# THE ROLE OF DYSFUNCTIONAL COMMUNICATION INTO THE APPROACH OF DEPRESSIVE DISORDERS

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*Abstract*

**Purpose:** The aim of the present work is to study the implications of dysfunctional communication in depression and the importance of a multidisciplinary approach for patients with depression.

**Methods:** presentation of some explanatory models of depressive disorders in terms of cognitive distortion and communication family systems theory. Presentation and analysis of three case report studies using the above theories.

**Results:** we have identified patterns of a dysfunctional communication, not only in the systemic relationships within the family but also in relation with other systems: social, professional, academic.

**Conclusions:** The paper demonstrates the need for a multidisciplinary approach in case of the depressed patients and the need for focusing the therapeutic intervention on the individual, taking into account the fact that he is in a permanent relation and communication with the family system and the external systems.

**Keywords: depression, family, communication, dysfunctional, multidisciplinary**

## Introduction

What does it mean to be depressed? Being depressed is more than a simple sadness, is when you feel that everything around you is falling apart, is vanishing, it is disappearing into the darkness. When things that made you happy before does not represent anything for you anymore, when everything is useful and full of emptiness. You feel like you lost a war not just a simple battle and you want to give up everything, sometimes even to your own life. Everything and everybody is annoying you, when remembering things is useful because you shall remember only bad and sinful things that you did in the past.

In Psychiatry, Major Depressive Disorder is a debilitating and chronic disease characterized by a broad spectrum of emotional and physical symptoms that coexist during a depressive episode and may reappear at a certain moment. It is believed that in 2020 depression will be the second cause of morbidity on earth after cardiovascular diseases.

Are we able to do enough for a depressed patient with biological treatments or we can do more than that? Today we have a lot of available treatments for depression, but still there are many patients that do not achieve remission that do not feel good, like before the start of the illness. For patients who experience an initial major depressive episode, the probability of experiencing another episode at some point in the future can be as high as 85%. [1] It is now

demonstrated that 15% of patients may have chronic symptoms after the first episode, while 35% may experience recurrent episodes. [2] Remission rates are low for initial antidepressant monotherapy treatment (less than 30%) and partial also known as incomplete or suboptimal response is common. [3] Incomplete response to treatment for MDD is associated with an increased risk of relapse, [4,5] impaired social and occupational functioning, [6] and consequently, an increased economic burden. [7,8]

Strategies adopted for patients with incomplete response to antidepressives include: optimising dose; switching treatment to another antidepressive; combining antidepressives; augmentation of existing treatment with lithium, buspirone, thyroid hormones or an atypical antipsychotic; and combining pharmacotherapy with psychotherapy. [9]

Even when we are using the right dose and the right drug for the patient sometimes the results are not as good as we expected. It is the moment when a psychiatrist begins to wonder. Maybe I am not doing enough for my patients! Maybe when I am talking to them I am not actually communicating with them! It might be possible that I listen to everything that they are telling me, but I hear only some parts. I hear symptoms that are helping me to establish the right diagnosis, to put the right stamp and to give the right pharmacological treatment. Can I do something better? Some studies have showed that the most effective treatment in depression is a combination of pharmacotherapy and psychotherapy from the beginning.

**Purpose:** The aim of the present work is to study the implications of dysfunctional communication in depression and to prove the importance of a multidisciplinary approach for patients with depression.

**Methods:** presentation of some explanatory models of depressive disorders in terms of communication family systems theory. Use of structural family therapy as an augmenting therapy in 3 cases of depression with incomplete response to biological treatment and analyzation of these cases from the perspective of structural family therapy theories.

**Results and discussions:** we will present some definitions and concepts of Structural Family Therapy for a better understanding of the 3 cases of depression that we will analyze next.

Structural Family Therapy is a method of psychotherapy developed by Salvador Minuchin in 1970, which addresses problems in functioning within a family order. The therapist tries to understand the invisible rules which govern the family functioning, map the relationships between family members or between subsets of the family, and to disrupt dysfunctional relationships within the family, causing it to stabilize into healthier patterns. Minuchin is a follower of systems and communication theory, since his structures are defined by transactions among interrelated systems within the family. [10]

Families are composed of subsystems, such as marital subsystem, the parental and the brotherhood subsystem, between there are mutual interactions and boundaries, rules defining who participates and how. [11] Problems of any kind, including depression, can occur where there is no differentiation between members or when each member is an independent subsystem. The intervention means to re-align family boundaries and roles to be more adaptable for whole family. The therapist:

- Joins the family in a position of leadership
- Maps the family's underlying structure (boundaries, hierarchy, subsystems)
- Intervenes to transform the structure.

