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Assessment and Management of Depressive Disorder of an Adolescent: A Case Report of 16-year-Old Client

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Abstract

Depression, with its wide range of symptoms and severity, presents as especially challenging to healthcare providers, researchers, and policymakers. This case report details the assessment, diagnosis, and management of depressive disorder in a 16-year-old male adolescent, emphasising the unique challenges and considerations pertinent to this age group. The patient presented with persistent feelings of sadness, anhedonia, sleep disturbances, decreased appetite, and withdrawal from previously enjoyed activities. A comprehensive assessment (both formal and informal) was conducted. The evaluation encompassed cognitive, emotional, and behavioural domains. Notably, there were marked academic declines and increased irritability, which initially masked the underlying depression. The development of the management plan was informed by the utilisation of cognitive behavioural therapy approaches, including motivational interviews, family therapy, art therapy, and social therapy. This case underscores the importance of considering the broader socio-environmental context and the need for a multidisciplinary approach to the management of adolescent depression.

Keywords: Cognitive-Behavioural-Therapy, Depressive Disorder, Family therapy, Multi-modal approach, Nigeria, Personality Assessment.

Introduction

According to Bello (2016), an adolescent is a young person who has undergone puberty but has not reached full maturity. It is a period of profound transition, encompassing physiological, psychological, and social changes (Dorn et al., 2019). During this period, many individuals encounter the challenges of forming an identity, navigating peer relationships, and meeting increasing life demands (including academic demands). According to the World Health Organisation (WHO, 2021), it is also during these years that some adolescents face the onset of mental health disorders, among which depressive disorders stand out as particularly impactful. Depressive disorders not only affect an adolescent's current functioning but can also set the stage for long-term mental health challenges and decreased life potential (Evans et al., 2005; Atilola, 2015). Given the intricacies of this developmental stage and the serious implications of depression, accurate assessment and effective management tailored to adolescents are paramount. This report delves into a specific case of a 16-year-old male, highlighting the complexities of diagnosing and treating depressive disorders in this age group and the

intertwined role of personal, familial, and societal factors in the onset and course of the illness. The assessment and management plan present notable characteristics of the Draw-A-Person (DAP) personality test, the Incomplete Sentence Blank College (ISBC) form, and the Minnesota Multiphasic Personality Inventory (MMPI). Comprehensive management encompassed a multi-modal approach: Cognitive Behavioural Therapy (CBT), family therapy, and art therapy.

Case Description

S.H., a 16-year-old male, was brought in for personality assessment and therapy by his parents. A Muslim of the Yoruba tribe, the client was an SSCE holder who resides at #204 XXX Street, Iyanapaja, Ilejemeje, Ekiti State. He was dark in complexion, tall, and ectomorphic. Physically, the client appeared healthy and well-developed for his chronological age, with no obvious signs of deformity. He looked fit for his age, maintained eye contact, and appeared well-groomed and kept. He wore black jeans, a striped shirt, and leather slippers. His mood was unhappy, his speech was coherent and soft, and his tone was moderate. His thought process seemed normal, and his judgement and insight were good. The client was well-oriented in person, place and time and had a focused concentration.

The client's father, Mr J.H., reported him to have experienced a lack of attention (reduced concentration), keeping to self (withdrew from going out), loss of interest in pleasurable activities (visiting friends), smiling to self with no apparent/obvious reason, odd behaviour (wandering within the house) and poor academic performance, which is reflected in his promotion examination and SSCE results. According to the father, the mother started complaining one and a half years ago about the client's lack of concentration in the house. According to the client's elder brother, the client's friend mentioned that the client's behaviour changed at the beginning of their SS3 year when, all of a sudden, the client started avoiding his friends.

S.H. is from a monogamous family of six with four children (3 boys and 1 girl). Mr. J.H. is a 52-year-old lecturer with a PhD. The client's mother, Mrs A.H., is a 48-year-old secondary school teacher with an MSc. The client's eldest sibling is a 22-year-old medical student at a Federal University, while his older sibling is an 18-year-old Electrical Electronics student at a Federal University. The only girl in the family is an 11-year-old secondary school student at a Federal Model College. The client was reported to have a cordial relationship with his parents and siblings.

