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Case Report

Developing self-aware mindfulness to manage mood disorder in the adolescent - A Case Report

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ABSTRACT

Major depressive disorder (MDD) with psychotic is a complicated affective disease characterized by abnormal clinical sympotms, including neurovegetative disfunction (appetite or sleep disturbances), cognitive dissonance (inappropriate guilt, feelings of worthlessness), aberrant psychomotor activities (agitation or retardation), and elevated suicide risk with psychotic features such as delusions or nihilistic, non-bizarre delusions, somatic, poverty, worthlessness, or delusional beliefs about guilt and being punished, and sometimes appear hallucination. The prevalence of MDD with psychotic features increases with age. In general population, the point prevalence of MDD is about 2% to 4% and it is increasing about 20% lifetime risk. Depression is a leading cause of burden of disease among young people. Current treatments are not uniformly effective, in part due to the heterogeneous nature of MDD. MDD is caused by many factors. A 22-year-old male presented to the inpatient psychiatric unit with suicide attempt. The patient reported experiencing a lack of energy, difficulty falling asleep, lack of motivation, and feeling overwhelmed about his work and experiencing auditoric hallucination. The insight level was 5. Multiaxial diagnosis are axis I: major depressive episode with psychotic symptoms; axis II and III: currently not found; axis IV: problems with workplace; axis V: GAF 20-11. Patient treated with pharmacotherapy group Selective Serotonin Reuptake Inhibitor (SSRI) and second-generation antipsychotics which combined with supportive psychotherapy such as mindfullness.

Keyword: *Major depressive disorder, Mood disorder, Depressive, Self-Aware, Mindfulness, Adolescent*

INTRODUCTION

As gleaned from the literature self awareness is self-concept behaviors such as being fully vibrantly alive in the present moment, exercising self-control, and enacting self-awareness dovetail with qualities of mindfulness.[1] Major depressive disorder (MDD) with Psychotic is a complicated affective disease characterized by abnormal clinical symptoms, including neurovegetative dysfunction (appetite or sleep disturbances), cognitive dissonance (inappropriate guilt, feelings of worthlessness), aberrant psychomotor activities (agitation or retardation), and elevated suicide risk.[2,3,4]

The prevalence of MDD with psychotic features increases with age. In general population, the point prevalence of MDD is about 2% to 4% and it is increasing about

20% lifetime risk.[5] Depression is a leading cause of burden of disease among young people. Current treatments are not uniformly effective, in part due to the heterogeneous nature of major depressive disorder (MDD). Refining MDD into more homogeneous subtypes is an important step toward identifying underlying pathophysiological mechanisms. Patients with psychotic depression have a greater number of suicide attempts, longer duration of illness, more Axis II diagnoses, and more motor disturbances than those in being aware of the self, abnormal knowledge about the self, and/or abnormal judgments about the self (National Institute of Mental Health; NIMH). As a sub-construct of perception and understanding of MDD.[7] This includes abnormal processes and/or representations involved of the self, self-knowledge, which refers to Abnormal perception and understanding of the self is a core symptom the ability to make judgments about one's current cognitive or emotional internal states, traits, and/or abilities (NIMH), is also impaired in individuals with MDD. For instance, individuals with MDD, unlike non-depressed healthy individuals, often exhibit negative self-evaluation, inappropriate self-blame, and excessive self-criticism with psychotic features.[6]

Based on the ICD 10 (International Classification of Diseases) 10th revision) and Diagnostic and Statistical Manual of Mental Disorders (DSM-5), categorize to uphold the case of depressive symptom patterns within a single MDD diagnosis a minimum of 5 of the 9 DSM criteria for MDD have to be met. The criteria include consisting of there are increased versus decreased appetite, weight gain versus loss, insomnia versus hypersomnia, and psychomotor agitation versus retardation, around 1500 different combinations of MDD symptoms lead to the same DSM diagnosis of MDD. Thus, patients with the same diagnosis show heterogeneous depressive symptom profiles, which may reflect different underlying neurobiological mechanisms that could require different treatments. Several attempts to identify subtypes of depression have been made to overcome these issues associated with the traditionally, subtypes of depression have been defined based on subjective expert consensus. An example of describing different subtypes traditional diagnostic classification and the heterogeneity of MDD.[6]

Based on Kiang et al research about Evidence from MDD related to brain potensials, there are 16 MDD patients and 16 respondent as controls who viewed trials comprising a self-referential phrase followed by a positive, negative, or neutral adjective. Participants' task was to indicate via button-press whether or not they felt each adjective described themselves. Controls endorsed more positive adjectives than did MDD patients, but the opposite was true for negative adjectives.

