**Dysthymia At A Glance**

Adapted from *Ten-Year Prospective Follow-Up Study of the Naturalistic Course of Dysthymic Disorder and Double Depression* (Klein DN, Shankman SA, and Rose S. Am J Psychiatry 2006; 163:872–880)

Dysthymic disorder is a chronic, low-grade depressive condition that affects as many as 6% of individuals in the community (1) and 36% of outpatients in mental health settings (2). Although dysthymic disorder is characterized by mild to moderate symptoms, more than 75% of individuals with dysthymic disorder have exacerbations that meet the criteria for a major depressive episode, a phenomenon known as “double depression” (3).

Despite the central role of chronicity in defining dysthymic disorder, there are few data on its long-term course. With the exception of one study of pediatric patients (4), all longitudinal studies of dysthymic disorder have had follow-up periods of 2 years or less (5–11). The limited duration of follow-up constitutes an important gap in the research on dysthymic disorder, as it is difficult to determine the rates and timing of recovery and relapse in chronic disorders and to examine their stability over time without long-term follow-up. In one study, the estimated 5-year recovery rate from dysthymic disorder was 53% and that there was a 45% chance of relapse into another chronic depressive episode. Persons with dysthymic disorder and double depression experienced significantly higher levels of depression and spent more time in depressive episodes and less time fully recovered than patients with nonchronic major depressive disorder

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**The following is adapted from “Online Diagnosis”, Phillip W. Long, M.D., updated August 19, 1997** (http://www.mentalhealth.com)

**Medical Treatment**

**Basic Principles**

Recent research shows that approximately 62% of patients with dysthymic disorder will benefit from antidepressant medication. The guidelines for assessing the potential utility of drug therapy are a contributory family history and a past history of poor response to other forms of treatment. The relative ease and efficiency with which such a trial can be undertaken usually outweigh concerns about risks of medications or the appropriateness of their use.

**Hospitalization**

For almost all patients, treatment can take place on an outpatient basis.

**Antidepressant Drugs**

Both fluoxetine and imipramine have repeatedly been shown to be effective treatments for this disorder in placebo-controlled randomized double-blind studies. Interesting enough, the response rate to antidepressant therapy is usually in the order of 62%; whereas the response rate to placebo therapy ranges from 19% to 44%.

**Antianxiety Drugs**

A number of drugs are not of value for long-term treatment. Those drugs include the amphetamines, thebarbiturates, and the benzodiazepines. Those drugs are often prescribed for patients with chronic symptoms of insomnia, fatigue, or tension. However, clinical experience and systematic research indicate that they are little better than a placebo and are at times worse.

**Psychosocial Treatment**

**Basic Principles**

Psychotherapy is the principal treatment resource for patients with dysthymic disorder. Reassurance that the clinician understands the depth of the patient's pain, assessment of suicidal and other self-destructive potential, and optimism for the future are all useful.

**Individual Psychotherapy**

"Short-term" focused psychotherapy and therapeutic programs that stress changes in interpersonal relationships and cognitive self-awareness are becoming more popular, in part because long-term analytic approaches to personality change are economically unfeasible. Patients who receive psychotherapy of any of several types - notably cognitive, interpersonally-oriented, or behavior therapy with social skills training - tend to have a good prognosis, with or without antidepressant medication. Analytic and other insight-oriented therapies appear useful for some patients, provided specific neurotic conflict patterns can be elucidated, the patient meets other criteria for this

form of treatment, and the clinician is experienced in its use. No matter what the form of psychotherapy, supportive measures are important. These may range from simple reassurance and education of the patient with respect to the characteristics of his or her illness, to unqualified acceptance of the patient who may at times appear hostile or draining to the therapist, to working with significant others in the patient's life. Treatment

usually involves warmth and availability on the part of the psychiatrist, and not the classically "neutral" stance which the patient easily misperceives as uncaring. Psychotherapy with chronically depressed individuals is an emotionally draining process for the therapist, and recurrent examination of the therapist's own feelings toward the patient is required. Analysis of one's own anger, boredom, or frustration about some aspect of the patient's behavior can help to isolate the key issue in therapy and lead to symptomatic improvement. The patient's unrealistic and idealistic expectations of himself or herself may, for example, be transmitted to the therapist and give rise to overlying optimistic expectations of progress in therapy. If the patient shows no subjective improvement over time, the therapist may inadvertently respond somewhat in the way significant individuals in the patient's life have responded. Interpretation of such personal experiences by the therapist can, in the proper context, be therapeutic.

**Group Therapy**

Although individual psychotherapy is the most common psychosocial treatment offered, many individuals with dysthymic disorder will benefit from group therapy and from active investigation and restructuring of maladaptive social functioning.

**Family Therapy**

Family-centered approaches differ from individual methods in their direct focus on the "role of the sick member" in the family system rather than on the symptoms of the identified patient.