

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.

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 of 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, obsessive-compulsive disorder, anorexia nervosa, bulimia nervosa, and borderline personality disorder.

Persistent Depressive Disorder (Dysthymia)

Diagnostic Criteria

300.4 (F34.1)

This disorder represents a consolidation of DSM-IV-defined chronic major depressive disorder and dysthymic disorder.

A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years.

Note: In children and adolescents, mood can be irritable and duration must be at least 1 year.

B. Presence, while depressed, of two (or more) of the following:

1. Poor appetite or overeating.
2. Insomnia or hypersomnia.
3. Low energy or fatigue.
4. Low self-esteem.
5. Poor concentration or difficulty making decisions.
6. Feelings of hopelessness.

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. Criteria for a major depressive disorder may be continuously present for 2 years.

E. There has never been a manic episode or a hypomanic episode, and criteria have never been met for cyclothymic disorder.

F. The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g. hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: Because the criteria for a major depressive episode include four symptoms that are absent from the symptom list for persistent depressive disorder (dysthymia), a very limited

number of individuals will have depressive symptoms that have persisted longer than 2 years but will not meet criteria for persistent depressive disorder. If full criteria for a major depressive episode have been met at some point during the current episode of illness, they should be given a diagnosis of major depressive disorder. Otherwise, a diagnosis of other specified depressive disorder or unspecified depressive disorder is warranted.

Specify if:

With anxious distress (p. 184)

With mixed features (pp. 184–185)

With melancholic features (p. 185)

With atypical features (pp. 185–186)

With mood-congruent psychotic features (p. 186)

With mood-incongruent psychotic features (p. 186)

With peripartum onset (pp. 186–187)

Specify if:

In partial remission (p. 188)

In full remission (p. 188)

Specify if:

Early onset: If onset is before age 21 years.

Late onset: If onset is at age 21 years or older.

Specify if (for most recent 2 years of persistent depressive disorder):

With pure dysthymic syndrome: Full criteria for a major depressive episode have not been met in at least the preceding 2 years.

With persistent major depressive episode: Full criteria for a major depressive episode have been met throughout the preceding 2-year period.

With intermittent major depressive episodes, with current episode: Full criteria for a major depressive episode are currently met, but there have been periods of at least 8 weeks in at least the preceding 2 years with symptoms below the threshold for a full major depressive episode.

With intermittent major depressive episodes, without current episode: Full criteria for a major depressive episode are not currently met, but there has been one or more major depressive episodes in at least the preceding 2 years.

Specify current severity:

Mild (p. 188)

Moderate (p. 188)

Severe (p. 188)

Diagnostic Features

The essential feature of persistent depressive disorder (dysthymia) is a depressed mood that occurs for most of the day, for more days than not, for at least 2 years, or at least 1 year for children and adolescents (Criterion A). This disorder represents a consolidation of DSM-IV-defined chronic major depressive disorder and dysthymic disorder. Major depression may precede persistent depressive disorder, and major depressive episodes may occur during persistent depressive disorder. Individuals whose symptoms meet major depressive disorder criteria for 2 years should be given a diagnosis of persistent depressive disorder as well as major depressive disorder.

Individuals with persistent depressive disorder describe their mood as sad or “down in the dumps.” During periods of depressed mood, at least two of the six symptoms from Criterion B are present. Because these symptoms have become a part of the individual’s day-to-day experience, particularly in the case of early onset (e.g., “I’ve always been this

way”), they may not be reported unless the individual is directly prompted. During the 2-year period (1 year for children or adolescents), any symptom-free intervals last no longer than 2 months (Criterion C).

Prevalence

Persistent depressive disorder is effectively an amalgam of DSM-IV dysthymic disorder and chronic major depressive episode. The 12-month prevalence in the United States is approximately 0.5% for persistent depressive disorder and 1.5% for chronic major depressive disorder.

Development and Course

Persistent depressive disorder often has an early and insidious onset (i.e., in childhood, adolescence, or early adult life) and, by definition, a chronic course. Among individuals with both persistent depressive disorder and borderline personality disorder, the covariance of the corresponding features over time suggests the operation of a common mechanism. Early onset (i.e., before age 21 years) is associated with a higher likelihood of comorbid personality disorders and substance use disorders.

When symptoms rise to the level of a major depressive episode, they are likely to subsequently revert to a lower level. However, depressive symptoms are much less likely to resolve in a given period of time in the context of persistent depressive disorder than they are in a major depressive episode.

Risk and Prognostic Factors

Temperamental. Factors predictive of poorer long-term outcome include higher levels of neuroticism (negative affectivity), greater symptom severity, poorer global functioning, and presence of anxiety disorders or conduct disorder.

Environmental. Childhood risk factors include parental loss or separation.

