



dysthymic disorder ii) to use psychological scale to assess dysthymic disorder and iii) to assess the qualitative changes in dysthymic patients after the intervention and at follow-ups.

### **Method**

#### **Sample:**

Forty woman outpatients, who had the symptoms of dysthymic disorder, were randomly classified into two groups- namely Pharmacotherapy (PT) group (N=20), and combined Pharmaco and Psychological therapy (PPT) group (N=20). The former group received only drugs and the latter group received both drugs and cognitive behavior therapy. The duration of the therapies was 15 sessions, each comprising 50 minutes. The follow-ups were done once in a month by using the Cornell Dysthymia Rating Scale (CDRS).

#### **Design:**

Pre and post Research design is used for the study. Forty patients who had the symptoms of generalized body pain, irritability, loneliness, insomnia, loss of appetite, feeling of hopelessness, easy fatigability, palpitation, low self-esteem, and poor concentration for more than two years, came for treatment to the hospital. They were randomly classified into two groups as Pharmacotherapy (PT) group, and combined Pharmaco and Psychological Therapy (PPT) group. Data were collected before, after, and follow-ups by using the scale. Self-report was also collected for the care and support of them.

#### **Measures:**

Mason, Kocsis and Leon (1993) developed the Cornell Dysthymia Rating Scale (CDRS) to evaluate the milder symptoms of chronically depressed out patients. It is a 20 item clinician rated scale, rated on a 0 to 4 spectrum (0= not at all, 4= severe). The assessment of the scale covers both frequency and severity of symptoms.

#### **Pharmacological Management:**

The antidepressant drugs - Cap. Prodep 20mg 1-0-0, Tab. Dothip 50mg 0-0-1, and anti-anxiety drug Tab. Rivotril 0.5mg 0-0-1, - were given by the psychiatrists to all the patients for the entire sessions to arrest the symptoms of the dysthymic disorder. After a couple of days, the patients found a relief from the symptoms such as generalized body pain, insomnia, and loss of appetite. Later on they had relief from all other symptoms.

#### **Psychological Management:**

Besides taking drugs, Cognitive Behavior Therapy (Hales, Yudofsky, & Talbott, 1999), was given to the PPT group i.e., combined Pharmaco and Psychological Therapy group. It was a short-term program oriented towards current problems and their resolution. Initially patients were assigned reading material on coping with depression. The focus of the therapist was to recognize the nature of the dysfunctional thinking. During the therapy session, mood shifts helped the therapist to identify automatic thoughts. He observed the strong emotions, such as anger, irritability, anxiety, and depression, and asked the patients to describe the thoughts that went through their head just prior to mood shifts.

The patients were instructed to recognize schemas (core beliefs or basic assumptions) on their own for which psycho educational approach was used to explain the concept of schemas and their linkage to superficial automatic thoughts (Dobson & Shaw, 1986). After identifying schema, the patients had to do pro- cons analysis; it induced them to doubt the validity of the schema and to start to think of alternative explanations. Modifying schema included examining evidence, listing advantage and disadvantage, generating alternatives and cognitive rehearsals. In cognitive rehearsal, they had to imagine various steps in meeting and mastering a challenging task and to rehearse various steps of it. Behavioral

intervention used to change dysfunctional patterns of behavior (e.g. helplessness, isolation, and phobic avoidance), to reduce troubling symptoms (e.g. intrusive thoughts), and to assist in identifying and modifying maladaptive cognitions (e.g. activity schedules with mastery and pleasure when they engaged in each activity).

A weekly activity log was employed in which patients recorded what they did during each hour of the day and rated each activity for mastery and pleasure. They reviewed the data in the next therapy session with the

therapist. In graded task assignment, a behavioral goal was broken down in to small steps that could be taken one at a time to solve a part of the problem. Moreover, patients were instructed to stop dysfunctional behaviors e.g. crying spells and diverted them from intrusive thoughts by engaging activities such as physical activity, social contact, play and visual imagery. Role-play is a particularly powerful and useful technique to elicit automatic thoughts and to learn new behavior (Kendell & Panichelli-Mindel, 1995).

