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UNDERSTANDING UNSPECIFIED MAJOR DEPRESSIVE DISORDER: A CASE STUDY ON DIAGNOSIS, ASSESSMENT, AND MANAGEMENT

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ABSTRACT

This qualitative case study explores the diagnosis, assessment, and management of an 18-year-old male laborer diagnosed with Unspecified Depressive Disorder with mild anxious distress. Through thematic analysis, the study highlights the patient's experiences, family perspectives, and the impact of external factors such as peer pressure, substance abuse, and emotional distress on depression onset. The therapeutic intervention combined psychoeducation, behavioral activation, and cognitive behavioral therapy, emphasizing early intervention and family involvement. The study advocates for a personalized, holistic approach addressing biological, psychological, and social factors to improve mental health outcomes in adolescents with depression.

***Key Words**: Depression, anxious distress, CBT/BA, Family Therapy, Cultural aspect.*

INTRODUCTION

Unspecified Depressive Disorder is diagnosed when an individual exhibits depressive symptoms that cause significant distress or impairment but do not meet the full criteria for any specific depressive disorder. This classification allows healthcare professionals to acknowledge and address the presence of depressive symptoms, ensuring appropriate care is provided (American Psychiatric Association, 2013).

Depressive disorders encompass a range of conditions characterized by persistent feelings of sadness, hopelessness, and a lack of interest or pleasure in activities. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), categorizes depressive disorders into several types, including Major Depressive Disorder (MDD), Persistent Depressive Disorder (formerly known as dysthymia), Disruptive Mood Dysregulation Disorder, Premenstrual Dysphoric Disorder, Substance/Medication-Induced Depressive Disorder, Depressive Disorder Due to Another Medical Condition, and Unspecified Depressive Disorder (American Psychiatric Association, 2013).

Major Depressive Disorder (MDD) is a significant contributor to the global burden of disease. In 2008, the World Health Organization (WHO) ranked MDD as the third leading cause of disease burden worldwide and projected it to become the leading cause by 2030 (World Health Organization, 2008). MDD is characterized by a range of symptoms, including persistent sadness, loss of interest in previously enjoyed activities, changes in appetite and sleep patterns, feelings of guilt or worthlessness, and psychomotor agitation or retardation (American Psychiatric Association, 2013).

In children and adolescents, depression often presents with irritable mood rather than the classic presentation of sadness observed in adults. This age group may also experience academic decline, social withdrawal, and increased sensitivity to rejection. The onset of MDD during childhood or adolescence is associated with a higher likelihood of recurrent episodes in adulthood, underscoring the importance of early

detection and intervention (Fava et al., 2000).

The course of MDD is often chronic and recurrent, with many individuals experiencing multiple episodes throughout their lives. Approximately 20%–25% of individuals with MDD may endure a chronic, unremitting course, highlighting the need for long-term preventive treatment strategies (Mueller et al., 1996).

The etiology of depression in adolescents is multifaceted, involving a complex interplay of biological, psychological, and social factors. Biological contributors may include genetic predisposition and neurochemical imbalances, while psychological factors encompass cognitive distortions and maladaptive coping mechanisms. Social influences, such as family dynamics, peer relationships, and exposure to adverse life events, also play a critical role in the development and maintenance of depressive symptoms (Fava et al., 2000).

Given the complexity and heterogeneity of depressive disorders, particularly in younger populations, a comprehensive, individualized approach to assessment and treatment is essential. This approach should integrate pharmacological interventions, psychotherapeutic techniques, and psychosocial support to address the diverse needs of affected individuals and improve long-term outcomes.

Aim of the Study

The objective of study is to evaluate that negative peer influences, substance abuse, and emotional distress can contribute to the development of depression in young individuals.

Research Question

How negative peer influences, substance abuse, and emotional distress can contribute to the development of depression in young individuals?

Method

Research Design

This study uses a single case study design. According to Creswell (2013), a case study design involves the in-depth exploration of a bounded system, such as an activity, event, process, or individual, within its real-life context. This approach allows researchers to gather comprehensive insights into the complexities of the case, utilizing multiple data sources to develop a nuanced understanding of the phenomenon under investigation.

Sample

The participant in this study was an 18-year-old boy who had completed education up to the 8th grade and was employed as a laborer. He came to a psychologist with depressive mood, lack of interest, low energy, substance use, sleep disturbance, social withdrawal.

Illness Recount and Family History

The young boy exhibited symptoms consistent with unspecified depressive disorder, which he reported beginning around the age of 17. His symptoms included sadness, loss of interest, social withdrawal, and feelings of hopelessness. His family history revealed that his mother struggled with anxiety, while his father had a history of substance use. The boy himself developed an addiction to alcohol. During adolescence, he experienced feelings of abandonment and neglect. The family's history of mental health disorders and substance use appears to have contributed to his depression and anxiety.

