

# Short-term cognitive therapy shows promise for dysthymia

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Short-term cognitive therapy offers a potentially effective approach to treating the chronically depressed patient. While drug therapy—either alone or in tandem with psychotherapy—can help, some patients with dysthymia can adopt a cognitive approach to conquer a life-long problem in just 3 to 6 months.

**C**hronic depression has long been understood as a psychological constellation and a personality disorder. In the past, recommended treatment focused on long-term psychotherapy,<sup>1</sup> although it was acknowledged that the “depressive personality” rarely responded well.<sup>2</sup>

Psychiatrists today commonly offer antidepressant drug trials to patients with dysthymia. Yet while tricyclic antidepressants have been shown to have some value in the treatment of chronically depressed patients,<sup>3</sup> investigations of selective serotonin reuptake inhibitors in this population have produced inconsistent results.<sup>4</sup>

This article presents two case studies that illustrate how I use the cognitive approach to dysthymia in my psychiatric practice. Both patients were treated successfully with a short-term approach to therapy. While the final verdict on brief psychotherapy as an approach to dysthymia is not in, I believe there are reasons for optimism.

## What is dysthymia?

Chronic depression (dysthymia) is thought to be a heterogeneous condition in which comorbid psychiatric and medical conditions frequently occur.<sup>5</sup> According to DSM-IV diagnostic criteria (*Table 1*), dysthymia differs from major depression in the number of changes necessary for diagnosis (only two of

Table 1

## DSM-IV DIAGNOSTIC CRITERIA FOR DYSTHYMIA

- A. Depressed mood (for most of the day, for more days than not) for at least 2 years**
- B. Associated features (at least two):**
  1. Poor appetite or overeating
  2. Insomnia or hypersomnia
  3. Low energy or fatigue
  4. Low self-esteem
  5. Poor concentration or indecisiveness
  6. Hopelessness
- C. Patient has not been symptom-free for more than 2 months at a time for at least 2 years (1 year for children and adolescents)**
- D. No major depressive episode during the first 2 years of the disturbance (1 year for children and adolescents)**
- E. No manic, mixed or hypomanic episode, or cyclothymic disorder**
- F. Disturbance does not occur exclusively with a chronic psychotic disorder (e.g., schizophrenia)**
- G. Symptoms not directly caused by substance abuse or a medical condition**
- H. Symptoms significantly impair social or occupational functioning**

\*Adapted from: *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Text revision. Washington, DC: American Psychiatric Association, 2000.

six) and in the longer duration of symptoms (at least 2 years).

The lifetime prevalence of dysthymia is 6%. The chron-

### Primary care physicians, who often are the first to see patients with depression, need to understand the value of brief psychotherapy

ically depressed face a 10% risk each year of developing major depression. Women are two to three times more likely to suffer dysthymia than men.<sup>6</sup>

Thase and Howland, in a classic 1995 article, described three clinical routes that lead to dysthymia:

- incompletely resolved major depression;
- chronic depressed mood with associated symptoms below the threshold for a diagnosis of major depression;
- dysthymia secondary to medical illness, medications, or substance abuse.<sup>7</sup>

The clinical term dysthymia has its roots in three older

constructs: neurotic depression, depressive personality, and chronic depression.<sup>8</sup> Use of the term “neurotic depression” is now discouraged as it has numerous meanings, some of which are contradictory. “Chronic depression” also obscures more than it illuminates. The term “depressive personality” has survived, with a new set of criteria for diagnosis outlined in DSM-IV. Its separation from “dysthymia” is not clear.

Although the subsyndromic nature of dysthymia might suggest a condition milder than major depression, its lifetime comorbidity with a range of serious emotional problems (Table 2) suggests otherwise.

### Cognitive therapy for dysthymia

Cognitive therapy targets depressive thinking as the major culprit in depression.<sup>9</sup> Researchers have found that a brief course of psychotherapy is sometimes as effective as pharmacotherapy in treating major depression.<sup>10</sup> While it may seem counter-intuitive that a short-term approach would solve a long-term problem such as dysthymia, I have found that cognitive therapy can offer a cost-effective, life-sustaining contribution of lasting value.

