UNIVERSITY OF MANITOBA
School of Social Work

SOCIAL WORK INTERVENTION WITH THE OLDER FAMILY

by
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A Practicum Report Submitted to the
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Fulfillment of the Requirements
for the Degree of
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Chapter I

INTRODUCTION

In every industrialized country the proportion of elderly in the population has increased dramatically in the last two generations, and this trend can be expected to continue into the forseeable future. As large numbers of people live longer and healthier lives, it can be expected that social changes which accompany this phenomena will have far reaching effects, altering the fabric of life in countless ways.

One effect of increased longevity is the increased need for services which offer care to people at the extreme end of the life span, when illness and disbility may hinder or prevent the elderly from caring for themselves. Because of the dramatic increase in the number of people who need some degree of care in their later years, pressure has been placed on the community to provide such care, particularly for those elderly citizens whose care needs involve expensive medical and/or protective services. The demand for an ever increasing number of personal care home beds for the elderly has become a drain on the public purse in every country in the western world, and economic factors, as well as a growing recognition by the geriatric professions that institutional care is not indicated or desirable except as a last resort for the severely disabled

has given impetus to the search for other solutions. Consequently, public policy has become committed in recent years to assisting the elderly to remain in the community, and a multitude of services have been developed in an effort to enable them to do so.

The well being of the aging population has become an important concern to the social work profession whose traditional focus on the individual in the context of his total environment has made the profession an obvious care-giver to this client group. The families of the elderly have been seen as an important part of that environmental milieu, but the focus, in traditional social work practice has been on the individual aging person.

Casual observation suggests however that as a result of increased longevity and public programs which help the vulnerable elderly remain in the community, that families may be taking increasingly important responsibility for the emotional and protective support of aging parents. The question arises, how relevant is the relationship between the elderly and their families to the well-being of the elderly, and what is the nature of this relationship in later life?

One might speculate that since the children of the elderly are likely to be middle aged or older, the pressures in their own lives as they face menopause, retirement and

other milestones of middle life may affect their ability to provide the care needed by aging parents, placing them in a position of some vulnerability also. If this is so, one wonders how social work intervention can assist the family in its role of caregiver? What kind of problems arise as families reconvene to care for elderly members and what therapeutic techniques may be appropriate in working with families who experience them?

Chapter II

REVIEW OF THE LITERATURE

The tendency of the helping professions to view the elderly as isolated and abandoned by their families has been described by Blenkner (1965) as a myth which has been perpetuated by the childless elderly and by professional social workers who see mainly those elderly pelple who come to the attention of social agencies. That the isolated, childless elderly are more likely to require help as they begin to experience illness and disabilities has been noted by Townsend (1957) who found that old people with relatives living nearby make the le ast claim on health and welfare services, while lpeople who are isolated from their families, or who are childless make the heaviest claims. In a later study, Townsend (1965) found admission to nursing homes to be more likely for those elderly whose families were not present. Similarly, Brody, Paulshock and Masciocchi (1978) found that the presence of a family "caring unit" is a critical factor in delaying or preventing institutionalization of a chronical ly ill older person.

That the isolated elderly person is the exception rather than the rule has been demonstrated by a number of studies which reject the concept of the nuclear family as the predominant urban family unit, and the extended kin network as being the more typical rural pattern. Reasearch

by Townsend (1957, 1965), Sussman (1965), Litwack (1965) and Hill (1965) demonstrate the presence of a viable kin network existing in the industrialized urban setting functioning to provide mutual aid and social support for its members. The majority of elderly exist within such networks, most of them living within fairly close proximity to an adult child and maintaining regular contact with them. Townsend (1957) found that while most elderly prefer not to live with their children, the 203 old people in his study of elderly families in a London borough had an average of 13 relatives living within a mile distance. Three quarters of his sample saw one or more of their children once a week and 1/3 of them, daily. In an American national survey of non-institutionalized elderly over 65, Shanus (1979) found that 3/4 of those with children had seen a child some time within the week preceeding the interview.

Comparing intergenerational help patterns by social class in Britain, Denmark and the U.S., Shanus (1968) concludes that the kin network and the modified extended family appears to be the basic social system in contemporary industrial societies.

A complex pattern of mutual help involving services, money and emotional support is exchanged between generations and is especially active in times of illness and crisis. Hill (1965), exploring "help exchanges" in three generational families, consisting of the older grandparents, the

middle aged parents, and the younger married children generations found the grandparent generation was a high recipient of help from parent generation in the areas of illness, household management and emotional gratification, receiving more help than it gave. The married child generation received most help in the area of child care, and the parent generation tended to act as patron, giving help to both older and younger generations and receiving little help in return. Most help exchanges tended to be vertical (grandparent-parent-married child) for all generations rather than horizontal, (between relatives of the same generation), especially for the grandparent generation. This tendency of the elderly to seek help first from adult children and grandchildren has been noted by a number of authors. (Sussman, 1965; Townsend, 1957; Kirschner, 1979; Brody, 1966)

The foregoing descriptive information underlines the importance of family to the wellbeing of the elderly, but says little about the nature of the relationship or the stress which may occur as the needs of the elderly increase with age. In a recent interview, Neugarten (1980) ventured the opinion that families may be going too far in caring for elderly parents, stripping themselves of economic, social and emotional resources in doing so, and making parent caring a major source of stress in family life.

A review of the literature points to several theoretical approaches to understanding the nature of the intergenerational relationship, the sources of potential conflict inherent in it, and methods of intervention aimed at relieving this conflict as well as enhancing the family's ability to care for its elderly members:

1. Family systems theory, which sees the family as an interacting unit and provides a general frame of reference within which to conceptualize intergenerational relations.
2. Developmental theory, in which behavior is viewed as an inherent, progressive response to maturational processes.
3. Crisis theory, in which behavior is viewed as reactive response to changing situations.

In dealing with each area, its theoretical basis will be reviewed, followed by its application to the older family and implications for intervention.

FAMILY-SYSTEMS THEORY

In his overview of the major concepts in family therapy and the key ideas of its leading thinkers, Foley (1974) notes that although having its roots in the work of earlier theorists, family therapy received its major impetus in the mid 1950's from research with schizophrenics and their families which revealed the importance of disturbed patterns

of family communication in the development of individual pathology,and suggested a new way of viewing the family. The major concept upon which family therapy then came to be based is general systems theory, an approach which underlines the thinking of most theorists in the field.

Foley describes a system as a complex of interacting, interdependent parts characterized by 1) its wholeness or unity (i.e. it is more than the sum of its individual parts; 2) relationship, or the way in which its parts relate and transform one another; and 3) equifinality, the property that no matter were one begins, the conclusion will be the same. Applied to families this characteristic means that the pattern of interaction is the same regardless of the subject matter, so that the clinician need only observe an interaction in one area to see how family members relate.

Interaction within the system takes place through a process of feedback, the means by which new information is exchanged throughout the system. Since systems, being self-perpetuating, strive toward homoestasis, the feedback mechanism acts to preserve the system in a balanced state. Negative feedback (differing in systems terminology from its popular usage) serves to decrease the deviation created by the introduction of new information, thus correcting the system. Positive feedback amplifies the deviation, moving the system toward new growth.

Applied to families, dysfunction in the family system is corrected by the behavior of a member which re-establishes balanced functioning, and in so doing is reinforced by the system. The term "Identified Patient" refers to that member whose behavior provides the negative feedback which corrects the system. This member is often the family scapegoat, usually a child, who is blamed for all the ills of a family, and whose behavior serves the purpose of preserving the family system, and in turn, is reinforced by the system.

Positive feedback amplifies, or forces change in the system, and it is this to which therapists aim their intervention. The major theorists in the field propose different ways of changing the system; Minuchin (1974) for example by changing its structure, Satir (1967) by changing its pattern of communication.

Foley identifies the common themes of the major theorists; 1) that the family is crucial for survival since through it one fulfills goals and needs; 2) the nature of the family is interactional since one cannot view one part of it without taking into account the other parts. It is this latter point, that pathology is attributed to the interactional unit, the family, and not just to a person which Foley stresses as setting family therapy apart from traditional individual-oriented therapies. In this paradigm "it is looking at the ways in which the system operates, and producing

movement not through changes in intrapsychic forces but by the use of feedback which changes the pattern of how the system works."

Most published work on family therapy focusses on the nuclear family of procreation, which is most likely to come into therapy because of the acting out behavior of children and adolescents. The language which conceptualizes roles and interactional patterns is descriptive of this kind of younger family. But does this theory apply equally to the older family?

The following review of some of the literature on intergenerational families throws some light, piecemeal fashion, on the application of family systems concepts to the older family.

Sussman (1965) suggests a schematic structure for the extended family kin system, the parts of which he believes to be connected by affection and choice and the belief that relations between subsystems should not jeapordize the independence and unity of individual subsystems. This kin network is composed of x number of subsystems of four types: 1) the family of procreation which is created by marriage and composed of the husband, wife and children. 2) the family of orientation in which the individual is reared, composed of parents and siblings. 3) the family of gerontation, which is generationally linked in a vertical direction, composed of parents, children and grandparents. 4) the affinal family,

composed of the parents and siblings of one's spouse. (see fig. 1) The individual may be a member of all subsystems, playing a variety of roles related to the maintenance of the subsystem and the system as a whole. Sussman suggests that it is the family of gerontation subsystem which is appropriate for the analysis of the parents' relationship with adult children. While the schema suggests the complexity of family relationships when viewed beyond the boundaries of the nuclear family, it fails to illustrate its real complexity, which one may glimpse in reflecting on the possibilities for increasing numbers of relationships in families having many siblings. For example one might conceive of a number of families of gerontation fanning out from a single set of grandparents. The chart raises the question whether relationships are of equal importance, and whether interaction between subsystems of this large system differs from that within subsystems, and from that within the nuclear family?

Taking a closer look at the three generational family and implications for intervention within it, Boszormenyi-Nagy and Spark (1973) postulate an intergenerational approach to family therapy which is valuable for the light it sheds on the nature of the intergenerational relationship. In this formulation, individual symptoms are seen as an indication of problems in the multigenerational family system. The major connecting tie between generations is that of loyalty, based on reciprocal indebtedness

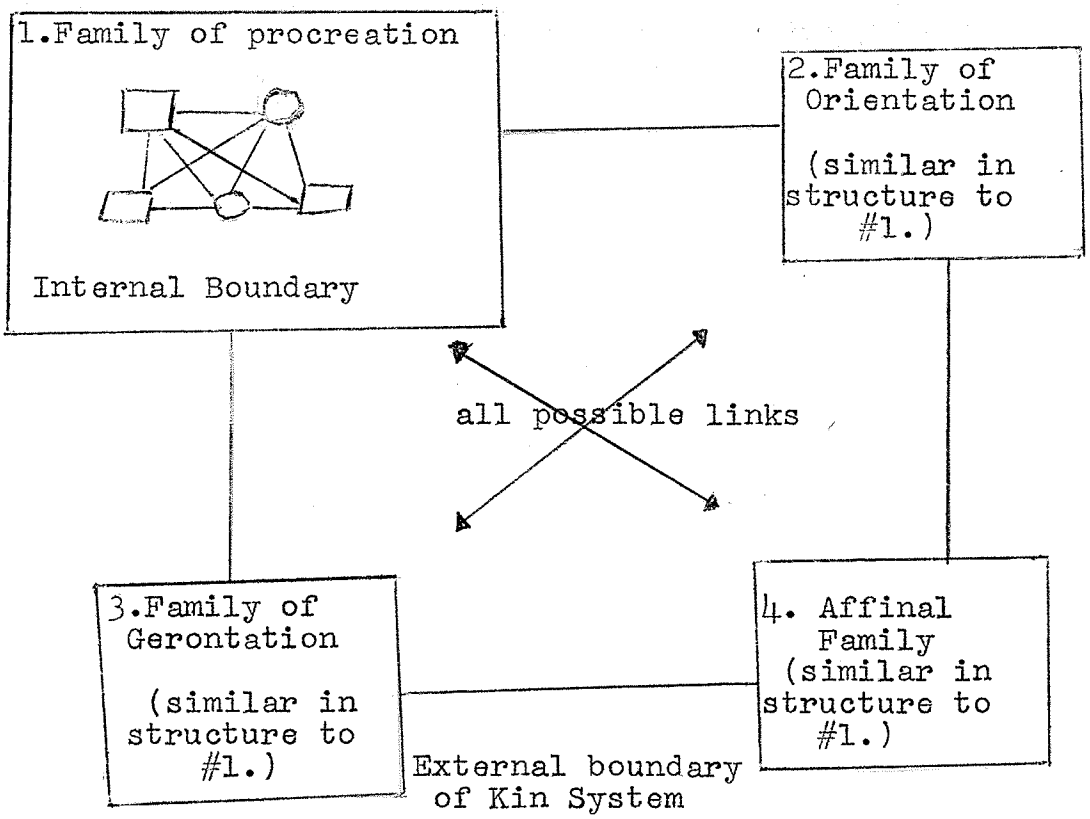

Fig. 1. Kin system of linked nuclear subsystems 1.

