Focus issues in dysthymia

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Practice points

- Dysthymia (dysthymic disorder) is characterized by chronic low grade depression lasting for at least 2 years in adults and 1 year in children and adolescents.
- The causation of dysthymia is multifactorial and underlying personality plays a role.
- In adults with dysthymia, substance abuse, major depressive disorder, anxiety disorders (particularly panic disorder) and borderline personality disorder may present as comorbid illnesses.
- Common comorbidities with dysthymia in children and adolescents are attention deficit hyperkinetic disorder, conduct disorder, anxiety disorders, learning disorders and mental retardation.
- Dysthymia coexists along with major depressive disorder as double depression.
- Treatment of dysthymia is similar to that of major depressive disorder.
- Selective serotonin reuptake inhibitors are commonly recommended (both for children and adults) for treatment of dysthymia.
- Cognitive behaviour therapy and interpersonal therapy are effective in the treatment of dysthymia.
- Combination therapy (pharmacotherapy and psychotherapy) is more effective than either pharmacotherapy or psychotherapy in isolation in treatment of dysthymia.

SUMMARY Dysthymia (dysthymic disorder) is one of the most commonly encountered psychiatric illnesses in day-to-day practice, affecting approximately one in every 20 people worldwide. Intensity of depressive content and impairment is less in dysthymia in comparison to major depressive disorder, but the management of dysthymia is similar to that of depression. Underlying personality plays a major role in dysthymia. This article focusses on current issues including management and research works of dysthymia. The issue of placement of dysthymia in current classificatory systems is also addressed.
Dysthymia (dysthymic disorder) is described as a depressive mood disorder that follows a chronic course. Dysthymia and major depressive disorder are two different entities. Dysthymia is not a sequel of well-defined major depressive episodes [1].

What is coined as dysthymia in International Classification of Diseases (ICD)-10 [101] is known as dysthymic disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV-TR. Onset of dysthymia is insidious and in most cases early (onset before the age of 21 years) [1]. Late-onset (onset at or after the age of 21 years) dysthymia is relatively rare. Early-onset dysthymia is associated with a higher risk of melancholia, more impairment, higher risk of recurrence of major depressive episodes and a higher risk of substance abuse in comparison to late-onset dysthymia [2].

Risk factors of early-onset dysthymia include early trauma, family history, attention deficit hyperactivity disorder and incomplete recovery from major depression [2]. Risk factors of late-onset dysthymia include life stressors (e.g., death of a loved one/accident) and substance abuse [2].

Dysthymia is more common in females than males. Studies revealed that there is impairment in quality of life, functioning, social support and marital adjustment among patients with dysthymia [3–9]. Impairments in dysthymia are comparatively less in comparison to major depressive disorder. Dysthymia was previously known as neurotic depression, chronic minor depression and characterological depression [1].

Niculescu and Akisal described dysthymia by dividing it into two subcategories [10]. The first subcategory anergic dysthymia is characterized by a feeling of anergia (lack of energy), anhedonia, loss of libido, weight loss and excessive sleep. This variant of dysthymia is common in males. Patients respond better to dopaminergic and noradrenergic agents. The second subcategory, anxious dysthymia, is characterized by a feeling of subjective restlessness, sense of insecurity, impulsivity and low self-esteem. This variant is common in females and responds well to serotonergic agents (selective serotonin reuptake inhibitors [SSRIs]) [10].

It is not a single factor, but rather many etiological factors that are responsible for the development of dysthymia. The etiology of dysthymia is quite similar to that of major depressive disorder. Important etiological factors are outlined in Box 1 [11].

