

A Case Study of Dependent Personality Disorder in a Male Patient: Treatment and Conceptualization from an Integrative Perspective

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Abstract: *This case study discusses the treatment and conceptualization of a male with Dependent Personality Disorder (DPD). This diagnosis is rare but especially so in males. Accordingly, this case study describes a seemingly effective treatment methodology utilized and a unique integrative conceptualization which guided this treatment.*

Keywords: therapist competency, Supportive-Expressive therapy, clinical case study, dependent personality disorder, persistent depressive disorder, anxious distress, diversity considerations, ethical issues

1. Introduction

This case study illustrates this therapist's clinical competency and ability to integrate the areas of rapport building, evaluation, assessment, diagnosis, case conceptualization, treatment formulation, therapeutic intervention, diversity considerations as well as legal and ethical issues. In compliance with the Health Insurance Portability and Accountability Act of 1996 and the American Psychological Association's Ethical Principles and Code of Conduct for Psychologists (2002), identifying information has been modified to safeguard the identity of the patient. Accordingly, the patient will be referred to as "Ben."

2. Pre-Treatment Evaluation

Presenting Problem

Ben is a 38-year-old White, German American man who presented to a community mental health center seeking help to manage his life better than he has done so far. He reported experiencing depressive and anxious symptoms as well as longstanding interpersonal difficulties associated with being "overly dependent." He presented with depressive symptoms including sadness, helplessness, hopelessness, guilt, low self-esteem, difficulty concentrating and anxious distress; he reported past suicidal ideation. He indicated that his depressive symptoms and feelings of anxiety are aggravated consequent to perceived rejection or abandonment by close others. He is seeking therapy because he feels persistently "sad" and "lonely", and he does not have "anyone to talk to" about his emotions.

History of Presenting Problem

The patient said that his symptoms of dependency, depression and anxiety began in early childhood. They have been present "for as long as [he] can remember." He reported that, as a child, he was frequently "unhappy" and "worried" because his parents were extremely critical and maintained high, even unrealistic, expectations of him. He said that his mother would threaten to "hurt herself" if he did not achieve what she expected of him. Whenever she would do this, Ben said that his symptoms would become more disturbing. At 17 years old, following the unexpected death of his father, his

symptoms worsened. He indicated that his father's death led to a marked change in the behavior of his mother which further affected him. Around this time, he was diagnosed with depression and treated with pharmacotherapy. Though, he reported that his symptoms persisted to the time of the initial evaluation.

Approximately two years ago, Ben's mother stopped communicating with him after she had threatened to kill herself when he was not able to help her move some of her belongings.

His symptoms worsened following this incident, and this exacerbation of his symptoms was the reported impetus for seeking treatment. After this, he sought out a romantic relationship "to feel complete." He described feeling "continually" depressed and anxious because of his interpersonal conflicts with close others. He worries excessively about what several valued others think of him and is concerned by the way in which he conducts himself around them. He particularly fears being abandoned or rejected by his girlfriend. He reported being "submissive", "dependent" and "passive" in his relationship with her. He said of his symptoms, "they sometimes worsen a little bit and sometimes they improve a little, but they're always there."

Developmental and Family History

Ben, an only child, was born in a Florida hospital following a full-term pregnancy. He was conceived naturally, the pregnancy was planned, and his mother received prenatal care. He was delivered without complication, and he met his major developmental milestones at the expected times. He reported that his mother did not use alcohol, tobacco or any other drugs during her pregnancy. He denied any history of sexual or physical abuse, but he endorsed a history of emotional abuse.

The patient was raised by his mother and father until he was 17 years old when his father died "unexpectedly" due to cardiac arrest. He said of his childhood that it was "not the best" citing his parents' high expectations and his need to excel to avoid their disapproval. He reported being subjected to corporal punishment, verbal degradation, and emotional abuse from his parents and particularly mother. For example,

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he reported that his mother would frequently threaten to hurt herself or “drive the car off the bridge” if he did not satisfy her demands. As a child, he was often left home alone while his parents would both work. He said that his parents were absent from “much of” his life and that they were not there for him when he “needed them to be.” He described his parents’ marriage as “bad” because they frequently argued and displayed little fondness for one another. He stated that his father “always slept on the couch” while his mother had her own room. He denied witnessing any physical violence between his parents.

The patient said that, throughout his life, he felt closer with his mother, but he described his father as “less critical.” For instance, his father passively supported his interests in the arts while his mother saw these interests as a “distraction” from his schoolwork and chores. He described his father as a “hardworking man” with “extremely high standards.” After his father died, he said that his mother would demean his dead father relentlessly. Ben reported fearing that his mother would degrade him in a similar manner if he were to do anything to upset or disappoint her. He described her as “bossy”, “guilt-instilling”, “critical”, “controlling”, “mean”, and “self-centered.” In adulthood, his mother has threatened to sue him “countless” times, but no legal complaints have been filed. She has “constantly” reminded him of how “disappointed” she is in him because he is not “a lawyer or a doctor.” Ben also described his mother as “Machiavellian” and said that he does not have the capacity to “defend [his] position against her.” For example, even though he bought his current residence, a house, with his own accrued savings, she persuaded him to establish her as a co-owner of the property.

About two years prior to the initial evaluation, Ben’s mother asked him to assist her in moving some of her belongings out of storage, but he was unable to do so as he was traveling for work. His mother demanded that he immediately return home to help her, and she is reported to have threatened to kill herself when he told her that this would not be possible. Following their conversation, she texted him saying that she would not speak to him any further and that he was “dead to [her].” His mother has since refused to converse with or see him, but she has sent him “a few” text messages since then, writing, for example, “I hate you”, “You have disappointed me” and “I hope you choke to death.” However, she does not respond to him when he reconciliatorily writes back to her. Ben reported feelings of guilt and shame for not speaking to his mother during this time. He said that her actions make him feel “disappointed”, “lonely” and “sad”, but he said that he misses her.

