

earlier, the diagnosis of disruptive mood dysregulation disorder should not be assigned if the symptoms occur only in an anxiety-provoking context, when the routines of a child with autism spectrum disorder or obsessive-compulsive disorder are disturbed, or in the context of a major depressive episode.

183

Major Depressive Disorder

Diagnostic Criteria

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
 6. Fatigue or loss of energy nearly every day.
 7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
 9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The episode is not attributable to the physiological effects of a substance or another medical condition.
- Note:** Criteria A–C represent a major depressive episode.
- Note:** Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.¹
- D. At least one major depressive episode is not better explained by schizoaffective disorder and is not superimposed on

schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

- E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

184

Coding and Recording Procedures

The diagnostic code for major depressive disorder is based on whether this is a single or recurrent episode, current severity, presence of psychotic features, and remission status. Current severity and psychotic features are only indicated if full criteria are currently met for a major depressive episode. Remission specifiers are only indicated if the full criteria are not currently met for a major depressive episode. Codes are as follows:

Severity/course specifier	Single episode	Recurrent episode*
Mild (p. 214)	F32.0	F33.0
Moderate (p. 214)	F32.1	F33.1
Severe (p. 214)	F32.2	F33.2
With psychotic features** (pp. 212–213)	F32.3	F33.3
In partial remission (p. 214)	F32.4	F33.41
In full remission (p. 214)	F32.5	F33.42
Unspecified	F32.9	F33.9

*For an episode to be considered recurrent, there must be an interval of at least 2 consecutive months between separate episodes in which criteria are not met for a major depressive episode. The definitions of specifiers are found on the indicated pages.

******If psychotic features are present, code the “with psychotic features” specifier irrespective of episode severity.

In recording the name of a diagnosis, terms should be listed in the following order: major depressive disorder, single or recurrent episode, severity/psychotic/remission specifiers, followed by as many of the following specifiers without codes that apply to the current episode (or the most recent episode if the major depressive disorder is in partial or full remission). **Note:** The specifier “with seasonal pattern” describes the pattern of recurrent major depressive episodes.

Specify if:

With anxious distress (pp. 210–211)

With mixed features (p. 211)

With melancholic features (pp. 211–212)

185

With atypical features (p. 212)

With mood-congruent psychotic features (p. 213)

With mood-incongruent psychotic features (p. 213)

With catatonia (p. 213). **Coding note:** Use additional code F06.1.

With peripartum onset (p. 213)

With seasonal pattern (applies to pattern of recurrent major depressive episodes) (p. 214)

Diagnostic Features

Major depressive disorder is defined by the presence of at least one major depressive episode occurring in the absence of a history of manic or hypomanic episodes. The essential feature of a major depressive episode is a period lasting at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in all or nearly all activities for most of the day nearly every day (Criterion A). The individual must also experience at

least four additional symptoms during the same 2-week period, drawn from a list that includes changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or thoughts of death, suicidal ideation, a suicide attempt, or a specific plan for suicidal behavior. To count toward a diagnosis of a major depressive episode, a symptom must either be newly present or have clearly worsened compared with the individual's pre-episode status. Moreover, the symptoms must occur nearly every day, for at least 2 consecutive weeks, with the exception of thoughts of death and suicidal ideation, which must be recurrent, and attempting suicide or making a specific plan, which only needs to occur once. The episode must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning. For some individuals with milder episodes, functioning may appear to be normal but requires markedly increased effort. The presenting complaint is often insomnia or fatigue rather than depressed mood or loss of interest; thus, the failure to probe for accompanying depressive symptoms can result in underdiagnosis. Fatigue and sleep disturbance are present in a high proportion of cases; psychomotor disturbances are much less common but are indicative of greater overall severity, as is the presence of delusional or near-delusional guilt.

The mood in a major depressive episode is often described by the individual as depressed, sad, hopeless, discouraged, or "down in the dumps" (Criterion A1). In some cases, sadness may be denied at first but may subsequently be elicited by interview (e.g., by pointing out that the individual looks as if he or she is about to cry). In some individuals who complain of feeling "blah," having no feelings, or feeling anxious, the presence of a depressed mood can be inferred from the individual's facial expression and demeanor. Some individuals emphasize somatic complaints (e.g., bodily aches and pains) rather than reporting feelings of sadness. Many individuals report or exhibit increased irritability (e.g., persistent anger, a tendency to respond to events with angry outbursts or blaming others, an exaggerated sense of frustration over minor matters). In children and adolescents, an irritable or cranky mood may develop rather than a sad or dejected mood. This presentation should be differentiated from a pattern of irritability when frustrated.

