The Bowen Family Theory and Its Uses

Aging and Institutionalization

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AGING AND INSTITUTIONALIZATION

The increasing proportions of the elderly in our population have heightened professional and personal interest in the topic of aging. Unfortunately, our strong public and private concerns for children and youth have generally been articulated in isolation from concerns for the elderly. Little consistent effort has been made to relate the functioning of younger age-groups to that of older-age groups in society. Young and old are perceived as members of intrinsically different and separate subgroups.

Society cannot meaningfully relate to older people if the elderly are persistently viewed as an isolated group with needs independent of those of young people. Co n temporary society may have to deal with many complex relationship problems owing to the widespread refusal or inability to perceive the underlying bonds between all human beings at deep-seated emotional levels. To the extent that public policies precipitate and reinforce cut-offs between generations and cut-offs in the degree of relatedness within each family, current

relationship problems are likely to increase.

A family systems approach to aging implies that there is a correlation between a lack of meaningful emotional contact between older and younger family members and the symptomatic behavior of those elderly relatives. An examination of cut-offs in a family, particularly those between members of different generations, can provide a fairly accurate means of predicting the timing and type of symptoms that might appear in the behavior of older family members. An increase in the number and intensity of cut-offs in meaningful emotional relationships in a family tend to precipitate the onset and development of aging processes and problems.

Case history data are used to illustrate the emotional systems phenomena that appear to influence the onset and development of symptomatic behavior in the elderly. The longitudinal methods of gathering and organizing the data are based on concepts and hypotheses generated by the Bowen family theory.

Problems

There are many stereotypical beliefs about aging processes and

problems in contemporary society. F our of the most prevalent perceptions about aging processes and problems held in professional and lay circles are discussed here. Although the four areas are interrelated, they are separated arbitrarily to describe some of the specific concerns more clearly.

Physical Debilitation. Aging is frequently believed to be a weakening of bodily capacities. This debilitation is expected to occur more or less at the same time as the onset of "middle age," following a course that is almost as predictable and as inevitable as death itself. The failing physical powers of older individuals are thought to be accompanied by symptoms that precipitate continuing increases in weakness and feebleness.

Senility. The onset and development of physical aging processes are frequently expected to be accompanied by mental infirmity. In senility, an older person is described as regressing to a childlike state of dependency. When senility occurs, younger family members generally respond with caretaking and helping patterns of behavior.

Loneliness. Loneliness is perceived as being an integral part of

aging processes and problems. Retirement from employment, for example, essentially decreases the extent and meaningfulness of social contacts of the elderly at a time when dependency needs usually increase (Rosow 1967).

Poverty. Old age is often characterized by increased economic dependence. Not only are the elderly viewed as incapable of earning their own way in a highly competitive and materialistic society, but they also are considered a financial liability to the community at large. As many elderly persons are not able to pay for the medical care that stereotypical views and beliefs of aging processes and problems have defined as necessary, providing these services becomes a community liability. Families frequently do not assume responsibility for the care of their older members. In some cases institutional care, with its prohibitive costs, may be the only viable option for meeting the needs of the elderly. Society must deal with the widespread poverty of the elderly and the increased financial costs involved in the care of the elderly. The total cost of the services provided for the elderly inevitably places heavy demands on other members of society.

Theoretical Orientation

A focus on aging and family processes from a systems perspective necessitates making several theoretical assumptions. One premise is that there is a direct correlation between the quality of members' participation in the family emotional system and individual behavior patterns. Aging is conceptualized as a product of the older person's position and behavior in the family emotional system. When emotional bonds between an older person and younger family members are tight, rigid, intense, and restrictive—even though these relationships may be manifested as distant—the older person is more likely to become physically debilitated, senile, lonely, or impoverished. When an older person is an active participant in a flexible and open family emotional system, the probability of symptomatic behavior is considerably reduced.

A basic postulate of the Bowen family theory is that symptomatic behavior in older persons and others is a product of the quality of combined emotional relationships in a family. An anxious family with many cut-offs in its relationship system precipitates overdependence, isolation, and senility. When an elderly individual is in a dependent and vulnerable position in a family that is not well differentiated, a projection process focused on the older person is possible.

