CHAPTER I

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CHAPTER 1

INTRODUCTION

Moods are an important part of our everyday experiences and add a certain richness to the quality of life. From time to time everyone feels ‘down’ or ‘fed up’ or ‘out of sorts’.

Officials at the World Health Organisation have estimated that over 100 million persons in the world suffer from depression and perhaps three times that many are affected by them (Sartorius 1979).

1.1 DYSTHYMIA

The most common illnesses seen in psychiatric practice and general medical practice are mood disorders, mostly in their depressive forms. According to Lopez Ibor (1994), dysthymic disorder is a major category among the mood disorders but the concept is not widely understood in many parts of the world, where it is often considered as a new name for familiar categories, such as neurotic depression, depressive personality or even neurasthenia.

It is only in recent years that dysthymia has been recognized as a distinct and treatable clinical entity. It is incorporated into both the systems of diagnoses, namely, Diagnostic Statistical Manual (DSM) and International Classification of Diseases (ICD).
According to Costa e Silva et al (1994), dysthymics harbour pathologically negative beliefs about themselves, their experiences, and their future. Dysthymics selectively seek evidence to support their fundamentally negative views, thereby reinforcing their beliefs and perpetuating their depression.

Dysthymia is often overlooked in both general and psychiatric practice. Untreated dysthymia is debilitating not only to the patient, but also to the sufferer's family and to society as a whole. The effects include addictions to alcohol or drugs, marital breakdown, loss of job or inefficiency at work, unnecessary medical examinations and laboratory testing and significant risk of suicide. Treatment of dysthymia most often involves both drug therapy and psychotherapy (Supportive therapy).

Paykel (1994), in his review in psychological therapies, has said that the indications for cognitive therapy are at present less clear, but the evidence of its efficacy in mild acute depression is good, and its ultimate role may turn out to be considerable. His tentative recommendations in dysthymia are that cognitive therapy can be used as a measure to facilitate control of symptoms and prevention of relapse, when drug therapy is only producing a partial response or none at all.

From the available research literature, it is clear that there is a need to develop a better understanding of dysthymia and a particular need for good quality controlled trials of Cognitive-Behaviour Therapy (C.B.T.) on defined cases of dysthymia.
In the present study, emphasis has been on the identification of the factors contributing to dysthymia and the effectiveness of Cognitive-Behaviour Therapy (C.B.T.) in the treatment of dysthymia.

There are nine sections in this chapter namely:

i. Historical account on the definition of dysthymia

ii. Epidemiology

iii. Clinical Features

iv. Etiology

v. Measurement

vi. Management

vii. Definition of Cognitive-Behaviour Therapy (C.B.T.)


Besides the above, a brief note on the salient features of the present study will be given at the end of this chapter.

1.1.1 Historical Account on Definition of Dysthymia

In its Greek Origins, the term ‘dysthymia’ means ‘illhumoured’ and can be traced back to the description by Hippocrates of the melancholic temperament. The first clinical description of dysthymia was by Kahlbaum in 1863. He regarded it as a chronic form of melancholia, in contrast to ‘cyclothymia’ which was a disorder characterised by fluctuating mood. (Freeman, 1994).
Following the same conceptual tradition, Kraepelin (1921), referred to the ‘depressive temperament’, and believed that this was the substrate from which manic-depressive illness developed; it often led to a protracted depressive phase, preceding a more acute illness, but was essentially part of the same morbid process.

DSM-II (American Psychiatric Association, 1968) included ‘Neurotic depression’, in which the emphasis was placed on personality aspects rather than on symptoms; chronic states of depression were classified under personality disorders and neuroses; but persistent affective pathology was insufficiently recognised.

ICD-9 (World Health Organisation, 1978) listed ‘Depressive neurosis’, which also subsumed shorter, non-chronic episodes; as in DSM-11, this was a diagnostic concept heavily influenced by psycho-analysis.

In 1978, Akiskal et al reported a prospective follow-up of neurotic depressives; 40% were diagnosed as having Major Depressive Disorder (MDD) while many of the remainder were considered to be dysthymic. The latter pursued a low grade, intermittent, or chronic course.

In DSM-III (American Psychiatric Association, 1980), all chronic depression lasting more than two years was defined as ‘Dysthymic disorder’; this newly created category subsumed many depressive illnesses that had been previously considered to be characterologically based. For this diagnosis, at least a two-year history of continuous or numerous periods of depressive
symptoms, characteristic of major depression but not meeting the full severity and/or duration criteria for Major Depressive Disorder (MDD) was required.

