Therapeutic Intervention with
Adult Caregivers

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Introduction

As we begin this paper, we are reminded of Kurt Lewin's famous dictum: "There is nothing so practical as a good theory." Our focus today is therapeutic intervention with adult caregivers. Our message, fairly simple: Adult caregivers have three simultaneous tasks which face them: (1) Grieving for the changes and losses of the former level of competence of their impaired relative; (2) Care-giving to palliate the emotional and physical needs of their impaired relative; and (3) Individual development which will allow the care-giver to continue his/her own personal growth during and beyond the caregiving episode, even if that period lasts several years (Honn, 1984). These three tasks correspond quite clearly with what Brice and Nowak referred to as comfort, competence, and confidence. While scholarly work has focused on all three elements (Bloom, 1983; Smyer, 1983, 1984), recent writings from the popular press provide us with the most powerful portraits of the task trio. I would like to share with you the sensitive treatment of these tasks by reading a few short passages from Russell Baker's Pulitzer Prize Winner Growing Up and Mark and Dan Jury's photojournal Gramp.

On grieving, for his mother, Russell Baker writes:

> "The doctors diagnosed a hopeless senility. Not unusual, they said, "Hardening of the arteries" was the explanation for laymen. I thought it was more complicated than that. For ten years or more the ferocity with which she had once attacked life had been

turning to a rage against the weakness, the boredom, and the absence of love that too much age had brought her. Now, after the last bad fall, she seemed to have broken chains that imprisoned her in a life she had come to hate and to return to a time inhabited by people who loved her, a time in which she was needed. Gradually I understood. It was the first time in years I had seen her happy.

She had written a letter three years earlier which explained more than "hardening of the arteries." I had gone down from New York to Baltimore, where she lived, for one of my infrequent visits and, afterwards, had written her with some banal advice to look for the silver lining, to count her blessings instead of burdening others with her miseries. I suppose what it really amounted to was a threat that if she was not more cheerful during my visits I would not come to see her very often. Sons are capable of such letters. This one was written out of a childish faith in the eternal strength of parents, a naive belief that age and wear could be overcome by an effort of will, that all she needed was a good pep talk to recharge a flagging spirit. It was such a foolish, innocent idea, but one thinks of parents differently from other people. Other

people can become frail and break, but not parents.

She wrote back in an unusually cheery vein intended to demonstrate, I suppose, that she was mending her ways. She was never a woman to apologize, but for one moment with the pen in her hand she came very close. Referring to my visit, she wrote: "If I seemed unhappy to you at times--" Here she drew back, reconsidered, and said something quite different:

"If I seemed unhappy to you at times, I am, but there's really nothing anyone can do about it, because I'm just so very tired and lonely that I'll just go to sleep and forget it." She was then seventy-eight.

Now, three years later, after the last bad fall, she had managed to forget the fatigue and loneliness and, in these free-wheeling excursions back through time, to recapture happiness. I soon stopped trying to wrest her back to what I considered the real world and tried to travel along with her on those fantastic swoops into the past."

Dan Jury also expresses the grief work the caregiver must do:

"This evening, for the first time, I realized that Gramp is going to die. It's strange the way you can be assaulted by something and yet not realize it. For

myself--I don't know about the others--I have been
speaking of Gramp's inevitable death freely. Speaking
of it as if I were speaking of the inevitability of my
next birthday, and in the context that, death is of no
more consideration.

Tonight though, I stood in Gramp's doorway and
realized that Gramp was possibly only days away from
entering that dark, uncertain place that each of us
wonders about--but dreads to visit. And I wondered if
Gramp is aware that death is awaiting him. Does he see
Death? Is it an acquaintance? Does he understand that
death is near?

It is probably the feeling that Gramp is patiently
waiting for death that fascinates me the most. He lies
there, not stirring, not asking for anything, not even
calling for enough substance to keep away the pain of
thirst and maybe starvation.

Nink just spoke to me of funeral arrangements for
Gramp, which shows this whole death trip is being taken
in good stride. But will it all seem so simple and
procedural when I first see Gramp's corpse? I wonder
what my emotional response will be. After all these
months of preparing for Gramp's death, will it still hit
me with the force of an unexpected death?

Of one thing I am sure. No matter how many times I
have to clean Gramp, or feed him, or blow his nose, or
care for him in the middle of the night when my body
only wants to ignore him, I will always remember the
good times with Gramp before I recall the bad."

