Unipolar minor depression in adults: Epidemiology, clinical presentation, and diagnosis

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Literature review current through: **Oct 2023.**
This topic last updated: **Jul 06, 2023.**

INTRODUCTION

The continuum of clinical depression increases in severity from subsyndromal symptoms to the syndromes of minor depression and major depression [1-3]. Minor depression is defined by fewer symptoms than major depression, and tends to have shorter episodes, less comorbidity, less psychosocial and physical impairment, and fewer recurrences [1,2,4].

Nevertheless, minor depression is a common syndrome that causes clinically significant distress and impairs functioning [5-10]. In addition, minor depression is associated with somatic symptoms [6,11], comorbid psychiatric and general medical disorders [6,11], and substantial health care utilization and costs [1,11,12]. Most patients with minor depression do not seek treatment from a mental health clinician but are frequently seen in primary care [5,13]. Although minor depression is at least as prevalent as major depression, fewer patients with minor depression are accurately diagnosed by primary care clinicians [6,14].

This topic reviews the epidemiology, pathogenesis, clinical manifestations, assessment, diagnosis, and differential diagnosis of minor depression. The treatment of minor depression is discussed separately, as are the clinical features, diagnosis, treatment, and prognosis of major depression:

- (See "Unipolar minor depression in adults: Management".)
- (See "Unipolar depression in adults: Assessment and diagnosis".)

- (See "Unipolar major depression in adults: Choosing initial treatment".)
- (See "Unipolar depression in adults: Choosing treatment for resistant depression".)
- (See "Unipolar depression in adults: Course of illness".)

TERMINOLOGY

The term "depression" can refer to a mood state, syndrome, or specific disorder; these depressive clinical states are discussed separately. (See "Unipolar depression in adults: Assessment and diagnosis", section on 'Definitions of depression'.)

Other terms have been used to describe minor depression, including [13,15,16]:

- Mild depression
- Subthreshold depression
- Subsyndromal depression
- Subclinical depression
- Depressive symptoms
- Other specified depressive disorder

The definition of minor depression varies among different studies [13]. In the most widely used definitions, the number of concurrent symptoms ranges from one to three [1,17] or two to four [2,7], the symptoms cause clinically significant distress or psychosocial impairment, and the minimum duration of the syndrome is two to four weeks [10,13,18,19]. The diagnosis of minor depression is discussed elsewhere in this topic. (See 'Diagnosis' below.)

EPIDEMIOLOGY

General population — The estimated prevalence of minor depression in the general population varies across different time periods and among different countries:

- **United States** – A review found that the estimated point prevalence in the United States was 2 to 5 percent [10], and a subsequent study of a nationally representative survey of nonpregnant women of childbearing age (n = 3705) found that 4 percent screened positive for the disorder [20]. In addition, two nationally representative epidemiologic studies in the United States (n = 43,093 and 36,309) estimated that the lifetime prevalence was 9 percent [2,17,21].

- **Other countries** – A study of nationally representative surveys in 68 countries (United States not included) with more than 252,000 respondents estimated that the one-year prevalence was 2.8 percent [1]; the prevalence among different countries ranged from 0.1 to 8.6 percent. A subsequent community survey in Sweden of 3084 individuals age ≥60 years, without dementia, and another in Taiwan of 5664 individual age ≥55 years, without severe cognitive impairment, both found that the point prevalence of minor depression was approximately 4 percent [22,23].

Clinical settings — Among primary care patients, the observed point prevalence of minor depression ranges from 6 to 16 percent [5,6,8,11,24]. A study of 3400 psychiatric outpatients found that a variant of minor depression was present in 6 percent [25].

Sociodemographic correlates — In large, nationally representative surveys in the United States and many other countries, as well as clinical studies, minor depression was consistently more prevalent among females and previously married individuals [1,2,17,24]. Also, in studies that did not require impairment or significant distress to diagnose minor depression, the disorder was associated with adverse life events [23] and with psychosocial impairment (eg, unemployment) [17,26].

PATHOGENESIS

The etiology and pathogenesis of minor depression is not known.

