

EDUCATION UPDATE
Fundamentals of theory and practice

Family Therapy with the Elderly

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This article outlines health and lifestyle challenges to elderly persons and associated changes in their family systems. Flexibility, related to attachment patterns, is considered central to healthy adaptation. Family therapy approaches and relevant systemic and cultural factors influencing psychotherapy with the elderly are discussed. Key family therapy concepts and strategies (genograms, transmission of family histories and circular patterns of interaction), are reviewed and exemplified. Four types of family therapy presentations are elucidated by composite case examples. Firstly, the elderly person can be the identified patient. Secondly, another family member can seek help for him/herself in relation to the elderly person. Thirdly, another family member can be the identified patient without direct reference to the elderly person. Finally, the wider health care system involved with the elderly person and family can be the focus of therapy. Family therapy offers important conceptual and strategic advantages in working with the elderly and their systems.

Mother: 'My memory is getting worse. I am forgetting more and more. What will happen to me?' Daughter: 'It's OK, it's all part of getting older. You will be fine.'

Mother is expressing her fears about her health and her concerns about the future. Her daughter is reassuring her that her problems are a normal part of the aging process. This was a longstanding pattern in their relationship; whenever one of them expressed pain or concern, the other would minimise, reassure and offer hope. On reflection, the daughter became aware of the pattern and recognised that she was resisting the idea that her mother was showing early signs of cognitive impairment, might need help, and might not be as strong and as competent as she had always been. When the next opportunity arose, the daughter responded differently.

Mother: 'My memory is still getting worse. What will happen to me?' Daughter gives her mother a hug and says, 'I don't know. Whatever will happen, I will look after you.' Both become tearful. Mother: 'You will find me a place where they will look after me.'

When the daughter can hear her mother's fear, mother and daughter join emotionally and prepare for the hard road ahead. Mother is grateful that her daughter understands what is happening and that she is committed to taking care of her. The daughter is grateful that her mother gives her permission, and perhaps even encouragement, to place her in care when the time is right.

Mother and daughter are confronting an important life cycle stage and its associated stressors. The feelings are expressed and shared and a change in the relationship pattern is foreshadowed. In future years, the mother will frequently say to her daughter and to others that there was a time when she was the mother and cared for her daughter; now her daughter cares for her.

This interaction exemplifies a major role reversal which can occur as an elderly person becomes less able. It also highlights reactions to loss, severe illness, fear of the future and the unknown. When the family experiences high levels of stress in response to beginnings of progressive decline in the functioning of the elderly parent, members are likely to continue with relationship patterns which may now be inappropriate. In the vignette above, the existing coping pattern, one of denial and reassurance, was experienced as unhelpful and so a change was made. In this vignette, change was occurring in the elderly person's cognitive capacities. Changes can also occur in physical and emotional functioning and in independent living capacity. The consequent stress and trauma can disrupt the equilibrium of the family system and demand new patterns of functioning.

This paper reviews emerging approaches to understanding and working with the elderly from a family therapy perspective. It briefly discusses the range of challenges to individuals and families brought about by a family member moving through the elderly life cycle stage. Family therapy principles and practices which facilitate creative transitions by family members are then explored. Against this background, four types of family presentation are conceptualised, depending on whom the plea for help relates to.

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CHALLENGES TO ELDERLY INDIVIDUALS AND THEIR FAMILIES

Definitions of the age at which we become elderly vary, but a generally accepted age is 65. Recent literature suggests a differentiation between 'old' (60-80) and 'very old' (80+) (Orbach, 1996). Major changes in physical and social spheres can bring positive or negative experiences, or a mixture. The individual may encounter retirement from the paid workforce, grandparenthood, loss of a partner, illness, decline of physical, sensory or cognitive capacity (including continence difficulties) and associated dependency on caregivers. Epidemiologically, this age group is more prone to major depression, dementia and medical illness, conditions which may interact with each other. The individual recognises the proximity of death and usually becomes aware of a need to review his or her life's significance. This may lead to a new meaningful and satisfying synthesis of these experiences (Erikson's 'ego integrity'), or to a sense of despair grounded in regret that life has lacked meaningful achievement (Erikson, 1963; Oates, 1997) or to various combinations. Grief, often unresolved and ongoing, over losses across a lifetime, can play a central part. The complexity of major physical, cognitive, emotional and social changes confronting the elderly presents powerful challenges to existing ways of being.