Genetic and physiological. There are no clear differences in illness development, course, or family history between DSM-IV dysthymic disorder and chronic major depressive disorder. Earlier findings pertaining to either disorder are therefore likely to apply to persistent depressive disorder. It is thus likely that individuals with persistent depressive disorder will have a higher proportion of first-degree relatives with persistent depressive disorder than do individuals with major depressive disorder, and more depressive disorders in general.

A number of brain regions (e.g., prefrontal cortex, anterior cingulate, amygdala, hippocampus) have been implicated in persistent depressive disorder. Possible polysomnographic abnormalities exist as well.

Functional Consequences of Persistent Depressive Disorder

The degree to which persistent depressive disorder impacts social and occupational functioning is likely to vary widely, but effects can be as great as or greater than those of major depressive disorder.

Differential Diagnosis

Major depressive disorder. If there is a depressed mood plus two or more symptoms meeting criteria for a persistent depressive episode for 2 years or more, then the diagnosis of persistent depressive disorder is made. The diagnosis depends on the 2-year duration, which distinguishes it from episodes of depression that do not last 2 years. If the symptom

criteria are sufficient for a diagnosis of a major depressive episode at any time during this period, then the diagnosis of major depression should be noted, but it is coded not as a separate diagnosis but rather as a specifier with the diagnosis of persistent depressive disorder. If the individual's symptoms currently meet full criteria for a major depressive episode, then the specifier of "with intermittent major depressive episodes, with current episode" would be made. If the major depressive episode has persisted for at least a 2-year duration and remains present, then the specifier "with persistent major depressive episode" is used. When full major depressive episode criteria are not currently met but there has been at least one previous episode of major depression in the context of at least 2 years of persistent depressive symptoms, then the specifier of "with intermittent major depressive episodes, without current episode" is used. If the individual has not experienced an episode of major depression in the last 2 years, then the specifier "with pure dysthymic syndrome" is used.

Psychotic disorders. Depressive symptoms are a common associated feature of chronic psychotic disorders (e.g., schizoaffective disorder, schizophrenia, delusional disorder). A separate diagnosis of persistent depressive disorder is not made if the symptoms occur only during the course of the psychotic disorder (including residual phases).

Depressive or bipolar and related disorder due to another medical condition. Persistent depressive disorder must be distinguished from a depressive or bipolar and related disorder due to another medical condition. The diagnosis is depressive or bipolar and related disorder due to another medical condition if the mood disturbance is judged, based on history, physical examination, or laboratory findings, to be attributable to the direct pathophysiological effects of a specific, usually chronic, medical condition (e.g., multiple sclerosis). If it is judged that the depressive symptoms are not attributable to the physiological effects of another medical condition, then the primary mental disorder (e.g., persistent depressive disorder) is recorded, and the medical condition is noted as a concomitant medical condition (e.g., diabetes mellitus).

Substance/medication-induced depressive or bipolar disorder. A substance/medication-induced depressive or bipolar and related disorder is distinguished from persistent depressive disorder when a substance (e.g., a drug of abuse, a medication, a toxin) is judged to be etiologically related to the mood disturbance.

Personality disorders. Often, there is evidence of a coexisting personality disturbance. When an individual's presentation meets the criteria for both persistent depressive disorder and a personality disorder, both diagnoses are given.

Comorbidity

In comparison to individuals with major depressive disorder, those with persistent depressive disorder are at higher risk for psychiatric comorbidity in general, and for anxiety disorders and substance use disorders in particular. Early-onset persistent depressive disorder is strongly associated with DSM-IV Cluster B and C personality disorders.

Premenstrual Dysphoric Disorder

Diagnostic Criteria

625.4 (N94.3)

- A. In the majority of menstrual cycles, at least five symptoms must be present in the final week before the onset of menses, start to *improve* within a few days after the onset of menses, and become *minimal* or absent in the week postmenses.
- B. One (or more) of the following symptoms must be present:
 1. Marked affective lability (e.g., mood swings; feeling suddenly sad or tearful, or increased sensitivity to rejection).

2. Marked irritability or anger or increased interpersonal conflicts.
 3. Marked depressed mood, feelings of hopelessness, or self-deprecating thoughts.
 4. Marked anxiety, tension, and/or feelings of being keyed up or on edge.
- C. One (or more) of the following symptoms must additionally be present, to reach a total of *five* symptoms when combined with symptoms from Criterion B above.
1. Decreased interest in usual activities (e.g., work, school, friends, hobbies).
 2. Subjective difficulty in concentration.
 3. Lethargy, easy fatigability, or marked lack of energy.
 4. Marked change in appetite; overeating; or specific food cravings.
 5. Hypersomnia or insomnia.
 6. A sense of being overwhelmed or out of control.
 7. Physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of “bloating,” or weight gain.

