CONVERSATION WITH COLOMBIAN FAMILIES: THE EXPERIENCE OF MATERNAL DEPRESSION AND ITS IMPACT ON CHILDREN

Adaptation of the PIP in Colombia: Lessons learned and future possibilities

Pontificia Universidad JAVERIANA Cali

con Acreditación Institucional de Alta Calidad por 8 años

CONTEXT

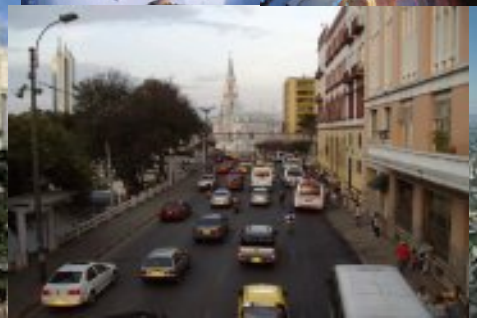
GENERAL INFORMATION

Santiago de Cali is the capital of Valle del Cauca, and is the second largest city of the Republic of Colombia.

Cali is the epicenter of Colombia on the Pacific.

Population : 2,119,908
60% of the population is black.


DCAMACHO Photographer



WHO ARE WE?

We are a group of teachers and researchers in the Familial Masters Program at the Pontificia University Javeriana Cali - Colombia. We are a team of professionals working in different educational and healthcare institutions, supported by the Preventive Intervention Project team (PIP) to implement a cultural adaptation project. Their interest is to develop projects that promote the improvement of mental health and quality of life for Columbia's families.

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COLOMBIAN TEAM

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THE ROAD

Partnership, Boston Children's Hospital – Pontifica Universidad Javeriana, Cali, Colombia

2010

Building the research project

2010-2012

Talks, Boston-Cali

(February 2011 – April 2011)

Training in PIP (Roxana Llerena-Quinn, PhD and Alexia Paez, MD)

May 2011

Training and support of the Colombian team

2011-2012

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REGARDING THE COLOMBIAN ADAPTATION OF PIP

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DESCRIPTION OF THE COLOMBIAN FAMILIES

OCCUPATION :

Housewives :6
Employed :1
Self-employed : 3

FAMILY COMPOSITION

Blended: 3
Nuclear : 3
Single-parent:4

STAGES OF FAMILY CYCLE

Adult children and adolescents: 4
Adolescent children: 3
Young children and adolescents:2
Young children, adolescents, adults : 1

RELIGION

Catholic: 8
Jehovah's Witness: 1
No denomination: 1

MARITAL STATUS

Married: 5
Single: 1
Separated: 2
Partner:1
Widowed :1

EDUCATION

University: 4
High School : 3
Technical:2
Elelmentary : 1

GENDER OF TARGET CHILDREN

Boys: 3 (average age 11)
Girls: 7 (average age 11)