Knowledge about the genetics of minor depression is limited to findings from two community studies, which found that the disorder does not aggregate within families, suggesting that genetic factors do not play a prominent role. Both studies enrolled individuals with a lifetime history of minor depression (but no major depression or dysthymia) plus their first degree relatives, as well as controls without depression (minor depression, major depression, or dysthymia) plus their first degree relatives:

- In one study, the lifetime prevalence of minor depression was similar among family members of probands with minor depression compared with family members of controls (9.4 versus 9.0 percent) [3].

- In the second study, the lifetime prevalence of minor depression was comparable among family members of probands with minor depression compared with family members of controls (odds ratio 1.6, 95% CI 0.9-2.6) [27].

Structural neuroimaging studies have found that the cingulate cortex is smaller in patients with minor depression, but it is not clear if these findings represent etiologic causes or sequelae because the studies investigated subjects after they developed symptoms. One study compared brain magnetic resonance images (MRI) from 21 community dwelling adults (mean age 51 years) with current minor depression (and no prior psychiatric or neurologic history) and 21 matched controls [28]. The gray matter volume of the right and left anterior cingulate gyri and the right rectal gyrus were smaller in depressed females compared with female controls; no differences were observed between depressed males and control males. An MRI study in 96 youth (age 7 to 17 years) found that the volume of the rostral anterior cingulate cortex was smaller bilaterally in boys with subclinical depressive symptoms than boys with no depressive symptoms; no difference was observed between depressed and nondepressed girls [29]. A third MRI study found that the right cingulate cortex was thinner in older patients with minor depression (n = 16; mean age approximately 75 years), compared with healthy controls (n = 16) of comparable age and sex [30]. A subsequent MRI study found that cortical thickness in several brain regions was positively associated with serum levels of brain-derived neurotrophic factor (BDNF) in patients with minor depression (n = 20) but not in matched healthy subjects (n = 40) [31]; BDNF was studied because of evidence for its role in the pathophysiology of major depression [32].

Functional neuroimaging studies have found that minor depression is associated with alterations in brain activity in multiple areas, including the cingulate cortex. In one study, 19 older subjects with subthreshold depression were compared with 18 older controls using resting-state functional MRI; depression was associated with lower regional homogeneity (synchronization) of spontaneous brain activity in the right orbitofrontal and left dorsolateral prefrontal cortex and the left postcentral, left middle frontal, and left inferior temporal gyri [33]. In the same set of subjects, subthreshold depression was also associated with increased functional connectivity in anterior dorsal cingulate cortex and dorsolateral prefrontal cortex and decreased functional connectivity in inferior orbitofrontal cortex, anterior insula, thalamus, and pallidum [34].

Medications — Several medications are associated with depressive syndromes. (See "Unipolar depression: Pathogenesis".)

CLINICAL PRESENTATION

Depression exists along a continuum, and minor depression is distinguished from major depression for purposes of treatment. (See "Unipolar minor depression in adults: Management" and "Unipolar major depression in adults: Choosing initial treatment".)

An episode of minor depression is generally defined as a period lasting at least two weeks, with two to four of the following symptoms: depressed mood, loss of interest or pleasure in most activities, insomnia or hypersomnia, change in appetite or weight, psychomotor retardation or agitation, low energy, poor concentration, thoughts of worthlessness or guilt, and recurrent thoughts about death or suicide. The episode of minor depression is unipolar if the patient has no history of mania, mixed mania, or hypomania [35].

Symptoms — Symptoms of minor depression are pleomorphic, and can include:

- **Emotional symptoms** – Many patients with minor depression present with depressed mood, crying spells, lack of pleasure in usually-enjoyable activities (ie, anhedonia), or irritability [10,36]. Patients may also present with symptoms of anxiety such as worry, tenseness, and feeling on edge.

- **Neurocognitive symptoms** – Minor depression can present with impaired concentration, memory, and decision making [10,36]. These symptoms are usually experienced subjectively to a greater degree than objectively demonstrated as deficits on neurocognitive testing.

- **Feelings of worthlessness or excessive guilt** – The self-perceptions of depressed patients may be marked by feelings of inadequacy, inferiority, failure, worthlessness, and inappropriate guilt [16].