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1 Marvin B. Sussman, Relationships of Adult Children with their Parents in the United States, in "Social Structure and the Family: Generational Relations." Eds. Ethel Shanas and Gordon Streib. Englewood Cliffs: Prentice-Hall, Inc., 1965, p. 66.

involving all members. Loyalty finds expression in the form of physical care, regular contact, demonstration of interest and respect and concern. Whether early relationships were experienced as good and loving or destructive and inadequate, the individual feels obligated to repay. Repayment may be expressed directly toward the parent or may be externalized and projected onto one's spouse and children. It may take the form of loving care or of physical and emotional neglect in revenge for bad early relationships. If repayment is denied or minimized, one may experience underlying feelings of guilt.

The work of the therapist is to rebalance these relationships; to balance out in reality one's obligations to one's family or origin, mate, and children. Grandparents are included in therapy and encouraged, along with the parents and children to disclose their own accounts of exploitation and unrequited merit, and this can lead to new understanding and mutual compassion between generations, with the goal being to enable each to discharge his obligations in a manner appropriate to his age and phase in life.

Although Boszormenyi-Nagy and Spart apply their theory to the symptoms appearing in the younger family, they point out that through assisting the intergenerationalfamily to rebalance its relationships by resolving past emotional debts and obligations, thus lessening the guilt feelings

associated with them, the adult child may be able to repay or care for his aging parent in a more responsible way than he was treated. The authors see this therapeutic process as breaking the circle of revange and guilt carried from one generation to another.

A number of authors have noted similarities between older and younger families in the way in which the family functions in order to maintain homeostasis and in the roles assigned to members. Brody and Spark (1966), in discussing the implications of the family's request for nursing home placement, note that in families characterized by long term impaired relationships, the elderly person may become the 'storm centre' of members' irrational feelings and be placed in the position of family scapegoat, thereby masking the relationship problems of the total family. This is especially likely to occur when the aged member is living with the family. A subsequent move to a nursing home may be seen as rejection by the elderly person and may result in feelings of guilt by the family. The authors use the term "burden bearer" for the adult child who takes responsibility for the elderly member, a role comparable to that of "parental child" whose existence other authors have noted in connection with the younger family (Minuchin 1974, Boszormenyi-Nagy and Spark 1973). Brody and Spark urge that the family, rather than the aged parent be seen as the client in order that placement be a growth producing experience for all.

Miller, Bernstein and Sharkey (1973) found that families may distort or deny the seriousness of the aging member's illness in order to maintain family homeostasis, and Bernstein and Sharkey (1974) found that the elderly are often extruded by placement in a nursing home when historic family splits, hostility, guilt and sexual conflict have been the prevailing family pattern.

Other authors recommend that the family be used as its own corrective by bringing normal family strengths into play. Shellhase and Shellhase (1972) recommend family therapy as a means of moving the family of a client suffering disabling injury to use sensitive family re lationships in assisting the member. Broom and Monro (1972) agree, seeing the major role of intervention with extended families as facilitating the activation of its supportive function.

While the literature recommends a family systems approach in intervention with the older family and contributes components to a theoretical conceptualization of it, a set of specific techniques is lacking. Herr and Weakland (1979) address this lack, applying the techniques developed at the Brief Therapy Centre at Palo Alto in working with younger families to the older family. Bases on an interactional approach which implies a focus on the present situation; the means of handling the problem by the persons involved

rather than the problem situation itself; and the possibility that small but strategic change will be reinforced by interaction within the system, the authors present a schema for practice with the older family which involves the following steps: 1) establishing contact with the clients, 2) definition of the problem: specifically, to whom it is a problem, 3) determining how the problem has been handled: attempted solutions, 4) establishment of minimum goals for change, 5) understanding where members are starting from: their view of the problem, 6) review and summary of the above points and strategic planning with the family: mobilizing the family, 7) specific interventions and their evaluation: this may involve such techniques as reframing, and prescribing work to be done between sessions, 8) termination.

Thus with the exception of the work of Herr and Weakland the theory reviewed here makes only a bare beginning in applying a systems approach to the older family. Sussman (1965) suggests a structure; others note similarities inroles and interactional patterns between the older, and the young family. But many questions are left unanswered and a comprehensive attempt to develop a theoretical framework which fits the characteristics of the older family is missing.

Turning now to an examination of the dynamics of the intergenerational family, two approaches, developmental

theory and crisis theory will be reviewed from the perspective that these dynamics take place within the context of a family system.

DEVELOPMENTAL THEORY

The concept of stages in individual development, originating in psyschanalytic theory of child development, was first expanded beyond the maturity stage by Erikson (1959). In this view, personality develops in a progressive manner throughout the life cycle. The process involves confrontation with core conflicts taking place at specific life phases. These conflicts or crises are precipitated by the individual's readiness, and by society's pressure to advance to a new stage. The conflict resolution which is achieved at each stage affects the way in which succeeding phases are dealt with.

McGreehan and Warburton (1978), pointing out areas of potential intergenerational conflict, observe that developmental crises usually bring about a change in reciprocal role relationships between family members, and Golan (1979) observes that the individual undergoing developmental change is vulnerable to other stresses. Thus an examination of the developmental tasks of middle and old age is pertinent to understanding the relationship between the elderly and their adult children.

Erikson (1959) describes the crisis of mid-adulthood as that of generativity vs. stagnation, in which generativity

is seen as a creative, productive urge; a concern for establishing and guiding the next generation. Failure to master this crisis results in a reversion to a search for intimacy, often resulting in pseudo-intimacy, and a sense of impoverishment and stagnation.

The last life crisis, ego integrity vs. despair implies the need to assure oneself that life has had a meaning and order to it; and a readiness to defend one's life style as being the one most full of integrity. If unable to do this, the individual is filled with a sense of despair that life is now too short to begin again, and a fear of death.

Expanding on Erikson's concepts, Peck (1968) identifies a number of stages within the middle and later years, each having its own developmental task. Thus middle age brings with it four stages, with the task related to each being 1) valuing wisdom or life experience vs. valuing physical powers; 2) socializing vs. sexualizing in human relationships; 3) cathectic flexibility, or the capacity to shift emotional investment from one person or activity to another, vs. cathectic impoverishment; 4) mental flexibility, or the ability to achieve a detached perspective on experience and events vs. mental rigidity.

The tasks of old age are seen as 1) ego differentiation, or a shift in values which redefines personal worth in terms other than those related to occupation, vs. work role preoccupation; 2) body transendence vs. body preoccupation;

3) ego transcendence or a concern for making life better for those who come after vs. ego preoccupation.

Scherz (1971) notes that certain universal psychological tasks of the family parallel those of the individual, influence each other's development, and are repetitive during the life cycle. These tasks are: 1) emotional separation vs. interdependence; 2) closeness vs. distance and 3) self autonomy vs. other responsibility. Conflict arises in families as family developmental needs clash with those of the individual and are repeated at each stage of development. The last two stages of family development are 1) achievement of adult status, as the last child leaves home, and a differentmarital equilibrium must be achieved, and 2) arriving at old age involving problems of loss and separation surrounding the inevitability of death and the need for the children to take care of parents in ways that arouse old conflicts about dependency and separation.

As Pincus (1967) points out in his discussion of the importance of a developmental view of aging to social work intervention, in this paridigm personality processes are in part inherent and developmentally determined, and not simply a reaction to changing situations. This approach provides a longitudinal view of human development, and a frame of reference for understanding the presenting problems of the elderly client.

A point of controversy in the literature relates to

whether the roles of parent and child are reversed as the parent ages. Brody and Spark (1966) maintain that in the healthy family the child should be able to accept and meet increased dependency of the parent and assume a quaisi-parental role. Kent and Matson (1972) describe the role reversal which occurs in both husband-wife and parent-child relationships when family roles are disrupted due to the illness of a family member. McGreehan and Warburton (1978) speak of a gradual role reversal in which adult children do not become parents to their own parents, but take on parental attributes.

Authors who subscribe to the developmental approach maintain that a role reversal, being regressive, does not occur or that if it does occur, it represents a pathological relationship: Milloy (1964) postulates that rather than a role reversal, new roles are assumed which require adjustment on the part of both parent and child, and which, like the assumption of any new role, may be fraught with conflict. Goldfarb (1965) refutes the idea of role reversal and the assumption of new roles, insisting that dependency in the parent need not be seen as regressive, but as a manifestation of a lifelong dependency which has emerged now with greater clarity. At other times this dependency may have been disguised, or displayed in a more socially acceptable manner.

Blenkner (1965) also adopts a developmental approach, suggesting that a filial crisis occurs in middle age when

the adult child realizes that the parent can no longer provide support in crisis but now is beginning to need the child's support. Accomplishment of the filial task, of being"depended on and dependable" promotes the achievement of filial maturity. In addition, it may lead to the successful accomplishment of the developmental tasks of old age through a recognition of the parent as a person in her own right with her own history, needs and individuality, and the abandonment of the rebellion and emancipation of early adulthood. Thus for Blenkner, the attainment of filial maturity is an essential part of the developmental process in middle age.

For these authors, one of the goals of intervention is to assist individual family members with developmental tasks appropriate to their own stage in life. Milloy suggests that an introspective, uncovering type of treatment may be too energy-consuming when what is required is that the middle aged client assume a new developmental role. She suggests that he be helped to understand that the parent is not a child for whom he must assume complete responsibility, but someone with whom he can share the responsibility of looking at alternatives and making decisions.

Similarly, Blenkner sees the therapeutic role as one of helping the adult child to accomplish his developmental task of attaining filial maturity.

Golan (1979) suggest that a large educational component is often required in dealing with maturationmal and develop-

mental crises to help people understand normal age-stage behavior.

Transitional processes, a period of change from one stage or role to another involving relational and personal change in one's life situation have received some attention in the literature. Although this concept may imply greater discontinuities than those occurring in normal developmental change, the means of intervention in transition states may be applicable to developmental change, especially when role change is implied.

Golan suggests a number of treatment strategies including reworking the earlier primary relationships which may be blocking passage through the transition, concrete problem-solving guidance, emotional support, opportunities for ventilation of emotion, teaching new coping skills and assistance in building new support systems.

Noting that the most useful form of help in all distress-inducing situations is support, Weiss (1974), and his associates at the Laboratory of Community Psychiatry at Harvard Medical School developed a program, 'Seminars for the Separated' aimed at helping people with the transitional situation following separation. These eight weekly meetings provided cognitive materials, support and an assured place in a temporary community for people experiencing common problems. The format was a lecture followed by group discussion. The benefits of this kind of intervention were considered to be 1) reassurance of the normalcy of the participant's emotional reaction, 2) group support

and 3) an aid in recovery. The author speculated that similar seminars might be used in other transition situations if the material presented is tailored to the problems inherent in the transition.

Developmental theory, in its recognition that intrapsychic conflict arises throughout one's life through the process of maturation, and by identifying the nature of the conflict, assists the practitioner in her understanding of the changes taking place in role relationships as the elderly and their middle aged children struggle through these processes. It also suggests that conflict between individuals, and between individuals and families may be inevitable as each works through his own developmental task. Intervention needs to aim at assisting the family and its members to resolve developmental crises in a manner which will be growth productive.

CRISIS THEORY

If it is to family that the elderly first turn for help, then when help is sought from social agencies it is often when needs are so massive as to be beyond the capabilities of the family. This implies a state of crisis, and Brody (1966) observes that a unique aspect of the aging phase of life is the clustering of a number of crises, any one of which challenges the individual's capabilities.Thus an exploration of crisis theory and its special relevance for the older family is important.

Golan (1979) describes crisis as occuring when a

hazardous event upsets the individual's homeostatic balance. He is thereby placed in a vulnerable state in which he attempts to apply his usual problem-solving strategies to resolve the crisis. If these attempts are unsuccessful, tension mounts until a precipitating factor, which can be of relatively minor proportions, throws the individual in to a state of acute crisis. Rappaport (1962) points out that the hazardous event may be perceived as a threat, a loss or a challenge, each having its characteristic mode of response. If perceived as a threat to instinctual needs, the event is likely to be connected to old threats to instinctive needs and reactivate unresolved unconcious conflicts. If perceived as a loss, the event will trigger a grief reaction with its characteristic effect, depression. If the crisis is viewed as a challenge, it is likely to activate new energy for problem-solving activities.

Kirschner (1979) points out that some families are able to accommodate to the changing needs of the elderly parent and are anxious to help when the aging parent needs it. For others, customary communications processes and relationship patterns become dysfunctional when adult children are drawn back to the family of origin by the needs of parents, and the family as a whole falls into a state of crisis.

A number of authors have dealt with the way in which crisis resolution is affected when it reactivates unresolved conflicts. Brody (1966), discussing interlocked

parent-child relationships which emerge in crisis situations involving four generation families, points out that neurotic guilt, the product of a long-term dysfunctional relationship inhibits responsible behavior, trapping both the parent and child in immature and destructive behavior.

Leach (1964) discusses those situations where parent-child conflict has led to a complete split in early adulthood, and where the child is called back, in later life to assist the ailing parent. In these cases, "unresolved neurotic conflict returns in full force and interferes with the child's ability to help the parent and the parent's ability to accept help from the child", and is further complicated by the guilt both feel about past failures.

