WORKING WITH THE FAMILY IN PRIMARY CARE

A Systems Approach to Health and Illness

Edited by

Janet Christie-Seely, M.D.

PRAEGER

New York
Westport, Connecticut
London

Chapter 30

Working with the Elderly and their Families

Dawn E. McDonald
Janet Christie-Seely

> No community can call itself civilized if it treats its older generation with a lack of consideration. But consideration requires understanding, and everyone needs to know more about the process of aging and the difficulties it may bring. Ultimately, the quality of life of elderly people, especially the very old and frail, rest on the attitudes and perceptions of those younger than themselves.[19]

This quotation from *Growing Older,* published by the British government, underlines the need to understand aging. The social responsibility of a civilized nation for its elderly citizens is made operational in the day-to-day interaction between these elderly, their families, and a broad spectrum of care givers.

The "old old," those over 75 years of age, are the most frail and disabled, and often those in greatest need of support services. It is projected that this group will show the largest proportional increase in the next few years. At the same time, Kane[9] suggests that the number of siblings and children available as caretakers will decrease.

While health care professionals provide care for those elderly persons who come in contact with the health care system it is important to realize that a relatively small proportion (5% to 8%) of the elderly are in institutions.[15] Despite the prevelant perception that families do not care for their aged members, recent studies[9,18,20] have shown that many frail or sick elderly are cared for by a spouse, a child, or a sibling. Often these caretakers are assisted by helpers paid privately or via government programs.

ATTITUDES TOWARD THE ELDERLY AND THE THEORETICAL FRAMEWORK

Beliefs about old age determine the provisions made by the community for the elderly and the responses of both families and health care professionals

to the care of the aged.[1] These beliefs are based on the prevailing values of the culture in question.

The belief system about provision of care toward the elderly is formed out of the clinician's experience in his or her own family, contacts with the elderly themselves, the clinician's stage in the life cycle, knowledge base, and conceptual framework. Physicians, nurses, psychologists, and social workers tend to emphasize different areas in work with the elderly and are guided by different theories, both of health care in general and the process of aging. Since teamwork of professionals involved with the elderly is essential, differences in beliefs about aging and goals for the elderly must be clarified and negotiated.

Myths and beliefs about the elderly are insidious and pervasive; it is therefore necessary that the practitioner be knowledgeable and be prepared to substitute well researched facts for these incorrect ideas. These myths and attitudes can be gathered under the general rubric of "ageism." Ageism is a very subtle prejudice whose effects are seen in decisions at many levels that affect policies, individual treatment, rehabilitation, and placement. For example, an administrator in a long-term care facility voices the conviction that the major goal in providing care for the elderly is to "keep them comfortable." This institution provides excellent physical care and nutritious food. There is no occupational therapy, little mental stimulation, or reality orientation. Staff are given a full orientation to custodial care but there is no continuing education. Anything more than washing, feeding, and moving from bed to chair is seen as a "frill."

There are certain physiologic and psychological changes that are found in varying degrees in individuals as they age. It is important to distinguish those changes that are considered part of normal aging and those which are seen as pathologic. Families often need help to recognize these often subtle differences as well. At the same time the realization that some physical changes occur should not be seen as a rationale for ignoring a new physical event or behavioral manifestation. "You're just getting older" is a potentially dangerous and defeatist oversimplification. Each change must be carefully evaluated when it occurs and in the total environment in which it occurs. For those insufficiently versed in the normal changes (most of us), Table 30.1 outlines some of these and suggests alterations to be made in professional practice and family life to accommodate them.[5,8,13]

Theories of aging, whether intuitive or formally labelled, necessarily affect the approach taken in providing service for the elderly. "Disengagement theory" suggests that there is a gradual mutual withdrawal from contact between the aging person and society and a giving up of roles. There is less willingness on the part of the older person to conform to the norms of society.[2] Belief in this theory of aging might lead the practitioner to accept some

Table 30.1 **Some Normal Changes in Aging and Professional and Family Accommodations to Meet Them**

