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# A Case of Depressive Personality Disorder: Aligning Theory, Practice, and Clinical Research

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Depressive personality disorder (DPD) is highly studied and common in clinical settings. Nevertheless, it is rife with controversies and often overshadowed by major depression and dysthymia with which it shares many similarities but also is clinically distinct. Possibly as a result, DPD is underdiagnosed and misunderstood in clinical care. Thus the goal of this practice review is to present a case from psychiatric clinical work illustrating how DPD may be commonly overlooked in routine care, and how the conceptualization of this case and its treatment plan changed course once DPD was considered by treating staff, ultimately contributing to the successful outcome of the case. Questions elicited by the case are subsequently discussed in the context of the empirical literature on DPD, allowing for a clearer picture to emerge on DPD and its role in the development, course, and treatment of depression.

**Keywords:** depressive personality disorder, DPD, major depression, dysthymic disorder, psychotherapy, treatment

Depressive personality disorder (DPD), or similar concepts, is one of the earliest recognized psychological maladies (Arikha, 2007), but it is also one of the most controversial (Huprich, 2001; Ryder, Bagby, & Schuller, 2002), having disappeared and reappeared again in the diagnostic nosology. DPD is currently recognized in Appendix B of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV;* American Psychiatric Association [APA], 2000) as a pervasive pattern of depressive cognitions and behaviors beginning by early adulthood and present across contexts, as indicated by five or more of the following criteria: (1) usual mood is dominated by dejection, gloominess, cheerlessness, joylessness, unhappiness; (2) self-concept centers around beliefs of inadequacy, worthlessness, and low self-esteem; (3) is critical, blaming, and derogatory toward self; (4) is brooding and given to worry; (5) is negativistic, critical, and judgmental toward others; (6) is pessimistic; and (7) is prone to feeling guilty or remorseful. The diagnostic criteria also stipulate this pattern should “not occur exclusively during Major Depressive Episodes and is not better accounted for by Dysthymic Disorder” (APA, 2000, p. 789).

Although controversy exists, the differentiation of DPD from Dysthymic Disorder (DD) and Major Depressive Disorder (MDD) can be accommodated in a straightforward manner. Specifically, many of the symptoms of DPD do indeed overlap with MDD and DD; however, MDD and DD both require vegetative symptoms to be present (e.g., sleep and appetite disturbance), while DPD includes more social–cognitive features not found in the criteria for

MDD or DD (e.g., critical of self and others, pessimistic, worrisome). Nonetheless, a DD diagnosis can be made, for example, with only psychological symptoms, an early and chronic course, and no remission. This presentation is highly similar to DPD (Ryder, Schuller, & Bagby, 2006).

Large-scale studies examining rates of comorbidity between DPD and MDD or DD have generally shown about 50% overlap between disorders in clinical and nonclinical samples (Hirschfeld & Holzer, 1994; Markowitz et al., 2005; McDermut, Zimmerman, & Chelminski, 2003; Ørstavik, Kendler, Czajkowski, Tambs, & Reichborn-Kjennerud, 2007a). Because there are no current conventions for determining rates of acceptable overlap, some have concluded that DPD fits within the broader conceptual space of the DD category (Bagby, Ryder, & Schuller, 2003), while others have determined DPD is a valid construct on its own (McDermut et al., 2003). The construct validity of DPD has now been extensively evaluated (see Huprich, 2009 for review), and there appears to be consensus that DPD and DD are, in fact, two separate clinical disorders. This is based on evidence garnered from pluralistic methods including statistical modeling (Ryder, Bagby, & Dion, 2001), prototype matching (Sprock & Fredendall, 2008), and high-powered twin studies (Ørstavik, Kendler, Czajkowski, Tambs, & Reichborn-Kjennerud, 2007b).