Diminished interest or pleasure in usual activities is nearly always present, at least to some degree. Individuals may report feeling less interested in hobbies, “not caring anymore,” or not feeling any enjoyment in activities that were previously considered pleasurable (Criterion A2). Family members often notice social withdrawal or neglect of pleasurable avocations (e.g., a formerly avid golfer no longer plays, a child who used to enjoy soccer finds excuses not to practice). In some individuals, there is a significant reduction from previous levels of sexual interest or desire.

186

Appetite change may involve either a reduction or an increase. Some depressed individuals report that they have to force themselves to eat. Others may eat more and may crave specific foods (e.g., sweets or other carbohydrates). When appetite changes are severe (in either direction), there may be a significant loss or gain in weight, or, in children, a failure to make expected weight gains may be noted (Criterion A3).

Sleep disturbance may take the form of either difficulty sleeping or sleeping excessively (Criterion A4). When insomnia is present, it typically takes the form of middle insomnia (i.e., waking up during the night and then having difficulty returning to sleep) or terminal insomnia (i.e., waking too early and being unable to return to sleep). Initial insomnia (i.e., difficulty falling asleep) may also occur. Individuals who present with oversleeping (hypersomnia) may experience prolonged sleep episodes at night or increased daytime sleep. Sometimes the reason that the individual seeks treatment is for the disturbed sleep.

Psychomotor changes include agitation (e.g., the inability to sit still, pacing, hand-wringing; or pulling or rubbing of the skin, clothing, or other objects) or retardation (e.g., slowed speech, thinking, and body movements; increased pauses before answering; speech that is decreased in volume, inflection, amount, or variety of content, or muteness) (Criterion A5). The psychomotor agitation or retardation must be severe enough to be observable by others and not represent merely subjective feelings. Individuals who display either psychomotor disturbance (i.e., psychomotor agitation or retardation) are likely to have histories of the other.

Decreased energy, tiredness, and fatigue are common (Criterion A6). An individual may report sustained fatigue without physical exertion. Even the smallest tasks seem to require substantial effort. The efficiency with which tasks are accomplished may be reduced. For example, an individual may complain that washing and dressing in the morning are exhausting and take twice as long as usual. This symptom accounts for much of the impairment resulting from major depressive disorder, both during acute episodes and when remission is incomplete.

The sense of worthlessness or guilt associated with a major depressive episode may include unrealistic negative evaluations of one's worth or guilty preoccupations or ruminations over minor past failings (Criterion A7). Such individuals often misinterpret neutral or trivial day-to-day events as evidence of personal defects and have an exaggerated sense of responsibility for untoward events. The sense of worthlessness or guilt may be of delusional proportions (e.g., an individual who is convinced that he or she is personally responsible for world poverty). Blaming oneself for being sick and for failing to meet occupational or interpersonal responsibilities as a result of the depression is very common and, unless delusional, is not considered sufficient to meet this criterion.

Many individuals report impaired ability to think, concentrate, or make even minor decisions (Criterion A8). They may appear easily distracted or complain of memory difficulties. Those engaged in cognitively demanding pursuits are often unable to function. In children, a precipitous drop in grades may reflect poor concentration. In elderly individuals, memory difficulties may be the chief complaint and may be mistaken for early signs of a dementia ("pseudodementia"). When the major depressive episode is successfully treated, the memory problems often fully abate. However, in some individuals, particularly elderly persons, a major depressive episode may sometimes be the initial presentation of an irreversible dementia.

Thoughts of death, suicidal ideation, or suicide attempts (Criterion A9) are common. They may range from a passive wish not to awaken in the morning or a belief that others would be better off if the individual were dead, to transient but recurrent thoughts of dying by suicide, to a specific suicide plan. More severely suicidal individuals may have put their affairs in order (e.g., updated wills, settled debts), acquired needed materials (e.g., a rope or a gun), and chosen a location and time to accomplish the suicide.

Motivations for suicide may include a desire to give up in the face of perceived insurmountable obstacles,

an intense wish to end what is perceived as an unending and excruciatingly painful emotional state, an inability to foresee any enjoyment in life, or the wish to not be a burden to others. The resolution of such thinking may be a more meaningful measure of diminished suicide risk than denial of further plans for suicide.