Thus, there was a shift from the original view of dysthymia as a neurotic personality disorder to the current concept of it as an affective or mood disorder, characterised by its chronicity and low grade or subsyndromal nature.

The following table will reveal the change of terminology with each new nosology:

**TABLE 1: SHOWING THE CHANGE OF TERMINOLOGY WITH EACH NEW NOSOLOGY**

<table>
<thead>
<tr>
<th>Source</th>
<th>Date</th>
<th>Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSM-I*</td>
<td>1952</td>
<td>Neurotic Depression, Depressive personality</td>
</tr>
<tr>
<td>DSM-II</td>
<td>1968</td>
<td>Depressive Neurosis</td>
</tr>
<tr>
<td>RDC (Research Diagnostic Criteria)</td>
<td>1978</td>
<td>Dysthymia, Neurotic Dysphoria, Intermittent Depressive Disorder, Cyclothymia, Minor Depressive Disorder.</td>
</tr>
<tr>
<td>DSM-III</td>
<td>1980</td>
<td>Dysthymic Disorder</td>
</tr>
<tr>
<td>DSM-III R</td>
<td>1987</td>
<td>Dysthymia, Depression not otherwise specified, Cyclothymia, Adjustment Disorder with Depressed mood.</td>
</tr>
<tr>
<td>ICD-IX**</td>
<td>1978</td>
<td>Neurotic depression (Includes: Anxiety depression, Depressive reaction, Reactive depression, Neurotic Depressive State)</td>
</tr>
<tr>
<td>ICD-X***</td>
<td>1992</td>
<td>Dysthymia</td>
</tr>
</tbody>
</table>

* Karasu, T.B. (1992)
** World Health Organisation (1978)
*** World Health Organisation (1992)
The key characteristics of dysthymia are:

a. Not a residuum of major depressive disorder.
b. A chronic course of more than two years with persistent or intermittent symptoms.
c. Low-grade Symptomatology.
d. Insidious Onset.
e. Concurrent pathology of character.
f. Fatigue and tendency for social withdrawal.

In DSM-IV, although the core set of symptom criteria for dysthymia remains largely unchanged, the appendix contains a new set which concentrates on the more cognitive features and the various patterns of course. The following Table 1 and Table 2 will reveal the DSM-IV criteria for dysthymic disorder and the DSM-IV research appendix criteria for dysthymic disorder respectively.

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**TABLE 2: DSM-IV CRITERIA FOR DYSTHYMIC DISORDER**

**300.4 DYSTHYMIC DISORDER**

Diagnostic criteria for dysthymic disorder.

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A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation made by others, for at least two years.

Note: in children and adolescents, mood can be irritable and duration must be at least one year.

B. Presence, while depressed, of at least two of the following:

1. Poor appetite or overeating
2. Insomnia or hypersomnia
3. Low energy or fatigue
4. Low self-esteem
5. Poor concentration or difficulty making decisions
6. Feelings of hopelessness.

C. During the two year period (one year for children or adolescents) of the disturbance, the person has never been without the symptoms in A and B for more than two months at a time.

D. No major depressive episode during the first two years of the disturbance (one year for children or adolescents); i.e. not better accounted for by chronic major depressive disorder in partial remission.

E. He never had a Manic Episode, a Mixed Episode or a Hypomanic Episode and has never met criteria for cyclothymic disorder.
F. Does not occur exclusively during the course of a chronic psychotic disorder, such as schizophrenia or delusional disorder.

G. The symptoms are not due to the direct physiological effects of a substance (e.g. drugs of abuse, medication) or a general medical condition (e.g. hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

Specify if:

- Early onset: If onset before age 21
- Late onset: If onset age 21 or older
- Specify:

(for most recent two years of dysthymic disorder)
With atypical features.

**TABLE 3: DSM-IV RESEARCH APPENDIX CRITERIA FOR DYSTHYMIC DISORDER**

Alternative Criterion B for Dysthymic Disorder.

There has been some controversy concerning which symptoms best define Dysthymic Disorder. The results of the DSM-IV Mood Disorders field trial suggest that the following alternative version of criterion B may be more characteristic of Dysthymic Disorder than the version of criterion B that was in DSM-III-R, and is in DSM-IV. However, it was decided that additional confirmatory evidence needs to be collected before these items should be incorporated.
Research criterion B for Dysthyemic Disorder.

