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Case Report

FAMILY FUNCTIONING AND ADOLESCENT DEPRESSION

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ABSTRACT

A 14-year-old girl student presented with a depressive mood that led to aggression. She is diagnosed with major depressive disorder with multiple histories of suicidal attempts resulting from family factors, life events and environmental factors. She is predisposed to her parents' divorce, leading to a weak parent-child relationship. This condition is precipitated by some physical and emotional abuse by her mother as well as attention deficit that causes an acute stress response, which manifests as feelings of persistent sadness and worry. It is perpetuated by the lack of social support and stigmata of mental illness towards her. The patient is treated with antidepressants for mood regulation and supportive psychotherapy. Additionally, psychosocial therapy such as cognitive behavioural therapy (CBT) could be used along with pharmacotherapy to optimize the effectiveness of major depression disorder for this patient. Psychosocial support is provided to her by the paediatrician, the Social Welfare Malaysia, the One-Stop Crisis Centre, and the police.

INTRODUCTION

Globally, it is estimated that depression occurs among 1.1% of adolescents aged 10–14 years, and 2.8% of 15–19 years old [1], yet these remain largely unrecognized and untreated. There are a number of factors that contribute to adolescent depression and among all, the common variable in adolescent depression is family factors. Greater bonding between parents and child predicts lesser depressive symptoms and it is also associated with a decrease in externalizing problems [2]. Family relationship variables of high discord, low cohesion, and high affectionless control were all important predictors of general child pathology, including depression [3]. Therefore, the relationships among adolescent depressive symptoms with family cohesion and family social support were inversely related.

The objective of this case report is (i) to discuss the impact of family dysfunction on adolescent mental health, and (ii) to examine the bio-psycho-social-spiritual perspective in the management of family dysfunction.

CASE PRESENTATION

A 14-year-old Malay girl, single and Form 2 student at SMK Keat Hwa, presented to the hospital with aggressive behaviour. She has been a known case of major depression disorder for the past year. She described her feelings as frustration and anger towards her mother. It started with an issue occurring at school on the day of admission. She claimed of accused by her teacher and embarrassing her in front of other students. The teacher accused the patient of badmouthing her to PK HEM and asked her to rectify to PK HEM. Hence, she went back to PK HEM to clear up the misunderstandings. In return, PK HEM told her not to worry about it and sent her back to her classroom. At that time, she felt very frustrated, overwhelmed, and stressed as she felt that whenever she tried to feel better, there were always problems to bring her down. Therefore, she thought that it was best if she died. In the classroom, she harmed herself by slitting her forearm with scissors. She denied any suicidal thoughts or attempts. The act was noticed by her math teacher and she was brought home by her mother. Once they arrived home, the patient locked herself in the bedroom and slit her forearm once again with a

kitchen knife that she kept inside her room. She also called her boyfriend and found out that her mother called him first to ask about her stressor that day. At the same time, the mother went to seek help from her neighbour and called the patient's stepbrother. The patient was furious as she hated her mother interfering with her relationship. She went out to confront her mother at the house compound. She strangled her mother and pushed her mother down to the ground. The neighbour witnessed the incident and called the police and ambulance. The patient cried and refused to go to the hospital but was able to do so after persuading her for 30 minutes.

She also complained of persistent low mood, difficulty sleeping and frequent night awakening, easily irritated, cried for no reason and poor attention in school for the past four days. She has no psychotic or manic symptoms. She has no history of abuse of illegal substances.Her father, a 58-year-old working odd jobs, and her mother, a 54 -year-old HR manager, had separated when she was 11 years old. Her mother was the second wife and she is the only child from her parent's marriage. Her father had a 30-year-old son and a 12-year-old daughter resulting from his marriage to his first wife. Before her parent's divorce, she had a good relationship with her father compared to her mother. After the divorce, she lived with her mother and occasionally visited her father. She no longer feels comfortable around her father and has not been close to him since, although she still gets along well with him, the stepmother, and the step-siblings.

