IN THE UNITED STATES COURT OF APPEALS
FOR THE ARMED FORCES

UNITED STATES,
Appellee

v.

SALVADOR JACINTO,
Aviation Structural Mechanic First Class, (E-6)
United States Navy,
Appellant

USCA Dkt. No. 24-0144/NA

Crim. App. No. 201800325

INTERVENOR E.B.'S ANSWER

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December 3, 2024

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TO THE JUDGES OF THE UNITED STATES COURT OF APPEALS FOR THE ARMED FORCES

INTRODUCTION

Intervenor E.B files this answering brief to protect her psychotherapist privilege granted by M.R.E. 513. The Court's granted issues and the Appellant's arguments directly affect Intervenor's privilege. Intervenor, as a party before the Navy-Marine Corps Court of Criminal Appeals ("NMCCA"), has standing to file this brief as an intervenor.

Although this Court, in dictum, stated that Intervenor was not a party, that dictum is not binding and has no effect on the filing of this answering brief by Intervenor E.B. To date, no party has objected to Intervenor participating in this case as an intervenor for the limited purpose of protecting her privilege.

The Appellant's brief omits and ignores the evidence in the record supporting the trial judge's, *DuBay* judge's, and NMCCA's identical conclusions that [redacted]. Appellant further omits and ignores evidence, including testimony from his own expert, indicating [redacted]. The evidence in the record indicated [redacted]. Intervenor's answering brief will identify the evidence in the record ignored by the Appellant.

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Appellant incorrectly states the instructions this Court gave to the NMCCA when it remanded the record. Appellant also misapplies numerous cases and legal principles. More importantly, Appellant asks this Court to decide an issue that it pointedly did not ask this Court to decide—whether privileged communications are ever constitutionally required to be disclosed to an accused.

STATEMENT OF THE CASE

I. This Court's 2021 Decision.

In its 2021 decision, this Court focused on the military judge's two key findings of fact: (1) "There was no evidence that E.B. ever experienced psychotic agitation"; and (2) Thorazine was "never administered to [Intervenor]." *United States v. Jacinto*, 81 M.J. 350, 354 (C.A.A.F. 2021) (quoting from App. Ex. 74[1]). This Court explained that it needed to determine whether these two factual findings were clearly erroneous before assessing the military judge's continuance and in camera rulings. *Id.*

[1] Intervenor will use Arabic numerals instead of Roman numerals for clarity and to avoid the mistakes made by the *DuBay* judge in numbering appellate exhibits. *See* J.A. 177, 224-25. In the appellate exhibit list, J.A. 177, App. Ex. CLXXXVII (187 in Arabic numerals) is described as "full medical records [Intervenor] from Calvert Hospital." In his findings of fact, the *DuBay* judge identifies the "entire medical record from Calvert for [Intervenor]" as App. Ex. CLXXXVI (186 Arabic). Hereinafter, Intervenor will use Arabic numerals corresponding to the appellate exhibit list and not the incorrect numbers in the *DuBay* findings of fact.

Because the record was unclear and incomplete (it omitted pages), the Court could not make an informed decision about whether the military judge's "crucial factual findings [were] clearly erroneous." *Id.* The Court ordered the NMCCA to "obtain the missing record evidence and any other evidence relevant to whether E.B. was *diagnosed with psychotic agitation* in May 2017." *Id.* at 355 (emphasis added). The Court further directed that once the record was fully developed, the NMCCA should reexamine the military judge's continuance and in camera review rulings. If the NMCCA found that the military judge abused his discretion in denying either ruling, it must then determine whether such denial materially prejudiced the Appellant. *Id.*

II. E.B.'s Entire Psychotherapy Record Was Disclosed to the Appellant.

The NMCCA ordered a *DuBay* judge to obtain the missing records and make findings of fact. After the *DuBay* judge issued his findings, the Appellant moved to examine sealed records, including appellate exhibits obtained by the *DuBay* judge that Appellant had not previously viewed. These exhibits consisted of App. Ex. 187 (Intervenor's entire psychotherapy records) and App. Ex. 188 (redacted therapy records and Intervenor's assertion of privilege). Counsel for Appellant falsely claimed to have previously viewed App. Ex. 187 and 188. *See United States v. Jacinto*, No. 20-0359/N, Intervenor E.B.'s Motion to Stay

NMCCA Order at 4-5 (C.A.A.F. Dec. 13, 2022). After protracted motion practice at the NMCCA and appeal to this Court, the Appellant was ultimately granted access to Intervenor's entire psychotherapy records in February 2023. *United States v. Jacinto*, 83 M.J. 255 (C.A.A.F. 2023).

STATEMENT OF FACTS

The Appellant has now obtained and reviewed the missing record pages as well as E.B.'s entire 212 pages of privileged psychotherapy records. App. Ex. 187.[2] Tellingly, the Appellant is unable to cite a single fact within these additional records that supports reversing the military judge's factual findings [redacted] He does not cite any facts because there are none.

On the contrary, the Appellant ignores the voluminous evidence indicating that [redacted] Intervenor's statement of facts highlights only some of this evidence.

I. [redacted]

[2] Intervenor E.B. maintains the Appellant's review of her records was unlawful. She intends to claw-back these records. Her reference in this Answer to information from these unlawfully obtained and disclosed records does not waive her privilege.

[redacted]

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[redacted]

[redacted]

[redacted]

III. [redacted]

[redacted]

[redacted]

[redacted]

[redacted]This Court's decision recognized that the dispute centered on whether Thorazine was prescribed "*when* needed" because Intervenor displayed psychotic agitation or whether it was prescribed "*if* needed in the event Intervenor subsequently displayed symptoms of psychotic agitation." *Jacinto*, 81 M.J. at 354 (emphasis in original).

The Appellant's brief fails to identify any fact within the additional records reviewed that indicate Intervenor took Thorazine. Instead, he ignores the evidence indicating that Thorazine was never taken or administered.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

IV. [redacted]

The Court is reminded that the Appellant has reviewed Intervenor's complete mental health records. If any facts within those records demonstrated that Intervenor exhibited psychotic behavior, Appellant would have identified those facts in his Brief. There were none.

[redacted]

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[redacted]

In its 2021 decision, this Court relied upon Dr. Stein's trial testimony that raised the issue of whether Intervenor was diagnosed with psychotic agitation. The

Court directed the NMCCA to determine whether Dr. Stein was correct. [redacted]

[redacted]

ARGUMENT

I. The NMCCA Complied with this Court's Remand Order.

The NMCCA fully complied with this Court's remand order.

The Appellant inaccurately interprets the Court's order. The Court directed the NMCCA to "obtain the missing record evidence and any other evidence . . . relevant to whether [Intervenor] was *diagnosed with psychotic agitation*." *Jacinto*, 81 M.J. at 354-55 (emphasis added); Br. 10-11, 16, 21. The Court did not order the NMCCA to determine whether Thorazine was administered or whether Intervenor exhibited psychotic agitation.

