

Family relationship and systemic intervention for depression

Camillo Loriedo¹⁻²

Here we examine the interpersonal relations of the depressed patient, by evaluating the existent literature and basing on our clinical experience in applying relational-systemic therapy.

In the marital relation of the depressed person we can identify few typical relational patterns such the “*care eliciting behavior*”, the *helping relation*, and the *incongruous marital hierarchy*.

Family system lacks of internal interactive exchanges, that are also impoverished towards external world.

We discuss about the highly frequent observation of parents with affective disorders and suggest hypothesis on family dynamics of depression.

We finally propose few guidelines on the principles of relational intervention in depression.

¹ Director of the “Istituto Italiano di Psicoterapia relazionale”, Rome, Italy.

² Professor at the University “La Sapienza” Rome, Italy

Family relations and depression

Back in “Mourning and Melancholy” Freud already noted the relational aspect of depression: “Carefully listening to the myriads of self-accusing of the melancholic, we cannot doubt the impression that instead referring to himself they rather refer to people that the patient loves, has loved or should love”.

Generally speaking, the analysis of current literature points toward the couple relation as a privileged environment for expressing a depressive symptomatology.

Depression in the couple

Janowsky et al., observing psychotherapeutic sessions, say: “Spouse’s sentiments toward depressed partner are a mix of anger for the dependency established between them, sympathy for the pain suffered by the patient, and occasionally guilt for feeling personally responsible for his depression ... The “healthy” partner, in addition to anger and guilt, feels a sentiment of superiority, almightiness and high self esteem, aware of being important and essential for the satisfaction of the partner’s needs”.

Cadoret et al., and Schless found the depressed person to be highly *susceptible to the stress coming from marital life*.

Friedman conducted a research on 196 patients, aged 21-67 years, with diagnosis of reactive depression, psychotic depression and maniacal-depressive psychosis. He found a high correlation between depressive disorder and marital conflicts, often leading to a break-up of the relation.

The Author speculates that the conflict *i*) precedes or predisposes the depressive episode, or that *ii*) is a consequence of it, or *iii*) that is enhanced and exasperated by the depressive episode.

According to the Author, some personal tendencies of both partners might auto-reinforce up to maintain depressive symptomatology.

Hincliffe, Hooper and Roberts, support the idea that marriage has a protective function regarding many psychopathologies. However this protection would not be effective in the case of depression, a highly frequent disorder among married couples.

Hautzinger et al., basing on the assumption of depression as the result of a distorted communication between partners, analyzed 63 conflictual couples. Thirteen couples had a partner suffering of serious unipolar depressive disorder. They were compared with thirteen couples in which none presented depressive symptoms.

The Authors found significant differences between the groups in the communicative models: in the “non-depressed” couples communication was overall positive, with attitudes to comprehension and to reciprocal exchange. On the contrary, the “depressed” couples showed negativity, discordance and asymmetry. The non-depressed partner of these couples showed a tendency toward expression of positive moods and good self esteem, being at the same time very exigent with the partner and expressing negative opinions on him.

Depressed partners defined themselves and their future negatively but judged positively their partner or their relation, justifying their disapproval behavior.

The Authors hold the idea that the differences observed in the communicative models develop as a result of depression beginning or after first depressive episode.

Matussek and Feil pointed out that episodes of neurotic depression are usually correlated to critical situations in the marital life, whereas endogenous forms of depression appear in apparently “undamaged” marital relations.

Hooley analyzed marital relations in depression using the Emotional Expression Evaluation protocol founding high levels of *negative affect expression* and a *relative lack of support and positive communications*.

In Haas and Clarkin’s analysis emerges the protective value of intimate relations against depressive disorders, but at the same time Authors underline the relevant lack of assistance attitude, support, and intimacy expression as a usual pattern in couples with a depressed partner.

Many studies (Feldman; Friedman; Hautzinger et al.; Coyne; Hincliffe et al.) identify a typical sequence in which an initial, and not necessarily serious, depressive episode is followed by a reinforcing behavior adopted by the healthy partner. Reinforcement is itself enhanced by more serious other episodes of depression. In our experience we recognized this pattern together with other modalities that we describe in the following paragraph.

Communicative patterns

In depression we observed a high occurrence of two communicative patterns: disqualification and paradoxical messages. These communicative patterns have been identified, as everybody knows, in families with a schizophrenic index-patient, but in depression they hold some peculiar attributes.

Disqualification. It is a communicative pattern tending to deprive or diminish the value of a previous communicative act.

Disqualification can deprive or diminish the value of a communication or of an entire situation. In concrete terms, through disqualification it is declared that the communicative acts of the transmitter, of the receiver, or the qualities of the context, have small value or worthless.

