

Patient-Centered Clinical Management of a 48-Year-Old Internally Displaced Trader with Major Depressive Disorder: A Case Report from a Primary Care Clinic of a Tertiary Hospital in North-Western Nigeria

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Abstract

Original Research

Background

Violent bereavement, displacement, and loss of livelihood significantly affect mental health and hinder access to care. This report describes the management of depressive symptoms in a trader affected by banditry in northwestern Nigeria.

Case presentation

A 48-year-old married trader presented to Federal Medical Centre, Gusau, on 22 March 2022 with four weeks of low mood and three weeks of disturbed sleep following his son's death after a kidnapping. His two daughters were released unharmed, but repeated attacks forced the family to relocate. He reported loss of interest in pleasurable activities, poor concentration, reduced appetite, fatigue, and impaired daily functioning. There was no history of suicidal thought and ideation. Major depressive disorder was diagnosed, with adjustment disorder as a differential.

The diagnosis and management options were explained to him, and shared decision-making was achieved regarding his requested investigations. Due to financial constraints, he was commenced on tablet amitriptyline 25 mg nocte for two weeks. He was counselled on medication adherence, its side effects, and contraindications. He was further counselled on family support, lifestyle modification, and regular follow-up visits.

He was referred to a clinical psychologist for cognitive behavioural therapy (CBT) and was given a two-week appointment to see the author. He attended his monthly follow-up appointments with his wife regularly, with significant improvement. The dose of the tablet Amitriptyline was reduced to 12.5 mg on 22 June 2022 after symptom resolution and was discontinued on 22 December 2022, after psychoeducation on a relapse prevention plan. He was discharged from the clinic and referred to the wellness clinic.

Conclusion

This case demonstrates how patient financial circumstances, treatment preferences, and family-centred care influence clinical outcomes. It highlights the importance of diagnostic clarification, structured safety assessment, and relapse-prevention planning in trauma-related presentations in resource-limited primary care settings.

Keywords: Depressive symptoms; violent bereavement; banditry; patient-centred care; cognitive behavioural therapy; internal displacement; Nigeria.

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Introduction

Violent bereavement overlaps with disrupted sleep, low mood, financial insecurity, and displacement. These experiences often present alongside depressive symptoms and trauma-related disorders, making careful diagnostic assessment critical. This report describes the presentation and patient-centred management of a trader whose son was killed during a banditry-related kidnapping in northwestern Nigeria.

Case Presentation

AY is a 48-year-old married Fulani Muslim man who traded in staple foods. He attended Federal Medical Centre, Gusau, on 22 March 2022 after moving from Magazu in Tsafe Local Government Area to Tudun Wada, Gusau, following repeated banditry attacks.

AY reported persistent sadness for four weeks and sleep difficulties for three weeks. His eldest son and two daughters were kidnapped. To raise the ransom, he sold farmland and other assets. His daughters were released unharmed, but his son was tortured and killed after a delay in payment. AY frequently thought about the loss, experienced difficulty falling asleep, woke readily to minor movements, and often awoke early. He no longer enjoyed his usual morning radio programme. He described poor concentration, reduced appetite and energy, which interfered with his daily activities. He had no history of suicidal thoughts or ideation. He had no history of previous traumatic exposure, recollections of distressing events or nightmares. There was no history of restlessness, strongly fixed unusual beliefs, or history of hearing the voices of unseen people in clear consciousness. He had no history of irrational talk, irrational behaviour, restlessness, or extravagant spending. He reported no previous depressive episodes and no history of self-harm or assault of family members. He denied fever, weight loss, heat or cold intolerance, excessive sweating, palpitations, cough, dyspnoea, or swelling.

AY reported no previous history of hypertension, diabetes mellitus, or asthma. He had no previous

hospital admission, surgery, or blood transfusion.

