Effect of family relationships on psychogeriatric patients[1]

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Summary: Severe strain has been repeatedly reported in the families of psychogeriatric patients. Nevertheless, many families continue to provide a great deal of support, despite the undoubted burden involved. A retrospective study of short-term outcome in 60 psychogeriatric referrals demonstrated the importance of some aspects of the relationship between the patient and their key supporting relative. In the sample as a whole, and in functional patients, the extent to which a positive communication system existed was significant. In patients with dementia, poor outcome was related to the patient being less dependent and more dominant in their interaction with the relative. The implications of this study for intervention and future research are discussed.

Introduction

Most elderly people suffering from psychiatric disorders – organic and functional – are not in old people's homes or hospital. They live in the community, alone or with relatives or friends (Kay *et al.* 1964). Grad & Sainsbury (1968) demonstrated the burden borne by the families, including loss of leisure, mental and physical strain and occupational and financial losses. Nevertheless, families were prepared to bear the burden, especially when supported by a community-orientated service.

Neurotic and affective disorders do not alienate the elderly from their families to any great extent, especially when they commence in later life, though there may be some relationship between chronic neurosis and estrangement from children (Bergmann 1971). Even in vulnerable and stressed families support seems to be strong. Indeed, guilt and psychopathological bonds may be the basis for very strong attachments such as the 'mother-daughter' syndrome (Post 1958).

Strain is also seen in the families of dementing patients, coping with the resulting physical and mental changes. Sanford (1975) examined which aspects relatives found hardest to tolerate in continuing to care for the patient at home. Behavioural disturbances of the kind associated with dementia were of great significance. Night disturbance due to behavioural problems was the most destructive feature in eroding the relative's tolerance. Remarkably, 44% of relatives could tolerate physically aggressive behaviour, 50% accepted the inability to communicate, and 38% could live with dangerous and irresponsible behaviour.

The considerable coping ability of many families is emphasized by the 12 month follow-up by Bergmann *et al.* (1978) of a series of first referrals to a day-hospital for dementia. Family support, and not medical and social measures, related significantly to survival in the community. Younger relatives (mainly daughters) were most effective in aiding survival in the community, followed by elderly relatives (usually spouses). Elderly demented patients living alone were the most vulnerable despite receiving more social support (from social services and other agencies). Families often seemed to be left to cope unaided. In fact, prior

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to referral to the day-hospital, demented patients generally received less services than those suffering from an affective disorder.

Levin (1983) has studied the principal supporters of 'confused' elderly people. Where the supporter lived with the confused person, this had often been a longstanding arrangement (average 36 years). Supporters not living with the confused person were much more likely to be prepared to accept institutional care. Over a third of the supporters had a score on the General Health Questionnaire (Goldberg 1978) suggestive of the need for psychiatric attention. Admission of the confused person led to a significant reduction in these scores. Relatives experience a great deal of strain in coping with the need for continuing practical and personal care, with the presence of behavioural disturbance and with negative changes in the relationship.

To date empirical research on the dynamic issues of family relationships in the elderly has been neglected, perhaps through lack of a theoretical framework or of systematic empirical data. One of us (KB) was impressed in community surveys by the apparent relationship between the treatment children had received from their parents, years previously, and the way in which they were now handling their elderly parents, who were themselves now becoming dependent. It was evident that relatively dependent and helpless older people were able to dominate and impose an unrealistic degree of power and fear over younger relatives. The pattern of interaction – warm and pleasant or harsh and critical – that the parent had initiated and taught the younger supporter also seemed important. Further observation of a mixed group of psychogeriatric day-patients, all having a skilled social and family assessment, supported the use of at least three dimensions in considering these relationships: the degree of physical dependence, the degree to which the elderly person was dominant over the relative and the extent to which the pattern of interaction was warm and positive. A model of 'balance' between dominance, autonomy and negative or positive communication was constructed (Bergmann 1979).

