J. Kim Penberthy

Advances in Psychotherapy –
Evidence-Based Practice

Persistent Depressive Disorders

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Persistent Depressive Disorders

About the Author

J. Kim Penberthy, PhD, ABPP, is the Chester F. Carlson Professor of Psychiatry & Neurobehavioral Sciences at the University of Virginia School of Medicine in Charlottesville, VA. She has spent her career treating patients with depressive disorders, training other professionals regarding effective treatments, and conducting research in the effective diagnosis and treatment of depression and related disorders. Dr. Penberthy is internationally known for her research regarding effective treatment for persistent depression and related disorders using the cognitive behavioral analysis system of psychotherapy (CBASP) and has developed applications for comorbidities and group administration.

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Description of Persistent Depressive Disorders

1.1 Terminology

The American Psychiatric Association (APA) *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5; APA, 2013) lists eight distinct depressive disorders, with the common feature of all being the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that negatively impact functioning. What differs among these depressive disorders is chronicity, timing of symptoms, and presumed etiology. This book will focus on the DSM-5 category of **persistent depressive disorder** (PDD), which is an amalgamation of the categories from the DSM, fourth edition (DSM-IV; APA, 1994), of **dysthymic disorder** (DD), chronic **major depressive disorder** (MDD), and DD with a **major depressive episode** (MDE) also referred to as **double depression**

Persistent depressive disorder is a newly named category in DSM-5 that integrates DD and MDD

PDD and DD are both coded as 300.4 in the DSM-5. In the International Classification of Diseases, 10th edition, PDD is coded as F34.1 and Dysthymic Disorder is coded as 6A72 in the ICD-11 (ICD-10, WHO, 1992; ICD-11, WHO, 2018). The DSM-5 code for MDE is 296.XX with extensions to distinguish recurrence and severity (unspecified 296.X0, mild 296.X1, moderate 296.X2, severe with psychotic features 296.X4 or without psychotic features 296.X3, full 296.X6 or partial remission 296.X5) and identifiers that specify with anxious distress, mixed features, melancholic features, atypical features, mood-congruent psychotic features, mood-incongruent psychotic features, peripartum onset, catatonia (for which there are the additional DSM-5 code 293.89 and ICD-10 code F06.1), and seasonal pattern (used with recurrent episodes only). The ICD-10 code for MDE, single episode, is F32.X and recurrent MDE is coded as F33.X, with severity extensions (mild F3X.0, moderate F3X.1, severe F3X.2, with psychotic features F3X.3, unspecified F3X.9, and partial F3X.4 or full remission F3X.5). Other specifiers include early onset (onset prior to age 21 years) or late onset (onset at age 21 years or older). The ICD-11 code for single episode depressive disorder is 6A70 and recurrent depressive disorder is coded as 6A71 (WHO, 2018). The ICD-11 also has a diagnostic code for mixed depressive and anxiety disorder where neither sets of symptoms, considered separately would justify a depression or anxiety diagnosis, but symptoms are present and impair functioning (WHO, 2018).

1.2 Definition

Researchers have found few meaningful differences between DD and chronic MDD (Keller et al., 1995; Klein & Santiago, 2003), and thus these were merged into PDD in DSM-5. This new category of depressive disorders gives more weight to duration than to severity of symptoms. DSM-5 defines PDD using the same set of symptoms as that used for DD, with the assumption that most patients who meet the full criteria for chronic MDD also meet the criteria for DD. However, because of differences in symptomatic criteria, especially regarding duration of symptoms, some patients with chronic MDD will not meet the DSM-5 criteria for PDD. The diagnosis of PDD in DSM-5 includes both chronic MDD and DD as defined by the DSM-IV (APA, 1994), and provides specifiers that define the combination between these two conditions. Thus, the diagnosis of PDD is indicated if any of the following are present:

- PDD as pure DD with no MDE during a 2-year period;
- Double depression: PDD with intermittent MDEs, where the criteria for one or more MDEs have been met during a 2-year period of DD, but the symptoms did not reach the diagnostic threshold of MDE for at least 8 weeks;
- PDD and chronic MDD (MDE criteria have been met for > 2 years) both diagnosed;
- Chronic MDD only where the MDD has been present for > 2 years.

