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Investigating the Role of Family in Management of Depression Cases Treatment Among Adult Patients in Saudi Arabia Families

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Abstract

Depression in later life takes a heavy toll on patients and families alike. Family members of adults with depression have moderate to high levels of the overall caregiver burden. In contrast, family members may play an important role in the response of older relatives to depression treatment. This research explores the role of family in management of depression cases treatment among adult patients in Saudi Arabia families. Empirical studies are reviewed and research evidence for the use of family therapy interventions is examined. While there are only a few randomized studies that contradict the effectiveness of family therapy compared to other approaches, there is nevertheless a widespread clinical opinion that families should be incorporated into the treatment plan with this population. This research attempts to bridge the gap between our current knowledge of family factors associated with depression in adolescents and the paucity of studies of family therapy outcomes. Family relationships can positively or negatively affect a child's development. This effect also occurs in the opposite direction: the family affects the general health of the child and the child affects the general health of the family.

Keywords: Depression, family, treatment, Family Therapy adult patients, Saudi Arabia.

1. Introduction

Depression is not an easy thing to get rid of, and it is known as severe depression disorder, or clinical depression. It is a disease that affects the soul and the body and affects the way of thinking and behaving, and it would lead to many emotional and physical problems, as it is one of the most prevalent diseases in the world, and people with depression usually cannot continue their daily lives as usual, as depression causes them A feeling of lack of any desire to live. Depression may affect all age groups as it is not limited to a specific age, gender, race or group (Dix & Meunier, 2009).

A family medicine may help treat depression, but in other cases, a qualified psychologist is needed to treat depression, such as a psychiatrist, psychologist, and social worker. It is very important for the patient to have an active role in treating depression. In cooperation and joint work, the doctor or therapist can decide with the patient the type of depression treatment that is best and most appropriate for the patient's condition (Buck, 2018).

Despite the public health and policy importance of the family in the care of people with depression and other chronic diseases, family involvement in providing primary health care for depression has received little attention (Wolf, 2012). This knowledge gap is particularly striking given that family members are important partners in patient-centered care and the home medical primary care model (Stang et al., 2010). Failure to consider family roles (positive and negative) in the treatment of depression may lead to contextual errors (i.e., failure to consider clinically relevant aspects of the patient's psychosocial and environmental context) in medicine (Schwartz

et al., 2010). Understanding the role(s) of the family may be particularly important for older adults, many of whom are accompanied by family members during primary care visits or rely on family members for health-related assistance at home (Wolf and Roter, 2011), and for men Older adults, who may be more conservative in detecting depressive symptoms (Apesoa-Varano et al., 2010).

Depression is a common, disabling and often chronic condition for which there are effective treatments (Park and Unutzer, 2011). Men are at increased risk of treatment with depression, which may contribute to higher rates of male suicide (Crystal et al., 2003; Hinton et al., 2006). Several factors may support the treatment of depression in older men, including criteria for masculinity and gender. As men prefer family involvement in the treatment of depression (Dwight-Johnson et al., 2013), family involvement is a promising strategy for reducing this gender disparity. Determining the role of the family in treating depression may also help clinicians mobilize the family more effectively to improve the care of older men for depression. While relatively few studies have focused on clinician views on treating depression in late life, two previous studies have highlighted clinician views on the important role of family in enhancing care (Apesoa-Varano et al., 2010). Therefore, the main objective of this research is to investigate the role of family in management of depression cases treatment among adult patients in Saudi Arabia families (Hinton, 2014).

2. Literature review

2.1 Depression

Depression is a mood disorder in which a person experiences persistent sadness, negative feelings, and a loss of interest in activities that the person normally enjoys. Also called major depressive disorder or clinical depression (Habib, 2010), it can affect a person's thoughts, behavior, and motivations (Hinton, 2014). It is also one of the most common mental disorders; The World Health Organization estimates the number of people with depression around the world at nearly 300 million (Tölle, 2012).

In general, the disease affects women more than men. It is classified as a mental disorder characterized by mood disorders. The diagnosis is made according to symptoms that mainly affect the emotional sphere: such as constant sadness and the desire to cry, irritability, irritability and anxiety. They may also experience loss of appetite or overeating, decreased concentration and memory of details, hesitation, confusion, feelings of low self-esteem, guilt or hopelessness, and a loss of enthusiasm and interest in work, social life, and usual leisure activities. The most important characteristic of depression is the gradual - or acute and sometimes accelerated - decrease in mood and aversion to activities (Hinton, 2014).