Social History

The patient was raised in a rural area in the Southeastern United States which he described as being “very isolated.” Although he said that he had some friends from school, he was not permitted to spend time with them after school as his mother expected him to spend his day completing schoolwork or housework. He asserted that he had difficulties engaging with other children. For example, his peers physically assaulted and harassed him on many occasions beginning in the second grade and lasting until he graduated high school. He reported that he was bullied for

being Jewish, “short”, and “a nerd.” In college, he began socializing more often and dating intermittently, but he specified that he has never had more than “a few” close friends at a time.

The patient said that he has four “very close” friends at present, but he does not see them often as “they all have families and children.” Although he feels lonely and would like to spend more time with them, he feels uncomfortable contacting them for fear of “annoying them.” He stated that he often internalizes his feelings rather than risk distancing his friends and girlfriend, but he also reported having difficulty being “emotionally alone.” At the time of the initial interview, Ben lived with his girlfriend. He described their relationship as being close and mutually satisfying but “difficult at times.” Approximately nine months into treatment, she ended their relationship and ceased all contact with him.

Educational and Vocational History

The patient excelled academically and described himself as an “overachiever.” He was the valedictorian of his high school class and he graduated with a GPA of 4.6. He was accepted with a “full ride” scholarship to a prestigious university where he graduated with two Bachelor of Arts (B.A.) degrees. The first was in technology management and the second in journalism. He maintained a GPA of 4.0 throughout college and received the summa cum laude honors designation upon graduation.

In 2007, following his graduation, Ben moved to a larger city to work as a freelance videographer. Over time, his customer base, reputation and interest in the field grew. He said that he enjoys his work and typically does “very well” financially but COVID-19 negatively affected his business. Ben’s income is “less than half” as compared to a “typical” year pre-covid. This loss of business reportedly contributed to decreased self-worth, pronounced feelings of helplessness and increased sadness.

Medical History

The patient has never previously attended psychotherapy. At age 17, following his father’s death, his primary care physician prescribed him Zoloft (50mg/day) to manage better his depression. Ben has been continually taking this medication since this time. He indicated that his medication has worked “well” but he “sometimes struggle[s]” when in conflict with valued others. He said that he has never been hospitalized or suffered from serious medical illness, and he denied a history of blackouts or concussions.

Risk Assessment

The patient denied past and present self-injurious behavior as well as homicidal ideation, plan or intent. He said that in the past, when depressed, he has “sometimes thought about what it would be like if I killed myself.” He has thought of methods to kill himself in the past (e.g., carbon monoxide poisoning), but he denied ever developing a specific plan with details or intent to act. He reported that such suicidal ideation manifests following conflict with valued others (e.g., mother, romantic partners). He recalled four instances of suicidal ideation in his life, first occurring when he was 18 years old. The most recent reported incident was

approximately two years ago following his mother's cessation of contact with him. During the intake interview, the patient agreed to seek immediate help if feeling that he may hurt himself, and he agreed to discuss such thoughts in therapy. Self-injurious behavior and suicidal ideation, plan and intent were monitored throughout the treatment.

During the eighth session of individual therapy, Ben's girlfriend of two years, to whom he was closely attached, "threatened" to end their relationship. This resulted in him experiencing pronounced suicidal ideation. For example, he said "If I had a button in front of me right now that would kill me instantly if pressed, with no repercussions, I feel like I would." At the time, he also said that he had been thinking about the ways in which he "could" kill himself (i.e., intentional overdose, firearm). Accordingly, an extensive suicide assessment was conducted.

Upon further evaluation, Ben said that he "would never actually kill [him]self" citing his will to live, the religious repercussions of such an act as well as the impact that it would have on his friends and family. Although he denied having either a specific plan or intent to act, an extensive safety plan was collaboratively devised, and Ben agreed to get rid of items that may be used to harm himself (i.e., certain medications, firearms), and to seek help and support from his close friends. He agreed to call a Mobile Crisis Unit or 911 if he believes that he may hurt himself. He agreed to scale his mood three times daily as a means to self-monitor when to seek additional support. He also agreed to discuss in therapy when having thoughts about hurting himself.

Self-harm and suicidality continued to be routinely evaluated throughout treatment, especially during periods of adversity and increased emotional disturbance.

Substance Use History

The patient reported that he began "occasionally" drinking alcohol during his first year in college, at age 18, "to fit in." He continues to drink alcohol in limited social settings and estimated his consumption level to be 1-2 standard drinks per week. He stated that his alcohol consumption remains stable during adverse life experiences. He said that he has "never had a problem with drinking too much." The patient said that he has never used any other substances, including tobacco. He denied any family history of alcohol, tobacco or other drug use.

Cultural and Diversity Factors

Ben is a cisgender, heterosexual male who was raised in a middle-class family. He is religious and identifies as an Ashkenazi Jew. He prays often and regularly attends shabbat temple services. He said that his religious values are a "big piece" of who he is and that religion "really helped" him when his father died. Although Ben was born in the United States, his maternal and paternal grandparents were Ashkenazi Jews who emigrated from Germany after World War I, during the rise of the Nazi party. His parents were described as "extremely religious." They did not teach him to speak German, but many of his cultural traditions have been maintained (e.g., Ashkenazic siddur, German-Ashkenazi cuisine). He said that the difficulties of growing up in a rural area were exacerbated by the fact that he was Jewish for

there were no nearby temples and few other Jews lived in the area. He reported experiencing "anti-Semitism" throughout his life but "especially in childhood." Although no longer teased or treated as an "outcast", he believes that being bullied affected his relationships with and expectations of others.

Strengths and Protective Factors

Ben's strengths include his commitment to treatment (e.g., sustained adherence to psychopharmacological treatment) as well as his ability to develop a helping alliance as evidenced by his willingness to explore his feelings and engage openly with the therapist. He has several close friends, a supportive congregation at his temple as well as a rabbi on whom he can rely for support. His identification with the Jewish religion seems to have served as an important strength for him throughout his life. He also displayed resilience as he has continued to persevere despite facing adversity throughout his life.

