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Case Report

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Clinical management of depression using therapeutic models: case report

Abstract

The case report presents a clinical management of depression in a facility in Jos, Nigeria. Via the management process, clinician was able to assess client who was seemingly in distress, hence provided with a more tailored clinical response. After prolonged intervention of 12 sessions, client was able to pick up and reintegrate more appropriately in his own society. Clinically, client has shown improvements in significant domains of functioning.

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Binan Evans Dami

Clinical Psychologist/Writer/Researcher/Mental Health Practitioner, Nigeria

Correspondence: Binan Evans Dami, Clinical Psychologist/Writer/Researcher/Mental Health Practitioner, Nigeria, Email evansbinan@gmail.com

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Introduction

Kessler et al.[1] reported the annual incidents of Mood disorder (major depressive disorder, dysthymic, and bipolar) as approximately 20.9 billion American adults or 9.5% of the population. Studies conducted in Western Europe and North America suggests that depression is a common and often debilitating illness in old age. Its occurrence is associated with functional impairment, decreased quality of life and increased mortality. Projected to become the second most common cause of disability by 2020,[2] depression is now regarded as a major public health concern.[3] Very little empirical evidence is available to show how prevalent depression is across African societies. Indeed, even though the growth in the proportion of elderly persons in African populations is among the fastest in the world,[4] research on clinical management of depression for the young and the aged has received little attention. Many studies, mostly conducted in Western Europe and North America, suggest that depression in older persons is associated with low socioeconomic status, low social support as well as poor physical health.[5,6] Such social factors are indeed also common in many countries in Africa. Nigeria, the most populous country in Africa, provides an example of a place where social changes of potential deleterious effect on the lives of elderly persons are on-going. Rich in land and mineral resources, the country is nevertheless among the poorest countries in world. Its rate of urban growth is among the fastest in the world.[7] Many of its cities are characterized by squalor and tough daily existence. Looking at the wave of events in most African societies, depression has become a necessary evil. With persistent conflict and the others, poverty, rising unemployment, deteriorating family institutions and the depletion of social support structures in most African societies, depression is likely to have a fertile ground. The paper presents in clear view a clinical management of depression with a teenager.

Case presentation

Date of first Assessment: 08/05/16

Name: Client A

Gender: Male

Date of birth: 10/6/1994

State: Plateau

Nationality: Nigerian

Religion : Christianity

Occupation: Student

Educational attainment: SSCE.

Residential address: Plateau State, Nigeria.

Referral source: Community leaders.

Referral reasons: Client was referred to facility a (child remand Home.) as a form of punishment.

Informants: None except facility head and teacher.

Presenting complaints: withdrawing self from people and events.

Client hardly takes his meal.

Easily angered.

Client sleeps a lot even at times that others are in for study.

History of problem

Client was brought to facility some three years ago i.e 2013 thou couldn't recall the date vividly and that since then he had been at facility without much psychosocial support mechanism. The client's teacher and the facility head reported some changes noticed in the patient. They said that the patient had decided to always be on his own, that the patient spends most of the time in his room and not even making any attempt to have a lengthy conversation with other persons around as he used to. They complained that client will rather want to remain indoor all through the day and if not called upon to perform a task client will remain indoor for days. This stops client from eating, social interaction with colleagues, studying, and other things that client does. They stated that they have noticed these changes in the client's attitude just a month past i.e on the 7th of April, 2016 when it was reported around facility that client lost his mother some two (2) days before. That after the information was shared with client by his elder brother, client cried at that moment and afterwards these changes started occurring.

The client was then invited to hear his viewpoint and client gave the same information about self and how he was told about the demise of his mother. Client narrated further that since then he has had problems with sleep where he had difficulty initiating sleep, and difficulty maintaining sleep. When client was asked what he normally does whenever he is unable to sleep, client now stated that he used to think and feel himself communicating to his death mother before she now orders him to sleep. And that each time he sleeps, he feels her in his dreams, telling him that he is the light of the family and so she puts her hope and trust in him. Client complained further that he doesn't feel like communicating with people around him and so resulted to be on his own, not even to attend classes or even to go on errands as he used to. Also, client stated that his appetite was gone completely and that he feels no need for him to take any meal, so he remained indoor and that anytime he remains indoor, his mother appears to him and they interact.

