abstract

Part II of this series briefly reviews the literature on the success of family therapy in families with dementia. A case from the author's practice (with significant details modified to conserve privacy) is then presented with a view toward applying family therapy. Finally, as the author has an interest in medical education, a proposal on how to integrate family therapy for families with dementia into an educational program is briefly described. The author welcomes comments and suggestions at darcy.little@geriatricsandaging.ca.

Key words: dementia, Alzheimer's disease, family therapy, family, Systems Theory.

Family Therapy in the Context of Families with Older Members and Members with Dementia: Part II

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Family Therapy in Families with a Demented Older Member: A Literature Review

The body of literature concerning the effectiveness of family therapy for those coping with an older demented member is relatively new. The content of the interventions for caregivers and families of demented patients is varied, ranging from education only to education and counselling to counselling only (Table 1).[1] There have been several systematic reviews [2,3] and non-systematic reviews [1,4] addressing the effectiveness of psychosocial interventions for caregivers and families with a demented older member. In general, the overall methodology of studies addressing the effectiveness of family therapy in this context is poor. Sample sizes are small and interventions and randomization procedures are poorly described.[2,3] Approximately two-thirds of the studies show no improvement.[1] However, those studies that fare best include a social component (support group, increased social supports, improvement of social skills, and social activities for caregivers)[1] or a combined social-cognitive intervention (cognitive problem solving, cognitive therapy, or improved cognitive skills). This is attributed to the fact that carers of patients with dementia are prone to social isolation, which affects their mental heath and consequently their caregiving abilities. The social component of the therapy addresses this. The cognitive component also enhances the psychological well being of the carer.[1] Several studies make the point that the older demented person should be involved in therapy. They may not recall all the content of such sessions, but they will recall being included and taken seriously.[2] There is likely a role for both approaches—psychoeducational approaches may be used to prevent a crisis and more systemic approaches to provide counselling in a crisis.

It is not my objective to review each study individually; however, several studies fared well in the systematic reviews.[5,6,7] In 1993, Mittelman *et al.* published a randomized controlled trial to ascertain whether a multifaceted, structured treatment program could enable spouse-caregivers to postpone or avoid nursing home placement while at the same time minimizing the negative consequences for themselves.[5] There were 120 female caregivers and 86 male caregivers in the study. One hundred and three were randomized to each of the treatment and control groups. The treatment group received a comprehensive intervention, including individual and family counselling sessions as well as an AD support group. The participants in the treatment group could also request additional help, advice or counselling at any time. Education was a key component of the intervention. The counselling included two sessions with the caregiver alone and four sessions with the caregiver and the family. These sessions were tailored to address problems uncovered in an initial intake evaluation. They aimed to improve

understanding and communication between the caregivers and the family, to educate the family members on the effects of AD on patient behaviour, and to resolve conflicts resulting from the impact of AD on the family's ability to share responsibilities. The control group received informal counselling and resources, and only when these were specifically asked for. The study served to stave off nursing home placements in the treatment group. While there were 35 nursing home placements within one year of intake, 11 were in the treatment group and 24 were from the control group ($P<0.05$). Nursing home placement was also correlated to the need for assistance with ADLs, patient income, and the age of the patient and the caregivers (Table 2).

A further analysis of the above data published in 1996 concluded that caregivers in the treatment group intervention were only two-thirds as likely to place their spouses in a nursing home, and that on average, the time from baseline to nursing home placement was 329 days longer in the treatment than the control group ($P=0.02$) (Figure 1).[6]

Another aspect of the same intervention was published by Mittelman *et al*. in 1995. They found by a complicated regression analysis that the comprehensive program maintained the level of depression in the treatment group caregivers as measured at 4-, 8-, and 12-months by the Geriatric Depression Scale, whereas the level of depression in the control group caregivers increased over the same time period.[7]

In summary, it appears that social support, including family therapy, of families can have a significant impact on both nursing home placement of demented elderly and on levels of depression in their family caregivers.

