

## IS HER DIAGNOSIS MAJOR DEPRESSION OR SEXUAL REPRESSION?: A NON-WESTERN FIJIAN FEMALE CLINICAL SINGLE CASE STUDY

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### ABSTRACT

*This article presents a case of a 25-year-old non-western Fijian working class woman who became severely depressed following a love relationship problem. During six months of cognitive-behavioral treatment involving two 1 hour weekly session specifically applying Beck, Rush, Shaw, and Emery (1979) standard cognitive therapy resulted in no treatment gain.*

*This indicates the inefficacy of such intervention, thus being attributed to differential clinical diagnosis of the syndrome. After termination of therapy, a further in-dept case analysis and review of the patient revealed the importance of sexual repression as possible underlying syndrome, thus suggesting Freud's psychoanalytic conceptualization of this problem as a possible explanation of her many depressive and anxious symptoms.*

*A prospective suggestion on possible psychoanalytic treatment is advocated for in such future case of similar nature. The problems of classification of mental disorders in Diagnostic Statistical Manual (DSM), clinical diagnosis, clinical judgment, and therapeutic bias, are briefly highlighted and discussed with some concluding suggestions.*

**Keywords:** *Diagnosis Major Depression or Sexual Repression*

The issue of clinical diagnosis of various psychological disorders has been an area of controversy in clinical psychology and psychiatry. For instance, the diagnosis of depression and anxiety has stimulated a lot of intense debates because some clinicians claim that both syndromes are similar while others view them as distinct entities (e.g., Akiskal, 1990; Dobson, 1985; Stravakaki & Vargo, 1986).

Nevertheless, there is a general consensus in the literature that depression and anxiety.

Exist concomitantly in clinical case (Watson, Clark & Carey, 1988; Watson & Kendall, 1989). These debates are usually centered on theoretical issues and treatment outcomes. In order to demonstrate the correct diagnosis of a particular psychological disorder, the outcome of the intervention or treatment has been utilized

as one major criterion in assessing the therapeutic effectiveness. In simplicity, if the treatment is successfully demonstrated than this can be attributed to proper diagnosis. On the other hand, when the treatment is ineffective than the diagnosis is assumed to be incorrect.

In what follows, I present a comprehensive single clinical case study of diagnosis of major depressive disorder in a female patient, thus showing the appropriate diagnosis based on self-reported symptom measures with well defined psychometric properties derived from Beck's cognitive theory of depression and anxiety. Similarly, the Diagnostic Statistical Manual for Mental Disorders III Revised edition (DSM-III-R) diagnostic criteria for major depressive disorder concomitantly confirmed the diagnosis of this syndrome. Subsequently, I show the inefficacy of cognitive therapy because of differential diagnosis and thus suggest a possible diagnosis of *sexual repression* from psychoanalytic theory of Sigmund Freud as a causal explanation of the patient's major depressive episode with anxiety symptoms.

## **PATIENT'S BACKGROUND**

The patient, Miss Betty Z is a single indigenous non-western Fijian, who was self-referred for therapy. At the time of initial evaluation at the clinic, she was 25 years old, and employed as a public relation officer in a financial institution. She is the only daughter in the family, and a graduate from a local university. She lives with her mother and described her as authoritative and domineering. Her father died when she was 20 years old while studying at the university.

## **PRESENTING CONCERN AND HISTORY OF AFFECTIVE DISORDER**

Prior to clinical intervention, the patient had no personal and family history of emotional or psychiatric disorder. Further evaluation through her mother confirmed the foregoing information.

A year and two months before visiting the clinic, she was admitted to hospital when she collapsed in the washroom of her work place. She recalled collapsing as a result of severe continuous abdominal pain concentrated around gaenacological area of her body. When admitted to the intensive care unit of the hospital, she was when then diagnosed of ovarian cyst. Surgery was performed immediately and her left ovary was removed (this medical data was confirmed via patent's record in the hospital through the consent of the patient).