He had no formal education and earned approximately ₦3,000 daily. His wife was 35 years old, and they had four surviving children (three daughters, one son). The family lived in a rented three-bedroom home with tap water and a pit latrine. He paid for healthcare out of pocket and identified his wife as his closest source of support. His Family APGAR score was 8, consistent with good family functioning. He reported no family history of psychiatric illness, hypertension, or diabetes mellitus. He had no history of cigarette smoking, alcohol consumption, or illicit drug use, and he had no known drug allergies. Based on his premorbid personality, he was calm, sociable, and generally cheerful, with no previous forensic history.

On physical examination, AY was alert, afebrile (36.3 °C), not pale, anicteric, cyanosed or dehydrated, with no palpable peripheral lymphadenopathy and no pitting pedal oedema. His weight was 68 kg, height was 1.6 m, and his BMI was 26.6 kg/m² (overweight).

On mental examination, he was well groomed and appropriately dressed, with limited eye contact, flat affect, and low speaking tone. His speech was normal; thought processes and content were intact. His short- and long-term memory and orientation were preserved and has good insight.

His vital signs, pulse rate 88 beats/min, blood pressure 120/80 mmHg, and respiratory rate 22 breaths/min, were normal.

The diagnosis of major depressive disorder was made according to DSM-5 criteria, with differential diagnosis of adjustment disorder, prolonged grief response, and post-traumatic stress disorder.

In the aspect of management of AY, he was educated on his diagnosis; his fear and anxiety were allayed. Common ground was achieved with the patient regarding the need to do the following investigations: full blood count, fasting blood glucose, electrolytes/urea/creatinine, and fasting lipid profile.

Due to his financial constraints, tablet amitriptyline 25 mg nocte was prescribed to him. The benefits of medication adherence, contraindications, and

potential side effects (dry mouth, constipation, weight gain) of tablet amitriptyline were explained to him. He was referred to a clinical psychologist for cognitive behavioural therapy and given a two-week appointment to see the author at the next follow-up visit.

The first follow-up visit was on 5th April 2022, when AY and his wife attended, and he reported significant symptom improvement. He was clinically stable and had attended a CBT session with a clinical psychologist. His laboratory results showed WBC 6.4×10^3 , neutrophils 50.8%, lymphocytes 40%, eosinophils 3.1%, basophils 1%, monocytes 8.1%, HGB 12.5g/dL, MCV 87.4 fL, MCH 30.3 pg, MCHC 34.7g/dL, and PLT $333 \times 10^3/\mu\text{L}$. His Fasting blood glucose was 4.2 mmol/L; his Lipid profile parameters were TG 2.8, HDL 1.7, LDL 3.1, TC 5.2 mmol/l. His electrolyte urea and creatinine results were Na 143, K 3.8, Cl 103, HCO_3 25 mmol/l; urea 5.3, creatinine 95 $\mu\text{mol/l}$ the tablet. He was continued on the tablet Amitriptyline 25 mg nocte and encouraged to continue his follow-up visit with the clinical psychologist for CBT. He was given a one-month appointment.

His second follow-up was on 5th May 2022: AY attended clinic with his wife. He reported improved mood and sleep. He continued CBT sessions. The tablet amitriptyline 25 mg nocte was continued; medication adherence, lifestyle modification, family support, and further CBT sessions were encouraged for AY. He was given a one-month appointment.

Third follow-up and subsequent follow-up visits (6 June to 22 December 2022): AY attended his monthly follow-up appointments regularly and remained adherent to both medication and CBT. At the fourth follow-up (22 June 2022), the tablet amitriptyline dose was reduced to 12.5 mg nocte due to symptom resolution. AY was counselled on the possibility of recurrence of symptoms of depression following complete discontinuation of medication; he was advised to present to the hospital whenever he has recurrence of such symptoms. He was counselled on regular exercise, adequate sleep and nutrition. Following complete recovery of his presenting symptoms and psychoeducation on relapse prevention plan to AY, his medication was

discontinued on 22 December 2022. He was discharged to the wellness clinic for continuity of care.