On providing care which meets the emotional and physical
needs of an impaired relative, the Jurys write:

Gramp was no longer able to dress himself, so one of
us had to be with him when he first got up. Usually,
we'd look for his teeth (which he would hide almost
every night) and maybe clean him up after an "accident."
We'd also make breakfast for him and help him eat. Once
he was dressed, fed, and around people for a while, he
made a remarkable daily comeback and was able to
function in his own world.

Over a period of months, however, these comebacks
became less and less successful. He was also beginning
to withdraw from the family. After two years of
"constantly being underfoot" (as Nan described it), he
now preferred to sit in his room alone.

He was also falling out of his bed during the night,
and we decided to put his mattress on the floor to
minimize his chances of getting hurt.

The time we all dreaded, but knew was inevitable,

came without warning--Gramp lost control of his bowels

completely. In one incredible day, the Tugend house

became a military-like operation of diapers, rolls of

toilet paper, and a well-orchestrated platoon system for

getting him cleaned off before the next "accident"

happened.

The crisis was so unexpected and the pace so hectic

that none of us realized that the intolerable time had

undoubtedly arrived. On that day, Nan voiced the

feelings of everyone when she said, to no one in

particular, "Gosh, it's an awful ordeal."

Finally Russell Baker notes the importance of Individual

Development:

"Of my mother's childhood and her people, of their

time and place, I knew very little. A world had lived

and died, and though it was part of my blood and bone I

knew little more about it than I knew of the world of

the pharaohs. It was useless now to ask for help from

my mother. The orbits of her mind rarely touched

present interrogators for more than a moment.

Sitting at her bedside, forever out of touch with

her, I wondered about my own children, and their

children, and children in general, and about the

disconnections between children and parents that prevent

them from knowing each other. Children rarely want to
know who their parents were before they were parents,
and when age finally stirs their curiosity there is no
parent left to tell them. If a parent does lift the
curtain a bit, it is often only to stun the young with
some exemplary tale of how much harder life was in the
old days.

I had been guilty of this when my children were
small in the early 1960s and living the affluent life.

As I hovered over my mother's bed listening for
muffled signals from her childhood, I realized that this
same dispute had existed between her and me. When she
was young, with life ahead of her, I had been her future
and resented it. Instinctively, I wanted to break free,
cease being a creature defined by her time, consign
her future to the past, and create my own. Well, I
had finally done that, and then with my own children I
had seen my exciting future become their boring past.

These hopeless end-of-the-line visits with my mother
made me wish I had not thrown off my own past so
carelessly. We all come from the past, and children
ought to know what it was that went into their making,
to know that life is a braided cord of humanity
stretching up from time long gone, and that it cannot be

defined by the span of a single journey from diaper to shroud."

The caregiver role, to use the terminology of those concerned with life events may best be described as an unscheduled transition; a transition involving multiple endings and beginnings. From such a perspective, transitions which have the following five characteristics: (1) are unscheduled; (2) are not controlled by individual choice; (3) have little or no warning; (4) result in status loss; and (5) have no rite of passage associated with them are most likely to result in crisis (Hagestad & Smyer 1982). Given that all five risk factors characterize the caregiver role, thoughts on therapeutic interventions with this population must be given greater attention than has been true in the past.

As we consider therapeutic interventions aimed at helping people deal with the tasks of grieving, caregiveing, and development, two theoretical frameworks become particularly useful. These include contributions of life-span development scholars such as Paul Baltes and his colleagues and the work of family stress theorists such as Hill and his colleagues. In this paper, we will review briefly these two major theoretical formulations and their implications for intervention. Then we will present case material to exemplify the intervention approaches which derive from these theoretical foundations.

Finally, we will conclude with a consideration of the appropriate blend between disciplines and between formal and informal support which embracing these frameworks requires.

Before proceeding, however, clarification of some key terms must be made. Adult caregivers are by no means a homogeneous group. They are defined more by their role than by their age. In fact we may do more justice by referring to them as caregiving adults. They are persons charged with the responsibility of "being there" both mentally and physically for another person. Historically, when the identified patient was elderly, short life expectancies yielded caregiving adult children who were typically in their 20's. Demographic changes which our society has experienced during this century, such as a dramatic increase in average life expectancy and sharp rise in the number and percentage of older adults has led to a growing awareness of the important tasks of "parent-caring." The primary caregiving adults of todays' elderly are middle-aged children, especially daughters, and elderly spouses, especially wives. The important point to be made here is that the caregiving role may be but one of many for which an individual adult is responsible, and that it is only by considering the problems of the individual in the context of the myriad of his/her roles that appropriate strategies for intervention may be made. More about this later.

