T2 ($P = 1$). Likewise, there were no significant differences in the number of patients in depression between T0 and T1 ($P = 0.9397$), T0 and T2 ($P = 1$) or T1 and T2 ($P = 1$). Mean satisfaction was good (question 14 on the satisfaction questionnaire: 8.7/10 at T1 and 7.7/10 at T2), but with a significant decrease between T1 and T2 ($P = 0.0009$: i.e., < 0.05). Percentage information remembered (question 12) significantly decreased between T1 (mean 86%, standard deviation 0.2, median 94%) and T2 (78% ± 0.2, median 81%) ($P = 0.03$). Presence in the MTM did not appear to induce or increase anxiety or pre-existing depressive syndrome.

1. Introduction

Multidisciplinary Team Meetings (MTM) have been mandatory since the French Ministry of Health circular of February 22, 2005. Their advice is, however, consultative in status.

An MTM quorum comprises at least 3 physicians with different specialties: head-and-neck or maxillary-facial surgeons, radiotherapists, oncologists, radiologists, nuclear medicine specialists, pathologists and/or reconstructive surgeons [1]. The complete medical file is presented at the meeting: disease history, clinical examination, endoscopy report, pathology findings, and imaging. After discussion, treatment is proposed in presence of the patient or in the medical file. It is based on regional, national or international guidelines, which in turn are based on the most recent scientific data [2]. On the day following the meeting, the proposal is sent to all relevant present and future actors and correspondents, so as to begin treatment as soon as possible. The patient is at the center of the treatment proposal and care project [3]; although actively involved in the decision-making process, whether he or she actually attends the MTM depends on the particular department's habits.

Some centers opt for a dedicated consultation between patient and head-and-neck surgeon to discuss the MTM's proposal. In our own department, patients usually actually attend the MTM; in a prior consultation, announcing the diagnosis of cancer, the MTM is explained. The patient may then attend accompanied by a person of trust or other persons, or alone in front of a number of physicians that he or she does not know but who were known to be going to be present. This may prove traumatic and induce anxiety/depression syndrome.

Instituting MTMs significantly reduces the interval between pathologic diagnosis and treatment initiation [4] and improves

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1879-7296/

survival [5]. In 10% of cases, the treatment protocols are altered in the light of MTM opinion and in 49% diagnosis needs completing or refining by reviewing imaging or by further pathology analysis [4]. In the field of head and neck oncology, few studies have assessed satisfaction in patients attending the meeting or their anxiety/depression status after the meeting.

The main objective of the present study was to assess psychological impact before, at the end of and 1 month after an MTM on an adapted questionnaire and to assess satisfaction immediately and 1 month after the MTM.

2. Patients and methods

A single-center prospective study was conducted in our ENT and head-and-neck surgery department between December 1, 2016 and March 2, 2017.

2.1. Population

2.1.1. Inclusion criteria

Inclusion criteria comprised: first head and neck cancer confirmed on histology, first attendance at an MTM, with consent form signed after reading an information letter, and with complete response to both questionnaires.

2.1.2. Exclusion criteria

Exclusion criteria comprised: age < 18 years, history of head and neck cancer, and/or attendance at an MTM related to any other organ; likewise: illiteracy or poor command of French, or severe cognitive disorder with protected status preventing good understanding and participation. Data for patients failing to follow the questionnaire instructions or with incomplete responses were also excluded.

2.2. Study design

Patients to be included on the MTM presence-list were preselected on the above criteria by the investigating physician. They were visited in the department, and were given the information letter presenting the study and the consent form to be signed. Those agreeing to participate filled out the Hospital Anxiety and Depression Scale (HADS), without medical or paramedical assistance, ahead of the MTM. All included patients did actually attend their MTM.

After the meeting, the patient again filled out the HADS, without medical or paramedical assistance, plus the "MTM experience" satisfaction questionnaire, and handed these to the consultation nurses who handed them on to the investigating physician. All responses were then rendered anonymous.

Thus, the HADS questionnaire was given to the patient before (T0) and just after the MTM (T1) and then sent to his or her home address 1 month later (T2). The specific MTM questionnaire was given at T1 and then at home at T2. At T2, the two questionnaires were sent by mail with stamped-addressed envelope to simplify return.