INCOME LEVEL

Medium high: 2
Middle :4
Middle low: 2
Low :1

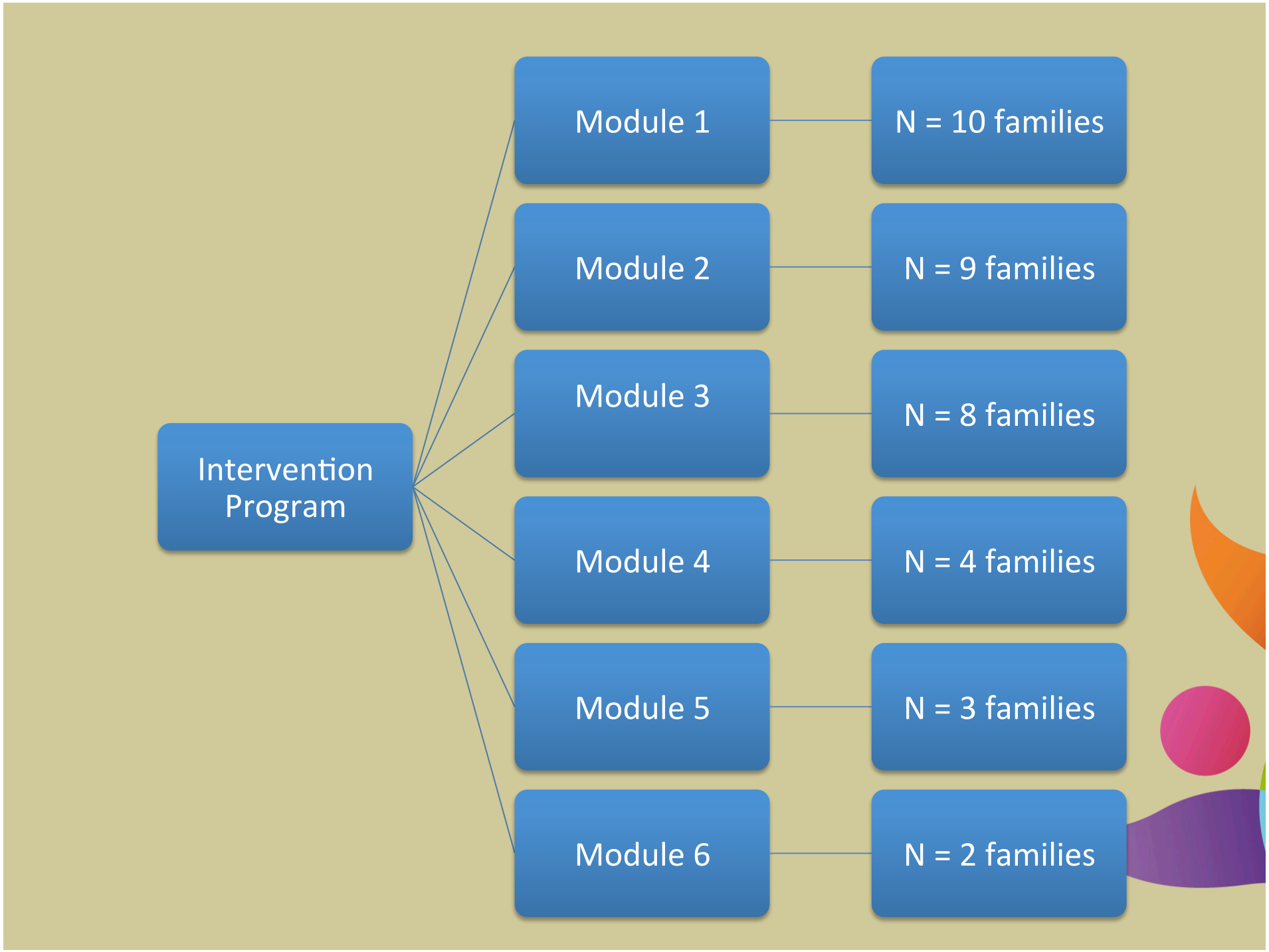
PARENTS' AVERAGE AGE

Fathers : 50
Mothers : 41

PARTICIPATING FAMILIES: 10

CHILDRENS' AVERAGE AGE

Children: 10
Adolescents :16
Adults :22


Intervention Program
Module 1
N = 10 families
Module 2
N = 9 families
Module 3
N = 8 families
Module 4
N = 4 families
Module 5
N = 3 families
Module 6
N = 2 families

MODULE 1. ESTABLISHING THE THERAPEUTIC RELATIONSHIP AND CONSTRUCTING THE FAMILY HISTORY OF DEPRESSION

Alliance and Collaboration

100% compliance

Orientation to the Intevention

100% compliance

Collect History of Parental Depression

70% compliance
20% partial compliance
10% did not comply

General Observations

✓The patient fears talking
✓Emotion and crying
✓Complexity in the reconstruction of the history of depression
✓Required time: 2 sessions
✓Family commitment to attend the intervention
✓Depression immersed in other life situations

MODULE 2: EXPERIENCE OF DEPRESSION AND PSYCHOEDUCATION

Collection of Mental Illness Experience from the Partner's Perspective

100% compliance

Psychoeducation about Depression Symptoms and Treatment

90% compliance
10% did not comply

Preparation of Parents for the Child Meeting and Expression of Concerns

60% compliance
40% did not comply

General Observations

- ✓Activation of depressive symptoms
- ✓Patient hospitalization
- ✓High level of information by family
- ✓Too much content to address in one module
- ✓Inquiry to individual family members
- ✓Family commitment to participate in the intervention
- ✓Identifying other problems in the marital relationship
- ✓Incorporate the marital relational context in which the problem emerges, is maintained, and transforms the experience of depression

