Case Report
Volume 11:12, 2021

Clinical Case Reports

ISSN: 2165-7920 Open Access

Case Report on Assessment and Management of Major Depressive Disorder

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Abstract

Client Z.I was 36 years old man with presenting complaints of sleep disturbance, difficulty in concentration, restlessness, fatigue, lack of interest in anything, suicidal ideation and history of suicide attempt. In Forma assessment; Siddique Shah Depression Inventory (SSDI), Suicidal Ideation Scale (SIS) were used and in informal assessment observations, clinical interview, mental status examination, Dysfunctional Thought Record chart (DTR) used for diagnosis. Client was diagnosed with major depression disorder. Management plan was devised based on cognitive behaviour therapy techniques such as identifying distortions, ABC model, distraction techniques, motivational interviewing and hope box/survival kit, moreover no harm contract, art therapy, social therapy were used. Total 14 sessions were conducted.

Keywords: Siddique Shah depression inventory • Suicidal ideation scale • Dysfunctional thought record

Introduction

Identifying data

Initials: Z.1

Age: 28 years

Gender: Male

Education: M.A

Birth order: Middle

No. of sibling: 3(1 sister, 2 brothers)

Marital status: Married

No. of children: None

Religion: Islam

Informant: Wife

No. of sessions: 14

Reason and source of referral

Client was referred to trainee clinical psychologist with presenting complaints of restlessness, fatigue, difficulty in concentration, lack of interest in any activity and suicidal ideation with history of suicide attempt for psychological assessment and management.

Initial observation

Client Z.I was 28 years old man wearing T-shirt and jeans. His hair was not combed. He had good height and average weight. He maintained good eye contact during observational period. He seemed to be restless and depressed. His mood was congruent to his thoughts, as he reported he lost interest in everything. His voice was low toned. Rapport was built, client was cooperative.

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Received 13 December 2021; **Accepted** 20 December 2021; **Published** 30 December 2021

History of present illness

As started from client's childhood, client had cold parents, who were emotionally void. They did not show emotional love to children although they fulfilled their physical needs. Client mother was so emotionally detached from children that client reported she never kissed or hugged her children. Client became mature before his age, as childish behaviour was not appropriate in their home. They act like adults who never demand or show tantrums. Client uncle had bipolar disorder and was taking therapy for this purpose.

Client involves himself in studies to overcome this emotional void of cold parenting. Even siblings were detached and cold toward each other; they didn't know how to make relationship with anyone. He completed his graduation and got job in a company at the age of 24 years. At the age of 26 he committed suicide by taking pills after breakup with girlfriend. He reported he was complete failure and unlovable. He also reported he don't know how to keep and maintain a relationship.

After suicide attempt, he was admitted in government psychiatric hospital and his stomach was washed, he took therapy for few weeks. He tried to remain positive but his colleagues and relatives make fun of him that he committed suicide due to a girl and she left her for someone else. In this hard time, her sister supported her and took care of her. They became close to each other and he was comfortable to share things with her sister.

His sister helped him to overcome adverse situation and he started taking interest in daily life activities. At the age of 27 he got married and things were better at the start of marriage. After few months, her mother and wife had some conflicts regarding household activities. His wife was very supportive and caring toward her. He blamed himself for being cold and unresponsive to her needs. His mother was taking hold of everything, and wanted everything should be the way she wanted. Things get worse when he lost his job due to downsizing of company. Conflicts on minute issues between her mother and wife became daily routine.

After these issues, his sleep became disturb, and he had suicidal ideation. He lost interest in daily life activities and had feeling of worthlessness and hopelessness; he reported he was complete failure. Client's wife forced him to visit hospital, as he had restless and difficulty in sleeping from past 1 month. Client reported that he didn't want to live, things were out of his control.

Background Information

Personal history

Birth and early childhood: Client was born with normal delivery and was healthy child. But throughout his childhood he suffered from fever and chest infection on and off. He had a road accident at the age of 10 while crossing the road in front of his house, and his left leg was fractured. His mother was working women and most of the time maid took care of him. He badly felt her absence, he wanted to be with her mother when he was ill but she could not manage to give him time due to her busy schedule.

Moreover, she was emotionally detached from children, she was of the view that their physical needs are fulfilled, what else they needed. Her mother was from broken family that could be the reason of her cold behaviour.