The most common treatment for MDD patients are Selective Serotonin Reuptake Inhibitor (SSRI) and second-generation antipsychotics which combined with supportive psychotherapy. Selective serotonin-reuptake inhibitors (SSRIs) is a first lined therapy for major depressive and preferred over tricyclic antidepressants (TCAs) in suicidal patients due to lower risk in overdose. When indicated, there is evidence supporting a reduction in risk of suicide for those treated with clozapine or lithium. One of the best treatments for MDD patients is supportive psychotherapy.

Mindfulness therapy is a type of psychotherapy that involves a combination of cognitive therapy, meditation, and the cultivation of a mindfulness or present-oriented attitude. Mindfulness therapy, also known as mindfulness-based therapy (MBT), is beneficial for improving mental and physical health. According to Germer, Siegel, and Fulton (2005) define mindfulness as a form of full attention to the present state and being able to receive it with full awareness. Meanwhile according to Mace, mindfulness emphasizes awareness. In the sense of being fully aware

of what is going on and being able to divert it to another experience. In other words, mindfulness is accepting completely without judgment. Jon Kabat Zinn defines mindfulness as awareness that emerges from your present attention without being judgmental.

Practicing mindfulness can help patients to be more focus and enjoy every moment that happens. It also makes it easier for them to focus on the ego and is less likely to get caught up in worrying about the future or regretting the past. You also won't be bothered by worries about success and self-worth. Mindfulness will help patients to have the ability to build better quality relationships with other people. Thus, mindfulness is useful in making everyone enjoy life more. Improve Mental Health Psychotherapists have adopted mindfulness as an important element in the treatment of various mental health problems. This means that mindfulness is useful in dealing with stress, eating disorders, obsessive compulsive disorders, to depression. Mindfulness can also reduce excessive anxiety. Mindfulness meditation helps increase endorphins, which can reduce negative thoughts. Endorphin hormones can also improve the quality of sleep better.

How to do mindfulness is take the comfortable seat, recommend the patient to use a meditation cushion, and find a spot that gives a stable, solid seat, not perching or hanging back. Cross the legs comfortably in front of, do some kind of seated yoga posture. If on a chair, it's good if the bottoms of your feet are touching the floor. Straighten but don't stiffen the upper body. Situate your upper arms parallel to your upper body. Then let the hands drop onto the tops of your legs. With your upper arms at your sides, your hands will land in the right spot. Drop the chin a little and let the gaze fall gently downward. If you feel the need, may lower them completely, but it's not necessary to close the eyes when meditating.

Be there for a few moments and relaxing all of the muscles. Bring the attention focus to controlling the breath or the sensations in the body. Feel the breath or some say "follow" it as it goes out and as it goes in. Some versions of this practice put more emphasis on the outbreath, and for the inbreath you simply leave a spacious pause. Either way, draw the attention to the physical sensation of breathing: the air moving through your nose or mouth, the rising and falling of your belly, or your chest. Choose focal point, and with each breath, you can mentally note "breathing in" and "breathing out."

Inevitably, theattention will leave the breath and wander to other places. Don't worry. There's no need to block or eliminate thinking. Practice pausing before making any physical adjustments, such as moving your body or scratching an itch. With intention, allowing space between what the experience and what the individual choose to do. Afterwards, gently lift the gaze and open the eyes. Take a moment and notice any sounds in the environment. Notice how the body feels right now. Notice your thoughts and emotions. Pausing for a moment, decide how the invidu would like to continue on with daily activities.

It is important for the patient to understand that inner observing is how to develop sell-awareness. Without this inner observer, thus couldn't develop self-awareness. Self-aware mindfulness requires frequent practice to get the focus that the individual needs.

