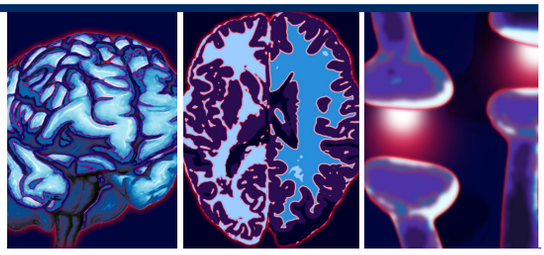

Perinatal distress (depression or anxiety) and DSM-5: a wish-list

Stephen Matthey[†1,2]

"...it is important that users of DSM are clearly informed which parts of a diagnostic disorder are empirically based and which parts are opinion based."

There are two specific points that I consider would improve the current diagnostic structure for perinatal mood disorders when the Diagnostic and Statistical Manual of Mental Disorders (DSM)-5 is published in 2013. In addition, there are two general points that I consider would improve the whole of DSM, therefore including diagnoses in the perinatal period.

Perinatal

■ Depression: postpartum onset specifier

Currently, depression must occur within 4 weeks of the birth for the postpartum onset specifier to apply [1]. However, no rationale or empirical evidence is provided for this specific onset time. From a research perspective, very few, if any, studies use this definition – most studies generally consider the depression to be 'postnatal depression' if it has occurred within 6 months or even 1 year postpartum. Boyd *et al.* are an example of a group who question the adequacy of this current 4-week specifier [2].

I believe that there should be some rationale for whatever onset specifier is 'mandated', and that this should be explained in DSM-5. Preferably, empirical data should support the onset specifier – it should not simply be a matter of opinion. Empirical data such as whether perceived (or actual) etiology differs beyond a certain onset time may be useful, or whether there is a differential impact of the mood disorder depending upon time of onset could be used. In the absence of such empirical information, the onset specifier could be based upon that which is most commonly used in research studies, necessitating a review of recent publications to determine what this is (e.g., 6 or 12 months postpartum).

■ Validity of depression symptoms in the perinatal period

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period. Clearly, the depression symptoms of fatigue, appetite or weight changes, psychomotor retardation and sleep disturbance may simply be related to the normal physical changes of pregnancy (or postpartum). Similarly, the anxiety symptoms of nausea, sweaty or clammy hands and shortness of breath may also be symptoms of normal pregnancy or postpartum.

While one of the exclusion criteria for a diagnosis of depression or an anxiety disorder includes that the "symptoms are not due to … a general medical condition" [1], I am unaware of any perinatal studies (clinical or research) that have considered this criterion. The purpose of this exclusion criterion is to accurately ascribe symptoms to mood difficulties, as opposed to physiological symptoms that are a result of a medical condition. It could thus be argued that pregnancy, and possibly postpartum, comes under the rubric of a 'medical condition'. Clearly, pregnant women become more tired, they have poorer sleep, their appetite changes and they are less able to do things they did before becoming pregnant. To ascribe these symptoms as being indicative of a mood disorder ('a mental illness') without probing for more information appears unsound. However, no mention of this consideration is made in DSM-IV-text revision (TR).

DSM-5 should therefore, I believe, consider this aspect. Myself and a colleague have conducted a study looking at how often various depression or anxiety disorder symptoms are perceived by women as being due to their mood, or simply due to the normal physiological changes of their pregnancy [3]. In our antenatal study, we used a symptom attribution question, and asked women "Do you think that [symptom] is due to the physical changes of your pregnancy, or due to your mood or worries?" Their responses were coded as either due to 'Pregnancy', 'Mood', 'Both' or 'Not sure'. We found that between 40 and 81% of each of the endorsed symptoms were attributed by the women to just the physical changes of their pregnancy, and not due to their mood or worries. Importantly, even the core depression symptom of anhedonia was attributed to the physical changes of the pregnancy by approximately half of the women who experienced this symptom. Examples of pregnancy-attributions for this core symptom included no longer being able to go hiking in order to ensure their baby was not at risk, or being less interested in work or other interests now that she was focused on having the baby.