Through the *DuBay* judge, the NMCCA obtained the missing record evidence and additional evidence relevant to whether Intervenor was diagnosed with psychotic agitation. The additional evidence includes Intervenor's 212-page psychotherapy records, which contain significant evidence that Intervenor was

never administered Thorazine and was never diagnosed with psychotic agitation. *See supra* pp. 5-7.

Additionally, Appellant's expert, Dr. Stein, testified [redacted]

While Appellant ignores unfavorable evidence, the NMCCA reviewed "the entire record." Br. 21 (quoting *Jacinto*, 81 M.J. at 354-55). This included the 212 pages of Intervenor's psychotherapy records and Dr. Stein's testimony. The NMCCA determined that Intervenor was never administered Thorazine and had no problems with perception[3] or memory. *Id*. The Appellant ignored the record evidence relied upon by the NMCCA. *See supra* pp. 4-7.

[3] [redacted] The NMCCA's conclusion that Intervenor had no problem with perception is essentially stating that she was not psychotic.

[redacted]

To support his argument that Thorazine was administered, Appellant curiously argues that the NMCCA is victim to the logical fallacy *argumentum ad ignorantium*, or argument from ignorance. Appellant incorrectly translates and applies *argumentum ad ignorantiam*. This fallacy occurs when a proposition is argued to be true solely because it has not been *proven* false, or vice versa. *Alabama-Tombigbee Rivers Coalition v. Kemphorne*, 477 F.3d 1250, 1257-58 (11th Cir. 2007). However, as the *Alabama-Tombigbee* court explained, the absence of evidence can sometimes serve as conclusive evidence. *Id*.

Appellant's misstatement—"the absence of evidence is not evidence of an absence" [5]—is logically flawed. For example, the lack of snow on the ground in the morning, while not conclusive proof, is evidence that it did not snow the night before.

[4] [redacted]

[5] Appellant's brief asserts *argumentum ad ignorantium* is "commonly conveyed" as this quoted language. No court anywhere has ever conveyed *argumentum ad ignorantium* in this language. The *Alabama-Tombigbee* case is the only federal appellate decision that discusses *argumentum ad ignorantiam*.

Furthermore, Appellant cannot apply the "absence of evidence" standard because there is no absence of evidence on either the psychotic agitation or the Thorazine issues. [redacted]

Appellant argues that the NMCCA did not address the question of what documents *should* have been produced. Br. 23-24. However, Appellant's brief ignores the precise language of this Court's remand order and seeks to expand the inquiry to whether production was constitutionally required.

This Court's remand order directed the NMCCA to identify "any documents that were produced or should have been produced pursuant to the military judge's

June 14, 2018 orders." *Jacinto*, 81 M.J. at 355. [redacted]

The *DuBay* judge erred in venturing into conclusions of law regarding whether any of the documents were constitutionally required to be disclosed to Appellant. *United States v. Jacinto*, No. 201800325, 2024 CCA LEXIS 14, at *9 (N-M. Ct. Crim. App. Jan. 18, 2024). The June 14, 2018 order "clearly exempted privileged material." *Id*. The NMCCA found that the *DuBay* judge erred in concluding that privileged communications were constitutionally required to be disclosed. *Id.* at *12. The records the *Dubay* judge identified as constitutionally required were not requested by the June 14, 2018 order and should not have been produced.

This Court's remand decision did not direct the NMCCA to address the constitutionally required issue. The Court did not decide whether there is a constitutionally required exception to M.R.E. 513. *Jacinto*, 81 M.J. at 354 n. 10. The Court's focus was solely on whether Appellant established a factual basis for the continuance and in camera review motions. *Id*.

Appellant was aware that the NMCCA ruled that the *DuBay* judge's finding that the records included constitutionally required information was erroneous. Supp. 16-17. Despite his awareness of this issue, he chose not to present this issue for the Court's review, presenting instead only the two issues the Court granted.

Appellant now seeks to have this Court decide an issue he failed to include in his petition for review. Br. 23-24 ("Without specific identification of the portions of [Intervenor's] records in dispute, the Court cannot review the conclusions of law regarding whether such unidentified portions contain 'discoverable and admissible information that would have helped Appellant's defense.'"). He cannot challenge the NMCCA's holding on this issue at this stage of the proceedings.[6]

II. Appellant Did Not Suffer Prejudice from Denial of Continuance.

Each of Appellant's arguments regarding prejudice fail.

Appellant first relies on *Brescia v. New Jersey*, 417 U.S. 921, 924 (1997), which is a dissent from a denial of certiorari. The dissent in *Brescia* addressed late appointment of counsel, not continuance motions, and is irrelevant. Appellant's claim of " last-minute disclosure of discovery" Br. 27, also fails because the information sought was not evidence in the possession of military authorities under

[6] Intervenor disagrees with the NMCCA's conclusions that the military judge abused his discretion in denying the continuance and in camera review. She does not argue this issue here because it is not included in the granted issues.

R.C.M. 701 but third-party records from Calvert Hospital. *United States v. Stellato*, 74 M.J. 473 (C.A.A.F. 2015) is not applicable.

The Appellant speculates he "may have taken significantly different steps to prepare for trial" by engaging a more qualified expert specializing in pharmacological treatment. Br. 30. However, Dr. Stein's CV shows she has expertise in psychopharmacology, lecturing on the subject for the national psychology license exams for twenty years. J.A. 115.

The Appellant ventures into unsupported and speculative arguments, such as pursuing a *folie à deux* theory. Such claims lack any evidentiary basis. *Folie à deux* requires identical delusional content shared by intimately associated individuals, which is not supported by the record. *See United States v. McRary*, 616 F.2d 181, 184 (5th Cir. 1980). There is no evidence that Intervenor (*see supra* pp. 4-5) or her sister were delusional. The Appellant's *folie à deux* theory may the basis of a movie, but it is not based upon any evidence in this case.

Although Appellant concedes this case does not rise to a structural error, he argues the Court should apply structural error analysis. Br. 28-29. He ignores this Court's precedent that there is a strong presumption that an error is not structural, requiring the appellant to show prejudice. *United States v. Brooks*, 66 M.J. 221, 224 (C.A.A.F. 2008). In *United States v. Gonzalez-Lopez*, 548 U.S. 140, 148 (2006) (cited in *Brooks*), the Supreme Court distinguished between trial errors and structural

errors. At most, discovery rulings amount to trial error. Appellant cannot cite any precedent finding structural error in these circumstances.

The NMCCA found that there was no prejudice resulting from the military judge's denial of a continuance because, upon its complete review of App. Ex. 187, there was nothing further that would have been required to be produced to Appellant. *Jacinto*, 2024 CCA LEXIS 14, at *12-13. Appellant fails to present any evidence to dispute this NMCCA's finding, and instead makes spurious structural defect, expert qualification, and *folie à deux* arguments

CONCLUSION

Intervenor E.B. respectfully requests the Court affirm the findings and sentence.

