Original article

Interpersonal psychotherapy in the depression of patients with schizophrenia: proposal of a therapeutic model based on a study of three clinical cases

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INTRODUCTION

Schizophrenia affects about 1% of the population. Approximately 25% of these patients present depressive symptoms during the course of the disease.[1,2] The presence of such symptoms is related to longer hospital stays, negative response to medication, lowering of social performance, chronic progression of disease, higher relapse and suicidal rates.[1]

Treatment of depression in patients with schizophrenia depends on the severity and characteristics of their clinical symptoms. Strategies such as reducing or increasing the dose of antipsychotic medication or even changing medication are recommended. Other resources that can be used in these cases are the introduction of antidepressants, hospital admission and multidisplinary support.[1-3] Psychotherapy, on its turn, should be considered both in the treatment of comorbid and isolated depression.[4]

The interpersonal psychotherapy (IPT) has been employed in the treatment of depression since the mid 1970's.[5-11] It is a focused and time-limited psychotherapy, which has been systematically appraised in randomized controlled clinical trials and in systematic reviews and meta-analysis studies.[12] Over the last years, the IPT has been tested and used as a treatment to other psychiatric disorders, such as bipolar disorder, bulimia, anxiety disorders and in special situations such as: depression in the elderly, adolescents, and puerperal period, or depression secondary to chronic diseases such as AIDS, among other indications.[13-21]

In the present article we intend to develop a model of IPT as an aid in the treatment of schizophrenic patients. We are based on studies concerning IPT in patients with depression associated to chronic diseases such as AIDS,[21] on studies about psychosocial care to individuals with schizophrenia,[22-27] and on the supervision of three cases.

DEPRESSION IN SCHIZOPHRENIA

Depressive symptoms in individuals diagnosed with schizophrenia have been reported in the literature since that beginning of the century, as it was described in the works by Kraepelin.[1]

Initially, symptoms were more frequently reported after the acute psychotic episode and were associated to a better prognosis.[1]

The “depressive phase” that occurs after a psychotic episode was believed to be the adequate moment for psychotherapy interventions.

Several psychodynamic formulations were created to explain post psychotic depression. Bressan[1] highlights the most important ones:

- reaction to psychosis affects the individuals’ self-esteem: it is characterized by grief and loss of symbiotic mechanisms that, though not totally adequate, were comfortable ways of dealing with the others;

- symptomatic reaction to changes in the process of individuation, which makes the individual become more responsible for his or her own life.

- entrance in a depressive position that would allow for a unique opportunity to grow up.

After the 1970’s, the depressive symptoms were shown not to be constrained to the post psychotic period, but rather could take place at any moment in the course of the disease.[3,28,29] Many times, the depressive symptomatology takes place in the acute phase of the disease and improves after remission of the acute psychotic status.[1,28,30]

Epidemiologic studies have found a high frequency of depressive symptoms in patients diagnosed with schizophrenia with a stable clinical state.[1] Others have shown that depressive symptoms are not among the most frequent prodomal symptoms.[1]

The idea that symptoms of depression would be linked to better prognosis has lost its strength, and some studies have even evidenced the opposite, including longer hospital stays,[31] worse response to medication,[32] lowering of social performance,[31] trend to becoming more severe, higher relapse rates,[33,34] and higher suicide rates.[4,33,34]

Suicide is present in 2 to 13% of patients diagnosed with schizophrenia, a 10 to 20 times higher risk than in the general population. The risk is higher in young male patients.[28,35]

The clinical picture of depression in schizophrenic patients is heterogeneous.[3] In order to decide upon which treatment to indicate, the clinician must identify what type of depressive symptom affects the patient.

