CASE STUDY: DEPRESSION

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Abstract

Ms R was came with the complaints of low mood, guilt feeling, lack of energy, lack of interest, decreased libido, disturbed sleep, decreased appetite and the complaints of not feeling what is happening around. All these complaints were intensified in the past 15 days. There is no history of any other psychiatric illness. There is no family history of any psychiatric illness. She is also suffering from the problems related to menopause since 9 to 12 months. At that time she started feeling lethargic and complained of lack of interest and weakness etc. Therefore the doctor prescribed medication for depression. After sometime she started taking homeopathic treatment for the same. Then she consulted another doctor, who also prescribed some medication. On MSE he was looking sad and the thoughts were pre-occupied with the feelings of guilt, hopelessness, helplessness, worthlessness and somatic complaints. Eye to eye contact could be maintained and rapport was easily established. Psychomotor activities were decreased and tone of speech was low.

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Case History

Ms. R is 47 years old married Punjabi female, educated up to 12th standard, belongs to a higher middle class family. She is a house wife. The information is gathered through her husband and self which seems to be reliable. The total duration of illness is about 9-12 months. The onset is gradual, course is continuous and progression is increasing. No significant stressors could be elicited as if now.

Presenting Complaints

At the time of the interview the patient reported that for about 15 days she was experiencing symptoms like low mood, guilt feeling, lack of energy, lack of interest, decreased interest in sexual activities, decreased appetite, disturbed sleep and insensitivity as to what is happening around.

History of Present Illness

The patient was well till about a year back. On 9th March 2013, she complained of chest pain. Then, as per her husband reported, she started to show childish behaviour sometimes like stubbornness etc. She also used to report or lack of interest, lack of energy, low mood and physiological symptoms related to neck. The patient reported of unclear disturbance due to the external environment. This continued for 3 to 4 months. She reported that she has not laughed for so many months. She also complained of lack of concentration, attention and isolation for the past four months. Since 15 days she is facing much problem in sleep as she raises around 4 'o' clock in the morning. She also has difficulty in getting out of the bed in the morning. Lack of energy, low mood, lack of interest and lack of concentration is also increased than earlier. There is no history of any other psychiatric illness prior to the current one.

Negative History

There is no history of hearing voices and suspiciousness.

No history of any extremely elated or agitated mood.

No history of any obsessive-compulsive symptoms.

No history of any alcohol dependence or drug abuse.

Past History

The patient has been ill for the past 9 to 12 months. During this time she became more introvert than earlier. Her mood started remaining low. Some concentration deficits also aroused during this time. She was not able to shift her attention from one object to another. When she

thought about some disturbing event, it used to disturb her for a long time. She was not able to understand the television serials also. She also does not want to cook food since the problem has started. She reported that she does not feel anything for her husband, though he is very good. She said that somebody has done some black magic on her.

Medical History

In Jan. 2013, she did not get the periods. For that she took some hormonal treatment. After that when she got the period, it continued for one month with excessive flow. Now it is normal and she is undergoing menopausal treatment.

Treatment History

In March 2013, she went to a hospital in Delhi and consulted a psychiatrist for the first time. He prescribed some medication but she did not take that medication. In May or June 2013 she took homeopathic treatment for depression for the first time but it was not very effective according to the patient. Then on Nov. 20th 2013 she approached another hospital where she was prescribed some other medicines for depression.

Family History

Around 5 years back her parents expired at the interval of 3 months. She belonged to a middle class family and she was the only child of her parents. Her father was the head of the family. The relationship with her parents was fair. There is no history of any psychiatric illness in the family.

Personal History

She was a full term normal vaginal delivery with immediate birth cry. Developmental milestones were achieved normally. Her education was started at the age of 3.5 years. There was no history of any school phobia. She had fewer friends since childhood and she was also introvert from the beginning. She was an average student, educated up to 12th standard.

She got married 20 yrs before. The relationship with in-laws was fair.

She also said that she was less interested in sexual activities since marriage. This according to her may not be satisfactory for her husband. She said – "Kai kamiyan rahi hongi mujh me bhi.Apsi sambandh ki kami he.Mera man shuru se us taraf nai he." She has 2 children- one daughter in class11th, one son who is doing engineering from U.S.A. She told that whenever she entered her daughter's room she said- "jao yaha se mujhe kaam karne do" She represses her desires also because she reported that she wanted to talk to her daughter but she compromises for

her daughter's studies- "mera man karta he baat karne ka par fir sochti hu chalo koi baat nai.bacchho ki padhai he.

