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Case Study

A Detailed Case Study of Major Depressive Disorder with Psychotic Features in Adolescence

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ABSTRACT

This case study examines the clinical presentation, diagnostic process, and treatment approach of a 16-year-old male patient, referred to as Mr. X, diagnosed with Major Depressive Disorder (MDD) with psychotic features. The patient's symptoms included persistent suicidal ideation, auditory hallucinations, self-injury, and marked social withdrawal, all of which progressively worsened over the span of one year. These symptoms were initially triggered by the end of a romantic relationship, but the deeper root of his depression appeared to be unresolved grief stemming from the suicide of his father. His family dynamics, characterized by ongoing dysfunction and trauma related to his father's death, further exacerbated his condition. The treatment strategy employed in his care incorporated pharmacotherapy (including SSRIs and antipsychotic medications), psychotherapy (CBT and DBT), family therapy, and nutritional support. After engaging in this comprehensive approach, Mr. X demonstrated significant improvements in his depressive and psychotic symptoms, including a reduction in suicidal ideation, improved social and academic engagement, and a notable decline in the severity of his hallucinations. This case underscores the necessity of early recognition and a multi-faceted treatment approach in managing adolescent depression with psychotic features.

Keywords: *Adolescent Depression, Psychotic Features, Suicide Prevention, Family Therapy, Cognitive Behavioral Therapy, Auditory Hallucinations*

Adolescence is a critical period of emotional and psychological development, during which young people are particularly vulnerable to the onset of mental health disorders. Among these, Major Depressive Disorder (MDD) with psychotic features represents a complex and challenging condition to diagnose and manage. Adolescents with MDD may experience significant mood disturbances, compounded by psychotic symptoms such as hallucinations or delusions. These features complicate the diagnostic process and can lead to misdiagnosis, as they often overlap with other developmental or behavioral concerns. This case study focuses on a 16-year-old male, Mr. X, who was diagnosed with MDD with psychotic features. Through an in-depth exploration of his symptoms, the underlying factors contributing to his condition, and his treatment approach, we aim to

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demonstrate the importance of a comprehensive, multidisciplinary treatment plan in addressing this severe form of adolescent depression.

Mr. X, a 16-year-old male, was admitted for psychiatric evaluation after a suicide attempt involving self-inflicted cuts to his left hand. Over the course of a year, his depressive symptoms had intensified, marked by profound social withdrawal, persistent suicidal ideation, and a significant decline in academic performance. Initially, his family attributed his mood fluctuations to typical adolescent behavior. However, as his symptoms worsened, it became clear that his mental state was deteriorating. The initial trigger for his depression appeared to be a breakup with his girlfriend, but the root cause of his condition appeared to lie in unresolved grief surrounding the suicide of his father four years earlier. The emotional distress associated with his father's death, compounded by family dysfunction related to his mother's response to his father's extramarital affair, contributed significantly to the onset of his depressive and psychotic symptoms.

During the assessment, Mr. X exhibited a range of symptoms consistent with MDD, including pervasive feelings of sadness, anhedonia (loss of interest in activities he once enjoyed), significant weight loss (approximately 10% of his body weight), and a history of self-harm. He reported frequent suicidal thoughts, and his previous suicide attempt indicated a high level of risk. Additionally, Mr. X experienced auditory hallucinations, including hearing his name being called by an unseen voice, which led him to believe that the voices were warnings of impending danger. and delusions of unreality. One of the more striking symptoms involved Mr. X repeatedly questioning his mother's authenticity. During moments of confusion and emotional distress, Mr. X would approach his mother and ask, "Are you even for real, Mom? Or am I imagining you as well?" This persistent questioning of his mother's reality was a clear indication of his deteriorating mental state. His psychotic experiences, coupled with the grief from his father's death and the breakup, created an overwhelming sense of disconnection from the world around him, including the people he loved and trusted most. This sense of unreality extended beyond his mother to include other significant relationships, exacerbating his emotional isolation.

He also described physical symptoms of dizziness, chest pain, and blackouts. Despite a history of self-harming behaviors since the sixth grade, the intensity of his current symptoms was far more severe than previous episodes. He withdrew completely from social interactions, discontinued his extracurricular activities, and his academic performance drastically declined. His hygiene deteriorated, and he displayed signs of psychomotor agitation, including restlessness and tremors. A review of his medical history revealed that he had been under the care of a neurologist for recurrent seizures, but otherwise, his physical health appeared stable. Notably, Mr. X was adopted and had no significant prenatal or developmental concerns. However, his family history played a crucial role in the development of his psychiatric condition. The trauma of his father's suicide, compounded by unresolved grief and family dysfunction, was a significant factor in his depression.

