Navigating Emotional Distress: A Forensic Psychological Case Study on Recovery and Resilience

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Abstract

This article presents a case study of a 23-year-old female patient hospitalised after a suicide attempt following a misunderstanding with her neighbour. The patient had a history of incarceration due to her criminal activities and was subjected to stigmatisation in her community. Psychological evaluations showed a low level of social support (Social Support Questionnaire - 6 = 5), minimal depressive symptoms (Patient Health Questionnaire - 9 = 3) and moderate hopelessness (Beck Hopelessness Scale =12). This analysis used the Labelling Theory (Becker, 1963) to examine how internalised criminal identity and societal stigma may have fuelled the patient's suicidal thoughts and feelings of loneliness and worthlessness (Joiner, 2005). The forensic psychological interventions that were used centred on improving coping mechanisms, social support networks, and cognitive restructuring to challenge internalised labels. By highlighting the connection between mental health and the criminal justice system, this case emphasises the need for anti-stigma strategies in treating suicidal thoughts in people who have served time in prison.

Keywords: suicide, stigmatisation, internalised criminal identity, forensic psychological interventions, coping mechanisms, anti-stigma strategies

Case Context and Method

The patient, a 23-year-old female, Lynn (pseudonym), was brought to Parirenyatwa Hospital by relatives after ingesting an overdose of pills in response to perceived social rejection and threats because of her criminal past. She had a criminal history that led to her being labelled as an ex-convict in her community. She was incarcerated at the age of 20 for assault with intent to cause grievous bodily harm. She spent two months in remand prison and was sentenced to community service on condition that she did not commit a similar crime for the next five years. She had not committed another offence three years after her release from incarceration. During incarceration, she was bullied by other inmates and had no visitors. When she was released, the community shunned her. This stigma intensified her feelings of isolation and hopelessness, particularly during conflicts. The methodology involved a comprehensive assessment of the patient's mental health status, social environment, and prior experiences of trauma. A psycho-

social approach was adopted to understand the interaction of various factors that contributed to her suicidal behaviour.

Confidentiality: A pseudonym (Lynn) was used to refer to the client, and no personal information identifying the client was disclosed in this write-up.

Client Demographic Information

Lynn is a single woman of Zimbabwean nationality, aged 23. She is a holder of three ordinary level (O' level) passes and has not been employed in any formal sector since she completed her O' level. She was first assessed on 11/02/25 at Parirenyatwa Hospital after being hospitalised for attempting to commit suicide.

Background Information

Lynn is the only daughter in a family of four. She was raised in a child-headed family since her parents died while she was a toddler. Lynn's brothers are all married, leaving her and her elder brother in their family's house built in a high-density suburb. She said she did not manage to rewrite her ordinary levels after the first attempt because of a lack of funds. She started doing menial jobs for her upkeep. Lynn said, since her brothers got married, their sibling relationship has been strained, but she had to continue staying at their family house because she could not afford the rent for lodging. She said she was close to her maternal uncle, but he was also not financially stable, thus she could not stay with him. She had no history of psychiatric, medical or substance abuse.

General Observations

Appearance	Kempt
Behaviour	Calm, maintained eye contact.
Mood	Sad
Affect	Congruent
Speech	Coherent
Thought Process	Normal
Thought Content	Normal
Orientation	Normal
Suicidality	Not anymore
Insight	Fair
Judgement	Fair

Assessment

History of presenting problems

Lynn had a dispute with her neighbour, who is almost her age, over grapevine issues. After confronting the neighbour, they started shouting at each other, and a few people began to gather. In the middle of the shouting, the neighbour insulted Lynn, saying she was a violent person who always looked for trouble because she was an ex-convict. The neighbour then threatened to report Lynn to the police for her behaviour. The patient said she then had a reflection of her experiences in remand and immediately went back to her house. She arrived and locked herself inside her room. She did not care to share with her sister-in-law, who was at the house at that time. She called her friend and told her that she was tired of living and had decided to take her own life. Lynn then drank an overdose of pills in an attempt to commit suicide. She was rushed to the hospital by her sister-in-law, who was alerted by Lynn's friend on the phone.