The medical files were checked to ensure that T2 was at least 10 days before initiation of the treatment decided on in the MTM.

Responses to the 2 questionnaires were entered in an Excel spreadsheet.

2.3. Questionnaires

2.3.1. MTM questionnaire

A dedicated MTM questionnaire was drawn up to assess the patient's experience and satisfaction after the meeting. It was submitted to the center's Clinical Research and Innovation Delegation, and met with no objections (Appendix 1).

It comprised 15 questions, including 12 yes/no questions. Two other questions were in the form of a 0–10 cm visual analog scale (VAS), with 0 as the most negative and 10 the most positive appreciation. The other question required a percentage response on a 10 cm scale from 0 to 100%. A free comment was invited at the end of the questionnaire. Self-administration time was less than 5 minutes.

2.3.2. Hospital Anxiety and Depression Scale (HADS)

In 1983, Zigmond et al. [6] validated the HAD Scale for assessment of anxiety and depression in patients admitted to non-psychiatric health-care structures. It is a short questionnaire, not dependent on the organic aspect of the respondent's pathology. It takes account only of the psychological aspect, and administration can be repeated (Appendix 2). It is very widely used in cancer patients, and has been specifically validated in head and neck cancer [7]. Although short, its sensitivity and specificity are as good as those of the General Health Questionnaire (GHQ), Beck Depression Inventory (BDI) and State-Trait Anxiety Inventory (STAI) [7]. It comprises 7 items assessing depression, focusing on anhedonia secondary to depression, and 7 items assessing anxiety. We therefore used this scale to assess patients' anxiety and depression before and after attending the MTM. The 7 anxiety questions are scored 0 to 3, for a total score of 0–21; depression is assessed in the same way. Global scores 0–7 indicate absence of symptoms of anxiety or depression, scores 8-10 are inconclusive, and scores $\geq$ 11 indicate anxiety/depression.

2.4. Statistics

Statistical analysis was performed by the hospital's Biostatistical Methodology and Data Management department. Data were transmitted on an Excel spreadsheet, with patients identified only by a number, ensuring total anonymity.

Responses to the MTM questionnaire were collected as follows:

- for items 1–8, 10–11, 13 and 15: 0 for "no" and 1 for "yes";
- items 9, 12 and 14 were scored respectively out of 10, as a percentage, and out of 10, with 0 or 0% = 0 cm and 10 or 100% = 10 cm;
- all item scores were compared between T1 and T2.

Responses to the HADS were collected as follows:

- 0 = no symptoms of anxiety/depression (global score 0–7);
- 1 = confirmed anxiety/depression (global score $\geq$ 11);
- 2 = doubtful symptomatology (global score 8–10).

HADS scores were compared between T0, T1 and T2 to see whether patients changed status over time between "anxiety syndrome", "no anxiety syndrome", "depressive syndrome" and "no depressive syndrome". For this, patients were dichotomized as "syndrome present" or "syndrome absent", with doubtful anxiety or depression counted as "no anxiety syndrome" and "no depressive syndrome" respectively.

The MTM questionnaire assessed change in response between T1 and T2.

Numerical variables were expressed as mean, standard deviation, median and range, and qualitative variables as number and percentage. Normal distribution was checked visually on histograms and also by Shapiro–Wilk test. Analysis of change in anxiety and depression over time and according to cancer stage (early stages 1 and 2 versus advanced stages 3 and 4) used analysis of variance for repeated measures on a mixed linear model with Bonferroni correction for post-hoc analyses. Comparison between

Table 1
Epidemiology and TNM classification.

	n = 34 (%)
Age (years)	60.5 [25;73]
Gender	
Male	25 (73.5%)
Female	9 (26.5%)
Sex ratio	2.78:1
Tumor site	
Oropharynx	9 (26.5)
Oral cavity	9 (26.5)
Larynx	8 (23.5)
Piriform sinus	3 (8.8)
Nasal cavity	1 (2.9)
Adenopathy with unknown primary	4 (11.8)
T	
Tis	2 (5.8)
T1	7 (20.6)
T2	8 (23.5)
T3	6 (17.6)
T4	7 (20.6)
Tx	4 (11.9)
N	
N0	17 (50)
N1	7 (20.6)
N2a	1 (2.9)
N2b	2 (5.9)
N2c	5 (14.7)
N3	1 (2.9)
Nx	1 (2.9)
M	2 (5.8)