Note: The symptoms in Criteria A–C must have been met for most menstrual cycles that occurred in the preceding year.

- D. The symptoms are associated with clinically significant distress or interference with work, school, usual social activities, or relationships with others (e.g., avoidance of social activities; decreased productivity and efficiency at work, school, or home).
- E. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as major depressive disorder, panic disorder, persistent depressive disorder (dysthymia), or a personality disorder (although it may co-occur with any of these disorders).
- F. Criterion A should be confirmed by prospective daily ratings during at least two symptomatic cycles. (**Note:** The diagnosis may be made provisionally prior to this confirmation.)
- G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition (e.g., hyperthyroidism).
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Recording Procedures

If symptoms have not been confirmed by prospective daily ratings of at least two symptomatic cycles, “provisional” should be noted after the name of the diagnosis (i.e., “premenstrual dysphoric disorder, provisional”).

Diagnostic Features

The essential features of premenstrual dysphoric disorder are the expression of mood lability, irritability, dysphoria, and anxiety symptoms that occur repeatedly during the premenstrual phase of the cycle and remit around the onset of menses or shortly thereafter. These symptoms may be accompanied by behavioral and physical symptoms. Symptoms must have occurred in most of the menstrual cycles during the past year and must have an adverse effect on work or social functioning. The intensity and/or expressivity of the accompanying symptoms may be closely related to social and cultural background characteristics of the affected female, family perspectives, and more specific factors such as religious beliefs, social tolerance, and female gender role issues.

Typically, symptoms peak around the time of the onset of menses. Although it is not uncommon for symptoms to linger into the first few days of menses, the individual must have a symptom-free period in the follicular phase after the menstrual period begins. While the core symptoms include mood and anxiety symptoms, behavioral and somatic symptoms commonly also occur. However, the presence of physical and/or behavioral symptoms in the absence of mood and/or anxious symptoms is not sufficient for a diag-

nosis. Symptoms are of comparable severity (but not duration) to those of another mental disorder, such as a major depressive episode or generalized anxiety disorder. In order to confirm a provisional diagnosis, daily prospective symptom ratings are required for at least two symptomatic cycles.

Associated Features Supporting Diagnosis

Delusions and hallucinations have been described in the late luteal phase of the menstrual cycle but are rare. The premenstrual phase has been considered by some to be a risk period for suicide.

Prevalence

Twelve-month prevalence of premenstrual dysphoric disorder is between 1.8% and 5.8% of menstruating women. Estimates are substantially inflated if they are based on retrospective reports rather than prospective daily ratings. However, estimated prevalence based on a daily record of symptoms for 1–2 months may be less representative, as individuals with the most severe symptoms may be unable to sustain the rating process. The most rigorous estimate of premenstrual dysphoric disorder is 1.8% for women whose symptoms meet the full criteria without functional impairment and 1.3% for women whose symptoms meet the current criteria with functional impairment and without co-occurring symptoms from another mental disorder.

Development and Course

Onset of premenstrual dysphoric disorder can occur at any point after menarche. Incidence of new cases over a 40-month follow-up period is 2.5% (95% confidence interval = 1.7–3.7). Anecdotally, many individuals, as they approach menopause, report that symptoms worsen. Symptoms cease after menopause, although cyclical hormone replacement can trigger the re-expression of symptoms.

Risk and Prognostic Factors

Environmental. Environmental factors associated with the expression of premenstrual dysphoric disorder include stress, history of interpersonal trauma, seasonal changes, and sociocultural aspects of female sexual behavior in general, and female gender role in particular.

Genetic and physiological. Heritability of premenstrual dysphoric disorder is unknown. However, for premenstrual symptoms, estimates for heritability range between 30% and 80%, with the most stable component of premenstrual symptoms estimated to be about 50% heritable.

Course modifiers. Women who use oral contraceptives may have fewer premenstrual complaints than do women who do not use oral contraceptives.

Culture-Related Diagnostic Issues

Premenstrual dysphoric disorder is not a culture-bound syndrome and has been observed in individuals in the United States, Europe, India, and Asia. It is unclear as to whether rates differ by race. Nevertheless, frequency, intensity, and expressivity of symptoms and help-seeking patterns may be significantly influenced by cultural factors.

Diagnostic Markers

As indicated earlier, the diagnosis of premenstrual dysphoric disorder is appropriately confirmed by 2 months of prospective symptom ratings. A number of scales, including the

Daily Rating of Severity of Problems and the Visual Analogue Scales for Premenstrual Mood Symptoms, have undergone validation and are commonly used in clinical trials for premenstrual dysphoric disorder. The Premenstrual Tension Syndrome Rating Scale has a self-report and an observer version, both of which have been validated and used widely to measure illness severity in women who have premenstrual dysphoric disorder.

