Family Intervention with Two Cases of Severe Depression

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ABSTRACT

Introduction: Among all the other disorders, depression nowadays is not only specified to mental health disorders, but it has become a primary global health concern also. Individuals having persistent unhappiness, lack of interest in pleasurable or any other activities, lack of confidence, sleep disturbance, problems with deciding, suicidal thoughts or attempts, agitation or reduced activity, self-blame for most of the time for at least two weeks are the common symptoms of depression. **Methodology:** In this present work, two case reports, one 65-year-old male, complaining of decreased sleep, lack interest in activities, hopelessness, suicidal ideas, weakness, and 51-year-old female complaining of worries, pessimistic thoughts, palpitation, forgetfulness, reduced interest in activities, and suicidal attempt have been illustrated. This comprehensive and methodological psychosocial work focuses on a qualitative approach to subjective questions and responses. This case report aims to generate knowledge and analyze perceptions concerning social and psychological phenomena for male and female clients. For assessment, Beck Depressive Inventory, Family interaction pattern scale, Hamilton Anxiety scale have been used. **Result:** The psychosocial intervention strategies follow rapport establishment, activity scheduling, supportive therapy, problem-solving and other techniques made possible to reduce psychological distress. Overall, a positive outcome was established by a low depression level. **Conclusion:** It can be concluded that scientific psychosocial management with family intervention played the primary role in positive results.

Keywords: Family Intervention, Severe Depression

INTRODUCTION

The twenty-first century has been a period of flurry of variations worldwide. These social changes unquestionably affect the social elements, resourcefulness, and reactions to mental disorders. Mostly depressive disorder has a massive impact on persons' capability to determine their constancies, relationships and other esteemed activities. Considering the global health concern, depression has always been an interesting domain for researchers worldwide. Depression is a serious mental health issue contributing to serious personal, interpersonal and societal consequences. Individuals having persistent unhappiness, lack of interest in pleasurable or any other activities, lack of confidence, sleep disturbance, problems with making a decision, suicidal thoughts or attempts, agitation or reduced activity, self-blame for most of the time for at least 2 weeks are the common symptoms of depression. According to the World Health Organization, 450 million across the world suffer from psychiatric illness. Meeting the symptoms of psychiatric illness by one in four people at some time of their life has also been reported by The World Health Organization (Mossie et al, 2016). Another article conducted within Indian states revealed 197.3 million people reported to have psychiatric disorders which included depressive disorder for 45.7 million people (Sagar et al, 2020). In cases of depression and other psychiatric illnesses, the prevalence rate differs between males and females. Females usually suffer from depression

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more often 21% than males 13% as per the previous studies due to internalizing factors (Ryba, & Hopko, 2012). In terms of gender differences to the prevalence of depression, including with other genetic, hormonal factors, psychosocial variables like gender role, social role, and interpersonal relation contributed to be established factors (Nolen-Hoeksema, 2002). In this report, two case reports have been presented, both of them were suffering from depression.

CASE INTRODUCTION

Case 1 Mr B.D. 65 years old, male, Hindu by religion, graduate, retired, married, hailing from middle socio-economic status, belonging from a nuclear family with urban domicile.

Case 2 Mrs T.M. was 61 years old, female, Hindu by religion, H.S passed, married housewife, hailing from middle socio-economic status, belonging from extended family with urban domicile.

Sources of Information: In both cases, family members and prescriptions were the sources of information.

