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Does the family "need" depression? A pilot study of family consultations

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Summary

Aim. The aim of the presented study was to analyse associations between drug-resistant depression and the way the illness is described by patients and members of their families. In particular, a hypothesis to be verified was that being ill may be a factor stabilising the family system, and consequently treatment of this kind of depression may encounter additional difficulties and enforce "drug-resistance" by "sustaining depression" by the family.

Methods. The study included 20 patients and their families. The consultations that were conducted with each of the families constituted data for the presented research. Initial results indicate an explicit association between the way the patient and his or her family define circumstances of the illness and treatment and the type of interactions between them that are manifested verbally and nonverbally.

Results. Results of qualitative analysis indicate that if a patient during consultation reflects on how to describe his or her situation and precipitating factors of the illness, it usually takes place in opposition to other members of the family of origin. On the other hand, if a patient manifests depressive symptoms, he or she assumes a dependent role, while the rest of the family express an attitude of warmth towards him or her.

Conclusions. Drug-resistant depression should be considered, also with the context of the patient's family.

Key words: drug-resistant depression, interpersonal communication, discourse

The study was not sponsored.

Introduction

It is estimated that about one third of depressive patients do not improve symptomatically after treatment with the first antidepressant. Patients, with whom consecutive pharmacological treatment strategies do not lead to symptom remission or whose improvement is insufficient, are diagnosed with so-called drug-resistant or treatment--resistant depression (TRD) [1, 2]. However, biological treatment is not the only element in the treatment of depression. Pharmacological and non-pharmacological methods of treatment, that are a standard of care are most clearly characterised by the ABCD scheme, where "A" stands for adequacy of treatment, "B" for behavioural reinforcers of depressive symptoms, "C" for treatment compliance, and "D" for diagnosis, including comorbidity with other psychiatric and somatic disorders that may exacerbate the course of the depressive episode or complicate the treatment [1].

Research on insufficient effects of treatment of depression has been concerned with compliance in the therapeutic process [3] as well as comorbid anxiety disorders, suicide risk, melancholic features of depression and lack of response to the first antidepressant, personality disorders, history of multiple hospitalisations, psychoactive substance abuse, disturbed social functioning, inadequate social support, and negative social interactions [4–8].

Among studies of psychosocial factors influencing the course of depressive disorders, the most prominent are those that focus on patients' familial environment. The Index of Expressed Emotion (IEE), described in the 1960's as an important predicting factor of recurrence of schizophrenic symptoms [9], was proved to be important in the course of depression. Although high IEE in relatives of patients, expressed by controlling behaviours towards patients – a predictor of recurrence in cases of schizophrenia – was not associated with recurrence in cases of depression [10], however, it turned out that significant involvement of a relative in depressive symptoms of the patient delay accepting depression by the relatives, leading to increasing problems in family functioning [11]. Furthermore, studies that used 5MSS (5-Minute Speech Sample, a simple method that allows to assess the level of Expressed Emotions, EE) as a research tool, showed that the higher the level of EE in the family, the more often suicidal ideation occurs among teenagers with bipolar depression [12]. Research on families with one depressive parent indicate significant differences in the level of EE in relationships, compared with the control group. Their results show that less expressed emotions are associated with less satisfaction with marital relationship and more frequent expression of negative emotions. In addition, low level of EE was also associated with more negative relationship patterns rooted in the partners' childhood experiences [13]. These results have a practical dimension: the effect of systemic couple therapy may lower the IEE.

Research that focused on functioning of depressive patients in their partner relationships is also worth mentioning. Marital stress has been identified as a predicting factor of depression [14]. Longitudinal research conducted by Peterson-Poat et al. [15] show that better marital fit and lower criticism between spouses are significant factors that prevent depression. Perceiving depression as determined by biological factors is

significantly correlated with intensity of symptoms and intensity of the burden in the partner [16]. The partner's infidelity and risk of separation proved to increase six fold the risk of depression in women [17].