During the Mental Status Examination (MSE), Mr. X appeared disheveled with poor personal hygiene, which reflected the severity of his depressive state. His mood was described as "empty," and his affect was restricted, with little emotional expression during the interview. His psychomotor activity was heightened, as evidenced by shaking hands and noticeable restlessness. His speech was slow and often required prompting to continue. Mr. X seemed disengaged and distracted at times, struggling to maintain focus on the interview. His thoughts were overwhelmingly negative, dominated by feelings of worthlessness,

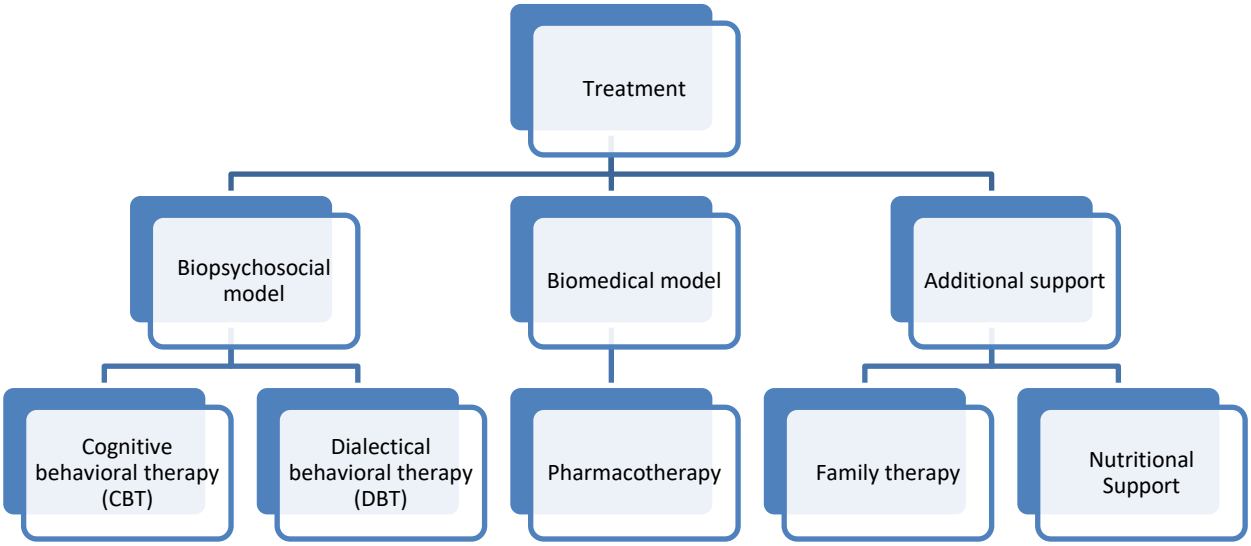
hopelessness, and guilt, accompanied by a strong, persistent desire to end his life. He also described experiencing auditory hallucinations, such as hearing his name being called out loud by a voice that no one else could hear. These experiences intensified his distress and caused him to feel increasingly detached from reality. Although Mr. X was oriented to time, place, and person, his insight into his condition was limited. He did not recognize that the hallucinations he experienced were likely a manifestation of his depressive illness. His judgment appeared impaired, as evidenced by the impulsive nature of his self-harming behavior.

Several clinical tools were utilized to assess the severity of Mr. X's symptoms and to guide his diagnosis and treatment plan. The Beck Depression Inventory (BDI), a widely used self-report tool to evaluate the severity of depressive symptoms, indicated that Mr. X was experiencing severe depression, consistent with his clinical presentation. The Columbia-Suicide Severity Rating Scale (C-SSRS) assessed his risk for suicide, categorizing him as a high-risk patient due to the intensity of his suicidal ideation and his prior suicide attempt. The Positive and Negative Syndrome Scale (PANSS), which is designed to measure psychotic symptoms, revealed moderate psychotic features, including auditory hallucinations and social withdrawal. The Mini International Neuropsychiatric Interview (MINI) was used to confirm the diagnosis of MDD with psychotic features and to rule out other psychiatric conditions that could mimic his symptoms, such as schizophrenia or bipolar disorder. Additionally, a comprehensive family assessment revealed significant dysfunction, particularly regarding unresolved grief and the trauma associated with his father's suicide. His nutritional assessment indicated severe weight loss, likely due to his refusal to eat, highlighting the importance of addressing his physical health alongside his mental health concerns.

