

Case Study 2

Major Depressive Disorder With Comorbid Depressive Personality Disorder

Presenting Problem and Client Description

Ms. S. called my office late one night crying uncontrollably. Through her sobbing and in a soft voice she explained she was under a lot of pressure at work, she was having difficulty concentrating, unable to sleep, and frequently found herself in tears. As a result, she was having difficulty completing her work, which further contributed to her distress as she had a lot of responsibility as an executive vice president at a major corporation. She explained that she was currently in treatment—a treatment that I would learn later was ongoing for 2 years but that she was becoming increasingly dissatisfied with. As I listened to the voicemail, I thought she sounded desperate and I worried about her safety. She certainly sounded depressed and even in a brief phone message appeared to meet a number of criteria for major depressive disorder (MDD) (e.g., reports of difficulty concentrating, difficulty sleeping, clearly sad with low mood). I returned her call the next morning. She sounded somewhat relieved but nonetheless depressed. Her voice was low and she spoke slowly. She assured me that although she had felt at her wit's end, she was not suicidal. After a brief conversation, I agreed to see her for a consultation as a second opinion in order to give her recommendations about whether or not I thought her concerns merited a change in therapists.

During our initial meeting, I found out that Ms. S. was a 45-year-old woman of Arab descent with a master's in business administration from an Ivy League business school. She was the oldest of four children and had two brothers and a sister. Her father was a successful physician and her mother ran the household and was an amateur musician of local note. She described her family as religious Christians and strict, and that growing up she regularly went to church, although as an adult she identified as an atheist. She described being a very well-behaved and dutiful child. Her father and mother both had standing in their church, and her mother was particularly active within it.

Ms. S. was substantially older than her sister, who was her youngest sibling. Ms. S. described her father as a kind and unassuming man but who allowed her mother to emotionally and physically abuse her. Although she described her father with much affection, she felt he had a blind spot when it came to her mother. The patient described a long history and many credible-sounding incidents of emotional and physical abuse as well as controlling behavior that intensified when the patient entered high school. The physical violence, which occurred throughout her childhood, began to happen more frequently, and her mother would scream at her, accusing her of having impure motives, questioning her commitments to the religion, the family in general, and to her. During these fights, her mother frequently called her names such as *slut* and accused her of desiring and engaging in sex. Additionally, the patient described her mother as attacking her during these incidents, which included slapping her, hitting her with open hands, punching her with a closed fist, throwing objects at her, throwing her into walls, knocking her down, and kicking her. The patient was tearful during these descriptions, sometimes angry, and other times appeared perplexed by her mother's behavior. Ms. S. reported that the mother showed little remorse during or after these incidents but instead described that the mother blamed her for having become so upset and hitting her.

Ironically, the patient reported that she was not very interested in sex at that time but instead was interested in her schoolwork and friendships. She further noted that she had not engaged in any sexual behavior during her high school years and reported that her first sexual experience occurred rather late in her college career.

Now grown, all her siblings were highly successful. Although she described initially being close to her siblings, particularly her closest-in-age brother, she described having been estranged from her family after she went off to college. Rather than going to a small local religious college as her mother wanted, she chose to go to a large university with a strong reputation. This caused a lot of conflict with her mother and, according to the patient, led to her being "disowned" and turned the family against her. During her time as an undergraduate, she did not have many conversations with her father, siblings, or even extended family as she felt her mother spoke badly about her and limited others' contact with her by actively forbidding it. During this time, she felt very much alone and like a family pariah. When she did talk with her mother, it inevitably resulted in an argument. She described feeling hurt that her father abandoned her, but at other times spoke sympathetically about the dilemma he was in vis-à-vis her mother. As she described this time in her life, she became angry with herself, questioning the kind of person she was and blaming herself for abandoning her family and her lack of loyalty. She was not able to show herself the same kind of sympathy she exhibited toward her father.

Upon graduating from college, she took a job at a major corporation and quickly worked her way up through her intelligence, hard work (e.g., long hours), and creativity in solving problems. A number of times, she developed very innovative solutions to problems facing the company. The company sent her to complete her MBA and promoted her. She continued to shine in her work and was responsible for important developments that resulted in the company making significant profits.