Changes for the individual entail challenges to ongoing family processes. The family must find new ways of being that take account of the elderly person's development as well as the development of younger members (Carpenter, 1994; Erlanger, 1990; Herr and Weakland, 1979). The development of a new equilibrium in the family system (Benbow, Egan, Marriott, Tregay, Walsh, Wells and Wood, 1990; Bogo, 1987; King, Bonacci and Wynne, 1990; Montalvo, Harmon, and Elliott, 1998) involves renegotiation of communication patterns, role relations, power hierarchy and family structures, including boundaries and rules. Resolution of dependency issues is particularly important (Greene, 1989).

For all families engaged in this process of change, there is likely to be a revisiting of past shared experience, possibly accompanied by a resurgence to conscious awareness of past relationship patterns, which may present further challenges to existing patterns in the system. Changed roles can generate warmth, love and mutual expressions of caring, with appropriate adjustments. Unresolved conflicts between family members and past disappointments in relationships, with the associated emotions of fear, rage, sorrow, disgust and distancing, may arise (Goldstein, 1990; Miller, 1989; Virtanen, 1993; Watzlawick and Coyne, 1980). Family interactions may become dominated by ambivalence, rejection, outright hatred or neglect, in response to resentment and guilty feelings hitherto suppressed or even repressed. Fear and protectiveness may reappear, with family members being excluded from information about illness or financial affairs. Other family members may distance themselves from the elderly person through fear of becoming ill themselves, through shame associated with the older person's behaviour, from stress

associated with providing care (Pruchno, Peters, Kleban and Burant, 1994; Snowden and Brodaty, 1986) or from guilt about being unable to meet the elderly relative's needs. These changes in roles often occur at the same time as middle aged children, commonly referred to as the 'sandwich generation', are reassessing relationships with partners and seeing their own children launch into independence. Cultural beliefs regarding aging, disability and illness may influence expectations of self and other family members. Comments such as 'They are tired and just need to be left alone', 'No point trying to talk to them, they just complain' or 'They have finished their contribution to society', reflect attitudes of ageism and/or the impact of stress on middle aged children. Scapegoating may be a common response to the discomfort.

Particular subsystem patterns which may emerge include helplessness and control issues between parents and children (Miller, 1989; Salamon, 1998; Virtanen, 1993), rivalry and fairness issues between siblings (Anderson and Hargrave, 1990; King et al., 1990) and separation and jealousy within a marital couple (Carni, 1989). This can be a crisis time when tyranny of the elderly by their children may become a pattern, when middle aged siblings may fight over appropriate responses to their parent/s, when alliances between parent and child are formed to help the ill or 'incompetent' parent, and when financial insecurities arise, especially in relation to powers of attorney, preparation of new wills, and accusations of undue influence being exercised by one child or by the elderly person's partner.

Flexibility of roles is a key factor in determining healthy adaptation through this life cycle stage. Each family's response to these challenges evolves from cultural and family patterns developed for stability and integration. Change occurs in the context of established patterns of attachment between family members (Antonucci and Akiyama, 1993; Crose, 1994; Pruchno et al., 1994), such that predominant patterns of secure attachment can be expected to enhance creative change, whilst patterns of anxious or avoidant attachment may hamper the capacity of members to renegotiate their relationships confidently and successfully.