There are differences in the literature about the way in which this kind of conflict should be dealt with in intervention. Crisis theory according to Golan asserts that where previous unresolved conflicts resurface, emphasis should be on the similarities and differences between the past and present, and on severing inappropriate connections so that the person regains control of his responses to the present situation. Leach maintains that in this situation the caseworker must continue to work with both parent and child, involving the children in planning and helping both parent and child ventilate so that they can tolerate each other. Her focus is on the strained interaction, and services to one generation is dependent on the responses of the other.

Brody (1966) however points out with regard to impaired relationships that it may be inappropriate to try to help adult children accept and meet parents' needs,that this may assume a capacity which is not present, or realistic to expect of the adult children, especially when they are of an age when they are coping with their own increasing age-related needs. In opposition to Blenkner's position that caseworkers should assist children in reaching filial maturity, Brody points out that it is not appropriate in a crisis situation to work on developmental issues.

Golan points out that when the unanticipated hazardous event precipitating a crisis involves loss, the loss may be real or threatened and may involve a person, a capacity or a function. Since losses occur frequently in aging, and involve loss of physical capabilities and independence as well as loss of significant people, a brief exploration of grief reactions is appropriate.

In his classic work on bereavement, Parkes (1972) explores typical and atypical grief reactions in great depth. Turning to a briefer examination of reactions to other types of loss, the author outlines seven features which he considers to be common to losses of all kinds: 1) a process of realization in which the person moves from denial and avoidance of the loss towards acceptance over a period of time: 2) an alarm reaction involving anxiety and the physiological accompaniments of fear; 3) an urge to search for

and find the lost person or function; a preoccupation with it; 4) anger and guilt, including outbursts against those who press the bereaved toward prematurely accepting the loss; 5) feelings of mutilation; 6) a tendency to identify with the lost person or object; 7) pathological variations of grief: e.g. excessive and prolonged or inhibited and inclined to emerge in distorted form.

Silverstone and Hyman (1976) describe the losses experienced by the elderly, in addition to the highly likely loss of a spouse, to be loss of social contacts, through other deaths of friends and relatives, loss of physical capabilities such as sensory capacities and mobility; role loss, loss of financial security and of independence. They point out that these losses need to be mourned, and reactions of rumination, anxiety and fear are not uncommon. Behavior patterns emerge which tend to ward off these emotions and reestablish control over change such as living in the past, a preoccupation with death, denial of the loss, mistrustful behavior often directed to those closest to the elderly person, stubbornness in avoidance of change and ritualistic behavior.

McGreehan and Warburton (1978) suggest that parents who may not be able to face the reality of their failing capabilities may deny this by withdrawing from their children or by putting on a facade of independence. Some compensate for losses in health, physical strength and work role by attempting to control their children, even by making them

feel guilty for having their own lives.

In her study of the relationship between adults and their aging parents in 50 families where the adult child requested service of a Jewish family agency for the parent, Simos (1970) found one of the three major problems which emerged in assessment was the psychological problems exhibited by the parents due to attempts to compensate for losses. In these cases the children were able to recognize the parents' need to turn to them in the loss of a significant person, but not regarding other losses.

Exploring the impact of the husband's disability or the wife's morale and life-style, Fengler and Goodrich (1979) found the morale of wife and husband to be interdependent, suggesting that the spouse of those experiencing disabling loss needs support also.

Milloy (1964) points out that in assisting clients in grieving for losses, it is important that the worker understand and recognize what the client is grieving for. The grief reactions of older persons are related to present and past losses, thus the worker must help him relate past losses to present ones. In order to form new ties, the client needs to free himself from his ties to lost objects.

Grief and loss are extremely important phenomena in the lives of the elderly and the elderly family. An understanding of its process, recognition of its symptoms, and techniques of intervention in situations involving loss must be an integral part of social work intervention with the

older family. The above review only touches on some of the salient points in the extensive literature dealing with grief, since a more thorough exploration of the subject would be so lengthy as to be beyond the parameters of the present paper.

Returning to a discussion of crisis intervention, the combination of a family approach with crisis intervention techniques would seem to provide an appropriate framework for intervention with the elderly family. Langsley and Kaplan (1968), in developing a system oriented model for crisis intervention with families experiencing mental breakdown in one of their members, take the position that the outcome of a crisis may depend on a variety of social subsystems in the patient's field which influence his struggle for stress mastery, as well as on the individual and his history and on the external stresses which impinge on him. This approach assumes that the symptoms of a family member are, in part, expressions of family conflict or a reaction to instability in the family system. They point out that in addition to being a source of stress, the family is a major resource in the resolution of stress. Crisis intervention in this model involves 1) immediate aid, 2) defining the crisis as a family problem by immediately calling together all members to work on crisis resolution, 3) involvement of all members in working on the crisis by defining the symptoms as a family responsibility, 4) a general prescription directed toward the symptoms,helping

the family to see the symptoms as the client's means of communication, 5) prescription of a specific task related to the crisis, 6) renegotiation of role conflicts, 7) preparation of the family for future crises by teaching them new ways of problem solving.

Kuypers and Trute (1978) while acknowledging the value of using the older family as its own corrective in crisis work, observe that its mobilization is "difficult, if not impossible" for a number of reasons. The adult children seldom see themselves as part of the problem, believing that the problems of their parents are related to the process of aging, and the responsibility of social service agencies to deal with. They note a tendency on the part of the adult children to exaggerate the proportions of the crisis, seeing it as leading inexorably to increasing dependency, a prospect they may wish to reject since it runs counter to their expectations that their obligations should decrease, rather than increase as they approach their own aging stage of life. When the family does come together to work on the crisis they are likely to resist opening up relationship problems even if their unresolved conflicts are blocking any capability to work on the identified problem.

In working with older families, the authors recommend that the worker develop a sympathetic understanding of the factors which are creating resistance, and openly acknowledge the fears the family may be experiencing; to focus on tasks which provide some assurance of success in accomplishment; avoid forming allegances with individual members,

build a sense of confidence in the family by taking an optomistic approach, reframing the problem, identifying and communicating family strengths and helping the family learn new skills in dealing with the problem; and gaining each member's assent to working on the task.

Approaching the crisis of aging as a normal problem in living, Kirschner (1979) recommends an ecological approach, taking in not only the elderly person and his family, but also including forces in the social environment which influence the crisis state and require for intervention a knowledge of community resources and government entitlements. A rapid diagnostic assessment enables the worker to determine what kind of intervention is likely to relieve the immediate situation and includes an assessment of physical and mental health, social, financial and environmental factors. The use of external supports and community services is also stressed by Kuypers and Trute, who suggest that their use may decrease the family's fear of the parents' increasing dependency.

The importance of an active, immediate approach is stressed by Kirschner in order to relieve the family's tension and feelings of helplessness and hopelessness, with the goal being to deal with the present reality. Kirschner, like Kuypers & Trute acknowledges the reluctance of adult children to become involved, and stresses the importance of reassuring members that the goal is not to reconstruct family relationships but to work on a practical solution to the crisis. Where pathological relationships emerge, a new contract

must be made in order to deal with it, with the mutual consent of members. Like other authors who stress a family approach Kirschner recommends a family conference be convened to work on the problem, but points out that individual counselling with an adult child may also be helpful since a change in one part of the system affects the system as a whole.

Crisis theory makes an important contribution to intervention with the older family for whom crises can be expected to occur with some frequency. Reactions to crisis have been reviewed, focussing on its potential in reactivating unresolved family conflict and in initiating reactions of grief and loss. An exploration of intervention with families in crisis, and with the older family in particular has pointed up the importance, as well as the difficulties in involving family members in social work intervention in crisis situations regarding its older members.

Chapter 111

THE PRACTICUM SETTING AND CLIENT CHARACTERISTICS

In order to explore the questions raised in the foregoing examination of theoretical approaches relevant to intervention with the older family, and findings which have been reported in the literature regarding their application to practise, a practicum was designed which would afford an opportunity for intervention with elderly persons whose families were involved in some way in their care.

The choice of agency in which to find appropriate clients created some difficulties. Casual observation suggests, and the literature confirms that older families do not ordinarily seek help of social agencies except as a last resort, in crisis situations and when their needs are beyond their own coping abilities. In addition, it is unlikely that the values of this client group permit them to see problems which involve family relations as appropriate to take to strangers for help. Hence family agencies and agencies serving the well elderly were ruled out, as were hospital extended care units, since if impairment were not great, the patient's stay in hospital was likely to be short, and thus not appropriate for ongoing intervention. Nursing homes were not considered because of the anticipated degree of the client's impairment and because it was assumed that involvement of those family members who were available to the patient might be marginal.

The service chosen for the location of the practicum was the Continuing Care program operated by the Provincial Department of Corrections and Community Services. Since this program provides a wide array of home care services designed to assist the vulnerable elderly to remain in the community, it was expected that in those cases where family was available to the client, it could be expected to be involved with him in some manner.

The Provincial Continuing Care program is a coordinated program designed to provide services in the home setting for persons who require assistance and support because of illness or disability, and whose functioning without such assistance is likely to deteriorate. The program aims to maintain functioning, provide an alternative to institutional care and relieve excess strain on families who are involved in supportive and/or physical care of elderly members. Elegibility is based on the needs of the client as determined by a clinical, functional and social assessment including assessment of care which is, or can be provided by family. It is designed to fill the gap between the person's needs and those services the individual and family members can provide for themselves.

Services which are available through the program include homemaking services; personal and hygiene care; health supervision, care and treatment; counselling; equipment loan; and services provided by volunteers such as meals-on-wheels and friendly visiting. Services outside the home, respite care

and day care offered by some nursing homes are also available through the program.

The program serves as a gateway through which admission to nursing home is arranged, the appropriateness of admission being determined by a medical panel who review each application and priorize admissions.

Service is delivered by a Home Care team, usually composed of a social worker and a public health nurse, who together assess the needs of the elderly person and develop a care plan in consultation with the client and his family. Depending on the nature of the client's needs, one team member becomes the case coordinator and takes responsibility for instituting the care plan, arranging for input and withdrawal of the required services, evaluating the client's progress and completing the required documentation.

Continuing care operates under the policy that the service provided is to be "the minimum service required to meet the person's need in order to ensure that the person makes maximum use of the capabilities he possesses", and that "family resources are mobilized if they exist". Each case is reviewed quarterly.

The Home Care teams who deliver this service are located in the District offices of the Provincial Department of Corrections and Community Services, which provide a base for a variety of provincially administered social service programs (excluding income security and corrections services which are located elsewhere). District offices are

responsible for service delivery within their designated catchment area. The number of Home Care teams located in each District office varies in accordance with the size of the case load.

This practicum was situated in the North West District Office located at 408 McGregor Street in Winnipeg's North End. One of the larger districts in the Winnipeg Region, it is responsible for an area which includes a large portion of Winnipeg's core, and also includes older, established residential areas, new low income residential developments, an industrial park, an extensive middle-class suburb and semi-rural market garden area.

Three and one half Home Care teams are based in this district office, each worker carrying a caseload of over 100 cases. As in other district offices, there is a large turnover of cases, in that a number are opened and others closed each month. Since Home Care cases tend to be of a crisis nature, clients enter the system with urgent, immediate needs, and leave the system usually through admission to a personal care home or hospital, or when the service is no longer needed.

The aim of the practicum was interpreted to the Home Care staff as being:

> "To assist the family to work together on the problems presented in the care of an aging member by:
> 1. Assisting the family in learning new coping skills and in using external supports effectively. (i.e. other services being provided by Continuing Care)

2. Assisting the family in working through difficulties and conflicts in their relationships with one another which may emerge or re-emerge to impede their ability to deal with the main problem."

The service was to be considered as one component within the package of Home Care services, offered to those families who can make use of it and who meet the following criteria:

"Families should be composed of at least one elderly person and at least one middle aged child who may or may not live together. Families might be composed of additional members who are living with either the elderly or middle aged principles or who are available to them in a helping or supportive role."

"Families chosen for referral must be willing to engage as a unit in the counselling process, although meetings with individual members may also be part of the intervention."

It was suggested that cases be referred by the Case coordinator to whom I would be responsible for ongoing reports about the progress of the case.

The practicum was carried out over a four month period, January to the end of April 1980. Clients were seen on an average of once a week in their homes, and visits were frequently conducted on weekends or in the evening to accommodate the working members of families.

Six families were referred by Home Care staff, one of which was unwilling to engage for ongoing counselling after the first interview. In each case the family was highly involved in the care of the parent (or parents) although the relationship was not a satisfying one in all cases. Of the five families who continued in an ongoing counselling

relationship, one involved a parent who was living with a child and her family and four who lived in separate accommodation, but within 15 minutes drive. In one family the disabled person was in her 60's with the adult children ranging from 19 to about 35; in the other four families the parents were all over 80 and the adult children, over 50. In all cases the relevant caregiver or caregivers in the adult child subsystem were daughters. In three cases the parent was institutionalized before my involvement with the case was terminated.

