

## **Integrative Modular Psychotherapy During Psychiatric Hospitalisation for Severe Major Depression with Suicide Risk: A Case Report**

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**Abstract:** *Background: Major depressive disorder (MDD) is associated with elevated suicide risk. Integrative psychotherapeutic approaches that combine psychoeducation, behavioural activation, cognitive restructuring, mindfulness, social connection, and relapse prevention may be effective and feasible in routine care. Case: A 36-year-old male software engineer presented with a severe major depressive episode without psychotic features, precipitated by occupational stressors. Assessment indicated high depressive severity (e.g., MADRS), high stress and anxiety (DASS 21), elevated dysfunctional attitudes (DAS A), and moderate suicide risk without plan (C SSRS). Intervention: A four week, six module program included: (1) psychoeducation about depression and personalised triggers; (2) behavioural activation and daily routine; (3) problem solving and cognitive restructuring to address catastrophising and self-blame; (4) mindfulness practices to reduce rumination; (5) social connection skills and structured re- engagement in valued relationships; and (6) relapse prevention planning and values based goals. Sessions were accompanied by homework and symptom monitoring. Outcomes: Over the course of four weeks, the patient reported reduced rumination and anxiety, an improved sleep routine and energy levels, greater engagement in work and family activities, and increased self-efficacy. Suicidality decreased from recurrent passive ideation to infrequent, brief thoughts without plan or intent, along with enhanced safety planning and help seeking. Conclusion: A brief, structured integrative psychotherapeutic intervention may reduce suicide risk and improve functioning in severe depression. The modular format and emphasis on activation, cognitive change, mindfulness, social reconnection, and relapse prevention suggest practical utility for similar cases.*

**Keywords:** *major depressive disorder; suicide risk; behavioural activation; cognitive restructuring; integrative psychotherapy; inpatient psychiatry.*

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## 1. Introduction

Major Depressive Disorder (MDD) is one of the most prevalent and disabling mental disorders worldwide, with an estimated incidence exceeding 280 million people, representing a leading cause of disability and reduced quality of life (WHO, 2017). Symptoms include persistent depressed mood, loss of interest and pleasure, fatigue, feelings of guilt or worthlessness, difficulty concentrating, sleep and appetite disturbances, as well as suicidal ideation (APA, 2013). Suicidal risk is one of the most serious complications of depression: studies indicate that between 10% and 15% of patients with severe forms of depression may commit suicide over their lifetime (Sokero et al., 2003).

Pharmacological treatment with antidepressants is considered a first-line option for moderate and severe episodes, contributing to the reduction of symptom intensity and to the patient's biological stabilisation (Cipriani et al., 2018). However, monotherapy has its limitations: some patients may not achieve full remission, residual symptoms can persist, and the risk of relapse remains high (Rush et al., 2006).

Psychotherapy plays a crucial complementary role by addressing dysfunctional cognitions, rumination, maladaptive coping strategies, interpersonal difficulties, and relapse prevention (Beck et al., 1979). Evidence-based interventions such as cognitive-behavioural therapy, interpersonal therapy, and mindfulness-based therapies have demonstrated efficacy in reducing symptoms and improving psychosocial functioning (Cuijpers et al., 2020).

Numerous meta-analyses and clinical guidelines converge on the finding that combined treatment (pharmacotherapy plus psychotherapy) has superior efficacy compared to monotherapy, both in terms of response and remission rates, as well as in relapse prevention (Cuijpers et al., 2010; Hollon et al., 2005; NICE, 2022). For example, Cuijpers et al. (2010) demonstrated that combined therapy results in better long-term outcomes than medication alone, while Hollon et al. (2005) found that adding psychotherapy to pharmacological treatment significantly reduces the risk of relapse. The APA and NICE guidelines explicitly recommend the combination of psychotherapy and medication for moderate and severe forms of depression (NICE, 2022).

In Romania, recent research has investigated the association between depression, suicidal risk, and cognitive coping strategies. Nicoară et al. found that dysfunctional coping strategies, such as self-blame and catastrophising, predict the severity of suicidal risk in patients with depression (Nicoară et al., 2022). Moreover, brief integrative psychotherapy models with modular structures have been evaluated and shown to be effective in reducing suicidal ideation among psychiatric inpatients (Nicoară et al., 2024). These findings indicate that an integrative program combining psychoeducation, behavioural activation, cognitive restructuring, mindfulness, social reconnection, and relapse prevention could serve as a feasible and effective clinical approach.