CASE PRESENTATION

A 22-year-old male presented to the inpatient psychiatric unit with suicide attempt. The patient reported experiencing a lack of energy, difficulty falling asleep, and feeling overwhelmed about his work during the previous month. He reported that his initial depressive symptoms started when he was transferring to work in the lighting department two months ago. The patient reported a sense of losing control of his life and feeling "mad about everything" in his life. The patient admitted that he was very uncomfortable working in that place

because of the pressure from his co-workers, which according to the patient was very high, so that it made the patient depressed, especially if he was reminded via WhatsApp messages and admitted that his work was not his passion and did not match his abilities.

Despite exhibiting symptomatology consistent with MDD the patient reported having never been diagnosed with it or receiving any treatment for her symptoms until he thought of self-harming. When patient's symptoms worsened he felt someone whispering to the patient to end his life immediately. No other interventions for the patient's symptoms were attempted. At the time of admission, the patient was positive for six of the PPDGJ III criteria for MDD with psychotic symptoms, including depressed mood, insomnia, fatigue, agitation, reduced appetite, and suicidal ideation.

The patient's social history appeared marginally contributory to his condition. he reported he was single and lived with a roommate at his army dorm. The patient's support system consisted of his friends, mother, father, all of whom occasionally helped to take care of him. The patient is the third child of three siblings, the patient has a closed personality, and if there is a problem the patient never talks, the patient has a personality that is easy to get along with his friends and follows organizations around his home and school, the patient has a very close relationship with his mother and tends to has a dependent personality, during his lifetime the patient has never received a stressor that weighs on the patient. The patient had graduated from high school and accepted as a soldier because of his own will and attended education for 6 months then transferred to the lighting department. the patient feels uncomfortable and depressed at work.

On his first day of hospitalization, the patient's mental status examination was significant for a disheveled appearance and poor eye contact. The patient exhibited a depressed mood and a blunted affect. His thought process was logical, and his thought content was positive for auditory hallucinations, and suicidal ideation.After diagnosing the patient with MDD with psychosis, the treatment team discontinued the patient's antipsychotic and started his on quetiapine 200 mg daily and fluoxetine 20 mg daily. Additional treatment consisted of group therapy and daily team meetings.

On the fifth day of hospitalization, the patient reported marked improvement in his depressive symptoms and expressed an interest in returning back at work unless he is transferred to another department at his office. The patient have plan to continue treatment with a psychiatrist and therapist on an outpatient basis.

DISCUSSION

This case demonstrates the need for further understanding of the current correlation between self-knowledge and depressive disorder. In the exploration of self-knowledge in depression, there are still many unanswered questions. First, although the discrepancy between explicit and implicit self-esteem in depression has been confirmed by several previous studies, and the neural mechanism of explicit self-esteem has been richly explored, little is known about the neural basis of implicit self-esteem in depression, suggesting the need for further research.[11,12,13]

Knowledge of the signs and symptoms of depression needs to be known well by health workers and by the community in the context of primary and secondary prevention efforts that can be carried out in the patient's social environment, and the handling of suicide attempts which are included in psychiatric emergencies by health workers, especially at health facilities level. first. The process of diagnosing mental disorders based on PPDGJ-III is enforced multiaxially using five axes, namely Axis I is a clinical disorder and other conditions that become the focus of clinical attention, Axis II is personality disorders and mental retardation, Axis III is a general medical

condition, Axis IV is a problem. psychosocial and environmental, and Axis V is a global assessment of functioning. In this case Multiaxial diagnosis are axis I: major depressive episode with psychotic symptoms; axis II and III: currently not found; axis IV: problems with workplace; axis V: GAF 20-11.[14]

According to PPDGJ III, the diagnosis of major depressive disorder with psychotic symptoms can be made with three main symptoms that must be present, plus a minimum of four of the other symptoms and some must have severe interactions, lasting at least two weeks or less can be justified if symptoms are unusually severe and progress quickly and very unlikely to be able to continue social activities, work or household affairs with delusions or hallucinations or depressive stupor. Delusions usually involve the idea of sin, poverty or impending doom, and the patient feels responsible for it. Auditory or olfactory hallucinations are usually in the form of insulting or accusing voices or the smell of feces or rotting flesh. Based on the history, physical examination and analysis of the patient's psychiatric status, the patient has met the diagnostic criteria based on PPDGJ III as described in Table 1.

