

Psychosocial Intervention in an Elder Person with Depression: A Case Report

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ABSTRACT

Background: The elderly are said to be more prone to depression as they become more isolated from their communities. Living alone, stressful life events, lack of social support systems, the recent loss of a loved one, lower socioeconomic status and presence of co-morbid medical illnesses are some of the risk factors for depression in the elderly which needs more than medical management. So, to demonstrate the scope, feasibility and possible outcome of the psychosocial intervention, a case of elderly person with depressive disorder and associated psychosocial problems formed the background of this case report. The positive outcome of this case also gave us an opportunity to critically assess the feasibility of psychosocial intervention in a facility named “Psychosocial Intervention Clinic” which has started functioning recently in the Department of Psychiatry, Government Medical College and Hospital, Chandigarh. **Assessment & Management:** The case presented here is that of a 78 years old, married, male, retired professor hailing from an upper-middle-class nuclear Hindu family with multiple psychosocial problems. Through an in-depth case study using face to face interview with the client and his family members, a psychosocial formulation was made and a plan for psychosocial intervention was made. As the sessions progressed, further associated issues were discussed. Consent was taken from the patient and family members for future possible reporting of this case in any journal. **Outcome:** After psychosocial intervention, understanding and awareness about the illness and psychosocial problem related to that in the family was enhanced, there was better involvement and interactions among the family members, self-esteem of the client improved, unwanted behaviour of the client decreased, family decided to resolve the inter-personal issues and family conflicts were significantly minimized, The client was contented and satisfied with the outcome of the intervention. **Conclusion:** The case study illustrates the nature and extent of psychosocial problems in a case of elderly person with depression and enhanced the understanding on some psychosocial issues associated with depression in elderly. It also demonstrated that psychosocial intervention plays a key role in the treatment of depression especially in the elderly.

Keywords: Elder person, depression, psychosocial intervention

INTRODUCTION

WHO had a year-long campaign “Depression: let's talk” in 2017 since depression is the leading cause of ill health and disability worldwide. More than 322 million people are now living with depression, an increase of more than 18% between 2005 and 2015.^[1] India is home to an estimated 57 million people (18% of the global estimate) affected by depression.^[2]

As per NMHS (2015-16) in India, one in 20 (5.25%) people over 18 years of age have ever suffered (at least once in their lifetime) from depression amounting to a total of over 45 million persons with depression in 2015.^[3] Depression contributes to a significant disease burden at national and global levels. At the individual and family level, depression leads to poor quality of life, causing huge social and economic impact.^[4]

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Depression can affect people from all backgrounds across the lifespan, from early childhood to the end stages of life, with an increased toll at certain time points. Much of the understanding in this area is centred around depression among adults, but it is essential to recognize the fact that children, adolescents and the elderly population are susceptible and affected as well.^[3]

The elderly are said to be more prone to depression as they become more isolated from their communities.^[5] With an ageing population, depression among the elderly is likely to increase in the coming years, with higher prevalence among the elderly than that in the general adult population. A systematic review reported a median prevalence of 21.9% (11.6–31.1%) for depression among the elderly in India.^[6] Among the community based studies in the elderly, the prevalence of depression ranged from 3.9% to 47.0% with higher rates among female and urban residents. Living alone, stressful life events, lack of social support systems, the recent loss of a loved one, lower socioeconomic status and presence of co-morbid medical illnesses are some of the risk factors for depression in the elderly.^[3]

ASSESSMENT

Case Introduction: Index client VS, 78 years old, married, male, studied up to doctorate level, retired professor of physical education hailing from an upper middle class nuclear Hindu family of Chandigarh city.

Sources of Information: The client himself, his daughter in law, son, and case record file were sources of information which were reliable and adequate.

The reason for Referral: The case was referred for psychosocial intervention.

Chief Complaint: Presented with the chief complaint of (on Sep 1, 2016):

Loss of interest	}	for last 4 months
Sadness		
Crying spells		
Death wishes and		
Forgetfulness	—	for last 6 months

Onset was insidious, course was continuous, and there was deterioration which was aggravated frequently due to family conflicts.