A second form of intervention, which was not anticipated in the original practicum plan, but which was suggested by a social worker who conducted groups with the well elderly, involved a group for middle aged and older persons who were concerned with the care of an elderly parent. This group was conducted through the Institute for Continuous Learning, a program of the Age and Opportunity Centre Inc.

The Institute for Continuous Learning offers a variety of courses for the elderly in classrooms situated in a large senior citizens residence and day centre at 185 Smith Street in downtown Winnipeg. The Institute's courses include such wide ranging topics as personal growth, eastern philosophy and reflexology, as well as such things as sewing and a writers' workshop. Although having its main focus on education, a few problem-oriented counselling groups have also been offered.

The six-week group which was conducted as part of this practicum, called 'You and Your Aging Parent', was a semi-structured transition group, with a large informational and educational component and an opportunity for participants to discuss common problems. Topics were chosen to meet the needs expressed by participants at the initial meeting.

The group attracted six participants, from four families, and represented the principal caregivers in each, all of them daughters except for one lonely son-in-law. Participants were all over 50 and their parents over 80. One family was concerned with two parents, the other three, with widowed mothers. Two parents were living in personal care homes and the remainder in the community. None were living with group members, but a pair of sisters were considering taking their mother into one of their homes. The parents all had some degree of age-related illness or disability and two of the three parents living in the community were receiving Home Care services.

Thus the four families represented in the Institute group bore characteristics striking in their similarity to the five families involved individually in the Home Care portion of the practicum. Indeed only one Institute family was not being served by the Provincial Continuing Care program. The major difference between the two sets of

families was that the presenting problems of the Institute families did not involve the component of crisis, and their situations remained stable during the intervention.

It is important to note that in all nine cases, the family tie was a strong one and the relationship between the parent and the "burden bearing" child was an historically close one with no apparent discontinuities. Thus in no case was it necessary to bring together a fragmented family in order to provide, or plan for the care of the parent. In all cases but one Institute family there were other adult children who were not involved with the elderly parent, usually because they lived in other cities, but in one case, because of a refusal to be involved.

Detailed case summaries on the Home Care families may be found in Appendix 1, page 72, and on the Institute families in Appendix 11, page 93.

Chapter IV

THE INTERVENTION

HOME CARE FAMILIES

The therapeutic approach chosen for use with the elderly Home Care clients in this practicum was a family-systems approach. This implied working with the older family as a unit, and an attempt to adapt family therapy techniques to this client group.

Provincial Home Care workers, as a general rule, regard the elderly individual as their client, and family, who are often the persons who refer the client, as collateral contacts. Thus a family approach is not one to which the client is accustomed, and since in all cases but one, the referring worker was the nursing member of the Home Care team, this approach may have been unfamiliar to most of the workers who referred cases as well.

Home Care staff had some difficulty in finding cases which met the criteria for inclusion in the practicum because their caseloads contained large numbers of cases with which they anticipated I would have difficulty communicating with clients due to language differences or to the nature of the elderly person's disability. Also, in many cases, no family was available to the client. (It may be possible however that staff may not always be aware of clients' relationship with children because of their customary focus

on the individual client.) For these reasons, only six cases were referred.

In referring cases, Home Care staff first sought agreement from the family to have me visit. I then followed the referral with a telephone call to the adult child, and in most cases to the parent as well, identifying myself as a graduate social work student and explaining my role as specializing in working with the elderly and their families. It soon became evident that the purpose of my work was unclear as clients seemed unsure of the reason they had been referred. After the first couple of referrals I was careful to expand on my purpose for being there, stressing the counselling role. However the focus of my work seemed to remain somewhat unclear to clients, a problem which was to remain with me throughout the duration of the practicum.

In all six cases it was requested that as many family members as possible be present for the initial interview and it was left to the family to decide who came. The exceptions to this were the B and F families where the parent lived in the same household, and in these cases I urged that all members of the household be present. None of the families objected to this request and in each case where the parents lived alone, the principle caregiving daughters were present for this interview. None brought spouses and it appeared that in each of these cases, in-

cluding the B family, spouses were minimally involved with their wives' parents, tolerating the relationship and extending help when requested to do so by their wives.

In addition to demonstrating who the principle caregivers were, the purpose of this first interview with the family system was to assess family relationships and presenting problems, and to attempt to contract with the family around a specific goal for ongoing work. This interview proved to be a valuable device for obtaining a picture of the family's relationships and feeling tone, and members perceptions of their problems related to the elderly parent. The A daughters' pattern of talking about their mother as if she were not there revealed the rift in this parent-child relationship and their underlying anger with their mother. The D daughters' tendency to argue defensively with their father indicated some degree of guilt in their relationship with him, but they also demonstrated respect for him and an affectionate support for one another. Most revealing was the B family, where the initial interview with Mrs. B, her daughter and grandchildren, with whom she lived, indicated a family with a tight cap on the expression of feeling and an inability to speak openly in front of Mrs. B about the difficulties her presence in the home was creating for the family. The use of audio tapes in this first home visit proved to be invaluable in picking up factors which had been missed in the live interview. The degree to which Mr. F's son dominated his sister, making decisions to which she

agreed but had difficulty accepting emotionally only became evident on replaying the tape recording of the interview.

Contracting with these families was difficult and where it was achieved, was to some degree, ineffectual. What was being sought primarily was a contract which would involve the family as a unit in an ongoing process. This was not achieved except when a crisis created an opportunity or a necessity for the adult children to engage with me, and where this happened it was as a subsystem intervention rather than with the system as a unit. Because of its influence on the direction of the practicum, this problem merits a detailed exploration.

The technique used in attempting to contract with these families was first to explore the presenting problems with them, then to choose one which was giving pain and which appeared amenable to deeper exploration, identify it and gain some agreement to work on it with the person most involved (in most cases, the parent). Then, pointing out the stress it was causing to the children, I invited them to join in the counselling process. For example, in contracting with the E family, I learned that Mr. E's anger with Mrs. E and his delusional accusations of infidelity caused her a great deal of pain, making her upset and defensive, and adding to her general feelings of hopelessness and helplessness. Her daughter had tried to intervene but could not break this pattern. My suggestion that in future visits we might work

on helping Mrs. E deal with this brought scepticism from Mrs. E and encouragement from her daughter. But when I pointed out that her parents' difficulties affected her also and asked the daughter to meet with us, she refused, indicating that even though her parents' problems caused her some distress, it was Mrs. E who needed help.

This reaction was typical of the three cases (A,D and E) where this method was used to set a goal and involve the family in working together: parents, although sceptical about the possibility of change, welcomed additional visits and children encouraged them as long as my visits did'nt involve them.

No contract was achieved with the F and B families. Perceiving the stress Mr. F's son and daughter were experiencing I suggested ongoing counselling for them as a means of helping them wait for their father's admittal to a nursing home. Their refusal terminated my contact with this family. The B family, which was referred with the express purpose of counselling assistance in the family's adjustment to Mrs.B's move to the home, advanced so quickly into crisis that the daughter found it necessary to turn to the Home Care worker for urgently needed services. The original reason for referral was no longer viable, and my role became limited to offering support to the daughter.

The adult children in these cases did not seem to perceive themselves as being part of the overall configuration

related to the parent's problem even though their relationship with the parent was extremely close and the stress created by the physical aging and disability of the parent profoundly affected their lives in many practical, observable ways. Mr. F's son, for example, was very open about his reaction to the situation caused by his father's disability: he felt tied down, trapped and expressed increasing irritability.

On the assumption that a small change in a subsystem reverberates throughout the system, I proceeded to work with whatever subsystems were willing to engage in counselling. With the A, D and E families, this involved work on a particular counselling goal with the parent subsystem, and with the B family, supporting the daughter through a series of crises precipitated by her mother's rapid deterioration. (The C family differed from the others and will be dealt with separately.)

Strategic behavioral change was attempted with Mr. D and Mr. E. This form of intervention, consistant with family intervention suggested by Herr and Weakland (1979) attempts to introduce a small change in a family's pattern of behavior on the assumption that a small change will reverberate through the system, changing patterns of family interaction, or in systems language, initiating positive feedback. In these cases, Mr. D, whose inability to accept his wife's mental deterioration led him to persist

in testing her, with the result that her failure to meet the test increased his frustration and anxiety, was advised to substitute "I'm glad you're home" for "what did you do today?" when his wife returned from day care. He refused to make this change because he said she would not understand and appreciate his expression of pleasure at seeing her. Although this might seem to indicate a paradoxical form of insight, where his resistance indicated that the strategy had achieved its purpose in confronting him with his wife's inability to respond, this was not the case, and he continued in his original pattern. Mr. E, who was incontinent, was asked to change his bedding each morning, thus relieving his ailing wife of this task. Although he agreed to try, his wife refused to allow it, fearing he would not do the job adequately. The failure of these directives suggest that a good deal of experience and planning is necessary in the use of strategic intervention in order that the directive be appropriate and introduced in a manner that is likely to be acceptable and carried out by the client. A good portion of my time with Mr. D was spent assisting him in a life review;reminiscences of some of the important events of his life, affirming its value and purpose, and relating his past successes in adapting to change and to the change he was about to experience as he moved to nursing home. Assuming that this process is a necessary part of the last stage of development in the life cycle, it seemed important that Mr. D describe his

life to me, even though it was an extremely time consuming process. It appeared that by reflecting on his life and seeing it as worthwhile, he was able to release his hold on the life style to which he was accustomed and make a move which was extremely difficult for him. Since he did not yet need the kind of care offered by a nursing home, but had been accepted so that he might be with his wife, he gave up a good deal of freedom in making this move.

If reminiscence was a satisfying experience for Mr.D, it did not have that effect for Mrs. E, who had only pain and hardship to remember as she traced her life in Europe during two world wars, and the history of her unhappy marriage, while Mrs. A could only relate the death of a child. It would appear that not all elderly people find reminiscence a positive therapeutic experience in working through transitional stages.

In two cases, a situation which they perceived as an emergency brought an adult child subsystem to engage in a counselling relationship with me. For a brief period after his move to nursing home Mr. D threatened to move out if he were not given a private room. The daughters requested my assistance in making an alternative plan for him, but before we had proceeded very far with planning Mr. D had become resigned to his new situation.

The second situation proved more challenging: a bad fall suffered by Mrs. A was perceived by her daughters

as indicating a need for nursing home care and opened an opportunity for me to meet with them. Their interaction during our meetings revealed a good deal of resentment and rivalry in their relationship with one another which hindered them in dealing effectively with their mother. Mrs. A was a difficult woman whose pattern was to pit her daughters against one another by favoring one and rejecting the other. This proved to be the most challenging intervention of the practicum as I attempted to apply techniques of family therapy: observing and sharing my perceptions about their interaction with one another and with their mother, confronting them with the implications of their request for admittal in the light of their mother's refusal to consider nursing home placement, and helping them to develop a plan to manage their obligations to their mother in a manner acceptable and equitable to both.

Although this situation exemplified the kind of relationship problem the practicum was designed to address, my work with these sisters raises a concern about the legitimacy of working on issues not directly related to the one contracted with the client system. In this case it seemed clear to me that some relationship work had to be done in order to enable the siblings to carry out their tasks with their mother. However it seemed important, since the contract related to the mother's self-imposed isolation, that work with the sisters be seen as a

means and not as an end in itself (a difficult distinction in this case because of the pain the relationship was giving the younger sister.) Thus my work with them was done in the context of improving their effectiveness with their mother.

Three of the elderly persons I worked with individually, Mrs. A, Mr. D and Mrs. E talked about their death. For Mrs. A, and Mrs. E, death was an anticipated release from a life they felt had already lasted too long. Subtle differences in feeling tone between the two women suggested differences in their attitude: Mrs. A's expression of the death wish seemed to be part of her attention seeking negativism and self-pity, while for Mrs. E, a highly religious woman, death was integrated into her belief system as a reward. A different tone emerged with Mr. D as he incorporated death into his life view. For him, death was an inevitability and a final end which he accepted but did not seek as did the two women. He still had a purpose in life in caring for his wife.

Themes of loss and death permeate work with the elderly. In the present work, loss and death were issues for both generations, and for the adult child, were related to the parent's deterioration. Mrs. D, confused and disoriented, and Mrs. B, who was deteriorating daily were both formerly sociable vivacious women, much admired by their daughters, and the loss of that person required some form of mourning.

As I worked with these families, it seemed important

to me to provide an opportunity for both parents and children to acknowledge and work through their feelings related to loss and death. One wonders to what extent they were able to talk to one another about these things? I was most aware that in each family there were subjects which they could not discuss together and this selective lack of openness was also apparent in the Institute families, who will be described later in this paper. In view of the cultural taboo in North America against open discussion of death, one might be fairly sure that this was among the subjects not discussed in these families.

However Mrs. B's daughter, tightly contained and having many things she refused to talk about in her mother's presence, was later able to help her mother make preparations for her death, saying goodby to relatives, making financial preparations and even crying with her. It may be that having had the opportunity to ventilate her grief over her mother's decline helped her later to move to a position where she could deal openly with death itself.