Respectfully submitted,

Electronic original certified as true and correct by the undersigned

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Certificate of Filing and Service

I certify that this document with sealed information redacted was filed by email with Court on December 3, 2024, and that a copy was simultaneously served by email to counsel for the Appellant and Appellee. The sealed document without redaction was mailed by United Parcel Service to the Court on December 4, 2024.

Certificate of Compliance with Rules

I certify that this brief complies with the maximum length authorized by Rule 24(b)(1) because this brief contains 4232 words. This brief complies with the typeface and type style requirements of Rule 37 because it was prepared using Microsoft Word with Times New Roman 14-point font, a monospaced font.

Respectfully submitted,

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EXHIBIT OF DSM-5 EXCERPTS

The page numbers in this exhibit correspond with the page numbers in the DSM-5 and are centered above the text as in the DSM-5.

Depressive Disorders

Depressive disorders include disruptive mood dysregulation disorder, major depressive disorder (including major depressive episode), persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder. Unlike in DSM-IV, this chapter "Depressive Disorders" has been separated from the previous chapter "Bipolar and Related Disorders." The common feature of all of these disorders is the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function. What differs among them are issues of duration, timing, or presumed etiology.

In order to address concerns about the potential for the overdiagnosis of and treatment for bipolar disorder in children, a new diagnosis, disruptive mood dysregulation disorder, referring to the presentation of children with persistent irritability and frequent episodes of extreme behavioral dyscontrol, is added to the depressive disorders for children up to 12 years of age. Its placement in this chapter reflects the finding that children with this symptom pattern typically develop unipolar depressive disorders or anxiety disorders, rather than bipolar disorders, as they mature into adolescence and adulthood.

Major depressive disorder represents the classic condition in this group of disorders. It is characterized by discrete episodes of at least 2 weeks' duration (although most episodes last considerably longer) involving clear-cut changes in affect, cognition, and neurovegetative functions and inter-episode remissions. A diagnosis based on a single episode is possible, although the disorder is a recurrent one in the majority of cases. Careful consideration is given to the delineation of normal sadness and grief from a major depressive episode. Bereavement may induce great suffering, but it does not typically induce an episode of major depressive disorder. When they do occur together, the depressive symptoms and functional impairment tend to be more severe and the prognosis is worse compared with bereavement that is not accompanied by major depressive disorder. Bereavement-related depression tends to occur in persons with other vulnerabilities to depressive disorders, and recovery may be facilitated by antidepressant treatment.

A more chronic form of depression, persistent depressive disorder (dysthymia), can be diagnosed when the mood disturbance continues for at least 2 years in adults or 1 year in children. This diagnosis, new in DSM-5, includes both the DSM-IV diagnostic categories of chronic major depression and dysthymia.

After careful scientific review of the evidence, premenstrual dysphoric disorder has been moved from an appendix of DSM-IV ("Criteria Sets and Axes Provided for Further Study") to Section II of DSM-5. Almost 20 years of additional research on this condition has confirmed a specific and treatment-responsive form of depressive disorder that begins sometime following ovulation and remits within a few days of menses and has a marked impact on functioning.

A large number of substances of abuse, some prescribed medications, and several medical conditions can be associated with depression-like phenomena. This fact is recognized in the diagnoses of substance/medication-induced depressive disorder and depressive disorder due to another medical condition.

Disruptive Mood Dysregulation Disorder is Omitted.

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Major Depressive Disorder

Diagnostic Criteria

A. Five (or more) 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 (1) depressed mood or (2) loss of interest or pleasure.
   Note: Do not include symptoms that are clearly attributable to another medical condition.
   1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)
   2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

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   3. 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 gain.)
   4. Insomnia or hypersomnia nearly every day.
   5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
   6. Fatigue or loss of energy nearly every day.
   7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
   8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
   9. 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.

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

C. The episode is not attributable to the physiological effects of a substance or another medical condition.
   Note: Criteria A–C represent a major depressive episode.
   Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness,

rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss. See Footnote 1

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
E. There has never been a manic episode or a hypomanic episode.
   Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

Coding and Recording Procedures

The diagnostic code for major depressive disorder is based on whether this is a single or recurrent episode, current severity, presence of psychotic features, and remission status. Current severity and psychotic features are only indicated if full criteria are currently met for a major depressive episode. Remission specifiers are only indicated if the full criteria are not currently met for a major depressive episode. Codes are as follows:

Severity/course specifier	**Single episode**	**Recurrent episode***
Mild (p. 188)	296.21 (F32.0)	296.31 (F33.0)
Moderate (p. 188)	296.22 (F32.1)	296.32 (F33.1)
Severe (p. 188)	296.23 (F32.2)	296.33 (F33.2)
With psychotic features** (p. 186)	296.24 (F32.3)	296.34 (F33.3)
In partial remission (p. 188)	296.25 (F32.4)	296.35 (F33.41)
In full remission (p. 188)	296.26 (F32.5)	296.36 (F33.42)
Unspecified	296.20 (F32.9)	296.30 (F33.9)

*For an episode to be considered recurrent, there must be an interval of at least 2 consecutive months between separate episodes in which criteria are not met for a major depressive episode. The definitions of specifiers are found on the indicated pages.

**If psychotic features are present, code the "with psychotic features" specifier irrespective of episode severity.

In recording the name of a diagnosis, terms should be listed in the following order: major depressive disorder, single or recurrent episode, severity/psychotic/remission specifiers, followed by as many of the following specifiers without codes that apply to the current episode.

Specify:

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 catatonia (p. 186). **Coding note:** Use additional code 293.89 (F06.1).

With peripartum onset (pp. 186–187)

With seasonal pattern (recurrent episode only) (pp. 187–188)

Diagnostic Features

The criterion symptoms for major depressive disorder must be present nearly every day to be considered present, with the exception of weight change and suicidal ideation. Depressed mood must be present for most of the day, in addition to being present nearly every day. Often insomnia or fatigue is the presenting complaint, and failure to probe for accompanying depressive symptoms will result in underdiagnosis. Sadness may be denied at first but may be elicited through interview or inferred from facial expression and demeanor. With individuals who focus on a somatic complaint, clinicians should determine whether the distress from that complaint is associated with specific depressive symptoms. Fatigue and sleep disturbance are present in a high proportion of cases; psychomotor disturbances are much less common but are indicative of greater overall severity, as is the presence of delusional or near-delusional guilt.

The essential feature of a major depressive episode is a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities (Criterion A). In children and adolescents, the mood may be irritable rather than sad. The individual must also experience at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation or suicide plans or attempts. To count toward a major depressive episode, a symptom must either be newly present or must have clearly worsened compared with the person's pre-episode status. The symptoms must persist for most of the day, nearly every day, for at least 2 consecutive weeks. The episode must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning. For some individuals with milder episodes, functioning may appear to be normal but requires markedly increased effort.