Family background

Client hails from a monogamous family. Father is still alive, has six (6) siblings, client is the sixth child; there are three (3) girls and four (4) boys with him inclusive. All his brothers and sisters are married but he and his younger brother who is 19years old are yet to marry. Client's mother died some time weeks back due to some sudden illness. Client said that one of his brothers resides in Kano and the other resides in Benue State of which both are married and have their families. Client said the one in Kano is the eldest and so he has been closest to the eldest aside from his late mom. Brother in Kano is an Engineer while the other in Benue is a pastor. Client confessed that his grandparents from both sides all death. Client said he has had poor relationship with his sisters in relation to what he used to have with his mother and currently his brothers. That since after he lost his mom, he became closer to his younger brother not because he was close then but rather his late mom told him to do so in order to honour her death. Information from significant others around the facility re-emphasized that client and family members share a lot of love and concern for one another. Client stated that there is no family history of mental illness, to the best of his knowledge.

Client's personal history

a. Development history: client stated that he had no any known medical, mental and developmental history since he was born. Although he was told that his mom was operated upon during the process of his delivery, he still confirmed that there isn't any developmental challenge. When asked if he is aware of history of mental illness in the family he confirmed with a no.

b. Marital status: Single.

1. **Educational:** Client started with a primary education. Client had his primary education in a community primary school within his locality and then proceeded to secondary school for his secondary education. Client completed his secondary school in 2012. Client said he sat down for WAEC and obtained three (3) credits in the WAEC result with English inclusive. Clint said that his education was plagued by serious financial crisis and that at times he could forfeit schooling for irrigation farming in order to be able to raise his school fees. Client didn't go to any tertiary institution after the secondary education and stayed back to become an irrigation farmer.

a. Work history: client started farming from when he was 10 years old. He was introduced into irrigation farming by his father who happens to be an irrigation farmer. Client delved into farming in 2012 after completing secondary school. Farming has been his occupation before been taken into the remand home for alleged crimes.

b. Interests/hobbies: reading novels and sport magazines.

c. Premorbid personality: client was described as more of an inward person.

d. Substance use history: client has no history of substance use and abuse. Client parents have no history of substance use and abuse as well. Client said he had never used any substance at all and can't recall whether any in his family abuses substances.

e. Forensic history: had just an issue with the law enforcement agencies, and on such account, he was taken to a remand home. He said that he was arrested at some point in time because he was accused of being part of a mob group that had been terrorizing his community.

f. Psychosexual history: no history of any social relationship with an opposite sex and no sexual exposure.

g. Future goals: client would love to go back home, open a shop, go back to school, write his WAEC and obtain his papers, then go in for tertiary education either in a polytechnic or a university. Client said he would love to be an Agricultural Engineer. And lastly, that he would love to go back home and continue with his irrigation farming which will enable him to save some money to start up with these plans.

Past medical history: None.

Mental status/behavioral examination

1. **Appearance:** slim and chocolate in complexion, well dressed, cloths mostly clean.
2. **Insight:** poor.
3. **Appetite:** poor.
4. **Speech:** audible speech but not willing to speak much except when persuaded.
5. **Perception:** absence of hallucinations.
6. **Thoughts:** feelings of guilt and pessimism.
7. **Mood:** feelings of sadness which also reflects on clients facial expressions.
8. **Judgment:** intact/coherent.
9. **Orientation:** good to person, place and time.
10. **Memory:** memory span intact.
11. **Impulse control:** client looked calm but highly impulsive. Patient gets angry easily.