There is an urgent need to educate primary care clinicians about the value of a brief psychotherapy approach to chronic depression. They

are the first clinicians to see 75% of patients with depression.

In the medical setting, patients with dysthymia most often present with physical complaints, such as fatigue and insomnia.<sup>11</sup> When the internist or family physician does recognize dysthymia and treat it appropriately, pharmacologic approaches predominate.

Medical training guiding whom or which disorders to refer for psychotherapy is woefully lacking. Studies documenting the value of psychotherapy as a treatment for dysthymia are needed to broaden referring physicians' options. While long-term, psychodynamic therapy for depression may sound obscure to the medical referrer, short-term cognitive therapy typically makes sense. Moreover, both consumers and managed care organizations are demanding quicker results from providers of mental health services.

Table 2

## LIFETIME COMORBIDITY ASSOCIATED WITH DYSTHYMIA

Diagnosis	Incidence (%)
Any psychiatric disorder	77.1
Personality disorder	47.0
Anxiety disorder	46.2
Major depression	38.9
Substance abuse	29.8
Eating disorder	23.0
Panic disorder	10.5
Bipolar disorder	2.9

\*Adapted from: Markowitz JC. Co-morbidity of dysthymia. *Psychiatr Ann* 1993;23(11):617-24.

Cognitive therapy is most clearly distinguished from traditional psychodynamic psychotherapy by its focus on the present. While a cognitive therapist may believe that current thinking in the patient with dysthymia has its roots in the past, reworking the past is not seen as necessary for change to occur.

The cognitive approach is more collaborative and problem-solving than traditional psychotherapy. The therapist questions, and the patient responds. Periods of monologue are uncommon, and dialogue prevails. How the patient thinks is assumed to have an impact on affect (e.g., sadness) and behavior (e.g., withdrawal). The primary focus is on meanings (expectations, beliefs, assumptions, attributions). The therapist often assigns homework to set the expectation that the patient will work between sessions and to structure the nature of that work.

Cognitive therapy is concerned with conscious thought, and the construct of an unconscious is not employed. While the relationship between therapist and patient may be a focus (at times) for the cognitive inquiry, transference is not encouraged, assumed, or interpreted as such.

Standard cognitive interventions encourage the patient:

- to take responsibility for an aspect of the problem;
- to take reasonable risks;
- to consider assertive behaviors;
- to express feelings appropriately.

**Key elements** The automatic thought is the central feature of cognitive therapy (Table 3). In psychoanalytic terminology, automatic thoughts would be considered “pre-conscious”

(accessible but requiring attention to be identified). The early sessions of cognitive therapy are usually devoted to identifying the thoughts associated with the patient’s distress. In dysthymia, these thoughts may concern the patient’s self-view, his or her representation of a significant relationship, or a meaningful situation.

Errors in thinking are another important consideration for the cognitive therapist. In dysthymia, typical errors in a patient’s thinking include:

- polarization (black-and-white thinking);
- personalization (inordinate focus on the self);
- overgeneralization (drawing conclusions beyond the scope of the data).

### Case 1: ‘There’s something wrong with me’

Rebecca, age 38, was referred to me by her former psychodynamic therapist for a course of cognitive therapy.

The older of two daughters in a middle-class family, Rebecca said she had been depressed “for as long as she could remember.” Recently, her sister died suddenly of a heart attack. Her mother had died at a young age from complications of hypertension, and her father died 2 years ago of lung cancer. This left Rebecca alone, but that was not the whole story.

Her memories of childhood were dominated by her father’s physical abuse of her mother and his negative and critical commentary about Rebecca. She described her sister, too, as “mean and inaccessible.” Not surprisingly, Rebecca poured herself into schoolwork, and she did extremely well. After college, she passed a challenging

Table 3

## MAJOR FEATURES OF COGNITIVE THERAPY

- Active, structured dialogue
- Focus on here-and-now
- Goal-directed, problem-solving collaboration
- Often time-limited
- Assumes that affect and behavior are affected by how one thinks
- Uses homework assignments
- Does not interpret unconscious factors
- Transference neurosis is neither encouraged, assumed, nor interpreted

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CPA exam and began a career in accounting. Although her work was fulfilling, she described “an inner voice” that was constantly belittling and blaming her. Relationships with men always ended badly, with Rebecca believing: “There’s something wrong with me; that’s why I always end up alone.”