The client's father reported that the client's pregnancy was not eventful but had a prolonged labour of about 14 hours for a multiparous woman. The client's developmental milestones (crawling, sitting, and walking) were reported to have been normal. During childhood, the client experienced severe convulsions, which were treated. The client was reported to have been quick to tears when he was much younger. He cried excessively, especially when his older siblings told him they would not play with him anymore. The client had no history of psychoactive substance use, and there was no known family psychiatric history. The client used to be calm, loves football, wants to make mummy and daddy proud, to be an engineer, and takes to correction, but was introverted and shy. The client had just completed his SSCE, where he failed his core subjects (Mathematics, English, and Chemistry), and NECO, where he had no single credit.

Assessment

The clinical interview focused on obtaining information on the reason for referral, a detailed history of the present disorder such as the first occurrence, frequency of occurrence of symptoms, major events in S.H's life, when he first experienced the symptoms, major impairments, his difficulties at present, how he has been coping with his difficulties, what previous medical, psychological or psychiatric help has been sought, his belief about the problem, attitude towards the difficulties experienced, his cognitive functioning, prevailing mood, family history, early developmental and educational history, psychosexual history, occupational history and subjective ratings of presenting complaints were taken from the client.

Measurement

Both objective and subjective measurements were adopted during the assessment. The client indicated his overall problem severity at an '8' average on a 0-10 rating scale. For the objective measure, the Beck Depression Inventory (BDI) was administered to the client to examine the severity of his depression. During the assessment, the client was asked to tick statements that best described his feelings in the last two weeks. Each statement was scored on a scale of 0 (absent), 1 (mild), 2 (moderate), and 3 (severe). The lowest possible score of the BDI is between 0-13, indicating minimal depression, while the highest possible score is 29-63, indicating severe depression. The client scored 44, indicating severe symptoms of depression. The T-score of 69 and 60 on the VRIN and TRIN of the Minnesota Multiphasic Personality Inventory (MMPI-A) indicated that the client was consistent in his responses. The T-scores of 78, 60, and 69 on the F1, F2, and F scales, respectively, indicated that S.H.'s profile is valid. On the defensive scale, the client had a T-score of 55 and 40 on the L and K scales, respectively. This indicated that the client was not defensive in his response. On the clinical scale, the client had moderate elevation on Psych asthenia (scale 7) and Paranoia (scale 6) with T-scores 65 and 66, respectively. This showed that the client was prone to depressed mood or anxiety symptoms; also, suicidal ideation should be assessed. A moderate score on scale-6 suggested suspicion and mistrust, tending to interpret innocuous interpersonal stimuli as threatening or insulting. Also, chronic social maladjustment was common with moderate scores. Minnesota Multiphasic Personality Inventory-2 (MMPI-2) indicated the potential for suicidal ideation, which was subsequently assessed on the Beck's Scale for Suicidal Ideation (BSSI). The client recorded a score of four out of the maximum possible score of 38 on the BSSI. Notably, a score of "1" was observed on item "4", which indicated mild intention towards suicidal ideation. Although the cumulative score of four does not approach the scale's upper limits, its significance is underscored by the fact that the client recorded scores on the crucial screening items, specifically items "4 and 5". Furthermore, the Incomplete Sentence Blank College form (ISBC) indicated that the client exhibits a range of feelings and perceptions related to social interactions, personal capabilities, and future aspirations (see Table 1). The presence of avoidant traits and challenges with interpersonal relationships indicate potential areas of difficulty in social settings. Feelings of weakness, fear of under-performing, and desires for strength suggest internal conflicts related to self-worth and efficacy. The client's uncertainty about the future, distraction, and indecisiveness suggests a need for clarity and direction in life's pursuits.

Table 1: Themes in S.H.'s Responses to the ISBC

THEMES	DESCRIPTIONS
Avoidant Traits	Indicated by responses in items (4, 32).
Difficulty with Interpersonal Relationships	Signified by entries in items (5, 34, and 40).
Perceived Weakness	Exemplified in item (7).
Fear of Drowning/Under-performing	Identified in item (13).
Social Difficulty	Highlighted in item (19).
Distraction	Revealed in item (23).
Uncertainty About the Future	Denoted by item (24).
Desire for Strength and Power	Reflected in item (26).
Indecisiveness	Expressed in item (29).