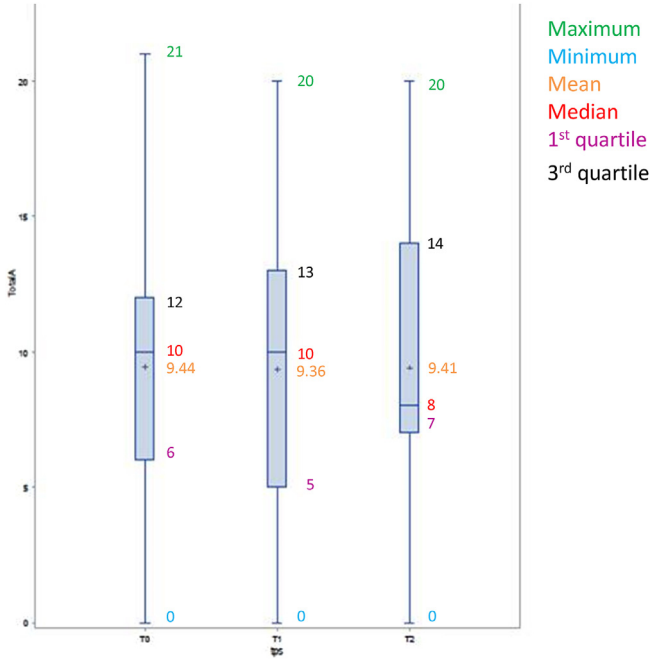

Fig. 1. Comparison of anxiety scores at time-points T0, T1 and T2. NS: Non-significant.

responses just after the MTM and 1 month later used the McNemar test for binary variables, and matched Student or matched Wilcoxon test according to normality of distribution.

The significance threshold was set at 5%. Analyses were performed on SAS software v 9.3 (SAS Institute).

3. Results

3.1. Epidemiology

Between December 1, 2016 and March 2, 2017, 255 cases were discussed in MTMs, with 144 patients present, 74 of whom met the study criteria; 54 of these agreed to take part in the study, but only 34 (63%) filled out all questionnaires at T0, T1 and T2 correctly and precisely. This final study population comprised 25 male (73.5%) and 9 female patients (26.5%), for a sex-ratio of 2.78:1, with mean age 60.5 years, median 60 years and range 25–73 years. Lesions involved the oral cavity in 9 cases, oropharynx in 9, larynx in 8, piriform sinus in 3 and nasal cavity in 1, plus 4 cases of adenopathy with unknown primary. TNM stages comprised 2 Tis (in situ), 7 T1, 8 T2, 6 T3, 7 T4, and 4 Tx. Half of the patients (*n* = 17) showed lymph-node status N0, 7 N1, 1 N2a, 2 N2b, 5 N2c, 1 N3, and 1 Nx. Only 2 patients showed metastatic status M1 (Table 1).

3.2. HADS results

3.2.1. Descriptive statistics

At T0, 12 of the 34 patients showed no anxiety syndrome, 10 were anxious and 12 were classified as doubtful; 22 showed no depressive syndrome, 6 showed depression and 6 were classified as doubtful.

At T1, 13 patients showed no anxiety syndrome, 14 were anxious and 7 were classified as doubtful; 24 showed no depressive syndrome, 3 showed depression and 7 were classified as doubtful.

At T2, 11 patients showed no anxiety syndrome, 12 were anxious and 11 were classified as doubtful; 20 showed no depressive syndrome, 5 showed depression and 9 were classified as doubtful.

There were no differences in the number of patients showing anxiety ($P = 0.51$) or depression ($P = 0.97$) according to early versus advanced tumor stage.

3.2.2. Comparative analysis according to time-point

Total anxiety score did not significantly change over time: T0, median 10 [6–12], T1 median 10 [5–13] ($P = 1$); T0–T2, $P = 1$; and T1–T2, $P = 1$ (Fig. 1).

There were likewise no significant differences in presence of anxiety syndrome (anxiety score ≥ 11) between T0 and T1 ($P = 0.6085$), T0 and T2 ($P = 1$) or T1 and T2 ($P = 1$).