Taking into consideration the morbidity rate of drug-resistant depression with an unidentified mechanism of treatment-resistance, as well as the significant number of studies indicating the role of family environment in the course of depressive disorders, it seems justified to conduct further research in this direction. From a systemic point of view, it seems particularly important to establish the function of treatment-resistant depression in the family.

Aim

The aim of the study was to find elements of family dynamics that are connected with depression and with treatment resistance.

Material and methods

The starting point was a family consultation that was the source of data for the study. The consultations, conducted by consultants who were not directly involved in the treatment, were one and a half hour sessions with participation of all members of the family, including the index patients. The consultations were aimed at assessing particular elements of the family process and phenomena of intrafamilial dynamics. In particular, the aim of the study was to determine the function of depression of one of the family members, in the family homeostasis. In order to acquire in-depth data, both qualitative and quantitative methodology was adopted [18]. Thus, the study had an explorative character.

Table 1. **Characteristics of the study group**

No	Sex of the IP	Diagnosis	Participants of the consultation
1.	F	Dysthymia (F34.1)	Mother, Father, Sister
2.	F	Mixed and other personality disorders (F61)	Mother, Father
3.	F	Dysthymia (F34.1)	Daughter
4.	F	BD (F31)	Partner (M)
5.	F	BD (F31)	Partner (M)
6.	F	BD (F31)	Partner (M)
7.	F	D (F33)	Partner (M)
8.	M	BD (F31)	Partner (F), Mother, Father
9.	M	Dysthymia (F34.1)	Mother, Father
10.	F	BD (F31)	Partner (M), Daughter

table continued on the next page

11.	F	D (F33)	Daughter, 2 Sons
12.	F	D (F33)	Partner (M), Daughter, Son
13.	F	D (F33)	Partner (M), Son
14.	M	D (F33)	Partner (M), Sister, Mother
15.	M	D (F33)	Partner (F)
16.	M	D (F33)	Partner (F), Mother, Father
17.	M	D (F33)	Partner (F), 2 Son
18.	F	D (F33)	Partner (M)
19.	M	D (F33)	Partner (M), Daughter, Son
20.	F	D (F33)	Partner (M)

IP– index patient

Initial qualitative analysis of family consultations

The study was conducted as a cooperation between two research centres, one being an inpatient unit for affective disorders and the other, an outpatient family therapy unit. The inpatients were asked to participate, with their family members, a family consultation during their hospitalisation.

In the first stage of the study 10 consultations with families of patients diagnosed with treatment-resistant depression were video recorded and the recordings were analysed during the initial thematic analysis [19]. In this way, the main themes and categories of the consultation emerged for further analysis. In particular, dominating discourses (language) were selected, i.e. modes of discourse that were used by particular members of the family and the patient to refer to the problem. In this way, the following discourses emerged: interpersonal (relational) discourse, intrapsychic (inner) discourse, medical discourse and socioeconomic discourse. The second group of categories discerned in the initial analysis were attitudes towards the patient expressed overtly, verbally. They were: warmth, hostility, overinvolvement, cut-off, and skewness. The first three categories were established following those of the Expressed Emotion Theory [9]. The categories were used to construct a Questionnaire of Observation of Family Consultation (Kwestionariusz Oceny Konsultacji Rodzinnej, KOKR). In the questionnaire both verbal and nonverbal behaviours between patient and family members, were marked. It also included open-ended questions about verbally expressed experiences of particular persons.

With the use of the questionnaire, constructed during the initial stage of the study, 20 families were assessed during the next stage. These families form the study group presented here. The assessments were made by observers (family therapists in their last year of family therapy training or after the training). Because two groups of items

of the Questionnaire KOKR were open questions (nonverbal behaviours and verbally expressed emotions), descriptions of behaviours obtained in this way required further categorisation by thematic analysis [19]. It was done by five family therapists, whose task was initial coding (categorising) of statements of particular family members. Using comparative analysis they defined common themes, which became the main research categories. As a result of this analysis, two groups of categories emerged. The first group referred to nonverbal behaviours and included such categories as: towards others, away from others, towards some members, inwards, inhibition, expression, towards the IP (index patient), away from the IP. The second group of categories referred to the verbal description of experiences. In this group the following subcategories were defined: helplessness, cut-off from emotions, expression of suffering, emotions aimed at the IP, lack of will, energy and initiative.