*Case report number 1.*

It is the story of a young man 22 years old, Michael, who came to see me for his "depressive and anxious symptoms". I was contacted by his mother who told me that she is very worried because her son is not interested in doing anything, he is tired all the time, is unhappy and he has a lot of physical symptoms like dizziness, difficulty breathing, cramps in hands and legs. They came together for the first meeting and I found out that Michael is already taken antidepressive medication for over 4 months, with a small improvement in his emotional state. He already took two different antidepressants but the response was incomplete. We decided together to continue the medication and to associate family therapy to the biological treatment that he is receiving. At the first session after we have established the contract and some rules about family therapy, I started to gather information about the persons that came to therapy – Michael and his mother – Andra and also to do the joining. Michael said that his parents were separated for 20 years, actually the husband did not stated any reason. He left his pregnant wife and Michael, 2 years old by that time and he moved suddenly in Hungary. Michael lived together with his mother, his sister 20 years old and with his grandmother – Maria. I invited also Maria to the psychotherapy, but she refused to come.

Family and couple Psychotherapy has a lot of different approaches: cognitive-behavioral, strategic, structural, experiential, narrative. As a psychotherapist I have chosen the structural model, although sometimes I use techniques from all other models, so I do an integrative therapy. The structural therapist is not the expert that knows everything and has to resolve alone the problem of the family. He is like a catalyst, a facilitator that gives family the chance to make the changes needed to become functional again.

In the next sessions, after evaluating this family, I have identified several things:

- the spouse subsystem in which the couple relationship and roles are contained does not exist anymore. The husband left his wife 20 years ago and since then they do not talk to each other anymore. After the trauma of being „ abandoned " pregnant and with a 2 year old child, Andra did not want to start a new relation with another man.
- the parental subsystem in which the parental relationship including its roles and function are maintained is a monoparental subsystem because one parent is missing. Actually Maria took the place of the father and she helped Andra in the 20 years to take care of Michael and Ana.
- the sibling subsystem in which the children's' relationship, function, and roles are contained is composed of Michael and his sister Ana.

According to Minuchin, understanding a family requires identifying the processes and boundaries that operate the subsystems and coalitions in that family. Minuchin defined three types of interpersonal boundaries (clear, rigid, or diffuse) that determine the overall ability of the family to adapt successfully to change:

- Clear boundaries around generic subsystems are ideal because they are firm yet flexible, permitting maximum adaptation to change.
- Rigid boundaries imply disengagement between family members or subsystems. The prevailing non-communicative hinders support and limits effective adaptation.

- Diffuse boundaries imply enmeshment where everyone is into everyone else's business. In this case, no one and everyone is taking charge and effective guidance during times of change is impossible. [12]

Either of the two latter boundary styles makes the family incapable to attain optimal adaptation because the family structure either lacks flexibility (it is too rigid) or has too much flexibility (it is too diffuse) to permit the successful re-adjustment of all the family members.

In our case we can easily identify diffuse boundaries:

- between Maria and Michael
- between Maria and Andra
- between the nuclear family and Maria – representing the suprasystem of grandparents.

I considered Michael's depression related to the fact that he lives in a family with a dysfunctional communication, a non-effective hierarchy where the decisions are made by his grandmother and the father's model is missing. During intervention I tried to restructure the family in a more functional way, by reshaping the boundaries between family members, using enactment (role play, observe the interactions), home works (to increase Michael's independence in relation to his grandmother), unbalancing (take the part of one family member for a short period of time), shaping competence. After 8 sessions of psychotherapy, we decided together that we reached our goal, Michael was feeling a lot better and we stopped our meetings.

*Case report number 2.*

George is a 45 years old driver, married with Claudia for 20 years, with one son, Alex - 18 years old. He was recently discharged from a University Clinic of Psychiatry, having a diagnosis of Major Depressive Disorder and he was on antidepressive treatment. He came alone to see me at the Emergency Room in the hospital because he said that he is not feeling good at all and he "really has the need to communicate, to talk to somebody". We had only this one hour meeting because he did not come back with his wife, for family therapy, as I recommended him. He has a depressed mood, headache and he is feeling very bad because of a severe tightness, tension in his legs. He made a lot of medical investigations but the doctors were not able to find out any organic reason for his state and they told him that it is a "psychiatric condition related to stress". He told me that he cannot find a reason for his depression because he does not have any problems: he is getting along very good with his colleagues, with his family and with everybody.