Figure 1 provides a visual representation of these course profiles.

Children or adolescents may endorse irritability instead of depressed mood

PDD is characterized by depressed mood that occurs for most of the day, for more days than not, for a duration of at least 2 years in an adult, or at least 1 year in a child or adolescent. Children or adolescents may experience irritability instead of depressed mood. During periods of depressed mood or irritability, at least two of six additional symptoms listed in Box 1 must be present to diagnosis PDD, and any symptom-free intervals must last no longer than 2 months to maintain the diagnosis of PDD. Additionally, there must never have been a manic, mixed, or hypomanic episode in the first 2 years, and criteria must never have been met for cyclothymic disorder. To meet the diagnostic criteria for PDD, the symptoms must not be due to the direct physiological effects of the use or abuse of a substance (e.g., alcohol, illicit drugs, or medications), a general medical condition (such as cancer or a stroke), or be better explained by the patient meeting criteria for schizoaffective disorder, schizophrenia, delusional disorder, or other psychotic disorder. The symptoms must also cause significant distress or impairment in social, occupational, educational, and/or other important areas of functioning.

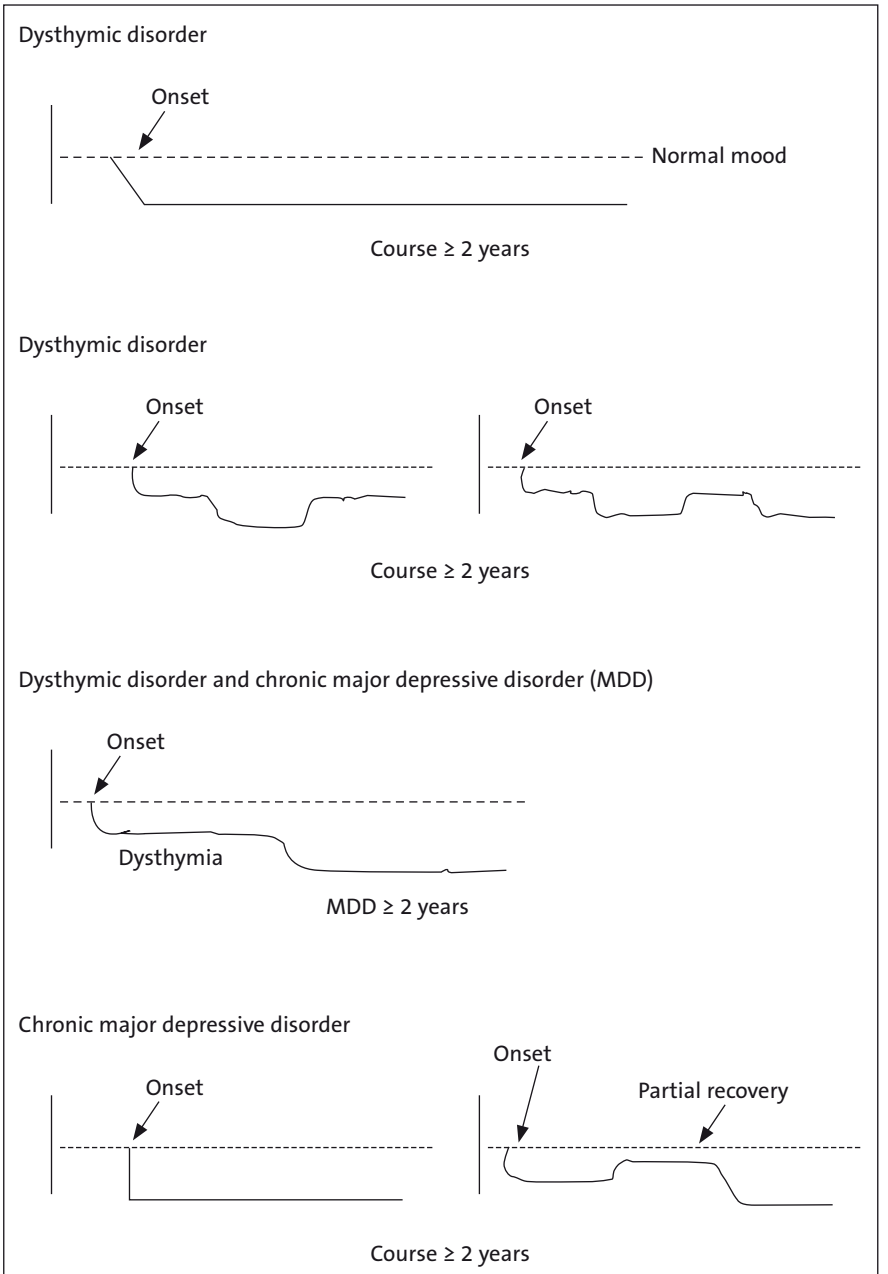


Figure 1
Course profiles of persistent depressive disorders. Reprinted with permission from unpublished material by James P. McCullough, Jr., 2018.
MDD = major depressive disorder.

Box 1
Summary of DSM-5 Diagnostic Criteria for Persistent Depressive Disorder or Dysthymic Disorder

- Depressed mood most of day, more days than not for 2 years. Adolescents or children may have irritable mood for 1 year.
- While depressed, must have two or more of the following:
  - Poor or increased appetite or eating
  - Insomnia or hypersomnia
  - Low energy or fatigue
  - Low self-esteem
  - Concentration or decision-making difficulties
  - Hopelessness
- Must not be without symptoms for more than 2 months
- MDD may be present for 2 years
- No mania or hypomania present
- Symptoms cause functional impairment or distress
- Symptoms not better explained by other psychiatric disorder, effects of substances, or medical condition

Note. For full diagnostic criteria, see APA (2013), pp. 168–169. MDD = major depressive disorder.

PDD patients who also meet MDD criteria for 2 years should be given a diagnosis of both PDD and MDD

The 2-year minimum duration has been debated, and researchers examining characteristics of DD in adults occasionally use symptom duration of 1 year or longer (Brown, Craig, & Harris, 2008). For clinical and prognostic purposes, the duration of depressive symptoms is important both below and above the 2-year mark regardless of criteria met. MDD may precede PDD, and MDEs may occur during PDD. Patients who meet MDD criteria for 2 years should be given a diagnosis of PDD as well as MDD.

