Molly Depression Case Study

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Case Overview

Molly is a 29-year-old woman who presents with depressed mood, loss of interest, irritability, impaired concentration, sleep and eating changes, reduced energy, and declining occupational functioning. Before these difficulties, she performed well in a computer-based workplace. Her relationship with a colleague became known to others, she reports threats or humiliating treatment, the colleague was dismissed, and he ended contact with her. Molly then lost status at work, performed poorly, and was fired. She has used cocaine, cannabis, alcohol, and tobacco. The original case concludes immediately that she has recurrent major depressive disorder with severe psychotic features. That conclusion is not supported by the information provided. The case strongly indicates clinically significant distress requiring prompt assessment, but diagnosis must remain provisional until duration, substance timing, suicide risk, mania, psychosis, trauma, medical causes, and prior episodes are evaluated.

Presenting Symptoms

Molly reports several symptoms commonly associated with depression: low mood, reduced interest, sleep disturbance, appetite or weight change, fatigue, concentration difficulty, irritability, and impaired work performance. A major depressive episode requires a defined cluster of symptoms during the same two-week period, with either depressed mood or loss of interest present, and clinically significant distress or impairment. The case gives inconsistent durations—one month in one place and two months in another—so the clinician should establish an accurate timeline. Symptoms should be described in Molly's own words rather than inferred from a checklist alone.

Functional Impairment

The loss of occupational functioning is important. Molly was previously effective at work but became unable to perform at her usual level. Functional decline supports the seriousness of the problem, although it does not determine one diagnosis. Workplace hostility, grief over the relationship, substance use, sleep loss, and depression could each contribute. Assessment should also explore self-care, finances, housing, relationships, daily routine, and whether she can complete essential tasks. Function may reveal urgency even when the precise diagnostic category remains uncertain.

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Depressed Mood and Anhedonia

A clinician should clarify how often Molly feels depressed, empty, hopeless, numb, or tearful and whether the mood lasts most of the day. “Loss of interest” should be explored through activities she previously enjoyed, including social contact, sexuality, hobbies, food, work, and future plans. A person may stop activities because of shame, financial loss, fatigue, fear, or lack of access rather than anhedonia alone. The distinction helps build an accurate formulation and treatment plan.

Sleep, Appetite, and Energy

The case mentions difficulty sleeping and an “eating disorder,” but these terms are too broad. Molly may have insomnia, hypersomnia, reduced appetite, increased eating, irregular meals, or a separate eating disorder. Cocaine can suppress appetite and sleep, while cannabis and alcohol can alter both. Withdrawal can also produce fatigue, irritability, anxiety, and disturbed sleep. The assessment should record pattern, severity, timing, substance relationship, and medical consequences rather than count each vague statement as a confirmed depressive symptom.

Concentration and Psychomotor Change

Molly reports difficulty concentrating and poor performance. The clinician should ask whether she loses track of conversations, makes errors, cannot initiate tasks, or feels mentally slowed. Objective observation can assess agitation or retardation, but ordinary nervousness is not automatically psychomotor disturbance. Anxiety, sleep deprivation, intoxication, withdrawal, attention disorder, trauma, and workplace stress may also impair concentration. Multiple causes can coexist.

Suicide Risk Assessment

Any person presenting with significant depression, substance use, job loss, shame, and relationship loss requires direct suicide assessment. The clinician should ask about thoughts of death, wishing not to wake up, suicidal thoughts, plans, intent, access to lethal means, preparatory behavior, and past attempts. Questions do not create suicidal thoughts; they identify risk. Protective factors, reasons for living, social support, future commitments, and willingness to accept help should also be assessed. If imminent risk is present, safety and emergency evaluation take priority over routine diagnostic interviewing.

Safety Planning

A safety plan is a collaborative, written sequence identifying warning signs, internal coping strategies, people and places that provide distraction, trusted supporters, professional crisis resources, and steps to reduce access to lethal means. It is not a promise that Molly will not harm herself. Follow-up contact and a clear pathway for urgent care are necessary. In the United States, 988 can provide crisis support, while life-threatening emergencies require emergency services. Local resources should be used according to the actual setting.

Substance-Use History

Molly’s cocaine, cannabis, alcohol, and tobacco use requires detailed assessment. The clinician should ask what she uses, dose, frequency, route, context, last use, tolerance, withdrawal, unsuccessful attempts to reduce use, financial consequences, overdose history, and interaction with work or relationships. The statement that cannabis was cheaper and provided the same pleasure as cocaine is clinically questionable because the substances have different effects and risks. Molly’s own experience should be explored without assuming equivalence.

Substance-Induced Depressive Disorder

A depressive syndrome can occur during intoxication or withdrawal or as a consequence of medication or substance use. Cocaine withdrawal commonly includes low mood, fatigue, sleep changes, reduced pleasure, and craving. Alcohol can worsen depression and sleep, while cannabis effects vary. To consider a substance-induced condition, the clinician needs a temporal relationship between exposure and symptoms and evidence that the substance can produce the syndrome. Symptoms that clearly preceded use or persist well beyond expected withdrawal may support an independent depressive disorder, but the distinction can require longitudinal observation.