Depression may not necessarily be a psychological disorder, but rather a natural reaction to specific life and environmental events, such as psychological and social stress, poor diet, physical inactivity, obesity, smoking, gum disease, vitamin D deficiency, or the loss of a loved one. Or certain negative feelings derived from emotional disappointment. Depression can also be a symptom of some physical illness or a side effect of some medications (Hinton, 2014). The origin of depression is

multifactorial. Biological, genetic and psychosocial factors may influence. A family history of the disease increases the risk. In some cases, the person suffering from it may begin to abuse alcohol or other psychotropic substances. At worst, depression can lead to suicide. Medically speaking, depression is a serious illness that requires treatment and is often fatal and cannot be affected by a person's strength of will or self-discipline. It is the leading cause of suicide and the second leading cause of death among the 15-29 age groups (Hagop, 2017).

Treatments for depression include psychotherapy, antidepressants, and in severe cases where other treatments do not work, brain stimulation therapy [10] is used, as well as electroconvulsive therapy, which is an effective and rapid treatment for depression (Hinton, 2014).

However, research has shown that some interactions between a person with a mental illness and family members can improve or worsen mental illness. Therefore, family therapy techniques have been developed that protect patients with chronic mental illnesses from the need to enter clinics. Today, the family of a mentally ill person is more involved than ever as an ally in treatment. The family physician also plays an important role in the rehabilitation of the mentally ill person in society. In addition, people with mental illnesses who must be in hospitals are less likely to be isolated and restrained than in the past, and are often discharged earlier from day treatment centers. These centers are less expensive, because there is a need for fewer staff, the focus is on group therapy rather than individual therapy, and people sleep at home or in rehabilitation centers halfway houses (Abdelwahid & Al-Shahrani, 2011).

2.2 Adult depression in Saudi Arabia

In Saudi Arabia, prevalence has been estimated in several studies, with prevalence rates varying across different population groups, age groups, times, and geographical locations. Psychiatric morbidity in primary care in 1995 was estimated at 30-46% of visiting patients (Lowe, 2004). In 2002, depression and anxiety disorders were observed by about 18% among adults in central Saudi Arabia (Shehatah, 2010). Al Ibrahim et al. showed, in 2010, an overall prevalence of 41% in a systematic review of depression (Asal & Abdel-Fattah, 2007). Al-Rifai et al., noted a 17% prevalence of depression among Dammam residents. Al-Qahtani et al., in Asir reported a prevalence of depression of 27% in 2008 (Qureshi, 2009). Abdul Wahed (2011), an overall prevalence of depression approaching 12%, with 6% as severe cases, was reported in the southeastern region. In Riyadh-Becker et al., they found the prevalence of depression to be 20% in primary care settings (Taqui, 2007).

Therefore, Saudi Arabia has a high prevalence of depression, and with a growing population, coupled with increasing risk factors for depression such as chronic disease, modernization stress, sedentary lifestyle and social isolation, along with pre-existing stigmas for developing a mental health disorder, there is a dearth of psychiatrists and supportive resources For mental health, the direct and indirect costs of depression are expected to rise (Chou & Chi, 2004).

In a study conducted in Saudi Arabia to validate PHQ-9, the authors concluded that the prevalence of somatization and comorbid depression in the primary care community in Saudi Arabia is similar to published rates in the United States and worldwide, and PHQ-9 is a valid screening tool

for depression in primary care (Becker, 2002). The PHQ-9 questionnaire contains 9 separate questions. These questions focus on pleasure experience, sleep habits, energy, appetite, focus, and suicidal ideation (Phelan E, 2010), each item being scored 0 with no symptoms at all, then 1 point for several days, 2 points for more than half days, and 3 points for each symptom. Patient had nearly every day for the past 2 weeks, A meta-analysis of 14 studies found PHQ-9 to be 80% sensitive (95% CI 0.71-0.87) and 92% specific (95% CI 0.88-0.95) to major depressive disorder in primary care institutions, compares well with longer or doctor-administered instruments (Abdelwahid & Al-Shahrani, 2011).

The family is a fundamental force in the field of achieving care and even in the treatment process, as it is important in terms of correct identification and treatment of this disease, not only in the beginning but in all stages. They are the ones that provide care, willingly or without it. It also contributes to creating the appropriate atmosphere in which a person suffering from depression lives, and its members may turn into factors helping to recover from illness or vice versa (Buck, 2018).

