The "Ins" and "Outs" of the Depressive Disorders Section of *DSM-5*

Ian H. Gotlib and Joelle LeMoult, Stanford University

In this article, we review and evaluate changes in the depressive disorders section from *DSM-IV* to *DSM-5*. We describe characteristics of three new depressive disorders: disruptive mood dysregulation disorder, premenstrual dysphoric disorder, and persistent depressive disorder. We also discuss the controversial decision in *DSM-5* to remove the bereavement exclusion from the criteria for major depressive disorder. Next, we review the decision to replace the diagnosis of depressive disorder not otherwise specified with two new diagnoses: other specified depressive disorder and unspecified depressive disorder. Finally, we discuss the inclusion of two novel specifiers in the *DSM-5* depressive disorders section: "with anxious distress" and "with mixed features." For each of these changes, we examine the relevant research and discuss implications of the changes for research and clinical practice.

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The depressive disorders section of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association [APA], 2013) has changed considerably from the comparable section in *DSM-IV*. In fact, this section contains some of the most substantial and controversial changes in *DSM-5* (see Table 1 for an overview). From a structural perspective, depressive disorders are no longer grouped with bipolar disorders under the general mood disorders heading. Depressive disorders are now accorded their own chapter, to which three new disorders were added. The first, disruptive mood dysregulation disorder, was added to *DSM-5* in response to concerns that bipolar disorder was being overdiagnosed and overtreated in children and adolescents. This new disorder is designed to capture youth who present with persistent irritability and frequent tantrums. The second disorder, premenstrual dysphoric disorder, was moved to the depressive disorders section of *DSM-5* from an appendix in *DSM-IV* ("Criteria Sets and Axes Provided for Further Study"). After more than 20 years of research on premenstrual dysphoric disorder, the *DSM-5* depressive disorders workgroup decided that this disorder was necessary to capture the unique depressive disorder that begins shortly after ovulation and remits within a few days of menses. As we will discuss in greater detail below, despite the relatively large body of research on premenstrual dysphoric disorder, its move to the depressive disorders section of *DSM-5* is not without controversy. The third disorder is actually an integration of the *DSM-IV* categories of chronic major depression and dysthymic disorder into a new category: persistent depressive disorder (dysthymia). Persistent depressive disorder is diagnosed when the mood disturbance continues for 2 years (1 year in children), regardless of whether major depressive disorder (MDD) is present, reflecting a slight shift in the conceptualization of chronic forms of depression.

Table 1. Summary of changes from *DSM-IV* to *DSM-5*

Diagnostic Category	Change(s)
Disruptive mood dysregulation disorder	Addition of diagnostic category
Premenstrual dysphoric disorder	Moved from appendix of *DSM-IV* to main body of *DSM-5*
Persistent depressive disorder (dysthymia)	New diagnostic label that combines *DSM-IV* diagnoses of chronic major depression and dysthymia
Major depressive disorder	Removal of bereavement exclusion
	Addition of "with anxious distress" specifier
	Addition of "with mixed features" specifier
Other specified depressive disorder	Added in place of depressive disorder not otherwise specified
Unspecified depressive disorder	Added in place of depressive disorder not otherwise specified
Persistent complex bereavement disorder	Added to Section III of *DSM-5* "Conditions for Further Study"

In addition to these three new disorders, there are also three noteworthy changes from *DSM-IV* to *DSM-5* related to the diagnostic criteria for MDD. The first is the decision to remove the bereavement exclusion, which is among the most controversial decisions associated with *DSM-5*. Therefore, we give this issue particular attention below and also discuss the related diagnosis of persistent complex bereavement disorder, which was not added to the depressive disorders section but was included in Section III of *DSM-5* as a condition for further study. The second two changes are the addition of two new specifiers: with anxious distress and with mixed features. These specifiers can be added to either bipolar disorder or MDD when subclinical symptoms of anxiety or mania are present.

Finally, *DSM-5* changed the way subthreshold, yet impairing depressive symptoms are diagnosed. The depressive disorder not otherwise specified diagnostic category was removed from *DSM-5* in favor of two new diagnostic categories: other specified depressive disorder (which includes recurrent brief depression, short-duration depressive episode, and depressive episode with insufficient symptoms) and unspecified depressive disorder.

Despite these changes, there are aspects of the depressive disorders section of *DSM-5* that are consistent with *DSM-IV*. Most notably, the diagnostic criteria for a major depressive episode are unchanged across *DSM* editions. In addition, although the diagnostic criteria for substance-/medication-induced depressive disorder and depressive disorder due to another medical condition are now applied specifically to depressive disorders rather than to mood disorders more generally,

the criteria otherwise are consistent from *DSM-IV* to *DSM-5*.

In the following sections, we discuss each of these diagnostic changes. In doing so, we offer a critique of the research surrounding the changes and discuss the implications of each change for both research and clinical practice.