Despite the empirical separation of disorders, DPD remains difficult for clinicians to distinguish from MDD and DD in routine clinical situations. Moreover, it is not particularly clear what value there is in delineating them for case conceptualization and treatment planning. Thus, the purpose of this practice review is to present a clinical case that highlights the presentation of DPD, the difficulty identifying its presence during episodes of depression, and the clinical utility of it once it is diagnosed and care is adjusted to acknowledge its presence. The case is subsequently discussed in the context of the empirical research on DPD, with an overarching goal to highlight the value of recognizing DPD in clinical settings.

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### Clinical Case: Mark

The following depicts Mark, a patient who was treated at a University-affiliated psychiatric clinic over approximately 12 years. The clinic provides services for people with a variety of psychiatric diagnoses within a geographic area of about 60,000 inhabitants, comprising both local and rural areas. The clinic houses both outpatient and inpatient units as well as more specific rehabilitation and day-care units. These units are staffed by licensed, multiprofessional teams (e.g., psychiatrists, psychologists, nurses), and clinicians make their own treatment decisions, although there is also some collaborative overall planning. The individual needs of a patient at intake determine in which unit he or she is to be treated, and the treating clinician is selected based on his or her therapeutic orientation and expertise and in accordance with the treatment plan.

Diagnoses are made in accordance with the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*. When describing the patient as being “improved,” this means that his symptoms have ameliorated. When describing the patient as being “in recovery,” this means he no longer fulfills the *DSM-IV* criteria. These distinctions are determined by the treating clinician. No structured assessments were used, as this is not routine procedure in our clinical setting. However, there are a number of measures that are available for clinicians who may be interested in more formally assessing for DPD. These include the Diagnostic Interview for Depressive Personality (DIDP; Gunderson, Phillips, Triebwasser, & Hirschfeld, 1994), a 63-item semistructured interview, and the Depressive Personality Disorder Inventory (DPDI; Huprich, Margrett, Barthelemy, & Fine, 1996), a 41-item self-report questionnaire that can be completed in a very brief time. In addition, other broadband measures contain subscales for assessing DPD, including clinician-rated interviews such as the Structured Clinical Interview for *DSM-IV* Axis-II Personality Disorders (SCID-II; First, Spitzer, Gibbon, Williams, & Benjamin, 1997), the Diagnostic Interview for *DSM-IV* Personality Disorders (DIPD-IV; Zanarini, Frankenburg, Sickel, & Yong, 1996), the Structured Interview for *DSM-IV* Personality (SIDP-IV; Pfohl, Blum, & Zimmerman, 1997), and the Personality Disorder Interview-IV (PDI-IV; Widiger, Mangine, & Corbitt, 1995). Also useful may be the Personality Diagnostic Questionnaire-4+ (PDQ-4+; Hyler et al., 1988) and the Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon, 1994, 2006), which assesses DPD as part of a comprehensive personality assessment. The Revised NEO Personality Inventory (NEO PI-R; Costa & McCrae, 1992) can also be used to identify a profile that conceptually relates to DPD (Huprich, 2000).

The particular patient described in the following vignette was treated on the basis of these normal routines at the clinic, and decisions at various time points in different units were made by respective staff on the basis of their clinical knowledge. A synopsis of the case is presented first, followed by more specific details about the patient as well as the diagnostic and treatment decisions made during the course of his care. Two important questions are raised by the case, which are then addressed using the extant empirical research. Briefly, Mark was treated in both outpatient and inpatient units for separate episodes of depression, during which time he also attempted suicide. Only after a considerable period was it recognized by clinical staff that he may have depres-

sive personality disorder (DPD), accounting for, in combination with a biological predisposition, his experiences of deep depression. This salient personality piece, once acknowledged, subsequently contributed to a change in case conceptualization and treatment planning, which ultimately resulted in the depression lifting. It is important to note in the following depiction how the cardinal symptoms of DPD were present yet difficult to discern during the presentation of his depressive episodes.

