6. The Elderly and Their Families: An Interactional View

Wendy L. Watson
Lorraine M. Wright

W HAT IS THE PERFECT PICTURE OF AGING? OLD KING COLE BEING merry? 01' man river just rollin' along? An old owl and old man of the mountain exuding wisdom? Society's view of aging is often that of deterioration, depression, dependency, dereliction, and, of course, death. In his crusade against this agist portrait, Comfort (1976) educated the "now" and the "new" old about the facts and falsehoods of aging by presenting the aged as achievers. Pointing out the political, artistic, anthropological, and philosophical feats of individuals in their later years, Comfort reveled in the profiles of persons such as Golda Meir, Ghandi, George Bernard Shaw, Margaret Mead, and Bertrand Russell. Comfort's 8 by 10 inch glossy of "old age as triumphant" is initially appealing; like the agist image of "old age as tragic," however, it promotes a homogeneous view of the elderly. The greatest handicap of the elderly may be the assumption that all are alike or the belief that age is a handicap. Rather than age itself, the response of the aged and their families to the older person's mental and physical health symptoms may be the handicap.

Generally speaking, there is a positive correlation between advancing age and the incidence of physical and psychological problems. According to Brody and Kleban (1983), the elderly experience an average of four symptoms daily. They found that pain and fatigue/weakness were bothersome to three-fourths and two-thirds of their elderly respondents, respectively. Of their elderly subjects, 55% experienced mental health problems, such as depression, anxiety, sleep difficulties, loneliness, and boredom on a day-to-day basis, while 52% experienced daily worries about their family, friends, and themselves (i.e., their cognitive decline, physical health, and ability to perform daily tasks). Upsetting events were troublesome to 43% of the elderly, while 20% to 30% of the elderly were bothered by nocturia, digestive discomfort, and colds/fever.

PHYSIOLOGICAL PROBLEMS OF AGING

Among the most common physiological changes associated with aging are

- an increase in high-frequency deafness, especially in males
- a decrease in visual acuity, particularly night vision
- a decrease in the amount and depth of sleep
- an increase in the duration of a response to a stimulus, which contributes to a decreased ability to do two things at once

- an increased sensitivity to drugs
- a decreased ability to distinguish blues from greens
- an increased sensitivity to glare
- a decreased flexibility of joints
- an increase in the occurrence of chronic conditions, such as heart disease, hypertension, arthritis, diabetes, and stroke

Signs and symptoms of physical illness may be absent or diminished in the elderly. For example, because of changes in nerve sensitivities, the aging patient may not experience the classic chest pain of younger associates during a heart attack. The aging patient may not develop a fever in response to infection because of a decreased ability to generate white blood cells. These differences in the manner in which physical ailments may appear makes it necessary to approach a diagnosis of hypochondriasis in the elderly with much caution. The complaints of an aged person, such as "Something isn't quite right. I just don't feel like myself today," should not be casually disregarded.

Physical disease in the elderly may manifest itself as a change in thinking. Confused thinking, produced by an insufficient supply of blood to the brain, may be the only symptom of the onset of a heart attack in an elderly person. The adult child's diagnosis of a parent's condition may be senility, while the pneumonia that is causing inadequate oxygen flow remains unidentified. Before considering the interactional and psychological aspects of confused thinking, the prudent family therapist investigates possible physical origins, recommending a thorough physical examination in search of something reversible and treatable.

A change in thinking may indicate acute brain syndrome induced by drug toxicity, heart attack, infection, stroke, or dehydration. It may also indicate chronic brain syndrome caused by Alzheimer's disease in 75% of cases. Generalized loss of intellectual functions with a slow and uncertain onset characterizes chronic brain syndrome. The elderly person with this syndrome may experience difficulty making decisions, understanding conversations, and recalling recent events. Finally, there is a loss of remote memory.

In the initial stages of chronic brain syndrome, the person's appropriate social behavior masks the intellectual decline, but suspiciousness, moodiness, and bizarre tales may follow. The elderly person is usually aware of these changes and becomes depressed. In the latter stages, however, the person is unaware of these thinking difficulties.

Herr and Weakland (1979) cautioned those working with families of the aged to avoid the assumption that a decline in mental functioning is a part of normal aging or "hardening of the arteries." The influence of maladaptive interaction should be considered before the dreaded label *senility,* which most professionals designate as a wastebasket term, is imposed on the elderly person with the concomitant hopelessness and lack of treatment.