The concept of "intervention" does not have a singular meaning nor does that of "therapeutic". For the purpose at hand, intervention is defined along the lines suggested by Baltes (1973) as "a progammatic attempt at alteration" and Urban (1976) as "planned intrusive inputs into an organized network of active and ongoing processes." Interventions may be therapeutic or non-therapeutic. Sargent (1980) defines as therapeutic a contact or experience which results in certain kinds of beneficial change in the person. As Baltes and Danish (1980) point out, specifications about therapeutic interventions gain meaning only in the context of theories about individual development and societal functioning and that of values and norms about what is desireable and beneficial. As such, before moving to the who, when, how, and what for aspects of intervention, theoretical and value issues must be addressed.

Life span developmental psychology provides an orientation to the study of behavioral development from which to describe, explain, and modify the lives of caregiving adults. Relevant assumptions and propositions about the nature of life-span development will be described briefly, while more complete accounts may be found in the writing of Baltes and associates (Baltes, Reese & Lipsitt, 1980; Baltes, 1979; Lerner & Ryff, 1978). These propositions will be contrasted with more traditional views and distinctions drawn between the

implications of various views for therapeutic intervention with caregiving adults.

Development throughout the life span

The first assumption of a life span development orientation is that behavior-change processes that fall under the rubric of development can occur at any point in the life course from conception to death (Baltes, Reese & Lipsitt, 1980). This proposition has been contrasted with a traditional biological growth orientation which posits a certain state of maturity as the endstate of a developmental change process (Harris, 1957). Subsequent change from this biological viewpoint is seen as decline rather than development (Baltes, Reese, & Lipsitt, 1980). A life-span orientation assumes no special state of maturity, and therefore, development is seen as a life-long process.

The major implication of this assumption for providing therapeutic intervention into the lives of caregiving adults is that regardless of age, caregivers will be receptive to change; change in problem-solving strategies, change in behavior toward the impaired relative, change in belief systems. For caregiving adults, a number of developmental objectives and processes exist (Kastenbaum & Aisenberg, 1972; Riegel & Riegel, 1972, Schulz, 1978). These include adaptation to a process of physical debilitation (Murphy, 1982; Mace & Rabins, 1981), adaptation to

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loss, and the continued restructuring of physical and social environments because of loss of the significant other (Jury & Jury, 1976). Identified and investigated as developmental phenonema, these are processes which caregivers experience with some degree of regularity and whose effects on the further development of the caregiver are modifiable.

Although studies support the thesis that there is no relationship between age and rate of successful therapeutic outcome (Garfield & Bergin, 1978; Smith & Glass, 1977), this assumption and these research findings, are antithetical to more traditional views. Although never testing its usefulness, Freud and the vast majority of his followers, for example, ruled out therapy for the aged. More recently, Butler & Lewis (1977) have chastized the mental health field for "professionalizing ageism"-- Acts of prejudicing and stereotyping applied to older people sheerly on the basis of their age. The life span orientation, with its focus on the potential for change at any age clearly takes issue with these propositions.

The Context of Development

A second assumption of the life-span developmental orientation is that development does not occur in a vacuum. Rather, human development involves the coalescing of several dynamically interactive change processes (Meacham, 1976; Riegel, 1975). Baltes, and associates argue that because development

extends over substantial periods of time, it is necessary to view it in the framework of historical change.

In a similar spirit, though from a more "micro" approach, based on theories of attachment, interdependence, and people as role partners, we developed the concept of "life event webs" in an earlier paper (Pruchno, Blow and Smyer, 1984) as capturing the essence of the intricate linking which exists among individual lives. Given the interlinking of lives, change in one life begets change in all those lives with whom the "target person" is associated. The clearest example of this is one person becoming a caregiver in response to another becoming ill. However, the web of impact does not stop there. A middle aged woman, for example, who becomes caregiver to her ailing mother may be caught in an inter-generational crunch and forced to change her relationship with her young adult offspring who need support in establishing themselves as adults (Silverstone & Hyman; 1976) or caught in an intra-generational crunch as she changes her relationship with her husband who relies on her support for his midlife career change or her best friend whose husband has just died (Hagestad, 1981). The extent of the impact of change on the web depends on the degree to which its members are enmeshed.

This assumption has dramatic implications for interventions with caregiving adults. The question becomes to whom do we

target interventions? During the past 20 years a growing number of theoreticians and practitioners have contended that interventions should be targeted beyond the individual--at levels including the family, neighborhood, community, and social policy (Albee, 1959; Berger & Neuhaus, 1977; Bryant, 1978; Goodstein & Sandler, 1978). Such suggestions are very much in line with a webs perspective in which the target of change becomes the web rather than the individual.