Total depression score differed significantly between T1 (median 5 [3–8]) and T2 (median 7 [4–9]) ($P = 0.04$): i.e., a significant increase 1 month after the MTM. Total depression score, on the other hand, did not differ significantly between T0 and T1 ($P = 1$) or T0 and T2 ($P = 0.22$) (Fig. 2).

There were no significant differences in presence of depressive syndrome (depression score ≥ 11) between T0 and T1 ($P = 0.9397$), T0 and T2 ($P = 1$) or T1 and T2 ($P = 1$).

And there were no significant differences at the 3 time-points in the number of patients showing anxiety ($P = 0.88$ at T0, $P = 0.53$ at T1 and $P = 0.21$ at T2) or depression ($P = 0.13$ at T0, $P = 0.14$ at T1 and $P = 0.20$ at T2) according to early (stages 1 and 2) or advanced (stages 3and 4) cancer.

3.3. MTM questionnaire results

3.3.1. Descriptive statistics

The vast majority of patients did not find the wait-time before the MTM too long (Q1: 88.2% at T1 and 91.2% at T2) and were not bothered by the presence of patients under treatment in the waiting room (100% negative responses to Q2) (Appendix 3 Table 2). Wait-time before the MTM was largely considered stressful at T1, but less so retrospectively at T2 (Q3: 52.9% at T1 and 47.1% at T2). Most patients considered the MTM room to be appropriate; 88.2% at T1 and 91.2% at T2 (Q6). According to 76.5% of respondents at T1 and 81.8% at T2, the specialists present in the meeting introduced themselves to the patient (Q7). Unease at being in the presence of

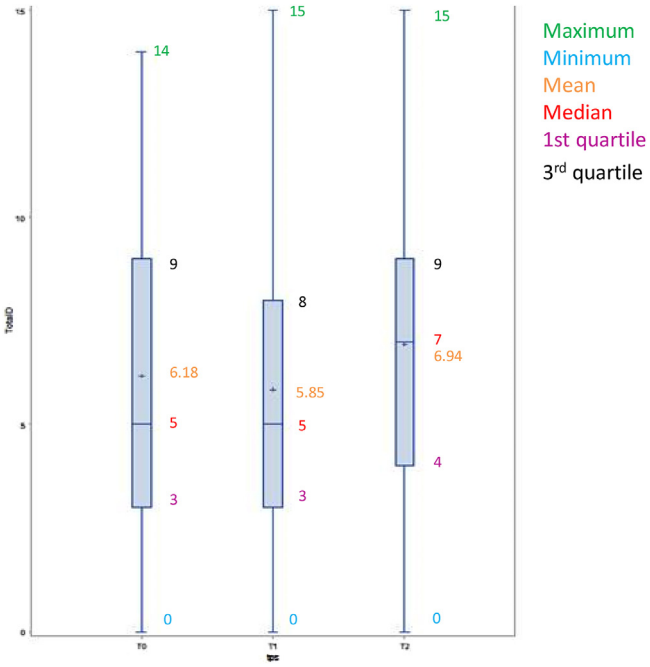

Fig. 2. Comparison of depression scores at time-points T0, T1 and T2. S: significant.

so many physicians was assessed at a mean 3.8/10 at T1 and 5.1/10 at T2 (Q8). Patients hardly ever felt bothered by undergoing clinical examination in the presence of so many physicians (Q9: 3% at T1 and 6.1% at T2). All patients understood the information concerning their pathology and the vocabulary used at T1, but rather fewer at T2 (Q10 and Q11); a large percentage of the information seemed to have been understood (Q12: 86% at T1 and 78% at T2). Most patients were able to ask questions during the MTM (Q13: 90.9% at T1 and 87.9% at T2).

Mean satisfaction with the MTM was good (Q14: 8.7/10 at T1 and 7.7/10 at T2). Most patients were informed as to the MTM procedure and the various treatment options (Q4 and Q5: respectively, 73.5% and 85.3% at T1).

3.3.2. Comparative analysis according to time-point

There were no significant differences in responses at T1 versus T2 for questions Q1 ($P = 0.32$), Q3 ($P = 0.41$), Q4 ($P = 1$), Q5 ($P = 0.34$), Q6 ($P = 0.65$), Q7 ($P = 1$), Q9 ($P = 0.56$) or Q13 ($P = 0.56$). Thus, there were no significant differences in patients' positive assessments at end of MTM and 1 month later regarding:

- wait-time leading up to MTM;
- time in the waiting room before MTM;
- information on MTM and treatment options;
- freedom to ask any questions in the meeting;
- suitability of the meeting room for the patient;
- or physicians' introductions and discomfort with clinical examination during the meeting.