Discussion

Depressive disorders are among the most common psychiatric conditions globally, affecting an estimated 280 million people worldwide.¹ In northwestern Nigeria, the prevalence of depression among internally displaced persons (IDPs) is estimated at 60%.² The common risk factors for depression in IDPs include loss of property, reported death of family members, and forced evacuation.³ AY experienced all three: loss of assets (farmland and property sold for ransom), death of a son, and forced relocation. Low socioeconomic status is a risk factor for major depressive disorder.¹ As a low-income trader with minimal formal education, AY met the sociodemographic profile of a higher-risk IDP.² The sensitivity and specificity of primary care providers in diagnosing depression in primary care settings are 50.1% and 83%, respectively.⁴ Early identification in resource-limited settings requires clinical suspicion when an IDP presents with depressive symptoms.³ According to DSM-5 diagnostic criteria, major depressive disorder requires five or more symptoms from a list of nine, present for at least two weeks, causing significant functional impairment.⁴ AY presented with sadness, sleep disturbance, anhedonia (loss of interest in radio programme), reduced concentration, reduced appetite, fatigue, and functional impairment, hence meeting diagnostic criteria. The absence of prominent trauma-related intrusive symptoms or nightmares helped distinguish AY's clinical condition from post-traumatic stress disorder. At the same time, the presence of depressed mood supported major depressive disorder over adjustment disorder.³ Cognitive behavioural therapy is an evidence-based and acceptable first-line treatment for depression.⁵

Cognitive behavioural therapy combined with pharmacotherapy is a first-line treatment modality and shows greater efficacy than either modality alone.⁶ AY received both: amitriptyline and referral

for CBT with the clinical psychologist. The additive benefit of this combined approach has been established, with integrated treatment showing better outcomes than monotherapy in individuals with depressive disorders.^{4,6} Tricyclic antidepressants (TCAs) remain the most frequently prescribed antidepressants in primary care settings in low-income regions due to affordability, efficacy, and cost-effectiveness.⁷ Amitriptyline was the appropriate choice for AY given his financial constraints and the lack of contraindications. The dose was titrated on (22/6/2022) from 25 mg initially to 12.5 mg after symptom resolution. Six months (22/12/2022) after his complete symptom resolution, the amitriptyline tablet was discontinued, and he was discharged to continue with his follow-up care for hypertension.

Patient-centred care requires considering the patient's cost constraints, symptoms, values, and preferences when selecting an antidepressant.⁸ AY's concern about affordability, his fear about side effects, and his expectation for recovery were all explored and addressed before commencing treatment. The team recommended lifestyle modifications such as exercise, sleep hygiene, and adequate nutrition as adjunctive measures.⁹

Family involvement in follow-up appointments reinforced adherence and provided ongoing psychosocial support.⁵

Patient-Centred Care and Shared Decision Making in family practice integrate patient-centred care, respecting the patient's preferences, values, and needs, with the patient central to the decision-making process.⁸

The patient and physician must establish mutual understanding before instituting the care plan.⁸ In this case, AY's concerns (sadness, sleeplessness), his understanding of symptoms (linked to his son's death), and his expectations (that treatment could help him recover) were explored during the consultation. The team reached common ground before investigations and medication were commenced. The selection of amitriptyline as a cost-effective, efficacious antidepressant reflected AY's low socioeconomic status and preference for

affordable treatment.

Conclusion: This case demonstrates successful management of major depressive disorder in a trauma-affected, internally displaced trader in a resource-limited primary care setting.

Patient-centred care incorporating the patient's financial circumstances, treatment preferences, and family involvement achieved good clinical outcomes. The combination of pharmacotherapy, psychological intervention, and psychosocial support resulted in symptom resolution and sustained recovery. The case underscores the importance of clinical suspicion in IDPs, structured diagnostic assessment, and integrated treatment planning in primary care practice.

Confidentiality:

Informed consent for the publication of this case report was obtained from the index patient after complete resolution of depressive symptoms.

Ethical approval: Ethical approval for the publication of this case report was obtained from the research and ethics committee of the Federal Medical Centre Gusau

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