B. Presence, while depressed, of at least three of the following:

1. Low self-esteem or self-confidence, or feelings of inadequacy
2. Feelings of pessimism, despair or hopelessness
3. Generalised loss of interest or pleasure
4. Social withdrawal
5. Chronic fatigue or tiredness
6. Feelings of guilt, brooding about the past
7. Subjective feelings of irritability or excessive anger
8. Decreased activity, effectiveness or productivity.
9. Difficulty in thinking, reflected by poor concentration, poor memory or indecisiveness.

International Classification of Diseases - 10 (ICD-10 World Health Organisation, 1992) defines dysthymia as a chronic depression of mood which does not currently fulfill the criteria for recurrent depressive disorder (of mild or moderate severity) in terms of either severity or duration of individual episodes. ICD-10 dysthymia includes depressive neurosis, depressive personality disorder, neurotic depression (of more than two years duration) and persistent anxiety depression. The following Table 4 and Table 5 will reveal the ICD-10 clinical and descriptive criteria and ICD-10 research criteria.
TABLE 4: ICD-10 CLINICAL AND DESCRIPTIVE CRITERIA

F34.1 DYSTHYMIA

A chronic depression of mood which does not currently fulfil the criteria for recurrent depressive disorder, mild or moderate severity (F33.0 or F33.1) in terms of their severity or duration of individual episodes, although the criteria for mild depressive episode may have been fulfilled in the past, particularly at the onset of the disorder. The balance between individual phases of mild depression and intervening periods of comparative normality is very variable. Sufferers usually have periods of days or weeks when they describe themselves as well, but most of the time (often for months at a time) they feel tired and depressed; everything is an effort and nothing is enjoyed. They brood and complain, sleep badly and feel inadequate, but are usually able to cope with the basic demands of everyday life. Dysthymia therefore has much in common with the concepts of depressive neurosis and neurotic depression.

If required, age of onset may be specified as early (in late teenage or the twenties) or late.

DIAGNOSTIC GUIDELINES

The essential feature is a very long standing depression of mood which is never, or only very rarely, severe enough to fulfil the criteria for recurrent

depressive disorder, mild or moderate severity (F33.0 or F33.1). It usually begins early in adult life and lasts for at least several years, sometimes indefinitely. When the onset is late in life, the disorder is often the aftermath of a discrete depressive episode (F32.) and associated with bereavement or other obvious stress.

Includes : Depressive neurosis
Depressive personality disorder
Neurotic Depression (with more than 2 years duration)
Persistent anxiety depression.

Excludes : Anxiety - depression (mild or not persistent) (F41.2)
Bereavement reaction, lasting less than 2 years (F43.21, prolonged depressive reaction)
Residual Schizophrenia (F20.5).

TABLE 5: ICD-10 RESEARCH CRITERIA

F.34.2 DYSTHYMIA

A. There must be a period of at least 2 years of constant or constantly recurring depressed mood. Intervening periods of normal mood rarely last for longer than a few weeks and there are no episodes of hypomania.
B. None, or very few, of the individual episodes of depression within such a 2-year period should be sufficiently severe/or/long-lasting to meet the criteria for recurrent mild depressive disorder (F33.0).

C. During at least some of the periods of depression, at least three of the following should be present:

1. Reduced energy or activity;
2. Insomnia;
3. Loss of self-confidence or feelings of inadequacy;
4. Difficulty in concentrating;
5. Frequent tearfulness;
6. Loss of interest in or enjoyment of sex and other pleasurable activities;
7. Feeling of hopelessness or despair;
8. A perceived inability to cope with the routine responsibilities of everyday life;
9. Pessimism about the future or brooding over the past;
10. Social withdrawal;
11. Reduced talkativeness.

Note: If desired, time of onset may be specified as early (in late teenage or the twenties) or late (usually between age 30 and 50 years, following an affective episode).
1.2.2 Epidemiology

Data from the NIMH Epidemiologic Catchment Area (ECA) study (Weissman, et al., 1988b), which involved five communities in the United States, indicated a lifetime prevalence rate for dysthymia of 3.1%.

Dysthymic disorder is a common disorder among the general population, affecting 3 to 5% of all persons, and it is common among patients in general psychiatric clinics, affecting between one-third and one half of all clinic patients. Dysthymia disorder is more common in women less than 64 years old, than in men of any age. Dysthymic disorder is also more common among unmarried and young persons and in persons with low incomes. Moreover, dysthymic disorder frequently co-exists with other mental disorders, especially major depressive disorder, anxiety disorders (especially panic disorder), substance abuse, and borderline personality disorder. (Kaplan, et al., 1994, p.556).