Depression has a significant impact on the family, and the family has a significant impact on depression. As depression is not only a medical condition, but rather it is a matter of the family concerned. The behavior and moods of those who suffer from depression affect the entire family. There is anger and anger that provokes conflicts and affects family relationships, and leads to the emergence of a pattern of negative thoughts that afflict everyone with pessimism. This is in addition to the withdrawal behavior that leads to the confusion and severing of relationships, and also results in feelings of lack of acceptance and isolation. The basic

responsibilities of family members are also harmed and the tension increases (Taraban, 2017).

It is not possible to reach a correct diagnosis of depression without the role of the family, because many people, especially those who are old or young, or those who suffer from a certain health condition, do not realize that they are depressed or may attribute their symptoms to other things. Thus, the consideration and appreciation of family members is a beneficial factor. In addition, the family's follow-up to the patient's taking of the prescribed medications constitutes the difference between adherence to medication and the continuation of the disease (Alfakhri et al., 2018).

Specialists recommend family members to provide care and attention to those who suffer from depression, because they usually feel isolated and face pain and despair alone. In some cases, depression may lead to a split in the family if some of its members do not understand this matter but rather want to escape from confronting it, while there are other families whose members do everything in their power to treat the patient and improve his health condition to the point of searching for alternative treatment solutions Such as resorting to magic and healers by other means (Abdelwahid & Al-Shahrani, 2011).

Expressing such feelings may lead to tension in the relationship between the patient and his relative. This may also lead to biological effects, as the patient becomes extremely stressed. Studies of brain images have shown that fear centers in the brain are triggered when a person prone to depression listens to a member of his family criticizing him. Also, those critical feelings directed at the patient seem to impede the full benefit of the drug. This is partly due to the fact that the drug works better in treating

symptoms, but that does not necessarily mean that it works better in restoring our normal functioning. It seems that patients improve their condition upon intervention directed in the interest of resolving family issues (Alfakhri et al., 2018).

Family therapy is a type of psychological counseling (psychotherapy) that can help family members improve communication and resolve conflicts. Family therapy is usually provided by a psychiatrist, clinical social worker, or licensed therapist. These therapists who have graduated from or have completed graduate studies with the American Association for Marriage and Family Therapy (AAMFT) may be accredited by (Broderick & Weston, 2009).

Family therapy is often short-term. It may include all family members, or those who are able or willing to participate. The specific plan will depend on the family situation. Family therapy sessions can teach the patient skills to strengthen family relationships and get through tough times, even after the therapy sessions are over. In the case of depression, family therapy can help you:

- Identify specific challenges and how the family deals with them
- Identify new ways of interacting with and overcoming unhealthy patterns of bonding
- Determine individual and family goals and working on ways to achieve them

Family therapy doesn't automatically resolve family disputes or eliminate troubling situations. But it may help the patient and his or her family

members understand each other better and can provide skills to adapt to difficult situations in a more effective way. It may also help the family achieve a sense of participation (Alfakhri et al., 2018).

2.3 Family Therapy with a Depressed Adolescent

Family relationships can positively or negatively affect a child's development. This effect also occurs in the opposite way: families affect the general health of the child and the child affects the general health of the family. This two-way effect is greater when a child has a psychiatric disorder (Practice Parameter for the Assessment of the Family., 2007). When treating children, family interventions are usually more or less incorporated. In fact, child therapy has been referred to as de facto family therapy (Diamond & Josephson, 2005). The psychiatrist or therapist who performs family therapy uses the relationship between the child and the family in order to improve the overall performance of the family. When the family works better, the child does better (Glick, 2001).

Family therapy is a form of psychotherapy that directly involves all family members as well as the 'specific patient' - and is explicitly concerned with interactions between all family members. If the focus is on the set of relationships in which a person is intertwined, the family business can be done regardless of who is involved initially (Broderick & Weston, 2009). The child may be the only individual with overt psychological symptoms. This is because even though one family member may be a 'symptomatic carrier', the whole family is in distress. Interventions in family therapy are directed towards the family as a unit with the perspective that some individual symptoms are the product of relationship struggles within that

unit. These individual symptoms are seen as arising from the matrix of the family system and its complexity. Family therapy is more oriented than a specific type of therapy (Glick, 2001)

The biopsychosocial model attempts to understand the whole person by clarifying the interactions between the biological, psychological and social aspects of the individual. Using this model in relation to the child, the family environment will be the most important social factor. 6 A child's normal development is associated with positive family processes of secure bonding, effective parenting practices, and emotional nurturing environments. On the other hand, risk factors for childhood mental disorders include negative family processes of parental illness, family and marital conflict, coercive parenting practices, and persistent negative influence (Hinton, 2014).

