Selections from current literature: minor depression
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The term “minor depression” has had several accepted definitions with differing diagnostic criteria. A review of papers published during the period 1991–1996, in which minor depression was a component of the study, demonstrates the extent of these differences. The heterogeneity of definitions of minor depression has been an obstacle to research on a mental disorder that appears to have a high prevalence and causes significant functional disability. As a result of these differing definitions, there is uncertainty about its natural history and prevalence, and whether therapy is beneficial. Agreement on a standard definition is necessary for investigations that are required to describe adequately these components of minor depression. This paper details the variety of definitions of minor depression and suggests use of the research diagnostic criteria published in the Diagnostic and Statistical Manual, fourth edition (DSM-IV) in future research.

Keywords. Classification, depression, functional status, nosology.

Introduction

Minor depression is a disorder that has multiple synonyms, each with somewhat differing diagnostic criteria. Yet, depending on definition, it may be the most prevalent mental disorder in primary care settings, a cause of significant functional disability and a risk for major depressive disorder (MDD). Although there is an extensive literature on MDD and its variants, there is a paucity of literature on minor depression. A review of papers in which minor depression is a component of the study highlights the diversity of definitions. In our review, we found some studies equated minor depression with dysthymia, some used research diagnostic criteria (RDC) proposed by Spitzer and colleagues, some used degree of severity of depressive symptoms, and some used fewer depressive symptoms than are required for MDD. The definitions used and the findings from each study are described. Although comparisons between findings from these several studies are unwarranted owing to differing criteria, some insights into the general nature of minor depression are possible.

Diagnostic criteria

The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) publications combine a classification in which each diagnostic term is defined, including explicit inclusion and exclusion criteria, with an official nomenclature. First published in 1952, its revisions are preceded by extensive literature reviews by several work groups charged with provision of “comprehensive and unbiased information to ensure that DSM-IV reflects the best available clinical and research literature”.

None of the four DSM publications categorizes minor depression as a separate and distinct mental disorder. Instead it is relegated to a category titled “Depressive Disorder Not Otherwise Specified” without a clear definition or specific diagnostic criteria. In contrast to earlier versions, however, the fourth revision provides research diagnostic criteria (RDC) for minor depressive disorders in Appendix B, for use by investigators who wish to study this disorder. In short, the new criteria contain the following requirements:

(i) either depressed mood or loss of interest or pleasure in activities;
(ii) at least two but fewer than five of the symptoms of a major depressive episode;
(iii) significant functional status impairment;
(iv) absence of a prior major depressive or manic episode.

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TABLE 1  DSM-IV: Research criteria for minor depressive disorder

(A) A mood disturbance, defined as follows:

(1) At least two (but less than five) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (a) or (b):

(a) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful). Note: In children and adolescents, can be an irritable mood.

(b) Markedly diminished interest of pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective accounts or observations made by others).

(c) Significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains as significant weight loss.

(d) Insomnia or hypersomnia nearly every day.

(e) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

(f) Fatigue or loss of energy nearly every day.

(g) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

(h) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective accounts or as observed by others).

(i) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

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

(3) The symptoms are not due to the direct physiological effects of a substance (e.g. drug abuse, a medication) or a general medical condition (e.g. hypothyroidism).

(4) The symptoms are not better accounted for by bereavement (i.e., a normal reaction to the death of a loved one).

(B) There has never been a Major Depressive Episode (see p. 327), and criteria are not met for Dysthymic Disorder.

(C) There has never been a Manic Episode (see p. 332), a Mixed Episode, or a Hypomanic Episode, and criteria are not met for Cyclothymic Disorder. Note: This exclusion does not apply if all of the manic-, mixed- or hypomanic-like episodes are substance or treatment induced.

(D) The mood disturbance does not occur exclusively during Schizophrenia, Schizophasiform Disorder, Schizoaffective Disorder, Delusional Disorder or Psychotic Disorder Not Otherwise Specified.

Since DSM-IV was published in 1994, the new research criteria were unavailable to most of authors of studies reviewed in this paper, and criticism for failure to use them is not implied. Indeed, we have not been able to locate any study that has clearly used these new RDC criteria, although such studies may be in progress. The complete text of the criteria is detailed in Table 1.

Minor depression is, of course, related to MDD, defined in DSM-IV as five or more of nine symptoms present during the same 2-week period with the presence of depressed mood and/or loss of interest or pleasure and representing a change from previous functioning. The other seven symptoms include significant weight loss or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive guilt, diminished ability to think or concentrate, and recurrent thoughts of death or suicidal ideation. Most (but not all) definitions of minor depression require fewer symptoms than is needed for a diagnosis of MDD.