Brief Clinical History: The client was apparently well six months back when the family members observed changed the behaviour in him. They noticed lack of interest in some activities which he used to do like paying the bills (electricity, water, phone etc.), collection of house rent, going for shopping for household items. While asking he replied, "Ab mere se nahi hoga ye sab (I will not be able to do these things), I don't know what happened to me as I am having no energy or self-esteem; I was very active and energetic person". His mood was sad all the time, he would prefer to talk less and on asking replied, "Kya karun ab kuch nahi hota mere se ... man nahi lagta (What to do now as I am unable to do anything...not keen to do anything anymore)". The client had started to have on and off crying spells without any apparent reason and he was not able to explain why he was crying. Occasionally he expressed death wishes also. Often he was found standing in front of a cupboard or elsewhere in the house and whenever asked would say that he had forgotten forgot what he was searching/doing. He was also seen muttering to self with some facial gestures (he never explained about it whenever asked). Once he drove a long distance and forgot where he was going and didn't know how to return; he had to take help of people in finding his way back home. He was very actively participating in day to day work of the house so others found it difficult managing without his participation but considering his growing age and ongoing family conflicts they thought it's common.

Gradually the problems were increasing and one day he was found under the bed and on asking he said people are thronging stone and started crying so, the client was brought to the GMCH, OPD for further management.

Biological functions: His sleep was disturbed and appetite was decreased.

Negative History: No cognitive impairment (MMSE score 25)

Past History: Nil contributory

Treatment History: The client was not treated anywhere, his first treatment was at GMCH. He was reluctant to take any medicineso whateverwas being prescribed he didn't take that. He was also referred to Clinical Psychology Services for CBT but

somehow he attended very few sessions and dropped out. He himself chose to continue with the psychosocial intervention only.

Family History

Family History of Illness: Wife was having severe depression, currently doing well with treatment

Family Composition

Client: The client is 78 yrs old, Ph.D., retired as a Professor from a reputed University

Wife: The wife is 77 yrs old, M.A., retired teacher, Govt. job

First child: The daughter 47 yrs, a widow since 2000, lives in the same house on 2nd floor with her two children.

Second child: The son 43 yrs old, married, MBA, private job, lives with parents

Grandchildren: The grandson 14 yrs old, studying in class 8th.