### Background

Mark was married with three children. His parents were farmers, and he has three siblings (he is the second oldest). Mark trained and worked as a carpenter, and at the onset of his depression was attending an educational program to become a foreman in the construction industry. Mark claimed feeling forced into the education due to a traffic accident where he lost some strength and mobility in one arm, making it difficult to function as a carpenter. He has several hobbies—among other things, he breeds birds and is active in sports, especially running. Since the accident he has occasionally participated in races, including long-distance marathons, but is always dissatisfied with the result (the time and place of finish). Throughout his life, Mark has been very demanding of himself, both in work and leisure activities. He always aims to “be the best” and, in situations where this is not the case, his already low self-esteem is reinforced and he feels resigned. Since adolescence he has been described as an active and demanding person, although also an unhappy and gloomy person.

Mark grew up with a very strong, authoritarian and demanding father and a passive, absent, and slightly depressed mother. His mother had a single depressive episode that was pharmacologically treated. Mark describes that he was often beaten and criticized by his father as a child, and the atmosphere in the family was fierce, intense, demanding and critical. He also describes a lack of love, support, and warmth in the family.

During the latter part of Mark’s treatment (below), it became clear that as an adult he has always been more or less dejected and depressed. Since early childhood, he has tried to live up to being “capable and competent,” but always felt he was living a lie. Behind the competent and somewhat “cocky outside,” he never felt good enough and describes himself as always feeling “down and unhappy.” He was characterized by low self-esteem and occupied by ideas of insufficiency and self-accusation. His mood could be described as gloomy, and he has always had difficulties experiencing joy, even when he himself, his children, or his wife were successful in their activities (e.g., school and work). He calls himself the gloomy, pessimistic, and anxious brooding type, and he has pondered a great deal about both the past and the future. Moreover, he can be characterized as very self-critical and self-complaining, but also critical and accusatory toward others, such as work colleagues. At times he has been in conflict with colleagues and/or supervisors, and he often felt misunderstood criticism against him. As a result of this, his gloominess is fortified. When Mark was involved in military service as a younger man, he was released due to his depressive state of mind and, as he states himself, cooperation problems. He felt that his colleagues were allied against him, that they were careless and not as scrupulous as he was, and due to this he felt criticized and worried over his own abilities.

## History of Depressive Episodes

The first time Mark came in contact with psychiatric care was following involvement in a traffic accident where he injured his arm, resulting in a minor loss of function. He had difficulties continuing with his job as a carpenter and gradually became dejected. Mark was referred to the outpatient unit where he was found to have minor depression and treated with a combination of antidepressant medication and brief crisis-oriented psychotherapy. His symptoms ameliorated and the depression lifted although he continued to have some contact with a psychiatrist and remained on a low-dose antidepressant medication for about 4 years (mostly because of his anxious, negativistic, and brooding personality he dared not to stop).

The second time Mark sought contact with the outpatient unit was 6 years after the first. This time he presented in a severe depressive state and was diagnosed as having major depression with symptoms including guilt, meaninglessness, loss of appetite, difficulties with sleep, and poor facial expression. He was initially treated pharmacologically but did not respond. During this time, Mark described suicidal thoughts but denied concrete plans. Gradually worsening, he was taken into an inpatient ward. Mark continued to decline, became more regressive including an increased dependence, passiveness, and helplessness. He soon refused to eat and drink, became unintelligible in his speech and after some time became almost mute and very self-destructive, including behaviors such as hitting himself and attempting to throw himself out of a window. He was also aggressive toward staff on the unit and was taken into compulsory institutional care. Parts of the aggressive reaction were believed to be a side effect of medication, and he improved relatively quickly after a change of medication. However, though he partly recovered, the major depression was still present with cardinal symptoms of passiveness and helplessness.

Mark was discharged from inpatient care, but he continued with psychopharmacological treatment and also began behavioral-activation (BA) psychotherapy in outpatient care. BA psychotherapy was chosen as it aimed to break the passiveness and inactivity and encourage his functioning in everyday life, and he was treated by a psychologist who specialized in this form of treatment. This combination was unfortunately not helpful for Mark, and he became more depressed, resigned, listless, and joyless. He was again treated in inpatient care where his condition stabilized, however during a leave, he tried to commit suicide by shooting himself with a rifle. He aimed at his head but instead badly injured his shoulder and arm. He asserts that he does not remember anything around the suicide attempt.