Bressan[1] divides symptoms into two groups:

1. Depressive symptoms with acute psychotic symptoms:

Depressive symptoms are intrinsic to the psychotic episode and must be managed with antipsychotics.[1]

2. Depressive symptoms without acute psychotic symptoms:

a) Acute dysphoria

Many times, dysphoric states may indicate a psychotic prodome and must be closely followed; families should be given advice in order to reduce eventual psychosocial stressors. Many times the antipsychotic medication dose must be incremented or changed.[1,3]

b) Secondary depression symptoms

Episodes of secondary depression must be managed with antidepressants. In this phase, awareness as to the possible drug interactions between antidepressants and antipsychotics is very important. In such cases, a number of authors indicate psychotherapy as the best approach.[4]

c) Severe demoralization

In severe demoralization, the depressive state is mild, but due to the individual's hopelessness it many times ends up in suicide. These patients have a negative response to antidepressants therapy and respond better to psychosocial interventions, such as psychotherapy.[1]

The differential diagnose must be made with depressive symptoms secondary to organic factors (side effects of medication, substance-related disorders and other organic causes), other

symptoms of schizophrenia (negative and unspecific symptoms) and depressive symptoms in other diagnoses (schizoaffective disorder and other psychotic disorders).[1]

INTERPERSONAL PSYCHOTHERAPY

The use of IPT in the treatment of depression has been reported in several clinical trials, with proven efficacy, especially when associated to pharmacotherapy.[12-21,36,37] It was developed by Klerman, Weissman and cols. at the early 1970's. The authors of the present article used concepts from the interpersonal school by Sullivan and Mayer, from the social psychiatry by Fromm-Reichmann and from the attachment, separation and loss therapy by Bowlby.[5,6] The theoretical presuppose is that difficulties in interpersonal relations of vulnerable individuals may trigger or worsen a depressive episode. The therapy has three phases:

a) Initial phase (one to three sessions):

The therapist obtains the clinical history, focuses on interpersonal relationships and identifies the interpersonal issues related with the patient's depression, the patient is assigned the sick role, and the therapist explains the illness to the patient. The therapy focus may be one or more of four major problematic interpersonal areas:[5,6]

- Grief (Complicated bereavement): real loss of a meaningful person.
- Role transition: difficulties in dealing with life changes.
- Interpersonal role disputes: conflict in an interpersonal relation.
- Interpersonal deficit: difficulty in setting intimate and long-standing relationships with other people.[5,6]

b) Intermediate phase (four to eight sessions)

The focal areas guide the therapist's interventions, which are conducted through specific techniques.[5]

c) Termination phase (one to three sessions)

The therapist helps the patient to acknowledge gains, anticipate depressive symptoms and identify possible problematic interpersonal issues, in case they arise in the future, and gives support to the patient with relation to the sense of termination and independence towards the therapy.

REASONS TO USE IPT IN DEPRESSED PATIENTS WITH SCHIZOPHRENIA

The proven clinical efficacy of IPT in the treatment of depression,[12-21,36] as well as in the treatment of chronic clinical diseases such as AIDS,[21] support the assumption that it can be useful in the treatment of depressed patients with schizophrenia.

Patients with schizophrenia are subject to problems in almost all interpersonal areas.

These patients face difficulties in role transitions such as moving city or country, changing and leaving jobs, having social status lowered and facing changes in familial rules. They frequently do not adapt themselves to such necessary changes, which triggers psychotic or depressive episodes.[23-26]

Role disputes are also frequent. They are influenced by psychotic symptoms, family acceptance and troubled interpersonal relationships they are exposed to, usually characterized by mutual dependence and hostility. Families with elevated rates of expressed emotions can contribute to a worse evolution of the disease.[23-25]

These patients usually have difficulties in handling with bereavement or with the possibility of grief by people or relatives with whom they have a relation of affection or dependence and symbiosis, many times progressing to suicide.[38,39]

In general, they are patients with some level of interpersonal deficit, this means they have difficulties in establishing affective relationships, they are in general socially withdrawn.[1,25,29]

The psychotherapy may create situations that enable the individual to find an adequate way to deal with the others. Such relational alteration is also associated to changes in brain activities.[10,11,40]

ADAPTING THE IPT TO DEPRESSED PATIENTS WITH SCHIZOPHRENIA

The authors of the present article developed an IPT approach to those patients based on a pilot study. Some studies that adapted the IPT to treatment of depression secondary to chronic clinical conditions were taken into consideration, as well as the work proposed by Gabbard, which approaches the therapist position in the psychotherapy with schizophrenic patients[22] (Table 1).