Educational history: Client started his school at the age of 5, he was bright and shy student. He was very hardworking and performed well in school. He had very few friends in school, as he didn't socialize much with children. He didn't participate in play activities and spent time in reading books. He reported that it took him more time to memorize content then other children that's why he always spent time reading books to overcome this problem.

In college life, he had good relationship with teachers, as he was brilliant student. His classmates make fun of him that he was bookworm, he reported that he was fearful that when he will interact with them, they will dislike him, as he was very boring and don't know how to enjoy things. He graduated from well-known institute and got job in a company.

Occupational history: Client was working in a company; he was very reserve and had only one friend who was a girl. He was very reluctant in forming any relationship, it was the girl who gave him confidence and he started loving him, it was the best time of his life. But things get worse when she left him and married to his boss. After that he committed suicide and was admitted in hospital for 2 weeks. When he re-joined his office, everyone mocked him that a girl left him.

He was hard working but some time could not concentrate on office's task and make mistakes which seemed careless mistakes to his boss. So sometimes it was difficult for him to complete tasks due to his overthinking. He lost job due to downsizing of company and it was very stressful for him to accept this. He blamed himself of this that he was incompetent and failure.

Sexual history: Client age of monarchy was 14, he had no information prior to monarchy. He was very shy and did not aware of pubertal changes. He was confused why his voice had change spontaneously. At first instance he thought, he had some throat infection or illness later on he used to it, when his peer group had voice frequency equivalent to him. He was reluctant and uncomfortable while sexual history intake as he was very shy and privacy oriented.

Marital history: Client was married at the age of 27. He had good relationship with his wife. His wife was supportive and caring toward her. After his marriage, his mother and wife had some issues, he felt overwhelmed by daily conflicts of mother and wife.

Premorbid personality: Client was shy and very few friends before his illness but he enjoyed reading books. After his illness, he lost interest in everything and spent time lying on bed. He was fond of food but after illness, he lost his appetite.

Family history: Client belong to extended family, he was last born and had 3 siblings (1 sister and 2 brothers). Client father was businessman and his mother was lecturer in university. Client had very cold relationship with parents. He reported that they never showed love toward any child. They full filled their physical needs but were not emotionally present. The relationship of mother and father was also cold, both don't interfere in each other matters and hardly talk to each other.

Client had good relationship with his sister but relationships with brothers were not normal, they hardly communicate with each other. Client all siblings were married and were living separate, only client was living with his parents. He reported, although his parents are emotionally detached but he can't live separately.

Client was married and had good relationship with his wife. She was supportive and caring toward him. Client overall home environment was stressful; his mother had conflicts with his wife. Client was stressed due to daily based conflicts of mother and wife.

Family history of physical and psychiatry illness: Client had family history of psychological illness; his uncle had schizophrenia and was admitted in mental hospital.

Psychological assessment

Psychological assessment of the client was carried out at two levels:

- Informal psychological assessment
- Formal psychological assessment

Informal assessment

- Observation
- Clinical interview
- Mental status examination
- Subjective ratings of client's problems
- Dysfunctional Thought Record (DTR)

Clinical interview

The clinical interview is an interpersonal process designed to simultaneously initiate a therapeutic relationship and gather assessment information. It has been and remains the default entry point for patients (or clients) seeking mental health treatment. The clinical interview constitutes the first opportunity for clinicians to build a therapeutic alliance and conceptualize the patient's presenting problem [1].

Mental status examination

The mental status examination is a structured assessment of the patient's behavioral and cognitive functioning. It includes descriptions of the patient's appearance and general behavior, level of consciousness and attentiveness, motor and. speech activity, mood and affect, thought and perception, attitude and insight, the reaction evoked in the examiner, and, finally, higher cognitive abilities. The specific cognitive functions of alertness, language, memory, constructional ability, and abstract reasoning are the most clinically relevant [2].

Subjective ratings of problems

Subjective ratings were taken at pre and post levels to have an idea about improvement in Client condition and to assess the effectiveness of Therapeutic intervention. Subjective ratings were taken from client about her current problem. The ratings were taken from 0-10, in which "0" means "not at all" problematic and "10" indicates "severely problematic" (Table 1).

Dysfunctional thought record

Thought records are cognitive restructuring techniques which encourage balanced thinking. The Dysfunctional Thought Record is a style of thought

Table 1. Subjective rating of client's problems as rated bay herself.