PSYCHOLOGICAL PROBLEMS OF AGING

The impact of aging on an individual is difficult to predict because of the interplay between physiological and psychological functioning, as well as the eminent influence of context. Factors such as the amount of change experienced at one time, the pace of the change, the supports available, and the individual's history of coping with change all affect the aging adjustment. The systems concept that a change in one part affects every other part seems to be particularly salient in the life of the aging person. One physiological change increases the person's susceptibility to other physiological changes and may induce psychological and sociological changes in the aged person's world. Psychological and sociological changes can, in turn, affect the elderly person's physical health.

Multiple losses, such as loss of work, independence, mobility, home, spouse, friends, and income, impinge on the elderly person's sense of well-being, contributing to loneliness and depression. Loneliness is one of the most common problems of aging parents, according to the information garnered by Hirschfield and Dennis (1979) from 100 unstructured interviews with the children of aging parents, gerontological professionals, and aging parents themselves. Depression has been identified as the most widespread psychological problem among the elderly (Kaplan, 1979).

PROBLEMS OF AGING AND THE FAMILY

Robinson and Thurnher (1979) found that an adult child's perception of an elderly parent's independence and success with aging was a "source of comfort and reassurance to the child" (p. 590) and contributed to a positive intergenerational relationship. Conversely, the morale of the adult child and, subsequently, the affective quality of the elderly parent-adult child relationship were found to be diminished when the predominant interaction was based on the care of the elderly parent (Robinson & Thurnher, 1979).

Studying a similar context of elderly parent-adult child interaction, Zarit, Reever, and Bach-Peterson (1980) measured the level of burden experienced by the primary care-givers of impaired elderly. These burdens were described as "lack of time for oneself, the excessive dependency of the patient on the caregiver, and [the] caregiver's fears about further deterioration in the patient's behaviour" (p. 652). The results of this investigation indicated that the level of burden experienced by the care-giver was not related to the behavior problems caused by the impairment of the elderly person, but was associated with the social support the care-giver received (specifically, the number of visits of other family members to the elderly parent). This association was a negative correlation; the greater the perceived support system, as indicated by the number of visits, the lower the level of burden experienced by the care-giver.

When Lieberman (1978) asked 1,100 Chicago adults about the significant changes in their lives during the past 4 years, a change in a parent or parent-in-law was the second most frequently reported change, exceeded only by the death of a significant other. Of the total sample, over 50% of those with living parents had perceived a major change in a parent, and 40% of those found this parental change very troublesome to them personally. Adult children reported a deterioration in the parent's health or a parent's increased need for moral support three times more frequently than they reported a problem with a parent's finances. The impact of a change in the parent on the adult child was not related to the physical or psychological distance between the parent and the adult child.

In a seminal study of adult children and their view of problems with aging parents, Simos (1973) found that the children could cope with the physical problems of their parents, even though they required considerable time and attention. The psychological problems, the interpersonal problems, and the social problems of isolation or ineptness of their elderly parents was more disturbing. The children responded to their perception of these problems by

> attempting to console or comfort the parent, struggling with negative feelings aroused by the parent, serving as peacemaker with caretaking personnel and others, dealing with family disruptions sets off by the parent, or in rare cases attempting to limit the parent's insatiable demands, (p. 80)

Silverstone and Hyman (1976) indicated that children of aging parents respond with feelings of guilt, helplessness, and resentment when they perceive loneliness, depression, and dissatisfaction in their elderly parents.

INTERACTIONAL ASPECTS OF AGING

An examination of the cybernetic aspects of family interactions can reveal vital information about the elderly, their problems and potentials, and the impact of aging on the family.

- What is the cycle of family interaction that maintains or escalates the problems of the elderly?
- What continues to create concerns and complications for other members of the aging person's family?
- What behaviors, thoughts, and feelings of each family member perpetuate the maladaptive interaction?

Kramer and Kramer (1976) indicated that vicious cycles "accelerate like a spinning gyroscope and that gyroscopic effect is more powerful than the simple sum of the two [original behaviors]" (pp. 36-37). Circular pattern diagrams (Tomm, 1980) can be utilized to clarify the vicious cycles in which the family of an elderly person may be trapped. The cognition, affect, and behavior of each family member can be diagrammed.