The mood in a major depressive episode is often described by the person as depressed, sad, hopeless, discouraged, or "down in the dumps" (Criterion A1). In some cases, sadness may be denied at first but may subsequently be elicited by interview (e.g., by pointing out that the individual looks as if he or she is about to cry). In some individuals who complain of feeling

"blah," having no feelings, or feeling anxious, the presence of a depressed mood can be inferred from the person's facial expression and demeanor. Some individuals emphasize somatic complaints (e.g., bodily aches and pains) rather than reporting feelings of sadness. Many individuals report or exhibit increased irritability (e.g., persistent anger, a tendency to respond to events with angry outbursts or blaming others, an exaggerated sense of frustration over minor matters). In children and adolescents, an irritable or cranky mood may develop rather than a sad or dejected mood. This presentation should be differentiated from a pattern of irritability when frustrated.

Loss of interest or pleasure is nearly always present, at least to some degree. Individuals may report feeling less interested in hobbies, "not caring anymore," or not feeling any enjoyment in activities that were previously considered pleasurable (Criterion A2). Family members often notice social withdrawal or neglect of pleasurable avocations (e.g., a formerly avid golfer no longer plays, a child who used to enjoy soccer finds excuses not to practice). In some individuals, there is a significant reduction from previous levels of sexual interest or desire.

Appetite change may involve either a reduction or increase. Some depressed individuals report that they have to force themselves to eat. Others may eat more and may crave specific foods (e.g., sweets or other carbohydrates). When appetite changes are severe (in either direction), there may be a significant loss or gain in weight, or, in children, a failure to make expected weight gains may be noted (Criterion A3).

Sleep disturbance may take the form of either difficulty sleeping or sleeping excessively (Criterion A4). When insomnia is present, it typically takes the form of middle insomnia (i.e., waking up during the night and then having difficulty returning to sleep) or terminal insomnia (i.e., waking too early and being unable to return to sleep). Initial insomnia (i.e., difficulty falling asleep) may also occur. Individuals who present with oversleeping (hypersomnia) may experience prolonged sleep episodes at night or increased daytime sleep. Sometimes the reason that the individual seeks treatment is for the disturbed sleep.

Psychomotor changes include agitation (e.g., the inability to sit still, pacing, hand-wringing; or pulling or rubbing of the skin, clothing, or other objects) or retardation (e.g., slowed speech, thinking, and body movements; increased pauses before answering; speech that is decreased in volume, inflection, amount, or variety of content, or muteness) (Criterion A5). The psychomotor agitation or retardation must be severe enough to be observable by others and not represent merely subjective feelings.

Decreased energy, tiredness, and fatigue are common (Criterion A6). A person may report sustained fatigue without physical exertion. Even the smallest tasks seem to require

substantial effort. The efficiency with which tasks are accomplished may be reduced. For example, an individual may complain that washing and dressing in the morning are exhausting and take twice as long as usual.

The sense of worthlessness or guilt associated with a major depressive episode may include unrealistic negative evaluations of one's worth or guilty preoccupations or ruminations over minor past failings (Criterion A7). Such individuals often misinterpret neutral or trivial day-to-day events as evidence of personal defects and have an exaggerated sense of responsibility for untoward events. The sense of worthlessness or guilt may be of delusional proportions (e.g., an individual who is convinced that he or she is personally responsible for world poverty). Blaming oneself for being sick and for failing to meet occupational or interpersonal responsibilities as a result of the depression is very common and, unless delusional, is not considered sufficient to meet this criterion.

Many individuals report impaired ability to think, concentrate, or make even minor decisions (Criterion A8). They may appear easily distracted or complain of memory difficulties. Those engaged in cognitively demanding pursuits are often unable to function. In children, a precipitous drop in grades may reflect poor concentration. In elderly individuals, memory difficulties may be the chief complaint and may be mistaken for early signs of a dementia ("pseudodementia"). When the major depressive episode is successfully treated, the memory problems often fully abate. However, in some individuals, particularly elderly persons, a major depressive episode may sometimes be the initial presentation of an irreversible dementia.

Thoughts of death, suicidal ideation, or suicide attempts (Criterion A9) are common. They may range from a passive wish not to awaken in the morning or a belief that others would be better off if the individual were dead, to transient but recurrent thoughts of committing suicide, to a specific suicide plan. More severely suicidal individuals may have put their affairs in order (e.g., updated wills, settled debts), acquired needed materials (e.g., a rope or a gun), and chosen a location and time to accomplish the suicide. Motivations for suicide may include a desire to give up in the face of perceived insurmountable obstacles, an intense wish to end what is perceived as an unending and excruciatingly painful emotional state, an inability to foresee any enjoyment in life, or the wish to not be a burden to others. The resolution of such thinking may be a more meaningful measure of diminished suicide risk than denial of further plans for suicide.

The evaluation of the symptoms of a major depressive episode is especially difficult when they occur in an individual who also has a general medical condition (e.g., cancer, stroke, myocardial infarction, diabetes, pregnancy). Some of the criterion signs and symptoms of a major depressive episode are identical to those of general medical conditions (e.g., weight loss with untreated diabetes; fatigue with cancer; hypersomnia early in pregnancy; insomnia later in pregnancy or the postpartum). Such symptoms count toward a major depressive diagnosis except when they are clearly and fully attributable to a general medical condition. Nonvegetative symptoms of dysphoria, anhedonia, guilt or worthlessness, impaired concentration or indecision, and suicidal thoughts should be assessed with particular care in such cases. Definitions of major depressive episodes that have been modified to include only these nonvegetative symptoms appear to identify nearly the same individuals as do the full criteria Zimmerman et al. 2011.

Associated Features Supporting Diagnosis

Major depressive disorder is associated with high mortality, much of which is accounted for by suicide; however, it is not the only cause. For example, depressed individuals admitted to nursing homes have a markedly increased likelihood of death in the first year. Individuals frequently present with tearfulness, irritability, brooding, obsessive rumination, anxiety, phobias, excessive worry over physical health, and complaints of pain (e.g., headaches; joint, abdominal, or other pains). In children, separation anxiety may occur.

Although an extensive literature exists describing neuroanatomical, neuroendocrinological, and neurophysiological correlates of major depressive disorder, no laboratory test has yielded results of sufficient sensitivity and specificity to be used as a diagnostic tool for this disorder. Until recently, hypothalamic-pituitary-adrenal axis hyperactivity had been the most extensively investigated abnormality associated with major depressive episodes, and it appears to be associated with melancholia, psychotic features, and risks for eventual suicide Coryell et al. 2006; Stetler and Miller 2011. Molecular studies have also implicated peripheral factors, including genetic variants in neurotrophic factors and pro-inflammatory cytokines Dowlati et al. 2010. Additionally, functional magnetic resonance imaging studies provide evidence for functional abnormalities in specific neural systems supporting emotion processing, reward seeking, and emotion regulation in adults with major depression Liotti and Mayberg 2001.