Although the DSM is intended for all physicians who treat mental disorders, psychiatrists and mental health practitioners are its main users. Failure officially to designate minor depression as a mental disorder may be explained as follows. Patients with fewer symptoms than required for diagnosis of a major depressive episode are unlikely to receive treatment from psychiatrists. Minor depression may be highly prevalent in primary care settings, but research on mental disorders in these settings is a relatively recent phenomenon. In addition, lack of inclusion of minor depression as an official diagnosis in earlier versions of DSM acts as an impediment to research, and the absence of such research discourages DSM work groups from including it as a new and separate disorder in more recent editions. Absence of an official designation
contributes to investigators using different diagnostic criteria.

Varieties of diagnostic criteria

Dysthymia

Many authors equate minor depression with dysthymia as defined in the DSM-IV, which requires a depressed mood, for more days than not, for at least 2 years and two or more of the following symptoms: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, and feelings of hopelessness. When using this diagnosis, however, some investigators require a 2-year duration of symptoms as specified in DSM, some do not, and others fail to specify the duration of symptoms for patients enrolled in their study.

In the following studies of depression in patients with medical problems, the authors define minor depression as dysthymia with a duration of symptoms of less than 2 years. In a 1-year longitudinal study of 70 patients with myocardial infarction, 24 patients developed major depression (18 in the acute stage and six during follow-up). Two patients had minor depression at the time of the infarction and six developed it during the follow-up period. These incidence data have little meaning, however, without comparative incidence data in a control group. Morris and colleagues assessed depression in 103 consecutive patients 1–3 weeks following a stroke. At 10 years' follow-up, patients diagnosed as having either major or minor depression were 3.4 times more likely to have died than those who were not depressed. Mortality rates were similar in both depressed groups.

In a study of depression following spinal cord injury in 60 patients, 22% had major depression and 8% minor depression when admitted to a rehabilitation hospital. Three months later, about half of the depressions had resolved. Non-recovery was associated with lack of social support. Parmelee and colleagues report the relationship of pain to depression in institutionalized older persons. Those with minor depression reported intense pain more frequently than patients with no depression, but less frequently than patients with major depression. Both major and minor depression were more likely to be present when a cause for the pain had been determined as compared with conditions for which the cause for localized pain could not be diagnosed.

In two reports by Maes and colleagues, the full DSM criteria for dysthymia are used for minor depression. Their work involved study of adrenocorticotropic hormone responses to corticotropin-releasing factor. There were differences in response between patients with MDD, those characterized as melancholic and those with minor depression, but it is difficult to discern clinical significance in these differences.

Some authors who use DSM criteria for dysthymia fail to state duration of symptoms required in selection of their patients. Such is the case in a paper on depression and mortality among the institutionally aged, in which significantly higher mortality rates at 6, 12 and 18 months are reported in patients with major depression as compared with those with minor or no depression. Lastly, in a paper that equates minor depression with dysthymia, the authors require a dysphoric mood plus at least three of ten symptoms. Among patients with Parkinson's disease, they found cognitive decline and deterioration in activities of daily living, higher in patients with major depression than in those who had minor depression or were non-depressed.

Research diagnostic criteria

Spitzer, Endicott and Robins first published research diagnostic criteria (RDC) in 1978 because explicit criteria for some psychiatric diagnoses were lacking in DSM-I and DSM-II. They defined minor depression as "nonpsychotic episodes of illness in which the most prominent disturbance is a relatively sustained mood of depression without the full depressive syndrome, although some associated features must be present".

Some of these criteria differ from those suggested in DSM-IV in that they do not specify duration of symptoms, functional impairment or absence of a prior major depressive disorder.

Several authors, during the period reviewed, used this 1978 research diagnostic criteria for minor depression. In a study of 103 patients with ventricular tachycardia, 11 of whom had major and minor depressive disorders, Carney and colleagues found significantly more episodes of ventricular tachycardia in patients who were depressed than in those who were not depressed. The rate of ventricular tachycardia was the same in patients with minor and major depression. In a comparison of 50 patients with ulcerative colitis and 50 matched controls with renal stones, Magni et al. found that 18 patients had minor depression compared with one in the control group. RDC criteria were also used in the study of computer-administered therapy for depression, but the total number of patients with minor depression was too small for comparisons.

Revised research diagnostic criteria

Two authors used research diagnostic criteria from the 1985 revision of the 1978 RDC paper by Spitzer et al. This revision defines minor depression as an episode of illness with a persistent depressed mood for a duration of 1 week for probable diagnosis and 2 weeks for definite diagnosis, plus two additional symptoms taken from the other eight symptoms of MDD and eight more additional symptoms. These additional eight symptoms are tearfulness or sad face, pessimistic attitude, brooding, feelings of inadequacy, resentful or
angry, demandingness, self-pity and excessive somatic concern. Using these revised criteria in a study of 26 patients with Alzheimer’s disease, Vida et al. found that four patients had major depression and six minor depression. Skodol and colleagues used the 1984 criteria for minor depression in a cohort of 52,000 young adults in Israel. The 1-year prevalence rate for definite major depressive disorder was 4% and that for definite minor depressive disorder was 2.2%. If probable syndromes were included the rates rose to 5.6 and 2.6%, respectively.

