Family relationships and mental illness: Impacts and service responses

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The significance of mental health problems in Australia cannot be overstated. Prevalence estimates from the 1997 National Mental Health and Wellbeing Survey indicate that around one in five adults had experienced a mental health disorder, including depression, anxiety and substance use disorders, within the previous 12-month period (Andrews, Henderson & Hall, 2001). Information on the burden of mental disorders serves to emphasise the seriousness of the issue; around 680,000 work days per month are lost due to sickness absence for mental health reasons (Lim, Sanderson & Andrews, 2000). Depression plays a significant role in these figures, and is expected to become the second leading cause of disease burden and the major cause of disability worldwide by 2020 (Murray & Lopez, 1997). Mental illnesses such as depression are also a major risk factor for suicide.

The presence of mental illness can have a significant impact on family relationships and dynamics, and as such the burden of mental illness is particularly relevant for family relationship services for a number of reasons. These include:

- Mental disorders impact not only on individuals but also on those around them—including immediate family and other relatives—and can be both a cause and a consequence of family or relationship difficulties.
- Although most common mental disorders are amenable to treatment, the majority go undiagnosed and untreated.
- Many disorders are chronic or recurrent and often call for long-term management, not just acute care.
- Much of the care provided for people with mental disorders (even very serious disorders) is informal care provided by family members.
- Many of the “vulnerable” family groups that represent the clientele of family relationship services have a greater risk of mental health problems than the population average.

Clients of a family relationship service may present with issues linked to mental health problems in many ways. One example is a changed or changing relationship arising from a family member’s mental illness, which may involve issues related to living with, or caring for, that person.

Living with someone who has a mental health problem

Research indicates that mental illness in married couples co-occurs at a greater level than expected by chance. Explanations for this co-occurrence (or spousal concordance) include that:

- People marry partners who are similar to themselves, and this could include existing, or a propensity for, mental health problems.
- Spouses have similar life experiences and environments after marriage and these contribute to mental health status.
- Mental health problems in one spouse impact on the mental health of his or her partner.

The intrinsic connection between mental health and marital relationships is complex, and additional aspects of a spouse’s behaviour, such as violence, sexual or psychological abuse, or more common forms of negative marital interactions, such as hostility or threats, may have strong effects on mental health.

The experiences of children living with a parent who has a mental illness has attracted greater attention in recent years, with Australian estimates of between 21–24% of children living in such households (Maybery, Reupert, Patrick, Goodyear & Crase, 2005). Outcomes may include a detrimental impact on their direct care or socioemotional wellbeing, an increased risk of developing mental health problems, and a range of feelings, emotions and reactions such as confusion and fear. Children may grieve for the relationship they once had with the parent who has a mental illness.

Caring for someone with a mental health problem

Interest in the experiences of carers has increased since deinstitutionalisation, when the role of families in caring became more prevalent. Estimates suggest that more than one in ten adults are carers (ABS, 2004). Whilst not all these carers look after a person with a mental illness, there is consistent evidence that informal caregiving is associated with poorer mental health. This may be related to the burden of caring, often defined by the degree of impairment or severity of the disability and associated symptoms. Caring, however, is not
always a negative experience, with many carers indicating that their role had brought them closer to the recipient and that the role can be rewarding or gratifying.

Caring can have an impact on social networks, in particular at the onset of caring. This is an important consideration, as social support for carers can serve as a protective factor against stress associated with the role. Stigma associated with mental illness may erode the morale of carers and result in a withdrawal of support. This may be especially true for CALD families, as beliefs about the causes of mental illness amongst some CALD communities can impact on the acceptance of families dealing with these issues. For example, beliefs such as mental illness being the result of bad deeds, criminal behaviour or bad karma, or that mental illness is contagious.

**Responding to mental health problems in a family relationship service**

Despite the challenges, there is an undoubtable public health opportunity within the family relationship sector for mental illness prevention and early intervention. The capacity of a service to deal with clients’ mental health problems is likely to vary according to resources, knowledge and skills, but three approaches seem appropriate:

- Mental health problems of a less serious nature may be amenable to being dealt with in the context of family or relationship counselling or therapy, depending on the skills and knowledge of the professional involved.
- Serious mental illness, substance use or dual diagnosis issues may require referral to specialist care before family or relationship issues can be addressed.
- A collaborative approach between specialist family relationship services and mental health treatment services, with a close interface between sectors at a local level.

**Assessment of mental health problems**

Assessment and referral procedures are the cornerstones to any of the above approaches. Unfortunately, no simple assessment exists that would indicate the most appropriate approach for any one individual. Complicating this issue is that potential clients with mental health problems may choose family relationship services as they are not directly associated with mental illness, thus reducing the stigma attached to help seeking. In the absence of information gleaned from formal assessment tools, indicators of mental health problems may include an inability to fulfil daily roles (e.g., parenting, work), a feeling of being overwhelmed, a fear of “losing it” (particularly with children), and/or specific suicidal thoughts. If there is no immediate suicide threat and referral is appropriate, general practitioners or Community Health Centres are typically first ports of call in the absence of specialised mental health services.

**Dealing with a client’s mental health problems within the service**

Practitioners can help alleviate mental health problems for clients in three key ways:

- Provision of information on: recognising mental health problems; local sources of treatment and support; self-help approaches that promote wellbeing or alleviate distress.
- Encouragement and support to deal with mental health problems.
- Teaching or reinforcing problem solving skills that may help to deal directly with, or minimise the stress related to personal problems.

Particular needs for carers may include: support for dealing with challenging issues; education, particularly at the onset of an illness; understanding and empathy; and respite. The challenge is to provide families with an opportunity to care while minimising the associated social and economic costs.

**References**


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1 Culturally and linguistically diverse