She dated a number of men off and on through college and during her early work years. By her description, these men seemed kind and the relationships appeared healthy, but for various reasons, the relationships ended. She typically remained friends with these men. In her late 30s, she met a man who also worked at the same company but in a different division and responsible for very different concerns. He was very much a larger-than-life kind of person. He came from an extremely wealthy and connected family. Had attended the best schools and was highly successful within the company. Together, they were a power couple, a status she very much enjoyed. Both Ms. S. and her relationship partner were not only leaders in the company in their respective areas but within the corporate world. After a number of years dating, they were married. It was a big storybook type of wedding for her husband and his family's sake. She indicated she would have preferred to elope or not even get married but simply live together as they had been.

Despite the storybook description, by the time Ms. S. came to therapy there were significant problems in the relationship. Although he was brilliant, handsome, dashing, and highly successful, he had a prominent dark side. He was very needy with her and controlling of her. Although there was little reason to be jealous, he was very vigilant about her whereabouts and with whom she was interacting. He also needed her to dote over him, which she did, but in those moments where she was not attending to him or had to take care of her own concerns, he could become irate and angry with her. Although over the years he had never been physically abusive toward her, he had frequently lost his temper with her and, similar to her mother, called her all sorts of names, including derogatory sexual ones. A number of times, he threatened physical violence toward her or his suicide. One time during her treatment with me, he had even made a vague but serious threat of homicide against her.

Prior to beginning therapy with me, she had broken up and separated from her husband a number of times. These breakups/separations tended to be short, and neither of them would share with others that they were broken up or separated. One separation, however, was a bit longer than the others were, and during this breakup, she began dating another man. She broke up with this other man when she got back together with her husband, but she kept this relationship from him for many years, fearing that it would hurt him deeply and make him infuriated. Over time, she was becoming increasingly aware of and comfortable with leaving her husband; however, he was easily able to guilt her into staying with him. This was easy to do in part because she had a very strong sense of loyalty and desire to "save" him. Additionally, she felt extremely guilty when she felt that she was not being loyal, committed, or perceived herself as abandoning him. However, he was also able to coerce her into staying with him because of her low self-esteem. Despite her obvious intelligence and successes, she felt undeserving of better. Finally, he was also able to manipulate her into staying in this relationship because the dynamics were familiar to her, as they were very similar to the dynamics of her relationship with her mother. Later in therapy, we would discuss how she was so committed to this relationship because in part it represented an opportunity to fix or correct the relationship with her mother.

Diagnosis and Case Formulation

Based on her description and presentation (beginning with the voicemail she left for me), the diagnosis of MDD was a clear consideration. Other considerations would include what at the time was called *dysthymic disorder* and now called *persistent depressive disorder*. In order to meet criteria for MDD, a person must meet five or more of the nine symptoms shown in Box xx-xx. At least one of those five must be either a depressed mood, most days, most of the day for at least a 2-week period, or loss of interest or pleasure in all or nearly all activities, again for most of the day for at least a 2-week period. One then needs to meet either three or four additional criteria depending on whether or not a person meets both the depressed mood and loss of interests/pleasure criteria or not. Other criteria include what are referred to as neurovegetative signs, which include significant loss of appetite (with corresponding weight loss), insomnia, psychomotor slowing, and fatigue. Conversely, these neurovegetative signs can show themselves through increased appetite, hypersomnia, and psychomotor agitation. (This display is often part of an atypical depressive presentation that also includes interpersonal hypersensitivity.) The remaining criteria for MDD can be characterized as feelings of worthlessness, inappropriate guilt, and recurrent thoughts of death and suicide, and the cognitive symptom of difficulty concentrating or indecisiveness. As with depressed mood, these symptoms need to be nearly every day. Additionally, these symptoms must represent a change from previous functioning. In this way, MDD is conceptualized as an episodic disorder. The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5) also includes a number of specifiers for the severity of the episode, whether or not the episode is characterized by psychotic features or and if the remission or not.

