



BY PAUL J. FINK, M.D.

## FINK! STILL AT LARGE

*A recent study shows that dysthymic disorder leads to more disability than major depressive disorder. How should we think about dysthymic disorder?*

**D**ysthymic disorder is one of those diagnoses in the DSM-IV that seems to be characterized by ambiguity. I think that many psychiatrists like me do not use this category very often because we see it as a fall-back diagnosis. For example, if you don't think that the patient has a serious depression, you might call it dysthymic disorder.

The finding of Dr. Jonathan W. Stewart and his colleagues that dysthymic disorder causes a "significant public health burden" that carries with it a significant amount of disability ("Dysthymic Disorder Causes More Disability Than Major Depression," p. 1) is in line with what I've seen over the years. Coming up with effective treatment for these patients is particularly challenging.

My approach is to do a careful assessment of a patient who complains of depression. If I don't believe that supporting evidence of major depressive disorder exists (MDD), I will call it dysthymic disorder and look for a "major" diagnosis for the patient. I always use dysthymia as a secondary condition. The patient talks depressed but doesn't look depressed. Since the entire category of depression is under affective disorders in the DSM-IV, I expect a great deal of affective symptomatology for MDD and still some in dysthymic disorder.

### Inability to Work Is Key

An important component is the degree of impairment in these patients. They can't get to work and are inconsistent. According to Dr. Stewart, "dysthymia is what ruins people's lives." Work history, history of success, and failure in social settings are clearly part of dysthymic disorder. These patients also consume more Medicare, Medicaid, and Social Security Disability Insurance than do people with other forms of depression. These patients also had fewer full-time jobs than did those with other diagnoses.

These objective findings are important, because patients with dysthymic disorder do not have a lot of symptoms. They know they do not feel good; instead they are sad, not joyous, and have a lot of self-blame and guilt. The patient's failure in social engagement and poor work history are important factors to note. The patient rarely has a lot of vegetative signs. Sleep is the exception. The dysthymic disorder patient has some sleep disturbance, but not of the degree found in MDD or bipolar illness.

I was trying to provide a case history for this essay and couldn't come up with a patient who had a pure DD. As I said in the beginning, the diagnosis reminds me of "not otherwise specified" or the way in which the ER physician decides that the patient has a psychiatric illness—he can't find anything physiologically definitive to affirm a diagnosis in his mind.

When I interview a patient who has been on the inpatient service, there is a group of them who respond to my question, "When did you first become depressed," with a quick, "I've been depressed all my life." When I get that answer, I search for a history of physical, sexual, and/or emotional abuse early in that person's life. The person sitting in front of me might not be clearly depressed, but between major depressions—the sense of a lifetime of depression might actually be dysthymic.

If we were to plot the illness, perhaps it would look like a sine curve graph. This is just a conjecture, but it might look like this: dysthymic—MDD—suicide attempt—dysthymic disorder—MDD—suicide attempt, and so on. We have all seen patients like this. Nothing is accomplished; the patient has no job and usually no attachments; the family is not interested. I would like to hear from others who have seen this kind of syndrome or life history. We know that when a patient says she has been depressed her whole life, that is that patient's impression retrospectively to what happened between major episodes. I have found that major depressive episodes are aborted by a suicide attempt, usually with hospitalization and a discharge. But discharge to what?

The dysthymic patient needs a support system that he usually does not have. And he does not know how to reach out and build such a system.

One man I saw who fit this description had had four intense affairs with women but was unable to consummate any of the relationships into marriage. Of course, he took no responsibility for the breakdown between him and any of the women.

In long-term outpatient cases, we see the diagnosis changing from year to year. In one patient I saw for more than 2 decades, his condition varied over time. He was never free of complaint and sometimes would talk of his depression, which generally was not visible. Yet, there were times in which he became seriously depressed with a lot of crying and discomfort. Again, at other times, his affect was not deeply impaired. Looking back, I would say that this patient had dysthymia at those times.

We have to keep our eye on the diagnostic ball and not feel constrained to keep our original diagnosis as a sacred cow. People change over time and as a result of therapy. We see these changes but usually do not note them. There are numerous anxiety disorders, and we do not find it strange for people to go from one to another. I am suggesting that the same is true of the depressive spectrum.

Dr. Stewart's thesis is that dysthymic patients have more disability than other depressive disorders. We need to assess the psychosomatic symptomatology of these patients and other kinds of psychiatric disability. We already have reviewed some of the major disabling behaviors.

