



The anxiety, depression, and TMD: Multidisciplinary therapy

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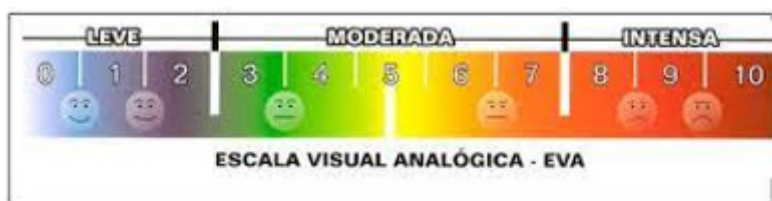
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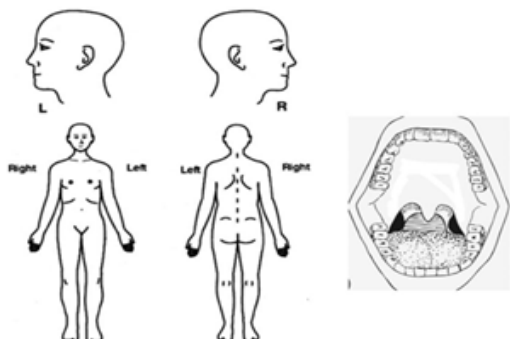
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Appendix 1: EVA



Appendix 2: Pain Drawing



Appendix 3: Scoring report form

Pain Drawing Number of body areas with pain	0	1	2	3	4	5	>5
	NONE	MILD	MODERATE	SEVERE			
Chronic Pain Grade	0	I	II	III	IV		
	NONE	NO DISABILITY	NO DISABILITY	MODERATELY LIMITING	SEVERELY LIMITING		
PHQ-9 Depression	0-4	5-9	10-14	15-19	20-27		
	NONE	MILD	MODERATE	MOD-SEVERE	SEVERE		
GAD-7 Anxiety	0-4	5-9	10-14	15-21			
	NONE	MILD	MODERATE	SEVERE			
OBC Parafuncion	0	1-24		25-84			
	NONE	LOW		HIGH			

Submitted: November 16, 2024
 Accepted: December 16, 2024
 Published online: December 30, 2024



Appendix 4: PHQ-9

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 of 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	0	1	2	3

Add columns + +

(Healthcare professional: For interpretation of TOTAL, TOTAL: + + please refer to accompanying scoring card).

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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Appendix 5: PHQ-9 Anxiety Disorder,

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 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.

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-24	Severe depression

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A2662B 10-04-2005



Appendix 6: GAD-7- Patient Health

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day." GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety



Appendix 7: Graded Chronic Pain Scale Appendix 4: PHQ-9

Graded Chronic Pain Scale

1. How would you rate your facial pain on a 0 to 10 scale AT THE PRESENT TIME, that is right now, Where 0 is "no pain" and 10 is "pain as bad as could be". (circle number)

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as could be

2. In the PAST SIX MONTHS, how intense was your WORST facial pain? (Circle number)

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as could be

3. In the PAST SIX MONTHS, on the AVERAGE, how intense was your facial pain? That is, your usual pain at times you were experiencing pain,) (Circle number)

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as could be

4. About how many in the LAST SIX MONTHS have you been kept from your usual activities (work, school, housework) because of facial pain? (EVERY DAY = 180)

			DAYS
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5. In the PAST SIX MONTHS, how Much has facial pain interfered with your daily activities rated on a scale from 0 to 10, Where 0 is "no interference" and 10 is "Unable to carry on any activities"? (Circle number)

0	1	2	3	4	5	6	7	8	9	10
No interference										Unable to carry on any activities

6. In the PAST SIX MONTHS, how Much has facial pain interfered with your ability to take part in recreational, social, and Family activities? (Circle number)

0	1	2	3	4	5	6	7	8	9	10
No interference										Unable to carry on any activities

7. In the PAST SIX MONTHS, how Much has facial pain interfered with your ability to work (including housework)? (Circle number)

0	1	2	3	4	5	6	7	8	9	10
No interference										Unable to carry on any activities



Appendix 8: Oral Behaviors Checklist (OBC) Appendix 6: GAD-7

How often have you done each of the following activities, based on the last month? If the frequency of activities varies, choose the most frequent option. Mark (v) one answer for each item and do not skip any item. If you change your mind, completely fill in the incorrect mark and then mark (v) the new response.

Atividades durante o sono		Never	<1 night/ month	1-3 nights/ month	1-3 noites/ semana	4-5 noites/ semanas
1	Clench or grind your teeth while sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Sleep in a position that puts pressure on your jaw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atividades durante a vigília (acordado)		Never	A small part of the time	Some part of the time	Most of the time	All the time
3	Grind your teeth when you're awake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	You clench your teeth when you're awake. Presses, touches or keeps teeth in contact other than upper and lower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Grind your teeth when you're awake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Hold, tense or tense the muscles, without clenching or touching the teeth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Holds or projects the jaw forward or to the side.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Press your tongue tightly against your teeth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Put your tongue between your teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Bites, chews, or plays with the tongue, cheeks, or lips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Holds the jaw in a rigid or tense position, such as to hold or protect the jaw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Holds between teeth or bites objects, such as hair, pipe, pencil, pens, fingers, nails, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Use chewing gum (gum)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Plays a musical instrument that involves the use of the mouth or jaw (e.g., wind, brass, or string instruments)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Tilt your hand on your jaw, as if you were going to place or rest your chin on your hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Chew food on one side only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Eats between meals (i.e. food that requires chewing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Prolonged speaking (e.g. teaching, sales, customer service)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	Sing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	Yawns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	Hold the phone between your head and shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Markiewicz MR, Ohrbach R, McCall WD. Oral Behaviors Checklist: reliability of performance in targeted waking-state behaviours. J Orofac Pain. 2006; 20:306–316.