Table 1 - Principles and techniques of psychotherapy in the treatment of schizophrenic patients[23]

1. The main focus must be on the construction of a relationship.
2. The therapist must keep a flexible posture towards the form and content of psychotherapy.
3. For a good course of psychotherapy, therapists and patients must find and keep an optimal posture.
4. The therapist must create a warm environment.
5. The therapist must be the “container” for the patient.
6. The therapist must be an auxiliary self to the patient.
7. The therapist posture must be genuine and open towards the patient.
8. The therapist must postpone interpretation until the therapeutic alliance is consolidated.
9. The therapist must respect the patient’s necessity of being ill.

By observing pilot cases, we found the importance of the inclusion of a fifth area of interpersonal focus in the psychotherapy work: the **perception of the healthy self loss.** This focus is thought to be intertwined to the patient's perception of carrying a chronic disease that can lead to an unfavorable evolution, possible autonomy loss, and need of using medication for indefinite time, besides social, affective and professional limitations, which are related to the chronic demoralization described.

During the therapy, some goals must be reached:

- Help the patient acknowledge the multiple events of life (interpersonal focuses) he or she is subject to and identify the most evident one and that can be related to the current depressive episode. Usually, ssuch patients tend to have more than one focus and, in general, they have also interpersonal deficits. We opted to handle firstly other focuses than the interpersonal deficit, which is difficult to handle, long-lasting and closely related to other factors present in schizophrenia that sometimes mix up with the deficit symptoms.

- Teach the IPT presupposes to the patient; the therapist explains the patient that there may be a connection between depressive mood and interpersonal difficulties. The therapist should define depression as an illness, explaining the patient that he or she suffers from two different conditions, that one can be transient and come in phases, and that therapy focused on a problematic interpersonal area can treat depression, thus fostering a better chronic evolution.

- Extend the psychoeducative approach of the first sessions to both depression and schizophrenia, in order to associate both states.

- Part of the patients have almost exclusive relations with their care givers, which sometimes may be symbiotic. The idea of loosing these people can be emphasized in the IPT sessions, as if they anticipated grief. In this case, the therapist's task is to help the patient to express affections related to this situation and establish new forms of care, be it self-care or accepting and getting closer to other care givers. The therapist also provides support and continence in an eventual

mourning (loss). Something similar may happen with the anticipation of role transition, as when the patient must retire, move home or change physician.

- Interpersonal disputes are frequent and, many times, they can be related to the patient's transgression of social rules. The identification of those rules and feelings related to them, the consequences of transgressive behavior in a tense interpersonal relation and its association with the current depressive state can be clarified. Helping the patient express feelings such as anger and discontentment may contribute to the decrease of interpersonal troubles. When the therapist is managing a focus of dispute within the family, it is necessary to help the patient talk to his or her relative(s). This may be carried out in joint sessions.

- These patients have a lot of difficulties with role transition; in these cases, the therapist must stimulate the patient to express feelings and thoughts in relation to negative aspects of transition, inciting him or her to acknowledge positive possibilities.

- The interpersonal therapist must be prepared to treatment discontinuation due to acuteness of the psychotic state, eventual hospital stays and follow-up difficulties. In such cases, contact by phone or visits at home/hospital authorized in advance by the patient are useful and necessary.

Case report 1: focus on role transition

Male patient, 17 years-old, single, presented the first psychotic episode after a long-lasting period of abusive substance use: marijuana, alcohol, cocaine and crack. He had delusions and hallucinations (he felt as if he was being chased on the streets, heard voices commenting on his attitudes and criticizing him), he had complaints about body abnormalities (he felt his arms were shorter and disproportionate, besides feeling tingles all over his body) and behavioral changes (agitation, restlessness, locking himself at home). The patient remained symptomatic even 4 months after abuse drugs abstinence. He started treatment with risperidone 4 mg/day, 4 weeks later replaced by quietiapine 300 mg/day, due to important extrapyramidal symptomatology. After 3 weeks, the patient had significant clinical improvement, showing organized behavior, delusions and

hallucinations remitted but body abnormalities complaints persisted. After 2 months he started to complain about feeling bored, having increased fatigue, trend to social withdrawal and negative ideation towards future. He was diagnosed with depression (14 points in the Calgary Depression Scale for Schizophrenia),[3] and fluoxetin 40 mg/day was administered. After four weeks he presented mild improvement (CDSS = 11) and IPT was initiated.

