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CASE REPORT

Interpersonal psychotherapy for comorbid prolonged grief disorder and persistent depressive disorder in a Japanese patient: A case report

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Abstract

Background: Prolonged grief disorder (PGD) is a new diagnostic entity. However, treatment for PGD is not yet available. Interpersonal psychotherapy (IPT) may be effective for PGD.

Case Presentation: A single 27-year-old Japanese woman lost her brother to suicide. However, she did not express her grief to anyone or visit a psychiatric clinic. After experiencing strong depressive symptoms triggered by work stress, she visited a psychiatric clinic, where she was diagnosed with depression as well as PGD. Through pharmacotherapy, her depressive symptoms improved, but no improvement was noted in her PGD symptoms. She therefore began IPT for PGD at our hospital, 5 years after her brother's suicide and after 4 years of PGD symptoms. In the introductory phase of IPT, she was diagnosed with comorbid persistent depressive disorder (PDD). After this diagnosis, through psychoeducation on PDD, she could identify the symptoms that reflected her personality traits as "PDD symptoms." Furthermore, she could affirm her positive and negative feelings and share them with others. Consequently, the grieving process was facilitated, and her interests and relationships were re-established. Her PGD and PDD symptoms improved.

Conclusion: IPT may be effective for PGD comorbid with PDD among Japanese.

KEYWORDS
interpersonal psychotherapy, persistent depressive disorder, prolonged grief disorder

BACKGROUND

Prolonged grief disorder (PGD) was considered a diagnostic entity in the *Eleventh Revision of the International Classification of Diseases* (ICD-11) and the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, Text Revision (DSM-5-TR).[1] As pharmacotherapy is ineffective, it has been recommended that complicated grief, which is superseded by PGD, can be managed with nonpharmacological interventions.[2] Interpersonal psychotherapy (IPT) is a method that focuses on interpersonal relationships. It may be effective for PGD

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because it was effective for complicated grief.[3,4] Meanwhile, persistent depressive disorder (PDD) is a chronic mood disorder that is common.[5] It is frequently missed because clinicians are more likely to focus on more acute conditions.[6] Patients with PDD commonly consider dysphoria as part of their personality.[5] Various psychotherapies for PDD, including IPT, have been proposed.[7,8] However, their efficacy has not been fully elucidated.[9] Herein, we present a patient with PGD who was diagnosed with PDD during IPT sessions for PGD, thereby resulting in improvement in PGD and PDD symptoms.

CASE PRESENTATION

A single 27-year-old Japanese woman lost her older brother to suicide by train when she was 22 years old. Her deceased brother was a cheerful mood-maker. She relied emotionally on her brother. Her surviving family members were her parents and her younger sister.

At the time of her brother's suicide she lived with him, but she was out and she only learned of her brother's death through a phone call from family members. She had not expected him to commit suicide. He left a suicide note addressed to their family thanking them. Following her brother's suicide, she grieved for a long time. She continually blamed herself for not being able to prevent his suicide, despite having no reason to do that. She attended the funeral with family members. However, she did not have the opportunity to mourn. Her family hid her brother's suicide from those around them. The patient believed that expressing her grief would be a psychological burden on her family members, who were also grieving her brother's death privately. Therefore, she did not tell anyone and she mourned privately.

At 25 years old, she had been working as an engineer after one career change. She did not talk to people at work even when she had trouble with her job because she did not want to bother the people in her busy workplace with her talk. However, her coworkers told her that "You are difficult to talk to." She continually experienced challenges in socialization at work. At 26 years old, her depressive symptoms gradually emerged, hence she visited a mental health clinic. She was then diagnosed with depression and PGD based on the ICD-11. At that time, DSM-5-TR had not yet emerged. Immediately, she took a leave of absence. The initial pharmacotherapy (sertraline, 50 mg) was discontinued because it was not effective. The second antidepressant (duloxetine, 40 mg) was discontinued due to excessive sweating. In the final treatment with antidepressants, vortioxetine (10 mg) was used in combination with aripiprazole (2 mg) and the patient's depressive symptoms improved. However, her PGD symptoms did not improve.