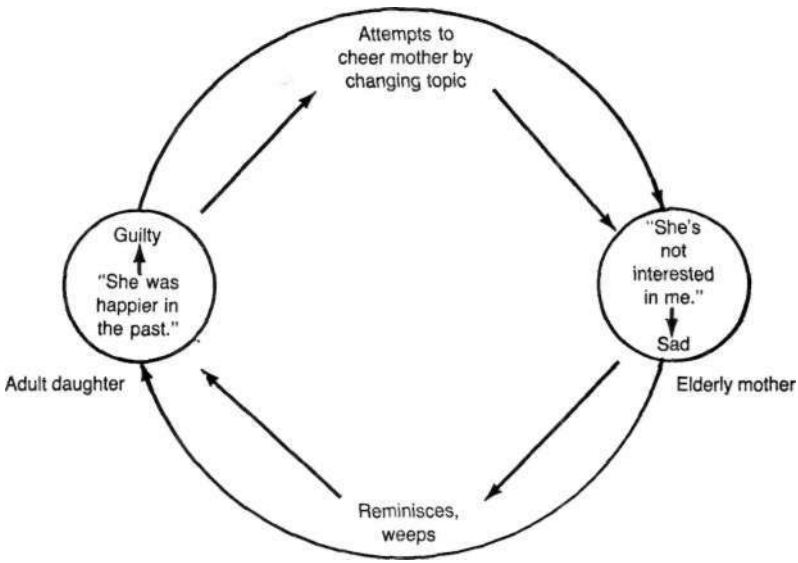
Case Example: Depression

A middle-aged daughter observes her 72-year-old mother reminiscing and weeping. The daughter interprets this to mean that her mother is not happy now, inferring that she, as a daughter, has not been fulfilling her filial responsibilities. She feels guilty and attempts to cheer her mother by changing the topic. Her mother interprets this to mean that her daughter is not interested in her. The mother feels sad (initially, she had felt nostalgic), cries, and wishes for days past. The daughter observes this crying, and the cycle begins again, culminating in depression for the elderly parent (Figure 6-1).

Case Example: Confusion/"Senility"

A dutiful daughter visits her aged mother only to find the stove left on and her mother unable to tell her when she turned it on. Her mother cannot locate her glasses and becomes so overwhelmed in the face of her daughter's questioning that she cries. The daughter perceives these behaviors of her mother's as "senile." (Behavior that is termed "forgetful" in a 20-year-old and "preoccupied" in a 50-year-old is quickly labelled "senile" in an 80-year-old). The daughter is worried and feels

Figure 6-1 Vicious Cycle: Depression

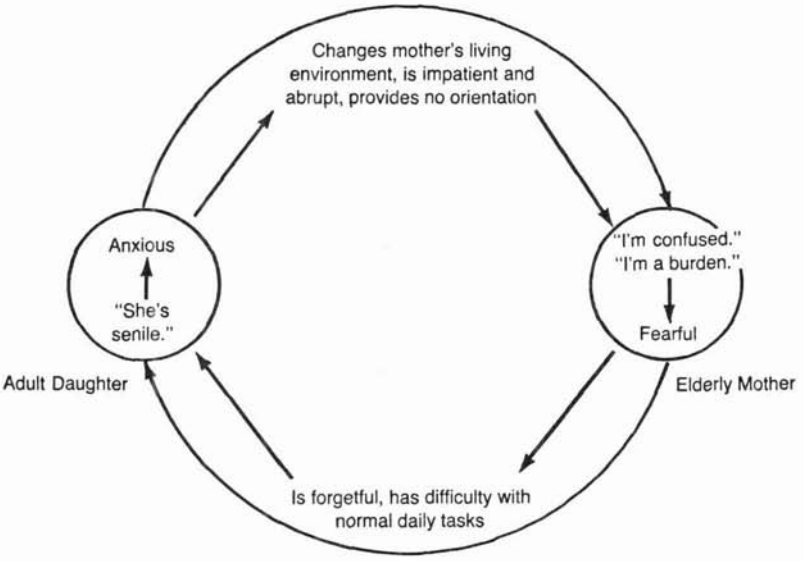


she should observe and take care of her mother for a while. She decides, without consulting her mother, that the best solution is for her mother to live at her (the daughter's) home. She neglects to orient her mother to the new living arrangements and to the daily routines, however, becoming impatient and abrupt with her mother's questions. Perceiving this impatience and quick change of scenery, her mother deduces, "I'm a burden. I'm so confused." Her anxiety about being an encumbrance and her fear about not thinking clearly further block her normal functioning, and the cycle escalates (Figure 6-2).