Initial phase

After interpersonal investigation, the patient reported he felt alone and that the drug abstinence drove him away from social activities and friends; moreover, he lost status in his neighborhood. He said he had a feeling of belonging nowhere because where he lived, people who were not drug users used to go to Pentecostal churches, and he did not fit this condition. We observe that the need for changing social groups in order to get rid from the psychoactive drugs created a situation of isolation, and such difficulty in building a new social network could be related to the onset of a depressive episode. The patient agreed with the treatment proposed.

Intermediate phase

At first we made an assessment of the old role (popular in the neighborhood due to drug use) and its importance to the patient. In general, patients with role transition difficulties tend to increase the value of the positive aspects of the previous role. The patient believed that in the former group he was welcome, almost considered an idol, which did not occur at home and school, where we usually did not get the attention he wanted. He thought that his friends and the activities associated to those individuals could no be replaced, such as playing soccer, flying kites and painting graffiti on the walls. He tended to minimize eventual negative aspects, such as frequent troubles with the police, difficulties in getting drugs and frequent conflicts within the group. During the therapy process, the patient could realize losses related to the transition and started to present a more realistic view towards the old condition. Later, the patient was aided to express his affects, specially

his fear of being alone, his guilty and disappointment for falling ill and having to deal with the limitations related to the disease.

In the following sessions, we started to assess positive and negative aspects towards the new role and to develop a better social support network. He realized that returning to school, which he had abandoned, and the possibility of getting a job could contribute to his recovery. His uncle offered him the opportunity to work as a street vendor, with whom he worked in the afternoons and on Saturdays. During this process, he discussed ways of getting closer to his parents and could also apologize for countless defying episodes that took place between them. In a joint session, his father could also admit the patient had no space to report his difficulties about their relationship. In the last sessions he was able to make positive plans considering his new role. During one of the sessions he said he had had contact with a friend from his group and he realized that he could keep a friendship relation with him, although it could not be associated to former leisure activities.

Termination phase

During final sessions, we consolidated the relation of the difficulty in the role transition with the onset of depression and talked about the progressive improvement of therapy upon such focus. We observed and highlight the symptomatic improvement (CDSS = 20) and the fact that the social network was being reestablished again. We discussed the possibility of a new depressive episode and how to deal with the first symptoms.

After psychotherapy treatment, fluoxetine was reduced to 20 mg/day and, after 1 month, it was discontinued. After 6 months of follow up, the patient did not present depressive symptoms anymore (CDSS = 0).

Case report 2: focus on grief

Initial phase

Male patient, 39 years-old, single, retired because of his clinical condition, under treatment for paranoid schizophrenia since the age of 19. He took olanzapine 10 mg/day with monthly clinical follow-up, he complained about feeling bored, having low self-esteem, being socially withdrawn, crying frequently and having fragmented sleep. He denied having suicidal ideation. Moderate depressive episode diagnosed. His initial scores were 15 in the CDSS and 26 in the Hamilton scale (HAM-D-17).[41] He presented some improvement after the use of citalopram 20 mg/day for 30 days, however, the depressive symptoms persisted. At that moment, his score in the CDSS scale was nine points and in the HAM-D-17 it was 19 points. The IPT was introduced as an adjuvant in the antidepressant treatment. The patient was informed about this type of psychotherapy, about the diagnostic of depression and the need for an adequate treatment.

During the meetings, the patient could make a relationship between his depressive status with the worse clinical status of his mother, who was under treatment for leukemia for one year and was admitted to an intensive care unit with a real possibility of death. Our focus was the threat of loss.

Intermediate phase

Since he was 19 years-old, with the onset of the disease, he reported to have withdrawn socially. At that time, he abandoned the Engineering course and started to live a very limited routine. He lived with his parents in a wide house, where he performed only a few tasks, such as walking his dog. During this period, he was admitted to hospital twice due to psychotic episodes, characterized by delusions and hallucinations and important psychomotor agitation. He believed that so many hospital stays had contributed to his social isolation, the reason why he got very close to his mother. During this period, his mother was responsible for taking him to doctors,

administering drugs, and cooking among other tasks. Part of the family income came from his mother.