Disqualification can regard the totality or only a part of the messages emitted in a given relation, producing different pragmatic effects that influence the quality and intensity of emotional response to it.

Disqualification is the predominant communicative pattern in the couple relation. We face a particular kind of disqualification. In depression it is unlike to find the well-known “incongruent disqualification”, that is very common in families with a schizophrenic member, and that is based on expressive incongruence of contrasting messages that are contemporary sent in different communicative channels.

The peculiar kind of disqualification that occurs between the depressed person and his partner is the so-called “sequential disqualification”, in which two contrasting assertions are sequentially contained in the same verbal message. Since the messages are held at the same level or even share the same channel, it is much harder to identify what is the truth or what is declared.

An example of this modality is the classical remark of the wife facing a timorous husband: “Do you really think that I would stay with such an impotent as you if I did not appraise you?”. In practice, the partner of the depressed person tends to explicitly express him both approval and disapproval, not reaching, however, the ambiguity intensity of the schizophrenic communication.

Paradoxical messages. Within couple relation the depressed person often receives from the partner a specific paradoxical message that invites him to make proposals (“You have to make proposal”), or more frequently reproaches because he/she does not make proposal (“You never take initiatives”). This kind of message put the depressed person in the undecidable position of being proponent only when he does not make proposals and being passive only when he does.

Even in this case the depressed person does not only receive the paradoxical message, but confirms by his response the behavior of the partner. The response, as much paradoxical, that permits to the depressed person only to assume the initiative to avoiding taking initiatives, is: “Tell me what to do”.

Relational patterns

In our clinical observation, we found some redundant patterns that qualify themselves as models of relation.

The “Care Eliciting Behavior”. Henderson describes the “care eliciting behavior” as the system of behaviors that an individual acts to evoke in others relief and reassurance responses. These responses assume the form of physical and emotional proximity, and are communicated toward verbal and non-verbal behaviors indicating esteem and affect.

The “care eliciting behavior” is a physiologic behavior in children and in few situations of adult life (disease, loss, stressing events, et cetera) in which proximity and consolation is very important.

During depression the care eliciting behavior is particularly evident and exasperated. Usually it keeps on during the whole depressive phase, and in some cases longer, evoking consolatory and reassurance interventions from the others, especially from the partner.

The Helping Relation. The “Care Eliciting Behavior” induces in the couple relation a strong emphasis on the official designation as “patient” of one of the partners, in contrast to the strong rejection of the partner to frankly recognize on himself any form of weakness or pathology. These rigid positions give rise to the typical “Helping Relation”, in which the partner seems to dedicate all his energies to assist the other (“Care Giving Behavior”).

The Benevolent Severity. The provided help is often enclosed in a severity approach that occasionally becomes punitive. However, these attitudes are defined as a proof of affect: “If I punish you, it means I love you”).

The Victory of the Defeated and the Incongruous Marital Hierarchy. The power in the relation is easily recognized to belong to the healthy partner, that in practice dominates in every situation, furthermore appearing hyper-competent. The only exception to this unchallenged supremacy is the symptomatic behavior, that is uncontrollable.

Depression represents then the Victory of the Defeated, the only reality in which the depressed partner has his supremacy.

From this comes a sort of Incongruous Marital Hierarchy, in Madanes’s words, in which both partners are *weak and strong at the same time*. The illness becomes a source of power in the relation for the depressed person, but also a blatant demonstration of his weakness.

The spouse, on the other hand, apparently holds a supremacy position, but his constant failures to change the partner hold him in an inferiority position.

The Interactive Cycle of Depression. The attempts to solve the depression by the healthy partner become more and more onerous because he feels the loss and the impotence as unacceptable states. Apathy, sadness and passivity of the spouse become for the healthy partner a challenge: any failed attempt to modify the situation becomes a new reason to intensify the efforts, any failure reactivates the helping relation.

Coney has described this pattern as *Interactive Dead Point*. In our opinion we are facing a real interactive cycle in which, starting from a first depressive behavior consistent in a "care eliciting behavior", the partner responds with a "care giving behavior", generally producing none resolutive effect, and these failures lead the healthy partner to a transitory separation that increase itself depression and "care eliciting behavior", and so on. These cycles are over and over repeated during depressive episodes.

The Yielding Partner. In one fifth of the cases we observed a different communicative model, in which the healthy partner does not play a supremacy role but seems on the contrary very yielding, giving no chance to be criticized by the depressed person for his behavior.

In one of this cases the depressed wife complained about egoistic behavior of the husband. They spent first day of honeymoon watching the national soccer team on TV. When she was near her time he took her to hospital and, notwithstanding the throes of childbirth, forced her to wait in the car until midnight to pay one day less in the parking.

