abstract

Family Therapy in the Context of Families with Older Members and Members with Dementia: A Review

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Seniors are one of the fastest growing population groups in Canada.[1] Approximately 20% of our population is over the age of 65, and this phenomenon has been referred to as the "graying" of the population.[1,2] Families often play a central role in the lives of older people. "Life's rhythms and seasons" are usually marked within the context of the family.[3] Whether independent or dependent, older people view the family as integral to their daily life and wellbeing.[4] When dependent, the family offers crucial support,[3] especially in cases of dementia. Alzheimer's disease (AD) is the most common cause of severe intellectual deterioration in the aging.[5] Approximately 8% of people over 65 years and 35% of people over 85 years suffer from dementia.[6] The majority of patients with dementia live in the community and are cared for by family and/or friends.[7] However, research into and the clinical application of family therapy techniques and principles in older people and their families has been slow to develop.[3] This may be due to the fact that early practitioners of family therapy focused on families in which a child or young adult was the identified patient.[2]

Key words: Dementia, Alzheimer's Disease, Family Therapy, Family, Systems theory

Objective

The objective of this paper is to review the application of the principles of family therapy to the older family, with specific reference to the condition of dementia. This will include a discussion of the relevance of the influence of cultural and ethnic factors and the consideration of a case study from the author's own practice. Finally, the development of a teaching strategy enabling physicians to apply these concepts to interactions with students will be discussed.

Method

A literature search was performed on Medline from 1966 to the present. The search string used was "systems theory" or "family therapy" or "family support" and "aged" and "dementia". The search was limited to human subjects and the English-language literature, and initially to review articles. Articles published after 1990 were preferred. This strategy resulted in 62 articles of relevance. The abstracts of these articles were reviewed to determine their relevance to the objective. Relevant articles were pulled and their bibliographies were reviewed for more relevant articles. When possible, preference was given to randomized controlled clinical trials. Journal articles were supplemented by a selection of textbooks culled from a search of the Department of Family Medicine Library and the Sigmund Samuel Science and Medicine Library at the University of Toronto concerning family therapy in older people.

Results

The above search resulted in 20 articles and six texts of relevance, on which the remainder of this review is based.

Discussion

Background

Principles of Family Therapy as Applied to Older Families

Concepts important to this consideration of the older family include family organization and structure, systems and subsystems, roles and rules, boundaries and hierarchy.

Family Organization and Structure

Marital and family therapy encompasses services provided to individuals, couples and families that seek to improve or enhance interpersonal relationships.[8] The locus of behavioural or emotional disturbance is ascribed to the entire family unit, rather than any one individual.[9] For the older person, family structure may often be modified and extended. Unlike the classical extended family, members may not live under one roof or depend on each other for economic survival, but the essential emotional ties and interactions include partaking in common activities and mutual support.[9] With the increase in the number of people living to 85 years and beyond, multigenerational families are now commonplace.[8] While some older people are isolated, most are active members of these multigenerational families, often both giving and receiving support from other members, and sometimes con-

tributing to intergenerational conflict.[2] Such conflict often occurs at times of major transition, such as grandparenthood, retirement, widowhood, illness, relocation and disability.[10] This adversity can affect the well-being of the older person as well as other family members. In general, families are very important social relationships for the older person.[3] As a result, some authors have advocated that clinicians always consider family when assessing and counselling older patients.[2]