The development of Mr. X’s MDD with psychotic features appears to be the result of a complex interplay of genetic predisposition, environmental stressors, and maladaptive coping mechanisms. His family history is particularly significant, as both genetic vulnerability and the trauma of his father’s suicide played crucial roles in his emotional and psychological decline. The emotional devastation caused by his father’s death likely triggered the onset of Mr. X’s depressive symptoms. In addition, unresolved grief, compounded by his mother’s emotional unavailability due to her own struggles with his father’s extramarital affair, exacerbated his sense of abandonment and contributed to the worsening of his depression. Family dysfunction, characterized by poor communication and unprocessed trauma, played a significant role in his emotional distress. Mr. X’s history of self-harming behavior, which began in the sixth grade, further highlights the role of maladaptive coping strategies in the development of severe mood disorders and psychotic symptoms. This multifactorial etiology emphasizes the need for a comprehensive, integrated treatment approach that addresses both genetic and environmental factors contributing to the patient’s illness.

TREATMENT PLAN

Figure No. 1 Comprehensive treatment approach for Mr. X's condition



The treatment plan for Mr. X was comprehensive, encompassing pharmacotherapy, psychotherapy, family therapy, and nutritional support to effectively meet his psychiatric and psychosocial needs.

Pharmacotherapy

- **Fluoxetine (20 mg/day):** This selective serotonin reuptake inhibitor (SSRI) was initially prescribed to alleviate the patient's depressive symptoms. The dosage was gradually increased to 40 mg/day due to partial symptom improvement, which helped stabilize mood swings and mitigate suicidal thoughts.
- **Risperidone (2 mg/day):** Introduced to manage the patient's psychotic symptoms, including auditory hallucinations, this atypical antipsychotic proved effective in reducing these symptoms and helping the patient reconnect with reality.
- **Lorazepam (1 mg/day):** To address high levels of anxiety and agitation, Lorazepam was administered to manage acute anxiety and insomnia, with the dosage gradually reduced as the patient's anxiety symptoms improved.
- **Psychotherapy:** The treatment for Mr. X integrated Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT), both of which are evidence-based approaches effective in treating Major Depressive Disorder (MDD) with psychotic features, particularly among adolescents.

Cognitive Behavioral Therapy (CBT)

Overview: CBT is a structured and goal-oriented approach that focuses on recognizing and modifying negative thought patterns and behaviors. It helps individuals understand how their thoughts, feelings, and actions are interconnected, empowering them to challenge and transform maladaptive beliefs that contribute to mental health difficulties. In adolescents, CBT often emphasizes developing coping strategies and engaging in activities that promote a sense of accomplishment and enjoyment.

Application for Mr. X: In Mr. X's case, CBT targeted his pervasive feelings of worthlessness and hopelessness. Through structured sessions, he learned to identify cognitive distortions, such as "all-or-nothing" thinking, and to replace these with more balanced viewpoints. Behavioral activation was a central component, encouraging Mr. X to participate in enjoyable activities to combat his anhedonia.

Dialectical Behavior Therapy (DBT)

Overview: DBT is a comprehensive form of cognitive-behavioral therapy that combines individual therapy with group skills training. It focuses on developing skills in mindfulness, emotional regulation, distress tolerance, and interpersonal effectiveness. DBT is particularly beneficial for individuals experiencing intense emotions and self-destructive behaviors, making it well-suited for adolescents with MDD and psychotic features.

Application for Mr. X: DBT equipped Mr. X with strategies to manage emotional dysregulation and impulsivity—key challenges he faced. The mindfulness aspect enhanced his ability to observe his emotional states without judgment, while emotional regulation skills provided effective strategies for managing his feelings. Distress tolerance techniques were essential in helping him cope with overwhelming emotions, thereby decreasing the likelihood of self-harm.

Integration of CBT and DBT

The combination of CBT and DBT in Mr. X's treatment established a strong framework for addressing his multifaceted psychological needs. This integrated approach ensured that both cognitive and emotional aspects of his disorder were addressed concurrently, promoting a more holistic recovery.

Cognitive Restructuring and Mindfulness: Through CBT, Mr. X learned to identify and challenge negative thought patterns that worsened his depressive symptoms. He evaluated the evidence for and against these thoughts, leading to more rational perspectives. Concurrently, DBT's mindfulness practices helped him view his thoughts and emotions as temporary events, reducing their emotional burden.