A webs perspective for intervention suggests that therapeutic intervention may be most helpful when focused on the web of individuals affected by a particular stress. In the case of caregiving adults, it may be most useful to target therapeutic interventions not solely on the identified caregiver, but on his/her spouse and children as well. Keeping in mind a developmental perspective reminds us that individual web members, in the midst of fulfilling various developmental tasks themselves (Havighurst, 1948; Erikson, 1968), may be unprepared for the demands placed upon them by changes in the lives of other web members. For example, in the case of the middle aged woman who becomes caregiver to her ailing mother, we may see an increase in acting out on the part of her teenaged son. The problem is neither the middle aged woman, her infirm mother, nor her son. Rather it is a problem defined by the unique mixture of lives coalescing and developing in conjunction

with one another. Treating any of the three actors separately misses the point and may in fact have negative results.

Intervention focused on the web modifies and extends the traditional focus of family therapy. Webs are defined by their members and may extend beyond the confines of blood or kinship ties. Problems experienced by webs may also extend beyond age-related disciplines such as child psychology or gerontology. When working with three or four generations for example, a narrow focus from an age-related discipline serves only to put blinders on the therapist, who is then apt to fall short of the mark. Maintaining a life-span orientation, on the other hand allows various developmental tasks and their crises to be included in both problem definition and solution.

Contextual specificity for intervention

A third set of propositions associated with the life-span developmental orientation involves the view of what constitutes development and what its determinants are. Research has contributed to the conclusion that a restricted definition of the nature of development such as that suggested by a biological growth model is inappropriate. Instead, life-span changes may take many forms in terms of directionality of change, interindividual variability, and plasticity (Baltes, Reese, & Lipsitt, 1980). As such, life-span changes are conceptualized

as developmental processes which are not only linear, but also multilinear and discontinuous.

This pluralistic view of development leads to a reformulation of the type of question asked regarding intervention (Lerner & Ryff, 1978). As Lerner and Ryff argue, "rather than debate which behaviors should be the targets for intervention, or which theories, definitions, or facts about a given process are most useful, we must address the more difficult issues of which behaviors, for which individuals, in which contexts are most likely to lead to optimal development outcomes." In order to appropriately address these issues there must be an alignment made between the theoretical knowledge base concerning development and interventive strategies, for the course of development can be modified in terms of a variety of indicators.

Considering caregiving adults and their webs from this perspective suggests that the goal of therapeutic intervention is not long term personality change. Rather, efforts are made to help solve situational problems. Herr and Weakland (1979) distinguish between situational problems which have solutions, such as those relating to meeting physical care needs of the impaired relative, and situations in life which can be classified as having no really satisfactory solution, such as death, disease, and social loss. Adult caregivers are faced

with both types of concerns. Regardless of the type of problem, however, how they're faced and handled makes a difference in the development of all involved. This strategy assumes that people are active problem solvers and participants in interventions who have both skills and deficits, and is in line with a developmental perspective.

The approach to intervention described by Herr & Weakland involves a few simple ideas, yet its implications and potential advantages have the capacity to produce profound effects. The intervention focuses on the here-and-now situation. The approach focuses not on the concrete difficulties or limitations involved in a problem situation; rather, it addresses their handling by the people involved. The contention of this view is that while the concrete difficulties may be patched up, how the difficulties are being handled is open to useful, beneficial change. The approach has the capacity to help people faced with overwhelming problems avoid the discouraging belief that either global change must be achieved or extensive and continuing support will be needed. Instead, the possibility is raised of accomplishing small but strategic changes whose effects will be reinforced by interaction within the system. As such, the viscious cycles involved in the persistance of a problem can be replaced by more productive ones. The concept of contextual specificity for interventions suggests that the therapeutic

agent (therapist, neighbor, etc.) must assess which of the three major tasks of caregiving (grieving, care-giving, personal development) is currently most problematic and requires the most immediate attention.

The life-span principles proposed thus far indicate that development or change may be conceptualized as both multidimensional as well as multidirectional. In addition, there are large differences in the life course patterns of individuals, what Baltes et al (1984) have referred to as interindividual variability, as well as clear evidence for modifiability, or to use Baltes' term, intraindividual plasticity. This focus on dynamic, yet diverging patterns of development may at first seem antithetical to programatic attempts at invervention. However, what it does suggest is that one intervention strategy will not work for all cases. What is needed, instead, is a model which identifies specific components to consider when implementing change. One such model, whose goal is to identify characteristics of caregiving adults which put them at risk for various physical, social, and emotional concomitants which deter their ability to function in the role of caregiver will be described. The model is couched within the family stress framework, although, similar principles apply to webs. Following presentation of the model, intervention strategies which derive from the model will be described.