Severity of symptoms
Some authors define minor depression in terms of severity of symptoms. Lazarus suggests use of scores on the Beck Depression Inventory for a "multimodal psychotherapeutic approach to treating minor depression". He does not, however, define which scores constitute a cut-off between major and minor depression. Scores on the Beck Depression Inventory were also used by Miranda and Munoz in their study of a cognitive-behavioural treatment of minor depression. Over a 1-year period, patients who received treatment had a reduction in depressive symptoms and missed fewer appointments with their primary care physicians than did those who did not receive treatment. Philipp and colleagues suggest using scores of 13 or more on the Hamilton Depression Scale in patients with fewer than five of the nine major depression symptoms to define eligibility for antidepressant drugs.

Symptom-based definitions
Many authors define minor depression as at least two but fewer than the five symptoms of major depression. Some require the presence of depressed mood and/or anhedonia, while others do not. Most require that symptoms be present for at least 2 weeks. Most authors do not require impaired functional status or exclude patients with a history of MDD. Katon and colleagues used telephone interviews to contact 159 patients 4 months after starting antidepressive medications. At the initial interview, a depressed mood and two or three additional symptoms of major depression present for at least 2 weeks were required for a diagnosis of minor depression. Of the total sample, 42% were classified as having minor depression and 58% as MDD. At the 4-month interview, 66.7% of patients with minor depression had none or one symptoms, while almost 30% still had two to four symptoms. Four per cent of the sample had developed a major depressive disorder.

Jaffe and colleagues, in their study of a primary care population, required either depressed mood or anhedonia and a total of between two and four symptoms of depression. Minor depression was present in 15.6% of patients, in whom functional impairment was midway between patients with no depression and those with major depression. Using the same definition of minor depression in primary care populations in Japan and Israel, Froom and colleagues found a similar monotonic relationship between functional impairment in patients with major, minor and no depression. Using the definition of either depressed mood or anhedonia and between one to three symptoms of depression for "subsyndromal depression" in their study, Williams et al. found functional impairment across all eight domains of health status in their sample of primary care patients.

Koenig and colleagues, in their study of hospitalized male veterans, use the term "minor depressive disorders" to include dysthymia, organic mood syndrome, bereavement, adjustment disorder and depressive disorder not otherwise specified. Using that definition, 18.1% of young males and 29.2% of older males had minor depression. In a study of families of probands with major depression, Maier and colleagues found an increased lifetime risk for minor depression. They require the presence of depressed mood for at least 2 weeks, with at least two but fewer than five symptoms of major depression and significant psychosocial impairment.

Screening-based criteria
Other authors use screening-based criteria to describe an affective disorder which does not meet criteria for MDD. Such is the case in the study by Sherbourne and colleagues, who use a two-step depression case finding procedure based on the intensity and duration of symptoms. The authors use an eight-item scale to screen for depression which has a reported sensitivity of 86–96%, but with a reported positive predictive value of 20–37% in a primary care population. Positively screened patients received the DIS, a structured psychiatric interview based on DSMIII criteria. Those patients who did not meet criteria for MDD based on the DIS but exceeded the cut-off score on the screening instrument were classified as having "subthreshold depression". These patients are found to have less severe symptoms than those with MDD, to be at high risk for the development of MDD and to experience impairment in functioning. Using the same screening criteria, Lynch and colleagues report the efficacy of telephone counselling for treating patients with subthreshold or minor depression in a family practice setting. McCormick used severity of symptoms on the Zung Self-rating Depression Scale to screen 59 mothers of children with attention deficit hyperactivity disorder for depression. Subsequent unstructured psychiatric interviews identified an apparent eight patients with a major depressive disorder and seven with minor depression, according to DSMIV criteria.

Other criteria
The term "subsyndromal symptomatic depression" is used by Jude and colleagues, who define it as any
two or more symptoms of depression (depressed mood or anhedonia not required) present for at least 2 weeks, associated with evidence of social dysfunction but distinguished from the diagnoses of minor depression, major depression or dysthymia. Williams and colleagues defined subsyndromal depression as including depressed mood or anhedonia plus one to three symptoms of depression, and they found a prevalence of 16% among a sample of 221 subjects in three settings. Their definition allowed for the inclusion of a variety of “less-than-major depressions” including minor depression. Baldwin and colleagues found it difficult to categorize minor depression in their study of depressed elder patients, because some patients met the DSM-III criteria for dysthymic disorder while others failed to meet the 2-year criteria.

