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Schema therapy for patients with chronic depression: A single case series study

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ABSTRACT

Background and objectives: This study tested the effectiveness of schema therapy (ST) for patients with chronic depression.
Methods: Twelve patients with a diagnosis of chronic depression participated. The treatment protocol consisted of 60 sessions, with the first 55 sessions offered weekly and the last five sessions on a biweekly basis. A single case series A–B–C design, with 6 months follow-up was used. Baseline (A) was a wait period of 8 weeks. Baseline was followed by introduction to ST and bonding to therapist (phase B) with individually tailored length of 12–16 sessions, after which further ST was provided (phase C) up to 60 sessions (included the sessions given as introduction). Patients were assessed with Hamilton Rating Scale for Depression three times during baseline, at the end of phase B, then every 12 weeks until the end of treatment and at 6 months follow-up. Secondary outcome measures were the Hamilton Rating Scale for Anxiety and the Young Schema Questionnaire.
Results: At the end of treatment 7 patients (approximately 60%) remitted or satisfactorily responded. The mean HRSD dropped from 21.07 during baseline to 9.40 at post-treatment and 10.75 at follow-up. The effects were large and the gains of treatment were maintained at 6-month follow-up. Only one patient dropped out for reasons not related to treatment.
Limitations: The lack of control group, the small sample and the lack of a multiple baseline case series.
Conclusions: This preliminary study supports the use of ST as an effective treatment for chronic depression.

1. Introduction

Approximately 20% of all depressed individuals develop a chronic course (Arnow & Constantino, 2003; Gilmer et al., 2005). This implies that 2.5–6% of the adult population in the community suffers from chronic depression (Kessler et al., 2005, 1994). Chronic depression is associated with increased functional impairment (Klein, Schwartz, Rose, & Leader, 2000; Klein, Shankman, & Rose, 2006; Wells, Burnam, Rogers, Hays, & Camp, 1992), higher levels of health care utilization, hospitalization and economic costs (Berndt et al., 2000; Gilmer et al., 2005; Howland, 1993; Klein et al., 2000; Smit et al., 2006) compared with non-chronic forms of depression.

Four types of chronic depression are usually distinguished in the literature: 1) dysthymic disorder, 2) chronic major depressive disorder (MDD), 3) double depression (MDD superimposed on a dysthymic disorder) and 4) recurrent major depressive disorder with incomplete remission between the episodes (Torpey & Klein, 2008). There are consistent findings supporting the idea that the various manifestations of chronic depression do not represent distinct disorders (Cuijpers et al., 2010; Klein, Shankman, Lewinsohn, Rohde, & Seeley, 2004; Klein et al., 2006; McCullough et al., 2003, 2000). The DSM-5 (American Psychiatric Association, 2013) diagnosis of persistent depressive disorder (dysthymia)

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includes both the DSM-IV diagnostic categories of chronic major depression and dysthymia.

It is suggested that the determinants of chronic depression do not necessarily differ qualitatively, but only quantitatively from those of acute depression, with involvement of increased levels of these determinants in chronic forms (Riso, Miyatake, & Thase, 2002). Among the several possible determinants of chronic depression that have been investigated so far, the strongest support has been found for the role of developmental antecedents and early adversity (Bifulco, Brown, Lillie, & Jarvis, 1997; Brown, Craig, & Harris, 2008; Brown, Craig, Harris, Handley, & Harvey, 2007; Brown, Harris, Hepworth, & Robinson, 1994; Brown & Moran, 1994; Klein et al., 2009; Lizardi et al., 1995; Riso et al., 2002). Family problems, anxious personality in childhood and low self-esteem and mastery in early adulthood have been associated with chronicity (Angst, Gamma, Rossler, Ajdacic, & Klein, 2011). A recent meta-analysis reported that childhood maltreatment is associated with elevated risk of developing chronic depression and lack of response during treatment (Nanni, Uher, & Danese, 2012).

Several studies have emphasized the close relationship between chronic depression and Axis II personality disorders (Garyfallos et al., 1999; Klein et al., 1995; Maddux et al., 2009; Pepper et al., 1995; Riso et al., 1996, 2002). Among dysthymic patients the rates of personality disorders tend to be high, up to 65% (Klein et al., 1995; Riso et al., 2002). Cluster C personality traits in patients with chronic depression predict poor outcome in a naturalistic study at 5 (Hayden & Klein, 2001) and 10-year follow-up (Klein, Shankman, & Rose, 2008).