- **Neurovegetative symptoms** – Minor depression can present with insomnia or hypersomnia, increased or decreased appetite, and psychomotor agitation (eg, wringing one's hands or inability to sit still) or psychomotor retardation (feeling slowed down) [36,37]. In older primary care patients with minor depression, persistent or worsening sleep disturbance was associated with decreased likelihood of remitting [38].

- **Suicidality** – Suicidal ideation or behavior can occur in minor depression [36,37,39]. An epidemiologic survey found that a lifetime history of suicide attempts was greater among individuals with minor depression (n = 4337) than individuals with no depression (n = 13,068) (5 versus 1 percent) [40].

  However, the presence of suicidal ideation in depressed patients often indicates that the patient has major depression rather than minor depression. A study of minor depression (n = 161) and major depression (n = 993) found that suicidal ideation was observed in far fewer patients with minor depression than major depression (12 versus 84 percent) [41]. In addition, patients with suicidal ideation have the highest odds of subsequently

developing major depression, compared to patients with other symptoms of minor depression [42]. (See 'Course of illness' below.)

In addition, somatic symptoms are common in minor depression; in a study of 162 patients treated at specialty mood disorder clinics, somatic symptoms were present at baseline in 61 percent [10]. Among primary care patients with minor depression, common somatic symptoms include abdominal discomfort (constipation, diarrhea, indigestion, gas, nausea, pain, or vomiting), chest pain, dizziness, dyspnea, fainting, fatigue, headache, insomnia, menstrual problems, muscle tension, pain (back, joint, or limb), palpitations, and sexual problems [43,44]. Primary care based studies of minor depression show a direct correlation between the number of depressive symptoms and somatic symptoms.

The severity of minor depression ranges from mild to moderately severe episodes that overlap with major depression, based upon clinical ratings of patients with standard assessments such as the Hamilton Rating Scale for Depression [10].

Many patients with minor depression have a past history of major depressive episodes [45]. As an example, a treatment study of 162 patients with minor depression found that major depression had previously occurred in 32 percent [10]. In addition, minor depression may occur as a prodromal, intra-episodic, or residual stage of major depression [46].

COMORBIDITY

Psychiatric comorbidity — Psychiatric comorbidity is common in minor depression. An epidemiologic study of 810 individuals with minor depression found a lifetime history of at least one comorbid disorder in 54 percent [2]. Another epidemiologic study found that other psychiatric disorders were present in twice as many individuals with minor depression (n = 4337) compared to individuals with no depression (n = 13,068) (30 versus 15 percent) [40]. In two studies of primary care patients with minor depression (n = 83 and 91), comorbidity was present in 37 and 33 percent [8,11].

In an epidemiologic study, the lifetime prevalence of the following disorders was greater among individuals with minor depression (n = 3232) than individuals with no depressive symptoms (n = 23,214) [17]:

- Anxiety disorders
  - Panic disorder
  - Social phobia

- Specific phobia
- Generalized anxiety disorder
- Posttraumatic stress disorder

- Alcohol use disorder
- Drug use disorder
- Personality disorders

Other psychiatric comorbidities in patients with minor depression include [40,47,48]:

- Somatic symptom disorders
- Neurocognitive disorders
- Eating disorders
- Sleep disorders (eg, sleep apnea)

General medical comorbidity — Minor depression occurs at higher rates in patients with general medical disorders [4,6,9]. A nationally representative epidemiologic survey found that among individuals with one chronic, general medical condition (eg, asthma, blindness, cancer, chronic kidney disease, deafness, hepatitis, HIV infection, hypothyroidism, hypertension, or peptic ulcer disease), the estimated one-year prevalence of minor depression was 7 percent [2]. In a meta-analysis of 10 community or primary care studies (n = 51,220), the prevalence of depression was higher in patients with type 2 diabetes mellitus than controls without diabetes (18 versus 10 percent); heterogeneity was moderate to large [49]. Other general medical illnesses associated with depression include coronary heart disease [50], inflammatory diseases such as rheumatoid arthritis [51] and systemic lupus erythematosus [52], and neurologic disorders (eg, dementia, epilepsy, multiple sclerosis, Parkinson disease, and stroke) [53-55].