The degree of impairment associated with a major depressive episode varies, but even in milder cases, there must be either clinically significant distress or some interference in social, occupational, or other important areas of functioning (Criterion B). If impairment is severe, the individual may lose the ability to function socially or occupationally. In extreme cases, the individual may be unable to perform minimal self-care (e.g., feeding and clothing self) or to maintain minimal personal hygiene.

The individual's report of symptoms may be compromised by difficulties in concentrating, impaired memory, or a tendency to deny, discount, or explain away symptoms. Information from additional informants can be especially helpful in clarifying the course of current or prior major depressive episodes and in assessing whether there have been any manic or hypomanic episodes. Because major depressive episodes can begin gradually, a review of clinical information that focuses on the worst part of the current episode may be most likely to detect the presence of symptoms.

The evaluation of the symptoms of a major depressive episode is especially difficult when they occur in an individual who also has another medical condition (e.g., cancer, stroke, myocardial infarction, diabetes, pregnancy). Some of the criterion signs and symptoms of a major depressive episode are identical to those of another medical condition (e.g., weight loss with untreated diabetes; fatigue with cancer; hypersomnia early in pregnancy; insomnia later in pregnancy or the postpartum). Such symptoms count toward a major depressive diagnosis except when they are clearly and fully attributable to another medical condition. Nonvegetative symptoms of dysphoria, anhedonia, guilt or worthlessness, impaired concentration or indecision, and suicidal thoughts should be assessed with particular care in

such cases. Definitions of major depressive episodes that have been modified to include only these nonvegetative symptoms appear to identify nearly the same individuals as do the full criteria.

Associated Features

Major depressive disorder is associated with high mortality, much of which is accounted for by suicide; however, it is not the only cause. For example, depressed individuals admitted to nursing homes have a markedly increased likelihood of death in the first year. Individuals frequently present with tearfulness, irritability, brooding, obsessive ruminations, anxiety, phobias, excessive worry over physical health, and complaints of pain (e.g., headaches; joint, abdominal, or other pains). In children, separation anxiety may occur.

Although an extensive literature exists describing neuroanatomical, neuroendocrinological, and neurophysiological correlates of major depressive disorder, no laboratory test has yielded results of sufficient sensitivity and specificity to be used as a diagnostic tool for this disorder. Until recently, hypothalamic-pituitary-adrenal axis hyperactivity had been the most extensively investigated abnormality associated with major depressive episodes, and it appears to be associated with melancholia (a particularly severe type of depression), psychotic features, and risks for eventual suicide. Molecular studies have also implicated peripheral factors, including genetic variants in neurotrophic factors and pro-inflammatory cytokines. Additionally, volumetric and functional magnetic resonance imaging studies provide evidence for abnormalities in specific neural systems supporting emotion processing, reward seeking, and emotion regulation in adults with major depression.

Prevalence

Twelve-month prevalence of major depressive disorder in the United States is approximately 7%, with marked differences by age group such that the prevalence in 18- to 29-year-old

individuals is threefold higher than the prevalence in individuals age 60 years or older. The most reproducible finding in the epidemiology of major depressive disorder has been a higher prevalence in females, an effect that peaks in adolescence and then stabilizes. Women experience approximately twofold higher rates than men, especially between menarche and menopause. Women report more atypical symptoms of depression characterized by hypersomnia, increased appetite, and leaden paralysis compared with men.

Systematic reviews show that the 12-month and point prevalence of major depressive disorder vary eight- to ninefold across global geographic regions. In the United States, prevalence increased from 2005 to 2015, with steeper rates of increase for youth compared with older groups. After stratification by ethnoracial groups, non-Hispanic Whites showed a significant increase in prevalence after adjustment for demographic characteristics, whereas no significant change in rate of depression was observed among non-Hispanic Blacks or Hispanics.

Development and Course

Major depressive disorder may first appear at any age, but the likelihood of onset increases markedly with puberty. In the United States, incidence appears to peak in the 20s; however, first onset in late life is not uncommon.

The course of major depressive disorder is quite variable, such that some individuals rarely, if ever, experience remission (a period of 2 or more months with no symptoms, or only one or two symptoms to no more than a mild degree), while others experience many years with few or no symptoms between discrete episodes. The course of depression may reflect social-structural adversity associated with poverty, racism, and marginalization.