When I asked him about his family, he told me that everything is "normal"- he does not talk too much with his son, Alex, because due to his job, as a driver, he is away from home in the majority of time. Alex has a close relation with his mother, Claudia and they are taking care of the problems in the house together. In regarding his relation with his wife, he stated that everything is ok.

Then suddenly, without any specific reason, something has changed in our communication. He told me the real problem - in the last weeks he is very preoccupied with one thing – he found out that his father is not actually his natural father; her mother had a relation with somebody else, but he never talked to them about this. He cannot talk to his parents about this – "everybody in my hometown village talks about this, I know it is true, but

I cannot talk to my parents about this. These are things that you do not talk about!". Moreover during the last argue that he had with his wife, three weeks ago, she would have said to him that "he was a fool and if he would be more careful, he could see that Alex is not even his son". He plans to divorce without discuss this subject with his wife.

Maybe after a single session is premature to give an interpretation of this problem, but we could formulate the hypothesis that George comes from a family with rigid boundaries between all members and that such boundaries exist also in his nuclear family, in relations with his wife and his son. If we give a symbolic interpretation of his symptoms, we could say that the burden, the stone that George is carrying on his back became too heavy for him and he is blocked because of it.

- He cannot enjoy things like he does before.
- He cannot do anything anymore.
- He cannot move because he feels that pain, that constant tension in the legs and in his head.
- He does not know to communicate, especially when it comes to sensitive issues. In his family home he was learned to be independent, to fend for himself.

The above case shows that the boundaries between subsystems in disengaged families are too rigid, the family members develop a high autonomy, but the sense of belonging is reduced, communication is extremely difficult. Reactions are usually exaggerated in the context of the need for flexible adaptation to internal or external stressors.

Case report number 3

Sometimes the role of the therapist is to help the family to make the transition from one stage to another, during life-cycle stages.

The family goes through different stages of development, some of them being found in the majority of the families. Each stage has its specific:

- Forming the marital couple, in which rules are negotiated and the system's boundaries are established in relation to family of origin.
- Family with young children, when rules should be renegotiated in relation to the role of parent. Many problems have their origin in this stage because, with the advent of children, the privacy of the couple suffers.
- Family with school children and adolescents when ecological context plays an important role: interaction with school, the group of friends and others. Gradually there is a loss of control on adolescent parent, sometimes with the appearance of pathological situations related to the reversal of the hierarchy, when the teenager is the leading system in the family and the parents listen to him.
- Family with older children when relationships between parents and children should become the standard adult – adult relationship.
- Launching children - rather a return to the stage of the marital couple, when the wife and the husband had to renegotiate rules and to spend more time together.

Ioana can't sleep, has a decreased appetite and she lost weight in the last months. Ioana is 40 years old, married to Alin for more than 20 years. They have a son – Marius, 18

years old. She works as a teacher in Tirgu Mures, and her husband is an officer in the Romanian Army. Problems occur when Marius left home, 2 month ago, for studying at the university, in another town. We talked about family stages and about the transition periods, I tried to make Ioana more responsible and to help her regain trust in herself. I made the family more flexible to this change, caused by the "empty nest", reshaping the boundaries between the child and the parental subsystem and working with their marital relationship. I used structural techniques like: enactment, home works, and unbalancing, shaping competence. Ioana begun to feel better when she realized that Marius is not a child anymore, he is a responsible adult able to take care of himself, responsible for his failures and for his successes. Partners were able to focus more on the other roles that they had beside the role of the parents: on their relation, on their profession, on taking care of the extended family.

Ioana developed depression during the transition from family with older children to launching children. Ideally this transition entails the development of a less hierarchical relationship between parents and children. During this stage, the parents are faced with the task of adjusting to living as a couple again, to dealing with disabilities and death in their families of origin and of adjusting to the expansion of the family if their children marry and procreate. However, the process of midlife re-evaluation, which began in the previous life-cycle stage, takes on a particular prominence as the nest empties. [13]

**Conclusions:**

Whether we talk about the physician-patient relationship, the relationships within the family members of the subject or within the members of the therapeutic team, dysfunctional communication has a significant impact on the evaluation, evolution and long-term prognosis in patients suffering from depression. This paper demonstrates the need for a multidisciplinary approach in case of the depressed patients and the need for focusing the therapeutic intervention on the individual, taking into account the fact that he is in a permanent relation and communication inside the family system. New strategies need to be developed for patients with incomplete response to pharmacological antidepressive treatment.

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