Mark was subsequently treated with ECT and slightly improved, and he was transferred to daycare where the psychopharmacological treatment and BA psychotherapy continued. However, he was still considerably depressed. Mark expressed disappointments with the focus of the psychiatric care he had received, and for the first time, staff began to consider other aspects of his life than the actual depressive conditions. Clinicians reviewed his life history and concerns were raised as to whether a personality disorder should be considered within the case conceptualization. It was discussed and acknowledged that his long-standing pattern of thinking and behaving may be indicative of depressive personality disorder, which stood "behind" the depressive episodes and could explain the lack of improvement when he received the usual treatments indicated

for episodic depression. Flushing out the case further, Mark indeed described that he had always felt anxious and broody, unhappy and dejected, having low self-esteem, feeling worthless and critical and negativistic toward both himself and others. It was evident that Mark's depressive pattern occurred not only during his depressive episodes.

The diagnosis of dysthymic disorder was also discussed but was excluded in favor of DPD for various reasons. One reason was the relational aspects of the DPD diagnosis present with the patient, such as a history of cooperational problems with colleagues. Another was the existence of the aggressive content, such as critical blaming of the self and others, which are also elements included in the DPD diagnosis. Another reason was the lack of anhedonia, fatigue, and low energy—symptoms that are common in dysthymic disorder. He also did not show any signs of problems with appetite, sleep, or decreased concentration or problems with making decisions. Instead he displayed an existence of energy and self-enhancement during most parts of his life history; however, this always sided with a basic gloominess. Based on these indications, it was decided by the BA psychologist and treatment team that the more depression-focused BA therapy should stop, and in addition to continuation with psychopharmacological treatment, a psychotherapy more focused on underlying, internal aspects of the patient should start.

Psychodynamic therapy began with an experienced psychologist specializing in this form of treatment and proceeded one time per week for just over 2 years. The psychodynamic therapy initiated was a relatively traditional one focusing on affects, defenses, and on gradually identifying "depressive themes" of the patient (including the aggressive aspects), and on interpreting and raising the level of consciousness regarding these defenses and themes, rather than focusing on the overt depressive symptoms. Basically two themes were identified and considered in the therapy. One was a narcissistic vulnerability of the patient, which resulted in a sensitivity for failures and rejection which, in turn, aroused aggressiveness turned both against the self and toward others, resulting again in an increased narcissistic vulnerability. The other formulated dynamic theme was on his low self-esteem resulting in disappointments and ensuing defenses of withdrawing, avoidance, and affect isolation, which in turn reinforced the low self-esteem. Therapy also focused on an empathic holding, and at the same time it also addressed the underlying aggression.

Initially Mark was still very depressed but improved, and when therapy was complete (2 years later), he was recovered from the depression and no longer fulfilled criteria for depressive personality disorder. His mood was not dominated by gloominess and unhappiness and his overall self-esteem and his relational capacities were much improved, although at times he still had a tendency to be brooding and to worry. What seemed especially efficacious and important in the treatment of this patient was not to focus on the major depressive disorder and the symptoms associated with it. Instead, focusing on the personality, on the problems, symptoms, and the aspects underlying these was found to be more successful. Like the patient himself stated "it was much better when the treatment became interested in the whole of me and not just the depression and focusing on getting me doing things." After the termination of psychodynamic psychotherapy, Mark continued on a low dose antidepressant medication for about a year and a half. Since then, he has had no psychiatric contact at all.

## Questions Raised by the Clinical Case and Corresponding Theory and Empirical Research on DPD

The case of Mark highlights at least two critical questions at the heart of DPD assessment and treatment. Specific to assessment, it is important to determine the extent to which DPD precedes the onset of depressive episodes, putting these individuals at risk for experiencing periods of depression. Specific to treatment, it is important to determine the extent to which identifying DPD among individuals seeking treatment for depression changes in some way case conceptualization and guides treatment decisions. To answer these questions, we now turn to the clinical research literature that has aimed to provide some answers.

