CLINICAL VIGNETTE

Olivia H. is a 28-year-old cisgender female, White/European American, who presents to her third psychiatric evaluation in four months following a five-day hospitalization two weeks ago for "severe depression with suicidal ideation." She was discharged on sertraline 100 mg daily and is on medical leave from her job as a high school chemistry teacher. She lives alone, separated from her ex-husband eighteen months ago.

Her current presentation began eight months ago with "burnout." She was assigned three new course preparations and her school implemented a new grading system requiring retroactive adjustments for 300 students. Two months into this (six months ago), she developed severe insomnia (2-3 hours latency despite fatigue). Three months ago, she called in sick for a week, remained in bed, and told her sister "I couldn't do this anymore," though she denies suicidal intent at that time. One week later she returned to work and functioned briefly. Two weeks after resuming work, she experienced her first panic attack during a department meeting when questioned about grade delays. She felt short of breath, heart racing, believed she was having a heart attack, went to urgent care (EKG normal), received lorazepam, and did not return to work for four days.

Following this panic attack, her symptoms escalated. She developed intrusive thoughts of being "incompetent," "failing students," and "ruining people's lives" multiple times daily. She began checking behaviors: re-reading emails before sending, re-checking grades online, and asking her department chair weekly to review her work. Sleep deteriorated to 4-5 hours with early morning awakening at 4:30-5:00 AM. Appetite decreased significantly; she eats once daily and has lost 18 pounds over three months. She describes feeling "heavy" and stopped attending yoga classes (twice weekly) and social events. She reports anhedonia, noting reading and cooking now feel "pointless." Her mood is dysphoric and flat with "numb underneath the anxiety." Crying episodes occur 1-2 times weekly, triggered by perceived mistakes. Her concentration is severely impaired; she cannot read more than 1-2 pages without losing focus. She describes her thinking as "foggy."

Three weeks ago, following complaints from three parents about grading delays, her sister found her on her kitchen floor crying and saying "I can't do this anymore, I just want it to stop." She was hospitalized and reported passive suicidal ideation without plan: "sometimes I think the world would be better without me," but denied intent or planning. Discharged with diagnosis of "Major Depressive Disorder, single episode, severe with psychotic features," though no psychotic content appears in discharge summaries and she denies hallucinations or delusions.

Since discharge two weeks ago, minimal improvement. She remains largely confined to her apartment on four weeks approved medical leave. Insomnia persists. Intrusive thoughts continue daily. Checking behaviors have expanded: now checks apartment doors, bills, and repeatedly reviews pre-hospitalization text messages ruminating about whether she "sounded crazy." She has a new romantic partner (colleague, three months) whom she has not told about the hospitalization, reporting shame about her mental health.

Substance use: denies alcohol for four months (previously 1-2 drinks weekly); denies recreational drugs. Takes sertraline 100 mg daily, lorazepam 0.5 mg as-needed (used 3-4 times since discharge, partial relief only), and melatonin 5 mg nightly (ineffective). No other prescriptions. Severe influenza 11 months ago with four-week residual fatigue. No concussions. Last menstrual period five weeks ago; cycles previously regular 28-30 days but became irregular (6-8 week intervals) approximately five months ago, roughly coinciding with divorce finalization; has not sought gynecological evaluation.

Family history: maternal grandmother hospitalized twice for "severe depression"; maternal uncle diagnosed with bipolar disorder type II treated with lithium; mother reports anxiety and periodic untreated depression; father "stable," no psychiatric history; younger sister (age 25) no documented illness but stress-related insomnia.

Developmental history unremarkable. High-achieving student with BS in chemistry and MS in secondary science education. Five-year teaching career with no prior performance concerns; evaluations describe her as "dedicated," "organized," "well-liked." Describes self as "organized, bit of a perfectionist," acknowledging she "always cared a lot about doing things right." Close friendships from college, participated in yoga and book clubs prior to illness. Amicable, non-traumatic separation and divorce. Raised Catholic, now spiritual but non-religious.

