

Implications of the DSM's emphasis on sadness and anhedonia in major depressive disorder

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Abstract

At least five symptoms must occur for a DSM diagnosis of major depressive disorder (MDD), one of which must be sadness or anhedonia. The present study is the first known investigation of the implications of the presence or absence of these prioritized symptoms on symptom expression and clinical characteristics among 564 young adults with MDD. Differences in symptom expression and clinical characteristics occurred among MDD participants with sadness relative to those without sadness as well as among MDD participants with anhedonia relative to those without anhedonia. Differential symptom expression could have important implications for the etiology, prevention, and treatment of MDD.

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1. Introduction

According to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, American Psychiatric Association, 2000)*, at least five symptoms must occur for a diagnosis of major depressive disorder (MDD), one of which must be either sadness or anhedonia. Given that these two symptoms are prioritized by the DSM, the question arises as to what are the implications of presence or absence of these symptoms in individuals with MDD. In other words, do patients with anhedonia have a different pattern of symptoms than patients without an-

hedonia and do patients with sadness have a different pattern of symptoms than patients without sadness? Such differential symptom expression could have important implications for understanding the etiology, prevention, and treatment of MDD. For example, perhaps the emphasis on these two depressive symptoms at least partially explains the heterogeneity of symptom expression among individuals with MDD, such as why some individuals with MDD experience increased appetite while others experience decreased appetite. However, to our knowledge, this question has not been empirically examined.

There is some evidence to suggest that differential symptom patterns may exist. MDD individuals with anhedonia have been found to demonstrate greater social impairment, have higher scores on measures of

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depression and hopelessness, be less neurotic, be younger, and to be more often female when compared with MDD individuals without anhedonia (Fawcett et al., 1983). There is also evidence to suggest a correlation between anhedonia and psychomotor retardation among adults with MDD (e.g., Lemke et al., 1999). Depression with melancholia (a defining characteristic of which is loss of interest or pleasure in nearly all activities) has been found to be associated with loss of appetite (e.g., Kazes et al., 1993). Additionally, negative emotions such as sadness have been linked to increased eating in some individuals (e.g., Geliebter and Aversa, 2003).

The present study serves as the first known comprehensive attempt to examine the effects of the presence or absence of sadness and anhedonia on the remaining DSM symptoms of MDD among young adults. The present study also examined the effects of the presence or absence of sadness and anhedonia on both DSM criteria as well as clinical characteristics of MDD. Clinical characteristics were examined to investigate a wider range of the implications of the prioritization of sadness and anhedonia on the expression of MDD. It was hypothesized that different symptoms would be correlated with the presence of anhedonia than the absence of anhedonia and that different symptoms would be correlated with the presence of sadness than the absence of sadness. We specifically expected that the presence of anhedonia would be associated with indicators of impaired hedonics (e.g., decreased appetite, decreased desire to socialize). Gender differences were also analyzed to determine if males and females differ with regard to how the presence or absence of sadness and anhedonia influenced overall symptom expression.

2. Method

2.1. Participants and procedures

The sample was drawn from the Oregon Adolescent Depression Project. Participants were randomly selected from nine senior high schools representative of urban and rural districts in western Oregon. A total of 1709 adolescents completed the initial (T1) assessments, with an overall participation rate of 61%. Specific comparisons were made to determine the representativeness of this sample (see also Lewinsohn et al., 1997; Lewinsohn et al., 2001). First, demographic characteristics of participants were compared to 1980 census data, revealing no differences in gender, ethnicity, or parental education between our sample and census data for the region. Second, demographic characteristics of participants were compared to those of adolescents who declined.

Differences were minimal. Decliners were less likely to be from two-parent families (74% vs. 66%) and had a lower average socioeconomic status, although both groups represented the middle class. Decliners did not differ from participants on type or number of current and lifetime diagnoses, number or extent of clinical symptoms, race, current employment status of parents, and questionnaire variables. Overall, the analyses indicated that the participants in our sample may be considered to be representative of high school students in Western Oregon. At T1, approximately one-half of the sample was female (53.7%), with an average age of 16.6 (S.D. = 1.2). A total of 8.9% were non-White, 71.3% were living with two parents (53% were living with two biological parents), and 12.3% had repeated a grade in school. Parental education level (maximum value for mother or father) was as follows: 46.9% had an academic or professional degree, 35.1% had a partial college education, 16.1% had completed high school, and 1.9% had not completed high school. After a thorough description of the study, written informed consent was obtained.

Approximately 1 year after T1, 1507 participants (88.1%) returned for a Time 2 (T2) readministration of the interview and questionnaire (mean T1–T2 interval = 13.8 months, S.D. = 2.3). Few differences emerged between participants and nonparticipants at T1, and details are provided elsewhere (Lewinsohn et al., 1993). There was no relation between MDD status and attrition.

At age 24 (mean = 24.6 years, S.D. = 0.61), all participants with a history of MDD at T2 ($n=360$) or a history of non-mood disorders ($n=284$), and an approximately equal number of young adults with no history of psychopathology by T2 ($n=457$) were invited to participate in a T3 evaluation. Of the 1101 T2 participants invited for a Time 3 (T3) interview, 941 (85%) completed the evaluation. The 941 T3 participants included 539 (57%) women. Most participants were Caucasian (89%), with 3% Hispanic, 3% American Indian, 3% Asian, 1% African American, and 2% "other." The majority (61%) were single, with 34% married, 2% separated, and 3% divorced. Almost all (97%) had graduated from high school or received their general educational development diploma, and 31% had received a Bachelor's degree or higher. Mean time between the T2 and T3 assessments was 6.8 years (S.D. = 1.4). Although women were more likely than men to complete the T3 assessment (89% vs. 81%), $\chi^2(1, 1101) = 13.55, P < 0.001$, T3 participation differences as a function of other demographic variables or T2 diagnostic status were nonsignificant.

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