Normal Changes	*Professional and Family Accommodations*
Alteration in the brain's cellular chemical composition and activity patterns leading to —memory loss —some degree of depression —altered sleep patterns	Nonjudgmental acceptance of decreased function Transmission of respect and awareness of "personhood" of the elder in spite of changes Determination of "best times" for interviews, teaching sessions, family visits, etc.
Decreased reaction time particularly in complex tasks	Scheduling longer periods for medical interviews or for shopping trips, visits (for example, 45 minutes) Teaching material in "chunks" with planned reinforcement Evaluation/performance tests not linked to time Evaluate environment for safety
Decreased response to pain sensation and temperature changes	Careful monitoring of any activity Alertness to temperature of environment and its safety
Diminished synthesis and secretion of some digestive enzymes, changes in sense of taste	Monitoring of quality and quantity of food and fluid intake
Slowed motility of the digestive tract and absorption	Evaluation of elimination Teaching of dietary aids to elimination for example, use of bran, fruits, and adequate fluid intake
Altered response to chemical changes, (slowed recovery to glucose overload, slowed liver metabolization)	Alertness to responses to drugs—family should also understand these —interactions —idiosyncratic responses Clinician awareness of differences in "normal" ranges in laboratory values and physiological measures
Changes in senses, altered/decreased —vision —hearing —balance	Use of more than one medium when communicating/teaching Willingness and ability to switch from visual to auditory media
Loss of teeth	Routine use of checklists, fact sheets, and presentation of these to patients so they may take the information away with them

Table 30.1 **Some Normal Changes in Aging and Professional and Family Accommodations to Meet Them (continued)**

Normal Changes	*Professional and Family Accommodations*
	Routine checks to see if aids used, (glasses, hearing aids, false teeth) are clean, being maintained, and are in working order before information giving, teaching sessions and activities of daily living
	Selective use of items/activities that aid "orienting" functions in private homes, clinics and institutions —large print clocks, calendars, signs and name tags —high-contrast colors in furniture, rugs —maintenance of established routines —periodic repetition of vital information (date, time, names) —discussion of daily events, weather sports
Alterations in circulatory, musculoskeletal, and respiratory tracts leading to easier fatiguability	Monitor during any activity for fatigue Intersperse short activity periods with rest periods or "quiet" activities
Role changes due to —retirement —progression in individual and family developmental stages	As well as physical and mental status a full clinical assessment must include consideration of —capabilities in activities of daily living —support systems —family dynamics —recreation/diversion —usual patterns of social activity —living arrangements —coping/problem solving ability —availability and willingness to use community resources —financial status —individuals' or couples' plans and
Progressive multiple losses —friends and family through death —individual health, physical, and mental capabilities —living arrangements, (for example, move from family home to an apartment)	
Alteration in independence-dependence relationship	
Change in financial status	expectations re aging

degree of idiosyncratic behavior and gradual loosening of ties with family as usual behavior. This withdrawal from contact would not be seen as the norm if the practitioner espoused "activity theory," which "suggests that life satisfaction in older age occurs when the individual is involved in social

interaction."[2] This practitioner would look for evidence of continuing ties and be prepared to initiate intervention(s) if social interaction began to wane. The practitioner who accepts "exchange theory" would examine the reward-cost balance of the elder's interaction with his environment and seek to foster greater usefulness and mutual satisfaction in social contacts, if interactions appeared to be decreasing. For example, babysitting can be suggested by a competent grandparent in exchange for transport and a good meal.

Systems theory as in other areas of health care provides a new orientation to the elderly. Expectations and family myths may be important determinants of health and relationships. "We all live to a ripe old age" suggests a satisfaction with this stage of the life cycle, and may be a self-fulling prophecy. A promise by one mother never to live with her children in old age resulted in a 95-year-old lady, completing the newspaper crossword before breakfast and teaching a grandson German. She died within a year after deafness and blindness necessitated care by an elderly family retainer in her own home. All her children followed the same pattern. "Good genes" are usually evoked in such families. In other families the elderly are expected to be dependent. The role reversal feared by the above family is encouraged either out of gratitude for parental caring ("She changed my diapers once, why should I complain about changing hers.") or as a means of turning the tables on a not-so-loved parent.