It is important to distinguish individuals who present for treatment during an exacerbation of a chronic depressive illness from those whose symptoms developed recently. Chronicity of depressive symptoms substantially increases the likelihood of underlying personality, anxiety, and substance use disorders and decreases the likelihood that treatment will be followed by full symptom resolution. It is therefore useful to ask individuals presenting with depressive symptoms to identify the last period of at least 2 months during which they were entirely free of depressive symptoms. Cases in which

depressive symptoms are present for more days than might warrant an additional diagnosis of persistent depressive disorder.

Recovery from a major depressive episode begins within 3 months of onset for 40% of individuals with major depression and within 1 year for 80% of individuals. Recency of onset is a strong determinant of the likelihood of near-term recovery, and many individuals who have been depressed for only several months can be expected to recover spontaneously. Features associated with lower recovery rates, other than current episode duration, include psychotic features, prominent anxiety, personality disorders, and symptom severity.

The risk of recurrence becomes progressively lower over time as the duration of remission increases. The risk is higher in individuals whose preceding episode was severe, in younger individuals, and in individuals who have already experienced multiple episodes. The persistence of even mild depressive symptoms during remission is a powerful predictor of recurrence.

Many bipolar illnesses begin with one or more depressive episodes, and a substantial proportion of individuals who initially appear to have major depressive disorder will prove, in time, to instead have a bipolar disorder. This is more likely in individuals with onset of the illness in adolescence, those with psychotic features, and those with a family history of bipolar illness. The presence of a “with mixed features” specifier also increases the risk for future manic or hypomanic diagnosis. Major depressive disorder, particularly with psychotic features, may also transition into schizophrenia, a change that is much more frequent than the reverse.

There are no clear effects of current age on the course or treatment response of major depressive disorder. Some symptom differences exist, though, such that hypersomnia and hyperphagia are more likely in younger individuals, and melancholic symptoms, particularly psychomotor disturbances, are more common in older individuals. Depressions with earlier ages at onset are more familial and more likely to involve personality disturbances. The course of major depressive disorder within individuals does not generally change with aging. Mean times to recovery do not change

over multiple episodes, and the likelihood of being in an episode does not generally increase or decrease with time.

Risk and Prognostic Factors

Temperamental. Negative affectivity (neuroticism) is a well-established risk factor for the onset of major depressive disorder, and high levels appear to render individuals more likely to develop depressive episodes in response to stressful life events.

Environmental. Adverse childhood experiences, particularly when they are multiple and of diverse types, constitute a set of potent risk factors for major depressive disorder. Women may be disproportionately at risk for adverse childhood experiences, including sexual abuse, that may contribute to the increased prevalence of depression in this group. Other social determinants of mental health, such as low income, limited formal education, racism, and other forms of discrimination, are associated with higher risk of major depressive disorder. Stressful life events are well recognized as precipitants of major depressive episodes, but the presence or absence of adverse life events near the onset of episodes does not appear to provide a useful guide to prognosis or treatment selection. Etiologically, women are disproportionately affected by major risk factors for depression across the life span, including interpersonal trauma.

Genetic and physiological. First-degree family members of individuals with major depressive disorder have a risk for major depressive disorder two- to fourfold higher than that of the general population. Relative risks appear to be higher for early-onset and recurrent forms. Heritability is approximately 40%, and the personality trait neuroticism accounts for a substantial portion of this genetic liability.

Women may also be at risk for depressive disorders in relation to specific reproductive life stages, including in the premenstrual period, postpartum, and in perimenopause.

Course modifiers. Essentially all major nonmood disorders (i.e., anxiety, substance use, trauma- and stressor-related, feeding and eating, and obsessive-compulsive and related disorders) increase the risk of an individual developing depression. Major depressive episodes that develop

against the background of another disorder often follow a more refractory course. Substance use, anxiety, and borderline personality disorders are among the most common of these, and the presenting depressive symptoms may obscure and delay their recognition. However, sustained clinical improvement in depressive symptoms may depend on the appropriate treatment of underlying illnesses. Chronic or disabling medical conditions also increase risks for major depressive episodes. Prevalent illnesses such as diabetes, morbid obesity, and cardiovascular disease are often complicated by depressive episodes, and these episodes are more likely to become chronic than are depressive episodes in medically healthy individuals.

Culture-Related Diagnostic Issues

Although there is substantial cross-cultural variation in the prevalence, course, and symptomatology of depression, a syndrome similar to major depressive disorder can be identified across diverse cultural contexts. Symptoms commonly associated with depression across cultural contexts, not listed in the DSM criteria, include social isolation or loneliness, anger, crying, and diffuse pain. A wide range of other somatic complaints are

common and vary by cultural context. Understanding the significance of these symptoms requires exploring their meaning in local social contexts.