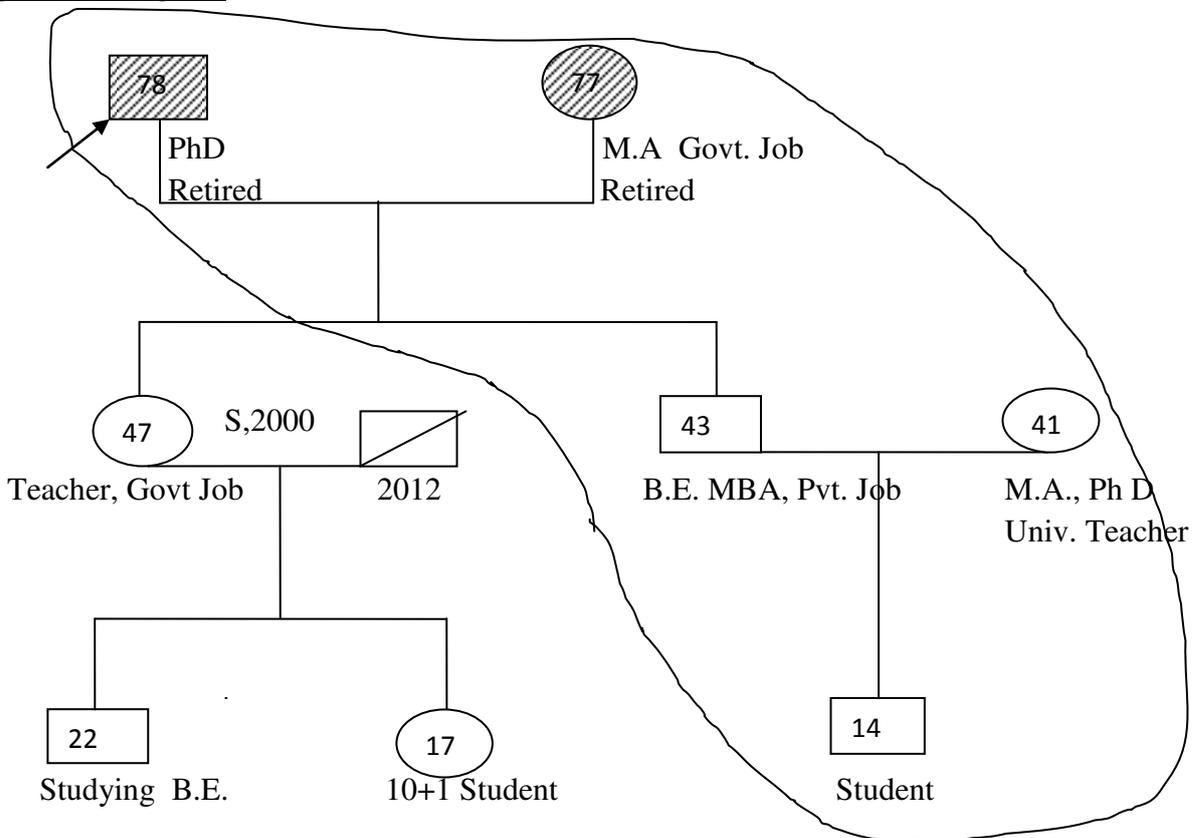
Interaction Pattern

The maintaining factor of the illness was the frequent quarrels in the family mostly between

the client's daughter and daughter-in-law. The client's daughter is a widow and stays in the same house on the first floor. The client along with his wife, son, daughter-in-law and grandson stays on the ground floor. For many years the daughter and daughter-in-law didn't get along well with each other and currently, his son has started supporting his wife. The client also supports his daughter-in-law as he understands that she has been managing the house well. The client's wife is on treatment from the department since 2013 and it was the daughter-in-law who had taken care of her mother-in-law. It is the constant interference of daughter that aggravates the problem. Son was preoccupied with his own job and was often not able to pay attention to his father's concerns or manage the property related issues. At times the son was unable to even talk to his father and so many a times the client was having a lonely feeling; this was further aggravated by the fact that his wife was ill and his daughter was not talking properly.

Only the daughter-in-law was talking to him and taking care of his needs, including bringing him to the hospital for his treatment.

Figure 1 Genogram



Family Dynamics

Boundaries: Parental subsystem was well formed but due to the illness the spouse of the client, it had become non-functional. The sibling subsystem is not well-formed but well supported by parents. There was a frequent encroachment of boundaries from sister side leading to frequent quarrels among brother, his wife and sister. Parent-child subsystem was well formed. Boundaries in the family were closed and rigid.

Family developmental stage: The family was in the 8th stage of family development life cycle i.e. 'Ageing family members' where involvement with grandchildren and dealing with difficulties of ageing is expected (Duvell).^[7]

Leadership pattern: The client is the nominal and the daughter-in-law is the functional head of the family. This leadership was well accepted in the family.

Decision-making process: The client was the main decision maker and follows a democratic style of decision making. However, all household related decisions are taken by the daughter-in-law in consensus with all the other family members. All the family members were equally participating in it.

Role structural and functioning: The role allocation was adequate in the family and there was no role conflict. Everyone was accountable for their allotted role and were performing their role adequately. After the mother (client's wife) got an illness the daughter-in-law has compensated her role in the form of managing the household activities. But after the client got an illness there was some ambiguity of role particularly that of dealing with the property and taking care of client's daughter. The role performance of client's daughter seems inadequate as she was living (on a different floor, after having difficulties living alone following the death of her spouse) in the same house but never took part in taking care of the parents or attended any family rituals or activities. The daughter has been indifferent towards clients' illness and client seems to be more worried about her daughter's future and her two children's future. This has been the maintaining factor of client's illness.

Communication: There was an open and direct communication reported in the family but once the mother fell ill she was a bit inactive and communicating less. When the daughter started living with them she had very faulty patterns of communication. At times she would be abusive and accused her brother and father of not giving her any share of the property (which was not a fact). So, at times noise level was very high. This was frequently happening in the house and aggravated the client's illness even though the son and daughter - in - law effectively communicated to the client and told him that they support his decision in all the financial and household matters.

Reinforcement: There are inadequate reinforcement measures in the family.

Cohesiveness: Cohesiveness is present in the family. There is a healthy connectedness between all members of the family and it had the 'we-feeling'. They have love and concern for others.

Family rituals: The entire family follows a routine in the form of eating together, going out for a walk, enjoying leisure activities and through these rituals maintain a healthy home environment.

Adaptive pattern: The family's problem-solving abilities are inadequate. They try to resolve family problems by discussing among themselves and seek help when necessary but their coping skills were inadequate, and as a result the family used to have frequent quarrels which the client was unable to handle and so started giving up. He even had suicidal wishes where he started feeling he couldn't handle his two children and should die.

