International Journal of Clinical Psychiatry 2014, 2(2): 17-20
DOI: 10.5923/j.ijcp.20140202.01

Major Depressive Disorder without Psychotic Features- A Case Report

Sri Dashinie Sri Renganathan

Faculty of Medicine, Universitas Udayana, Denpasar, Bali, Indonesia

Abstract Major depression is one of the four basic forms of mood disorder. It is considered as a serious medical illness that affects a person's behavior, feeling, mood, thoughts and also health. A patient is associated with major depression when he or she possesses at least five of these clinical symptoms; sadness (also known as depressed mood), lack of concentration, sleeping disorder such as insomnia and hypersomnia, fatigue, loss of interest, lack of appetite, excessive guilt, unworthy feeling and suicidal thoughts. The mentioned symptoms should be present for a minimum period of two weeks for the diagnosis of major depression to be established. Left untreated, major depressive disorder may interfere with daily life activities and eventually leads to suicide, which is one of the leading cause of death in the United States. In this report, the referred case study for major depressive disorder will be the scenario of a 30 year old woman who attempted suicide by consuming 8 *bodrex* pills. She was given psychotherapy and treated with antidepressant of selective serotonin reuptake inhibitor group which indeed showed a good improvement on her health.

Keywords Major depressive disorder, Psychotic features, Suicidal ideation

1. Introduction

An episode of major depression includes five or more mental or physical symptoms in which if the symptoms last for at least two weeks, it will be classified as major depression. The prominent symptoms are usually sadness or depressed mood, lack of concentration, sleeping disorder (insomnia, hypersomnia), fatigue, loss of interest, lack of appetite, excessive guilt, unworthy feeling and lastly the suicidal thoughts. [1, 2]

Patients may also express physical symptoms such poor eye contact, limited expression, soft voice, lack of prosody, a passive gesture. Some of the depressed patients tend to neglect personal hygiene while some withdraws themselves from friends and family. [3]

Major depressive disorder is a common disorder with a lifetime prevalence of approximately 15% and 25% more likely to occur in women than men. Regardless of culture or country, the prevalence of major depressive disorder is two times higher in women than men. The average onset age for major depressive disorder is said to be 40 years old. Statistic shows 50% of the patients had an onset between 20 and 50 years old. [3-5]

The etiology of major depressive disorder remains unknown, but it is believed that there are a few contributing factors to this scenario. According to a research done, it was concluded that major depressive disorder is associated with dysregulation of the neurotransmitters such as the norepinephrine and serotonin. A decrease in the serotonin level can trigger depression. Some of the patients who have committed suicide in the past had low level of metabolic serotonin their cerebrospinal fluid as well as low level of serotonin up take site in the platelets. It is also believed that first-degree relatives of patients with major depressive disorder have a possibility to suffer the similar disorder by 1.5 to 2.5 times. A study of twins, demonstrated a compliance rate of monozygotic twins as much as 50%, compared to 10-25% in dizygotic twins. The patient's life experience, age, sex, hormone changes, substance use and other illnesses all play significant roles in the development of depression. [5, 6]

In DSM IV and PPDGJ III, the diagnostic criterion for major depressive disorder has been clearly separated from the ones with mild, moderate and recurrent depression. Additionally, in PPDGJ III diagnostic guidelines for major depressive disorder were further divided into major depressive disorder without psychotic symptoms and major depressive disorder with psychotic symptoms. [5, 7] The diagnosis of major depression is established based on the type, number of clinical symptoms and the duration of exacerbation as stated in DSM IV. [7]

The majority of clinicians and researchers believe that a combination of psychotherapy and pharmacotherapy are the most effective treatment for major depressive disorder. [2, 8] It is known that the combination of this treatment helps in

* Corresponding author:
dashinie_13@hotmail.com (Sri Dashinie Sri Renganathan)
Published online at http://journal.sapub.org/ijcp

both recovery and in preventing recurrence. Psychotherapy helps to address the causative factor and the maintaining factor in depression. Three types of short-term psychotherapy will be the cognitive therapy, interpersonal therapy and behavioral therapy. [4, 9] Cognitive behavior therapy is one of the most common therapies adapted by psychologists. Through cognitive behavior therapy, negative view and thoughts of a person can be changed, specifically their perspective on how they see themselves, the world and their future. [4, 9, 10] Interpersonal therapy is developed to solve problems in relation to personal roles and interpersonal relationship of depressed patients. Mainly there are four interpersonal areas that are commonly associated with major depression. There are abnormal grief reaction, interpersonal role disputes, difficult role transitions and interpersonal deficit. [4, 9, 10, 11]