In the context of hospitalisation, the implementation of such an intervention is particularly relevant. Hospitalisation provides a setting for continuous medical monitoring and supports treatment adherence while allowing for the implementation of structured psychotherapeutic interventions within a short time frame (Möller et al., 2016). However, the relatively limited duration of hospitalisation necessitates that interventions be concise, well-organised, and tailored to the patient's immediate needs (Bowers et al., 2019).

On this basis, we present the case of a 36-year-old patient hospitalised for a severe major depressive episode associated with suicidal risk, who benefited from an integrative psychotherapy program delivered during hospitalisation in combination with pharmacological treatment. This case report does not merely describe the clinical course of a single patient, but rather illustrates the practical application of a short, modular integrative psychotherapy model that targets the cognitive and emotional mechanisms associated with suicidal risk in major depression. By linking assessment-driven formulation (dysfunctional beliefs, maladaptive emotion regulation strategies) to specific psychotherapeutic modules, this case demonstrates how individualised, mechanism-focused intervention can be implemented effectively in a time-limited inpatient setting. Thus, the report

provides a clinically grounded illustration of how theoretical models of depression and suicide vulnerability can inform real-world therapeutic decision-making and may guide the development of structured interventions for patients with similar profiles.

## **2. Methodology**

This is a descriptive single-case clinical report prepared in accordance with the CARE guidelines. The patient was a 36-year-old male hospitalised in a psychiatric inpatient unit for a severe major depressive episode with suicidal risk, diagnosed according to DSM-5 criteria. Written informed consent for treatment and publication of anonymised case information was obtained. Clinical evaluation was conducted at admission and discharge using standardised instruments: MADRS, DASS-21, DAS-A, CERQ, and C-SSRS. The patient received SSRI pharmacotherapy and a structured six-session integrative psychotherapy program delivered during hospitalisation. Symptom change was assessed descriptively by comparing baseline and discharge scores; no inferential statistical analysis was applied due to the single-case design.

## **3. Case Presentation**

The patient reported a gradual onset of depressive symptoms over the preceding 4–5 months, characterised by persistent sadness, decreased interest in daily activities, fatigue, sleep disturbances, and pervasive guilt related to perceived professional failure. Occupational stressors included increased workload, reduced performance efficiency, and concerns regarding disappointing colleagues. Suicidal ideation emerged progressively over the last month before admission, described as recurrent thoughts of “being a burden” and “not deserving to continue,” without a concrete plan or intent.

### ***3.1. Past Psychiatric History***

The patient had no prior psychiatric hospitalisations and no previous diagnosis of depression or anxiety disorders. He had not received psychological counseling or psychotropic medication before this episode. He denied any previous suicide attempts.

### ***3.2. Medical and Substance Use History***

No chronic medical illnesses were reported. Laboratory investigations and physical examination did not indicate any organic condition contributing to the symptoms. The patient denied alcohol misuse, tobacco use, or illicit substance use.

### ***3.3. Social and Family History***

The patient is married and lives with his spouse and child. He described his relationship with his family as supportive, although communication had decreased during the depressive episode. There is no known family history of psychiatric disorders. The patient identifies his paternal role as a key source of meaning.

### ***3.4. Psychiatric Examination***

At admission, the patient was orientated to time, place, and person, with adequate hygiene and appropriate clothing. Facial expression was rigid, with a fatigued appearance, and reduced eye contact. The overall attitude was cooperative but marked by hesitation and restlessness. Speech was slow, with a monotonous tone, short sentences, and frequent pauses, indicating difficulties with concentration and psychomotor inhibition. Affect was noticeably restricted, with a markedly depressed mood and low emotional reactivity. Thought content was dominated by negative ruminations related to professional failure and its impact on family life. No hallucinations, delusional ideas, or thought disorganisation were observed. Short-term memory and attention were diminished. Insight was preserved, as the patient acknowledged the severity of the symptoms and accepted the need for treatment.

### **3.5. Differential Diagnosis**

Bipolar disorder: excluded based on the absence of any history of hypomanic or manic episodes.

Psychotic disorders: excluded, as the patient did not present hallucinations or delusional ideas.

Somatic disorders: excluded based on clinical evaluations and laboratory investigations, which did not indicate any organic causes for the symptoms.

