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A SYSTEMIC APPROACH TO THE TREATMENT OF DEPRESSION WITH ONLY ONE FAMILY MEMBER PRESENT

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ABSTRACT: The purpose of the present article was to demonstrate a systemic treatment of depression for a 70 year-old woman. In this treatment, other family members were unavailable, but a family therapy systems perspective was used throughout. Results of the demonstration ABAB single case design and two year followup were suggestive of treatment effectiveness in decreasing depression. The need for additional replication of the study was noted.

Despite therapist efforts family members important to treatment sometimes decline to attend therapy. At this point, therapists can choose to see accessible members of the system or refuse treatment in the absence of an important member. Rationales have been given supporting both positions, making an informed decision difficult. For example, Gurman and Kniskern (1981) noted negative outcomes for marital problems treated with only one spouse present. However, Haley (1963), Minuchin (1974), and Fisch, Weakland, and Segal (1983) have reminded therapists that focusing upon one individual can be one of many points of intervention into the family system. This article is a
case demonstration where a systemic approach to the presenting problem of depression was attempted though important members of the family system were inaccessible.

**CASE STUDY**

The subject (Mrs. C) was a 70 year old Caucasian female married for over 50 years. She had been employed as a seamstress but had been retired for 10 years. Mrs. C had a long history of depression dating back at least 16 years. Previous treatment had consisted of psychiatric care, drug therapies, hospitalizations, and electroconvulsive shock therapy with no noticeable lasting change in her depression.

Mr. C was unwilling to participate in therapy; therefore, information about him was obtained from his wife. He had suffered a heart attack five years previously and was taking medication as a result. Mrs. C described him as being noncommunicative, spending most of his waking hours watching television or reading a newspaper. She further stated that he rarely initiated conversation except to command her to do some task. She complained about Mr. C’s inattention to personal hygiene reporting that she had to plead with him to take a bath and that he had a habit of spitting tobacco in the sink or drooling it on the floor. She also complained that her husband resented her visiting her shut-in friends, and that whenever she wanted to do so, he would increase his negative behavior. Mrs. C stated that though he was not physically impaired “he expected to be waited upon hand and foot.”

**Hypothesis About Relationships**

Mrs. C’s voice tone indicated an intense anger toward Mr. C because of arduous cleanup and caretaking duties. When she attempted to discuss her feelings with him, he accelerated his demands and increased spitting on the floor. However, if she did not attempt to discuss her feelings with him, she became more depressed. Mrs. C found the only way to comment on her dire situation was to become so depressed that her physician referred her for psychiatric or psychotherapy treatment. At this extreme, Mr. C decreased his demands and paid attention to how she felt. When this occurred, Mrs. C reported that she did not resent Mr. C’s requests and sometimes volunteered to bring him the paper or serve him a beverage. This stage of the cyclical pattern caused positive exchanges between the couple. During these times, Mrs. C’s depression subsided.
**Therapeutic Goal**

Mrs. C’s depression, at least in part, was reactive to interactions surrounding the marital relationship. Since conjoint marital therapy was not an option, other less direct alternatives were explored. It was hypothesized that if Mrs. C reversed her anger toward Mr. C then, he would also reverse his negative actions. Reversing this negative conflictual cycle might then decrease Mrs. C’s depression.

**THERAPEUTIC ASSESSMENT**

*The Beck Depression Inventory* (BDI) (Beck, 1980) was administered to Mrs. C prior to treatment, at the conclusion of treatment, and at a six week and two year follow-up. Possible BDI scores range from 0 (a very low level of depression) to 63 (a very high level of depression). The cutoff for potentially serious depression levels is 16 (Lewinsohn, Muñoz, Youngeren & Zeiss, 1978).

*The Depression Adjective Checklist* (DACL) (Lubin, 1965) a daily measure was also given. Possible DACL scores range from 0 to 34 with scores of 10 or more considered to be indicative of depression. Mrs. C completed the DACL daily for two weeks prior to intervention, during all of treatment and for two weeks at the two year follow-up.