From these clinical observations some typologies of family disturbance have emerged. These are neither exhaustive nor exclusive, but are intended to identify some typical situations. The 'mother-daughter' syndrome is encountered where a longstanding subordinate and dominated younger relative experiences difficulty in coping with the increasing dependence of the parent, previously so much in charge. A converse situation (power reversal) is where the life-long, passive, dependent, elderly person, obedient and unassertive but useful within the household, experiences a physical or mental illness which may give them, in old age, a dominating or powerful position such as they have never previously enjoyed. Finally, the 'fallen tyrant' occurs when a harsh, tyrannical parent becomes demanding and difficult when an illness renders them helpless and dependent. Their family may relish the opportunity to take over a position of power previously denied to them by physical aggression or a strong tongue. In each situation family problems arise when the changes are coped with, or resisted by using a negative communication system, e.g. emotional blackmail, abuse, criticism, harshness, withdrawal or use of coercion. These examples show how a relatively stable equilibrium can be disrupted by the role changes that may be needed to cope with increased dependency. They differ with respect to the initial dominance pattern and level of negative communication in the relationship, with the 'fallen tyrant' showing the highest initial level of negative interaction.

A prospective study to test clinical hypotheses concerning the breakdown of supportive bonds would be valuable. As a first stage, we report here the findings of a retrospective study to test the feasibility and potential fruitfulness of this area of enquiry.

Method

The study utilized contemporary material documented in the case-notes of patients assessed at a psychogeriatric assessment unit having a large day-hospital and small short-term inpatient facility. The unit was the centre of a number of research studies at that time, so that this retrospective use of case-notes was less problematic than is often the case. Sixty patients, assessed within a 3-year period at the unit, were randomly selected. Patients were

excluded only if they had no supporting relative, or if a detailed social assessment had not been carried out by the unit's full-time social worker.

Background data were collated: age, diagnosis, score on a memory and information test (Blessed *et al.* 1968) and on a modified form of the Crichton behaviour rating scale – giving an indication of the level of memory impairment and behavioural disability respectively.

In evaluating the quality of the relationship between carer and patient, three 7-point rating scales were devised to assess the variables described above: autonomy-physical dependence (AD), submissiveness-dominance (SD), negative-positive communication system (NPC). These scales are available on request. Two of the authors (VM and RW) rated independently 25 relationships as a reliability check. The major source of information for these ratings was the social report, which routinely included details of the family interaction system.

Outcome was rated 3 months following the patient's assessment from detailed records of multidisciplinary reviews of the case. In only one case could outcome data not be traced. Four categories were used: good – presenting problems had improved; intermediate – no change, or improvement and then relapse in the three-month period; bad – presenting problems deteriorated or (in 2 cases) there was placement in residential care against the patient's expressed wishes; and dead. A reliability estimate of the outcome measures was derived for a sample of 25 patients (excluding cases where the patient had died at 3 month follow-up). To prevent contamination from any anticipated association with relationship factors, one of us (KB) assessed outcome from the follow-up reports, with all identifying material removed, so that there could be no influence from the social report. Apart from reliability assessments, all ratings were made by the social worker.

Results

Reliability

The inter-rater reliabilities of the relationship rating scales are satisfactory, except for autonomy where the range of ratings was very restricted (SD 0.70; NPC 0.78; AD 0.60; all $P<0.01$). Inter-rater reliability of outcome categorization was also satisfactory. Values of weighted Kappa (Hall 1974) were 0.57, 0.74 and 0.77 in the 3 paired-comparisons between raters.

Relationship of variables with outcome

Tables 1 and 2 present the results for each outcome group. Some behaviour rating scale (BRS) and memory and information test scores were not available, but these were evenly distributed across outcome groups. To test for differences between outcome groups, one-way analyses of variance were carried out on age, behaviour rating and memory and information test score. Kruskal-Wallis one-way analyses of variance by ranks were carried out on SD, NPC and AD, and chi-square tests were carried out on diagnosis and relationship of key relative. Significant effects were found for only two variables, BRS ($F=12.9$, d.f.3 & 42, $P<0.01$) and NPC ($H=9.78$, d.f.3, $P<0.05$). Individual paired comparisons showed that patients who died had significantly higher BRS scores at the time of assessment than any other outcome group (t tests, $P<0.05$ in each case). Other outcome groups did not differ on BRS score. The bad outcome group showed significantly less positive communication than the good outcome group (Mann-Whitney U test, $P=0.008$). The intermediate outcome group tended to show a higher level of positive communication than the bad outcome group, but less than the good group (Mann-Whitney U tests, $P=0.08$ and $P=0.06$ respectively).