The diagnostic criteria for an MDE are listed in Box 2. To have a diagnosis of MDE, the patient must endorse having five or more of the nine symptoms within the same 2-week period, with at least one of the symptoms being depressed mood or loss of interest or pleasure. The other caveats for diagnosis of MDE are the same as those for PDD. The diagnosis of MDD is made if criteria for MDE are continually met for at least 2 years, and there is a lifetime absence of mania and hypomania.

Box 2
Summary of DSM-5 Diagnostic Criteria for a Major Depressive Episode

- Five or more symptoms are present for 2 weeks, and they are a change from previous functioning. At least one of the symptoms must be depressed mood or lack or loss of interest or pleasure
- Criteria for MDE may be present continuously for 2 years or more, and that would be a separate diagnosis from PDD
- Possible symptoms include all of those in PDD as well as:
  - Decreased interest or pleasure in activities or things
  - Physical or psychomotor agitation or slowness
  - Feelings of worthless or guilt which are not warranted
  - Recurrent thoughts of death, or suicidal ideation, plan, or attempt

Note. For full diagnostic criteria, see APA (2013), pp. 160–161. MDE = major depressive episode; PDD = persistent depressive disorder.

2

Theories and Models of Persistent Depressive Disorders

Biopsychosocial model attributes disease to interaction of biological, psychological, and social factors

The etiology of PDD can be conceptualized within a multifactorial biopsychosocial framework. The biopsychosocial model attributes disease outcome to the variable interactions of biological factors (genetic, biochemical, biological), psychological factors (mood, personality, behavior), and social factors (cultural, familial, socioeconomic). Accompanying this framework is a **diathesis–stress model**, which has been increasingly popular in describing the etiology of PDD. The diathesis–stress model explains a disorder as the result of an interaction between a predisposed vulnerability and current psychosocial stress. The influences within such a model include genetic and biological factors, developmental and learning history, social and cultural influences, coping strategies, personality, chronic stress, trauma, and medical illness. Although there are multiple theories and models used to explain the development and continuation of depression, less research has been conducted specifically for PDD. Current major theories or models of depression will be reviewed here, with a focus on PDD and models that have associated empirically supported treatment approaches for PDD.