Case Example: Hypochondriasis

An elderly father talks of his physical pain and discomfort to his son, who feels frustrated and impotent, not knowing what to do. The son responds by trying to distract his father or by not commenting at all. The father interprets this behavior to indicate that his son just does not understand the seriousness of his condition or does not believe him. He feels rejected and worried, which drives him to talk more explicitly about his symptoms, e.g., "The pain is right over here, and it hurts when I get up

Figure 6–2 Vicious Cycle: Confusion



from sitting." The cycle continues as the son becomes increasingly aware of the complaints, attributing them to his father's old age (Figure 6–3).

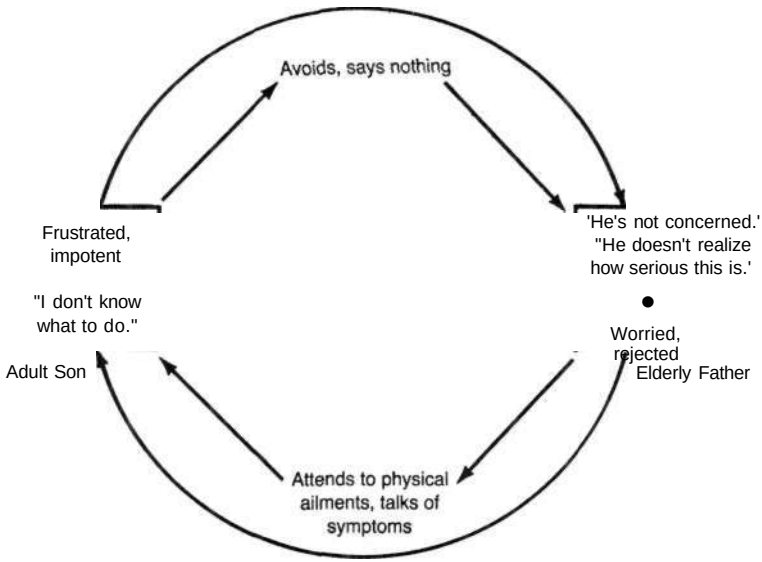
The way in which the attempted solution to a problem perpetuates the problem instead of solving it is striking. Diagramming the vicious cycles of family interaction that affect and are affected by the problems of aging assists the professional in identifying new connections to "old" problems. An awareness of the cybernetic effect allows the therapist to see how "small but strategic changes, whose effects will be reinforced by interaction within the system, can interrupt the vicious cycles" (Herr & Weakland, 1979, pp. 52–53).

Case Example

A family was self-referred to the Family Nursing Unit,* Faculty of Nursing, University of Calgary, because of the 72-year-old maternal

*We are grateful to Fabie Duhamel, R.N., M.N., University of Calgary, for her permission to document some of her work with this family.

Figure 6-3 Vicious Cycle: Hypochondriasis



grandmother's "anxiety attacks" and refusal to get out of bed. At the time of referral, the household was composed of the mother, age 51, a part-time clerk in the husband's business; the father, age 50, self-employed; and the maternal grandmother (MGM), age 72. The couple had three daughters, aged 28,24, and 20. The eldest two daughters were married, and the youngest daughter was attending college in another city. The maternal grandfather had died 4 years earlier of a coronary.

On the day of the first appointment, the mother called to cancel, stating that the MGM did not feel well enough to come to the Family Nursing Unit. It was decided to offer the family an appointment in their home and to use this important context change for the first interview as an opportunity to engage the MGM. To begin the engagement process, the therapist arranged the time for the home interview with the MGM. At the end of the first session in the home, the engagement of the family was evident by their agreement to have the second session at the Family Nursing Unit.

After a thorough family assessment by means of the Calgary family assessment model (Wright & Leahey, 1984), two problems were identified: (1) adjustment to a new living arrangement (whole family system

problem) and (2) maladaptive interactional pattern between MGM and adult daughter (elderly parent-adult child system problem).

The MGM had relocated from another city to live with her eldest child and only daughter 2 months before the referral. This change in living arrangements was precipitated by the decision of the 46-year-old unmarried son (third child) to sell his mother's house. He felt that his mother was unable to continue living alone, since she had suffered a mild stroke. Though not involved in the decision to sell the house, the mother was asked to choose where she would like to live. She chose to live with her adult daughter, to whom she felt closest, even though this living arrangement constituted a move to another city.