Questions 2, 10, 11 and 15 could not be assessed statistically for lack of power.

For question 8, regarding unease at being confronted by so many physicians, there was no significant difference between T1 and T2 ($P = 0.06$): mean 3.81/10 (SD, 3.8; median, 3.6) at T1 and 5.1/10 (SD, 3.7; median, 5.4) at T2. Question 12, on percentage information recalled, showed a significant decrease between T1 (mean, 86%; SD, 0.2; median, 94%) and T2 (mean, 78%; SD, 0.2; median, 81%) ($P = 0.03$).

Global satisfaction (Q14) decreased significantly between T1 and T2 ($P = 0.0009$; i.e., < 0.05), from a mean 8.7/10 (SD, 1.8; median, 9.3) to 7.7/10 (SD, 2.3; median, 8.2).

4. Discussion

Files of all patients with head and neck cancer are discussed in MTM, which has been made mandatory by the French Ministry of Health since 2005; certain rules are laid down, including a quorum, but it is not specified whether the patient must be present. In our own department, the former Oncology Decision Committees, now MTMs, usually include patient presence. In case of first tumor requiring general health status assessment to guide treatment, if the patient is willing, his or her presence is suggested, but never required.

To ensure rigorous interpretation, we wished questionnaires to be filled out entirely, respecting the instructions, and without medical or paramedical assistance. However, 20 of the 54 eligible patients were excluded due to incomplete questionnaires, with 1 or more missing responses, or questionnaires accompanied by comments that light influence interpretation.

The impact of MTMs on survival is well-established. In 2011, Friedland et al. compared 5-year survival in stage IV head and neck cancer when treatment was or was not determined in an MTM; 5-year survival was significantly improved by the MTM [8]. In 2012, Wang showed reduced relative risk of death in oral cavity cancer patients with versus without therapeutic discussion in MTM [9]. In 2007, Butow et al. assessed MTMs in breast cancer: 93% of patient association representatives (all themselves breast-cancer patients) were in favor of patient presence at MTMs [10]; in contrast, fewer than a third of surgeons and oncologists were in favor. No studies, however, have focused on patient presence and experience in MTMs in head and neck oncology.

5. Satisfaction with MTM

Stalfors et al. studied patient satisfaction with participation in head and neck oncology MTMs [11], with 2 groups: patients physically present alongside their ENT physician, and others participating via a telemedicine system, but with their community physician alongside. Satisfaction questionnaire responses showed little difference, except for 2 items: "I felt everyone was speaking about me but not directly to me", and "I was reassured to have my doctor beside me" (i.e., hospital ENT physician or community physician, depending on the group). Patients physically present in the meeting significantly more often answered "yes" to the first question than those attending remotely, while the telemedicine group significantly more often answered "yes" to the second question. These are interesting points, showing that, when patients are present in the meeting, they wish to be at the heart of decision-making and to be able to express their point of view and their hesitations in the questions they ask the physicians. When this direct contact is not possible and the meeting takes place as a video-conference, patients want the support of a person of trust (in this study, their community physician). The present study did not use or assess telemedicine; but it did emerge that when patients were present alongside their ENT physician, global satisfaction was high, with 8 out of 10 patients satisfied both at the end of the meeting at 1 month later. In the study by Choy et al. [12], 91% of patients reported better understanding of their disease, 71% reported better understanding of the proposed treatments, 84% said they were better informed. These findings are similar to those of the present study, where more than 90% of patients understood the information given in the MTM, and 86% of the information was remembered at T1 and 78% at T2, although at T2 the rate of understanding was

lower, probably due to the passage of time. Moreover, it did not seem that patients were bothered by the clinical examination or inhibited in their questioning.

Patients did not seem particularly bothered by the wait-time before the meeting or by the presence of patients under treatment or the discomfort of the meeting room. These are points that might seem disagreeable to an outside observer (medical or paramedical). On the other hand, the number of physicians present at the meeting seemed to be a source of non-negligible bother retrospectively; this might be reduced by having the patient present in a dedicated examination room with the requisite quorum of physicians, with video transmission to another room where senior and trainee practitioners could see the examination and discussion.