MODULE 3: CHILD MEETING

Acknowledge the Importance of the Child's Perspective

70% compliance
10% partial compliance
20% did not comply

Assess Child's Current Functioning

80% compliance
20% did not comply

Concerns and Questions Regarding the Family Meeting

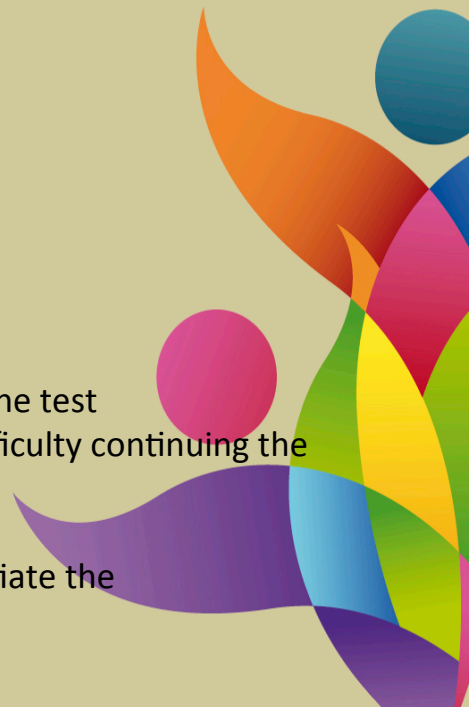
80% compliance
20% did not comply

Information about Depression, Exploration of Child's Concerns

50% compliance
50% did not comply

General Observations

✓Available to talk about the patient
✓Fear of talking about the illness
✓The exhaustion of the children at the end of the test
✓The exhaustion of the children and having difficulty continuing the session
✓Explore doubts and perceptions of children
✓Request that children draw their family to initiate the conversation about family illness



MODULE 4: PLANNING THE FAMILY MEETING

Feedback to Parents Regarding Assessment of Child Functioning

20% compliance
10% partial compliance
70% did not comply

Create a Link Relating Mothers' Perceptions of Depression with the Children's Experiences

20% compliance
10% partial compliance
70% did not comply

Planning the Family Meeting

10% compliance
90% did not comply

General Observations

✓Mothers' health problems
✓ Module content requires 2 sessions
✓Mothers' emotional states require reorienting session
✓Therapeutic alliance between the mothers and the clinicians was the key to the fulfillment of the meetings' objectives
✓ Required the use of psychoeducational materials for support

MODULE 5 : THE FAMILY MEETING: FACILITATING THE CREATION OF A SHARED UNDERSTANDING OF THE PARENTAL ILLNESS

Review the Purpose of the Family Meeting

Share Understanding of Parental Illness

Empower Parents toTtalk Openly and Honestly about Depression with their Children

30% compliance
70% did not comply

General Observations

- ✓Concerns about what will happen after the program ends
- ✓Positive reflection on the usefulness of the program
- ✓Importance of deepening the theme of family communication
- ✓Two sessions are necessary to deepen the theme
- ✓Complex information processing during the family meeting takes time
- ✓ Evaluation of subject content
- ✓Reframing of the process by the clinician
- ✓Assessment of the voices of all participants, resolution of their initial concerns

MODULE 6: REVIEW AND PLANNING FOR THE FUTURE

Review the Purpose of the Family Meeting and Whether Goals were Met

20% compliance
80% did not comply

Review Information Shared with Children and Parents' Reactions to Openly Discussing Depression

Review the Purpose/Limitaitons of the Intervention and Help Parents Plan for the Future

10% compliance
10% did not comply with first session
80% did not comply

General Observations

✓Positive evaluation of the family about the process
✓Value of the dialogue that arises about the illness and its impact on the family
✓Search for alternatives to overcome crises
✓Creating space for the participation of family members
✓ Crisis situations for the mother during the process

LESSONS LEARNED

ABOUT THE PROGRAM

✓Assertive communication and listening to the experiences/conceptions of the mother and her family, were important to various issues that occurred in the program.