Baby talk to the elderly, taking over all decision-making, and control may thinly disguise hostility to a previously autocratic or unloving parent or anger at the burden they currently represent. Sometimes a gentle comment by the clinician about the possibility of such anger can give permission for its expression in a less destructive manner. Problem solving and improved communication are often prevented when such feelings remain repressed. Confrontation with the elderly about the past is rarely productive, but expression of negative feelings to the clinician may allow more positive feelings and positive memories to surface. Guilt can be decreased by normalizing statements (see Chapter 14) such as "I'd be fed up too if I was so tied to the house/had to keep changing the sheets/had my discipline of the children undermined."

Family myths and secrets play their role in the elderly. The myth that "Mum is weak and frail and must not be disturbed" can become more virulent in another form: "If you (at age 35) leave home she will have another heart attack and die." The strong woman in bed who rules the household may be impairing her own health further by lack of activity, and may be depriving herself of the real respect owed to her as someone who is tough and who is well able to organize those around her. Relabelling the woman as such may help her get out of bed and may help her children encourage her independence and eventually their own. Needless to say such families often resist change, but an awareness of their family pattern may contribute to prevention of such patterns in the next generation.

Family secrets can play a destructive role and are often more easily dealt with while those who perpetuated them are still living.

> A father of three adolescents began to have marital problems after the death of his grandmother. Until the age of 16 he had been told by the two women who raised him that they were friends of his parents who had been killed in a car accident when he was a baby. Then when he was 16 years old, he accidently discovered his birth certificate and found out that his two caretakers were in fact his mother and grandmother. They had hidden their true identities from him to protect him from the stigma of illegitimacy. He had met his father, a married man with a family, on three occasions but had not known who he was.
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> Thoroughly shocked by this revelation he had kept it a secret from his three children who were told the car accident story. He believed it was his mother's wish that the secret remain. He was encouraged by the clinician to discuss this with her. The following week in a family interview held for other reasons he announced that he had been mistaken about the car accident story. He told his three sons the truth with his mother's delighted permission. The oldest (19 years old) was "shocked" but not upset by it, the 16-year-old, who identified with his father, and the 13-year-old were "not at all surprised." As usual secrets are often conveyed at a nonverbal level. Revelation of this secret markedly improved the relationship with the grandmother 6 months before her death and contact increased. Her son's overly close relationship with his three sons to avoid his father's uninvolved role could now be discussed. The mother's role as "odd-woman out" could now be understood and corrected by all four males.

Triangulation of an elderly person can replace triangulation of children, particularly when the couple has a need to stabilize their relationship by detouring conflict through a third person and the children are of an age to leave home. This may be responsible for considerable distress and symptom formation in the old person.

> The N. family took an elderly uncle into their home after the departure of their youngest child. The old man had always lived alone and was very difficult to live with. His annoying behavior (sloppy eating, forgetfulness, and poor personal habits) became a source of grievance and a topic of conversation for the couple, which served to bring the couple closer together. At the same time, however, it reduced the uncle's already low self-esteem and made it more difficult for him to relate to others. A decision was made to send him to live in a boarding home. His difficult behavior there resulted in his returning to live with the couple. Although tension had risen between the couple during the absence of the uncle, their relationship improved after his return.

In a situation such as this, where change would involve a major restructuring of the system, the ethics of interventions must be considered. The well-being of the uncle and of the couple must also be taken into consideration. Problems of adjusting to the empty nest and improving couple

communication obviously must be dealt with. Resolving these problems will depend on their motivation for change. A comment that they seemed to get along better when the uncle was present might prompt a request for help and referral for family therapy. Community resources (see Chapter 8) might be able to provide a better environment for the uncle.

