

Case Report

EFFECT OF FAMILY DYNAMICS ON MENTAL HEALTH: A CASE REPORT

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ABSTRACT

A mental illness disrupts the atmosphere, not only of the individual, but of the whole family, not only emotionally, but also socially and financially. An attempt is made, through this case report, to understand family dynamics and the effects it has on carers and care receivers.

Keywords: *Family Dynamics, Mental Health, Effect on Carers*

INTRODUCTION

Depression is estimated to become the second leading cause of disease burden and the major cause of disability worldwide by 2020 (Robinson *et al.*, 2008). With rates of mental health problems on the rise, there is a need for the understanding of the role of family dynamics in an individuals' mental structuring and the problems faced by carers in caring for their loved ones. This case report aims at understanding the various stressors faced by carers of patients with manic-bipolar disorders.

CASES

A 30 year old man, well oriented to time, place and person with adequate insight and judgment, came with depressed mood, decreased sleep, early morning awakening, decreased concentration at work, decreased interest in his hobby of golfing and decreased energy for the past few months. He never had these episodes before nor did he report any evidence of manic symptoms in his past or social history. There were no sudden changes in his work pattern or recent tragedies.

He had been newly married since six months. He indicated that his wife had a few spells of labile mood and rapid speech which he could differentiate from her speech on other days. During these spells, he would end up spending increased time caring for her rather than at work. This was having a toll on his professional life and it seemed to have worn him to the point of frustration leading to signs of major depression.

His wife was eventually diagnosed and treated for mania with Lithium and he was given minimal doses of Fluoxetine for 6 weeks. Eventually, after 6 weeks, there was a definitive elation in his mood and abatement of his wife's manic symptoms. The man showed signs of depression because of frustrations from putting up with his wife's manic symptoms. Once identified, they were properly followed up with appropriate medications and family counselors.

DISCUSSION

Mental illness often has a ripple effect on families, creating tension, uncertainty, troubled emotions and big changes in how people live their lives. Different family members are likely to be affected in different ways. These effects on the family are sometimes not acknowledged adequately by health professionals. In the present era of long working hours, the strength of their already strained emotional lives are tested to the core. With feeble social support, there tends to be increased morbidities owing to mental ailments.

Mental disorders are also found to be linked with a range of adverse social outcomes, including marital dissatisfaction and the likelihood of marital breakdown. This makes it all the more important to understand the role society and family play in shaping the mental health of an individual.

The social class position and mobility have been documented to be associated with social and psychodynamic factors in the development of mental illnesses in a study done on fifty patients and their families by Roberts and Myers in Oxford, England (1959).

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There are two ways for early diagnosis of concealed mental ailments in families: the family history method (obtaining information from the patient or a relative concerning all family members), and the family study method (interviewing directly as many relatives as possible concerning their own present or past symptomatology).

A study comparing the two techniques showed that the family study method is preferred since information is likely to be more accurate. The family history method leads to significant underreporting (Andreasen *et al.*, 1977).

A large study in Edmonton, Canada used standardized interviews to assess lifetime psychiatric history in 519 pairs of spouses and reported significant associations between diagnosed disorder in one spouse and diagnoses in the other (Galbaud *et al.*, 1998). The associations were found for different types of disorders as well as for the same diagnoses in couples. For example, major depression was about twice as common in spouses whose partner had major depression compared with those whose partner did not have this diagnosis; and alcohol abuse or dependence was about three times as likely when a spouse had alcohol dependence. Instances where associations were found for different diagnoses included higher rates of major depression, phobia, PTSD, and alcohol and drug use disorders in wives if their husband had antisocial personality disorder. Husbands showed similar increased likelihood of disorders (except for major depression) if their wives had antisocial personality disorder. These findings were broadly similar to an earlier study conducted in Detroit that used a more limited range of diagnostic categories (McLeod, 1995).