Research using twin and adoption studies was conducted to investigate the influence of genetic and familial factors. One study found that adopted children with a high genetic risk of schizophrenia were more sensitive to negative parenting practices in their adoptive families than adopted children with a low genetic risk of a high genetic risk, which was not seen in children with a low genetic risk. Family functioning characteristics associated with troubled upbringing included a tendency to be critical, to be restrictive, and to have borderline problems. The conclusion was that both genetic risk and the breeding environment were interactive in enhancing protection against or onset of schizophrenia in the adopted child (Heru, 2006).

Family therapy can be divided into several different schools of thought: psychodynamic, structural, strategic, and cognitive-behavioral. Although the goals of each school are similar, the methods and strategies that each school uses are unique. A combination of these approaches is used in contemporary family therapy. The psychodynamic approach to family therapy is based on psychoanalytic theory. From this viewpoint, family psychopathology is based on the intrapsychic processes of individuals (Broderick & Weston, 2009). These intrapsychic processes shape an individual's interactions with others, and more prominently in intense emotional relationships such as those between family members (Buck, 2018).

According to psychoanalytic theory, prominent intrapsychic processes occur in the unconscious. These include repression, projective recognition, some aspects of unresolved grief, and transition. One important concept that includes these processes is "psychological determinism". Psychological determinism refers to the idea that mental events do not occur randomly and that every behavior has a cause or source embedded in an individual's history. The process of dynamic family therapy involves bringing unconscious conflicts between family members into awareness using techniques such as interpretation. Change is facilitated by "working through" distortions of the unconscious transmission of each family member. Through this process, parents become aware of how the conflicts in the current family system relate to their unconscious attempts to control the old conflicts arising from their original family (Broderick & Weston, 2009).

On the other hand, the first task of a structuralize family therapist is to determine the structure of the family. This is achieved through careful observation of how family members speak and interact within the counseling room regarding the current problem (Griffith, 2008). Therapy involves changing the family structure, and this is accomplished by re-creating family dialogues and by manipulating geographic order during sessions and through behavioral duties outside the session. Recreating family dialogues occurs when a therapist instructs a family member to speak directly to another individual rather than someone else about the behavior of a particular family member. This technology is valuable because it forces families to enact transaction patterns rather than describe them (Broderick & Weston, 2009).

Strategic direction is to "focus on the solution." The family therapist is responsible for planning a strategy to solve the presentation problem. Strategic therapy can be viewed as almost the opposite of psychodynamic therapy in terms of focus. The strategic family therapist focuses on how families behave differently, not why families act the way they do. The past is largely ignored, while importance is placed on current recurrent family operations (Broderick & Weston, 2009).

Paraphrasing challenges the way family members perceive family reality based on their individual perspectives. This challenge reframes the symptom or situation in a way that is less conflicting and often more positive. This helps family members see the problem differently and ultimately act differently (Glick, 2001). Restricting the system is when the therapist discourages change or emphasizes the dangers of change in an attempt to push the family toward change as a reaction against the

therapist's advice. A strategic family therapist should encourage the same symptoms he or she is trying to suppress. One must be careful not to appear insincere or manipulative when using this intervention. If done appropriately, the family's perception of symptoms changes from something outside their control to something within their control. Once family members realize they have the power to alter or manipulate symptoms, the elusive quality of symptoms disappears and is replaced by a sense of control (Glick, 2001).

2.4 The role of family in management of depression among adult patients in Saudi Arabia

The family provides emotional support and encouragement. Family members were able to overcome men's depression by supporting them emotionally, helping men deal with symptoms of depression or offering moral encouragement (Taqui, 2007). Many men, for example, described how their wives would counter their feelings of worthlessness or uselessness by assuring men of their intrinsic worth. Other men described how family members instilled a sense of hope for the future when they felt despair. Family members also helped the men solve stressful problems or simply encouraged the men to talk about their stress (Hinton, 2014).