The ABCX Theory of Family Stress

The ground upon which the model is imbedded is the classic ABCX theory of family stress proposed by Hill (1949). Hill's theory, based on war-induced separation and reunion, although slightly modified (Burr, 1973,Hanson & Hill, 1964; Hill, 1958) has remained virtually unchanged for over 30 years. The theory holds that: A (the event and related hardships)-interacting with B (the family's crisis meeting resources)-interacting with C (the definition the family makes of the event) produce X (the crisis). The second and third determinants of the model, family resources and family definition of the event lie within the family itself and must be seen in terms of the family's structure and values. The hardship of the event, which comprises the first determinant, lies outside the family per se, and includes attributes of the event itself. The model is depicted schematically in Figure 1.

The first component of the model, Hill's A is defined as the event and related hardships, or the stressor. It is important to note that the model distinguishes between stressor, stress, and crisis. Stressors are those life events or occurrences of sufficient magnitude to bring about change in the family system. Stress is not seen as inherent to the event itself but rather is conceptualized as a function of the response of the distressed family to the stressor and refers to the residue of

tensions generated by the stressor which remain unmanaged. Crisis refers to the amount of incapacity or disorganization in the families where resources are inadequate.

For purposes of this model, components of the stressor include length of illness, behavioral manifestations, and demands made by the impaired relative, while the adjustment/crisis outcome is comprised of the mental health of the family members, associated physical sequelae, altered participation in social and recreational activities, and continued performance of the caregiver tasks.

Hill's B factor, the family's crisis-meeting resources has received considerable attention from family stress researchers. Factors which have been addressed include: (1) family members' personal resources; (2) family system's internal resources; and (3) social support.

Personal resources refer to the reserves and aids available to people in the family. People who have sufficient, appropriate resources are less likely to experience adjustment problems than persons who lack such resources. Personal resources include financial status, educational background, physical health, and personality characteristics, especially methods of coping. Family system resources include family adaptability or flexibility to change and family cohesiveness. According to theoretical propositions advanced by Olson and

Associates, families functioning along moderate dimensions of both cohesion and adaptability are likely to make a more successful adjustment to stressors than families functioning at either of the extremes.

Although Social Support has been defined in a myriad of ways, the elements which appear to be most useful include those of formal versus informal support and information regarding the specific type of aid provided to the family. In short, pertinent data include: (1) who in the system is providing assistance to or support for the caregiver, and (2) what type of support are they providing. The issue of formal versus informal support is viewed as salient because of the very different type of and meaning attached to the assistance provided. For example, both a professional nurse and a caregiver's daughter may be providing emotional support to the caregiver, yet, the implications of the two types of support may be quite different.

The C component of the model is the most poorly defined, and the one given the least amount of attention in the literature. Yet, it is important to include because it contains the subjective perceptions or definition the family members give to the situation. Included herein are: (1) the family's perception of the burden placed on them as a result of the stressor and (2) the degree to which the family members

understand the disease prognosis and correctly anticipate future changes in the identified patient.

The X factor of the model represents the amount of crisis. It denotes variation in the amount of disruptiveness or disorganization experienced by the family system. The factor varies continuously from no crisis to a high degree of crisis. The proposed model conceptualizes crisis as comprised of the following: (1) mental health problems which include development of major psychopathologies as well as affect disorders and associated physical disorders; (2) disengagement from social/recreational activities, and (3) failure to perform needed caregiver tasks. These components have obvious parallels to the task trio outlined earlier.

The Double ABCX Model

Suggestions have recently been made that the original ABCX Model may be strengthened by the addition of postcrisis variables which could help to explain why some families are better able to achieve positive adaptation to crisis than other families. This extension is especially pertinent when the issue of concern is why some families are better able to adjust to and manage chronic, long-term stressors than others. The Double ABCX Model, postulated by McCubbin and Patterson (1982) provides a useful framework from which initial efforts at understanding

the differential impact of chronic long-term stressors may be addressed. The model is depicted schematically in Figure 2.

The Double A factor described by McCubbin and Patterson is comprised of three types of stressors which contribute to a "pile up" in the family system during a crisis situation. First is the initial stressor event with its inherent hardships which played a part in moving the family into a "crisis" state. Second are family life changes and events, both normative and nonnormative which occur irrespective of the initial stressor. Stressors which are consequences of the family's efforts to cope with the hardships of the situation represent the third type of stressor.

McCubbin and Patterson postulate the Double B factor to be comprised of two general types of family resources. First are those resources that are initially available to the family; resources which minimize the impact of the initial stressor and reduce the probability that the family will enter into a crisis situation. Second are the personal, family, and social coping resources which develop or are strengthened in response to the crisis situation.