Pharmacotherapy with proven efficacy in treating major depressive disorder are the anti-depressants namely, the tricyclic group such as: amitryptylin, imipramine, clomipramine, opipramol, the tetracyclic group such as: maproptiline, mianserin, amoxapine, the reversible MAOI (RIMA, reversible inhibitor of Mono Amine Oxsidase-A) such as: moclobemide, the atypical groups, like as trazodone, tianeptine and mirtazepine and lastly the SSRIs (Selective Serotonin Re-uptake Inhibitors) such as sertraline, paroxetine, fluvoxamine, and citalopram fluxetine. [3, 5, 7]

Major depressive disorder is not a condition to be taken lightly. This situation turns out to be a chronic process and patients tend to have relapse of the disorder if the treatment is not proper. Patients that are hospitalized during their very first episode of depressive disorder have shown 50% chance of recovery in their first year. Recurrence of major depressive episodes is also frequent, where approximately 30 to 50% happens in the first two years and approximately 50 to 70% within the 5 years. The incidence of relapse was significantly low in patients who continued prophylactic psychopharmacologic therapy and in patients who have only one or two episodes of depression. [1, 3, 8]

Major depression is a common disorder that could affect anyone regardless of their age and thus may strike at any point of their life either directly or indirectly. [9, 10] Major depression causes a person to have difficulty in functioning causing a major risk factor for suicide. [9] Therefore, with this case report, readers can have a good knowledge of major depression, which could be useful in helping their family member or friends who are suffering from major depression. This could be the best way to reduce the number of suicides among major depression sufferers.

2. Case Report

A 30 year old woman was brought to Sanglah General Hospital by her parents with chief complain of profuse vomiting and nausea after attempting suicide with 8 bodrex pills. The patient appeared tired, sad, her hair was messy and her clothes were rumpled. Throughout the interview session, her expressions were flat and she spoke in a soft voice giving unelaborated responses to the examiner's questions. When asked about the reason behind the act of attempting suicide, patient admitted it was due to the problems she was facing with her spouse.

Patient has been married for the past 14 years now. She got married at the age of 16 after getting pregnant out of wedlock. She has two children, a son and a daughter whom both are currently in high school. Her education was halted even before she completed high school due to lack of interest and teenage pregnancy. She was keener to devolve into her newly wed life. She claimed that she was a Muslim before marriage but converted to Hindu after marrying her husband who is a Hindu. When questioned about her job, she said that she is a full time housewife as her husband does not allow her to work. Further questioning revealed the reason was because the husband was afraid that their kids will be left unattended without any surveillance. When enquired about her social economic status she admits that her husband earns enough for their family and didn't elaborate more on his salary as she is not sure of the exact amount of her husband's salary. She denied consuming alcohol or smoking. She said she only consumes one glass of coffee every morning which is her only visible addiction. Patient claimed to have a happy marriage until lately about a month ago when patient found out that her husband was having an affair with one of his fellow colleague.

Since then, patient experiences commotions with her husband every other day and at times, it gets extreme where patient suffered from domestic violence. Patient did admit that the suffered bruises as a result of husband hitting her. According to patient, she was still having hopes that their marriage will work out till three weeks back when the husband told her that he wants to marry the colleague that he was having affair with.

Quoting the patient, her husband's announcement caused her to loss interest in anything and everything. She was neither able to perform her daily household chores nor carry on with her responsibility as a mother. She also complained on having trouble to fall asleep and even if managed to sleep, she could not maintain them for the similar hours she used to sleep. This means she has not been able to have a good continuous night sleep and this has been occurring for the past three weeks. Plus, her appetite has dropped drastically which was obvious when she loss almost 8 kg in just 3 weeks.

However patient denied of having hallucination (seeing things that are not visible to others or hearing voices that are not audible to others). Patient claimed to be having these suicidal thoughts for past one week as she felt worthless and claims that there is no meaning to her life anymore. Two hours prior to admission to hospital, the patient had a phone call from her husband saying that he's going to legally divorce her, triggering the patient to succumb to the voices in her head, to end her life by consuming 8 bodrex pills (paracetamol 350mg, propifenazon 150mg, kafein 50mg) with a bottle of sprite.