Subsequently, after ovarian cyst removal and her discharged from hospital, she continued to experience the same intensity of pain around her gaenacological is. Specifically, the pain is normally associated and experienced during her menstrual cycle. However, the pain is so intense that many times it proves difficult for her to walk. Although analgesic and anti-biotic drugs that were prescribed by her doctor and taken by her, the pain persisted from month to month. The patient at various times further consulted various gaenacological doctors as well as receiving acupuncture treatment, but there were no success obtained from these treatments. Since after the surgery, this episode of pain lasted for 14 months, and that was the time she came for psychological intervention.

Before the history of developing pain, patient *Betty Z* had a first boy friend that was a foreigner on contract attachment working in Suva city. After months of their intense love relationship, the boy friend left for his country after his contract has expired. During the period of their relationship, the patient admitted falling deeply in love with her boy friend. Their relationship did not result in sexual intercourse, but sex foreplay was exercised. These involve kissing, sucking the breast, and touching sexual organs of each other. The patient recalled having no orgasm. According to the patient, this was her first sexual experience. Nevertheless, sexual intercourse was not entertained because the patient comes from a Protestant religious group, and also a strong cultural background that prohibits and condemns sex before marriage.

Initially when she came for psychological intervention, she complained of missing her boy friend and expressed longing ness to be with him soon. The patient could not develop another love relationship because she loved her boy friend so much. Another factor influencing her present status quo was of culture related morality and that is, her immediate family knew her present relationship and to venture into another one is seen as immoral. In compounding the problem, her boy friend promised to send an airline ticket so that she can travel to his travel to his country, get married, and live there. This was not forthcoming as expected, and as result, the patient began to develop severe pain in her gaenacological area as well as depression and anxiety symptoms. She felt uncertain about her future.

## COGNITIVE AND BEHAVIORAL EVALUATION

Because of the unsuccessful treatment of her pain and associated depressive and anxious symptoms noted by her medical doctor, *Miss Betty Z* was advised to consult a clinical psychologist or psychiatrist. At intake, the patient's symptoms included depressed mood, anhedonia, insomnia (difficulty in falling asleep), diurnal variation of mood (night worst) loss of appetite, loss of weight, and being anxious at times. In terms of quantitative measures, the Beck Depressions Inventory (Beck, Ward, Mendelson, Mock & Erbaugh, 1961) score was 30, Hopelessness Scale (Beck, Weissman, Lester & Trexler, 1974) score was 15, and Beck Anxiety Inventory (Beck, Epstein, Brown & Steer, 1988) score was 13.

These scores were consistent with severely depressed mood thus qualifying her for a major depressive disorder diagnosis. The DSM-III-R diagnosis was as follow:

Axis I : Major depressive disorder  
(296.23)

Axis II : No diagnosis

Axis III : Physical condition: Pain

Axis IV : Psychosocial stressors: Broke up  
with the boy friend family  
pressure

Axis V : Current GAF = 70; Best GAF  
past year = 68

## TREATMENT

Treatment consisted of cognitive-behavioral therapy specifically utilizing standard cognitive therapy for depression

(Beck, Rush, Shaw & Emery, 1979). One hour weekly sessions were held twice weekly. The treatment lasted for a total of 48 sessions (6 months).

### **Cognitive Content**

The patient exhibited cognitive content symptoms typical of depression, including such negative thought as: "I am a loser", "there is no future for me", "I am always wrong when I do something good" "I am not interested in anything I do these days", "things just won't work out the way I want them to." These negative thinking characterized her depressed mood.

### **Therapeutic Strategy**

The therapeutic intervention involved techniques such as *challenging* negative automatic thoughts and developing positive thinking was encouraged. The utilization of cognitive techniques of *guided discovery* and *collaboration empiricism* (Beck, ET. Al, 1979) were also administered to the patient. Furthermore, the use of *down ward arrow* technique was applied in identify the dysfunctional attitude of the patient.