The C family present a slightly different focus since it was a younger family, still involved in lingering issues of dependence and separation in spite of the fact that all the children were married. This highly complex case, in which Mrs. C, a 62 year old, totally disabled woman suffering from motor neuron diseas was being cared for at home at her own insistence, presented a clearer picture of systemic interaction than the cases discussed above where

intervention did not appear to produce changes in the system within the duration of the practicum.

The C family presented as being seriously fragmented by alliances between Mrs. C and the daughters, and a split between Mr. C and the mother-daughter alliances. A further split emerged with the sons who appeared totally disengaged from both subsystems. The focus of intervention was in assisting the family plan for Mrs. C's care, and was carried out through family conferences and subsystem work with Mr. C and with the daughters. As the mother's disability left her unable to speak, little direct work was possible with her. The focus of the case was complicated by other issues such as the daughters' scapegoating of Mr. C because of his alledgedly abusive treatment of Mrs. C, and Mr. C's refusal to cooperate with and accede to Home Care policy. A good deal of my work with the family involved attempting to keep members reality oriented and avoiding being drawn into their quarrels.

Structural changes were effected around the father-daughter subsystem split, the first of which was due to intervention with the daughters. The oldest daughter, whose relationship with Mrs. C was a highly enmeshed one, had been taking a role of leadership in a movement to obtain a legal separation for her parents. The second daughter, being somewhat more reasonable, was hesitant

about this move, and by focussing on the second daughter's concerns and using her as the contact person for this subsystem, the oldest daughter was distanced from the centre of action. At the same time, by focussing on Mr. C's concerns individually and in family meetings, he was brought closer to the daughter group and was able to work with them for a short period of time. This split re-emerged when Mrs. C was later moved to an extended care hospital, a move which both mother and daughters resisted and for which Mr. C was blamed. The split closed again after I worked individually with the oldest daughter on her relationship with her mother, helping her to distance herself slightly from her mother's demands. It was interesting to observe how this kind of movement toward and away from Mr. C was always preceded by a movement in the opposite direction in the tightly enmeshed mother-oldest daughter dyad.

Summarizing intervention with these five families (not including the F family who did not proceed after the first interview), the orientation of my work was based on family-systems theory, implying an awareness of the way in which movement in one part of the system affects other parts. In practice, however, it was seldom possible to work with the family as a unit due to the resistance of the adult children to engage in an ongoing counselling process. Intervention for the most part was aimed at

subsystems, and occasionally this included adult child subsystems, and was carried out using techniques common to individual therapy. This included, in all cases, support and encouragement to ventilate, and in some cases, specific interventions around developmental issues, in particular assisting in the process of a life review, and working through of issues around loss and death. Attempts at strategic behavioral change were spectacularly unsuccessful. Some intensive work in assisting a pair of siblings to work on a relationship problem which was impeding their ability to manage their parent's care, and structural changes in the youngest of these five families were the high points of the Home Care portion of the practicum.

INSTITUTE FAMILIES

The course which was offered through the Institute for Continuous Learning, called "You and Your Elderly Parent", was advertised in the Institute's winter brochure as follows:

> For the first time in history, many families contain two generations of elderly people. If you are a "young elderly" with an older parent, you may be concerned about such things as whether your parent should live alone, whether you can care for her or find a nursing home, and what community resources are available to help. This group will explore the joys and sorrows of having an elderly parent. THIS COURSE IS OPEN TO PEOPLE OF ALL AGES.

The course attracted six people, all in their 50's and 60's, including two sisters and a husband and wife. Thus four

families were represented in this group and as noted earlier, these families bore many similarities, both in demographic characteristics and in presenting problems to the Home Care families. The interesting and instructive aspect of my work with this group was the light it shed on the stresses placed on children in late middle age by the care of an elderly parent, and their reaction to it.

This reaction became apparent early in the life of this group as one of the first "getting acquainted" exercises asked participants to describe their experience with their elderly parents. The expressions of repressed anger, guilt, confusion over priorities and frustration with institutional policies, as well as expressions of loving concern which emerged, created a common bond around which the group coalesced, becoming a supportive, cohesive unit with greater rapidity than is usual with most groups.

The following problems were identified in the first group meeting: isolation in old age; living with an elderly parent; deafness; nursing home policy and adjustment to nursing home; dealing with confusion and irrationality; feelings of guilt; setting priorities between obligations to parents, to one's children and personal interests and activities.

From this list I developed the topics to be covered in the remaining five meetings, checking them out with group members for confirmation that the topics covered

their main concerns. The group also agreed to a format in which I would act as facilitator to their exploration of the topics, with the exception of a session dealing with the mental and physical aspects of aging, in which I would give a short lecture. This format, based on literature and my own experience regarding transition groups, was considered appropriate to this group because of the impressions I received in the first meeting of people who were attempting to deal with difficult new roles, for which there were few models for them to follow, and for which there existed little social support, as can be the case in many transitional situations. The similarity of their problems and their sensitivity to one another provided the potential for good mutual support and I believed my role should be one of drawing out and facilitating the inherent strengths and potential of the group.

The content of the remaining five meetings was as follows:

Session 2: Taking Stock and Setting Priorities

Participants were given a pencil and paper exercise requiring them to list the main activities in which they were engaged (e.g. housework, bowling, visiting mother etc,) and using a numerical scale, to rate each task with regard to 1) the amount of time required, 2) its importance, 3) how much they enjoy it, 4) how much they dislike it. Discussion then centred on the picture this exercise gave

participants about the way in which they were using their time, and several found that although they were not spending great amounts of time in parent related activity, a concern about the parent tended to permeate everything they did.

Session 3: Physical and Mental Aspects of Aging

This took the form of a brief lecture followed by a discussion in which members focused on issues related to the difficult behavior their parents were exhibiting. This session brought out an expression of the frustration and tension these people were experiencing.

Session 4: Your Relationship with Your Elderly Parent

Members were asked to draw a life chart of their parent in preparation for this session, and to superimpose on it their own life chart. This was aimed at helping them to distance their lives from that of their parent, seeing the two from a new perspective with an awareness of the similarities and differences between them. Most participants reached these objectives, and found that their parents' lives contained more hardship, were less rewarding and gave fewer opportunities for fulfillment than their own.

Session 5: Planning for the Worst

The focus of this meeting was a gentle approach to loss and death, working toward preparing members for their death and that of their parents. Two exercises were used, the first asked members to say goodby to the important things they had lost or were now losing, and the second to plan their own funeral. Surprisingly, members had given

a good deal of thought to the kind of funeral they wanted for themselves, but not surprisingly, none had been able to discuss funeral arrangements with their parents.

Session 6: Living with Your Elderly Parent

Members discussed the topic fully, some sharing their own experiences and recollections of having a grandparent live with them. In the last hour I summarized the main points which had emerged in the six meetings, and members were asked to complete a simple evaluation of the course.

The first three group meetings brought out a good deal of ventilation of members' feelings of frustration with the irrational demands placed on them by their parents, their feelings of being manipulated and of being unfairly treated, often becoming the recipients of parents' unjustified anger. Guilt seemed to be universal and was usually related to ambivalence over the feeling that they should be doing more, but resenting the demands that were already made on them. At the same time there were feelings of desperation and helplessness at seeing loved parents deteriorate physically and mentally, and anger at institutions and professionals who did not treat the elderly with proper respect. There was a constant aura of surprise during these early meetings in the discovery that others felt as they did, and a good feeling of mutual support grew among members.

Beginning with the fourth meeting individuals began spontaneously to try new ways of understanding and dealing

with their parents, and shared the results of these changes with the group. Each time this happened, I focussed the group's attention on the new insight, developing members' experiences into a set of guidelines for dealing with parents, and these were summarized as follows at the end of the last session:

1. Mr. W learned that by deciding how far he will go in meeting his mother-in-law's demands and being firm in interpreting his limits to her and in adhering to them he was able to prevent much of her nagging behavior.

2. Mrs. X found it did little good to try to persuade her mother to an action she was unwilling to take. Her mother acted on her own initiative when she was ready to do so.

3. Mrs. Z began to understand that the anger with which her mother greeted her on every visit was not related to her personally. By not defending herself and letting the anger run its course, she and her mother could then relate in an amicable way. She also found that when the anger became too upsetting for her, it was useful to take a brief 'time out' until she regained her composure.

4. Mrs. W realized that she had been expecting her parents to behave as they did when they were younger and in good health. She learned that she had to let go of her expectations of her parents, and accept them as they are. She also decided that she must stop making

assumptions about her mother's expectations of her and to react only to those requests which were made directly.

Members expressed a good deal of satisfaction with their experience in this group in the brief pencil and paper evaluation conducted at the end of the last session. They found it particularly helpful to learn that others were dealing with similar problems and experiencing the same feelings about them as they were. Sharing ways of dealing with these problems was particularly helpful to them.

The success of this small semi-structured group was due in part to its composition: members happened to be experiencing similar problems and to be sufficiently compatible and open to develop into a supportive, cohesive group at an early stage. Two other factors contributed to its success: the close relationship between participants' expressed concerns and the topics chosen, and the fact that participants were allowed to find their own solutions rather than having solutions presented to them. The problem solving which took place through group process and through individual members continuing work between sessions demonstrates the way in which a thorough ventilation of emotionally charged problem areas works to discharge those emotions which block problem solving and opens the way for fresh insights.

Chapter V

COMMENTS AND CONCLUSIONS

There is little in theory or in reported case material which applies directly to the subject matter of this practicum except for the approach taken by Herr and Weakland in applying family theory and technique to older families. Consequently the questions asked in Chapter I regarding the nature of the intergenerational relationship in this last stage of the family's life cycle and a means of intervention appropriate to this stage are only partially answered in the literature. The purpose of the practicum has been to explore these questions experientially and although the number of families who compose the two parts of the practicum represent a sample too small to form a basis from which to generalize conclusions, they raise some interesting questions which may merit further study.

These ten families were, by definition, ones in which the adult children were highly committed to the wellbeing of the parent. The commitment however was not single-minded: the most compelling observation about these relationships is their great complexity. In all cases the affective quality of the relationship contained some negative aspects whose proportions ranged from being a relatively minor component, in the case of the D and Y sisters, to being the major component of the relationship

in the A and W families. Negative feelings about the parent did not appear to lessen the adult child's feelings of obligation however, it only made the role more unsatisfying and anxiety producing. In this connection one might reflect on Boszormenyi-Nagy and Spark's theories regarding the uncompromising nature of family loyalties and the way unsatisfied obligations can carry over from one generation to another, and wonder if these parents are exacting from their adult children the caring they may not have received from their own parents? On the other hand, since these ambivalent relationships have not resulted in a split between parent and child perhaps they may indicate an unresolved developmental issue reflecting an inability to successfully separate from the family or origin. Indeed in all these cases one has a sense of mutual dependency between the two generations which might be considered by some to be greater than one would expect to find in most extended families.

Feelings of guilt on the part of the adult child is another theme which runs through these relationships. In spite of the fact that these children are already devoting a great portion of their time and attention to their parents they have a feeling they should be doing more, and in many cases the parent plays on this feeling in a highly manipulative manner. This was especially true in the A,

C, and W families where the parent was never completely satisfied with the daughter's services. Even in the more healthy relationships a sense of existential guilt seems to pervade the relationship, as if the children felt they should be able to reverse their parent's aging process.

In observing the family as a unit, one becomes aware of the way in which the elderly person's disabilities affect other members. The most dramatic effect, in these practicum families was on the spouse of the disabled member whose own physical and emotional health was profoundly affected. Mrs. E, a frail and arthritic woman was taking a heavy, regular dose of tranquillizers; Mr. C suffered increasing back pain and Mr. D required a pacemaker shortly after moving to the nursing home. These three individuals had all spent many years living with and caring for a severely disabled spouse.

Somewhat less dramatic was the crisis orientation of the adult children. For those whose parents were not in nursing home, the children's lives were poised in a constant state of readiness to deal with some crisis which seemed always to be imminent. Their awareness of the fragility of the parents' situation, that they may at any time fall ill or have an accident and would require immediate help is a factor which is constantly part of their consciousness. One might expect that similar emotional and physical effects may emerge with those middle aged children

who experience prolonged stress of this nature as is seen so obviously with older spouses. If this is so, an important factor in crisis intervention with the older family may be in supporting and assisting the caregivers to deal with the pressures placed on them, a point which has been frequently made in the literature and which is an aim of this practicum.

Although much has been written about the importance of the application of crisis theory and intervention in work with the older family, little mention appears to have been made of the aims of crisis resolution, which appear to differ with this client group. Theoretically crisis intervention aims at assisting the client to reach an improved level of functioning, or at least, to restore him to his original level. This goal is seldom possible with the elderly client, for whom the crisis may involve irreparable loss. The goal of intervention then becomes severely limited to helping the client adapt to that loss or to assist the family in formulating a plan which will insure that the required care is given to the person suffering the loss. Therapeutic measures around issues of grief and mourning are then of prime importance.

It is an inescapable fact however that for the older family, the final loss lies ahead in the eventual death of the parent, and the death of the last parent signifies the end to its existence as a family. The implications

of this event, while not explored in this practicum, might be expected to be of great importance to adult children like those represented here, for whom the family tie has great significance. This might provide an interesting and important subject for further study.