Patterns of behavior in the multigenerational transmission of a family also influence whether older family members become trapped or triangled in the intensity of the emotional field. In families where older members usually become senile, this behavior may be repeated in subsequent generations. An individual who was very dependent in early life and had symptomatic behavior in times of stress is more likely to repeat these patterns in later years. Intermittent dependency through a life-course can be a frequent pattern of family behavior.

Another basic theoretical assumption is that people are primarily biological beings. Emotional dependence on an intimate group is believed to be a relatively unchanging universal condition that must be dealt with more or less effectively throughout life. Emotional dependency is considered the foundation of all relationship systems. Social norms and mores are conceptualized as specific characteristics of this emotional field, with the biological, emotional, and social aspects of aging being inextricably interrelated and interdependent.

Hypotheses

Four hypotheses serve as a guide for systematizing observations

on aging and family processes:

1. Physical debilitation, symptomatic, and senile behavior of the elderly vary directly with an individual's emotional dependency on the family. Emotional dependency is generally manifested as symbiotic caretaking, helping, or "feeling-sorry- for" behavior patterns.

2. Where symptomatic behavior patterns, including marked economic dependency, occur at an early age, the same or similar patterns are more likely to be repeated at older ages, especially in times of stress.

3. When an individual's parent or grandparent, particularly a parent or grandparent of the same sex, manifests symptoms in old age, that individual is more likely to repeat these behavior patterns in subsequent years.

4. The degree of alienation, isolation, or loneliness of the elderly varies directly with the degree of emotional cut-off with other family members.

Case Histories

Six case histories are used to document these hypotheses. The case histories were selected from several hundred families in clinical and nonclinical settings to illustrate different characteristics of family

emotional processes. Three functioning and three dysfunctioning older individuals are presented in the context of their families. The examples are paired; each pair consists of one functioning older person and one dysfunctioning 150 older person. Each pair of examples illustrates functioning and dysfunctioning in different life situations and with different clinical approaches: (1) families where an older person was coached to make changes in functioning in relation to the family; (2) families where a younger person in the family was coached to make changes in functioning, especially in relation to a member of an older generation; and (3) families where there was no clinical intervention. The third pair of families may be viewed as a control group in relation to the other pairs of families.

Families with Older Person Coached

Functioning older person. The older person in this family was a divorced man who was contemplating remarriage. He was the father of two daughters and the grandfather of one grandson. He initiated therapy because he had been concerned that he would be unable to relate meaningfully to the woman who was to be his next spouse. His first wife's divorce action had taken him by surprise, and his present

wife-to-be constantly complained about his lack of responsiveness to her needs. The man was a talented musician who worked in the same conservatory as his older daughter. One week before the father began therapy, his older daughter left her husband and child and moved into the home of another man.

After three months of therapy, the father was able to function more effectively in his work. He was also able to act more responsibly in relation to the emotional demands made on him by his daughters and his fiancée than he had been before. Having previously been paralyzed by these relationship concerns, he was now able to formulate plans for himself and put them into action. He had not functioned as effectively since his divorce, which had occurred about ten years before.

Dysfunctioning older person. A grandmother initiated therapy because she had been unable to communicate satisfactorily with the oldest of her three daughters. This oldest daughter had a daughter of her own. The grandmother's wish to see her granddaughter frequently prompted the grandmother to be particularly anxious to resolve the conflict between herself and her daughter. When arguments occurred

between mother and daughter, the older woman was not allowed to see her granddaughter.

The grandmother was not able to lower the level of her anxiety in her relationship with her older daughter. The grandmother’s father died during the course of therapy, and she became preoccupied with how she could manage to please her mother and cater to her mother’s whims in an extended period of mourning. The grandmother’s relationship with her oldest daughter continued to be volatile, and eventually the daughter, with her husband and daughter, left town to take up residence in a distant city. In the next few weeks, the grandmother’s youngest daughter ran away from home, and the grandmother took increasing numbers of tranquilizers. The grandmother suffered from frequent depressions and a variety of physical ailments. She was unable to focus on self, and she complained about others in her family and blamed them for her difficulties. She terminated therapy at a low point of functioning.

Families with Younger Person Coached

Functioning older person. A woman who had two elderly parents

initiated therapy because she had been extremely anxious about the well-being of her incapacitated mother who lived with her and needed round-the-clock physical care. The woman found that the responsibility she had assumed for her mother demanded more tolerance than she was easily able to muster, and she frequently experienced crying spells and depressions.

