occurred less than two weeks after the significant loss, because such symptoms were considered to be appropriate to the bereavement period. DSM-5, however, allows such diagnosis to be made. It states that the presence of depression in addition to the normal response should be carefully considered, based on the patient’s individual history and cultural norms related to the expression of distress in the event of a significant loss.

This makes diagnosis of depression in DSM-5 more inclusive than it used to be in DSM-IV: a larger number of people can now be diagnosed with depression in the bereavement period.

**ATL skills: Thinking and communication**

To what extent is this a positive (or a negative) trend? Discuss methodological and ethical implications of this change in the diagnostic criteria.

### Prevalence rates of major depressive disorder

The main parameters used in epidemiology to characterize the spread of a disorder are prevalence rate (point prevalence and period prevalence) and onset age.

- **Point prevalence rate** is the proportion of people in the population currently diagnosed with the disorder.
- **Period prevalence** is the proportion of a population that has the disorder at some time during a given period. For example, to study 12-month period prevalence you take a representative sample of people and count the number of people who have depression currently or develop it at any time during the subsequent 12-month period. Likewise, lifetime period prevalence is the proportion of a population who had depression at least once in their life. Thus, lifetime prevalence is always greater than 12-month prevalence, and 12-month prevalence is always greater than point prevalence.
- **Onset age** is the average age when individuals in a given population first develop the disorder.

According to the WHO forecast, depression will be the second leading cause of disability in the world by 2020 (currently ranked the fourth).

Prevalence rates of MDD have been found to vary considerably across cultures. A cross-national comparison in 2003 found lifetime prevalence of MDD that ranged from 1% (Czech Republic) to 16.9% (USA) (Kessler and Bromet, 2013). Lifetime prevalence of MDD is generally higher in high-income countries than in low-income countries. These differences may be the result of several possible factors, for example, severity threshold for reporting depression: how severe should the symptoms be before a typical representative of a given culture decides to report a mental health issue?

In 2015 the National Survey on Drug Use and Health in the USA estimated 12-month prevalence of MDD among adults (aged 18 or older). The average 12-month prevalence was found to be 6.7%, with women at 8.5% and men at 4.7% (NIMH, 2015). The risk of MDD for women has been consistently found to be roughly twice as much as for men. This has been explained by a variety of factors including hormones, work-related stressors, home responsibilities, caring for children, abuse and relationship strains.

![Figure 5.4 12-month prevalence of MDD among US adults (NIMH, 2015)](image)

Cross-cultural differences in the age of onset have also been found to be greater than for many other mental disorders. It ranges from adolescence to the early forties, but the median age of onset is in the mid-20s (Kessler and Bromet, 2013).

Depression has a tendency to be a recurrent disorder. A depressive episode typically lasts for 3–4 months and 80% of people experience at least one subsequent episode. In about 12% of cases, depression becomes a chronic disorder with symptoms lasting for two years or more.
Factors influencing prevalence rate estimates

Determining prevalence of disorders is not an easy task. Here are some of the factors that need to be taken into account when discussing this topic.

Exam tip
The topic “Prevalence rates and disorders” is closely linked to two other sections: “Classification systems” and “The role of clinical biases in diagnosis”. You can use material from all three sections in response to the examination questions, but remember to stay focused on the requirements of the question and the command verb.

Classification system. As you know, diagnosis is made on the basis of a list of symptoms and diagnostic criteria. These may be subject to change with every subsequent edition of the diagnostic manual (for example, the bereavement exclusion for MDD was removed from DSM-5, thus resulting potentially in higher estimates of prevalence rates). It needs to be understood that there is no such thing as prevalence rates independent of a classification system.

Clinical biases in diagnosis. Let’s conduct a thought experiment and imagine that a single classification system is used all around the globe. Even in this scenario, estimating prevalence of disorders may still be subject to bias. A lot would depend on how consistently this classification system would be applied across psychiatrists and across populations. What could go wrong?

Some populations may experience depressive symptoms, but be reluctant to report them. This is known as reporting bias. In some societies (such as China or India) it may be “shameful” to have depression, especially among traditional groups and older people. It needs to be understood that prevalence rate estimates are based on the number of people who sought psychological help and were diagnosed with a disorder, but societies differ considerably in terms of the amount of people who are likely to seek psychological help in the first place. For an example, see Furnham and Malik (1994) below (in “The role of clinical biases in diagnosis”)—a study that attempted to explain why British Asians were rarely diagnosed with depression.

For now, let’s continue the thought experiment and assume that all populations are equally willing to report depression. Even so, we can still face the problem of cultural, gender and age variations in the expression of symptoms. For example, Payne (2012) demonstrated that African-American and Caucasian clients would often express their symptoms differently, but clinicians tend to be insensitive to these cultural differences, which results in bias and misdiagnosis (see “The role of clinical biases in diagnosis”). A related problem is somatization—expressing psychological disturbance in the form of physical symptoms (see the section below for a more detailed discussion of this).

Given all the difficulties mentioned above, it is probably true that prevalence rate estimates on a national level are more accurate than cross-cultural comparison of prevalence rates. At the same time, group differences in prevalence rates (such as 8.5% versus 4.7% prevalence of depression in women and men, respectively) may probably be attributed to one of two factors: either genuine differences in the prevalence of a disorder, or differences in the way the disorder is presented or reported. It is not always easy to say which of the factors contributes more, so estimates of prevalence rates remain just that—estimates.