Systems theory provides the conceptual tools to assess the elderly in their family or social context. It presents simplistic solutions that do not take into account the total picture. It also provides a framework in which empathy with all parts of the system is facilitated, thereby reducing conflict of interests. So often professionals dichotomize between the elderly on the one hand and the family on the other and side with one against the other. This is particularly true of abuse of the elderly, a problem similar to child abuse and wife abuse in that it is complex, contributed to by all family members concerned and often undetected and unreported. A high index of suspicion and complete family assessment are mandatory.

The cornerstone of any intervention is assessment, or diagnosis: What is going on? How is this problem being aggravated or perpetuated by the family system, the community, or the health care system? Intervention can then be planned from a position of knowledge and detrimental effects kept to a minimum. Negotiation and communication play a major part in such management.

FAMILY CARE-GIVERS

When an elderly person requires assistance of any kind that need is often felt first in the family or support system. Much of the need is fulfilled by the family, and professionals are called in when the situation is beyond the support system's capabilities. As mentioned earlier, there is ample evidence that families continue to visit and aid their older relatives. Even though families tend to live in separate homes they often live close to each other and maintain contact[12,17] or communicate regularly by letter and telephone.

Usually family means those persons linked legally or by blood relationship. However, for an elderly person who has no descendants, whose close family has died or who is isolated for some reason from family, friends, neighbors, members of interest groups or professionals may become "family." The key requirement is a willingness to establish and maintain the affectional tie and provide aid in times of need.

Elders and their families must inevitably confront some or all of a number of issues which may require professional intervention. These include the following:

1. growth and development conflicts;
2. change in roles and relationships;
3. caretaker "burn out"; and
4. decisions regarding institutionalization.

Whether they are spouses, siblings, or children the caretakers often become as needy as the patient.[3] Health care professionals must be aware of these issues and be prepared to deal with them when necessary. Failure to do so may result in a proliferation of patients or earlier institutionalization of the initially designated patient, or both. The manner in which help is given and the type of support provided may make the difference between a family being able to continue caring for their aged member and having to institutionalize that elderly person.

Conflict of Developmental Tasks

If care-givers are children then conflict can occur between two sets of developmental tasks. If care-givers are spouses or siblings, the conflict may lie more in the realms of distribution of resources to meet the same set of developmental tasks for the carer and cared for. The problems encountered by middle-aged children and aging spouses as primary care-givers, are discussed later in this chapter, in the section on "Time in the Life Cycle."

Care-taker Burn-out

When shouldering the burden for an elderly parent or spouse, the care-taker is highly susceptible to overextension leading to exhaustion and inability to continue caring. The alerting event for the professional can be demands for precipitous institutionalization/hospitalization of the elder or health breakdown in the care-giver.

The role description of the female care-giving spouse reported in Fengler and Goodrich[6] is evocative of the tenuous balance in which many care-givers live. While the care-giving wife is being described, many aspects apply equally to care-giving children, siblings, or husband:

> She is not trained for her job, a priori. She may have little choice about doing the job. She belongs to no union or guild, works no fixed maximum of hours. She lacks formal compensation, job advancement, and even the possibility of being fired. She has no job mobility. In her work situation, she bears a heavy emotional load, but has no colleagues or supervisor or education to help her handle this. Her own life and its needs compete constantly with her work requirements. She may be limited in her performance by her own ailments.

Kane[9] outlines four variables important to a stable patient–caretaker situation:

1. the patient's level of disability and dependence;
2. the caretaker's own health and functional mobility;

3. the presence or absence of other assistants; and
4. the caretaker's other roles and responsibilities.

Each of these factors interacts with the others. There is a point in every patient-caretaker relationship, which is individually set, at which the caretaker becomes overloaded and breakdown is inevitable.