Social support system: The family's primary support is adequate in terms of financial, emotional, informational, instrumental and appraisal. The secondary and tertiary support was also adequate.

Personal history

Birth and early developmental history: The client was first born of a non-consanguineous marriage and a full term normal delivery. He had attained developmental milestone at the appropriate age. There was no abnormality reported.

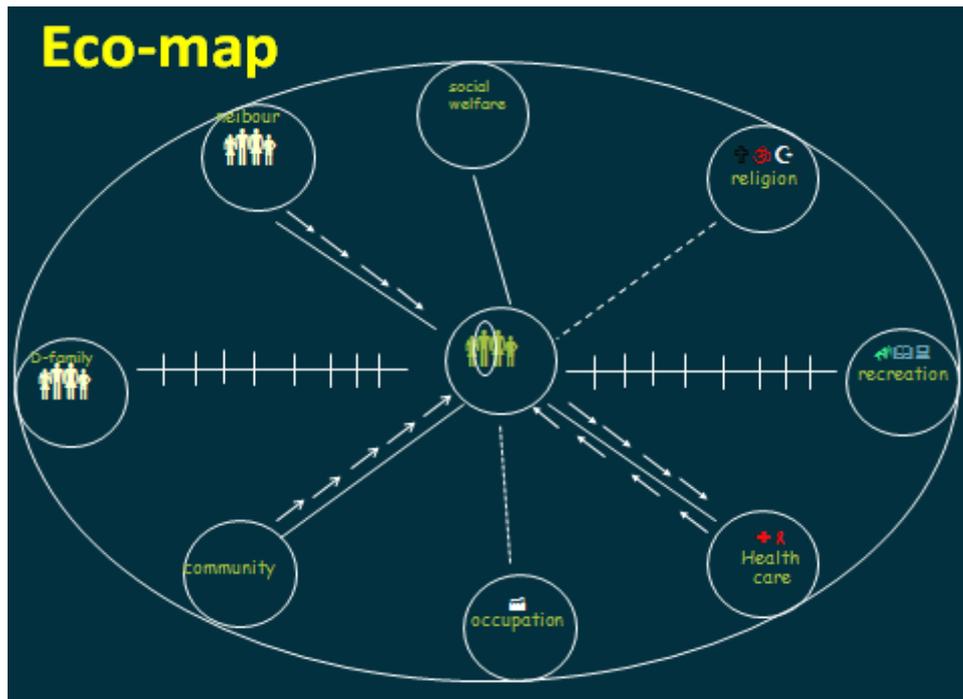


Figure – 2 Eco-map

Scholastic history: Client had started schooling at the age of 4 years; he had attended Hindi medium school. He was good in studies; no disciplinary complaints received and had normal play behaviour with peers.

Occupational history: The client worked at a teaching post in the university and retired as Professor. He was a pioneer in his field, did excel in many areas in his field and supervised around 50 doctoral scholars. He had been guest faculty in many esteemed institutions and had written twenty books on his field.

Sexual history: Nil contributory.

Marital history: Client is having a good interpersonal relationship with his spouse.

Use & abuse of alcohol, tobacco & drugs: The client has no history of substance use or abuse.

Premorbid Personality: The client was sociable, extrovert enjoyed travelling to different places, reading books, writing books, teaching, doing a repair of household items on his own and watching T.V. He was very hardworking, sincere and punctual not only in his work but in leisure and social life as well.

The client had a good working habit, he was ambitious, had a good level of self-esteem, and good interaction with peer and family members. So, he had **well-balanced** premorbid personality.