The family encourages self-management of depression at home. Family involvement in the treatment of depression in older men often occurs in the broader context of treatment that men receive for other chronic illnesses. Men have relied on family members, often husbands or daughters, to assist them with a variety of aspects of disease management that have led to the extension of depression treatment men receive in primary care, such as antidepressants or behavioral stimulation. The family's role in disease

management included helping with regulation, counseling and persuasion, and bringing men's attention to their depressive symptoms. For example, family members organized antidepressants and encouraged or reminded the men to take them. When the men ignored or minimized symptoms of depression, family members told the men that their symptoms were serious and encouraged them to talk to their doctors. Family members also helped with other practical aspects of disease management, such as keeping track of appointments, arranging transportation to doctor visits, and helping men implement lifestyle changes (such as exercise, nutrition, and social activity) that were recommended by their doctors (Abdelwahid & Al-Shahrani, 2011).

The family facilitates communication about depression during primary care visits. Family support in the clinic was often an integral part of their participation in the general health care of older men. During primary care visits, family members sometimes disclosed information to caregivers about the man's depressive symptoms. Family members also supported the men in other ways, for example by helping the men understand a doctor's instructions, translating when an interpreter was not available, or simply by being a supportive presence during discussions with doctors about health issues, including depression. In addition, primary care providers emphasized that the perspective of family members was often helpful in obtaining more accurate descriptions of older men's behavior, especially when the older man had a tendency to reduce their depression (Hinton, 2014).

Children from adolescence face a number of developmental challenges that increase their risk of developing depressive symptoms. Examples include

puberty; increased sensitivity to peer evaluations, cognitive changes associated with an imaginary audience and increased social comparison. Hence, a stable family structure and supportive family relationships may protect adolescents from the negative effects of these stressful experiences (Walsh, 2016).

The risks associated with single-parent families with regard to child adjustment have been well documented. Examples include poor school performance, deviation, and poor psychological adjustment (Anderson, 2002). Children in single-parent families are 4.7 times more likely to develop mood disorders than children in two-parent families (Teel, 2016). Children in a two-parent family experience fewer negative life events, are less likely to live in poverty, and have more social support from friends and family (Roy & Raver, 2014). Research on depressive symptom pathways has identified two-parent families as a protective factor against adolescent depression. Costello and colleagues (2008) found that two-parent families predicted membership in the 'not depressed mood' group when compared to the 'depressed mood' pathway group. Although a two-parent family appears to protect against the onset of depressive symptoms, it is unclear whether it reduces children's current symptoms as they enter adolescence. The support that children may receive from having both parents at home may be particularly important for reducing depressive symptoms during the transition into adolescence, given that developmental events (e.g. puberty and sensitivity to peer assessment) are known to increase vulnerability to depression and exacerbate depressive symptoms (Costello, 2008).

Family systems theory may shed light on family relationships that explain improvements in depressive symptoms in children as they enter adolescence. Family systems theorists emphasize the interdependence of individuals within the family, such that the well-being of one family member is affected by the action of multiple subsystems within the entire family unit. The marital subsystem in particular has a prominent influence on children's adaptation (Buck, 2018). A wealth of research has documented the relationship between parental conflict and children's internal problems (Schudlich & Cummings, 2007). Inter-parental conflict is believed to deplete the emotional resources needed for parents to share, keep warm, and monitor their children's whereabouts (Buck, 2018). Despite consistent evidence documenting the negative impact of parental conflict on children, there is little research examining whether a positive parent-parental relationship contributes to a normal reduction in depressive symptoms in children. The absence of parental conflict does not guarantee the child's positive adjustment, but an intimate relationship between parents may create an emotional climate within the family system that supports the child's mental health and reduces symptoms of depression during the transition into adolescence. In families characterized by a positive emotional climate, adolescents seek parental support in discussing problems with their peers and evaluating parental guidance as beneficial (Gregson, 2016).

So far, research has focused on the negative fallout that occurs when marital conflict weakens parenting or the parent-child relationship. The indirect hypothesis can be applied more broadly by using a resilience lens in examining whether intimacy between parents promotes a positive

parent-child relationship. Previous research has shown that parental intimacy is linked to parents' positive perceptions of their infant and their children's sensitivity at age 3 years (NICHD Early Child Care Research Network , 2000). This suggests that parental intimacy may promote a positive parent-child relationship in early childhood, but whether the effect persists through adolescence is unknown. Costello et al (2008) showed that adolescents who reported feeling supportive of their parents were more likely to be in the 'non-depressed group' compared to the 'low stable' or 'high early regression' depression pathway groups (Buck, 2018).