Conflict of duties is a major problem. Families often assign the role of caretaker to the member perceived as having the fewest other responsibilities. However, it may be the person closest to the patient or the family member who has always "shouldered the burden." In the case of the spouse it is a social expectation, particularly, that the wife cares for the husband. A family meeting, to discuss caretaking and division of responsibility, is often highly useful in confronting any abdicating members as well as pointing out to the caretaker the possibility of delegation. Care-givers may lack knowledge of sources of help to support their caregiving activities. It is not unusual to find care-givers totally unaware of resources readily available that could have prolonged their ability and willingness to care and perhaps prevented burnout.

Decision Making Regarding Hospitalization or Institutionalization

Institutionalization is often precipitated by caretaker burnout. Other reasons for institutionalization are the addition of one more factor such as incontinence to the caregiver load or additional health problems for the care-giver. A study by Sanford[18] estimated that 12% of geriatric admissions were made because relatives could no longer cope. Ninety-two percent of family members could identify which problem would have to be alleviated for them to have the elderly patient back home. The problem most frequently reported as causing the most difficulty was sleep disturbances. Others were incontinence, inability to be mobile or perform activities of daily living (A.D.L.), falls, behavioral problems, inability to communicate, and wandering away.

In spite of the burden of care and the length of time it has been carried, families and spouses often feel tremendous guilt at finally "placing" the patient. This guilt appears to be a combination of self-expectations and perception of societal expectations. The patient's response can do much to heighten or alleviate the care–giver's guilt.

The clinician can help the family or spouse include the patient in decision-making if possible, be aware of available alternatives, and work out a set of criteria for choosing an institution. Once the patient is institutionalized the clinician can help the family maintain contact, avoid unnecessary guilt, and avoid conflict with the new "foster family" of the institution.

FAMILY ASSESSMENT

The practitioner must be alert to family membership, interaction patterns, and developmental tasks. A systems orientation aids the practitioner as it provides direction for entry into the family system, assessment, interventions, and evaluation of those interventions.

Roles, Affect, and Communication

As in other areas of family function, the family with clear communication patterns, well-defined but permeable boundaries, and close affectional ties often deals effectively with the problems of an aged member. Entry to the family system is relatively easy and a supportive, noninvasive role is appropriate. When asked to, the practitioner provides information and anticipatory guidance, discusses alternatives, facilitates communication, and listens while planning an early withdrawal.

The B. family asked for an appointment with the nurse clinician in geriatrics. Mrs. B. wished to discuss the problems she saw arising with her 85-year-old mother, Mrs. D. Mrs. D. lived alone in the family home, an older house in a rundown neighborhood. Mrs. B. felt her mother could no longer live alone, her health was slowly deteriorating, she was becoming less functional in activities of daily living, and she had had two falls in the past 3 months. Fortunately Mrs. D. had only shaken herself up and sustained a few bruises.

The nurse clinician explored with the B. family what they felt the problem was and the basis for their identification of the problem. She asked what they felt would be a good solution and what alternatives they had considered. She also inquired if they had discussed the situation with Mrs. D.

It turned out that the B. family had given a great deal of thought to the problem and had considered leaving Mrs. D. where she was or taking her in with them, and had also explored a number of types of housing from senior citizens apartments to nursing homes. Their real needs were to work through feelings of guilt as they were unable to have Mrs. D. live with them and to be sure they had considered all resources. They also needed to plan a way of broaching the subject to Mrs. D.

The nurse clinician accepted their expressions of guilt and helped them realize that many of their feelings were shared by others in the same situation. She verified their information concerning living accommodations. An approach was planned that allowed the B. family to initiate the subject with Mrs. D., starting with their deep concern with her well-being. They would then ask her about her ideas regarding what would be best for her in the future.

It turned out that Mrs. D. was very worried about her future but was overwhelmed by the thought of planning a change. As the discussion developed it became clear that Mrs. D. did not want to live with the B. family as she felt this would be an imposition. Also, Mrs. D. had well-developed routines that supported her lifestyle and she did not want to change these patterns to accomodate to those of the B. family. She had a friend living in an apartment in a senior's complex that included a multi-level nursing home and was interested in such a solution for herself.

Three months later Mrs. D. moved in to an apartment in this complex. Her level of function improved. She enjoyed the socialization available and felt more secure.