### Box 1. Etiological factors of dysthymia.

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<th>Biological factors:</th>
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<td>Genetic linkage, twin studies, neurochemical mechanisms</td>
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<th>Sleep studies:</th>
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<td>Increased rapid eye movement density and decreased rapid eye movement latency</td>
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<th>Neuroendocrinologic factors:</th>
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<td>Involvement of the thyroid and adrenal axes</td>
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<th>Psychosocial factors:</th>
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<td>Conflict in oral and anal sadistic phase</td>
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<td>Interpersonal disappointment in early life leading to defective ego development</td>
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<th>Cognitive theory</th>
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<td>Mismatch between reality and fantasy leading to decreased self-esteem</td>
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Data taken from [11].
be diagnosed with major depression in their lifetime [18], while 25–50% of the patients with major depression have comorbid dysthymia [19]. When a major depressive episode overlaps with dysthymia, the condition is called double depression [20]. In double depression there is always a risk of prolongation of the major depressive episode and complete recovery is unlikely [21]. Laptook et al. had conducted a 10-year follow-up study on patients of dysthymia who experienced major depression [22]. They found that the majority (70%) of the patients had short recovery period and the major depressive episode followed a chronic course. The relapse rate following recovery was also as high as 70% [22].

### Diagnosis & management

Currently, the DSM-IV-TR [1] mentions that a diagnosis of dysthymia includes depressed mood, accompanied with two or more of the following: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, and feelings of hopelessness. The mood can be irritable in children and adolescents. These symptoms persist most of the day and last over a period of 2 years or more. In children and adolescents, duration of at least 1 year is sufficient to make the diagnosis of dysthymia. Individuals may have symptom-free periods but not for more than two consecutive months. The symptoms are generally milder but longer lasting than those of a major depressive episode. If the symptoms are associated with another psychiatric impairment such as schizophrenia, manic episodes or organic psychosis, a diagnosis of dysthymia does not apply. Individuals with this disorder must not have had a major depressive episode during the first 2 years of the disturbance unless a full remission occurred without significant signs or symptoms for 2 months before development of the dysthymia. Patients are diagnosed with chronic major depression if their depressive symptoms are caused by major depression and not dysthymia during the first 2 years of the disturbance. If it recurs in a patient with dysthymia after the first 2 years, the patient is diagnosed with double depression. Diagnosis of dysthymia is not made if there is any episode of hypomania, mania, mixed episode, cyclothymia or if the symptoms of dysthymia are secondary to physical illness (hypothyroidism), medication, substance abuse or psychotic disorder. It must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. As per the ICD-10, depressive personality disorder is also included under the category of dysthymia [101]. It was previously also known by the name of ‘melancholic personality disorder’. It was removed from DSM-III and DSM-III-R. In DSM-IV-TR, it is placed under the category of ‘personality disorder not otherwise specified’ [1]. The differential diagnoses for dysthymia are outlined in Box 2 [11].

In depressive personality disorder, there is distorted self-image, chronic feeling of low, constant unhappiness, pessimism, humorlessness, self-blame and a proneness for excessive worrying. Most of the features of depressive personality disorder overlap with that of dysthymia, so it is considered a differential diagnosis of dysthymia. Early-onset dysthymia closely resembles depressive personality disorder. The diagnosis of dysthymia is based primarily on somatic symptoms whereas the diagnosis of depressive personality disorder mainly focuses on cognitive and intra-psychic symptoms [102]. Patients of dysthymia may have comorbid depressive personality disorder [23,24]. Functional health status is an important parameter that distinguishes dysthymia from that of depressive personality disorder. Huprich et al. in their study in a primary care population found that depressive personality disorder is less associated with functional health status as compared to dysthymia [25]. In adults with dysthymia, substance abuse, major depressive disorder, anxiety disorders (particularly panic disorder) and borderline personality disorder may present as comorbid illnesses [11]. Common comorbidities with dysthymia in children and adolescents are attention deficit hyperkinetic disorder, conduct disorder, anxiety disorders, learning disorders and mental health status as compared to dysthymia (hypothyroidism), medication, substance abuse or psychotic disorder. It must cause clinically significant distress or impairment in

### Box 2. Differential diagnoses of dysthymia.

- Minor depressive disorder: contrary to dysthymia it follows an episodic course
- Recurrent brief depressive disorder: differs from dysthymia by its episodic nature and severity
- Double depression: dysthymia with superimposed major depressive disorder
- Substance abuse disorders: substance abuse is significant and the dysthymic state is explainable by substance abuse. A definite temporal correlation between substance abuse and mood symptoms is always present

Data taken from [11]
In dysthymia the treatment aims at:

- Improving depressive symptoms
- Reducing risk of development of other mood disorders (e.g., major depressive disorder)
- Improving global psychosocial functioning and overall quality of life

Treatment of dysthymia is almost the same as that of depression. It includes pharmacotherapeutic intervention (antidepressants) and psychotherapy. These treatment modalities can be used alone or in combination.