She described her father as a strict but loving father meanwhile her mother as a non-understanding mother that controlled her. Her mother's personality often leads to physical fights among them. Her mother always verbally abused her and physically disciplined her by choking her or scratching her. Her mother has had a new partner for the past one year. Her mother's boyfriend is a gangster who benefits from her mother's money. Her mother bought him a new car and lent him thousands of ringgits. She also noticed that her mother was busy with her new partner and no longer spent time with her. Her mother spent the weekends with her boyfriend and was on the phone with him for two to three hours every night. The mother's boyfriend is a hot-tempered person, and they frequently argue with each other. The patient described it as an unhealthy relationship. She felt sad and thought that her mother did not care about her anymore. She also worried about her mother's safety.

As a result, she developed depressive moods and psychotic features that led to multiple histories of suicidal attempts. She attempted suicide by overdosing on medication and cutting her wrist. She compensates for her condition by vaping and smoking. She had a history of two admissions within two months due to suicide attempts. It was due to non-compliance to medication as she complained of feeling more anxious than before.

She is a Form 2 student at SMK Keat Hwa. She had poor academic school performance as a consequence of missing school because of hospital admission and medical leave prescribed by her psychiatrist. She is also unable to keep up with her studies and feels anxious about the upcoming exam. Her mother complained of her frequently skipping school whenever she had minor problems such as arguing with her boyfriend. The patient would use depression as an excuse to skip school. Because of that, the teachers disliked her and had a prejudice against her. She did not have any close friends as other students saw her as a problematic student. For the past two years, she has changed schools multiple times due to disciplinary problems and was unable to cope with the school environment. Previously, she was suspended from school due to vaping and smoking. Hence, her mother moved her to SMK Keat Hwa against her will to discipline her. Furthermore, she felt anxious and hated going to school because students around her talked behind her about her behaviour. In addition, the boy seniors verbally assaulted her and she was afraid of being molested by them.

She has been in a relationship with a 21 years old boy for one year. She knows him from a dating app. She deeply loves and trusts him as he is a loving and soft person. The boyfriend always accompanied her at home when her mother was busy with work. She describes him as someone who respects her and has boundaries in the relationship. Her boyfriend always calmed her whenever she had a fight with her mother. Sometimes, she felt stressed and mad at her boyfriend as he always backed up her mother. This is because she felt as if her boyfriend did not understand her. She denied any sexual activity with her current boyfriend.

Mental status examination reveals a medium build and height Malay girl, in school uniform, who appears sad and irritated. She is cooperative and speaks in Malay. Her speech is rational, relevant, and coherent. The mood is low and affect is appropriate. She cries through tears. No formal

thought disorders. She also does not exhibit psychotic features. Her cognitive functions are intact. She has poor judgement and insight. Physical examinations showed a superficial cut wound over her left wrist.

A diagnosis of major depression disorder with anxious distress resulting from multiple stressors including family factors, life events and environmental factors is made. She is predisposed to family crises at a young age along with some physical and emotional abuses. Her condition was precipitated by environmental factors that caused an acute stress reaction, expressed in anger, anxiety, and sadness. It is perpetuated by the lack of social support and the absence of a close confidant. Biological investigations such as a complete full blood count, renal profile, liver function test, thyroid function test, fasting blood glucose, and lipid profile show no abnormalities. Psychosocial investigations also show no abnormalities.

Treatment includes prescription of selective serotonin reuptake inhibitors, fluvoxamine 50 mg ON and zolpidem 10 mg PRN. Supportive therapy on coping skills and emotional regulation may help improve her condition. The prognosis depends on the safety of her living environment, the availability of social and legal support, and the coping strategies she uses to deal with stress reactions to emotional neglect.

DISCUSSION

Depression is a common mental disorder characterized by sadness, inability to experience happiness, self-criticism, and physical symptoms such as poor concentration, fatigue, loss of energy, and disturbed sleep or appetite [4]. Depression can seriously affect adolescents' physical and mental development, leading to other problem, including lower grades, dropping from school, low self-esteem as well as externalizing problems. It also can increase risk of substance abuse and, in severe cases, even suicide.