Assessment Tools Used

Mental Status Examination (MSE)

Structured Interview for DSM-V-TR (SCID-5-TR)

Beck Hopelessness Scale (BHS)

Patient Health Questionnaire 9 (PHQ-9)

Social Support Questionnaire - 6 (SSQ-6)

Longford Risk Assessment Tool

Assessment Results and Analysis

Mental status examination

The patient appeared calm during sessions. She was always smartly dressed, and her movements were coordinated. During initial sessions, the client was sad and would tear up during the sessions. Her mood and affect were congruent. Her thought process and content were normal, and the client had no notable difficulties in speech, save for being soft-spoken and at times speaking in low tones.

Beck hopelessness scale

The patient scored 12 on the hopelessness scale, which shows a moderate level of hopelessness. The client's results indicated that she believed that things were unlikely to improve and had

negative thoughts about her life predicament. She was not motivated to put any effort into changing her situation because she felt that her efforts would not make any difference.

Patient Health Questionnaire - 9

The patient's total score was 3, which indicates the absence of a depressive disorder. However, the patient scored 2 on item number 6 and 1 on item number 9, which showed that the patient regarded herself as a failure, thus having low self-esteem. This resulted in her thinking about committing suicide, thus necessitating the need for intervention despite her scoring low on the test.

Longford Risk Assessment Tool

The patient was seen as moderate to high risk, particularly in terms of suicidal or self-harm risk, emotional unpredictability under pressure and potential reactive aggression in specific interpersonal contexts.

The patient scored medium under offence severity as it was an assault, but nothing life-threatening, high on age at first offence as she was 20, low on time since last offence as she had 3 years without recidivism. Other scores include high on lacking close support or positive reinforcements, moderate on mental health stability, high on current crisis characterised by the recent suicide attempt following an interpersonal threat and medium on treatment compliance.

The patient scored high on suicide or self-harm risk, high on risk of psychological decline, moderate on future violent risk because there was no violent ideation, and moderate or high risk of re-offending, as left untreated, emotional triggers could lead to impulsivity.

Structured Clinical Interview for DSM-5-TR

DSM-5 TR diagnostic impression

According to the DSM-5 TR diagnostic, the patient's symptoms fulfilled the criteria for adjustment disorder with Depressed Mood 309.0 (F43.21). The patient was hospitalised following a suicide attempt, which was precipitated by a verbal altercation with her neighbour. The patient had no prior psychiatric, medical or substance use history. The neighbour's threat to report her to the police triggered intense fear of re-incarceration since she had a criminal history. Patient exhibited feelings of hopelessness, social withdrawal, tearfulness and low mood.

309 Diagnostic Criteria

A. The development of emotional or behavioural symptoms in response to identifiable stressor(s) occurring within three months of the onset of the stressor(s).

B. These symptoms or behaviours are clinically significant as evidenced by one or both of the following:

1) Marked distress that is out of proportion to the severity or intensity of the stressors, taking into account the external context and the cultural factors that might influence symptom severity and presentation. (*The patient's attempt to commit suicide after quarrelling with her neighbour could be regarded as out of proportion.*)

2) Significant impairment in social, occupational, or other important areas of functioning. (*Lynn reported that she no longer has any close relationships with most of her family members and friends. She also said her social standing in the community has been remarkably affected; thus, she spends most of her time alone).*

C. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a pre-existing mental disorder.

D. The symptoms did not represent normal bereavement and were not better explained by prolonged grief disorder.

E. Once the stressors or their consequences were terminated, the symptoms did not persist for more than an additional 6 months.

F43:21 With depressed mood: Low mood, tearfulness, or feelings of hopelessness were predominant.

Social Support Questionnaire - 6

The patient scored 5, which suggested limited social support. The patient's responses showed her lack of connections with others, resulting in feelings of isolation.

Problem Formulation

Predisposing factors: The client's history of trauma and instability due to past incarceration resulted in low self-esteem and a negative self-image.

Precipitating factors: Recent misunderstandings with her neighbour, leading to public humiliation and threats of being reported to authorities due to her criminal past.

Perpetuating factors: Social stigma, labelling as an ex-convict, lack of supportive relationships, and prolonged feelings of isolation.

Protective factors: Supportive family members willing to assist in her recovery and engagement in therapy.

Formulation Summary

According to the findings from the Mental Status Examination, clinical interview, assessments conducted, and the DSM-5 TR diagnostic assessment, it can be concluded that the client had a probable adjustment disorder with depressed mood. This is because the patient's emotional response began after the fight and the threat of being reported to the police. Her fear of being sent to prison led to her suicide attempt. Lynn mentioned that she was afraid no one would believe her testimony when compared to her neighbour, who had no criminal history. This was because she had once been in prison. Lynn's suicidal behaviour was therefore a crisis response to psychological stress caused by fear of re-incarceration and not a reflection of a depressive disorder. She reported no evidence of a pervasive mood disorder outside of the immediate stressor and did not meet the full symptom criteria for Major Depressive Disorder, as seen by the results of PHQ-9.