1.1.3 Clinical Features

![Basic characteristics of dysthymia](image)

Fig.1 Showing Basic Characteristics of dysthymia
Dysthymia is defined as a chronic, low-grade depression. It is a chronic disorder that is characterized not by episodes of illness but, rather, by the steady presence of symptoms. Nevertheless, dysthymic disorder patients can have some temporal variations in the severity of their symptoms. The severity of the depressive symptoms in dysthyemic disorder is generally less than in major depressive disorder, but it is the lack of discrete episodes that most weighs towards the diagnosis of dysthymic disorder.

Patients with dysthymic disorder can often be sarcastic, nihilistic, brooding, demanding, and complaining. They can be tense and rigid and resistant to therapeutic interventions, even though they come regularly to appointments. As a result, the clinician may feel angry towards the patient and may even disregard the patient’s complaints. By definition, dysthymic disorder patients do not have any psychotic symptoms.

Associated Symptoms

Associated symptoms include changes in appetite and sleep patterns, low self-esteem, loss of energy, psychomotor retardation, decreased sexual drive, and obsessive preoccupation with health matters. Pessimism, hopelessness, and helplessness may cause dysthymic disorder patients to be seen as masochistic. However, if the pessimism is directed outward, the patients may rant against the world and complain that they have been poorly treated by relatives, children, parents, colleagues and the system.
Social Impairment

Impairment in social functioning is sometimes the reason why patients with dysthymic disorder seek treatment. In fact, divorce, unemployment, and social problems are common problems for these patients. They may complain that they have difficulty in concentrating and may report that their school or work performance is suffering. Because of complaints of physical illness, patients may miss workdays and social occasions. Dysthymic disorder patients may have marital problems resulting from sexual dysfunction (for example, impotence) or from an inability to sustain emotional intimacy.

1.1.4 Etiology

Several well-controlled studies suggest that the development of dysthymia depends on both genetic and environmental factors. Therefore, the overall clinical picture results from a complex interaction between genetic factors and a number of important environmental factors, as well as the long-term effects of the illness on personal development. Genetic factors may play a particularly important role in early onset dysthymia and may in large measure be responsible for the disorder's chronicity and its disruptive effects on personal development. Family history of mood disorder is a useful clue to dysthymia. Epidemiological studies have clearly shown higher rates of dysthymia in those who have first-degree relatives with a history of any type of mood disorder, and especially depression (Costa e Silva, et al., 1994).
Biological Factors

Some studies of biological measures in dysthymic disorder support the classification of dysthymic disorder with the mood disorders. One hypothesis drawn from the data is that the biological basis for the symptoms of dysthymic disorder and major depressive disorder are similar. The main biological similarity between dysthymia and major depression comes from sleep electroencephalographic studies. Both residual depressive (Akiskal, 1982) and dysthymic (Akiskal et al., 1980) patients have generally been shown to have short REM latency and related circadian abnormalities, similar to those of primary major depressives. Some patients show marked diurnality (Akiskal et al., 1980), with gloominess, anhedonia and lassitude much worse in the morning.

Neuroendocrine Axes

The two most studied neuroendocrine axes in major depressive disorder and dysthymic disorder are the adrenal axis and the thyroid axis, which have been tested by using the dexamethasone - suppression test (DST) and the thyrotropin-releasing hormone (TRH) - stimulation test, respectively. Although the studies are not absolutely consistent, the majority of the studies indicate that patients with dysthymic disorder are much less likely to have abnormal results on a DST than are patients with major depressive disorder. The studies of TRH-stimulation test have been fewer in number but have produced preliminary data indicating that abnormalities in the thyroid axis may be a trait variable that is associated with chronic illness. This hypothesis is supported by a generally increased percentage of patients with dysthymic
disorder who have thyroid axis abnormalities when compared with normal controls (Kaplan, et al., 1994, p.556-57).

Psychosocial Factors

Psychodynamic theories regarding the development of dysthymic disorder posit that the disorder results from faulty personality and ego development, culminating in difficulty in adapting to adolescence and young adulthood. Karl Abraham, for example, thought that the conflicts of depression center on oral and anal-sadistic traits. Anal traits include excessive orderliness, guilt and concern for other's anal traits and are postulated to be a defense against preoccupation with anal matters and with disorganization, hostility and self-preoccupation. A major defense mechanism used is reaction formation. Low self-esteem, anhedonia and introversion are often associated with the depressive character.