FAMILY THERAPY WITH THE ELDERLY: INTRODUCTION

Since the publication in 1979 of *Counselling Elders and their Families* (Herr and Weakland, 1979) authors (mostly in the USA) have begun to focus on systems based approaches to work with families of the elderly (Hargrave and Hanna, 1997a; Richardson, Gilleard, Lieberman and Peeler, 1994; Shields, King and Wynne, 1995). Family therapy models drawn on include problem-solving or solution-focused strategic family therapy (Bepko, 1984; Bonjean, 1989; Bonjean, 1997), contextual family therapy (Atwood and Ruiz, 1993; Hargrave and Hanna, 1997b; Viney, Benjamin and Preston, 1988), systemic family therapy (Mazor and Mendelsohn, 1996; Pottle, 1984) and self differentiation therapy (DeGenova, 1991; Greene, 1989; Quinn and Keller, 1981).

Factors Influencing Psychotherapy with the Elderly

The relative dearth of literature on psychotherapy with the elderly is gradually being addressed, especially with the publication in 1996 of Orbach's *Not too Late: Psychotherapy and Ageing*. A number of systemic factors influencing psychotherapy with the elderly can be identified.

Discomfort with psychotherapy and disclosing 'private' matters

This age group generally has little experience with the psychotherapy process and has expectations that assistance will be biomedical rather than psychosocial. There is also embarrassment or discomfort with talking about 'private' matters which they 'should be able to deal with in the family' (Roper-Hall, 1993). Not wanting to 'wash dirty linen in public' is a common concern. It is important to explain the psychotherapy process clearly, to clarify why the process may be relevant at this point in time and to use language that is appropriate, for example, the term 'meeting' is likely to be more familiar than 'session'. Breaking the process down into segments is also likely to be helpful, for example, offering two or three meetings to gather information and look at the options is more likely to gain acceptance than offering weekly therapy sessions.

Attitudes of other helping professionals to psychotherapy

Medical, nursing and allied professionals and agencies are likely to be involved and their attitudes may influence therapy. For example, the local doctor may think that seeing a family therapist is a waste of time or the nurse in a residential facility may think that talking about things is unnecessarily upsetting. Conversely, these professionals may be supportive and communicate the value of therapy to the elderly person and his or her family. The therapist needs to understand how therapy is being viewed by other involved professionals.

Influence of physical, cognitive and sensory impairments

It is vital that the therapist understand any limitations associated with the condition of the elderly person and how these may influence the therapy process. A constructive dialogue with other treating professionals and family members may be valuable in obtaining such information. For example, hearing impairment and memory loss may require accommodation to include the elderly person in an effective way. Clarifying these needs and adjusting for them is also important in modeling to family members and treating professionals.

Influence of medication on behaviour and on therapy

The elderly generally use many different medications which may affect their behaviour. Often the elderly person and/or his or her family are concerned about particular

medications or their side effects and may have difficulty in communicating about this to the person prescribing. Often several practitioners are prescribing and the family may welcome assistance to clarify questions for discussion with the GP.

Concerns about financial and medical responsibility

Financial arrangements can be significant. Temporary and enduring financial and medical arrangements may have been drawn up with appropriate working through of feelings and in the context of trusting relationships, or they may be associated with resentment and underlying anger, hurt or mistrust. What will happen to the money if the elderly person becomes incapable of managing his or her affairs, or dies, can be a major issue and is often unspoken by relatives for fear of appearing greedy, playing favourites, etc. A related issue is medical power of attorney, concerns associated with who will take responsibility for decisions about health care. Difficulties in raising these issues can arise both for the older person and for family members, often associated with denial of declining capability and fear of dependency, infirmity and death.

THREE FAMILY THERAPY FUNDAMENTALS

Genograms

Genograms are central in work with the elderly (Erlanger, 1990; Ingersoll-Dayton and Arndt, 1990) and with the richness and complexity of their life experience, a great deal of important information emerges. Genograms should include the elderly person's family of procreation, but should also include their siblings, parents and possibly grandparents. Thus the genogram is likely to be four or five generational. For this population, who are facing their own mortality, focusing on those who have been before them will allow them to talk about their anxieties and wishes for their own remaining years. They will also be able to talk about their experiences of the illness and/or death of their parents and siblings and to share some of these with other family members. A genogram will also offer an opportunity for talking about the elderly person's early years, and cultural changes (if migration has occurred) and encourage a natural framework for life review, relating problems to a context and to the past. Completion of a genogram is generally an empathic, comfortable activity for the family, takes the focus away from the 'identified patient' and recognises the expertise of the elderly person. It can help to close generation gaps and provides information regarding strengths in the family.