After this stage of analysis, the emerged categories were used in quantitative analysis.

Results

Quantitative analysis

Due to the low variance of most of the variables, interactive models could not be identified. For this reason, only regressions with one or more predictor variables, but without interactions were fitted. Initial analyses showed that data for patients' partners can have different interdependencies with other variables than data for the other members of the family (e.g. mother, father, siblings, children). As a result, additional variables were introduced by comparing the average values for the whole family, for the partner and for the family with the exclusion of the partner. Due to the nature of the research questions, the dependent variables in the analyses were variables in the category referring to description of experiences and types of discourses, and the independent variables were types of attitudes and types of nonverbal behaviours.

After considering the level of statistical significance in the quantitative analysis, the following research categories emerged:

1. Discourse: type of the dominating language and vocabulary, used by a particular person during the family consultation, with reference to the nature of the IP's problems. Three types of discourses were defined:
   - Interpersonal, in which dominated notions that referred to relationships between family members or other significant persons for the family system. For example, a comment by an IP's wife: "I do everything for the better, and he says it's getting worse – I feel guilty." A comment of a mother: "I didn't leave him without attendance. I didn't oversee anything." A comment of a wife: "I don't give such support to my husband as he gives to me."
   - Intrapsychic, in which dominated notions referring to inner experiences of a particular member of the family and of the IP. For example, a comment of a patient: "I'm in such a phase that I've surrendered." A comment of an IP's wife: "He tried to take his life to stop feeling anxious." A comment of an IP's

son: "It started during the trip. He was afraid that someone will be after him, want something from him. Faith in oneself may be helpful, overcoming oneself, getting too much involved leads to illness."
- Medical, in which dominated medical vocabulary in descriptions of phenomena and correlations. For example, an IP said: "Sometimes I think that I am disabled because my brain ventricles are widened." A comment of an IP's wife: "He received such medication that it made him lie down completely." A comment of an IP: "The true cause of my illness was incorrect delivery." A comment of an IP's father: "One has to find a quick solution, so we are seeking the ECT."

2. Nonverbal behaviours: a type of nonverbal behaviours occuring during the consultation. Three characteristic types of nonverbal behaviours emerged:
   - "Away from others", which meant avoiding relating with others during the consultation by not referring to verbal and nonverbal behaviours;
   - "Inwards", which meant that nonverbal behaviours were associated with expressing oneself (moving during speech, looking around the room) without nonverbal behaviours that demonstrated any interaction with others (e.g. looking towards other participants of the consultation);
   - Inhibition, which meant having a fixed posture and facial expression throughout the conversation.
3. Verbal behaviours of members of the family towrds the IP.

Four main types of behaviours of family members towards the patient were observed: warmth, hostility, overinvolvement, cut-off.

Discussion

The first group of results refers to types of discourses about illness and being ill: intepersonal, intrapsychic, and medical discourse, that are associated with particular kinds of experiences and behaviours identified among members of the family.

1. Interpersonal discourse on the part of the IP was negatively correlated with the attitude of warmth on the part of the whole family ($r = -0.53$; $p = 0.04$). In families, in which patients depicted their illness in relational categories, lower expression of positive emotions was observed in the family. In other words, the more directly the family speaks about relationships between each other, the less they express the attitude of warmth.

2a. Intrapsychic discourse on the part of the IP proved to be negatively correlated with nonverbal behaviours "away from others" on the part of the whole family ($r = -0.56$; $p = 0.04$). If the patient connects his or her illness with inner experiences, members of the family show less nonverbal cut-off, i.e withdrawing behaviours. In other words, the more a patient is inclined to depict his or her illness in categories of inner experiences, the less other members of the family are withdrawn from each other.