After each relationship ended with disappointment, Rebecca would overgeneralize: “All men criticize me,” and then personalize: “So, I must be bad.” She had no physical symptoms of depression other than constant low energy and easy fatigue, along with low self-esteem.

Prior to consulting me, she had been treated unsuccessfully with an assortment of antidepressant medications. For 10 years, she had been treated with psychodynamic psychotherapy by a competent therapist with whom she had a “wonderful relationship.” Unfortunately, little had changed.

**Comment** My diagnosis was dysthymic disorder, 300.40. Rather than attempting another trial with antidepressants, I recommended—and she agreed to—weekly cognitive therapy sessions for an undetermined duration.

### Disputation techniques

Once the dysthymic patient’s automatic thoughts have been identified, adopting alternate ways of thinking can bring about change. The therapist’s task is to teach disputation techniques and consideration of options. If a cognitive error

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is recurrent, calling attention to it may facilitate change.

Disputation is typically done in conversation, but some patients with dysthymia learn the process more easily when it is demonstrated visually. One effective approach is the triple column technique, in which situations, feelings, and thoughts are illustrated on a chalkboard (*Figure 1*).

Rebecca’s intake evaluation was completed in the initial session. I taught her the cognitive method for identifying automatic thoughts at the beginning of session two, using the blackboard to illustrate the relationship between situations and responses.

Primitive animals, I told her, do little more than respond to stimuli. Humans, however, assign a meaning to the situation that will affect their response, whether it is a feeling or a behavior. Cognitive therapy focuses on these meanings. I used her history to illustrate how the model worked.

Encouraged to talk about something distressing, Rebecca described in detail a love relationship that was ending. Cued by her distress at various points in the discussion, I asked about relevant meanings. She located a series of personalized and polarized assumptions with ease. We worked to separate her boyfriend’s contribution to the relationship’s outcome from her own. We labeled the errors in her thinking. She had a surprisingly easy time coming up with alternate ways to view the situations we discussed (*Figure 2*).

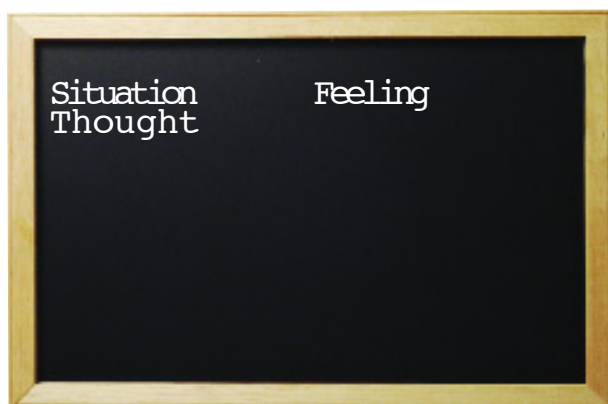
### Searching for alternate meanings

Shift of set is another useful approach to disputation. Often a patient has searched diligently for answers to his or her problems and has come up “empty.” The patient many times describes this process as “feeling trapped.” With shift of set, the therapist uses metaphor, humor, or self-disclosure to analyze the problem from another perspective. Asking the patient to comment on the therapist’s “story” often elicits an alternative applicable to the patient’s own circumstance.

**Metaphor** It is beyond the scope of this article to consider the place of metaphor (or analogy) in psychotherapy. To explore the subject further, you might consult an excellent book by Barker.<sup>12</sup>

Figure 1

### TRIPLE COLUMN TECHNIQUE



Humor is a useful accessory to disputation in cognitive therapy. Be forewarned, however, that the dysthymic patient may distort the point of the joke and personalize it as an insult. When a therapist is naturally witty or funny, I encourage him or her to use this resource. If not, it is better to avoid attempts at humor.