Transmission of Family History

The writing of autobiographical accounts by elderly people is an important therapeutic process (Botella and Feixas,

1993). It can be threatening if it opens up areas which have not been thought or talked about for some time, and accordingly should be undertaken slowly, after considerable discussion and in the context of an ongoing therapeutic relationship. Life review therapy (DeGenova, 1991) involves reminiscence, using family albums, scrapbooks, genealogies, reunions and pilgrimages. This enables transmission of family history to take place to following generations.

Some communities have generated a structure or context in which such transmission occurs. For example, survivors of the World War II Holocaust and their children and grandchildren have the opportunity to share in community based commemoration processes in many countries. Over a 50 year period since the end of World War II, previously untold secrets and traumas have been shared with younger generations. Schools have encouraged children to interview grandparents and record their experiences, movie directors have established a precedent for talking about difficult experiences and a community ethos has developed that survivor memoirs are very important for future generations and should be recorded. Many books have been written by survivors and their children and have included detailed accounts of the interactive processes of opening up these areas both from the viewpoint of the survivors and of the children (for example, Rosner Blay, 1998).

Recounting and being heard validates the older person's experience, can be cathartic emotionally and can bring about a sense of peace and closure for the individual and family. The process needs to be within a context of time and space appropriate to the individual's life experience. There may be a history of secrecy or suppression of information and both the older person and the family need to be ready to hear and absorb the emotion associated with the telling of the story. Silence after trauma also needs to be respected (Lang, 1995). Thus opening up family histories can be very positive, but respect for, and sensitivity to, the culture of the individual and the family are critical.

Circular Patterns

Circular patterns of interaction can lead to unproductive repetitions of the status quo and in many instances a spiralling into more destructive patterns. Through their repetitive influence, resistance to change becomes entrenched, blocking the therapists' attempts to facilitate new ways of thinking and behaving. From the therapist's perspective, identifying circular patterns requires conceptualisation of a balanced interaction where the involved parties are perceived as simultaneously influencing and being influenced. Usually both parties in a circular pattern have similar underlying feelings, such as helplessness, emotional hurt and rejection, which cannot be expressed openly. Working with circular patterns enables the therapist firstly to conceptualise the pattern of mutual feelings and interaction and secondly to assist the parties to gain strength so that their communication can become more overt.

Betty, an 85 year old lady, was admitted to an aged care facility after two episodes of depression and some concern about suicidal behaviour. She had been living alone since her sister Mary died, not long before Betty's admission. She was the eldest of four children. Her brother died when he was a young boy and she and her sisters grew up in a South American country, children of divorced parents. When conditions became politically difficult, Betty and Mary received a permit to emigrate to Australia whilst their sister Joan and mother stayed in South America. Betty never married; Mary married and had one child, a son, Barry, who is now 54, married to Deborah, with a child, Vivienne. Deborah and Betty had never had a good relationship.

Betty had taken a range of anti depressant medication, none of which seemed to help, according to the treating psychiatrist. At the aged care facility her behaviour was of concern to the staff. In particular, she refused to eat for long periods of time and also refused any medication. She would lie on her bed and stare vacantly at the ceiling. When the cleaner came in she would not respond and all attempts by the nursing and kitchen staff to communicate with her met with no response. She was referred to the therapist working at the Home.

The therapist took time to develop a relationship of trust by visiting Betty weekly over a three month period. Three circular patterns were identified:

Betty's relationship with her treating medical practitioner. Betty was angry with and frustrated by the GP, who was called in by the nurses to 'fix the problem'. In Betty's perception, the nurses and the GP colluded to treat her like a child and she was particularly enraged when the GP said to her, 'There is nothing more we can do for you. Pull yourself together'. Betty felt the GP did not understand her.

