Assessment and treatment of dysthymia.
The development of the Cornell Dysthymia Rating Scale

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Summary – The understanding and classification of persistently depressed mood has undergone many changes since the term ‘dysthymia’ was first used nearly 150 years ago. Originally it was applied to both melancholia and mania; later it was applied to depressive personality. The Diagnostic and Statistical Manual (DSM)-III in 1980 and in subsequent updates classified dysthymia as a mood disorder, characterized by a frequently insidious onset and a course that is chronic and unremitting. The assessment of clinical response in the pharmacologic treatment of dysthymia has been more difficult than that for major depression. The Hamilton Rating Scale for Depression, among others, is oriented towards episodic rather than chronic states of depression. A new rating scale, the Cornell Dysthymia Rating Scale, has been developed to better assess milder symptomatology in chronically depressed patients. Early studies suggest its utility, but further validation of the scale is needed in patients with dysthymia and without major depression.

dysthymia / major depression / Cornell Dysthymia Rating Scale

INTRODUCTION

From the early 1940s through the mid-1970s, diagnosis and classification were minor concerns of American psychiatry (Klerman, 1983). By the early 1960s, there was widespread concern among clinicians and researchers that the absence of an objective and reliable system for description and diagnosis of psychopathology was limiting progress. In 1965, the Psychopharmacology Branch of the National Institute of Mental Health (NIMH) sponsored a conference on classification in psychiatry. Perhaps the most important advance in the United States occurred in 1972 with the publication of what have come to be known as the Feighner Criteria (Feighner et al, 1972). The operational criteria formulated by the Washington University group opened the way for improved reliability and empirical tests of validity (Klerman, 1983). The Research Diagnostic Criteria (RDC) developed by the NIMH Psychobiology Collaborative Study (Spitzer et al, 1975) provided further impetus for outcome studies in clinical settings. At this time, the ICD-8 and the Diagnostic and Statistical Manual (DSM)-II were in general use in Europe and the United States but were considered inadequate to the task. The DSM-III attempted to deal with these deficiencies by incorporating a multi-axial framework (APA, 1980).

The problem of how to classify persistently depressed mood has been with us since ancient times. Kahlbaum coined the terms ‘dysthymia’, which referred to a chronic form of melancholia, and ‘cyclothymia’, which referred to a disorder characterized by a fluctuating mood (Jelliffe, 1931). The DSM-II defined chronic depression as a personality disorder. Dysthymic disorder was used in the DSM-III (APA, 1980) to describe an affective disorder that was non-episodic, and frequently not severe. It was analogous to the term depressive neurosis. The term was changed to dysthymia in the DSM-III-R (APA, 1987) and back to dysthymic disorder in the DSM-IV (APA, 1994).
In the DSM-IV, chronic depression has been classified as a mood disorder under dysthymic disorder, although 'chronic' may also be applied as a specifier for a major depressive episode. Dysthymic disorder differs from major depression in terms of onset, course, features, severity and duration. Its onset is frequently insidious and it follows a course that is chronic and unremitting (McCulloch et al., 1994). Typical neurovegetative symptoms are frequently lacking and there is a high prevalence of cognitive and behavioral symptoms.

While dysthymia has been considered treatment refractory, recent controlled studies have shown a good response to antidepressant medication (Kocsis et al., 1988; Howland, 1991; Angst and Stabl, 1992; Hellerstein et al., 1993). However, few published studies on the pharmacologic treatment of dysthymia have not been confounded by a high occurrence of other disorders. Probably the majority of patients have also had major depression. Hellerstein et al (1993) studied only patients with 'pure' dysthymia. They noted that in the study by Kocsis et al. (1988) 96% of chronically depressed patients met criteria for 'double depression', i.e. concurrent dysthymia and major depression. Nardi et al. (1992), in a large placebo-controlled study, compared the efficacy of moclobemide and imipramine in patients with a DSM-III-R diagnosis of dysthymic disorder. The final data have not yet been published.