Diathesis–stress views disorders as interaction between a genetic vulnerability and psychosocial stress

2.1 Biological Models

There is a strong biological component to PDD

All forms of PDD are thought to have strong biological components in their etiology. Depression has been associated with multiple neurochemical changes, including deficiencies in norepinephrine, serotonin, and dopamine, and to variations of dopamine autoreceptors, 5-GT receptors, alpha-NE or beta-NE receptors. These changes may also be influenced by hormonal variations that contribute to the vast array of individual differences biologically and symptom-wise within and across depressed patients. In addition, chronic stress or trauma can provoke, exacerbate, or help maintain MDD, DD, and PDD.

2.1.1 Genetics

There is a genetic component to MDD and DD; depression runs in families

It is fairly well established that there is a genetic component of depression and that depression runs in families (Howland & Thase, 1991). Prevalence rates of MDD, DD, and double depression differ in families, suggesting their distinctions, even though they have substantial similarities. Environmental stress may be a greater influence in the etiology of DD, less severe depression, or

3

Diagnosis and Treatment Indications

Differentiating PDD from acute or episodic depression is important for determining treatment approach

PDD is conceptualized differently from acute or episodic depression, and effective psychotherapeutic approaches to PDD differ from the approaches for those. Compared with an acute or episodic course, PDD is associated with earlier onset, increased rates of abuse and adverse early experiences (Klein & Santiago, 2003); increased comorbidities, especially personality disorders (Angst et al., 2009); and poor social and interpersonal adjustment (Ley et al., 2011). PDD patients may need more intense and longer courses of treatment (Cuijpers, van Straten, et al., 2010) or treatments designed specifically for their needs (McCullough, 2000, 2006). Medical disorders must also be evaluated, since some medical conditions can present with depressive symptoms and may respond to treatment of the underlying medical condition (Goodwin, 2006). The age of onset, severity of depressive symptoms, developmental trauma history, current interpersonal functioning, and dysfunctional schemas and cognitions should be evaluated and considered when making treatment recommendations, since these factors may be used to direct a more effective treatment. A flowchart of this approach to diagnosis and treatment can be found in Figure 2. Additional information related to aspects of the flowchart is presented in the next paragraphs.

The initial assessment should be based on a detailed history, including diagnostic interview and physical examination if possible, with thorough blood work checking for medical issues that may be contributing to the depressive symptoms. Depression is a clinical diagnosis, based on the patient's history and physical findings. No diagnostic laboratory tests are available to diagnose PDD, but focused laboratory studies may be useful to identify and treat medical illnesses or side effects from medications that may present as depression, be associated with depression, or worsen depression.

3.1 Motivation or Readiness to Change

Patient motivation, treatment history, and engagement should be used to inform the approach used

It is important to determine the patient's **motivation to change** or readiness to engage in treatment. Readiness to change can be assessed directly or inferred based on patient behaviors and statements. Treatment history should include the types of any antidepressants used, dose, compliance, response to treatment, and side effects experienced. Treatment history should also include the type of psychotherapy or supportive services obtained, if any, and the degree of engagement, belief in efficacy, and treatment response. Reasons for discontinuing prior psychotherapy should also be assessed, and it is important to

