

Protocol for Week 2 - Depressive Disorders Part I

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Van Gogh's *At Eternity's Gate* portrays the intense sadness often associated with depression, but depression does not always present with such visible sadness. Identifying, distinguishing, and differentiating accounts and displays of negative emotions is a critical aspect of considering a depressive disorder diagnosis, and is understandably a difficult task for clinicians.

Dr. Brankley referred to MDD as the "common cold" of mental disorders because it is one of the most common and well-known mental health disorders. He separately noted that its presentation can vary substantially: Criterion A requires at least five of nine symptoms in the same two-week period, including depressed mood or loss of interest or pleasure, allowing for different symptom combinations. He mentioned A1) Depressed mood and A2) loss of interest or pleasure as the foreground of the disorder. Foreground and background symptoms of a disorder are important when considering differential diagnoses, as they allow us to narrow the range of diagnostic possibilities. Anhedonia may be less apparent than low mood. In a behavioural account, it can be both a symptom of depression and part of what maintains it: diminished pleasure may lead to disengagement from activities, leaving fewer opportunities for rewarding experiences (A2). Dieting and medication effects should be assessed when evaluating significant changes in weight or appetite (A3). When asked whether menstrual-cycle water retention could be mistaken for the weight-change symptom of depression (A3), Dr. Brankley noted that ordinary cyclical changes are generally smaller. The DSM-5-TR gives more than 5% body-weight change in a month (over 7.5 lb at 150 lb) as an example, compared with roughly 2-5 lb of gain around menstruation¹. The person's usual pattern and timing of measurement still matter. Stimulants and dieting may also affect appetite and should therefore be considered when evaluating A3.

While hypersomnia may be what one typically expects during depression, insomnia may also nevertheless form part of its presentation (A4). MDD with anxious features may warrant exploration, while substances and medications should also be considered as possible contributors to sleep disruption. Psychomotor agitation or retardation (A5), such as constant motion or slowed movement and speech, should be directly observable by the interviewer or others. Sleep, substances, and medications may also be functionally linked to fatigue (A6), highlighting the importance of case formulation in determining whether disruption reflects depression or a more discrete factor. Feelings of worthlessness and excessive or inappropriate guilt (A7) can be difficult to disentangle from A1. When asked how to discriminate inappropriate guilt, Dr. Brankley suggested looking beyond thought content for an inconsistency in thinking: an individual may apply flexible standards in parallel situations but become fixated and extreme when applying the same standard to themselves. Internal consistency across situations and rigidity in assigned responsibility may therefore help identify inappropriate guilt. Clinicians may vary their interpersonal style to evaluate diminished concentration or indecisiveness (A8). For individuals who are typically distractable, assessing whether this represents a significant change from their longstanding pattern may help differentiate MDD from ADHD.

Thoughts of death or suicidal ideation (A9) must be taken seriously, although their prevalence varies by population. When asked about imminent suicide risk, Dr. Brankley emphasized lethality, impulsivity, and opportunities to intervene. Although individuals with MDD are more likely to experience suicidal thoughts than behaviours, clinicians must evaluate risk and consider whether their judgement is defensible. Timelines and frequencies are necessary and

¹ Mayo Clinic Staff (2024), Water retention: Relieve this premenstrual symptom ([mayoclinic.org](https://www.mayoclinic.org)); Cleveland Clinic (2025), Why You Might Gain Weight Around Your Period (health.clevelandclinic.org; about 2-5 lb of cycle-related gain).

critical to evaluate when considering a diagnosis (e.g., behaviour occurring most of the day, nearly every day for A1 and A2; nearly every day for A4–A8, with A3 distinguishing weight change from appetite change). Moreover, clinicians should use caution when diagnosing MDD versus Bipolar disorders, as antidepressants can trigger a manic or hypomanic episode.

While a major depressive episode requires at least two weeks, Persistent Depressive Disorder (PDD) is characterized by greater chronicity, involving depressed mood most of the day, more days than not, over at least two years in adults without a break in symptoms longer than two months. However, these temporal distinctions do not establish natural boundaries between disorders; while applying the diagnostic duration requirements, clinicians should also look for stable changes in mood and functioning over time. Dr. Brankley drew five horizontal lines, labelled from top to bottom mania, hypomania, euthymia, dysthymia, and depression, to illustrate a way of mapping a long or fluctuating mood history. Concrete periods from a client's life can then serve as anchors for comparing other periods and tracing changes in mood over time. Because MDD and PDD may contain similar symptoms (e.g., worthlessness versus low self-esteem), severity alone does not distinguish them; a major depressive episode may persist throughout PDD.

Context is especially important for Prolonged Grief Disorder (PGD) because culture does not merely create variability in how grief is expressed, but may actually shape the meaning of the experience itself, consistent with Hilberdink et al. (2023), who also consider cultural meanings of grief. Some features of PGD may overlap with other disorders; for instance, diminished interest may resemble anhedonia, while traumatic grief may overlap with Posttraumatic Stress Disorder (PTSD). Depression, by contrast, may involve more pervasive negative views across the self, the world, and the future, whereas grief often remains tied to the loss of the deceased. Positive emotions can occur during grief and may become easier to experience with time and emotional distance from the loss. More broadly, gender bias, culture, and even the location in which a clinician was trained may influence differential diagnosis and create a risk of pathologizing otherwise normative experiences. For instance, clinicians should be especially cautious when diagnosing older adults with PGD and consider the reason for help-seeking.

Clinicians should consider what may be associated with an individual's negative mood in order to better understand the history and course of the depression, as well as its development and maintenance. Dr. Brankley used a fire as an analogy to the kindling hypothesis- similar to how hot coals require less to reignite, progressively decreased stress levels may sufficiently trigger subsequent depressive episodes. Instead, behavioural models illustrate a cycle in which doing less creates fewer opportunities for positive experiences, which may further contribute to depressive symptoms. Behavioural activation attempts to interrupt this cycle by increasing opportunities for reinforcing experiences and can be adapted across different abilities and individual differences.

Similarly, cognitive models emphasize the rigidity of an individual's thinking, as discussed earlier in regard to determining inappropriate guilt (A7) in MDD. Rather than prescribing a particular way of thinking, clinicians assess whether an individual can generate and consider alternative interpretations, as flexibility itself may represent an adaptive component of thinking. Cognitive vulnerabilities may develop through earlier experiences and interact with later stressful events, resulting in depressions or other forms of dysfunctional cognitive reactivity. Although clinicians may not be able to identify the exact origin of a schema, earlier instances of the same pattern may help clarify its development. Ultimately, understanding the dimension a disorder is attempting to describe may be more diagnostically useful than evaluating symptoms piece by piece. History, course, and the function of current stressors can be useful for symptomology, diagnosis, and prognosis.