Analysis of a Case Study: The Case of "EG"

The analysis of a case study may be useful to illustrate many of the points in this paper. Presented here is the case of EG, a 76-year-old woman in my practice with combined progressive Lewy body dementia and Alzheimer's dementia. Her condition has deteriorated significantly over the last six months. She also has hypertension and Paget's disease of the pelvis. She is hard of hearing and intermittently wears a hearing aid. She is on Ramipril 10mg po od, hydrochlorothiazide 25mg po od, and Aricept 5mg po od. She lives alone in her own home since being widowed in 1995. A 40-year-old daughter lives out of the country. Her 45-year-old son, Jim, lives nearby and helps her with groceries and yardwork. He, however, works as a truck driver and is on the road six days per week. Jim is married and has two pre-teen children of his own. EG and Jim's wife, Barb, have never seen eye to eye. Jim's job has put a great deal of strain on his marriage. He and his wife argue regularly, more so over the last six months, although there have never been any physical fights. A further strain is that their youngest son, Adam, is having difficulty at school, getting into fights with other kids and doing poorly in his classes over the last six months. Yet Barb has always been and remains supportive of Jim helping his mother. She has adjusted their schedules so that he can assist her when he is home. She often helps with EG's grocery shopping. They are united when helping EG.

The Aricept, supervised by a geriatrician, initially seemed to stabilize that patient's cognitive decline. However, she has increasingly prominent visual hallucinations. She "sees" a man in her house who repeatedly tries to rape her. The son is often called over to combat this man. EG even calls Jim on his cell phone when he is on the road and demands that he come home to help her with this man. Judicious use of antipsychotic medications do not help, and EG occasionally begins calling 911 when she "sees" this man. EG refuses homecare/ nursing support in her home because she doesn't want "more people disrupting her

Table 1: Elements of Caregiver Interventions

Psychological
– Support ventilation, group process, sharing, acknowledging, learning, mutual support, recognition of universality
– Counselling, insight therapy, cognitive therapy, relaxation training, stress management
– Emotional impact—stress, anger, grief, guilt
– Self-care
– Interpersonal relations and communication
Educational
– Information
– Improving home care skills
– Developing therapeutic skills, problem-solving, behavioural techniques
– Planning—emergencies, legal, financial
Developing support system
– Personal, family
– Community
– Professional

Source: Brodaty H, 1992

Table 2: Change in Patient Status within 12 Months of Baseline

Status	Treatment Group(n=103)		Control Group (n=103)		Total (n=206)	
	Number	%	Number	%	Number	%
Patient at home	83	80.6	74	71.8	157	76.2
Patient placed in nursing home	11	10.7	24	23.3	35	17.0
Patient died	9	8.7	9*	8.7	18	8.7

* Four patients in the control group died after nursing home placement, therefore, percentages do not add up to 100%
Source: Mittlemann, 1993. Copyright © 1993, The Gerontological Society of America. Reproduced by permission of the publisher.

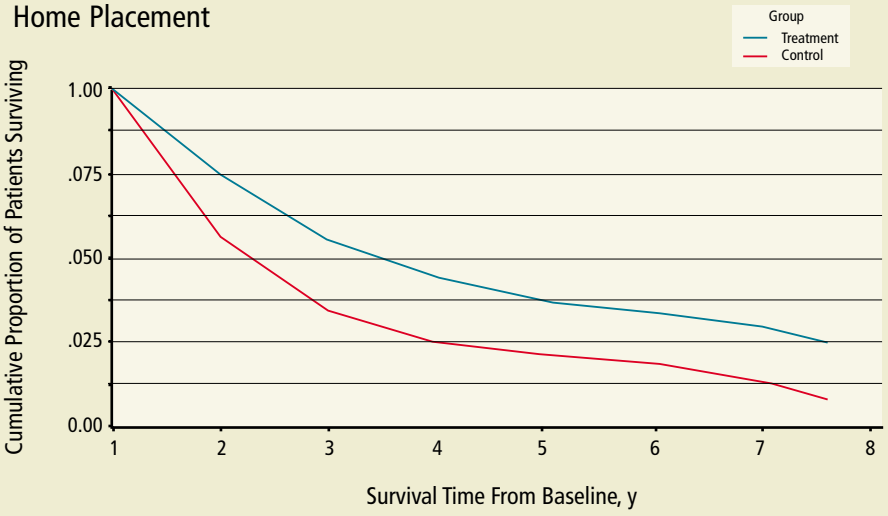
home." She feels it is Jim's responsibility to help her out after all she has done for him. (She gave him and his wife the down payment for their home.) She has been and remains quite critical of Jim and has always been very involved in his life. She is adamant in her refusal to consider nursing home placement. She will not leave her home. Jim has considered having EG move in with his family, but Barb absolutely refuses this suggestion because it would further disrupt their sons—particularly the troubled Adam.