**Treatment**

In keeping with a systemic approach to therapy, a cyclical pattern was identified surrounding Mrs. C’s latest referral by her physician. Mrs. C typically met Mr. C’s increasing negative behavior with increased negative behavior or by noncompliance to his requests. Mrs. C’s negative behavior in turn was met by Mr. C’s increasing demands for service and spitting behavior. Therefore, the more negative he became the more she focused upon his negative behavior and the less likely she was to comply with his requests. In turn, he refused to listen to her feelings and she became more depressed. Next, the physician entered the feedback loop by treating Mrs. C for depression and referring her to therapy: In turn, Mr. C and their non-resident son would encourage Mrs. C not to worry about them so she would not become more depressed. This also meant that Mr. C reduced his demands and took care of himself while offering to help her as well. The net effect of the pattern was that as Mrs. C became more depressed, her husband began to do the positive things that she had been asking for all along.

Previous therapy had contributed to the problem by allowing Mrs.
C an opportunity to talk about her feelings to someone, thereby reducing the marital tension. After a time, Mrs. C would depart from treatment and a gradual escalation of the previous pattern would reoccur.

Therapy was conducted by the first author. During the first session, the therapist attempted to join with Mrs. C by demonstrating an understanding for her perspective of her depression and by using the highly religious language with which she was comfortable. Also during this initial session, through a process of circular questioning (Tomm, 1984) patterns were identified which have been previously described. Finally, directions for the standardized assessments were explained. DACL data was collected for two weeks before Mrs. C’s second appointment (see Figure 1: A1 Baseline, No Treatment Phase).

Upon an inspection of the interactional descriptions which emerged around the circular questioning process, a positive feedback loop was apparent. First, it was conceptualized that the stronger Mrs. C held to her “Christian duties” of helping her shut-in elderly friends the more Mr. C demanded that she care for him. The request to diminish her religious activities seemed ironic to Mrs. C since it was her religious convictions which kept her married to Mr. C even though she had considered divorce.

During the second session it was considered important to understand the perspective of Mrs. C and to not challenge her value system. As described by Coyne (1985), this required creating a new understanding of the problem which made as much sense as her previous one, yet, which allowed a new level of understanding that would change the context of the problem. To facilitate this shift in context the therapist agreed that Mrs. C not only had a right but a responsibility to pursue her Christian duties. However, it was suggested that she may not be zealous enough in her efforts. It was pointed out that she lost a lot of valuable time when Mr. C was in charge of telling her when she should perform her wifely duties. This was especially true when she became so wornout that she had to take rest in the hospital. Though Mrs. C believed that she had a responsibility to Mr. C, it was suggested that she not surrender the choice of when she fulfilled her duty both to her friends and to her husband. The therapist optimistically assured Mrs. C that she was the kind of woman who could figure out a solution to the problem. Further it was offered that when Mrs. C could catch Mr. C in a better mood might be the appointed time for her... “to be subject to her husband...” by tending to his needs while when his moods worsened might be the best time to visit her shut-in friends.

At this point in treatment, the therapist departed for a two week vacation. DACL scores were collected and are shown in Figure 1 (A2 Baseline, No Treatment Phase). During the vacation period, increas-
FIGURE 1

DAILY DEPRESSION LEVEL
ing depression was noted. Because of this increase, additional intervention was needed.

In the third session, it was determined that Mr. and Mrs. C's middle-aged son needed to be discussed. The son, who lived 150 miles away, seemed to contribute to the pattern established between Mr. and Mrs C. That is, the more Mrs. C did not comply with his requests, the more Mr. C would report this to his son. The son would then remind Mrs. C of her duty to Mr. C and of his weak condition. Mrs. C would criticize Mr. C, arguing that he was not helpless. The son, in turn, vigorously defended Mr. C and accused her of not doing her duty toward her husband.

