

A Case Study of Major Depression: Conflict with Primary Support Group

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The study demonstrates the case of a 45 year old man. He was brought to the psychiatry ward on account of depressive behavior; such as agitation, dryness of mouth, isolation, loss of appetite, loss of sleep, weight loss, lack of energy, loss of pleasure, feelings of worthlessness, deterioration from previous level of functioning, and inactivity. His symptoms fulfilled the DSM-IV-TR criteria of Major depressive Disorder (recurrent), and relational problems with primary support group (DSM-IV-TR, 2000). The recent episode triggered before the wedding of his daughter. He was assessed informally (with Mental Status Examination and subjective rating on several depressive symptoms) and formally (with Beck depression Inventory, Hamilton Rating Scale, House Tree Person Test, and Rotter's Incomplete Sentence Blank). These measures revealed severe depression, severe maladjustment, acute interpersonal conflict, suicidal ideation and feeling of loneliness. The intervention plan comprised of Cognitive Behavior Therapy (e.g., Cognitive Restructuring, Graded Task, Mastery and Pleasure Technique), physical exercise and family psycho education. The client showed marked improvement in his areas of dysfunctioning and significant decrease in severity of depression.

Key words: depressive behavior, support group, maladjustment, interpersonal conflict. Suicidal ideation, cognitive behavior therapy.

Childhood circumstances leave crucial impact on the behavior of an individual in later life. Early separation from parents and influence of surrogate parents aggravate the situation and cause psychological dilemma for children, especially loss of mother while under the age of 20 predicts depression (Kivela, 1996). Beck (1987) argued that negative schemas of depressed individuals develop as a result of adverse childhood experiences, in specific the loss of parent figure, and in stressful situation these negative experiences will reactivate. Epidemiological studies have strongly supported the association of adverse experience during childhood, such as abuse, neglect or loss with dramatic increases in the risk to develop depression, and the relationship between the number of experienced childhood adversities and the presence of lifetime chronic depression (Chapman et al., 2004; Edwards, Holden, Felitti, Anda, 2003). Role of childhood traumas in the development of major depression has also been supported in the twin studies (Kendler et al., 1993, 2000; Nelson et al., 2002). Childhood distress is a potential risk factor for developing depression in adulthood; particularly in response to additional stress, neuroendocrine changes secondary to early life stress likely reflect risk to develop depression in response to stress, potentially due to failure of connected neural circuitry implicated in emotional, neuroendocrine, and autonomic control to challenge (Heim et al., 2008).

Method

Participant

The present study demonstrates the case of Mr. X: A 45 year old school teacher belonging to a lower middle class family. He was the only child of his parents. Mr. X's mother died when he was 12 year old, and father married to his widow sister in law with four children. The step mother used to abuse Mr. X verbally and physically, and

his father always beat him on the complaints of his step mother. According to Mr. X, his father never satisfied his demands like toys, new dress, storybooks etc after the death of his real mother. His step siblings maintained distance and used to abuse him verbally and physically. Mr. X developed feelings of loneliness and self pity after the death of his real mother, as he stated, "I felt lonely at my own home due to the attitude of step mother and step siblings". Mr. X reported that it all made him very reserved, isolated, shy, and coward child. He hesitated to face guests at home in childhood, still he had no close friend and avoided interacting with strangers.

After passing matriculation from local Government High School, Mr. X joined as a teacher in a government primary school in his town. He was married to his cousin 25 year back. According to Mr. X, his wife was not caring and compassionate; she criticized him for low income, and non luxurious life. There were frequent fights between them on financial issues. He had two daughters and three sons. Mr. X reported that his daughters were very caring and loving and he was closer to them.

Mr. X was brought to the Psychiatry ward due to complaints of restlessness, loss of appetite, loss of sleep, weight loss, lack of energy, loss of pleasure, feelings of worthlessness, and deterioration from previous level of functioning, and inactivity for last seven months. He was diagnosed with major depression (recurrent).

First psychiatric episode occurred at the age of forty, before the wedding of his elder daughter. Mr. X reported that he was very upset due to the wedding expenditures, as he had no friend and real sibling to support him at that difficult moment. He said feelings of deprivation and loneliness prevailed over him. According to Mr. X, thinking of separation from her daughter was quite painful for him and made him sad. The current episode occurred before the marriage of his younger daughter. Mr. X reported this event as a financial challenge for his family.