Assessment of clinical response in dysthymia has been hampered by the limitations of the existing rating scales (Frances et al., 1989). The scale most widely used to measure depressive severity in clinical trials, the Hamilton Rating Scale for Depression (HAM-D) (Hamilton, 1960, 1967), was developed to assess endogenously depressed inpatients. It is heavily weighted toward neurovegetative symptoms and was intended to measure episodic rather than chronic states of depression. Improvement is measured referent to recent normal premorbid periods. Another difficulty, when assessing milder depression, is its restricted range of possible scores. Ten of 24 items are 3-point (0–2). Fourteen items are 5-point (0–4), but many of the 3- and 4-point severity ratings require spychosis or a level of severity not usually found in an outpatient dysthymic sample.

The Cornell Dysthymia Rating Scale (CDRS) (Mason et al., 1993) grew out of a desire for a scale which would be able to assess milder symptomatology in chronically depressed outpatients. There was a need to include cognitive and behavioral symptoms in addition to neurovegetative symptoms, and to have anchor points relating to current and recent frequency and severity.

### Table I. Cornell Dysthymia Rating Scale.

<table>
<thead>
<tr>
<th>Item</th>
<th>Code</th>
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<tbody>
<tr>
<td>1. Depressed mood</td>
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<tr>
<td>2. Lack of interest or pleasure</td>
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<td>3. Pessimism</td>
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<td>4. Suicidal ideation</td>
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<td>5. Low self-esteem</td>
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<td>6. Guilt</td>
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<td>7. Helplessness</td>
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<td>8. Social withdrawal</td>
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<td>9. Indecisiveness</td>
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<tr>
<td>10. Low attention and concentration</td>
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<tr>
<td>11. Psychotic anxiety</td>
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<tr>
<td>12. Somatic anxiety</td>
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<tr>
<td>13. Worry</td>
<td></td>
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<tr>
<td>14. Irritability or excessive anger</td>
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<td>15. Somatic general</td>
<td></td>
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<tr>
<td>16. Low productivity</td>
<td></td>
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<td>17. Low energy</td>
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<td>18. Low sexual interest, activity</td>
<td></td>
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<tr>
<td>19. Sleep disturbance</td>
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<tr>
<td>20. Diurnal mood variation</td>
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</tbody>
</table>

### MATERIAL AND METHODS

#### Development of the Cornell Dysthymia Rating Scale (CDRS)

The first step was to identify those items most descriptive of dysthymia. A total of 43 items were identified, 24 from the HAM-D and 19 from a DSM-III-RDC list of dysthymia symptoms. Fifty-five research subjects having DSM-III dysthymic disorder were assessed by research psychiatrists or psychologists. Frequency distributions were then computed for all items. Items considered to be frequently endorsed were those that were rated mild or greater by more than two-thirds of the sample. Twenty-four items, 12 items from the DSM-III symptom list and 12 items from the HAM-D, met these criteria. Overlapping items were identified and consolidated into single CDRS items, namely:

**CDRS**
- Depressed Mood
- Pessimism
- Low self-esteem
- Low productivity

**HAM-D**
- Depressed Mood
- Hopelessness
- Worthlessness
- Work and activities

**DSM-III**
- Dysthemia
- Pessimism
- Inadequacy
- Decreased effectiveness

The final CDRS included 20 items which are shown in table I.

#### Structure of the Cornell Dysthymia Rating Scale

Each item was characterized by an explanatory or illustrative description and rated from 0 (symptom absent) to 4 (severe symptoms). Specific anchor points were described for each item. Examples of the descriptions of the items and anchor points are shown in figure I. Eleven of 20 items were rated by frequency of occurrence, five items were rated by severity or degree, and four items were rated by both frequency and severity.
1. **DEPRESSED MOOD**: Subjective feelings of depression based on verbal complaints of feeling depressed, sad, blue, gloomy, down in the dumps, empty, “don’t care”. Do not include such ideational aspects as discouragement, pessimism, and worthlessness or suicide attempts (all of which are to be rated separately).

