A Clinical Significance Criterion Is Essential for Diagnosing Subthreshold Depression

To the Editor: In the March 2010 issue of the *Journal*, Jerome C. Wakefield, Ph.D., D.S.W., et al. (1) examined the redundancy thesis of the DSM-IV clinical significance criterion for major depression. The authors highlighted that the introduction of a clinical significance criterion does not meaningfully alter the prevalence rates of major depression, regardless of whether a clinical significance criterion with a low or high threshold is used. Furthermore, they concluded that the use of a clinical significance criterion for subthreshold depression is questionable, since "virtually all individuals reporting extended sadness also reported significant distress" (1, p. 302).

However, the conclusions for subthreshold depression were drawn on the basis of a questionable definition of clinical significance. Dr. Wakefield et al. (1) defined *clinically significant* distress or impairment as reporting *some* distress or impairment, which constitutes a low threshold for clinical significance. Different from major depression, clinical significance is not already an inherent part of the symptom cluster of subthreshold depression because of the low number of symptoms needed for the diagnosis. Hence, the low threshold of clinical significance conflicts with the purpose of a clinical significance criterion to reduce the risk of pathologizing human behavior. Using data of a general population survey, one recent study (2) demonstrated that the prevalence rates of subthreshold depression based on a clinical significance criterion with a low threshold (Munich-Composite International Diagnostic definition of clinical significance) were approximately equal to those obtained by using a cut-off score of 49 on the Short Form-36 Mental Component Summary score. Considering that a Mental Component Summary score of 50 represents the mean score of the general population, a low threshold of the clinical significance criterion seems inappropriate. It is crucial to define a threshold for clinical significance, which distinguishes persons whose level of distress reflects common human behavior from persons whose level of distress justifies a subthreshold diagnosis (2–4).

Using a higher threshold, Dr. Wakefield et al. (1) showed that 43.5% of all respondents who reported non-major depression sadness did not report severe distress. This high reduction of subthreshold cases by using a higher threshold for clinical significance corresponds with the aforementioned study (2), which highlighted that only 26.5%–61.1% of subthreshold diagnoses remain valid, if any clinical significance criterion is used in addition to a symptom count. Thus, the risk of pathologizing the general population is significantly reduced when a clinical significance criterion is taken into account. Diagnosing subthreshold depression is therefore a question of an appropriate threshold rather than a question of whether or not a clinical significance criterion is necessary (2–4).

References

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Reply to Baumeister Letter

To the Editor: Dr. Baumeister has argued that in diagnosing subsyndromal depression, raising the distress threshold of the clinical significance criterion substantially reduces prevalence, preventing false positive diagnoses of normal distress (1). In his letter, he observes that our article's seemingly contrary finding that the clinical significance criterion's distress component had little impact on subsyndromal diagnosis was because of the very broad DSM-IV-based criterion of the National Comorbidity Survey Replication. Moreover, we too reported that higher distress thresholds may eliminate many cases. Unlike the redundancy of DSM-IV's clinical significance criterion with major depression symptoms, a high-threshold clinical significance criterion is not redundant with subsyndromal depression's more limited symptoms.

Further analysis supports the contention that raising clinical significance criterion distress thresholds substantially reduces subsyndromal depression prevalence. The National Comorbidity Survey Replication liberally allowed positive answers to any of four questions to establish distress, and the threshold was "moderate/sometimes." Our analysis included all non-major depression sadness cases (N=817), a heterogeneous mix. To more closely examine Dr. Baumeister's claim, we reanalyzed the data, including only respondents reporting sadness plus between one and three additional symptoms (N=241), using one-item criteria. For the item, "severity of emotional distress during sad episode," moving the threshold from "moderate" to "severe" reduced the rate of prevalence in the sample from 85% to 34% (if "very severe," to 7%). Using the more stringent item "emotional distress so severe could not carry out activities," moving the threshold from "sometimes" to "often" reduced the rate of prevalence from 21% to 5%.

How thoroughly such increased thresholds eliminate false positives remains uncertain because the symptoms' context is ignored. Even severe distress after major losses may not indicate mental disorder. But, context aside, we agree with Dr. Baumeister's contention that higher subsyndromal depression distress thresholds substantially impact prevalence and plausibly help to fix a serious false positives problem.

If this conclusion is correct, then proposed DSM-5 criteria for "depressive conditions not elsewhere classified" must be reconsidered. The proposal allows diagnosis of subsyndromal depression (sadness and one or more other symptoms lasting 2 weeks) that causes distress or role impairment. No dis-