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Psychological Assessment of Depressive Patient: A Case Study

Suman Kumari (M.Phil.)
sumanab.cp@gmail.com

Abstract: The present study is mainly oriented to examine the detailed assessment of depressive patient.Patient A 40 year old adult Hindu male, married, belonging to an rural background and middle socioeconomic status, present with the chief complaints characterised by suicidal ideas, low mood and disturbed sleep and repetitive thought. Patient has death wishes and social withdrawal and disturbed biological functions and socio-occupational functioning with no family history of any psychiatric illness. Mentalstatusexamination reveals depressed affect which is appropriate, with suicidal ideation, hopelessness and helplessness, intact personal judgment and insight IV/V.
Keywords: depression, suicidal idea.

CASESTUDY
SOCIO-DEMOGRAPHIC DETAILS

Name	:	MrA
Age/Sex	:	40 years / male
Education	:	12thstd.
Occupation	:	Farmer
Marital Status	:	Married
Socioeconomic Status	:	Middle Socioeconomic States
Background	:	Rural
Informant	:	Self and wife (38 year old, 8th pass stay with the Patient)

Information is adequate and reliable.

CHIEF COMPLAINTS
According to patient:

Man udasrahtahai
Neendnahiaati
Man meinvichaarchalaterehtehai
Bar barnhatahai

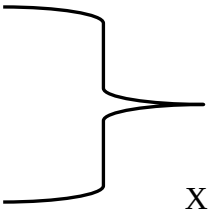
} X 20 days

Acc to informant:-

Kaam me ruchinahileta

Sara din nhatarhtahai

Udasrhtahai



X 20 days

Onset – acute
Course –episodic, progressive

Total duration of illness – 19years and current 20 days

Precipitating factor: - not known.

History of Present Illness:

History dates back to 20 days ago when he was apparently well. He had difficulty in sleeping at night time; he would get up frequently in between initially. During the day time he noticed that that he was having odd ideas with distressed him a lot. He would feel like staring at same object or same person or something thought that he did not want to do. He tried to shift his attention on other thing but found it impossible for himself to do so. He was very distressed and to reducing his distress he took bath but was not able to control his behaviour, when not satisfied after taking bath once, he took bath again for about 5-8 times in a day. Still he would not able to overcome his problem and having disturbed and starting crying many times in front of his wife. He also said that he was failed to make himself comfortable, he was unable to overcome this distress. For this problem, since last two week, he would feel disturbed that he wishes to die. His sleep pattern fully disturbed sleep only two three hours early in the morning. When got up felt distressed not able to house hold work. His appetite also has decreased and he is hardly eating 2chapatti in whole day previously he ate 7-8 chapatti per day. Patient reported that he has suicidal plans and when he get chance he commit suicide because he thinks life is not good. Since 20 days, his symptoms were increased. So, family members brought him department of psychiatry PGIMS Rohtak for treatment and management and patient was admitted in Dept. of Psychiatry.

Negative History

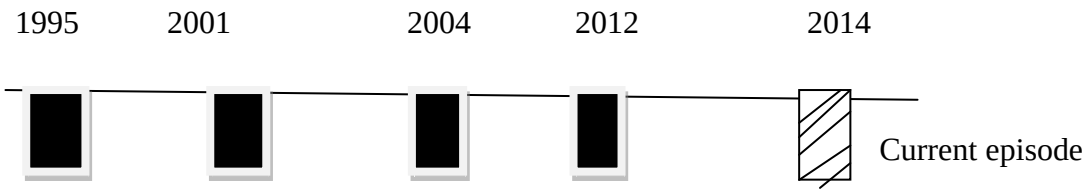
- No h/o suggestive of any head injury, seizure or high grade fever.
- No h/o of suicide in the past.
- No h/o any fixed, firm, irrational belief or hearing of voices and seeing images in absence of any external stimuli.
- No h/o over cheerfulness, over talkativeness, big talks and overspending.
- No h/o any specific irrational fears of any specific objects, situations or open spaces.
- No history suggestive of panic attacks.

Past History

No past history of significant medical or surgical illness.