The relationship between minor depression and general medical illness may be bidirectional [56]. Minor depression is associated with increased rates of smoking, lack of physical exercise, poor diet, and obesity [57,58]; these health risk behaviors may lead to chronic medical illnesses (eg, diabetes and coronary heart disease). In addition, depressive symptoms may be associated with increased cortisol levels [59] and inflammatory factors [60], as well as decreased self-care or lifestyle modifications (eg, diet and exercise) [61], which may hasten onset or worsen the course of chronic general medical illnesses. Conversely, chronic illnesses are associated with functional impairment that may precipitate or exacerbate depression [56].

If minor depression is the direct physiologic consequence of a general medical disorder, the diagnosis is mood disorder due to a general medical condition with depressive features, rather than minor depression. (See 'Differential diagnosis' below.)

COURSE OF ILLNESS

Prospective community studies indicate that many episodes of minor depressive eventually resolve:

- A study of minor depression (n = 176) found that during follow-up lasting one year, remission occurred in 37 percent [62].
- Two studies (n = 3232 and 435) found that during follow-up lasting three years, remission occurred in 76 and 59 percent [17,63].

Nevertheless, minor depression can persist or recur:

- Two prospective community studies identified 3232 and 435 individuals with minor depression at baseline; three years later, minor depression was observed in 12 and 19 percent [17,63].
- A prospective study of minor depression in primary care patients (n = 59) found that at five-year follow-up, minor depression was present in 19 percent [6].
- A retrospective, nationally representative survey of 810 individuals with a lifetime history of minor depression found that multiple episodes had occurred in 72 percent; the mean number of episodes was nine, and the average length of the longest episode was 21 weeks [2].

Progression to major depression — Minor depression can progress to major depression [42,64-66]. A review of 20 prospective studies (total n >43,000) that included community samples and primary care patients found that in most studies, major depression was more likely to occur in subjects with minor depression than subjects without minor depression [67]. Specific studies have shown the following results:

- A three-year prospective study of a nationally representative sample from the United States included individuals with minor depression (n >3000) and individuals with no depressive symptoms (n >23,000); major depression occurred in more individuals with minor depression than controls (9 versus 5 percent) [17].
- A one-year prospective study of 4285 primary care patients (identified in an epidemiologic study) found that the risk of developing major depression or dysthymia was six times greater among patients with two depressive symptoms at baseline compared to patients

with no symptoms (relative risk 6, 95% CI 2-14). Among patients with three depressive symptoms at baseline, the risk was nine times greater (relative risk 9, 95% CI 3-26) [36].

- A three-year prospective study of a nationally representative sample from the Netherlands included individuals with minor depression (n = 120) and asymptomatic individuals (n = 4111) [68]. Major depression occurred in more individuals with minor depression than controls (12 versus 5 percent).

Progression to other psychiatric disorders — In addition, patients with minor depression are at increased risk of developing other psychiatric disorders (eg, anxiety disorders) [17,36]. A prospective community study of adolescents who were followed into adulthood (age 22 or 33 years) found that compared to adolescents without minor depression (n = 694), adolescents with minor depression (n = 62) were more likely to develop disruptive disorders (eg, attention deficit disorder), eating disorders, and personality disorders, as well as major depressive episodes and anxiety disorders [69].

Health care utilization — Minor depression may be associated with increased use of health care. A three-month prospective study of primary care patients age 65 years or older (n = 753), which controlled for demographics, functional status, and medical illness burden, found that the number of outpatient medical visits was greater in patients with minor or subsyndromal depression, compared with patients who were not depressed (four versus three visits) [70].

All-cause mortality — Minor depression may be associated with increased all-cause mortality. In a meta-analysis of 22 prospective observational studies that followed subjects with minor depression (n >3000) and controls with no depression (n >14,000), the risk of mortality in subjects with minor depression was 30 percent greater [71]. However, it is not clear how many of the studies adequately controlled for general medical comorbidity and health risk behaviors. Indeed, a subsequent prospective observational study followed a nationally representative sample from Singapore aged 60 years or more (n = 1070), and found an increased rate of all-cause mortality for those with subthreshold depression (hazard ratio 1.6, 95% CI 1.1–2.3). However, the association between minor depression and increased mortality was no longer statistically significant after controlling for potential confounding factors, including general medical comorbidity and health risk behaviors [72]. Nevertheless, a more recent study found that after adjusting for potential confounding factors such as age, smoking, and somatic comorbidity, older adults with minor depression (n = 378) had a greater six-year mortality rate than nondepressed comparators (n = 132; hazard ratio 6.6, 95% CI 1.8-24.2) [73].