Brief Clinical History

Case 1

The index client. Mr. B.D. presented with complaints of decreased sleep, lack of interest in activities, lack of energy and suicidal ideas for the last one year. He was apparently well before 61 years of age. The client was quite sincere and a dedicated employee, always preparing himself for the accomplishment of his professional role and responsibility in a perfect manner. The same way he expected and hoped for the best academic performance from his son. Over the years, with frequent changes of location for transferable jobs, the scholastic performance of his son got reduced drastically. Poor academic performance of son coincided with resentment of father, making him more critical, using disapproval and blaming comments directing son. With the daunting rising, the client's son stepped into his career. In this present case, the client's vision towards professional success was high for his son. He wanted his son to clear a competitive exam to get a high salaried, socially recognized job. But, due to the high competing and battling situation, he could not accomplish it and ultimately got frustrated. Not getting a suitable and well-recognized job created a negative effect on their subjective well-being. However, with repeated criticism and the negative attitude of the client, a feeling of self-contempt and guilt developed in the client's son. In return, the client's impaired mental health client's son started reacting to the father by blaming him for persistent force and high expectations from his career. Hence, repeated arguments followed by critical comments, blaming, comparing, often led to family conflict. This made the client worried and thoughts of his misdeeds and misfortune. Since then, the unemployment of his son, made him suffer from disturbed sleep, pessimistic thoughts for his son, reduced interest in any activities, lack of energy, irritability, suicidal ideas, due to which he consulted a psychiatrist. The concerned psychiatrist referred him for psychosocial intervention and management.

Case 2

A 61 years old, female, Mrs. T.M presented uncontrolled worries, trouble in falling asleep, feeling of worthlessness, forgetfulness, headache with suicidal attempts for the last 6 months. It was reported that she was apparently well before the age of 54 years. According to the client, she had an unsatisfied marital relationship and expectations from marriage were unfulfilled due to this she always tried to form amicable and protective relationships with children. The client's daughter, due to conflict with her husband, attempted suicide by

setting fire and burned almost 75% of her body. Soon after this incident, her youngest son started staying separately due to his occupation. In this present case, the client was disappointed with the social life of her son. Her son refused to stay at home despite repeated requests and urges and used to give excuses of occupation, as reported by the informant. With all mental agony and recurrent thoughts of family disharmony and emotional deregulations, she attempted suicide by taking an overdose of sleeping pills. Since then, the client started having regular crying spells, decreased interest inactivity, lack of social interaction, and futility for life accompanied by sleeplessness. With these complaints, she consulted a psychiatrist as insisted by her husband. The client was ultimately referred for psychosocial assessment and therapy.

Psychosocial Issues across Family Life Cycle Stages

Married Couples without Children

Case 1: The client, Mr. B.D. expected a homely partner who would be performing all the domestic activities sincerely and on the other hand, the wife's expectation was for a friendly and supportive husband. It was reported that during the first year of their marital relationship, both of them were happy, but gradually over the period of time, the marital bond was exacerbated. As per the information, the client was unconditionally focused on his professional growth, could not bear adequate time for family responsibilities.

Case 2: From the very initial phase their marital tie was not formed as the client, Mrs. T.M., was not ready for the marriage. The family decisions, opinions were never being discussed with the client, due to the autocratic nature of the husband. According to the client, her husband used to keep himself busy with his own stuff which also caused a lack of marital harmony.

Marriage is a specific life event, a socially recognized unit with emotional connotation. Marriage being a standardized bond involves adjustment and understanding from both spouses. Studies have shown, marriage has an enormous impact on mental health and psychological illness, some common disorders are reported to be depression, obsession, substance abuse etc (Mina, 2019).

Childbearing stage:

Case1: As per the informant's report, the index client, Mr. B.D. was more focused on achieving his target and oriented towards rapid increment. Hence, the consistent pressure of work made him ineffective to perform his role as a husband and as a father.

Case2: The client, Mrs. T.M., was over-involved with her children. She used to be a protective and caring mother desiring to stay all together. At this phase, the unfulfilled responsibility played by her husband made him distressed.

Research suggests poor marital interpersonal relationships, maladjustment, unshared responsibilities promote the risk factor of depression (Du Rocher Schudlich, 2011).

Family with preschool and school going children:

Case 1: To get a promotion, frequent changes of work location made it difficult for children to adjust to new places and school environments. In this connection, academic performance worsened which ultimately led to distress in the client.