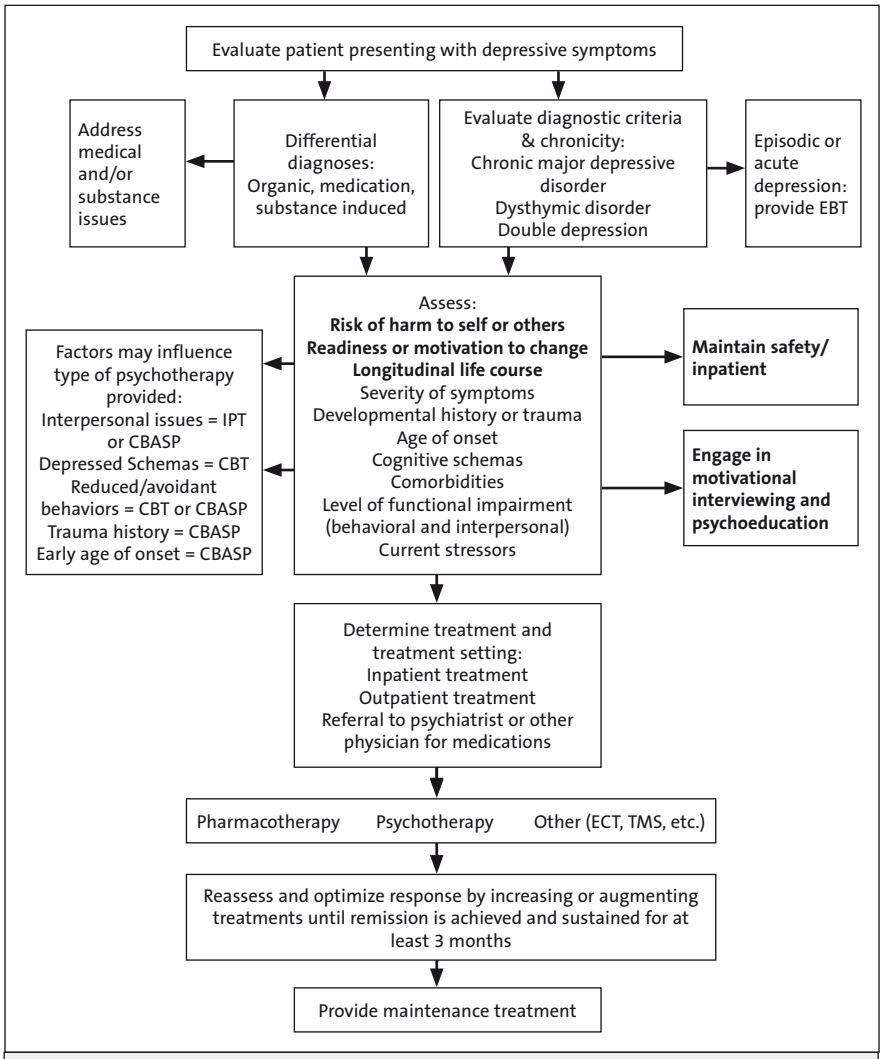


Figure 2
Diagnosis and treatment algorithm for persistent depressive disorder (PDD). CBASP = cognitive behavioral analysis system of psychotherapy; CBT = cognitive behavior therapy; EBT = evidence based therapy; ECT = electroconvulsive therapy; IPT = interpersonal psychotherapy; TMS = transcranial magnetic stimulation.

proactively monitor and assess any recurrence of these problems. Compliance issues can interfere with effective implementation of treatment and may need to be addressed via additional interventions, such as motivational interviewing to clarify ambivalence and advance readiness to change and increase adherence to treatments, or through psychoeducational interventions to help provide information and support (Donker, Griffiths, Cuijpers, & Christensen, 2009). The CBASP approach includes proactive techniques to address therapy-interfering behaviors of the patient and help increase engagement of the patient (McCullough, 2006).

insight-oriented, supportive, brief psychodynamic, relaxation) with CBT and found that all were equally efficacious, with a small effect size ($d+ = 0.16$).

However, in a review of meta-analyses, Hoffman, Asnaani, Vonk, Sawyer, and Fang (2012) summarized research on CBT for depression and DD and found that CBT was more effective than control conditions such as waitlist and relaxation, or no treatment, with an overall medium effect size. Additionally, Tolin (2010) showed CBT to be superior to psychodynamic therapy at both posttreatment and 6-month follow-up, although this occurred when depression and anxiety symptoms were examined together, and it is unclear if the depressive symptoms were chronic.

Hollon et al. (2016) investigated a subgroup of 159 patients with MDD who were randomly assigned to CBT plus pharmacotherapy or to pharmacotherapy alone, and reported that combined treatment enhanced the rate of recovery when compared with medication alone, 75.2% versus 65.6%; $t_{451}=2.44$; $p = .02$; hazard ratio (HR) = 1.32; 95% CI, 1.06–1.65; NNT = 11; 95% CI, 6–91. This effect was limited to patients with severe but nonchronic MDD: 84.7% versus 57.7%; $n = 147$; $t_{146}=3.88$; $p = .001$; HR = 2.21; 95% CI, 1.48–3.31; NNT = 4; 95% CI, 2–8.

