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The information in this column is not intended as a definitive treatment strategy but as a suggested approach for clinicians treating patients with similar histories. Individual cases may vary and should be evaluated carefully before treatment is provided. The patient described in this column is a composite with characteristics of several real patients.

Therapeutic abstention in the treatment of depression in first-episode psychosis

Priyadharshini Sabesan, MD, MRCPsych; Lena Palaniyappan, MD, PhD

A 26-year-old woman was referred to the emergency department for new-onset paranoia and auditory hallucinations.

Over the previous 2 months, she claimed that someone was replacing her furniture each night with replicas that changed in size. She also reported voices discussing how to change her clothes and asking her to urinate on her bed. She was waking up at 3 am, feeling sad and anxious. She also stopped going to work and using her bedroom.

On examination, she reported low mood, feelings of hopelessness, and guilt about not being able to work and being a burden for her husband. She appeared sad, avoided eye contact, and gave hesitant responses. She had limited insight regarding her delusions about the furniture. She admitted to thoughts of ending her life in response to the voices as well as the distress of losing work and having to stay at home where intruders were operating. No notable life events preceded the onset of psychosis, and her partner noted no change in her mood before this episode.

The patient was antipsychotic naive. Her father had a diagnosis of schizophrenia, with treatment details unknown. She had consulted her family doctor the previous year for low mood without psychotic symptoms, suicidal ideas, excess fatigue and crying spells that had lasted for 3 months. At the time, she reduced her working hours and received online counselling but refused antidepressants.

We administered the 6-item Positive and Negative Syndrome Scale (PANSS-6), on which she scored 23 out of 42 (the summed score of items P1–3 being 13), and the Calgary Depression Scale for Schizophrenia (CDSS), on which she scored 19 out of 27. She was started on aripiprazole 5 mg following admission. The dose was titrated to 10 mg after a week. She developed notable akathisia that resolved 2 days after the dose increases, with the use of clonazepam 1 mg on an as-required basis.

She expressed concerns about hospital workers intruding in her room and continued to experience auditory hallucinations instructing her and pre-empting her actions in the first 2 weeks of admission. These symptoms reduced in frequency and intensity over the subsequent 2 weeks. By week 4, she was keen to return home but continued to exhibit early morning awakening and feelings of guilt and episodic hopelessness. By week 5, she was no longer suicidal and scored 11 out of 42 on the PANSS-6, and 12 out of 27 on the CDSS. She was started on sertraline and discharged for outpatient follow-up. The dose was titrated to 100 mg by week 8, and by week 10, her CDSS score dropped to 6, and the PANSS-6 score dropped to 9.

Depressive symptoms are extremely common in first-episode psychosis (FEP), with 25%–50% of patients satisfying criteria for a major depressive episode (MDE), of whom nearly 50% show persistent depression at 1 year.[1,2] Symptomatic relief from depression is a top priority for many patients.[3] Evidence based on randomized controlled trials for addressing depression in FEP is sparse.[4] Various national guidelines recommend active screening for depression in early psychosis but abstaining from intervention until positive symptoms resolve.[4] Nevertheless, it is not clear how long intervention should be delayed when depression is prominent in FEP or how to respond if either psychosis or depression does not abate with first-line antipsychotics.

Therapeutic abstention is controversial and is based on limited case series data of non-FEP samples.[4] In patients with FEP, 59% report persisting depression despite psychotic symptom resolution by the time of discharge.[5] Only 15.2% of the variance in reduction of depression relates to the improvement in psychosis.[6] The use of antidepressants appears to be well-tolerated and beneficial for pronounced depression in stable schizophrenia.[7] Robust effects are noted with agents such as sertraline, and in samples with treatment resistance, although evidence in FEP is sparse[7] and the choice of selective serotonin reuptake inhibitors is not always supported.[8] More recently Goff and colleagues[9] reported the lack of efficacy of citalopram for subthreshold depression (CDSS score < 7) in FEP over 1 year.

Therapeutic abstention is not advisable in the presence of mood-congruent psychosis.[10] Earlier antidepressant use may also be required in patients with a documented history of MDE, as in our patient's case. While early onset of action (by 2–4 weeks) for antipsychotics is well-established,[11] in FEP cumulative improvement continues beyond a window of 4–24 weeks.[12–15] An early evaluation of the relationship between CDSS and PANSS-6 scores may help in timely clinical decision making. With a more than 50% drop in PANSS-6 score, but a CDSS score still being clinically significant (> 7), antidepressant therapy was used in our patient's case. Current guidelines recommend 6 months of use if antidepressants are needed in patients with schizophrenia.[4] If both PANSS-6 and CDSS scores show no notable changes by weeks 4–6, a different second-generation antipsychotic can be considered. With depression being the most important risk factor for suicidality in FEP,[16] earlier consideration of clozapine, an agent with antisuicidal effects, may be warranted in the presence of depression.

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