✓The construction of the therapeutic alliance, empathy and positive emotional bond that is generated between family and clinician, are key to the success of the sessions.

✓The professional who leads the PIP intervention needs to take ownership of the logic of the process, content, and clinical skills required.

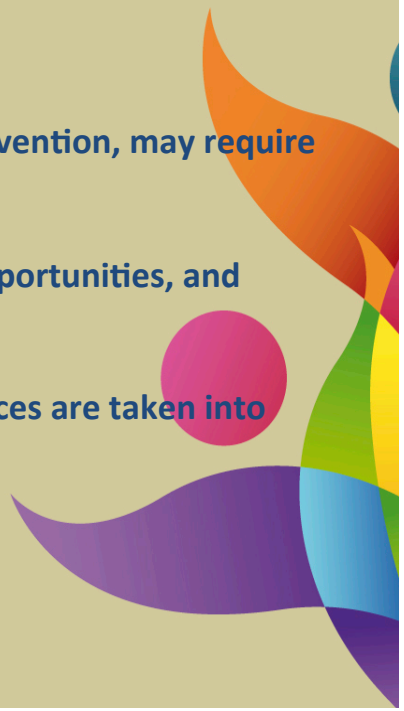
✓It takes at least two sessions, on average one and half hours each, to cover the material of each module.

✓Unpredictable relapses dictate the intervention process.

✓Complex family situations, and the vicissitudes of the illness, beyond the process of intervention, may require referrals to other interventions.

✓The clinician's role is as a counselor, and as a facilitator of readings, social networking opportunities, and community resources.

✓Families are positive about the intervention, and appreciate that all family members' voices are taken into account, and that resiliency is promoted in the face of parental depression.



ABOUT FAMILIES

✓ Families expressed a great need to be heard, to be supported, to be given the opportunity to express themselves fully, and to talk about all their concerns extensively.

✓ Depression prevention necessitates recognitzing cultural and contextual aspects of families, and requires that other issues affecting family functioning are addressed. This gives confidence and allows families to build a shared narrative of the experience of depression in the family.

✓The need to promote open channels of communication in the family, and put into words the condition of parental depression and its impact on family members, is essential to generate understanding and hope.

✓ The volume of the information in the modules requires a high processing demand on the part of the family, since most of these families have had individual medical care with little guidance on the psychosocial aspects of depression.

✓Concern about what will happen after the program is finished.

✓For families to take in this material requires emotional support, attentive listening, continuous feedback, and psychoeducational counseling, which enables families to bring out individual and relationship strengths despite illness and other adversitites.

MOTHER'S VOICES

Depression is….

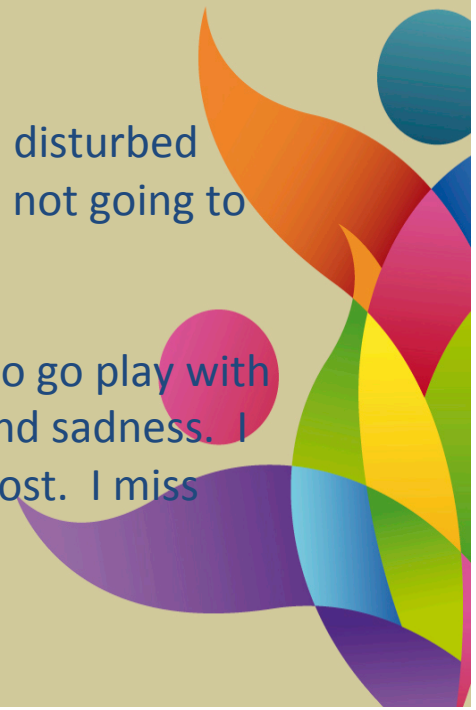
"The response to multiple stressful situations, like economical difficulty, and the inability to adequately communicate emotion"

"A nostaligia, isolation and sadness. Not wanting to do anything"

"A disease that includes episodes of sadness, moments when I speak and behave like a child, I become hysterical easily, I throw myself to the floor, and sometimes I do not remember what I just said.