Analysing the data separately for the two major diagnostic groups revealed slightly different patterns. Functional patients followed the overall trend, with only NPC differentiating good and bad outcome groups (Mann-Whitney U test, $P=0.04$). For the organic group, good and intermediate outcomes were combined (improvement being rare). Here there was a smaller non-significant difference on NPC. A bad outcome was associated with a higher level of autonomy, with a trend towards the patient being less submissive

Table 1. Means and standard deviations of variables for each outcome group – whole sample (n=59)

	Outcome							
	Good		Intermediate		Bad		Dead	
	Mean	s.d.	Mean	s.d.	Mean	s.d.	Mean	s.d.
Age (years)	75.3	4.8	72.9	4.9	76.1	6.4	78.1	7.4
Sex	5M, 9F		3M, 15F		6M, 14F		4M, 3F	
Behaviour rating scale	4.3	2.6	6.4	4.5	4.5	3.1	17.8	9.0
Memory and information test	31.8	6.9	28.1	7.9	29.7	5.3	22.3	8.6
Submissive-dominant	3.3	1.0	3.9	1.6	2.7	1.4	3.6	1.8
Negative-positive communication	4.8	1.6	3.7	1.3	3.1	1.5	3.7	1.1
Autonomy-dependence	2.8	1.3	2.3	1.1	2.8	1.2	2.1	1.3

Table 2. Diagnosis and relationship of key supporter by outcome group

	Outcome			
	Good	Intermediate	Bad	Dead
Diagnosis				
Broadly organic	3	11	11	4
Broadly functional	11	7	9	2
Relationship of key supporter				
Spouse	6	8	3	2
Child	6	7	14	4
Other	2	3	3	1

(Mann-Whitney U tests, $P=0.03$ and 0.057 respectively). The finding of more dependence in 'good' outcome organic patients is reflected in higher levels of disability on the behaviour rating scale and lower memory test scores in this group.

Although there appeared to be a preponderance of carers who were children in the bad outcome group, the only difference on the relationship variables between husband-wife and parent-child (or child-in-law) was that spouses were more dominant in the relationship with the patient than were children (Mann-Whitney U test, $P=0.023$). This was particularly marked in the functional group ($P=0.017$). Finally, there were a disproportionate number of sons among the children in the bad outcome group; only one son was involved in a good or intermediate outcome (Fisher exact probability test, $P=0.048$).

Discussion

Putting aside the unsurprising finding that death at 3 months is related to higher initial levels of behavioural disability, the major result is that relationship variables – even when measured fairly crudely – do relate to short-term outcome. Among patients whose diagnosis is broadly organic, a good outcome is associated with a higher level of dependency on and submission to the key relative. Both factors would contribute to a more manageable dementing patient. Many studies have shown (e.g. Isaacs *et al.* 1972) that it is mental disturbance, and not physical disability, that relatives find most difficult.

With functional patients (and in the overall sample) it is the degree of positive communication in the interaction between patient and key relative that is associated with a good outcome.

For all outcome groups, the relative is never, on average, rated as dominant in the relationship; perhaps more submissive elderly people are not so likely to be referred for psychiatric help; a stereotyped view of the elderly as frail and submissive is mistaken! Children tend to be less dominant than spouses in these relationships, perhaps reflecting

difficulties in role-reversal. The concentration of sons in the poor outcome group needs exploring further.

Our impression is that the communication system and dominance pattern in the relationship tended to reflect longstanding patterns of interaction, but there are considerable difficulties in rating the quality of a relationship retrospectively. The informant is bound to be influenced by recent events in selecting and interpreting the past. It is clear that factors between the patient and their key relative are crucial in relation to short-term outcome and, of course, to strain on the relative. This emphasizes the need for skilled intervention in these relationships; indeed, in our sample, skilled case work led to a good outcome in at least one functional case where communication was predominantly negative. Relatives of some dementing patients, for instance, may need help in being more assertive with the patient in order to manage difficult behaviour.

In the future more emphasis needs to be placed on the dynamic nature of relationships; how a previously established equilibrium adapts (or fails to adapt) to the changes accompanying dementia or other disorders. Within a developmental framework the impact of changes in dominance or in dependency and the influence of a negative communication system on the process of adaptation may be clarified.

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