Mental Status Examination

The patient was neatly groomed and appropriately dressed. He arrived on-time, and he was polite and respectful. His volume, rhythm and rate of speech appeared to be within normal limits. Initially, eye contact was infrequent, however, once he appeared to be at ease, appropriate eye-contact was maintained. He was attentive, cooperative and compliant during sessions, and he quickly developed rapport with the therapist. He demonstrated appropriate psychomotor movement. He presented with depressed mood which was congruent with his affect. He was fully oriented to person, place and time; he did not evidence disturbances in memory. At the time of the evaluation, insight and judgment appeared to be good. Though, he has a history of impaired judgment. His thinking was logical, goal-directed and non-tangential. He denied any history of dissociative experiences or hallucinations, and delusional material was not elicited during session. He denied symptoms consistent with a manic or hypomanic episode. He denied current suicidal ideation, plan or intent but endorsed past suicidal ideation (without a specific plan or intent to act).

Assessment and Diagnosis

Treatment progress was monitored through behavioral observation as well as continued consideration of the patient's self-reported symptomatology. This continual reassessment of the patient's symptoms afforded this clinician a measure of treatment progress. For instance, during the beginning phase of treatment, Ben would react intensely to adverse emotional stimuli, such as confrontation, both, inside and outside of therapy, but his reactions further into the treatment were tempered as he employed more mature and appropriate means of coping with his emotions. Comparing the symptoms and behaviors of the patient throughout the course of treatment suggested that improvements in the patient's functioning and understanding of himself were realized.

Diagnostic Impressions

The following diagnostic impressions were informed by patient symptomatology, mental health history and behavioral observations using the diagnostic parameters espoused by the Diagnostic and Statistical Manual of Mental

Disorders, Fifth Edition (DSM-5) and the International Statistical Classification of Diseases and Related Health Problems, 11th Revision (ICD-11). When taken together, Ben meets criteria for:

- Dependent Personality Disorder - 301.6 (F60.7)
- Persistent Depressive Disorder (Dysthymia) with Anxious Distress (Moderate), Early-Onset with Pure Dysthymic Syndrome - 300.4 (F34.1)

For detailed diagnostic justification of diagnosis and DSM-5 criteria see Appendix A.

Differential Diagnoses

Other diagnoses were also considered but ultimately ruled out including generalized anxiety disorder, avoidant personality disorder, borderline personality disorder, cyclothymic disorder with anxious distress, and major depressive disorder with anxious distress, recurrent episode.

For detailed diagnostic justification of ruling out the differential diagnoses identified see Appendix B.

Intervention

Theoretical Conceptualization

Ben's case was conceptualized through the lens of Supportive-Expressive (SE) therapy. SE therapy is a therapeutic modality that focuses on the patient's relationships to identify a conflictual relational pattern which is the focus of the treatment (Luborsky, 1984). A principal benefit of this method is that it facilitates the identification of the patient's core conflictual relational theme (CCRT). The CCRT is identified and explored by analyzing the thematic overlap of the patient's current out-of-treatment relationships, past relationships and in-treatment relationship within his relational narratives as the CCRT represents such themes across relationships over time (Luborsky, 1984). The CCRT is developed throughout the therapy beginning at the initial visit. It includes three components, the patient's main relational wishes (W), the expected responses of others (RO), and the response of the self (RS) which refers to how the patient responds to the interaction (Luborsky, 1984).

SE therapy is designed to foster a helping alliance while listening to the patient's narratives about his past and present relationships (including with the therapist) with the goal of identifying his principal maladaptive pattern of relating to others using the CCRT. The CCRT uncovers a framework of the patient's interactions with others that is partly unconscious.

Helping Ben to become aware of, and to understand the nature of his interpersonal issues as well as related thoughts and feelings is a principal aim of SE therapy. The theory of change in SE therapy is that by attaining an increased self-awareness and understanding of his CCRT patterns, the patient will become able to adopt different, more mature and adaptive ways of interacting with others, and this may facilitate an alleviation of symptoms (Crits-Christoph & Connolly, 1998; Luborsky, 1984). Considering Ben's symptomatology, treatment was enhanced via practitioner adherence to Luborsky's (1984) SE therapy manual. Treatment was also informed by supervisor guidance as well

as the techniques described in the SE therapy manuals for anxiety (Leichsenring et al., 2014) and depression (Luborsky et al., 1995). This treatment has demonstrated efficacy in the treatment of depression and personality disorders (Barber et al., 1997; Gibbons et al., 2012; Vinnars et al., 2005). Leichsenring and co-researchers (2020, p. 273) said of SE therapy, "[it] is among the empirically best-supported methods..."

SE therapy entails both supportive and expressive techniques. Supportive techniques refer to the methods that facilitate the therapist's helping alliance with the patient. The use of supportive techniques serves to improve the patient's opinion of his own strength (Luborsky, 2000). The aim of the expressive techniques is to facilitate the patient's attainment of self-awareness, understanding and, consequently, change. Specifically, such techniques serve to advance the patient's awareness of his maladaptive relational patterns and to subsequently work through them. Such awareness is often realized when the patient becomes cognizant of the fact that his maladaptive pattern of relating to others is manifest in therapy, in the "here-and-now" (Gill, 1979; Luborsky and Mark, 1991; Schattner, 2018). Scholars have long supposed that relational patterns are reenacted in the context of therapy (e.g., Freud, 1920; Klein, 1936; Mayman, 1978) and this is supported by empirical evidence (e.g., Beretta et al., 2007; Fried et al., 1992).