   - 0 = Not at all.
   - 1 = Slight, e.g., only occasionally feels “sad” or “down”.
   - 2 = Mild, e.g., often feels somewhat “depressed”, “blue”, or “down-hearted”.
   - 3 = Moderate, e.g., most of the time feels “depressed”.
   - 4 = Severe, e.g., most of the time feels “very depressed” or “miserable”.

2. **LACK OF INTEREST OR PLEASURE**: Pervasive lack of interest in work, family, friends, sex, hobbies, and other leisure activities. Severity is determined by the number of important activities in which the subject has less interest or pleasure compared to nonpatients.

   - 0 = All activities as interesting or pleasurable.
   - 1 = One or two activities less interesting or pleasurable.
   - 2 = Several activities less interesting or pleasurable.
   - 3 = Most activities less interesting or pleasurable, with one or two exceptions.
   - 4 = Total absence of pleasure in almost all activities.

3. **PESSIMISM**: Discouragement, pessimism and hopelessness.

   - 0 = Not at all discouraged about the future.
   - 1 = Slight, e.g., occasional feelings of mild discouragement about the future.
   - 2 = Mild, e.g., often somewhat discouraged, but can usually be talked into feeling hopeful.
   - 3 = Moderate, e.g., often feels quite pessimistic about future and can only sometimes be talked into feeling hopeful.
   - 4 = Severe, e.g., pervasive feelings of intense pessimism or hopelessness.

4. **LOW SELF-ESTEEM**: Negative evaluation of himself, including feelings of inadequacy, failure, worthlessness.

   - 0 = Not at all.
   - 1 = Slight, e.g., occasional feelings of inadequacy.
   - 2 = Mild, e.g., often feels somewhat inadequate.
   - 3 = Moderate, e.g., often feels like a failure.
   - 4 = Severe, e.g., constant, pervasive feelings of worthlessness.

Fig 1. Examples of four CDRS items.

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**RESULTS**

The scale is currently being validated. The original validation was conducted on 108 patients with dysthymic disorder when CDRS and HAM-D ratings were compared prior to treatment. Patients were included whether or not they met current or past criteria for major depression. Two subscales were identified. The first, labeled the “dysthymic factor”, consisted of 11 items (depressed mood, lack of interest or pleasure, pessimism, suicidal ideation, low self-esteem, helplessness, social withdrawal, indecisiveness, low attention and concentration, low productivity and low energy). The second, called the “anxiety/somatic factor”, consisted of five items (guilt, psychic anxiety, somatic anxiety, somatic general and low sexual interest).

<table>
<thead>
<tr>
<th></th>
<th>HAM-D change</th>
<th>CDRS change</th>
<th>BDI change</th>
<th>GAF change</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAM-D</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDRS</td>
<td>0.80</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BDI</td>
<td>0.49</td>
<td>0.65</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>GAF</td>
<td>-0.69</td>
<td>-0.71</td>
<td>-0.42</td>
<td>1.00</td>
</tr>
</tbody>
</table>

The correlations among the change scores for the HAM-D, CDRS, Beck Depression Inventory (BDI) (Beck et al, 1972) and Global Assessment of Functioning (GAF) (APA, 1994) are shown in Table II. Similar correlations were found in a sam-
Table III. CDRS correlation analysis in the change from baseline scores. Major depression sample (n = 33).

<table>
<thead>
<tr>
<th></th>
<th>HAM-D change</th>
<th>CDRS change</th>
<th>BDI change</th>
<th>GAF change</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAM-D change</td>
<td>1.00</td>
<td>0.79</td>
<td>0.67</td>
<td>-0.76</td>
</tr>
<tr>
<td>CDRS change</td>
<td></td>
<td>1.00</td>
<td>0.60</td>
<td>-0.69</td>
</tr>
<tr>
<td>BDI change</td>
<td></td>
<td></td>
<td>1.00</td>
<td>-0.46</td>
</tr>
<tr>
<td>GAF change</td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
</tr>
</tbody>
</table>

A sample of 33 depressed patients being treated in an open-label trial of a new antidepressant (table III). All had a DSM-IV diagnosis of major depression; eight of the 33 met the criteria for 'double depression'. The CDRS change was highly correlated with the HAM-D and GAF changes.