In order to disrupt this cyclical pattern the following instructions were given to Mrs. C.

It would be tempting to continue to argue with your son since you are obviously right. However, because you're feeling so bad I would like for you to outsmart him and avoid arguing. Instead, tell him how proud you are that he learned how to "honor his father and mother".

Mrs. C was instructed not to offer an exegesis since the scripture was inspirational enough to stand on its own; rather, she was to move immediately to another room. It was believed that it was necessary to alter the pattern of interaction between the son and Mrs. C simultaneous to the change in interaction patterns between Mr. C and Mrs. C. The above intervention was designed to do just that. In Figure 1, the period B2 Treatment Resumed represents the time after the third session. She reported a marked decrease in depression during this period as shown by the DACL scores.

Prior to the third session, Mrs. C had been unable to fully implement the first intervention because of interference from her son. After the third session, she implemented the intervention with her son. In addition, she was able to implement the first intervention once her discussion with her son had had the desired effect.

In the fourth and subsequent sessions, several steps were initiated to assure the effects of treatment across time. First, after Mrs. C experienced a notable decrease in her depression, therapy sessions were thinned to once every six weeks, then to once every six months and finally to one contact during the following year. This spreading of sessions was designed to show Mrs. C that her gains could be maintained though therapy was not convening as often. Second, change which occurred was attributed to her efforts, not to the therapist (Haley, 1963). Thus, Mrs. C could have confidence in her ability to control her depression without the help of a therapist or physician. Third, it was pre-
dicted that new events would occur which might prevent her from continuing her efforts that kept her from being depressed.

RESULTS

Prior to treatment Mrs. C’s BDI was 28 indicating a high level of depression. At the conclusion of treatment, her BDI was 5 and at the six-week and two year follow-up her BDI was 7 and 13 respectively. The DACL data in Figure 1 also indicated a decrease in depression. As can be seen, Mrs. C’s depression level was highest during no treatment periods. Her depression levels decreased during treatment periods and stayed low at follow-up. Such a pattern of up and down changes in depression level associated with treatment suggests a relationship between treatment and changes in depression (Crane, 1985).

DISCUSSION

From the BDI and DACL data, it appears that Mrs. C’s depression level decreased from pretreatment to posttreatment and follow-up. Though not conclusive, this example suggests that this type of treatment may have use in the treatment of depression when only one spouse is available for therapy.

The most convincing evidence for the effectiveness of this approach was provided by DACL data reported in Figure 1. During baseline (A₁), it can be seen that depression levels were relatively high. For the first treatment period (B₁), visual inspection reveals a decrease in depression levels. Period A₂, a reestablished baseline due to the therapist's vacation indicates that depression levels returned to levels similar to those during the first baseline (A₁). Treatment was resumed (B₂) and once again the depression levels dropped.

The two-year follow-up was conducted in two phases because of the steep upward trend in the DACL scores during the first phase of follow-up. Since conclusions from such a trend are difficult to analyze, a second seven-day assessment was conducted. As can be seen, her depression levels were within the normal range for 11 of the 14 days. According to Mrs. C, the high level of depression on three days was caused by crises events and had little long term effect on her. Upon the strength of the argument of the ABAB design (Crane, 1985), it can be suggested that the decrease in depression levels was due to treatment.
However, additional replications using the ABAB design would be required to increase confidence in this observed relationship.

An important caution must be raised in regards to this report. The major issue has to do with the potential reactivity of the self-report measures used in this example. Such measures may not be accurate measures of treatment effectiveness. However, the assumption of most clinicians must be that their clients will accurately report their experiences. Whether this assumption can be met in this case is open to speculation. However, the three days of high depression levels during the two-year follow-up suggests that Mrs. C was being as honest as possible. If she was attempting to distort the data, such peaks would probably not have been reported.

In general, the results of this demonstration are supportive of further research in the systemic treatment of depression with only one family member. Further studies with more complex research designs would be necessary for additional support of this claim.

REFERENCES