Adjustment disorder with depressed mood: excluded, as the severity and duration of symptoms meet the DSM-5 criteria for a severe major depressive episode.

**Final Diagnosis (DSM-5):** Major Depressive Disorder, current episode severe, without psychotic features (APA, 2013).

**Psychological Examination and Psychometric Assessment.** To objectively evaluate the severity of symptoms and the cognitive profile, the patient was assessed using a range of internationally validated instruments:

**Montgomery–Åsberg Depression Rating Scale (MADRS):** score = 38/60, corresponding to severe depression. The MADRS is sensitive to clinical changes and is frequently used in treatment trials (Montgomery & Åsberg, 1979).

**Depression, Anxiety and Stress Scales (DASS-21):** scores = Depression: 22/42 (severe), Anxiety: 18/42 (severe), Stress: 26/42 (severe). These results confirm the affective and cognitive intensity of the episode (Lovibond & Lovibond, 1995).

**Dysfunctional Attitudes Scale (DAS-A):** total score = 165/200, with high values in the perfectionism and self-blame dimensions. This score indicates the presence of persistent dysfunctional cognitive beliefs associated with vulnerability to depression (Weissman & Beck, 1970).

**Columbia Suicide Severity Rating Scale (C-SSRS):** level = moderate suicidal risk, characterised by recurrent suicidal ideation without a specific plan or active intent. The C-SSRS is internationally recognised for its validity and reliability (Posner et al., 2011).

On the **Cognitive Emotion Regulation Questionnaire (CERQ)**, the patient obtained high scores for self-blame (18/20) and catastrophising (17/20), along with low scores for positive reappraisal (6/20) and putting into perspective (7/20). Compared to Romanian normative data, these results indicate a frequent use of maladaptive strategies and a markedly reduced use of adaptive ones. This profile suggests a predominance of a maladaptive cognitive–emotional regulation style, consistent with literature associating these strategies with the persistence of depressive symptoms and increased suicidal risk (Garnefski & Kraaij, 2007).

The results of this psychological assessment confirm the presence of severe depression, associated with high levels of stress and anxiety, pronounced dysfunctional cognitions, and maladaptive emotional regulation strategies. These findings align with the clinical picture and with recent literature highlighting the association between cognitive dysfunctions and suicidal risk in major depression (Nicoară et al., 2022).

**Pharmacological treatment:** The patient received standard antidepressant medication (SSRI, titrated to therapeutic dose) with good tolerance; no adverse effects were reported.

**Psychotherapy Intervention:** The intervention was designed as a brief, integrative, and modular programme implemented during hospitalisation, in combination with pharmacological treatment. The general objectives were:

1. To reduce the intensity of depressive symptoms and suicidal ideation.
2. To develop adaptive coping strategies and improve emotional regulation.
3. To restructure automatic thoughts and dysfunctional beliefs (perfectionism, self-blame).
4. To increase engagement in pleasurable and meaningful activities.
5. To strengthen the sense of safety and prevent relapse.

The programme included six individual sessions, each focused on a main theme and specific therapeutic techniques.

**Session 1** – Psychoeducation and therapeutic alliance: The initial session focused on establishing a therapeutic relationship based on trust and safety. The patient presented as withdrawn, with a low voice tone and minimal eye contact. The therapist validated the patient's experience, emphasising that the reported symptoms represent manifestations of a recognised clinical disorder rather than a "personal weakness." Through psychoeducation, the cognitive model of depression was explained—specifically, how negative automatic thoughts may influence emotions and behaviours. A concrete example discussed was: "I'm not good enough at work, I feel guilty and worthless, I withdraw and stop communicating with my wife." The patient acknowledged that this pattern felt familiar and expressed relief upon understanding that there was a clinical explanation for his experience. Together, the therapist and the patient formulated general therapeutic goals, emphasising the patient's active role in therapy and in the recovery process.

**Session 2** – Cognitive-behavioural techniques for symptom reduction: In the second session, the patient was encouraged to identify and record negative automatic thoughts in a journal. Statements such as "I'm destroying my family through my failure" and "I'm a loser who doesn't deserve to live" were highlighted. The therapist introduced the cognitive-behavioural disputation technique, jointly examining with the patient the 'evidence for and against' these thoughts. Through a Socratic exercise, the patient was able to recognise that although his work performance had declined over the past few months, he had a consistent history of professional success and had previously been appreciated by his colleagues. He also acknowledged that despite his sense of "worthlessness", his family continued to support him and perceive him as an involved father. By the end of the session, the patient formulated an alternative statement: "I have gone through a difficult period, but that does not mean I have lost my value as a professional or as a father." The exercise was experienced as challenging but resulted in a slight reduction in the intensity of guilt.