After every weekly session, the patient was given *homework assignments* to monitor and record her depressive and anxiety symptoms. These were focused specifically on time, situation, and behavior being exhibited by the patient (Wilson, Spence & Kavanagh, 1989). Such behavioral strategy was aimed at stimulating and motivating the patient to realize that she can be able to independently do the tasks, thus building her positive ness and sell confidence.

In countering anxiety, *progressive-muscular relaxation exercise* training was taught to the patient. After mastering it, she utilized the technique to prevent anxiety in situations that normally precipitate her anxious symptoms.

### **Treatment Outcome**

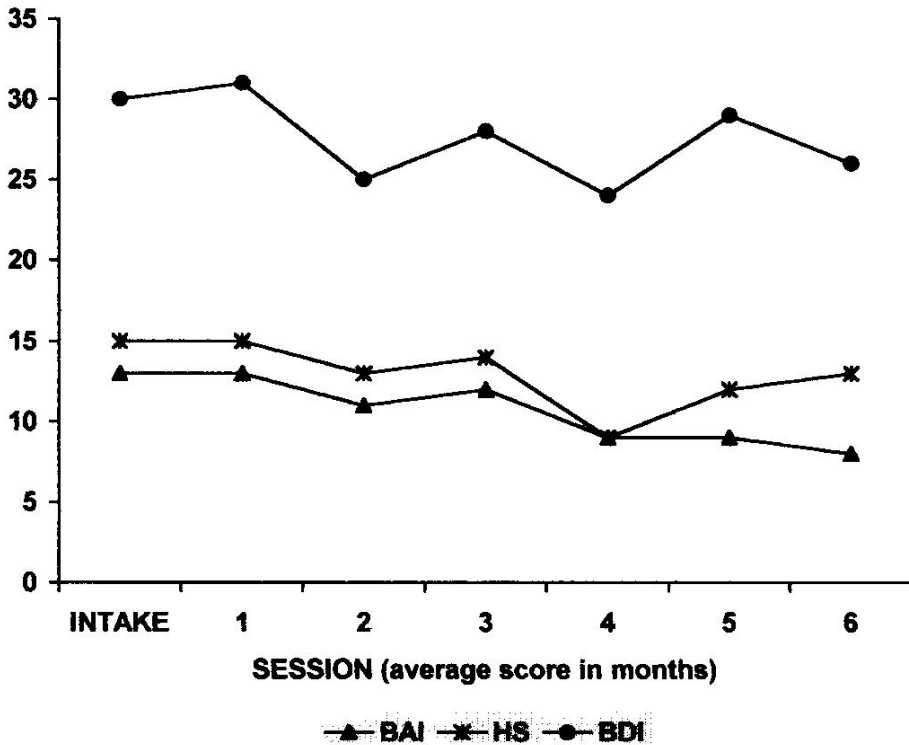
As can be seen in *Figure 1*, treatment was unsuccessful, although the symptoms decreased slightly after intervention; there were increases there after from session to session. As a result of continuous failure in treatment gain, after six months, the therapy was terminated on ethical grounds, and the patient was referred to another psychotherapist for alternative therapeutic intervention.

## **DISCUSSION, CONCLUSION, AND SUGGESTIONS**

Despite evidence of treatment efficacy in treatment of psychological depression (Dobson, 1985) with cognitive therapy (Beck, et. al, 1979), this particular case proves ineffective. In this particular clinical case, the failure of cognitive therapy intervention may be attributed to the problem of differential diagnosis, and *not* the therapy itself. This was revealed after reviewing and analyzing the case of the patient. Although the diagnosis was major depressive disorder according to DSM-III-R criteria, the main aspect of the patient's account was based on sexual themes or content, thus having sexual link and sexual connotation. These themes exhibited by patient in form of psychological and physiological expressions, and therefore lead to a possible hypothesis of *sexual*

repression in Freudian conceptualization as a major syndrome causing the symptoms of depression and anxiety. Since *sexual repression* is not accounted for as diagnostic criteria in DSM-III-R, its inclusion would be of “unscientific” a dubious clinical merit. Despite that, Freudian influence is evident in present day

diagnostic classification system as one clinician pointed out: “*The differentiation of the psychoneurotic reactions from other functional disorders as well as the subdivision of these reactions is largely dictated by psychoanalytic theory*” (Maher, 1970, p.26).