Booster sessions of CBT may help prevent relapse

Booster or maintenance sessions of CBT have been demonstrated to have a substantial effect on lowering the recurrence of depression in chronic patients who were CBT responders (Fava, Rafanelli, Grandi, Conti, & Belluardo, 1998). Jarrett et al. (2001) conducted a maintenance CBT study with patients suffering from chronic recurrent MDD and found that over an 8-month period, CBT significantly reduced relapse rates more than a control intervention (10% vs. 31% relapse, respectively).

4.1.3 Cognitive Behavioral Analysis System of Psychotherapy

CBASP is specifically for early-onset unipolar chronic depression and is especially effective for patients with trauma histories

CBASP was designed to address the entrenched interpersonal problems and maladaptive cognitive behavioral patterns that are so often found in PDD patients (McCullough, 2000). The CBASP theory proposes that early interpersonal trauma or repeated psychological insults result in a learned lack of emotional felt safety, which leads to avoidance; derailed affective, social, and motivational regulation; and impaired **perceived functionality**. Perceived functionality is described as the ability to recognize the consequences of one's own behavior on other individuals and develop social problem-solving skills and empathy to achieve one's predetermined realistic and attainable interpersonal goals (McCullough, 2000; McCullough et al., 2015).

Primary goals of CBASP: to increase felt emotional safety and perceived functionality in PDD patients

The CBASP theory posits that PDD patients enter therapy dominated by interpersonal rigidity, and they are stuck in unproductive interactions because the current environment is not informing them. Specifically, the CBASP approach theorizes that the depressed patient does not grasp their contribution to the life difficulties they encounter, and that therapeutic strategies that rely on rational disputation, as in cognitive therapy, will not be effective with these PDD patients. The primary goal of CBASP is to enable patients to interact with greater interpersonal flexibility and to generate empathy for the therapist and eventually for others. This is achieved by increasing felt emotional safety

of the patient and facilitating more effective connection with the environment – that is, increasing the patient's perceived functionality. The CBASP approach is different from other therapies in that it explicitly describes the necessity of the therapist becoming involved as a representative of the social-emotional environment to facilitate learning, early in the therapeutic process with patients who have a paucity of interpersonal relationships or skills (McCullough, 2006).

One of the goals of CBASP is to help the patient gain the ability to recognize the interpersonal consequences of their behavior to be able to do the work of change. CBASP has demonstrated effectiveness in treating PDD and is also well-suited for patients who have extensive avoidance learning, high rates of early trauma, or repeated interpersonal failures, or who cope by "escaping," "avoiding," or "numbing" (Locke et al., 2017; Nemeroff et al., 2003). The phases of treatment and associated work to be done in CBASP for PDD are summarized in Box 3 and are compiled from McCullough and his colleagues (McCullough, 2000, 2006; McCullough et al., 2015).

Box 3
Stages of CBASP for Persistent Depressive Disorder

Assessment

- Therapist conducts a clinical or diagnostic assessment to determine presence of persistent depressive disorder (PDD) and other symptoms or diagnoses, with focus on clinical course over time.
- Severity of depression is assessed, as is suitability for cognitive behavioral analysis system of psychotherapy (CBASP).
- If patient is deemed suitable for CBASP, the therapist socializes the patient to CBASP and provides the Patient's Manual for CBASP (McCullough, 2003).
- Patient is asked to generate a list of significant individuals who have played a decisive and influential role in their life, and to bring it for the next session. This list should be fairly short with about three to five individuals listed. The patient is encouraged only to write down the names and not to think too hard about this exercise.

Initial sessions

- Therapist reviews the Patient's Manual with the patient and answers additional questions about CBASP.
- Therapist describes the rationale for the significant other history (SOH) and elicits the SOH from the list provided by the patient. Therapist formulates the causal theory conclusions from the SOH with the patient and also develops the transference hypothesis, which may or may not be shared with the patient.
- Therapist assesses the interpersonal impact of patient on the therapist via the Impact Message Inventory (IMI) or similar tool.