When directly questioned about prior mood episodes, initially states "never felt like this before." However, when probed, reports that during her first year of teaching (five years ago), she had a three-month period where she felt "overwhelmed and exhausted" and "didn't enjoy things I used to," though it resolved on its own and she denies significant suicidal ideation, though felt "hopeless." Also reports a college episode lasting weeks after a breakup where she "shut myself off," which she attributes to the breakup rather than pathology. Describes baseline as "anxious about doing well" but states this was always manageable through hard work.

Current suicidal ideation: "I don't want to die, but sometimes I wish I could disappear or not exist. It's not a plan, just a feeling." Denies current intent to harm herself and minimizes hospitalization as "more about my sister freaking out." Denies homicidal ideation, hallucinations, delusions, or paranoia. Denies manic/hypomanic symptoms: no elevated mood, grandiosity, racing thoughts, decreased sleep need, increased goal-directed activity, or recklessness. However, prior to her first episode, she reports staying up late preparing curriculum materials feeling "energized," which she characterizes as typical work enthusiasm. Denies substance relapse. Regarding OCD symptoms, describes checking and rumination as "compulsive" and distressing, yet acknowledges checking provides temporary anxiety relief. Uncertain whether thoughts

are intrusive or self-generated.

Mental status: appears stated age, casually dressed (leggings, oversized sweatshirt), visible weight loss with prominent collarbones. Hygiene adequate but hair unwashed. Fair eye contact, frequently looks downward. Posture slumped, withdrawn. Psychomotor activity slightly slowed, minimal spontaneous movement, no fidgeting. Affect predominantly blunted-flat with occasional dysphoric coloring; tearful when discussing teaching or hospitalization. Cooperative, engaged, asks clarifying questions, shows warmth. Self-reported mood: "numb with underlying anxiety and dread." Emotional range markedly restricted with minimal baseline facial expression. Speech rate normal, no pressured quality, no flight of ideas. Volume quiet but audible; tone monotone. Normal fluency, no dysarthria. Thought process goal-directed and coherent with logical connections; no loose associations or tangentiality. Thought content centers on incompetence, failure, and harm to others; rumination about work performance and adequacy as teacher. Denies delusions. Fair insight: acknowledges thinking "might not be realistic" and "anxiety probably making this worse," yet minimizes psychiatric attribution: "I had a really hard year, so maybe this is just stress." Minimizes hospitalization severity.

Orientation intact to person, place, time, season. Objective attention/concentration deficit; loses focus during 40-minute interview, requires question repetition. Immediate recall intact (three-word repetition). Delayed recall intact but notably slow (eight seconds). Abstraction intact. Language intact, no anomia, comprehension appropriate. Judgment appears intact; sought help when needed.

DIAGNOSTIC ANALYSIS RESULTS

Clinical Discussion

The patient is Olivia H., a 28-year-old woman who presents after a five-day psychiatric hospitalization two weeks ago for severe depressive symptoms with suicidal ideation. Over the past eight months she has developed progressive insomnia, anhedonia, profound concentration difficulties, 18-lb weight loss, psychomotor slowing, recurrent intrusive self-critical thoughts with checking behaviors, and passive suicidal ideation, resulting in work leave and significant functional impairment.

Diagnostic Reasoning
The diagnosis is Major Depressive Disorder, single episode, severe, with anxious distress because the patient meets the symptomatic and temporal thresholds for a major depressive episode and demonstrates marked impairment. History reveals pervasive depressed mood and markedly restricted affect (“numb underneath the anxiety,” reports of crying 1–2× weekly), loss of interest/pleasure (reports that reading and cooking feel “pointless”), significant weight loss (18 pounds over three months), insomnia with early morning awakening, psychomotor retardation (slowed posture and minimal spontaneous movement), diminished concentration (cannot read more than 1–2 pages; objective attention lapses during interview), and passive suicidal ideation (“I don’t want to die, but sometimes I wish I could disappear”), all persisting beyond the

minimum duration. Functional impact is substantial (hospitalization, medical leave, homebound behavior). Anxious distress is present: she reports underlying anxiety, a discrete panic-like episode with autonomic fear and catastrophic cardiac fear, intrusive anxious cognitions about incompetence, and repetitive checking behaviors that temporarily relieve anxiety, meeting clinical threshold for the anxious-distress specifier.