Prevalence

Twelve-month prevalence of major depressive disorder in the United States is approximately 7%, with marked differences by age group such that the prevalence in 18- to 29-year-old individuals is threefold higher than the prevalence in individuals age 60 years or older Kessler et al. 2003. Females experience 1.5- to 3-fold higher rates than males beginning in early adolescence Kessler et al. 2003.

Development and Course

Major depressive disorder may first appear at any age, but the likelihood of onset increases markedly with puberty. In the United States, incidence appears to peak in the 20s; however, first onset in late life is not uncommon Kessler et al. 2003.

The course of major depressive disorder is quite variable, such that some individuals rarely, if ever, experience remission (a period of 2 or more months with no symptoms, or only one or two symptoms to no more than a mild degree), while others experience many years with few or no symptoms between discrete episodes. It is important to distinguish individuals who present for treatment during an exacerbation of a chronic depressive illness from those whose symptoms developed recently. Chronicity of depressive symptoms substantially increases the likelihood of underlying personality, anxiety, and substance use disorders and decreases the likelihood that treatment will be followed by full symptom resolution Coryell et al. 1990; Klein et al. 1988. It is therefore useful to ask individuals presenting with depressive symptoms to identify the last period of at least 2 months during which they were entirely free of depressive symptoms.

Recovery typically begins within 3 months of onset for two in five individuals with major depression and within 1 year for four in five individuals Coryell et al. 1994. Recency of onset is a strong determinant of the likelihood of near-term recovery, and many individuals who have been depressed only for several months can be expected to recover spontaneously. Features associated with lower recovery rates, other than current episode duration, include psychotic features Coryell et al. 1996, prominent anxiety Clayton et al. 1991, personality disorders Holma et al. 2008, and symptom severity Szádóczky et al. 2004.

The risk of recurrence becomes progressively lower over time as the duration of remission increases Solomon et al. 1997. The risk is higher in individuals whose preceding episode was severe Coryell et al. 1991, in younger individuals Coryell et al. 1991, and in individuals who have already experienced multiple episodes Eaton et al. 1997. The persistence of even mild depressive symptoms during remission is a powerful predictor of recurrence Pintor et al. 2004.

Many bipolar illnesses begin with one or more depressive episodes, and a substantial proportion of individuals who initially appear to have major depressive disorder will prove, in time, to instead have a bipolar disorder. This is more likely in individuals with onset of the illness in adolescence, those with psychotic features, and those with a family history of bipolar illness Fiedorowicz et al. 2011; Zimmermann et al. 2009. The presence of a "with mixed features" specifier also increases the risk for future manic or hypomanic diagnosis. Major depressive disorder, particularly with psychotic features, may also transition into schizophrenia, a change that is much more frequent than the reverse Bromet et al. 2011.

Despite consistent differences between genders in prevalence rates for depressive disorders, there appear to be no clear differences by gender in phenomenology, course, or treatment response. Similarly, there are no clear effects of current age on the course or treatment response of major depressive disorder. Some symptom differences exist, though, such that hypersomnia and hyperphagia are more likely in younger individuals, and melancholic symptoms, particularly psychomotor disturbances, are more common in older individuals Brodaty et al. 1997. The likelihood of suicide attempts lessens in middle and late life, although the risk of completed suicide does not Coryell et al. 2009. Depressions with earlier ages at onset are more familial and more likely to involve personality disturbances. The course of major depressive disorder within individuals does not generally change with aging. Mean times to recovery appear to be stable over long periods Solomon et al. 1997, and the likelihood of being in an episode does not generally increase or decrease with time Coryell et al. 2009.

Risk and Prognostic Factors

Temperamental. Neuroticism (negative affectivity) is a well-established risk factor for the onset of major depressive disorder, and high levels appear to render individuals more likely to develop depressive episodes in response to stressful life events Kendler and Gardner 2011.

Environmental. Adverse childhood experiences, particularly when there are multiple experiences of diverse types, constitute a set of potent risk factors for major depressive disorder Chapman et al. 2004. Stressful life events are well recognized as precipitants of major depressive episodes, but the presence or absence of adverse life events near the onset of episodes does not appear to provide a useful guide to prognosis or treatment selection.

Genetic and physiological. First-degree family members of individuals with major depressive disorder have a risk for major depressive disorder two- to fourfold higher than that of the general population Sullivan et al. 2000. Relative risks appear to be higher for early-onset and recurrent forms Sullivan et al. 2000. Heritability is approximately 40%, and the personality trait neuroticism accounts for a substantial portion of this genetic liability Kendler et al. 2004.

Course modifiers. Essentially all major nonmood disorders increase the risk of an individual developing depression. Major depressive episodes that develop against the background of another disorder often follow a more refractory course. Substance use, anxiety, and borderline personality disorders are among the most common of these, and the presenting depressive symptoms may obscure and delay their recognition. However, sustained clinical improvement in depressive symptoms may depend on the appropriate treatment of underlying illnesses. Chronic or disabling medical conditions also increase risks for major depressive episodes. Such prevalent illnesses as diabetes, morbid obesity, and cardiovascular disease are often complicated by depressive episodes, and these episodes are more likely to become chronic than are depressive episodes in medically healthy individuals.

Culture-Related Diagnostic Issues

Surveys of major depressive disorder across diverse cultures have shown sevenfold differences in 12-month prevalence rates but much more consistency in female-to-male ratio, mean ages at onset, and the degree to which presence of the disorder raises the likelihood of comorbid substance abuse Weissman et al. 1996. While these findings suggest substantial cultural differences in the expression of major depressive disorder, they do not permit simple linkages between particular cultures and the likelihood of specific symptoms. Rather, clinicians should be aware that in most countries the majority of cases of depression go unrecognized in primary care settings Ballenger et al. 2001 and that in many cultures, somatic symptoms are very likely to constitute the presenting complaint. Among the Criterion A symptoms, insomnia and loss of energy are the most uniformly reported.

Gender-Related Diagnostic Issues

Although the most reproducible finding in the epidemiology of major depressive disorder has been a higher prevalence in females, there are no clear differences between genders in symptoms, course, treatment response, or functional consequences. In women, the risk for suicide attempts is higher, and the risk for suicide completion is lower. The disparity in suicide rate by gender is not as great among those with depressive disorders as it is in the population as a whole.

Suicide Risk

The possibility of suicidal behavior exists at all times during major depressive episodes. The most consistently described risk factor is a past history of suicide attempts or threats Oquendo et al. 2006, but it should be remembered that most completed suicides are not preceded by unsuccessful attempts Isometsä et al. 1994; Nordström et al. 1995. Other features associated with an increased risk for completed suicide include male sex, being single or living alone, and having prominent feelings of hopelessness. The presence of borderline personality disorder markedly increases risk for future suicide attempts.