DISRUPTIVE MOOD DYSREGULATION DISORDER

Persistent irritability and explosive anger are among the most common reasons children and adolescents seek psychological services (Egger & Angold, 2006; Leibenluft, Blair, Charney, & Pine, 2003). Given that these symptoms can be indicative of any of a number of psychiatric illnesses—including depression, anxiety, bipolar disorder, and oppositional defiant disorder—accurate diagnosis has been difficult. Indeed, there is increasing concern that children and adolescents are frequently misdiagnosed as having bipolar disorder (Leibenluft, 2011; Leigh, Smith, Malavic, & Stringaris, 2012) and, consequently, that they are being overtreated with potent medications, such as mood stabilizers and antipsychotics, that may have harmful and long-term side effects (Wakefield, 2012). More recently, however, researchers have posited that this heightened degree of persistent irritability and extreme anger reflects a unique disorder that is distinguishable from the less severe symptoms of irritability that are common to many disorders. In addition, symptoms consistent with disruptive mood dysregulation disorder were associated prospectively with greater risk for depressive and anxiety disorders (e.g., Brotman et al., 2006; Stringaris et al., 2010). In response, a new diagnostic category

was added to *DSM-5*: disruptive mood dysregulation disorder. The hallmark feature of this disorder is chronic and severe irritability. Irritability is captured via two core symptom criteria: (a) the presence of severe and recurrent temper outbursts, and (b) pervasive irritable or angry mood. Disruptive mood dysregulation disorder is diagnosed in children older than age 6 when developmentally inappropriate outbursts occur before age 10. To meet diagnostic criteria for disruptive mood dysregulation disorder, outbursts must occur three or more times per week for at least 1 year in multiple settings (e.g., at home and school; APA, 2013).

The addition of disruptive mood dysregulation disorder to the depressive disorders section of *DSM-5* has been controversial. Critics of this addition call into question its clinical utility; they highlight evidence that the disorder is not associated with current diagnostic profiles, is not related to parental history of mood or anxiety disorders, and does not predict future mood, anxiety, or psychotic disorders (Axelson et al., 2012). Furthermore, data suggest that it is difficult to differentiate disruptive mood dysregulation disorder from oppositional defiant disorder or conduct disorder (Axelson et al., 2012). In fact, Axelson and colleagues found that 58% of participants with oppositional defiant disorder and 61% with conduct disorder also met *DSM-5* criteria for disruptive mood dysregulation disorder. Investigators have questioned, therefore, whether disruptive mood dysregulation disorder offers novel information about etiology, course, or treatment.

Critics also raise concerns about clinicians' ability to accurately diagnose disruptive mood dysregulation disorder. They point to evidence that diagnostic accuracy is dependent in large part on how well the frequency, persistence, and duration of tantrums are assessed. Given that children and caregivers can find it difficult to recall such information from the past year, the dependence on the accuracy of these details is an issue (Axelson, 2013). Indeed, these concerns are underscored by findings of low test–retest reliability for this diagnosis in the *DSM-5* field trials (pooled kappa of 0.25 and single-site estimates as low as 0.06; Regier et al., 2013), which critics posit may contribute to the questionable stability of the disorder over time (Axelson et al., 2012). Research also suggests that there are few circumstances in which disruptive mood dysregula-

tion disorder might actually reduce the likelihood of children being diagnosed with bipolar disorder, despite the fact that this was the original purpose of its inclusion in *DSM-5*. More specifically, Margulies, Weintraub, Basile, Grover, and Carlson (2012) found that diagnoses of bipolar disorder were reduced when clinicians used in-person observation but not when they relied on parental report, further calling into question the utility and the accuracy of this diagnosis in clinical settings.

In an attempt to address criticisms concerning the addition of disruptive mood dysregulation disorder to *DSM-5*, proponents of the disorder point to recent evidence that its prevalence is not as high as critics claim. Although nearly 50% of school-age children and adolescents report severe temper outbursts over a 3-month period, this prevalence rate drops to 1% when all disruptive mood dysregulation criteria are applied (Copeland, Angold, Costello, & Egger, 2013). Parallel decreases in prevalence have been reported in a preschool-age sample. Whereas severe tantrums were present in 81% of preschool-age children, only 3.3% met full criteria for disruptive mood dysregulation disorder. In addition, proponents report relatively low overlap between symptoms related to persistent mood dysregulation disorder and oppositional defiant disorder (Leibenluft, 2011). Moreover, despite critics' claims to the contrary, data from prospective studies indicate that youth with disruptive mood dysregulation disorder are at greater odds for developing a depressive disorder than are youth without disruptive mood dysregulation disorder (Brotman et al., 2006). It is important to note, however, that these studies were not based on *DSM-5* criteria of disruptive mood dysregulation disorder, but rather on self-determined criteria that are similar, but not identical, to the *DSM-5* diagnostic criteria.