Symptoms of major depressive disorder may be underdetected or underreported, potentially leading to misdiagnosis, including overdiagnosis of schizophrenia spectrum disorders in some ethnic and racialized groups facing discrimination. Cross-nationally, higher levels of income inequality in a society are associated with higher prevalence of major depressive disorder. In the United States, the chronicity of major depressive disorder appears to be higher among African Americans and Caribbean Blacks compared with non-Latinx Whites, possibly because of the impact of racism, discrimination, greater sociostructural adversity, and lack of access to quality mental health care.

Sex- and Gender-Related Diagnostic Issues

There are no clear differences between genders in treatment response or functional consequences. There is some evidence for sex and gender differences in phenomenology and course of illness. Women tend to experience more disturbances in appetite and sleep, including atypical features such as hyperphagia and hypersomnia, and are more likely to experience interpersonal sensitivity and gastrointestinal symptoms. Men with depression, however, may be more likely than depressed women to report greater frequencies and intensities of maladaptive self-coping and problem-solving strategies, including alcohol or other drug misuse, risk taking, and poor impulse control.

Association With Suicidal Thoughts or Behavior

Age-adjusted rates of suicide in the United States have increased from 10.5 to 14.0 per 100,000 over the past two decades. An earlier review of the literature indicated that individuals with depressive illness have a 17-fold increased risk for suicide over the age- and sex-adjusted general population rate. The likelihood of suicide attempts lessens in middle and late life, although the risk of death by suicide does not. The possibility of suicidal behavior exists at all times during major depressive episodes. The most consistently described risk factor is a past history of suicide attempts or threats, but it should be remembered that most deaths by suicide are not preceded by nonfatal attempts. Anhedonia has a particularly strong association with suicidal ideation. Other features associated with an increased risk for death by suicide include being single, living alone, social disconnectedness, early life adversity, availability of lethal methods such as a firearm, sleep disturbance, cognitive and decision-making deficits, and having prominent feelings of hopelessness. Women attempt suicide at a higher rate than men, while men are more likely to complete suicide. The difference in suicide rate between men and women with depressive disorders is smaller than in the population as a whole, however. Comorbidities, including aggressive-impulsive traits, borderline personality disorder, substance use disorder, anxiety, other medical conditions, and functional impairment, increase risk for future suicidal behavior.

Functional Consequences of Major Depressive Disorder

Many of the functional consequences of major depressive disorder derive from individual symptoms. Impairment can be very mild, such that many of those who interact with the affected individual are unaware of depressive symptoms. Impairment may, however, range to complete incapacity such that the depressed individual is unable to attend to basic self-care needs or is mute or catatonic. For individuals seen in general medical settings, those with major depressive disorder have more pain and physical illness and greater decreases in physical, social, and role functioning. Depressed women report greater functional impairment in their relationships than men.

191

Differential Diagnosis

Manic episodes with irritable mood or with mixed features. Major depressive episodes with prominent irritable mood may be difficult to distinguish from manic episodes with irritable mood or with mixed features. This distinction requires a careful clinical evaluation of the presence of sufficient manic symptoms to meet threshold criteria (i.e., three if mood is manic, four if mood is irritable but not manic).

Bipolar I disorder, bipolar II disorder, or other specified bipolar and related disorder. Major depressive episodes along with a history of a manic or hypomanic episode preclude the diagnosis of major depressive disorder. Major depressive episodes with a history of hypomanic episodes and without a history of manic episodes indicate a diagnosis of bipolar II disorder, whereas major depressive episodes with a history of manic episodes (with or without hypomanic episodes) indicate a diagnosis of bipolar I disorder. On the other hand, presentations of major depressive episodes with a history of periods of hypomania that do not meet criteria for a hypomanic episode may be diagnosed as either other specified bipolar and related disorder or major depressive disorder depending on where the clinician judges the presentation to best fall. For example, the presentation may be best considered other specified bipolar and related disorder because of the clinical significance of the subthreshold hypomanic symptoms, or the

presentation may be best considered a case of major depressive disorder with some subthreshold hypomanic symptoms in between episodes.

Depressive disorder due to another medical condition. A diagnosis of depressive disorder due to another medical condition requires the presence of an etiological medical condition. Major depressive disorder is not diagnosed if the major depressive-like episodes are all attributable to the direct pathophysiological consequence of a specific medical condition (e.g., multiple sclerosis, stroke, hypothyroidism).