In contrast, families may develop very rigid boundaries through which little information flows and professional entry is often difficult if allowed at all. In this case the professional may be able to help the family develop greater trust in outsiders, help problem solving within the family, or alternatively help the elder develop substitute supports in the broader social system. Some families are so disengaged or separated emotionally that there is little willingness to give assistance and the health profession becomes the family. The opposite end of the continuum is the family that is so enmeshed that there is little differentiation between family members and a problem with one member reverberates through the system, creating considerable stress. In this case the practitioner may take a more active role helping family members to define their roles, functions, and expectations more clearly. Facilitation of communication, education, and specific suggestions may all be necessary. A family may have developed problem-solving skills in the past but need assistance to see the application of these skills in a new situation. The elder's needs may be overly provided for, and help may be required to develop a greater degree of individuation and independence from a "smothering" or over-anxious family. Conversely, families may require help in dealing with an overly demanding parent.

Role reversal is the essential problem in many families. With incapacitated aged parents it is now the children whom the parents must depend on; the children must be dependable in their relationships with their parents.[9] The adult children may lack the maturity needed to stop looking for parental support and provide it instead. Faced with their own signs of the aging process they may deny their parents' aging and obvious mortality. They may react by withdrawing and decreasing visits and attention. If the parents did not, in the past, evoke affection in their children, such affection and caring will not be forthcoming now, particularly with the increase in irritability and selfishness that can occur in some elderly. Often, however, such behavior is a mask for fear—fear of death or loneliness or, more often, fear of loss of control and loss of independence. He or she may mask infirmities, such as deafness, and strenously resist any signs of role reversal.

Desperate attempts to maintain a role and meaning in life lead to bossiness, obstinancy, focusing on the past and past glories, all of which may further alienate family and friends. Helping the elderly to accept some dependency on others as a just return for a life of hard work, and to maintain meaningful activities and relationships can help them maintain health. There is considerable evidence that hopelessness and helplessness are associated with disease and death, and a sense of meaning with survival (see Chapter 9). A role in decision-making and a sense of some control over one's fate must be preserved for as long as possible. Some families do not understand the difference between support and interference and may be highly destructive if not abusive. These families often tax the professional's resources. At all times the practitioner must be prepared to refer families who require more in-depth intervention and treatment.

Time in the Life Cycle

Knowledge of the developmental stages of individuals and families helps the practitioner anticipate and plan for some obvious problems, as discussed in Chapter 5. Duvall[4] provides an outline of these tasks for both the individual and the family (see Tables 30.2 and 30.3). Duvall's tasks and stages are probably still valid for the elderly of today. However, as future generations age they may become less valid due to role changes presently occurring in North American society. The elderly person, developmentally, is in the final phases of life while her children are middle-aged. As people live longer it is becoming commoner to find both the older parent and the child or children in the final stages of life.[2]

Scrutiny of the developmental tasks suggest that conflicts may occur between the developmental stage demands of older parents and their children. Middle-aged children are often trying to cope with many changes that demand time and energy. Their own children are passing through adolescence and leaving home; a wife may now wish to pursue a long deferred career or develop a latent talent. Finances may be strained due to the demands of their children's education. The husband is peaking in his career and looking forward to or dreading retirement. Both are facing the inevitable evidence of their own advancing age. Just when they have the potential to relax, re-establish their relationship and look forward to a less demanding time, the needs of their own aging parent(s) may intervene. These aging parent(s) now have less energy to cope with bereavement, chronic health problems, and necessary changes in lifestyle or living arrangements. They may find it difficult to accept professional help or become excessively demanding of families or professionals.

Being aware of conflicts between the two generations' developmental tasks allows the professional to provide anticipatory guidance to both the elders and the "sandwich" generation:

> Men and women pulled in three directions, trying to rear their children, live their own lives, and help their aging parents, all at the same time.[10]

Professionals can help the children deal with anger and guilt over some demands and develop strategies to meet them. Support may be needed in decision-making and implementation. Elders may need assistance in taking part in understanding and accepting decisions. Both elders and middle-aged children may need help to learn about and understand the normal demands of their own developmental stage and that of one another. Both individuals and the family system may need support to adapt to a new equilibrium.