Investigators who support the addition of disruptive mood dysregulation disorder to *DSM-5* also highlight differences between youth with this disorder and youth with bipolar disorder. For example, Towbin, Axelson, Leibenluft, and Birmaher (2013) found that youth who present with chronic irritability are not at increased risk for developing bipolar disorder with age, unlike the case with milder forms of bipolar disorder. There is also evidence that the irritable mood domain of

oppositional defiant disorder is associated with higher rates of subsequent depressive and anxiety disorders, suggesting that identifying youth with oppositional defiant disorder and irritability is important diagnostically and preventatively (Rowe, Costello, Angold, Copeland, & Maughan, 2010; Stringaris & Goodman, 2009). Unfortunately, however, no study to date has directly addressed concerns about differentiating disruptive mood dysregulation disorder and bipolar disorder during a single diagnostic assessment, leaving unanswered concerns about the diagnostic accuracy of disruptive mood dysregulation disorder.

Overall, there are significant consequences, in terms of both research and clinical practice, of adding disruptive mood dysregulation disorder to *DSM-5*. One consequence involves the potential for misdiagnosis of children who exhibit heightened irritability. Although proponents argue that adding disruptive mood dysregulation disorder to *DSM-5* will reduce the misdiagnosis of bipolar disorder in children and adolescents, there is little evidence to support this position. Instead, the majority of evidence suggests that the validity and reliability of disruptive mood dysregulation disorder will be compromised given its novelty and its overlap with other disorders, particularly with oppositional defiant disorder and conduct disorder. Certainly, results from the initial *DSM-5* field trials do little to allay these concerns (Regier et al., 2013). To increase reliability, the *DSM* offers guidance on differentiating oppositional defiant disorder from disruptive mood dysregulation disorder: The latter is warranted when clinical presentations include severe and frequent outbursts interspersed with persistent disruption in mood (APA, 2013). Even with this *DSM* guidance, however, there is risk that children with chronic irritability will continue to be misdiagnosed.

Certainly, children and adolescents who have frequent irritability and severe tantrums are in need of effective treatment without the long-term consequences that are often associated with psychotropic medications (Carlson, Potegal, Margulies, Gutkovich, & Basile, 2009). It is possible that the addition of disruptive mood dysregulation disorder in *DSM-5* will move clinicians away from the heavy use of psychotropic medications and toward alternative interventions, such as behavioral, psychosocial, or family therapy

(Axelson, 2013). At this same time, however, it is important to note that, to date, there is no prospective research that offers evidence-based recommendations for treating disruptive mood dysregulation disorder should it be diagnosed.

Clearly, given that disruptive mood dysregulation disorder has now been added to *DSM-5*, it is critical that researchers design and conduct studies to examine the etiology, features, consequences, and course of the disorder. Thus far, research on disruptive mood dysregulation disorder has relied predominantly on retrospective analyses of large datasets (Axelson et al., 2012; Copeland et al., 2013). Although these analyses have provided preliminary knowledge about the disorder, carefully designed longitudinal studies are sorely needed.

PREMENSTRUAL DYSPHORIC DISORDER

Premenstrual dysphoric disorder was first added to Appendix A of *DSM-III-R*, "Proposed Diagnostic Categories Needing Further Study" (APA, 1987). After more than 20 years of research, this disorder is now officially in the depressive disorders section in *DSM-5*. The decision to move premenstrual dysphoric disorder to the main body of *DSM-5* was based on evidence that 2% to 5% of menstruating women experience a unique depressive disorder that begins following ovulation, remits within several days of menses, and leads to significant interference in daily life. A diagnosis of premenstrual dysphoric disorder requires at least five clinically significant symptoms that occur repeatedly during the premenstrual phase of the cycle and that remit at or shortly after the onset of menses (APA, 2013). At least one symptom must reflect disturbance in general mood: mood lability, irritability, dysphoria, or anxiety. In addition, individuals must endorse at least one of the following physical/behavioral symptoms: anhedonia, difficulty concentrating, lethargy, appetite changes, sleep changes, overwhelmed feelings, and physical symptoms. These symptoms must have occurred in most of the menstrual cycles during the past year and must be severe enough to cause marked impairment in work or social functioning.

Despite the years of research assessing premenstrual dysphoric disorder, the decision to move this disorder to the main body of *DSM-5* has been controversial. A cen-

tral topic in this debate involves the utility and the validity of the disorder. Those who argue that premenstrual dysphoric disorder should not have been moved to the main body of *DSM-5* express concerns that it pathologizes natural female responses that vary in intensity but rarely meet criteria for a mental illness (Offman & Kleinplatz, 2004; Stotland, 2012). Even when it was introduced in *DSM-III-R*, concerns about the potential for "misuse, particularly against women," were cited (APA, 1987, p. xxi). More recently, Stotland (2012) expressed concern that the diagnosis would lead to stigmatization and discrimination. Still, other critics have challenged the validity of premenstrual dysphoric disorder given evidence that it does not correspond to changes in the menstrual cycle (Offman & Kleinplatz, 2004). Critics also note that there are not significant biological differences between women who report symptoms of premenstrual dysphoric disorder and women who do not (Alberts & Alberts, 1990; Richardson, 1995).