Middle sessions

- IMI is reviewed by therapist to help inform the therapist of the patient's interpersonal "stimulus values" to help define therapist's interpersonal role with the patient and any potential interpersonal "hot spots."
- Therapist orients the patient to the mainstay of CBASP – the situational analysis (SA) of the Coping Survey Questionnaire.
- Therapist conducts elicitation phase and remediation phase of the SAs during sessions, based on past or future events brought by the patient.

7

Appendix: Tools and Resources

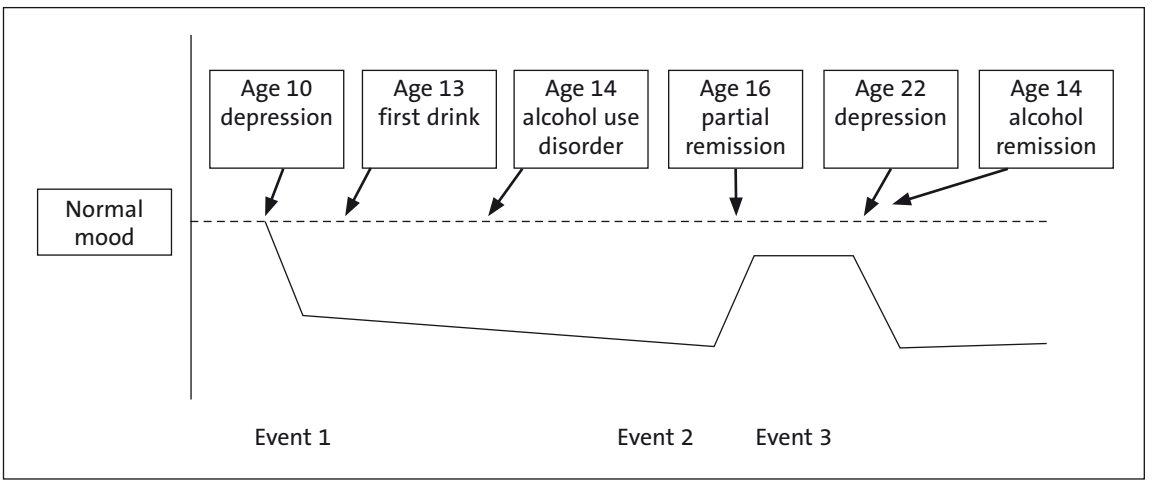
CBASP Case Formulation Sample Worksheet of Patient Allison D.

Allison D. is a 32-year-old woman who presented for treatment for persistent depression stating that she had always been depressed, and she reported that she thinks it is getting worse. She also has a history of alcohol abuse. She has been sober for 10 years and does not want to relapse. Allison reported that she does not remember much of her childhood. Her mother, who was also depressed, died when Allison was 10 years old, and this is when Allison thinks she realized her own depression. Allison's father was an alcoholic who became unpredictable when he was drunk. She has some memories of him being sexually inappropriate with her and exposing himself to her, but she does not remember if there was additional abuse. Her father introduced her to alcohol, giving her liquor when she was 13. She soon began to use it to "numb" her feelings of sadness, and by age 14 she was abusing alcohol regularly. At age 16, Allison moved in with her paternal grandparents when her father was sent for treatment of his addiction. She reported some improvement in both depressive symptoms and her drinking behavior, improvements which persisted until the death of her grandparents when she was 22. Allison stated that although she stopped drinking around age 17, her depression never fully improved, and when her grandparents died, she became severely depressed again but has been able to stay sober. Allison provided a significant other history with her mother, father, grandparents, and one close school friend, who moved away without telling her goodbye. Interpersonally, she appears to have difficulty getting close to people (intimacy domain), having experienced repeated loss and disappointment. She comes across to the therapist as interpersonally avoidant and distant. Allison is currently unemployed after being downsized at her job and is looking for work. She endorsed feeling depressed, lonely, and lethargic. She does not have any social support and avoids people. She does not enjoy looking for work and is not searching very hard but knows that her unemployment benefits will run out soon. She endorsed feeling severely depressed and scored 23 on the HDRS.

