**(C) Diagnostic Profile and Justification**

**Diagnostic Profile (DSM-5-TR Nonaxial Assessment):**

* Major Depressive Disorder, Single Episode, Moderate (F32.1)

**Justification:**  
Lucy’s symptoms align closely with Major Depressive Disorder, meeting six of the nine criteria under Criterion A (depressed mood, loss of interest, insomnia, psychomotor retardation, fatigue, feelings of worthlessness/guilt) for at least three months, exceeding the two-week minimum. Her symptoms cause significant distress and impair her academic, social, and occupational functioning (Criterion B). There are no indications of psychotic disorders (Criterion D) or manic/hypomanic episodes (Criterion E). While Lucy uses marijuana, her symptoms began with the honours year and persist during periods without cannabis use, suggesting they are not primarily substance-induced, though further assessment is needed (Criterion C). The severity is moderate due to the number of symptoms and their impact. Generalized Anxiety Disorder is less likely due to the shorter duration (three months vs. six months required) and predominance of depressive symptoms over anxiety. Cannabis Use Disorder is not supported, as Lucy does not meet the minimum two criteria, with no reported cravings, withdrawal, or functional impairment directly tied to cannabis.

**QUESTION 2: ADDITIONAL INFORMATION**

**(A) Clarification of Diagnosis/Diagnoses**

* **Medical history and tests**: Obtain a full medical history and conduct tests (e.g., thyroid function, sleep studies) to rule out conditions like hypothyroidism or sleep apnea that could contribute to fatigue, low mood, or sleep disturbances.
* **Substance use details**: Clarify the frequency, quantity, and context of marijuana use, including any tolerance or withdrawal symptoms, to confirm whether it contributes to her symptoms or meets Cannabis Use Disorder criteria.
* **Mood episode history**: Explore the duration and severity of her Year 12 episode to determine if it met criteria for a prior depressive episode, which could affect whether this is a single or recurrent episode.

**(B) Clarification of Case Formulation**

* **Family mental health history**: Gather detailed information about her father’s and grandmother’s low mood episodes, including any diagnoses or treatments, to assess genetic predispositions.
* **Early life experiences**: Investigate childhood experiences or family dynamics (e.g., the family rule of “just coping”) to identify potential cognitive schemas or stressors that may predispose her to depression.
* **Current stressors**: Assess the extent of academic pressure, social isolation, and supervisor interactions to understand precipitating and perpetuating factors more clearly.

**(C) Treatment Planning**

* **Client preferences and goals**: Determine Lucy’s preferences for therapy modality (e.g., in-person vs. online, CBT vs. other approaches) and her specific goals (e.g., improving mood, managing academic stress) to tailor the treatment plan.
* **Social and environmental factors**: Explore her living situation, social support network, and access to resources (e.g., UQ mental health services) to identify barriers or facilitators to treatment adherence.
* **Baseline functioning**: Assess her pre-honours functioning in academic, social, and personal domains to establish a benchmark for treatment progress and goal-setting.

**QUESTION 3: CASE FORMULATION (Cognitive-Behavioural Perspective)**

**(A) Predisposing Factors**

From a cognitive-behavioural perspective, Lucy’s predisposing factors include a potential genetic vulnerability to depression, as her father and grandmother experienced periods of low mood, suggesting a familial pattern. Her family’s rule of “just coping” and not burdening others may have fostered a cognitive schema of self-reliance and perfectionism, leading to negative self-evaluations when she struggles academically. Her history of similar symptoms in Year 12 indicates a prior vulnerability to stress-related mood disturbances, possibly reinforcing negative thought patterns, such as feeling like a failure when facing challenges.

**(B) Precipitating Factors**

The transition to her honours year, marked by increased academic demands and social isolation, likely precipitated Lucy’s depressive episode. The lack of structure compared to undergraduate studies and limited supervisor support contributed to feelings of overwhelm. A specific triggering event was her embarrassing experience presenting her thesis plan, which intensified her sense of inadequacy and fear of disappointing others, aligning with cognitive distortions like overgeneralization (e.g., “I should know what to do”).

**(C) Perpetuating Factors**

Lucy’s ruminative thoughts about quitting her degree and failing maintain her low mood, as rumination is a key perpetuating factor in depression from a CBT perspective. Her avoidance behaviors, such as leaving experiments incomplete and reducing social contact, reinforce feelings of guilt and isolation. Regular marijuana use, while not meeting disorder criteria, may disrupt sleep and exacerbate fatigue, perpetuating her symptoms. Her reluctance to seek help due to feeling like a burden further prevents her from accessing support that could alleviate her distress.

**(D) Protective Factors**

Lucy’s supportive family relationships and close friendships provide a strong social network that can buffer stress and aid recovery. Her history as a high-achieving student suggests resilience and capability, which can be leveraged in therapy to rebuild confidence. Her engagement in the session and motivation to feel better indicate a willingness to participate in treatment, a critical protective factor. Access to UQ’s mental health resources, such as the Sharper Minds program, offers additional support for her recovery.

**QUESTION 4: TREATMENT**

**(A) Justification of Therapy Choice**

Cognitive Behavioral Therapy (CBT) is selected for Lucy’s treatment due to its robust empirical support for treating Major Depressive Disorder. A meta-analysis by Cuijpers et al. (2013) found CBT to be highly effective for depression, with effect sizes comparable to pharmacotherapy, particularly for moderate episodes like Lucy’s. Hofmann et al. (2012) demonstrated that CBT significantly reduces depressive symptoms by targeting cognitive distortions and maladaptive behaviors, which align with Lucy’s rumination and avoidance. Additionally, a randomized controlled trial by DeRubeis et al. (2005) showed that CBT is effective in preventing relapse in depression, making it suitable for Lucy given her history of a prior episode. CBT’s structured, skill-based approach is also appropriate for a high-achieving student like Lucy, who may benefit from clear strategies to manage academic stress.

**(B) Description and Application of Therapy**

CBT is a structured, time-limited therapy that focuses on modifying negative thought patterns and behaviors to alleviate emotional distress. For Lucy, therapy would begin with psychoeducation about depression and the CBT model, emphasizing the link between thoughts, emotions, and behaviors. Cognitive restructuring would target her negative self-beliefs (e.g., “I’m a failure”) by challenging distortions like overgeneralization and teaching her to generate balanced thoughts (e.g., “Struggling with my thesis doesn’t define my worth”). Behavioral activation would encourage re-engagement in enjoyable activities, such as tennis or socializing, using activity scheduling to gradually increase her involvement. Problem-solving skills would address academic challenges, such as breaking research tasks into manageable steps. Therapy would also address her marijuana use by exploring alternative coping strategies, like relaxation techniques, to reduce reliance on substances.

**Prioritization of Goals**:

1. **Reduce depressive symptoms**: Initial sessions would focus on improving mood through behavioral activation and cognitive restructuring to alleviate tearfulness and fatigue.
2. **Improve sleep**: Teach sleep hygiene techniques (e.g., consistent bedtime, limiting screen time) and address rumination with thought-stopping strategies to enhance sleep quality.
3. **Enhance academic functioning**: Develop skills to manage research tasks and communicate with her supervisor, reducing guilt and overwhelm.
4. **Rebuild social engagement**: Gradually reintroduce social activities to combat isolation, leveraging her supportive friendships.