When facing these and others complaining the husband was never defeating himself but always answering with a humble tone: "Forgive me, dear, but you know, that's me. Unfortunately I'm a superficial person and cannot realize such things ...".

The depressed person counteracts such a disarming ability of self-accusing only by blaming himself more and more.

Depression in the family system

As we have already noted, depressive outcomes have a strong effect on the couple; this is probably the reason why the majority of studies have focused on marital relation.

Since few years, however, it has become frequent to use the term "depressive system".

Senay, the first to apply to depression the General Theory of Systems, considers the depression as a process that takes place in those systems that are unable to react adequately (to maintain an internal homeostasis) to changes coming from the external reality (loss, stress). However, he does not consider interpersonal systems, but only refers to the individual and to his internal homeostatic processes.

On the other hand, Feldman refers to interpersonal systems but limiting his consideration to the couple, and holds the opposite opinion: in the depression, homeostatic mechanisms are hyper-active in voiding any external interference.

Boszormenyi-Nagy and Spark, pointing to the fact that a son's depression is often neglected within a family system, support a relation between depressive symptomatology of the index-patient and the effort to take on himself the affliction of the parents that deny the its presence.

Stierlin et al. describe the *Restricted Complementariness* in which spouses are involved, also embroiling the children. Such complementariness is characterized by the tendency of one of the partner toward a depressive tendency. These position might be very stable in time or (less often) fluctuate between one role to the other within the couple.

Sons play a role, involved by parents or as a personal choice, and take part in the restricted complementariness, with the effect that each member of the family only develops restricted aspects of his personality, delegating the others to the other members of the family.

The “Almost Therapeutic” Competence. The Hoffman’s description of this family modality corresponds to the efficacious analogy of “the sleeping giant annoyed by the midge”. According to Hoffman, these are disorganized and disengaged families in which once the mother (or the father) get depressed, sons act aggressive behavior that leads the parent to come out of his depressive apathy in the attempt to stop their aggression. As soon as sons stop their aggressive behavior the parent falls depressed again and the cycle repeats.

In our experience Hoffman’s observation are, at least partially, confirmed. Indeed in the depressed person family system, internal exchanges are highly reduced and often only limited to punishments and reprimands. However, as far as we know, such methods are hardly effective and failures enhance the inadequacy feeling of the depressed parent.

Unlike the typical disengaged family, that of the depressed person shows not very permeable borders toward the external world. The healthy partner occasionally cultivates friendships, in which he reintroduce the same parental attitude establishing helping relations.

The index-patient only cultivates superficial relations with those who pose a reassuring attitude toward him.

However, in some cases the depressed person shows unbelievable therapeutic abilities, even leaving all his problems to take care of those of others.

A depressed mother interrupts her apathy to help the daughter that was passing through a serious marital crisis; a lawyer, almost at the point of resigning from his job, overcomes this situation by helping a poor chap that had been seriously abused; an old woman forgets her depression to support a friend facing a similar problem. Those are just few examples of the therapeutic vocation of the depressed person.

Billings and Moos’s observations show that the family system of the depressed person is characterized by *less cohesion* and *interpersonal expressivity* comparatively to control groups.

Miklovitz, Goldstein and colleagues found a significant relation between values of the Expressed Emotions (EE) and Affective Style (AS) of families with a depressed member and the occurrence of depressive episodes. In their study, the family AS level could predict the level on the future adaptation scale.

The Bond with the Origin Family and the Acquisition of Assistance Attitude. In the extended families of both spouses it is not rare to observe affective diseases and is common to find a clear depression. Sometimes in the anamnesis of the depressed person or of his partner there is a alcoholic or toxic dependent parent. Probably it is from these experiences in their own origin family, after a long habit to face with an affective disease, that the depressed person, or his partner, acquire the “almost therapeutic” competence.

The healthy spouse has in general spent not small time in assisting one or more relatives chronically incompetent in providing for themselves.

The Hypothesis of Transgenerational Competition. An interesting aspect of this model is the presence of a competition (usually without winners, because of the absence of results) between the healthy partner and the healthy parent of the depressed person. This competition for being the best assistant is drastically reduced when the son chooses for himself a depressed spouse, to show to the parent that he can do better.

The failure in the project of curing the spouse's depression brings together again the healthy parent and the healthy son.

We can deriviate the suggestive hypothesis, to be further confirmed, that a "depressed marriage" is the result of a transgenerational competition with the parent of the same sex.

This competition, and the behavior and feeling of the depressed person, seem to continuously challenge the abilities and the social competence of others.