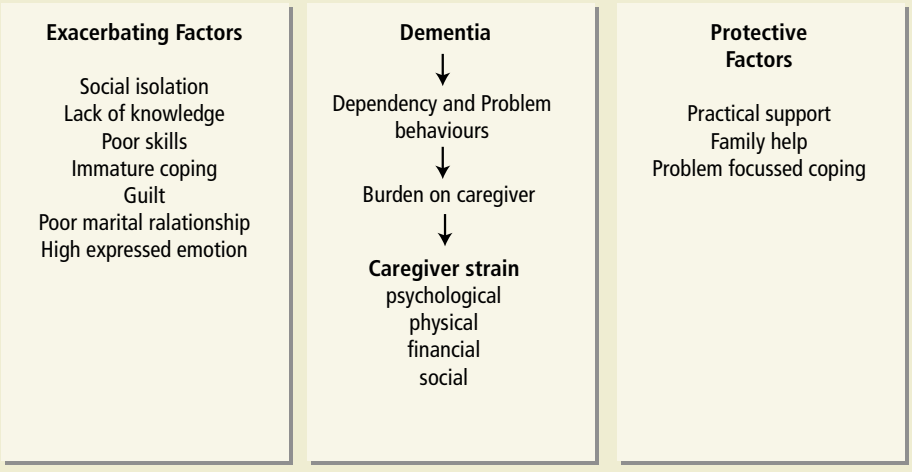
The structural approach to family theory views families in terms of systems and subsystems, roles and rules, boundaries, power, and hierarchy.[11] In other words, families are organized and structured within roles and behaviour patterns that are used to engage in specific tasks to make the family function.[2,12] A healthy family maintains clear boundaries between individuals and subsystems, encourages individual growth, actively promotes generational hierarchies and provides rules that are flexible and adaptable to internal and external changes facing the family.[11] Organization refers to the consistent way in which people in the family system are related.[8] Structure designates family arrangements, such as nuclear or extended families, as well as the way in which various components or subsystems of the family are arranged with respect to boundaries, hierarchy, roles and routes of communication.[2,8,12] Such structure within a family allows family members to support an individual's health by defining who will take responsibility for specific family functions, but it can also be the root of family dysfunction. For example, who will take care of the grandmother now that she is sick? Family members are viewed as operating within subgroups called subsystems. Problems can occur when a subsystem is not performing its necessary function(s). These units usually serve particular tasks such as decision making.[3] For example, who will be the one to decide to place grandmother in a nursing home? Boundary refers to what lies inside and outside a system. Boundaries can be characterized on a continuum of enmeshment (over-involvement) to disengagement (lack of connection). How boundary lines are drawn around older people is a major potential cause of family conflict and dysfunction. Over-intrusive or neglectful children and bossy elders are symptoms of boundary issues. Family therapy may involve renegotiation of these boundaries between the older and middle generations to rectify existing enmeshment or disengagement. Hierarchy refers to the organization of a family's generations, with each having a different level of status and power. Dysfunction can occur at this level when a family's hierarchy is either unclear or fixed in a pattern that may have suited an earlier stage in the lifecycle but no longer works. An example would be an older mother who still treats her adult son as a child, with the result of alienating or emasculating him at a time when she is in need of critical support.[2]

Each member of a family system plays a role—a set of predictable behaviours. Roles are often influenced by the family of origin and cultural factors. For example, in a family the prominent role sets are that of husband and wife, and of parent and child. Family members also can play other roles such as victim, prosecutor or rescuer, depending on the situation.[2,8] However, in a healthy aging family there needs to be role flexibility to allow adaptation to changing circumstances. This allows families to share or reassign tasks in response to developmental needs and emergencies. Such a family is poised to support the adjustments of the older members in later life, such as caregiving and nursing home placement.[2] In addition, most families have stated or implied rules about who plans for certain family functions such as care planning for aging parents. In the case of a widowed, demented older patient, this often falls on the shoulders of the patient's daughter(s).[13]

Family Dynamics

As a "system," the family has specific characteristics that are typical of other systems.[8] The family is dynamic (constantly changing), and for routine functions such as the provision of food, clothing and shelter, the family regulates itself to achieve homeostasis (actions in a family are met with reactions that balance the system). However, in a healthy family this is coupled to anamorphosis where revised perspectives can lead to growth. The family operates on the principle of equifinality—regardless of the initial problem, the same reaction patterns are used to maintain balance. This principle can lead to the scapegoating of certain family members. All family behaviours, even symptoms, serve a positive function for the family system, every family member plays a part in the system, and every action in a family system generates a reaction.[8]

Figure 1: Model of Effects of Dementia on Caregivers



Source; Brodaty H, Gresham M, Luscombe G. The Prince Henry Hospital Dementia Caregivers' Training Programme Int J Geriatr Psychiatry 1997;12:183-92

Transitions in families alter structures in ways that are likely to affect the family's capacity to meet an older member's needs. Examples include birth, death, marriage, divorce, significant changes in health and nursing home placement. With these transitions, family structures morph to accommodate the changes brought about by these transitions. Most of these structural shifts occur without a dysfunctional disruption, and often positive wellbeing results form the adjustment process.[3] As a result, poor adjustments to older life events such as heart attack or retirement are relatively rare, and a true renegotiation of relationship structures within the family is often unnecessary. However, in families caring for a person with dementia, renegotiation of family decision-making sub-systems is the norm, and successful execution of this renegotiation is predictive of good outcomes for the patient.[3,14]

Role of Family Therapy in the Elderly

Family therapy is relevant to those families whose structures impede effective family functioning or whose structures have not adapted to the changing family context.[3] Such therapy attempts to either change a system's functional approach towards a task or the structural makeup (systems, subsystems) that the family uses. Some family systems are adequately "structured" to meet the needs of members at times of transition but lack necessary information, skills or personal or environmental resources.