At 27 years old, the patient visited our hospital for IPT for PGD. She had no family history of mental health clinic visits. She claimed that she was distressed due to the pain she felt because of her brother's death. According to a careful examination, the patient did not meet the depression criteria. However, she met the ICD-11 and DSM-5-TR criteria for PGD. She had had intense yearning for her deceased brother and had difficulty accepting her brother's death. She felt intense sadness and guilt over her brother's death and believed that her life was meaningless. Furthermore, she had a strong sense of loneliness.

At 1 month after the initial visit, she received 16 IPT sessions, each lasting 60 min. The sessions were conducted approximately once per week over 4 months. The treatment was delivered by the second author (Y. T.), who is a certified trainer/supervisor. The therapist conducted IPT for PGD, focusing on grief, based on a published treatment manual,[10] which included the introductory, middle, and termination phases. During the first strategy, to facilitate the grieving process, the therapist encouraged the patient to express how she felt before and after her brother's death. During the second strategy, to enhance social support and counter the patient's depression-associated social withdrawal, the therapist explored the possibility of re-establishing interests and relationships. These strategies of IPT were culturally adapted.[11]

Notably, in the introductory phase, a detailed history taking and a detailed interpersonal inventory revealed that the patient had PDD with no comorbid depressive episodes until she met the criteria for a depressive episode at 26 years old. She had often felt depressed since her early teens and had low self-esteem. Moreover, she experienced a sense of hopelessness. That is, she felt that nothing she did was going well, and she had an excessive sense of self-doubt and was sorry for what she couldn't do well which she felt. She never disclosed her feelings because she had low self-esteem and lacked confidence in expressing her feelings, particularly negative ones. Furthermore, she believed that her negative feelings were attributed to her own feelings of inadequacy. She thought that the symptoms were part of her negative personality, and she had never visited a psychiatric clinic. In the middle phase, the understanding of PDD via psychoeducation in the patient and her family gradually helped the patient to believe that all her feelings were valid. In the treatment setting, the patient could fully express the negative feelings that had been difficult for her to express, such as guilt and sadness regarding her brother. In addition, she still had difficulty expressing her negative feelings about her deceased brother to her family. Nevertheless, she had more emotional interactions with them and occasionally talked about the memories of her deceased brother. It was difficult for the patient to talk to people around her with a sense of security because she was afraid that she might bother them by talking them. However, after psychological education for PDD and communication practice, the patient gradually began to feel more secure in her interactions with others, and her emotional interactions with her family and friends increased. In the termination phase, she admitted to feeling less guilty. She stated that she was glad to talk about her deceased brother with her close friend as she had never done this before.

She completed the Patient Health Questionnaire 9 (PHQ-9)[12,13] and Inventory of Complicated Grief (ICG)[14,15] to evaluate depressive and grief symptoms severity, respectively.

After IPT completion, 30-min maintenance IPT was performed once a month for 3 months, during which pharmacotherapy was discontinued. The patient started working far away from the mental

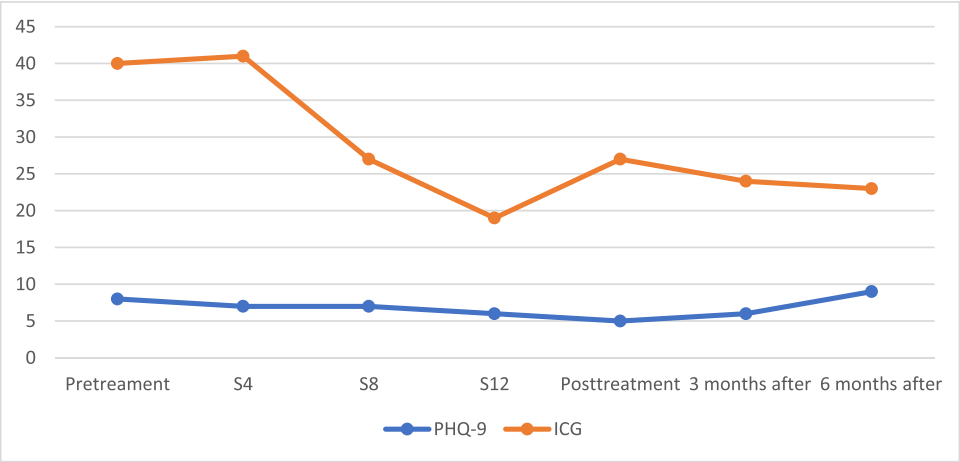

FIGURE 1 Patient Health Questionnaire 9 (PHQ-9) and Inventory of Complicated Grief (ICG) scores of the patient.