Clinical assessment results

1. **Test administered:** Eysenck Personality Questionnaire (EPQ) and Beck's Depression Inventory.
    a. Date of tests administration: 08/06/16

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2. **Personality:** the first personality test was administered and the EQP are as follows:

S/no	EPQ item	Patient's scores	Norms	Remarks
1.	Psychoticism	9	4.62	Significant
2.	Extraversion-introversion	17	13.32	Significant
3.	Neuroticism	18	6.43	Significant
4.	Lie	6	14.56	Insignificant

The lie scale shows that client likely answered questions honestly. Client was significant on Psychoticism, neuroticism, and Extraversion. This implies that client is likely to be an outward person, social, easy to associate etc. the mixture of neuroticism and psychoticism likely reveals a client personality that is tough minded in decision making, anxious at times, depressive at times, at times has low self-esteem, etc

Beck's Depression inventory: client obtained a score of 24, therefore client is likely to be having symptoms for moderate depressive episode.

Diagnostic impression: from the outcome of the assessment, client is likely to be put in with a diagnosis of moderate depressive episode.

Treatment plan

1. Insight orientation therapy.
2. Motivational therapy.
3. Relaxation therapy and coping styles.
4. Cognitive behavioral therapy.
5. Goal setting.
6. Anger management.
7. Assertiveness style.

Therapeutic model

An eclectic approach was used. The Becks[8] and Ellis[9,10] Cognitive Behavioral perspectives were used, the Freudian[11] Psycho analytic approach was used and some Person Centred Approach by Rogers[12] was used too. These therapeutic models came into play when trying to understand the roots clients' current state of functioning and how to improve his condition. What was also more prevailing in the management process was the understanding of the defensive mechanisms used by the client in the process of the session the need to go eclectic to break these defenses.

Psychotherapy sessions

First session: Results of the test were presented to the client. The outcome of the results was now discussed with the client. Client understood at that moment that he was having some depressed moods but what was causing the depression was what he wasn't sure of. Moving forward, client said that the thoughts of his late mother have always been coming to his consciousness but still wasn't able to link it to his depressed moods. Client was not taught on the difference between life and death and what makes an individual alive or death. Client was given assignment to go and highlight the differences between livings and been alive. Client was asked of what he knows about depression and what the likely symptoms could be; this also was given as a home work.

Second session: Client came back with the assignment and was saying that he doesn't know the reason why he is being kept in facility that his mother is still alive, and he is still in facility; that he needs to see his mother. Client was now asked whether he used to talk to her on phone and he said yes. Then client was asked to forward the telephone number, so we can call her to hear her talk, but client said she wouldn't pick because where she went to, she is with God and there aren't handsets there. At this point, the client was living in denial but his confirmation of where he thinks the mother was created so much anxiety in him. Client then became anxious and tensed after saying that his mother cannot be reached. The client was then taken through the Autogenic relaxation and the Diaphragmatic relaxation as well. Client was now provided with the definition of psychological depression and how it alters consciousness. A check in through the assignments of the previous sessions revealed opened up a new conversation where client was expressed that the death is no longer living and that we may not see the death again, except that according to his faith, he is sure of meeting his mother someday. Client said e remembers her a lot because she never said good bye and then went into tears - there was silence in the room for a short time and he wiped his tears and said to himself that he will be fine. He then requested that the session come to an end for that day.

Third session: The client was taken through the activities of the previous two sessions. The client was taught some more relaxation technique to do whenever thoughts of his mother begin to come to his consciousness. Client was taught the Deep muscle relaxation to add up to the others he was taught of before. Client was later educated about the negative impact of thinking and was given an assignment to go and write down any ten impacts of thinking on his physical and mental well-being.