Table 1. Criteria diagnosis and case's symptoms analysis

Dianostic criteria	Symptoms
The three main symptoms of depression must be present	1. Depressive affect 2. Low interest and ambition 3. Fatigue and reduced motor function
Plus at least 4 of the other 7 depressive symptoms must be present and of severe intensity	1. Concentration, attention and memory decrease 2. Feeling less confident 3. Interests and ambitions (aspirations) in the future are low 4. Sleeping and eating disturbed
Psychomotor agitation/ retardation	reduced motor function
The depressive episode must last for at least 2 weeks	It's been 2 months on patient
Has limitations in doing homework and social activities	There is impairment in the patient's work and social life with friends at work.
There are hallucinations/ delutions/ depressive stupor	Auditory hallucinations, which are sounds the patient hears asking him to end his life

Based on the analysis of the biopsychosocial risk factors that exist in patients, the risk of depression found in patients is derived from the psychological factors of patients who tend to have closed and dependent personalities. When the patient gets a mental stressor mechanism is repression until there is a failure of mental decompensation mechanism, then there is a depressive disorder with psychotic symptoms accompanied by suicidal ideation in the patient.[15]

Major depressive disorder with psychotic symptoms must be diagnosed at the primary care level and treated in a

hospital by a psychiatrist, but this case is a psychiatric emergency due to a suicide attempt and must be treated at a primary health care provider so that sufficient understanding is needed to carry out the first treatment. in cases of attempted suicide.

Management of suicide includes screening for suicidal ideation or behaviors, performing an assessment of the individual's current risk of imminent harm, and creating a treatment plan in collaboration with the patient and any involved supports. This process needs to be individualized, collaborative, and completed using a calm, cooperative, and curious interview style. Patient Health Questionaire-9 (PHQ-9) and Columbia Suicide Severity Rating Scale (C-SSRS) are tools that can help to screen for suicide and form a detailed account of an individual's suicidal ideations or behaviors. [16]

Brief therapeutic interventions, such as psychotherapy, case management, or supportive telephone calls and letters, are more effective for long-term suicide prevention when they are directed towards the symptoms of suicide, rather than indirectly targeting symptoms associated with suicide, such as depression or hopelessness.[17]

Selective serotonin-reuptake inhibitors (SSRIs) is a first lined therapy for major depressive and preferred over tricyclic antidepressants (TCAs) in suicidal patients due to lower risk in overdose. When indicated, there is evidence supporting a reduction in risk of suicide for those treated with clozapine or lithium. As with psychotherapy, there is evidence that suicide attempts are increased in the month before treatment, the month after treatment, after discontinuation of medications, and after any dose change. Close follow-up and monitoring are warranted during treatment.[18,19]

One of the pharmacological treatments for patients is fluoxetine, which is an SSRI antidepressant drug class that is the first line of treatment for depression. This drug works by inhibiting the resorption of serotonin. The action of this drug inhibits the re-uptake of serotonin and noradrenaline and is not selective. The therapeutic dose of this drug is 20 mg/day (morning), a maximum of 80 mg/day (in single or divided doses). Side effects that can be caused are severe kidney failure, hypersensitivity to fluoxetine. Due to the presence of psychotic symptoms in the patient, Risperidone, an atypical antipsychotic, was also given. The mechanism of action of this drug is by blocking dopamine at its post-synaptic receptors in the brain, especially the limbic system and the extrapyramidal system. This drug has an affinity for dopamine D2 receptors and serotonin 5HT2 receptors, making it effective for both positive and negative symptoms. The therapeutic dose used is 4-6 mg per day. Side effects that can occur include sedation, headache, nausea, vomiting, constipation, insomnia and palpitations. Atypical or second-generation antipsychotic drugs are the right choice of therapy in adolescents patients because the extrapyramidal and cognition side effects are not as severe as first generation antipsychotic drugs. [20,21]

ECT is proposed as an effective treatment in monotherapy or in combination to prevent the risk of relapse, but ECT is never recommended as a first-line treatment for the initial major depressive episode, irrespective of the clinical severity or clinical features. While the non-pharmacological management of this patient during treatment is interpersonal psychotherapy and cognitive therapy which aims to reduce or eliminate complaints and prevent the recurrence of maladaptive behavior patterns or psychological disorders carried out by the patient and the patient's family. [22]

Mindfulness therapy is a type of psychotherapy that involves a combination of cognitive therapy, meditation, and the cultivation of a mindfulness or present-oriented attitude. Mindfulness therapy, also known as mindfulness-based therapy

(MBT), is beneficial for improving mental and physical health. Mindfulness is a form of observational meditation, the meditators place their awareness on a focal point. This point can be the process of breathing or thoughts, but it can also be any information coming in through the five senses.