Behavioral Activation and Emotional Regulation: Mr. X's engagement in behavioral activation—participating in enjoyable activities—resulted in positive reinforcement, improving his mood and motivation. This engagement was crucial for breaking the cycle of anhedonia and isolation. DBT complemented this by providing tools for managing intense emotions, promoting resilience and adaptive emotional responses to stressors.

Interpersonal Effectiveness and Cognitive Awareness: DBT's focus on interpersonal effectiveness helped Mr. X develop essential communication skills, enabling him to articulate his needs and feelings appropriately—an important factor given his history of social withdrawal and family dysfunction. Simultaneously, CBT enhanced his cognitive awareness, helping him understand how his negative beliefs influenced his interactions and enabling him to apply interpersonal skills more effectively.

Summary of Integrated Outcomes

The combined treatment approach for Mr. X, which included both pharmacotherapy and integrated psychotherapy, led to several beneficial outcomes:

- Effective Symptom Management: The pharmacotherapy regimen, involving fluoxetine, risperidone, and lorazepam, contributed to the stabilization of mood

symptoms, reduction of psychotic features, and alleviation of anxiety. These medications were crucial for managing his depressive symptoms and enhancing overall functioning.

- Holistic Skill Development: The integration of CBT and DBT provided Mr. X with a diverse range of skills, enhancing his coping abilities across various areas of his life.
- Enhanced Self-Understanding: Through the combined therapies, Mr. X gained a deeper understanding of how his thoughts, emotions, and behaviors were interconnected, fostering a sense of agency in his recovery process.
- Improved Relationships: The interpersonal skills learned during therapy contributed to healthier family dynamics and social interactions, reinforcing the therapeutic progress made in individual sessions.
- By addressing both the psychiatric and psychosocial components of Mr. X's condition, the integrated treatment plan proved effective and tailored to his specific psychological profile, promoting a comprehensive and enduring recovery from Major Depressive Disorder with psychotic features.

Additional Support

Family Therapy

Family therapy played a vital role in addressing the dysfunctional dynamics between Mr. X and his mother, particularly in relation to unresolved grief and trauma stemming from his father's suicide. Therapy sessions aimed to improve family communication and address deep-seated feelings of guilt and abandonment.

Nutritional Support

Due to significant weight loss and refusal to eat, nutritional support became necessary. Involving a dietitian ensured the stabilization of Mr. X's physical health and provided adequate energy intake to facilitate psychological healing.

RESEARCH EVIDENCE

The research findings are closely tied to the case of a 16-year-old male diagnosed with Major Depressive Disorder (MDD) that includes psychotic features. The studies reveal that adolescents experiencing psychotic depression often show more severe symptoms, including increased suicidal thoughts and functional impairment. This is reflected in Mr. X’s situation, where he demonstrates significant emotional distress, marked by feelings of worthlessness, suicidal ideation, and physical signs such as weight loss, self-harm, and agitation. His psychotic symptoms—auditory hallucinations and a disrupted sense of reality—further corroborate findings that indicate these features are linked to greater clinical severity and worse outcomes in depressive disorders. The treatment regimen for Mr. X, which involves both fluoxetine (an antidepressant) and risperidone (an antipsychotic), is consistent with evidence showing that combining these medications is more effective for managing psychotic depression than using either type of medication alone.

Furthermore, the influence of trauma and family dynamics in the onset of psychotic depression is another critical similarity between the research and Mr. X's case. The studies point to a higher incidence of traumatic experiences, such as family dysfunction and unresolved grief, among adolescents with psychotic depression. Mr. X's traumatic background, notably his father's suicide and the subsequent family discord, significantly contributed to the development and worsening of his depressive and psychotic symptoms. This highlights the idea that psychosocial stressors, particularly unresolved trauma, can

trigger or intensify depressive episodes that feature psychotic symptoms. Additionally, Mr. X's history of self-harm, which began in early adolescence, aligns with research that identifies maladaptive coping strategies like self-injury as common in adolescents with severe mood disorders. This reinforces the importance of thoroughly assessing both clinical presentations and psychosocial backgrounds when diagnosing and treating adolescents with complex mood disorders.