In the intermediate sessions, the patient described his mother and what her role within the family was and what they did together. In the following sessions, we explored what would happen with the loss. He believed he would not be able to take care of himself, and imagined that as he was distant from his father, who did not know much about his treatment, he would be alone and if he was ill he would be confined to a psychiatric hospital forever.

We facilitated the expression of feelings as fear, insecurity and rage because his mother was abandoning him. He acknowledged that part of his insecurity to take care of himself was because of the excessive and anxious care from his mother.

During this period, his mother died and his father started to go to therapy sessions with him, something the patient thought it was impossible. This fact made him realize that his father could help him, and that the father did not take part in the treatment because of the intense relation of the patient with his mother. He was encouraged to talk about his father about this issue. At home, he changed his behavior, undertaking some tasks which were firstly carried out by his mother, such as cleaning the garden and tidying some rooms in the house. The therapy helped him to have interest in other relationships: he got closer to his sister and accepted to take part in family meetings, which he had avoided so far.

Termination phase

At the end of the psychotherapy treatment, M. was almost asymptomatic (CDSS = 3). He was able to value to the approximation with his father and sister, and started to believe he had conditions to take care of himself and that this was partially prevented because his mother offered him intense and continuous care. He started to walk his dog and with the aid of his sister, he walked his neighbors' dogs too, which gave him a little income every month. He was suspicious with the end of the therapy and again was encouraged to express his disappointment. He restarted to go to

monthly clinical sessions. After 6 months taking citalopram 20 mg/day, medication was discontinued due to remission of the depressive status (CDSS = 0), and the antipsychotic medication was maintained.

Case report 3: focus on the perception of the healthy self loss

Initial phase

Female patient, 29 years, oriental origin, single. Under treatment for paranoid schizophrenia for 6 years. She had recurring depressive episodes and during one of them she made a severe suicide attempt, taking different medications. Her clinical status remained stable, she was taking olanzapine 10 mg/day when she started to present daily drowsiness, inappetence and an 11-point score in the CDSS scale. She discontinued the occupational group therapy and language classes, frequently reporting increased fatigue. She did not have suicidal ideation, although she felt quite negative about the future. During the interpersonal evaluations, she reported she had good familial relationships, a good social network and she was not involved in dispute situations. She associated the onset of the depressive status with awareness about the consequences of schizophrenia in her life. She left the university, stop working and there had been a long time since she had a boyfriend. She used medications and complained about weight gain (about 8 kilograms in the last 6 months.) She said she felt unable to undertake any responsibility, due to her diagnostic of schizophrenia. She confirmed she disappointed many of her and her parents' expectations. During sessions, the focus was directed to the perception of losses caused by the disease.

After a short introduction to the psychotherapy, once the patient had regular knowledge on her pathology, we started the focal work.

She asked not to be administered antidepressants, because she was afraid of gaining weight. An agreement was reached that in case she had a non-satisfying response to the psychotherapy treatment she would accept the administration of specific medication.

Intermediate phase

As in the case of role transition, we facilitated the expression of the patient's senses concerning losses caused by the disease. She demonstrated to be angry with herself, because she was not able to reach the goals she wanted to, she was ashamed of her relatives, who had high expectations on her, and she was disappointed with treatment failures and with the need of using medications with unwanted side effects, such as weight gain. We could clarify that she had a high level of demand on herself, and that this could be related to constant frustrations. She realized the disease imposed some limitations on her, but she concluded that in some circumstances they were over valued, as in the case of avoiding making regular physical activity, which she promptly committed herself to change. During this phase, she asked us to invite her parents to therapy to explain that their expectations were too high, and that they did not value her attempts to reach some independence. They prevented her from entering a technical course, because they thought she would not be able to conclude it.