The patient met criteria for depressed mood by her report and my observation. Additionally, she reported that she had bouts of insomnia characterized by anxious worrying and rumination about unfinished tasks, tasks that awaited her, and rumination about decisions she made and her self-worth. However, she also described being able to work very hard at the tasks at hand, and although she would evaluate fruits of her labor quite negatively, much to her surprise her supervisors and coworkers saw her production as exemplary. Nonetheless, she complained of fatigue and loss of energy. She would spend days in bed feeling that she was a failure and a fraud who would soon be found out. The distress about failure would continue until she described it as unbearable, and then she would jump into action and work nonstop until she had completed what needed to be done. This was not a typical pattern for her as she typically had a large work capacity, but from time to time when she described being depressed, she would fall into this pattern. Her descriptions of "being depressed" tended to occur subsequent to her relationship difficulties, and although these feelings involved lowered self-worth, they were rarely precipitated by negative evaluations or failures but instead by relationship difficulties. Although not actively suicidal, during this time she occasionally thought her family and the world in general would be a better place without her. At other times, the thought of not being alive provided a

respite from all the stress and tension she felt. There were no other neurovegetative signs, her appetite was good, she showed no psychomotor slowing and very little agitation, and she described her libido (sex drive) as normal—desiring and interested in sex with her partner a few times a week. She described both feelings of worthlessness and excessive and inappropriate guilt. Although these feelings were also characteristic of her typically, during this time they seemed worse than usual. Thus, the diagnosis of MDD was deemed appropriate. However, despite describing feelings of depression that have occurred throughout her life, from the time she was young, she did not meet criteria for persistent depressive disorder because she reported never having had a period of feeling depressed that lasted 2 years without a period of being depression free that lasted more than 2 months at a time. Nonetheless, she reported a personality style that was consistent with the *DSM-4* description of depressive personality disorder, a disorder included in *DSM-4* for further study but not included in *DSM-5*. The concept of depressive personality or characterological depression has a long history in psychiatry; however, a number of authors have suggested that it could be subsumed under persistent personality disorder. Although the concept of a depressive personality disorder sounds similar to that of persistent depressive disorder, and the two disorders show some comorbidity (about 30%), the two disorders are conceptually different. Persistent depressive disorder focuses on somatic symptoms consistent with MDD but milder and more chronic. Depressive personality disorder focuses less on somatic symptoms and more on personality and cognitive/affective aspects. Ms. S. met five of the seven criteria, which was sufficient for the diagnosis. Criteria met included (1) having a self-concept that centered around beliefs of inadequacy, worthlessness, and low self-esteem; (2) being critical, blaming, and derogatory toward the self; (3) brooding and given to worry; (4) being critical and judgmental toward others; and (5) being prone to feeling guilty and remorseful. It was unclear whether or not her feelings of pessimism were sufficiently chronic to meet criteria nor could it be said that her usual mood was dominated by gloominess, cheerlessness, joylessness, or unhappiness to the extent required to meet that criteria. She was certainly prone or susceptible to such feelings and was easily dejected, which is part of that criterion. Regardless, she met enough criteria to meet diagnosis for the disorder.

Another consideration was the diagnosis of borderline personality disorder (BPD). I considered this diagnosis for a number of reasons. First, it is important to evaluate a patient for a comorbid diagnosis of BPD whenever the criteria is met for MDD. This is because the two disorders are frequently comorbid and such comorbidity is meaningful in that when that is the case, the presence of BPD negatively effects the course and outcome of MDD. Second, when the patient initially called and complained about her current therapist, I considered that her negative evaluation of the therapist might be consistent with the kind of devaluation that those with BPD are prone toward. However, during the evaluation it became apparent that the patient did not meet criteria for BPD, which are described in detail in Chapter xx.