Course of Therapy

Dialectical Behaviour Therapy (DBT) was used to help address the patient's emotional and interpersonal challenges effectively. Each session was structured in a way that it was built on the previous one, facilitating a comprehensive understanding and application of DBT principles. This aimed for the client's improved emotional regulation and healthier relationships.

Session 1: Initial assessment with goal setting

Objectives: Establish rapport with the patient and conduct a thorough assessment of emotional states, triggers and interpersonal relationships. Collaboratively set specific therapy goals.

Summary

The patient was seen alone during the first session. She was informed of her rights in relation to the therapy sessions. She was introduced to the expected course of therapy, the need for full participation from her, and she gave her consent. Rapport was established. The client then gave an account of her life from childhood to date. She also recounted the conflict she had with her neighbour that led to her ingesting pills and being hospitalised. The patient said she regretted her decision to attempt to commit suicide and attributed it to the difficulties she had faced in life. She showed motivation to participate in the sessions and had a good insight into her condition.

Mental Status Examination was done, and the client reported that she was feeling sad. Her mood was congruent. She was oriented to place, time and date. She had not experienced hallucinations or delusions, and her thought process was normal. A thorough assessment of the patient's key relationships, focusing on her interactions with her family members and neighbours was conducted through clinical interview. This helped identify patterns of conflict and the client's underlying feelings of isolation and stigma. Patient Health Questionnaire 9 was administered, and the patient scored 3 on the scale. Psycho-education and insight orientation was done. With the guidance of the therapist, Lynn came up with her own goals for therapy.

Lynn set her goals of therapy goals as below:

1) I want to learn how to identify my emotions and respond to them in healthier ways.

2) I want to develop skills to cope with any overwhelming feelings without resorting to self-harm or withdrawal.

3) I want to communicate my needs effectively and resolve conflicts without escalating situations.

4) I want to engage more with supportive people in my life and build a stronger social network

5) I want to process my experiences related to my past and reduce their impact on my current relationships.

Session 2: Introduction to dialectical behaviour therapy

Objectives: Introduce DBT with a focus on mindfulness and distress tolerance skills.

Summary

In this session, the client was seen alone and demonstrated good orientation to place, time, date and year. She was appropriately dressed, indicating an adequate level of self-care. The client had a fair insight into her circumstances, and her judgment appeared sound throughout the session. During the session, specific interpersonal conflicts were highlighted, particularly the preceding dispute with her neighbour, which triggered feelings of being threatened and misunderstood. The client expressed her concerns about how these interactions resulted in her emotional distress.

The session delved into themes of grief and loss, particularly regarding her past incarceration. The client articulated emotional responses related to the stigma associated with her criminal record, indicating that these feelings contributed to her overall sense of hopelessness. The therapist explained to the patient in detail the four main components of DBT, which are mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness. She also explained the relevance of each component of the approach to ensuring the overall wellness of the client.

Various anger management strategies were discussed, and the client proposed potential methods for handling her anger in constructive ways. She was introduced to basic mindfulness techniques, including breathing exercises and grounding techniques aimed at enhancing her emotional regulation and distress tolerance. She was tasked with doing one breathing exercise during the session, which she claimed was soothing. This exploration provided her with a proactive framework for addressing emotional triggers.

The Beck Hopelessness Scale was administered, with the patient scoring 12 indicative of moderate hopelessness. The results were interpreted collaboratively, and the client positively identified with the findings, demonstrating insight into her emotional state. The therapist gave the client an action plan, which included identifying specific situations where she might apply the skills of DBT, reflecting on her goals and how she could start working towards them in her daily life. The client decided to journal her thoughts and practise a mindfulness exercise daily as homework. The session was terminated.

Session 3: Emotion regulation skills

Objective: Help the client identify and manage her emotions effectively.

Summary

The client was seen alone. She was smartly dressed and calm during the session. She was oriented to the time, place, date, and year. Her speech was coherent and audible. She said she had no new complaints and felt much more alive. She was eager to have the session, and her mood was euthymic. Her affect was congruent with the mood.