**Self-disclosure** Traditional psychotherapy preaches the avoidance of self-disclosure, which risks (even momentarily) shifting the focus from the patient to the therapist and breaking the rhythm of the therapy hour. Even so, I have found that properly thought-out self-disclosure can be useful in cognitive therapy.

Consistent with the power in a shift of set, self-disclosure offers the benefits of surprise, a sign of caring and involvement, and a chance for the patient to learn. A recent report by the Group for the Advancement of Psychiatry addresses self-disclosure in detail.<sup>13</sup>

**Polls and balance sheets** At times the therapist may suggest an experiment aimed at generating useful alternatives. Questioning peers or friends (poll-taking) may be one way for the patient to elicit viable options. Another tool for making particularly difficult decisions is a balance sheet (either written or conversational) in which the patient lists the pros and cons of various alternatives. When choices are identified, the patient and therapist typically discuss their consequences.

### Resolution: 'Feeling empowered'

By session four, Rebecca reported using the cognitive method regularly, and finding that she was "no longer accepting the conclusions she used to jump to." She noticed that when she responded differently, others responded differently to her as well. She was "beginning to feel empowered," she said.

Figure 2  
CASE 1: REBECCA'S TRIPLE COLUMN

Situation Thought	Feeling
My boyfriend is ending our relationship	<p>Sadness</p> <p><b>Thought:</b> If I had acted more as he expected, we'd still be together</p> <p><b>Alternative:</b> I need to find a man who will accept me as I am; I can't continually try to change myself to please others</p> <p><b>Thought:</b> It's my fault that he's leaving, and I have failed again</p> <p><b>Alternative:</b> Assigning blame won't solve my problems. Relationships are a two-way</p>

Over the next month, I met with her each week. Her mood brightened, and she reported that her energy level was up. She was "actively reviewing her life." We focused therapy on her self-worth, especially the beliefs that had contributed significantly to it. Upon identifying and examining them, she found that these beliefs were often inconsistent with what she "knew of" herself. We discussed the inconsistencies and worked together to identify alternate views.

She described her views about men in detail. She found several beliefs to be "irrational" and others to represent "poor strategy" if a lasting relationship with a man was an important goal. In the 10th session, she announced that she was "no longer feeling or acting depressed." She had had an epiphany: "It was all within me," she said, "not outside of me .... I had kept myself in a perpetual state of feeling diminished and victimized."

Two weeks later, we met for a final time to review what she had accomplished and to terminate therapy. She expressed amazement that she could accomplish "in 12 short weeks" what had not been achieved in 10 years of work. A follow-up call 6 months later found that her gains had been maintained.



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**Comment** When an automatic thought (meaning) is identified, the next step is to test its usefulness for the patient. I encourage my patients to consider two key criteria: rationality and strategic worth. First, does the meaning make sense? Often, when examined in this way, it does not. Second, even a rational meaning may not serve the patient's purpose. It may represent a poor strategy, unlikely to help the patient reach his or her goal. If the patient judges the meaning to be inadequate, we work together to find alternatives. We treat these options as choices and consider their consequences.

### Case 2: A lifetime of anger

Richard, age 51, is an optometrist referred to me by his internist, who described a patient who was "too influenced by anger from the past, had consistently unsatisfactory relationships with women, and generally needed to take control of his life."

Richard spent the first four sessions with me relating the story of his life. He described a dominating mother, a passive father, and a successful older brother (attorney). He said he constantly felt discriminated against because of his obesity and religion (Judaism).

While attending a school of optometry in the Midwest, he had suffered a severe attack of ulcerative colitis that sent him home for a year to live within his "dysfunctional family." He married 2 years later, initiating a stormy 10-year relationship that produced his two daughters. Divorce, from a woman he described as "critical and controlling like my mother," resulted in a serious financial setback.

Fifteen years ago, his father died and Richard underwent intestinal surgery. Soon thereafter, his ex-wife insisted that he raise the two girls, which he was pleased to do. He has not remarried, and subsequent relationships with women have been consistently unsatisfying. He is unhappy at work, where he teaches students and sees some clients, receiving "little recognition for successes."

**Comment** I was impatient with the lengthy 4-hour intake, but it became clear that Richard wanted to tell his story his way. My diagnosis was dysthymic disorder in a personality with narcissistic features.