Problematic Behaviors	Ratings
Restlessness	8
Sleep disturbance	9
Difficulty in concentration	8
Suicidal ideation	9
Fatigue	8

record which encourages identification of any cognitive biases/cognitive errors which are operating. It can be useful to use this form in combination with the Unhelpful Thinking Styles information sheet - clients are encouraged to identify in which ways their specific cognitions are distorted. This thought record was used to identify characteristic ways in which client's cognitive styles were distorted.

Formal assessment

- Siddique Shah Depression Inventory (SSDS)
- Suicide Ideation Scale (SIS)
- Rotter incomplete sentence blank (RISB)

Siddique shah depression scale

SSDS was developed by Salma Siddique and Syed Ashiq Ali Shah in 1997 to measure depression in clinical and non-clinical Pakistani population. It consisted of 36 items, client was asked to fill questionnaire and it took him 10 minutes to fill questionnaire. Qualitative and quantitative analysis was carried out for result interpretation [3].

Quantitative Analysis

Quantitative report

Client raw score on SSDS were 41, which fall under the category of moderate depression (Table 2). Client highest score was on the items such as:

Suicide ideation scale: The Suicidal Ideation Scale is a 10 item self-report measure designed to assess the severity or intensity of suicidal ideation among university students. Using a 5-point Likert scale (1=never or none of the time; 5=always or great many times) participants report the extent to which each statement is true of the way they have felt or behaved in the past year. The SIS was designed to represent a continuum of suicidal ideation ranging from covert suicidal thoughts ("Life is so bad I feel like giving up") to more overt or intense suicidal ideation ("I have been thinking of ways to kill myself"). All items are scored in a positive direction and the SIS yields a single score, with higher scores representing greater levels of suicidal ideation. SIS was administered on client; it took him 5 minutes to complete questionnaire. Qualitative and quantitative analysis was carried out to interpret results [4].

Qualitative Analysis

Client raw score was 29, which fall under the category of severe, it means client have severe symptoms of suicidal ideation. Client score highest on items such as "thinking about attempting suicide", "attempted suicide", "better to die" and lowest score on items "informing other about suicide attempt". As client reported that he didn't want to live, it's better to die rather than live like a failure. Results indicates that client have severe form of suicidal ideation and had attempted suicide (Table 3).

The rotter incomplete sentences blank

It is a projective psychological test developed by Julian Rotter and Janet E. Rafferty in 1950. It comes in three forms i.e. school form, college form, adult form for different age groups, and comprises 40 incomplete sentences which the client has to complete as soon as possible but the usual time taken is around 20 minutes, the responses are usually only 1-2 words long such as "I regret ..." "Mostly girls...". The test can be administered both individually and in a group setting [5]. It doesn't have long set of instructions and can be easily worked out on a greater population. RISB was given to client and was asked to complete the sentence. It took him 15 minutes to complete test (Table 4).

Qualitative analysis

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Table 2. Showed raw score, cut off score and clinical significance of SSDS.

Raw Score	Cut off Score	Clinical Significance
41	37-49	Moderate

Table 3. Showed raw score, cut off score and clinical significance of SIS.

Raw Score	Cut off Score	Clinical Significance
29	20-40	Severe

Table 4. Table showed client response category, relative response score and obtained score on RISB.

Responses Category	Relative Response Scores	Obtained Score
P1	4	4 × 2=8
P2	2	2 × 1=2
P3	3	3 × 0=3
Neutral	6	6 × 3=18
C1	7	7 × 4=28
C2	11	11 × 5=55
C3	7	7 × 6=42
Total	40	156

had attempted suicide.

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Qualitative interpretation

RISB was administered on the client in order to assess the client inner feelings, conflict wishes and desires. The result showed three type of reactions in corresponding to items, neutral, positive and conflict behaviours. He showed positive responses in following areas such as the best…, I can't, marriage and happiest time. It showed the areas of his life which he like most, as he reported marriage was his happier time, because he had good relationship with wife. As throughout his life, there was no one who showed warm and care toward him, most important figure in his life his mother was emotionally detached to her, so wife's love and care was positive factor in his life. Moreover, client conflicted responses were on the statement like "when I was child, I was helpless", "A mother should love his children", "my great fear is rejection". these conflicting behaviours represented that client feel uncomfortable when talk about them. and client's neutral responses were on "my mind is working well". The client obtained 156 scores, which indicated that client was maladjusted in his life.