"The changes in mood, lack in motivation to do everyday things, disturbed sleep, and falling into the thoughts I cannot, I could not, and I'm not going to be able to"

"I was depressed since childhood, cried a lot, and did not want to go play with my friends. Now I isolate myself, I cry a lot, and I have a profound sadness. I feel I cannot do anything, and I punish myself with what I like most. I miss going for walks and riding bikes. I feel fat"



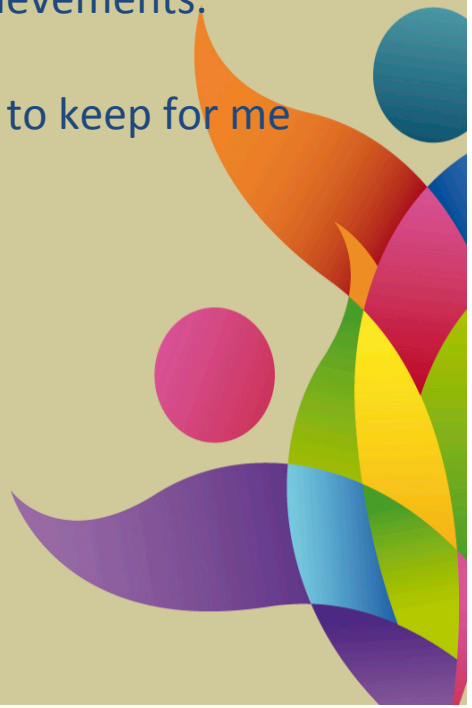
……WHAT THEY THINK CAUSES DEPRESSION

"The conflict has caused problems in my relationship with my husband's children. Also, I have little support because my husband is not with me because of his work and his infidelity. I have difficulty expressing my emotions and feelings, and I feel that household chores are a monotonous burden."

"…The mistreatment at home by my brother, which is known to my husband and children."

"Events of my childhood, and frustrations about life tasks or achievements."

"…what caused the depression is a tendency to hide my feelings, to keep for me what happens to me."



….. WHAT ALLEVIATES DEPRESSION?

“Having couple’s alone time, perceive that I can count on him to make decisions and reduced debt.”

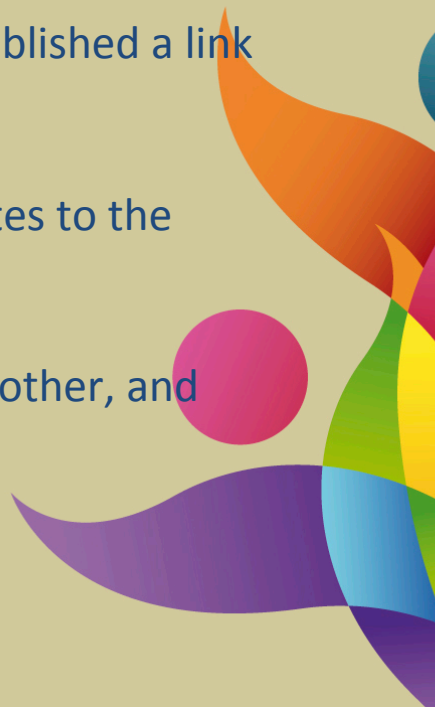
“Maintaining a work activity is very positive; woodworking makes me feel busy and useful.”

“ To feel accompanied and heard, to make progress in expected accomplishments.”

“The support system established by my inlaws is useful, as is established a link with my children.”

“ I am relieved when things work well in business, and it permeates to the home in silence and peace.”

“I try to calm myself down, to finish an activity before starting another, and breathe deeply before facing a problematic situation.”