Parental depression may interfere with parents' ability to evaluate children's behavior and respond in an emotionally appropriate manner (Dix & Meunier, 2009). Fortunately, when parents feel each other's support, their depressive symptoms may decrease. Traban and colleagues have argued that this support allows fathers to maintain "routine and regularity in the family," which may reflect the family climate that supports children in their transition to adolescence (Taraban, 2017). One study found that lower maternal depression predicted lower depressive symptoms in adolescents aged 11–15 years. Thus, based on existing research, it is hypothesized that lower parental depression would mediate the association between parental intimacy and decreased depressive symptoms in children (Buck, 2018).

To our knowledge, in Saudi culture, family support is strongly emphasized, and caregivers are expected to support their relatives with dementia, regardless of their financial status or any factors that may limit a caregiver to fully provide the needed support. Compared with the West, in Saudi Arabia, nursing homes are significantly fewer. It is our understanding

based on our knowledge of Saudi society that the notion of patients with dementia residing in nursing homes is perceived as taboo in Saudi culture; therefore, caregivers are obliged to provide the full extent of the required support. This social pressure may increase the burden on the caregivers, exposing them to anxiety and depressive symptoms that may develop to clinical depression (Alfakhri et al., 2018).

3. Discussion

In the treatment of major depression, the role of the family is often defined in terms of what they should not do rather than what they should do. They certainly should not quarrel or pre-empt the authority of the attending psychiatrist. They should not interfere with treatment by suggesting that what the patient needs is vacation, vitamin injections, home remedies of one kind or another, hard work for change, or good talk with him. They should not mock or downplay a patient's fears, no matter how ridiculous they may seem. At the other extreme, they themselves should not be disturbed by the patient's distress which increases his feelings of guilt and distress.

No one should tell patients that it is absurd to feel guilty, because they will feel guilt nonetheless, but they will not talk about it anymore to anyone. The family especially should not argue with them about the reasons they gave for their feelings, because they are not the real reasons. An elderly woman, for instance, may become depressed and attribute her grief to shame due to some minor sexual abuse that occurred as a teenager and which has not entered her thoughts again during the intervening years. Whatever the true cause of her depression, it sure isn't.

The family should not expect patients to be able to explain their situations. Nor should they ask them to work at a level beyond their ability. There's no point in telling them to go out into the world and work - or have some fun - if they can't do it. If they are given a task beyond them, they will fail and feel worse. Nevertheless, they should not be encouraged to give up completely and fall asleep. Most of all, they should not be scolded or punished for their depression. People with major depression don't cry, complain, cling, and act helplessly, but because they can't help it.

Nevertheless, family members play a positive role, as they are the main actors in the life of a seriously ill person. In times of crisis they have the greatest influence on the sick person in their midst, and they are his main resource. Nevertheless, such people are difficult to help, and they are often stubborn and angry; Therefore, family members must be patient and persistent in their determination to provide care. They cannot bear to be angry and raise their hands in despair. When patients become depressed and withdrawn and seem out of their reach, they may still appreciate on some level those normal things that people do for each other. So the family must ensure that patients are not isolated. They should be treated with kindness and tolerance and included in family planning as if they are expected to recover and stay with them rather than fade away. They should not be allowed to make such decisions themselves while suffering from severe depression.

When patients are well enough to stay home, no matter how irritable they are, they should not be isolated in a room away from their children, the rest of their household and the daily chores of the household. In all matters

relating to their treatment plans, they must be informed immediately. Living in a hospital is a very lonely experience, however, and the family, out of their sympathy, must not succumb to any demands they may make for their premature discharge and against medical advice. Generally during this treatment period, they should encourage patients to carefully follow their doctor's advice.

Patients should be reminded that the important issues are not in the irreversible past, or in the unknown future, but in the present. They should think about their days one by one and attend to their daily needs, eat and dress properly and be with other people for at least some of the time. They often do these simple things for the sake of their families. Applying these simple principles of nursing care makes the difference between an illness that comes and goes like any other and one that is so life-disrupting that it predisposes to disability and leaves a lasting mark on the individual and his family.