**Session 3** – Emotional regulation and stress management: This session focused on identifying and regulating emotions. The patient acknowledged that he had difficulty labeling his emotional states, expressing that he felt "empty inside". The therapist used an emotion list and an intensity scale to guide him in differentiating between sadness, guilt, anxiety, and irritability. Subsequently, diaphragmatic breathing and progressive muscle relaxation exercises were introduced. During the guided exercise, the patient reported for the first time "a slight feeling of calmness in the body." The use of these techniques in the evening, prior to bedtime, was discussed as a means of reducing insomnia. The session concluded with a brief mindfulness practice focused on bodily sensations, during which the patient was able to observe, without judgment, muscle tension and the rhythm of his breathing.

**Session 4** – Restructuring dysfunctional schemas: Building on the DAS-A results, this session addressed the patient's core beliefs: "I must do everything perfectly in order to have value" and "Mistakes are unacceptable." The therapist employed the reframing technique, asking: "If a colleague made a mistake, would you consider him worthless?" The patient responded, "No, I would tell him it's normal." This dissonance was explored, leading the patient to begin recognising his own rigid self-imposed standards. Through written exercises, he formulated alternative statements such as "Mistakes are opportunities for learning" and "My worth as a person does not depend solely on my performance." Additionally, scaling techniques were used: the patient rated how realistic the thought "If I don't succeed all the time, I don't deserve appreciation" felt to him (initially 90/100, decreasing to 60/100 by the end of the session). This reduction in cognitive rigidity was perceived as a significant step forward.

**Session 5** – Suicide risk intervention and safety planning: Given the initial C-SSRS score (moderate risk), this session focused on safety. The therapist validated the patient's suffering and normalised the occurrence of suicidal thoughts in depression. A detailed safety plan was developed, including: recognising warning signs (severe insomnia, intensified self-blame), using calming strategies (breathing exercises, mindfulness), promptly contacting his wife or a close friend, and

calling emergency services if the thoughts became intrusive. The patient wrote down this plan on a sheet of paper to keep accessible. Protective factors—such as his bond with his child and his wife’s support—were emphasised and reframed as motivational anchors. At the end of the session, the patient stated: “This is the first time I feel like I have a clear plan for when I’m not feeling well.”

**Session 6** – Existential reconstruction and relapse prevention: The final session focused on consolidating the progress and formulating a post-discharge plan. Through existential exploration techniques, the patient was invited to reflect upon his personal values. He identified three fundamental directions: being a present father, contributing professionally, and cultivating close relationships. Together, they established specific objectives: resuming a pleasant activity with his son (weekly walks), engaging in open communication with his wife about emotional needs, and gradually returning to professional tasks without excessive perfectionism. Self-regulation and cognitive restructuring techniques were reviewed, and the patient expressed confidence in his ability to use them independently. The session concluded with the formulation of an anchoring statement: “I have resources and support; I am not alone, and I can move forward step by step.”

### 3.6. Clinical Course and Outcomes

During hospitalisation, the patient showed a favourable evolution, both clinically and psychometrically. Within the first two weeks of the intervention, a reduction in the intensity of depressive symptoms was observed—particularly in negative rumination and self-blame—accompanied by a gradual increase in engagement with daily ward activities.