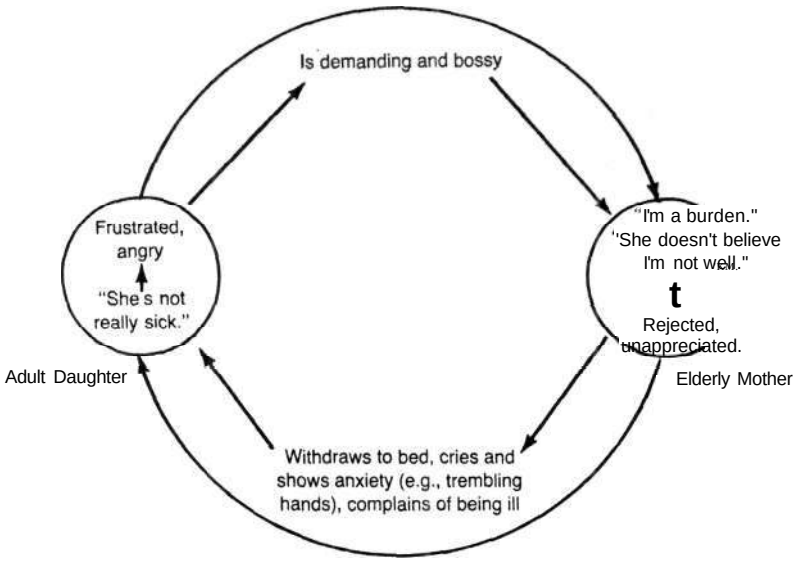
The family assessment further revealed that the MGM presently felt rejected by both her sons and thought she was a burden to her adult daughter. She claimed, "I don't know where I belong or where to go." The adult daughter stated that she was willing for the MGM to live in her home as long as her mother behaved like a "healthy adult," which meant that the MGM be dressed, out of bed, and active each day. The son-in-law tended to be rather passive about the situation, which was hypothesized to be his way of avoiding triangulation between his wife and his mother-in-law.

Shortly after the MGM moved into her adult daughter's home, the daughter became frustrated with her mother's crying, complaining, and refusing to get out of bed. The daughter's reaction was to tell her elderly mother what to do in a rather bossy and demanding manner. The more demanding the adult daughter became, the more rejected and anxious the MGM became. Consequently, the MGM withdrew to her bed, crying and complaining. This, in turn, increased the adult daughter's frustration, thus continuing the vicious cycle. It is important to note that the onus of blame is *neither* with the elderly parent *nor* with the adult daughter; the problem is a relationship problem (Figure 6-4).

Recognizing the interrelationship of the two identified problems, the therapist hypothesized that the contributions of the MGM and those of her adult daughter to their interactional vicious cycle were attempts to control the other's behavior. Thus, the goal of the primary intervention was to break the maladaptive pattern and give *both* parties an opportunity to be in control. First, the therapist normalized the new joint living arrangement by noting that they were undergoing a major adjustment in living together as *adults.* The therapist stated that she was impressed with the caring and their desire to help one another.

The therapist prescribed an odd day/even day ritual (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978) to enhance their caring and to interrupt the problematic cycle. The adult daughter was instructed to care for her mother (e.g., bring meals to her room) on the odd days of the week. On these days, the mother was to do as she pleased (e.g., stay in bed all

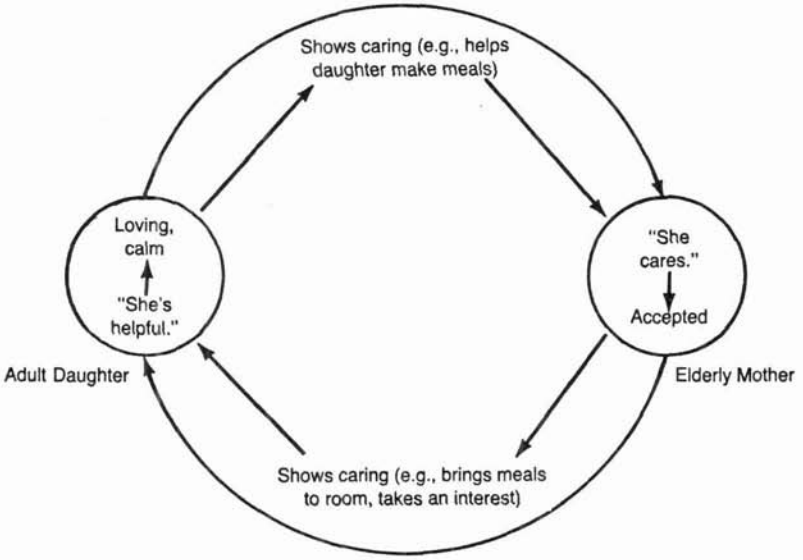
Figure 6-4 Vicious Cycle: Anxiety Attacks/Refusal to Get Out of Bed