Pharmacotherapeutic intervention is carried out with antidepressant medications such as tricyclic antidepressants, SSRIs and serotonin (5-HT)–norepinephrine (NE) reuptake inhibitors. Among the antidepressants, serotonergic agents (SSRIs) are found to be highly effective in the treatment of dysthymia [11,32]. SSRIs are the first-line drugs recommended for treatment of dysthymia in children and adolescents [32]. SSRIs are well tolerated by children and adolescents. Therapeutic effects of the SSRIs start in 3–4 weeks. Treatment usually starts at lower doses and continues up to a minimum of 3 months. Gradually the doses are built up, if the patient responds to the treatment then treatment should continue for 2–3 years. Approximately 56% of individuals with dysthymia benefit from antidepressant medication [33]. Commonly prescribed SSRIs for dysthymia are fluoxetine, sertraline and paroxetine (under consideration). One serotonin–norepinephrine reuptake inhibitor found to be effective in dysthymia is venlafaxine [11,34,35]. Although not commonly used to treat the US population, tricyclic antidepressants are found to be effective in dysthymia. Among the tricyclic antidepressants, are commonly tried medications including imipramine and desipramine [36–39].

Antidepressants exert their action mainly through 5-HT or NE receptor modulation. Studies were conducted to find the role of dopamine in the depressive symptom profile of dysthymia. Unfortunately the studies are few in number. The selective D2 and D3 receptor antagonist amisulpride, which has dopamine receptor agonistic properties at low doses, was found to be effective in dysthymia [29,30]. Avoidant and obsessive–compulsive disorders frequently coexist with dysthymia [31].

Many medical conditions like diabetes mellitus, hypertension and other chronic medical conditions may coexist with dysthymia. In dysthymia, the factor for relapse is comorbid personality disorder [29,30]. Avoidant and obsessive–compulsive disorders frequently coexist with dysthymia [31]. Many medical conditions like diabetes mellitus, hypertension and other chronic medical conditions may coexist with dysthymia [31].

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During management of dysthymia in a pediatric population, psychoeducation of the family members and psychosocial factors are also important issues that need to be addressed [46]. Recent research on treatment outcomes of patients with dysthymia suggest that treatment with psychotherapy in isolation has the poorest outcome when compared to pharmacotherapy alone and the combined treatment of psychotherapy and pharmacotherapy has the best outcome [47]. A minimum of 18 psychotherapy sessions, at weekly intervals, is found to be effective. Among the different psychotherapy modalities available, cognitive behavior therapy shows better efficacy [48].

Teaching coping skills and relaxation methods to individuals with dysthymia is beneficial.

The Cornell Dysthymia Rating Scale (CDRS) and Hamilton Depression Rating Scale (HDRS) are the most common standard rating scales used to assess the clinical severity of dysthymia [49]. The former scale is a clinician rated scale where as the latter is an observer rated scale. The Global Assessment Scale (GAS) is used to rate the global functioning and Quality of Life scales are used to assess the quality of life [50].
Patients of dysthymia are similar to that of other psychiatric disorders, it has opened the door for research in this area to find out a specific immunologic role in development of dysthymia.

In a study on an elderly population suffering from dysthymia with comorbid major depression conducted in 2004, Devanand et al. found that patients with late-onset dysthymia are more at risk of cardiovascular disease compared with patients with early-onset dysthymia who are more prone to develop anxiety disorders [58]. Barbu et al. conducted a study on an Italian population in 2006. In this study population of patients with dysthymia, more than 80% of patients had their onset of illness before the age of 21 years (i.e., the early-onset type). It was also found that those individuals with the early-onset type of dysthymia needed more inpatient psychiatric admissions [59]. Keeping in mind the raising trend of stressful lifestyle, substance abuse and increased incidence of depression, it can be predicted that dysthymia will be one of the leading psychiatric illnesses in the coming decades.