IMPACT ON THE MOTHER, SPOUSE AND CHILDREN

"Managing economic stressors and emotions is exhausting." (A mother)

"I don't think that M is sick, she needs to learn to manage her emotions and stop taking the medication. I think it is a matter of attitude and not being really sick." (A husband)

"The girl (7 years), has no awareness or knowledge of the depression that I suffer." (A mother)

"The depression is not spoken, it is an issue not known and not accepted in the family." (A mother)

"What happens is that the members of this family tend to internalize the pain associated with the effects of the depression and hospitalizations, especially when the children were young." (A father)

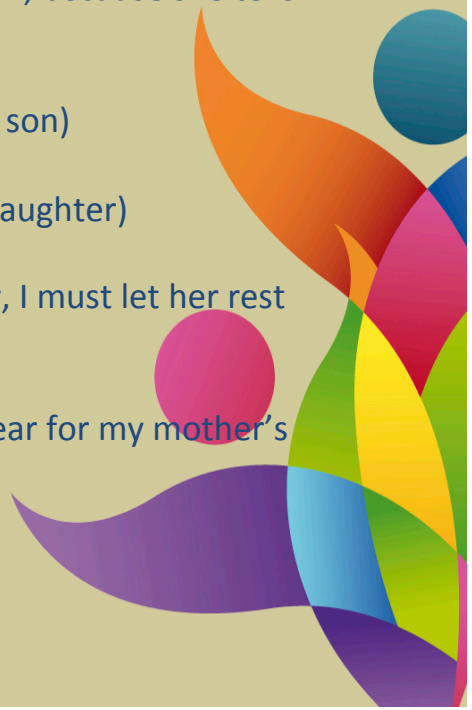
"On occasions, I cannot speak with her about the difficulties in relation to the children, because she tells me not to tell her the problems, so I feel alone in the task." (A husband)

"My mom's hospitalization is an experience of abandonment and great anguish." (A son)

"I associate my mother's depression with my lack of motivation for everything." (A daughter)

"I know my mom is sick, I must take care of her, I must not make noise or bother her, I must let her rest and not ask her to play with me. I have to check up on how she is doing." (A son)

"The children have been very affected by the illness. They have a lot of fears, they fear for my mother's life." (A daughter)



WHAT STRENGTHS WERE FOUND IN THE FAMILIES?

"The desire to hold onto life, with the support of the maternal family, both financially and emotionally."

"The family's knowledge about the diagnosis, the mother's handling of her symptoms as they evolve over time, have helped make the illness more manageable".

" The mother's feeling of personal agency."

"Art as a resource, and common goals. Toughness, the hope to suceed, and the ability to fight."

"Faith in God."

"The mother's love of her children and the ability to express that affection."

"Perseverance and work as a necessary option to provide economic stability for the children."

THE VOICE OF THE CLINICIAN: DEFINIING RESILIENCE

"They do not understand the term and need it explained to them. However, they identify aspects of resilience in a person's autonomy, capacity, and character."

"They do not recognize the word resilience, and it is the first time they have heard it, but they recognize it as a capacity of people's ability to advance and overcome."

"They relate the term resilience with inner strength, love of their children, and resistance to adversity."

"Resilience is associated with being linked to a support network of extended family."

PARENTS CONCERNS FOR THEIR CHILDREN

"The concerns are for the debts and not being able to respond to them."

"It worries me not to be able to care for my children, accompany them, they demand all of me, and I do not feel able to respond."

"I am concerned that my children do not see me as a good mother, and feel that I am not able to provide guidance, exercise authority, and set limits."

"It concerns me that my husband does not understand my illness, and does not worry about the children."

"I worry about losing control of my reactions and making mistakes with them."

"I worry that because of my condition, my son feels guilty, nervous, and worries too much about me."

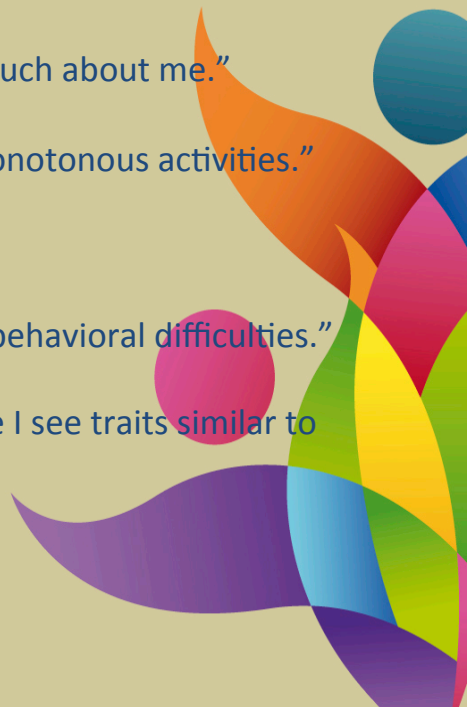
"Not having good time for the family due to my husband's employment status and monotonous activities."