Sons: between punishments and therapy. As we noted, in the depressed person's family punitive attitudes toward sons are prevalent.

Punishment is, on one hand usually proposed as a demonstration of affect, on the other hand it represents nothing less than one of the numerous ineffective strategies adopted in these families.

Failing in the relation with his sons increases the sense of defeat of the depressed person. However, his almost therapeutic attitude prevails in the case of illness on one of the sons. The matter is not to maintain the discipline (as Hoffman holds) rather to awakening of the depressed person from his lethargy caused by the symptomatology of one son. In such way, the advent of a symptom in one son can put on the background even serious forms of depression of one of the parents.

The origin families, often conflicting each other, find in the *parental inefficiency* of the depressed person a justification for their intrusive behavior in the education of sons. In this light, the family of the depressed person represents an atypical disengaged system: in the name of necessity and helping need, these families create strange "indirect binds" through sons the sons of index-patient.

The therapeutic intervention

Different models have been proposed to cope with depression: *strategic* (Watzlawick and Coyne; Coyne), *systemic* (Weber and colleagues), and *psychoeducational* (Anderson and colleagues; Clarkin and colleagues). Studies are not so many but enough to have the impression of an increasing interest and application of the relational approach to depression.

In our experience the intervention on the family system of the depressed person revealed to be undoubting effective, at least showing that the previous renouncing attitude to treat such family typology by the most important leaders of systemic approach was unjustified.

The difficulties we faced in our clinical experience persuaded us to take in high account few critical aspects of family therapy.

The fidelity of therapeutic relation.

The links of depressive system with the external world are very limited, often reduced only to giving or receiving help. Indeed the depressed person is considered by relatives and friend as a person who can understand others and give good advises. In a patient worlds: "Nobody can understand my sufferance, because nobody has ever experienced it. On the contrary I understand the feelings of others because I had already experienced that sufferance".

We are not surprised to find out that the relations with physicians and therapists are often the unique links with external world of the depressed person. Indeed, unlike other typologies of family, in these families the relation is quickly established and lasts in time:

the risk of premature interruptions or desertions is virtually absent. However, this fidelity to the therapeutic process hides different traps.

Limiting expectations. A general principle is that of avoiding to create too strong expectations. This principle is as much true as more serious are the conditions of the index-patient. It is often useful to avoid the world therapy and substitute it with less demanding definitions like “attempt”, “support”, or “relief”.

Another principle is that of *limiting the requests only to small changes*: this family system does not tolerate disproportionate changes; furthermore making attempts for big changes contrasts with the immobilist catastrophic ideation that rules these families. Small changes on the contrary do not seem to be threatening and can be gradually amplified in relation to adaptations of the family.

Avoiding reassurances. Towards the index-patient is necessary to check the spontaneous encouraging disposition to he tends to elicit. In other world it is to *avoid the typical helping relation* like the one in which the healthy partner is normally engaged. Another attitude to avoid consists in the attempt to convince the healthy partner to stop the myriads of initiatives that he usually makes to sustain the depressed partner.

Usually the healthy partner expects criticisms to his attempts but he can strongly and rationally motivate his behavior. However he can be caught off balance when the therapist accepts his “care giving behavior” or even invites to *make more* to “give relief” to the spouse.

Avoiding giving tasks to the depressed person. It is necessary to accept as valid the motivations that the depressed stands to explain his state; even inconsistent and futile reasons must be taken in great account and, when possible, should be anticipated by the therapist.

Minimizing the proposed explanations of depressive illness is useless and exacerbates the initial symptomatology.

Other remarking aspects in the brief therapy of depression

We finally wish to point some aspects of the depressive system that are generally less considered.

1) Avoiding neglecting the origin family

Because depression rises almost always in the couple, the origin family might be improperly ignored from the therapist. Indeed depressive episodes rise in the life cycle of a stabilized marital life but, intrinsically, recall an unresolved stage of origin family.

2) Avoiding neglecting sons

There are at least three good reasons to do avoid to make this mistake.

a) When one of the parents is depressed, sons are usually involved in the family dynamics, especially by blaming the parent.

b) Because they represent in the family the most intense space of emotive expression.

c) Because the risk of sons presenting even more serious pathologies is very high.

3) Avoiding to neglect the own-depression of the therapist

Therapist's depression should never be masked, how often happens, behind hypermaniacal attitudes or by showing to be always ready to face any situation. This is a general rule, even more valid in the therapy of depressed persons.

Obviously, it is not a matter of strategically simulating a non-existent depression but rather to utilize as a therapeutic tool the sincere depressive feelings that inevitably the therapist faces when working with this typology of families.