In "Mourning and Melancholia", Sigmund Freud (as cited in Kaplan, et al., 1994, p.557) asserted that a vulnerability to depression can be caused by an interpersonal disappointment early in life that leads to ambivalent love relationships as an adult; real or threatened losses in adult life then trigger depression. Persons prone to depression are orally dependent and require constant narcissistic gratification. If deprived of love, affection, and care, they become clinically depressed. When those persons experience a real loss, they internalize or introject the lost object and turn their anger on it, and, thus on themselves.
found that adult children of alcoholics and drug addicts
discountably higher lifetime rates of dysthymia compared with age-
and sex-matched subjects who did not report having alcoholic or drug
acted parents.

Traumatic life events have been recognized as risk factors for
development of dysthymia. A significant loss, for example, the death of a
parent, brother, or sister at an early age greatly increases the risk of
dysthymia. Although such losses can precipitate the disorder at any age, they
are particularly associated with early onset dysthymia.

Traumatic events such as becoming blind, deaf, or disabled can
contribute to the insidious onset of dysthymia at any stage of life. Stroke is
particularly strongly associated with the onset of dysthymia. Although
dysthymia is not now regarded as a personality disorder, having a personality
disorder appears to increase the risk of an individual suffering from
dysthymia.

Other possible predisposing factors for dysthymia: Although it is difficult
to find a consistent relationship between social group and the occurrence of
dysthymia, there appears to be a higher prevalence of dysthymia amongst 18
to 44 year old subjects on low incomes.

There is no significant difference in prevalence of dysthymia between the
sexes in children. On the other hand, an important difference between the
sexes is seen in adults; women are twice or three times more likely than men
to suffer from dysthymia.
Cognitive Theory of Dysthymia

The cognitive theory of depression is also applied to dysthymic disorder; it holds that a disparity between actual and fantasized situations leads to diminished self-esteem and a sense of helplessness. The success of cognitive therapy in the treatment of some patients with dysthymic disorder may provide some support for that theoretical model.

1.1.5 Measurement

Moving from a suspicion of chronic, low-grade depression to a firm diagnosis of dysthymia requires eliciting relevant information from the patient and comparing this with the diagnostic criteria for dysthymia set out by the American Psychiatric Association’s DSM-IV and the World Health Organisation’s ICD-10.

Because dysthymic symptoms are difficult to observe, diagnosis relies more on what the patient says than on how he or she looks or behaves. Uncovering and diagnosing dysthymia therefore depends on good interviewing technique, with emphasis on taking a complete history of the patients starting from childhood. Good eye contact, empathetic comments, specific questions, directed open questions are important techniques for conducting an interview. Once encouraged to talk, dysthymic patients typically complain of a chronic feeling of being gloomy (dysphoria), and exhibit irrational patterns of negative thoughts. They are often chronically pessimistic and have a low self-esteem. The classical portrayal of a dysthymic individual is that of a person who is
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habitually gloomy, introverted, brooding, over conscientious, incapable of having fun, and preoccupied with their own inadequacy.

In the present study, Beck Depression Inventory (B.D.I.) was self-administered to assess the degree of depreciation as well as to find out the effectiveness of the therapy in reducing the depressive features. It was used as pre-mid-and-post-assessment measures. Hamilton Rating Scale for Depression (H.R.S.D.) was also used as an adjunct to Beck Depression Inventory, because it emphasizes on symptoms reflecting the intensity of depression and its behavioural manifestations. Here the rating was done by the investigator.

Depressive cognitions symptoms checklist (D.C.S.C) developed by the investigator was used as a screening instrument to quantify the depression cognitions. It also helped to classify the dysthymics into two groups, namely, low cognitive dysthymics and high cognitive dysthymics.

Crandell Cognitions Inventory (CCI) was chosen in the present investigation to measure the content of the depressive thoughts and also to find out as to what extent the therapy was effective in reducing the frequency of negative thoughts in the cognitive triad. It was used as pre-mid-post-assessment measures.

Dysfunctional Attitude Scale (DAS) was used to assess the cognitive distortions and the degree to which they predispose the client's depression. It was used as pre-mid and post-assessment measure to see the effect of cognitive behaviour therapy in correcting distortions in thinking patterns.
The details of the above mentioned inventories and scales are given in the Chapter IV.