"I am concerned about my child's anger, which I relate to depressive symptoms."

"I worry about my other son [who has a diagnosis of depression] and his academic or behavioral difficulties."

"I am afraid my daughter will suffer from bipolar disorder when she grows up, because I see traits similar to mine. She is nervous and needy."

"I fear for my son, too, who has struggled with substance abuse."



CHILDREN'S CONCERNS

"I am afraid that my mom has a new partner again." (The child associates the mother's crises with the acquisition of new partners.)

"It negatively affects me NOT to have family time."

"I am very afraid that my mom will die from her illness."

" It worries me to leave her alone, I am always checking on her. I feel guilty for interrupting her and wanting her to stay with me because I know that she is tired."

"My mother's illness was caused by the death of the maternal grandmother when she was small, and because I fight with my brother too much. I feel responsible for my mother's illness."

WHAT FACILITATES FAMILY CONVERSATION

“The empathy and the therapeutic alliance achieved in the first session.”

“That the family understand and have clarity about the program and the intention of it.”

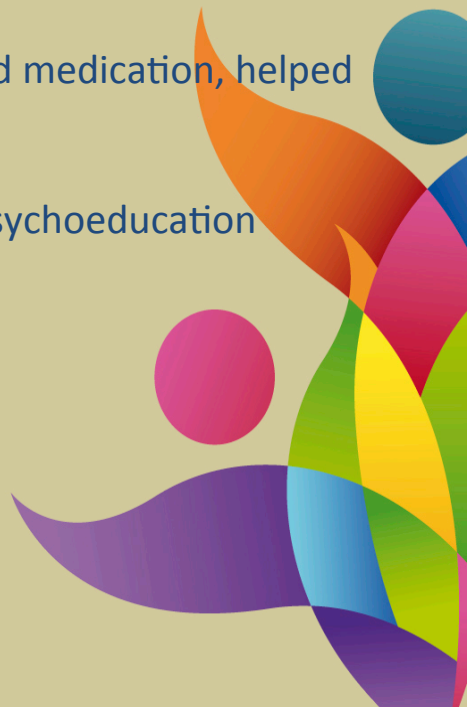
“The active and empathic listening, adjusted to the style of the family.”

“Belief that this program would serve to enhance family relationships.”

“The good referral made by the treating psychiatrist as a recommendation, influenced the mother’s positive attitude toward the process.”

“Knowing the diagnosis for some time, having received psychotherapy and medication, helped and gave a context of openness to a conversation related to depression.”

“The willingness of the mother to participate in the program during the psychoeducation session, generates an empathic, respectful and confidential atmosphere.”



WHAT COMPLICATES THE FAMILY CONVERSATION

"The children being misinformed about the program, its objectives, and the mother's illness."

"Because of these barriers, the work has only been able to be done with the mother and daughter and not the husband. Due to his work, he could not participate."

"People from low income tend to constantly change cell numbers, therefore, it is important to get as much data to contact people by other means, in case the phone number changes again."

"Clinicians who are implementing the process must have the professional skills and also have a high degree of ownership of the program, so they are able to deal wtih any emotional situations that may emerge during the sessions, such as life cycle, patterns of parenting, etc."

"One initial barrier was the suspicion the patient felt about the fact that the sessions would be recorded, however a stronger relationship was established with the clinician to overcome this barrier."