Presenting or Key Problems of Living

1. Depressed affect, low mood, avoidant, lethargy
2. Estranged from family and loved ones
3. Unemployed

Clinical Course Profile With Timeline for Onset, Remission, and Relapse



Clinical course of depressive symptoms as well as symptoms of co-occurring disorders are charted on the timeline. Substance use data are captured in the boxes above to distinguish them from depressive symptoms. Start at the left with age of onset and underpin with estimations of duration for each phase of the pattern derived. You can annotate dates or other important information that best serves your purpose. You can also note these below:

Age of onset of diagnosed disorder	Trigger/timing event 1: Onset of disorder	Trigger/timing event 2: Remission of disorder	Trigger/timing Event 3: Relapse of disorder
Depression: 10 years old	Death of mother	Patient moved in with grandparents	Death of grandparents
Alcohol use disorder: 14 years old	Father introduces alcohol	Grandparents placed father in treatment for alcoholism	Patient leaves grandparents' home

Significant Other History (SOH)

Significant other	Causal theory conclusion (stamp)
Mother	"Positive relationships don't last."
Father	"Men are dangerous and confusing, I can't trust them."
Grandparents	"Good people can only do so much, and they don't last."
Friend	"Getting close to people only leads to disappointment and pain."

Transference Hypothesis

Domain	Transference hypothesis
Intimacy	"If I get close to Dr. Penberthy, she will leave me or hurt me."
Making mistakes	
Expressing negative affect	
Expressing needs	

Ideally, try to construct at least one transference hypothesis as it may apply to the relationship between the therapist and the patient.

A comprehensive and practical guide to assessing and treating people with persistent depressive disorders

This compact guide is packed with the latest knowledge on the assessment and treatment of persistent depressive disorders (PDDs) – the new DSM-5 diagnosis that amalgamates the categories dysthymic disorder (DD), chronic major depression (MDD), and DD with major depressive episode (MDE). Written by a leading expert, the book guides us through the complexities of assessing PDDs and the models for understanding how these difficult-to-identify and potentially life-threatening disorders develop and are maintained over long periods. It then outlines those therapies that have the strongest evidence base. The author goes on to explore in detail the cognitive behavioral analysis system of psychotherapy (CBASP), a treatment specifically developed for PDDs. This compelling integrated approach incorporates components of learning, developmental, interpersonal, and cognitive theory with aspects of interpersonal mindfulness. We are led expertly through the therapeutic process using clinical vignettes and practical tips, with particular attention paid to identifying the assessment and therapy methods most valuable in CBASP. Printable tools in the appendices can be used in daily practice. This book will interest clinical psychologists, psychotherapists, psychiatrists, counselors, and students.

"Prof. Penberthy has written an excellent overview of the recent chronic depression category in DSM-5, persistent depressive disorder (PDD), reviewing a highly relevant body of literature and providing extensive summaries of empirically validated treatments. This text is a must-read for psychiatric and psychological practitioners and researchers, as well as anyone who is interested in depression, its biological, psychological, and genetic features, and clinical course."
James P. McCullough, Jr, PhD, Emeritus Professor of Psychology, Virginia Commonwealth University, Richmond, VA

"This compact volume provides an insightful summary of the diagnosis, assessment, and clinical features of persistent depressive disorder and an excellent overview of treatment options. A major strength is Prof. Penberthy's detailed and expert introduction to the cognitive behavioral analysis system of psychotherapy (CBASP), the best-validated psychotherapeutic approach for chronic depression. Busy clinicians and trainees in all mental health fields will benefit from reading this book."
Daniel N. Klein, PhD, State University of New York Distinguished Professor, Department of Psychology, Stony Brook University, Stony Brook, NY

"Persistent Depressive Disorders *does a masterful job of laying out the nature of and treatments for those depressions that do not remit, with an emphasis on the cognitive behavioral analytic system of psychotherapy (CBASP), the most efficacious and best tested of them all. It is a real tour-de-force."*
Steven D. Hollon, PhD, Gertrude Conaway Vanderbilt Professor of Psychology, Vanderbilt University, Nashville, TN

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