Evidence of stress and illness in other parts of the system point to the importance of adopting a family-systems approach in work with the elderly. However, the older extended family does not fit neatly into this theoretical framework, designed as it is to apply to the young nuclear family living in one household.

A number of theoretical differences exist between the nuclear family of origin and the extended family of gerontation with regard to their function and structure. If the family of origin is essential for survival and growth of members (Satir, 1967) then relationships within it differ in significance from those in the family of gerontation which functions for the mutual aid and social support of members (Sussman 1965, Litwack 1965, Hill 1965). In visualizing the family of origin as part of an extended kin network as in Fig. 1 (p.12) relationships within its boundaries are of primary importance, standing out as figure against the ground of other larger system relationships. In the family of gerontation however, each member relates to a number of other subsystems which may be of relatively equal importance. In this paradigm the adult child's relationship with her own adult children and perhaps grandchildren and

with in-laws may be of equal importance as those with her parents. This suggests a structure of greater complexity in the family of gerontation with a greater potential for conflicts in roles and obligations, but it may also be a structure in which the number of relationships have the effect of diffusing their intensity. If these differences in structure and function are correct it would mean that the older family would not have the powerful emotional influence on its members that the family of origin exerts on its members.

This calls into question the application of the concept that the symptoms of the identified patient are an expression of dysfunction within the system. In the young family, living under one roof and having to maintain a balanced state to preserve the system, the sensitivity and resonance of the system may be far greater, and exert more power over individuals than does the older family, where individual survival does not depend on survival of this larger system and relationships are diluted by their number and complexity. Thus dysfunction in the older family may not produce an identified patient whose symptoms maintain system homeostasis as occurs in the younger family.

At the same time, an ill or disabled older parent often does play a role similar to that of I.P. in the sense of becoming the 'storm centre' and scapegoat for family problems. It is my belief however that this role is not entirely

comparable to that of I. P. for the reasons discussed above, and since dysfunctional relationships within the family cannot be seen to create a broken hip or arteriorsclerosis, although they may have a profound influence on the way in which the elder reacts to disability. What may be more important as a site for the expression of family dysfunction is the way in which the family deals with the problems created by these disabilities in the elderly parent. This construct may also be consistent with the observations of both developmental theorists, who see failure in one's ability to be "reliable and relied upon" as indicative of a failure to master the normal developmental processes, and the crisis oriented theorists who see blockages in problem solving ability in crises as related to one's perception of the meaning of the crisis situation.

Relating these considerations to this practicum experience, my suspicion that the older family does not possess the resonance of the nuclear family may explain why the C family, being younger than the other practicum families and having not completely mastered its dependency-separation crises may have exhibited more system reverberations during intervention than did the other older families.

As noted earlier, the concept of "parental child" who in the young family assumes parental duties, has its counterpart in the older family as "burden bearer", the one who chooses, or is chosen to assume responsibility for the parent. Minuchin (1974) maintains, with regard to

the young family, that alliances across generational boundaries is an indication of dysfunction, although the presence of a parental child is, in itself, not always dysfunctional depending on the degree to which parental demands clash with childhood developmental needs. It is a commonplace in the older family that one child, usually a daughter, plays the necessary role of caregiver to the parent, and as Blenkner (1965) has pointed out, the assumption of this role may be an important developmental process for the child. The question arises; when, in the older family, does this phenomena become dysfunctional? Several authors (Milloy, 1964; Goldfarb, 1965) have suggested that it does so when an actual role reversal takes place.

Since the adult daughters in the practicum families are the "burden bearers" of their families, an examination of their roles may shed some light on the question, and in this connection it is interesting to note that the daughters who appear to have best adapted to the role with the most "normal" relationship with the parents were those in which two daughters (in the D and Y families) shared the role equally, providing mutual support for one another in doing so. Those who appear to suffer most in the role were the A daughters, where one daughter had been chosen early in the history of the family as the favored child and confidant of the mother and the other daughter, rejected, and the C and W families in which an historic symbiotic

relationship existed between mother and caregiving daughter. This might suggest that similar to the young family, it is not the role of burden bearer per se which is dysfunctional but the characteristics of the parent child relationship which produces the role which may be the site of dysfunction.

Although this practicum experience was sufficient to yield the foregoing general observations and questions, it provided few insights into the application of therapeutic interventions from a systems orientation. A number of difficulties in the design of the Home Care portion of the practicum mitigated against experimenting with these techniques.

My position in the Continuing Care program as a resource within the Home Care package of services to whom appropriate clients, who agreed to counselling services were referred created problems unforeseen at the beginning of the practicum. These clients did not request counselling on their own initiative, nor were they likely to have seen a need to work toward change in their relationships. Because their situations were unstable or approaching crisis, their request was for the practical and concrete services which Home Care provides, and their motivation for accepting counselling may have been based on an expectation that by so doing the other services could be more easily obtained.

For this reason, in dealing with the adult children's avoidance of being involved in the counselling process,

it would not have been appropriate to insist on their participation as is sometimes done by therapists who work with younger families. In any event the older family does not have the power to make attendance of all members compulsory as does the younger family, and it may be that subsystem intervention is the most pragmatic way of working with this client group.

Related to the lack of voluntary committment on the part of the family was a lack of a clear mutual understanding of the purpose of counselling, and consequently the difficulty in contracting with them. I suppose it is difficult for a client such as Mr. D to become convinced of the value of making a small change in his management of his wife when what he really wants is that she be admitted to nursing home. His implicit agenda for our meetings was one of convincing me to hasten her placement, while my explicit one was to help him wait. In this situation the client had difficulty in believing that I had no control over home care services, and indeed my role may have been more effective, and certainly easier if I had that control (with the possible exception of the C family where because of their hostility toward Home Care, my lack of power permitted me to take a neutral position).

This is not to suggest that my involvement was not of help to these clients; the developmental work with Mr. D, relationship work with the A daughters and crisis intervention with the C family were useful to these families.

The more successful Institute group was, without question, a good experience for the participants and an excellent learning device for me. This portion of the practicum led to an improved understanding of the mentality of the middle aged caregivers and provided a good practical experience in planning and presenting content and observing group process.

While this may have been an unusually 'good' group, the success of the format in permitting the development of individual problem solving and change suggests that it might be repeated in order to confirm that mutual support transition groups of this nature are a useful resource for this client group.

It must be noted however, that the number of participants was very small in spite of extensive pre-registration publicity by the Institute for Continuous Learning. Thus the adult child group may be just as difficult to engage in a group intervention as it is in family therapy.

As a whole, the practicum leaves many questions unanswered. Principally, it has not shed any new light on the application of family therapeutic techniques with older families as it floundered on the necessary first step of engaging adult children in the process.

Some gains were made in an improved understanding of the nature of the older family, some suggestions regarding the theoretical structure of the older family as a system, and a model for group intervention with middle aged children.

APPENDIX I

Case Summaries

Home Care families

CASE REPORT: A. FAMILY

Presenting problem

This case was referred for supportive family counselling in maintaining the present care plan through which Mrs. A, who lives alone, receives housekeeping help 6 hours per week and attends day care one day a week. The problems which emerged in the initial interview were as follows:

1. Mrs. A is gradually failing in her ability to care for herself; her poor eyesight and difficulty in walking result in occasional falls, and she sometimes has difficulty picking herself up. She has occasionally allowed a pot to burn on the stove. She will not use the telephone to call out, but in an emergency has been successful in attracting the attention of the caretaker.

2. Mrs. A is refusing to attend day care and isolates herself from her neighbors. She presents a depressed and negative attitude.

3. Mrs. A's two daughters are dedicated to her care, investing a great deal of time and effort in insuring her comfort and safety. Nevertheless their relationship with her is unrewarding and guilt-producing. They requested additional time from the housekeeper (this request was referred to the case coordinator), and expressed the wish that proceedings be begun for her admission to nursing home.

Summary of Intervention

The goal agreed upon in the initial interview, which involved Mrs. A and both daughters, was that I would visit Mrs. A weekly to work toward decreasing her isolation, and in particular, to explore with her a return to day care.

I saw Mrs. A 5 times, and found her to be very firm in resisting returning to day care. Nursing home care, which was also explored with her met with equal resistance, as did any suggestion that she take initiative in leaving her apartment to socialize with her neighbors, even though she enjoyed it when they visited her.

In assessing Mrs. A, it appears to me that she possesses greater competence in caring for herself than she is willing to display, and that her appearance of helplessness may be an attention-getting device. She is unable to see the inconsistency between her appearance of helplessness and loneliness, and her self-isolation and refusal to consider day care or nursing home care. In retrospect, a better approach might have been to reframe her behavior positively, using her resistance as indicative of strength and competence.

During my contact with this family, Mrs. A fell, sustaining some cuts and bruises to her face, and alarming her daughters sufficiently that they demanded that application be made for her admission to nursing home. This crisis provided an opportunity to work with the two daughters, who had initially refused counselling.

Two intensive interviews with the daughters alone revealed the ambivalence of their relationship with their mother, and the way in which she had divided them by choosing one to lean on and rejecting the other. Intervention with these women became directed toward helping them to work together in caring for Mrs. A by exploring the way in which she manipulates them and their reaction to it. Specifically, counselling with the daughters dealt with the implications of Mrs. A's refusal to apply for nursing home, and helped them to acknowledge that her remaining ability to care for herself does not indicate the need for institutionalization at this time. In addition, they came to an agreement concerning sharing weekend visiting and shopping for Mrs. A. Although there was considerable hostility toward one another ventilated in these meetings, their relationship appeared to have improved by the time the case was terminated.

CASE REPORT: B. FAMILY

Presenting problem

This family was referred to me for family counselling related to the family's adjustment to the addition of Mrs.B to her daughter's family. Problems which were identified on referral and/or revealed themselves in the first interview were:

1. Changes to the family's life style and its adjustment to them. In particular, the displacement of the children (19 year old son gave up his room; 10 year old daughter has less time with her mother).

2. Daughter's anxiety related to

i) her work load; she is a meticulous housekeeper and a conscientious mother who finds the addition of Mrs. B's care very taxing.

ii) her need for temporary relief: she was unable or unwilling to share the load with the extended family and received only limited help from her nuclear family. In addition, Mrs. B refused to attend day care as planned.

iii) Mrs. B's physical decline.

3. Interference and criticism from another daughter regarding the planned program of respite care.

Summary of Events

Mrs. B deteriorated rapidly during the time I was involved with this case; she became progressively weaker; got up at night and wandered about the house, often falling and bruising herself; experienced periods of confusion and disorientation; and found locomotion progressively difficult. This deterioration was not slowed by two weeks of respite care in March, and became sufficiently serious that she was panelled and accepted for nursing home care. Mrs. B was admitted to nursing home on April 16.

Summary of Intervention

My contact with the family extended from February 18 to April 28 and involved two home visits, an initial assessment with Mrs. B, her daughter and the two children (the son-in-law declined), a following interview with Mrs. B and her daughter, and 9 telephone interviews with the daughter.

A counselling goal was never agreed upon in this case: 1) all members of this family, and the daughter in particular were reluctant to discuss their concerns in front of Mrs. B. While there was an indication at the initial interview that daughter had a problem she wished to work on (her sister's interference) she did not deal with it openly. 2) The crisis caused by Mrs. B's rapid deterioration made the presenting problems irrelevant and became the main focus of the case. The daughter regarded home visits as time

consuming and unproductive, but was able to use telephone contact to ventilate her anxiety around mother's condition, her own work load and frustrations with the continued interference from the sister.

A recurring theme in working with the daughter was her unpreparedness, when Mother moved into her home, for the degree of deterioration and the amount of care she required. Both Mrs. B and the sister dismissed this, but in my contact with daughter the seriousness of the situation was acknowledged, with the added recognition that living with daughter's family might be inappropriate for Mother herself, since it gave her little opportunity to socialize, an important need for this woman. This approach gave daughter permission to ventilate her anxiety and to see Mother's care needs realistically.

Through ventilating her feelings and experiencing support for her role, daughter was able to move to a firm and assertive position with her sister, limiting those whose advice she took to the health care professionals involved with her mother's case.

Daughters expression of concern about mothers rapid decline might be considered a form of mourning for the changes taking place in her mother which permitted her, when Mrs. B actually began preparing for death a few weeks prior to her admission to nursing home, to discuss death openly with her, to cry with her and to assist her in making certain

arrangements. In view of daughter's earlier difficulty in being open with mother, it seemed to me that this indicated considerable movement on her part.

Because of the number of professionals who were involved with this case during this time, isolation of the effects of my intervention is problematic. The net result however, was that daughter was able to deal realistically and responsibly with the crisis, and was able to admit mother to nursing home without guilt or self reproach.

CASE REPORT: C. FAMILY

Presenting Situation

Mrs. C is a 62 year old woman with motor neuron disease who was being cared for at home at her own request by her husband and a 24 hour/day, 6 day/week Personal Care attendant. This case was referred for crisis intervention at the threatened breakdown of the home care plan due to the resignation of the current PCA and daughter Wendy's request for assistance in negotiating a legal separation for Mr. and Mrs. C.