Functional Consequences of Major Depressive Disorder

Many of the functional consequences of major depressive disorder derive from individual symptoms. Impairment can be very mild, such that many of those who interact with the affected individual are unaware of depressive symptoms. Impairment may, however, range to complete incapacity such that the depressed individual is unable to attend to basic self-care needs or is mute or catatonic. Among individuals seen in general medical settings, those with major depressive disorder have more pain and physical illness and greater decreases in physical, social, and role functioning.

Differential Diagnosis

Manic episodes with irritable mood or mixed episodes. Major depressive episodes with prominent irritable mood may be difficult to distinguish from manic episodes with irritable mood or from mixed episodes. This distinction requires a careful clinical evaluation of the presence of manic symptoms.

Mood disorder due to another medical condition. A major depressive episode is the appropriate diagnosis if the mood disturbance is not judged, based on individual history, physical examination, and laboratory findings, to be the direct pathophysiological consequence of a specific medical condition (e.g., multiple sclerosis, stroke, hypothyroidism).

Substance/medication-induced depressive or bipolar disorder. This disorder is distinguished from major depressive disorder by the fact that a substance (e.g., a drug of abuse, a medication, a toxin) appears to be etiologically related to the mood disturbance. For example, depressed mood that occurs only in the context of withdrawal from cocaine would be diagnosed as cocaine-induced depressive disorder.

Attention-deficit/hyperactivity disorder. Distractibility and low frustration tolerance can occur in both attention-deficit/ hyperactivity disorder and a major depressive episode; if the criteria are met for both, attention-deficit/hyperactivity disorder may be diagnosed in addition to the mood disorder. However, the clinician must be cautious not to overdiagnose a major depressive episode in children with attention-deficit/hyperactivity disorder whose disturbance in mood is characterized by irritability rather than by sadness or loss of interest.

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 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.

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Persistent Depressive Disorder (Dysthymia) through **Depressive Disorder Due to Another Medical Condition** is OMITTED.

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Other Specified Depressive Disorder

311 (F32.89)

This category applies to presentations in which symptoms characteristic of a depressive disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the depressive disorders diagnostic class. The other specified depressive disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific depressive disorder. This is done by recording "other specified depressive disorder" followed by the specific reason (e.g., "short-duration depressive episode").

Examples of presentations that can be specified using the "other specified" designation include the following:

1. **Recurrent brief depression:** Concurrent presence of depressed mood and at least four other symptoms of depression for 2–13 days at least once per month (not associated with the menstrual cycle) for at least 12 consecutive months in an individual whose presentation has never met criteria for any other depressive or bipolar disorder and does not currently meet active or residual criteria for any psychotic disorder.
2. **Short-duration depressive episode (4–13 days):** Depressed affect and at least four of the other eight symptoms of a major depressive episode associated with clinically

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significant distress or impairment that persists for more than 4 days, but less than 14 days, in an individual whose presentation has never met criteria for any other depressive or bipolar disorder, does not currently meet active or residual criteria for any psychotic disorder, and does not meet criteria for recurrent brief depression.

3. **Depressive episode with insufficient symptoms:** Depressed affect and at least one of the other eight symptoms of a major depressive episode associated with clinically significant

distress or impairment that persist for at least 2 weeks in an individual whose presentation has never met criteria for any other depressive or bipolar disorder, does not currently meet active or residual criteria for any psychotic disorder, and does not meet criteria for mixed anxiety and depressive disorder symptoms.

Unspecified Depressive Disorder

311 (F32.9)

This category applies to presentations in which symptoms characteristic of a depressive disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the depressive disorders diagnostic class. The unspecified depressive disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific depressive disorder, and includes presentations for which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

Specifiers for Depressive Disorders

Specify if:

With anxious distress: Anxious distress is defined as the presence of at least two of the following symptoms during the majority of days of a major depressive episode or persistent depressive disorder (dysthymia):

1. Feeling keyed up or tense.
2. Feeling unusually restless.
3. Difficulty concentrating because of worry.
4. Fear that something awful may happen.
5. Feeling that the individual might lose control of himself or herself.

Specify current severity:

Mild: Two symptoms.
Moderate: Three symptoms.
Moderate-severe: Four or five symptoms.
Severe: Four or five symptoms and with motor agitation.

Note: Anxious distress has been noted as a prominent feature of both bipolar and major depressive disorder in both primary care and specialty mental health settings Coryell et al. 1992; Fava et al. 2004; Fava et al. 2008. High levels of anxiety have been associated with higher suicide risk, longer duration of illness, and greater likelihood of treatment nonresponse. As a result, it is clinically useful to specify accurately the presence and severity levels of anxious distress for treatment planning and monitoring of response to treatment.

With mixed features:

A. At least three of the following manic/hypomanic symptoms are present during the majority of days of a major depressive episode:
   1. Elevated, expansive mood.
   2. Inflated self-esteem or grandiosity.
   3. More talkative than usual or pressure to keep talking.
   4. Flight of ideas or subjective experience that thoughts are racing.
   5. Increase in energy or goal-directed activity (either socially, at work or school, or sexually).

   6. Increased or excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, foolish business investments).
   7. Decreased need for sleep (feeling rested despite sleeping less than usual; to be contrasted with insomnia).

B. Mixed symptoms are observable by others and represent a change from the person's usual behavior.

C. For individuals whose symptoms meet full criteria for either mania or hypomania, the diagnosis should be bipolar I or bipolar II disorder.

D. The mixed symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment).

   Note: Mixed features associated with a major depressive episode have been found to be a significant risk factor for the development of bipolar I or bipolar II disorder. As a result, it is clinically useful to note the presence of this specifier for treatment planning and monitoring of response to treatment.

With melancholic features:

A. One of the following is present during the most severe period of the current episode:
   1. Loss of pleasure in all, or almost all, activities.
   2. Lack of reactivity to usually pleasurable stimuli (does not feel much better, even temporarily, when something good happens).

B. Three (or more) of the following:
   1. A distinct quality of depressed mood characterized by profound despondency, despair, and/or moroseness or by so-called empty mood.
   2. Depression that is regularly worse in the morning.
   3. Early-morning awakening (i.e., at least 2 hours before usual awakening).
   4. Marked psychomotor agitation or retardation.
   5. Significant anorexia or weight loss.
   6. Excessive or inappropriate guilt.

   Note: The specifier "with melancholic features" is applied if these features are present at the most severe stage of the episode. There is a near-complete absence of the capacity for pleasure, not merely a diminution. A guideline for evaluating the lack of reactivity of mood is that even highly desired events are not associated with marked brightening of

mood. Either mood does not brighten at all, or it brightens only partially (e.g., up to 20%–40% of normal for only minutes at a time). The "distinct quality" of mood that is characteristic of the "with melancholic features" specifier is experienced as qualitatively different from that during a nonmelancholic depressive episode. A depressed mood that is described as merely more severe, longer lasting, or present without a reason is not considered distinct in quality. Psychomotor changes are nearly always present and are observable by others.