I taught him the cognitive model for identifying key

meanings and disputing them. We worked over two sessions separating the controllable aspects of this life from the uncontrollable. We discussed the implications of stage-of-life changes (his younger daughter was in the process of leaving home for college), as well as his views of women in general.

He identified a strong need for approval, as well as a tendency to discount positive feedback, especially in the workplace. We employed the framework of identifying choices and tracing likely consequences. When he focused on being overweight, I suggested that he keep a baseline food record from which we could together formulate a weight-loss plan. The major cognitive error we discussed was polarization—he thought categorically, with no grays.

By session nine, Richard reported his first "decent week," noting especially a marked reduction in anger. He had twice failed to produce a food record, however, saying: "I resist the things I know I need to do." We talked about identity: his idea of who he was and what was important to him.

He began session 10 by forcefully telling me that something had "clicked for him last hour." He realized for the first time that he "could define himself;" he did not have to be a "prisoner of the past." He brought in several typed pages of thoughts he had had about himself. We reviewed them in detail. "I have the power to re-create myself," he said. He felt renewed energy, more interest in his work, more accepted by his friends. "It had been there all along," he said, "I was just unable to see it."

He now kept his office door open at work, questioned his previous "all-or-nothing" attitude, and vowed to "get out more and meet people." He was markedly less often angry and was actively using cognitive techniques when he felt dissatisfied. "These changes," he told me "are the mental equivalent of bypass surgery!"

**Comment** We met three more times over the next 6 weeks (13 sessions in all), and his gains were maintained. He felt that he could tackle the remaining issues on his own. He has called twice in the past year. The first time, he reported that he lost a substantial amount of weight. The second call described a gratifying relationship with a woman.

Cognitive changes are a component of most successful psychotherapies, brief or otherwise

## Discussion

Each of these patients was strongly motivated to do the work of therapy, both in the office and between sessions. They alluded to a degree of “rethinking of the past” as a by-product of psychotherapy, not as its focus. I believe the relevant changes *preceded* the rethinking rather than following it.

Cognitive changes are a component of most successful psychotherapies, brief or otherwise. The therapist-patient relationship, thought to be essential to how change occurs in psychodynamic psychotherapy, is a necessary ingredient in cognitive therapy as well. The first stage of any successful psychotherapeutic venture is, quite properly, called *engagement*. No engagement likely means little gain for the patient. I felt strongly connected to each of these patients.

My second patient’s 4-hour soliloquy notwithstanding, my interaction with my patients typically takes the form of a conversational dialogue. I use analogy, humor, and sometimes self-disclosure to focus attention on an aspect of a problem or an alternative.

As I stated earlier, the final verdict on brief psychotherapy as an approach to dysthymia is not in. In its favor, patients often say they prefer psychotherapy to medication.<sup>14</sup> On the other hand, they also prefer to discuss depression with their family physicians, rather than with mental health professionals.<sup>15</sup> Markowitz reviewed empiric research on psychotherapy for dysthymia and found data supporting “some response” of chronic depression to brief cognitive therapy.<sup>16</sup> Subsequently, two small studies by Dunner et al<sup>17</sup> and Miranda and Munoz<sup>18</sup> found small or no gains with psychotherapy.

Short-term cognitive therapy is being used with success in some patients as a psychotherapeutic approach to dysthymia. When it enables a chronically distressed individual to function normally, cognitive therapy may be a cost-effective, life-sustaining contribution of lasting value.

Short-term use of disputation techniques and consideration of options can help dysthymic patients identify their automatic thoughts and cognitive errors. Alternate ways of thinking can ease dysthymic symptoms and improve patients’ quality of life.

**Bottom**Line

## Related resources

- ▶ Schuyler D. *A Practical Guide to Cognitive Therapy*. New York: Norton, 1991.
- ▶ Moore JD, Bona JR. Depression and dysthymia. *Med Clin North Am* 2001;85(3):631-43.
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18. Miranda J, Munoz R. Intervention for minor depression in primary care patients. *Psychosom Med* 1994;56(2):136-41.