The research also explores key psychological factors that affect adolescents, particularly those with MDD with psychotic features, as illustrated by Mr. X's case. One study investigates the links between impulsivity, risk-taking behavior, and self-esteem, finding a negative relationship between self-esteem and risk-taking, especially in males. This suggests that individuals with low self-esteem may be more inclined to engage in risky behaviors, while impulsivity does not significantly predict risk-taking across the sample. Another study looks at how the quality of parent-child attachment and communication patterns influence adult relationship satisfaction, revealing that strong emotional bonds and effective communication correlate positively with satisfaction. Conversely, factors such as separation anxiety and restrictions on individual exploration can negatively impact communication and relationship quality. Additionally, research into anger expression in young adults shows gender differences, with males typically exhibiting more physical aggression, while females demonstrate more verbal aggression. This highlights the need for effective anger management strategies, particularly during key transitional periods, to reduce maladaptive expressions of anger that may lead to mental health challenges.

Overall, these findings carry significant implications for Mr. X, as his low self-esteem and dysfunctional family dynamics are pivotal aspects of his mental health issues. His experiences illustrate the interrelationship between self-esteem, familial connections, and emotional expression, highlighting the necessity for targeted therapeutic interventions. By focusing on improving self-esteem, enhancing family dynamics, and fostering healthier emotional expression and anger management techniques, a comprehensive treatment plan can be created to effectively address the complexities of Mr. X's condition, ultimately supporting his recovery from MDD with psychotic features.

CONCLUSION

An illustration of the intricate, multidimensional character of mental illnesses in adolescents is the case of Mr. X, a 16-year-old teenager with a diagnosis of Major Depressive Disorder (MDD) and psychotic symptoms. It emphasizes, in particular, the difficulties in treating depression that are exacerbated by psychosis and underlying trauma. Due to the fact that Mr. X had a history of self-harm, severe depressive symptoms, and psychotic experiences like auditory hallucinations, it is important to recognize and treat mood disorders in adolescents because biological, psychological, and environmental factors are all interrelated.

The intricacies of Mr. X's disease required a multidisciplinary approach to treatment. Pharmacological, psychological, family, and dietary support were all part of his treatment approach. SSRI fluoxetine was used to control mood, atypical antipsychotic risperidone was used to treat psychotic symptoms, and lorazepam was used to reduce anxiety as part of the pharmaceutical approach. Dialectical Behavior Therapy (DBT) and Cognitive Behavioral Therapy (CBT) were used to address the emotional dysregulation and negative cognitive patterns that underline depression and psychotic symptoms. By combining these therapy, Mr. X was able to significantly reduce his symptoms and learn more effective coping and emotional management techniques.

A crucial component of the treatment was family therapy, which focused on the dysfunctional family relationships that followed Mr. X's father's suicide and the unresolved pain associated with it. Relations within the family were further strained by his mother's emotional lack of availability. Mr. X's recovery was greatly aided by the better communication, restored trust, and more supportive atmosphere that family therapy fostered. Nutritional support was also required to treat Mr. X's physical health, making sure he had the right nourishment to support his physical and psychological rehabilitation, especially considering the dramatic weight loss and poor nutrition that sometimes accompany severe depression.

Adolescent psychotic depression research supports the value of combining pharmacological and therapy therapies, especially when there are major psychosocial stressors present, like trauma and dysfunctional families. More severe symptoms, such as a higher risk of suicide, cognitive distortions, and social disengagement, are often seen in adolescents with psychotic depression, as was the case with Mr. X. There is substantial evidence in the literature that the combination of SSRIs and antipsychotics, as was employed in his therapy, is a successful strategy for treating the disorder's mood and psychotic components.

Additionally, this particular case highlights the importance of taking psychosocial aspects into account while treating adolescent mood problems. Mr. X experienced severe depressive and psychotic symptoms, which were exacerbated by unresolved bereavement, familial trauma, and maladaptive coping strategies. Research already in existence suggests that early traumatic events, including a parent's suicide, significantly raise the risk of mood disorders with psychotic symptoms. In order to guide treatment, it is crucial to conduct a comprehensive evaluation of the patient's coping mechanisms, trauma history, and family history.

In conclusion, the case of Mr. X illustrates the significance of an all-encompassing, individualized treatment strategy that takes into account every aspect of adolescent mental health. The treatment strategy decreased Mr. X's symptoms and enhanced his general functioning by integrating family therapy, evidence-based psychotherapy, medication, and dietary support. To avoid relapse and encourage long-term recovery, however, given the chronic nature of major depressive disorder with psychotic symptoms, conventional family participation, follow-up care, and monitoring will be crucial. This case emphasizes how crucial a comprehensive, customized strategy is when treating adolescents with complex psychiatric conditions, emphasizing the need to integrate biological, psychological, and social factors in the recovery process.

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Conflict of Interest

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