Diagnosis

Major Depressive Disorder, Moderate, 296.21 (F32.1) recurrent episode with anxious distress.

Prognosis

Client prognosis was satisfactory, client was suffering from recurrent episodes of depression and suicidal ideation, it required proper treatment for recovery. His wife was supportive, and client showed compliance to therapeutic intervention, so prognosis was satisfactory.

Case Formulation

Client Z.I was 36 years old man with presenting complaints of sleep

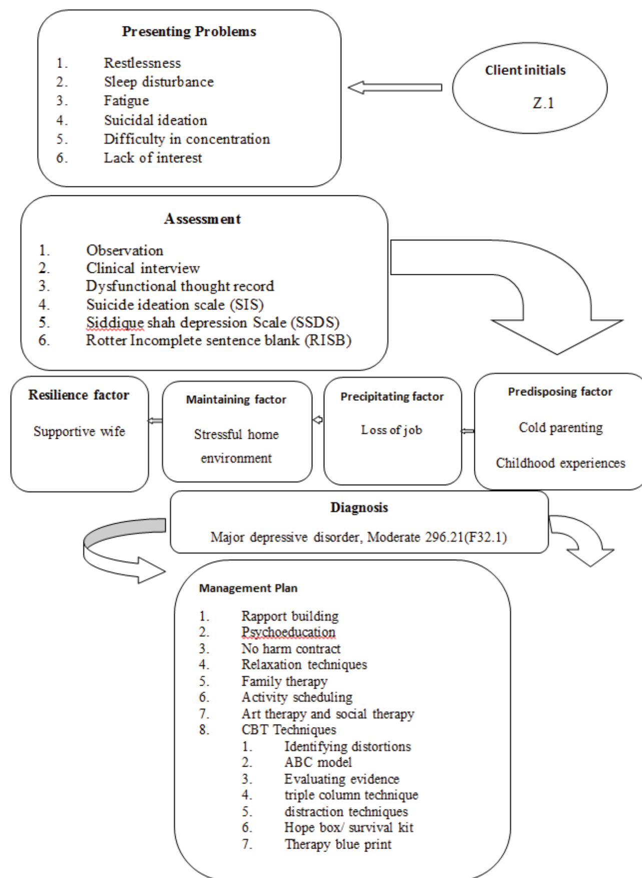

Figure 1. Summary of case formulation.

disturbance, difficulty in concentration, restlessness, fatigue, lack of interest in anything, suicidal ideation and history of suicide attempt. These symptoms caused significant impairment in client's functioning. Formal and informal assessment was carried out to assess client's symptoms. According to DSM V, client was diagnosed with major depression disorder (Figure 1).

Predisposing factors in development of major depression were cold parenting. His parents were emotionally unavailable for children. Object relations theorists (the psychodynamic theorists who emphasize relationships) propose that depression results when people's relationships leave them feeling unsafe and in secure. People whose parents pushed them toward either excessive dependence or excessive self-reliance are more likely to become depressed when they later lose important relationships.

Precipitating factor in client case was loss of job, again psychodynamic explanation of loss, which indicated that many people become depressed without losing loved one, Freud explained this through symbolic or imagined loss, in which a person equates other kind of events with the loss of loved one. Client job loss equate with the loss of his loved one such as wife, believing that his loved one only love him when he will perform well. Lewiensohn proposed that social rewards are particularly important in the downward spiral of depression. Researches indicated that depress persons received less reward then non depressed persons and their mood improved when their social reward increased.

Maintaining factor in client case was stressful home environment, there was continues conflict between his mother and wife. As Beck believed that some people develop maladaptive attitudes as children. This attitude results from their experiences, their family relationships, and the judgement of the people around them. According to Beck, upsetting situations in one's life may trigger an extended round of negative thinking and reactions. Client's stressful home environment further triggered the negative thoughts as he reported things were out of his control.

Protective factor in client case was care and support of his wife. As client's mother was emotionally detached since birth, wife was whole support system for client. She was cooperative and wanted that client get better and move back toward normal life.

Client was diagnosed with major depression. Family was psycho educate about client and his risk of suicide. Management plan was devised on based of cognitive behaviour techniques.

Management Plan

Management plan was devised, short term and long-term goals were formulated to help client deal with his problem (Table 5).