Regarding the families' understanding of depression	• Families understand depression as a medical issue. They recognize their diagnosis, and adhere more or less to the prescribed depression treatment. • Depression seems to be represented as the product of "something wrong" in the person, and, although this is not directly stated, there is a perception that the person has a background of "madness." This divides the family into those who are "sick" and those who are "healthy." • In spite of rational discourse, clinicians can see that, for those who suffer depression, the illness dominates, and they can have little or no influence. Families hope that the expressed will of the patient can be improved.
Regarding the causes of depression	• Overall, both patient and family tend to believe that depression is driven by childhood and current life events. • Depression in families is the product of biology, traumatic experiences, and current situations (e.g., unemployment, marital problems and difficulties with children). They do not make connections that enable them to understand the origins of the disease, its development and its management systematically. For example, there is a family where the husband thinks the cause is the close relationship the wife maintains with her family of origin. • It can be said that, although there is an emerging understanding of biopsychosocial causes of depression, people find it challenging to understand their inter-relationship and give them meaning.
Regarding elements conducive to recovery	• The medical system is consulted, and in many cases accessing the medication assists psychological therapy. The family hopes that, through an act of will, the patient is able to resolve the difficulties; in many cases, the patient feels guilty because, despite the efforts to help her, she is unable to control her symptoms. This conflict is inherent to the dynamics of depression. From the experience of the patient, in some cases the combination of psychotherapy and medication has been very useful.

Regarding the impact on the patient

- Question of own self-worth
- Fear of abandonment
- Fear of losing children through death or in judicial process
- Fear of dying
- Guilt for not being able to resolve their situation, despite many efforts
- Feeling anxiety that is affecting their children
- Feeling pain at being rejected, criticized, questioned, and non-hierarchical in their role as mother and wife

Regarding the impact on the partner

- Strong feelings of helplessness and anger at each other, the patient feels pressured and misunderstood; the husband feels that she does not do enough on her own behalf.
- Threats of separation and psychiatric hospitalization
- Intrusion of the extended family. Though they enter as a source of support, in many cases they become one more stressor.
- Diminishment of sexual life, both in quality and frequency. In many cases it adheres to the rhythm of the illness.
- Bring the issue of coalitions between father, mother and children, and triangulation, to the table.
- In general, the mother lacks power and feels emotionally excluded.

Regarding the impact on the children

- Fears of losing the mother. Here it is possible to connect with the concept of "ambiguous loss." The mother is physically there, but her presence is not felt.
- Solidarity with the mother, parentification of the children who often must become responsible caregivers.
- Anger with the mother, the father or both. Sometimes they feel neglected and loaded with the mother's difficulties, and with struggles between the parents.

Strengths of Families

- ✓Ability to fight
- ✓Ability to put their concerns into words
- ✓Deep interest in the welfare of their children
- ✓In some cases, access to health services
- ✓Faith and spirituality
- ✓Personal skills to engage in work and informal activities
- ✓Ability to connect emotionally when they are invited properly

Regarding the Facilitating Factors

- The willingness of the patient and family for support, guidance and information about the disease, its processes and implications for family life
- The creation of the therapeutic alliance, the base of which includes a cordial, professional relationship and a climate of openness and trust that facilitates the construction of a context to talk about family, naming the experience of depression, and possible effects on the lives of children. The professional relationship is a product of the clinican's disposition to listen, give information, generate pertinent and respectful questions, and to obtain the maximum amount of significant information.
- Have clear objectives for the intervention and maintain the focus of the work
- Understand the referral circumstances, the way that the mother, partner and children understand the meaning of the intervention and its benefit, and understand the family's motivation to participate.

Regarding the Limiting Factors

- The desertion of some couples (i.e., drop-out)
- Husbands' opposition to the process

QUESTIONS

1. How much time can pass between modules without losing utility?
2. If the mother has recurrent depressive crises, is it possible to continue the program?
3. In reviewing the criteria for admission to the study of this adaptation, we see that many of the mothers have had long-term depressions. Should we include other families with a more recent first episode of the illness?
4. How many more families, and what conditions would we need to say that our program has been well-adapted to the realities of families' contexts and varied experiences with depression?
5. What would be the best way to document the process of our adaptation in Columbia?

WHAT FOLLOWS?

1. Finish the process of adapting the PIP Program in Columbia.
2. Think about the possibility of developing joint publications on the results of the Columbian adaptation, and on more general work on the prevention of depression in Columbia.
3. Find ways to integrate PIP with the Columbian health system.
4. Develop a pilot project in Cali concerning the prevention of mental illness, especially depression and anxiety, through a strategy of working with the Columbian educational system and working with preschool teachers and primary school teachers.
5. Strengthen collaborative work between Universidad Javeriana Cali and the Boston team.