Such families can accommodate to developmental changes in the lives of the older member if provided with information or resources. Examples include self-help books, lectures, homecare, respite care, etc. On the other hand, family structure may not be sufficient to support the developmental needs of the older member. For example, a weak marital bond may show up in a couple when one member is ill or disabled, such that the healthy spouse shifts responsibility for care of the ill spouse to the adult children.[3]

An Approach to Family Therapy in the Elderly

One of the early approaches to family therapy in older adults comes from the work of Herr and Weakland. They hypothesized that "most of the problems you will encounter in your counselling with elders and their families will be problems created by and perpetuated by inappropriate solutions."[15] Their counselling approach consisted of a series of seven related steps, which I felt were quite practical and useful:

1. Establishment of initial contact
2. Problem definition
3. Attempted solutions
4. Determination of minimum goals
5. Review and planning
6. Interventions
7. Termination

During the initial contact, the counsellor gives the family permission to talk about feelings, personal problems and the reason for seeking counselling. He or she conveys the idea that family members can help one another to address the problem. The next step is to define the problem because only then can it be solved. At this point the problem is redefined as belonging to the entire family—the identified patient is usually only the "weak link in a stressed chain."[9] The third step is to determine what solutions have already been tried to direct the therapy away from failed measures, but also towards ones that have been partially successful but perhaps terminated prematurely. The counselor is a useful guide here but the responsibility for coming up with solutions rests with the family. The family must always be designated the agent of change so that its members are empowered to choose what works for them, given their unique needs. Next, the family identifies the smallest amount of change necessary to give a sense of progress. This subdivides the family's problem into manageable pieces. The next step is an integration of the problems in the family system by the therapist—relating the problems to the family and looking at relationships between various aspects of the problems and different family members. After this, the therapist is ready to consider specific interventions such as reframing the problem, thus allowing the family to find its own solutions.[3] Termination involves giving the family credit for finding solutions as well as imparting a sense of restrained optimism.

The Influence of Culture on Family Therapy in the Elderly

Ethnicity may be instrumental in affecting how family members view or respect a family hierarchy.[2,11,16] For example, the traditional Chinese family is highly structured with clear generational boundaries and roles. In this context, the therapist is often seen as an expert and must be more direct and assertive in the therapeutic process. Also, these families may not espouse traditional Western ways to resolve conflict, favouring strong family ties over individual growth and autonomy.[16] Such factors must be kept in mind when dealing with ethnic families. Whenever there appears to be a block to therapy, ethnic and cultural issues should be considered.

Ethnicity is especially relevant to the consideration of family in the context of dementia because it may strongly influence who is in change of caregiving and decision making.[17] One example is that African-Canadians may be more likely than Caucasians to include the elderly in their family structures and to regard them with more respect. It is hypothesized that the institutions that the Caucasian family views as supportive (government agencies, educational institutions, etc.) may be perceived by black families as more exploitive.[17,18]

Application of Family Therapy to Families with a Demented Older Member

The vast majority of the cognitively impaired elderly receive their ongoing care from family members.[3] Most of the demented elderly live with or near family members.[13,19] Caring for these

impaired older members can be seen as a normative experience for many families.[3] However, assisting a relative with dementia often results in family problems and is more difficult than caring for someone with physical health problems alone.[19] Some of the consequences for the carer include financial hardship, physical health problems, emotional problems related to isolation, and conflicting responsibilities as well as restrictions of time and freedom.[10] Indeed, multiple family members may respond in competing ways with conflicting plans.[3] Some of these conflicting family relationships may even lead to poorer outcomes for the demented patient—one example being early nursing home placement (Figure 1).[20]

Conflicts can arise between parents and children, among the children or even between the children and grandchildren. The work of family therapy then is to assist individual family members and the family as a whole progress beyond old family conflicts and towards roles that will support the care of the demented older relative and the effective functioning of the family.[19]

One of the most significant changes that a family with a demented older member must address is the altered decision-making structure within the family.[3] This is to ensure that patients do not endanger either themselves or other family members through poor decisions. One example is to evaluate whether additional assistance to care for the patient is required. However, each decision to remove or add assistance alters the decision-making hierarchy further. In this context, the generational hierarchy of the family is paramount. Early in life, parents hold absolute power for decision making for their children. This power is gradually relinquished through childhood, adolescence, until there is recognition of mutual autonomy in adulthood. The older marital couple will make decisions, but at the death of one parent, decision making will shift to the other parent. If this parent's cognitive abilities decline, the children will be forced to get involved.

Active family restructuring occurs in family members who care effectively for demented older members.[3] Families with clear decision-making structures (generally featuring one designated decision maker who gets input from others but is ultimately responsible for the decision) do better than those with more democratic/less organized systems.[14] Families who resist changes in decision-making structure or families with more "boundary ambiguity" report more depression than those families with clear boundaries.[21] Older members of these families are more likely to be institutionalized.[3] This mirrors research into families caring for persons with chronic illness, whereby families with low cohesion, high conflict, overly rigid or permeable boundaries, disorganization, hostility, excessive criticism and lack of clear communication do worse over time.[22]

To be continued in an upcoming issue of *Geriatrics & Aging*: Gauging the results of family therapy for caregivers and families of demented older individuals. ◆

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