Both the doctor and Betty were feeling helpless and powerless. The GP needed Betty to improve so that he would feel useful and appreciated by the staff. Betty needed the GP to understand how she felt, especially the helpless feelings she had, and to take some time with her, listening to her distress. The more Betty needed time from the GP, the more the GP felt exasperated, helpless and distanced from her. The more the GP behaved in an exasperated way and distanced from her, the more helpless Betty felt and the more she withdrew and refused food and medicine.

Betty's relationship with the staff of the facility. Betty felt that the staff 'bullied' her by trying to force her to eat and take her medication. She said that they even threatened to send her away if she did not cooperate with them and she felt quite humiliated by them.

Both Betty and the staff were feeling helpless. The more Betty refused to eat and accept medicine, the more the staff felt afraid that she would become ill or die and they might be held responsible. Accordingly, they bullied her to help her and threatened to send her to hospital if she did not cooperate. The more they bullied and threatened, the more Betty felt that they did not understand her and wanted to get rid of her, and the more she withdrew into not eating and wanting to die.

Betty's relationship with her nephew Barry who has her power of attorney. Betty believed that Barry was using her money for his own ends and without authorisation from her. She felt that he was doing this under the influence of his wife Deborah and was very hurt that he would do this whilst she was alive when in fact he was the sole beneficiary of her estate and would get everything in due course anyway. At the same time, he was her only living relative and thus Betty was reluctant to tell him of her concern in case he abandoned her completely.

Barry and Betty both felt uncomfortable and guilty and covered these feelings up by being nice to each other. At the same time, both felt

the other's discomfort and distancing. Betty felt guilty about Barry because she did not trust him with her power of attorney and did not like his wife. Barry felt guilty about Betty because he did not like the burden of caring for her and felt she was ungrateful.

Identifying the circular patterns was the first important step. Sharing some of these patterns with Betty strengthened her because she was perceived and treated by the therapist as an equal party to the others in the circular pattern. As Betty felt stronger, she began to consider options, such as sacking her doctor, telling the staff what she needed and having some joint meetings with Barry and the therapist. Role play and empty chair techniques facilitated Betty's expression of feeling. Betty talked about her parents, the separation between them, their deaths, the secrets, the discrimination that her family suffered, and her grief about many things, particularly her most recent loss of her sister. She also began to get up in the morning and get dressed, eat her meals, take some interest in her appearance (including hairdressing) and assert her views about what medication was useful.

FOUR TYPES OF FAMILY THERAPY PRESENTATIONS

The value of systemic conceptualisations and approaches as discussed above is exemplified by the range of ways in which elderly people and their families can present with a plea for help. The plea for help can relate directly to the elderly person as the identified patient, to another family member in relation to the elderly person, to a family member as the identified patient without direct reference to the elderly person, or to the network of health and other professionals involved with the elderly person and family. Four types of presentations are proposed and demonstrated by typical vignettes which use composite case examples to safeguard confidentiality.

The Elderly Person as the Identified Patient

The elderly person is the identified patient and help is sought by him/herself or by a family member. Therapy can occur with the individual elderly person, with family members, or with a combination.

Jane, aged 75, was widowed with one son, Tom, married to Marie. Jane had been helping her grandson, Mark, financially. Mark continued to ask Jane for more money and did not talk to his parents who were angry with Jane for giving him money against their wishes. Jane was feeling increasingly frail and lonely and felt caught between wanting to help Mark and wanting to have a good relationship with her son and daughter-in-law. She was also concerned that she might need to appoint a power of attorney to look after her financial affairs and was not sure that she trusted her son. She was very agitated, a little confused and depressed. The family therapy process commenced with some sessions with Jane. Jane then told Tom and Marie about the sessions and suggested that they meet with the therapist, which they did for several sessions. The next step was some sessions between Jane, Tom and Marie. Mark became involved further on in the process and attended sessions with his parents.