2b. In case of the variable intrapsychic discourse on the part of the patient, a negative correlation with inhibition of the patient was observed ($r = -0.49$; $p = 0.03$), but

a positive correlation with inhibition of other members of the family ($r = 0.43$; $p = 0.02$) and the partner ($r = 0.50$; $p = 0.03$). It means that if patients perceive their illness in categories of inner experiences, they manifest less inhibition and more openness during the session, and the family and the partner manifest more inhibition. (Inhibition is understood as remaining passive verbally and nonverbally during the session. This variable can be referred to individual features of particular persons).

2c. Intrapsychic discourse on the part of the patient proved to be positively correlated with the cut-off on the part of the patient ($r = 0.70$; $p = 0.02$), but negatively correlated with the cut-off on the part of the family members, excluding the partner ($r = -0.83$; $p = 0.01$). It means that if patients perceive their illnes in categories of inner experiences, they are cut off more from members of their families, while the other members of the family are cut off less from each other. Patients' partners behave differently, that is they are cut off more, just like patients. (Cut-off is an interpersonal variable that involves active cutting off from others, both verbally and nonverbally).

3a. Medical discourse on the part of the patient proved to be positively correlated with the attitude of hostility on the part of family members towards the patient ($r = 0.85$; $p < 0.001$). In other words, in families in which patients treat their illness mainly in medical terms (key words such as: medications and symptoms), a greater expression of hostility between family members towards the patient was observed.

3b. Medical discourse on the part of the patient was negatively correlated with the attitude of overinvolvement on the part of the patient ($r = -0.40$; $p = 0.03$) and the partner ($r = -0.78$; $p = 0.003$). It means that patients, who treat their illness in medical terms, are less involved in family relationships. Also their partners are less involved in family relationships.

The second group of results refers to variables that have to do with manifestations, by particular family members, of emotional states associated with the patient's illness.

4. Cut-off from emotions on the part of the patient was positively correlated with nonverbal behaviours "inwards" on the part of the family ($r = 0.57$; $p = 0.03$) and the partner ($r = 0.67$; $p = 0.04$). In other words, in families of patients who did not express emotions, the other members of the family, including partners, manifested nonverbally signs of being shut and a lack of reaction to verbal and nonverbal behaviours of the other participants of the consultation.

5. Lack of will, energy and initiative on the part of the patient was positively correlated with the attitude of warmth manifested by the family ($r = 0.67$; $p = 0.01$) and the partner ($r = 0.95$; $p = 0.003$). In other words, in families of patients who manifested symptoms typical of depression, such as lack of will, energy and initiative, an attitude of warmth on the part of all members of the family, including the partners, was observed during the consultation.

Conclusions

The presented results refer to recurrent patterns of interactions between members of the studied families. They indicate that, according to the perspective of social constructionism, there is an interdependence between the way depression is perceived by the family (the way it is "conceptualised") and the interactions in the family [20, 21]. In case of depressive disorders, it seems particularly important because there are significant differences in social, medical, and life circumstances for the patient and his or her family, depending on how the problem is verbalised (e.g. in terms of "sadness" or "depressive illness"). Domination of medical discourse in the family will mean transferring responsibility for the depressed member to medical staff. It has been confirmed by data referred to in paragraphs 3a, 3b, and 4, which allows to draw a conclusion that adopting medical discourse may be associated with venting emotions by the family (including negative emotions) and a sort of "de-involvement". It may mean transferring the responsibility for the fate of the patient to a psychiatrist (or psychiatrists) and – in extreme cases – "psychiatrisation" of sadness [22]. It is intriguing that in families, in which patients treat their illness mainly in medical terms, there was a greater expression of hostility and a lesser attitude of caring towards the patient. From the systemic point of view we may consider a bilateral direction of this relationship, which allows to ask a question, to what extent experiencing hostility and a lack of care in the family makes a patient inclined to give him or herself over to "the care" of psychiatry and deny any relational or intrapsychic aspects of his or her experiences.