Melancholic features exhibit only a modest tendency to repeat across episodes in the same individual. They are more frequent in inpatients, as opposed to outpatients; are less likely to occur in milder than in more severe major depressive episodes; and are more likely to occur in those with psychotic features.

With atypical features: This specifier can be applied when these features predominate during the majority of days of the current or most recent major depressive episode or persistent depressive disorder.

A. Mood reactivity (i.e., mood brightens in response to actual or potential positive events).

B. Two (or more) of the following:
    1. Significant weight gain or increase in appetite.
    2. Hypersomnia.
    3. Leaden paralysis (i.e., heavy, leaden feelings in arms or legs).
    4. A long-standing pattern of interpersonal rejection sensitivity (not limited to episodes of mood disturbance) that results in significant social or occupational impairment.
C. Criteria are not met for "with melancholic features" or "with catatonia" during the same episode.

Note: "Atypical depression" has historical significance (i.e., atypical in contradistinction to the more classical agitated, "endogenous" presentations of depression that were the norm when depression was rarely diagnosed in outpatients and almost never in adolescents or younger adults) and today does not connote an uncommon or unusual clinical presentation as the term might imply. Mood reactivity is the capacity to be cheered up when presented with positive events (e.g., a visit from children, compliments from others).

Mood may become euthymic (not sad) even for extended periods of time if the external circumstances remain favorable. Increased appetite may be manifested by an obvious increase in food intake or by weight gain. Hypersomnia may include either an extended period of nighttime sleep or daytime napping that totals at least 10 hours of sleep per day (or at least 2 hours more than when not depressed). Leaden paralysis is defined as feeling heavy, leaden, or weighted down, usually in the arms or legs. This sensation is

generally present for at least an hour a day but often lasts for many hours at a time. Unlike the other atypical features, pathological sensitivity to perceived interpersonal rejection is a trait that has an early onset and persists throughout most of adult life. Rejection sensitivity occurs both when the person is and is not depressed, though it may be exacerbated during depressive periods.

With psychotic features: Delusions and/or hallucinations are present.

> **With mood-congruent psychotic features:** The content of all delusions and hallucinations is consistent with the typical depressive themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment.
>
> **With mood-incongruent psychotic features:** The content of the delusions or hallucinations does not involve typical depressive themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment, or the content is a mixture of mood-incongruent and mood-congruent themes.

With catatonia: The catatonia specifier can apply to an episode of depression if catatonic features are present during most of the episode. See criteria for catatonia associated with a mental disorder (for a description of catatonia, see the chapter "Schizophrenia Spectrum and Other Psychotic Disorders").

With peripartum onset: This specifier can be applied to the current or, if full criteria are not currently met for a major depressive episode, most recent episode of major depression if onset of mood symptoms occurs during pregnancy or in the 4 weeks following delivery.

> **Note:** Mood episodes can have their onset either during pregnancy or postpartum. Although the estimates differ according to the period of follow-up after delivery, between 3% and 6% of women will experience the onset of a major depressive episode during pregnancy or in the weeks or months following delivery Gaynes et al. 2005. Fifty percent of "postpartum" major depressive episodes actually begin prior to delivery Yonkers et al. 2001. Thus, these episodes are referred to collectively as peripartum episodes. Women with peripartum major depressive episodes often have severe anxiety and even panic

> attacks Miller et al. 2006. Prospective studies have demonstrated that mood and anxiety symptoms during pregnancy, as well as the "baby blues," increase the risk for a postpartum major depressive episode O'Hara et al. 1991.
>
> Peripartum-onset mood episodes can present either with or without psychotic features. Infanticide is most often associated with postpartum psychotic episodes that are characterized by command hallucinations to kill the infant or delusions that the infant is possessed, but psychotic symptoms can also occur in severe postpartum mood episodes without such specific delusions or hallucinations.

Postpartum mood (major depressive or manic) episodes with psychotic features appear to occur in from 1 in 500 to 1 in 1,000 deliveries and may be more common in primiparous women Terp and Mortensen 1998. The risk of postpartum episodes with psychotic features is particularly increased for women with prior postpartum mood episodes but is also elevated for those with a prior history of a depressive or bipolar disorder (especially bipolar I disorder) and those with a family history of bipolar disorders.

Once a woman has had a postpartum episode with psychotic features, the risk of recurrence with each subsequent delivery is between 30% and 50% Munk-Olsen et al. 2009. Postpartum episodes must be differentiated from delirium occurring in the postpartum period, which is distinguished by a fluctuating level of awareness or attention. The postpartum period is unique with respect to the degree of neuroendocrine alterations and psychosocial adjustments, the potential impact of breast-feeding on treatment planning, and the long-term implications of a history of postpartum mood disorder on subsequent family planning.

With seasonal pattern: This specifier applies to recurrent major depressive disorder.

A. There has been a regular temporal relationship between the onset of major depressive episodes in major depressive disorder and a particular time of the year (e.g., in the fall or winter).
   Note: Do not include cases in which there is an obvious effect of seasonally related psychosocial stressors (e.g., regularly being unemployed every winter).
B. Full remissions also occur at a characteristic time of the year (e.g., depression disappears in the spring).
C. In the last 2 years, two major depressive episodes have occurred that demonstrate the temporal seasonal relationships defined above and no nonseasonal major depressive episodes have occurred during that same period.
D. Seasonal major depressive episodes (as described above) substantially outnumber the nonseasonal major depressive episodes that may have occurred over the individual's lifetime.
   Note: The specifier "with seasonal pattern" can be applied to the pattern of major depressive episodes in major depressive disorder, recurrent. The essential feature is the onset and remission of major depressive episodes at characteristic times of the year. In most cases, the episodes begin in fall or winter and remit in spring. Less commonly, there may be recurrent summer depressive episodes. This pattern of onset and remission of episodes must have occurred during at least a 2-year period, without any nonseasonal episodes occurring during this period. In addition, the seasonal depressive episodes must substantially outnumber any nonseasonal depressive episodes over the individual's lifetime.

   This specifier does not apply to those situations in which the pattern is better explained by seasonally linked psychosocial stressors (e.g., seasonal unemployment or school schedule). Major depressive episodes that occur in a seasonal pattern are

often characterized by loss of energy, hypersomnia, overeating, weight gain, and a craving for carbohydrates. It is unclear whether a seasonal pattern is more likely in recurrent major depressive disorder or in bipolar disorders. However, within the bipolar disorders group, a seasonal pattern appears to be more likely in bipolar II disorder than

in bipolar I disorder. In some individuals, the onset of manic or hypomanic episodes may also be linked to a particular season.