The patient asked about medication and indicated a strong desire for something that would make her feel better quickly. Despite being highly educated, Ms. S., like

many others, was unclear about who could and could not prescribe medication. She was surprised when I told her that as a psychologist, I was not able to prescribe medication. We discussed medication as an option for her. I shared with her my understanding of the empirical literature with regard to medication for depression and my belief that psychotherapy would be a good option for her given her pattern of symptoms. However, I also encouraged her to seek a consultation with a psychiatrist or other psychopharmacologist prescriber (e.g., nurse practitioner). I told her that I had colleagues I could recommend to her or that she was free to find a prescriber on her own. She decided to see someone who I recommended but who was also on her independent list of treaters. With the psychiatrists, as with me, she expressed a strong desire for a medication that might offer immediate relief from her distress. The pharmacologist explained that the medication may provide her some relief; however, it too would take time to reach therapeutic levels before beginning to work. She additionally explained that the relief would most likely be partial in that many of her concerns would not be amenable to medications but instead would need to be worked out in therapy. Nonetheless, it was explained that on the positive side, medication may help reduce her distress in a manner that would allow her to be more psychologically available for psychotherapy and in addition might provide her with more energy. On the negative side, it was noted that the medication had some minor side effects such as temporary dry mouth and blurred vision, and more long-lasting side effects such as decreased sexual desire, weight gain, and constipation. Additionally, a serious side effect of antidepressant medication can be manic-like symptoms and agitation associated with the increased energy. Ms. S. expressed concerns about these side effects in the context of preexisting concerns about her bowels, already feeling energized and agitated at times, and concerns about possible weight gain and diminished sexual functioning. The psychopharmacologist suggested that she continue without medication for now, that she and I closely monitor her for worsening symptoms, and that she be reevaluated for medication in one or two months. Additionally, she expressed a concern about what it meant to her self-concept to be someone who needed medication.

Course of Treatment

The patient began treatment in a very distressed state of mind, frequently asking for reassurance but continuing to talk in a way that precluded the therapist from having the opportunity to do so. Early on I brought this up with the patient. In the discussion, I raised the possibility that maybe she was afraid to give me a chance to reassure because she was concerned that my reassurances would not be enough or might run hollow. I offered that maybe there was a part of her that even wondered if I would offer reassurance. Maybe she feared I did not believe that things would get better for her and talking the way she did prevented her from these difficult possibilities. She reflected on what I had just said and indicated that it resonated with her. My comment seemed to help in the moment, for she settled a bit and allowed me to engage productively in a conversation with her. As we discussed her feelings and concerns more directly, she described

how she was afraid that I would tell her that she was hopeless and doomed to fail. She was also afraid that I would tell her that she had to leave her husband and that I would not understand her loyalty to him. Hearing about her husband's behavior during the assessment phase and during the course of the therapy did evoke feelings in me that she should leave him. Sigmund Freud referred to the feelings evoked in the therapist during the treatment as countertransference feelings or as countertransference. As she described how the husband responded and treated her, I too, like her previous therapist, wanted to say something and encourage her to consider leaving him. It was difficult and I restrained myself because, although I wanted to be authentic and true to my feelings state, I also wanted to create an atmosphere that was open and that encouraged her to bring up her thoughts and feelings for us to explore rather than convey my values and make judgments about her perceptions and behaviors. I was afraid that if I responded by encouraging her to leave the husband that she would experience me as judging her and controlling her like the last therapist and her husband. Instead, what I did was lay in wait for those moments that she brought up her own concerns about him. I carefully crafted my comments as to acknowledge both sides of her conflict: the part of her that was committed to him, devoted, and loyal, and who admired him and loved him, as well as that part of her that felt judged, controlled, belittled, and emotionally abused by him. I tried to gently bring both sides of her experience into her awareness for us, as a team, to grapple with. It was difficult because she would vacillate back and forth between feeling committed to him and feeling fed up with him. It was like watching a tennis match with the ball going back and forth, back and forth. It was as if articulating one position for her forced her to rebound into the other position. Therefore, if she spoke negatively about her husband, she would eventually need to reaffirm her admiration and commitment to him. When she spoke negatively about him, she would often attack herself for doing so and question what kind of person was she who would say such things. In those moments, I felt she needed reassurance, but I was afraid that my reassurances would not be experienced as intended. When I tried to reassure her, instead of feeling reassured, she responded as if I was naïve or unable to see how truly bad she was. I not only failed to reassure her but I invalidated her experience and made myself look inept. Instead, I joined her in her commendation, but only in the mildest way and only briefly, before I questioned us both by asking her if she, or anyone, could be a good, well-meaning person and still have doubts or questions. She acknowledged that one could be a good person and well-intentioned and legitimately have doubts. Moreover, confronting one's doubts is inherently honest and genuine. When she acknowledged that, I asked her what got in the way of showing herself the same attitude she allowed others. As the therapy progressed, she would bring up her concerns about her husband more frequently and be able to stay with them for longer periods before swinging back into a defense of him. Additionally, she was much more tolerant of her ambivalence toward him. This allowed us to discuss his attitude and behavior toward her more directly and resulted in her becoming more aware of his limitations. Early on she wanted me to tell her that he would change and get better. As the treatment went on, she became more aware and tolerant that he was not changing but that she was.