Suicide — Psychological autopsy studies indicate that depressive disorders are proximal risk factors for suicide. These studies interview proxy respondents of the decedents (eg, family

members), and collect comparable data on nonsuicide controls. A meta-analysis of 12 psychological autopsy studies (number of subjects not reported) found that minor depression was associated with a threefold risk in suicide (odds ratio 3, 95% CI 2-5) [74].

ASSESSMENT

The initial assessment for minor depression includes a psychiatric history and mental status examination, as well as a general medical history, physical examination, and focused laboratory tests based upon findings from the history and physical examination. Some clinicians routinely screen for general medical disorders with a basic panel of tests (eg, thyrotropin, complete blood count, electrolytes, glucose, calcium, phosphate, serum urea nitrogen, creatinine, liver function tests, and urine toxicology for drugs of abuse) [75,76].

The psychiatric history should emphasize:

- Symptoms of depression
- Chronological history of depressive symptoms and disorders
- Anxiety, personality, and substance use disorders
- Medications
- Prior history of mood and anxiety disorders
- Current and chronic psychosocial stressors
- Level of social support
- Family history of mood and anxiety disorders

The patient's appearance during the interview may also provide clues to depression, such as sadness, tearfulness, irritability, and psychomotor retardation or agitation. In addition, it is often helpful to query family members about the patient's clinical status.

Suicide — All depressed patients should be assessed for suicidal ideation (including plans) and behavior. Initially inquiring about hopelessness can lead to a discussion of suicidal thoughts. If suicidal ideation is present, clinicians should ask about specific plans. Gauging the risk associated with the suicide plan helps determine if inpatient psychiatric care is necessary and whether others (eg, family members or the police) need to remove potentially lethal items from the house (eg, guns).

Screening tools — Several instruments are available to screen for minor depression, including the Patient Health Questionnaire – Nine Item (PHQ-9) (table 1) [77]. A score of 5 to 9 indicates a high probability of minor depression. However, the PHQ-9 does not generate a diagnosis of minor depression; thus, patients who screen positive require a clinical interview to make the

diagnosis. Screening for depression, the PHQ-9, and reasonable alternatives to the PHQ-9 are discussed separately. (See "Using scales to monitor symptoms and treat depression (measurement based care)", section on 'Patient Health Questionnaire - Nine Item' and "Screening for depression in adults", section on 'Two-step approach to screening'.)

DIAGNOSIS

We suggest diagnosing minor depressive episodes according to the following criteria (table 2) [2,7,10,13,18,19]:

- Two to four of the following symptoms have been present during the same two week period:
  - Dysphoria – Depressed mood most of the day, nearly every day
  - Anhedonia – Markedly diminished interest or pleasure most of the day, nearly every day
  - Significant appetite or weight change
  - Insomnia or hypersomnia nearly every day
  - Psychomotor agitation or retardation (observable by others)
  - Anergia – Fatigue nearly every day
  - Thoughts of worthlessness or inappropriate guilt nearly every day
  - Impaired concentration or memory nearly every day
  - Recurrent thoughts of death or suicide, or suicide attempt
- At least one of the symptoms includes dysphoria or anhedonia
- The symptoms cause clinically significant distress or psychosocial impairment
- The symptoms are not due to the physiologic effects of a substance, medication, or general medical condition
- Persistent depressive disorder (dysthymia) and cyclothymic disorder are not present (see "Bipolar disorder in adults: Assessment and diagnosis", section on 'Cyclothymic disorder'

and "Unipolar depression in adults: Assessment and diagnosis", section on 'Persistent depressive disorder (dysthymia)')

- The mood disturbance does not occur exclusively during a psychotic disorder (see "Psychosis in adults: Epidemiology, clinical manifestations, and diagnostic evaluation", section on 'Determining the etiology')

These criteria for minor depression are similar to the criteria that are used in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) for the diagnosis, "Other specified depressive disorder, depressive episode with insufficient symptoms" (ie, the depressive episode is characterized by an insufficient number of symptoms to meet criteria for major depression) [16].