Overall, however, the majority of evidence supports the addition of premenstrual dysphoric disorder to the main body of *DSM-5*. Proponents of its addition clarify that it is present in only a small subset of menstruating women (with estimates between 2% and 5%; Epperson et al., 2012). To increase reliability, *DSM-5* distinguishes between premenstrual syndrome (PMS) and premenstrual dysphoric disorder, with the former being more common and less severe than the latter. *DSM-5* also emphasizes that a diagnosis of premenstrual dysphoric disorder is contingent on the presence of clinically significant impairment or distress. In addition, proponents of premenstrual dysphoric disorder point to evidence from biological, epidemiological, and treatment outcome research underscoring the validity of the diagnosis. For example, Schmidt, Nieman, Danaceau, Adams, and Rubinow (1998) found that manipulating the amount of ovarian hormones influenced symptom levels in women with premenstrual dysphoric disorder but not in healthy controls. Proponents also note evidence of important distinctions between premenstrual dysphoric disorder and MDD, including a differential response to serotonin reuptake inhibitors (Dimmock, Wyatt, Jones, & O'Brien, 2000; Pearlstein, Bachmann, Zacur, & Yonkers, 2005; Schmidt et al., 1998; Yonkers & Foegh, 2004).

We think that the decision to move premenstrual dysphoric disorder to the main body of *DSM-5* will have largely positive implications for research and clinical practice. Because the more stringent diagnostic criteria included in *DSM-5* should sharpen the classification of women who participate in studies of MDD or premenstrual dysphoric disorder, there should be greater specificity in elucidating the etiology, course, and treatment of these two disorders. The decision to include premenstrual dysphoric disorder in *DSM-5* is also likely to increase funding for research aimed at gaining a better understanding of the disorder. Therefore, in the future, we can expect to see more research examining the etiology and correlates of premenstrual dysphoric disorder, as well as randomized clinical trials that should yield information about the optimal treatment approach for this disorder.

Clinical implications of this move are likely to be far-reaching as well. Most notably, the addition of premenstrual dysphoric disorder to *DSM-5* should encourage treatment providers to assess cyclical mood symptoms that would otherwise have been missed or misdiagnosed. Given the goal of having distinct treatment recommendations for different depressive disorders, accurate diagnosis of premenstrual dysphoric disorder is critical. Although we acknowledge that there is potential for women diagnosed with premenstrual dysphoric disorder to be stigmatized, we agree with the chair of the subcommittee focused on premenstrual dysphoric disorder, who argued that the presence of stigmatization signals a need to educate the public rather than a reason to not include a valid diagnostic category in *DSM-5*. Moreover, providing women with an empirically based diagnosis would allow them greater access to health care and insurance coverage, benefits that may outweigh any potential drawbacks from unsubstantiated stigmatization.

PERSISTENT DEPRESSIVE DISORDER (DYSTHYMIA)

Persistent depressive disorder is a new diagnostic label in *DSM-5* that reflects a slightly modified approach to conceptualizing chronic forms of depression. Persistent depressive disorder consolidates the *DSM-IV* diagnoses of dysthymic disorder and chronic major depressive disorder. The new *DSM-5* criteria for persistent depressive disorder parallel the former diagnostic crite-

ria for dysthymic disorder, with the exception that in persistent depressive disorder, a major depressive episode is allowed to be present during the first 2 years of disturbance. In general, the hallmark of both *DSM-IV* dysthymic disorder and *DSM-5* persistent depressive disorder is a depressed mood that occurs for most of the day, more days than not, for at least 2 years (1 year in children and adolescents). During times of depression, at least two of the following symptoms must be present: appetite change, sleep change, low energy, low self-esteem, difficulty concentrating, and feelings of hopelessness (APA, 2013). Thus, individuals can now be diagnosed with both persistent depressive disorder and MDD, without relying on retrospective accounts of illness progression during the first 2 years.

The decision to consolidate these two diagnoses reflects research findings that there are few meaningful differences between them (Klein & Santiago, 2003). For example, patients with chronic depression alone are similar to patients with comorbid MDD and dysthymia with respect to demographic correlates, clinical characteristics, comorbidity, family history, early adversity, social functioning, and response to pharmacological and psychological treatment (see Klein & Santiago, 2003, for a review). Moreover, most individuals diagnosed with dysthymic disorder have experienced a superimposed depressive episode at some point in their life; in fact, cross-sectional studies report that up to 75% of individuals with dysthymic disorder have experienced a past episode of MDD (Keller et al., 1995), and prospective studies yield estimates greater than 90% (Klein, Schwartz, Rose, & Leader, 2000). Thus, these two groups of patients do not appear to differ in any meaningful way.

Although it is unlikely that this diagnostic shift will lead to significant changes in research or clinical practice, it is possible that allowing the occurrence of a depressive episode during the first 2 years of disturbance could increase the diagnostic reliability of this category over the *DSM-IV* diagnosis of dysthymic disorder. In previous *DSM* editions, clinicians needed to assess whether criteria were met for MDD within the first 2 years of a patient's dysthymic episode. Because relying on retrospective accounts of two or more years prior can compromise the reliability of patients' reports,

eliminating the need to assess a depressive episode in those 2 years may lead to more consistent assessments of persistent depressive disorder. Despite the potential utility of persistent depressive disorder, there is some concern that the disorder will be heterogeneous, given that it consolidates *DSM-IV* diagnoses of chronic major depressive disorder and dysthymic disorder, two disorders with markedly different levels of symptom severity and impairment. Whereas chronic MDD is traditionally one of the most severe and treatment–resistant depressive disorders, dysthymic disorder has been conceptualized as a milder form of depression (Klein & Santiago, 2003). There are also important distinctions in treatment and expected course. Indeed, compared with dysthymic disorder, chronic major depressive disorder is associated with greater inpatient treatment, more persistent course, and lower rates of naturalistic recovery (Klein & Santiago, 2003).