1.1.6 Management

Historically, patients with dysthymic disorder received no treatment or were seen as candidates for long-term, insight-oriented psychotherapy. Contemporary data offer objective support for pharmacotherapy, cognitive therapy and behaviour therapy. The combination of pharmacotherapy and either cognitive or behaviour therapy may be the most effective treatment for the disorder. Other therapies may be beneficial; however, the benefit has yet to be proved in well-controlled studies.

Pharmacological Therapy of Dysthymia

For a number of years, dysthymia was considered to be non-responsive to antidepressant treatment. During the last decade, early studies with tricyclic antidepressants (TCAs) demonstrated the superiority of the TCAs over placebo. The side effect profile of the TCAs and the moderate degree of symptomatology resulted in reduced compliance and thus to the clinical impression of lack of efficacy. The newest generation of antidepressants, the selective serotonin Re-uptake Inhibitors (SSRIs) and the Reversible Inhibitors of Monoamine Oxidase Type A (RIMAs), with their more acceptable side effect profiles, allowed for the adequate evaluation of pharmacotherapy in dysthymia. The initial open studies with SSRIs indicate a clear efficacy of this group of antidepressants. Likewise, a 5 HTz antagonist, ritanserin, has been shown to be superior to placebo. More recently, a large placebo-controlled study of
moclobemide, a RIMA, clearly demonstrated the superiority of this drug over placebo. Based on this evidence, it is now appropriate to consider antidepressants as a clearly effective method of treating dysthymia (Lapierre, 1994).

Psychological (Non-pharmacological) Therapies of Dysthymia

Psychological therapies for dysthymia may have several different targets:

1. Symptom amelioration
2. Relapse prevention and
3. Improving social adaptation.

For cognitive therapy the targets are mainly the first two of these, for dynamic psychotherapies particularly the third. Cognitive-Behaviour Therapy (C.B.T.) attempts to counter pathologically negative thoughts which perpetuate dysthymia. Interpersonal psychotherapy (IPT) attempts to alter the interpersonal context in which the illness developed. In dysthymia, provision of a coping repertoire for a long term illness may also be important. There have been few controlled trials of psychological therapies in dysthymia, but one study has found benefit from marital therapy. Uncontrolled studies suggest some benefit from cognitive therapy. Controlled trials in other forms of depression of specific targeted psychotherapies, most commonly interpersonal psychotherapy, but also group, marital and family therapy show benefit on symptoms. Controlled trials of cognitive therapy show symptom benefit in
milder depression, and strongly suggestive evidence of relapse reduction (Paykel, 1994).

1.2 Cognitive-Behaviour Therapy

1.2.1 Definition

Cognitive therapy is a system of psychotherapy based on a theory of the emotional disorders (Beck, 1967), a body of experimental and clinical studies (Kovacs & Beck, 1978; Blackburn, 1988a) and well-defined therapy techniques (Beck et al., 1979). It is a structured form of psychotherapy designed to alleviate symptoms and to help patients learn more effective ways of dealing with difficulties contributing to their suffering. The therapeutic thrust of cognitive therapy is problem-orientated. It is directed at correcting the combination of psychological and situational problems which may be contributing to the patient’s distress.

The label ‘Cognitive Therapy’ is used because the techniques employed are directed at changing errors or biases in patients’ cognitions. This includes the way in which situations and stresses are appraised, assumptions about self, world and future and the beliefs and attitudes which are presumed to increase vulnerability to emotional disorders. Cognitive therapy also employs techniques which are behavioural: patients are required to carry out actions which are chosen because they are judged likely to change the way the person thinks. This ‘learning from experience’ is an essential element in cognitive therapy and it is for this reason that Beck prefers to speak of ‘Cognitive-Behaviour Therapy’. This term is used to describe a combination of cognitive
and behavioural techniques which have the common aim of identifying and changing dysfunctional cognitions.

1.2.2 Historical Perspective

The philosophical origins of cognitive therapy can be traced back to Stoic philosophers, particularly Zeno of Citium (fourth century B.C.), Chrysippus, Cicero, Seneca, Epictetus and Marcus Aurelius.

Epictetus wrote in the Enchiridion: "Men are disturbed not by things but by the views which they take of them". Like Stoicism, Eastern philosophies such as Taoism and Buddhism have emphasized that human emotions are based on ideas. Control of most intense feelings may be achieved by changing one's ideas (Beck, A.T. et al., 1979, p.8).