The supportive and expressive techniques exist on a bi-polar continuum with some degree of overlap. Moreover, these techniques are not mutually exclusive. For example, many therapist responses can harbor an expressive, interpretive component whilst concurrently being supportive (Luborsky, 1984). One of the main aims of SE therapy is to encourage new behaviors and to provide a new relational experience. Working on top of the established helping alliance, this therapist sought to provide a safe environment in which the patient could, without fear, express his thoughts and feelings openly. Ben was met with a relatively atypical response to his expressions (i.e., the therapist's non-judgmental and accepting attitude) allowing him to have a different, new relational experience. Over time such unexpected responses and the consequent relational experiences serve to effectively undermine the patient's dysfunctional style of relating to others. (Levenson, 1970; Luborsky, 1984).

Case Conceptualization

Ben's case was further informed using the DSM-5 (APA, 2013), the PDM-2 (Lingiardi & McWilliams, 2017) as well as writings on depression by Sydney Blatt (1974 & 2004).

According to the PDM-2 individuals with dependent personality and depressive features may present as socially inhibited or shy, they may feel inferior or inadequate, they may have difficulties identifying their emotions, particularly in the absence of an attachment figure, and they may avoid doing certain things (e.g., talking about their emotions) especially if a negative reaction from valued others is anticipated (Lingiardi & McWilliams, 2017). Ben presented initially as somewhat inhibited; he reported having difficulty in expressing his emotions, especially as they relate to close others. His symptoms were likely stoked by a conflict

between his desire to reach intimacy with the object(s) of his attachment and his desire to protect himself from injuries and suffering (Blatt, 2004; Dimaggio & Norcross, 2008). For example, he avoids showing anger towards close others by internalizing this anger with the aim of maintaining a relationship with them and avoiding being attacked or abandoned. This internalized anger or “aggression turned inward” (Lingiardi & McWilliams, 2017, p. 29) has long been theorized to lead to depression (Beck, 1972; A. Freud, 1936; S. Freud, 1917). Ben’s difficulties appear to be rooted in an early instilled fear of abandonment from close others likely fostered by a non-secure attachment style with his primary caregivers ultimately leading to a state known as anaclitic (dependent) depression. Anaclitic depression is an empirically validated depressive subtype associated with dependence (Blatt, 2004; Blatt et al., 1982). Those with anaclitic depressive features, such as Ben, desire to be nurtured by and connected with others but instead feel abandoned, lonely, weak and helpless. This patient seeks the acceptance of close others as a means to bolster his low self-worth but perceives such objects as unpredictable and volatile resulting in anxiety, depression, and fears of abandonment (Blatt, 2004). He utilizes ego defense mechanisms with the aim of negating negative thoughts and feelings surrounding his relationships to maintain superficial harmony and preserve those relations even to the detriment of himself. Ben’s desire for a secure attachment when bestrode by his oft unconscious perception of others as being volatile and unpredictable appears to cause conflict within him. This conflict likely contributes to his maladaptive relational patterns as well as his symptoms. Although the negative thoughts and feelings associated with Ben’s inner conflicts are, for the most part, shackled by his defense mechanisms, they nevertheless appear to affect his social and emotional functioning.

Ben, an only child, was raised by a “hypercritical”, “inconsistent” mother and by a father who had “a short temper.” He reported having “always” felt that he could not live up to their expectations. His mother and father were reported to not be regularly present during childhood likely contributing to his developing anaclitic depression (Blatt, 2004). Ben perceived his mother as “manipulative”, “critical” and “uncaring.” He said that his father did not recognize his accomplishments and that his parents, especially mother, would frequently verbally degrade him. He sought validation, attention, affection, support, and love, but his parents were unable or unwilling to reliably provide him with these. As a consequence, he appears to have been unable to establish a sense of agency, sufficient coping strategies or a firmly positive view of himself.

Due to an inadequate environment, constant criticism, and continued rejection and abandonment throughout life, the patient internalized many of his negative thoughts and emotions with the goal of avoiding the associated anxieties. Periods in Ben’s life of minimal interpersonal conflict appear to allow for a greater constraining of his negative thoughts and feelings, and their impact on his functioning is reduced, but, following relationship loss or conflict, such thoughts and feelings enter his awareness leading to pronounced emotional disturbance.

Ben’s CCRT

Ben’s CCRT was likely developed early and reinforced throughout his life. His CCRT was conceptualized as follows: I wish to be respected, accepted, loved and cared for; to establish a secure relationship and sense of agency (W). However, others will be rejecting, controlling, aggressive, and punishing (RO). I feel depressed and anxious; therefore, I maintain my dependence (i.e., submissiveness, passivity) and internalize my feelings to preserve the relationship and prevent further anticipated distress (RS). He described his anxiety in childhood as having begun with “tip-toeing” around his mother because he “didn’t know what would make her snap.” It is likely that similar relational dynamics with his father further stoked symptom formation. Additionally, Ben evidenced at least two competing wishes, (1) to be self-determined and respected and (2) to be cared for and loved by others. Psychodynamic theorists have long conceptualized dependency problems in terms of such “dependency conflicts” (Bornstein, 2007, p. 39; Coen, 1992). Ben’s history when viewed through the lens of the CCRT, demonstrates how he may have developed problematic dependency as well as depression and anxious distress.

The patient’s parents, on whom he had to rely, denied him the love, care, and respect that he desired. They did not afford him the opportunity to develop a strong sense of agency. For instance, Ben said “my mother always had a need to control me.” He felt that he “did not have a choice” when he obeyed his parents for fear of physical reprimanding or verbal derogation.

Having not been allowed to properly express his anger without retaliation, Ben kept his feelings of anger and frustration to himself. Though, he inwardly rebuked the rejection, aggression and condemnation of his parents. The associated thoughts made anger and frustration unbearable feelings which contributed to his depression, anxiety and problematic dependency. His fear of abandonment coerced him in adulthood to assist and obey valued others despite their sometimes- cruel intentions and the anger and frustration that he felt. This position is similar to that of his childhood, a state in which he feels powerless, helpless and sad.