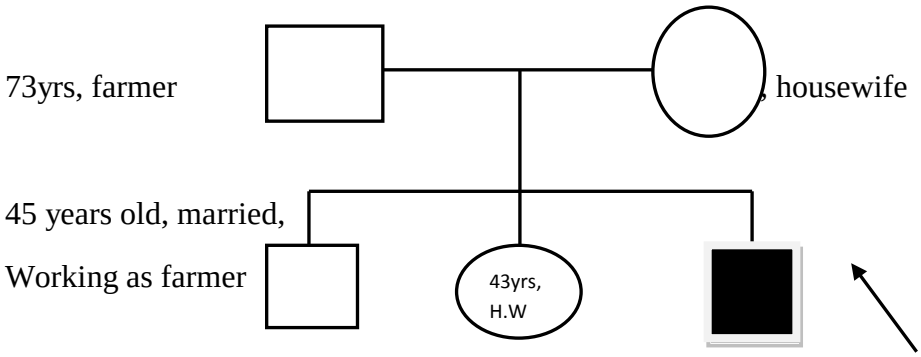
Treatment history is not available.

Past history of psychiatric illness:



1st episodic 1995, that time he had failed to get army recrument and felt rejected. He developed symptoms like stay alone, low mood, low energy, no interaction with others, decreased sleep and appetite and cries own self. He got admission around one month in PGIMS Rohtak in Dept. of Psychiatry. On medicines and regular follow up, he maintaining well till 1998. 1998 he left treatment without any treatment he maintaining well till 2001. In 2001 there would a finical problem. He again developed symptoms similar to past episodic that time history of 5 MECT was there. On medicines he was maintaining well till 2004.he left treatment in 2004 and maintaining well without medicines till 2011. Patient developed symptom similar to past episodic in 2012. Pt. was admitted again around 2 month and history of 8 MECT. Before two years patient was on medicine on and off follow up.

Family History



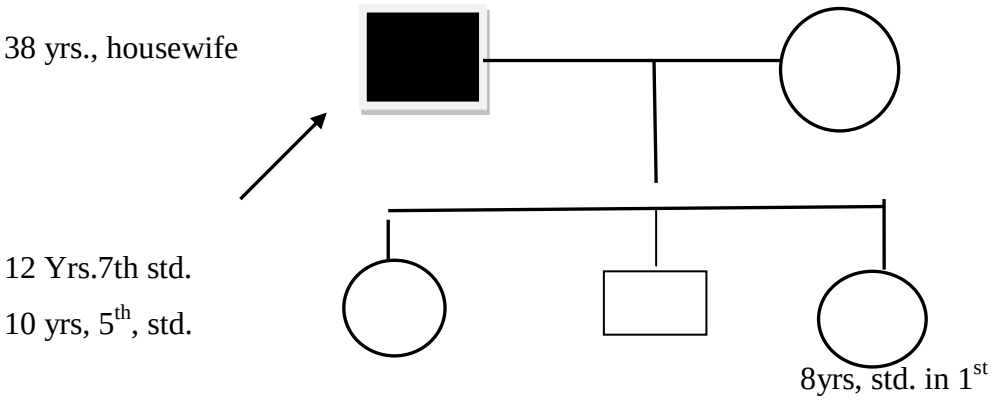
Patient lives in a joint family. Patient's elder brother is the nominal and functional head of the family.Attitude of the family members towards illness as they thinks that his behavior is problematic and he needs treatment.There is no family history of psychiatric illness and substance abuse.

PERSONAL HISTORY

Birth History:
Birth history could not be elicited.
Developmental history:
Development history could not be elicited.
Educational history: He started schooling at the age of 5 years.He is educated up to 12th and was well adjusted in his school and respected his authorities in his school and had good academic performance.

Occupational History:
Started working at the age of 16 year as a helper in the sweet shop with his father. Now he is working as a helper in elder's brother sweet shop.

Marital and sexual history:



The patient got married in 1998. It was an arranged marriage. Patient has cordial relationship with wife.

Pre morbid Personality:
Interpersonal relationship: Patient had satisfactory interpersonal relationship with family members, friends, and neighbours.

Use of leisure time;in leisure time he used to play cards and watch TV.

Predominant mood: Euthymic.

Attitude toward self and others: cooperative.

Attitude to work and responsibility: He used to take his decision by himself. He has no difficulties in fulfilling the responsibilities which was given to him.

Religious beliefs: He believes in God.

Impression – Adjusted Pre- morbid personality.

Mental Status Examination
General Appearance and Behaviour:
A moderately built male looking of stated age, adequately and appropriately dressed according to culture, weather and gender, entered the interview room in normal gait along with his wife and sat when chair offered. During interview he was sitting comfortable and response to question. He was cooperative and appeared willing to talk. Eye to eye contact

was maintained and rapport could be established. His psychomotor activity was within normal limits. Patient became tearful between the interview.