What I believe is most disabling is the chronic nature of the illness, the length of time the person feels bad, the complaints, and, in particular, the unhappiness.

### Viewing the Illness as Cyclical

I am caring for a patient now with bipolar illness who seemed very depressed for months and then, with a change in medication, became manic—loud, disruptive, very talkative, and filled with complaints. That was a real change from his depressive state. He started going out, seeing people, and was overjoyed with his "improvement."

Recently, however, this patient has become less joyous, filled with physical complaints of all kinds, and unable to do anything. He quit his part time job and now complains of having nothing to do. He says repeatedly, "I am not depressed,"

**What I believe is most disabling is the chronic nature of the illness, the length of time the person feels bad, the complaints, and, in particular, the unhappiness.**

but he also is not manic. I think he is dysthymic at this time—although the DSM-IV would disagree with me.

On some points, the DSM-IV is clear about dysthymia. It starts early in life, is chronic, and must last for 2 years before one can call a patient dysthymic. Other symptoms include poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, and feelings of hopelessness.

All of these symptoms also are seen in MDD. This tells us why the diagnosis is so difficult to make. From what I've already said, I don't agree with the DSM-IV about the absence of any full depression in the 2-year period that must precede diagnosis, according to the manual. Most important is the long-term nature of the disorder. For example, the patient who says "I've been depressed all my life" could be a candidate.

The extent to which this diagnosis is related to abuse and trauma in childhood never has been studied. Whenever a person tells me about a lifetime of unhappiness, I inquire about abuse and trauma. What started a life of unhappiness? In the movie "Precious," the main character says "no one ever loved me," a pathetic moment in the film but true of many children we see today. Alice Miller, Ph.D., the researcher on childhood, says a child must have one person in his life who gives him unconditional love.

Unconditional love is just what the name implies: no constant criticism (emotional abuse), no constant punishment (physical abuse), and protection from getting hurt or further abused by people, at school, or on the street. Without it, the child might develop dysthymia. I see people gratuitously hitting children in public venues, and being shamed in this way can lead to dysthymia.

Recently, I attended an alternative high school graduation. I was sitting next to a family in which the mother had a 4-year-old on her lap, constantly hit the boy, and yelled "Shut the &%\$# up." The grandmother eventually rescued the boy, and he ran to her as fast as he could. Later during the program, he ended up back with his mother and she started her admonition again. Finally, she sat the little fellow in her chair and stood right in front of him so that she could see the events. All he could look at was the back of her body. I was very upset by witnessing firsthand what this boy was going through. Of course, I have no way of following up on the child 10 or 15 years from now to see how he is doing. But I can predict that he will either be delinquent or dysthymic.

Those of us who practice in the office each day must be vigilant about identifying dysthymia disorder and finding effective treatments. ■

DR. FINK is a psychiatrist and consultant in Bala Cynwyd, Pa., and professor of psychiatry at Temple University in Philadelphia.

## EDITORIAL ADVISORY BOARD

LEE H. BEECHER, M.D., University of Minnesota, Minneapolis

CARL C. BELL, M.D., University of Illinois at Chicago

DANIEL E. CASEY, M.D., Oregon Health and Science University, Portland

PAUL J. FINK, M.D., Temple University, Philadelphia

MARY ELLEN FOTI, M.D., University of Massachusetts, Worcester

CATHERINE A. FULLERTON, M.D., Harvard Medical School, Boston

ANTONIO Y. HARDAN, M.D., Stanford (Calif.) University

THELISSA A. HARRIS, M.D., Private Practice, Hartford, Conn.

JAMES W. JEFFERSON, M.D., University of Wisconsin, Madison

SIMON KUNG, Mayo Clinic, Rochester, Minn.

THOMAS W. MEEKS, M.D., University of California, San Diego

THERESA M. MISKIMEN, M.D., University Behavioral Healthcare, Piscataway, N.J.

CLIFFORD K. MOY, M.D., Texas Medical and Healthcare Partnership, Austin

RODRIGO A. MUÑOZ, M.D., University of California, San Diego

ANTHONY T. NG, M.D., Acadia Community Hospital, Bangor, Maine

CYNTHIA R. PFEFFER, M.D., Cornell University, New York

DAVID SPIEGEL, M.D., Stanford (Calif.) University

PETER J. WEIDEN, M.D., University of Illinois at Chicago

JOHNNY WILLIAMSON, M.D., Hartgrove Hospital, Chicago