Jane needed to be heard and to have her views understood and feelings validated. The family therapy approach opened up an opportunity for Jane to invite other family members into the process. Care was taken to clarify with Jane that the invitation should be an expression of her own need rather than a blaming of the others. For example, 'I have been upset about our relationship and have sought the help of a therapist. She has said that she would be pleased to meet with you with a view to possibly having some joint meetings further on so that we can improve our communication' is less likely to cause escalation of conflict and blame than 'My therapist wants to see you'. The process of assisting Jane to invite others in also strengthens her and increases her options in handling her difficult situation. Interventions with other family members need to be sensitive to their perceptions and as they feel stronger also, the possibility of joint meetings can be pursued.

John, aged 43, was worried about his 73 year old mother, Claire, who was increasingly 'eccentric' and who believed that Edward, her husband of 50 years, had tried to kill her and might try again. Claire's doctors prescribed anti depressant medication and advised Claire to leave Edward. John, an only child, believed that the attitude of the doctors was exacerbating Claire's fears and worsening the relationship between his parents. John reported a longstanding history of relationship problems between his parents but did not believe that Claire would leave her husband. Although his father had a bad temper, John did not believe he would hurt his mother. He wanted some help for his parents' relationship and was prepared to be involved as needed. The therapist first met with John, then with John and Claire, then with John and Edward. Further on in the process, sessions were held with Claire and Edward.

Sometimes medical conditions, depression and/or early stages of cognitive decline can exacerbate difficult behaviours. Arguments can develop, each party believing the other to be wrong and blaming the other. Children can be caught between parents, struggling to help them, yet feeling powerless and stuck. It is important to validate each party's position and reframe the behaviour of the other in a more positive way if possible, for example, 'John must care about you a great deal to be so concerned about your relationship with your husband'. The role of other helping professionals (such as Claire's doctors) can reflect their feelings of powerlessness with these presentations and their consequent attempts to solve the problems presented to them by prescribing solutions such as separation. The family therapy role may include working with the doctors as well as with the family and also helping the family place the doctors' advice in perspective.

A Family Member seeks Help for him/herself in Relation to an Elderly Family Member

A person may wish to obtain help for him or herself in relation to problems generated by changes in an elderly family member. In this situation, the elderly person may or may not be involved in the process.

Margaret aged 55 was very upset because her mother was rejecting her, and she needed help for herself to 'accept her lot in life'. Margaret alternated between being very angry and very tearful. Her mother, Irene, had been living alone and showing early symptoms of cognitive decline. Margaret had taken on the role of carer and called in daily to check that Irene was all right. Margaret had a high profile job and lived alone, her two children living their own lives away from home. Her brother, Tim, lived in Melbourne also, but they had both agreed that Margaret was the best person to care for their mother. Some three weeks earlier, Margaret had become concerned because Irene had lost a lot of weight and on one occasion refused Margaret entry to her house. Margaret rang a local aged care team and they came to Irene's house, forced the door and took Irene into care. When Margaret went to visit her mother at the residential facility, Irene hit her and told her never to return. Margaret was very distressed and felt very guilty about making the call to the aged care team.

Her brother Tim was angry with Margaret because he believed that she should have consulted with him before making the call and agreeing to have their mother moved. After several sessions, Margaret was able to identify that she was angry with the team because when she rang she wanted some help and strategies to deal with her mother better and instead she found that the situation escalated out of control. She also did some work on her grief about the changes in her mother, her resentment about the pressure of caring combined with her job demands, her failed marriage, and her conflicts with one of her adult children. She invited her brother to come to some sessions. Long standing sibling issues were aired and some resolution occurred. Tim and Margaret were able to work out a shared view of how to look after their mother. Margaret was able to apologise to Irene. She also wrote to the aged care team describing her frustration and disappointment about their reaction to her call, explaining how she would have preferred them to have proceeded.

Margaret's presentation illustrates the importance of sibling relationships when changes occur in the elderly sub-system. Old patterns which have lain dormant may emerge, with jealousies, competitiveness and triangulation occurring. Often the elderly person is aware of and distressed by what is going on and may feel helpless about it. His or her symptoms may be an expression of this conflict. Thus although the plea for help is often couched in terms of wanting the parent treated, the first response may need to clarify the issue and involve the sibling or some other family network.