Treatment Plan and Formulation

It was recommended that Ben be seen weekly for open-ended SE therapy to address his dependent personality, depression, anxious distress and related interpersonal difficulties. This theoretician incorporated cognitive behavioral therapy (CBT) techniques, psychoeducation, gestalt, humanistic and relational techniques as indicated. The therapy attended to the patient’s sadness, hopelessness, helplessness, fears of abandonment as well as his relationship with himself and others. The therapy endeavored to provide Ben with the opportunity to explore his thoughts and feelings surrounding his past and present relational difficulties. Given the nature of his symptomatology, an emphasis was placed on the utilization of supportive therapy techniques in all phases of treatment.

Treatment Integration

Ben attended a total of 41 individual, weekly, in-person,

psychotherapy sessions each lasting approximately 50 minutes in length. Ben's treatment goals were devised collaboratively as follows: (1) increase his awareness of how his perceptions of self affect his social interactions and serve to maintain his symptoms, (2) increase his awareness of how his patterns of relating to others affect his emotional state, (3) increase understanding of and reduce depressive and anxious symptoms, and (4) increase understanding of and reduce feelings of dependency.

Following the intake interview, Ben's treatment can be described in three phases, beginning phase (sessions 1-18), middle phase (sessions 19-36), and termination phase (sessions 37-41).

Intake Interview

During the intake interview, the therapist described the treatment to the patient and determined its appropriateness. He began to establish rapport and a relationship of trust with the patient through the use of active listening, Meichenbaum-style questioning, and reflection of feeling and content. Historical information was provided, and a mental status examination was conducted.

The patient's disturbances were discussed, treatment goals were collaboratively identified, and treatment arrangements were made. The patient's questions and concerns were examined and addressed. During the later parts of this treatment phase, this therapist began to understand and respond to the patient's problems.

Early (Supportive-Oriented) Phase (Sessions 1-18)

In the beginning of treatment, this therapist sought to develop a good helping alliance, a "we bond" (Luborsky, 1984). This was done through the emphasized use of supportive techniques such as affirmation, validation, empathy, "we" statements, reflection of feeling and content, active listening, Meichenbaum-style questioning, and understanding. In this phase, treatment was focused on furthering the patient's and therapist's understanding of Ben's symptoms. He was encouraged to "talk about whatever it is that is on [his] mind." This early phase of treatment also investigated the genesis of Ben's pathology and the defense mechanisms he principally employs. During this stage, the therapist sought to identify the CCRT by listening to the patient's relational narratives. In this phase of treatment, a formidable helping alliance was established as evidenced by his consistent, punctual attendance as well as his open discussion of his dependency and other anxiety provoking issues (e.g., conflicted feelings towards mother).

Ben's CCRT was conceptualized collaboratively and discussed often. Utilization of the CCRT method permitted the reframing of Ben's symptoms as a means of coping as opposed to a fault of the self which served to empower the patient (Luborsky, 1984; Luborsky & Crits-Christoph, 1998). This therapist sought to maintain a non-judgmental attitude. For instance, this therapist did not act with disappointment or anger when the patient experienced suicidal ideation during the eighth session. Rather, this clinician invited the patient to talk about what had happened as well as his related thoughts and feelings with the goal of providing a new relational experience. This therapist strived to maintain an accepting, understanding and non-judgmental stance when exploring

such issues with aims to undermine Ben's dysfunctional expectations of others while providing a safe, stable environment in which he could increasingly express his feelings and discuss intimate topics without fear of derogation, rejection or abandonment. Although this stage was supportive-oriented, therapist responses often contained expressive, exploratory aspects.

Middle (Expressive-Oriented) Phase (Sessions 19-36)

During the middle phase of treatment, this therapist continued to encourage the patient to explore his thoughts and feelings to work through his core conflicts with an increased emphasis on the employment of expressive techniques including clarification, confrontation, interpretation and working through. Following the continued use of supportive techniques and an emphasis on the development of the helping alliance, Ben became more open in discussing his thoughts and feelings. In this phase, this therapist sought to acquire a joint understanding with the patient of his intentions in social relationships as well as the consequence thereof through an analysis of resistance and the emerging transference. Intermittent goal review was also conducted, and the CCRT was refined as notable themes began to emerge across Ben's relational narratives which provided information for its development. For example, Ben's attention was drawn onto his relationship with girlfriend at the time. In one instance, we collaboratively identified his wish to be respected, accepted, loved and cared for by her, and to develop a sense of agency (e.g., being able to express himself freely) (W) but he anticipated that "she won't respond well" despite their being no articulable evidence of this aside from his experience in past relationships (RO). With the aim of avoiding rejection, conflict, aggression and abandonment, he reported that he would not confront her on issues on which they disagreed (RS); we explored his tendency to internalize these feelings of anger which leads to increased emotional turmoil within himself for the sole sake of "not rocking the boat." We also discussed how such relational themes were apparent across his relationships (e.g., with his mother, father, friends and therapist). When we explored his feelings towards his therapist, the patient conveyed his desire to be cared for and accepted (W). He discussed his disinclination to express thoughts, feelings, beliefs and events (RS) that could lead to him being "judged" by the therapist (RO). Such examples of his CCRT became manifest throughout the course of therapy. The repeated examination of Ben's reenactment of his interpersonal relationships with others through the "here-and-now" lens with the therapist allowed for such behaviors to be examined with the goal of furthering the patient's understanding of his relationship with himself and others while identifying and exploring related thoughts, feelings, motives and beliefs of which he was not previously aware (Luborsky, 1984; Gill, 1979). Heightening the patient's awareness and understanding of his conflictual relational patterns is a principal goal of the expressive techniques used in this phase of the treatment. The therapist sought to support new behaviors as well as new relational experiences with others (and the self) thereby enabling Ben to reappraise and modify his expectations of others (RO) and response of the self (RS). For instance, Ben would often ask for this therapist's opinion especially during interpersonal conflicts, but the therapist did not fulfill his expectation. Instead, this

therapist encouraged the patient to make his own decisions.