4. Conclusion

In conclusion, depression is a common health problem among primary care patients. Primary care physicians should be the cornerstone in detecting an underlying depressive disorder and initiating appropriate referral or treatment. The PHQ-9 is one of the most widely used screening tools that should be used in the daily practice of primary health care. Depression is a common mental disorder that causes human distress and costs society significant costs. The research highlighted the role of family in management of depression cases treatment among adult patients in Saudi

Arabia families, which may have long been ignored. Depression tends to negatively affect an individual's quality of life.

Family therapy shifts the psychiatrist's focus away from the child and onto the family as the source of pathology and the goal of treatment. It is clear that a child's mental health stems from genetic factors and family dynamics. Although a child's genes cannot be modified at the moment, family dynamics are at our disposal. The historical background and subsequent findings of the various schools of thought on family therapy are similar to those of schools of thought on individual therapy. It has arisen from theoretical trends in the broader mental health community and sometimes from reactions against earlier trends. Although there are many different schools of family therapy and recommended treatment strategies vary, contemporary family therapy that uses a multimodal approach incorporates insights and techniques from each school of thought based on the needs of the individual family and the style of the therapist.

More research is needed to identify effective strategies for treating and preventing depression in the elderly population. It is also recommended to raise awareness of the benefits of early diagnosis for patients to prevent the main form of depression and to save on health system costs. Depression screening programs should be implemented in primary care settings.

Reference

- Abdelwahid, H., & Al-Shahrani, S. (2011). Screening of depression among patients in Family Medicine in Southeastern Saudi Arabia. Saudi Med J; Vol. 32 (9).

- Alfakhri, Abdullelah & Alshudukhi, Ahmed & Alqahtani, Ali & Alhumaid, Abdulrahman & Alhathlol, Omer & Almojali, Abdullah & Alotaibi, Muteb & Alaqeel, Meshal. (2018). Depression Among Caregivers of Patients With Dementia. INQUIRY: The Journal of Health Care Organization, Provision, and Financing. 55. 004695801775043. 10.1177/0046958017750432.

- Anderson, A. (2002). Individual and contextual influences on delinquency: The role of the single-parent family. Journal of Criminal Justice 30: 575-587.

- Apesoa-Varano EC, Hinton L, Barker JC, Unutzer J. 2010. Clinician approaches and strategies for engaging older men in depression care. Am J Geriatr Psychiatr 18: 586–595

- Asal, A., & Abdel-Fattah, M. (2007). Prevalence, symptomatology, and risk factors for depression among high school students in Saudi Arabia. Neurosciences ; 12: 8-16.

- Becker, S. A. (2002). Screening for somatization and depression in Saudi Arabia: a validation study of the PHQ in primary care. Int J Psychiatry Med ; 32: 271-283.

- Broderick, P., & Weston, C. (2009). Family therapy with a depressed adolescent. Psychiatry (Edgmont (Pa. : Township)), 6(1), 32–37.

- Buck, K. (2018). The role of family processes in depressive symptom recovery during the transition to adolescence Ment Health Addict Res, .

- Chou, K., & Chi, I. (2004). Childlessness and psychological wellbeing in Chinese older adults. International Journal of Geriatric Psychiatry ; 19: 449-457.

- Costello, D. S. (2008). Risk and protective factors associated with trajectories of depressed mood from adolescence to early adulthood. J Consult Clin Psychol 76: 173-183. [Crossref].

- Crystal S, Sambamoorthi U, Walkup JT, Akincigil A. (2003). Diagnosis and treatment of depression in the elderly medicare population: predictors, disparities, and trends. J Am Geriatr Soc 51: 1718–1728.

- Diamond, G., & Josephson, A. (2005). Family-based treatment research: a 10-year update. J Am Acad Child Adoles Psychiatry. ;44(9):872–887. [PubMed] [Google Scholar].

- Dix, T., & Meunier, L. (2009). Depressive symptoms and parenting competence: An analysis of 13 regulatory processes. Developmental Review 29: 45-68.

- Dwight-Johnson M, Apesoa-Varano C, Hay J, Unutzer J, Hinton L. (2013). Depression treatment preferences of older white and Mexican origin men.Gen Hosp Psychiatry 35: 59–65

- Glick, I. (2001). Marital and Family Therapy. Washington, DC: American Psychiatric Press, Inc.; . [Google Scholar].

- Gregson, K. E. (2016). Are They Listening? Parental Social Coaching and Parenting Emotional Climate Predict Adolescent Receptivity. J Res Adolesc 26: 738-752. [Crossref].

- Griffith, J. S. (2008). Psychiatry. Third Edition. Hoboken, NJ: Wiley; . Family therapy.