The double family perception factor, Double C is comprised of: (1) the family's perception of the stressor event; (2) the family's view of how stressful the event may be, and (3) the family's perception of the crisis, including not only their view

of the stressor and related hardships, but also their perception
of the pile-up of life events and the meaning attached to the
total family situation.

In their extension of the ABCX Model, McCubbin and Patterson
view family crisis as one phase in the continuum of family
adjustment to stress over time. They introduce the concept of
family adaptation as one possible outcome for the course
families may follow after experiencing crisis. Adaptation
involves the processes of "stimulus regulation, environmental
control, and balancing" to achieve a level of functioning which
preserves family unity and enhances the family system, member
growth, and development. Such balancing is a difficult process
which involves assimilation, accomodation, and compromise.

Applications: Case Examples

The Double ABCX Model has proven to be a useful framework in
which to consider the impact of coping with cerebral palsy on
families. A study by McCubbin, Nevin, Cauble, Larsen, Comeau,
and Patterson (1982) revealed that in families of cerebral palsy
children, family members are called upon to respond to the
ever-changing needs and demands made by the disease. Family
responsibilities and tasks shift and change in response to the
child's changing medical condition as well as to his/her
normative developmental changes. Postulates derived from the
Double ABCX Model were useful in explaining which families were

most likely to be vulnerable to crisis. As such, the families most vulnerable to crisis were those in which a pile-up of life event strains were experienced and where neither mother nor father had yet developed coping behaviors needed to manage the stressors. The parallels between the tasks of caregivers of cerebral palsy victims and those who care for impaired elderly will become clear in the following case histories.

In the first case, the identified patient, Mr. R. is a 71-year-old former salesman diagnosed as suffering from dementia and Parkinson's disease. His illness has resulted in behavior problems during the past three years which include day-night reversal, paranoia, and hallucinations upon which he acts. His primary caregiver is his 67 year old wife with whom he lives. Mrs. R. felt that she was forced to give up her job selling real estate in order to care for her husband. The couple have two daughters, both in their early 40's; one who lives with her husband down the hall from the R's, the other who lives within a half hours' drive. They have 5 grandchildren, 4 of whom live within a half-hour drive. The grandchildren range in age from 18 to 25. Despite the close proximity within which the family lives, the two younger generations are estranged from the R's.

The R's have a housekeeper 5 days a week, but Mrs. R. has taken full responsibility for caring for her husband. She was feeling overwhelmed when we talked. In addition to the demands

placed on her by her husband's illness, she still mourns for a sister who died three years ago and her mother who died 4 years ago following Parkinsons disease. Mrs. R. had full responsibility for caring for her mother during her 4 year illness. Mrs. R. is in good physical health yet complains of high blood pressure and occasional itching of her arms. She has stopped socializing outside of her home, but talks frequently on the phone with her sister and a friend whose husband also suffers from dementia.

Talking to Mrs. R. makes it clear that she feels she is in need of some form of help. Surrounding her is a web of uninvolved persons including her daughters and grandchildren, and a group of semi-involved persons including her housekeeper, sister, and telephone friend. She has a number of unresolved issues with which to deal, including her relationships with her daughters and the deaths of her sister and mother. Appropriate therapeutic intervention would take the following 3-part form: (1) Short-term counseling which would allow Mrs. R. to work through her unresolved issues; (2) strategic work to strengthen the existing web and enlarge the support available to Mrs. R; and (3) some form of respite care. (As we can see, all three elements of the task trio, grieving, caregiving, and development--are addressed.) A program which could serve both the second and third goal was suggested by Mrs. R. herself.

When asked what type of program she would like to see put into action to help people like herself she suggested that what was needed was a place where family members could go with their impaired relative to have fun. This could be in the form of an evening of musical entertainment or an afternoon of bingo. Her point was very much grounded in a web perspective. Her need was not for a "drop-off" respite center nor a support group. Rather it was a suggestion guided by the desire to maintain the integrity of the web, while providing strengths in the form of opportunities for socializing and meeting new people experiencing similar problems.

In the second case, the identified patient, Mrs. M. is a 90-year-old woman suffering from dementia and requiring total care for the past year. She lives with her 92 year old husband who is himself in poor health, yet quite able to manage for himself, and their 35-year old unmarried son who is a university professor. Dr. M., the son, has become primary caregiver to his mother. He was beginning to feel that the care required by his mother was jeopardizing both his relationships with his girlfriend, who often helped him care for his mother, as well as his ability to work. Dr. M. had recently been hospitalized for kidney problems during which time Mom was sent up North to live with another son. Mr. M. was quite able to take care of himself during this time, in fact, during the two weeks time, Dr. M.

described his father as "blossoming" in a way he had not seen for a long time.