Wells and colleagues considered “subthreshold lifetime depression” as a category distinct from dysthymia and defined it as either dysphoria or anhedonia plus three other symptoms for depression. A 2-year follow-up of patients revealed that those with subthreshold depression were similar to those with major depression on a number of recent bedridden days. The subthreshold group also evidenced a high rate of future episodes of major depression (24.5%).

Johnson et al. examined epidemiological catchment area data and defined “subclinical depression” as at least two MDD symptom groups. Over 23% of the population were found to meet their criterion for subclinical depression. These patients had increased rates of social disability and use of hospital services when compared to non-depressed patients. Given their large numbers, the subclinically depressed were associated with a larger societal burden of care than those with MDD.

Coyne and colleagues found that primary care physicians detected over 70% of patients with “severe” depressions, but detected only 18% of “mild” depressions which were defined as those meeting minimum DSM criteria with a high Global Assessment of Functioning (GAF) score on Axis 5.

Studies of treatment of minor depression

There have been few randomized controlled studies of the treatment of minor depression. Katon and colleagues report a randomized study of 217 primary care patients diagnosed as depressed by their physicians and who were willing to take antidepressant medication. Ninety-one patients met the criteria for major depression, and 126 for minor depression. The intervention included visits to a psychiatrist and additional visits of increased intensity to the primary care physicians. Minor depression for this study was defined as at least two but fewer than five symptoms of major depression over a period of at least 2 weeks. Fifteen per cent of the 126 patients, however, had fewer than two symptoms. It is uncertain whether depressed mood or anhedonia were required. Although, the intervention improved outcomes in patients with major depression, there was no improvement in those with minor depression.

In a review of pharmacological therapy of minor depression, Stewart and colleagues comment on differing criteria for the diagnosis of minor depression used by several investigators. Included in their review are studies of patients with the diagnosis of neurotic depression, non-major depression, premenstrual syndrome, dysthymia, double depression and adjustment disorder with depressed mood. Almost all of these studies occurred before 1990. They conclude that in placebo-controlled trials, tricyclic antidepressants, MAOIs and several newer antidepressants appear to be slightly more effective than placebo in treating these depressions. Some of the reviewed studies included patients with major depression and part of the apparent benefit may be explained by improvement in those patients.

Clinical relevance

By any definition of minor depression, there appears to be a high prevalence and impaired functional status in primary care patients. It has been associated with increased health care utilization and medical costs, increased length of hospital stay and increased disability days. Although the natural history and response to drug therapy are uncertain, counseling and other measures such as exercise and interventions for social dysfunction may reduce functional impairment. Yet, as compared with MDD, the smaller number of symptoms required for diagnosis of minor depression can make differentiation of the latter from similar symptoms caused by organic illness difficult. For example, diagnosis of minor depression in patients with diabetes mellitus and ischemic heart disease, taking multiple medications, who also have a depressed mood and appetite and sleep problems can be a formidable task.

Summary

Our review demonstrates the extraordinary variety of definitions of minor depression used by investigators in recent publications. Lacking a standard definition in DSM, some used dysthymia, but most found the requirement of a 2-year duration of depressed mood unacceptable for what might be a minor disorder. Some investigators turned to the RDC published in 1978 by Spitzer et al. but these criteria lacked specificity. The 1984 revision was unwieldy because it contains a choice of too many symptoms. Some used fewer depressive symptoms and others lower scores on depression
detection instruments than is required for a diagnosis of MDD. Some used a screening and psychiatric interview model, which is impractical in a primary care population. The result has been a babel of definitions. Extrapolation of findings from these studies to the general population in order to estimate prevalence, natural history or response to therapy, therefore, is unwarranted. The problems in synthesizing the results of various studies using different criteria for minor depression is highlighted by the review by Beck and Koenig.46

Research on minor depression has been hampered by lack of a widely accepted standard definition and criteria for diagnosis. Nevertheless, a review of papers published between 1991 and the present indicates that minor depression is prevalent and, when functional status is measured, that there is significant impairment. There are insufficient data to determine the efficacy of either antidepressant medication or psychotherapy. Additional research using a standard definition is needed. Some investigators may not agree with the recommended research diagnostic criteria in DSM-IV. For example, we would prefer not to exclude patients with a history of MDD because minor depressive symptoms in those who have recovered would be difficult to classify. Nevertheless, the prestige of the American Psychiatric Association and widespread use of its several DSM publications suggest that these criteria be used in future studies. Investigators who chose alternative criteria should demonstrate how their cohort of patients is similar to or differs from those who meet the DSM-IV research criteria for minor depression. Failure to do this will result in the persistence of voices proclaiming as Humpty Dumpty did, "When I use a word, it means just what I choose it to mean—neither more nor less."47

References


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