### Temporal Ordering of DPD and Depressive Episodes: Assessment Implications

Regarding question 1, the empirical work examining DPD as a predecessor of depression has borne out in the literature in at least two major studies. First, Kwon and colleagues (2000) explored whether individuals with the sole diagnosis of DPD were at higher risk for developing Dysthymic Disorder (DD) and Major Depressive Disorder (MDD) than healthy comparison individuals. They identified 85 women with DPD who had no comorbid Axis-I or Axis-II disorders and 85 age-matched healthy comparison women, evaluating all participants with the Diagnostic Interview for Depressive Personality (DIDP; Gunderson et al., 1994). Three years later, participants were reinterviewed to evaluate the cumulative incidence rate of DD and MDD. Results indicated that those with DPD had a significantly greater odds ratio for developing DD than their healthy comparisons (19.4% vs. 4.0%). In terms of the risk for developing MDD, more DPD participants met criteria for current or lifetime MDD at follow-up (6.9%) as compared to participants without DPD (1.3%) although this was not a statistical group difference.

In another study, Johnson, Cohen, Kasen, and Brook (2005) used data from the Children in the Community Study, a prospective longitudinal investigation of more than 600 participants, to investigate the association of personality traits, evident by early adulthood, with the risk for developing unipolar depressive disorders by middle adulthood. Here, items used to assess personality disorders (including DPD) were adapted from instruments including the Personality Diagnostic Questionnaire (Hyler et al., 1988), the Structured Clinical Interview for *DSM-III-R* Personality Disorders (SCID-II; Spitzer & Williams, 1986), and the Disorganizing Poverty Interview (Kogan, Smith, & Jenkins, 1978). Items were combined using computer algorithms and modified to maximize correspondence with the *DSM-IV* diagnostic criteria. Moreover, because PD symptoms must be persistent for an adolescent to be diagnosed, a PD was not indicated unless criteria were met on two occasions, separated by at least 1 year. The authors found that, among other trait sets, depressive personality levels between the ages of 14 and 22 were associated with a significantly elevated risk for DD or MDD by the mean age of 33 (OR 1.36; 95% CI 1.05–1.76). This was evident even after history of depression and other psychiatric disorders were statistically controlled.

The case of Mark also illustrates the possibility that patients with depression and DPD may have a complex course of illness.

The patient's second episode of depression was persistent, worsened to a degree requiring inpatient care, and deteriorated to such an extent that he engaged in violent suicidal behavior. The clinical research that examines the course of depression echoes this case, showing that individuals with DPD may in fact have a more stubborn course of illness than individuals without DPD. Klein and Shih (1998), for example, studied 156 outpatients with mood and personality disorders. They found that DPD present at baseline, as assessed by Akiskal's criteria (1983, 1989), was associated with a significantly higher level of depressive symptoms at 30-month follow-up. In a replication of these findings, Markowitz and colleagues (2005) followed patients with personality disorders or MDD in the Collaborative Longitudinal Personality Disorders Study. Survival analysis indicated that those with MDD who met baseline criteria for comorbid DPD via the DIDP had a lower probability of MDD remission at 2 years as compared to those without DPD. More specifically, patients with baseline DPD had a 33% lower likelihood of MDD remission than patients without baseline DPD.

Similar findings have been published from a study that aimed to identify predictors of course and outcome in Dysthymic Disorder (Hayden & Klein, 2001). DPD, again detected by Akiskal's criteria, was found to be associated with a slower rate of recovery from DD at 5-year follow-up. This was also the case in a follow-up study of the same patients over a 10-year trajectory (Laptook, Klein, & Dougherty, 2006). The authors concluded that the presence of depressive personality contributes unique information in predicting the long-term course of dysthymia. It is interesting to note that these authors also found that patients who had remissions of depressive symptoms at the 5-year and 10-year marks showed a significantly greater decrease in DPD than patients who continued to experience depressive symptoms. This type of amelioration of both problems was also seen in the clinical case of Mark.