During the course of the therapy, Ms. S. separated with the husband a number of times. However, they tended to be in contact and he would exert great pressure on her to reconcile, which she did a number of times. However, during one separation she was particularly resolute about not getting back together. He responded by being more aggressive in his coercion, which generally followed a pattern of acknowledging that they were separated, admitting that he behaved badly but begging her until she broke down to have dinner with him or get together with him for pleasure or work. She often agreed to do these things. There were a number of reasons. Part of her held out hope that he would change. Another part caved because she was worn down by his constant barrage of insistence, and another part of her also was trying to appease him. During these dinners and meetings, he would be especially charming, leaving her to doubt her decision. However, one dinner get-together during a separation evolved quite differently. As dinner came to a close, he pressed her to come back to his hotel with him. She refused and reminded him that they were separated. In public, he loudly accused her of having an affair and became visibly angry and threatening of suicide, all of which was common in these situations between them. However, her resistance was stronger than typical, and he responded by angrily threatening to kill her. She was scared by his affect and words and called me. I was also concerned. While I was soothed by the fact that he had never previously been physically violent toward her, I was also very concerned given his affect and the seriousness of this threat, and therefore advised her not to return home but to get a hotel room, stay with a friend or relative (she had a sister within a few hours), or to go to the local women's resource center. This incident crystallized for Ms. S. the seriousness of the situation with her husband and led to greater resolve on her part to separate from him and to divorce him. Over a period of a few months, she was able to complete her separation and to resist his attempts to persuade her to allow him into her life. He found a permanent separate residence, and after initial threats of suicide and declarations of his need for her, he began to be more accepting of their separate lives. She began seeing the man who she briefly dated during one of her previous separations from her husband. This relationship quickly became serious, although she did not share being in a relationship with her ex-husband. Both Ms. S. and her new boyfriend had reasons for wanting to keep their relationship private. Ms. S.'s new boyfriend was also a titan of the corporate world, in some ways even more so than her ex-husband. He worked in a similar but noncompeting capacity for another company, which provided her with some more freedom than did working at the same company with her ex-husband.

One aspect of the treatment that I found difficult was to keep the focus on her own issues rather than on her husband. Sometimes I felt it was the husband who was in therapy by proxy rather than Ms. S. (this despite the significant issues Ms. S. struggled with). She wanted reassurance about her husband and had a difficult time staying with her own experience or wanting to explore her own role in the dynamics with him. However, with the separation firmly in place and as she was able to proceed with the divorce, the focus on the treatment was more on her and similar dynamics that were playing out with a new romantic partner and with coworkers. The new boyfriend was

emotionally intimate with her in satisfying ways when they were alone on trips but much less so other times. They both traveled for business and often to the same cities or were able to arrange rendezvous in nearby locations. While they were together, she experienced him as romantic, intimate, and close. He talked about getting married and even adopting children. This level of intimacy was belied by the fact that they kept their relationship private, and when out in public they acted as colleagues, not lovers. As time went on, Ms. S. wanted to be more open about the relationship. Her ex-husband now knew about the relationship, and although somewhat jealous, he was accepting of the relationship, he was doing well on his own, and he was even dating other women. Ms. S. wanted to proceed with his talk of getting married, albeit doing so relatively slowly. At this point, her boyfriend began to distance himself from her. He was less available when traveling and began expressing concerns about going public with their relationship and getting married. Ms. S. began to feel as if she was not really his girlfriend but instead his mistress. After discussing this in the therapy, the patient became more confident about confronting him regarding her concern. His response was very dismissive, and she was quite upset. Eventually, she broke up with him and began casually dating men who were both successful and appeared nice.