Substance/medication-induced depressive disorder. This disorder is distinguished from major depressive disorder by the fact that a substance (e.g., a drug of abuse, a medication, a toxin) appears to be etiologically related to the mood disturbance. For example, depressed mood that occurs only in the context of withdrawal from cocaine would be diagnosed as cocaine-induced depressive disorder.

Persistent depressive disorder. Persistent depressive disorder is characterized by depressed mood, more days than not, for at least 2 years. If criteria are met for both major depressive disorder and persistent depressive disorder, both can be diagnosed.

Premenstrual dysphoric disorder. Premenstrual dysphoric disorder is characterized by dysphoric mood that is present in the final week before the onset of menses, that starts to improve within a few days after the onset of menses, and that becomes minimal or absent in the week postmenses. By contrast, the episodes of major depressive disorder are not temporally connected to the menstrual cycle.

Disruptive mood dysregulation disorder. Disruptive mood dysregulation disorder is characterized by severe, recurrent temper outbursts manifested verbally and/or behaviorally, accompanied by persistent or labile mood, most of the day, nearly every day, in between the outbursts. In contrast, in major depressive disorder, irritability is confined to the major depressive episodes.

Major depressive episodes superimposed on schizophrenia, delusional disorder, schizoaffective disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

Depressive symptoms may be present during schizophrenia, delusional disorder, schizoaffective disorder, or other specified or unspecified

schizophrenia spectrum and other psychotic disorder. Most commonly, such depressive symptoms can be considered associated features of these disorders and do not merit a

192

separate diagnosis. However, when the depressive symptoms meet full criteria for a major depressive episode, a diagnosis of other specified depressive disorder may be made in addition to the diagnosis of the psychotic disorder.

Schizoaffective disorder. Schizoaffective disorder differs from major depressive disorder, with psychotic features, by the requirement that in schizoaffective disorder, delusions or hallucinations are present for at least 2 weeks in the absence of a major depressive episode.

Attention-deficit/hyperactivity disorder. Distractibility and low frustration tolerance can occur in both attention-deficit/hyperactivity disorder (ADHD) and a major depressive episode; if the criteria are met for both, ADHD may be diagnosed in addition to the mood disorder. However, the clinician must be cautious not to overdiagnose a major depressive episode in children with ADHD whose disturbance in mood is characterized by irritability rather than by sadness or loss of interest.

Adjustment disorder with depressed mood. A major depressive episode that occurs in response to a psychosocial stressor is distinguished from adjustment disorder, with depressed mood, by the fact that the full criteria for a major depressive episode are not met in adjustment disorder.

Bereavement. Bereavement is the experience of losing a loved one to death. It generally triggers a grief response that may be intense and may involve many features that overlap with symptoms characteristic of a major depressive episode, such as sadness, difficulty sleeping, and poor concentration. Features that help differentiate a bereavement-related grief response from a major depressive episode include the following: the predominant affects in grief are feelings of emptiness and loss, whereas in a major depressive episode they are persistent depressed mood and a diminished ability to experience pleasure. Moreover, the dysphoric mood of grief is likely to decrease in intensity over days to weeks and occurs in

waves that tend to be associated with thoughts or reminders of the deceased, whereas the depressed mood in a major depressive episode is more persistent and not tied to specific thoughts or preoccupations. It is important to note that in a vulnerable individual (e.g., someone with a past history of major depressive disorder), bereavement may trigger not only a grief response but also the development of an episode of depression or the worsening of an existing episode.

Sadness. Finally, periods of sadness are inherent aspects of the human experience. These periods should not be diagnosed as a major depressive episode unless criteria are met for severity (i.e., five out of nine symptoms), duration (i.e., most of the day, nearly every day for at least 2 weeks), and clinically significant distress or impairment. The diagnosis other specified depressive disorder may be appropriate for presentations of depressed mood with clinically significant impairment that do not meet criteria for duration or severity.

Comorbidity

Other disorders with which major depressive disorder frequently co-occurs are substance-related disorders, panic disorder, generalized anxiety disorder, posttraumatic stress disorder, obsessive-compulsive disorder, anorexia nervosa, bulimia nervosa, and borderline personality disorder.

While women are more likely than men to report comorbid anxiety disorders, bulimia nervosa, and somatoform disorder (somatic symptom and related disorders), men are more likely to report comorbid alcohol and substance abuse.

Persistent Depressive Disorder