Co-Occurring Disorders

Mental-health and substance-use problems often occur together. Treatment should not require Molly to solve one problem before receiving help for the other. Integrated care can combine motivational interviewing, cognitive-behavioral strategies, contingency management where appropriate, medication for indicated disorders, relapse-prevention planning, and social support. Judgmental language may cause her to conceal use. Accurate disclosure is more likely when the clinician explains confidentiality and its limits.

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Major Depressive Disorder as a Possibility

Major depressive disorder is a reasonable differential diagnosis if Molly has at least five qualifying symptoms during the same two-week period, including depressed mood or anhedonia, and the episode is not better explained by substances, a medical condition, bipolar disorder, or another diagnosis. Severity depends on symptom number, intensity, impairment, and risk—not simply job loss. The current information does not justify the word “recurrent” because no previous depressive episode is described. If criteria are ultimately met and no prior episode is found, the specifier would involve a single episode rather than recurrence.

Psychotic Features Are Not Established

The original essay calls Molly psychotic because she fears being fired from a future job. That fear is understandable after a recent dismissal and does not demonstrate delusion or hallucination. Psychotic features would require evidence such as fixed false beliefs not explained by culture or circumstances, hearing voices, severe thought disorganization, or other loss of reality testing. A worried prediction may be exaggerated or anxious without being psychotic. Assigning a severe psychotic diagnosis without evidence can stigmatize Molly and lead to inappropriate treatment.

Adjustment Disorder

Adjustment disorder with depressed mood or mixed anxiety and depressed mood should be considered when symptoms develop in response to identifiable stressors and do not meet criteria for another disorder. Molly experienced workplace exposure, threats, relationship loss, humiliation, and termination. If her symptoms are closely tied to those events and fall short of major depression, adjustment disorder may fit. The diagnosis should not minimize suffering; it describes a stress-related pattern and still warrants treatment when impairment is significant.

Bipolar-Spectrum Screening

Before prescribing an antidepressant or confirming unipolar depression, the clinician should ask about past periods of elevated or unusually irritable mood, reduced need for sleep, increased energy, rapid speech, racing thoughts, inflated confidence, excessive spending, risky behavior, or marked productivity. Substance effects must be separated from spontaneous episodes. A history of mania would change the diagnosis and treatment substantially. Family history is useful but absence of known bipolar disorder does not rule it out.

Anxiety and Trauma

Molly may have anxiety related to social humiliation, threats, job loss, or future employment. The clinician should assess panic, constant worry, avoidance, hypervigilance, intrusive memories, and trauma symptoms. If the workplace threats involved stalking, coercion, assault, or retaliation, safety planning and legal or advocacy resources may be needed. Trauma should not be assumed from limited information, but it should not be overlooked because the case focuses on romance and depression.

Workplace Harassment and Consent

The relationship occurred between colleagues, but the case does not describe power differences, consent, policy, or how information became public. The clinician should ask whether Molly experienced coercion, exploitation, harassment, discrimination, threats, or retaliation. Treatment should not blame her for the relationship or assume that reputational loss was deserved. Employment-law questions require appropriate professional advice; the therapist's role is to assess safety, emotional impact, and available support.

Medical Differential Diagnosis

Medical conditions and medications can produce symptoms resembling depression. Assessment may include physical examination and targeted laboratory testing based on history—for example, thyroid function, blood count, metabolic concerns, pregnancy testing when relevant, nutritional deficiency, infection, medication effects, and sleep disorders. Vitamin D deficiency should not be presented as a universal explanation requiring routine testing in every case. Clinical judgment should guide evaluation.

Reproductive and Sexual Health

Because Molly has had a sexual relationship and uses substances, the clinician should ask sensitively about pregnancy possibility, contraception, sexually transmitted infection testing, reproductive goals, sexual coercion, and medication safety. These questions should be explained and asked without moral judgment. Pregnancy status can affect diagnosis, risk, and medication decisions. Confidentiality and local consent rules should be discussed.

Past Psychiatric History

The statement that Molly has no history of depression may mean no previous diagnosis, not necessarily no prior symptoms. The clinician should ask about earlier low mood, treatment, hospitalization, self-harm, anxiety, trauma, eating problems, attention issues, and periods of unusually high energy. Previous response to therapy or medication is relevant. Family history can include depression, bipolar disorder, psychosis, substance use, suicide, and treatment response, while recognizing that family information may be incomplete.

Mental Status Examination

A mental status examination would document appearance, behavior, cooperation, speech, mood, affect, thought process, thought content, perception, orientation, attention, memory, insight, judgment, and suicide or homicide risk. It is a structured snapshot, not a complete diagnosis. Intoxication or withdrawal should be considered. The clinician should distinguish what Molly reports from what is observed and avoid conclusions based on clothing, eye contact, or cultural communication style alone.