Occasionally problems may be such that referral for family therapy may be required. It is also true that families in family therapy for other reasons may benefit from the addition of a grandparent in the sessions, particularly when the older person is closely involved with problems.[21] If grandparents are in the same household it is often essential they be part of the therapy.

Environmental Resources

Essential to the professional working with the elderly and their families is a comprehensive view of the services available in the community.[22] There are families who are only too willing to turn the care of their aging member over to the professionals. However, many families are ready to provide care to a degree that demands tremendous outlays of time and energy. It is important to realize that these families may only turn to the health care or social service system when they are in crisis due to a breakdown in their own strategies and resources. Availability of sources for assistance, support and respite care (1 to 2 weeks in an institution) may make the difference in the length of time a family is able to care for their older member.

The family often turns to the clinician who will be in a better position to help if fully cognizant of the availability of home care, Meals-on-Wheels, day centers, and temporary placement beds in care facilities, along with the eligibility criteria for the use of these services will be in a better position to help. The presence of a geriatric assessment unit or team in the community is an invaluable resource for the professional. The team can provide a pool of expertise to aid in perplexing diagnoses and treatment as well as provide support to family, patient, and practitioner, when difficult decisions must be made. Team members may be able to provide access to services to which the community practitioner cannot provide entry. If the individual is totally independent in self-care, and coping well with life events, the most appropriate action is to support this positive state as long as possible.

It is useful, while doing the complete assessment of the elderly individual to keep in mind a number of risk factors, several of which include the environment. While none of these alone is cause for concern, the accumula-

Table 30.2 **Developmental Tasks in Ten Categories of Behavior**

	Maturity (early to late active adulthood)	*Aging (beyond full powers of adulthood through senility)*
I Achieving an appropriate dependence-independence pattern	1. Learning to be interdependent—now leaning, now succoring others, as need arises 2. Assisting one's children to become gradually independent and autonomous beings	1. Accepting graciously and comfortably the help needed from others as powers fail and dependence becomes necessary
II Achieving an appropriate giving-receiving pattern of affection	1. Building and maintaining a strong and mutually satisfying marriage relationship 2. Establishing wholesome affectional bonds with one's children and grandchildren 3. Meeting wisely the new needs for affection of one's own aging parents 4. Cultivating meaningfully warm friendships with members of one's own generation	1. Facing loss of one's spouse, and finding some satisfactory sources of affection previously received from mate 2. Learning new affectional roles with own children, now mature adults 3. Establishing ongoing, satisfying affectional patterns with grandchildren and other members of the extended family 4. Finding and preserving mutually satisfying friendships outside the family circle
III Relating to changing social groups	1. Keeping in reasonable balance activities in the various social, service, political, and community groups and causes that make demands upon adults 2. Establishing and maintaining mutually satisfactory relationships with the in-law families of spouse and married children	1. Choosing and maintaining ongoing social activities and functions appropriate to health, energy, and interests
IV Developing a conscience	1. Coming to terms with the violations of moral codes in the larger as well as in the more intimate social scene, and developing some constructive philosophy and method of operation. 2. Helping children to adjust to the expectations of others and to conform to the moral demands of the culture	1. Maintaining a sense of moral integrity in the face of disappointments and disillusionments in life's hopes and dreams