BEREAVEMENT

There are several changes from *DSM-IV* to *DSM-5* in the way bereavement is conceptualized. The first change involves the decision to remove the bereavement exclusion from MDD diagnostic criteria, making it possible for individuals with mild to moderate symptoms of depression to be diagnosed with MDD within the first 2 months of a loved one's death. The second change is the addition of persistent complex bereavement disorder to the *DSM-5* section "Conditions for Further Study," which acknowledges the clinical significance of long-term grief.

Removing the Bereavement Exclusion
DSM-IV stipulated that MDD should not be diagnosed if symptoms of depression occurred within 2 months of the death of a loved one and were not associated with marked functional impairment, morbid preoccupation with worthlessness, active suicidal ideation, psychomotor retardation, or psychotic features (APA, 2000). This criterion has come to be known as the bereavement exclusion. It was first introduced in *DSM-III* (APA, 1980) in response to the work of Paula Clayton and her colleagues, who examined the development of depressive symptoms in widows and widowers shortly after their spouses' death (Clayton, 1990; Clayton, Desmarais, & Winokur, 1968; Clayton, Halikes, & Mau-

rice, 1971). They found that it was common for widows and widowers to develop symptoms that resembled a depressive episode. In fact, in the first weeks postloss, 87% reported depressed mood, 85% reported sleep disturbance, and approximately 50% reported anhedonia, difficulty concentrating, and diminished appetite. Therefore, the bereavement exclusion was implemented to discourage clinicians from diagnosing individuals with MDD when they were experiencing normative grief.

The removal of the bereavement exclusion in *DSM-5* was particularly controversial. In place of the bereavement exclusion, *DSM-5* offers guidance on distinguishing normative grief (with hallmark symptoms of emptiness and loss) from a depressive episode (with hallmark symptoms of depressed mood and anhedonia). In addition, *DSM-5* provides instruction on correctly classifying suicidal thoughts by distinguishing thoughts associated with bereavement from thoughts associated with MDD. More specifically, whereas in bereavement, thoughts of death generally focus on the deceased or on joining the deceased, in MDD suicidal, thoughts typically focus on ending one's life because of feeling worthless, undeserving, or unable to cope with the pain of one's depression (APA, 2013).

Considerable research has been marshaled for both sides of the bereavement debate (First, Pies, & Zisook, 2011). Critics of removing the bereavement exclusion are primarily concerned that individuals who exhibit normative responses to loss—typically evidenced by increased sadness, sleep disturbance, appetite disturbance, difficulty concentrating, and anhedonia (Clayton et al., 1968)—would unnecessarily be diagnosed with MDD according to *DSM-5*. They also emphasize differences between bereavement-excluded depression and MDD in clinical symptoms and course (see review by Paksarian & Mojtabai, 2013), noting that bereavement-excluded depressions are less severe on numerous indicators of pathology (Wakefield & Schmitz, 2013; Wakefield, Schmitz, First, & Horwitz, 2007). For example, Wakefield and Schmitz (2013) found that, compared to individuals with MDD, those with bereavement-excluded depression had fewer suicidal attempts, shorter duration of depressive episodes, fewer hospitalizations, fewer depressive symptoms, and fewer melancholic features. Bereavement-excluded depression is also associated with

less severe psychosocial impairment and fewer past depressive episodes than is MDD (Gilman et al., 2012). In addition, prospective data from the National Comorbidity Survey indicate that individuals with bereavement-excluded depression are less likely to experience a recurrent depressive episode than are individuals with MDD (Gilman et al., 2012; Mojtabai, 2011; Wakefield & Schmitz, 2012); in fact, rates of recurrence in bereavement-excluded depression were comparable to rates of MDD in never-depressed controls. Importantly, Wakefield (2013a, 2013b) also found that bereavement-excluded depression and mild MDD differ in clinical features, significance, and severity, suggesting that differences between bereavement-excluded depression and MDD cannot be attributed entirely to severity.

As further evidence of the dissimilarity between bereavement-excluded depression and MDD, researchers have documented differences between these disorders with respect to course and treatment. For example, individuals with bereavement-excluded depression were less likely than were individuals with MDD to have received any treatment (19.5% versus 33.3%) or to have been prescribed medication (9.1% versus 23.9%) for their low mood (Mojtabai, 2011). Moreover, although bereavement-excluded depressed individuals have been found to benefit from antidepressant medications (Zisook, Shuchter, Pedrelli, Sable, & Deaciuc, 2001), critics contend that these findings are "spurious," based on results from a single small, uncontrolled study (Wakefield, 2013a, 2013b). They argue instead that bereavement reflects a transient and context-specific form of depression that is more likely than MDD to remit independent of treatment (First et al., 2011). For example, Zisook and Shuchter (1991) observed that some normally grieving widow(er)s who met core symptom criteria for a depressive episode would have been inappropriately diagnosed as having MDD were it not for the bereavement exclusion, yielding a false-positive rate of 8.6%.