Short term goals

- Rapport was built for effective communication, assessment and intervention
- Client and his family will be psychoeducate about illness and treatment interventions.
- client will be asked to make a no herm contract with therapist, which will be a written promise to not harm himself, whenever suicidal thoughts come in his mind, he will make a call to his sister/ brother/ therapist and try to distract himself by keeping himself busy.
- Family therapy will be used to sort the family problems and to ensured support for client.
- Relaxation and mindfulness techniques will be used to address client's fatigue and sleep issues.
- Activity scheduling will be devised to make client maintain a healthy routine.
- Client will be asked to write down his thoughts and feelings on paper for written ventilation. It will help client in catharsis.
- To make client distract himself from negative and suicidal thoughts distraction techniques will be explained to client such as "focus on now", and "backward counting" etc.
- Art therapy will be used to address client's emotional distress such as frustration to help him identify and understand his emotions and thoughts.
- Cognitive behaviour therapy techniques such as ABC Model, identifying thought's distortions, proselytizing technique, examining the evidence, cognitive restructuring, motivational interviewing will be used to deal with client's dysfunctional thoughts.
- Social therapy will be used to help client in decision making and problem solving.
- Client will be given a survival kit/hope box, which consist of motivational videos, quotes of people about suicide, who experienced

Table 5. Following table show comparison of client rating of the problems before and after management.

S.No.	Problems	Pre-assessment Ratings	Post-assessment Ratings
1	Restlessness	8	6
2	Sleep disturbance	9	6
3	Difficulty in concentration	8	5
4	Suicidal ideation	9	7
5	Fatigue	8	6

difficult times but manage to overcome them. Moreover, virtual hope kit app was installed in client mobile in case he had difficulty in keeping hope box.

- Therapy blue print will be used at the end of session to help client summaries the therapy and what he had learn in therapy sessions and how he will use these techniques in future.

Long term goals

Short term goals will be continued for relapse prevention and follow ups will be scheduled on monthly basis.

Summary of Therapeutic Intervention

Therapeutic outcome

Therapeutic outcome was assessed both at quantitative and qualitative levels to see the efficacy of the treatment.

Subjective rating of problems

Subjective rating of problems was taken at the post assessment in order to check the efficacy of outcome.

Qualitative Interpretation

Limitations and suggestions

- There was no proper room for therapy.
- Client family was abroad, and she needed family support.
- Suggestions
- There should be proper therapy room free of distraction and noise.

Conclusion

Session reports

Session 1: In this session behaviour observation and rapport building were focused. Client was ensured support by active listening to his problem.

Session 2: Client was explained the no harm contract, and was asked to read and fill this contract that he will not harm himself till the next session.

Session 3: In this session clinical interview of client and family was taken. Detailed history of present illness, family history, occupational history and subjective ratings of presenting complaints were taken from client.

Session 4: Siddique Shah Depression Scale (SDSS), and Suicide Ideation Scale (SIS) were given to client and asked him to fill the questionnaire.

Session 5: Client was explained dysfunctional thought record chart and he was asked to fill the chart at home.

Session 6: Client and family was psycho educated about assessment, and treatment process.

Session 7: Family Therapy was given to ensure the family support for client. Client's mother and wife were explained that support of family can better help client in managing his depression.

Session 8: Client activity schedule was formulated and some activities of client interest were also added in schedule. Client was asked to follow the activity schedule.

Session 9: Relaxation exercises were carried out throughout therapy session at the start of session to deal with client's sleep and fatigue issue.

Session 10: ABC model and proselytizing technique were explained to client with examples that how activating event, behaviour and consequence are interlinked. Client was asked to give example of it for better clarity.

Session 11: In this session identification of core belief of client and client was explained about rational and irrational belief and how to restructure cognition. Client was given chart to write down thoughts and rate them irrational or rational and gave reason of each. After this practice, he was asked to restructure thoughts into rational thoughts.

Session 12: Social therapy was given to client, to help him develop problem solving ability.

Session 13: Hope box / survival kit was given to client and was explained how he can take help whenever negative or suicidal thoughts come into his mind.

Session 14: Client was given therapy blue print and he was asked to give the summary of his therapy, his problems, techniques he learned and his future goals. He was encouraged to take follow ups to prevent relapse.

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How to cite this article: Khan, Maimoona and Rabia Siraj. "Case Report on Assessment and management of Major Depressive Disorder." Clin Case Rep 12(2021): 1483.