Another result worth noting is the fact that signs of lack of will, energy and initiative on the part of the patient turned out to be positively correlated with a manifested attitude of warmth among the family. It may be interpreted that signs of depressiveness in the patient, associated with his or her helplessness, adopting a role of a child in the family, provoke other members of the family to assume an attitude of warmth towards him or her. We may say that thanks to manifesting his or her helplessnes, the patient gains warmth from relatives. On the other hand, signs of activeness on the part of the patient, which was manifested during the consultation by searching for understanding of his or her own illness, create a distance in other members of the family.

Interpersonal discourse on the part of the patient was also negatively correlated with the attitude of warmth in the family. It means that if patients refer to relationships in the family and try to describe their illness in relational terms, they lose what they could gain through a passive attitude and manifesting their depressiveness, i.e. an attitude of warmth from relatives. In other words, treating symptoms as elements of intrafamilial interactions "cools down" the relationships and – in a sense – "does not pay off" for the family. This phenomenon may be conceived in terms of disturbing the familial homeostasis [23], since associating depression with familial relationships induces anxiety and disturbs the fixed order in the family.

Relationships between intrapsychic discourse on the patient's part and other factors seem to be more complex. The negative correlation with inhibition of the patient, and positive correlation with inhibition of other members of the family, including the partner, may signify that activeness of the patient during the consultation, manifested

by revealing his or her inner experiences and searching for explanations of depression in terms of these experiences, is connected with decreased activeness of other members of the family during the session. It seems to show that in such families the patient and his illness become a central theme. It may be concluded that if patients during the consultation in any way (through various discourses) seek understanding of their illness, it usually takes place in opposition to members of their family of origin. They may be attempting in this way to differentiate themmselves, by cutting off from the relatives, sometimes evoking their hostility and lack of empathy, and sometimes their inhibition. On the other hand, in a situation where they manifest depressive symptoms, expressing helplessness, they adopt a dependent role and the other members of the family express an attitude of warmth towards them in return. Of course, from the systemic point of view, it is difficult to say where in these interactions is a cause and where an effect. These phenomena should be understood as loops of feedback or reciprocal behaviours.

Limitations of the study

The above conclusions are drawn on the grounds of an observation of behaviours that take place during a family consultation. It remains an open question to what extent these phenomena may be generalised to familial interactions in everyday life. Although it seems reasonable to assume that a family consultation to some extent reflects phenomena of everyday life, the multitude of variables, dynamics of familial process and influence of the context (a conversation taking place in the presence of and with "experts" in a psychitric institution) suggest caution in drawing any conclusions. Notwithstanding of the content of the ultimate conclusions, it was shown that what is taking place in the family of a hospitalised psychiatric patient finds a vivid response in intrafamilial processes. It is not yet the stage of the study where it could be unambiguously concluded what sort of family "wants to retain depression" and when effective treatment of depression seems "favourable". However, the results allow to get nearer to understanding of these implicit phenomena. The most probable hypothesis is that we are dealing with multiple processes, often contradicting each other (e.g. with a tendency to take responsibility for helping the depressed relative and a tendency to transfer responsibility to a psychiatrist).

Some doubts may be raised due to the high values of many observed correlations (e.g. $|r| > 0.6$), particularly because all variables assumed only a few possible values. It seems that such high correlations may result from the fact that assessments in various dimensions were done by the same persons and in case of variables that had strong semantic associations, the similarity of meanings may have led to relatively high correlations.

We did not use the Bonferroni's corrections, because the results of the stepwise regression analyses performed were far from being independent [24][1].

[1] It would be advisable in the case of such a large number of models of regression to be tested, to use some sort of correction for multiple comparisons. However, the only universal solution of this sort – Bonferroni's correction – assumes that tests ought to be independent, and in case of a large number of models of regression, matching one model allows to predict matching of other similar models and therefore independence of tests is not possible even in approximation.

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