With coworkers, she often felt judged and persecuted, and this was a pattern that existed from her earliest years at the company. She was long considered one of the favorites of the CEO of the company due to her strong work ethic and outstanding performance. She had a knack for solving complicated problems in ways that could be described as a win-win for the parties involved. When a win-win solution was not possible, she was able to fight hard for the company's interests. She was well liked by those with whom her company was negotiating, and her cultural background allowed her to work with foreign companies, particularly those in Saudi Arabia and other Middle Eastern countries. However, she and the person directly above her clashed on vision. This generally was not an issue because the company CEO held her in high regard, but it did cause tension at times in meetings. Ms. S. had a difficult time tolerating such tension. She often felt attacked and the victim of his and other people's mean-spirited aggression. She often perceived that others were bothered by her work ethic and success, and felt persecuted for it. What she described in session sounded well within normal limits for office politics, although at times understandably upsetting. Nonetheless, her response often felt exaggerated and more appropriate for a response to how she was treated by her mother and her ex-husband. From a nonjudgmental stance, we explored her response to her perception of other's provocations. In these discussions, her difficulty with her own aggression became central. Common in those prone to depression can be difficulties with one's own aggressive impulses. Depressed individuals often experience these feelings in magnified ways and experience intense guilt in relation to them. Ms. S. was no different.

A turning point in our work about this occurred one session when Ms. S. arrived shaken. In tears, clearly upset with herself, she recounted how she had just "lost it" and had an inappropriate outburst at an important executive company meeting. She was afraid she would get fired and conveyed to me that if she was in charge she would

have fired her on the spot. I asked her what happened. She began to describe the events in detail. I listened carefully for her outburst. The patient went on for about 15 minutes and still I had not heard the outburst, so I interrupted her and asked, "So when did your outburst occur?" She stared at me with a surprised expression and said that she already had described it. I stared back at her with a surprised expression, as I was unclear as to what part of what she had just described to me would constitute an outburst, a sentiment I shared with her. She then recounted the "outburst" in which she described responding to something glib that a colleague said by suggesting that his comment was not helpful to the discourse, and then she went on to focus the discussion in a more productive manner. What she described sounded perfectly appropriate, contained, and even helpful to the dialogue. I thought about sharing my opinion but reckoned that it might not resonate with her and could be invalidating. Instead, I thought it might be more impactful to ask how other people responded to her comment. She shared with me that a number of other people came up to her after the meeting to thank her for her comment. The coworker was often experienced as bullying the group and making fruitless comments and contributions, and people felt that her comment appropriately contained him. I then asked her what she makes of her reaction compared to what other people had shared with her. I then joked that it was a good thing she wasn't the boss because she would have fired herself rather than appreciate herself. She was able to laugh, and this led into a discussion about how she emotionally beats up on herself even when undeserved. We tied the pattern to how she not only experiences and responds to coworkers but to relationship partners and family members. This discussion led into a discussion of a difficult dynamic about how she had taken on the role of her mother, who no longer was emotionally or physically abusing her, by emotionally beating up on herself. She described this as an aha moment of great insight that led her to treat herself differently.

Follow-Up to the Treatment

Ms. S. was able to weather the difficult breakup with her boyfriend and manage the relationship with her ex-husband and coworker openly and with healthy boundaries. She was able to begin dating again and showed an increased capacity to reflect and make decisions about how she felt about these men without feeling pressured by them or her own desire to have a relationship. She seemed more at peace with where things were and confident that she would find a suitable relationship. She became more tolerant of her mother, despite resentments toward her and difficulties with some of her mother's values. Her relationships with her siblings strengthened, particularly her younger sister, with whom she became more tolerant and friendly. At work she continued to be successful but was now able to enjoy her success more fully. She was more tolerant of her coworkers and less entangled in their concerns. As she became more tolerant of herself, she also became more tolerant of others.