We started to explore other alternatives for failed experiences. She had the idea of working at home, because she knew she would probably not be employed officially. She attended again a quick course of massage and started to offer her services. She resumed the Japanese classes and started to study to pass the entrance examination in a faculty of languages. She did not intend to work, but to refine her knowledge on languages. During the final sessions, she said the same thing, but she was already wondering about offering private classes. She realized herself that she was creating a too high expectation again, considering her possibilities.

Termination phase

She accepted the treatment with drugs and started to make physical exercises regularly. She walked in a park near her home three times a week, two of which she was accompanied by her sister. She acknowledged the gains of having a more realistic perception of damages caused by the disease and recognized that she had already been depressed for the same reason. We opted for

monthly visits with the same focus, aiming at consolidating gains and evaluating the perception about over valued expectations, both from her and from family members. After 12 weeks of weekly sessions, she presented important interpersonal and symptomatic improvement (CDSS = 3).

DISCUSSION

We reported on three cases managed with IPT adapted to depressed patients with schizophrenia diagnosis with therapeutic success measured through the CDSS.

The IPT seems to be useful as a treatment to depression in patients with schizophrenia diagnostic. Such patients are prone to develop problems in different interpersonal areas, which can be related to the triggering or maintenance of a depressive episode. In the present study, we could establish an interpersonal focus. The focal work, according to presupposes of the ITP, made possible to manage the interpersonal problematic situation clinically. The three patients had an important improvement of depressive symptoms. This fact must not be assigned only to the use of antidepressants, provided that in the first and second cases, the patients were administered an adequate dose of antidepressants, during enough time and with partial clinical improvement, and, in the third case, the patient did not use antidepressants. All patients submitted to IPT were stable as to productive symptoms in schizophrenia.

Schizophrenia is a severe and chronic mental disorder that has affective and cognitive repercussion, which lead the individual to have damages in social relationships,[29] partially because of their lack of social communication ability. The manifestation of depressive symptoms is not uncommon in those patients, and the social environment contributes to the onset of this type of symptom.[25]

The interpersonal approach seems to be especially useful in these cases, because besides acting as a triggering or maintenance factor of depressive symptoms – conflicts in interpersonal relations – it is quite practical and easily understood by the schizophrenic patients, who, due to the

limitations the disease imposes on them, face communication problems, both of understanding and expression.[38,39,42]

The psychotherapy approach facilitates the creation of a good therapeutic alliance.[22] The fact that the IPT comprises diagnostic, medication and education also improves treatment compliance.[6] The focused approach and the "here and now" point of view make the action on pathologic behavior easier, through a direct work by the therapist, who does not make interpretations that cannot be understood by patients who are severely affected by the disease.[5]

We believe that the sum of all such features may partially explain the outcomes reported, however, there are many limitations in our study that must be highlighted. It reports only three cases. We managed patients with diagnosis of schizophrenic disorder, however, these patients were not as affected as the mean of patients with the same diagnosis and who were stable as to their schizophrenic status. We are appraising the action on depressive symptoms, not on positive or negative symptoms of schizophrenia. The use of IPT in the acute phase of the disease, especially when the patient presents delusions and hallucinations can be contraindicated, once clearing the expression of affective feelings (IPT technique) can contribute to worse the psychotic symptoms.[42]

The success of the biologic understanding of schizophrenia has led to the decrease of research in the psychotherapy area;[42] however, we know that carriers of chronic diseases have their psychological life affected and have difficulties in dealing with it. The model proposed must be put to proof as to their applicability and efficacy, through randomized and clinical controlled trials.

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ABSTRACT

Interpersonal psychotherapy is a time-limited treatment that was developed to treat depression, however, it has not been fully studied for the treatment of depression in patients with schizophrenia yet. These patients are frequently involved in interpersonal role disputes, grief, role transitions and

interpersonal deficits, associated with depressive episodes. The authors propose the use of interpersonal psychotherapy with adaptations as an aid in the treatment of depression in patients with schizophrenia based on a study of three clinical cases.

Keywords: *Depression, schizophrenia, psychotherapy, interpersonal psychotherapy*

Title: *Interpersonal psychotherapy in the depression of patients with schizophrenia: proposal of a therapeutic model based on a study of three clinical cases*

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