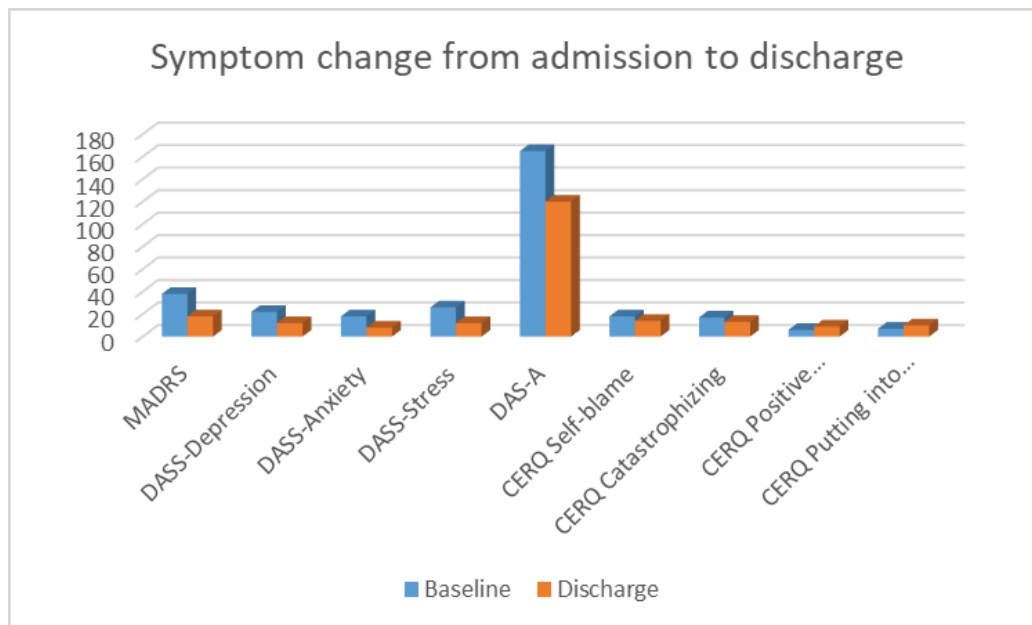
*Table 1. Psychometric scores at admission and discharge*

| Instrument / Subscale                  | Admission<br>(Baseline) | Discharge<br>(Endpoint) | Absolute<br>Change ( $\Delta$ ) | %<br>Change* | Clinical interpretation             |
|----------------------------------------|-------------------------|-------------------------|---------------------------------|--------------|-------------------------------------|
| MADRS (0–60)                           | 38                      | 18                      | –20                             | –52.6%       | From severe to moderate depression  |
| DASS-21 Depression (0–42)              | 22                      | 12                      | –10                             | –45.5%       | From severe to mild                 |
| DASS-21 Anxiety (0–42)                 | 18                      | 8                       | –10                             | –55.6%       | From severe to mild                 |
| DASS-21 Stress (0–42)                  | 26                      | 12                      | –14                             | –53.8%       | From severe to moderate/mild        |
| DAS-A (0–200)                          | 165                     | 120                     | –45                             | –27.3%       | Decrease in dysfunctional attitudes |
| C-SSRS                                 | Moderate suicide risk   | Low suicide risk        | —                               | —            | Reduction in suicidal ideation      |
| CERQ – Self-blame (0–20)               | 18                      | 14                      | –4                              | –22.2%       | From very high to above average     |
| CERQ – Catastrophising (0–20)          | 17                      | 13                      | –4                              | –23.5%       | From very high to above average     |
| CERQ – Positive reappraisal (0–20)     | 6                       | 9                       | +3                              | +50.0%       | From very low to below average      |
| CERQ – Putting into perspective (0–20) | 7                       | 10                      | +3                              | +42.9%       | From low to average range           |

Notes:

\* Percent change = (Discharge – Baseline) / Baseline  $\times$  100.

\*\* A negative sign (–) indicates a decrease in symptom severity or maladaptive cognitions.



*Figure 1. Changes in depressive symptoms, anxiety, stress, dysfunctional attitudes, and cognitive-emotional regulation from admission (baseline) to discharge*

Psychometric results showed a clinically meaningful improvement from admission to discharge. Depressive severity decreased from the severe to the moderate range (MADRS), while DASS-21 scores indicated shifts to mild levels of anxiety and stress. Importantly, suicidal ideation decreased from moderate to low risk on the C-SSRS, reflecting improved safety and stabilisation (Table 1, Figure 1).

In terms of cognitive–emotional regulation, scores for self-blame and catastrophising slightly decreased (–4 points each), while positive reappraisal and putting into perspective increased (+3 points each), suggesting a gradual shift from maladaptive to more adaptive strategies.

At the behavioural level, the patient began to participate more actively in discussions, initiate interactions with fellow inpatients, and show interest in the emotional regulation exercises practised in therapy. The patient’s wife, who was involved in the therapeutic process, reported improved communication and greater emotional availability toward their child.