During the session, the patient was encouraged to develop a range of skills aimed at enhancing her ability to manage and respond to her emotions effectively. Key strategies discussed in the session included identifying and labelling her emotions through journaling and the use of a feelings wheel to foster greater emotional awareness. The need to understand triggers that elicited intense emotional responses that contributed to the client's distress was also highlighted. Cognitive restructuring techniques such as challenging negative thoughts and employing positive self-talk were introduced to help re-frame her mindset and foster resilience.

Additionally, practical emotion regulation strategies, including self-soothing techniques and mindfulness practices aimed at promoting the emotional stability of the patient, were practised. The client was also trained in the art of active listening, meant to improve her ability to understand others' perspectives, reducing misunderstandings. This helped her to practise expressing her needs and feelings without escalation. The therapist explained how integrating these skills into her daily life would enhance her emotional resilience and improve her interpersonal relationships. Lynn was asked to keep a track of her emotions and responses back home and give feedback on the next session. The session was terminated.

Session 4: Interpersonal effectiveness skills

Objectives: Enhance the patient's communication skills.

Summary

The patient was seen alone. She was smartly dressed and calm during the session. She was oriented to the time, place, date, and year. Her speech was coherent and audible. Her thought process and thought content were normal. The patient reported not having any hallucinations or delusions. No suicidal ideations were noted, and the client said she was not going to attempt to take her life in the future. Social Support Questionnaire 6 was administered, and the patient scored 5, showing limited social support. The client said she was on talking terms with her family, but was not yet ready to confide in them when faced with difficult situations.

During the session, the emphasis was on enhancing social skills through role-playing scenarios, which allowed the client to practise assertive communication techniques. The DEAR MAN (Describe, Express, Assert, Reinforce, Mindful, Appear confident, Negotiate) technique was introduced. This is a technique designed to help individuals assertively express their needs while maintaining respect for themselves and others. It helps the client to foster the ability to handle confrontations without escalation.

The client was encouraged to reconnect with her siblings and family members for emotional support. Discussions on possible opportunities for community engagement were held to help her build new relationships and reduce feelings of isolation. She was tasked to practise the skills at home as homework. The session ended.

Session 5: Integration of skills

Objectives: Reinforce and integrate the skills learned in previous sessions.

Summary

The client was seen with her sister-in-law, the one who lived with her at the family's house. She said she had opened up to her, and the sister-in-law had been eager to attend the session with her and learn how she could assist in her recovery. She exhibited good judgment and insight. The client was well oriented to time, place, and date. She was now having a better understanding of her mental illness.

The Longford risk assessment tool was administered to evaluate recidivism risk, and the patient had evidence of moderate to high risk for recidivism under provocation or legal stress and high risk for psychological deterioration or suicide, if left untreated.

A progress review on mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness was done. The patient gave a narrative of how she had applied the skills in her life and how she felt about her milestones. She reiterated how it was still difficult for her to find a job; but, despite the setback, she was more hopeful about the future. The client was asked to develop a self-care plan that incorporates DBT skills and then referred to a clinical psychologist for further support and management. Sessions were terminated.

Concluding Evaluations

The patient demonstrated resilience and a growing understanding of her triggers. By the end of the intervention, she expressed a commitment to her mental health and a desire to rebuild her social relationships. She was positive about her continuing individual therapy sessions with a clinical psychologist. The therapeutic alliance established was crucial for her recovery. The assessment results, when analysed in conjunction with the Social Support Questionnaire 6 results, show the importance of improved reintegration programs for people previously convicted to help them settle back into their communities. The patient needs close supervision and monitoring by a multi-disciplinary team and informal caregivers to ensure that she would not relapse and had emotional regulation and impulse control. There is therefore a need to increase awareness in the communities in relation to accepting the previously convicted members back into society. Stigmatisation and labelling must be shunned at all costs to avoid feelings of shame and unworthiness in individuals with a criminal history.

Recommendations

The client required further support through individual therapy to reinforce coping strategies. In addition, the client ought to be encouraged to join peer support groups of individuals with similar experiences to reduce feelings of isolation. The patient was encouraged to see a social worker to rally for a social support system and for resources during the reintegration process, an occupational therapist for help with life and survival skills and a psychiatrist for review. There is therefore an imminent need for initiatives aimed at combating stigma associated with criminal records to foster a more supportive environment for individuals with a criminal history. The criminal justice system, particularly the correctional services, ought to have aftercare programmes for ex-offenders to ensure effective reintegration into their communities after they are released from prison.

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