The web in this case is larger and more involved than in the first case. Although Dr. M. was primarily responsible for his mother's care, his brother, father, and girlfriend were also active. Dr. M.'s illness, and the events surrounding it suggest a strategy for intervention. Transferring Mrs. M. from her home to a nearby nursing home would enable her to get the nursing care she needed; Dr. M., to carry out his own developmental tasks which included producing on the job and forming a permanent relationship with his girlfriend; and Mr. M. to continue to function independently in the community. Interventions that probably would not have been effective in this situation include support groups, respite care, or the family center idea suggested by Mrs. R..

Baltes & Danish (1980) state that " a comprehensive view of intervention needs to consider the interaction and joint impact of environmental and biological systems." Here lies the heart of perhaps the most fundamental, yet most overlooked aspect of therapeutic intervention with caregiving adults. Difficulties presented by caregivers are enveloped by a biolgical-psychological-social umbrella and must be responded to as such.

An Interdisciplinary Problem

The current state of affairs regarding caregiving adults is
that we have recognized the problem as multidimensional, yet
have failed to respond appropriately. We have realized that
caregiving adults need the attention of medical doctors, nursing
staff, social workers, psychologists, and chaplains, but have
responded as disjunct entities. We are guilty of having been
multidisciplinary rather than interdisciplinary. Our problem is
similar to that of a chef who has assembled all of the
ingredients necessary to make a souffle and then neglects to
turn on the oven. Like the chef, we are doomed to failure
before we begin.

A more productive approach to therapeutic intervention
requires that each discipline bring forth its knowledge and
expertise in a manner conducive of exchange. This requires both
a security within one's own discipline which opens up its
assumptions to challenge and a willingness to relinquish or at
least define the jargon which prohibits communication between
disciplines. It is only by extending ourselves beyond the
traditional parameters of a particular professional background
that productive solutions to caregivers' problems may be found.

An integral part of the interdisciplinary professional team
must be the natural care-giving networks, or as Smyer & Gatz
(1979) contend, "professional intervention should support rather

than supplant ongoing networks." Over the past twenty years, we have seen the pendulum swing from a situation in which only professionals were involved in therapeutic intervention to one characterized by the exclusivity of non-professional support groups. Neither is likely to be productive for the problems presented by caregiving adults. A joint venture, however, in which impact and knowledge from professionals and non-professionals coalesces has a greater likelihood for success.

The problems experienced by adult caregivers present a challenge never before faced by those charged with the task of providing therapeutic interventions. The simultaneous tasks of cargivers; grieving for the changes and losses of the former level of competence of their impaired relative, care-giving to palliate the emotional and physical needs of their impaired relative, and individual development require a sensitivity on the part of therapists to identify the task which is most problematic and solutions which will alleviate at least some of the pain. The principles of the life span development orientation and family stress theory provide a firm foundation on which to build. Problem definition and solutions suggested by combining these perspectives have the capacity to alter our thinking and allow us the opportunity to suggest appropriate therapeutic interventions for adult caregivers.

Caregiver Resources

B

A

Stressor

C

Caregiver
Definition
of Stressor

X

CRISIS
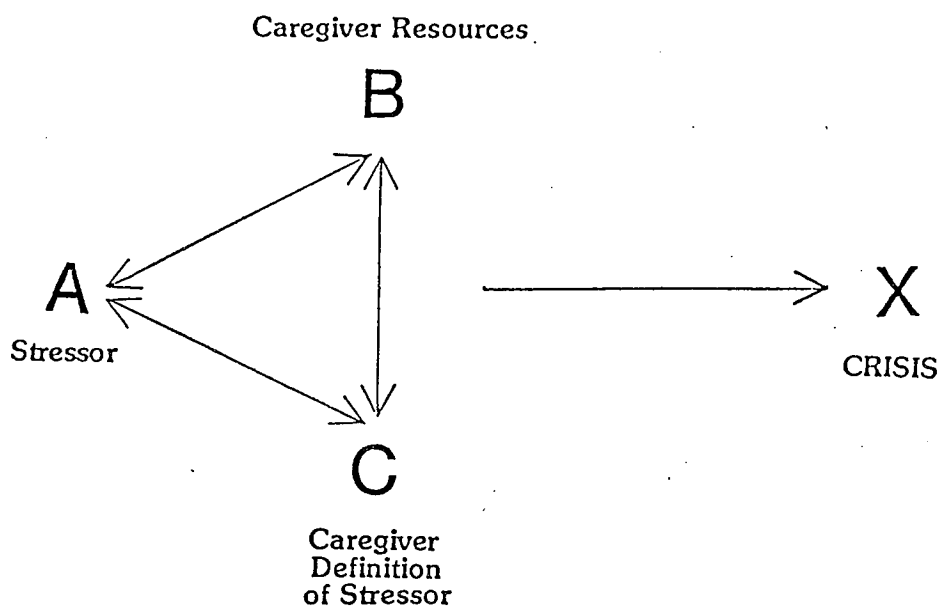
A=Length of illness, behavioral manifestations, demands
  made by impaired relative.