### Identifying DPD: Treatment Implications

The second question raised by the case concerns treatment; that is, does identifying DPD among individuals with depression change in some way the conceptualization of the case, guiding treatment decisions? As was seen with Mark, behavioral-activation psychotherapy was initially selected in conjunction with pharmacological treatment. This decision was taken because Mark presented in a deep depression, and BA therapy is an empirically supported psychological treatment indicated for treating depressive episodes (Dimidjian et al., 2006; Hopko, Lejuez, Ruggiero, & Eifert, 2003; Kanter et al., 2010). It was selected above other psychosocial treatments because of his individual presentation, with features of passivity and inactivity. The idea was to help him reengage in his environment and increase access to positive reinforcement. This combination unfortunately was not helpful for Mark, likely due to its emphasis on the manifest depressive episode. However, once DPD was acknowledged, psychodynamic therapy was deemed more suitable by clinical staff to address the underlying, internal psychological aspects that were likely at the core of his depression. Research has indicated that DPD is, in fact, associated with dynamic concepts such as poor object relations (Huprich, Porcerelli, Binienda, Karana, & Kamoo, 2007; specifically tied to DPD in this study were problems managing aggression and low paternal benevolence—both aspects seen in the case

of Mark), perfectionism (Huprich, Porcerelli, Keaschuk, Binienda, & Engle, 2008; also seen in the case), and vulnerable narcissism (Huprich, Luchner, Roberts, & Pouliot, 2012; also seen in the case).

Interestingly, and elsewhere in the literature, Akiskal (1996) has postulated that affective temperament—conceptually related to DPD—may be the characterological core of depression. Recent findings have indeed confirmed an association between depressive temperament and narcissistic disturbance (Tritt, Ryder, Ring, & Pincus, 2010). Unfortunately, there is dearth of empirical study examining the role of DPD in the treatment of depression, and no study has examined psychodynamic psychotherapy specifically. As the research and the clinical case together illustrate, much more work is needed in understanding the mechanisms behind good treatment outcomes for patients with clinical depression and DPD.

There are a small handful of studies examining DPD and treatment for depression. For example, in assessing individuals with mild, chronic depression on past treatment history, Phillips and colleagues (1998) found that the length of time spent in treatment was substantially longer for those with DPD as compared to those without DPD. More exactly, individuals with DPD spent an average of 63 months in therapy, which was more than twice as long as individuals without DPD (27 months).

To our knowledge, the first psychotherapy study to examine DPD in relation to treatment outcome was conducted by Saulsman, Coall, and Nathan (2006). One hundred and 19 patients ( $N = 119$ ) with a primary diagnosis of MDD were divided into high- and low-depressive personality groups according to scores on the Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon, 1994, 2006). Those with a base rate score below 85 were included in the low-depressive personality group ( $n = 60$ ) and those scoring 85 and above were included in the high-depressive personality group ( $n = 59$ ).

At baseline, all patients completed a series of measures including the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996), which captured depression severity and served as the primary outcome measure. Patients then underwent a Group CBT mood management intervention (Nathan, Smith, & Rees, 2004). Groups of 10–12 participated in 2-hr sessions over 10 consecutive weeks of treatment, in addition to a 1-month follow-up session.

When data were analyzed categorically, findings indicated that patients in the high-DP group had more residual depressive symptoms at posttreatment. However, these individuals also had greater baseline severity and, accordingly, they displayed poorer end-state functioning. The rate of improvement in depressive symptomatology was not different between high- and low-DP groups, indicating that patients with DPD were not differentially responsive to the intervention (even though they displayed poorer endpoint scores). Moreover, when analyzed from a dimensional perspective, DPD did not contribute any predictive value regarding treatment outcome for depression beyond baseline depression severity. Thus, the authors concluded that there was no association between DPD and treatment response to Group CBT for depression. This outcome is particularly salient, as the case of Mark demonstrates, such that psychotherapy aimed at underlying structures (such as cognitive schemas) may be suitable for patients with DPD presenting with depression.