Functional Consequences of Premenstrual Dysphoric Disorder

Symptoms must be associated with clinically meaningful distress and/or an obvious and marked impairment in the ability to function socially or occupationally in the week prior to menses. Impairment in social functioning may be manifested by marital discord and problems with children, other family members, or friends. Chronic marital or job problems should not be confused with dysfunction that occurs only in association with premenstrual dysphoric disorder.

Differential Diagnosis

Premenstrual syndrome. Premenstrual syndrome differs from premenstrual dysphoric disorder in that a minimum of five symptoms is not required, and there is no stipulation of affective symptoms for individuals who have premenstrual syndrome. This condition may be more common than premenstrual dysphoric disorder, although the estimated prevalence of premenstrual syndrome varies. While premenstrual syndrome shares the feature of symptom expression during the premenstrual phase of the menstrual cycle, it is generally considered to be less severe than premenstrual dysphoric disorder. The presence of physical or behavioral symptoms in the premenstruum, without the required affective symptoms, likely meets criteria for premenstrual syndrome and not for premenstrual dysphoric disorder.

Dysmenorrhea. Dysmenorrhea is a syndrome of painful menses, but this is distinct from a syndrome characterized by affective changes. Moreover, symptoms of dysmenorrhea begin with the onset of menses, whereas symptoms of premenstrual dysphoric disorder, by definition, begin before the onset of menses, even if they linger into the first few days of menses.

Bipolar disorder, major depressive disorder, and persistent depressive disorder (dysthymia). Many women with (either naturally occurring or substance/medication-induced) bipolar or major depressive disorder or persistent depressive disorder believe that they have premenstrual dysphoric disorder. However, when they chart symptoms, they realize that the symptoms do not follow a premenstrual pattern. Women with another mental disorder may experience chronic symptoms or intermittent symptoms that are unrelated to menstrual cycle phase. However, because the onset of menses constitutes a memorable event, they may report that symptoms occur only during the premenstruum or that symptoms worsen premenstrually. This is one of the rationales for the requirement that symptoms be confirmed by daily prospective ratings. The process of differential diagnosis, particularly if the clinician relies on retrospective symptoms only, is made more difficult because of the overlap between symptoms of premenstrual dysphoric disorder and some other diagnoses. The overlap of symptoms is particularly salient for differentiating premenstrual dysphoric disorder from major depressive episodes, persistent depressive disorder, bipolar disorders, and borderline personality disorder. However, the rate of personality disorders is no higher in individuals with premenstrual dysphoric disorder than in those without the disorder.

Use of hormonal treatments. Some women who present with moderate to severe premenstrual symptoms may be using hormonal treatments, including hormonal contraceptives. If such symptoms occur after initiation of exogenous hormone use, the symptoms

may be due to the use of hormones rather than to the underlying condition of premenstrual dysphoric disorder. If the woman stops hormones and the symptoms disappear, this is consistent with substance/medication-induced depressive disorder.

Comorbidity

A major depressive episode is the most frequently reported previous disorder in individuals presenting with premenstrual dysphoric disorder. A wide range of medical (e.g., migraine, asthma, allergies, seizure disorders) or other mental disorders (e.g., depressive and bipolar disorders, anxiety disorders, bulimia nervosa, substance use disorders) may worsen in the premenstrual phase; however, the absence of a symptom-free period during the postmenstrual interval obviates a diagnosis of premenstrual dysphoric disorder. These conditions are better considered premenstrual exacerbation of a current mental or medical disorder. Although the diagnosis of premenstrual dysphoric disorder should not be assigned in situations in which an individual only experiences a premenstrual exacerbation of another mental or physical disorder, it can be considered in addition to the diagnosis of another mental or physical disorder if the individual experiences symptoms and changes in level of functioning that are characteristic of premenstrual dysphoric disorder and markedly different from the symptoms experienced as part of the ongoing disorder.

Substance/Medication-Induced Depressive Disorder

Diagnostic Criteria

- A. A prominent and persistent disturbance in mood that predominates in the clinical picture and is characterized by depressed mood or markedly diminished interest or pleasure in all, or almost all, activities.
- B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):
 - 1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
 - 2. The involved substance/medication is capable of producing the symptoms in Criterion A.
- C. The disturbance is not better explained by a depressive disorder that is not substance/medication-induced. Such evidence of an independent depressive disorder could include the following:

The symptoms preceded the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance/medication-induced depressive disorder (e.g., a history of recurrent non-substance/medication-related episodes).
- D. The disturbance does not occur exclusively during the course of a delirium.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: This diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and when they are sufficiently severe to warrant clinical attention.

Coding note: The ICD-9-CM and ICD-10-CM codes for the [specific substance/medication]-induced depressive disorders are indicated in the table below. Note that the ICD-10-