PSYCHOSOCIAL FORMULATION

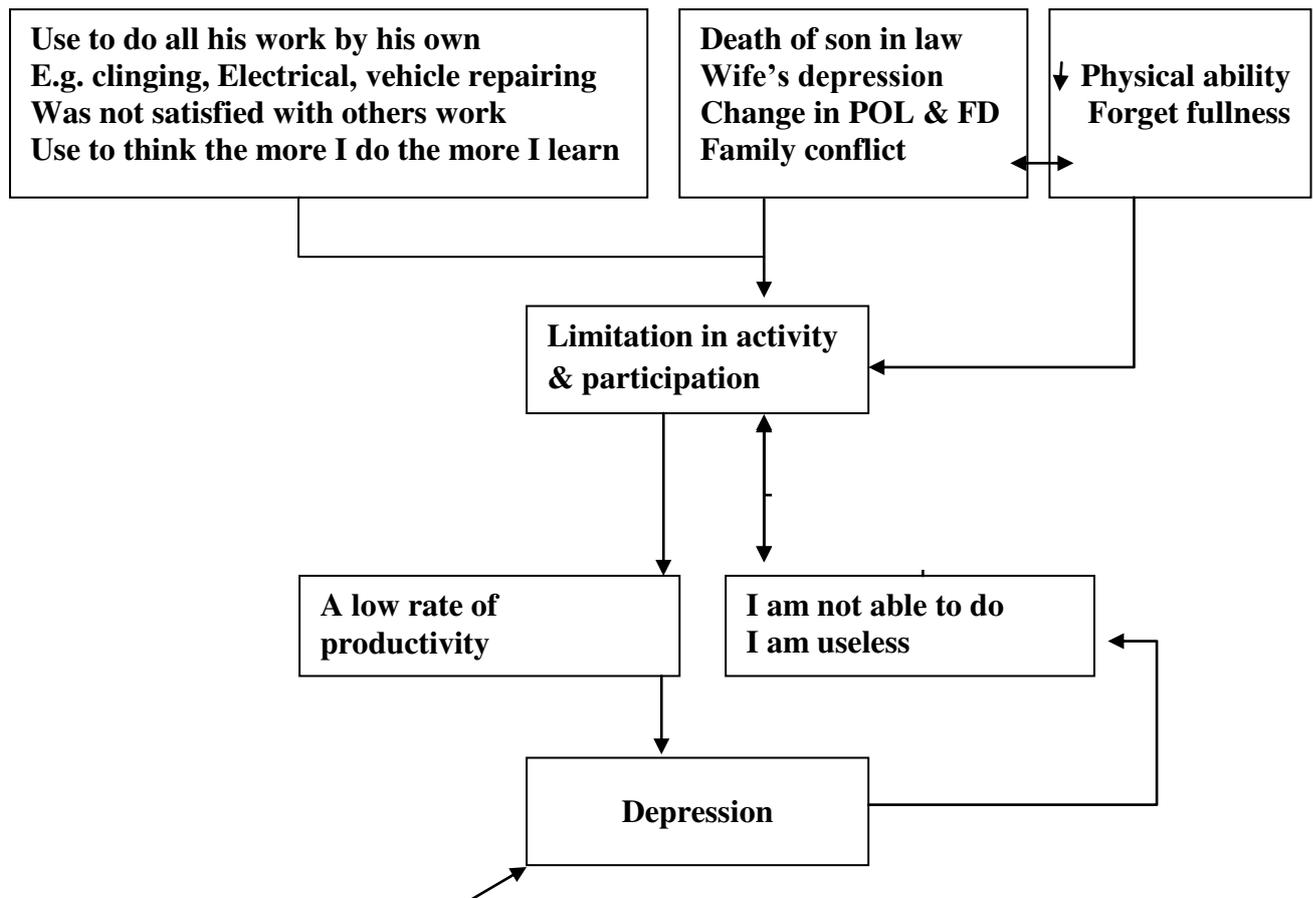
Index client V. S. 78 years married, male, studied up to doctorate level, a retired professor hailing from an upper middle class nuclear Hindu family, from Chandigarh, presented with the chief complaints of loss of interest, sadness of mood, crying spells, death wishes for last 4 months precipitated by family conflict; with no history suggestive of contributory past history and family history. Mental status examination revealed irritable mood, depressed affect, depressive cognitions and suicidal thoughts with grade IV insight.

Social and family analysis revealed that the client and the family members were having inadequate knowledge about the illness; there is a strained relationship between the daughter and father (client), and son and his wife also. The daughter had some allegation about not getting her part of the property, although this was not so and the brother and father was ready to fulfil her demand. There was a marked deterioration in most of the areas of family dynamics due to the illness of the client's wife and family conflict. The faulty communication pattern was leading to the high noise level in the family. Problem-solving abilities and adaptive pattern were inadequate because of poor coping strategies.

There was a strong feeling of emptiness, loneliness and low self-esteem in the client.

In terms of resource, the family has adequate social support, good economic and educational background.