One controlled trial of psychopharmacologic treatment outcome examining DPD has been carried out; however, the inclusion and evaluation of depressive personality was ancillary to the main investigative aim. Hirschfeld and colleagues (1998) examined predictors of response to acute treatment in the Chronic Major Depression and Double Depression Study (Keller et al., 1998). Six hundred and 23 patients ( $N = 623$ ) with a *DSM-III-R* diagnosis of chronic major or double depression and a minimum rating of 18 on the 24-item Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960) were randomized to 12 weeks of treatment with sertraline (50–200 mg/day flexible) or imipramine (50–300 mg/day flexible). In this study, sertraline-treated patients and imipramine-treated patients were pooled and subsequently analyzed in terms of treatment response ( $n = 324$ ) or nonresponse ( $n = 299$ ). Response was defined as a Clinical Global Impressions-Improvement (CGI-I; Guy, 1976) of 1 or 2 (very much or much improved) and a total HRSD score reduced by 50% or greater from baseline, with a HRSD total score  $\leq 15$  and a Clinical Global Impressions-Severity (CGI-S) score of  $\leq 3$  (mildly ill).

Depressive personality was captured at baseline via the DIDP, in addition to the seven Schneiderian traits comprising depressive temperament (1958, 1959). Results from this study found that neither the DIDP nor the Schneiderian trait set was predictive of drug response although significant mean differences between groups were found for some depressive personality characteristics. Individual trait ratings on the DIDP for low self-esteem, introversion, and quietness were significantly higher for the nonresponder group as compared to the responder group.

Lastly, two studies have examined DPD and treatment outcome for depression by way of designs that included both psychotherapy and psychopharmacology treatments. First, Maddux and colleagues (2009) investigated whether the presence of DPD would moderate treatment response for depression in a secondary analysis of data from a large, multisite clinical trial (Keller et al., 2000). Six hundred and 81 ( $N = 681$ ) patients with chronic forms of MDD were randomized to 12 weeks of treatment with nefazodone, the Cognitive Behavioral-Analysis System of Psychotherapy (CBASP; McCullough, 2000, 2003), or their combination. Of these patients, 35.7% ( $n = 243$ ) were diagnosed with DPD at baseline using the SCID-II (First, Spitzer et al., 1997). When treatment data were reanalyzed in terms of those with DPD versus without DPD, there were no significant differences in outcome between the two groups for any of the three treatments or for treatment overall. This suggests that the presence of comorbid DPD did not affect treatment response in a way that was different from the original study. It is important to note, however, that none of the other PD groups assessed in this analysis (avoidant, obsessive-compulsive, or a pooled group of those with any type of PD) showed a differential response to medication, psychotherapy, or their combination either.

Most recently, Ryder, Quilty, Vachon, and Bagby (2010) reported results from a trial that examined the ability of DPD to predict overall and preferential treatment outcome for 120 patients with major depression. Patients in this study were randomized to 16–20 weeks of treatment with Cognitive-Behavioral Therapy (CBT), Interpersonal Therapy (IPT), or antidepressant treatment (ADM) which included seven possible medications (bupropion, citalopram, fluoxetine, paroxetine, phenelzine, venlafaxine, or sertraline) in flexible dose ranges. DPD was assessed with the self-

report version of the SCID-II (First, Gibbon, Spitzer, Williams, & Benjamin, 1997), and a 6-item version of the HAM-D (Faries et al., 2000) was used to measure severity of depression while the 17-item version was used to determine remission status. Remission in this study was defined as  $\geq 50\%$  decrease in HAM-D scores and a final HAM-D score of  $< 8$ .

Results demonstrated that DPD did not predict overall treatment outcome; however, a pattern of preferential responding did. DPD was associated with poorer treatment outcome to IPT, but not to CBT or ADM, even after statistically controlling for effects associated with the presence of other personality disorders. Further, those individuals identified as high on DP traits (score  $\geq 5$ ) treated with IPT had significantly poorer remission rates (27%) as compared to those individuals identified as low on DP traits (77%). What remains unclear are the mechanisms responsible for the differential response patterns; however, a crucial consideration is that IPT—though derived from a dynamic theoretical background—is a *present-centered* treatment approach that addresses relational areas including interpersonal disputes and role transitions, rather than a therapy oriented toward underlying psychological structures and dynamics. Depressed individuals with PDs receiving IPT have been shown to have poorer outcomes in comparison to other treatment modalities in some (Carter et al., 2011; Joyce et al., 2007) but not all studies (Levenson, Wallace, Fournier, Rucci, & Frank, 2012).