Background Information

The client was initially friendly, calm, and had an ambivalent personality. Although he had a small circle of friends, he was religious. However, with the onset of his symptoms, his temperament changed, and he became distant, isolated, and detached from his valued friends, family, and religious practices. He began associating with a negative group of peers, which led to a drug addiction. His focus on academics diminished, resulting in him dropping out of school and engaging in undesirable activities.

Assessment

Informal assessment

The child was observed through behavioral observation and a clinical interview with his mother. Observations in various settings provided context-specific data on child attention span, impulse control, and social interactions.

Formal assessment

Rotters Incomplete Sentence Blank (RISB) and Beck Depression Inventory (BDI) were used as formal

assessment tools**.**

- **The Rotter Incomplete Sentence Blank (RISB)**

Rotter incomplete sentence blank is a semi projective personality test developed by Julian B. Rotter and Janet E. Rafferty in 1950. It has three forms for different age groups, comprises of 40 incomplete sentences. The subject asked to complete the sentences. The purpose of this test is to test the personality and socio-emotional functioning.

The score was "140" which lies below from cut off score that is 135. It indicates that client is "Socially Maladjusted".

Familial Attitudes. On this test a clients provided a picture of moderate relationship with his parents. As he narrated on item number 11, a mother...without her life is difficult as well as he also narrated on item number 35, my father...loved me so much, the fact was that he was the only son of his parents, so, he was overly protected and has been given all the facilities which he needed.

Social and Sexual Attitudes. The client showed his distress towards people who lie to him, which was depicted through his response on item 9 and 29. His response on item 14 depicted that he was very naughty in his childhood, showed that he had childhood full of life and he used to enjoy his life. His response on item 5 depicts that he had bears a strong guilt regarding his smoking behavior.

General Attitude. Items in general attitude category depicted that he had normal level of functioning. He daily analyzed his day routine and attitude at bed times that what he did wrong, and what he did right, which was very positive and strong step towards his treatment.

- **Beck Depression Inventory (BDI)**

The Beck Depression Inventory (BDI) is a widely used self-report tool designed to assess the severity of depressive symptoms in individuals. It consists of 21 multiple-choice questions that evaluate various emotional, cognitive, and physical symptoms of depression. The score ranges from 0 to 63, with higher scores indicating more severe depression. Each item is rated on a scale of 0 to 3 based on the severity of symptoms, and the total score is then used to interpret the level of depression.

The client scored **"12"** which indicates **"Lowest Depression".**

Diagnosis:

He was diagnosed with Unspecified Depressive Disorder (With mild anxious distress) [311 (F32.9)].

Interventions

The following intervention strategies have been implemented. The treatment is comprehensive, combining psychoeducation, behavioral activation (BA), and cognitive-behavioral therapy (CBT) to address the emotional, cognitive, and behavioral components of depression.

Psychoeducation

Psychoeducation is an essential component of the treatment plan, aimed at increasing the client's and their family's understanding of depression. This education helps normalize the experience of depression and empowers the client and their family to manage symptoms effectively.

The client and his family were educated about the issue, including its symptoms (such as sadness, loss of interest, fatigue, sleep disturbances), potential causes (genetic, environmental, and social factors), and its emotional impact (such as feelings of worthlessness and hopelessness). The family was encouraged to become an active part of the treatment process by offering emotional support, being patient, and fostering a positive environment for the client.

Behavioral Activation (BA)

Behavioral Activation (BA) focuses on increasing engagement in positive activities to break the cycle of depression. It encourages the client to re-engage in activities that once brought joy or a sense of accomplishment

- The client was guided to identify activities they once found pleasurable or meaningful. This could include hobbies, socializing with friends, or pursuing interests in work or study.
- Daily goals were set to ensure the client gradually re-engaged with these activities. Initially, small tasks (e.g., waking up at a set time, going for a walk) were introduced, and the difficulty level was gradually increased.
- The client was encouraged to reward himself for completing these tasks (e.g., allowing a small treat or acknowledging success), which helps

reinforce positive behavior and improves self-esteem.

Cognitive Behavioral Therapy (CBT)

Cognitive Behavioral Therapy (CBT) focuses on identifying and changing negative thought patterns that contribute to the client's depressive symptoms. CBT also addresses dysfunctional behaviors and helps the client develop healthier coping mechanisms.

Cognitive Restructuring

The client learned to identify negative thought patterns such as catastrophizing, all-or-nothing thinking, and self-blame. These distorted thoughts were replaced with more balanced and realistic thoughts. Cognitive restructuring exercises helped the client evaluate the evidence for and against negative thoughts and reframe them in a more positive and constructive way. For instance, the client was encouraged to question thoughts like "I'm a failure" and replace them with "I am facing challenges, but I can improve and learn from them."

Behavioral Techniques

Problem-solving skills were taught to help the client better manage stressors in daily life, such as difficulties in school or social interactions. Mindfulness practices were incorporated to teach the client to focus on the present moment and manage overwhelming thoughts by acknowledging them without judgment.

