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Research report

A comparative trial of psychotherapy and pharmacotherapy for "pure" dysthymic patients

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Abstract

Background: Psychotherapy of "pure" dysthymic disorder remains understudied. This article reports outcomes of an acute randomized trial of 94 subjects treated for 16 weeks with either interpersonal psychotherapy (IPT), brief supportive psychotherapy (BSP), sertraline, or sertraline plus IPT.
Methods: Recruited by clinical referral and advertising, subjects met DSM-IV criteria for early onset dysthymic disorder, with no episode of major depression in the prior six months. They were randomly assigned to one of four 16-week treatments, with options for crossover or continuation treatment. Results were analyzed from the intention-to-treat sample by ANCOVA, controlling for baseline depressive severity.
Results: Subjects improved in all conditions over time, with the cells including sertraline pharmacotherapy showing superiority over psychotherapy alone for response and remission. Response rates were 58% for sertraline alone, 57% for combined treatment, 35% for IPT, and 31% for BSP.
Limitations: The study was underpowered and may have employed too "active" a control condition. Follow-up data were unobtainable.
Conclusions: In this acute trial for "pure" dysthymic disorder, sertraline with or without IPT showed advantages relative to IPT and BSP. Methodological difficulties may have limited differential outcome findings. This study bolsters a small but growing literature on the treatment of dysthymic disorder, suggesting that pharmacotherapy may acutely benefit patients more than psychotherapy.

Keywords: Dysthymic disorder; Interpersonal psychotherapy; Supportive therapy; Pharmacotherapy; Combined treatment

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In 1994 we reviewed the limited literature on psychotherapy of dysthymic disorder (Markowitz, 1994), which comprised 74 "pure" dysthymic cases in 7 studies. Results were inconclusive. Despite the prevalence of dysthymic disorder and the frequency with which dysthymic patients seek treatment (Weissman et al., 1988), few studies had evaluated antidysthymic psychotherapy. Since then, researchers have examined pharmacotherapy of subtypes of chronic depression (Kocsis et al., 1996; Keller et al., 1998), including dysthymic disorder (Thase et al., 1996); psychotherapy of chronic depressions other than dysthymic disorder (Keller et al., 2000); and psychotherapies alone and in combination with pharmacotherapy of chronic depression (Keller et al., 2000; Feijó de Mello et al., 2001; Ravindran et al., 1999; Hellerstein et al., 2001; Browne et al., 2002).

One large ($n=707$) randomized controlled trial (Browne et al., 2002) compared 12 weekly sessions of interpersonal psychotherapy (IPT) to two years [sic] of sertraline and their combination for dysthymic patients, nearly a third of whom met criteria for "double" depression (current major depression superimposed on dysthymic disorder [Keller and Shapiro, 1982]). Generously defining response as a 40% improvement on the Montgomery–Asberg Depression Rating Scale (Montgomery and Asberg, 1979), Browne et al. (2002) found a 47% response rate for IPT alone, significantly less than the 60% rate for sertraline alone and 57.5% for combined treatment. Yet IPT was associated with lower health and social service costs, rendering combined treatment most cost effective. IPT may be judged to have performed well considering the study's dosage disparity between IPT and sertraline. The investigators did not perform separate analyses for subjects with "pure" dysthymic disorder without current major depression (M. Steiner, personal communication, 4/05).

Our open, pilot trial of a 16-session adaptation of IPT for dysthymic disorder (IPT-D; Markowitz, 1998) treated 17 subjects for up to 16 sessions. Patients had a mean age of approximately 40 years and met criteria for DSM-III-R dysthymic disorder 4 of early onset; about half met criteria for "double" depression. None deteriorated, and 11 (65%) achieved remission, defined a priori as a 24-item Hamilton Depression Rating Scale (Ham-D; Hamilton, 1960) decrease of more than 50% and a final Ham-D score ≤ 8. Overall, Ham-D scores fell from a mean of 21.5 (SD=4.4) at baseline to 7.4 (SD=4.7) at termination (Markowitz, 1994). Seven of the subjects had previously failed a rigorous 12-week research trial of desipramine.

We previously argued that dysthymic disorder was unfairly understudied because, being less acutely severe, it was deemed less "major" than major depression (Markowitz, 1994). Nonetheless, because of its chronicity, dysthymic disorder has a worse course than major depression (Wells et al., 1992). Dysthymic individuals tend to lack important social skills, and researchers and clinicians have generally acknowledged that dysthymic disorder is harder to treat than major depression (Markowitz, 1998). Another difficulty has been its high comorbidity (Keller et al., 1995), particularly with major depressive disorder, complicating recruitment of patients who do not have "double" depression. Some previous studies have failed to enroll adequate dysthymic patient samples for this reason (Waring et al., 1988; Markowitz, 1994), or have included many patients with double depression (Feijó de Mello et al., 2001; Browne et al., 2002).

This report describes a randomized, controlled, 16-week trial of IPT-D, brief supportive psychotherapy (BSP), sertraline, and combined IPT-D/sertraline for patients with "pure" dysthymic disorder (i.e., without major depression in the six months prior to presentation; not "double" depression). "Pure" dysthymic disorder has been considered sufficiently distinct a diagnosis from "double" depression that reviewers of this NIMH-funded grant insisted on exclusion of patients with current comorbid major depression. (To have excluded lifetime occurrence of major depression would have rendered the study unfeasible.) IPT is a time-limited psychotherapy of demonstrated efficacy in the treatment and prophylaxis of acute and recurrent major depression (Weissman et al., 2000). For this study we developed a manual adapting IPT for the chronic issues of dysthymic patients (IPT-D; Markowitz, 1998). BSP is an active but less specific, manualized control treatment, previously used in slightly different form in a comparative trial of IPT for HIV-positive patients with depressive symptoms. In that trial, BSP was associated with symptomatic improvement over time similar to cognitive behavioral therapy, but inferior to IPT and to imipramine (Markowitz et al., 1998). Sertraline, a serotonin