A CASE STUDY OF POST-ACCIDENT DEPRESSION IN A YOUNG WOMAN

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ABSTRACT:

This case study explores the psychological, emotional, and physical trajectory of a 28-year-old unmarried woman who developed mental health concerns following a traumatic road traffic accident. The patientR,presented with persistent disturbed sleep, depressive symptoms, and significant anxiety relating to financial instability and career disruption. The onset of her psychological symptoms was gradual, progressively worsening over a span of 12 months. Her condition was compounded by her long-term physical immobility, dependency on her family, and isolation during the COVID-19 lockdown. Diagnostic considerations point to depressive disorder due to another medical condition, with a differential diagnosis of PTSD also being explored. The report emphasizes the biopsychosocial nature of her distress and highlights the need for an integrated therapeutic approach including individual psychotherapy and family intervention.

KEYWORDS:

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INTRODUCTION:

The intersection between physical trauma and psychological health is a critical area of concern in clinical settings. In this case, we present the complex psychosocial aftermath of a severe accident experienced by R, a young, educated woman who was previously employed and leading an active life. The accident not only disrupted her physical functionality but also deeply affected her psychological state, self-concept, and interpersonal relationships. The compounding impact of long-term recovery, unemployment, perceived familial burden, and pandemic-induced isolation made her vulnerable to developing symptoms of depression and anxiety. This case underscores the importance of timely psychological assessment and intervention in patients with chronic medical conditions to prevent further mental health deterioration.

CASE DESCRIPTION

Ms.R, a 28-year-old B.Tech graduate residing in an urban setting, experienced a traumatic accident in December 2023 when she was grazed by a bus while riding her two-wheeler. This resulted in multiple leg fractures, necessitating several surgeries and extensive hospitalization. Two months into her treatment, she developed severe abdominal pain, which upon investigation revealed internal stomach injuries, further complicating her recovery process. The prolonged medical intervention led to her being bedridden for a year. Although her mobility has shown improvement over the last couple of months, she still requires a walker for assistance and has not regained her pre-accident physical condition. This physical limitation, along with her inability to resume her career, has triggered a cascade of psychological symptoms, including low mood, helplessness, social withdrawal, and feelings of being a burden on her family.

HISTORY TAKING

During the psychological assessment, Ms. R self-reported chronic sleep disturbances and a consistently low mood over the last 12 months. She expressed deep concern about her loss of independence and the financial strain her condition has placed on her family. Before the accident, she was employed and contributed to household expenses. Her abrupt dependency has been distressing, particularly as she sees her mother—whom she shares a close bond with—overwhelmed by the added caregiving responsibilities. The onset of the COVID-19 pandemic further isolated her, as other family members were engaged in their work-from-home routines, leaving her feeling neglected and increasingly alone. Although her family did not overtly express frustration, her internalized guilt and sense of helplessness led her to develop passive suicidal ideation. She emphasized, however, that the thought of the pain her death would cause her family dissuaded her from acting on these thoughts.

History of Present Illness (HOPI): Ms. R reports that her psychological distress began approximately 7-8 months following a serious road accident in December 2023.

Symptoms include persistent low mood, frequent crying spells, difficulty sleeping, feelings of helplessness, and concerns over her career and financial dependency. These symptoms have persisted for over a year and have impacted her ability to engage socially and professionally.

Past Psychiatric History: There is no documented history of psychiatric illness or treatment prior to the accident. She has never previously consulted a mental health professional or been prescribed psychotropic medication.

Medical History: Ms. R suffered multiple leg fractures from the accident and required several orthopedic surgeries.

Two months into her recovery, she developed gastrointestinal complications, requiring further treatment. Her mobility remains impaired, and she uses a walker. No chronic illnesses were reported prior to the accident.

Family History: There is no known family history of psychiatric disorders. R describes her family as supportive, particularly her mother, with whom she shares a close emotional bond. There is no reported history of substance abuse or serious medical conditions among immediate family members.

Personal History: R is the eldest child in the family. She was raised in a supportive environment and excelled academically, earning a B.Tech degree. Prior to the accident, she was employed and contributed financially to the household. She has never married and was socially active. Her hobbies included traveling, reading, and socializing, though these have significantly diminished post-accident.

Premorbid Personality:R was described as independent, sociable, responsible, and emotionally expressive. She had a positive self-image, was goal-oriented, and maintained healthy relationships with friends and colleagues. Post-trauma, she reports a decline in confidence, social interest, and emotional stability.