The term 'Cognitive-Behaviour Therapy' (C.B.T) refers to the treatment approach formulated by Aaron Beck (1964). However, Rational Emotive Therapy (RET) founded by Albert Ellis (1962) and Self-instructional Training (SIT) of Donald Meichenbaum (1975) are often included under the rubric of cognitive therapies. The latter two approaches will be dealt with briefly. The main focus of the present study will be on Beck's Cognitive-Behaviour Therapy.

Ellis (1962) postulated that certain 'core irrational ideas' are at the root of emotional disturbance. These centre around rigid expectations of social approval, mastery and control. All specific irrational beliefs can be traced to core irrational ideas. In treatment, these beliefs are challenged rationally and
their fallacies repeatedly exposed. This systematic challenging of beliefs is also referred to as cognitive restructuring.

Self instructional training (SIT) (Meichenbaum, 1975) assumes that internal monologues influence performance of various behaviours. SIT tries to prevent automatic behaviour and interpolates thought between stimulus and response. Meichenbaum is concerned with teaching patterns of implicit verbalization that will facilitate the self-control of overt verbal and motor behaviour.

The SIT program replicates the developmental sequence through which the overt verbalizations of an adult gradually become internalized in the child's own covert verbal control of his non verbal behaviour (Meichenbaum and Goodman, 1971). SIT has been used with children with impulsive behaviour (Meichenbaum and Cameron 1982).

1.2.3 Cognitive Therapy for Depression (Beck’s Model)

The premise of the cognitive model is that cognitions (images and thoughts) influence emotions and behaviours. This premise is grounded in a phenomenological approach to psychology, a perspective that assumes that behaviour is influenced by the individual’s perception of himself and the world. According to the cognitive model, the central feature of depression is distorted, negatively biased thinking. Therefore, within the cognitive model, other symptoms typical of depression (e.g., motivational deficits, suicidal impulses, and sadness) are augmented by distorted thinking patterns).
These cognitions or automatic thoughts are self-referent images or thoughts; they are what a person thinks about himself in a situation. According to the cognitive model, the automatic thoughts are important because they are related to the feelings and behaviour that occur in the situation.

The negative thoughts found in depression are automatic, involuntary, plausible, and persistent and often contain a theme of loss. Beck distinguished between socially accepted or objective definitions of particular events (e.g., loss) and private meanings of events (i.e., the significance of the event to the individual). He stressed that it is private interpretation of events that is critical to the emotional responses.
Fig. 2 shows the relationship between the world and the way one feels.

It is not the actual events, but one's perceptions that result in changes in mood. When one feels sad, one's thoughts will represent a realistic interpretation of negative events. When one is depressed or anxious, one's thoughts will always be illogical, distorted, unrealistic, or just plain wrong.

The emphasis on the private meanings of events reflects cognitive therapy's roots in phenomenological conceptualization of psychopathology. However, it is also the disparity between private and public meanings of events that results in cognitive therapy's discrimination between distorted and realistic automatic thoughts.

In describing and theorizing about depression, Beck identified three elements, considered essential to the psychopathology of depression:

1. The cognitive triad;
2. Silent assumptions;
3. Logical errors.

The cognitive triad consists of the negative views held by depressives about themselves, their world and their future (e.g., "I am no good", "My life is disappointing", and "Things will never improve". Generally, the depressed person assumes that he, his world, and his future lack some feature or features that are pre-requisite for happiness. For example, the depressed individual may view himself as unworthy, inadequate or incompetent. He may view his environment as continually demanding and unsupporting. He may describe the future as hopeless and predict that his deficits and current plan will continue indefinitely. These negative views (the cognitive triad) exacerbate or contribute to other symptoms commonly found in the depressive syndrome. That is, if the depressive thinks that "Everything I do turns out badly", he will be much less likely to initiate new behaviours because he assumes that this thought is true or valid. These negative views, automatic thoughts, can be reported in relation to specific situations by the depressed person.
The second element consists of silent assumptions. These are unarticulated rules that influence the depressed person's emotional, behavioural and thinking patterns (e.g., "If others don't like me, I can't be happy", and "If I get close to others, they will hurt me"). Silent assumptions are psychological constructs and thus are not automatically reported by the depressed patients. It is as if the patient bases his emotional, cognitive and behavioural responses on these silent assumptions. For example, the depressed person may believe, "If I am not loved by everyone, I am unworthy". Consequently, when this person perceives social disapproval, he may feel depressed, think "I am no good", and possibly avoid situations in which evaluation is likely. Presumably, these assumptions are rather stable beliefs that develop from early experience and subsequently influence the individual's responses to events. According to the cognitive model, these silent assumptions are typically stated as if-then premises that can be identified by examining patterns within a group of automatic thoughts or behavioural responses. Dr. Weissman's studies confirm the concept that one's silent assumptions represents a predisposition to emotional turbulence that one carried with the array of negative automatic thoughts. For example, a depressed person may report sadness when her spouse does not compliment her on her appearance. She may report thinking, "He is not attracted to me anymore because I am ugly". She may also report feeling dysphoric when a friend talks to her for only 5 minutes in the grocery store. She may report thinking, "She would want to spend more time with me if I weren't so dull". Through repeated examples and verbal exchange, the therapist and patient may infer the silent assumption, "If others don't attend to me, it's (1) something to be disturbed about and (2) because of a deficit I have".
According to the cognitive model, when a person is depressed, these dysfunctional assumptions are activated more frequently than the more adaptive alternative assumptions. Second, it is assumed that as the depression becomes more severe, the individual's thinking becomes more disparate from logical or objective evidence.