Previous studies have found that poor family functioning can make individuals depressed [5] and family functioning plays an important role in the development, process, and relapse of depression [6]. However, few studies have explored the mediating and moderating mechanisms of family functioning on depression. According to the ecological systems theory, family, peer, and individual psychological characteristics (e.g., self-esteem, etc.) have a strong impact on an individual's mental health [7]. The roles of self-esteem and peer relationships in the influence of family functioning on adolescent depression deserve attention.

Family functioning is the function of the family system itself, which refers to the ability of the family to function effectively to meet basic needs and manage conflicts [8]. The circumplex model of marital and family systems considers family as functioning in three dimensions: family cohesion, flexibility (initially called adaptability), and communication. Family cohesion is the ability to maintain strong emotional bonds among family members. Flexibility focuses on how the family system balances stability and change. Good communication promotes family cohesion and flexibility [9].

Numerous theoretical and empirical studies have linked family dysfunction to depression. The effect of family functioning on adolescent depression can be explained using the family system theory. According to family system theory, the better the overall function of the family system, the better the psychological state and behavioral performance of its members, leading to less depression or other emotional and behavioral problems [10]. Family cohesion can provide a warm family environment and positive emotional support, thus reducing the likelihood of adolescents developing depression or other forms of adverse emotional distress. Family flexibility, on the other hand, enables families to cope with change and reduces the impact of negative events on adolescents' mental health [11]. Positive communication leads to less family conflict, enhancing family adaptability and cohesion and thus playing a protective role in adolescent mental health. Empirical studies have found that family functioning has a significant influence on adolescent depression [12], that family cohesion is significantly negatively correlated with depression [13], and that low family adaptability and poor family communication play important roles in adolescent depression [14]. A recent meta-analysis showed that family dysfunction is closely related to depressive symptoms, and that family functioning is an important predictor of individual depression [15].

Available treatments used in intervention studies for depression in adolescent generally fit into one of the following categories: cognitive–behavioral therapy, interpersonal psychotherapy, and family systems approaches. Each treatment category represents diverse guiding assumptions, and there is considerable variation with regard to intervention techniques used within some of these categories.

Depression is seen as a natural consequence of the loss of social connectedness, attachment disruptions, or difficulties establishing emotional autonomy in relation to primary caregivers. Therefore, treatment emphasis is on rebuilding relationships and resolving

interpersonal conflicts. Interpersonal psychotherapy for adolescents (IPT-A) is a well-defined, manualized treatment. IPT-A believes that recovery can be facilitated once the interpersonal relationships are reconstructed to provide better social support. Hence, the unique emphasis of IPT-A is to develop skills that will help the depressed adolescent regain the sense of attachment and improve the quality of social relationships [16].

The family is a system that seeks to maintain its current functioning. The depressive symptoms would either be related to that family member's role in maintaining the homeostasis of the family system, or a sign that the current family system is not adequately meeting the needs of the family [17]. However, the general goal across systemic therapy approaches is to alter patterns of communication and behavior, to assist all family members in meeting their needs and the family's goals without psychologically distressing symptoms. There are two specific types of family systems approaches that have specifically been evaluated with depressed youth. One is the systemic-behavioral family therapy (SBFT) and the other is the attachment-based family therapy (ABFT). The components of SBFT include principles from systemic family therapy, functional family therapy, and behavioral therapy. SBFT includes skill-building in communication, incorporating reinforcement, and distinct aspects of cognitive restructuring [18]. ABFT incorporates family systems and attachment theory in a manualized treatment for depression in youth. ABFT is designed to assist the adolescent in the task of developing autonomy from the family, while simultaneously maintaining healthy communication and positive relationships in the family as a whole. Treatment progresses through two stages. First, the therapist assists the youth in identifying and confronting troubled family relationships. Next, the goal is to encourage developmentally appropriate and parent-supported autonomy for the youth, working with the family as a unit [19].

CONCLUSION

Family functioning and depression in adolescences are inversely related and can be treated according to the bio-psychosocial-spiritual paradigm.

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