day). On the even days of the week, the MGM was to care for her daughter (e.g., help daughter make meals). On Sundays, they were to behave spontaneously. The intervention was well accepted, and the family members expressed relief and satisfaction both verbally and analogically.

By giving each member of the dyad permission to be in control of the caring expressed on alternate days, the intervention ritual interrupted the vicious cycle that had perpetuated the initial problems. The behavior of both parties and their perceptions of each other improved. The instruction for the adult daughter to bring meals to her mother interrupted her (the adult daughter's) bossy, demanding behavior, while the MGM's efforts to assist her daughter with meals required her (the MGM) to get out of bed. The caring behavior of each was positively perceived by the other. The MGM felt accepted and less anxious about where she belonged, and her bouts of crying were dramatically reduced. The adult daughter enjoyed having the assistance of her mother, which made it easier for her to reciprocate the expression of caring. Thus, an intergenerational virtuous cycle of caring was established (Figure 6-5).

Figure 6–5 Virtuous Cycle: Caring



Since aging does not occur in a vacuum, it is most beneficial to consider the context within which an elderly person's concerns are arising. Failure to do so impedes a therapist's efforts to alleviate the handicapping symptoms. An interactional view of aging will help prevent the treatment of choice for an octogenarian from becoming "Take two tricyclic antidepressants and call the nursing home in the morning."

REFERENCES

Brody, E.M., & Kleban, M.H. (1983). Day-to-day mental and physical health symptoms of older people: A report on health logs. *The Gerontologist, 23*(1), 75–85.

Comfort, A. (1976). *A good age*. New York: Simon & Schuster.

Herr, J., & Weakland, J. (1979). *Counseling elders and their families*. New York: Springer.

Hirschfield, I.S., & Dennis, H. (1979). Perspectives. In P.K. Ragan (Ed.), *Aging parents*. Los Angeles: The Ethel Percy Andrus Gerontology Center, University of Southern California Press.

Kaplan, B.H. (1979). An overview of interventions to meet the needs of aging parents and their families. In P.K. Ragan (Ed.), *Aging parents*. Los Angeles: Ethel Percy Andrus Gerontology Center, University of Southern California Press.

Kramer, C.J., & Kramer, J.R. (1976). *Basic principles of long-term patient care.* Springfield, IL: Charles C Thomas.

Lieberman, G.L. Children of the elderly as natural helpers: Some demographic variables. (1978). In J.C. Glidewell & M. A. Lieberman, *American Journal of Community Psychology* [Special Issue], 6(5), 489--198.

Robinson, B., &Thurnher, M. (1979). Taking care of aged parents: A family cycle transition. *The Gerontologist, 19,* 586-593.

Selvini Palazzoli, M., Boscolo, L., Cecchin, G., & Prata, G. (1978). A ritualized prescription in family therapy. Odd days and even days. *Journal of Marriage and Family Counseling,* 4(3), 3-9.

Silverstone, B., & Hyman, H.K. (1976). *You and your aging parent.* New York: Pantheon Books.

Simos, B.G. (1973). Adult children and their aging parents. *Social Work, 18,* 78-85.

Tomm, K. (1980). Towards a cybernetic-systems approach to family therapy. In D.S. Freeman (Ed.), *Perspectives on family therapy.* Vancouver, BC: Butterworths.

Wright, L.M., & Leahey, M. (1984). *Nurses and families: A guide to family assessment and intervention.* Philadelphia: F.A. Davis.

Zarit, S.H., Reever, K.E., & Bach-Peterson, J. (1980). Relatives of the impaired elderly: Correlates of feelings of burden. *The Gerontologist, 20,* 649-655.