

DYSTHYMIC DISORDER

DSM-IV Diagnostic Code: 300.40

I. Diagnosis and Assessment

a) Elements needed to establish diagnostic accuracy:

- Establish diagnostic accuracy as defined in DSM-IV-TR.
- The clinician should determine the individual's symptoms are not due to the direct physiological effects a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

b) Diagnostic considerations:

- Dysthymic Disorder must be distinguished from a Mood Disorder Due to a General Medical Condition which is applicable if the mood disturbance is a direct physiological consequence of a specific, usually chronic, general medical condition.
- Dysthymic Disorder must also be distinguished from a Substance-induced Mood Disorder which is applicable if a substance (e.g. drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the mood disturbance.
- Evidence of a coexisting personality disturbance may often be in evidence. When an individual's Symptomology meets criteria for Dysthymic Disorder and a Personality Disorder, both diagnoses are designated.
- The diagnosis is not made if the individual has ever had a manic episode, mixed episode, hypomanic episode, or criteria have been met for Cyclothymic Disorder.
- In adults chronic Axis I disorders such as Substance Dependence or chronic psychosocial stressors may be associated. In children there may be an association with Attention-Deficit/Hyperactivity Disorder, Conduct Disorder, Anxiety Disorders, Learning Disorders, and Mental Retardation.

II. Treatment Guidelines

1. Strengthening the individual's self-esteem and interpersonal skills are common goals for treatment.

2. Cognitive and interpersonal approaches have been found particularly effective in individual psychotherapy. These include more focused, active and directive techniques, which support the individual in his/her efforts to achieve clearly formulated goals.

3. A referral for medication evaluation should be considered if there has been minimal symptom reductions after 4-6 sessions, if sessions are weekly. If vegetative symptoms such as anhedonia, lack of energy, sleep disturbance or

appetite disturbance worsen, a medication evaluation should be considered sooner.

4. Historically, it had been long thought that dysthymia was best classified as a character disorder, in which the individual's core problems stemmed from a depressive personality or temperament. The negative attitude toward pharmacotherapy was the result in part of the types of medication that were available (for example, tricyclic antidepressants characterized by unpleasant side effects) and the clinicians' hesitation to prescribe these medications in adequate doses and duration. Because dysthymia was conceptualized as a mild form of mood disorder, it was routinely treated with sub threshold doses of antidepressant, over inadequate durations of time.

5. The past decade has provided evidence for dysthymia's positive response to antidepressant medication, especially to the newer generation of drugs such as Prozac, Zoloft, Paxil, Effexor or Serzone. It is now understood, however, that although the symptoms may be less severe than those of major depression, dysthymia requires just as aggressive, often longer-term anti-depressant treatment.

The success in treating dysthymia with antidepressant medication supports the contention that, like major depression, dysthymia may have biological underpinnings. Research has been under way into the immunologic, hormonal and neurotransmitter correlates of dysthymia, as well as its genetic transmission.

III. Recommended Clinical Interventions:

1. Individual therapy
2. Group Therapy (in conjunction with individual)
3. Medication Evaluation
4. Medication Management
5. Peer Recovery Services

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