According to the cognitive theory of depression negative core beliefs or cognitive schemas represent key vulnerability factors to depression (Beck, 1976; Beck, Rush, Shaw, & Emery, 1979). Young, influenced by cognitive and attachment theory, elaborated the schema concept (Young, 1994; Young, Klosko, & Weishaar, 2003) and proposed that Early Maladaptive Schemas (EMS) are broad, pervasive, trait-like, cognitive and emotional self-defeating patterns, regarding oneself and one's personal relationships (Young et al., 2003). EMS are hypothesized to develop as a result of toxic childhood experiences and unmet core emotional needs, and to underlie the development of psychopathology and chronic psychological disorders (Young et al., 2003). To date 18 EMS have been identified and grouped in five domains: disconnection and rejection; impaired autonomy and performance; other directedness; over-vigilance and inhibition; and impaired limits (Young et al., 2003). EMS remain stable over time (Renner et al., 2013; Wang, Halvorsen, Eisemann, & Waterloo, 2010) and relate to depressive symptoms in depressed patients (Halvorsen et al., 2009; Hawke, Provencher, & Arntz, 2011; Petrocelli, Glaser, Calhoun, & Campbell, 2001). EMS of the domains impaired autonomy & performance and disconnection & rejection relate to depressive symptoms severity (Renner, Lobbestael, Peeters, Arntz, & Huibers, 2012), and EMS of the domains impaired autonomy & performance and over-vigilance & inhibition distinguish patients with chronic depression from patients with non-chronic major depressive disorder (Riso et al., 2003). The emotional deprivation schema mediates the relation between physical abuse and anhedonic depressive symptoms whereas social isolation and self-sacrifice schemas mediate the relation between emotional maltreatment and anhedonic depressive symptoms (Lumley & Harkness, 2000). In conclusion, the evidence so far suggests that EMSs play a role in chronic depression.

A schema model for chronic depression has been described proposing the interplay between distal factors (early adversity, personality pathology), which are mediated by proximal factors (EMS) triggered by life events (loss, failure) and maintained by avoidant coping strategies (Renner, Arntz, Leeuw, & Huibers, 2013).

Pharmacological (Kocsis, 2003; Kocsis et al., 2009) and psychotherapeutic (Keller et al., 2000; Markowitz, 1994) interventions have been developed for the treatment of chronic depression. Cognitive Behavior Analysis System of Psychotherapy (CBASP) (McCullough, 2000) is a model incorporating cognitive behavioral and interpersonal techniques, which was developed for the treatment of chronically depressed patients. Studies have supported its effectiveness (Keller et al., 2000; Schatzberg et al., 2005) suggesting equivalence to pharmacotherapy (Keller et al., 2000; Kocsis, 2009) and superiority to pharmacotherapy for chronically depressed patients with a history of childhood trauma (Klein et al., 2009; Nemeroff et al., 2003). Although the initial effects of the implementation of CBASP were good, when it comes to long-term effects, CBASP does not seem to do better than continued antidepressant medication (Gelenberg et al., 2003; Kocsis et al., 2009; Renner, Arntz et al., 2013).

A meta-analysis examining the effects of psychotherapy on chronic depression reported that the length of the studied psychotherapies may not be sufficient to treat dysthymia (Imel, Malterer, McKay, & Wampold, 2008). Indeed, the efficacy of psychotherapeutic interventions increases with the number of sessions (Cuijpers et al., 2010). Klein et al. (2008) suggests that chronically depressed patients with comorbid personality disorders may require a modified and more intensive course of treatment.

The above-mentioned literature suggests the crucial causal role of early adversity, EMS and comorbid personality disorders in the development of chronic depression. Moreover the effectiveness of the existed treatment interventions remains limited. A qualitatively different psychotherapeutic intervention lengthier and more intensive, which focuses on underlying psychological factors like childhood adversity and schemas might lead to improvement of treatment of chronic depression.

Schema therapy (ST) has been developed as the clinical implication of Young (1994) schema theory. It is an integrative therapy, which combines elements of cognitive behavior therapy, attachment theory, object relations theory and emotional-focused models and was developed for the treatment of patients with chronic emotional difficulties (Young et al., 2003). ST is an effective treatment for patients with borderline personality disorder (BPD) (Farrell, Shaw, & Webber, 2009; Giesen-Bloo et al., 2006; Nadort et al., 2009; Nordahl & Nysaeter, 2005) and for patients with cluster C personality disorders, including comorbid depression (Bamelis, Evers, Spinhoven, & Artntz, 2013). Recently a randomized clinical trial compared ST and CBT for patients with a current major depressive episode, in a protocol of weekly sessions for six months and monthly sessions for another six months (Carter et al., 2013). No difference was found between the two therapies. Brewin et al. (2009) tested the use of imagery rescripting (a core technique of ST) as a stand-alone treatment for chronically depressed patients with intrusive memories and found large treatment effects, maintained at one-year follow-up. Renner, Arntz et al. (2013) currently conduct a single case series study of ST for chronic depression testing the model described above.

To the best of the authors' knowledge so far no study has been published on the application of schema therapy in *chronic* depression. The aim of this study is to examine the effectiveness of schema therapy in a sample of chronically depressed patients.

2. Methods

2.1. Participants

Inclusion criteria were a primary diagnosis of DSM-IV chronic depression, age 18–65 years and a score of 15 or higher on the 24-item Hamilton Rating Scale for Depression ($HRSD_{24}$)