clinic and our hospital at 4 months after the end of IPT. Her visits were discontinued based on her request. The ICG score decreased significantly from 40 before IPT to 27 immediately after IPT and to 23 at 6 months after the end of IPT and at 3 months after the end of her psychiatric visits. By contrast, the PHQ-9 score was maintained at <10 (Figure 1).

DISCUSSION

In this case study, a Japanese patient who exhibited PGD comorbid with PDD and who did not respond to pharmacotherapy received IPT.[10,11] The patient's grief severity continuously decreased from before IPT to 6 months after IPT completion, with her ICG score decreasing to clinically insignificant grief severity degree (from 40 to 23 ≤ 26).[14] The patient had PDD symptoms, which eventually improved. Symptom improvement was continually observed for 6 months.

In the introductory phase of IPT, a detailed history taking and interpersonal inventory revealed comorbid PDD. This was extremely beneficial in IPT for PGD comorbid with PDD. On repeated psychoeducation on PDD, the patient was able to identify the PDD symptoms that she assumed as personality traits as “symptoms”, therefore she moved from considering her feelings (particularly negative ones) as “not good” to affirming all of them, including positive ones. Subsequently, she felt comfortable sharing her feelings with the therapist, family members, and others. This was beneficial not only in improving her PDD symptoms but also in facilitating the grieving process and re-establishing her interests and relationships, which were the strategies used in IPT for grief. First, in the process of facilitating the grieving process, when the therapist encouraged the patient to express how she had felt before and after her brother's death with therapeutic emotional exploration, the patient gradually expressed that she longed for her deceased brother and that she had strong feelings of sadness, guilt, and loneliness over his death. Second, in the process of re-establishing interests and relationships, which can strengthen social support and counter depressive social withdrawal, when the therapist encouraged the patient to provide psychoeducation on PDD to the family members by herself, she was able to talk to her family about PDD symptoms that she considered as a negative personality and struggled with. By letting her family fully understand the symptoms, the patient felt more secure with her family relationship. Thereafter, the patient could talk to her family about the memories of her deceased brother and go out to restaurants with a family member to eat his favorite dishes, with holding various feelings such as sadness and nostalgia about her deceased brother.

Due to the nature of case reports, the generalizability of the results was limited, and methodological rigor and objectivity might have existed. In addition, the ICG, which is used as a self-report instrument for clinically impairing grief symptom severity, does not reflect the ICD-11 or DSM-5-TR criteria for PGD. However, neither the Prolonged Grief Disorder-13-Revised[16] nor the Traumatic Grief Inventory-Clinician Administered,[17] which can evaluate the DSM-5-TR or ICD-11 criteria for PGD, has a reliable and valid Japanese version.

CONCLUSION

IPT may be an effective treatment for PGD comorbid with PDD in Japan.

AUTHOR CONTRIBUTIONS

Takuya Okami and Yuko Toshishige drafted the manuscript. Yuko Toshishige treated the patient. Masaki Kondo, Junya Okazaki, Hiroko Mizushima, and Tatsuo Akechi critically reviewed and revised the draft. All authors approved the final version of the manuscript.

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None.

CONFLICT OF INTEREST STATEMENT

Tatsuo Akechi is the Vice Editor-in-Chief of *Psychiatry and Clinical Neurosciences Reports* and a co-author of this article. He was excluded from editorial decision-making related to the acceptance and publication of this article. The other authors declare no conflict of interest.

DATE AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no datasets were generated or analyzed during this study.

ETHICS APPROVAL STATEMENT

This case report was conducted in adherence with ethical guidelines for case reports of the *Japanese Society of Psychiatry and Neurology*.

PATIENT CONSENT STATEMENT

A written informed consent to submit this case report for review and publication was obtained from the patient.

CLINICAL TRIAL REGISTRATION

N/A.

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