Pre- morbid Personality

She was an introvert person from the beginning and had a very limited friend circle. She was fond of watching television and was very religious also. She was also ready to take responsibilities.

Current Situation and Functioning

Presently she finds difficulty in rising up in the morning and rises somewhere around 9:00 'o' clock. Then she performs her daily activities like brushing her teeth, bathing, freshening etc. Does not take interest in household activities, sits idol and most of the times staring in neutral. Earlier there was a difficulty while going to sleep but now since when she is taking medication, sleep is improved.

Mental Status Examination

The patient came to interview room with her husband. She was well dressed, walked slowly towards the chair and obediently sat down when asked to. ETEC was less maintained.

Her psychomotor activity was decreased. Rapport could be easily established with the patient. Rate and quantity of speech was decreased and the volume and tone was also decreased. The speech was hesitant. Subjectively smood was reported low that authenticated the objective observation by therapist. Thoughts were preoccupied with somatic complaints, guilt, hopelessness, helplessness and worthlessness. Her perceptions had the content of depersonalization. The patient was conscious at the time of MSE and was oriented towards time, place and person. Her attention and concentration was reduced. Immediate and recent memory was intact but at times forgetfulness was reported in remote memory. Her abstract thinking was appropriate. Judgment was found to be intact.

The patient was aware of being sick, due to something unknown to self. Hence the insight is present at level 4.

Summary

Ms R was brought with the complaints of low mood, guilt feeling, lack of energy, lack of interest, decreased interest in sexual activities, disturbed sleep and decreased appetite. The patient also complained that she was not able to realize what is happening around. All complaints were intensified in the past 15 days and she was referred to the department of psychiatry of the

hospital she is taking treatment from. The patient had no personal and family history of any other psychiatric illness. She is also suffering from the problems related to menopause since 9 to 12 months. Since then she is on medication for the same. At that time she started feeling lethargic and complained of lack of interest and weakness for which she was prescribed medication of depression, which she did not follow. After sometime she started taking homeopathic treatment for the same, which did not work up to the mark. Then she consulted another doctor who prescribed some medication, which she is still taking. On MSE he was looking sad and the thoughts were pre-occupied with the feelings of guilt, hopelessness, helplessness, worthlessness and somatic complaints. Eye to eye contact could be maintained and rapport was easily established. Psychomotor activities were decreased and tone of speech was low.

Diagnostic Formulation

Ms R was came with the complaints of low mood, guilt feeling, lack of energy, lack of interest, decreased libido, disturbed sleep, decreased appetite and the complaints of not feeling what is happening around. All these complaints were intensified in the past 15 days from the day she reported to the therapist. No personal and family history of any other psychiatric illness was found. She was also suffering from the problems related to menopause since 9 to 12 months. At that time she started feeling lethargic and complained of lack of interest and weakness etc. Therefore she was prescribed medication for depression. After sometime she started taking homeopathic treatment for the same. On MSE he was looking sad and the thoughts were pre-occupied with the feelings of guilt, hopelessness, helplessness, worthlessness and somatic complaints. The subjective and objective report indicated low mood. Psychomotor activities were decreased and tone of speech was low.

Provisional Diagnosis

Major Depressive Disorder (ICD-10: F 33.3)

Psychological assessments and their significance

Hamilton Depression Rating Scale (HDRS): To confirm the diagnosis and to know the level of depression if it exists.

Beck's Depression Inventory (BDI): To cross check the obtained results of the HDRS.

Behavioral Observation during the Test Administration

In starting the patient showed less interest in the testing but after some time when she started she was looking interested in the testing. Sometimes she was looking confused regarding the items and she was sincerely doing the work. At the end of the testing she was more interested in knowing the results of the tests immediately.

Test Findings

Hamilton Depression Rating Scale (HDRS): On Hamilton Depression Rating Scale the patient scored 37 that is suggestive of severe depression and needs to be treated through professional help.

Beck's Depression Inventory (BDI): On Beck's Depression Inventory the patient scored 40, which is suggestive of severe depression and also very near to extreme depression or very severe depression.

Assessment summary

With case history, mental status examination and psychological assessments Ms. R. meets the criteria of Major Depressive Disorder.

Final Diagnosis

Major Depressive Disorder without Psychotic Features and with Somatic Features.
(ICD-10: F 33.3)

Prognosis

Good Prognostic Factor- Total support from husband and willingness to get well.