### Results and Discussion

**Table1: Means, SDs, and t-values for the scores of the Cornell Dysthymia Rating Scale of the two groups (n=20)**

Groups	Assessments	Mean	SD	t- value
PT	Before	27.90	4.84	
PPT	Before	28.30	4.97	0.26
PT	Before	27.90	4.84	
	After	24.30	5.14	2.27*
	After	24.30	5.14	
	Follow-up1	24.52	5.01	0.14
	After	24.30	5.14	
	Follow-up2	24.10	5.18	0.13
PPT	Before	28.30	4.97	
	After	20.60	4.86	4.96 **
	After	20.60	4.86	
	Follow-up1	21.00	5.03	1.07
	After	20.60	4.86	
PT &PPT	Follow-up2	20.36	4.93	0.50
	After	24.30	5.14	
	After	20.60	4.86	2.34*
	Follow-up1	24.52	5.01	
	Follow-up1	21.00	5.03	2.21*
	Follow-up2	24.10	5.18	
	Follow-up2	20.36	4.93	2.34*

PT - Pharmacotherapy group, and PPT - Pharmaco and Psychological Therapy group.

\*\*p < 0.01; \* p < 0.05

Mean and standard deviation were calculated for each of the group i.e. the Pharmacotherapy (PT) group and the

combined Pharmaco and Psychological therapy (PPT) group to facilitate the comparison of repeated assessments by Cornell Dysthymia Rating Scale (CDRS). The

main analysis of the data was to determine the significance of Mean difference between before and after, after and follow-up1, and after and follow-up2 assessments of each group i.e. PT and PPT groups. Besides, these two groups were compared between after and after, and follow-up1, and after and follow-up2 for significant differences. t- test was applied in the scores of woman patients to determine the significant difference between before and before assessments the two groups -(PT) and (PPT), which showed no significant difference ( $t=0.26$ ,  $p < n.s$ ). On comparison of the PT group showed a significant difference between before and after assessments ( $t=2.27$ ,  $p < 0.05$ ) and no significant difference between after and follow-up1 ( $t = 0.14$ ,  $p < n.s$ ) as well as between after and follow-up 2 ( $t=0.13$ ,  $p < n.s$ ). These showed that the PT group had maintenance of improvement even after two months.

The PPT group was compared between before and after assessments and it had a significant difference ( $t =4.96$ ,  $P < 0.01$ ) and no significant difference between after and follow-up1 ( $t = 1.07$ ,  $p < n.s$ ) as well as between after and follow-up2 ( $t =0.50$ ,  $p < n.s$ ). The findings showed that the PPT group also had maintenance of improvement of dysthymic disorder. When PT and PPT groups were compared, they had significant differences between after and after ( $t =2.34$ ,  $p < 0.05$ ), between after and followup1 ( $t=2.21$ ,  $p < 0.05$ ), and between after and follow-up2 ( $t =2.34$ ,  $p < 0.05$ ). The significant differences between these two groups showed that the PPT group is significantly more effective than the PT group. These findings imply that therapist/clinician could use PPT for relieving the symptoms and making changes in the dysthymic patients.

The present study confirms the finding of the previous studies (Conte, & Karasu, 1992; Mason, et al., 1993; Scott, 1998; Scott, 1992; Kocsis, Frances, Voss, & Mason, 1988; Klein, et al., 1996) for the treatment of dysthymic

disorder by Pharmacotherapy. The earlier studies (Kovacs, Rush, Bech, & Akiskal, 1981; Peter, Stark, & Naber, 2000; Simons, Murphy, Levines, & Garfield, 1996; Dobson 1989; Murphy, Simons, Wetzel, & Lustman, 1984) support the present finding that the combined Pharmaco and Psychological Therapy (PPT) is significantly more effective in improving dysthymic disorder and better maintenance at the assessment of follow-ups. The findings reveal that therapist/clinician could use PPT for relieving their symptoms and changing their pattern of coping.

#### **Report of the patients:**

The patients did not have complaints/problems after the training and were able to eat and sleep well. Besides, they involved in pleasurable activities. They did not have the symptoms of dysthymic disorder and there had been no impairment in social and occupational areas of functioning. A few patients had one or two residual symptoms after the intervention.

#### **Limitation:**

The present study did not have control group to compare with the PT and the PPT groups as the patients needed immediate care and treatment due to the suffering from the disorder more than two years. Possibly, psychological therapies could be tried out without giving drugs to dysthymic disorder. Psychologists could use techniques such as environmental modification, interpersonal therapy, coping skills training, and family counseling.

#### **Conclusion**

The symptoms of the dysthymic disorder are arrested significantly by the two therapies, i.e. the Pharmacotherapy (PT) and the combined Pharmaco and psychological therapy (PPT) but the PPT is significantly more effective in treating woman patients. The implication of the findings is that the PPT could be used to change the dysthymic patients in order to relive their symptoms and change their pattern of coping.

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