- Habib, Z. M. (2010). . Dictionary of Diseases and Their Treatment: The first comprehensive dictionary of all the terms and definitions of diseases circulating in the world. Dar Osama for Publishing and Distribution.

- Hagop, A. (2017). Mood Disorders: Clinical Features". In Sadock, Benjamin; Sadock, Virginia; Ruiz, Pedro name-list-format = vanc . Kaplan and Sadock's Comprehensive Textbook of Psychiatry (10th). New York: Wolters Kluwer.

- Heru, A. (2006). Family psychiatry: from research to practice. Am J Psychiatry. ;163:962–968. [PubMed] [Google Scholar].

- Hinton, L. &.-V.-J. (2014).). A descriptive qualitative study of the roles of family members in older men's depression treatment from the perspectives of older men and primary care providers. International Journal of Geriatric Psychiatry. 30. 10.1002/gps.4175.

- Hinton, Ladson & Apesoa-Varano, Ester & Unützer, Jürgen & Dwight-Johnson, Megan & Park, Mijung & Barker, Judith. (2014). A descriptive qualitative study of the roles of family members in older men's depression treatment from the perspectives of older men

and primary care providers. International Journal of Geriatric Psychiatry. 30. 10.1002/gps.4175.

- Lowe, B. G. (2004). Diagnosing ICD-10 depressive episodes: superior criterion validity of the Patient Health Questionnaire. Psychother Psychosom ; 73: 386-390.
- NICHD Early Child Care Research Network . (2000). Factors associated with fathers' caregiving activities and sensitivity with young children. Journal of Family Psychology 14: 200-219. [Crossref].
- Park M, Unutzer J. (2011). Geriatric depression in primary care. Psychiatr Clin North Am 34: 469–488.
- Phelan E, W. B. (2010). A study of the diagnostic accuracy of the PHQ-9 in primary care elderly. BMC Fam Pract ; 11: 63.
- Practice Parameter for the Assessment of the Family. (2007). J Am Acad Child Adoles Psychiatry. ;26(7):922–937. [PubMed] [Google Scholar].
- Qureshi, N. V.-H. (2009). Criteria for a good referral system for psychiatric patients: the view from Saudi Arabia. Eastern Mediterranean Health Journal ; 15: 1580-1595.
- Roy, A., & Raver, C. (2014). Are all risks equal? Early experiences of poverty-related risk and children's functioning. J Fam Psychol 28: 391-400. [Crossref].
- Schudlich, R., & Cummings, E. (2007). Parental dysphoria and children's adjustment: marital conflict styles, children's emotional

security, and parenting as mediators of risk. J Abnorm Child Psychol 35: 627-639. [Crossref].

- Schwartz A, Weiner SJ, Harris IB, Binns-Calvey A. (2010). An educational intervention for contextualizing patient care and medical students' abilities to probe for contextual issues in simulated patients. JAMA 304: 1191–1197.

- Shehatah, A. R.-S. (2010). Prevalence and correlates of depressive disorders in elderly with type 2 diabetes in primary health care settings. J Affect Disord ; 123: 197-201.

- Stange KC, Miller WL, Nutting PA, et al. (2010). Context for understanding the National Demonstration Project and the patient-centered medical home. Ann Fam Med 8(Suppl 1): S2-8–S92.

- Taqui, A. I. (2007). Depression in the elderly: does family system play a role? A cross-sectional study. BMC Psychiatry ; 7: 57.

- Taraban, L. S. (2017). Maternal depression and parenting in early childhood: Contextual influence of marital quality and social support in two samples. Dev Psychol 53: 436-449. [Crossref].

- Teel, K. V. (2016). Impact of a Father Figure's Presence in the Household on Children's Psychiatric Diagnoses and Functioning in Families at High Risk for Depression. J Child Fam Stud 25: 588-597. [Crossref].

- Tölle, R. (2012). Psychiatrie. , ISBN 978-3-662-22357-4, S. 238–239, Online. Archived January 25, 2019 on the Wayback Machine website.

- Walsh, F. (2016). Strengthening Family Resilience. NY: The Guilford Press.
- Wolff JL, Roter DL. (2011). Older adults' mental health function and patient-centered care: does the presence of a family companion help or hinder communication? J Gen Intern Med 27: 661–668
- Wolff JL. (2012). Family matters in health care delivery. JAMA 308: 1529–1530.