Finally, some have argued that giving a diagnosis of MDD shortly after an individual has lost a loved one pathologizes and stigmatizes normal grief (Wakefield, 2013a, 2013b). This may lead to unnecessary treatment, stigmatization by self or others (which is associated with diminished self-esteem and more limited opportunities for social interaction; Corrigan, 2004), and difficulty obtaining insurance in the future (First et al., 2011).

On the other side of the debate about removing the bereavement exclusion from *DSM-5* is the concern that individuals in need of mental health services are being overlooked and undertreated (Shear et al., 2011). Because these persons do not have a formal diagnosis, bereavement-related depression is often dismissed as a "normal" response to grief (Zisook & Shear, 2013). Proponents of the decision to remove the bereavement exclusion point out that even mild depressive episodes can have significant clinical implications and sequelae (Zisook, Paulus, Shuchter, & Ludd, 1997). In particular, authors have noted that MDD is a serious, potentially fatal disorder that can have harmful physical consequences, regardless of the precipitant (Cassem, 1995; Zisook & Shear, 2013; although see Wakefield & Schmitz, 2014, for recent evidence of lower suicide rates in bereavement-related depression compared to MDD). As evidence for both the treatability of bereavement-related depression and its similarity to standard MDD, those in favor of removing the bereavement exclusion point to data showing that individuals with bereavement-excluded depression benefit from the same antidepressant medications as people diagnosed with standard MDD (Zisook et al., 2001), a point also made by Jan Fawcett (2010, 2012), chair of the *DSM-5* mood disorders workgroup. By receiving a diagnosis within 2 months of their loss, people might receive more immediate and appropriate treatment and insurance coverage.

Proponents of removing the bereavement exclusion also note the high frequency with which bereavement-related depression and MDD present with similar clinical symptoms. Several recent reviews and population-based empirical studies have shown that bereavement-related depressive episodes and nonbereavement-related MDD are associated comparably with depressed mood and anhedonia, the hallmark symptoms of depression (Karam, Tabet, & Itani, 2013; Kessing, Bukh, Bock, Vinberg, & Gether, 2010; Zisook & Kendler, 2007; Zisook, Shear, & Kendler, 2007). In a recent review, Zisook et al. (2012) found that the majority of data indicate that bereavement-related depression and MDD are equivalent in their genetic risk, their frequency of occurrence in individuals with personal and family history of depression, and the odds for chronicity or recurrence. Zisook and colleagues also reported that

bereavement-related depression and MDD have similar personality and comorbidity profiles, including impaired psychosocial functioning, comorbidity with anxiety disorders, and presence of suicidal thoughts (Zisook & Kendler, 2007; Zisook et al., 2012). Moreover, in a statement explaining why the *DSM-5* mood disorders workgroup decided to eliminate the bereavement exclusion, Kendler (2010) pointed out the similarity between loss of a loved one and other stressors that might precipitate a depressive episode, including other life-altering or life-threatening experiences.

Those who support removing the bereavement exclusion respond to concerns about stigmatization by citing evidence that many people feel relief when their problem is named and treated (Johnson et al., 2009). Moreover, authors posit that framing bereavement-related depression as a diagnosable medical condition will serve to decrease stigma, while simultaneously identifying those who need treatment but who might otherwise be overlooked (Lamb, Pies, & Zisook, 2010). They also point to evidence that co-occurring MDD can prolong and exacerbate the grieving process, arguing that the importance of drawing attention and resources to treating depressive symptoms outweighs the potential risk of stigmatization (Zisook & Shuchter, 1993).

The decision to remove the bereavement exclusion from MDD diagnostic criteria has important implications for researchers, treatment providers, and insurance companies. Critics argue that removing the bereavement exclusion will increase the heterogeneity of MDD due to differences between bereavement-excluded depression and MDD in presentation and course (First et al., 2011; Holtzheimer & Mayberg, 2011; Paksarian & Mojtabai, 2013). As the heterogeneity of any disorder increases, of course, it becomes more difficult to establish unique biological predictors and correlates.

In contrast to the predominantly negative implications of removing the bereavement exclusion for research, the implications of this decision for clinical practice are likely to be largely positive for those who have recently lost a loved one. Although some suggest that bereaved individuals may be stigmatized by receiving a diagnostic label, the potential harm from stigmatization seems minor compared with the benefit of receiving treatment that would otherwise have been delayed or denied. For example, clinicians may be

more likely to suggest psychological or pharmacological intervention in the early stages of grief, and insurance companies may be more likely to cover this treatment if a diagnosis is provided. Of course, the benefits of removing the bereavement exclusion are contingent on clinicians accurately identifying MDD in the context of loss. Clinicians must now differentiate normative bereavement from clinically significant depression when symptom severity is milder and the distinction between grief and MDD is more blurred. Although some feel that clinicians do not have sufficient guidance on how to make this differential diagnosis, recent publications have made important strides in providing the necessary information for clinicians (e.g., APA, 2013; Pies, 2013).