V	Learning one's psychosocio-biological sex role	1. Learning to be a competent husband or wife, and building a good marriage 2. Carrying a socially adequate role as citizen and worker in the community 3. Becoming a good parent and grandparent as children arrive and develop	1. Learning to live on a retirement income 2. Being a good companion to an aging spouse 3. Meeting bereavement of spouse adequately
VI	Accepting and adjusting to a changing body	1. Making a good sex adjustment within marriage 2. Establishing healthful routines of eating, resting, working, playing within the pressures of the adult world	1. Making a good adjustment to failing powers as aging diminishes strengths and abilities
VII	Managing a changing body and learning new motor patterns	1. Learning the new motor skills involved in housekeeping, gardening, sports, and other activities expected of adults in the community	1. Adapting interests and activities to reserves of vitality and energy of the aging body
VIII	Learning to understand and control the physical world	1. Gaining intelligent understanding of new horizons of medicine and science sufficient for personal well-being and social competence	1. Mastering new awareness and methods of dealing with physical surroundings as an individual with occasional or permanent disabilities
IX	Developing an appropriate symbol system and conceptual abilities	1. Mastering technical symbol systems involved in income tax, social security, complex financial dealings, and other contexts familiar to Western man	1. Keeping mentally alert and effective as long as is possible through the later years
X	Relating oneself to the cosmos	1. Formulating and implementing a rational philosophy of life on the basis of adult experience 2. Cultivating a satisfactory religious climate in the home as the spiritual soil for development of family members	1. Preparing for eventual and inevitable cessation of life by building a set of beliefs that one can live and die with in peace

From Duvall EM: *Family Development*. Toronto, J.B. Lippincott, 1971.

Table 30.3 **Family Developmental Tasks**

Family Developmental Tasks in the Middle Years	*Developmental Tasks of Aging Families*
1. Maintaining a pleasant and comfortable home	1. Finding a satisfying home for the later years
2. Assuring security for the later years	2. Adjusting to retirement income
3. Carrying household responsibilities	3. Establishing comfortable household routines
4. Drawing closer together as a couple	4. Nurturing each other as husband and wife
5. Maintaining contact with grown children's families	5. Facing bereavement and widowhood
6. Keeping in touch with brothers' and sisters' families and with aging parents	6. Caring for elderly relatives
7. Participating in community life beyond the family	7. Maintaining contact with children and grandchildren
8. Reaffirming the values of life that have real meaning	8. Keeping an interest in people outside the family
	9. Finding meanings in life

From Duval EM: *Family Development.* Toronto, J.B. Lippincott, 1971.

tion of several should alert the clinician for the possibility of problems. Some of these risk factors are:

1. recent retirement;
2. recent bereavement;
3. solitary living;
4. very limited or no support system;
5. multiple pathology;
6. sensory deficits (for example, decreased hearing, vision, kinesthesia); and
7. changes in activities of daily living, especially when ADL become borderline or less than adequate for the environment in which the elder is living.

These risk factors do not necessarily indicate the need for immediate intervention. They are most useful as trigger points for closer observation and more data collection. Many people who have a spouse die go through a grieving process and then gradually re-establish their lives. However, a person who does not grieve or who has multiplied losses over a short period is highly at risk for somatic complaints, real physical illness, or death.[11,14] Some individuals have a life-long pattern of living alone and like it that way. But the

person who has always lived with others may find even the prospect of living alone terrifying. Again, these data must all be evaluated in light of the existing situation and previous patterns.

The greatest health care challenge of the next 50 years will be improved care of the elderly.[7] Any professional can attest to the increasing number of elderly clients in daily practice. Statistics for most northern industrial nations show a steady rise in the number of those 65 years old and over in the population.[16] Projections indicate that this rise will continue into the next century. The age group of persons aged 65 to 74 years old will increase by 20% by the year 2000, the 75 to 84 group by 50%, the 85-year-old and older group by 80%. In 1982 there were 13,000 persons in the United States over 100 years old, compared with 3200 in 1970.[9]

In summary, professionals who give care to older clients have a complex, demanding role to play. The elderly client usually has multiple sources of difficulty ranging across physical, social, and psychological parameters. Families and social networks are vital to the elder and the elderly are a vital part of the family system; thus professionals must be prepared to work with them and the elder when providing care. Knowledge of aging in all areas is essential, as is awareness of community resources. A systems orientation to the family and the community will result in better assessment and management of the problems of older clients and their families.

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