### Conclusion

Dysthymia is a common mood disorder that often escapes undetected. Few individuals seek treatment for their symptoms. Previously it was often ignored, but currently much importance is given to it due to many reasons (e.g., comorbidities, heritability and premorbid maladjustment with life). Underlying personality plays a key role in development of dysthymia [60–62]. Early life adversity giving rise to a maladaptive personality is a risk factor that is preventable. Current researches on dysthymia aim at finding out its neurochemical and neurobiological basis. Research is also going on different subtypes (i.e., early onset vs late onset, anergic vs anxious) of dysthymia along with potential drug treatment. Current focus is regarding proper placement of dysthymia in the classificatory system of DSM-5 and ICD-11.

### Future perspective

Dysthymia was associated with elevated levels of circulating natural killer (NK) cells. Since levels of plasma cortisol, adrenocorticotropic hormone or norepinephrine were not increased in the dysthymic subjects, it is likely that the elevated NK cell number was unrelated to these neuroendocrine measures. In control subjects, circulating NK cells were inversely related to the severity of stressors recently encountered, while in dysthymic patients, stress and coping factors were unrelated to NK cell numbers [57]. Although the preliminary immunological research findings in patients of dysthymia are similar to that of other psychiatric disorders, it has opened the door for research in this area to find out a specific immunologic role in development of dysthymia.

### Current controversies

Controversies are ongoing regarding the position of dysthymia in the clinical classificatory system of psychiatry. Initially dysthymia was thought to be a state of chronic mild depression or personality disorder, whereas the current belief concerning dysthymia is that it is a chronic or fluctuating, low-grade (subsyndromal) primary mood disorder [51]. Patients with dysthymia often have experiences of unexplained unhappiness in their early childhood. Whether DSM-IV-TR adequately addresses dysthymia in children and adolescents is a matter of some controversy [52].

In order to find a solution regarding the controversy of dysthymia, attempts have been taken in the upcoming DSM-5, where dysthymia is renamed as chronic depressive disorder [103]. The main reason behind putting dysthymia under the category of chronic depressive disorder is that studies conducted to find out differences between chronic unipolar depression and dysthymia revealed similar history, course and outcome [53–56]. The new domain chronic depressive disorder in DSM-5 highlights the risks of other psychiatric disorders along with its course and risk of recurrence. Placing dysthymia as a chronic depressive disorder will be more advantageous. By doing so much attention will be paid to underlying maladaptive patterns of thinking and behaviors that are sometimes focus of empirically supported cognitive behavioral treatment. It will open the door of research on different components involved in chronic depressive disorder [104]. The work group for DSM-5 proposed diagnostic criteria for chronic depressive disorder, which no longer includes history of major depressive episode in the first 2 years as an exclusion criterion, for making the diagnosis of chronic depressive disorder [103].

### Financial & competing interests disclosure

The authors have no relevant affiliations or financial involvement with any organization or entity with a financial interest in or financial conflict with the subject matter or materials discussed in the manuscript. This includes employment, consultancy, honoraria, stock ownership or options, expert testimony, grants or patents received or pending, or royalties.

No writing assistance was utilized in the production of this manuscript.
Bibliography

Papers of special note have been highlighted as:

- of interest


- Examines depressive personality disorder and dysthymia.


- Examines the course of dysthymic disorder.


Focus issues in dysthymia

REVIEW


• Review of nonpharmacological management of dysthymic disorder.

• Highlights classification of dysthymic disorder, and comparison of early- versus late-onset dysthymic disorder.

• Websites
104 MEMO on the inclusion of depressive personality disorder in DSM-V (or DSM-5) http://depressivepersonalitydisorder.com/blog/?p=48