Persistent Complex Bereavement Disorder

Related to the decision to remove the bereavement exclusion from MDD criteria is the addition of persistent complex bereavement disorder to the *DSM-5* section "Conditions for Further Study." Although this addition is also not without controversy (see, e.g., Wakefield, 2012), it is important to note that this diagnosis has been proposed as an addition to both the *DSM* and ICD. Alternatively labeled "prolonged" or "complicated" grief disorder, persistent complex bereavement disorder is proposed to capture intense and prolonged grief symptoms as a grief-specific disorder that can be present even when MDD and other disorders are not (Prigerson et al., 2009; Shear et al., 2011). More specifically, diagnostic criteria include persistent yearning/longing for the deceased, preoccupation with the deceased or circumstances of the death, or intense sorrow and emotional pain, which is accompanied by at least six symptoms reflecting reactive distress (e.g., ongoing feelings of disbelief that the person is gone) or social/identity disruption (e.g., difficulty trusting others since the death) for at least 12 months after the death (6 months for children).

Prior to *DSM-5*, there was no diagnostic category that captured aberrant yet nondepressive grief responses. Over the past several years, however, increasing evidence suggests that a group of individuals display chronic and intense grief that does not remit with time (Prigerson et al., 2009; Shear et al., 2011). Rationale for including this diagnosis in some form in

DSM-5 focused on evidence that the expression of intense grief for 6 months or more reflects failed adaptation to loss (Shear et al., 2011) and places individuals at risk for subsequent physical and mental disorders (Prigerson et al., 2009). Given that many individuals continue to recover from a significant loss at 1 year (Wakefield, 2012), concerns about high false-positive rates prompted the anxiety disorders workgroup (to which the category was assigned) to select a duration requirement of 12 months instead of 6. *DSM-5* also includes additional information on distinguishing persistent complex bereavement disorder from normal grief. It advises that persistent complex bereavement disorder should be distinguished from typical grief based on increased severity, duration, and impairment.

Although additional research is needed to finalize the clinical picture and diagnostic criteria of persistent complex bereavement disorder, the addition of this disorder is likely to offer both research and clinical advantages. From a research perspective, there is enthusiasm about the potential of the addition of persistent complex bereavement disorder to increase research necessary to better understand the trajectory of grief. Investigators have begun to conduct comprehensive studies in this area (see, e.g., Prigerson et al., 2009; Shear et al., 2011), and additional research will provide valuable information for future versions of the *DSM*.

Including persistent complex bereavement disorder as a diagnostic category in future editions of the *DSM* is also likely to have important clinical implications. It may provide additional treatment options for individuals who are suffering from long-term grief. Moreover, for those individuals who do not meet criteria for another *DSM* diagnosis, the addition of persistent complex bereavement disorder, and the insurance coverage likely to be associated with this diagnosis, could make such treatment financially feasible.

OTHER SPECIFIED DEPRESSIVE DISORDER AND UNSPECIFIED DEPRESSIVE DISORDER

There is also a noteworthy change from *DSM-IV* to *DSM-5* in the diagnosis of subthreshold yet clinically significant symptoms of a depressive disorder. Previously, such conditions were captured by the general depressive disorder not otherwise specified category. In *DSM-5*, however, this diagnostic category was

removed in favor of two new diagnoses: other specified depressive disorder and unspecified depressive disorder. Other specified depressive disorder is used when the clinician wants to specify the reason that full criteria for a depressive disorder are not met. Reasons can include "recurrent brief depression," reflecting repeated episodes of depressed mood lasting between 2 and 13 days at least once per month for at least 12 consecutive months, "short-duration depressive episode," indicating that five or more symptoms of a major depressive episode were endorsed for a period of time between 2 and 13 days, or "depressive episode with insufficient symptoms," reflecting a period of at least 2 weeks when 2–4 depressive symptoms were endorsed. When the clinician does not specify the reason that diagnostic criteria were not met for a depressive disorder, the diagnosis of unspecified depressive disorder is used. Regardless of whether the other specified or unspecified depressive disorder diagnosis is used, the authors of *DSM-5* underscore the importance of ensuring that a diagnosis is made only when individuals report clinically significant distress or impairment in social, occupational, or other areas of functioning.

Although the switch to other specified depressive disorder and unspecified depressive disorder reflects relatively minor changes to the depressive disorders section of *DSM-5*, the change allows additional information about clinical status to be assessed and recorded. This additional information is considered particularly valuable because it has the potential to facilitate treatment planning and monitoring. At the same time, the additional amount of information is minimal enough to allow for rapid assessments when required by the setting, such as in an emergency department.