Third, the cognitive model posits that negative automatic thoughts contain various logical errors indicative of the thinking process. Logical errors are identified by examining logical relationships between actual specific events and the associated negative automatic thinking.

The following are the systematic errors in reasoning:

1. **Arbitrary inferences** - conclusions that are made in absence of supporting substantiating evidence (e.g., the working executive who after a busy day in the office concludes, "I am a lazy employee").

2. **Selective abstraction** - conceptualizing a situation on the basis of a detail taken out of context, ignoring other information (e.g., a man who becomes jealous upon seeing his fiancee tilt her head toward another man in a conversation in order to hear him better during a noisy outing).

3. **Overgeneralization** - Allowing an isolated incident or two to serve as a representation of similar situations everywhere, related
or unrelated (e.g., after a skeptical meeting, an author concludes, “All editors are alike; I’ll always be rejected”).

4. **Magnification and minimization** - perceiving a case or situation in a greater or lesser light than it truly deserves (e.g. a professor worries, “If I appear the slightest bit disorganized while lecturing, my class will think I am inept”; or, less significant, "I did okay with my lecture this time, but I was lucky; next time may not be so good").

5. **Personalization** - Attributing external events to oneself when insufficient evidence exists to render a conclusion (e.g. a woman says hello to a neighbour and, failing to receive a return greeting, assumes, “I must have done something to anger her”).

6. **Labeling and mislabeling** - portraying one’s identity on the basis of imperfections and mistakes made in the past and allowing these to define one’s true self (e.g., subsequent to making a mistake an individual states, “I am worthless”, as opposed to recognizing his errors as being human).

7. **Dichotomous thinking** - codifying experiences as being black or white; for example, as a complete success or total failure (a researcher presenting a paper states, "unless I render one of the best presentations my colleagues have ever seen, I am a failure as a scientist").
According to Beck's model, it is the existence of rigidly held silent assumptions that increases an individual's vulnerability or predisposition to depression. These assumptions may develop through interactions with significant others. In particular, these assumptions are learned in the context of an unfavourable life situation (e.g., the loss of a parent or chronic rejection by peers). Later in life, when the person is exposed to a situation analogous to the original unfavourable life situation, he employs the previously learned assumptions.
**Fig. 3 The Schematic illustration of Beck's Cognitive Model of Depression**

Once activated, these assumptions are applied to an every widening array of stimulus situations and thereby lead to more and more negative automatic thinking. The typical emotional, motivational, behavioural and vegetative depressive symptoms (e.g. hopelessness, apathy, agitation, and sleep disturbance) are maintained by this negative automatic thinking. As depressive symptoms worsen, the distorted thinking increases. Beck has termed the relationship between depressive symptoms and thoughts a vicious cycle, a circular feedback model, and the downward spiral of depression.

1.3 THE PRESENT STUDY

The present study throws light on the factors that contribute to dysthymia so that suitable therapeutic programme based on Cognitive-Behaviour Therapy model could be chalked out. The intervention programme thus planned would be tested for its efficacy in management of dysthymia by employing an experimental design with repeated measures and having three conditions, viz., (i) C.B.T. alone, (ii) C.B.T. + Drug and (iii) Drug alone. Appropriate statistical techniques will be used for analysis of data.

Keeping these details of the present study in view, studies done in the past on dysthymia and cognitive - behavioural therapies (C.B.T.) of depression are reviewed in the next chapter.
CHAPTER - II