As was seen in the clinical case of Mark, the more present-oriented approach of BA, which focuses on one's environmental context and learning while combating the behavioral inertia of depression via activity and goal setting, was not helpful for him, whereas one that aimed to elucidate internal psychic structures and processes rooted in early experiences proved to be the turning point that ultimately led to restoration of his psychological health. Certainly it is important not to draw conclusions about the relative efficacy of different treatment approaches based on a single case. Indeed, as has been discussed recently in the literature, individuals vary widely in response to specific treatments, and there is a need to identify characteristics that reliably predict differences in benefits of various depression treatments (Simon & Perlis, 2010). Nevertheless, theory and data presented here are in line with the aspects of treatment that worked well for Mark and his response to the treatment options provides important information for research and clinicians to consider.

### Summary and Conclusion

This practice review focused on the course of treatment for a patient with DPD, bringing to bear existing theory and empirical work to this poorly understood condition. As highlighted in the practice review, there are difficulties in understanding DPD independently of MDD and DD. Accordingly, a particular challenge that faces clinicians in day-to-day clinical work is determining whether they are dealing with clinical depression or DPD or both, and whether identifying DPD among depressed patients has any substantive value for case planning and treatment outcome. We have offered an illustrative case example from our own psychiatric clinical work that focused specifically this situation; that is, how easy it may be to overlook DPD in routine clinical care and proceed with normal treatment plans indicated for a depressive episode. As was evidenced by the case, our clinic staff diagnosed

depression in the patient on two separate occasions and during the latter, more severe episode he was treated accordingly with empirically supported interventions for depression including psychopharmacology and behavioral-activation psychotherapy. We did not consider DPD in this patient until it became clear that we needed to turn to another form of treatment. We considered both Dysthymic Disorder and DPD in a reconceptualization of the case, resolving that DPD was the appropriate diagnosis because of the lack of vegetative symptoms (which would suggest a mood disorder) and that the patient's pattern of thinking, behaving, and relating to others aligned with the criteria for DPD. In addition, there was the important acknowledgment that these elements were displayed as part of a long-standing and characteristic pattern, even outside of his episodes of depression. Once DPD was factored into the case conceptualization, it shifted our treatment plan from one that focused on the overt depressive symptoms to one that addressed internal structures and processes. On this basis, our clinical team decided that a psychodynamic approach was suitable, and an experienced psychotherapist with this training and expertise was assigned to the case. Although to our knowledge there are no empirical studies investigating psychodynamic psychotherapy for the treatment of depression with comorbid DPD, there is a burgeoning research field that has shown relationships between DPD and several dynamic concepts, including object relations (Huprich et al., 2007), perfectionism (Huprich et al., 2008), and vulnerable narcissism (Huprich et al., 2012)—all aspects that appeared in the case of Mark.

The dearth of clinical research that exists on treatment outcomes for depression have generally found that the presence of DPD does not negatively impact response to treatment, and it is certainly conceivable that treatment may be effective in addressing personality pathology alongside any depression remediation (Quilty, Meusel, & Bagby, 2008; Tang et al., 2009). How the depression is therapeutically targeted may be a salient piece for clinicians to consider, as was elucidated in the Ryder et al. (2010) study and evidenced by the case of Mark. Future work that aims to determine which approaches are empirically supported for cases of depression and DPD will be important, and indeed, some hypotheses seem to be emerging based on recent research. Along similar lines, it appears that assessing for DPD may be a critical element to consider when depressed individuals present for treatment. Using reliable and valid measures might help clinicians accomplish this, in order to disentangle DPD from overt episodes of depression, assist in treatment decisions, and hopefully contribute to more rapid and successful outcomes.

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