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Research report

The categorisation of dysthymic disorder: Can its constituents be meaningfully apportioned?

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ABSTRACT

Background: Since its introduction in DSM-III, the validity of dysthymia has been debated. Our objective is to further examine the concept of dysthymia in an outpatient sample, and explore whether its constituents can be meaningfully apportioned.
Methods: 318 patients attending the Black Dog Institute Depression Clinic were assessed by the Mini-International Neuropsychiatric Interview, and completed several self-report measures, in addition to a clinical assessment by an Institute psychiatrist. The characteristics of patients with major depressive disorder (MDD), dysthymic disorder and double depression were examined. Latent Class Analysis (LCA) and Latent Profile Analysis (LPA) were then conducted with the aim of detecting distinct classes based on depressive symptomatology and personality domains, respectively. Finally, clinicians' formulations of the study patients were examined.
Results: Depression groups mainly differed on parameters of severity. Although LCA and LPA analyses indicated the presence of distinct classes, these only moderately correlated with the MINI-diagnosed groups. Finally, there was evidence for considerable heterogeneity within clinicians' formulations of dysthymia.
Limitations: Inadequate sample numbers for various measures limited the power of the LPA and our sample was weighted to patients with a more severe depressive condition which may affect the detection of a distinct 'dysthymic' personality profile.
Conclusions: Despite employing a variety of techniques, we were unable to obtain a clear homogeneous picture of dysthymia. Rather, there was evidence for a distinct heterogeneity in clinician-derived diagnoses. These findings allude to the questionable discriminant validity of dysthymia and may encourage future research and discussion on this important topic.

1. Introduction

It is not uncommon for clinicians and researchers to describe patients as having 'major depression' and/or 'dysthymic disorder'—diagnoses introduced within the 1980 DSM-III manual (American Psychiatric Association, 1980) and which have been largely viewed as describing depressive entities. Elsewhere (Parker and Manicavasagar, 2005) we have argued, however, for positioning major depression as a broad diagnostic domain subsuming multiple expressions of clinical depression. Conceptually, the same model might be applicable for dysthymic disorder – a depressive condition defined simply by fewer symptoms than major depression as well as by chronicity – with the individual having a depressed mood for most of the day for at least two years. At face value, it might be expected to include minor chronic as well as 'smouldering' depressive episodes, treatment resistant depressive conditions, and depression syndromes underpinned by perpetuating stressors or contributed to by multiple psychological and social factors. In this paper, we seek to critically examine the concept of dysthymic disorder and – in positioning it as a domain diagnosis rather than a diagnostic entity – seek to apportion constituent conditions.

The term dysthymia can be traced historically to the Ancient Greek term to describe one who was "ill humoured" (Freeman, 1994) and therefore was primarily conceptualised as a personality style. Subsequently, it received categorisation as a clinical mood state by Flemming (1799–1880), albeit being positioned as a set

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of mood disorders rather than a single condition (Freeman, 1994). Although Kraepelin (1899) did not employ the term 'dysthymia', he described the 'depressive temperament' as a substrate from which affective episodes subsequently developed (WPA Dysthymia Working Group, 1995). Similarly, Tellenbach (1961) identified a 'typus melancholicus' to describe the premorbid personality with a vulnerability to endogenous depression. This distinction was subsequently recognised in the revised DSM (DSM-II; American Psychiatric Association, 1968) which included a 'neurotic depression' – which emphasised personality aspects as opposed to symptoms – and which had the effect of classifying chronic depressive states as personality disorders and neuroses (WPA Dysthymia Working Group, 1995).

The term 'dysthymia' then lay dormant until its reintroduction into psychiatry via DSM-III in 1980 – an introduction that was to trigger an intense conflict between the Task Force and psychodynamic practitioners. DSM-III's category of depressive disorders, including dysthymic disorder, weighted a biological model of depression – a weighting that was opposed by the psychodynamic practitioners. Concerned about the proposed loss of 'neurosis' and, of relevance here, of 'neurotic depression', they contended that the DSM Task Force was "focusing so much on the brain" and thereby "losing the mind" (Mayes and Horwitz, 2005). Shorter (2009) has argued that, to pacify such concerns, dysthymia (with 'neurotic depression' in parenthesis) was introduced as part of a 'Neurotic Peace Treaty'—and with the "optics" being that, while major depression required pharmacotherapy, dysthymia required psychoanalytic therapy. Of further symbolic relevance – and illustrating the victory of the biological-oriented movement over the psychoanalytic tradition – neurotic depression was deleted in the subsequent revision of the DSM-IV (McPherson and Armstrong, 2006).