Case 2: During this phase, the burden of family activities overwhelmed her despondency. As reported, the index client, Mrs. T.M. used to overprotect her children. Sometimes her care and overprotection turned into worries which caused frequent arguments with children and husband.

Research findings support the relationship between insecure parental attachment and depression (Ayala, 2015). Another contributing factor in connection with social rejection, high competition, and impaired social recognition is all involved with the level of depression (Kupferberg et al, 2016).

Family with launching young adults and middle-aged parents:

Case 1: Persistent conflicts and arguments regarding the son's job role bothered him profoundly. The client, Mr. B.D., being always a perfectionist in his professional life, anticipated a better job role for his son. Repeated negative comments and blaming caused disturbed father-son bond.

Case 2: Most of the time family feuds happened due to a lack of adequacy of role performance. In the family, during this stage, role prescription was not adequate. According to the informants, prescribed and socially defined roles on a normative basis, are not performed by son.

Family with ageing and retired parents:

Case 1: The present client, Mr. B.D., retired from work life, mostly suffering from a lack of self-esteem due to his son's unemployment and superannuation.

Case 2: In this report, the client, Mrs. T.M., being so self-critical and judgmental, due to her son's circumvention, feels stressed and worthlessness.

Several research studies demonstrate the association between ageing and depression, focusing on most current trends of research findings, perceived isolation and social isolation has been identified as the risk factor of aggravating depressive symptoms (Courtin, & Knapp, 2017). Supporting the present case, Mr. B.D., studies have also confirmed the significance of the elevated rate of depression among unemployed men (Zuelke, 2018).

Tools administered: Beck Depression Inventory was administered in both cases. Scores showed 35 and 29 to Mr. B.D. and Mrs. T.M. respectively in BDI scoring, depicting severe levels of depression. The family Interaction Pattern Scale was administered to both the clients and family members separately. Mr. B.D. scored 132 on the Family Interaction Pattern scale, which is indicative of unhealthy interaction patterns among family members. An unhealthy interaction pattern was also observed among family members of Mrs. T.M., as she also scored 130.

PSYCHOSOCIAL INTERVENTION

The intervention process was conducted individually with each client; family members were called for corroborating information and further generating support systems in a positive manner.

Rapport establishment: In both cases, rapport was easily established; clients were allowed to ventilate their feelings and present complaints. Through this procedure, psychosocial assessment started and mental status examination was performed. In case 1, it was revealed that the pessimistic views were mostly concerned with the client's son about his problem related to unemployment and for case 2, the client was preoccupied with the thoughts of detachment with his son.

Psychoeducation: Due to lack of awareness about mental illness, proper information regarding the nature of the illness, triggering factors, prognosis rate, treatment plan, and the probable outcome was discussed with both the clients and their family members.

Activity scheduling: In both cases, it has been observed, overwhelmed problems along with dysfunctional reactions leading to consequent unhappiness was quite significant. Hence, the therapist emphasized externalization of interest, seeking to divert the clients' attention from the oppressive ideas through the pursuit of some activity and or interest. They were asked to maintain their activities by monitoring a specified activity log. Both the cases were encouraged to identify the benefits of increasing social network support. They were guided to understand how increased socialization would provide them with an outlet for suppressed feelings and greater emotional support.

Supportive counselling and problem-solving strategy: Wide research framework has shown the importance of supportive therapy in dealing with depressive cases (Cuijpers et al, 2012). Due to the maximised efficacy of supportive therapy, two clients were given non-directive support by reassurance, validation and empathy. With due respective support, a problem-solving approach, based on learning principles was initiated. From the previous studies, it has been explored that problem-solving therapy being a possible strategy for bringing a productive effect on reducing depression levels in elderly people (Arean, 1993). In the above cases, the problems were identified initially and strategic plans were discussed to resolve problems.