For diagnosing minor depression, a reasonable alternative are the criteria for "mild depressive episode" in the World Health Organization's International Classification of Diseases-10th Revision (ICD-10) [78]. Although the ICD-10 diagnostic criteria for a mild depressive episode overlap with the above criteria for minor depression, the primary difference is that ICD-10 mild depressive episodes require a minimum of four depressive symptoms and may include as many as 10 depressive symptoms; by contrast, the minimum number for minor depression is two and the maximum is four.

DIFFERENTIAL DIAGNOSIS

Symptoms of minor depression overlap with symptoms of other depressive disorders, especially major depression and persistent depressive disorder (dysthymia):

- **Major depression** – Each of the symptoms that can occur during an episode of minor depression can also occur during major depression (table 3), and both syndromes require a minimum duration of two weeks and cause clinically significant distress or psychosocial impairment. The two disorders are distinguished by the number of symptoms that are present; minor depression is diagnosed if two to four depressive symptoms are present, whereas major depression requires a minimum of five symptoms. Major depression that improves such that two to four residual symptoms are still present is classified as major depression in partial remission, rather than minor depression. (See "Unipolar depression in adults: Assessment and diagnosis".)

- **Persistent depressive disorder (dysthymia)** – Minor depression and dysthymia can both present with two to four depressive symptoms, but they are distinguished by their duration. If the symptoms persist for at least two years, dysthymia is diagnosed, whereas

minor depression is diagnosed if the symptoms have been present for less than two years. (See "Unipolar depression in adults: Assessment and diagnosis", section on 'Persistent depressive disorder (dysthymia)'.)

Minor depression and dysthymic disorder are treated differently. (See "Unipolar minor depression in adults: Management".)

- **Adjustment disorder with depressed mood** – If two to four depressive symptoms occur within three months of onset of one or more psychosocial stressors, the diagnosis is adjustment disorder with depressed mood, rather than minor depression. Adjustment disorder with depressed mood by definition is marked by dysphoria, tearfulness, or feelings of hopelessness; psychosocial impairment; distress that is out of proportion to the severity of the stressor; and resolves within six months once the stressor or its consequences has terminated [16]. (See "Unipolar depression in adults: Assessment and diagnosis".)

  Minor depression and adjustment disorder are often managed in the same manner. (See "Unipolar minor depression in adults: Management".)

- **Depressive disorder due to another medical condition** – If two to four depressive symptoms are the direct physiologic consequence of a general medical disorder, the diagnosis is depressive disorder due to another medical condition, rather than minor depression. Depressive disorder due to another medical condition by definition presents with depressed mood and/or diminished interest in activities, as well as psychosocial impairment and/or significant distress [16].

  Many general medical conditions can cause or mimic a depressive syndrome, especially if fatigue is present (table 4). Examples of illnesses to be distinguished from minor depression include:

  - Hypothyroidism, which is characterized by a slowing of metabolic processes (eg, fatigue, slow movement, slow speech, cold intolerance, constipation, and weight gain) and by accumulation of matrix glycosaminoglycans in the interstitial spaces of many tissues (eg, coarse hair and skin, puffy facies, enlargement of the tongue, and hoarseness) (table 5). Diagnosis of hypothyroidism relies heavily upon laboratory tests, including thyrotropin and free thyroxine. (See "Diagnosis of and screening for hypothyroidism in nonpregnant adults".)

  - Parkinson disease, which is characterized by bradykinesia, gait disturbance, rest tremor, and rigidity, and diagnosed by the history and physical examination. (See

"Diagnosis and differential diagnosis of Parkinson disease".)

- Stroke, which is characterized by neurologic dysfunction, depending upon pathophysiologic process (table 6). (See "Overview of the evaluation of stroke".)

- Systemic lupus erythematosus, which is characterized by fatigue, weight loss, fever, photosensitive rash, arthralgia or arthritis, Raynaud phenomenon, serositis, nephritis, and phlebitis, as well as abnormal laboratory findings such as positive antinuclear antibodies (table 7). (See "Clinical manifestations and diagnosis of systemic lupus erythematosus in adults".)