It is important not to respond in the first instance by seeing the elderly person as 'the problem', because this exacerbates the triangulation in the system. It is preferable to invite the person presenting the problem to initial therapy sessions, then, in the process of seeking information, to invite in others in that subsystem, such as siblings and possibly partners. Other helping professionals may respond to the plea for help in these situations by trying to effect change in the elderly person, when the need is actually in the person presenting the problem. This scenario demonstrates how high stress levels can be expressed in terms of blame of the elderly person and the importance of careful assessment of what the cry for help means. Rapid action in terms of institutionalisation, hospitalisation or drugs can be very traumatic both for the elderly person and the family members.

A recurring issue for families is balancing the elderly person's safety against their freedom. For the carers, there is often anxiety that if an accident should occur they would feel responsible or blamed because they did not take sufficient care. On the other hand, as with Margaret, prioritising safety can bring about confusion for the carer, and for the elderly person, anger and deterioration of functioning in response to the institutionalisation and guilt.

Another Family Member as the Identified Patient

Stresses in one generation can have significant repercussions in other generations. Children and grandchildren may present with symptoms which do not initially appear to have any relationship to the elderly, but in fact are directly related to changes in that elderly person. Presentations can be associated with responses to acute changes in the functioning of the elderly person or to chronic processes, such as unresolved transgenerational issues which are affecting all or some members of the family. Cultural and belief systems about illness and care are particularly important.

Depression, relationship problems and adolescent acting out are examples of symptoms which can be associated with changes and stresses occurring in elderly people. A genogram will make the association evident.

Robert was concerned about his son, Richard, aged fourteen. Richard's grades had slipped and he was mixing with 'undesirable' company. The situation reached boiling point when Richard was found to have stayed out all night when his parents thought he was asleep in bed. It also appeared that Richard was using marijuana. Robert attended with his wife Margaret, and Richard. At the session Richard appeared sullen and withdrawn, Robert seemed tense and angry and Margaret alternated between sympathy for Richard and anger with him for letting them down, feeling worried that he could not be trusted any more.

After the genogram was drawn there was a silence and change in atmosphere. Richard looked at his father in particular and Robert looked tearful, especially as the difficulties associated with his mother's dementia were discussed. He said that he generally tried to put his feelings out of his mind and dealt with each crisis as it arose. Richard said: 'I guess I didn't know how difficult looking after Gran has been'. There was a sense that the family had joined in a new way and that a taboo subject, grandmother's dementia and Robert's grieving, had been opened up.

Although the presenting problem was Richard's behaviour, when the genogram was drawn it became clear that Robert's distress levels about his mother were very high. Had the therapist not identified this area of family difficulty, the focus would have remained on Richard's adolescent behaviour and attempts to change this may have failed because the important family issue had not been identified. Robert had been withdrawing from his wife and from his children in his grieving for the changes in his mother and his struggle to care for her. Richard felt his father's absence but thought it was in response to his bad behaviour, which made him feel more ashamed and

bad about himself. Accordingly, he behaved even more badly. He was also worried about his parents' relationship and did not know what was causing the problem. The therapeutic process included offering an opportunity for Robert to identify his distress about his mother and for the family to hear this. Further steps were to have sessions with Robert and Margaret, helping them share Robert's grief, discuss the caring for his mother and look at parenting strategies for Richard which included sharing of feelings. Richard's behaviour was reframed from 'bad' to 'distressed' and Robert's behaviour was reframed from 'distant' to 'upset and grieving'. The work with the parents also clarified that whilst Robert had been distant, Margaret had turned to Richard for support. The couple work released Richard from the triangulation, freed him up to be himself and assisted Robert and Margaret to focus on their relationship.