Standardized Measures

Validated questionnaires such as the PHQ-9 can help quantify symptoms and monitor change, while substance-use screens can identify patterns requiring assessment. A score does not diagnose Molly by itself. Positive suicide items require direct follow-up. Measures should be available in an appropriate language and interpreted within culture, literacy, disability, and clinical context. Repeated scores can support treatment monitoring but should not replace conversation about function and goals.

Provisional Formulation

A cautious formulation is that Molly presents with a depressive syndrome and substantial functional impairment after interpersonal and occupational stress, in the context of polysubstance use. Major depressive disorder, adjustment disorder, and substance-induced depressive disorder are leading possibilities. Anxiety, trauma-related conditions, bipolar spectrum, and medical causes require assessment. There is no evidence currently presented for psychotic features or a recurrent course. The formulation should be updated as the timeline and response to abstinence or treatment become clearer.

Immediate Treatment Priorities

Priorities are suicide and safety assessment, intoxication or withdrawal evaluation, stabilization of sleep and nutrition, and connection with support. If Molly is at risk of severe alcohol withdrawal, urgent medical management may be required. She may need help with housing, insurance, employment benefits, legal concerns, or access to care. Social problems are not secondary distractions; they can maintain symptoms and limit treatment participation.

Psychotherapy

Evidence-based psychotherapy may include cognitive-behavioral therapy, interpersonal therapy, behavioral activation, motivational interviewing, or an integrated approach. Interpersonal therapy may be especially relevant to relationship loss and role transition. Behavioral activation can help Molly rebuild routine and rewarding activity. Cognitive work can examine shame, hopeless predictions, and self-blame without denying actual workplace harm. Treatment should set goals collaboratively rather than assume that “getting rid of depression” is one simple task.

Medication

Medication may be appropriate if a qualified prescriber confirms a depressive disorder and considers severity, bipolar risk, substance use, pregnancy, medical conditions, interactions, and patient preference. Antidepressants do not produce immediate relief and require monitoring. Medication alone will not resolve workplace trauma, housing, isolation, or substance patterns. If bipolar disorder is present, antidepressant treatment requires particular caution. The case does not provide enough information to recommend a specific drug.

Substance-Use Treatment

Molly should receive a nonjudgmental assessment of readiness to change. Treatment may include motivational interviewing, cognitive-behavioral relapse prevention, contingency management for stimulant use where available, peer support, and treatment for alcohol-use disorder if criteria are met. There is no approved medication specifically for cocaine-use disorder, but co-occurring conditions and alcohol or tobacco use may have pharmacologic options. Harm-reduction measures and overdose education should be individualized.

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Family and Social Support

Family support may help, but only with Molly's permission and when relationships are safe. Trusted friends, support groups, community resources, and vocational services can reduce isolation. The original recommendation assumes family involvement is beneficial; assessment should determine whether relatives are supportive, critical, controlling, absent, or unsafe. Molly should retain control over disclosure except where law requires action for imminent safety or other defined circumstances.

Work and Recovery

Employment loss can affect identity, income, routine, and access to healthcare. A gradual return-to-work plan, vocational counseling, résumé support, or accommodations may help when she is stable. Fear of another dismissal can be addressed through realistic planning, not labeled psychosis. Therapy can separate what Molly can control—skills, boundaries, treatment, support—from factors requiring legal or organizational response.

Monitoring Outcomes

Progress should be monitored through mood, interest, sleep, appetite, substance use, safety, function, and personally meaningful goals. A lower questionnaire score is useful only if daily life improves. Treatment should be adjusted if symptoms worsen, mania appears, substance risk increases, side effects occur, or the diagnosis changes. Follow-up soon after treatment initiation is important given the level of disruption described.

Question: What More Information Is Needed for a Proper Treatment Plan?

The clinician needs an exact symptom timeline; frequency and severity of each symptom; suicide and self-harm history; past mood episodes; mania or hypomania screening; psychotic symptoms; substance type, dose, timing, withdrawal, and consequences; medical and medication history; pregnancy and sexual-health information; trauma and workplace safety; legal and financial concerns; family and social support; living conditions; treatment preferences; and access barriers. A physical assessment and targeted laboratory evaluation may be appropriate. This information should be gathered collaboratively and revised over time.

Conclusion

Molly clearly needs timely professional care, but the original diagnosis is overconfident. Her symptoms may meet criteria for a major depressive episode, yet substance effects, adjustment disorder, bipolar spectrum, trauma, anxiety, and medical conditions must be considered. There is no evidence that her fear of future dismissal is psychotic, and no history establishing recurrent depression. The safest approach is a provisional, integrated formulation combined with direct suicide assessment, substance-use evaluation, medical review, psychotherapy, social support, and medication when indicated. Accurate diagnosis is not merely a label; it guides treatment while protecting Molly from unnecessary stigma and inappropriate intervention.

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