Discussion

The case of this 18-year-old male diagnosed with Unspecified Depressive Disorder (With mild anxious distress) presents a comprehensive assessment and treatment plan aimed at addressing both the emotional and cognitive components of depression. The results of the Rotter Incomplete Sentence Blank (RISB) and Beck Depression Inventory (BDI) have provided valuable insights into the client's socio-emotional functioning and the severity of his depressive symptoms, guiding the selection of appropriate therapeutic interventions. The treatment plan includes psychoeducation, behavioral activation (BA), and cognitive-behavioral therapy (CBT), each of which targets different aspects of depression and aims to improve the client's emotional well-being and overall functioning.

The RISB revealed that the client exhibits signs of being "socially maladjusted" based on the score of 140, which is below the cutoff score of 135. This suggests challenges in his ability to adapt to social environments and may reflect difficulties in interpersonal relationships, which could be exacerbating his depressive symptoms. The client's responses also indicated moderate familial relationships, particularly with his parents. While he described his mother as a significant support figure, indicating her importance in his life, the overprotectiveness described regarding his father may point to issues of autonomy and dependency. These family dynamics may have influenced his emotional development and contributed to feelings of frustration and maladjustment (Rotter & Rafferty, 1950).

The client's social and sexual attitudes, as reflected in his responses, suggest an underlying distrust in others, as indicated by his distress over people lying to him. This could be contributing to social withdrawal, a common symptom of depression (Nolen-Hoeksema, 2013). Additionally, his childhood experiences, marked by feelings of guilt regarding smoking behavior, indicate unresolved emotional conflicts that might require further attention during treatment. Despite these challenges, the client demonstrated a positive general attitude by reflecting on his daily routine, which suggests a willingness to engage in self-reflection and work toward improvement—an encouraging factor in his treatment.

The client's BDI score of 12 indicates "lowest depression," suggesting that while he may be experiencing depressive symptoms, they are not severe at the time of assessment. This aligns with the diagnosis of Unspecified Depressive Disorder with mild anxious distress (American Psychiatric Association, 2013). The BDI score reflects the client's self-reported experiences of sadness, loss of interest, and other depressive symptoms, but it also suggests that his symptoms are currently manageable and not debilitating. However, this score highlights the importance of ongoing monitoring to prevent the escalation of depressive symptoms.

Psychoeducation is a cornerstone of the intervention plan, as it helps both the client and his family gain a clearer understanding of the

nature of depression, its symptoms, and the impact it can have on mental health. Educating the client about the causes of depression, including genetic, environmental, and social factors, can help reduce feelings of shame and isolation. This knowledge empowers the client to recognize early signs of relapse and manage symptoms proactively (Fava et al., 2004). Additionally, educating the family about their role in supporting the client and creating a positive and understanding environment is crucial, as family dynamics significantly influence the course of depression (Hoagwood et al., 2007). The family's active involvement ensures that they can help the client during difficult times and foster a supportive environment conducive to recovery.

Behavioral activation aims to increase engagement in positive activities to counteract the inactivity and withdrawal often seen in depression (Martell, Addis, & Jacobson, 2001). In this case, BA interventions were tailored to gradually help the client reconnect with activities that were once meaningful or pleasurable. Starting with small, manageable tasks, such as setting a wake-up time or going for a walk, allows the client to experience success and build momentum. As the client begins to re-engage in activities, it is important to reward progress, helping reinforce positive behaviors and boosting self-esteem. This incremental approach allows the client to overcome the inertia of depression while fostering a sense of accomplishment and enjoyment.

CBT is a well-established therapeutic approach for treating depression by targeting negative thought patterns that reinforce depressive symptoms (Beck, 2011). Cognitive restructuring was employed to help the client identify and challenge distorted thoughts, such as catastrophizing and self-blame, which contribute to feelings of hopelessness. By encouraging the client to reframe these thoughts, CBT fosters more balanced and constructive thinking, promoting emotional regulation and resilience. For example, the client was guided to challenge the belief "I am a failure" and replace it with a more realistic thought: "I am facing challenges, but I can improve and learn from them."

Behavioral techniques within CBT, such as problem-solving and mindfulness practices, were also utilized to help the client develop healthier coping strategies. Problem-solving skills help the client address daily stressors, such as academic or social difficulties, while mindfulness encourages the client to focus on the present moment and accept overwhelming thoughts without judgment (Hofmann, Sawyer, Witt, & Oh, 2010). These techniques are especially useful for managing anxiety and preventing the rumination that often exacerbates depressive symptoms.

Conclusion

This case highlights the importance of a comprehensive and integrated approach to treating adolescent depression. The combination of psychoeducation, behavioral activation, and cognitive-behavioral therapy provides a holistic treatment plan that addresses the biological, emotional, and cognitive aspects of depression. Through psychoeducation, the client and his family gain a better understanding of depression, while behavioral activation helps break the cycle of inactivity and withdrawal. Cognitive-behavioral therapy targets negative thought patterns, fostering healthier coping strategies and emotional regulation. Together, these interventions offer the client a robust toolkit for managing depressive symptoms, enhancing their ability to navigate life's challenges, and preventing the chronicity of depression.

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