Developing this observing self is the key to developing self-awareness. The reason we are largely unconscious of our behavior is that our egos act autonomously. Through observational meditation, we create a space between the doer of actions, the thinker of thoughts, and the feeler of feelings. The observing self can then monitor our thoughts, feelings, and actions with objectivity.

It is important for the patient to understand that inner observing is how to develop sell-awareness. Without this inner observer, thus couldn't develop self-awareness. Self-aware mindfulness requires frequent practice to get the focus that the individual needs. The less the individual meditates, the more difficult it will be to focus monitoring the thoughts, feelings, actions, and behavior from moment to moment.[23]

CONCLUSION

MDD with psychosis is a main cause of disease burden worldwide, MDD is not a disorder exclusively limited to adult and elderly populations. Depression is a leading cause of burden of disease among young people. A substantial proportion of patients experience their first episodes of MDD during childhood and adolescence.

Abnormal self-knowledge is one of the cardinal symptoms of this disorder. Through a review of previous studies that measured abnormal self-knowledge in individuals with clinical MDD with psychosis, several abnormalities that distinguish patients with MDD as well as those at risk of the illness were revealed. For the patient described in this case report, comprehensive screening might have promoted earlier detection and treatment of his symptoms.

Four risk factors stand out in the consistency of their association with MDD with psychotic and the level of evidence suggesting that at least some of the association is indeed causal: gender, stressful life events, adverse childhood experiences, and certain personality traits.

Several treatment approaches to MDD with psychotic are currently available. These approaches include psychotherapy, antidepressant medications, electroconvulsive treatment (ECT), and other somatic therapies.

In the realm of psychotherapy, two types of time-limited psychotherapy have been shown consistently to be effective in treating MDD with psychotic, interpersonal psychotherapy and cognitive therapy which have some advantages these are Provides useful conceptual framework, diminishes stigma, high patient acceptance. There are combination between interpersonal psychotherapy and cognitive therapy called mindfulness.

Mindfulness therapy is a type of psychotherapy that involves a combination of cognitive therapy, meditation, and the cultivation of a mindfulness or present-oriented attitude. Mindfulness therapy, also known as mindfulness-based therapy (MBT), is beneficial for improving mental and physical health. Mindfulness emphasizes awareness, in the sense of being fully aware of what is going on and being able to divert it to another experience. In other words, mindfulness is accepting completely without judgment. Mindfulness would bring the patient’s attention to the present without being judgmental.

Of the many types of meditation, mindfulness has become the most popular based on Jon Kabat-Zinn's research conducted on how this form of meditation affects the brain. Mindfulness is a form of observational meditation, the meditators place their awareness on a focal point. This point can be the process of breathing or thoughts, but it can also be any information coming in through the five senses.

Developing this observing self is the key to developing self-awareness.The reason we are largely unconscious of our behavior is that our egos act autonomously. We have no one monitoring our thoughts, feelings, actions, and behavior from moment to moment.

Through observational meditation, we create a space between the doer of actions, the thinker of thoughts, and the feeler of feelings. The observing self can then monitor our thoughts, feelings, and actions with objectivity. It's important to understand that inner observing is how to develop sell-awareness. Without this inner observer, thus couldn't develop self-awareness.

In summary MDD with psychotic is often recurrent or chronic, and evidence suggests that genetic factors partially influence overall risk of illness but also influence the sensitivity of individuals to the depressogenic effects of environmental adversity. Therefore, supportive psychotherapy such as self-aware mindfulness is needed on MDD patients.

In addition, it is necessary to teach patients to meditate in the right way, so that it can help focus on carrying out activities of daily life. Thus, its life function can be maintained.

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DECLARATION OF INTERESTS

The authors declare that they have known competing financial interests or indirect including personal relationship. In any matter that raises or may raise a conflict that could have appear to influence the work reported in this paper. Also the authors declare the following financial interests/personal relationships which may be considered as potential competing interests.

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