A number of different explanations have been suggested for this co-occurrence (often called Spousal Concordance) (Robinson *et al.*, 2008):

■ **Assortative Mating:** The latest theory is that people marry partners who are similar to themselves, and this could apply either to mental health problems or to other characteristics which put people at risk of mental health problems in the future;

■ Spouses have similar environments and experiences (e.g., life events) after marriage and these contribute to the similarity in their mental health. An example of how similar life events (or the same single event) can impact a couple was shown in a Finnish study of major depression in spouses (Lindeman *et al.*, 2002). Recent bereavement was very common (48%) in couples where both had experienced major depressive episode in the past year compared with couples where only one partner had been depressed (13%).

■ Mental health problems in one spouse affecting the mental health of their partner may be due to difficulties in their relationship, through any consequences on their economic or living conditions, or as a direct consequence of one spouse having to care for the other.

In the HILDA Survey, the similarity in a couple's mental health was greater in accordance with the length of time they had been living together, up to about five years. In an AFRC issue, out of 8 couples 4 partner's experienced mental health problems including violence, and sexual and psychological abuse, and more common forms of negative marital interactions involving hostility, threats, overt and covert criticism, betrayal and disappointments (Beach *et al.*, 1998).

Such inextricable associations between mental health and marital relationships are reflected in the application of marital therapy in the treatment of depression and other mental health problems. A recent Cochrane Review (Barbato and D'Avanzo, 2006) indicated that whilst there is currently no evidence to suggest that marital therapy is more or less effective than individual psychotherapy or drug therapy in addressing depression, there may be improvements in the relations of depressed couples.

Objective stressors include the patient's physical disabilities, cognitive impairment, and problem behaviors, as well as the type and intensity of care provided. In caregivers, these objective stressors lead to psychological stress and impaired health behaviors, which stimulate physiologic responses resulting in illness and mortality (Vitaliano *et al.*, 2003). The effects on the caregiver's health are moderated by individual differences in resources and vulnerabilities, such as socioeconomic status, prior health status, and level of social support (Schulz and Sherwood, 2008).

Tables 1 summarize the physical and mental health effects reported in the caregivers over the past three decades (Schulz and Sherwood, 2008).

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Table 1: Physical and mental effects of caregiving on carers adopted from Schulz and Sherwood (2008)

Measure	Specific Indicators
Depression	Clinical diagnosis Symptom checklists Antidepressant medication use
Anxiety	Clinical diagnosis Symptom checklists Anxiolytic medication use
Stress	Burden
Subjective well-being	Global self-ratings Global quality-of-life ratings
Positive aspects of caregiving	Self-ratings
Self-efficacy	Self-ratings

Another study describing transitions over 5 years among community-dwelling elderly spouses into and within caregiving roles and associated health outcomes suggested that only half (49.5%) of non-caregivers at baseline remained non-caregivers at 5-year follow-up. The remainder experienced one or more transitions, including moving into the caregiving role, their own or their spouse's death, or placement of their spouse in a long-term care facility. The trajectory of health outcomes associated with caregiving was generally downward. Those who transitioned to heavy caregiving had more symptoms of depression, and poorer self-reported health and health behaviors (Burton *et al.*, 2003).

Transitioning into a carer role appears to be a key point at which early intervention may assist the carer's role adjustment. Marks *et al.*, found that both men and women experienced a greater increase in depression and decline in happiness, compared to non-caregivers, when transitioning into spouse care (Marks *et al.*, 2002). Spouse care is likely to incorporate important medical and life decisions, and any existing marital disagreement may make this even more difficult, leading to further distress and demoralization for the carer (Marks *et al.*, 2002).

Conclusion

Caregiving plays a major role in social support and early recovery of mental illnesses. Giving due importance to caregivers' health and relevant conditions is also a major portion of this clinical picture, considering carers are humans too and are fairly at increased risks of frustrations and stress. In fact, caregiving fits the formula for chronic stress so well that it is used as a model for studying the health effects of chronic stress (Vitaliano *et al.*, 2003). The take home message is that all patients should be interviewed about their social circumstances to diagnose occult familial conditions that may be leading to their presenting symptoms and all carers should be given due credit and equal empathy as for patients.

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