The following factors led up to this crisis:

1. The family and marital relationships were characterized by discord and hostility which apparently predated the onset of Mrs. C's illness and were intensified by it. The 4 married daughters objected to Mr. C's reportedly abusive treatment of Mrs. C, and Wendy in particular, considered legal separation to be the only means of protecting Mrs. C and her share of the family assets. They were angry with, and frightened of Mr. C and were looking for support from me in approaching him about the separation.

2. A number of problems surrounded the provision of PCA's in this home. Turnover had been frequent and replacement difficult due to the heavy lifting and total, 24 hour care required. Mrs. C was completely immobilized with some residual control of only neck muscles, swallowing and bowel and bladder control. In addition Mr. C exploited

staff, expecting them to perform extra household duties and in some cases, making personal advances to them. A point of contention in the hiring of a new PCA was the policy requiring the family to now be responsible for two days care. Mr. C refused to accept this change, and this attitude seemed to be typical of his relationship with the Home Care Coordinator.

Summary of Events

Jan. 24 - First family meeting involving Mrs. C, Wendy, Theresa and PCA to explore the issue of the parents' separation. Agreement was reached that as a first priority, an attempt be made to continue Mrs. C's care at home with increased involvement of the daughters and my support. The separation issue did not re-surface and Mr. C was never made aware of it.

Feb. 1 - The PCA left and Mr. C took a leave of absence from work to care for Mrs. C.

Feb. 2 - Second family meeting with Mr. and Mrs. C, Theresa, Susan and Elizabeth to discuss finding a new PCA and to involve the daughters in Mrs. C's care. A plan for the latter was developed but not carried by the daughters, due perhaps, to their lack of commitment.

Feb. 5 - A new PCA begins work. Mr. C stays home to train her but also because he is experiencing severe

back pains due to a disc condition which is aggravated by lifting Mrs. C.

Mid-Feb.- A new crisis developed: the PCA gives notice, Mr.C's back becomes worse and Mrs. C weakens, choking frequently on her food.

Feb. 21 - The Home Care Coordinator decided to work toward Mrs. C's institutionalization and began procedures for application to nursing home with admission to Princess Elizabeth Hospital as an interim measure until a nursing home bed became available. The PCA was replaced by 9 a.m. to 5 p.m. staff, leaving the bulk of Mrs. C's care to Mr. C.

Feb. 25 - Third family meeting with Mr. and Mrs. C, Theresa, Susan and Elizabeth to explore the family's perception of the situation and the rationale for institutionalization. By this time Mrs. C had indicated a reluctant agreement to go to nursing home but was opposed to hospitalization. The daughters supported her in this, and Mr. C, who had always been open in his desire for Mrs. C to be cared for outside the home backed off of actively pressing for hospitalization.

Mar. 6 - Mrs. C was admitted to Extended Care Hospital.

Mar. 17 - Mrs. C's application for nursing home was rejected by Health Care panel: her degree of disability required that she be cared for in hospital.

Summary of Intervention

My contact with this family extended over the period January 24 to April 11, and involved 8 home visits, including 3 family meetings, and numerous telephone interviews, many of which contained a counselling component. The sons in the family refused to be involved in the family meetings, and my contact was limited to Mr. and Mrs. C and their four daughters.

The purpose of the intervention was to deal with the initial crisis, and continued in an effort to help this contentious family to cooperate in Mrs.C's care, by active involvement in the early part of the intervention, and later in planning for her long term care. My role was one of activator and mediator, interpreting Home Care policy and trying to keep members reality oriented.

Although the family never did come to the point of working cooperatively, some lowering of hostilities and restructuring took place. At the beginning of intervention, Wendy and Mr. C were actively hostile toward one another, with the entire daughter subsystem caught up in Wendy's vindictive plan for the parents' separation. By encouraging Theresa's input into family meetings and using her as the contact person for this subsystem, Wendy's disruptive influence was avoided in favor of Theresa's more rational influence. Wendy chose to avoid the second and third family meetings and although I kept in touch with her by telephone,

she became distanced from the centre of action.

The daughters' relationships with Mrs. C were of great emotional involvement, and it became apparent early in my contact with the family that Mrs. C used her influence with them in a manipulative way. Their tendency to scapegoat Mr. C was based on information conveyed to them by Mrs. C, and the degree of scapegoating seemed to wax and wane depending on the quality of care they perceived Mrs. C to be receiving.

Much of my time was spent with Mr. and Mrs. C, and was directed toward acknowledging and validating Mr. C's difficult role in caring for Mrs.C. This position was also taken in family conferences and resulted in some movement away from the scapegoated position in which the daughters had placed him. By the third family meeting Mr. C seemed to have recognized that by insisting on Mrs. C's hospitalization his daughters would turn against him again, and he appeared to move back to let me attempt to move them to a position of looking positively at hospitalization. This meeting produced more accord than had been exhibited by the family during my contact with them, but this reversed itself when Mrs. C was hospitalized. At this point the daughters again turned against Mr. C, blaming him (and Home Care) for her admittal and for the Panel's decision to keep her there. My attempt to meet with them to interpret and discuss the decision was refused.

Several weeks after Mrs. C's hospitalization however, Wendy asked to see me, and in the interview which followed, revealed her enmeshment with Mrs. C and the conflict this was creating for her as she tried to meet Mrs. C's expectations around visiting. Through ventilating her ambivalence and discussing the priorities of her responsibility to Mrs.C, herself and her own family, Wendy was able to set a limit on her relationship with her mother. As an interesting aside when she reported this to me, she expressed a great deal of sympathy for Mr. C: the pendulum had apparently swung again.

CASE REPORT: D. FAMILY

Presenting Situation

Mr. D, 85, and Mrs. D, 84, lived together with a great deal of help and support from their two daughters. The case was referred to me for counselling in order to support the family while they waited for Mrs. D's admittal to nursing home. Problems identified at referral were:

1. Mrs. D had been panelled and accepted for nursing home placement, and was on the waiting list. She had extensive memory loss and was disoriented and confused. Mr. D expected to be admitted with his wife, but had not yet been panelled. He is mentally alert and was in reasonably good health.

2. Mr. D reacts with anxiety and frustration to Mrs.D's condition. He is unable to fully accept her limitations and finds caring for her so stressful that he frequently loses control of his temper, makes intemperate demands on his daughters and fears for his own mental and physical health.

Summary of Events

Mrs. D was admitted to nursing home on February 12. Following this, Mr. D lived alone until his application was accepted, and he moved to nursing home on March 20. Although admitted for hostel level care, Mr. D, at his own

request moved into Mrs. D's room in the level 2 section of the nursing home. On April 24 he was admitted to Health Science Centre where he received a pacemaker to regulate his heart, and was recovering from this minor surgery when the case was terminated.

Summary of Intervention

Contact with this family extended over the period January 17 to April 28, and involved 14 interviews.

At the initial meeting which included Mr. and Mrs. D and both daughters, it was agreed that I would see Mr. D weekly to work with him regarding his feelings of frustration about his care of Mrs. D. Intervention during this period focussed on providing an opportunity for Mr. D to ventilate and an attempt to bring about behavioral change in his management of Mrs. D. Mr. D persisted in testing his wife, apparently in the expectation that she might snap back to normal, and when she didn't he lost his temper. My effort to change this behavior, supported by the daughters, met with firm resistance, and there was no apparent movement in the case during this time.

Following Mrs. D's move to nursing home, I continued to meet weekly with Mr. D, focussing on preparing him to dismantle his home and adjust to a new environment. Mr. D did a great deal of reminiscing during this period, seeming to have a need to be confirmed in the successes and integrity of his life: the success of his family, his early hardships,

and a lifestyle that permitted the accumulation of sufficient money to live comfortably in retirement. By receiving acknowledgement of his competence and help in relating his life experiences to his present situation Mr. D was able to draw courage from his own inner resources, and when the move came he worked very hard with his daughters, selling his furniture and disposing of a lifetime of possessions, and making the move without apparent regret.

Adjustment to living at nursing home was not easy for Mr. D however. By sharing his wife's room, he found himself not only living again with a confused, disorientated woman, but surrounded by them: he was back in the same situation as before. After a few weeks, during which he became extremely anxious and demanded a private room, and threatened to leave when he thought he was going to have to share a room with another man, Mr. D resigned himself to the situation and decided to remain with his wife.

Although they were experiencing a great deal of stress because of Mr. D's behavior, the daughters refused counselling in the belief that their father was the one who needed attention, and because they received sufficient support from one another. Nevertheless they were present during three interviews and requested my assistance in alternative planning when it looked as if Mr. D would leave nursing home. This was a stressful period for the entire family,

and my involvement at this time was one of support and of consulting with social work staff at the nursing home.

On termination, Mr. D had resigned himself to the reality and irreversibility of Mrs. D's condition and had accepted the situation in which he found himself at nursing home. His anxiety had decreased and he was attempting to focus on the positive aspects of the situation.

CASE REPORT: E. FAMILY

Presenting Problem

This elderly couple live alone with the daily assistance of their daughter, and Home Care housekeeping and nursing services. Mr. E, 85, is incontinent, and although there appears to be no medical record of it, presents as having some degree of mental impairment. The case was referred to me for supportive counselling. Problems identified at referral and in the initial interview were:

1. The stress placed on this family by Mr. E's refusal to use respite care or to consider nursing home care. This places a considerable physical and emotional burden on his frail wife and gives a good deal of worry to daughter, who although not unduly distressed by her parents' situation, is in a constant state of readiness to deal with emergencies.

2. Mr. E's anger and accusations of infidelity directed at his wife, which cause considerable distress for her.

Summary of Intervention

My contact with this family extended from February 26 to April 27, and involved 7 home visits, 3 of which included daughter and one lengthy telephone interview with her.

My agreement with the family was to work with Mrs. E regarding her feelings of hurt and distress at the anger and delusional accusations directed at her by Mr. E. During the initial phase of my contact I worked with her alone (Mr. E

refused to join us) in an attempt to help her see Mr. E's behavior as a manifestation of his illness. This involved some reminiscing about the family's difficult life in Europe during the wars, and the history of this unhappy marriage, including Mr. E's infidelity. Reviewing this history did not comfort Mrs. E or relieve her of the strong sense of obligation to Mr. E which is rooted in her religious beliefs rather than any reciprocity in the relationship.

In later visits I moved to that part of the house where Mr. E sat during my visits to discuss his anger and to attempt to involve him to a greater degree in his own care, which is increasingly difficult physically for Mrs. E. The task which I set for him, of removing the incontinence pads and cleaning his bed in the morning was not carried out, partly because of Mrs. E's inability to trust him to perform this task.

The daughter refused to be involved in counselling because she believed it was her mother who was most stressed. In spite of this I had considerable contact with her, and supported her in the approach she wishes to take with her parents, of attempting to arrange for as much relief as possible for Mrs. E through day care, leaving Mr. E alone for brief periods to test his ability to care for himself.

Intervention with this family produced no observable change. The rigidity exhibited by Mrs. E, her deafness and Mr. E's apparently limited comprehension made working with this couple extremely difficult and limited any possibility of movement.

CASE REPORT: F. FAMILY

Presenting Problems

This case was referred for supportive family counselling. Mr. F, a 72 year old widower lives with his two unmarried adult children. He has Parkinson's disease and is awaiting admission to nursing home. Problems identified on referral and in the assessment interview are as follows:

1. The heavy responsibility being carried by the siblings who care for Mr. F with the assistance of a daytime sitter and their reactions to it: daughter has a chronic intestinal disorder which is believed to be aggravated by stress, and son reports increasing irritability and an attempt to distance himself emotionally from the situation.

2. Daughter's ambivalence about Mr. F's expected admission to nursing home, the severe sense of loss she may experience when this takes place and her adjustment to the resultant break up of her home.

3. Mr. F's reluctance to move to nursing home.

Intervention

I was unable to engage this family in ongoing counselling and contact with them was limited to one home visit involving the three members of the family. Both siblings had assumed the purpose of the interview to be directed toward research. They believed that counselling would not assist them to deal with their present situation. Both anticipated that Mr. F's admission would be difficult for all of them, but felt that this could only be dealt with when the time came.

APPENDIX II

Case Summaries

Institute Families

CASE SUMMARY: W. FAMILY

Presenting Problem

Mr. and Mrs. W, a retired couple in their 60's attended the group "You and Your Aging Parent" out of concern for Mrs. W's parents; her 85 year old mother who lives alone in an apartment and whose vision is impaired because of glaucoma and cataracts, and her father, 86, who is in nursing home, is blind and has difficulty in walking.

The W's see their problems:

1) Trying to cope with Mrs. W's mother who is described as domineering, demanding, manipulative, irrational and indecisive.

2) Concern with father's poor adjustment to nursing home. The W's are critical of nursing home policies, which they see as undermining the patient's dignity.

Mrs. W appears to be suffering excessively from the stress of caring for her parents, both of whom she sees daily. Both depend on her, and her relationship with her mother is especially painful to her because of the mother's abrasiveness. At times during the sessions she appeared to be at a point of desperation in her frustration with mother's irrational behavior. She is also highly concerned with father who she believes regards her visits as the only happiness in his life.