- **Substance/medication-induced depressive disorder** – A depressive syndrome of two to four symptoms can occur in both minor depression and substance/medication-induced depressive disorder. The two disorders are treated differently. (See "Unipolar minor depression in adults: Management" and "Substance use disorders: Determining appropriate level of care for treatment" and "Alcohol withdrawal: Ambulatory management".)

  If the depressive syndrome occurs during or soon after (eg, within a month of) intoxication or withdrawal from a drug of abuse (eg, alcohol or cocaine), or if it is due to the side effects of a medication (eg, steroids) and is judged to be etiologically related to the mood disturbance, the syndrome is classified as a substance/medication-induced depressive disorder, rather than minor depression. Evidence that the depressive syndrome may be better accounted for by minor depression includes the following clinical features [16]:

  - Minor depression precedes onset of the substance use

  - The depressive symptoms persist for a substantial period of time (eg, one month) after intoxication or withdrawal from the substance

  - History of recurrent episodes of minor depression

SUMMARY

- The spectrum of clinical depression increases in severity from symptoms to minor depression to major depression. (See 'Introduction' above.)

- The term "depression" refers to different types of clinical states. Clinically significant depressive syndromes that fall short of meeting criteria for major depression are often

classified as minor depression. (See "Unipolar depression in adults: Assessment and diagnosis", section on 'Definitions of depression' and 'Terminology' above.)

- Nationally representative epidemiologic studies in the United States estimate that the lifetime prevalence of minor depression in the general population is 9 to 10 percent. Comparable surveys in 68 countries (United States not included) estimate that the one-year prevalence of minor depression is 2.8 percent. In primary care patients, the observed point prevalence ranges from 6 to 16 percent. Minor depression is consistently more prevalent among females and previously married individuals and is consistently associated with psychosocial impairment. (See 'Epidemiology' above.)

- The etiology and pathogenesis of minor depression is not known. Family studies indicate that the disorder does not aggregate within families. Several medications are associated with depressive symptoms (table 8). (See 'Pathogenesis' above.)

- The clinical presentation of minor depression can include emotional, neurocognitive, and neurovegetative symptoms, as well as suicidality. Minor depression frequently occurs in patients with comorbid anxiety, substance use, personality, and general medical disorders. (See 'Clinical presentation' above.)

- Although many episodes of minor depression eventually resolve, the disorder can persist or recur and can also progress to major depression. In addition, minor depression is associated with an increased risk of developing other psychiatric disorders (eg, anxiety disorders), and with increased all-cause mortality. (See 'Course of illness' above.)

- The initial assessment for minor depression includes a psychiatric history and mental status examination, as well as a general medical history, physical examination, and focused laboratory tests. The psychiatric history should emphasize symptoms of depression, suicidal ideation and behavior, chronological history of depressive symptoms and disorders, other psychiatric disorders, medications, prior history of mood and anxiety disorders, psychosocial stressors, level of social support, and family history of mood and anxiety disorders. The Patient Health Questionnaire – Nine Item (table 1) can be used to screen for minor depression. (See 'Assessment' above.)

- Diagnostic criteria for minor depression include two to four depressive symptoms (dysphoria, anhedonia, appetite or weight change, sleep disturbance, psychomotor agitation or retardation, anergia, thoughts of worthlessness or inappropriate guilt, impaired cognition, and recurrent thoughts of death or suicide or suicide attempt), at least one of which is dysphoria or anhedonia. In addition, symptoms cause significant distress or psychosocial impairment. (See 'Diagnosis' above.)

- Symptoms of minor depression overlap with symptoms of other depressive disorders, including major depression; dysthymia; adjustment disorder with depressed mood; substance/medication-induced depressive disorder; and depressive disorder due to another medical condition, including neurologic disorders (eg, Parkinson disease or stroke), endocrine disorders (eg, hypothyroidism), infections (eg, HIV), and autoimmune diseases (eg, systemic lupus erythematosus). (See 'Differential diagnosis' above.)

ACKNOWLEDGMENT

The UpToDate editorial staff acknowledges Wayne Katon, MD (deceased), who contributed to an earlier version of this topic review.

Topic 83264 Version 27.0

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