When the daughter was able to relate to her mother with less of a helping, caretaking posture, the mother began to function more adequately. The mother began to take an active interest in caring for her own needs, and her daughter was able to leave her for longer periods of time than had been possible in the previous few years. Until that point, the daughter had been distancing from her mother through her helping and caretaking activities. When she was able to relate to her mother on a more personal level, her mother was able to function more effectively.

Dysfunctioning older person. A man began therapy when his wife refused to care for his ailing elderly father. Although the father had lived next door to his son for most of his son's marriage, for several years there had been an intense cut-off in the relationship between the

son and the father. When clinical sessions began, there had been no meaningful exchanges between the two households for about a year. The son arranged for his niece to live with his father and look after him. As she was divorced and did not have any children, this relationship between the niece and her great uncle worked out fairly well. The son no longer felt trapped by his responsibility to care for his father.

Throughout six months of therapy, the son made no efforts to visit his father or to communicate with him personally. He continued to believe that his father was his wife's responsibility, and he constantly pressured her to look after his father.

The father became increasingly dysfunctional, and eventually his son put him in a nursing home. Although the son, together with other family members, contributed toward his father's expenses, he did not visit his father at the nursing home. He rationalized that his father was senile and would not recognize him even if he did visit him. To alleviate his own anxiety about his estrangement with his father, he also began to encourage other family members to stay away from the nursing home. As the father's isolation from his family became greater,

his symptoms of senility increased.

Families Outside the Clinical Setting

Functioning older person. After the death of her husband, an older woman, who was a mother and grandmother, related more openly and more frequently to members of her family. Her relatives responded to the loss of her spouse by increasing their contact with her.

This elderly woman was able to continue making meaningful contacts with her family, including contacts with some members of her family of origin. During the next two-year period, when these relationships were reactivated, she functioned more effectively than she had for many years prior to her husband ’s death. She was able to make financial decisions independently, and she appeared to decrease some of her direct emotional dependence on her children. She had sufficient economic means of her own to be able to conduct her affairs separately from those of her children.

Dysfunctioning older person. After the unexpected death of his wife, an older man became dysfunctional. For about ten years, he and his wife had become increasingly estranged from their respective

families of origin. Their two daughters had moved away and had maintained no more than a superficial level of contact with their parents.

Upon the death of his wife, the man went into a prolonged state of shock. Within four weeks of her death, he had a mild stroke and was hospitalized; and he subsequently returned to his own home. However, as he was unable to care for himself, he sold his home and moved into a nursing home.

Six months after his move to the nursing home, he met a woman who had been a nurse before her retirement and he proposed to her. The two were married and moved into the wife's apartment, where she began to overcare for her husband. An intense, rigid, and emotionally dependent relationship developed between the spouses. The husband became increasingly cut off from his children and from his own family of origin. Neither his children nor his family approved of his remarriage. The husband's symptoms increased, and his financial affairs became too difficult for him to manage. To an increasing extent, his wife supported him both emotionally and financially.

Findings

An older person who was an active participant in a comparatively open emotional system appeared to function more effectively than an older person who was cut off from or trapped into a closed emotional system. When an older person made effective differentiating moves in a family, aging symptoms declined and emotional dependency on the closest family members was reduced. An effectively differentiated older person was generally more adept at coping with life crises, such as death, illness, retirement, or the dysfunction of others.

In families where the elderly were dysfunctional, the number and intensity of emotional cut-offs persisted or increased. The quality of emotional relationships in these families was rigid, superficial, and distant. Crises added stress to an already-tight emotional system, and the symptomatic behavior of the older persons increased.

Conclusion

The onset and development of symptomatic behavior in the elderly, as in the case of other family members, are precipitated and enhanced by crises and stresses in the family, such as the death of a

significant family member. Stresses increase the probability that an older person will be triangled into the emotional system of the family, and overadaptiveness after a crisis is atypical dysfunctional response. As symptomatic behavior must be reinforced for it to persist, clinical intervention may reduce the likelihood that an older person will lose self in relation to other family members. The case history data described suggests some tentative generalizations:

1. The degree of closure of a family emotional system precipitates and reinforces physical incapacitation or senile behavior among elderly family members. In some instances, economic dependence of the elderly appears to be a direct consequence of emotional dependence.