Mr. W is supportive of her but does not try to move her from her extreme enmeshment with her parents, which has been

an historic characteristic of her relationship with them.

Group Experience

Mrs. W dominated the group with her description and anecdotes about her parents' problems, and the group allowed her to do so. A highly intelligent and articulate woman, Mrs. W was able to learn from the content of discussions and worked through the information she received until the 5th session when she came to the conclusion that she had been expecting a level of behavior that her mother was unable to give. She decided she must cease confronting her mother and responding to her hidden messages, and react only to her direct requests. Proceeding further in this vein in the 6th session Mrs. W expressed grief for the person her mother used to be, reiterating her resolve to try to accept her as she is now.

CASE SUMMARY: X FAMILY

Presenting Problem

Mrs. X, a woman of about 62 works part time as a clerk-stenographer. Her husband is retired and a diabetic. Their children are married.

Mrs. X is concerned about her mother, an 87 year old widow who lives in Elderly Persons Housing. Mother is arthritic, walking with a walker indoors and using a wheel chair outdoors. She is a demanding woman who is recently exhibiting some signs of confusion. Home Care provides a housekeeper and nursing care supervision.

Mrs. X's concern is that her mother has not been out of the apartment since moving there nine months ago.

Group Experience

Mrs. X ventilated her concern and frustration with her mother's helpless and self isolating behavior, and her own fruitless efforts to encourage her to go out, expressing highly ambivalent feelings about her.

In the 4th session she told the group, with great excitement, that her mother had announced that she wanted to have her hair done and Mrs. X had taken her to the hairdresser in the apartment block. In the process mother had met many other elderly tennants and appeared to enjoy herself for the first time, in many months. Mrs. X felt very optimistic that mother would now find it easier to socialize with the other tennants.

CASE SUMMARY: Y FAMILY

Presenting Problem

The Y sisters, two married women in their late 50's came to the group in anticipation of the problems they expected to have to deal with concerning their 89 year old mother. Mother was a widow who had lived in elderly persons housing since her husband died about two years ago. A fiercely independent woman, mother was a quiet, undemanding person for whom her daughters felt a strong bond of loyalty and affection.

The daughters concern centred on their mother's deafness, which was creating difficulties in communicating with her, and was having the effect of isolating her socially. In addition, they anticipated a time when she could no longer care for herself and were considering asking her to live with one of them. Since both had young adult children living at home, they were concerned about the effect of such a move on their families, their mother and themselves.

Group Experience

These two women provided a balance in the group, injecting a note of normalcy, humanity and humor when other relationships were being described as poor ones.

The group spent half of the final session discussing both sides of the question of living with a parent, and while not providing answers, the discussion and sharing of other members' experiences gave the Y sisters a perspective from which to make their decision.

CASE SUMMARY: Z FAMILY

Presenting Problem

Mrs. Z, a woman in her late 60's who lived alone in elderly persons' housing, came to the group concerning her 93 year old mother, a nursing home patient in Brandon, Manitoba. Mother was blind but otherwise in good health and able to participate in most institutional activities. She was a demanding woman who stored up her anger and frustration to pour out on her daughter at her monthly visits. Since Mrs. Z spent one week a month with Mother, the abuse she received for that week was extremely trying.

Group Experience

Mrs. Z was attending a personal growth group at the same time as she participated in this group and putting together the insights from both groups she began to accept mother's anger as an expression of frustration with her infirmities and not as related to her (Mrs.Z) personally.This allowed her to let the anger flow and not react to it. Monitoring her own reaction, Mrs. Z became aware of the point at which mother's behavior began to upset her, and when this happened, excused herself until her own anger passed.

Mrs. Z was able to report to the group that by using this technique she and her mother spent the balance of her visit on friendly terms. This experience helped to influence the way other members began to gain increased acceptance of their parents.

BIBLIOGRAPHY

Atchley, Robert C. The Social Forces in Later Life: An Introduction to Social Gerontology. California: Wadsworth Publishing Co., 1972.

Bernstein, Herbert,and Sharkey, Harold B. "Family Extrusion of the Aged Patient: Family Homeostasis and Sexual Conflict" The Interdisciplinary Role of the Nursing Home Director. Ed. Michael B. Miller. Wakefield, Mass.: Contemporary Publishing Inc., 1976.

Blenkner, Margaret. "Social Work and Family Relationships in Later Life with Some Thoughts on Filial Maturity." Social Structure and the Family: Generational Relations. Eds. Ethel Shanas and Gordon Streib. New Jersey: Prentice-Hall, Inc., 1965.

Bloom, Martin, and Monro, Alexander. "Social Work and the Aging Family". The Family Coordinator 21 (1972): 103-115.

Boszormenyi-Nagy, Ivan, and Spark, Geraldine. Invisible Loyalties: Reciprocity in Intergenerational Family Therapy. New York: Harper and Row Publishers, Inc., 1973.

Brody, Elaine M. "The Aging Family". Gerontologist 6 (1966): 201-206.

Brody, Elaine M. and Spark, Geraldine M. "Institutionalization of the Aged: A Family Crisis." Family Process 5 (1966): 76-90.

Brody, Stanley J.; Poulshock, S. Walter; and Masiocchi,Carl F. "The Family Caring Unit: A Major Consideration in the Long-Term Support System." The Gerontologist 18 (1978)

Erikson, Erik H. Identity and the Life Cycle. Psychological Issues vol. 1,1. New York: International Universities Press, 1959.

Fengler, Alfred P. and Goodrich, Nancy. "Wives of Elderly Disabled Men: The Hidden Patients." The Gerontologist 19 (1979): 175-183.

Foley, Vincent D. An Introduction to Family Therapy. New York: Grune & Stratton, 1974.

Frenkel-Brunswik, Else. "Adjustment and Reorientation in the Course of the Life Span." Middle Age and Aging. Ed. Bernice Neugarten. Chicago: The University of Chicago Press, 1968.

Freed, Anne O. "The Family Agency and the Kinship System of the Elderly." Social Casework 56 (1975): 579-586.

Golan, Naomi. Treatment in Crisis Situations. New York: The Free Press, 1978.

Goldfarb, Alvin I. "Psychodynamics and the Three Generation Family." Social Structure and the Family: Generational Relations. Eds. Ethel Shanas and Gordon Streib. New Jersey: Prentice-Hall,Inc.,1965.

Gross, Ronald; Gross, Beatrice: and Seidman, Sylvia. The New Old:Struggle for Decent Aging. New York: Anchor Books, 1978.

Haley, J. Problem-solving Therapy. San Francisco: Jossey-Bass, 1976.

Herr, John J. and Weakland, John H. Counselling Elders and Their Families: Practical Techniques for Applied Gerontology. New York: Springer Publishing Co., 1979.

Hill, Ruben, "Decision Making and the Family Life Cycle." Social Structure and the Family: Generational Relations. Eds. Ethel Shanus and Gordon Streib. New Jersey: Prentice-Hall, Inc., 1965.

Kent, Donald P. and Matson, Margaret B. "The Impact of Health on the Aged Family." Family Coordinator 21 (1972): 29-36.

Kuypers, Joseph A. and Trute, Barry. "The Older Family as the Locus of Crisis Intervention." The Family Coordinator, October 1978: 405-411.

Kirschner, Charlotte. "The Aging Family in Crisis: A Problem in Living." Social Casework 60 (1979):209-216.

Langsley, Donald G. and Kaplan, David M. The Treatment of Families in Crisis. New York: Grune & Stratton, 1968.

Leach, Jean M. "The Intergenerational Approach in Casework with the Aging." Social Casework 45 (1964):144-149.

Litwak, Eugene. "Extended Kin Relations in an Industrial Democratic Society". Social Structure and the Family: Generational Relations. Eds. Ethel Shanas and Gordon Streib. Englewood Cliffs: Prentice-Hall,Inc.,1965.

Lopata, Helen Z. Widowhood in an American City. Cambridge: Schenkman Publishing Co. Inc., 1973.

Manitoba, Department of Corrections and Community Services. Guidelines for Continuing Care. (Mimeographed),1975.

McGreehan, Deidre M. and Warburton, Samuel W. "How to Help Families Cope with Caring for Elderly Members." Geriatrics June 1979: 99-106.

Miller, Michael B.; Bernstein, Herbert; and Sharkey, Harold. "Denial of Parental Illness and Maintenance of Familial Homeostasis." Journal of the American Geriatrics Society 21 (1973): 278-285.

Miller, Michael B. and Harris Audrey P. "The Chronically Ill Aged, Family Conflict and Family Medicine." The Interdisciplinary Role of the Nursing Home Director. Ed. Michael B. Miller. Wakefield: Contemporary Publishing Inc., 1976.

Milloy, Margaret. "Casework with the Older Person and His Family." Social Casework 45 (1964): 430-435.

Minuchin, Salvadore. Families and Family Therapy. Cambridge Mass.: Harvard University Press, 1974.

Napier, Augustus Y. and Whitaker, Carl A. The Family Crucible. New York: Harper & Row, Publishers,Inc.,1978.

Neugarten, Bernice. "The Awareness of Middle Age." Middle Age and Aging. Ed. Bernice Neugarten. Chicago: The University of Chicago Press, 1968.

_____ "Acting One's Age: New Rules for Old." (Interviewed by Elizabeth Hall) Psychology Today 13 (1980): 66-80.

Oberleder M. "Crisis Therapy in Mental Breakdown of the Aging." Gerontologist 10 (1970).

Parkes, Colin Murray. Bereavement: Studies of Grief in Adult Life. London: Tavistock Publications, 1972: reprint ed. Pelican Books, 1975.

Peck, Robert C. "Psychological Developments in the Second Half of Life." Middle Age and Aging. Ed. Bernice Neugarten. Chicago: The University of Chicago Press, 1968.

Peterson, James A. "Marital and Family Therapy Involving the Aged." The Gerontologist 13 (1973) 27-31.

Pincus, Allen. "Reminiscence in Aging", Social Work 15 (1970).

_____ "Toward a Developmental View of Aging for Social Work." Social Work 12 (1967): 33-41.

Rapoport, Lydia. "The State of Crisis: Some Theoretical Considerations." Social Service Review 6 (1962):211-217.

Satir, Virginia. Conjoint Family Therapy. Palo Alto: Science and Behavior Books, 1967.

Saul, Shura. Aging: An Album of People Growing Old. New York: John Wiley and Sons. 1974.

Scherz, Frances H. "Maturational Crises and Parent-Child Interaction." Social Casework 52 (1971): 362-369.

Seelbach, Wayne C. "Gender Differences in Expectations for Filial Responsibility." The Gerontologist 17 (1977): 421-425.

Shanas, Ethel. "Family Help Patterns." Middle Age and Aging. Ed. Bernice Neugarten. Chicago: The University of Chicago Press, 1968.

_____ "The Family as a Social Support System in Old Age." The Gerontologist 19 (1979): 169-174.

Sheehey, Gail. Passages: Predictable Crises of Adult Life. New York: E. P. Dutton & Company, 1974. Reprint ed. Bantam, 1977.

Shellhase, Leslie J. and Shellhase Fern E. "Role of the Family in Rehabilitation." Social Casework 53 (1972): 544-550.

Silverstone, Barbara, and Hyman, Helen Kandel. You and Your Aging Parent. New York: Pantheon Books, 1976.

Simos, Bertha G. "Relations of Adults with Aging Parents". The Gerontologist 10 (1970): 135-139.

Smith, Kristen Falde, and Bengtson, Vern L. "Positive Consequences of Institutionalization: Solidarity Between Elderly Parents and Their Middle Aged Children." The Gerontologist 19 (1979).

Sparks, Geraldine. "Grandparents and Intergenerational Family Therapy." Family Process 13 (1974): 225-237.

Streib, Gordon F. "Older Families and Their Troubles: Familial and Social Responses." The Family Coordinator 21 (1972) 5-12.

Streib, Gordon F. and Schneider, Clement J. Retirement in American Society: Impact and Process. Ithaca, New York: Cornell University Press, 1971.

Sussman, Marvin B. "Relationships of Adult Children with Their Parents in the United States." Social Structure and the Family: Generational Relations. Eds. Ethel Shanas and Gordon Streib. New Jersey: Prentice-Hall, Inc., 1965.

_____ "Intergenerational Family Relationships and Social Role Changes in Middle Age." Journal of Gerontology 15 (1960) 71-75.

Townsend, Peter. The Family Life of Old People: An Inquiry in East London. London: Routledge and Kegan Paul Ltd., 1957.

_____ "The Emergence of the Four-Generation Family in Industrial Society." Middle Age and Aging. Ed. Bernice Neugarten. Chicago: University of Chicago Press, 1968.

Teas, Judith. "Family Support Systems for the Aged: Some Social and Demographic Considerations." The Gerontologist 17 (1977)

Weiss, Robert S. "Transition States and Other Stressful Situations: Their Nature and Programs for Their Management." Stressful Life Events: Their Nature and Effects. Eds. Barbara S. Dohrenwend and Bruce P. Dohrenwend. New York: John Wiley and Sons. 1974.