Molly Depression Case Study

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Introduction

Molly is a 29-year-old woman whose functioning deteriorated after a cluster of interpersonal and occupational stressors. She reports depressed mood, loss of interest, irritability, concentration problems, disturbed sleep and eating, reduced energy, and declining work performance. A workplace relationship became known to others, she describes threats or humiliation, the colleague was dismissed and ended contact with her, and Molly subsequently lost status at work before being fired. She also reports use of cocaine, cannabis, alcohol, and tobacco. These facts support the presence of clinically significant distress but do not justify an immediate diagnosis of recurrent major depressive disorder with psychotic features. Major depression requires a defined symptom pattern, duration, impairment, and exclusion of better explanations, while “recurrent” requires evidence of a previous episode and psychotic features require hallucinations, delusions, or comparable loss of reality testing (American Psychiatric Association, 2022). A defensible case formulation must therefore remain provisional while clarifying timeline, suicide risk, substance effects, mania, trauma, medical causes, prior episodes, and the circumstances surrounding the workplace relationship.

Depressive Symptoms and Diagnostic Threshold

Depression is a reasonable diagnostic possibility because Molly describes several recognized symptoms, including low mood or reduced pleasure, sleep and appetite changes, fatigue, concentration difficulty, irritability, withdrawal, and impaired ability to meet responsibilities (National Institute of Mental Health, 2026). The assessment should establish whether the symptoms occurred most of the day, nearly every day, during the same period for at least two weeks and whether either depressed mood or loss of interest was present. Functional impairment is clear enough to require attention, but losing a job does not determine diagnosis or severity by itself. A clinician should ask how symptoms affected self-care, finances, relationships, routine, and ability to complete daily tasks. The case also gives inconsistent durations, so chronology matters. A depressive episode arising after a relationship breakup and workplace conflict may meet criteria for major depressive disorder, but an adjustment disorder could be more appropriate if symptoms are closely tied to identifiable stressors and do not meet another disorder’s criteria. Diagnosis should follow the evidence rather than the dramatic nature of the events.

Substance Use and Differential Diagnosis

Substance use substantially complicates the differential diagnosis because cocaine, alcohol, cannabis, and their withdrawal states can affect mood, sleep, appetite, concentration, energy, anxiety, and judgment. SAMHSA guidance for co-occurring disorders emphasizes establishing the chronological relationship between psychiatric symptoms and substance exposure and treating mental-health and substance-use conditions in an integrated manner rather than requiring one problem to be solved before the other receives care (SAMHSA, 2020; SAMHSA, 2026). Cocaine withdrawal can include depressed mood, fatigue, sleep disturbance, craving, and reduced pleasure, which may resemble an independent depressive episode. The clinician therefore needs details about frequency, dose, route, last use, periods of abstinence, tolerance, withdrawal, unsuccessful attempts to cut down, and consequences. Bipolar-spectrum screening is equally important before labeling the case unipolar depression or selecting an antidepressant. Past periods of unusually elevated or irritable mood, reduced need for sleep, increased energy, pressured speech, racing thoughts, grandiosity, or risky behavior must be distinguished from effects occurring only during intoxication or withdrawal (American Psychiatric Association, 2022).

Safety and Psychosis Assessment

Safety assessment should occur early because depression, substance use, relationship loss, shame, and job loss can combine to increase risk even when the case does not explicitly report suicidal thinking. The clinician should ask directly about thoughts of death, suicidal ideation, plans, intent, access to lethal means, preparatory behavior, prior attempts, self-injury, and protective factors. NIMH guidance emphasizes that changes such as hopelessness, withdrawal, dangerous risk-taking, sleep disturbance, and increased substance use can be warning signs requiring prompt evaluation (National Institute of Mental Health, 2025). A collaborative safety plan can identify warning signs, coping strategies, supportive people or places, professional crisis contacts, and steps to reduce access to lethal means. The interview should also explore workplace threats, coercion, sexual safety, stalking, retaliation, housing, financial stability, and whether any relationship currently places Molly at risk. Fear that she could be dismissed from another job is not evidence of psychosis after an actual termination. Psychotic features should be diagnosed only when there is evidence of impaired reality testing, such as delusions or hallucinations, rather than understandable anxiety about repeating a recent loss.

Medical and Contextual Assessment

Medical and psychiatric assessment should address conditions that can mimic or worsen depression. Depending on history and examination, clinicians may consider thyroid disease, anemia, sleep disorders, pregnancy, medication effects, nutritional problems, infection, chronic illness, or other

contributors. The mental-status examination should describe appearance, behavior, speech, mood, affect, thought process, thought content, perception, cognition, insight, judgment, and safety while separating what Molly reports from what the clinician directly observes. Standardized measures such as the PHQ-9 can quantify symptom severity and track change, but a questionnaire does not establish diagnosis by itself and any suicide-related response requires direct follow-up. The workplace context also deserves careful, nonjudgmental exploration. The available information does not establish whether the relationship was consensual, whether there was a power imbalance, or whether Molly experienced harassment, discrimination, threats, or retaliation. A therapist's role is to assess psychological impact and safety while referring employment-law questions to appropriate professionals. Accurate formulation requires understanding the environment in which symptoms developed rather than treating every problem as an internal defect.

Integrated Treatment Planning

Treatment should address confirmed depressive symptoms, substance use, interpersonal loss, and practical stressors together. Evidence-based options for depression include psychotherapy, medication, or both, selected according to severity, preferences, medical factors, and diagnostic clarity (National Institute of Mental Health, 2026). Cognitive behavioral therapy, behavioral activation, and interpersonal therapy may be relevant to hopeless predictions, withdrawal, disrupted routine, relationship loss, and occupational role transition. Integrated substance-use treatment can include motivational interviewing, relapse-prevention strategies, contingency management for stimulant-use disorders where available, peer or recovery support, and treatment for alcohol or tobacco problems when indicated (SAMHSA, 2020). Medication should not be selected until bipolar risk, current substance use, pregnancy possibility, medical history, interactions, and patient preference are reviewed. Social recovery matters as well: Molly may need help with housing, insurance, employment benefits, legal consultation, vocational planning, or reconnection with safe support. Family or friend involvement should occur with her consent and only when those relationships are genuinely supportive. Treatment goals should be collaborative, specific, and connected with daily functioning rather than only symptom-score reduction.

Conclusion

In conclusion, Molly's presentation is consistent with a clinically important depressive syndrome, but the available case information does not support an immediate label of recurrent major depressive disorder with severe psychotic features. Major depressive disorder, adjustment disorder, and substance-induced depressive disorder are leading possibilities, while bipolar-spectrum, trauma-related, anxiety, and medical conditions require assessment. There is no described prior episode establishing recurrence and no evidence that understandable fear of future job loss constitutes psychosis (American Psychiatric Association, 2022). The safest formulation is therefore provisional and integrated. It begins with direct suicide and safety assessment, a detailed chronology of

symptoms and substance use, medical and mental-status evaluation, and clarification of workplace and relationship stressors. Treatment can then combine psychotherapy, substance-use intervention, social support, and medication when a qualified clinician determines that it is appropriate. NIMH and SAMHSA guidance both emphasize individualized treatment and coordinated care when mental-health and substance-use problems coexist (National Institute of Mental Health, 2026; SAMHSA, 2026). Accurate diagnosis should reduce uncertainty, guide intervention, and protect Molly from both undertreatment and unnecessary stigma.

References

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