2. In times of stress, behavior patterns tend to be repeated automatically. These repetitions may duplicate previously established patterns of symptomatic behavior, or they may repeat symptoms of close family members.

3. Cut-offs are a powerful precipitation of dysfunctional behavior among the elderly. The probability of symptomatic behavior for an

older family member increases depending on the degree to which meaningful emotional relationships with other family members are lacking.

4. When intergenerational repetitions of symptomatic behavior occur, the “vertical” relationship of same sex child, parent, and grandparent appears particularly influential. Latent or overt helping and caretaking patterns of behavior between the different generations lead to increased repetitions of symptomatic behavior, particularly in times of stress.

Further Research and Social Policy

Although older people have been referred to as “ex-family members” (Beard 1949), they are equal participants in a family emotional system. Children and neighbors are impervious role-sets, and substitute social activity cannot effectively reduce an older person’s family dependence (Rosow 1967). Case history data suggest that aging is more intimately related to family emotional processes than to broader social forces, such as norms or public opinion.

Although the empirical and theoretical validity of the hypotheses

discussed cannot be confirmed, policy makers could act from a greater awareness of the extent and degree of interdependence of all members of society than currently exists. Policies and programs for the well-being of children will remain inadequate as long as they do not account for the inextricably linked needs of young and old. In addition to the financial costs involved, institutional care of the elderly tends to intensify the social and relationship problems we have with young and old alike by increasing the number and intensity of emotional cutoffs between young and old.

Enhanced awareness of the extent of emotional relatedness of the elderly to their families may facilitate clearer definitions of the responsibility of each family member and what that responsibility means. Questions concerning what aging processes and problems are and how they are related to family and societal emotional processes lead to the critical issue of what it means to die responsibly. How can I conduct my life toward a responsible death? In what ways do I contribute toward the type of death another will experience?

Alternatives to Institutional Care for the Elderly

Care of the elderly is an increasingly problematic topic in a society that must support rising numbers of older people (Rose 1968, Neugarten 1973). In most sociological studies on aging, observations and data about older people are selectively organized, so that the elderly are conceptualized as a distinct subcultural group. The elderly are generally viewed as being in isolation from other individuals and groups in society (Rosenberg 1967, Rosow 1967, Riley 1968) with their own separate needs. However, case history data indicate that the needs of members of all age-groups are inextricably related and that multigenerational family influences may have a significant impact on the functioning of the elderly. Even considering the special care that may be needed for older members of society, family relationships are tentatively conceptualized as a more meaningful and more effective environment than institutionalization. A family with an open and flexible relationship system could delay the incapacitation of older people or even prevent some kinds of physical debilitation.

An older person may be considered primarily a family member rather than a member of a special group in society. A research and theoretical orientation based on that view has not been utilized frequently in the literature (Dinkel 1944, Beard 1949, Bultena 1969).

A hypothesis directly related to this view of the elderly and to the public concern for their care is that an older person who is able to maintain meaningful contacts with family members is less likely to need institutionalization than an older person who is emotionally cut off and estranged from other family members (Hall 1976). A related hypothesis is that if economic and service incentives are provided to family members, there will be a reduction in the incidence and need for the institutionalization of the elderly. In this situation, families need not sacrifice their own ambitions or compromise their current efforts to maintain themselves because of the presence of an elderly member in their household (Hall and Sussman 1975).

Research

Many research studies already have dealt with general social or economic aspects of the aged as a distinct social group (Simpson 1966, Solomon 1967). Where research efforts have been directed to observing the elderly within the context of their families (Sussman 1955, Townsend 1957, Streib 1958, Shanas 1961), 158 however, there has been little attempt to link findings to proposals for alternative care systems. Although there have been some descriptive studies of family

help systems (Schorr 1960, Streib 1965, Shanas 1961), much of the literature that compares family environments to institutions or to other kinds of actual or proposed health and general care systems is based on unsystematic research or personal and professional opinions (Kaplan 1972, Kistin and Morris 1972, Hochschild 1973, Cohen 1973, Etzioni 1975).