6. HADS score

There was no evidence of increased anxiety just after the MTM or 1 month later, in agreement with Choy et al. [12], who found no difference in anxiety between breast cancer patients who attended the MTM and those who did not. Choy et al. used the STAI anxiety questionnaire; the present study used the HADS, recognized and validated in head and neck oncology for the assessment of anxiety and depression [13]. However, MTM attendance might be seen as a source of acute stress, which the HADS is not designed to detect; there are at present no questionnaires dedicated to this situation and validated in head and neck oncology.

The study also showed a significant increase in total depression score between T1 (end of meeting) and T2 (1 month later). During the interval, patients received support care which enhanced their awareness of their disease, possibly biasing interpretation of this increase. On the other hand, there was no significant change over time in the numbers of patients with or without anxiety or depression syndrome; it would thus seem that anxiety or depression syndrome is unaffected by MTM attendance. It might nevertheless be useful to target this T1–T2 period, offering more systematic onco-psychological help before initiating treatment.

MTM costs were not assessed in the present study. From the point of view of health expenditure, it could be useful to assess the overall cost of these meetings, on the physicians' side and the patients' side, and compare this with the global satisfaction, experience and compliance of patients attending or not attending the MTM [14,15].

7. Conclusion

MTMs only recently became mandatory, but their interest for the patient and benefit in terms of survival have been demonstrated. Few studies, however, focused on the experience of head and neck cancer patients; satisfaction associated with attendance has been little explored. The present study showed that attendance did not significantly induce anxiety and depression syndrome. Patient satisfaction was very positive. The presence of multiple specialties in the meeting did not seem to be a bother, and rather enabled the patient to question the physicians and obtain clear information while remaining at the heart of the decision-making process.

Table 2 Questionnaire on patient experience of MTM at T1 (end of meeting) and T2 (1 month later). Results reported as percentage, mean or median, depending on the question, with *P*-values.

Questions	**Yes (%)**		**No (%)**		***P***
	T1	*T2*	*T1*	*T2*	
Q1/Did the wait time before going into the MTM room seem long?	11.8	8.8	88.2	91.2	NS(p = 0.32)
Q2/Were you bothered by the presence of patients under treatment in the waiting room?	0	2.9	100	97.1	WE
Q3/Was it stressful awaiting the day of the MTM?	52.9	47.1	47.1	52.9	NS(p = 0.41)
Q4/Were you told how the MTM would proceed?	73.5	70.66	26.5	29.4	NS (p = 1)
Q5/Were you informed of the various treatment options?	85.3	73.5	14.7	26.5	NS(p = 0.34)
Q6/Did you find the MTM room appropriate (comfort, noise, etc.)? If not, why not?	88.2	91.2	11.8	8.8	NS(p = 0.65)
Q7/Were the main representatives of the medical team present?	76.5	81.8	23.5	18.2	NS (p = 1)
Q8/Were you overwhelmed or bothered by the number of people in the meeting?	Mean T1/T2 Median T1/T2 3.8/5.1 3.6/5.4 NS (*P* = 0.06)				
Q9/Were you bothered by the clinical exam in front of all of these doctors?	3	6.1	97	93.9	NS(p = 0.56)
Q10/Did you understand all the information provided?	100	90.9	0	9.1	WE
Q11/Was the vocabulary the doctors used comprehensible?	100	91.2	0	8.8	WE
Q12/What percentage of the information did you remember?	% T1/T2 86/78 *P* = 0.03				
Q13/Were you able to ask your questions?	90.9	87.9	9.1	12.1	NS(p = 0.56)
Q14/How do you rate your overall satisfaction with the MTM?	Mean T1/T2 MedianT1/T2 8.7/7.7 9.3/8.3 p = 0.0009				
Q15/Was it difficult for you to organize your attendance?	8.8	6.1	91.2	93.9	WE

NS: non-significant. WE: weak effect. NC: not concerned.

Disclosure of interest

The authors declare that they have no competing interest.