"...even the core depression symptom of anhedonia was attributed to the physical changes of the pregnancy by approximately half of the women who experienced this symptom."

Thus, I believe it would be an improvement in DSM-5 if such an attribution question was clearly described in a perinatal specifier section.

General

■ Evidence & counter-evidence

DSM-IV-TR gives a description of the extensive process undertaken when DSM-III-R was revised. On page XXIV, it concludes that it is "grounded in empirical evidence" [1]. From my perspective, however, it is disappointing that no reference is made to this empirical evidence throughout the entire DSM-IV-TR.

Work by various investigators has shown that in the area of depression there is mounting evidence that DSM criteria may not be valid. The symptoms for depression have been shown in some studies to lack validity or reliability [4,5], and the distinction between minor and major depression has arguably been shown to be spurious [6]. Zimmerman and colleagues have published a series of papers exploring these issues [7–10], and they conclude that "many of the sets of diagnostic criteria have not been subject to empirical scrutiny" [7], and that "[our series of papers examining the validity of DSM] is about 30 years too late. Ours is the type of methodical psychometric analysis that should have been conducted when initially developing the sets of diagnostic criteria" [7].

I therefore believe that it is important that users of DSM are clearly informed which parts of a diagnostic disorder are empirically based and which parts are opinion based. I also believe that a reference should be given to supportive empirical evidence, as well as a reference to evidence indicating the DSM may not in fact be valid (e.g., the work by Zimmerman and colleagues). Such referencing and acknowledgement of counter-evidence is a requirement in any good scientific paper, and it seems to me to be very unsatisfactory that a diagnostic manual that is treated as the 'gold standard' in mental health should not provide any evidence for its assertions.

Thus, at the beginning of each disorder, I would like to see information on the type of evidence (empirical or opinion), and a supporting reference where applicable, for each of: symptom duration requirement (e.g., 2 weeks or more); symptoms (e.g., fatigue or nausea); number of symptoms requirement (e.g., five or more for major depression); and any contrary evidence.

■ Depression criteria: likelihood of misinterpretation

As given on page XXXVII of the DSM, one of the reasons for the DSM classification system is to "…enhance agreement among clinicians and investigators" [1]. Unfortunately, reliability between clinicians or between researchers may not happen if different wordings, or less than clear wordings, regarding criteria for major or minor depression are given in the manual, and this has occurred in both DSM-IV-TR and in DSM-IV [11].

On page 345 of DSM-IV-TR, the manual states "Major Depressive Disorder: is characterized by … at least 2 weeks of depressed mood or loss of interest accompanied by at least four additional symptoms of depression". However, on page 356, the symptom criteria are: "Five or more … symptoms … at least one of which is either ... depressed mood or … loss of interest or pleasure".

Thus, using the criteria prescribed on page 345, major depression could understandably be interpreted by some people as always requiring at least four noncore symptoms; but if using the criteria on page 356, major depression can be diagnosed with just three noncore symptoms. This likelihood of confusion is a significant issue in DSM that needs to be corrected for DSM-5. Unfortunately, we cannot know the impact of this, as rarely do authors overtly state what number of symptoms they have used in the diagnosis of major or minor depression – more often they just state that they have used DSM criteria. However, a recent publication [12] that did give this information regarding minor depression has shown that different interpretations of the criteria do occur. In this study the authors state that they diagnosed minor depression as one core symptom "and at least two but less than five additional symptoms", whereas on page 720 of DSM-IV, minor depression requires "at least two (but less than five) … symptoms … at least one [of which is one of the core symptoms])". Anecdotally, I have frequently found confusion among psychiatrists and other health professionals on the diagnosis of major or minor depression. This difference in wording, or ease of confusion in interpreting the DSM criteria, is therefore likely to mean that different criteria for the presence of major or minor depression have been used across different studies, and thus research into the prevalence, treatment efficacy and validation of self-report scales has probably been compromised. This issue therefore needs to be addressed in DSM-5.