Strengthening family support: The evidence from different research work states the positive relationship between family support systems and mental well-being. Family members, specifically, in both cases, sons were being called. They were provided adequate and necessary information about the mental health condition of the said clients. Metaphors have also been used in describing poor family function contributing to poor mental health.

Conjoint session, case 1, Mr. B.D. with his son, was conducted, emphasizing reducing the gap between expectation and reality. The therapist helped them both to address their feelings of abandonment and directed them to explore their present strength focusing on the available resources. The client was helped to evaluate negative thoughts and to substitute them with more realistic thoughts.

Another conjoint session is done with case 2, Mrs. T.M. with his son, highlighted the importance of connecting with family members for maintaining psychological comfort and security. Regardless of family conflict producing symptoms of depression, anxiety, maintenance of direct, positive communication, family support strengthening activities have the potential role in the reduction of psychological distress. In both cases, the therapist worked on the ordeal technique by proving a worse alternative to the presenting dis-satisfactory feelings. And also directed them to be more rational and to be flexible in case of acceptance.

The family system delivery on over-expectation and rigid restrictions acknowledged the impact on faulty family functioning stated clearly in therapy sessions.

DISCUSSION

Though depression is a very common disorder, prevalence rates generally differ among genders, considering the implicit and explicit characteristics. The scenario of the incidence rate of depression could be due to various personal, biological, social and economic unstable reasons. During elderliness, some psychological and physiological changes have been playing an inevitable role. During this developmental stage, depression, being the most common disorder, affects both males and females (Sözeri-Varma, 2012). Late-life depression where the onset age is 60 years and above has been presented with mostly reasoning, neuroimaging, neuropathological and hereditary correlates, as per the research (Naismith et al, 2012). The presented case reports, belonging to the age group of 60

and above 60 years, appeared to be vulnerable to depression. Considering the men and women differences the occurrence rate of depression, several research studies have put forward various psychosocial reasons (Accortt et al., 2008). However, a body of research shows women present more depressive symptoms than men (Poutanen et al, 2009). Different factors like decreased social support, issues related to family relations, life events generally influence females more than males (Poutanen et al, 2009; Kessler, 2003). In this report, in female cases, issues like marital dissatisfaction, disturbed family functioning and relationships precipitated her depressive symptoms which supports the previous research. Similarly, suicidal rates have been reported to be affecting 60 million people in Asia every year, weighing more in females correlating the mortality and morbidity rates (Vijayakumar, 2015; Beautrais, 2006). And suicidal attempts have reported being twice in cases of women than men. From the psychosocial assessment, it has been found that a suicidal attempt was reported in the female case, Mrs. T.M. and her daughter but on other hand, recurrent suicidal ideas were significant in the male case, Mr. B.D. without any active attempt. Considering the gender differences, men are prone to competition and success-oriented Ogrodniczuk, & Oliffe, 2011). Supporting this finding, the male case presented here, exhibited more expectation to fulfil social competitive role, prestige and power dominance. Moreover, he was unable to seek help from his primary family members due to his self-determining beliefs and thoughts. Including these, other factors like retirement, absence of recognized position perpetuated depressive symptoms. The psychosocial issues on the prevalence rate of depression among genders are generally comparable in terms of rumination pattern, coping strategies and symptomatic representations. In view of the differences among genders, the treatment methodology used by therapists was unalike. However, two cases can be linked through numerous transactions emphasizing poor family functioning, social support, and emotional dysregulation intensifying depressive disorder. Thus, demonstrating two case reports, from a psychosocial perspective to assess and manage, is an attempt to draw a fine line between challenges and positive outcomes in men and female families.

CONCLUSION

Even though pharmacological and psychosocial treatment exists, millions of people suffering from depression are left out without any appropriate service and help. The present case report is an attempt to underline the importance of poor family relationships and interpersonal dysconnectivity with depression is unignorable. As demonstrated by the present case report, the psychosocial intervention strategies followed rapport establishment, activity scheduling, supportive therapy, problem-solving and family intervention made it possible to reduce their psychological distress significantly.

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