Regarding suicidal ideation, the patient reported a clear reduction in both frequency and intensity. Whereas at admission these thoughts occurred daily and were perceived as a possible solution. By the end of hospitalisation, he described them as “passing thoughts” without intent or planning, which he had learned to monitor and manage using the techniques discussed in therapy.

On an existential level, the patient began to redefine his personal values, identifying his role as a father and his connection with family as primary sources of meaning and motivation. He formulated a realistic post-discharge plan that included continuing outpatient psychotherapy, maintaining regular contact with the psychiatric team, and applying the coping strategies practiced during therapy.

Overall, the patient’s evolution during hospitalisation was favourable, characterised by a reduction in depressive and anxiety symptoms, a decreased suicidal risk, and an increased sense of hope and self-efficacy.

#### 4. Discussion

This case highlights the feasibility and potential efficacy of a structured integrative psychotherapeutic programme for severe depression with suicidal risk. Clinical improvement may also reflect the combined effect of pharmacological treatment and psychotherapy, which limits attribution to psychotherapy alone. The six modules addressed key domains: understanding the

disorder, restoring activity, modifying maladaptive cognitions, cultivating mindfulness, strengthening social ties, and preventing relapse. The brief format resulted in clinically meaningful improvements within one month.

Compared with standard single-modality interventions, the integration of different approaches allowed for tailoring to the patient's cognitive style and psychosocial context. Psychoeducation reduced fear and stigma, behavioural activation countered withdrawal, and mindfulness enhanced emotion regulation. Additionally, promoting social reconnection and relapse prevention contributed to the sustainability of treatment gains. Although generalisability is limited by the single-case design, these findings align with evidence supporting modular, skills-based interventions in depression and suicidality (Cuijpers et al., 2010; Hollon et al., 2005). The contribution of this case report lies in illustrating how a mechanism-focused, modular psychotherapeutic approach can be feasibly implemented within a short inpatient admission to reduce suicidal risk. Rather than applying techniques in a generic manner, the intervention was tailored to the patient's specific cognitive-emotional vulnerabilities (self-blame, catastrophising, withdrawal), guided by standardised assessment. This case thus provides a clinically grounded example of how theoretical models linking cognition, emotion regulation, and suicidality can be operationalised in routine psychiatric care, offering a structured framework that clinicians may adapt to similar patient profiles. These results are consistent with Romanian studies that have highlighted the predictive role of coping strategies in suicide risk (Nicoară et al., 2022), the importance of emotion regulation difficulties (Montgomery & Åsberg, 1979), and the preliminary effectiveness of short integrative models to reduce suicidal ideation (Nicoară et al., 2024). Furthermore, recent research on assessment tools reinforces the importance of accurate measurement in psychiatric practice (Möller et al., 2016).

**Limitations:** The brief follow-up period limits conclusions regarding long-term outcomes. The patient received SSRI pharmacotherapy, titrated to a therapeutic dose, with good tolerability and no adverse effects. Further controlled studies are warranted.

## **5. Conclusion**

The present case report illustrates the feasibility and clinical utility of a structured, modular integrative psychotherapeutic intervention for a patient hospitalised with severe major depressive disorder and suicidal risk. By targeting specific cognitive-emotional mechanisms, such as self-blame, catastrophising, and emotional dysregulation, the intervention supported a measurable reduction in depressive and anxiety symptoms, along with improved coping capacity and functioning.

The structured modular design enabled the therapeutic process to be individualised to the patient's psychological profile and delivered effectively within a limited inpatient period. This approach may provide clinicians with a practical and adaptable framework to guide intervention planning in acute psychiatric settings, where time is constrained and suicide-related risk must be addressed promptly and safely.

Although the conclusions are limited by the single-case design and absence of long-term follow-up data, the results align with emerging evidence supporting mechanism-focused, skills-based psychotherapeutic approaches in severe depression and suicidality. Further clinical studies, including follow-up monitoring and controlled designs, are warranted to examine the generalisability and durability of this intervention model.

## **6. Informed Consent**

At the time of hospital admission, the patient signed the standard institutional informed consent form utilised in university clinical settings, which includes agreement for the use of anonymised clinical data for educational and research purposes. All identifying information has been removed to ensure confidentiality. No additional ethical approval was required, as the intervention followed routine clinical practice and did not involve experimental procedures. The

case was handled in accordance with the ethical principles of the Declaration of Helsinki and relevant national regulations.

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