Instrumentation

In addition to presenting complaints, Mental Status Examination, and history of present illness; Rotter's Incomplete Sentence Blank (RISB) and House Tree Person (HTP) were used for diagnostic purpose. Score on RISB suggested severe maladjustment as his

score was $159 > 135$ cut off point. His low self esteem and depression was depicted from HTP drawings: drawings in the corner of the page, and gloomy remarks on drawing like child is weeping. His feelings of insecurity were reflected from baseless tree; and stiff neck showed his rigid behavior. Self rating score on BDI was 48 and therapist's rating on Hamilton Rating Scale (HRS) was 31, which suggested severe depression.

Case Formulation

On the basis of Mental Status Examination, Formal assessment tools, symptoms reported by the client, hospital staff and family members, Mr. X was diagnosed with Major Depressive Disorder (recurrent) fulfilling the criteria of DSM-IV-TR.

According to Mr. X, his father never fulfilled his desires in childhood, Goodman (2002) claims that individuals who report that their childhood needs were not adequately met by their parents are more likely to become depressed. Poor parenting as a risk factor for depression is also held up by (Lara, & Klein, 1990). Mr. X felt himself lonely due to the death of his real mother, unfriendly attitude and verbal and physical abuse of his step mother and siblings. Onset of depression as a consequence of loss, in particular, a response to the loss of loved one such as parents is supported by the pioneers of psychoanalytical school (Abraham, 1916/1960; Freud, 1917/1963; Harris, Brown, & Bifulco, 1990). Billings, Cronkite & Moos (1983) provided convincing evidence of chronic sources of psychosocial strains in the development of depression. Role of childhood stressors in the later onset of depression in adverse circumstances coincides with research outcomes by Kendler, Kuhn, Prescott (2004). In addition to maltreatment, parental loss due to death or separation is also associated with increased risk for depressive disorders. Individuals with early adverse experience appear to be sensitized to the depressive effects of acute stress in adulthood (Dougherty, Klein, Davila; Hammen, Henry, Daley, 2000; 2004; Kendler, Kuhn, Prescott, 2004). Felitti et al., (1998) found 4-fold increases in the risk of depression in persons with multiple childhood adverse experiences. Findings of the National Comorbidity Survey (Molnar, Buka & Kessler, 2001), the Ontario Health Survey (MacMillan et al., 2001), and a New Zealand community survey (Mullen, Martin, Anderson, Romans & Herbison, 1996) have provided concordant findings.

Mr. X wife quarreled with him frequently due to financial constraints. She always condemned Mr. X for low income and non luxurious life style. Lack of marital adjustment and severity of depression is supported by Frank et al. (1997). Costello (1982) supported the role of severe life events and difficulties in the onset of depression; specifically lack of intimacy with spouse increased the risk of depression. Relatively high rate of depression among people with poor marital support is also maintained by Jenkins (1998). Denton, Golden, and Walsh (2003) in a review article found strong relationship between marital discord and depression. Relationship between low support system and depression, negative comments of spouse and depression and poor relationship with one's spouse or marital conflict in the prediction of depression has been supported (e.g., Bifulco, Brown, & Movin, 1998; Brown & Harris, 1989; Hooley & Teasdale, 1989; Kivela et al., 1996; Niaz & Hassan, 2005).

Mr. X was a low income person and financial constraints made him upset on the weddings of his two daughters. Expenditures exceeded resources and he found himself helpless to handle the situation. These stressful events triggered the onset of depressive

episodes twice. Ilfeld (1997) explored the relationship of current social stressors (circumstances of daily social roles that are generally considered problematic or undesirable) to depressive symptoms. Stress or acute challenge has long been recognized as a potent risk factor for depression, often precipitating the onset of depressive episodes (Kendler et al., 1993, 2000). Barchas, Akil, Elliott, Holman, Watson (1978) and Thase, Frank, & Kupfer (1987) supported psychosocial stressors as risk factor in the development of mood disorder.