INVESTIGATION

A comprehensive mental status examination was conducted to assess her cognitive, emotional, and psychological functioning. Ms. R presented as a cooperative, oriented, and well-groomed individual, although visibly distressed and withdrawn. She avoided eye contact and appeared emotionally subdued. Her speech was slow but coherent, with appropriate tone and spontaneity. She reported subjective feelings of sadness and insomnia. Objectively, her mood was assessed as tense, depressed, and mildly anxious. Her thought process remained logical and goal-directed with no signs of delusions or perceptual disturbances. She did express thoughts of hopelessness and helplessness but did not show active suicidal intent. Her cognitive faculties including memory, attention, and intelligence appeared intact and appropriate for her socio-cultural background. Insight was graded at 4/6, indicating that she recognized something was wrong, although she was uncertain about the cause.

TREATMENT AND FOLLOW-UP

Initially, Ms. R received medical treatment for her physical injuries, including hospital-based care for the first three months post-accident. After she began experiencing psychological distress five months prior to this report, her consulting physician referred her for psychological evaluation and treatment. Given her willingness to engage in therapy and her insight into her condition, the treatment plan involves initiating Cognitive Behavioral Therapy (CBT) to address her depressive symptoms, maladaptive thought patterns, and anxiety. Additionally, due to the emotional strain and evolving family dynamics, sessions of family therapy are also recommended. These would help address any implicit communication issues, reinforce family support systems, and reduce her perceived burden. Long-term therapeutic goals include enhancing her coping mechanisms, promoting emotional regulation, and rebuilding her sense of agency and independence.

ADDITIONAL TREATMENT PLAN:

1. Cognitive Behavioral Therapy (CBT): To help identify and restructure negative thought patterns, improve coping strategies, and enhance problem-solving skills. CBT sessions will also target sleep hygiene and behavioral activation.

2. Supportive Psychotherapy:To provide emotional validation and a space to process trauma, loss of function, and evolving identity post-accident.

3. Family Therapy: To strengthen family dynamics, reduce perceived burden, and facilitate open communication regarding support needs and emotional resilience.

4. Psychoeducation: Educating Rand her family about depression, stress response, and recovery expectations to build insight and engagement.

5. Occupational Therapy Referral: To gradually reintegrate her into purposeful activities and develop a graded return-to-work plan.

6. Medical Follow-Up: Continued collaboration with her orthopedic and gastroenterology teams to ensure holistic care and address physical limitations.

7. Monitoring for Suicidality: Ongoing assessment for suicidal ideation, especially in phases of increased distress, to ensure timely intervention.

8. Goal Setting and Progress Evaluation: Structured goals will be reviewed bi-weekly to monitor therapy progress and make necessary adjustments.

Duration of therapy is planned for a minimum of 12 weeks, with reassessment and extension based on symptomatic improvement and functional recovery.

DIFFERENTIAL DIAGNOSIS

The primary diagnosis for R is Depressive Disorder Due to Another Medical Condition, characterized by persistent low mood, hopelessness, fatigue, and sleep disturbance. However, several differential diagnoses must be

considered:

1. Post-Traumatic Stress Disorder (PTSD): Given the traumatic nature of the accident, PTSD is a potential diagnosis. However, R did not report hallmark symptoms such as intrusive memories, flashbacks, or hyperarousal, making PTSD less likely.

2. Adjustment Disorder with Depressed Mood: The depressive symptoms emerged in response to identifiable stressors, including the accident and its consequences. Yet, the chronicity and intensity of symptoms surpass the typical presentation of adjustment disorder.

3. Major Depressive Disorder (MDD): While symptomatically similar, R's condition is better explained by the physical trauma and ongoing medical challenges, making Depressive Disorder due to a medical condition the more fitting diagnosis.

DISCUSSION

This case exemplifies the intricate interplay between physical disability and mental health. Ms. R psychological condition cannot be seen in isolation from her medical history, social context, and personality traits. Before the accident, she was independent, socially active, and professionally stable. The abrupt shift to dependency, social withdrawal, and immobility acted as potent stressors. Furthermore, the impact of the COVID-19 pandemic—often an overlooked factor—intensified her isolation, reducing both social interaction and emotional engagement within the household. Her psychological presentation aligns with depressive disorder due to another medical condition, characterized by sustained low mood, anhedonia, and functional impairment. The presence of suicidal ideation, though passive, signals the depth of her distress. However, her preserved insight, familial support, and personal motivation are all strong prognostic indicators. The case also prompts reflection on the need for psychological screenings in patients with chronic or traumatic medical conditions.

CONCLUSION

Ms. R journey reflects the substantial psychological burden that can accompany long-term physical illness, particularly in young adults accustomed to autonomy and productivity. While her depressive symptoms are significant, her clarity of thought, motivation to recover, and supportive family environment suggest that she is a strong candidate for psychological recovery. The case reiterates the necessity for timely psychological interventions in the post-trauma phase and advocates for a holistic treatment approach. With sustained psychotherapy, social reinforcement, and physical rehabilitation, R stands a good chance of regaining her emotional well-being and reconstructing a fulfilling life beyond her traumatic experience.

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