Work on family-bureaucracy linkages, which is a recent international research development, has a bearing on alternative and complementary systems to institutionalization for elderly persons (Litwak, Hollister, and Meyer 1974, Shanas and Sussman 1975). Interaction between families and bureaucracies has been examined within an exchange theory framework. A logical outcome of these studies is to describe the potential of family networks as a living environment for the elderly.

Findings from research on social structural and social participatory aspects of aging (Taietz and Larson 1956, Shanas and Streib 1963, Rose 1968) and on intergenerational, kin- relations aspects of aging (Sussman and Burchinal 1962, Litwak and Szelenyi 1969) indicate that there the degree of social participation of older

persons may be related to their physical and mental well-being. A hypothesis generated by this tentative correlation is that when older people interact frequently with others, “high interactors” are more likely to sustain an adequate level of physical and mental health than “low interactors.” This factor of “social participation” appears significant within families as well as between older persons and the wider society or members of social groups other than the elderly (Lowenthal 1965, Petroni 1969, Slaker, Sister, Sussman, and Stroud III 1970). These findings and case history data suggest that if older individuals can function well in their own families, they will be grandparents is an important part of the foster grandparent program (HEW 1972). Furthermore, because of the quality of interaction between old and young, there seem to be distinct benefits for the children as well as for the senior citizens participating in the program (Gray and Kasteler 1967, M.A. Hammond 1963). It seems legitimate to raise the question, if increased intergenerational contact is tangibly beneficial to unrelated members of older and younger generations, could there be as many or more dividends for older and younger members of the same family? It will be some time before specific benefits could be empirically substantiated, but data that define the

influence of interaction between different generations may be reliable guides for the formulation of effective policy for aging.

Social Policy

Current national practices are frequently geared toward institutional support programs for the elderly. Although no explicit policy has been established, revenue-sharing funds are increasingly being allocated to local communities, some of which support institutional and community-based human services for the elderly. The difficulty of deciding to fund programs for the elderly rather than more attractive and less stigmatized alternatives, such as drug addiction, rape, and alcoholism control, makes the search for institutional alternatives even more imperative.

Even if institutional environments could provide optimal conditions for interpersonal intimacy and gratification of physical and psychological needs for the elderly, which is highly unlikely (Noelker 1975), governments worldwide would find it difficult to increase financing for institution-based programs. Most complex and developing societies have reached their “absorptive capacity” to

provide care and services for dependent populations in relation to maintaining a healthy economy and rewarding the producers. Expenses of institutions for the elderly will create burdens that societies cannot bear.

The need for finding alternatives to institutionalization is exacerbated by the imminence of a national health insurance program and the absence of an organized health-care delivery system on the national or local level. The availability of nonstigmatized medical care may encourage people to become “sick.” Specialized medical care is generally not needed by most elderly people, and family members are easily able to cope with some of their minor dysfunctions.

Recommendations

There is some evidence of increased national concern and public interest in the topic of aging and its implications for American society (Burger 1969, White House Conference on Aging 1971, United States Senate Committee on Labor and Public Welfare 1975). In my opinion, the following recommendations could be considered:

1. Supported research priorities could be realigned to enable an

increase of research on alternatives to institutionalization for the aged (Administration on aging 1972), as well as on the impact of family interaction on aging and problems conventionally associated with aging.

2. In preparing long-range policy for the elderly (Ellwood 1972), social scientists and policy makers could study quality-of-life issues, such as the dignity and meaningfulness of life for elderly people, in addition to the more routinely addressed issues of economic and physical liabilities.

3. There could be increased support for projects such as the New Jersey negative income tax experiment (Pechman and Timpane 1975), which provides for financial and service incentives to families to establish creative environments for their elderly members.

4. Studies on the positive and negative impacts upon socialization in families of intergenerational living arrangements could be encouraged.

5. Inquiries on the advantages and disadvantages of alternatives to institutional care could be undertaken from the perspective of the older person. The question of who benefits the most and the least from alternatives to institutional care could be explored.

6. Family environments that foster autonomy, intimacy, and intergenerational interaction for the elderly could be designed. The family networks should optimally have access to services for nutrition and health.

7. There could be further research on political and government agency sources of support or opposition to family - oriented and family-controlled alternatives to institutionalization.

8. The linkages of families with nonfamily institutions and bureaucratic organizations could be studied.

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