Speech: Normal in rate, tone and volume, spontaneous as well as in response to questions.
Affect: Subjective –Udashai
Objective – depressed, appropriate, full in range, communicative

Thought
Stream
Form } NAD

Possession: obsession

Content:suicidal ideation, hopelessness and helplessness.

Perception : No perceptual abnormalities could be detected.

Higher mental functions :
Orientation

Time
Place oriented to time, place and person.
Person

Attention and Concentration
Attention and concentration arouse and sustained
Memory:
Immediate, Recent and remote memory: Intact

Adequate Higher Cognitive Function
Adequate general fund of knowledge
Personal judgement : intact.
Test judgement : Intact
Social judgement : Intact
Insight : IV/V

DIAGNOSTIC FORMULATION
Patient A 40 year old adult Hindu male, married, belonging to an rural background and middle socioeconomic status, present with the chief complaints characterised by suicidal ideas, low mood and disturbed sleep and repetitive thought. Patient has death wishes and social withdrawal and disturbed biological functions and socio-occupational functioning with no family history of any psychiatric illness.MSE reveals depressed affect which is appropriate, with suicidal ideation, hopelessness and helplessness, intact personal judgment and insight IV/V.
Differential Disorder:
Depressive disorder without psychotic feature
Obsessive Compulsive disorder

PSYCHODIAGNOSTIC ASSESSMENT

1. **Beck Suicide Intent Scale.** To assess the suicide intent.
2. **Beck Depression Inventory (BDI):** To assess the severity level of depression.
3. **Yale-Brown Obsessive Compulsive Scale:** To assess the severity of obsessions and compulsions.
4. **Million Clinical Multiracial Inventory (MCMI):** To assess the psychopathology
5. **Rorschach Psycho diagnostic Test:** To assess the psychopathology.

Behavioral observation

It took 6 sessions to complete the assessment. During testing patient was cooperative. His attention could be aroused and sustained. He entered the room in normal gait and sat on the chair when offered. Eye to eye contact was made and sustained. Rorschach psycho diagnostic test was administered for the diagnostic clarification.

Test findings:

Beck Suicide Intent Scale.

On Beck Suicide Intent Scale patient report score17 that indicate low intent level.

Beck Depression Inventory:

On Beck Depression Inventory patient scored 35 indicative of severe level of depression**.**

Yale-Brown Obsessive Compulsive Scale:

Keeping in the view of current symptom logy, Y-BOCS applied and his score were 22 indicative of mild level of obsession whenever no compulsion is there.

Million Clinical MultiracialInventories:

On MCMI protocol pt. score high on dysthymia that suggestivepreoccupied with the feeling of discouragement or guilt, behavior apathy, low self-esteem, tearfulness, suicidal ideation, a pessimistic outlook towards the future, social withdrawal. Pt. got score high on severe depression usually unable of functioning in a normal environment, severely depressed and expresses the dread of future, suicidal ideation and sense of hopeless resignation. Overall MCMI protocol finding suggestive the dysthymia and severe depression is on disorder level.

Rorschach Psycho diagnostic Test: On Rorschach Psycho diagnostic test patient was marginally productive (R=13) with delayed reaction time by rejecting two plates (plate no. 3 and 9) which suggests that patient is in conflict with reality and emotional tolerance. His approach was D dominating which is suggesting of practical intelligence (D= 7). His F% was low indicating that he has poor ego strength (F+% =33.3%), suggestive of he is less emotional stable and has difficulty to cope with stress. On the protocol, patient gave only two popular responses which indicate inability to conform social conventional norms and also showed narrow areas of interest.Due to poor productivity, quantities analysis could not be done. Less no. of human responses indicative of lack of empathy towards human environment (H=1).Patient shows restlessness as he rotate the cards frequently. Perplexity is

also present which indicates he has lack of confidence. To conclude the test findings patient showing features of depression.

Summery;

On MSE revel depressed affect suicidal ideas, hopelessness and helplessness. Patient report high score on Beck Depression Inventory but suicide intent is low. On Yale-Brown obsessive-compulsive scale patient scored mild level of obsession and no compulsion. On MCMI patient get disorder level score on dysthymic and depression. Rorschach test finding also suggest the depressive feature. Overall tests finding indicate depression feature.

Impression:
Overall test finding suggest that patient hasfeatures of depression disorder.

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