Throughout the treatment, but especially during this phase, goal achievement was readily recognized with the aim of supporting the patient, bolstering his sense of self while also exploring the meaning of such changes. During this phase of treatment, Ben continued to express his thoughts and feelings more openly. The therapist maintained a non-judgmental attitude with the intention of modeling while providing a new relational experience for the patient. Ben became aware of and more able to discuss and process his feelings of anger and sadness towards his parents' and others' treatment of him. Approximately nine months into the treatment, his girlfriend, to whom he was very closely attached, terminated their relationship.

Despite his previous suffers of suicidal ideation, the patient did not evidence suicidality in this instance. Although his depressive symptoms were marginally exacerbated and he reported feeling "rejected", Ben appeared to handle the termination of his principal relationship relatively well. For example, following this break up, he did not immediately begin searching for a new romantic relationship as he often had before. Rather, he informed this therapist that he felt inclined "to work on" himself. During such instances of adversity, a renewed emphasis was placed on supportive techniques as indicated by Luborsky's (1984) manual and supervisor direction.

Termination (Sessions 37-41)

Termination for this patient is premature at present. Persistent depressive disorder and personality disorders such as dependent personality disorder often require long-term treatment as such disorders are enduring and longstanding (Lingiardi and McWilliams, 2017). Moreover, the patient indicated that he would like to continue to receive services to "feel more secure" and to "continue [his] progress." Although Ben is continuing his treatment and being transferred to a new clinician within the same clinic, not being discharged, an emphasis was placed on termination and a number of the treatment sessions were dedicated to this. Given the nature of the patient's difficulties, an intermittent reminder of the termination date was provided throughout treatment to lessen any shock, address his concerns, and increase his preparedness.

An emphasis on termination was of particular importance for this patient as his CCRT had a specific risk of becoming actuated following the loss of the therapist as such a loss could be perceived as abandonment or rejection (Leichsenring et al., 2020; Luborsky, 1984). Accordingly, a renewed focus on supportive techniques was maintained during this phase as indicated by the literature (Luborsky, 1984). During this phase, termination and its implications were discussed, and this therapist explored the patient's feelings surrounding the subject of termination. Ben reported feeling "sad" about our relationship ending but "appreciative and thankful" for having had this relationship. He said that he felt "confident" in his ability to continue making progress. His sadness when explored were traced to rekindled feelings of abandonment. Given Ben's diagnosis and history of suicidal ideation, this therapist sought to ensure that there was no lapse in care related to the patient transfer.

Treatment Evaluation

Ben obtained a deeper understanding of himself, his symptoms, and his relational problems. Although he initially evidenced fear and anxiety in regard to developing a sense of agency (e.g., confronting close others), with the support provided by the therapist, he took risks, and he continued to attempt to convey his thoughts and feelings in an appropriate manner. This was understood as a manifestation of his improved ability to express himself rather than internalize his feelings. The patient's dependency, although improved, still influences his relationships (e.g., a desire to seek reassurance from valued others; a reluctance to "annoy" or "bother" close others for fear of being rejected or abandoned), but his increased awareness and understanding of himself, willingness to utilize his social supports, improved communication with others and enhanced self-worth should continue to support his psychosocial functioning over time. During the termination phase, Ben felt "much less depressed" and "less anxious" as compared to the start of treatment. He also feels "more secure" in his interpersonal relationships. Although Ben exhibited significant improvement in his self-esteem, self-worth, helplessness, dependency and depression, he continues taking Zoloft as prescribed by his physician. Throughout the therapy, Ben's main wish did not change which is consistent with the literature (Luborsky & Crits-Christoph, 1998; Nieuwenhove et al., 2018). Though, by working through the CCRT, Ben appeared to be able to take a more realistic stance towards relationships relative to the start of the treatment course. It is the opinion of this therapist that the treatment goals were realized.

Though, further treatment is warranted.

Cultural and Diversity Considerations

Numerous cultural and diversity issues were identified and examined with the patient throughout treatment. Ben is a 38-year-old, German Ashkenazi Jew and reported being religious. His ancestors emigrated from Germany after World War I during the rise of the Nazi party, a fact which constitutes a part of his identity. He was raised in a rural household and reported facing anti-Semitism throughout his life "especially in childhood." During one therapy session, the patient began crying when describing one such incident wherein a "friend" with whom he had argued drew a swastika on his locker. This therapist sought to validate and understand him. Ben reported feeling "safe" and "grateful" for this therapist's response to his disclosure. At that time, he indicated that emotional self-disclosure and the discussion of mental health are not a part of his family's culture. Accordingly, this clinician explored Ben's thoughts and feelings surrounding his defiance of such cultural values. Such cultural and diversity variables differed from those of this therapist. This therapist was not subjected to the vitriol and adversity that this patient encountered throughout his life. This therapist has not experienced anti-Semitism nor the loneliness of being Jewish in a community with no other Jews. Although this therapist was raised in a rural household, his experience relative to the patient's is markedly distinct.

Additionally, this therapist is younger than the patient and has not experienced the psychological suffers or familial conflicts reported by him. As such, Ben's life experiences

were often discussed and explored with a focus on diversity considerations to further this therapist's understanding of the patient's psychodynamics. Furthermore, this clinician regularly sought supervisor guidance in this regard. Despite myriad differences in diversity factors between the therapist and patient, Ben reported that he felt "secure", "safe" and "open" throughout the treatment. It is the belief of this therapist that the consideration and exploration of such factors were foundational to the patient's progress.