Therapeutic Intervention

The patient was brought to hospital second time for the treatment of depression. He was on Pharmacotherapy for last one month, but there was no significant improvement in his condition and functioning. Based on the case formulation as derived with the help of multiple available sources (viz., presenting complaints, mental status examination, personality tests, and diagnostic tests), family psycho education plan along with Cognitive Behavior Therapy Plan like Problem Solving, Cognitive Restructuring, Mastery and Pleasure Technique in collaboration with Daily Activity Schedule, and Graded Task Technique were used to deal with patient's negative thinking pattern, feelings of helplessness to handle adversities, lack of energy, inactivity and loss of pleasure. Numerous studies have supported the efficacy of Cognitive Behavior Therapy: Mastery and Pleasure technique and Graded Task in the treatment of depression (e.g., Meichenbaum, 1977; Beck, 1991). Recording of dysfunctional thoughts form was also used, so that the patient could record and change his irrational, negative thoughts and beliefs. The therapist and client worked in coalition to come across the evidence for the validity of these thoughts and beliefs and to replace them with positive thinking and beliefs.

Training in problem solving was imparted, so that he may improve his skill to manage family discord and adversities in life. Social skill training was given to the client; so that he could improve his interaction with the environment, communicate properly with his colleagues, maintain better relationship with people in general and wife and sons in particular. Psycho education was given to the patient about his automatic thoughts and relationship between thinking and emotions. His sons and wife were provided psycho education regarding early signs of depression and relapse as well. The client was motivated for morning walk and exercise. Therapists such as Elizabeth et al. (1987) recommended exercise to reduce the symptoms of depression.

Outcome

Intervention plan was used for 45 days in ten sessions. The outcome of the comprehensive intervention plan showed a significant decrease in depressive state of the client. Informal observation of the therapist, ward staff, family members, and client self reporting showed positive change in the behavior of the client. Different measures were used to compare symptoms of depression before and after the intervention. There was congruence between the scores on HAM-D (therapist's rating), and BDI (client's rating).

Hamilton Rating Scale for Depression (HAM-D): HAM-D was used to see the level of depression before and after intervention based on the observation of the therapist. The difference in total score of depression was as follows:

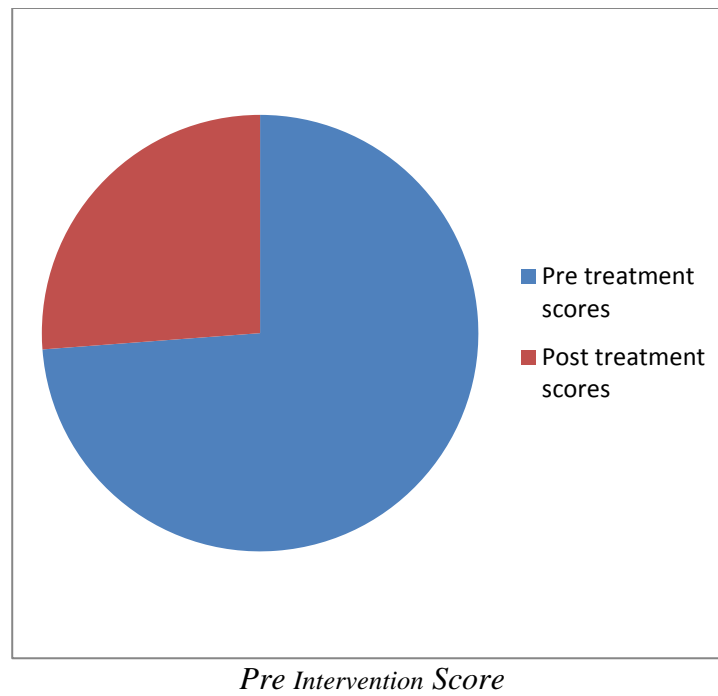


Figure 1
Pre and Post Intervention Total Score on HAM-D
Post Intervention score

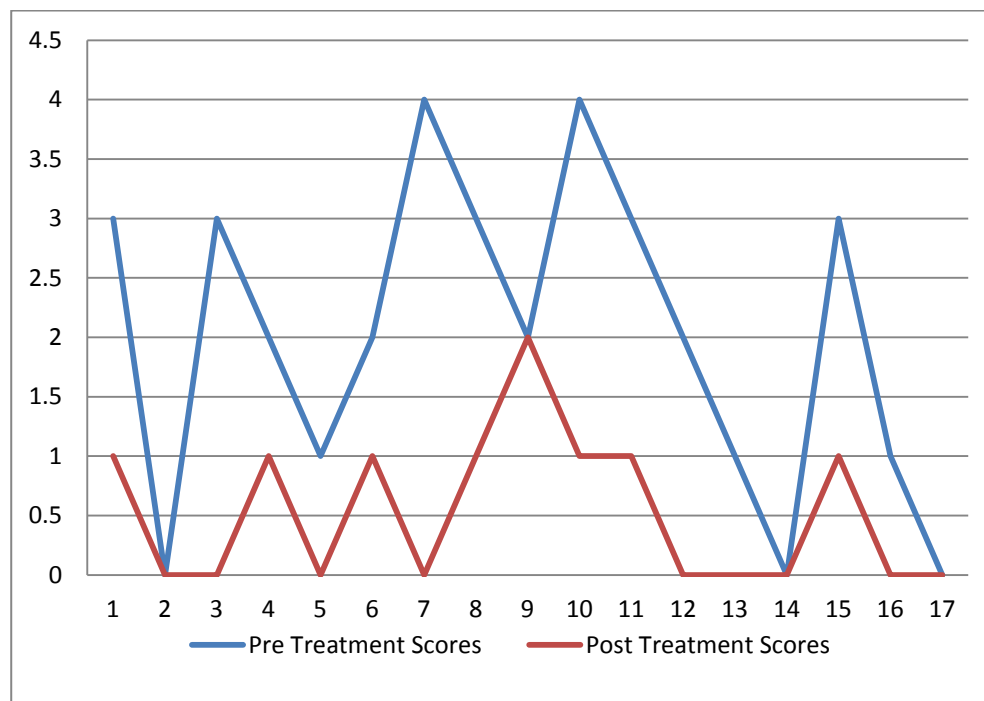


Figure 2
Pre and Post Intervention HAM-D Scores on Individual Items

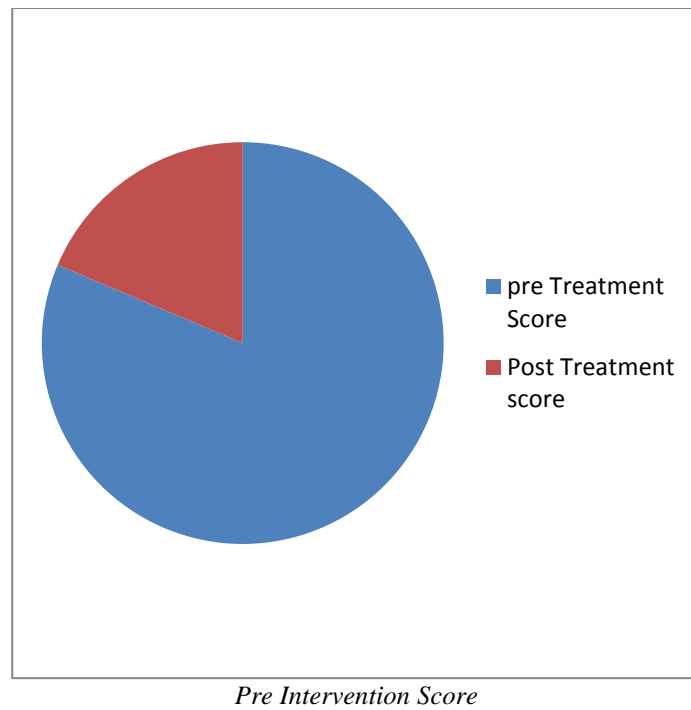


Figure 3
Pre and Post Treatment Score on BDI
Post Intervention Score

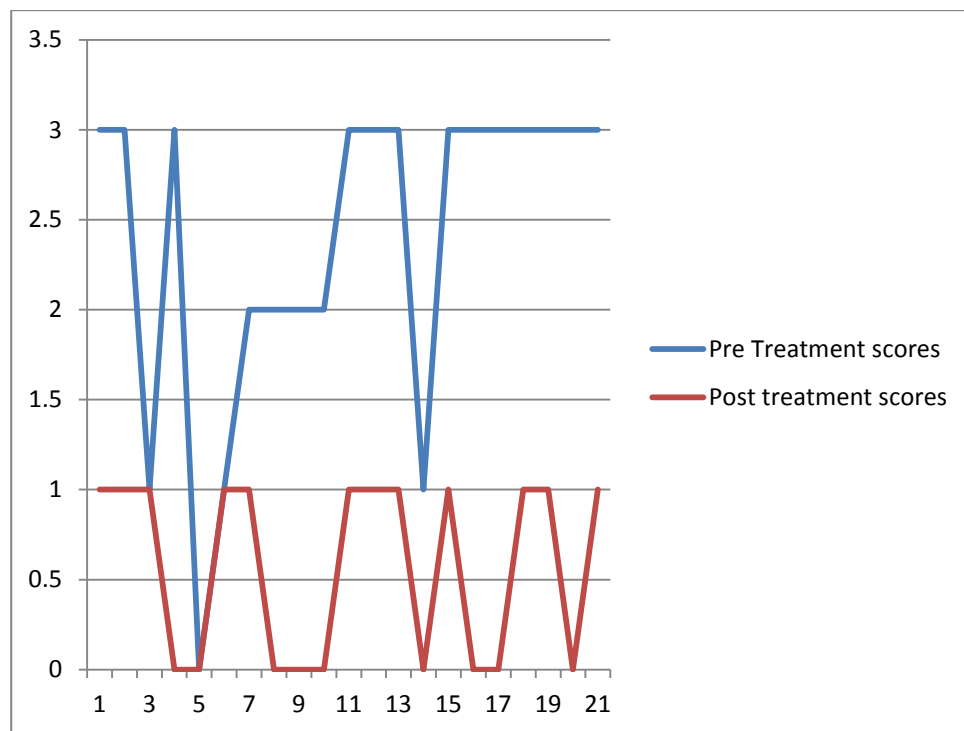


Figure 4
Pre and Post Intervention Scores on BDI Individual Items

Pre intervention score: 31 (severe depression)

Post intervention score: 11 (mild depression)

Beck Depression Inventory (BDI): BDI was applied to evaluate the patient's rating. Score on BDI before and after treatment was as follows:

Pre treatment score: 48 (severe depression)

Post treatment score: 13 (mild depression)

The results show that after intervention the score on depression scales decrease from severe to mild. The patient did not fully come out of depression, but showed mark difference on multiple items. Individual item analysis shows that there was marked difference on scores on HAM-D (viz., item 3, 7, 8, and 12) show that there was no suicidal ideation, lesser difficulty in routine work, improvement in pace of speech, and eating. OnBDI marked improvement on (items 4, 16, and 20) show his satisfaction with life and better health.

Statistical Analyses

Table 1

Mean, Standard Deviation and t- Value for Individual items of HAM-D

Assessment	M	SD	t
pre treatment scores	2.1250	1.2583	.421*
post treatment scores	.5625	.6291	

d.f = 16, * < .05

Table 2

Mean Standard Deviation and t- Value for Individual items of BDI

Assessment	M	SD	t
pre treatment scores	2.3810	.9207	8.932*
post treatment scores	.5714	.5071	

d.f = 21, **p* < .05

This case report reveals to us the childhood trauma, and later life long plight of a 45 year old school teacher, who was brought to the psychiatric ward in a severe depressive state. He was diagnosed with major depression (recurrent) and intervention plan was designed accordingly. Therapeutic plan worked well; Mr. X came out of his severe depressive state within 45 days, and joined his job. He was happy for communicating with his colleagues with confidence and his relationship with his wife and sons also improved.

Implications

The present case study suggests that childhood traumas play important role in determining the pre-morbid personality of an individual, and life stressors may trigger the onset of depression. The findings suggest that clinicians treating children and adults may take developmental perspective in diagnosis and treatment of depression. A person needs empathetic understanding on behalf of his/her spouse in adversities, so psycho education of caregivers especially spouse is extremely important. Improvement in certain areas of the client proposes that cognitive behavior therapy is effective in dealing with cognitive dysfunctioning and behavioral deficits.

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