**Figure 1.** Back Depression Inventory (BDI), Hopelessness Scale (HS), and Beck Anxiety Inventory (BAI) Scores at Intake Assessment, at Therapy Sessions in Months

The mental disorders classification system such as DSM has been criticized on several grounds. The DSM may be an inadequate guide in that criteria contain little indication of what constitutes

sufficient frequency, severity, or distressfulness of symptoms to discriminate between normal processes of recovery of the syndrome. Furthermore, in general the DSM lacks sufficient theoretical base, is

scientifically unprogressive, and should be replaced by competing theory-laden manuals (Follette & Houts, 1996). However, in response to Follette and Houts (1996) criticisms, Wakefield (1998) maintains that DSM's theory nosology is neutral and scientifically progressive (cf. Controversial debates between Follette and Houts, 1996, Houts and Follette, 1998; Wakefield, 1998, on this issue). Despite these debates about the efficiency and utility of DSM, one fact remain evident is that, DSM is limited in specificity in terms of determining the actual *cause* of any particular disorder. In the past, Cameron (1944) argued that all current attempts at classification of functional personality disorders, neurosis, as well as psychoses are unsatisfactory. This argument even remains valid today.

Another related common problem in clinical practice is that, clinical diagnosis and even clinical judgment (Dawson, 1994; Friedlander & Phillips, 1984; Meehl, 1954, 1997) have remained controversial and continue to be debate intensively in psychology and psychiatry. For example, Dawson (1994), and Meehl (1954, 1997) respectively have argued that clinical judgment is no better than actuarial or statistical prediction in diagnosing a particular disorder. Quite significantly, these problems have continued to plague and hinder the progress of psychotherapeutic advancement.

Freud (1954) has shown explicitly in the famous case of Dora whereby, *sexual repression* was her underlying cause of her many hysterical symptoms. By relating and explaining the present causing similar analogy, patient *Betty Z* experienced her first sexual contact with her boy friend, but

she did not achieve any orgasm. Her sexual wish for satisfaction is being repressed because of her religious and cultural norms (super ego). As a result, she repressed her sexual wish and then later developed physic-psychological symptoms such as pain, depression, and anxiety. For pain, Freud (1954) mentioned it to be a significant component of hysterical symptoms, thus it is not surprising that, in recent times the area of pain received a lot of attention in clinical psychological research and clinical intervention. The ovarian cyst may be attributed to stress, anxiety, and depression. In fact, medical and psychological researches have shown stress, anxiety, and depressions do have relationship to ovarian cyst as well as cancer of the uterus in female. However, the syndrome that causes these symptoms may be to *sexual repression* if sexual themes are prevalent in the clinical picture of patient as shown in the case of *Betty Z*.

Given the aboveproposed diagnosis of sexual repression, it is than suggested that the application of psychoanalytic treatment of future case of similar nature. In addition, more research are required in area of sexual relationship of patient who become depressed, thus taking into account the contribution of Freud's psychoanalytic concept of *sexual repression*. The inclusion of *sexual repression* in diagnostic classification system of mental disorder is warranted, however before that, a lot of research is required. A useful starting point is to access this concept empirically in determining its scientific and clinical significance and utility. One way of doing it is to define how *sexual repression* can be operationalized and measured in quanti-

tative term. In other words, this issue has to be addressed empirically.

Although his single case study is speculating on the diagnosis of *sexual repression* (which is not a diagnostic category in DSM-III-R or DSM-IV) Other than major depressive disorder, the history of the patient's problem can be best understood from psychoanalytic theory than cognitive theory of Beck. Therefore in essence, psychoanalytic treatment seems a first, appropriate, and viable choice in this case.

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