In addition, I agree with the sentiments of others (e.g., Parker [13]) that we are now pathologizing normal human emotions, and I feel that this is even more likely with the expansion of disorders proposed in DSM-5. This may result in the inappropriate labeling of people having a 'mental illness' or 'mental disorder', which is not, from my perspective, helpful.

> "I agree with the sentiments of others...that in the expansion of disorders to be classified in DSM-5, we are now seemingly pathologizing normal human emotions and behaviors."

Conclusion

Thus, my perinatal 'wish list' for DSM-5 includes:

- Providing a rationale for the postpartum onset specifier (and replacing the 4-week onset period with some other onset period);
- Recommending the use of an attribution probe question in order to determine the presence of depressive or anxious symptoms in the perinatal period;
- Providing statements regarding the type of justification (empirical or opinion) that has been used for various aspects of each DSM-5 disorder, together with a supportive reference, and also a reference to where the validity of DSM claims have been questioned with sound empirical evidence;
- Being consistent in the wording, and possibly give clear examples in order to reduce the likelihood of confusion, for the diagnostic criteria that are used for both major and minor depression.

I realize that the third point is most unlikely to ever happen. But I would ask users of DSM-5 to consider this particular wish from the following perspective: why is it a good idea not to provide evidence for the disorders in a manual that is used as the gold standard by so many clinicians and researchers?

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Bibliography

1 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition Text Revision*. American Psychiatric Association, VA, USA (2000).

2 Boyd RC, Pearson JL, Blehar MC. Prevention and treatment of depression in pregnancy and the postpartum period – summary of a maternal depression roundtable: a U.S. perspective. *Arch. Womens Ment. Health* 4, 79–82 (2002).

3 Matthey S, Ross-Hamid C. The validity of DSM symptoms for depression and anxiety during pregnancy. *J. Affect. Disord*. 133(3), 546–552 (2011).

4 Parker G. Beyond major depression. *Psychol. Med.* 35, 467–474 (2005).

5 Wakefield JC, Schmitz MF, Baer JC. Did narrowing the major depression bereavement exclusion from DSM-III-R to DSM-IV increase validity?: evidence from the National Comorbidity Survey. *J. Nerv. Ment. Dis.* 199, 66–73 (2011).

6 Sakashita C, Slade T, Andrews G. Empirical investigation of two assumptions in the diagnosis of DSM-IV major depressive episode. *Aust. NZ J. Psychiatry* 41, 17–23 (2007).

7 Zimmerman M, McGlinchey JB, Young D, Chelminski I. Diagnosing major depressive disorder introduction: an examination of the DSM-IV diagnostic criteria. *J. Nerv. Ment. Dis.* 194, 151–154 (2006).

8 Zimmerman M, Chelminski I, McGlinchey J, Young D. Diagnosing major depressive disorder X: can the utility of the DSM-IV symptom criteria be improved? *J. Nerv. Ment. Dis.* 194, 893–897 (2006).

9 Zimmerman M, McGlinchey JB, Young D, Chelminski I. Diagnosing major depressive disorder IX: are patients who deny low mood a distinct subgroup? *J. Nerv. Ment. Dis.* 194, 864–869 (2006).

10 Zimmerman M, Galione JN, Chelminski I *et al*. A simpler definition of major depressive disorder. *Psychol. Med.* 40, 451–457 (2010).

11 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (4th Edition)*. American Psychiatric Association, VA, USA (1994).

12 Wisner KL, Moses-Kolko EL, Sit DKY. Postpartum depression: a disorder in search of a definition. *Arch. Womens Ment. Health* 13, 37–40 (2010).

13 Parker G, Hickie I. Is depression overdiagnosed? *BMJ* 335, 328–329 (2007).