ANXIOUS DISTRESS SPECIFIER
The first of two new specifiers included in *DSM-5* is "with anxious distress." This specifier can be applied to both depressive and bipolar disorders. In *DSM-5*, diagnosticians are encouraged to use this specifier for individuals with a primary diagnosis of MDD who present with subclinical, yet prominent, symptoms of anxiety (APA, 2013). Anxious distress is defined as the presence of at least two of the following symptoms during most days of a major depressive episode or persistent

depressive disorder: keyed up, restless, difficulty concentrating because of worry, fear that something terrible will happen, or fear of losing control.

The addition of the "with anxious distress" specifier to *DSM-5* stems predominantly from research showing that subclinical anxiety is common and clinically significant. The high comorbidity between MDD and anxiety disorders has been well established, and importantly, depression is associated with greater severity and impairment in the presence of comorbid anxiety (Goldberg, Kendler, & Sirovatka, 2010). For example, individuals with MDD and comorbid anxiety have higher suicide risk, longer duration of illness, and poorer treatment response than do depressed individuals who do not have comorbid anxiety (Kessler et al., 2008; Silk, Davis, McMakin, Dahl, & Forbes, 2012).

Overall, the addition of the anxious distress specifier has been largely uncontroversial given considerable evidence of what the specifier will add to research and clinical settings. The anxious distress specifier has the potential to facilitate research aimed at identifying subgroups of depressed individuals who may behave or present differently based on the presence or absence of anxiety symptoms. More generally, some investigators believe that additional specifiers may help move the field toward identifying subtypes of illness that are more closely linked with biomarkers than are the broad diagnostic categories (Stetka & Correll, 2013). From a clinical perspective, this specification can provide an important signal for treatment providers, ultimately facilitating treatment planning and monitoring. For example, given the higher severity and impairment associated with MDD when it is comorbid with anxiety, this specifier may encourage a more aggressive or specialized approach to treatment.

MIXED FEATURES SPECIFIER
The second new specifier included in *DSM-5* is "with mixed features." This specifier can also be applied to both depressive and bipolar disorders. Within the depressive disorders section, the specifier is used when individuals display symptoms of mania or hypomania most days of a depressive episode, but do not meet criteria for a manic or hypomanic episode. More specifically, criteria for the "with mixed features" specifier are met when an individual with MDD also

presents with at least three symptoms of mania (APA, 2013). Importantly, symptoms associated with both the manic and depressive pole (e.g., distractibility or insomnia) are not included in the manic symptom count. Should full criteria for either a manic or hypomanic episode be met, the diagnosis of bipolar I or bipolar II would be given instead of the "with mixed features" specifier. It is also important to note that the "with mixed features" specifier can be distinguished from the other specified or unspecified bipolar and related disorders diagnoses on the basis of whether symptoms of mania/hypomania overlap temporally with the depressive episode. Only if symptoms of mania/hypomania overlap with the depressive episode should MDD with mixed features be diagnosed.

Proponents of including this specifier in *DSM-5* argue that mixed features are seen frequently in clinical practice (Benazzi & Akiskal, 2001; Goldberg et al., 2009). In previous versions of the *DSM*, mixed features could only be diagnosed in the bipolar section (e.g., bipolar I disorder, mixed episodes, which is not included in *DSM-5*). The addition of this specifier provides the first opportunity to capture less severe mixed-mood presentations in depression, which has the potential to facilitate research and treatment (Schneck, 2009). Proponents of the mixed features specifier contend that it will raise clinicians' awareness of any overlap in manic and depressive mood states, thereby facilitating more nuanced pharmacological and psychological treatment decisions. The importance of this perspective is underscored by findings from a prospective controlled study reported by Frye et al. (2009). These investigators presented data showing that patients in a depressive episode who display subclinical manic symptoms were at increased risk for developing treatment–emergent mania when given antidepressant medication. Proponents also note that the mixed features specifier is consistent with perspectives that conceptualize mania and depression as occurring along a dimension; they argue, therefore, that this specifier could encourage investigators to conduct studies examining subthreshold conditions and dimensional approaches to diagnosis (Stetka & Correll, 2013).

Despite general support of the mixed features specifier, its addition to *DSM-5* is not without criticism. Critics have raised concern that the mixed features specifier complicates and confuses diagnosis and treatment. They contend, for example, that it is not clear exactly what treatment recommendations should be made for a patient with MDD with mixed features, compared to an individual diagnosed with bipolar I or bipolar II (Schneck, 2009). Rather than concluding that the specifier should be eliminated from the *DSM*, however, we believe that this concern highlights the need for additional research to gain a better understanding of the mixed features specifier and its treatment implications.

CONCLUSION

Although there have been numerous changes made to the depressive disorders section from *DSM-IV* to *DSM-5*, the common feature of all depressive disorders remains the same: the presence of sad, empty, or irritable mood, accompanied by physical and cognitive symptoms, that significantly impairs functioning. Ultimately, the goals of these changes are to increase the reliability and validity of the assessment of depressive disorders and to enhance the effectiveness of treatments for these disorders. On many fronts, these changes move us closer to these goals and, at the very least, they should encourage research that will facilitate these objectives. Although some of the changes described here have already been well studied, others remain contentious. Attention to these controversial decisions will encourage additional research and fruitful debate, which should strengthen future versions of the *DSM*.

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