Through the heteroanamnesis done with the patient's parents, it was found that lately patient portrayed to be very passive and aloof. She locks up herself in her room for hours and refuses to respond to anyone even her own children. As for medical history among family members, no records of family members suffering from psychiatric illness was found. There were no abnormalities found from the physical examination of the patient. Whereas from the psychiatric examination patient was found to have good orientation towards time, place and people, there were no signs of diminished memory, and intelligence coherent with her education level.

However patient appeared sad with teary eyes, obvious lack of concentration, minimal eye contact and speaks with a low tone. The mood and affect of the patient was depressive and appropriate, the forms of her thoughts was logical coherent and realistic with the presence of suicidal ideation. Hallucinations and illusions were denied, and patient was found to be hypobulic, was suffering from late type insomnia. Patient appeared calm throughout the interview and while the examinations was carried out. History of agitation and physical assault of others was denied however.

Patient was diagnosed with major depressive disorder without the manifestation of psychotic features based on the DSM IV guidelines. She was admitted in the psychiatric ward of Sanglah General Hospital and was being treated with the combination drug such as the antidepressant (fluoxentine 20mg) and psychotherapy as well. The family members inclusive of the patient's children were given psychoeducation in order to speed up patient's recovery. The patient's condition improved after two weeks of observation in the psychiatric ward and patient denied of having suicidal ideation any longer. Patient was discharge 11 days from the day of admission.

3. Discussion

In establishing the diagnosis of major depression for the patient, a 30 year old woman, who attempted suicide with 8 bodrex pills due to marital breakdown based on DSM IV criteria, there must be at least expression of five of the symptoms which occurs for a period of 2 weeks. [1, 2] Patient in this case happen to portray symptoms like depressive mood, loss of appetite and weight, loss of pleasure, worthlessness, insomnia and on top of all suicidal ideation. The symptoms were present for more than 2 weeks which fits the diagnosis of major depression. Through the anamnesis it was found that there was no history of hallucination or illusion which rules out the possibility of having major depression disorder with psychotic features. Adjustment disorder was also ruled out for this particular patient. Adjustment disorder is divided into six subtypes, therefore it is important to rule out adjustment disorder with depressive mood in this patient which is the differential diagnosis. [9-11] The criteria based on DSM IV is symptom must develop within 3 months after onset of the stressor and doesn't exceed 6 months time unless it is a chronic type. It was also stated in DSM IV that one cannot be diagnosed as adjustment disorder if stress related disturbance meets the criteria for another specific axis 1 disorder. [10, 11] In this case patient meets the diagnosis criteria for major depression. Patient also denied of having any illness or history of substance abuse. It is highly recommended for lab tests to be conducted on this patient in order to rule out other illnesses which might also contribute as an organic factor to the condition.

The main reason or risk factor that caused the patient to fall into major depression is believed to be marital infidelity which comes under marital status risk factor. Besides marital problems, another contributing factor would be gender as it is well known that women are much more vulnerable to be at state of depressed compared to men. Additionally, social economic status played an important role towards her condition where the main and only source of income was from her husband and now her worries are on how she is going to survive with her two kids without any sort of income. Worst she had been too dependent on her husband all this while which made her felt that she can't live without her husband.

As for the treatment regimen the patient was treated with a combination of both drug and psychotherapy under the observation of the physician, Dr. Wayan Westa Sp. KJ in psychiatric ward of Sanglah General Hospital. A holistic approach in treating major depression has showed a better outcome in improving the symptoms compared to a single mode of treatment [2, 6, 7]. The drug of choice in this case was fluoxentine 20mg (SSRI) which functions as an antidepressant by increasing the level of serotonin in the synaptic cleft and causes minimal side effects. Another reason for the drug use was, it is considered to be one of the cheapest drug of its group and is also easily available. [2] Patient's family was advised to monitor her medication intake and behavior at home. [8, 9] Her parents took the responsibility of taking care of her and they brought her to their home after she was discharged because afraid that she might have a relapse. Her parents also took charge of bringing her to the hospital each time she has an appointment with the physician.