After its introduction in DSM-III, only minor changes in the definition of dysthymic disorder have been made, although controversy and challenges to its utility have long been evident. Epidemiological studies illustrating its lack of demarcation from other mood disorders across a broad range of demographic, clinical, psychosocial, family history and treatment response variables (McCullough et al., 2000, 2003; Klein et al., 2004) stimulated questions regarding its validity. In addition, the relatively low citation rate of 'dysthymia' compared to major depression following its introduction led some to claim that "major depression was the only real depression left standing" (Shorter, 2009). Although dysthymia citations did begin to rise in the early 1990s (McPherson and Armstrong, 2006), the relatively low rates indicate that diagnostic labels provided in manuals do not in themselves dictate the range of terms employed by professionals and individual clinicians.

In this paper, we examine the concept of dysthymia, implementing both 'top down' and 'bottom up' procedures weighting key depressive symptoms (i.e., to determine if dysthymia can be sub-typed by depressive features) and broad personality constructs, respectively, and thus in line with the DSM-IV (American Psychiatric Association, 1994; p. 732) contention that it is "controversial whether the distinction between depressive personality disorder and dysthymic disorder is useful". Using a top down approach we first examine whether dysthymic disorder can be demarcated from major depressive disorder (and their composite state—so-called 'double depression'; Keller and Shapiro, 1982) using a formal case-finding measure and rating a variety of clinical and non-clinical variables or factors. The main objective of this approach is therefore to examine whether dysthymia demonstrates discriminant validity. We then employ the data-driven techniques of latent class analysis (LCA) and latent profile analysis (LPA) to create clusters to determine constituent symptom and personality-based sub-classes or domains (i.e., a bottom up approach). Finally, in line with Robin and Guze's (1970) contention that clinical appraisal is a core validation strategy, we examine clinicians' formulations of these patients' conditions to determine if constituent heterogeneous sub-sets can be identified.

2. Methods

2.1. Study population

Patients were recruited through the Depression Clinic at the Sydney-based Black Dog Institute. All patients gave consent and the study was approved by the University of New South Wales Ethics Committee. The Institute provides a state-wide service, offering diagnostic and management advice to patients referred by general practitioners or mental health professionals. Elements of the assessment process have been detailed elsewhere (see Parker et al., 2006a). Patients referred over the 2010–2011 period that reached criteria for major depressive disorder (MDD) or dysthymic disorder according to the Mini-International Neuropsychiatric Interview or MINI (Lecrubier et al., 1997) were included. Patients with a lifetime MINI diagnosis of bipolar disorder (I or II) or schizoaffective disorder were excluded. The total study population consisted of 318 patients. The MINI is a structured diagnostic instrument based on DSM-IV and ICD-10 criteria, with respectable reliability and validity (Sheehan et al., 1998). Three groups were then defined, namely: (i) 'MDD only' ($n=148$) consisting of those meeting major depression but not dysthymia criteria, (ii) 'dysthymia only' and otherwise termed as 'pure dysthymia' ($n=42$) and (iii) 'double depression' ($n=128$) for those with comorbid dysthymia and MDD.

2.2. Principal assessment measures

Information on socio-demographic and clinical characteristics was derived from the Mood Assessment Program (MAP) and a self-report booklet. The MAP is an Institute-developed computerised assessment designed to assist clinicians with diagnostic decisions and the identification of contributing factors (Parker et al., 2008). The majority of patients complete both the MAP and the booklet prior to their clinical assessment. The final variables used to describe diagnostic groups were the patient's age, gender, depression severity (measured by the short version of the Quick Inventory of Depressive Symptoms—Self-Report measure or QIDS-SR, Rush et al., 2003), age of onset, family history, presence of a co-morbid anxiety disorder, bipolar symptoms (measured by the Mood Swings Questionnaire or MSQ; Parker et al., 2006b), severity of psychomotor disorder (measured by the CORE, Parker et al., 1995a, 1995b), level of functioning (assessed by a 6-item self-report measure assessing impairment across several key areas) and personality variables, as detailed in the next paragraph.

2.3. Variables selected for the LCA and LPA analyses

The variables selected for the LCA comprised the nine key depressive constructs outlined in the scoring guidelines for the QIDS-SR—namely; sleep disturbance, depressed mood, appetite or weight change, concentration problems, feelings of guilt, suicidal thoughts, anhedonia, fatigue and motor symptoms. The QIDS contains 16 items or symptoms which are usually rated on a 0 to 4 point scale and reflective of their presence over the preceding seven days (with coding roughly equating to 0=absent, 1=somewhat present, 2=moderately present, 3=largely present). In light of the small sample size and the number of items in the QIDS measure, items were dichotomized for the purposes