Appendix A

DSM-5 Diagnostic Criteria for Primary Diagnoses

***Bolded portions of the text indicate criteria that the patient met**

(I) Dependent Personality Disorder - 301.6 (F60.7)

Ben was assigned a diagnosis of dependent personality disorder as he evidences a longstanding, excessive, and pervasive need to be taken care of that leads to submissive and clinging behavior and fears of separation. These symptoms have been present since he was a child and manifest in a variety of contexts. Specifically, he demonstrates some difficulty in decision making without excessive reassurance and advice from others (e.g., seeking advice and reassurance from this therapist, his past romantic partners and, historically, his mother). The patient has difficulty expressing himself for fear of disapproval or loss of support (e.g., fear of expressing anger, disagreement, or setting boundaries in previous romantic relationships). The patient has difficulty initiating projects and doing things on his own. For example, during important business dealings, he would frequently report seeking reassurance, guidance, and support from his romantic partner. Moreover, Ben goes to excessive lengths to obtain nurturance from others to the point of volunteering to do things which are unpleasant (e.g., giving his mother

co-ownership of his home). He often feels uncomfortable and helplessness when alone which is related to exaggerated fears to care for himself. He reported that he urgently seeks a new relationship as a source of care when a close one ends. For example, Ben reported that, following the termination of his previous romantic relationships, he was compelled to seek out a new romantic relationship. Additionally, following his mother's cessation of communication with him, he immediately pursued a long-term romantic relationship as a source of care and support.

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- 1) Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.
- 2) Needs others to assume responsibility for most major areas of his or her life.
- 3) Has difficulty expressing disagreement with others because of fear of loss of support or approval (Note: Do not include realistic fears of retribution).
- 4) Had difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy).
- 5) Goes to excessive lengths to obtain nurturance and

support from others, to the point of volunteering to do things that are unpleasant.

- 6) Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself.
- 7) Urgently seeks another relationship as a source of care and support when a close relationship ends.
- 8) Is unrealistically preoccupied with fears of being left to take care of himself or herself.

(II) Persistent Depressive Disorder (Dysthymia), with Anxious Distress, Early onset, with pure dysthymic syndrome, Moderate - 300.4 (F34.1)

Ben was assigned a diagnosis of persistent depressive disorder with anxious distress, early onset, with pure dysthymic syndrome. This diagnosis was assigned as he reported feeling "continuously" depressed "for as long as [he] can remember", but especially since his father died. Since his father's death, Ben has been taking anti-depressant medication (Zoloft) as prescribed. He indicated that although the medication generally works "really well", he sometimes "struggles" during difficult times (i.e., periods of conflict with valued others). He reported that his depressive symptoms include feelings of hopelessness, helplessness, sadness, and low self-esteem. Other depressive disorders were considered (i.e., major depressive disorder) as Ben reported experiencing a "continuously" depressed mood, feelings of worthlessness or inappropriate feelings of guilt, and a diminished ability to concentrate. But Ben did not evidence a sufficient number of the symptoms needed to warrant a diagnosis of major depressive disorder. Given the duration of his symptoms, major depressive disorder was ruled out and the diagnosis of persistent depressive disorder was indicated. Additionally, Ben reported never experiencing a manic or hypomanic episode, and criteria for a cyclothymic disorder have never been met. The disturbance is not better explained by persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum or other psychotic disorder. The symptoms are not attributable to the physiological effects of a substance or other medical condition. The symptoms cause clinically significant distress and functional impairment across numerous domains. The diagnosis was regarded as early onset as the patient reported that his symptoms have been present since before the age of 21. The specifier of anxious distress was also indicated as Ben reported feeling restless, experiencing difficulty concentrating and making decisions because of worry, and fearing that something bad might happen; and he reported that these symptoms manifest exclusively while depressed. The pure dysthymic syndrome specifier was included as he did not report experiencing symptoms consistent with a major depressive episode at any point during the most recent two years of persistent depressive disorder.

Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years.

Note: In children and adolescents, mood can be irritable, and duration must be at least 1 year.

- a) Presence, while depressed, of two (or more) of the following:
 - Poor appetite or overeating.

- Insomnia or hypersomnia.
 - Low energy or fatigue.
 - Low self-esteem.
 - Poor concentration or difficulty making decisions.
 - Feelings of hopelessness.
- b) During the 2-year period (1 year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.
 - c) Criteria for a major depressive disorder may be continuously present for 2 years.
 - d) There has never been a manic episode or a hypomanic episode, and criteria have never been met for cyclothymic disorder.
 - e) The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.
 - f) The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hypothyroidism).
 - g) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With anxious distress - Anxious distress is defined as the presence of at least two of the following symptoms during the majority of days of a major depressive episode or persistent depressive disorder (dysthymia):

- 1) Feeling keyed up or tense.
- 2) Feeling unusually restless.
- 3) Difficulty concentrating because of worry.
- 4) Fear that something awful may happen.
- 5) Feelings that the individual might lose control of himself or herself.

Specify current severity:

Mild: Two symptoms.

Moderate: Three symptoms.

Moderate-Severe: Four or five symptoms.

Severe: Four or five symptoms and with motor agitation.

Specify if: Early onset

Specify if: With pure dysthymic syndrome: Full criteria for a major depressive episode have not been met in at least the preceding 2 years.

Appendix B

Diagnostic Criteria and Justification of Differential Diagnoses

***Bolted portions of the text indicate criteria that the patient met**

(I) Generalized Anxiety Disorder - 300.02 (F41.1)

Generalized anxiety disorder was considered as a diagnosis for Ben as he reported experiencing excessive anxiety and worry, more days than not for at least six months. However, the patient did not satisfy a sufficient number of symptoms to warrant a diagnosis of GAD. Ben's symptoms of excessive worry and anxiety were better explained by the assigned diagnoses.

Therefore, a diagnosis of GAD was ruled out.