The Wider System as the Focus of Therapy

The elderly interact with many systems, including medical, home care, residential and hospital, cultural and religious organisations. Families often need help in clarifying their relationship, and working more effectively, with these systems. Misunderstandings with doctors, concerns about residential care, the rush to shorten stays in hospitals and lack of respect for cultural or spiritual beliefs when they may not accord with the Australian norm, occur commonly. Thus families can present seeking help or advocacy in interacting with systems.

Jane's mother, Sophie, aged 85, was in a residential care facility where she had been for five years with a slowly declining vascular dementia. Jane reported significant sleep and eating disturbance and anxiety symptoms which she believed were associated with her feelings of powerlessness and helplessness when communicating with the management and staff of the facility. She was unhappy about many of the agency's practices concerning the hygiene and toileting of her mother, believing that her mother was being unnecessarily and punitively humiliated. Her attempts to speak to management of the facility resulted in her being told that she could take her mother away if she was not happy with the care being offered. Therapy commenced with sessions with Jane, looking at clarification of the problems. The work focused on Jane's grief about the changes in her mother and review of the ways she had been communicating with the home. As Jane felt supported and strengthened, she was able to plan her discussions with the staff so that they were more effective and less threatening for both sides.

Organisations may also request help. This may occur in a residential setting, where assistance is sought for the system as a whole, perhaps through staff training or group work, or for particular interactions between residents, family and staff, a common triangle which can exacerbate difficulties.

The Director of Nursing of a 100 bed facility asked for help for the staff who were having difficulty with the family of one resident where a major conflict had arisen. The therapist was asked to assist by debriefing the staff, seeing the family and effecting some reconciliation. The Director of Nursing also hoped that the staff could be given some skills

in understanding residents' families better, involving them actively rather than rejecting them on the basis that they made work with the residents more difficult. The therapist spent some time with the Director of Nursing, clarifying the problems, then with a group of staff, then with the family. The final stage involved sessions with the family and staff. Reframing to each party the blaming and rejecting behaviour of the other as an expression of stress, grief and frustration was an important part of the process.

As in the case of Betty, nursing or medical staff often respond minimally because of systemic constraints as well as the difficulty of being with residents who are depressed and who express feelings of failure and hopelessness. The interaction between staff and families can also be traumatic because both parties are having difficulties adapting to the stresses arising from the changes in the elderly person. The staff often distance and blame in order to cope with their work. Medical and nursing practice tend to focus on making people well rather than sitting with them as they await decline and death. The model does not encourage staff to share their stress or distress, or involvement in support or supervision processes. Gaining acceptance for family therapy in the systems of elderly patients can be a daunting task (Bepko, 1984; Herr and Weakland, 1979). However, once accepted, the family therapist can be instrumental in interpreting and responding to problematic behaviours which may arise for residents, families and staff (Duffy, 1986). Reframing strategies are particularly important in these situations.

CONCLUSION

The systemic framework of family therapy has increasingly been found to be very appropriate in understanding and working with the individual and family experience of the elderly stage of the life cycle. Changes in the elderly can manifest in many ways through intergenerational processes and therapists need to be cognisant of such processes in different presentations. The presenting problem relating to the elderly person may be brought out directly or indirectly. The therapist needs to be alert to changes in the elderly life cycle as associated with significant changes in other family members, including symptom generation which may not be linked in family members' minds to the elderly person.

As emphasised in this paper, there are many obstacles to family therapy (and indeed to psychotherapy of any kind) with this age group. These are reinforced by the biomedical perspective that dominates current thinking and practice in the psychogeriatric sphere. The cognitive, emotional and physical decline that often accompanies this life cycle stage predisposes the professional network to a paternalistic view, wherein the 'expert' is seen to hold the knowledge and the elderly patient and the family are seen as the passive recipients of help. The prevailing concept of 'making people well' in a life cycle stage where closure and preparation for death are central may be incongruent and place unrealistic demands on treating professionals and patients. A deeper systemic understand-

ing of the life cycle and intergenerational issues arising for the elderly, as well as of the complex networks of health care encompassing them, can benefit individuals and families striving for creative and satisfying responses to the challenges presented by old age.

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