Case Conceptualisation

S.H. was a 16-year-old male who reported difficulty concentrating, social withdrawal, lack of interest, self-smiling, aimless wandering, fatigue, and suicidal ideation. These symptoms significantly impacted the client's daily functioning. A combination of formal and informal assessments led to a diagnosis of major depressive disorder or clinical depression, according to DSM-V. A treatment plan was developed, guided by information obtained during pre-treatment evaluation. The treatment and evaluation (pre- and post-treatment) are shown in Table 2. The client experienced difficulties in social adjustment, and this predisposed him to depression. Individuals who experience social maladjustment may be at greater risk of developing depression due to the adverse effects of social isolation and lack of support for mental well-being. It should be noted that the emergence of major depression often results from a complicated interplay of multiple factors, such as genetic, environmental, psychological, and social elements. While some individuals may be more susceptible to depression due to inherited genetic risks, others may be vulnerable to their life experiences, such as social maladjustment or other negative events. It is worth noting that not all people who experience social maladjustment will develop major depression.

Table 2: S.H's Subjective Rating of Problematic Behaviours Pre- and Post-assessments

Problematic Behaviours	**Pre-assessment Ratings**	**Post-assessment Ratings**
Reduced concentration	8	5
Withdraws from going out	9	6
Loss of interest in pleasurable activities	8	6
Smiling to self	9	5
Wandering within the house	7	6
Fatigue	8	5
Suicidal ideation	4	2

Nonetheless, social maladjustment can play a role in the onset of depression for some individuals (Hammen et al., 2005; Egenti & Ebenebe, 2018; Fokum, 2023). Also, the client's poor academic performance played a precipitating role in the onset of depression. Poor academic performance can be a source of stress and may lead to feelings of failure or low self-esteem, which can be risk factors for depression (Fiorilli et al., 2019; Elum, 2022; Ladi-Akinyemi et al., 2023). It is important to note that not everyone who experiences poor academic performance will develop major depression (Ogunleye & Aluko, 2020). However, poor academic performance can be a contributing factor in the development of depression for some people. Additionally, academic difficulties may lead to social isolation, which can also increase the risk of developing depression (Ladi-Akinyemi et al., 2023).

Research has found that depression is linked to lower grade point averages and dropping out of school, with co-occurring anxiety potentially exacerbating this association (Eisenberg et al., 2009; McCurdy et al., 2022; Aliero et al., 2023). Theoretical frameworks such as Bruner's (1960) suggest that learning is an active process that builds on past knowledge. At the same time, Bandura and Walters's (1977) Social Learning Theory emphasises the role of learning, both through direct experience and observation, in shaping behaviour. Depressed individuals may

have different self-concepts than non-depressed individuals, as observed by McCarthy and Schmeck (1988). Psychodynamic explanations suggest that depression can stem from symbolic or imagined loss. The client equates poor academic performance with the loss of a loved one, in this case, maybe his wife. The client may believe his wife (his parents) only loves him when he performs well, as his parents expect him to do.

The client's case revealed that the home environment played a key role in maintaining their mental health condition, which in this case was major depression. A positive and supportive home environment can promote safety, security, and belonging, which can contribute positively to a person's mental health (Barnhart et al., 2023). Conversely, a negative or stressful home environment can worsen mental health conditions. This could stem from family members' lack of support or understanding, financial or relationship issues, physical discomfort, or safety concerns. Therefore, for individuals with major depression, having a nurturing and supportive home environment is crucial to their recovery and preventing relapses. Beck (2002) posits that upsetting life situations may trigger an extended bout of negative thinking and reactions. In the client's case, their home environment worsened their negative thoughts, and they reported feeling out of control.

The client's eldest sibling provided the client with essential support, which served as a protective factor in his case. The client's friends were not emotionally connected, and the eldest sibling was his only reliable source of support. She was helpful, worked towards improving the client's condition, and helped him return to normal life. The client was diagnosed with major depression, and his family was provided with psycho-education regarding his condition and the risk of suicide.