Figure – 3 Psychosocial Formulations



PSYCHOSOCIAL MANAGEMENT

The goal of the Interventions

Based on the assessment, the following goals were set:

- To build a worker-client relationship
- To educate the client and the family regarding the illness of the client
- To regularise client's daily routine
- To develop client's self-esteem
- To encourage others to spend more time with the client
- To enhance communication in the family
- To teach engagement and coping strategies
- To improve adaptive patterns in the family
- To enhance client's interaction with others and participation in social activity
- To utilize support and strengths available for the client and family
- To deal with interpersonal issues (IPR) and property issue

Interventions Plan

All intervention was done on OPD basis. Initially, a biweekly session lasting around 45-60 minutes and then monthly and subsequently

once in 3 months were held. The majority of the sessions were individual with the client; few sessions were conducted jointly with son, few sessions with daughter in law and one session with the wife

Interventions consisted of:

- ✓ Rapport building
- ✓ Psychoeducation to the client and the family
- ✓ Activity scheduling
- ✓ Family intervention
- ✓ Communication enhancement training
- ✓ Problem-solving training
- ✓ Consistent monitoring
- ✓ Follow up and support through phone

Course of Intervention and Assessment of Progress:

Initially the client was not ready to share anything about his family, he kept on crying frequently. Reassurance to provide help and active listening helped to build rapport. As soon as the client opened up, enough space was given for ventilation to all his rational as well as irrational thought. He shared everything in detail – his all achievements, self-dependent life and current inability to

maintain the same which was partly because of his age factor and partly because of family or psychosocial problems. He was very happy sharing information about his glorious career and achievements so, later on it was used as a reinforcement to initiate or continue talk and also to motivate and convince him to maintain his present socio-occupational functions.

Once the client's trust was gained, psychoeducation was initiated. The client's knowledge about his illness was checked. He was aware that he suffered from an illness called 'depression' but did not know what its symptoms were. The client was educated regarding the symptoms of the illness by explaining what happens when he gets into his 'depression'. This was done by giving the illustration from his own experiences. His suicidal thoughts were also explained. He was educated about symptoms, nature of the illness, the treatment, the course and prognosis. Finally, his queries about several aspects were clarified. His age related issues and its impact on the ability to perform day to day work and family or psychosocial problems were also discussed and assurance was given to work on it.

Following psychoeducation, an activity schedule was drawn with the help of client and he was guided to decide about the activities he preferred to incorporate in his daily routine as he was stopped from doing most of the things and the family also did not encourage him to go out because they were scared of his suicidal behaviours. The client was reinforced to restart and maintain the activities which he was doing previously. The client found it difficult to follow a structured routine, but with constant monitoring, support and reinforcement the client was helped to carry out the tasks gradually as he had done previously.

Family members were also educated about the symptoms, nature of the illness, the treatment, the course and prognosis. Finally, the different queries about several aspects were clarified. Following the psychoeducation, they were pursued to get involved in client's care and intervention that had to be followed in future. Particularly the fact that the son was not giving time to the father was pursued and the son was advised to spare some time on a daily basis. The family was also encouraged to talk and discuss the family issues and gradually they

were ready to understand the each other's view point and concerns and thus have a better understanding about their conflict.

In conjoint sessions, they were encouraged to participate in open discussion without showing aggression or indifferent attitude towards other members of the family. Negative expressions and possible points of conflict were explained and taught how to minimize them. Various alternative or possible solutions were demonstrated for family problems particularly those related to property.

Interpersonal issues were dealt with very carefully. Family members were taught how to be non-directive or non-judgmental towards other's point of view and concerns and minimize the conflicts. They were also trained in expressing their negative expression in a positive way. Day to day problems like parking, cleaning common areas etc. were taken up and possible solutions or alternatives were discussed.

During the entire course of treatment, they were consistently monitored and guided actively and continuous communication was maintained over phone. In due course, assessment of progress was done and outcomes were identified.

✦ OUTCOME OF THE INTERVENTIONS

- ❶ Increased understanding and awareness about the illness and problem related to that in the family
- ❷ Increased involvement and interactions
- ❸ Better parents - son interaction
- ❹ Improvement in self-esteem of the client
- ❺ Decreased unwanted behaviour of the client
- ❻ Family decided to resolve the IPR and family issues
- ❼ Finally, family conflicts were significantly minimized
- ❽ The client seems to be happy and satisfied with the intervention

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