In a double-blind comparison of fluoxetine and placebo in the treatment of patients with dysthymia, but without major depression, the dysthymic factor discriminated between treatment groups. However, the anxiety/somatic factor, and the full scale, did not show a significant difference between the groups (Hellerstein et al, 1993).

CONCLUSION

The refinements in the diagnosis and classification of dysthymia that have been incorporated into the DSM-IV have been helpful, but much work remains to be done in order to understand the spectrum of chronic depression. Treatment outcome studies demonstrating the effectiveness of pharmacotherapy in dysthymia have generally been flawed by the inclusion of many patients with 'double depression'. The development of the Cornell Dysthymia Rating Scale with its emphasis on frequency as well as severity, and its expanded symptom coverage over the HAM-D, may prove a useful instrument in the assessment of non-episodic depression.

REFERENCES

END OF WEEK 2

Instructions: Rate each item for the previous week.

1. **DEPRESSED MOOD:**
   Subjective feelings of depression based on verbal complaints of feeling depressed, sad, blue, gloomy, down in the dumps, empty, "don't care." Do not include such ideational aspects as discouragement, pessimism, and worthlessness or suicide attempts (all of which are to be rated separately).

   - 0 - Not at all
   - 1 - Slight, e.g., only occasionally feels "sad" or "down"
   - 2 - Mild, e.g., often feels somewhat "depressed," "blue" or "down-hearted"
   - 3 - Moderate, e.g., most of the time feels depressed
   - 4 - Severe, e.g., most of the time feels "very depressed" or "miserable"

2. **LACK OF INTEREST OR PLEASURE:**
   Pervasive lack-of-interest in work, family, friends, sex, hobbies, and other leisure time activities. Severity is determined by the number of important activities in which the subject has less interest or pleasure compared to nonpatients.

   - 0 - All activities as interesting or pleasurable
   - 1 - 1 or 2 activities less interesting or pleasurable
   - 2 - Several activities less interesting or pleasurable
   - 3 - Most activities less interesting or pleasurable with one or two exceptions
   - 4 - Total absence of pleasure in almost all activities

3. **PESSIMISM:**
   Discouragement, pessimism and hopelessness

   - 0 - Not at all discouraged about the future
   - 1 - Slight, e.g., occasional feelings of mild discouragement about the future
   - 2 - Mild, e.g., often somewhat discouraged but can usually be talked into feeling hopeful
   - 3 - Moderate, e.g., often feels quite pessimistic about the future and can only sometimes be talked into feeling hopeful
   - 4 - Severe, e.g., pervasive feelings of intense pessimism or hopelessness
### Cornell Dysthymia Rating Scale

**End of Week 2**

<table>
<thead>
<tr>
<th>Scale Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. Suicidal Tendencies:</strong></td>
<td>Suicidal tendencies, including preoccupation with thoughts of death or suicide. Do not include mere fears of dying.</td>
</tr>
<tr>
<td>0 - Not at all</td>
<td></td>
</tr>
<tr>
<td>1 - Slight, e.g., occasionally feels life is not worth living</td>
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</tr>
<tr>
<td>2 - Mild, e.g., frequent thoughts that s/he would be better off dead or occasional thoughts of wishing s/he were dead</td>
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<tr>
<td>3 - Moderate, e.g., often thinks of suicide, has thoughts of a specific method, or made an impulsive attempt not requiring medical attention</td>
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<tr>
<td>4 - Severe, e.g., has made a planned attempt requiring medical intervention</td>
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</tbody>
</table>

| **5. Low Self-Esteem:** | Negative evaluation of self, including feelings of inadequacy, failure, worthlessness |
| 0 - Not at all |  |
| 1 - Slight, e.g., occasional feelings of inadequacy |  |
| 2 - Mild, e.g., often feels somewhat inadequate |  |
| 3 - Moderate, e.g., often feels like a failure |  |
| 4 - Severe, e.g., constant, pervasive feelings of worthlessness |  |