This family is in conflict. EG is at a time of transition: she is symptomatic from her dementia and is unable to function independently in the community as she has previously. Her "modified extended family" includes Jim and his family, who are experiencing significant stress in their new caregiving roles. Boundary and hierarchy issues are playing a role. EG's enmeshment with Jim leaves him uncomfortable making decisions her care. Jim's sister, who lives in Australia, was always closer to EG and often contradicts Jim's actions long distance. The added caregiving stress on Jim is also affecting his health. He has been drinking and smoking more in the last six months. The stress is affecting Jim and Barb's marriage, and as a result, they are less effective as a parenting sub-system and as a sub-system aiding EG. Their level of cooperation with respect to EG has diminished.

A family therapist would likely be very helpful to this family.[8] Through "joining," the structural therapist could make contact with each family member. While respecting the family, she could work to understand and empathize with the family's problems. Through this process she may be accepted by the family, and the trust and mutual respect that develop will allow concrete therapeutic approaches to be implemented. The therapist could use enactment or psychodrama—the family members are thereby encouraged to act out their problems rather than just talk about them, allowing a clear view of family structure. From outside the enactment, the therapist can seek change by coaching the family on how to engage in, objectify, and redirect the dynamics of the family drama. This encouraging and assisting of family members to interact in different ways is possibly more effective than simply providing insight into the family's problems, although it would still be important here to help them see that all the current difficulties are related. Restructuring could be used to develop alternative familial interaction patterns. An example would be to block inappropriate communication channels and direct family members to develop new ones. Reframing could also be used. Instead of blaming the problem on one individual member, EG, the family dilemma could be reframed positively. This may promote change through alternative methods of behaviour. Jim and Barb were functioning well as a team in dealing with EG's illness, but with continued deterioration and stress, they are now in dysfunction. With help they can be effective again.

It is unlikely that education and in-home resources alone will suffice to bring this family back to proper functioning. As

Figure 1: Survival Curves for Time to Nursing Home Placement



Source: Mittelman, 1996. Adjusted for sex, patient age, and patient income. Curves are from a Cox proportional hazards model and are depicted as the mean of the covariates.) Copyright © 1996, American Medical Association. All rights reserved.

well, EG moving in with Jim and Barb would likely exacerbate rather than rectify the situation. The therapist could facilitate communication among the family members, including the sister in Australia, about possible solutions. What happened in the case of this family was that EG's visual hallucinations became so frequent and disturbing that she required hospitalization on a psychogeriatric ward for stabilization and was ultimately transferred to a nursing home. Despite this conclusion, therapy could still play a useful role. A therapist could help the family assimilate this information and encourage them to see that they did their best, that they improved their functioning as a family, but ultimately EG needed more specialized care.

A Teaching Strategy for Family Therapy in the Context of Families with Older Members and Members with Dementia: The PBSG Program

I am currently a program director for the Practice Based Small Group (PBSG) Learning Program at McMaster University, so I may be biased; however, I feel that a small group module would be ideal for use among medical students, residents, or practicing physicians to cover this topic.[9] PBSG modules are educational modules developed by practicing physicians and peer-reviewed by family physicians and relevant specialists. They provide a synthesis of evidence-based and reality-based medicine. The modules have a specific format. They start with defining a gap between ideal and current practice. In this case, the gap shows that issues of family are not always well addressed during periods of family conflict brought on by an older member's dementia and possibly requires nursing home placement. Next, the modules usually have several case studies relevant to the topic. One could be the case I discussed above. Each case is followed by questions to stimulate group discussion. Questions here could be:

1. How can the problems of this family be seen in the context of family structure and organization?
2. Who is the real "problem" in this family?
3. What techniques would the family therapist use to assist this family?

After the questions, there is an information section that would discuss the essentials of family therapy and the evidence behind its use. Finally, there are often chart aids or algorithms to aid the practicing physician. I would include a card briefly describing the issues and definitions to consider in structural family therapy. Finally, the module would end with resources that the physician could consult for further reading. When a group discusses a module, they emphasize how, practically, the knowledge contained in the module can be integrated into daily practice, and they complete a group log sheet to formalize a commitment to changes they will make to their practice after doing the module.

Conclusions

Many older adults maintain close ties to their families. Families become a critical support system for many aging individuals in mental or physical decline. However, it is precisely at these periods of transition that family conflict can occur. This is especially true in the case of Alzheimer's Disease, because by definition the decision-making hierarchy in the family usually needs to change. This paper has reviewed the role of family therapy in the care of the aging, with a specific relevance to dementia. In summary, older people are family members too, and the clinician should "think family" when problems arise at this age.[3] ◆

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