Fourth session: The clinician went to a review of the previous session. Client came back with the assignment. Among the effects of thinking he got includes death, depression, suicide, hypertension and many others. Clinician told client to clap for him for doing the assignment and the client clapped as instructed. Session became more interesting and client was now taken through each of the effect gradually, client got a bit tensed in the process. Client was then taken through the relaxation techniques again. Then session continued until insight was improved. Client was happier after the session as he told the Psychologist that his last nights have been the best ever, and that his appetite has improved. He also expressed that he has held so much to the believe that he will see his mother some day and that has helped to kill his guilt feelings.

Fifth session: A check in through the previous session revealed that client was still holding to the belief that is mom still exist even though feelings have drastically reduced. Client was then challenged to say if he sees her again. He said he does but in his dreams. That she appears to him and tells him that he is he light of the world. Then client was asked about seeing her after the dreams, but he said no but that he feels her around. Client was now told to touch her if he feels her around, but he couldn't. Client was reminded about footballer who plays for the football club he supports, and that the footballer died a couple of months ago. Client said he believed that, but he is finding it hard to belief that his mom died because of his closeness to her and what she used to say to him. That his mother loved him a lot and he

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is not ready to live without her. Client now went silent and left the counseling room.

Sixth session: From a recap of previous session, client was asked whether each time he worries, does he think that someone is concerned about the fact that he is worried. Client said he doesn't know. Client was asked if he was aware that if he keeps thinking of a person that doesn't exist he may not eat which will lead to starvation, he said he was aware but that doesn't matter to him at that time that all the time he thinks he ends up getting angry. He was asked some questions such as, does been angry change translates into seeing his mother right now? NO! Does been angry changes the fact that he never said goodbye to his mother as he had wished to? No! will starvation and hunger bring her back to life? NO! He was question again, who does the anger affects most? and he said himself. That anger has affected his relationship with everyone around him especially when they have something to say to him. That anger causes him dizziness, loss of appetite, and even his inability to sleep. Client was asked whether he knows the source of the anger and he said thinking about how much he misses his mom. He was asked; oh you missed your mom? He said yes. Where is she now? That she has gone to heaven to prepare a place for him. Session ended and client left looking better.

Seventh session: Session started with a review on previous session. Client was taught how to set goals, client was taught anger management techniques. Emphasis was laid more on teaching the client anger management where the anger trigger chart was used and paired with relaxation techniques to help ease tension and anxiety on the client. Client was then given assignment to go and practice this technique and return the next session.

Eight session: After a check in to know whether client mastered the anger management technique taught to him using the 5Ds (Delay, Discuss, Distract, Deep Breathe, Drink water) and relaxation technique. Client maintained the previous mood and has accepted the fact that his mother was gone and the need for his to start his life afresh.

Ninth Session: Client has now mastered how to use the 5Ds and sings and does it even while having a session. Client now brought out his goals clearly and presented to the clinician. Client and clinician walked through client's goals and it was realistic. Client was very cheerful and felt the need to move on with life.

Tenth Session: client came in cheerfully, smiling and telling the clinician that he can't wait to be home. Client was released from the remand home and was ready to leave the next day. Briefly, the clinician taught client how to be assertive and not passive nor aggressive. Client then went further and expressed his appreciation to the clinician for helping him through. Client was given some home works to perform while at home. Sessions ended.

Conclusion

The case report has shown the significance of psychotherapeutic management of mood and emotional related problem. Studies have shown how significant psychotherapeutic models have been to the management of depression.[8,9] Beck[8] when working with depressive patients realized how effective the use of Cognitive model which he used to manage most of his clients. Albert Ellis also used the Rational Emotive Behavior Therapy to manage his depressive patients. The use of the Freudian approach psychoanalysis, gave more insight to the unconscious realm of the client; this also created the atmosphere to know and break defensive mechanisms. Freud[11] when working with his clients realized the power of the unconscious. The Rogerian[12] approach created the core conditions for therapy which helped in putting the client as the centre of the therapy. In a nutshell, depression is becoming an increasing mental health concern and to deal with this, there is a need to use testable empirical measures.

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None.

Conflict of interest

The authors declare that there is no conflict of interest.

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