This patient was given cognitive behavior therapy for 10 weeks with one session each week and each session lasted around 30-40 minutes. It was carried out by Dr. Wayan Westa Sp.KJ(K) as he is the one who was incharge of her from day one. The purpose of psychotherapy was for the exploration of thoughts, feelings and behavior of the patient which helps in problem solving and in achieving higher levels of functioning of the patient. Psychotherapy also helps in order to increase one's senses which are essential in taking care his or her own well-being. [3-5]

The goal in treating a major depression patient is not only focused on improving the symptoms but also to prevent from worsening of the symptoms which then leads to suicides. A holistic approach with the combination of drugs and psychotherapy has proven a better prognosis. [1, 2, 8]

4. Summary

A 30 year old woman who came in with the chief complains of profuse vomiting and nausea after attempting suicide with 8 bodrex pills. She was diagnosed with major depression disorder without psychotic features as fulfills the DSM IV criteria by having symptoms such as worthlessness, loss of weight and appetite, loss of pleasure, insomnia, and suicidal ideation for more than two weeks. The physical examination of the patient showed no abnormal findings and from the psychiatric examination patient appeared to be conscious, has good orientation of time place and people, has logic and realistic thoughts, hypobulic, and speaks in a low tone with unelaborated respond and minimal eye contact to the examiner. It was concluded that the main risk factor for the patient was due to her marriage failure and her gender. However, this can be seen more as a problem that affects women in middle income group rather than a personal problem. The country still has a large number of women who did not have proper education and are depending solely on their husband to support them. Indeed there is high probability that these women are suffering from depression as well. As for treatment, patient was admitted in the psychiatric ward and treated with fluoxentine 20mg daily and psychotherapy. The family members were also given psychoeducation in order to help in the problem solving process of the patient. After two weeks patient was discharged as there was improvement in her condition and there was no more suicidal thoughts in her. However patient was asked to continue the medication and have a regular checkup at Sanglah Psychiatric Polyclinic.

ACKNOWLEDGEMENTS

First and foremost, I would like to express my prayer to lord for successfully completing my case report entitled “Major Depressive Disorder without Psychotic Features”.

I would like to express my special appreciation and thanks to my supervisor, **Dr. Wayan Westa, Sp. KJ(K),** whose contribution in stimulating suggestions and encouragement, helped me to coordinate in writing this case report.

Finally I would like to sincerely apologize if there are any weaknesses in this report that I wrote. I hope this case report could be beneficial to the readers.

REFERENCES

[1] Kaplan, H.I., Sadock, B.J., Grebb, J.A. 1997. Sinopsis Psikiatri Jilid I.

[2] Pedoman Penggolongan Diagnostik Gangguan Jiwa (PPDGJ III). Direktorat Jiwa Departement kesehatan Republik Indonesia 1993.

[3] Maslim. R Panduan Praktis Penggunaan Obat Psikotropika, Edisi II, Jakarta, 2001; 23 – 30.

[4] Casacalenda N, Perry JC, Looper K. *Remission in major depressive disorder: a comparison of psychotherapy, pharmacotherapy, and psychotherapy*.; Retrieved February 18, 2013. http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.159.8.1354.

[5] Cuijpers P, van Stratn A, van Open P, Warmerdam L, Andersson G. Psychologicaltreatment of depression: *A meta-analytic of database of randomized studies*. Retrieved February 18, 2013. http://www.biomedcentral.com/content/pdf/1471-244X-8-36.pdf.

[6] Cuijpers P, van Stratn A, van Open P, and Anderson G.. *Psychotherapy for depression in adults: a meta-analysis of comparative study*. Retrieved February 18, 2013. http://stijnvanheule.psychoanalysis.be/wp-content/uploads/2011/12/cuijpers.2008.meta-analysis-psychotherapies-depression.pdf.

[7] Cuijpers P, Smit F, Bohlmeijer E, Hollon SD and Andersson G. *Efficacy of cognitive-behaviouraltheraphy and other psychological treatment for adult depression.* Retrieved February 18, 2013. http://bjp.rcpsych.org/content/196/3/173.full.pdf+html.

[8] Wolf AV, Holzel LP, Westphal A, Harter M and Kriston L. *Combination of pharmacotheraphy and psychotheraphy in treatment of chronic depression.* Retrieved February19,2013. http://www.biomedcentral.com/content/pdf/1471-244x-12-61.pdf.

[9] Baldwin DS, Birtwistle J.2002. An Atlas of Depression.

[10] Goldman H.2000. Review of General Psychiatry.

[11] Kay J, Tasmana A.2006. Essentials of Psychiatry.

[12] Zimmerman M, Martinez JH, Dalrymple K, Chelminski I, Young D. Is the distinction between adjustment disorder with depressed mood and adjustment disorder with mixed anxious and depressed mood valid? Retrieved December 13, 2014. https://www.aacp.com/pdf%2F1113%2F1113ACP_Zimmerman.pdf.