Course of Treatment

The formulation of the client's condition was based on the cognitive model and cognitive behaviour therapy. According to Brewin (2006), the structured and systematic nature of CBT, combined with its focus on changing both thoughts and behaviours, makes it a well-established and preferred therapeutic approach for the treatment of depression and other mental health issue. For instance, Tamuno-opubo et al. (2023) used CBT in the management/treatment of conduct disorder of a 12-year-old in Nigeria. The formulation was communicated with the client to prepare him for psychological treatment. Short-term and long-term goals were formulated to help the client manage his condition. For efficient communication, assessment, and intervention, rapport was created. Psycho-education regarding illness and therapeutic strategies was given to the client and his family members. The therapist requested the client to sign a no-harm contract, which was a written pledge "not to harm himself." He will phone his sister, brother, or therapist if suicidal thoughts cross his mind and will try to keep himself occupied in order to divert his attention. A clinical interview of the client and family was taken in this session. A detailed history of the present illness, family history, occupational history, and subjective ratings of presenting complaints were taken from the client. Beck Depression Inventory (BDI) and Beck Suicide Ideation Scale (BSIS) were given to the client and asked to fill out the questionnaire. The dysfunctional thought record chart was explained to the client, and he was asked to fill the chart at home.

Family therapy was utilised to resolve the client's family issues and secure his or her support. The client's concerns with exhaustion and sleep were addressed using relaxation and mindfulness techniques. In order to ensure that the client had a regular schedule, activities were scheduled. The client's core belief was examined, and the therapist explained how rational and irrational beliefs can restructure his cognition. The client was given a chart to write down his thoughts, rate them as irrational or rational, and give a reason for each response. After this practice, he was asked to restructure his thoughts into rational ones. The client was given a survival kit/hope box, which consisted of motivational videos and quotes of people about suicide who experienced difficult times but managed to overcome them.

Moreover, a virtual hope kit app was installed on the client's mobile in case he had difficulty

keeping the hope box. The client was given a therapy blueprint and asked to summarise all he has done in sessions, his problems, the skills learned, and his future goals. The client was also encouraged to take follow-up sessions to prevent relapse.

Results

A subjective evaluation of the client's condition was also gathered during diagnostic and treatment sessions. On a verbal scale of 0 to 10, where 0 denotes a low level of difficulty, and 10 denotes a high level of difficulty, the clients' problems were rated. The subjective rating of the issue by the client, according to Table 2, was gradually decreasing. Most sessions used a standardised scale to measure change objectively and give the client and therapist comments on improvement. As unbiased indicators of progress, depression scales were used. The subjective and objective reports of the intervention's results strongly imply that progress has been made. Across all evaluated behaviours, improvements were observed between the pre-and post-assessment periods. While some behaviours, such as 'Withdraws from Going Out' and 'Loss of Interest in Pleasurable Activities', remain moderately concerning post-assessment, others, like 'Suicidal Ideation', have shown a significant positive shift. Continued monitoring and tailored interventions are recommended to ensure sustained improvement and well-being.

Conclusion

In studying the case of a 16-year-old child who was diagnosed with Major Depressive Disorder (MDD), some significant findings have been noted. A series of 14 sessions, each lasting 60 minutes per week, were carried out. The age of onset, a critical period in adolescence, highlights the necessity for a prompt and successful intervention method. Significant cognitive, emotional, and social changes occur during adolescence, and the onset of a severe mental health illness can make this period of transition more difficult and perhaps set the stage for long-term difficulties in adulthood. In addition to having an adverse effect on the client's present quality of life, the symptoms he displayed—from diminished focus to social withdrawal—pose dangers to his future academic success, social interactions, and self-esteem. Notably, the drop-in enjoyable activities and a possible suggestion of suicidal ideation are very worrisome, reflecting the severity of his depression.

Additionally, adolescence is a time of plasticity, adaptability, and resilience. The client has a strong possibility of not just managing his symptoms but also recovering a trajectory towards a full and productive life with the appropriate therapeutic interventions, familial support, and perhaps medication (if deemed appropriate by a psychologist). Moving forward, a multifaceted strategy that includes family and individual therapy, as well as educational aids, will probably be most helpful. It will be essential to continuously monitor and evaluate his progress in order to make the required adjustments to his interventions.

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