Differential Considerations

Obsessive–Compulsive Disorder: Considered and documented as comorbid because the patient endorses recurrent intrusive doubts about competence and repeated checking (re-reading emails, re-checking grades, checking doors/bills) performed to reduce anxiety; insight is at least fair. OCD is comorbid rather than primary because the pervasive low mood, anhedonia, weight loss, sleep disturbance, and psychomotor slowing predate or accompany the escalation of checking and explain the major impairment. Bipolar II disorder: Ruled out as the principal diagnosis because there is no reliable history of distinct hypomanic episodes—patient denies periods of elevated mood, grandiosity, decreased need for sleep, or increased goal-directed activity outside situational work enthusiasm; family history raises vulnerability, so continued longitudinal surveillance is warranted. Panic-attack specifier for the depressive episode: Not applied formally because documentation of a full panic-attack symptom cluster and rapid time-to-peak is incomplete despite a clinically significant panic-like event (patient believed she was having a heart attack and sought urgent care). Psychotic features: Ruled out—discharge note listed psychotic features but there is no contemporaneous report of hallucinations or fixed delusions and the patient denies such experiences, so psychotic-specifier assignment is not supported by current evidence. Substance/medical-induced mood disorder: Unlikely given denial of substance use and absence of acute medical red flags, but new menstrual irregularity and weight loss warrant routine medical assessment to exclude contributory endocrine or metabolic factors.

Specifier Justification

Single episode, severe: The episode is severe given the full depressive symptom set with marked functional impairment (hospitalization, work leave, inability to perform job duties). With anxious distress: The patient reports persistent anxiety accompanying the depressive syndrome (reports feeling "numb with underlying anxiety and dread," intrusive catastrophic thoughts, panic-like episode, and repeated checking that relieves anxiety temporarily), supporting the anxious-distress specifier. Panic-attack specifier: Not assigned because the record lacks complete documentation of the required panic symptom cluster and abrupt peak within minutes. With psychotic features: Not assigned because patient denies hallucinations or fixed delusional beliefs and no psychotic content is documented despite the discharge label.

Recommendations

• Obtain focused collateral and structured mood-history screening (e.g., clinician-administered timeline) to clarify any past hypomanic symptoms given family history of bipolar II.
• Clarify chronology and time burden of obsessive thoughts/compulsions (onset relative to depressive symptoms, hours/day spent, degree of interference) to confirm comorbid OCD and guide treatment prioritization.
• Assess current antidepressant adherence and response since discharge, and review lorazepam use frequency; coordinate psychiatric medication follow-up for optimization given persistent symptoms after 2

weeks on sertraline.
• Initiate evidence-based psychotherapy referrals: cognitive behavioral therapy for depression and anxiety and, if OCD confirmed, exposure and response prevention (ERP); consider collaborative care with psychotherapy as first-line adjunct.
• Routine medical evaluation (primary care/gynecology) including basic labs (TSH, CBC, metabolic panel, pregnancy test as indicated) and assessment of recent menstrual irregularity and weight loss to rule out contributory medical conditions.
• Safety planning and close outpatient follow-up given ongoing passive suicidal ideation—document a current safety plan and reassess SI regularly.

Diagnoses

Major Depressive Disorder, Single Episode, Severe, With Anxious Distress
Obsessive-Compulsive Disorder, With Good/Fair Insight