| **6. Guilt:** | Feelings of self-reproach or excessive, inappropriate guilt for things done or not done |
| 0 - Not at all |  |
| 1 - Slight, e.g., occasional feelings of mild self-blame |  |
| 2 - Mild, e.g., often somewhat guilty about past actions, the significance of which s/he exaggerates, such as consequences of his/her illness |  |
| 3 - Moderate, e.g., often feels quite guilty about past actions or feelings of guilt which s/he can't explain |  |
| 4 - Severe, e.g., pervasive feelings of constant guilt or generalizes feelings of self-blame to many situations |  |
### Cornell Dysthymia Rating Scale

**END OF WEEK 2**

<table>
<thead>
<tr>
<th></th>
<th>0 - Not at all</th>
<th>1 - Slight and of doubtful clinical significance</th>
<th>2 - Mild, e.g., of clinical significance, but only occasional and never very intense; effort to take initiative, but does so with difficulty</th>
<th>3 - Moderate, e.g., often aware of feeling quite helpless or occasionally feeling very helpless; misses opportunities for not taking initiative, needs a lot of coaching or reassurance</th>
<th>4 - Marked, e.g., most of the time feeling quite helpless or often feeling very helpless</th>
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<tbody>
<tr>
<td><strong>7. HELPLESSNESS</strong>:</td>
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<tr>
<td>Feelings of passivity, lack of control, needing someone's assistance to get mobilized</td>
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<tr>
<td><strong>8. SOCIAL WITHDRAWAL</strong>:</td>
<td>0 - Not at all</td>
<td>1 - Possibly less sociable than the norm</td>
<td>2 - At times definitely avoids socializing</td>
<td>3 - Often avoids friends and social interactions</td>
<td>4 - Almost all the time avoids interpersonal contacts</td>
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<tr>
<td>Lack of social contact with persons out of the home</td>
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<tr>
<td><strong>9. INDECISIVENESS</strong>:</td>
<td>0 - Not at all</td>
<td>1 - Slight, e.g., occasional difficulty making decisions</td>
<td>2 - Mild, e.g., often has difficulty making decisions</td>
<td>3 - Moderate, e.g., frequently ruminates excessively and feels unsure when decision making</td>
<td>4 - Severe, e.g., usually unable to make even simple decisions in most situations</td>
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<tr>
<td>Difficulty making decisions</td>
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</table>
10. **LOW ATTENTION AND CONCENTRATION:**

- Distractible, unfocused, confused thinking, impaired short-term memory.

11. **PSYCHIC ANXIETY:**

Subjective feelings of anxiety, fearfulness, or apprehension, excluding anxiety attacks, whether or not accompanied by somatic anxiety, and whether focused on specific concerns or not.

12. **SOMATIC ANXIETY:**

Has been bothered by 1 or more physiological concomitants of anxiety other than during a panic attack. They include symptoms associated with panic attacks, as well as headaches, stomach cramps, diarrhea, or muscle tension. This item should be scored whether or not the subject has had panic attacks.
### Cornell Dysthymia Rating Scale

**End of Week 2**

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. <strong>Worry:</strong></td>
<td>Worthing, brooding, painful preoccupation and inability to get mind off unpleasant thoughts (may or may not be accompanied by depressive mood).</td>
</tr>
<tr>
<td>14. <strong>Irritability or Excessive Anger:</strong></td>
<td>Feelings of anger, resentment, or annoyance (directed externally) whether expressed overtly or not. Rate only the intensity and duration of the subjective mood.</td>
</tr>
<tr>
<td>15. <strong>Somatic General:</strong></td>
<td>Physical symptoms such as heaviness in limbs, back, or head, backaches, muscle aches.</td>
</tr>
</tbody>
</table>

#### Worry:
- 0 - Not at all
- 1 - Slight, e.g., occasionally worries about some realistic problem
- 2 - Mild, e.g., often worries excessively about a realistic problem or occasionally about some trivial problem
- 3 - Moderate, e.g., very often worries excessively about a realistic problem and often worries about some trivial problem
- 4 - Severe, e.g., most of the time is spent in worrying or brooding