B=Family members' personal resources, family system's
  internal resources, social support.

C=Subjective perceptions/definition of situation.

X=Mental health of family members, associated physical
  sequelae, participation in social and
  recreational activities, continued performance of
  caregiver tasks.

Double ABCX Theory – Figure 2
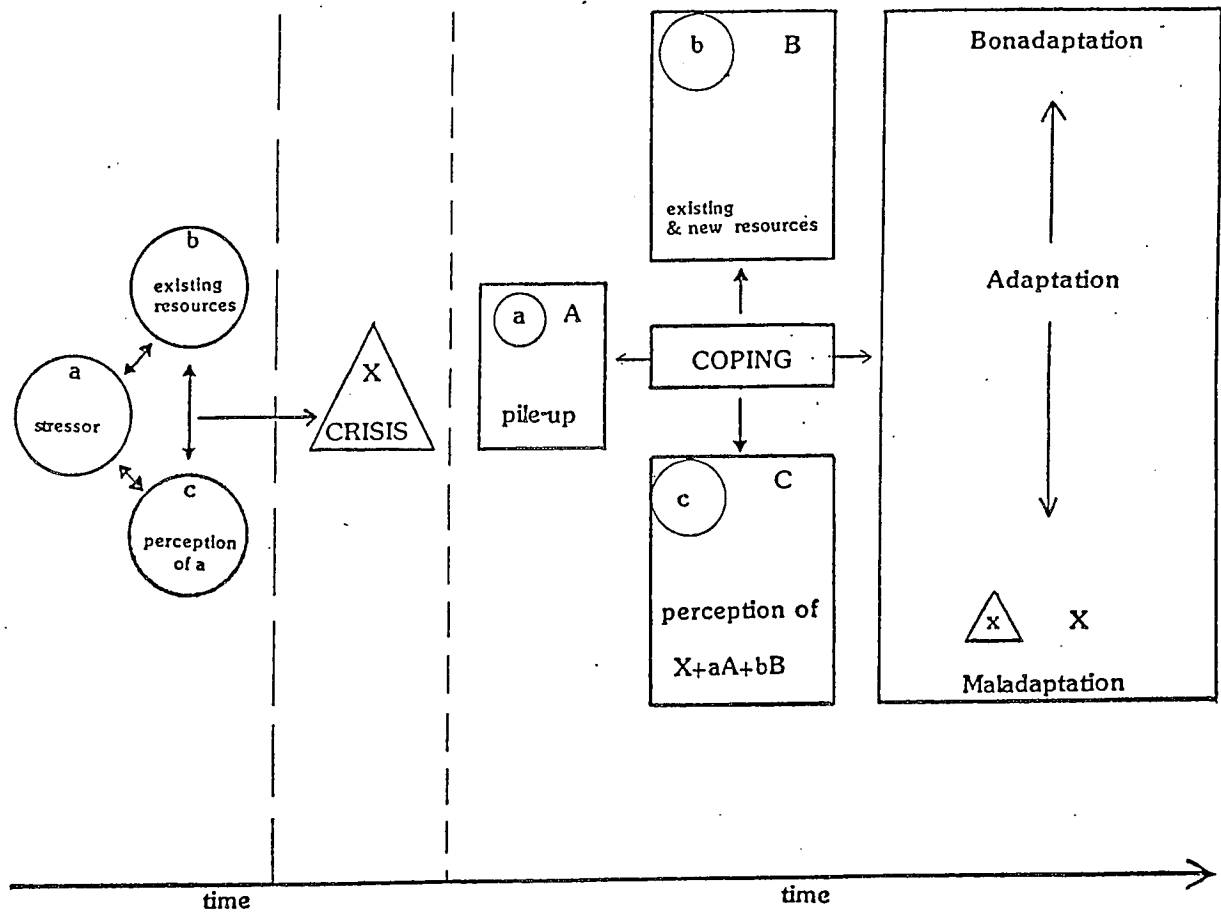
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