Poor Prognostic Factors- Less support from daughter.

Treatment Plan

Objectives of the Therapy

Short-term goal was to enhance the interest of the patient in different activities. Long-term goals targeted to reduce the level of depression, negatives thoughts and beliefs, to make the patient optimistic towards the future, to strengthen the patient to fulfill his wishes and to reduce the guilt feeling of the patient.

Therapeutic Process

- **Catharsis**
- **Relaxation**
- **Counseling**
- **Cognitive Behavior Therapy**

Session Summary

Session 1

Motivating the client to undergo therapy and rapport establishment

In the 1st session the patient was motivated to undergo the therapy as she was expressing some doubts in getting well. But at the end of the session she was successfully motivated for the treatment by reminding her of her disturbed and painful life which could be treated through the medication and psychotherapy. Rapport was also established in this session.

Session 2

Completing Diagnostic Interview, and Building Therapeutic Alliance

In the 2nd session Ms. R came along with her informant who was her husband. She was interviewed about the nature and development of the symptoms and the whole history taking was completed in this session with the help of the patient and her husband. Both the patient and her husband were very cooperative during the history taking.

A therapeutic alliance was also built on the basis of the following conditions-

1. Acceptance of regularly consulting the psychiatrist for pharmacotherapy.
2. Acceptance of regularly coming for the psychotherapy sessions.
3. Acceptance of doing all what is needed for the treatment.

Session 3

Psychometry

In the 3rd session the psychological tests were administered to see the level of the psychopathology.

Session 4

Counseling with special emphasis on exploration and probing

In the 4th session the patient was counseled emphasizing on exploration and probing. In this session the patient was explored and probed more about the relationship with her husband and children. The reason of guilt was also explored in this session.

Session 5

Catharsis and relaxation

In the 5th session catharsis was also done to release the negative emotions. Then relaxation training was also provided in this session before which the patient was explained about the mind body relationship, as to how her thinking pattern can affect her mind, which in

turn can bring about some changes that may cause disturbances in the body, which further disturbs the mind by strengthening the negative thinking. Ms. R. was taught to tense one group of muscles while the rest of the complete body was is to be kept relaxed. She was asked to concentrate on the therapist's voice and her own breathing throughout the session.

Session 6

Rational Emotive Behavior Therapy with special emphasis on cognitive interventions and Relaxation

In the 6th session the patient's irrational beliefs were disputed through functional, logical and philosophical disputes like- how continuing to think that you have done something wrong is affecting your life? Where is the logic that whatever you are thinking is true? Despite the fact that things will probably not go the way you want some of the time in this area, how can you derive some satisfaction for your life?

Rational coping statements were also made in this session like- "I can accomplish this task, I will do it without getting tensed" etc. Relaxation was also provided in this session.

Session 7 and 8

Rational Emotive Behavior Therapy with special emphasis on emotive interventions and Relaxation

In the 7th and 8th sessions forceful disputing and rational-emotive imagery was emphasized by forcing the client to dispute his own irrational beliefs through creating strong anti-worrying statements like- "I never ever have to focus on negative thought coming to my mind" and encouraging the patient to imagine one of the worst activating event that could happen to her. Relaxation was also done with special emphasis on pleasant imagery and it was observed that the patient could relax better.

Session 9 and follow-ups

Rational Emotive Behavior Therapy with special emphasis on behavioral interventions in collaboration with cognitive and emotional interventions and Relaxation

From the 9th session behavioral interventions were started with the patient like home assignments challenging irrational beliefs, skill training (training the patient cognitively in disputing the accompanying irrational beliefs and deriving self statements) and use of rewards and penalties. Cognitive and emotional interventions were also used when needed.

The therapist from session 5 to 9 provided relaxation. Each session was progressing. From the 10th session she was asked to do by herself without assistance. As she was able to do steps correctly as well, she was asked to continue the relaxation at home both in the morning and in the evening.

Outcome

A case of Major Depressive Disorder has been receiving weekly sessions, each lasting for about 90 to 120 minutes. The patient is being dealt with the help of the techniques like catharsis, relaxation, counseling and cognitive behaviour therapy. She is regularly and willingly coming for the sessions and showing interest also. She is sincerely doing all the work assigned and responding well to the relaxation exercises and therapeutic sessions. The patient is showing improvement over a number of sessions and reported that she had been enjoying the work assigned to her.

References

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