#### Irritability or Excessive Anger:
- 0 - Not at all, or clearly of no clinical significance
- 1 - Slight and of doubtful clinical significance
- 2 - Mild, e.g., definitely more than called for by the situation but only occasional and never very intense
- 3 - Moderate, e.g., often aware of snapping at others, feeling quite angry or occasionally very angry
- 4 - Marked, e.g., most of the time aware of losing temper, yelling, or often feeling very angry

#### Somatic General:
- 0 - Not at all
- 1 - Slight, e.g., occasional backache
- 2 - Mild, e.g., often has 1 or more physical symptoms to a mild degree
- 3 - Moderate, e.g., often has 1 or more symptoms to a considerable degree
- 4 - Severe, e.g., very frequently is bothered by 2 or more symptoms which interfere with function
**END OF WEEK 2**

16. **LOW PRODUCTIVITY:**
   Decreased effectiveness or productivity at school, work, or home, as compared with nonpatients.
   - [ ] 0 - Not at all
   - [ ] 1 - Occasional decrease in functioning in 1 or 2 areas
   - [ ] 2 - Frequent decrease in functioning in 1 or 2 areas
   - [ ] 3 - Frequent decrease in functioning in several areas
   - [ ] 4 - Decrease in functioning in almost all areas a great deal of the time

17. **LOW ENERGY:**
   Subjective feeling of lack of energy or fatigue? (Do not confuse with lack of interest.)
   - [ ] 0 - Not at all
   - [ ] 1 - Probably less energy than normal
   - [ ] 2 - At times definitely more tired or less energy than normal
   - [ ] 3 - Often feels tired or without energy
   - [ ] 4 - Almost all the time feels very tired or without energy or spends a great deal of the time resting

18. **LOW SEXUAL INTEREST, ACTIVITY:**
   - [ ] 0 - Not at all
   - [ ] 1 - Possibly less than normal
   - [ ] 2 - At times definitely low
   - [ ] 3 - Often low
   - [ ] 4 - Almost all the time
19. **INSOMNIA:**

Sleep disturbance, including difficulty in getting to sleep, staying asleep or sleeping too much. Take into account the estimated number of hours slept and subjective sense of adequacy of time spent sleeping. If subject is using medication, ask what he thinks it would be like without medication.

**A. DIFFICULTY GETTING TO SLEEP OR STAYING ASLEEP**

- 0 - Not at all
- 1 - Slight, e.g., occasional difficulty
- 2 - Mild, e.g., often has some significant difficulty
- 3 - Moderate, e.g., usually has considerable difficulty
- 4 - Severe, e.g., almost always has great difficulty

**B. SLEEPS TOO MUCH**

- 0 - Not at all
- 1 - Slight, e.g., occasional difficulty
- 2 - Mild, e.g., often has some significant difficulty
- 3 - Moderate, e.g., usually has considerable difficulty
- 4 - Severe, e.g., almost always has great difficulty
END OF WEEK 2

CHOOSE EITHER A. OR B.

A. WORSE IN MORNING

☐ 0 - Not worse in morning or variable
☐ 1 - Minimally or questionably worse
☐ 2 - Mildly worse
☐ 3 - Moderately worse
☐ 4 - Considerably worse

B. WORSE IN EVENING

☐ 0 - Not worse in evening or variable
☐ 1 - Minimally or questionably worse
☐ 2 - Mildly worse
☐ 3 - Moderately worse
☐ 4 - Considerably worse

20. DIURNAL MOOD VARIATION:
Extent to which, for at least 1 week, there is a constant fluctuation of depressed mood and other symptomatology coinciding with the first or second half of day. Generally, if the mood is worse in one part of the day it will be better in the other. However, for occasional subjects who are better in the afternoon and worse both in the morning and evening, choose the one time that represents the greatest severity of symptoms.

Look to change
Settles in one part of day the others

Rater's Name: ____________________________ Cornell Dysthymia Score: ______