- a) Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
- b) The individual finds it difficult to control the worry.
- c) The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):
 - Restlessness or feeling keyed up or on edge.
 - Being easily fatigued.
 - Difficulty concentrating or mind going blank.
 - Irritability.
 - Muscle tension.
 - Sleep disturbance (difficulty falling or staying asleep, or restlessness, unsatisfying sleep).
- d) The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- e) The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).
- f) The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

(II) Avoidant Personality Disorder - 301.82 (F60.6)

Avoidant personality disorder was considered as a diagnosis for this patient as he reported being restrained in his expression of himself with valued others due to fears of humiliation, aggression, rejection and abandonment. Although Ben was overly concerned with being criticized or rejected, such concern only manifested in specific interpersonal relationships (i.e., with valued others), not across social situations. Furthermore, Ben's symptoms were better explained by a diagnosis of dependent personality disorder, so a diagnosis of avoidant personality disorder was ruled out.

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- 1) Avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection.
- 2) Is unwilling to get involved with people unless certain of being liked.
- 3) Shows restrained within intimate relationships because of the fear of being shamed or ridiculed.
- 4) Is preoccupied with being criticized or rejected in social

situations.

- 5) Is inhibited in new interpersonal situations because of feelings of inadequacy.
- 6) Views self as socially inept, personally unappealing, or inferior to others.
- 7) Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

(III) Borderline Personality Disorder - 301.83 (F60.3)

A diagnosis of borderline personality disorder was considered for this patient because he evidenced recurrent feelings of insecurity in his interpersonal relationships which had begun by early adulthood. Moreover, he strives to avoid real or imagined abandonment, especially from valued others. He has a relatively unstable self-image that appears firmly rooted in his principal relationship(s), and he reported multiple instances of suicidal ideation. Nevertheless, the identified symptoms are not sufficient to warrant a diagnosis of borderline personality disorder. Moreover, his symptoms are better explained by the assigned diagnoses. Thus, a diagnosis of borderline personality disorder was not assigned.

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- 1) Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
- 2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
- 3) Identity disturbance: markedly and persistently unstable self-image or sense of self.
- 4) Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
- 5) Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
- 6) Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
- 7) Chronic feelings of emptiness.
- 8) Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
- 9) Transient, stress-related paranoid ideation or severe dissociative symptoms.

(IV) Major Depressive Disorder, with Anxious Distress, Recurrent Episode - 296.30 (F33.9)

Major depressive disorder with anxious distress was considered as a diagnosis for this patient because he reported experiencing a consistently depressed mood, feelings of worthlessness or inappropriate feelings of guilt, and a diminished ability to concentrate. The symptoms cause clinically significant distress in Ben's interpersonal functioning. Additionally, the depressive symptoms are not

attributable to the effects of a substance or other medical condition. Although the patient met partial criteria for major depressive disorder, he did not report a sufficient number of the symptoms for a major depressive episode even when his symptoms were exacerbated.

Moreover, his symptoms are better explained by the assigned diagnosis. For example, Ben's diminished ability to concentrate and make decisions (without the input of others) appears to be largely attributable to his dependency and associated fears of rejection. Additionally, as the patient's depressive symptoms were reported to have been present since his childhood ("for as long as [he] can remember"), major depressive disorder was ruled out and the diagnosis of persistent depressive disorder was determined for his case.

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either

- 1) Depressed mood or (2) loss of interest or pleasure. Note: Do not include symptoms that are clearly attributable to a medical condition.
- 2) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful).
- 3) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
- 4) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
- 5) Insomnia or hypersomnia nearly every day.
- 6) Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down).
- 7) Fatigue or loss of energy nearly every day.
- 8) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
- 9) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
- 10) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, a suicide attempt, or a specific plan for committing suicide.
 - a) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
 - b) The episode is not attributable to the physiological effects of a substance or another medical condition.
 - c) The occurrence of the majority depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
 - d) There has never been a manic episode or hypomanic episode.

*Note: Criteria A-C above constitute a major depressive episode.

Specify:

With anxious distress - Anxious distress is defined as the presence of at least two of the following symptoms during the majority of days of a major depressive episode or persistent depressive disorder (dysthymia):

- 1) Feeling keyed up or tense.
- 2) Feeling unusually restless.
- 3) Difficulty concentrating because of worry.
- 4) Fear that something awful may happen.
- 5) Feelings that the individual might lose control of himself or herself.

Cyclothymic Disorder with anxious distress – 301.13 (F34.0)

Cyclothymic disorder with anxious distress was also considered as a diagnosis for Ben because he reported experiencing persistent depressive symptoms that were present for at least half of the time for more than two years. He presented with depressive symptoms consistent with a diagnosis of cyclothymic disorder, but he did not evidence any history of “mood cycling” or hypomanic symptoms (excluding distractibility). Although, the patient reported difficulty concentrating, his difficulties are principally related to depression, worry as well as related fears of rejection and abandonment. The patient did not endorse “numerous periods” of hypomanic symptoms. Moreover, his difficulties concentrating do not appear during periods of increased energy or activity, or during periods of elevated, irritable or expansive mood but, rather, exclusively during periods of depression. Taken together, a diagnosis of cyclothymic disorder with anxious distress was not indicated.

- a) For at least 2 years there have been numerous periods with hypomanic symptoms that do not meet criteria for a hypomanic episode and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode.
- b) During the above 2-year period, the hypomanic and depressive periods have been present for at least half the time and the individual has not been without the symptoms for more than 2 months at a time.
- c) Criteria for a major depressive, manic, or hypomanic episode have never been met.
- d) The symptoms in Criterion A are not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.
- e) The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hypothyroidism).
- f) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With anxious distress – The presence of at least two of the following symptoms during the majority of days of the current or most recent episode of mania, hypomania, or

depression:

- 1) Feeling keyed up or tense.
- 2) Feeling unusually restless.
- 3) Difficulty concentrating because of worry.
- 4) Fear that something awful may happen.
- 5) Feelings that the individual might lose control of himself or herself. (American Psychiatric Association, 2013)

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