Appendix A. Appendix 1

Questionnaire assessing patient experience and satisfaction regarding the MTM
First 3 letters of your surname: _ _ _
First 3 letters of your first name: _ _ _
This questionnaire is intended to assess your satisfaction and experience regarding the Multidisciplinary Team Meeting you just attended. For questions 1 to 8, 10, 11, 13 and 15, answer "yes" or "no"; questions 9, 12 and 14 are answered on scales that you will find on page 2.

	YES	NO
Q1/ Did the wait time before going into the MTM room seem long?		
Q2/ Were you bothered by the presence of patients under treatment in the waiting room?		
Q3/ Was it stressful awaiting the day of the MTM?		
Q4/ Were you told how the MTM would proceed?		
Q5/ Were you informed of the various treatment options?		
Q6/ Did you find the MTM room appropriate (comfort, noise, etc.)? If not, why not?		
Q7/ Were the main representatives of the medical team present?		
Q8/ Were you overwhelmed or bothered by the number of people in the meeting?		
Q9/ Were you bothered by the clinical exam in front of all of these doctors?		
Q10/ Did you understand all the information provided?		
Q11/ Was the vocabulary the doctors used comprehensible?		
Q12/ What percentage of the information did you remember?		
Q13/ Were you able to ask your questions?		
Q14/ How do you rate your overall satisfaction with the MTM?		
Q15/ Was it difficult for you to organize your attendance?		

Q.9. Were you bothered by the clinical exam in front of all of these doctors?

0 10

Answer by marking a cross along the arrow at the level of how much you were bothered.
Q.12. What percentage of the information did you remember?

0 100%

Answer by marking a cross along the arrow at the level of the percentage of information you remembered.
Q.14. How do you rate your overall satisfaction with the MTM?

0 10

Answer by marking a cross along the arrow at the level of your satisfaction.

Thank you for your answers and the time you gave to fill out this questionnaire.
Please hand the filled out questionnaire to a nurse before you leave.

Appendix B. Appendix 2

Hospital Anxiety and Depression Scale (HADS)
Hospital Anxiety and Depression Scale (HADS)
Tick the box beside the reply that is closest to how you have been feeling in the past week.
Don't take too long over you replies: your immediate is best.

D	A		D	A	
		I feel tense or 'wound up':			**I feel as if I am slowed down:**
	3	Most of the time	3		Nearly all the time
	2	A lot of the time	2		Very often
	1	From time to time, occasionally	1		Sometimes
	0	Not at all	0		Not at all
		I still enjoy the things I used to enjoy:			**I get a sort of frightened feeling like 'butterflies' in the stomach:**
0		Definitely as much		0	Not at all
1		Not quite so much		1	Occasionally
2		Only a little		2	Quite Often
3		Hardly at all		3	Very Often
		I get a sort of frightened feeling as if something awful is about to happen:			**I have lost interest in my appearance:**
	3	Very definitely and quite badly	3		Definitely
	2	Yes, but not too badly	2		I don't take as much care as I should
	1	A little, but it doesn't worry me	1		I may not take quite as much care
	0	Not at all	0		I take just as much care as ever
		I can laugh and see the funny side of things:			**I feel restless as I have to be on the move:**
0		As much as I always could		3	Very much indeed
1		Not quite so much now		2	Quite a lot
2		Definitely not so much now		1	Not very much
3		Not at all		0	Not at all
		Worrying thoughts go through my mind:			**I look forward with enjoyment to things:**
	3	A great deal of the time	0		As much as I ever did
	2	A lot of the time	1		Rather less than I used to
	1	From time to time, but not too often	2		Definitely less than I used to
	0	Only occasionally	3		Hardly at all
		I feel cheerful:			**I get sudden feelings of panic:**
3		Not at all		3	Very often indeed
2		Not often		2	Quite often
1		Sometimes		1	Not very often
0		Most of the time		0	Not at all
		I can sit at ease and feel relaxed:			**I can enjoy a good book or radio or TV program:**
	0	Definitely	0		Often
	1	Usually	1		Sometimes
	2	Not Often	2		Not often
	3	Not at all	3		Very seldom

Please check you have answered all the questions Scoring:
Total score: Depression (D)..... Anxiety (A).....
0-7 = Normal
8-10 = Borderline abnormal (borderline case) 11-21 = Abnormal (case).

Appendix C. Appendix 2

References

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