The prevalence of winter-type seasonal pattern appears to vary with latitude, age, and sex. Prevalence increases with higher latitudes. Age is also a strong predictor of seasonality, with younger persons at higher risk for winter depressive episodes.

Specify if:

In partial remission: Symptoms of the immediately previous major depressive episode are present but full criteria are not met, or there is a period lasting less than 2 months without any significant symptoms of a major depressive episode following the end of such an episode.

In full remission: During the past 2 months, no significant signs or symptoms of the disturbance were present.

Specify current severity:

Severity is based on the number of criterion symptoms, the severity of those symptoms, and the degree of functional disability.

Mild: Few, if any, symptoms in excess of those required to make the diagnosis are present, the intensity of the symptoms is distressing but manageable, and the symptoms result in minor impairment in social or occupational functioning.

Moderate: The number of symptoms, intensity of symptoms, and/or functional impairment are between those specified for "mild" and "severe."

Severe: The number of symptoms is substantially in excess of that required to make the diagnosis, the intensity of the symptoms is seriously distressing and unmanageable, and the symptoms markedly interfere with social and occupational functioning.

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Footnote 1: In distinguishing grief from a major depressive episode (MDE), it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in an MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of an MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of an MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in an MDE. In grief, self-esteem is generally preserved, whereas in an MDE feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involves perceived failings vis-à-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about "joining" the deceased, whereas in an MDE such thoughts are focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

Glossary of Technical Terms

affect through **affective blunting** is OMITTED.

agitation (psychomotor) See PSYCHOMOTOR AGITATION.

agnosia through **defense mechanism** is OMITTED.

delusion A false belief based on incorrect inference about external reality that is firmly held despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not ordinarily accepted by other members of the person's culture or subculture (i.e., it is not an article of religious faith). When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility. Delusional conviction can sometimes be inferred from an overvalued idea (in which case the individual has an unreasonable belief or idea but does not hold it as firmly as is the case with a delusion). Delusions are subdivided according to their content. Common types are listed below:

bizarre A delusion that involves a phenomenon that the person's culture would regard as physically impossible.

delusional jealousy A delusion that one's sexual partner is unfaithful.

erotomanic A delusion that another person, usually of higher status, is in love with the individual.

grandiose A delusion of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person.

mixed type Delusions of more than one type (e.g., EROTOMANIC, GRANDIOSE, PERSECUTORY, SOMATIC) in which no one theme predominates.

mood-congruent See MOOD-CONGRUENT PSYCHOTIC FEATURES.

mood-incongruent See MOOD-INCONGRUENT PSYCHOTIC FEATURES.

of being controlled A delusion in which feelings, impulses, thoughts, or actions are experienced as being under the control of some external force rather than being under one's own control.

of reference A delusion in which events, objects, or other persons in one's immediate environment are seen as having a particular and unusual significance. These delusions are usually of a negative or pejorative nature but also may be grandiose in content. A delusion of reference differs from an *idea of reference*, in which the false belief is not as firmly held nor as fully organized into a true belief.

persecutory A delusion in which the central theme is that one (or someone to whom one is close) is being attacked, harassed, cheated, persecuted, or conspired against.

somatic A delusion whose main content pertains to the appearance or functioning of one's body.

thought broadcasting A delusion that one's thoughts are being broadcast out loud so that they can be perceived by others.

thought insertion A delusion that certain of one's thoughts are not one´s own, but rather are inserted into one's mind.

depersonalization through **grimace** is OMITTED.

hallucination A perception-like experience with the clarity and impact of a true perception but without the external stimulation of the relevant sensory organ. Hallucinations should be distinguished from ILLUSIONS, in which an actual external stimulus is misperceived or misinterpreted. The person may or may not have insight into the nonveridical nature of the hallucination. One hallucinating person may recognize the false sensory experience, whereas another may be convinced that the experience is grounded in reality. The term *hallucination* is not ordinarily applied to the false perceptions that occur during dreaming, while falling asleep (*hypnagogic*), or upon awakening (*hypnopompic*). Transient hallucinatory experiences may occur without a mental disorder.

auditory A hallucination involving the perception of sound, most commonly of voice.

geometric Visual hallucinations involving geometric shapes such as tunnels and funnels, spirals, lattices, or cobwebs.

gustatory A hallucination involving the perception of taste (usually unpleasant).

mood-congruent See MOOD-CONGRUENT PSYCHOTIC FEATURES.

mood-incongruent See MOOD-INCONGRUENT PSYCHOTIC FEATURES.

olfactory A hallucination involving the perception of odor, such as of burning rubber or decaying fish.

somatic A hallucination involving the perception of physical experience localized within the body (e.g., a feeling of electricity). A somatic hallucination is to be distinguished from physical sensations arising from an as-yet-undiagnosed general medical condition, from hypochondriacal preoccupation with normal physical sensations, or from a tactile hallucination.

tactile A hallucination involving the perception of being touched or of something being under one's skin. The most common tactile hallucinations are the sensationof electric shocks and formication (the sensation of something creeping or crawling on or under the skin).

visual A hallucination involving sight, which may consist of formed images, such as of people, or of unformed images, such as flashes of light. Visual hallucinations should be distinguished from ILLUSIONS, which are misperceptions of real external stimuli.

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hostility through **mood** is OMITTED.

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mood-congruent psychotic features Delusions or hallucinations whose content is entirely consistent with the typical themes of a depressed or manic mood. If the mood is depressed, the content of the delusions or hallucinations would involve themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment. The content of the delusion may include themes of persecution if these are based on self-derogatory concepts such as deserved punishment. If the mood is manic, the content of the delusions or hallucinations would involve themes of inflated worth, power, knowledge, or identity, or a special relationship to a deity or a famous person. The content of the delusion may include themes of persecution if these are based on concepts such as inflated worth or deserved punishment.

mood-incongruent psychotic features Delusions or hallucinations whose content is not consistent with the typical themes of a depressed or manic mood. In the case of depression, the delusions or hallucinations would not involve themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment. In the case of mania, the delusions or hallucinations would not involve themes of inflated worth, power, knowledge, or identity, or a special relationship to a deity or a famous person.

multiple sleep latency test through **psychometric measures** is OMITTED.

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psychomotor agitation Excessive motor activity associated with a feeling of inner tension. The activity is usually nonproductive and repetitious and consists of behaviors such as pacing, fidgeting, wringing of the hands, pulling of clothes, and inability to sit still.

psychomotor retardation is OMITTED.

psychotic features Features characterized by delusions, hallucinations, and formal thought disorder.

Psychoticism through **worry** is OMITTED.

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ALL CAPS indicate term found elsewhere in this glossary. Glossary definitions were informed by DSM-5 Work Groups, publicly available Internet sources, and previously published glossaries for mental disorders (World Health Organization and American Psychiatric Association).